Coordinated Entry System
Policies and Procedures
Region 3

Counties of:
Allen, Adams, DeKalb, Huntington, Lagrange, Noble, Steuben, Wells, and Whitley
Coordinated Entry Policies and Procedures

PURPOSE
The State of Indiana has implemented a state-wide Coordinated Entry (CE) program in its effort to end homelessness. This new system provides a process for entry, assessment, scoring, eligibility determination, prioritization, and referral for homeless housing and services. The Coordinated Entry process utilizes one standardized assessment, the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT), for all households entering the homeless services system. This tool will be administered at community entry points throughout Indiana’s Balance of State. Using this assessment process, Indiana regions will efficiently and fairly allocate resources by prioritizing severity of service needs and vulnerability using policies established by Indiana Balance of State Continuum of Care.

VISION
For households experiencing a housing crisis or homelessness, consumers are quickly assessed and offered appropriate interventions that align with their needs and will resolve the crisis. Our 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.
BASIC 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 one (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** – 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)
- **Consumer** – Person at-risk of or experiencing homelessness or someone being served by the Coordinated Entry process.
- **Coordinated Entry Liaison** - Responsible for HMIS data entry, client engagement, regularly scheduled follow-up and coordinating assessment site.
- **Coordinated Entry Steering Committee** – Responsible for proving guidance for the Indiana BOS CoC in creating, implementing and updating policies and procedures for the Coordinated Entry system statewide. The committee consists of Regional Chairs, Lead Agencies and Indiana Housing and Community Development Authority (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.
- **HEARTH** – Homeless Emergency Assistance and Rapid Transition to Housing Act
- **Homeless Management Information System (HMIS)** – A “local information technology system used to collect consumer-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 HMIS software solution that complies with HUD’s data collection, management and reporting standards.” (24 CFR Parts 578.7 and 580.3)
- **Housing Interventions** – Housing programs and subsidies; these include emergency shelter, rapid re-housing and permanent supportive housing programs, SSVF and HUD VASH.
- **Lead Agency** – Lead agencies from each of the 16 Regions 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.
- **List Managers** – Main contact persons responsible for updating, monitoring, and managing the Prioritization List for the region.
- **Project/Program/Provider** – Any organization in the CoC that provides services or housing to people experiencing or at-risk of homelessness.
- **Region** – The Indiana BOS CoC is made up of 16 Regions. Each region contains from one (1) to as many as 10 counties. SEE EXHIBIT A. Region 3 is made up of nine counties. SEE EXHIBIT B.
- **VI-SPDAT** – Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) as created and owned by Community Solutions and OrgCode Consulting, Inc. Standardized Assessment Tool 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 must complete required training through OrgCode Consulting, Inc., creator of the tool.
OVERVIEW

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 of coordinated entry include:

- A designated set of coordinated entry locations and staff members;
- The use of standardized assessment tools to assess consumer needs;
- A centralized wait list per region to prioritize referrals, based on the results of the assessment tools, to homelessness assistance programs (and other related programs when appropriate);
- Matching consumer needs to housing interventions through a “needs-first” approach versus a “first come, first served” approach; and
- Targeted and coordinated referrals tailored to household match for both the consumer and agency and coordinated across region.
- Wrap around services to support individuals on the waitlist and those being housed.
- Diversion efforts for those facing potential homeless situations.

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 a national best practice. When implemented effectively, coordinated entry can:

- Reduce the amount of research and the number of phone calls people experiencing homelessness must make before finding crisis housing or services;
- Reduce new entries into homelessness through coordinated system wide diversion and prevention efforts;
- Prevent people experiencing homelessness from entering and exiting multiple programs before getting their needs met;
- Reduce or erase entirely the need for individual provider wait lists for services;
- Foster increased collaboration among homelessness assistance providers; and
- Improve a community’s ability to perform well on Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act outcomes and make progress on ending homelessness.
- Identify opportunities to divert individuals from entering the Coordinated Entry System.

Coordinated Entry Guiding Principles

The goal of the Coordinated Entry process is to provide each consumer with adequate services and supports to meet their housing needs, with a focus on returning them to housing as quickly as possible.

- **Consumer Choice**: Consumers will be given information about the programs available to them and have some degree of choice about which programs they want to participate in. They will also be engaged as key and valued partners in the implementation and evaluation of Coordinated Entry process 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 among 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 among partners, and consistent reporting on the performance of the coordinated assessment 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 consumers need the most will be used to assist with reallocation of funds and other funding decisions. To capture this data accurately, all assessment staff must enter data into HMIS (with the exception of some special populations) in a timely fashion. Consumers’ 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 waiting 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 will most likely to reduce the average length of episodes of homelessness and result in better housing outcomes for all.

**Target Population**

This process is intended to serve people experiencing homelessness and those who believe they are at imminent risk of homelessness. Homelessness will be defined in accordance with the official HUD definition of homelessness. People at imminent risk of homelessness are people who believe they will become homeless, according to the HUD definition, within the next 72 hours. People who think they have a longer period of time before they will become homeless should be referred to other prevention-oriented resources available in the community.

This coordinated assessment process was developed primarily for residents of Region 3. In cases where it is forbidden by their funders or local, state, or federal law, providers may not be able to serve individuals who do not have adequate proof of residence in Region 3. Assessment staff will attempt to link consumers that fall into this category with resources that may be available in their area of origin or wherever they are currently staying.
Coordinated Entry Prioritization Policy

Region 3 has adopted 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>
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</thead>
<tbody>
<tr>
<td>Diversion</td>
<td>All Persons seeking assistance via Coordinated Entry</td>
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<tr>
<td>Permanent Supportive Housing **</td>
<td>Persons experiencing chronic homelessness</td>
<td>1. Longest history of homelessness</td>
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<td></td>
<td>VI-SPDAT scores of 8+ for Single Household and 9+ for Family Household</td>
<td>2. Most severe service needs as determined by VI-SPDAT</td>
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<td></td>
<td>Refer to HUD Guidelines/Prioritization</td>
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<tr>
<td>Rapid Re-Housing</td>
<td>Persons literally homeless</td>
<td>1. Length of homelessness</td>
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<td>SSVF</td>
<td>Veterans experiencing homelessness</td>
<td>2. Regional Prioritization</td>
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<td></td>
<td>VI-SPDAT Score of 6+</td>
<td>Veterans</td>
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<td>Youth</td>
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<td>Families</td>
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<td>Domestic Violence Survivors</td>
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<td></td>
<td>Single Adults</td>
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<tr>
<td>Emergency Shelter</td>
<td>Persons literally homeless and not diverted</td>
<td>3. Date and time of Assessment</td>
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<td></td>
<td></td>
<td>(Only in tie breaker situation)</td>
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<tr>
<td>Referrals to Mainstream Resources</td>
<td>VI-SPDAT Score 0-5</td>
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As the Coordinated Entry System continues to evolve, regional decision-making and prioritization needs will continue to be taken into consideration. If necessary, VI-SPDAT scoring ranges may be adjusted based on consumer need and program availability.

** 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.

KEY COMPONENTS OF COORDINATED ENTRY IN REGION 3

Coordinated Assessment

A key aspect of the Coordinated Entry process in Region 3 is the physical and mobile access points. All people experiencing homelessness or at imminent risk of homelessness should be directed to call Brightpoint’s Coordinated Entry Phone Line. A trained Brightpoint Family Development Worker (FDW) will screen each caller to determine if they are literally homeless and eligible for a Coordinated Entry assessment. The FDW will add the Consumer’s information to Brightpoint’s Coordinated Entry Call Log and record the client’s name, phone number, date they called, whether or not they are a veteran, which FDW returned the call and when, along with notes on information provided by the client regarding their current housing situation. Consumers who qualify for a Coordinated Entry assessment are provided with information about the Coordinated Entry assessment process and location. Any barriers (language, transportation, etc.) to completing the assessment are also explored.

The main centralized assessment site is located at Trinity English Lutheran Church in downtown Fort Wayne. Staff from Just Neighbors Interfaith Homeless Network, Brightpoint, and Park Center’s PATH Team are present two afternoons per week for in-person assessments.

For individuals living outside of Allen County and in counties where Brightpoint offers services in Region 3, Brightpoint may complete a VI-SPDAT assessment with the consumer in their community of residence.

In Allen County, the Park Center PATH team also completes assessments with those unsheltered individuals they interact with and are available to connect with individuals who are not able to come to the assessment site. This includes completing assessments at the Rescue Mission two days each week.

No additional locations may become designated assessment centers without approval from the Region 3 Local Coordinated Entry Steering Committee. Interested parties should submit a written proposal that aligns with these Policies & Procedures. Current Policies & Procedures will be amended with approved proposals.

System Entry

Consumers presenting at agencies other than the Coordinated Entry assessment site seeking homelessness assistance services will be referred to Brightpoint’s Coordinated Entry Phone Line to better understand their situation and identify diversion opportunities. If appropriate for Coordinated Entry, the consumer is provided information about the Coordinated Entry Process, assessment site location, and assessment hours. Any barriers (language, transportation, etc.) to completing the assessment are addressed. Consumers presenting at the Coordinated Entry assessment site seeking
homelessness assistance services will be screened using the Homeless Verification Screening tool to better understand their situation and identify diversion opportunities.

If a consumer is unable to make the call themselves, every effort should be made by the agency where they present to assist the consumer in connecting with Brightpoint. **It is prohibited for any Rapid Re-Housing or Permanent Supportive Housing program to admit or serve consumers without them having first gone through the coordinated assessment process and received a referral to their agency.**

**Assessment**

Coordinated Entry staff in Indiana will administer the VI-SPDAT assessment tools in its Coordinated Entry system. The process for those referred to Coordinated Entry after being assessed using the Homeless Verification Screening tool is as follows:

1. CE Greeter will present the consumer the Consent Forms (EXHIBITS C, D, & E) either in paper form or electronically. The CE Greeter will go over the forms with the consumer and explain what data will be requested, how it will be shared, whom it will be shared with, and what the consumer’s rights are regarding the use of the data. The CE Greeter will be responsible for ensuring consumers understand their rights as far as release of information and data confidentiality.
2. CE Assessor will explain the assessment process to the consumer and answer any questions presented by household/consumer.
3. CE Assessor will complete HMIS Coordinated Entry Intake Form.
4. The appropriate VI-SPDAT assessment will be administered per instructions.
5. Consumers are provided a receipt (EXHIBIT F) and informed of the following:
   a. If eligible, their name will be added to a pool of applicants who need housing. They will be contacted if housing that meets their individual needs becomes available. The wait could be weeks, or months, even years. There is no guarantee of assistance and they should continue to work on finding other solutions to their housing problem.
   b. Changes should be reported by contacting Brightpoint’s Coordinated Entry Phone Line.
   c. After 90 days, if the consumer’s homeless situation hasn’t been resolved, they will need to be reassessed.
6. Consumers who do not score for placement on the Coordinated Entry Prioritization List will be contacted directly.
7. All Consumers will be provided a Resource Packet of community information

All defined access point providers must administer the VI-SPDAT assessment tool according to HUD standards. The Coordinated entry process operates using a consumer-centered approach, allowing consumers to freely refuse to answer assessment questions and/or refuse referrals.

To ensure transparency in consumer care coordination and decision making, all CE participants receiving a comprehensive assessment and referral to a Region project must be offered written documentation of next steps. This receipt of CE assessment and referral process should include Brightpoint’s Housing Phone Line and directions for updating personal information as well as the date when the client will need to be re-assessed. SEE EXHIBIT F.
A note on data collection: **Consumers who do not agree to share their data through the Homeless Management Information System (HMIS) on the Consumer release of information (ROI) form should never have their data entered into HMIS.**

**Case Conferencing**

The Lead Agency holds a weekly Case Conferencing meeting with other CE agencies including, but not limited to: Brightpoint, Fort Wayne Housing Authority, Just Neighbors, Vincent Village, Park Center, The Rescue Mission, Cedars Hope, The VA and YWCA DV Shelter staff. These agencies collaborate to review the most recent assessments entered through Coordinated Entry.

When reviewing each assessment, the group discusses intermediate and long-term action plans for the client. At least one staff person will be on the case for each client, working through goals with them as they stay on the Prioritization List. The long-term goal is usually defined as which housing program the client is deemed eligible for.

Case Conferencing participants also review the Prioritization List to provide updates on clients and report any housing changes. This is also a time to recognize which clients are due for a 90-day re-assessment.

**Coordinated Entry Referral Process**

The CE Liaison is responsible for coordinating appropriate housing and service matches. This is achieved by understanding the 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. These criteria should be provided and kept updated with the Lead Agency. The CE Liaison is responsible for evaluating HMIS data and monitoring follow-up activities. Individuals and families are matched to appropriate housing opportunities, based on appropriateness, availability and in accordance with the CES Policy & Procedures regarding prioritization (see below).

The referral process consists of the following steps:

1. Housing Provider notifies the CE Liaison when they have an open unit/bed
2. CE Liaison completes final Homeless Verification Screening, Housing Provider Screening and provides a list of items for consumer to start gathering.
   a. If CE Liaison is unable to locate Consumer, three documented contacts made on three different days will be provided to Lead Agency
   b. Lead Agency exits client from CE in HMIS
   c. Lead Agency notifies Housing Provider that referral was not successful
   d. CE Liaison attempts to contact the next Consumer to be referred.
   e. This process is repeated until referral is successful or list of potential referrals has been exhausted
3. The CE Liaison provides completed screenings to Lead Agency.
4. The Lead Agency will inform the Housing Provider of a match by secure fax or secure email and provide referral packet that includes:
   a. HMIS Coordinated Entry Intake Form
   b. Signed Consent Forms
   c. VI-SPDAT Assessment
5. The Lead Agency will document confirmation that information was sent to Housing Provider by updating the client’s Referrals in HMIS.
6. The Housing Provider will contact consumer, verify eligibility, advise the Consumer of the housing opportunity, and determine interest, within ten (10) business days. It is critical that a minimum of three attempts on three different days are made and documented
7. If the Consumer agrees to pursue housing opportunity, they are given appropriate directions, contact information, any needed referral forms and transportation assistance (if eligible) to the Housing Provider
8. Housing Provider will conduct housing intake
9. Housing Provider must notify Lead Agency of outcome of the referral within 3 business days, including the date the Consumer was housed
   a. If referral is rejected, Housing Provider must notify Lead Agency of reason utilizing process below
10. If a Consumer is housed they will be exited from the Coordinated Entry workflow by Lead Agency within 3 business days

Coordinated Entry Prioritization

Permanent Supportive Housing

Permanent Supportive Housing (PSH) is permanent housing with indefinite leasing or rental assistance. PSH is paired with supportive services to assist homeless persons with a disability or families with a disabled adult or child member with a disability achieve housing stability.

Eligibility Criteria

- Households must meet the HUD definition of homelessness
- One adult in the household must have a qualifying disability
- Programs may not establish additional eligibility requirements beyond those specified here and those required by funders or other stakeholders.

Prioritizing Dedicated/Prioritized CoC

- Chronically Homeless Individuals and Families with the Longest History of Homelessness
- Most severe service needs as determined by VI-SPDAT
- Refer to HUD Guidelines/Prioritization for additional prioritization

In instances where two or more households have equal priority, applicants will be further prioritized as follows:
- Veterans Not Eligible for Housing/Health VA Services
• Victims of Domestic Violence
• Youth (18 – 24 years of age)
• First presented for assistance

Rapid Re-Housing

Rapid Re-housing (RRH) is available to help those who are homeless become quickly and permanently housed. RRH Projects provide housing relocation and stabilization services and short or medium term rental assistance as needed to help a homeless individual or family move as quickly as possible to permanent housing and achieve stability in that housing.

Eligibility Criteria for RRH

- CoC Program RRH
  - Households must meet the HUD definition of homelessness.
  - Programs may not establish additional eligibility requirements beyond those specified here and those required by funders or other stakeholders

- ESG Program RRH
  - Households must meet Category 1 or Category 4 the HUD definition of homelessness.

- SSVF Program RRH
  - Households must be a qualifying “Veteran family”.
  - Households must be “Very low-income” (income does not exceed 50% of area median income).
  - Household must be literally homeless, and at risk to remain in this situation but for grantee’s assistance.

Prioritizing for Rapid Re-Housing Programs

- CoC & ESG Program RRH
  - Eligible participants are referred to the Rapid Re-housing program for which they are eligible and prioritized based the following prioritization:
    1. Length of homelessness
    2. Regional Prioritization
       - Veterans
       - Youth
       - Families
       - Survivors of Domestic Violence
       - Single Adults
    3. Date and time of Assessment (Only in tie breaker situation)

- SSVF RRH
  - Eligible participants will be prioritized or targeted based on the agreed upon standards set forth in the provider’s SSVF grant agreement.
Referral Rejection/Decline Process

Client cannot be located – The Housing Provider will contact the Consumer within (10) business days. It is critical that a minimum of three attempts on three different days are made and documented. This documentation should be emailed to the List Managers who will log those attempts in HMIS. If the Housing Provider is unable to locate the client within ten (10) business days the Coordinated Entry Referral Process will be utilized to refer the next appropriate Consumer.

Client is not actually eligible – In the event that the Consumer is determined to be ineligible, the Housing Provider should inform them of ineligibility. The Housing Provider should notify the Lead Agency of the ineligibility (including reason) within 24 hours of notifying Consumer. The Consumer will be immediately placed back on the prioritization list at the appropriate priority level by the Lead Agency. The Coordinated Entry Referral Process will be utilized to refer the next appropriate Consumer.

Client declines housing opportunity – In the event that the Consumer declines the housing opportunity, the Housing Provider should notify the Lead Agency of the denial (including reason) within 24 hours. The Consumer will be immediately placed back on the prioritization list at the appropriate priority level by the Lead Agency. The Coordinated Entry Referral Process will be utilized to refer the next appropriate Consumer.

Housing Provider declines the referral – In the event that the Housing Provider does not agree that the referred individual or family meets the eligibility requirements, the Housing Provider must provide a written explanation to the Lead Agency. The Coordinated Entry Referral Process will be utilized to refer the next appropriate Consumer. Housing Providers may only decline clients based on established project eligibility criteria. The Region 3 Local Coordinated Entry Steering Committee will be monitoring agencies’ referral rejection rates and rationales and will provide additional information on the expectations of the system and seek clarification on program eligibility and requirements for housing providers who frequently decline referrals.

Veteran Assessments

1. All Veterans coming to the Northern Indiana Health Care System (NIHCS) Homeless Walk-in Clinic in Fort Wayne, identified through outreach in Region 3 by the VA or any other community outreach, or identified by any other agency, shelter, etc., who are assessed as literally homeless, will be referred to Brightpoint by calling 260-423-3546, ext. 332 and leaving a message. Brightpoint may complete the CE Evaluation (i.e., VI SPDAT and HMIS data collection) or refer them for a CE Evaluation either by the VA NIHCS Coordinated Entry Specialist (CES), other trained VA NIHCS Social Workers, or through the CE site at Trinity English Lutheran Church during screening hours (currently Monday and Friday afternoons, 1pm-4pm). (NOTE: VA NIHCS staff may also do a “warm hand-off” to the Supportive Services for Veterans and Families (SSVF) Program Manager at Brightpoint.) Exceptions will be made for those entering Transitional Housing (TH) as noted below.
   a. While awaiting a CE Evaluation, any literally homeless or at risk Veteran may be referred to VA NIHCS TH and/or local shelters. NOTE: Any community agency, shelter, outreach
team, etc., may refer a Veteran to VA-sponsored TH by calling 800-360-8387, ext. 72668 or by contacting the Homeless Outreach Worker at ext. 72016 or (cell) 260-760-0859. Veteran may also self-refer as above or by going to the VA NIHCS walk-in clinic located at the VA NIHCS Outpatient Annex, 2500 E. State Blvd, Fort Wayne, IN 46805.

b. If a homeless Veteran is admitted to a Grant and Per Diem type of TH without going through the CE Evaluation process, and he/she is not eligible for VA health care services, he/she will be immediately referred to Brightpoint by calling 260-423-3546, ext. 332 and leaving a message.

c. If a Veteran is admitted to any VA-sponsored TH program prior to CE Evaluation, they may not be referred to CE under the following conditions:

   i. HUD-VASH Resources are available to the community through CE for all eligible Veterans referred to NIHCS who score 9 or above on the VI SPDAT, and enough other HUD-VASH vouchers are available to meet the needs of those in TH who qualify. Notwithstanding, the Veteran will still be referred for CE Evaluation if he/she wants/needs PSH but does not want a VASH voucher.

   ii. The Veteran, in collaboration with the TH Case Manager, has a plan for self-resolving his homelessness or wants a referral to a PSH or other resource outside of Region 3.

2. Veterans scoring 8 or above on the VI SPDAT may be referred to the VA homeless team for evaluation of a HUD-VASH voucher. Vouchers will be issued based on the HUD-VASH Prioritization Chart attached (EXHIBIT G). Referrals may be sent by one of the following methods:

   a. Sending a Fax to 260-421-1029, attn “CES” or “Homeless Outreach Worker.”

   b. Via secure email to either the CES or Homeless Outreach Worker.

3. Veterans scoring 7 or below, if there are no community resources immediately available, may be referred to the VA NIHCS Homeless Outreach Worker for case management. (e.g., The Veteran is either not appropriate for SSVF or the resources are not immediately available due to lack of funds, etc.) The Outreach Worker may be reached by calling 800-360-8387, ext. 72668 or ext. 72016, or by cell phone at 260-760-0859.

4. If the Veteran is chronically homeless or in need of PSH, as assessed by a VA homeless team member, a preliminary referral to HUD-VASH may be discussed while awaiting results of the CE Evaluation and entry into the prioritization list for Region 3. (NOTE: This is currently possible due to the low volume of referrals to HUD-VASH from the CE process and will continue as long as the supply of VASH vouchers exceeds the community’s demand.) Veterans may later choose other available options which could include Emergency Solutions Grant-Rapid Rehousing (ESG-RR), SSVF, or other resources, based on their VI-SPDAT scores, if available.

5. Veterans at risk of homelessness will be referred to Brightpoint for homeless prevention through SSVF, referral to township trustees, or other options.

6. The CE Lead Agency will verify the Veteran status of anyone on the HMIS CE Prioritization List either directly or by contacting CES (800-360-8387 ext. 71662) or Eligibility Clerk (ext. 71008) at VA NIHCS.

7. The CE Lead Agency will refer any Veterans on the HMIS CE Prioritization List to the CES for entry on the By Name List (BNL) by completing the BNL worksheet (EXHIBIT H) and faxing to 260-421-1029 or via secure email to the CES.
8. The CES will place all homeless Veterans on the By Name List (BNL).
9. All Veterans on the BNL will be case conferenced at least monthly to check disposition and progress in obtaining permanent housing.

The CES will share aggregate data from VA Homeless Operations and Management Evaluation System (HOMES) and other VA data sources with Region 3 as requested.

**Process for Lead Agency Assessing DV Clients**

All clients fleeing domestic violence should be referred to Region 3’s domestic violence shelter, the YWCA. The YWCA completes CE assessments for clients on-site, therefore capturing most of the DV survivors in the area. The YWCA then shares the information with the Lead Agency in order to add the client to the Prioritization List.

Should a client come to the Lead Agency Intake Site and report fleeing domestic violence, the Lead Agency will follow every procedure listed in the following section pertaining to consent and protecting the client’s identity, depending on what consent the client gives. Additionally, the Lead Agency should refer the client to the YWCA for safe shelter and additional resources.

**Process for Non ESG/CoC Funded DV Providers**

1. The DV provider will provide the client a brief overview of Coordinated Entry: “Coordinated Entry is a system which is used to identify individuals and families experiencing a housing crisis that are currently homeless or at risk of homelessness. A standardized intake is completed at a Coordinated Entry Access/Intake Site using a standardized assessment tool that measures a client’s vulnerability. The Coordinated Entry process will assist us in identifying which housing assistance type(s) you may qualify and be eligible for. As a DV/SA survivor you have the choice of participating in the process by signing a Client Consent agreeing to have your Personal Identifiable Information (PII) entered into the HMIS database that will be shared with other housing providers in the area, or you may choose to participate in the process by keeping your Personal Identifiable Information (PII) confidential. If you choose to remain anonymous by keeping your PII confidential, we (DV provider) will assign you an Alternate Reference ID (ARI) number that will be forwarded to the Coordinated Entry Lead Agency/Intake Site in our area along with the results of the standardized assessment which we will complete with you here at the shelter. No information that might identify you and/or your children will be shared with the Lead Agency/Intake Site. When a permanent housing opportunity becomes available, the Lead Agency will notify us and we will assist you with moving through the housing process.”

2. If the client agrees to sign the Client Consent and agrees to share their Personal Identifiable Information (PII) and have the information entered into the HMIS database (Option #1 on the Client Consent Form [Exhibit E]), please refer the client to the nearest Coordinated Entry Access/Intake Site within your region.
3. If the client chooses to remain anonymous and not share their PII, the DV provider will complete their normal Client Intake in DV ClientTrack. The **DV provider will then assign the client an Alternate Reference ID number which appears on the “Client Information” screen.** This ARI will consist of a two-character DV provider identifier, the client’s DV ClientTrack Client ID# and a one-digit number as a Lethality Score. The DV provider identifier has been provided to the main contact for your agency as provided to us by ICADV. Please see the main contact person at your agency for the provider identifier. **The client will sign the Client Consent and choose Option #2.**

4. Next, it is important to gather information on the level of client danger by asking these three **Lethality Questions:**
   - a. Has your partner ever used a weapon against you or your children or threatened you or your children with a weapon?
   - b. Do you believe your partner is capable of killing you or your children?
   - c. Has your partner threatened to kill you or your children?

5. If the client answers “Yes” to one question, their **Lethality Score** will be a “1,” two “Yes” answers will be a “2,” and three “Yes” answers will be a “3.” **The Lethality Score is the final character in the client’s ARI.** The Lethality Score enables the Lead Agency/CE Staff to identify the level of client danger once the client is placed on the Prioritization List (PL) for permanent housing.

6. The ARI will look something like this: **XX-XXXXX-X** (XX is the DV provider identifier, XXXXX is the DV ClientTrack Client ID#, and the final X is the Lethality Score).

7. The DV provider will complete a paper “Single” VI-SPDAT for single clients, a “Family” VI-SPDAT for “Families,” or a TAY VI-SPDAT for Transition Age Youth ages 16—24 who are the **Head of Household.** The completed VI-SPDAT displays the client’s vulnerability score. **The DV provider will not write any Personal Identifiable Information on the VI-SPDAT form. The client’s ARI will be used as the Client’s Name and written on the form in the Client Name fields.**

8. The DV provider will then complete the **Referral Form** with the **Client’s ARI** and other non-identifying information. **Next, forward the Referral Form and a copy of the VI-SPDAT to the Lead Agency/Intake Site via secure fax or secure email.**

9. Please indicate the number of bedrooms the Client will need in a housing unit.

10. The **Lead Agency/Intake Site will then enter the client as a CE Intake in HMIS using the ARI. The Lead Agency/Intake Site will also enter the VI-SPDAT using the ARI as the client’s name in the Client Name field. All data fields that are PII and missing will be marked as “data not collected.” The Lead Agency/Intake Site staff will then use the electronic signature pad or mouse to indicate on the Client Consent Form “Paper copy uploaded to client’s file.”**

11. **Lead Agency/Intake Staff will scan the paper Client Consent and upload it to the client’s CE HMIS file.**

12. The client will now appear on the Prioritization List.

13. When the client’s name is next on the Prioritization List and a housing unit becomes available, the Lead Agency will contact the DV provider by telephone, secured email, or secured fax to inform the DV provider’s Case Manager of the opening.

14. The Lead Agency will then complete the bottom section of the client’s original Referral Form with the housing referral information and send the form to the DV provider via secured fax or secured email.
15. The DV provider will share the referral information with the client and if the client agrees to accept the referral, the DV provider Case Manager will assist the Client with contacting the Housing Provider to set an appointment for possible intake.

16. Once the client accepts the housing offer, the client will begin working with the Case manager from the housing agency. **Please follow your agency’s normal “Release of Information” policy when connecting your client with the housing Case Manager.**

17. If the client accepts the referral and is also accepted by the Housing Provider, the DV Case Manager will notify the Lead Agency when the client has moved into the housing unit. **The DV Case Manager will also provide the “Housing Move In Date” to the lead Agency.**
EXHIBIT C

PARK CENTER
909 EAST STATE BOULEVARD FORT WAYNE, INDIANA 46805 (260) 481-2700

Confidential PHI V 8 01.07.16

I request and authorize (Name and address of agency, office, or person):
Name: Park Center  Telephone: 260-481-2700
Address: 909 E State Blvd

To release/request information to/from the following (Name and address of agency, office, or person):
Name: Brightpoint  Telephone: 260-423-3546
Address: P.O. Box 10570

Relationship to client: Service Provider

Regarding (Client): D.O.B.
Address:

This information is for the purpose of (check only one): [ ] Personal Use [ ] Court Proceedings [ ] Benefits Mgmt
[ ] Continuity of Care [ ] Criminal Justice [ ] Employment Issues [ ] Financial Mgmt [ ] Social Services Coordination
[ ] Other: Specify:

[ ] Release is Also valid for exchange of information

The information to be released verbally or in writing is indicated by areas below. Information may be released (check all applicable): [ ] verbally [ ] printed [ ] electronically

[ ] ALL CLINICAL RECORDS (except therapy notes ) [ ] Correspondence
[ ] Assessment [ ] Medication
[ ] Lab [ ] Testing Results
[ ] Progress notes (General) [ ] Other: specify specific report or form: Coordinated Entry
[ ] Psychiatric [ ] Referral
[ ] Transfers / Discharge [ ] SPECIAL RELEASE
[ ] Treatment Plan [ ] Therapy Notes (requires a separate release form)

Specify the treatment period of the information to be released:
From: [ ] To:

I hold harmless Park Center, Inc. in regard to use of information authorized for release or exchange. I understand that the content of my Medical Record may include content related to drug and alcohol use or treatment, infectious disease including HIV/AIDS, and other personal information gained during assessment or treatment. I understand that this form is not required as a condition for treatment and that it may be revoked by me at any time, except to the extent that action has already been taken. According to Park Center, Inc. policy this consent will expire in (60) days unless otherwise stated.

Specify that this consent remain in effect until:

Alcohol and Drug Prohibition of Redisclosure notice:
If the record contains drug or alcohol information, then this information has been disclosed to you from records protected by Federal Confidentiality Rules (42 CFR Part 2). The federal rules prohibit any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is NOT sufficient for this purpose. The federal rules restrict use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

You should understand that the persons or entities to which you are authorizing us to release information (except Alcohol and Drug) may not be governed by HIPPA regulations. Information released to such persons or entities may be subject to redisclosure without your knowledge. IF this concerns you please contact those persons or entities for clarification prior to completing this document.

I hereby state that I have read and fully understand the above statements as they apply to me and may refuse authorization to release any/all information.

I have read and understand the above and acknowledge that it was properly completed prior to my signature. A photocopy of this authorization is as authentic as the original. An original will be retained. I understand that I am entitled to a copy of this consent if I request. Please note that our ELECTRONIC SIGNATURE does fall on the second page of this document.

Client Signature: Date:

Responsible Other Signature: Date:

Responsible Other Please Print:

Witness:

Date:

For Staff Use Only

[ ] Please SEND records to the designated person or agency in Box 2
[ ] This release is for file currently, but can be used to send records as needed.
[ ] Please REQUEST records from the agency named in Box 2

Data Entered into EMR: (name)
HMIS Client Consent

Purpose of this form: This Agency uses the Homeless Information Management System (“HMIS”). HMIS is 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.

Client Informed Consent

By signing this form:

☐ 1) 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.

☐ 2) 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.

☐ 3) 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.

Page 1 of 2
Effective Sept. 19, 2016
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. PII 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.

__________________________  ______________________
Signature of Client or Guardian       Date

__________________________  ______________________
Signature of Agency Witness       Date
Coordinated Entry
Permission to Share Confidential Information to Secure Necessary Services

Permanent Supportive Housing and Rapid Re-Housing providers in Indiana are participating in a coordinated entry process in which one common assessment tool is utilized for individuals and households that are in need of homeless assistance. Based on a thorough assessment using the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) assessment tool, eligibility and prioritization are determined and a coordinated referral is made to the most appropriate housing provider.

I authorize the personnel of United Way of Allen County 2-1-1, Brightpoint, and Park Center to gather basic demographic information, information about a possible disabling condition (substance abuse, mental illness, developmental disability, physical disability, HIV/AIDS), information about other medical conditions and my history of homelessness.

I authorize United Way of Allen County 2-1-1, Brightpoint, and Park Center to share my identity, the information collected on the VI-SPDAT and my need for housing and support services to the individuals, groups, or agencies listed below.

I understand that by participating in this assessment process there is no guarantee of housing. If eligible, my name will be added to a pool of applicants who need housing. I will be contacted if housing that meets my individual needs becomes available. My wait could be weeks, months, even years. There is no guarantee of assistance and I should continue to work on finding other solutions to my housing problem. If there is a change in my situation or contact information I must notify 211.

My signature authorizes the release of relevant and necessary information to the agencies and individuals below:

- United Way of Allen County 2-1-1
- Brightpoint
- Park Center, Inc.
- Bowen Center
- Northeastern Center
- Mental Health America – Cedar’s Hope
- Fort Wayne Housing Authority - Ready to Rent
- Veteran’s Administration
- Just Neighbors – Interfaith Hospitality Network
- The League
- Genesis Outreach
- Vincent Village
- Shepherd’s House
- Indiana Housing and Community Development Authority
- Huntington House & Second Chance Recovery
- YWCA Northeast Indiana
- The Rescue Mission
- Noble House Ministries, Inc.
- Turning Point of Steuben County, Inc.

Signature: _______________________________ Date: ______________________

Witness: _______________________________ Date: ______________________
We are unable to give you an anticipated length of time that you may be on the list. There is NO guarantee of assistance. Please continue to explore all other available options to address your housing crisis. If you have not obtained housing by the above date, please return to this Coordinated Entry site to be re-assessed.

**IMPORTANT** If there is a change in the information you provided or with your housing/homeless status, please call us at 260.423.3546 ext. 332 and leave a detailed message with the updated information.

*** We are unable to return calls and provide information regarding your status.
**EXHIBIT G**

*(Highest Priority = 17 / Lowest Priority = 0)*

<table>
<thead>
<tr>
<th>PRIORITY LEVEL</th>
<th>LEVEL CHARACTERISTICS</th>
</tr>
</thead>
<tbody>
<tr>
<td>17</td>
<td>Chronically homeless Veterans with disability and with children in their custody</td>
</tr>
<tr>
<td>16</td>
<td>Chronically homeless Veterans without disability but with children in their custody</td>
</tr>
<tr>
<td>15</td>
<td>Chronically homeless Veterans returning from combat in Iraq or Afghanistan (OIF)</td>
</tr>
<tr>
<td>14</td>
<td>Chronically homeless female Veterans</td>
</tr>
<tr>
<td>13</td>
<td>Chronically homeless Veterans with a disability</td>
</tr>
<tr>
<td>12</td>
<td>Chronically homeless Veterans meeting no above criteria</td>
</tr>
<tr>
<td>11</td>
<td>Homeless Veterans with disability and with children in their custody</td>
</tr>
<tr>
<td>10</td>
<td>Homeless Veterans without disability but with children in their custody</td>
</tr>
<tr>
<td>9</td>
<td>Homeless Veterans returning from combat in Iraq or Afghanistan (OIF)</td>
</tr>
<tr>
<td>8</td>
<td>Homeless female Veterans</td>
</tr>
<tr>
<td>7</td>
<td>Homeless Veterans with a disability</td>
</tr>
<tr>
<td>6</td>
<td>Homeless Veterans meeting none of the above criteria</td>
</tr>
<tr>
<td>5</td>
<td>Veterans who are at risk of homelessness with children and a disability</td>
</tr>
<tr>
<td>4</td>
<td>Veterans who are at risk of homelessness without a disability but with children in their custody</td>
</tr>
<tr>
<td>3</td>
<td>OEF / OIF Veterans who are at risk of homelessness</td>
</tr>
<tr>
<td>2</td>
<td>Female Veterans who are at risk of homelessness</td>
</tr>
<tr>
<td>1</td>
<td>Veterans who are at risk of homelessness with a disability</td>
</tr>
<tr>
<td>0</td>
<td>Veterans who are at risk of homelessness meeting no above criteria</td>
</tr>
</tbody>
</table>

- Exceptions are made based on clinical judgment with the approval of the HUD/VASH Supervisor - Coordinator.
BNL Master Worksheet

This Worksheet is to (Circle One): ADD A VETERAN EXIT A VETERAN UPDATE ANY ITEMS

Region: __________ County: ____________ Veterans Name (L, F): ________________

HMIS ID: _______ HOMES ID: ___________ ROI Signed: ___Yes ___No (attach copy)

List Status (circle one): Active, Unsheltered
- Active, ES/TH
- Inactive (unknown/missing)
- Inactive (Permanently Housed)
- Inactive (non-permanently housed)

Date Veteran ID’d: __________ Last review/update: ____________

Veteran Status Verified: YES NO VHA Eligible: YES NO SSVF Eligible: YES NO

Last Known location: ___________________________________________________________________

PSH Plan/Track (circle one): SSVF; other RRH; VASH; Other PSH; PH; self-resolve/no assist; none currently

Expected PSH Date: __________

Chronic Status: _______Chronic _____ Non-Chronic

Check all that apply:

_____ “continuously homeless 12 months”
_____ “homeless at least 4 times in past 3 years”
_____ “12 plus months total in last 3 years”

_____ Long Term Homeless Status (Meets the length requirements above but does not have a disabling condition or uses VA transitional housing to meet the length requirements above)

Veteran Email or Phone if known: ___________________ Veteran DOB: ______________

Assessment conducted: ___________________ Score (if applicable): __________________

Provider Name & Contact: ___________________

Current Project enrollment type: ____________ Date PSH Plan Created: ______________

PSH Plan Notes: ____________________________________________________________________

*NOTE: VETERAN SHOULD NOT ENTER TRANSITIONAL HOUSING UNLESS HE/SHE HAS BEEN OFFERED PERMANENT HOUSING AND EITHER TURNED IT DOWN OR IS GOING INTO A BRIDGE HOUSING BED.
Date of move to TH/GPD: __________ Date Exit TH/GPD: __________

Date of Permanent Housing Placement: ________________ Exit Destination (circle one):

- owned by client, no ongoing subsidy
- rented by client, no ongoing subsidy
- rented by client, with VASH ongoing subsidy
- staying with family-permanent
- owned by client, ongoing subsidy
- permanent housing for formerly homeless person
- rented by client with other ongoing subsidy
- staying with friends-permanent

Date of Non-PSH Placement/Exit: __________

Exit Destination (circle one):

- Deceased
- Foster care
- jail/prison
- psych facility
- family-temp
- SUD tx or detox facility
- no exit interview
- hospital or other residential non-psych medical facility
- hotel/motel paid without emergency shelter voucher
- long-term care facility/nursing home
- residential with no homeless criteria
- friends-temp
- other
- client doesn't know

Exit Notes: ______________________________________

Veterans Status Verification: ___ DD214 ___ HINQ Other: ________________

Discharge: __________ Dates of Service: __________ Service Component: __________

Notes & Other info: ______________________________________

_________________________________________________________________________

_________________________________________________________________________

Date of PSH Offer: __________ Type Offered: __________ Accept/decline Date: __________

Date of PSH Offer: __________ Type Offered: __________ Accept/decline Date: __________

Date of PSH Offer: __________ Type Offered: __________ Accept/decline Date: __________

Provider: ___________________________ Date: __________