BoS SSO Coordinated Entry Guidebook

BoS SSO CE Coordinated Entry Guidebook

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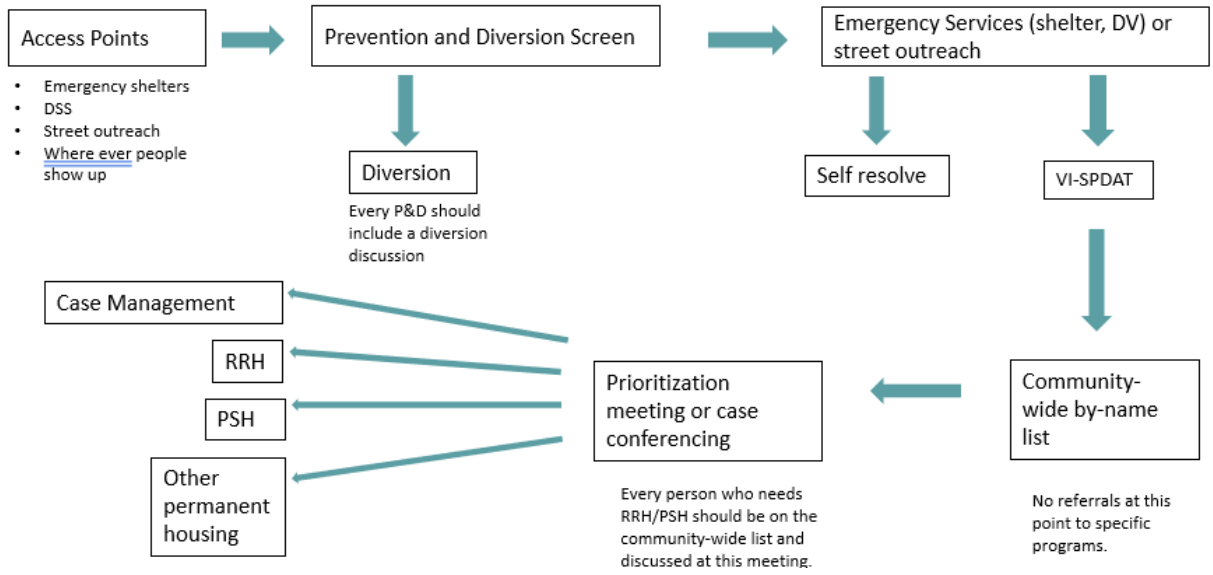
Section: Balance of State Supportive Services Only - Coordinated Entry Overview (BoS SSO-CE)

The Balance of State Supportive Services Only - Coordinated Entry (SSO-CE) grants have three basic goals:

1. Improve the regional Coordinated Entry system.
2. Provide access to Coordinated Entry to households who otherwise may not get access.
3. Maintain a By-Name List in HMIS to ensure the most vulnerable households are prioritized for housing.

Coordinated Entry Overview

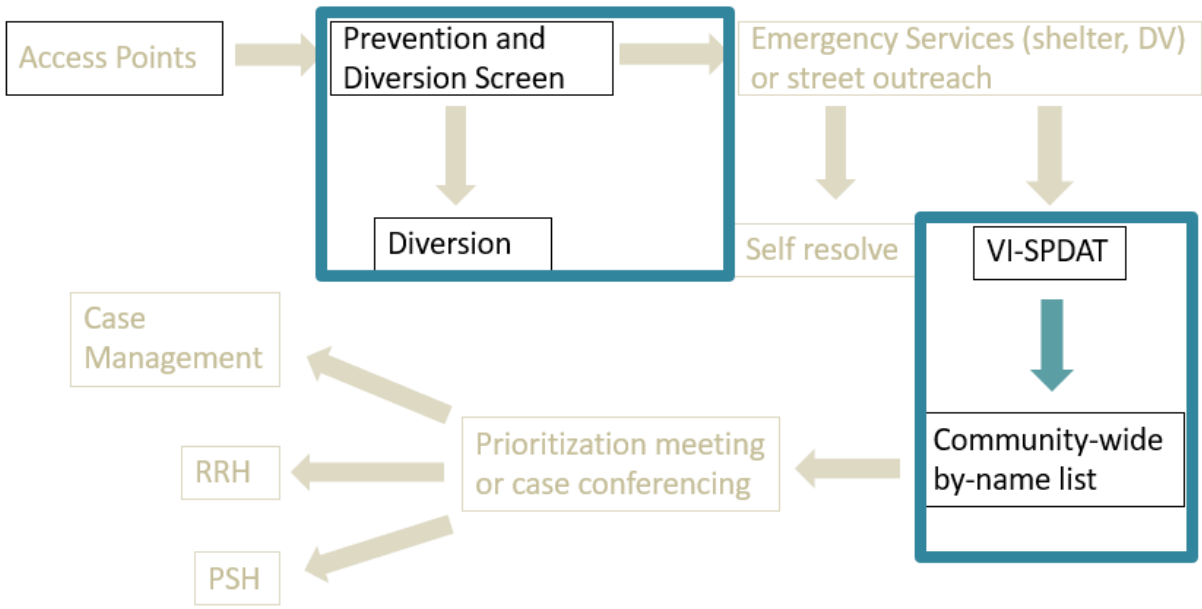
While a variety of agencies interact with the Coordinated Entry system, there is one basic workflow:



1. Each person/household who is literally or imminently homeless present at an identified Coordinated Entry access point (emergency shelter, DSS, street outreach etc).
2. Access point staff should engage each person/household in a Prevention and Diversion discussion in an effort to divert them from homelessness if possible.
3. Once a client does become literally homeless, they will be engaged with an emergency shelter, street outreach or some other type of homeless provider.
4. Each person/household who is unable to self-resolve their homelessness within 14 days will be assessed for vulnerability with the VI-SPDAT assessment.
5. Every literally homeless person/household will be added to the regional by-name list to be prioritized for housing opportunities.
6. The by-name list will be reviewed at regular case conferencing meetings to prioritize the most vulnerable households for the open housing resources.

7. Each literally homeless person/housed matched with housing projects will be referred to them via HMIS or other means for housing and appropriate supports.
8. The housing program will then work with the client to get them housed and provide appropriate supports along the way to stabilize them in housing.

Two main parts of the Coordinated Entry process will be captured by SSO grantees in the two SSO projects in HMIS.



1. The Prevention and Diversion project will capture all prevention and diversion activities that the *SSO CE grantee* engages in with clients.
2. The Coordinated Entry project will capture all homeless clients (regardless of which provider they are working with) in the region and track their progress through Coordinated Entry until they are successfully housed for 90 days. Every client that is literally homeless and has a VI-SPDAT assessment or has a length of time homeless long enough to be assessed (14 days or more) will need an entry into the SSO Coordinated Entry project. Clients should only be exited after they are housed for 90 days or more, have been unable to be found in the community for 90 days or more or have passed away.

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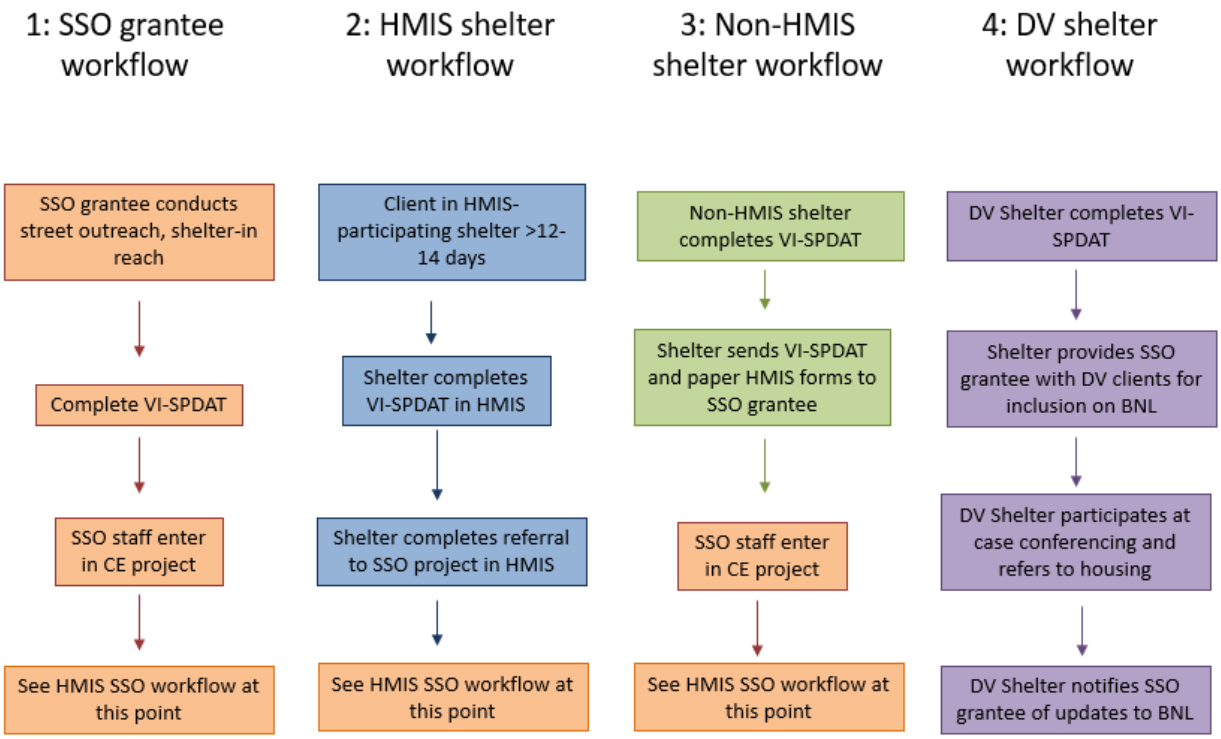
While there is one basic workflow, agencies interact differently with the Coordinated Entry system:



1: SSO-CE grantee workflow – SSO grantee finds people via street and/or shelter outreach, completes VI-SPDAT assessment, and enter the Coordinated Entry project via HMIS → move to HMIS SSO workflow

2: HMIS shelter or street outreach workflow – HMIS-participating shelter or street outreach conducts and enters a VI-SPDAT assessment after 14 days of literal homelessness, then refers to the Coordinated Entry project via HMIS → move to HMIS SSO workflow

3: Non- HMIS shelter or program workflow – Non-HMIS participating shelter or homeless program sends completed VI-SPDAT, ROI and other information to SSO grantee via paper form for grantee to enter the Coordinated Entry project via HMIS → move to HMIS SSO workflow

4: DV shelter workflow – DV shelter completes VI-SPDAT after 14 days of literal homelessness and works with SSO grantee for addition onto by-name list for case conferencing and housing prioritization. SSO grantee will add the DV shelter referrals onto the by name list prior to case conferencing meetings. Once a DV shelter client is matched with a housing resource the DV shelter does the referral to the housing provider. DV clients will not get an entry into the CE project in HMIS for safety reasons.

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SSO Coordinated Entry Workflow in HMIS

SSO grantees should follow this process for all literally homeless clients in the region.

Section: Eligibility

To receive services covered by the BoS SSO-CE grant, persons must be Category 1, Category 2 or Category 4 Homeless as defined below. Ineligible persons should receive referrals to other resources in the community.

Category 1 Homelessness (Literal Homelessness): A state in which a person lacks a fixed, regular, and adequate nighttime residence, as defined by one of the following conditions:

a. An individual or household has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, camping ground; or

b. An individual or household is living in a supervised publicly or privately-operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government program for low-income individuals); or

c. An individual or household is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Category 2 Homelessness: When a person or household will imminently lose their housing (within 14 days), no subsequent residence has been identified, and the person or household lacks the resources or support networks needed to obtain other permanent housing.

Category 4 Homelessness: When an individual or household is fleeing, or attempting to flee domestic violence, has no other residence; and lacks the resources or support networks to obtain other permanent housing.

See the SSO-CE Policies and Procedures, posted at www.ncceh.org/bos/ssoce for details about documenting homelessness.

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Section: Referrals to Coordinated Entry Project from Access Points

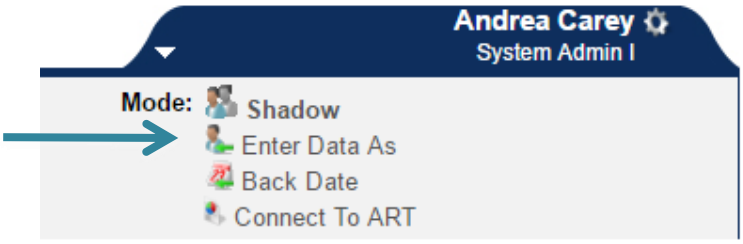
Access points (shelter, outreach, etc) should refer to the Coordinated Entry project after completing the VI-SPDAT assessment on clients. However, a referral is NOT required. It just alerts the SSO grantee that an eligible person needs access to Coordinated Entry. If a client has a long length of stay in shelter, then they should get a CE project entry and the SSO grantee can work with the access point to assess them or assist in assessing with their outreach/in-reach activities.

When access points refer to the Coordinated Entry Project, you can find these referrals below in HMIS using the steps below:

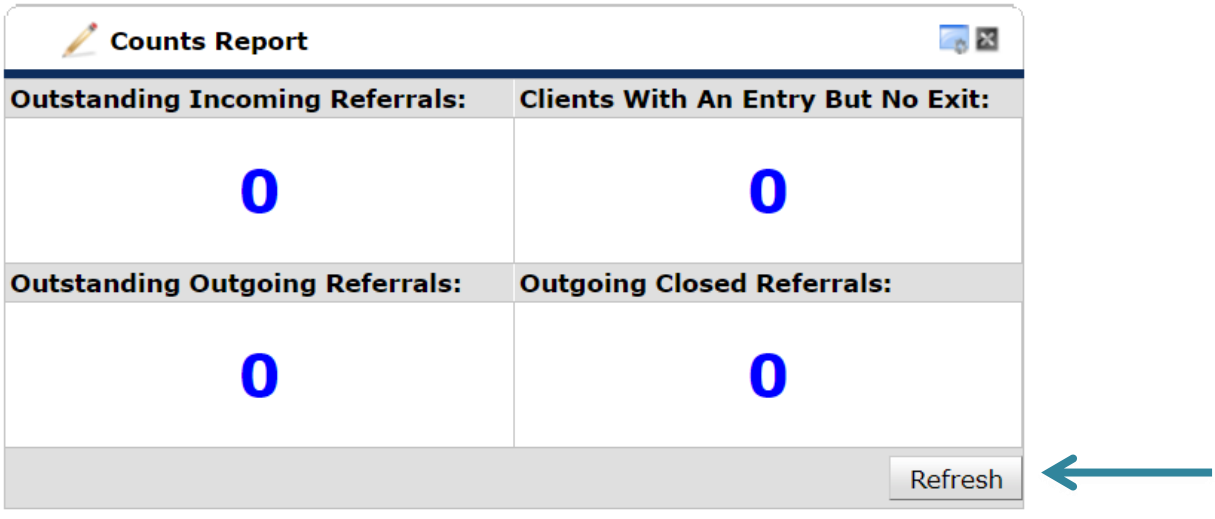
Step 1. Find Open Referrals

Use the dashlet counts reports on your HMIS home page to quickly locate outstanding open referrals.

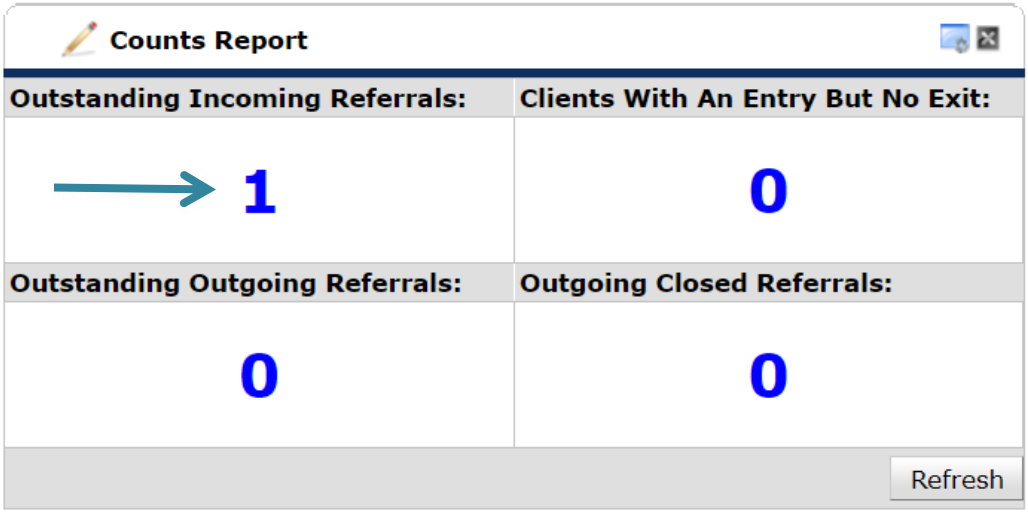
1. Once logged into HMIS, use Enter Data As function to find the region's Coordinated Entry project. Next, click the green plus sign next to the Coordinated Entry Project for your region. **Please note that each SSO grantee will only see their region's project.**



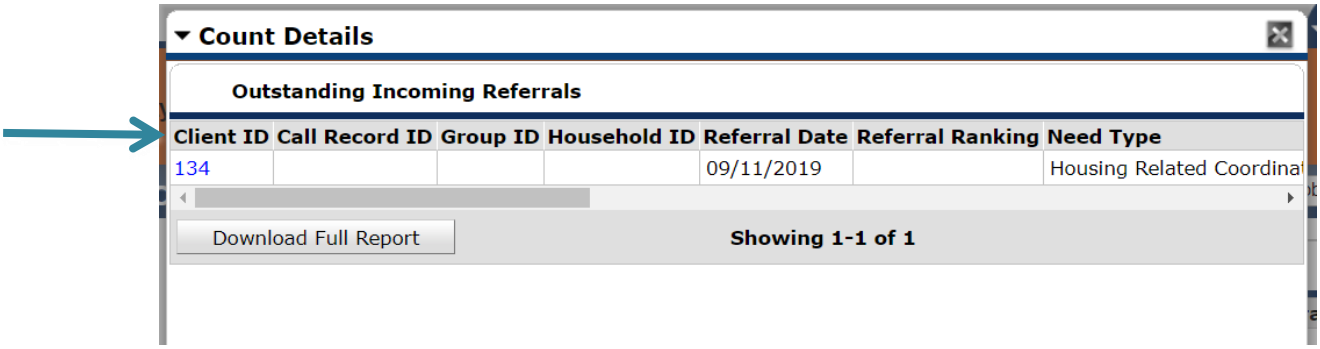
2. Click the Refresh button in the Counts Report box on home page to get the most updated and accurate referral counts.



3. Click on the blue number to see Outstanding Incoming or Outgoing Referrals.



4. Click on the blue HMIS Client ID to access that client record.



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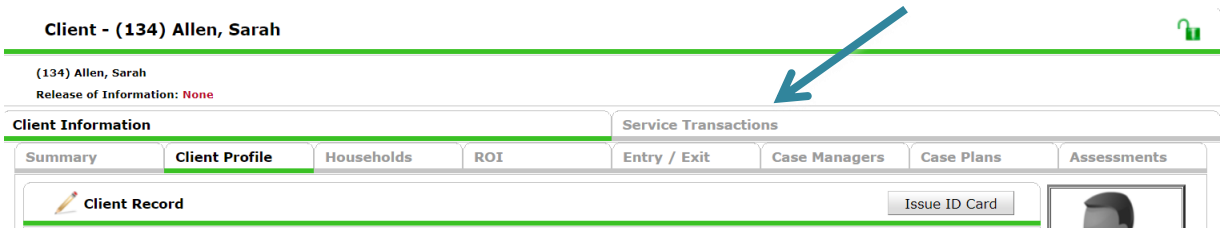
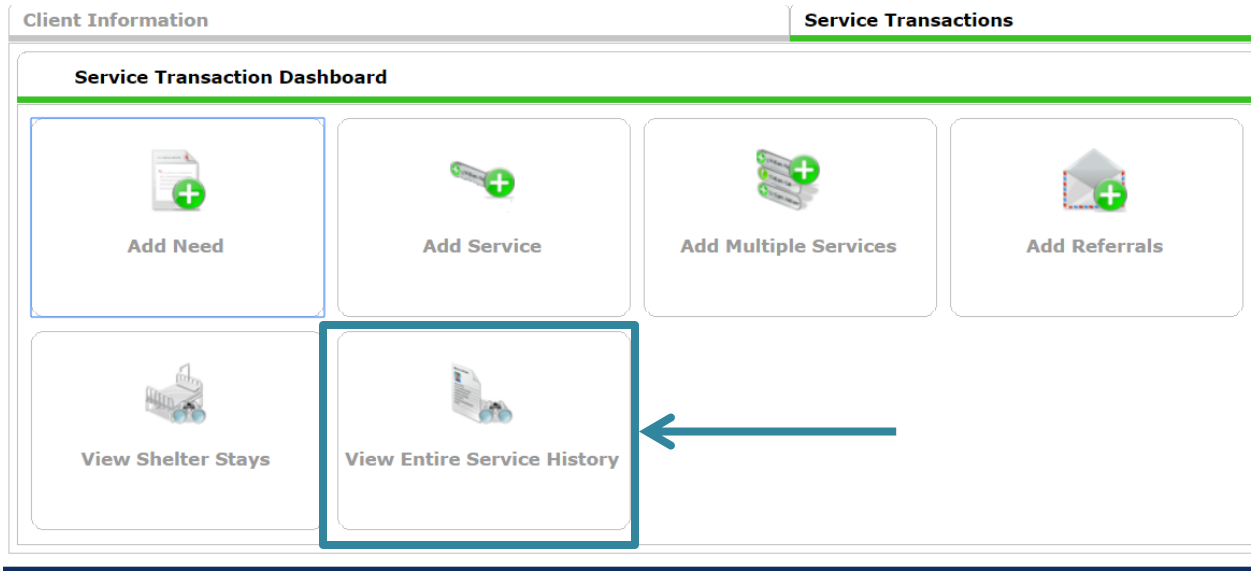
Step 2. View and Accept Referrals

All incoming referrals must be resolved. Typically this occurs when the CE project "accepts" the referral. If a referral is declined or cancelled, then a reason must be added.

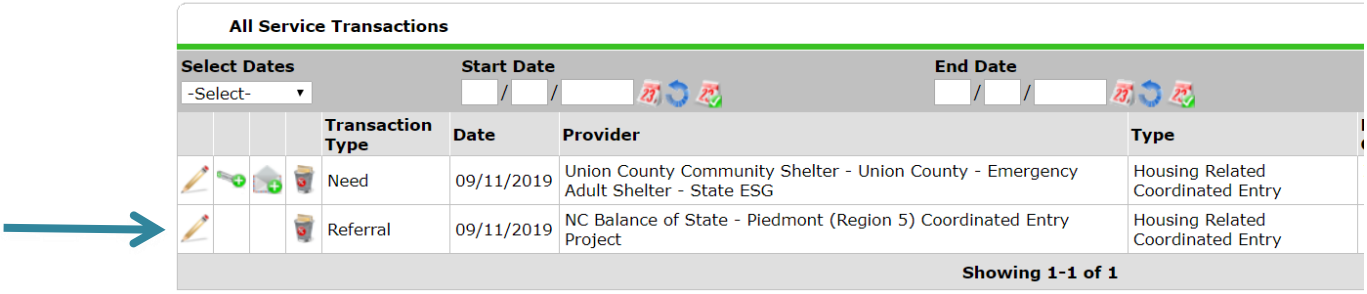
1. Navigate to the Service Transaction tab.



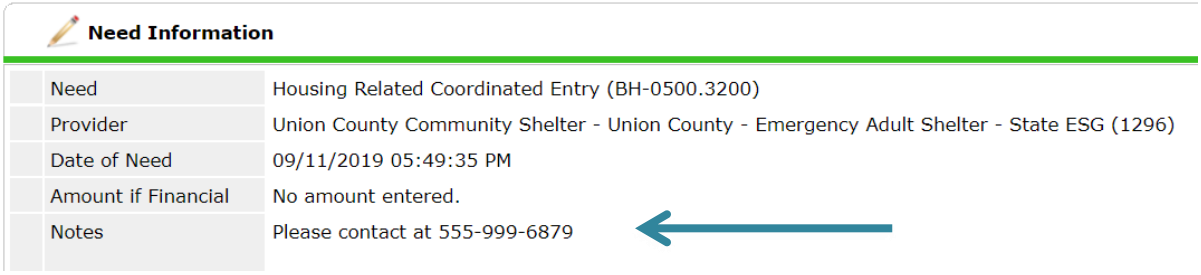
2. Click View Entire Service History.

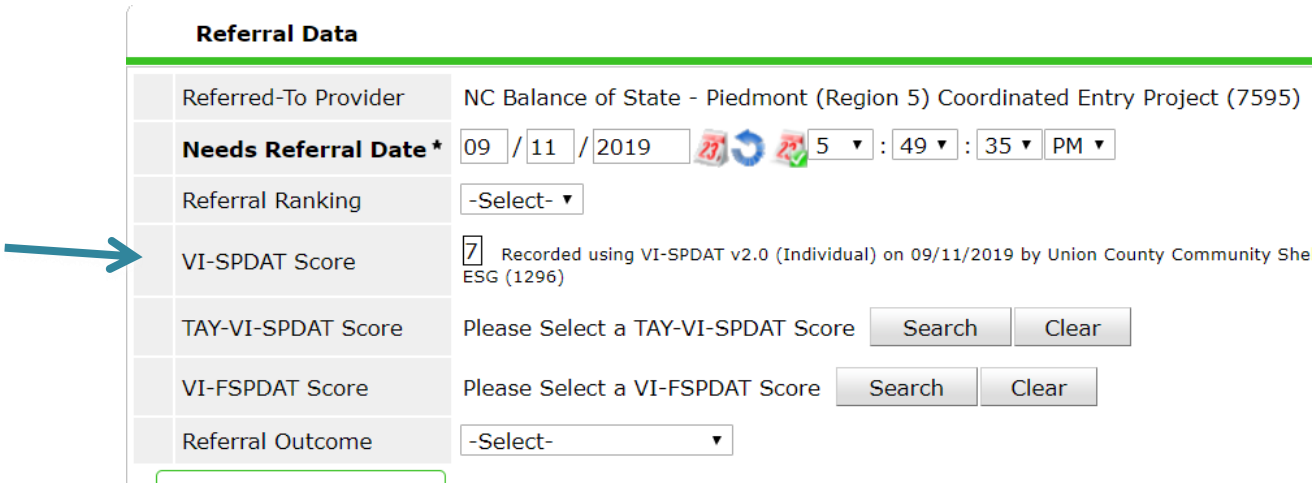


3. Click the pencil next to Referral to view additional information and update referral.

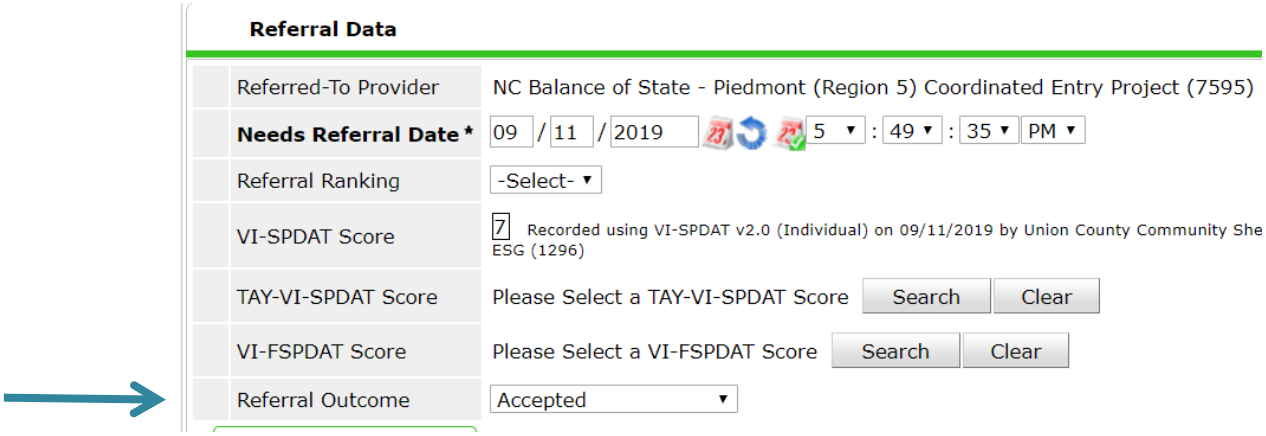


4. The referral information can now be viewed. The shelter may have added a VI-SPDAT or notes.



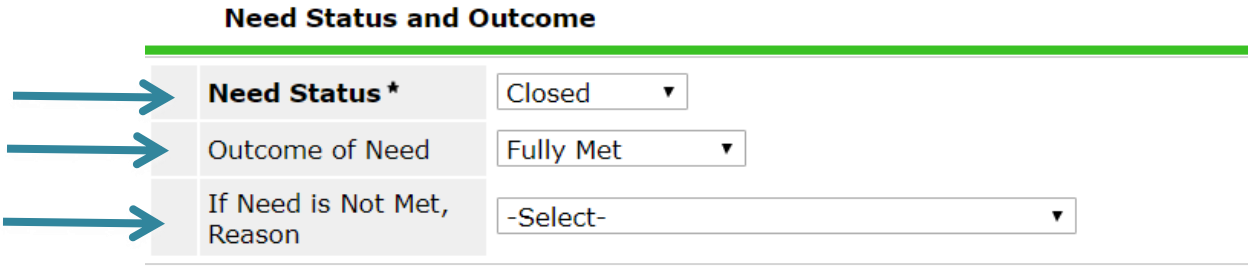


5. Scroll to the Referral Data section to update the Referral Outcome. If the referral is appropriate and you will enter the person into the CE project, change the referral outcome to Accepted.

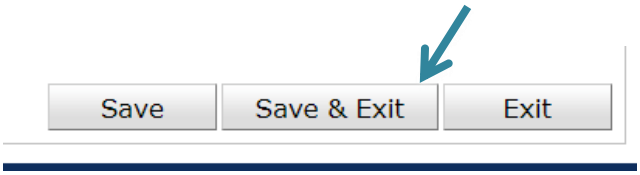


6. If there's some reason the referral needs to be declined or canceled then the field "If Canceled or Declined, Reason" will appear. This is a required field for all declined or canceled referrals.

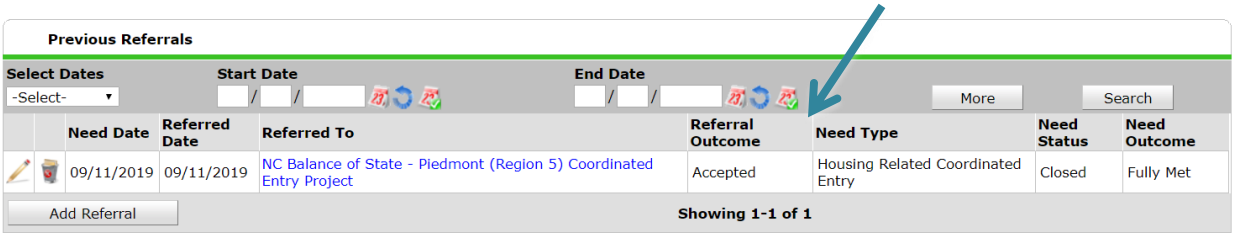
7. Scroll down to the Need Status and Outcome section and updated Need Status to Closed. Update Outcome of Need to Fully Met if referral was accepted and Not Met if declined or canceled. If the Outcome of Need has been changed to Not Met add the reason.



8. Click Save & Exit to save the updates and exit this screen.



9. Referral will now have an updated Referral Outcome, Need Status and Need Outcome.



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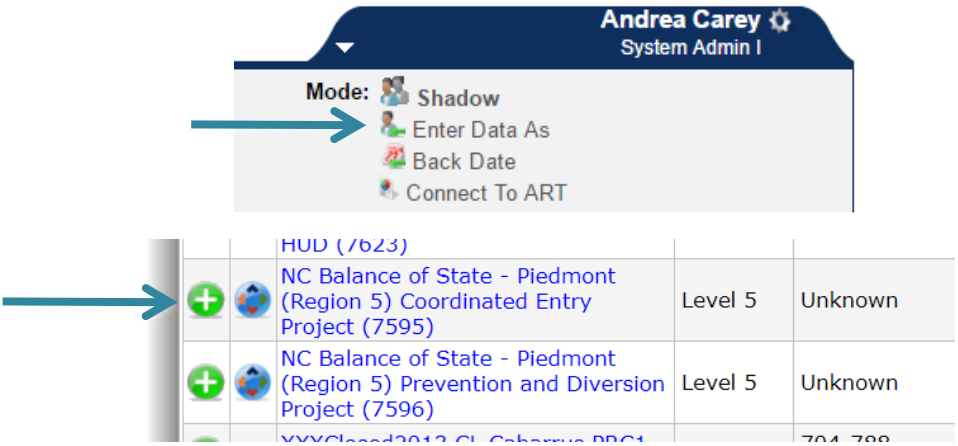
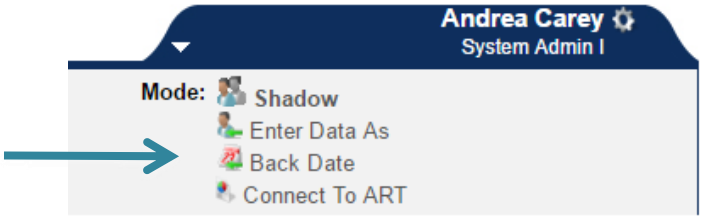
Section: Entry into Coordinated Entry Project

All literally homeless people in the SSO region will need an entry into the Coordinated Entry Project. This entry will be prompted by either a referral from an access point or the SSO grantee may see that the a person or household has been homeless for 14 days or more and enroll that person or Head of Household directly into the CE project regardless of whether or not the person also had a shelter entry. Or the SSO grantee will directly enter someone into the CE project if they are not connected to another provider.

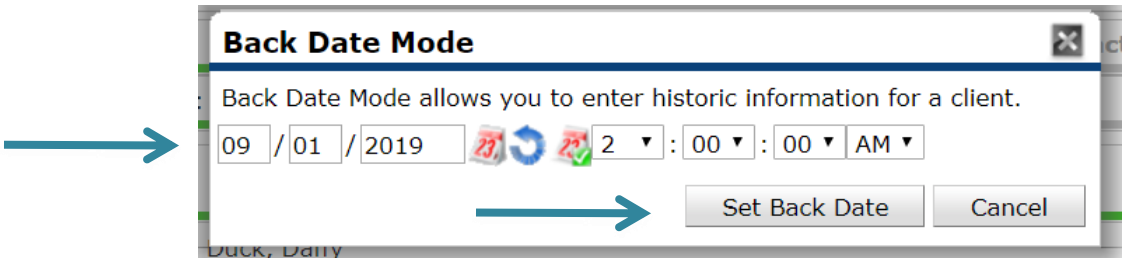
1. ALWAYS use Enter Data As mode when entering data or doing any activities for the Coordinated Entry Project. Click *Enter Data As* and click the green plus sign next to the *Coordinated Entry Project* for your region.



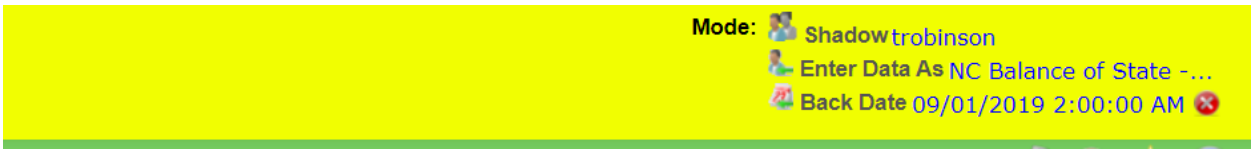
2. Use Back Date if entering data or doing activities for a day other than today.



a. Enter the date that you want to enter data for and click Set Back Date.

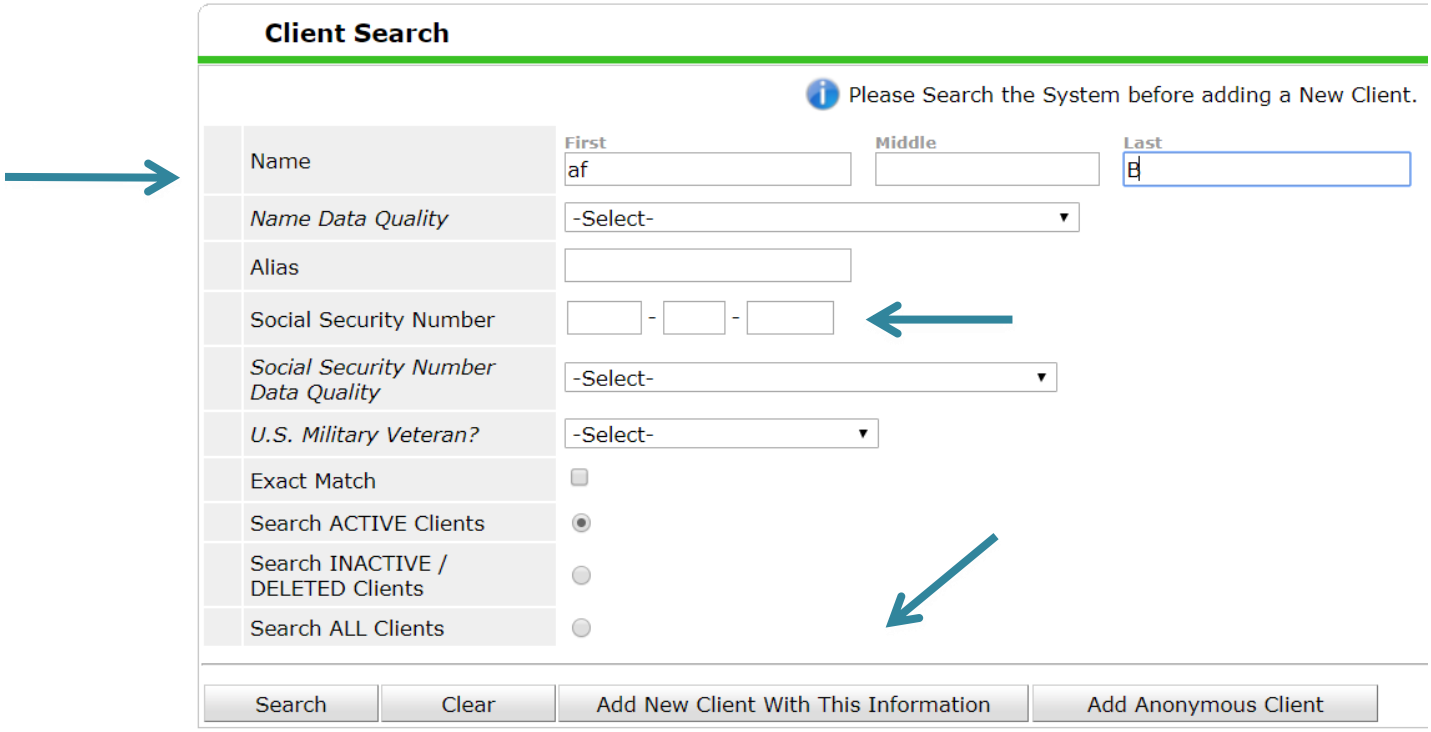


b. The top of your screen will be bright yellow when you are in Back Date Mode.

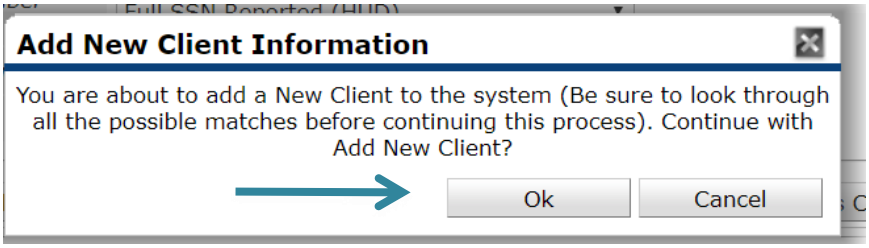


Step 1. Find or Create Client Profile

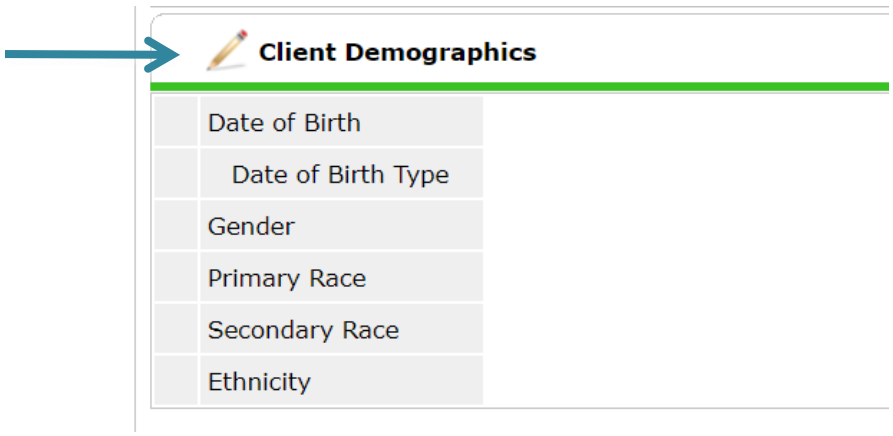
1. Search for person in ClientPoint in the Client Search screen in 3 different ways: by partial first and last name, last 4 of SSN, and alias then click Search. If client does not already have a client profile, then create one by adding ALL information on the Client Search screen and click Add New Client with This Information.



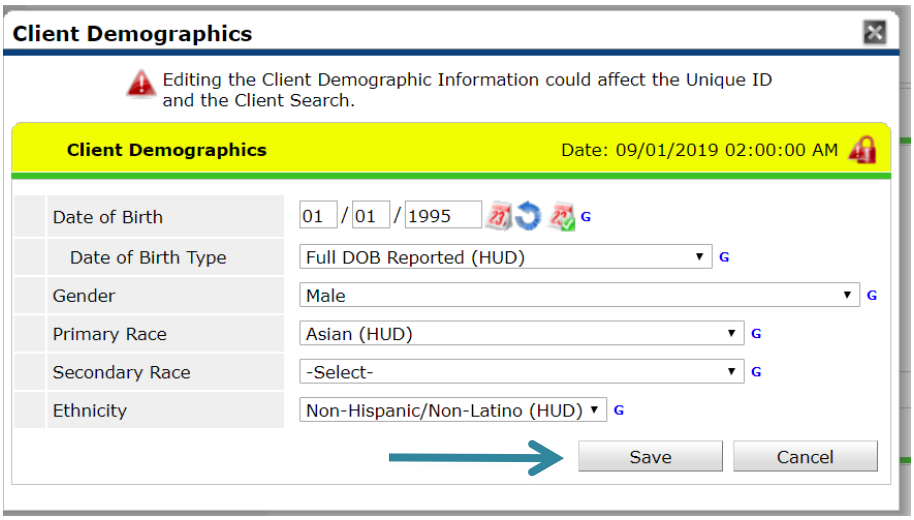
2. Click Ok when Add New Client Information box pops up



3. Navigate to the Client Demographics section under the Client Profile tab. Click the pencil next to Client Demographics to add information.



4. Add or correct information, review again for accuracy, and click Save.



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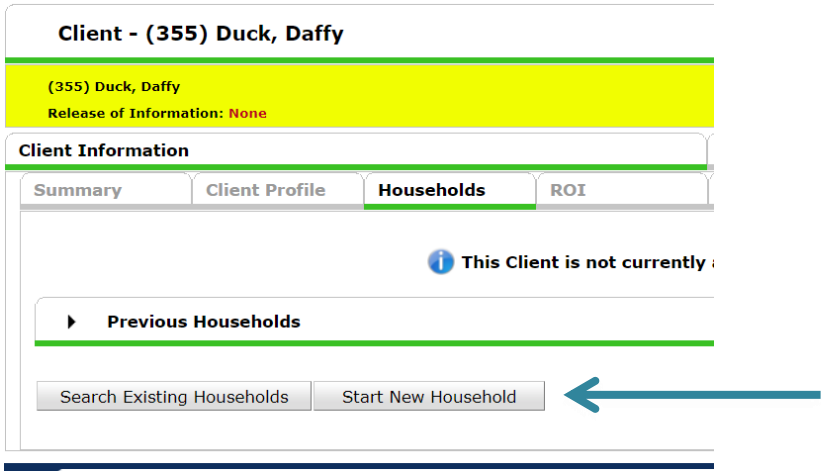
Step 2. Create or Update Household

Households are only created if multiple people present together for services and identify as 1 household (no matter the household composition). A single person should not have a household created for them in HMIS.

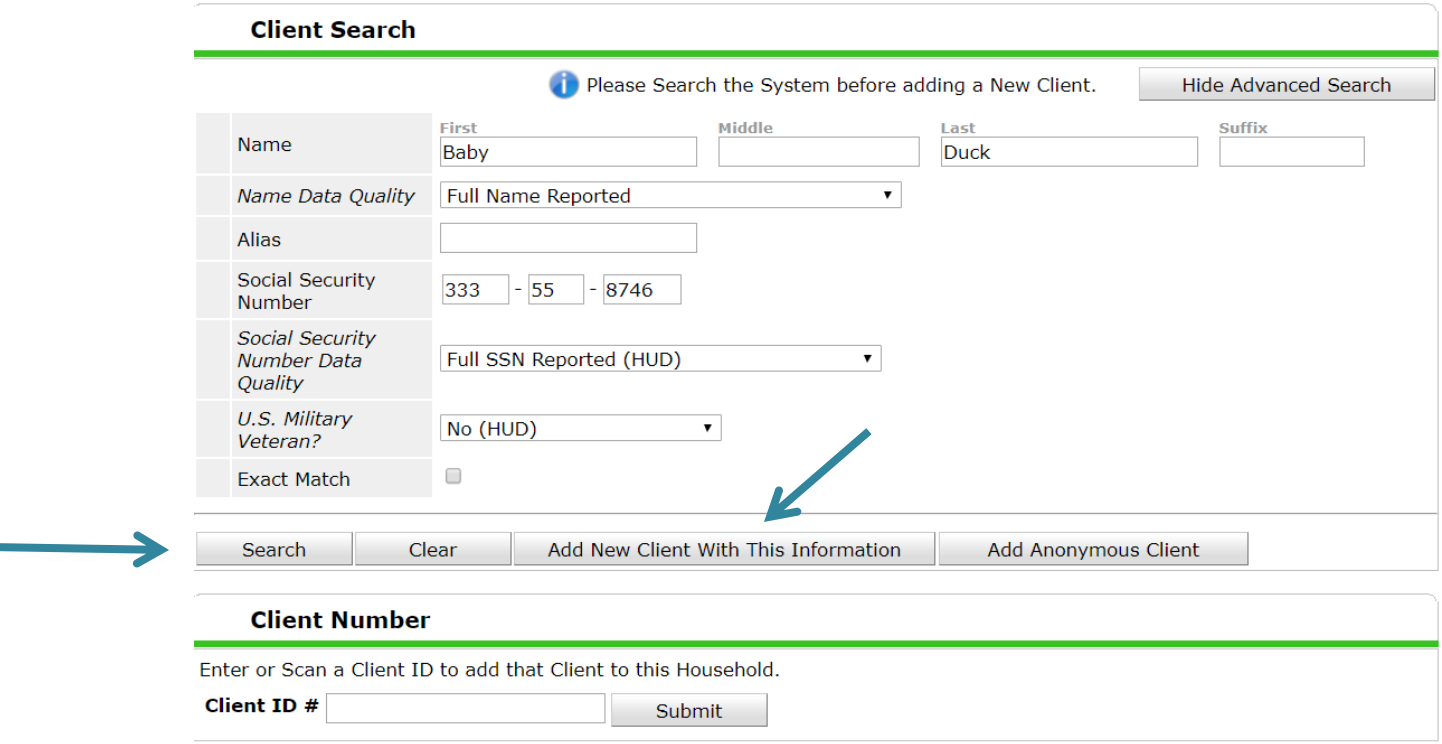
1. Navigate to the Head of Household's profile and go to the Households tab.

2. Determine if the Household tab is complete and accurate. A new household can be created, or a new client can be added to an already existing household. **Do not delete household members**. Any members not currently part of the household should not be added to entries or referrals.

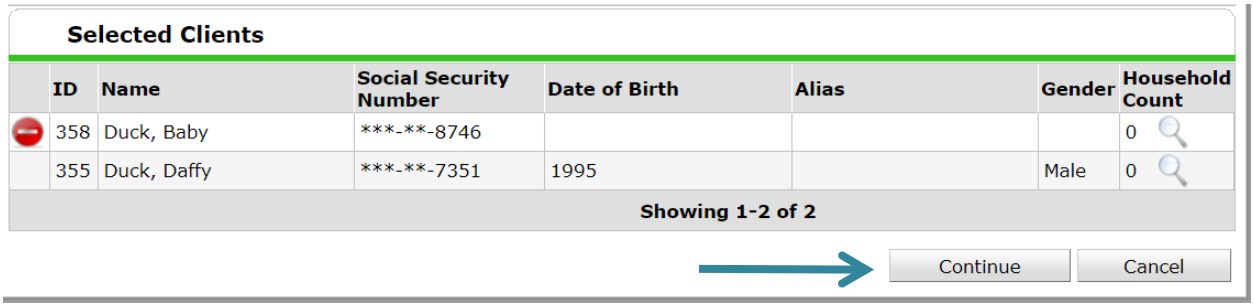
3. To create a new household, click on Start New Household. Search for someone using the same steps outlined in Step 1. Find or Create Client Profile. Click the Green plus sign to add them to the Selected Clients section.



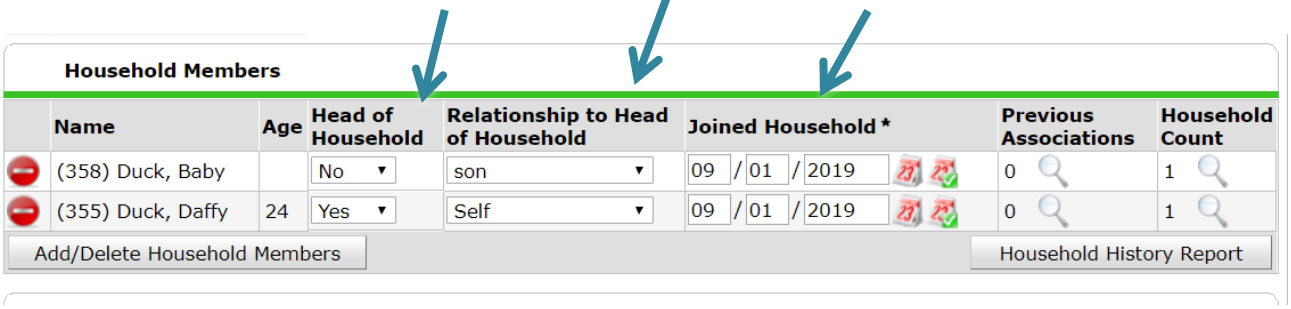
4. If a client profile is not found, complete all the fields in the Client Search section. Then, click on the Add New Client with this Information button.



5. Click Continue after all household members have a profile in the Selected Clients section.

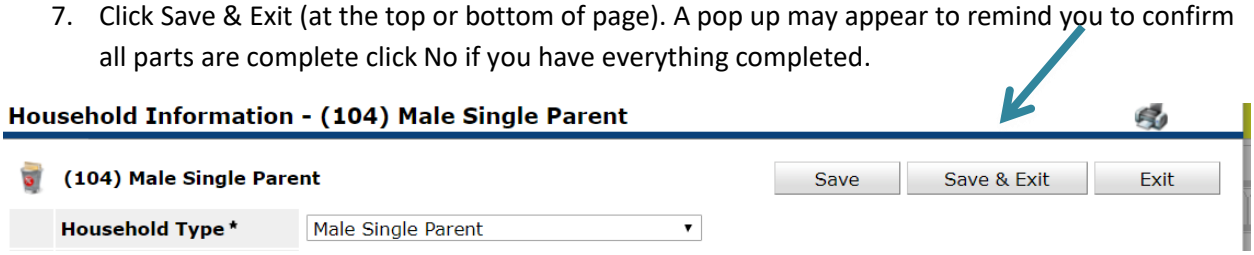


6. Complete the three household questions for each client.

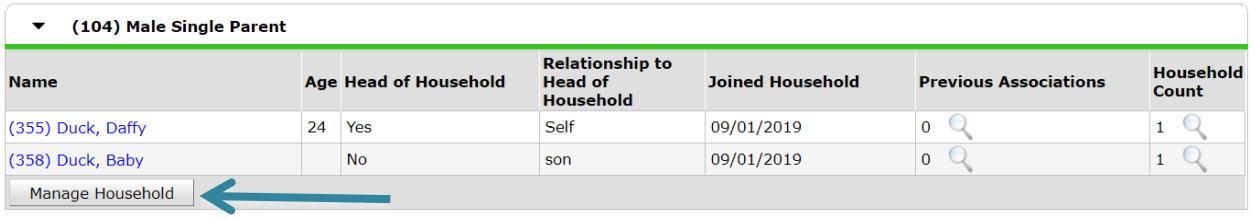


   a. Head of Household Yes or No.
   b. Relationship to Head of Household (heads of household list Self).
   c. Joined Household is the date when these clients presented for services together in HMIS which should be today or earlier and not the date of first dates, marriages, or initial family events.

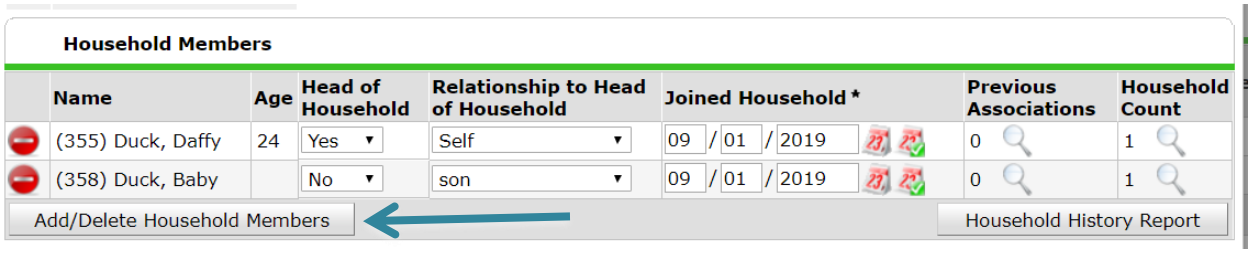
7. Click Save & Exit (at the top or bottom of page). A pop up may appear to remind you to confirm all parts are complete click No if you have everything completed.



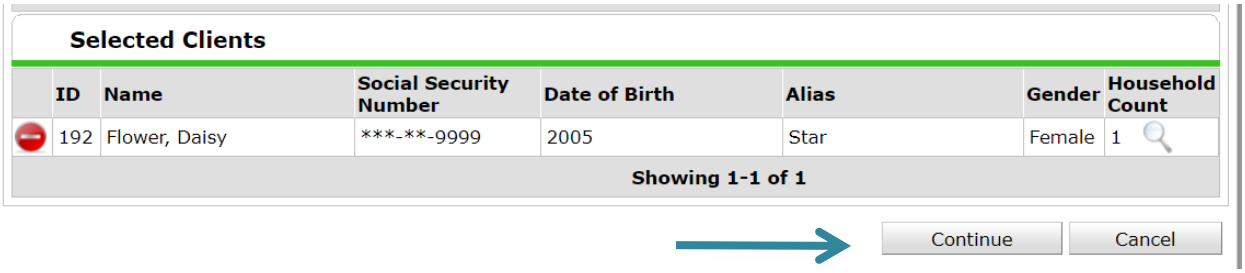
8. To add another client to the already created household, click the Manage Household button.



a. Click on Add/Delete Household Members.

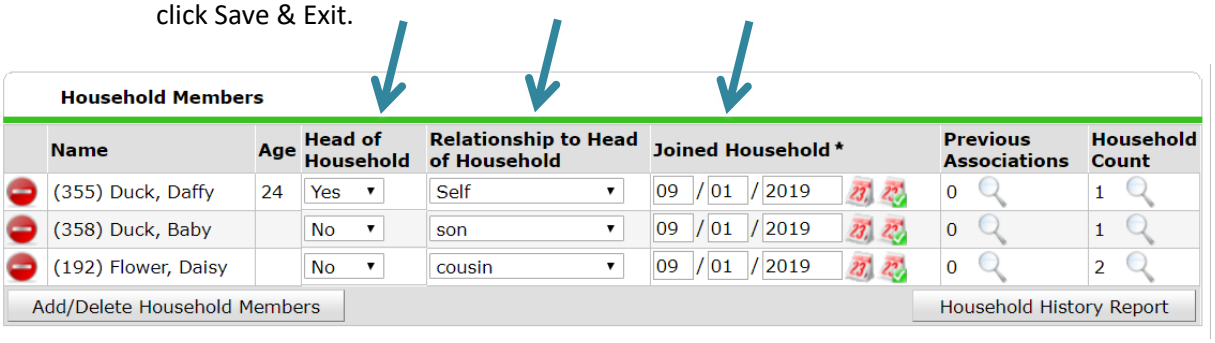


b. Click the black triangle next to Add Clients to the Household. Find and add all clients until all new household members are in the Selected Clients section.

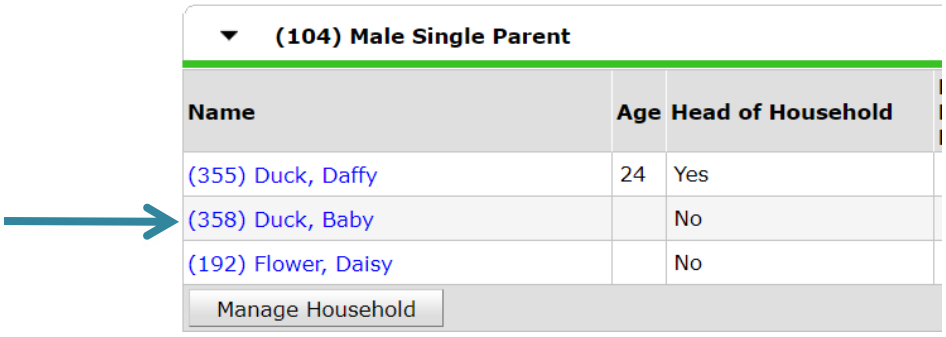


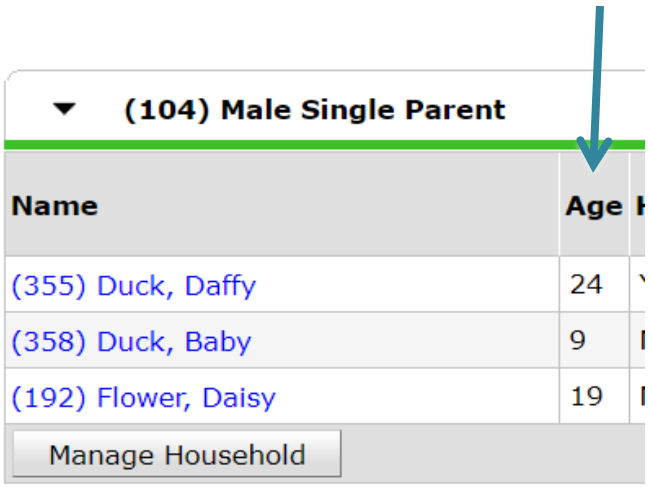
c. Click Continue.

d. Complete the three household questions for each new client as previously shown. Then click Save & Exit.



9. Click on each member's name in the household tab and then navigate to their Client Profile tab to add Client Demographics.





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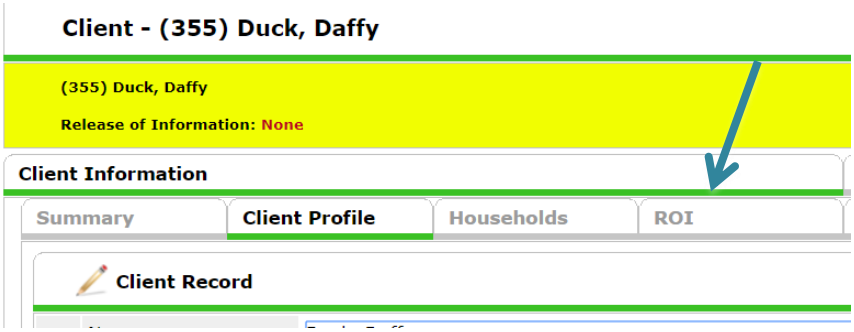
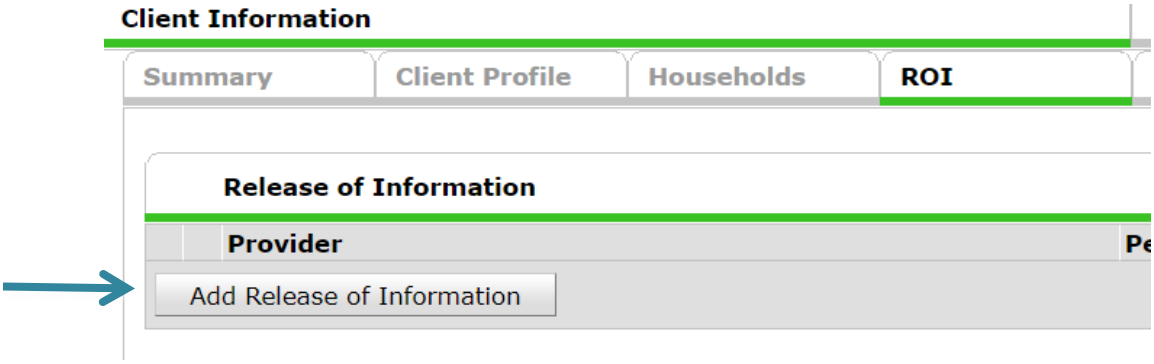
Step 3. Add Release of Information

Every person needs an electronic Release of Information in HMIS that reflects their written and signed paper Release. If a client says no to the ROI call the NCCEH Data Center so their profile can be locked to prevent unwanted sharing.

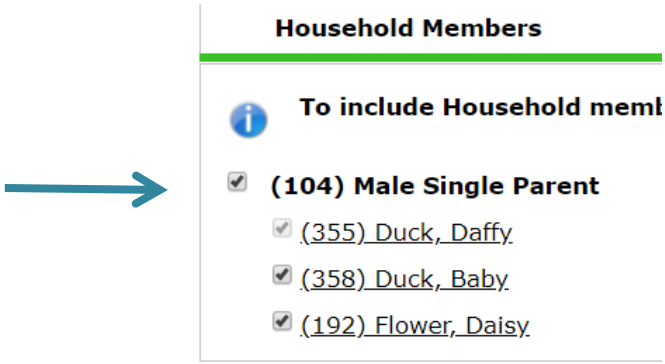
1. Click on the ROI tab.



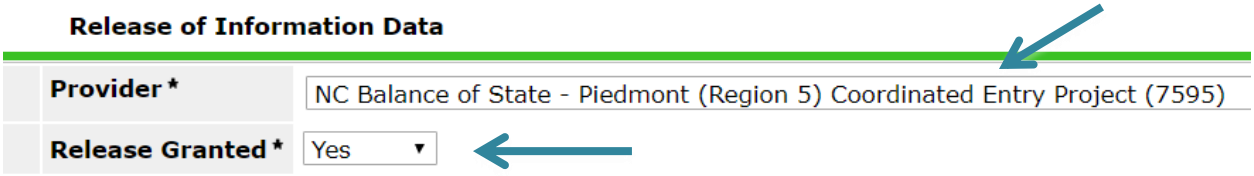
2. Click Add Release of Information.



3. Select all household members that should be connected in this entry by checking the box(es).

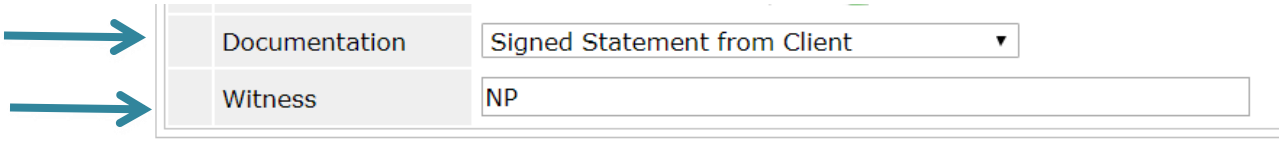


4. Confirm provider is the Coordinated Entry Project. If not, then change EDA to the CE project and return to this section. Change Release Granted to Yes.

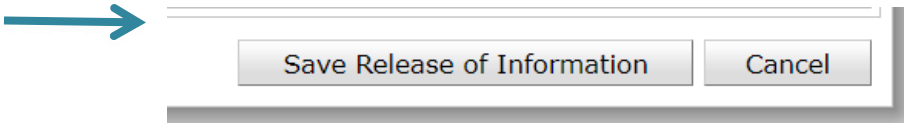


5. Enter Start and End dates. End Date is usually one year from Start Date unless otherwise specified by client.

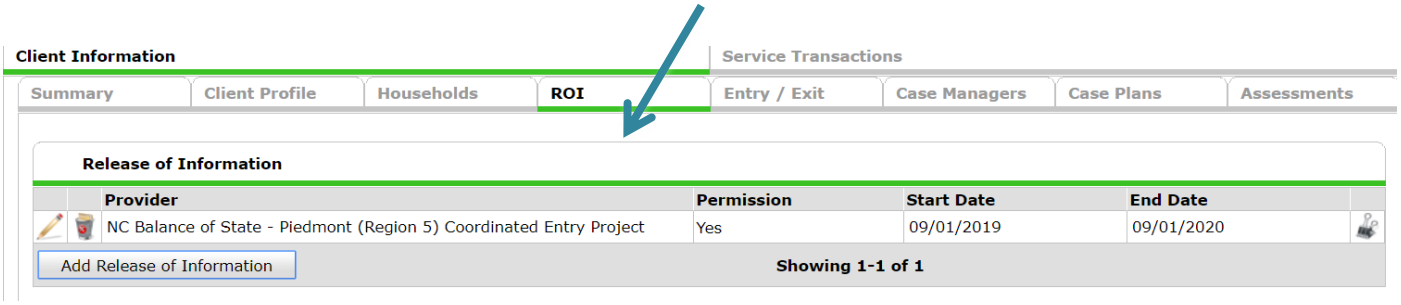
6. Select Documentation and add staff initials for Witness.



7. Click Save Release of Information.



8. Confirm ROI for correct dates shows up on ROI tab.



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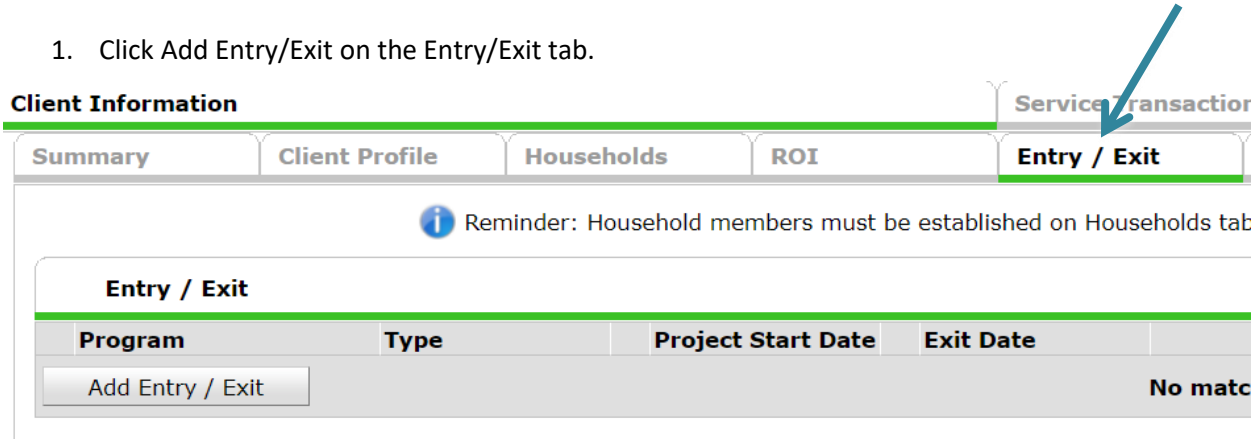
Step 4. Create CE Project Entry

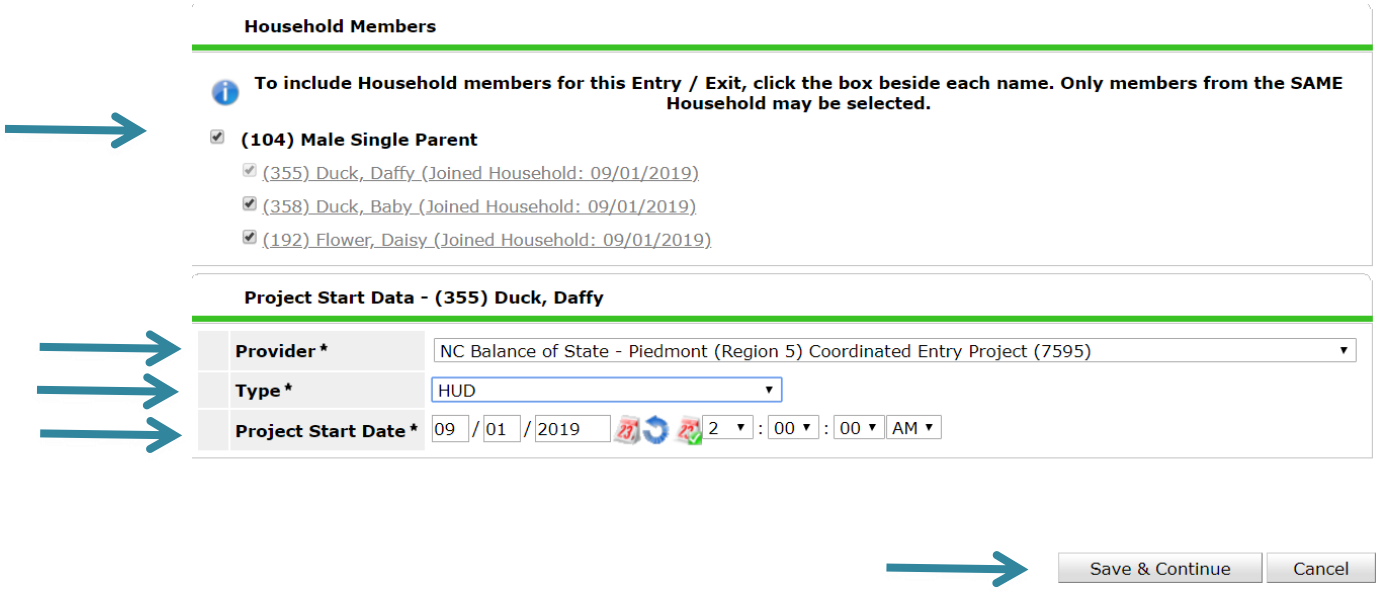
Every literally homeless person and/or Head of Household in the region should have an entry into the CE project. The Project Start Date should coincide with the date of a homeless verification marker (e.g., shelter stay or VI-SPDAT date).

If you are the first provider in the region to assess the person/household, you will need to enter all the data for that person/household. If another access point in the region has already assessed and created an entry for that client, then some or most of the data should share to and prepopulate data in the CE project entry. Contact the NCCEH Data Center for visibility/sharing issues.

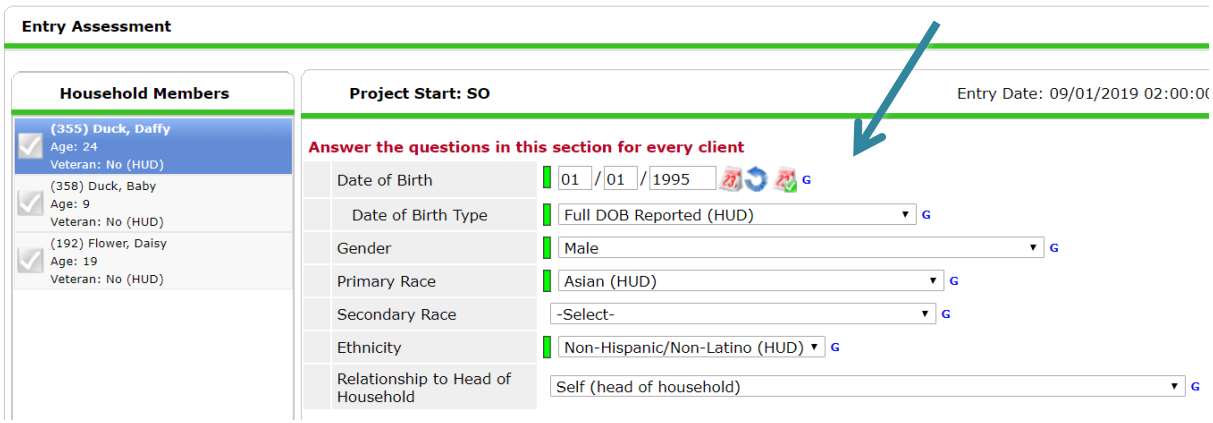
1. Click Add Entry/Exit on the Entry/Exit tab.



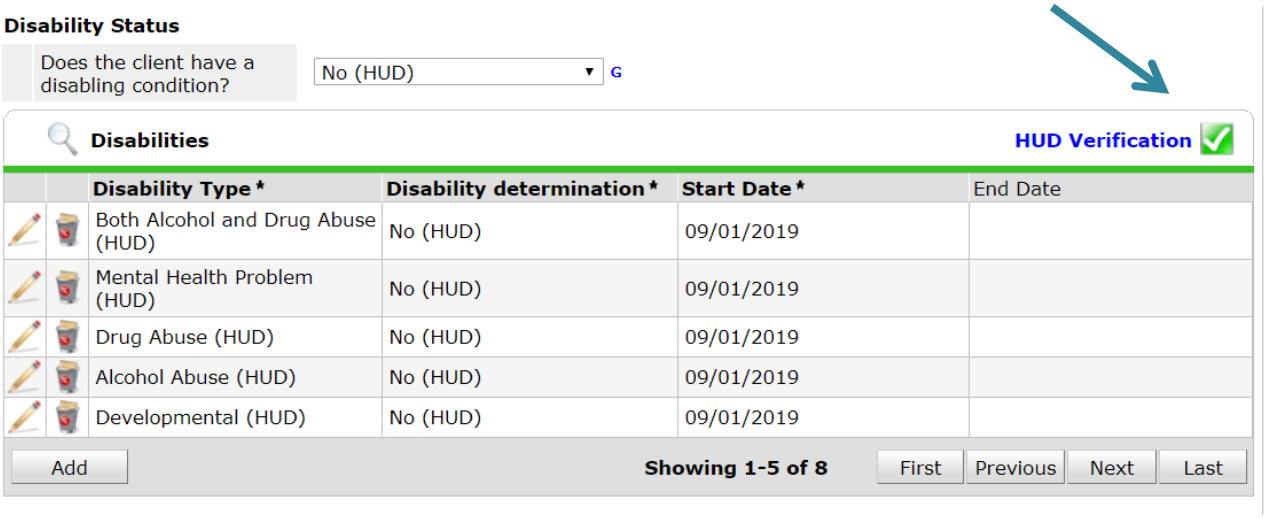
2. The Provider and Project Start Date should pre-populate with the correct information. If they do not, then fix your EDA and Backdate before going any further. The Type is HUD and everyone in this current household should have their box checked. Click Save & Continue when done.



3. Review all data that pre-populated from another access point. If no data pre-populated, then fill in the missing information.



4. Answer all of the question so that that there is a green check mark next to HUD Verification.



Disability Status

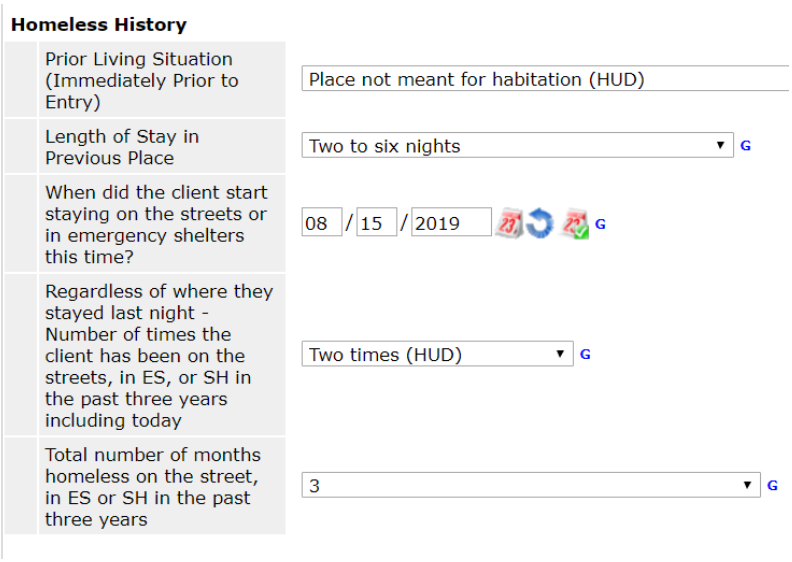
Does the client have a disabling condition?	No (HUD) G

Disabilities — HUD Verification

	Disability Type *	Disability determination *	Start Date *	End Date
	Both Alcohol and Drug Abuse (HUD)	No (HUD)	09/01/2019	
	Mental Health Problem (HUD)	No (HUD)	09/01/2019	
	Drug Abuse (HUD)	No (HUD)	09/01/2019	
	Alcohol Abuse (HUD)	No (HUD)	09/01/2019	
	Developmental (HUD)	No (HUD)	09/01/2019	

Add — Showing 1-5 of 8 — First | Previous | Next | Last

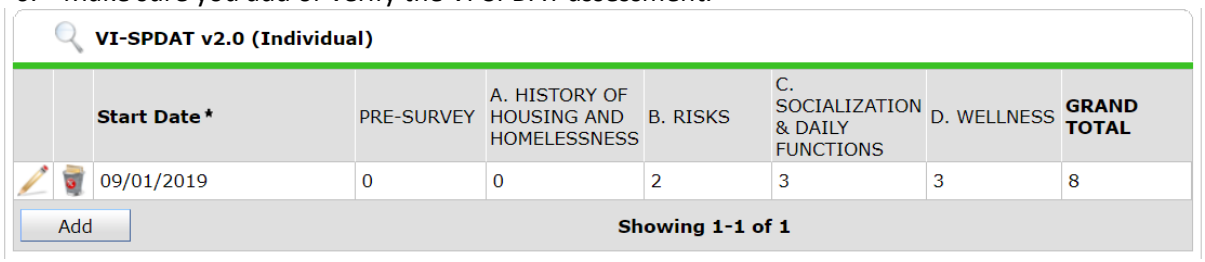
5. If the person or Head of Household came from a location other than emergency shelter, then check homeless history to ensure they are literally homeless.



Homeless History

Prior Living Situation (Immediately Prior to Entry)	Place not meant for habitation (HUD)
Length of Stay in Previous Place	Two to six nights G
When did the client start staying on the streets or in emergency shelters this time?	08 / 15 / 2019 G
Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today	Two times (HUD) G
Total number of months homeless on the street, in ES or SH in the past three years	3 G

6. Make sure you add or verify the VI-SPDAT assessment.

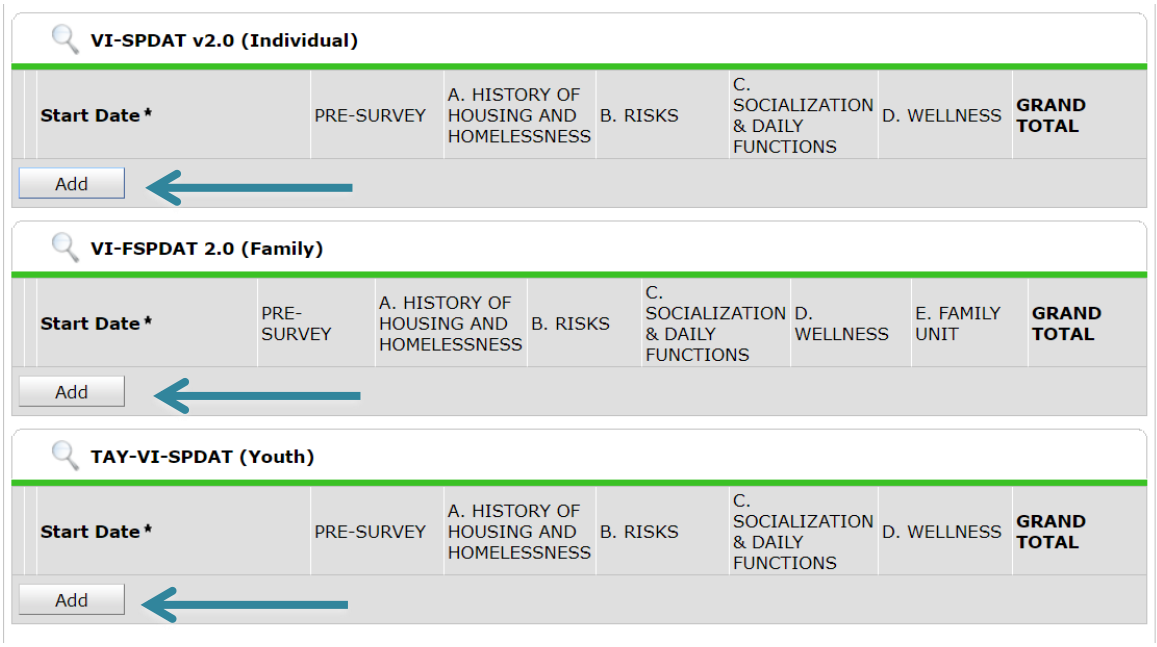


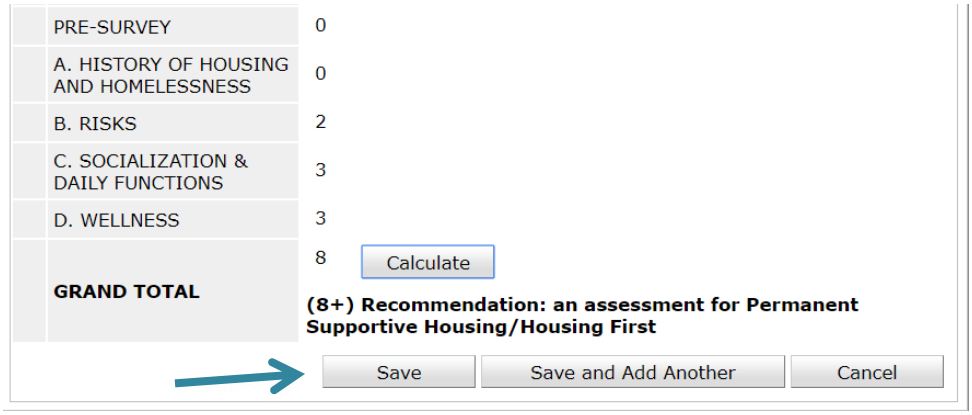
VI-SPDAT v2.0 (Individual)

	Start Date *	PRE-SURVEY	A. HISTORY OF HOUSING AND HOMELESSNESS	B. RISKS	C. SOCIALIZATION & DAILY FUNCTIONS	D. WELLNESS	GRAND TOTAL
	09/01/2019	0	0	2	3	3	8

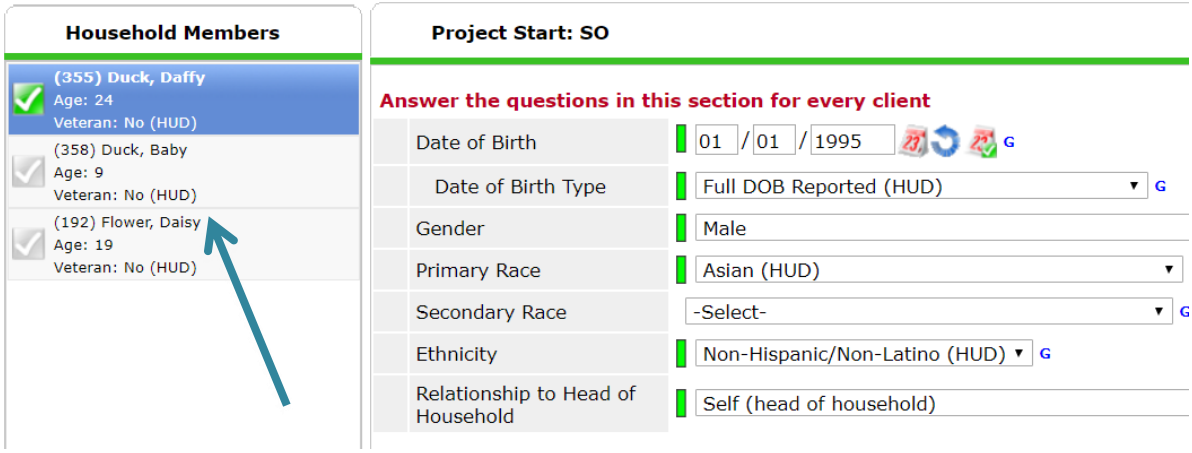
Add — Showing 1-1 of 1

7. To add a new VI-SPDAT assessment click the Add button in the appropriate box and answer the questions. Click Save when done.

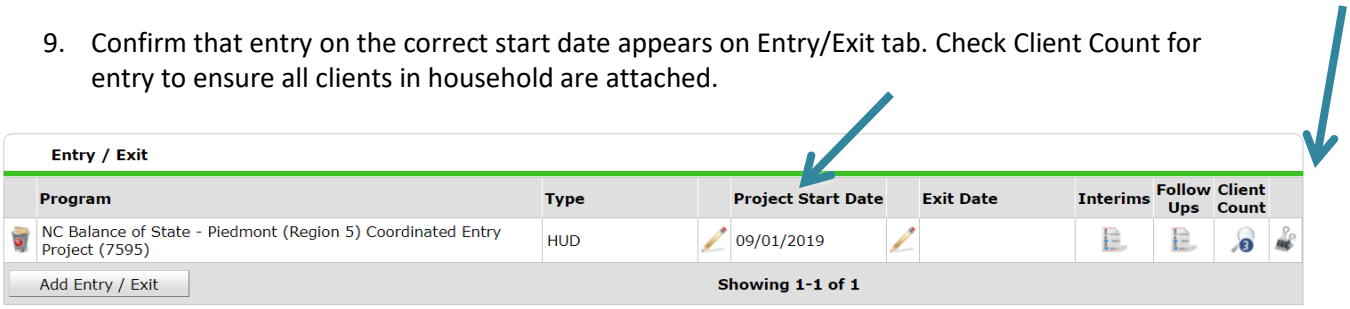




8. Complete or verify all data on the entry assessment for the Head of Household, then click Save at the bottom of the screen. Next, click on another household member in the column on the left. If the client does not have a household click Save & Exit at the bottom.



9. Confirm that entry on the correct start date appears on Entry/Exit tab. Check Client Count for entry to ensure all clients in household are attached.



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Section: Coordinated Entry Form

The NCCEH Coordinated Entry Form needs to be completed for the Head of Household only. This form tracks progress through the CE system and is only available to SSO grantees.

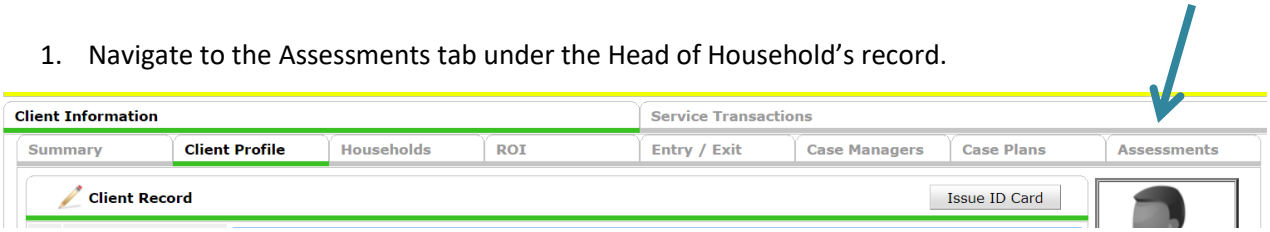
The form should be updated under these conditions:

1. At CE project start to get the form started, just add whatever information you have.
2. After the client/household is case conferenced.
3. After the client/household is referred to a housing provider.
4. After the client/household is housed.
5. After the client/household should be removed from the active by name list.
6. Any other time it is helpful for the SSO grantee to update a field.

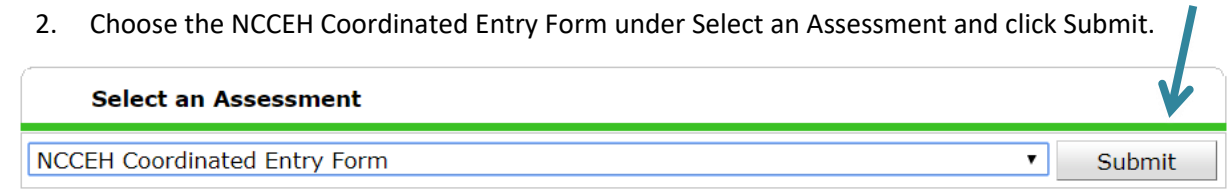
Navigating to the Coordinated Entry Form

As with other data entry you should ALWAYS be in EDA mode for the Coordinated Entry project when entering data on the Coordinated Entry Form. You can use back date mode as needed as well.

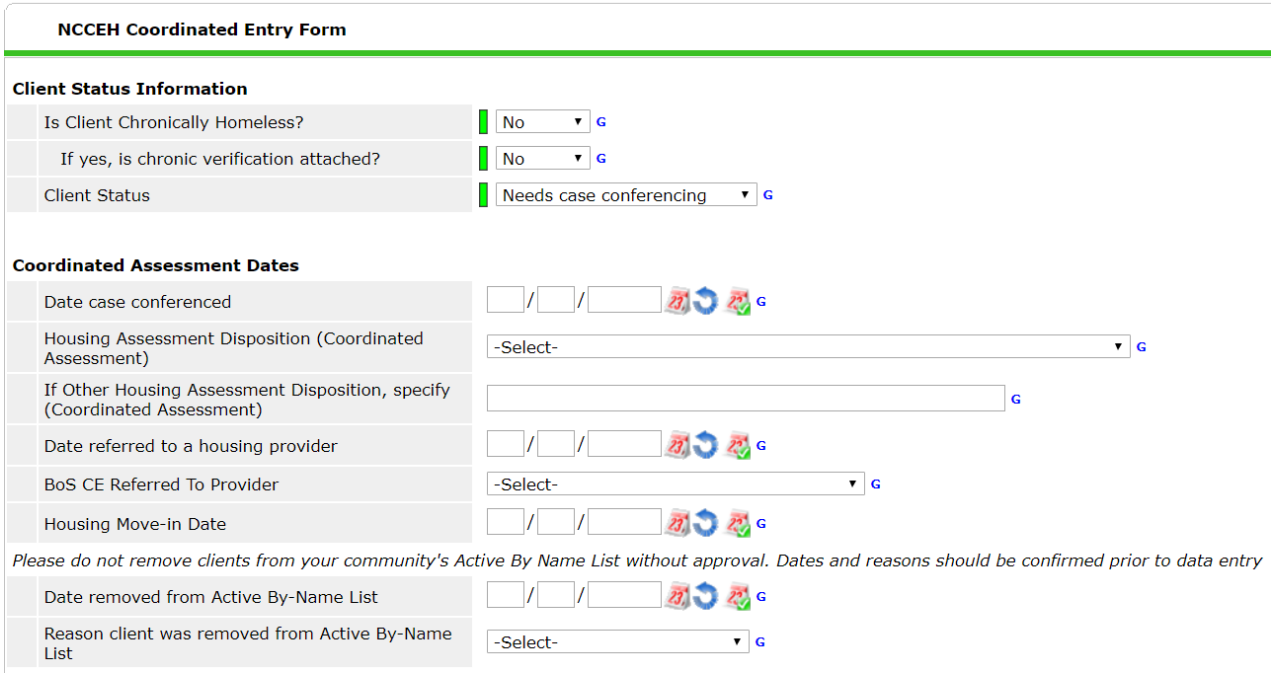
1. Navigate to the Assessments tab under the Head of Household's record.



2. Choose the NCCEH Coordinated Entry Form under Select an Assessment and click Submit.



3. The form should pre-populate with previously entered data.



4. Add or update fields and click Save.

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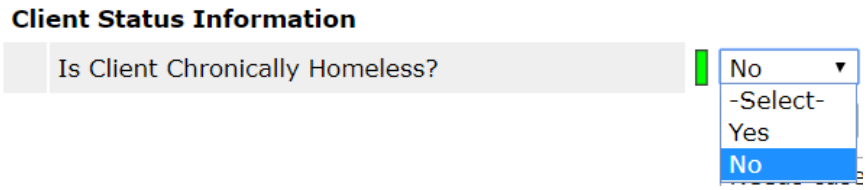
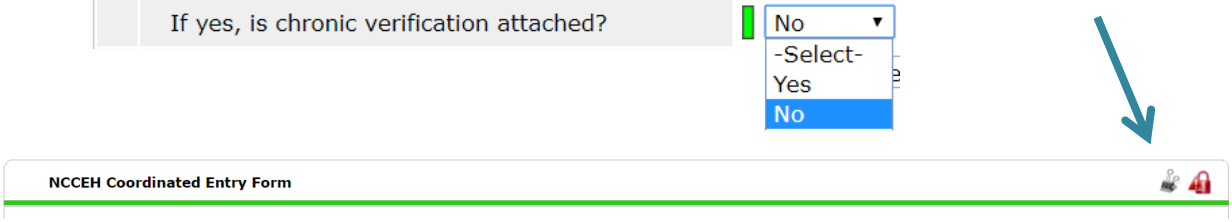
Coordinated Entry Form Fields

Complete for each client/household as they move through the CE process and get housed. All these fields will appear on the By-Name List report for community discussion and awareness.

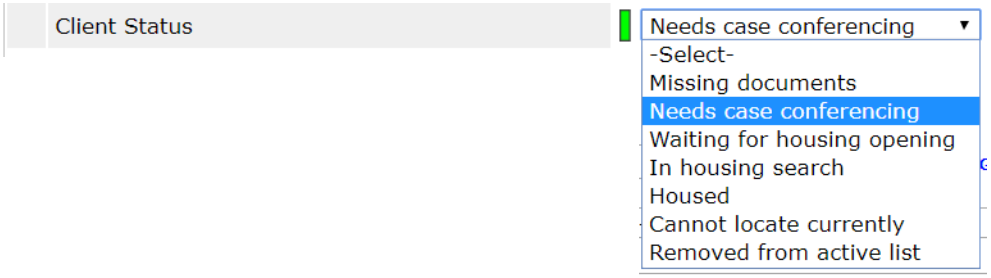
1. **Is Client Chronically Homeless?:** Is the Head of Household Chronically Homeless? This will be the field that pulls on the by name list report. If you do not complete this field for clients, then that column will not populate with information for them. ART and the homeless history are imperfect ways of tracking chronic status currently so we have provided this option instead so communities have more control and can make sure those clients that are chronic get marked as chronic on their by name list reports.



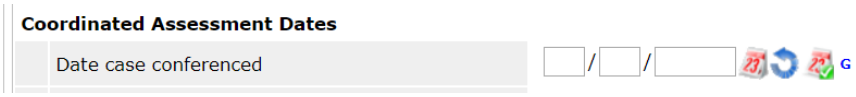
2. **If yes, is chronic verification attached?:** If yes, then attach the verification to the assessment via the binder in the upper right hand corner if wanted. Please note that verification is NOT required if yes is entered to a client being chronic, it's just an opportunity to attach it so it doesn't get lost.



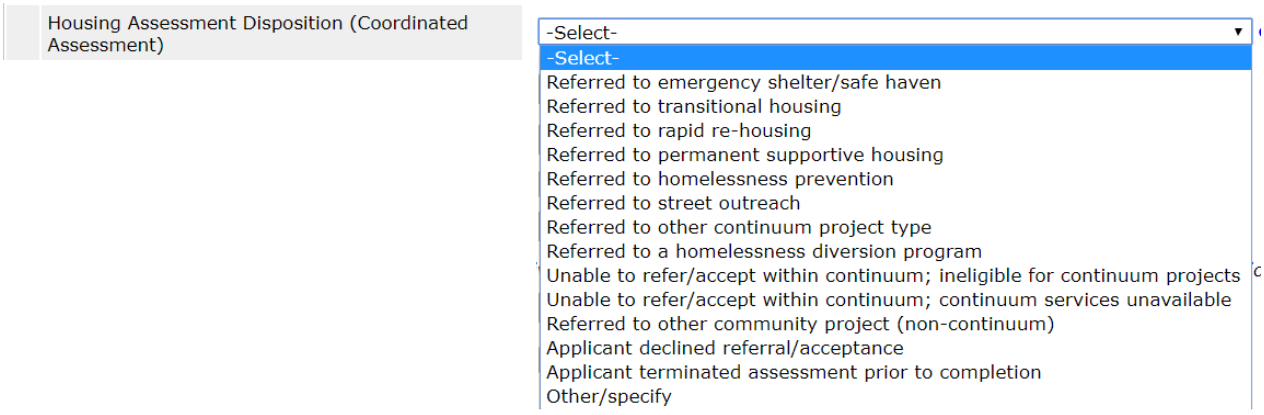
3. **Client Status:** What is the Head of Household's current phase/status in the coordinated entry process?



4. **Date case conferenced:** On what date was the Head of Household's needs and housing matches discussed in-depth. We are aware that case conferencing means different things in different regions. You can use this field for the date that makes the most sense for your community. However, just getting an update on a client probably should not count as a case conferencing date for this purpose.

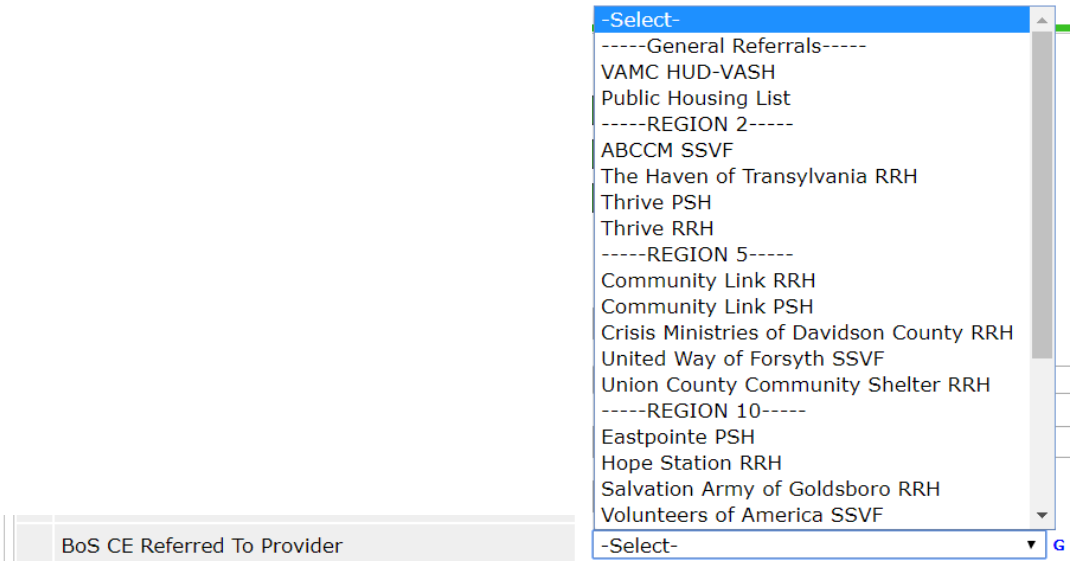


5. **Housing Assessment Disposition (Coordinated Assessment):** What is the Head of Household's referral status? If other/specify is chosen, please use the text box below to elaborate, but only use this option if the other ones are not applicable.

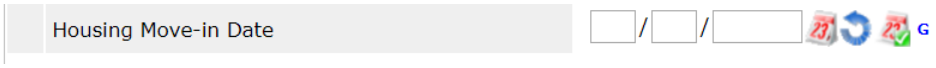


6. **Date referred to a housing provider:** When was the client referred to an open housing slot and matched with an appropriate provider?

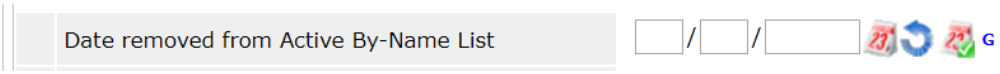
7. **BoS CE Referred to Provider:** Which agency/program was the Head of Household referred to? This allows SSO grantees to track which agencies to follow-up with about referrals and housing.



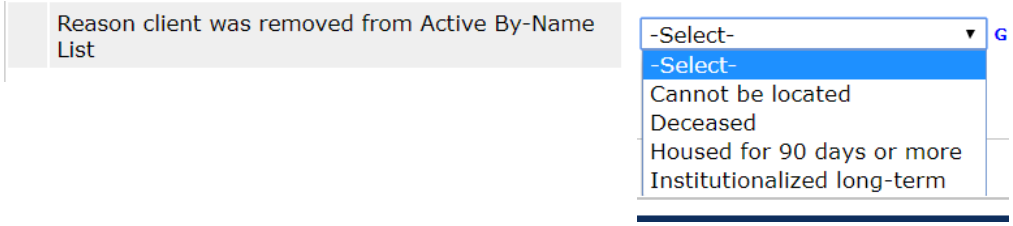
8. **Housing Move-in Date:** When was the Head of Household permanently housed? This field will NOT pre-populate with data so the SSO grantee must add this in.



9. **Date removed from Active By-Name List:** When was the client removed from the active list?



10. **Reason client was removed from Active By-Name List:** Why is the Head of Household no longer on the By-Name List? Remove people from the by name list after they have been housed for 90 days, they cannot be located for a period of time, they are entering an institution for long-term or they have died.



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Section: Service Transactions

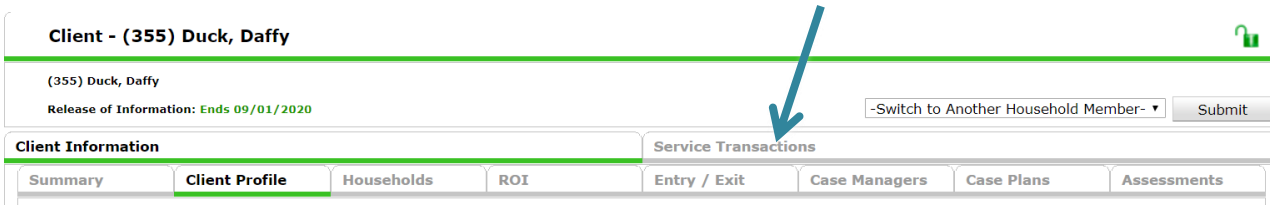
Service transactions allow agencies to track services they directly provide to clients. EVERY time a grantee provides an eligible service to a specific person/household a service transaction must be entered into HMIS. NCCEH has identified the applicable service codes. These are the only service codes that should be used. If you are providing a service not listed below, contact NCCEH for guidance:

Service Code	Service Code Name	SSO Grantee Activity
BH-0500.3200	Housing related coordinated entry	VI-SPDAT assessment
BH-0500.3100	Homeless diversion programs	P&D screen
BH-0500.3140	Homelessness Prevention programs	Prevention Activities
PH-8000	Street Outreach Programs	Street outreach Activities
PH-1000.8500	transitional case/care management	Developing housing plan/other case management
TJ-3000.8000	specialized information and referral	Information/referrals
FP-0500.8000	system advocacy	system advocacy
DD-1500.4650	Housing Complaints	Handling grievances

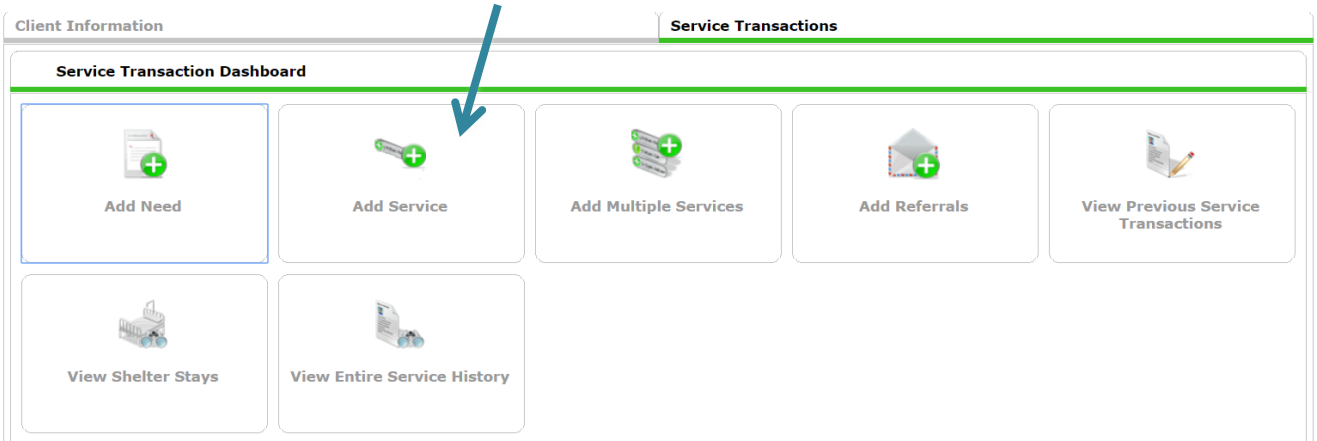
Add a Service Transaction

As with other data entry you should ALWAYS be in EDA mode for the correct SSO project when entering service transactions for the SSO grant activities. You can use back date mode as needed as well.

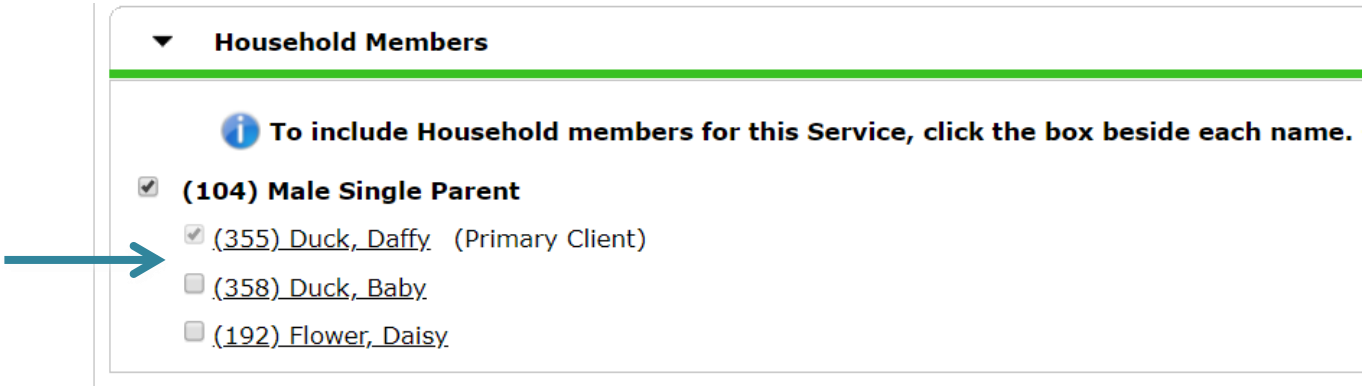
1. Navigate to the client profile for the Head of Household.
2. Click on the *Service Transactions* tab.



3. Click Add Service.

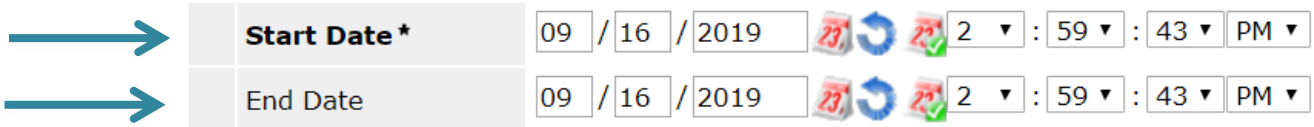


4. Check additional household members that are receiving that service. Not all members will always be provided the same service or a service.

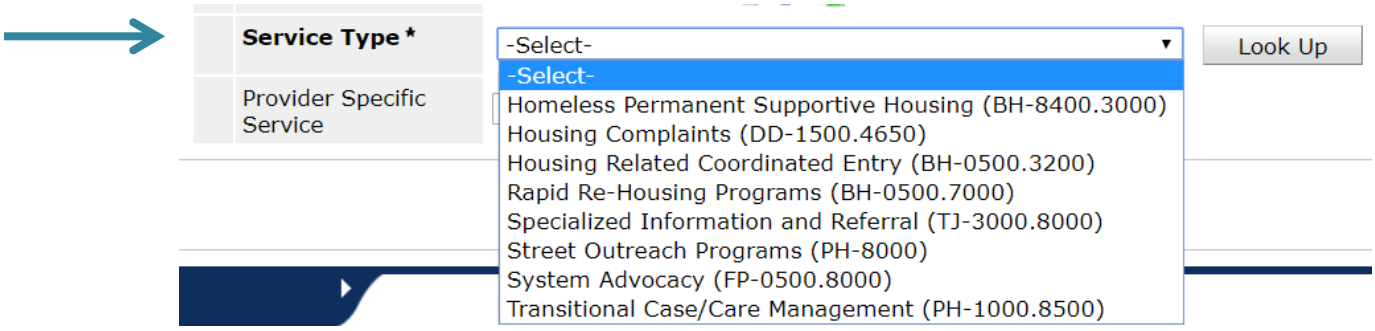


5. Ensure that Service Provider is correct SSO project before you enter data.

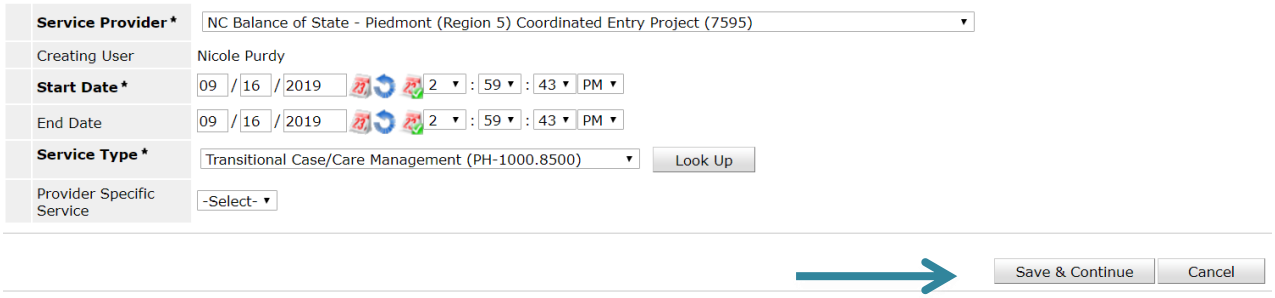
6. Start Date will auto-populate to the back date or current date. End date will usually be the same date as the Start Date as most applicable services are provided the same day. Create a separate service transaction for each session of case management the person/household receives.



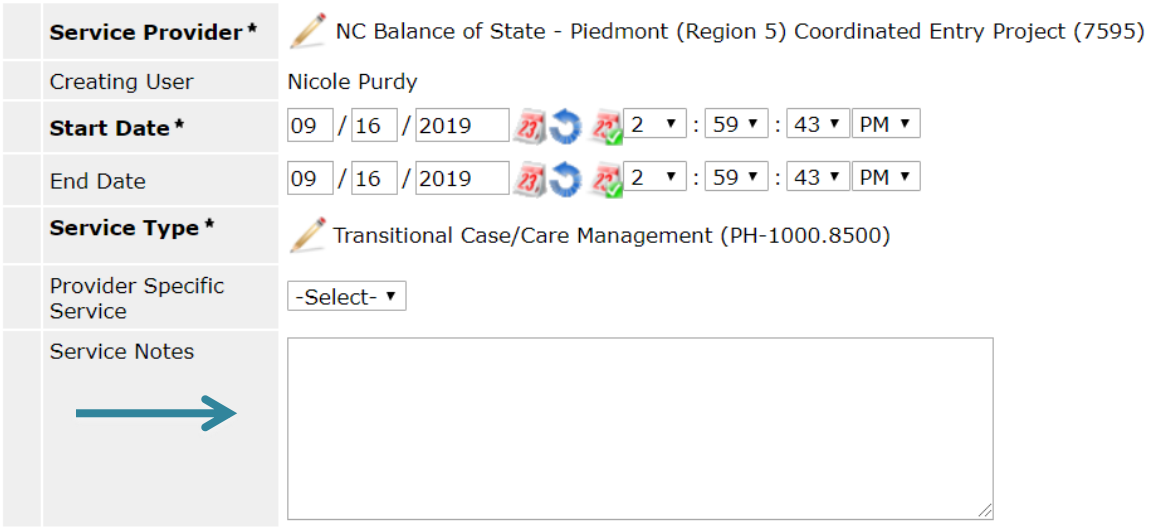
7. Select Service Type from the drop-down menu.



8. Click Save & Continue.

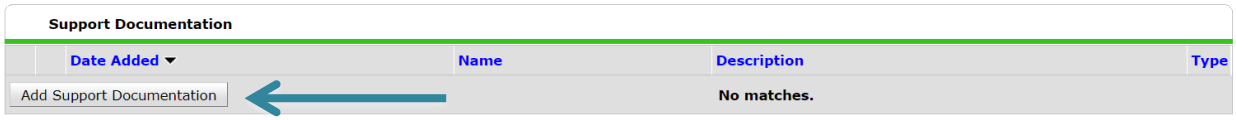


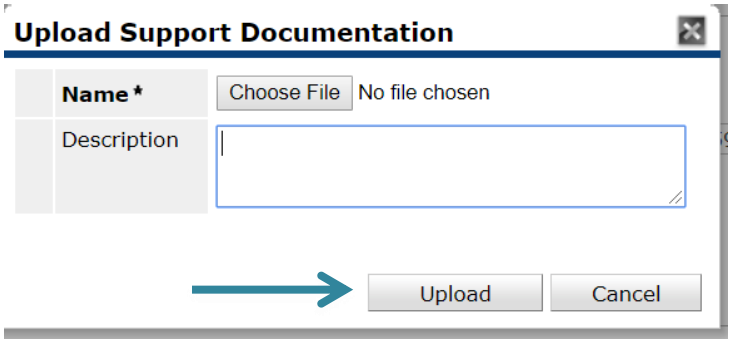
9. Add a Service Note (optional). This will only be visible when within that specific service transaction.



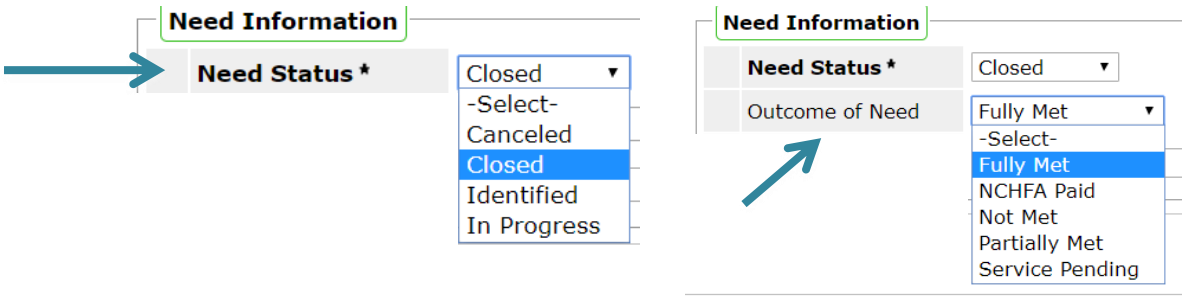
10. Skip the next few sections.

11. Support Documentation is optional, but file attachments can be added under this section. Click Add Support Documentation, select a file, add a description, and click Upload.

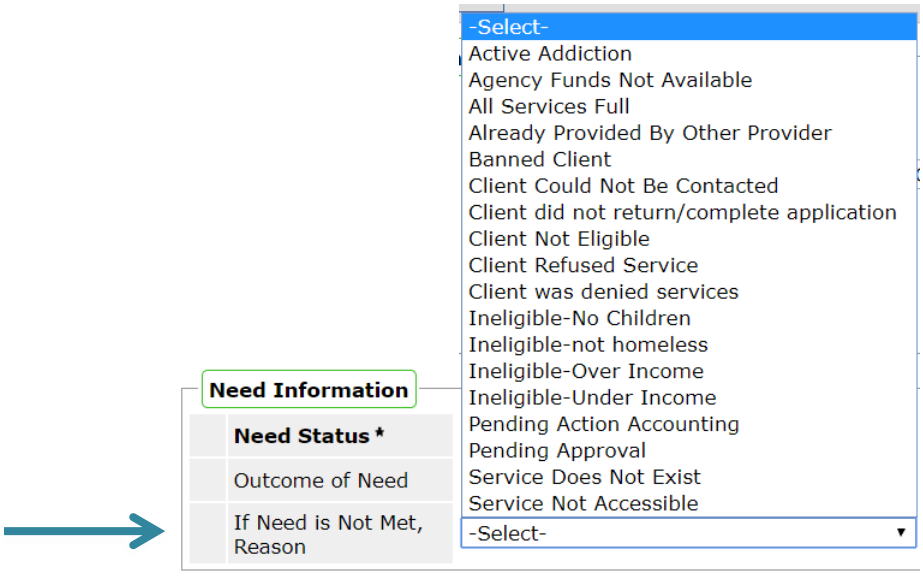




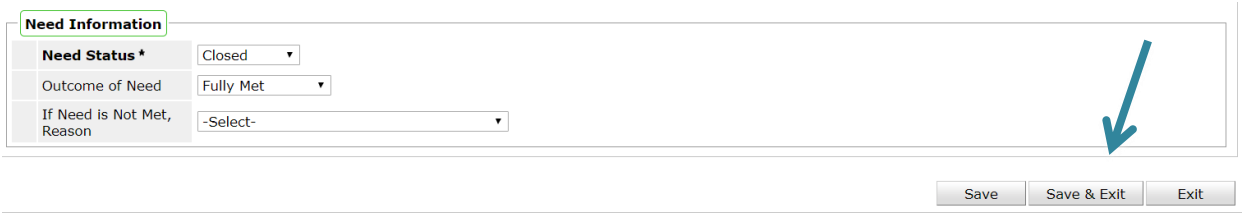
12. Scroll down to Need Information. Most often the Need Status will be Closed, and the Outcome of Need will be Fully Met. Leave Need Status as In Progress if there is more to do but update the Need Status after the service is complete.



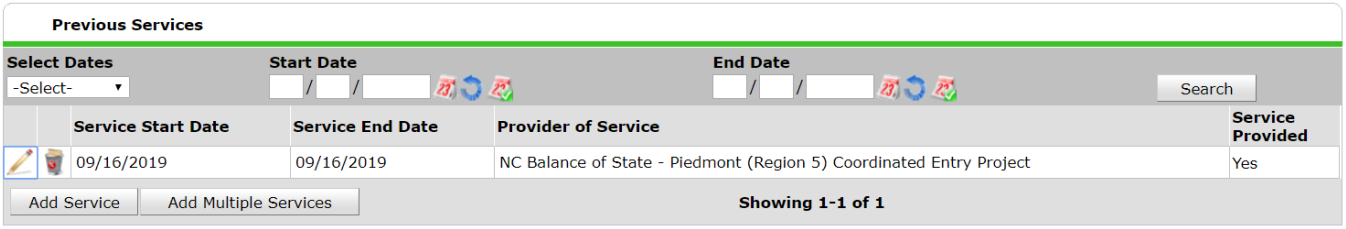
13. If Outcome of Need is Not Met, then select appropriate reason.



14. Click Save & Exit.



15. Check to ensure service shows up on services tab.



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Section: Referrals to Permanent Housing Provider

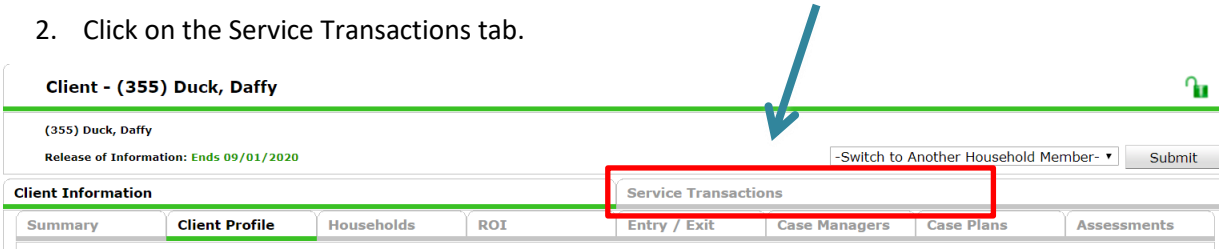
Every person/household that is matched with a HMIS-participating provider should have a referral to that provider in HMIS entered during or after case conferencing. If they are non-HMIS participating, then the provider will have to receive the referral some other way.

Create an HMIS referral to Housing Provider

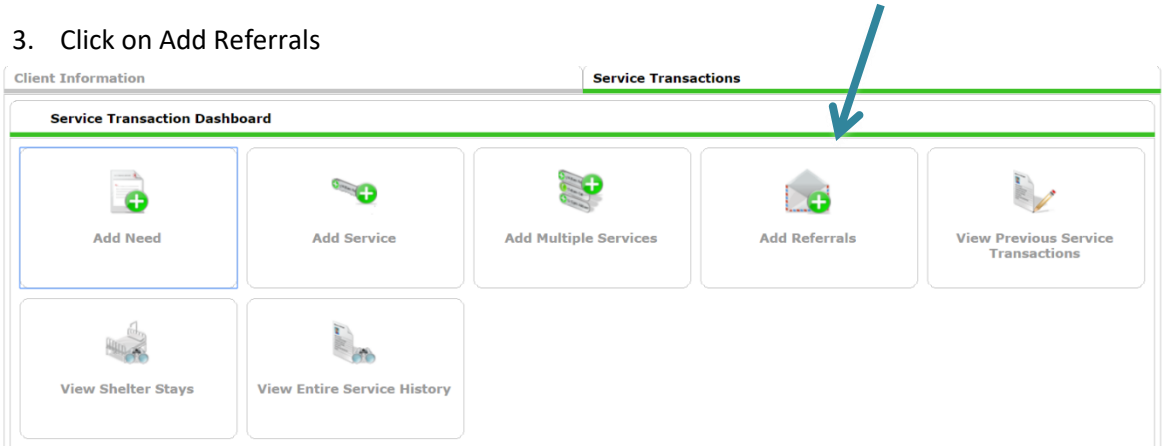
As with other data entry you should ALWAYS be in EDA mode for the Coordinated Entry project when entering referrals from the CE Project to housing providers. Use back date mode if needed.

1. Navigate to the client profile for the Head of Household.

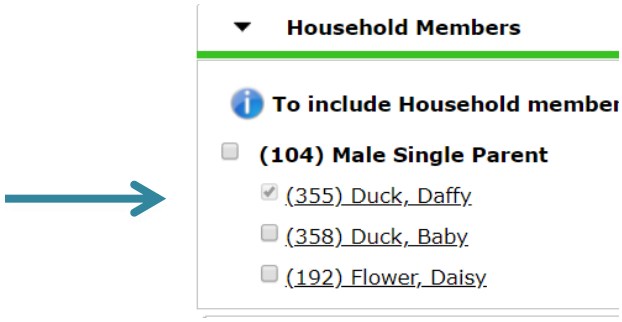
2. Click on the Service Transactions tab.



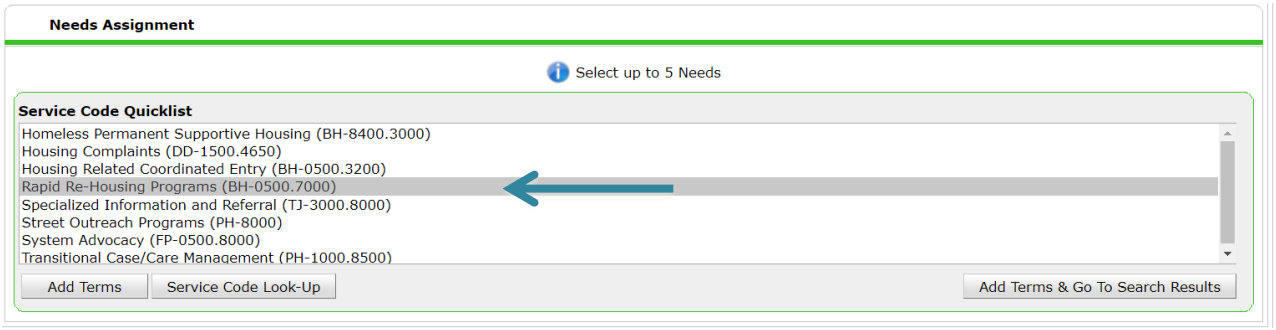
3. Click on Add Referrals



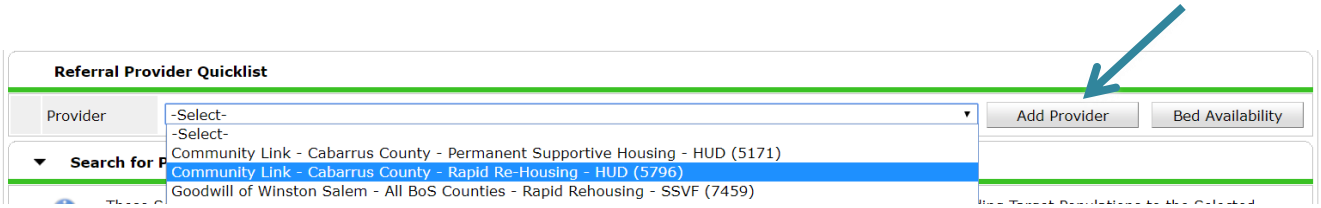
4. Referrals should only be created for Head of Households.



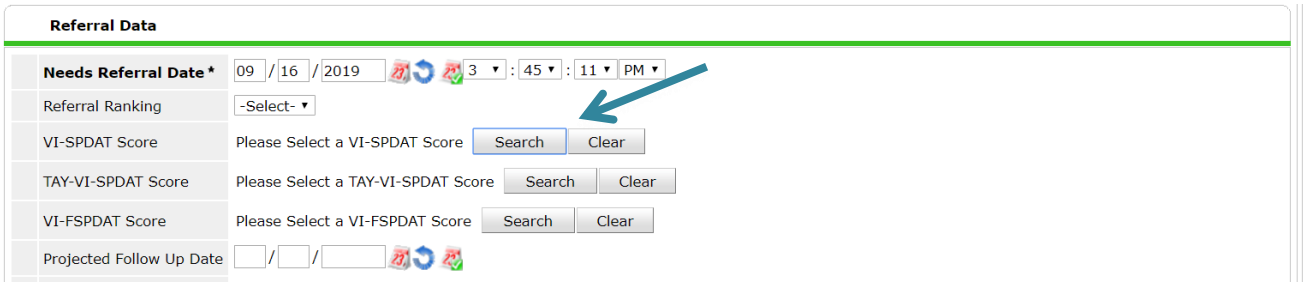
5. Select housing service from the Needs Assignment Service Code Quicklist and click Add Terms.

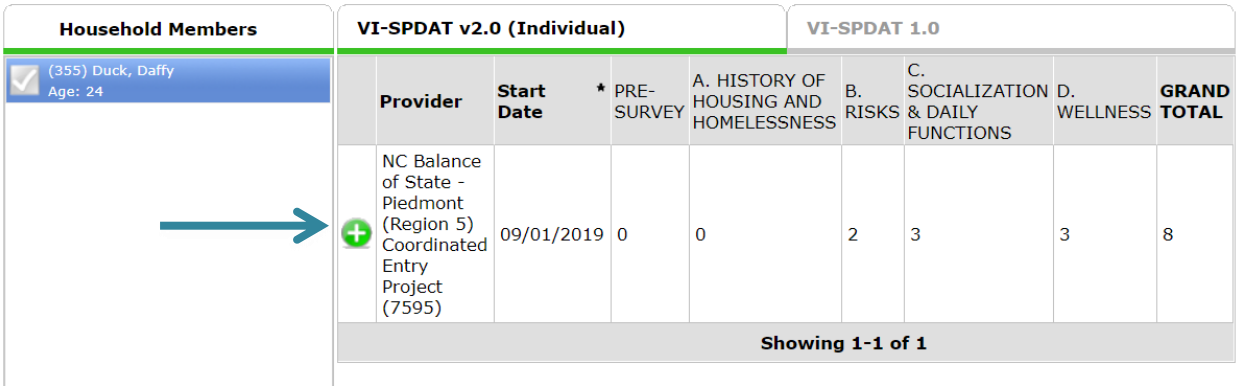


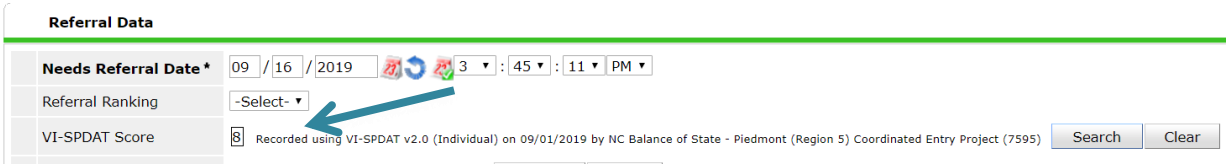
6. Select the correct housing provider from the Referral Provider Quicklist and click Add Provider.



7. Scroll down to Referral Data and add VI-SPDAT by clicking Search next to the assessment type then clicking the green plus sign next to the VI-SPDAT assessment you want to add.

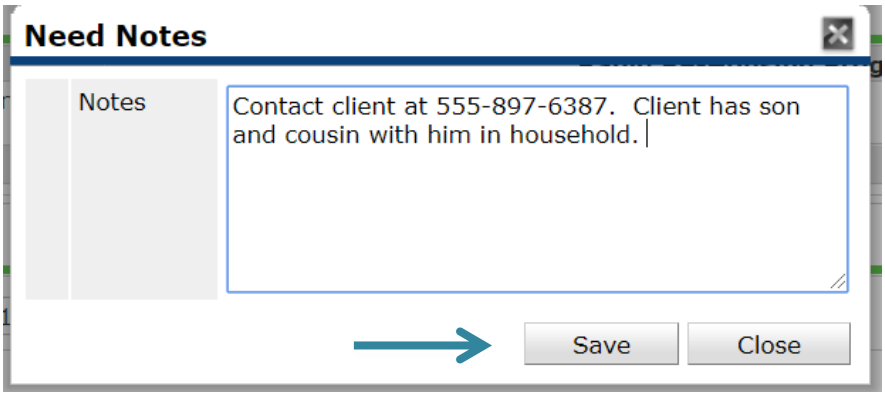




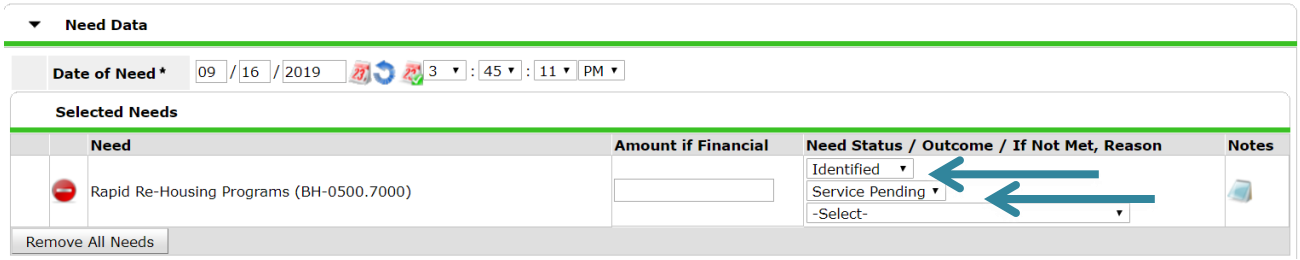


8. Click the box under referrals or the referral **<u>will not</u>** send correctly.

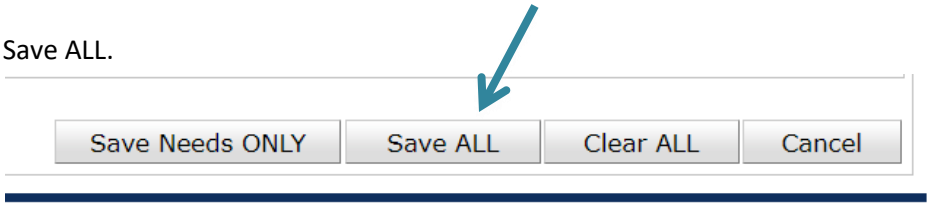
9. Scroll down to Need Data. Add a note with pertienent information including client contact information, and the household composition information if appropriate.



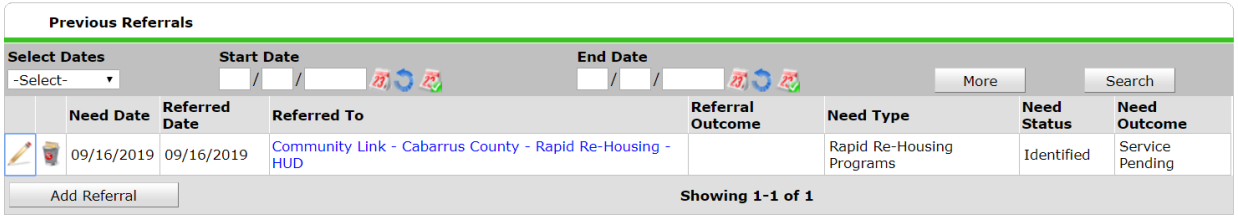
10. Change Need Status to Identified and Outcome to Service Pending.



11. Click Save ALL.



12. Confirm that referral shows up appropriately on tab.



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Section: Interim Assessments

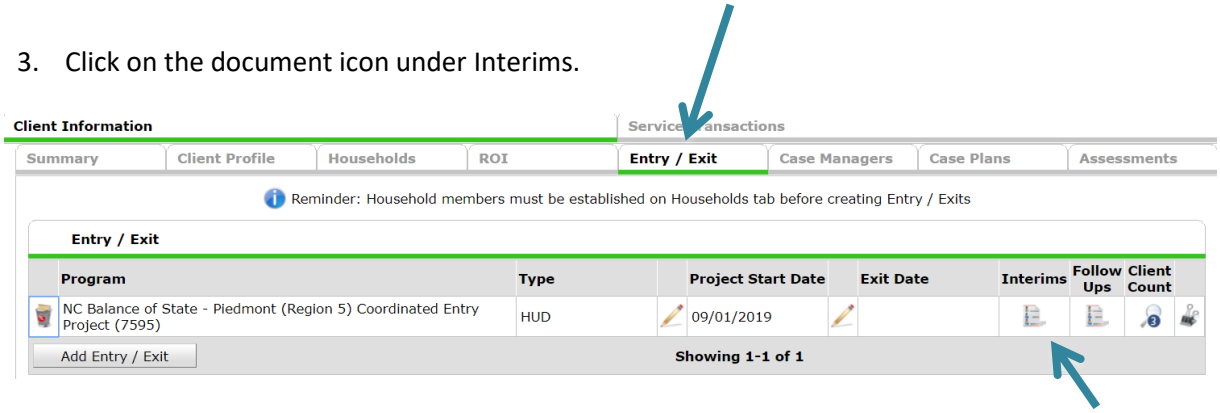
Interim assessments are completed if there is a change in information such as income, disability, non-cash benefits, or insurance. An Annual Assessment should be completed on the anniversary of the Head of Household's Project Start Date. It should be completed within 30 days before or after the anniversary.

Add Interim Assessment

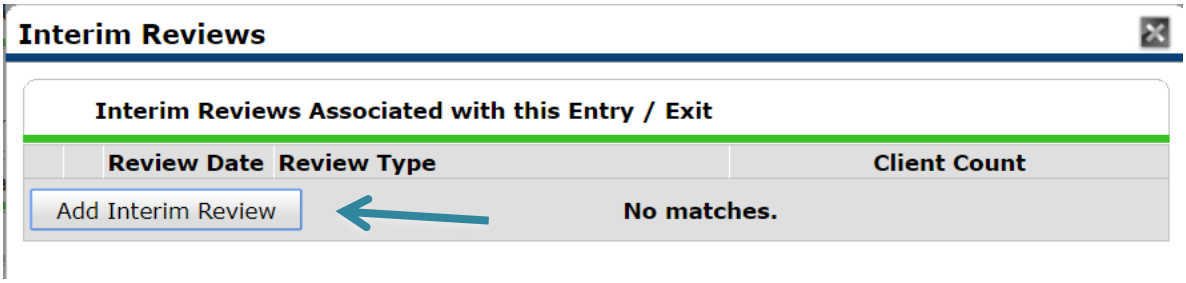
As with other data entry you should ALWAYS be in EDA mode for the Coordinated Entry project when entering interim assessments. You can use back date mode as needed as well. The interim date should be the date that the change occurred or within 30 days of entry anniversary for annual updates.

1. Navigate to the client profile for the Head of Household.
2. Click on the Entry/Exit tab.

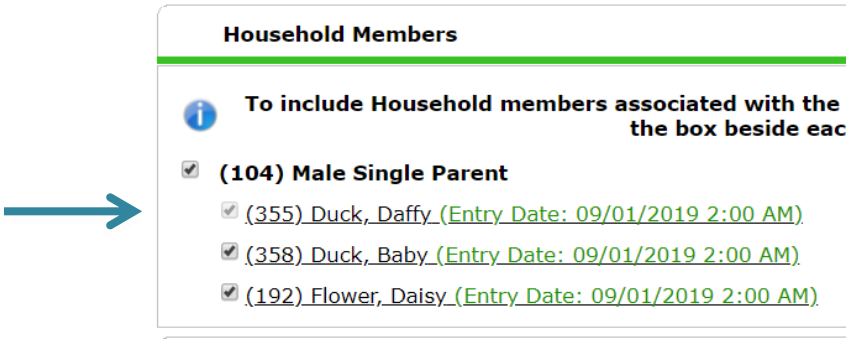
3. Click on the document icon under Interims.



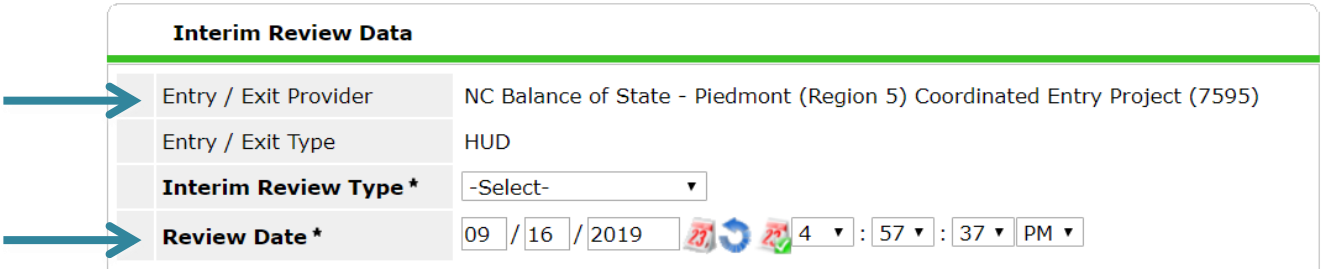
4. Click Add Interim Review



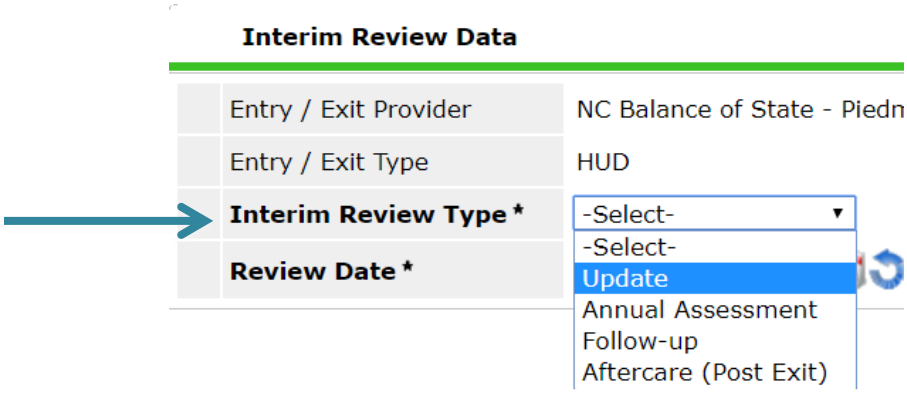
5. Check boxes next to all household members (if client has household).



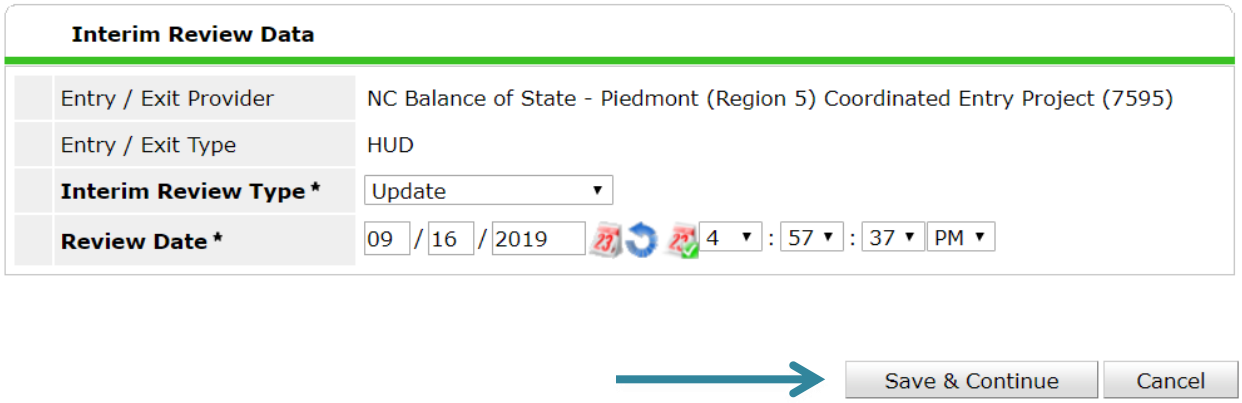
6. Ensure Entry/Exit Provider is CE Project and Review Date is correct back date or current date.



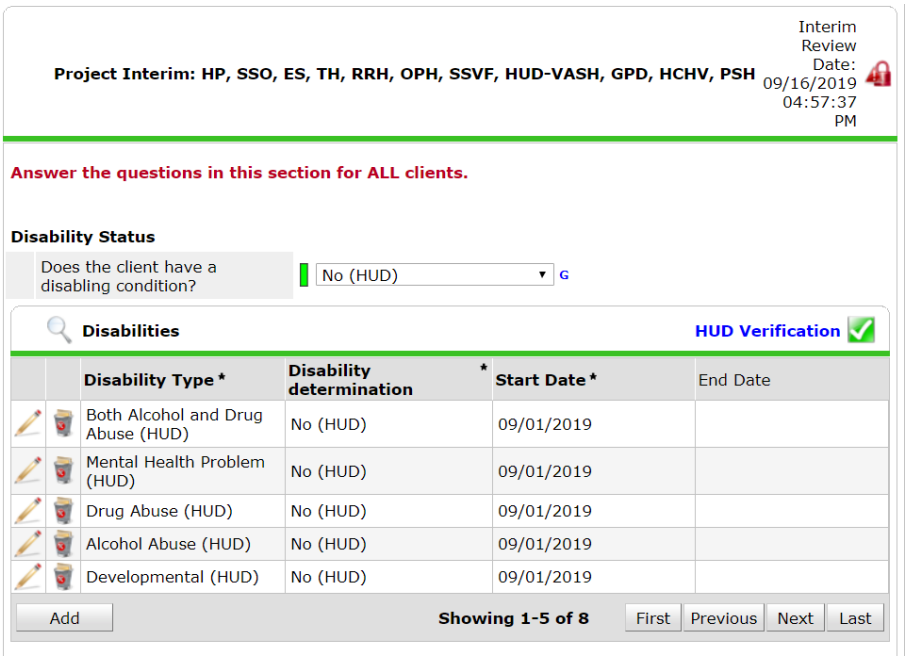
7. Select appropriate Interim Review Type of Update or Annual Assessment as described above.



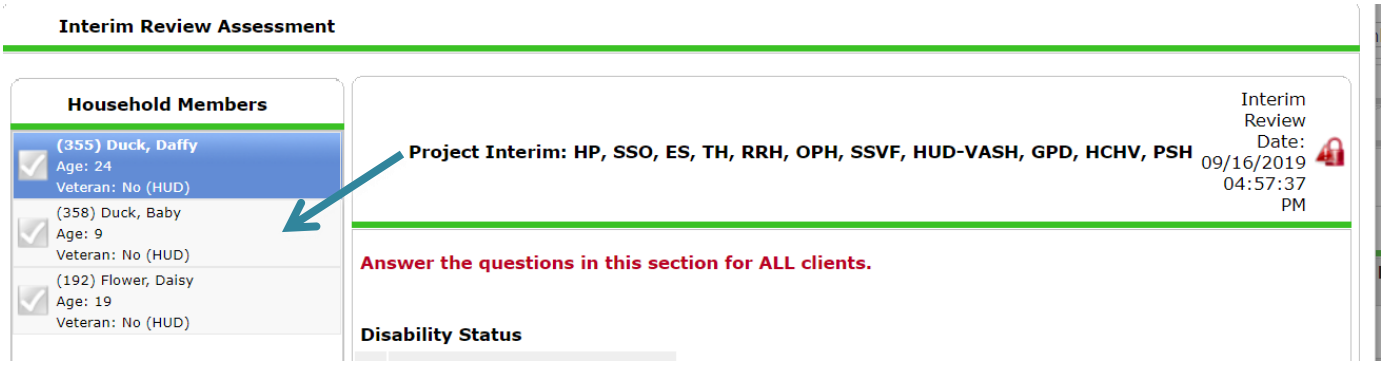
8. Click Save & Continue.



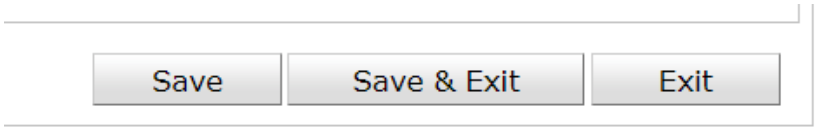
9. Update information on the interim assessment as appropriate.



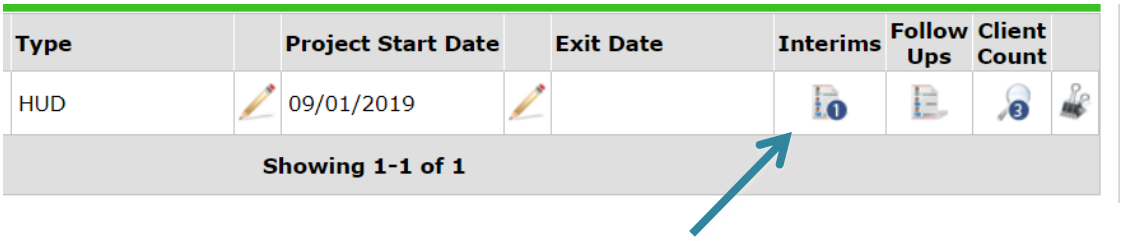
10. If needed, click on the other household members on the left-hand side of the screen to update their information as well.



11. Click Save & Exit at the bottom of assessment.



12. Confirm Interim shows up on Entry/Exit tab.



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Section: Coordinated Entry Exit

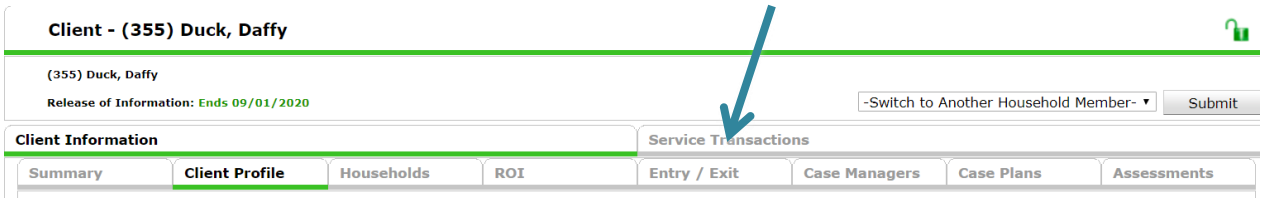
Every person entered into the CE Project also needs an exit out of the CE Project at some point. Exited people will no longer pull on the By-Name List report. A person/household should be exited when:

1. They have been housed for 90 days or more either through self-resolution or a housing provider.
2. They have not been able to be located or contacted for a community-specified amount of time (90 days or more).
3. They are going to an institution for long term (assisted living, nursing home, jail, prison etc).
4. They have passed away.

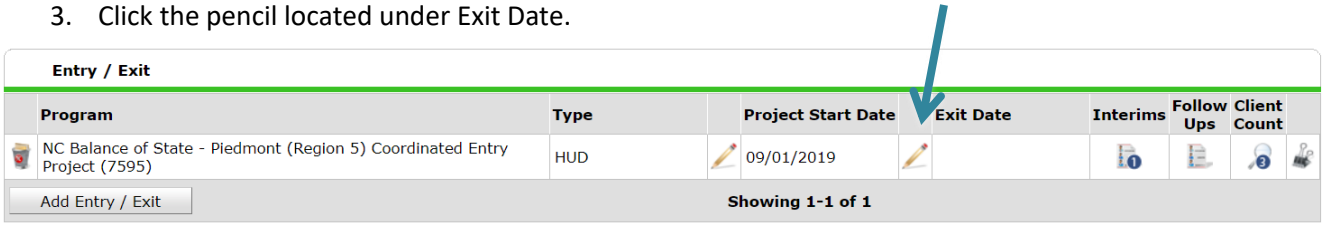
Add Coordinated Entry Project Exit

As with other data entry you should ALWAYS be in EDA mode for the Coordinated Entry project when entering exits. You can use back date mode as needed as well. The exit date should be the date that the client/household was housed for 90 days, could not be located cut off date, entered the institution or passed away.

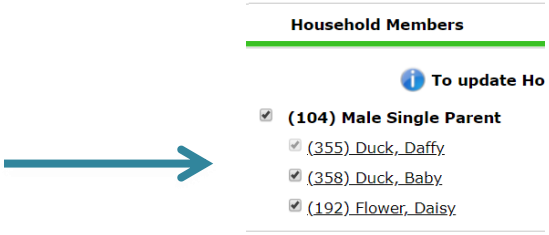
1. Navigate to the client profile for the Head of Household.
2. Click on the Entry/Exit tab.



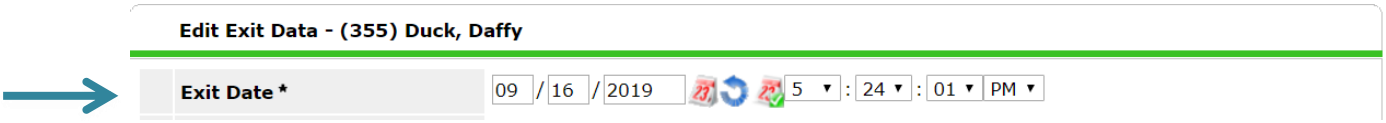
3. Click the pencil located under Exit Date.



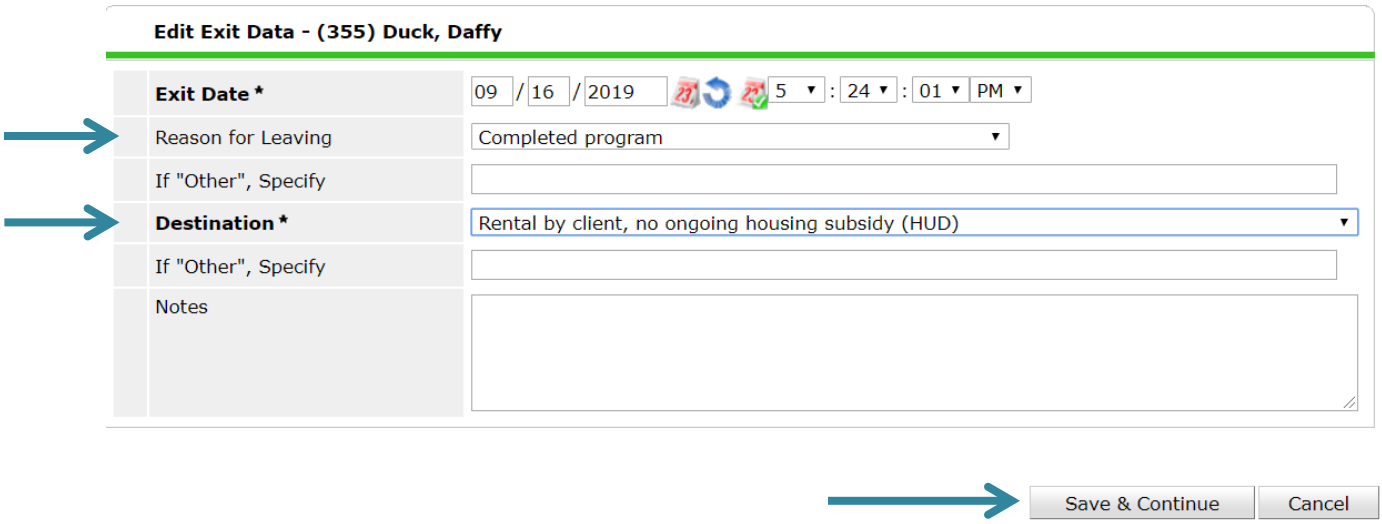
4. Check the boxes for all household members that need to be exited at this time.



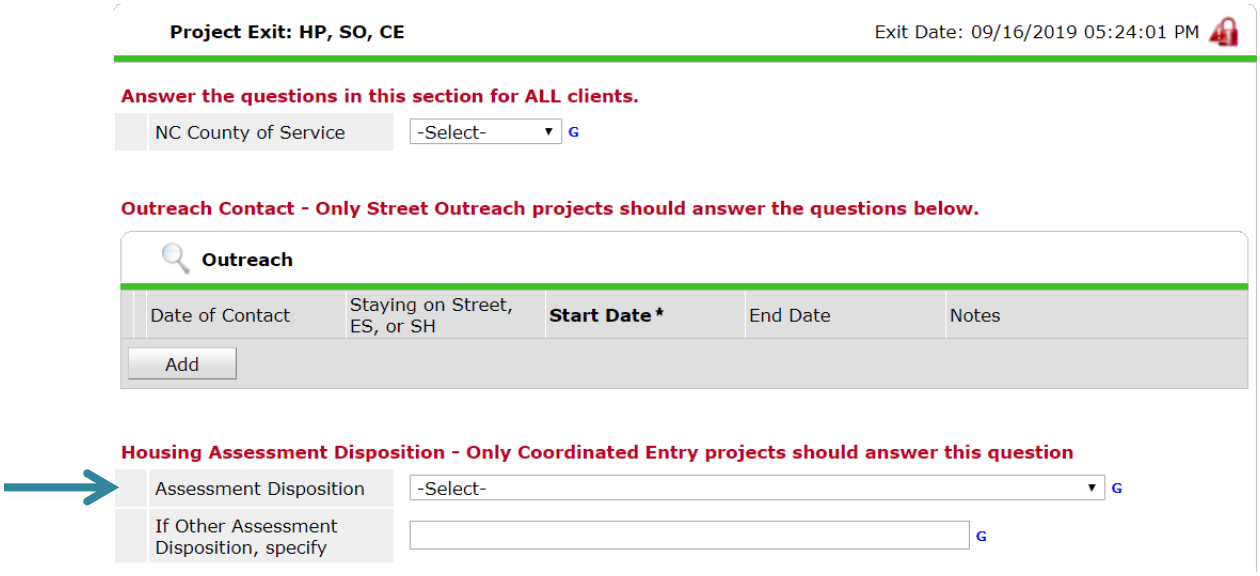
5. Check to ensure that the Exit Date is the appropriate date. If not your Backdate might be incorrect and should be checked before continuing.



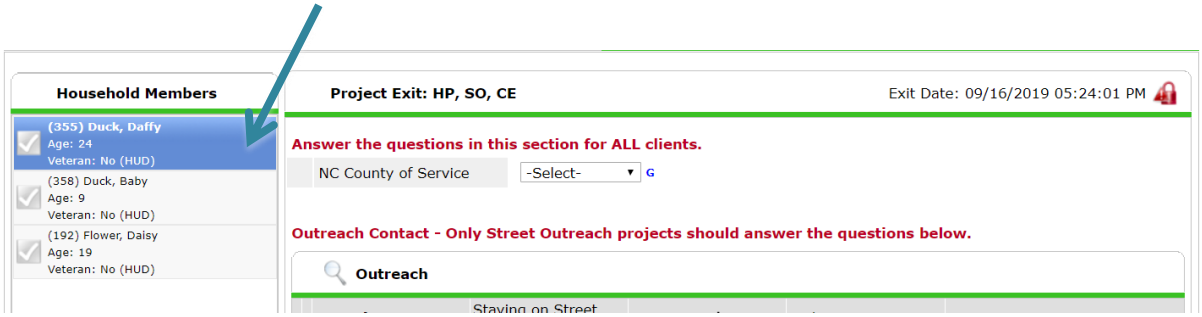
6. Select appropriate Reason for Leaving and Destination options. Please do not select Other if another option could be used. Click Save & Continue.



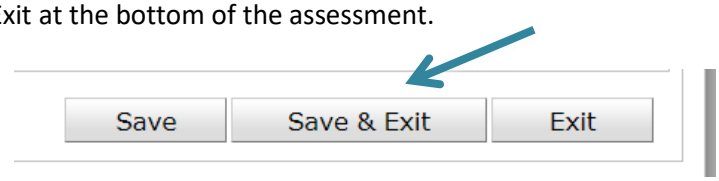
7. Complete and update the information on the Exit Assessment. Including the Housing Assessment Disposition field.



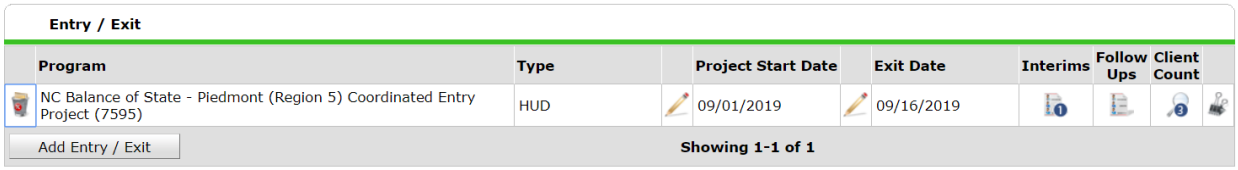
8. Navigate to other household members to update exit information if needed after clicking Save.



9. Click Save & Exit at the bottom of the assessment.



10. Confirm exit shows up on Entry/Exit tab.



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Section: Prevention and Diversion Workflow and Eligibility

Every person/household should have a Prevention/Diversion assessment in attempt to divert them from the homelessness system and attempt to find another solution to their housing crisis besides entering the homelessness system. The SSO grant does allow grantees to provide a prevention and diversion screen as well as some diversion services to clients.

Prevention and Diversion Eligibility

Not everyone is eligible or appropriate for prevention and diversion assessment and/or services by the SSO grantee:

1. People/households that are newly literally homeless (Category 1) and sheltered are eligible. Those that are unsheltered or homeless for 2+ weeks should skip the diversion assessments/services and immediately be assessed for Coordinated Entry.
2. People/households imminently at-risk of becoming homeless within the next 14 days (Category 2) are eligible and will be the majority of clients for this workflow.
3. People/households fleeing domestic violence (Category 4) are eligible. However, they will likely need a referral to a Domestic Violence shelter or hotline.
4. People/households not literally homeless or at risk of being homeless in the next 14 days are not eligible and should be referred to another resource.

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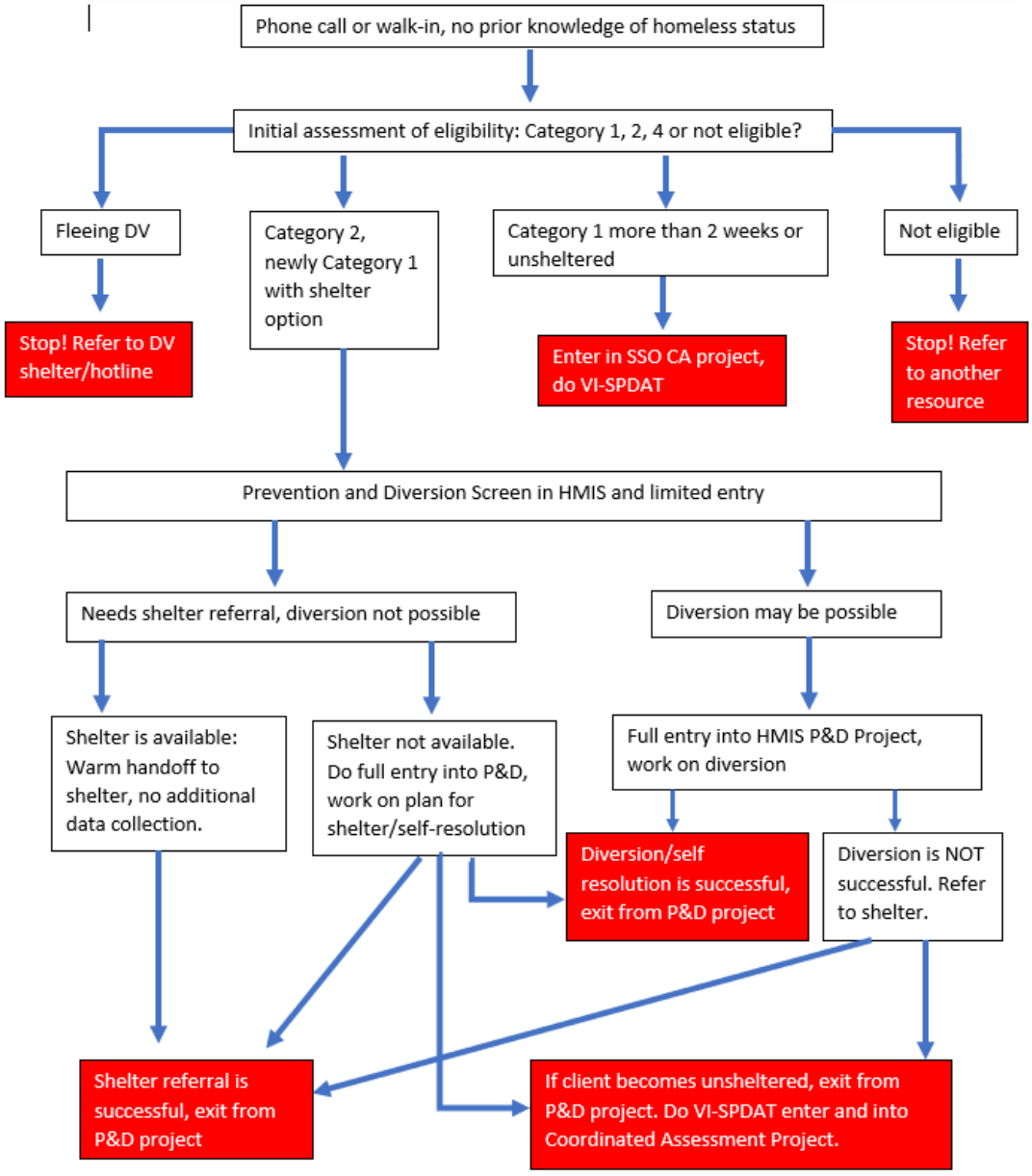
Prevention and Diversion Workflow



1. If a person/household calls or walks-in with no homeless status complete an eligibility assessment via paper form to determine if prevention and diversion is appropriate:
    a. Refer ineligible people/households elsewhere as listed above.
    b. Eligible people/households should be assessed per the workflow.

2. Eligible people/households should receive a prevention and diversion screen/conversation and a limited HMIS entry created.

3. If diversion is not possible and the people/households still need shelter, then:
    a. If a shelter bed is available complete a warm handoff to shelter and stop data collection.

b. If a shelter bed is not available, then complete a full HMIS entry for the Prevention and Diversion project collecting the additional data and then work on a plan for shelter or self-resolution with the person/household.

4. If diversion may be possible, then complete a full HMIS entry for the Prevention and Diversion project collecting the additional data and work on a diversion plan:
    a. If diversion is successful, follow through with diversion plan/services as needed.
    b. If diversion is not successful, refer to shelter or work on a plan for shelter/self-resolution.

5. SSO grantee should follow through on shelter referral, diversion plan, self-resolution plan or CE assessment as appropriate. An HMIS exit for the P&D project should usually be completed for that same day after:

    a. Shelter referral is successful.
    b. Diversion/self-resolution is successful.
    c. Client becomes unsheltered.

6. Clients that become unsheltered should be assessed with the VI-SPDAT and entered into the Coordinated Entry Project and that workflow should start.

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Section: Prevention and Diversion Screen and Limited Entry

Every client who may be able to be diverted from homelessness should get the prevention and diversion screen and conversation. The full screens should be tracked in HMIS by doing a limited entry into the prevention and diversion project. Clients that are only assessed for eligibility do NOT need to be entered into HMIS, only those clients that receive the full screen.

Step 1. Initial Assessment of Eligibility

Every client should get the initial assessment of eligibility. This assessment is the first part of the Prevention and Diversion Screen. If a client is not eligible their data does not need to be entered into HMIS.

NC Balance of State Prevention and Diversion Screen Form

Initial Homeless Assessment

1. **Are you homeless or do you believe you will become homeless in the next 72 hours?**
   ☐ Yes ☐ No

2. **Are you currently residing with, or trying to leave an intimate partner, family member, caregiver, or other person in your home who threatens you or makes you fearful?**
   ☐ Yes ☐ No

STOP *If yes to Question 2, refer to DV resources. If yes to second question, clients are referred to DV resources and DO NOT PROCEED WITH THIS ASSESSMENT or any part of the Coordinated Entry process*

3. **Where did you sleep last night?**

☐	Place not meant for habitation	☐	Interim Housing
☐	Foster care home or foster care group home	☐	Hospital or other residential non-psychiatric medical facility
☐	Jail, prison or juvenile detention facility	☐	Long-term care facility or nursing home
☐	Psychiatric hospital or other psychiatric facility	☐	Substance abuse treatment facility or detox center
☐	Hotel or motel paid for without emergency shelter voucher	☐	Owned by client, no ongoing housing subsidy
☐	Owned by client, with ongoing housing subsidy	☐	Permanent housing (other than RRH) for formerly homeless persons
☐	Rental by client, no ongoing housing subsidy	☐	Rental by client, with VASH subsidy
☐	Rental by client, with GPD TIP subsidy	☐	Rental by client, with other ongoing housing subsidy (including RRH)
☐	Residential project or hallway house with no homeless criteria	☐	Staying or living in a family member's room, apartment or house
☐	Staying or living in a friend's room, apartment or house	☐	Transitional housing for homeless persons (including homeless youth)
☐	Client doesn't know	☐	Client refused
☐	Emergency Shelter, including hotel or motel paid for with emergency shelter voucher		

4. **Was it a safe location?** ☐ Yes ☐ No

5. **If client slept in a homeless location last night based on their response to question 3 ask: How long have you stayed there?** ☐ Less than 2 weeks ☐ Longer than 2 weeks

STOP *If client is literally homeless for less than 2 weeks, skip to gathering demographic information. If client has been literally homeless for more than 2 weeks or unsheltered, start VI-SDPAT. If client is fleeing DV, refer to DV resources.*

If the client is not literally homeless and they answered No to Question 1, ask:

6. **Will you be forced to leave your current housing in the next 14 days?** ☐ Yes ☐ No

7. **If yes, is it for any of the following reasons:**
   - ☐ In a hotel/motel, client does not have the resources to pay for the room for more than 14 days.
   - ☐ In a rental unit, client has received a court order to leave in the next 14 days.
   - ☐ In a rental unit owned or leased by someone else, that person is requiring the client to leave the unit in the next 14 days.

STOP *If the client answers No to Question 6 or they do not meet the criteria in Question 7, they are not eligible. Refer them to a mainstream resource. If client answers Yes to Question 6 and meets Question 7 criteria, continue with screen and start collecting homeless verification documentation.*

1. Start initial homeless assessment at question 1 on the Prevention and Diversion Screen paper form and follow directions on the form depending on the client's answers.
2. If client responses yes to Question 2 refer to an appropriate DV shelter or hotline.
3. If client is not literally homeless or at risk of becoming homeless in the next 14 days refer to another resource, they are not eligible for SSO-CE services.
4. If client is literally homeless for more than 2 weeks or is currently unsheltered start VI-SPDAT assessment and Coordinated Entry workflow.
5. If client is at risk of being homeless in the next 14 days or newly homeless continue with screen to provide prevention and diversion conversation and services.
6. Gather demographic information and complete screen and conversation.

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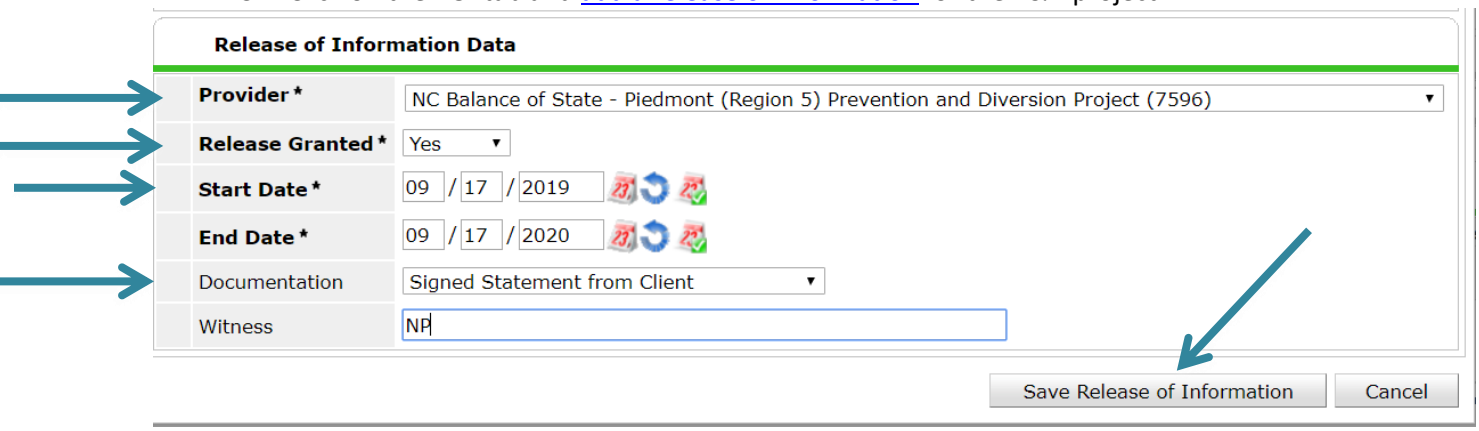
Step 2. Client Profile Set-up

As with other data entry you should ALWAYS be in EDA mode for the Prevention and Diversion project when entering prevention and diversion data. You can use back date mode as needed as well. Only full screens need to be entered into HMIS, if client person/household is ineligible then do NOT enter into HMIS.

1. Navigate to the Client Profile tab and update Client Demographics by clicking the pencil. Search for or create client profile (if needed).

2. Update or create household (if appropriate).

3. Click on the ROI tab and add a release of information for the P&D project.



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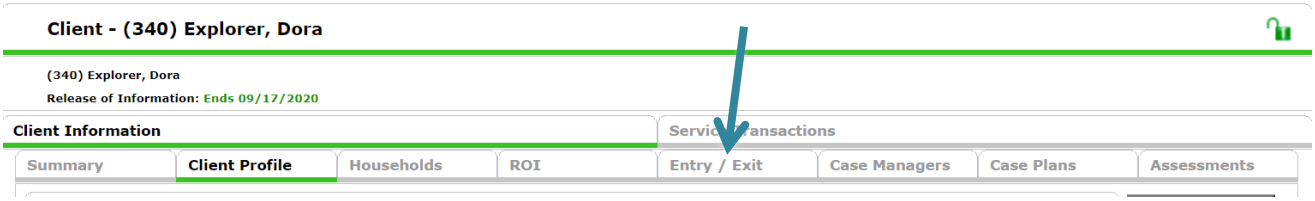
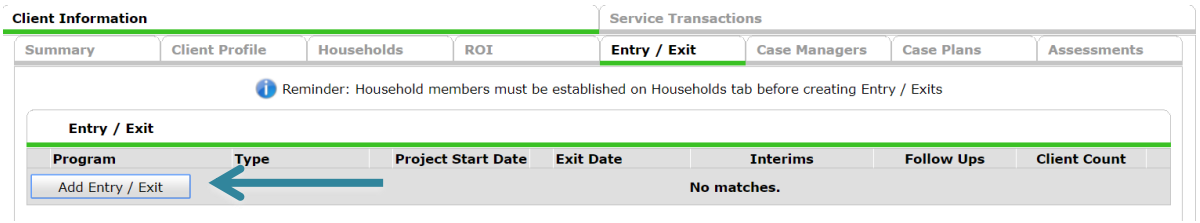
Step 3. Add Prevention and Diversion Project Entry

As with other data entry you should ALWAYS be in EDA mode for the Prevention and Diversion project when entering prevention and diversion data.

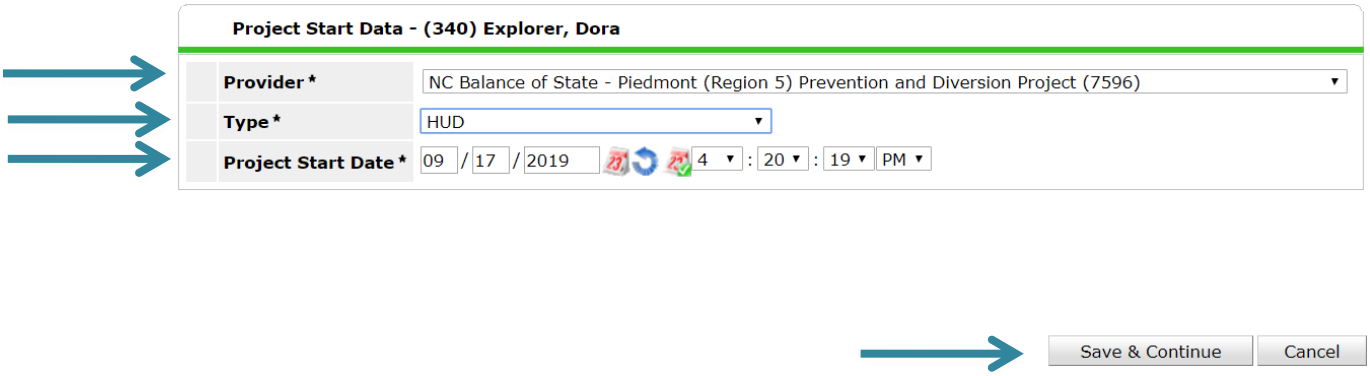
1. Once in client's profile click on the Entry/Exit tab.



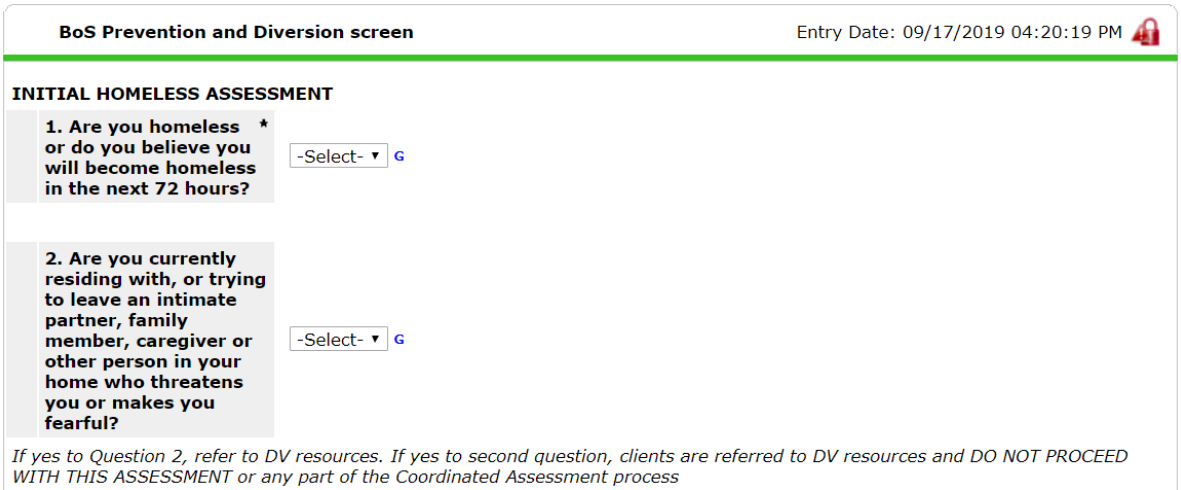
2. Click on the Add Entry/Exit.



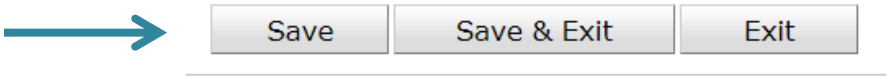
3. Confirm provider is the Prevention and Diversion Project and Project Start Date is the back date or todays date before continuing. Select HUD for Type and click Save & Continue.



4. Complete Prevention and Diversion screen. Answer as many fields as appropriate beginning with the Initial Homeless Assessment.



5. Click Save at the bottom of the assessment. If client requires a full P&D entry according to the workflow continue on to the next section. If they only required a limited P&D entry click Save & Exit.



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Section: Full Prevention and Diversion Entry

Some people/households will require a full entry into the P&D project for these scenarios:

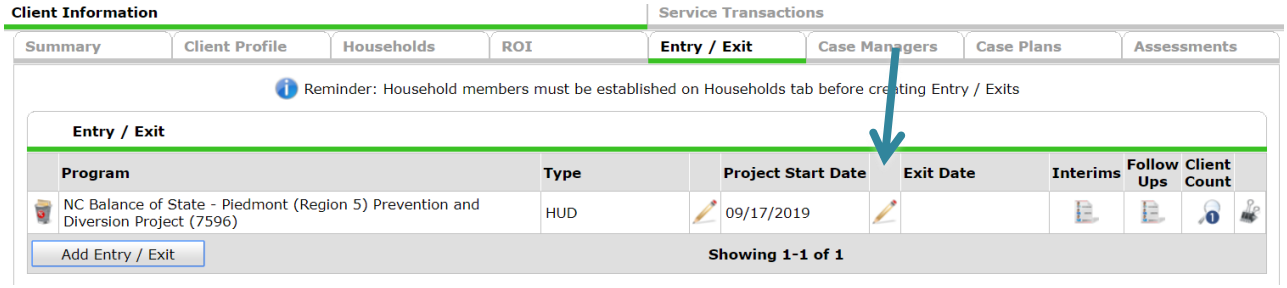
1. Neither diversion nor shelter is possible so SSO grantee will work on a plan for shelter or self-resolution with person/household.

2. Diversion may be possible so SSO grantee will work on a diversion/self-resolution plan.

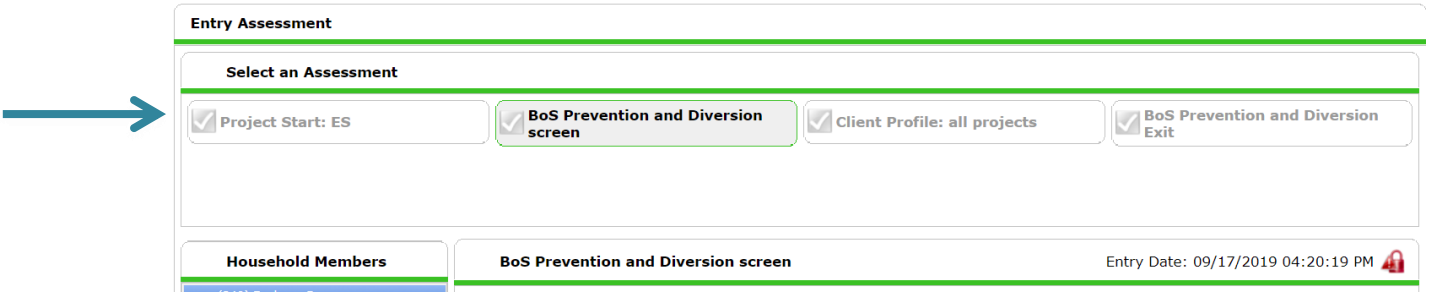
Add Full Prevention and Diversion Entry

As with other data entry you should ALWAYS be in EDA mode for the Prevention and Diversion project when entering prevention and diversion data. You can use back date mode as needed as well. Full entries need to be created for only some clients, if workflow does not require full entry do NOT complete full entry for P&D project.

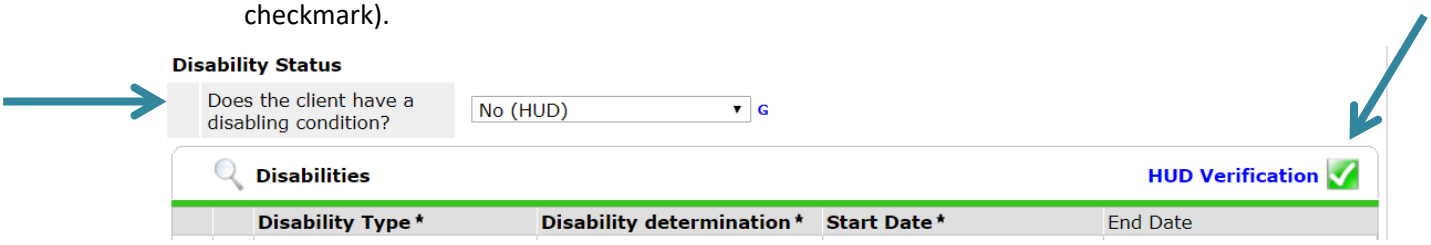
1. If already in Prevention and Diversion entry stay there! If not, then click on the pencil next to the Prevention and Diversion project start date to access the questions.



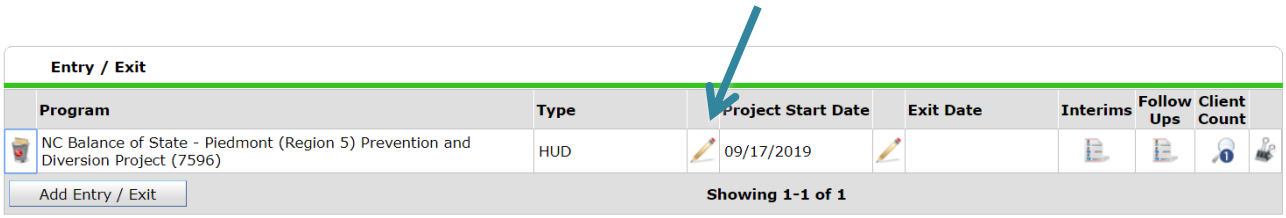
2. Within the P&D project entry click on the Project Start assessment under Select an Assessment.



3. Complete entire assessment and make sure you complete all HUD Verifications (look for green checkmark).



4. Click Save & Exit at the bottom of the assessment.
5. Ensure project entry for P&D Project shows up appropriately on the Entry/Exit tab.



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Section: Prevention and Diversion Service Transactions

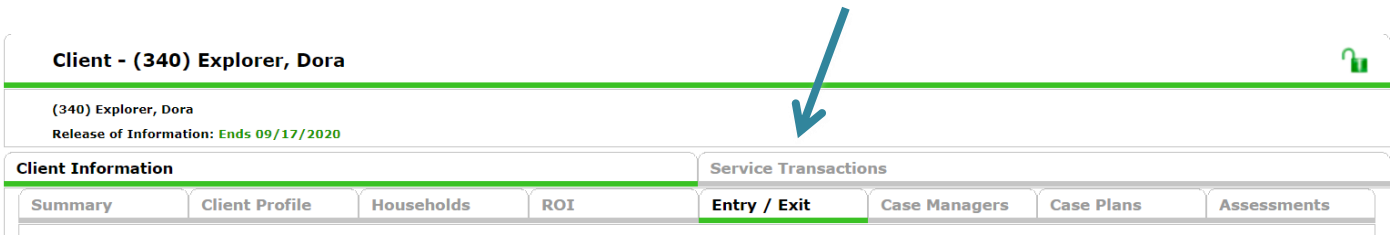
Service transactions allow agencies to track services they directly provide to clients. EVERY time a grantee provides an eligible service to a specific person/household a service transaction must be entered into HMIS. NCCEH has identified the applicable service codes. These are the only services codes that should be used. If you are providing a service not listed below, contact NCCEH for guidance

Service Code	Service Code Name	SSO Grantee Activity
BH-0500.3200	Housing related coordinated entry	VI-SPDAT assessment
BH-0500.3100	Homeless diversion programs	P&D screen
BH-0500.3140	Homelessness Prevention programs	Prevention Activities
PH-8000	Street Outreach Programs	Street outreach Activities
PH-1000.8500	transitional case/care management	Developing housing plan/other case management
TJ-3000.8000	specialized information and referral	Information/referrals
FP-0500.8000	system advocacy	system advocacy
DD-1500.4650	Housing Complaints	Handling grievances

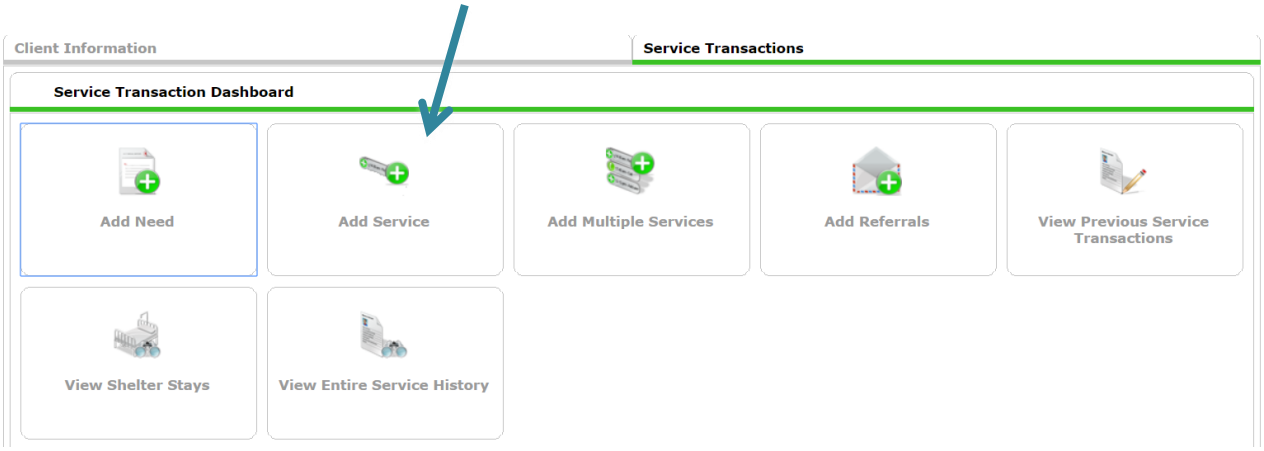
Add a Service Transaction

As with other data entry you should ALWAYS be in EDA mode for the P&D project when entering service transactions for prevention and diversion activities. You can use back date mode as needed as well.

1. Navigate to the client profile for the Head of Household.
2. Click on the *Service Transactions* tab.

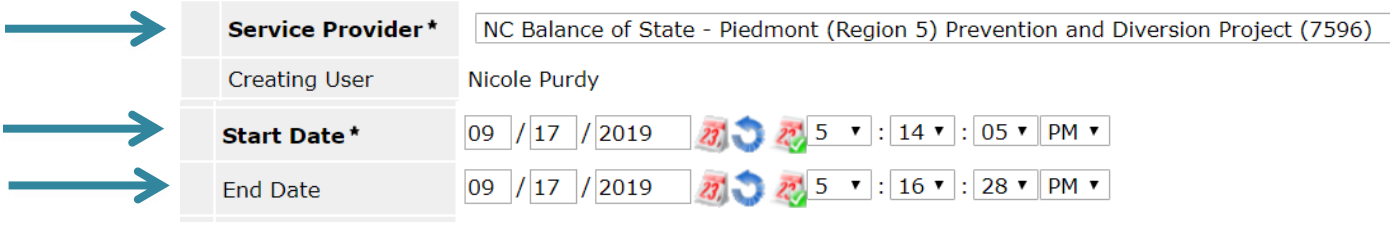


3. Click Add Service.

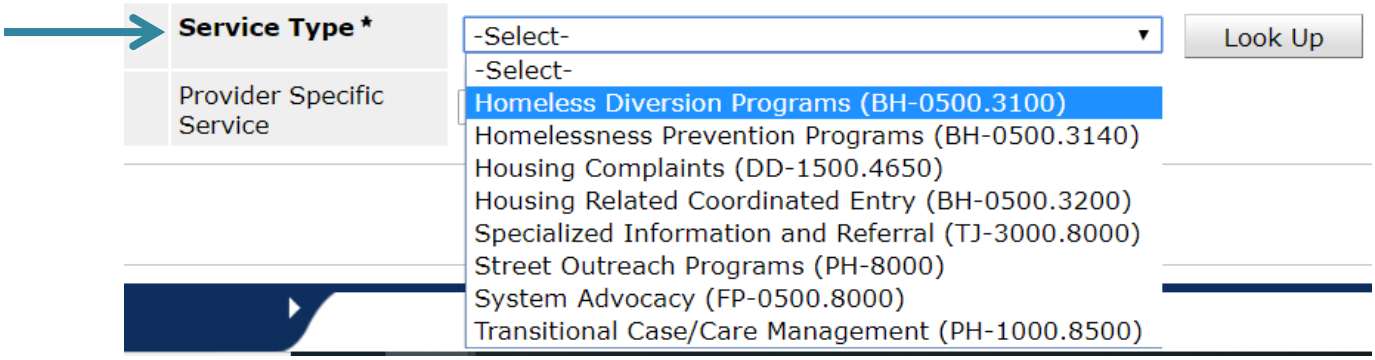


4. Check all household members that are receiving that service. Not all members will always be provided the same service or a service.

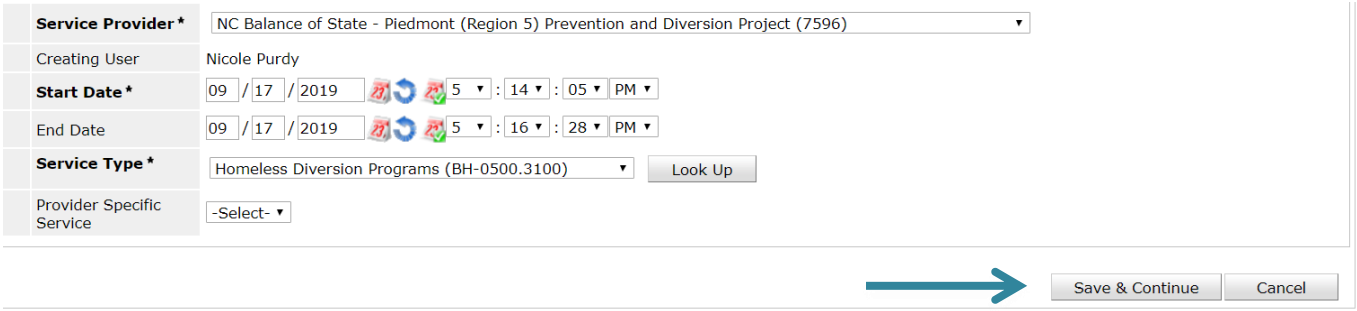
5. Ensure that Service Provider is the Prevention and Diversion project and that the dates are accurate. The End date will usually be the same date as the Start Date since these are a as prevention and diversion services should be same day services.



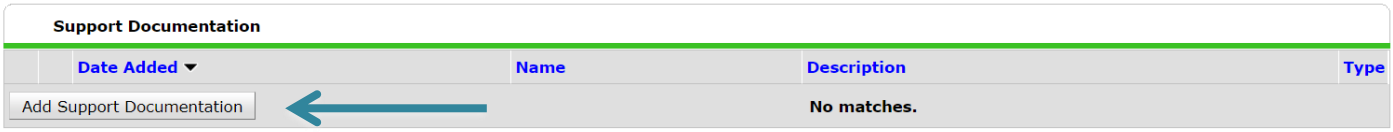
6. Select Service Type from the drop-down menu based on the eligible activity and appropriate service code as shown above.

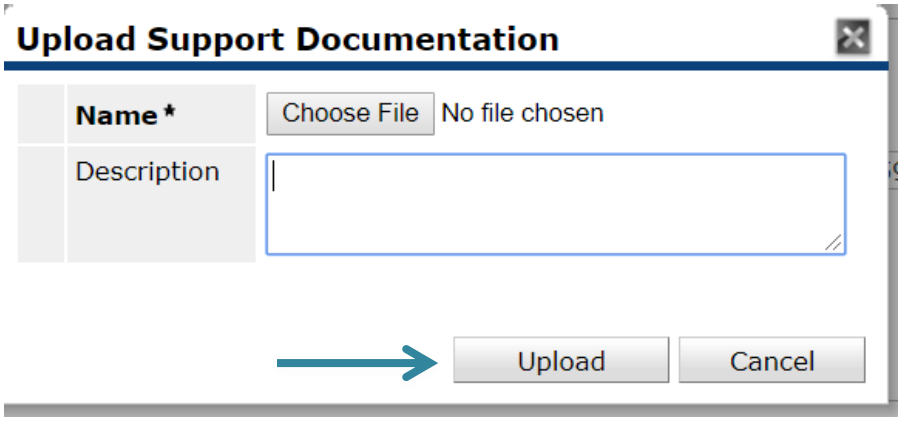


7. Click Save & Continue.

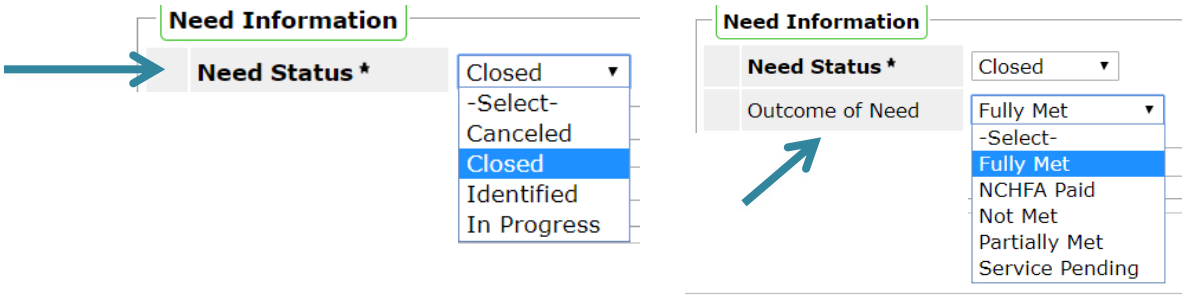


8. Skip the next few sections.
9. Support Documentation is optional, but click Add Support Documentation, select a file, add a description and click Upload if attaching a document.

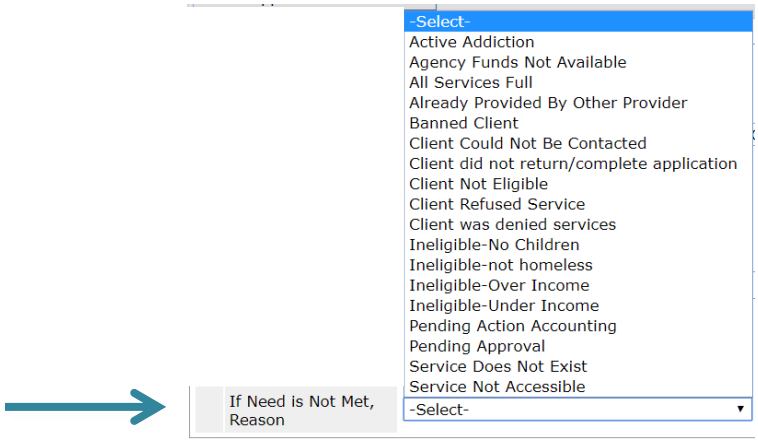




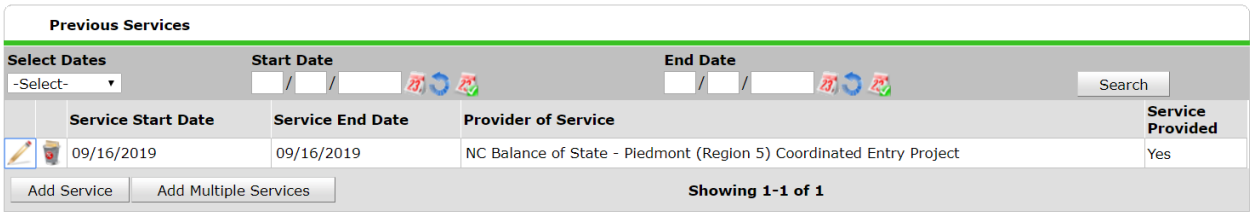
10. Scroll down to Need Information. Update Need Status and Outcome of Need to appropriate selections. Typically, the Need Status will be Closed and the Outcome of Need will be Fully Met. Keep Need Status as Service Pending if the service requires further action. Update the status to Fully Met after the service is completed.



11. If need is not being met select appropriate option for the If Need is Not Met, Reason.



12. Click Save & Exit.
13. Check that the service appears on the services tab.



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Section: Prevention and Diversion Exit

Every client that gets an entry into the P&D Project also needs an exit out of the P&D Project (usually that same day). A client/household should be exited from the P&D Project when:

1. Shelter referral is successful.

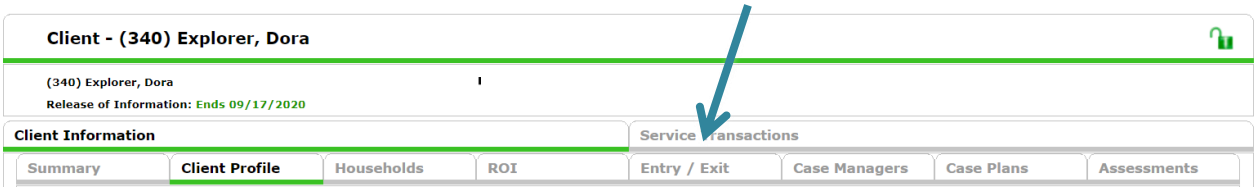
2. Diversion or self-resolution is successful.
3. Client becomes unsheltered.

Add Prevention and Diversion Project Exit

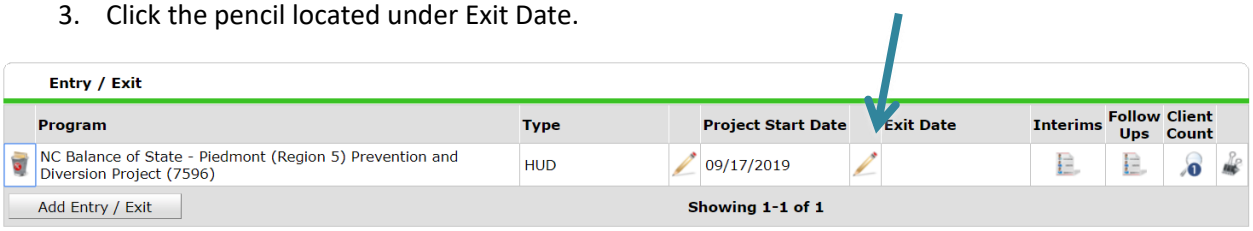
As with other data entry you should ALWAYS be in EDA mode for the Prevention and Diversion project when entering exits. You can use back date mode as needed as well. The exit date should usually be the same date that prevention and diversion assessment and services were provided.

1. Navigate to the client profile for the Head of Household.

2. Click on the Entry/Exit tab.

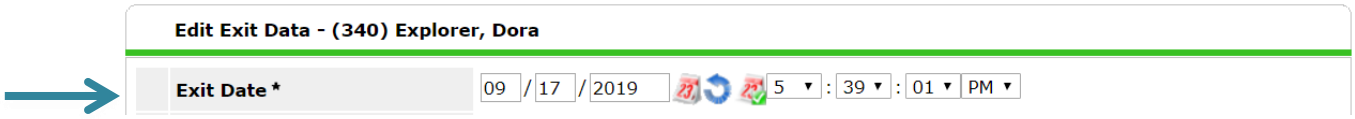


3. Click the pencil located under Exit Date.

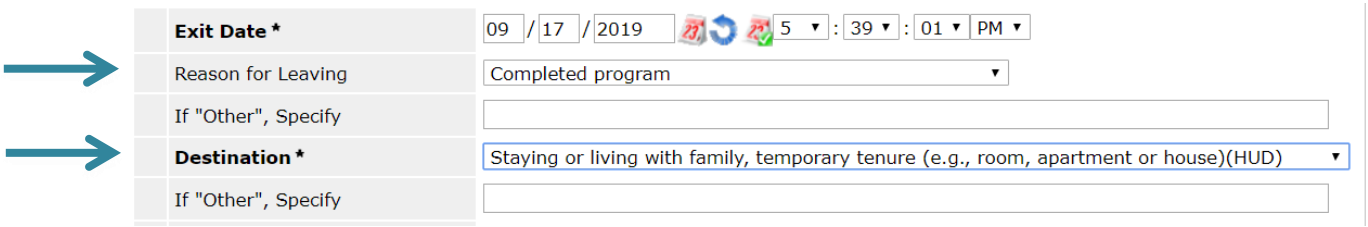


4. Check the boxes for all household members that need to be exited at this time.

5. Check to ensure that the Exit Date is the appropriate date. If not your Backdate might be incorrect and should be checked before continuing.

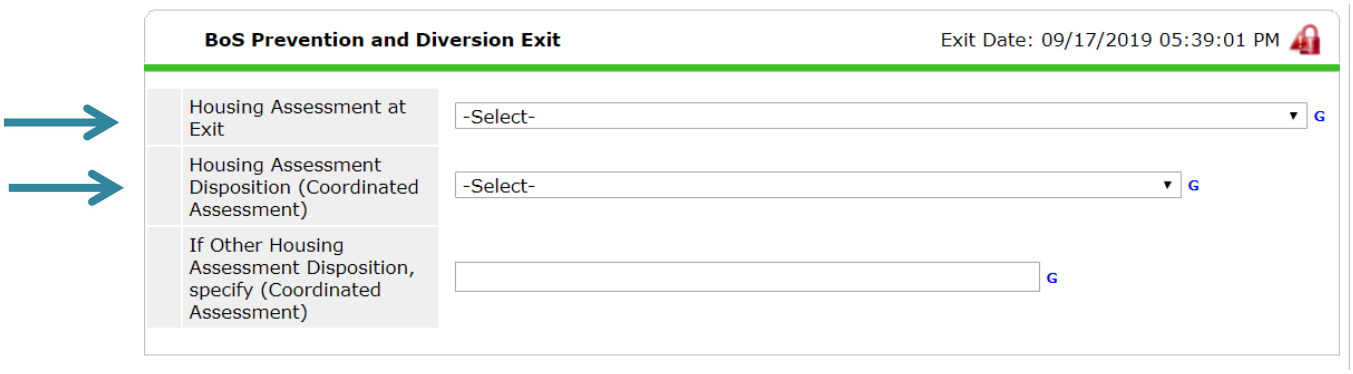


6. Select appropriate Reason for Leaving and Destination options. Please do not select Other if another option could be used.

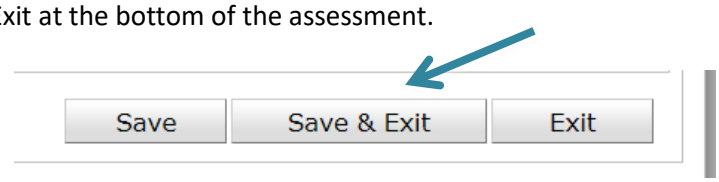


7. Click Save & Continue.

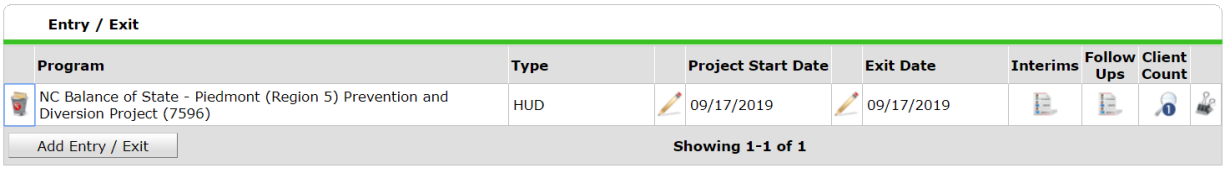
8. Complete the two questions on the Exit Assessment.



9. Click Save & Exit at the bottom of the assessment.



10. Confirm exit shows up on Entry/Exit tab.



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Section: Case Conferencing

Case conferencing meetings should happen at least every other week. All the community providers that serve people/households experiencing homelessness should be present including Domestic Violence and population-specific (Veteran, Chronically Homeless) providers. Topics/agenda items to include in case conferencing meetings:

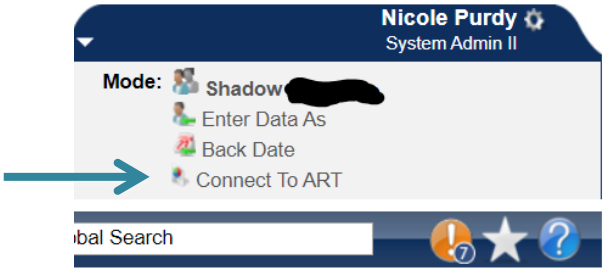
1. Match appropriate clients to open permanent supportive housing and rapid rehousing slots.
2. Match appropriate clients to other permanent housing (like public housing authorities)
3. Community updates like new resources or program changes
4. Updates on previous referrals to housing
5. Successes (who has been housed recently?)
6. Clients that are long stayers and have not yet been assessed.

7. Discuss clients that need additional support or have additional referral needs.

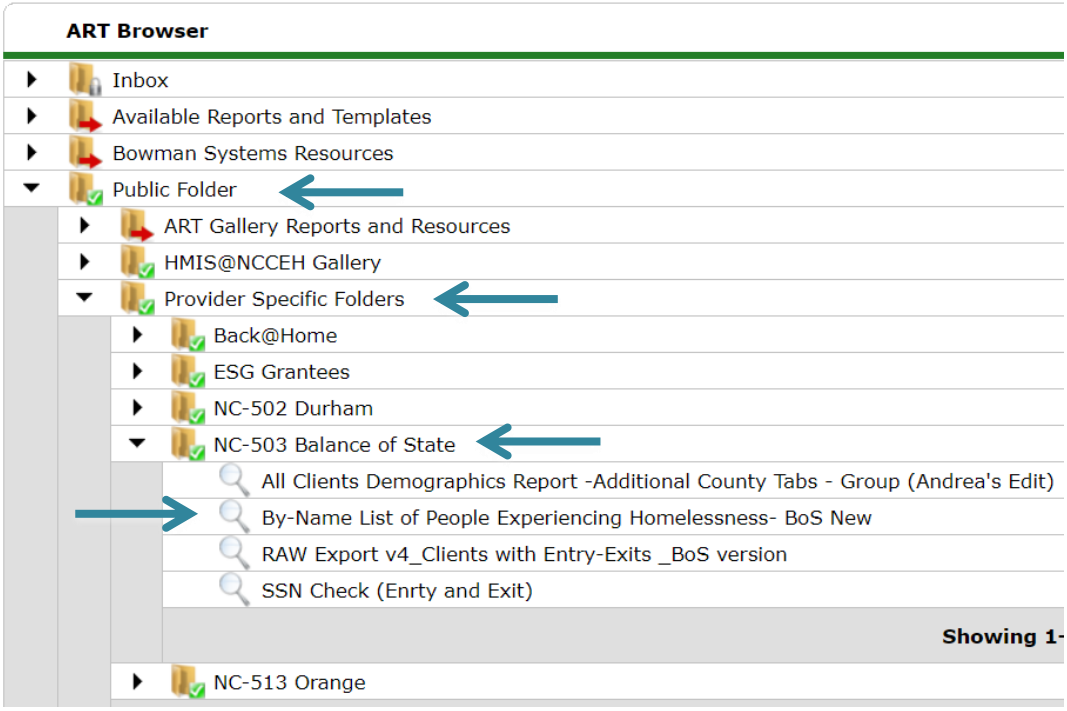
Running the By Name List Report:

The By-Name List report is an ART report that will be used for case conferencing, status review, flow through the Coordinated Entry system, and for visibility and/or data issues.

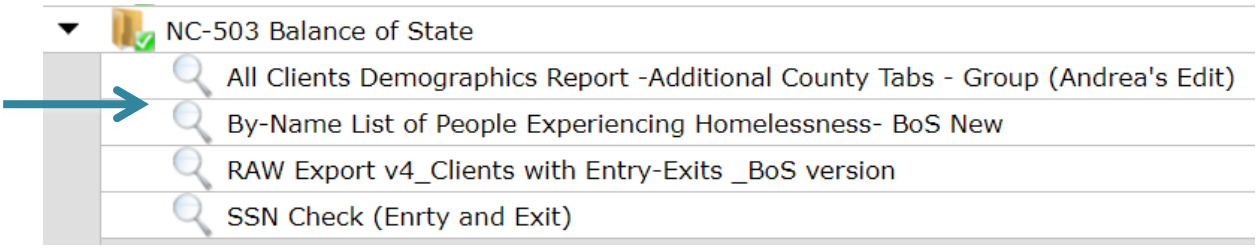
1. As with all ART reports you need to click Connect to ART to access and run the report.



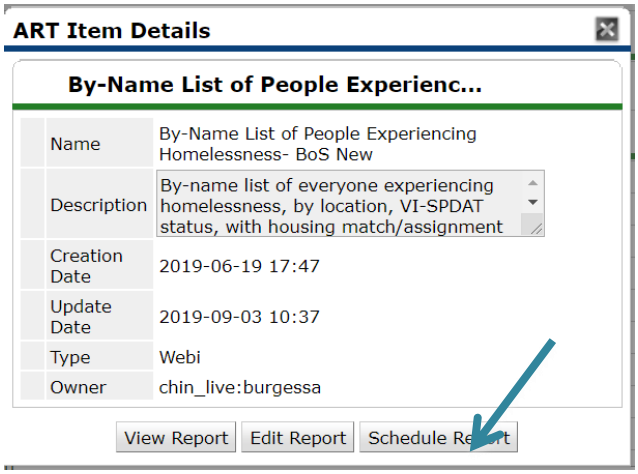
2. Navigate to Public Folder then click triangle to open the next menu. Click the triangle next to Provider Specific Folders to open the next menu. Click the triangle next to NC-503 Balance of State to open the next menu. Then locate the By-Name List report.



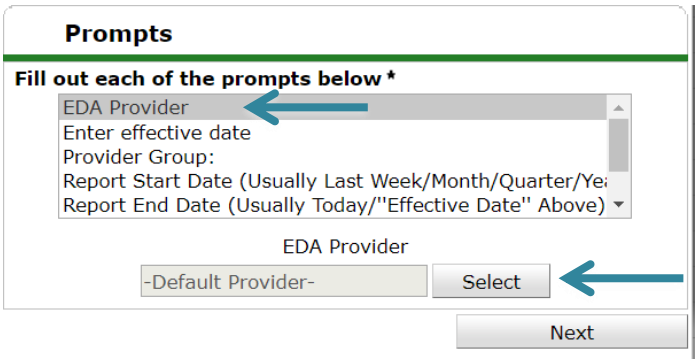
3. Click the magnifying glass next to the By-Name List of People Experiencing Homelessness report.

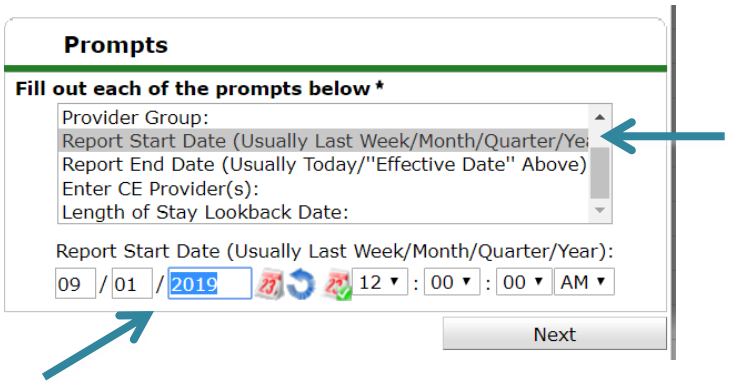


4. Click Schedule Report



5. A prompts box will pop up. Click on every prompt then click Select to access a search box. Date fields can be entered directly in the Prompts box. Do NOT hit the Next button until ALL the required prompts are completed.

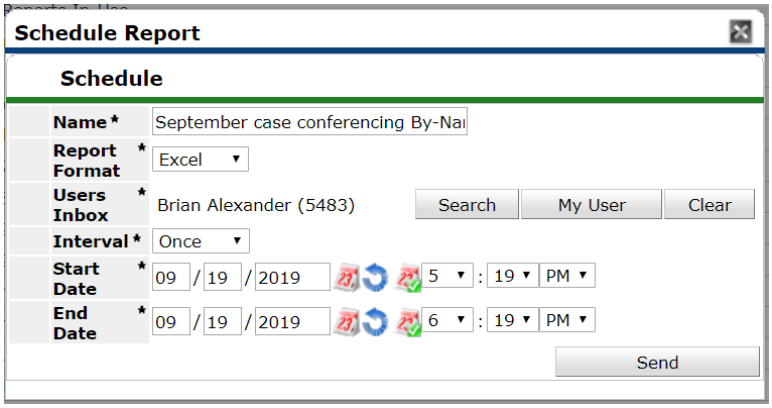




   a. **EDA Provider:** ALWAYS used. Select the CE or P&D Project.
   b. **Enter Effective date:** This is the same as your End Date, often the same date that you are running the report.
   c. **Provider Group:** ALWAYS used. Find and select your regional coordinated entry group.
   d. **Report Start Date**: this should be the date you want to start looking at the data for. For case conferencing it will likely be the last week or two. You can run the report for longer lengths of time for other data analysis and quality purposes.

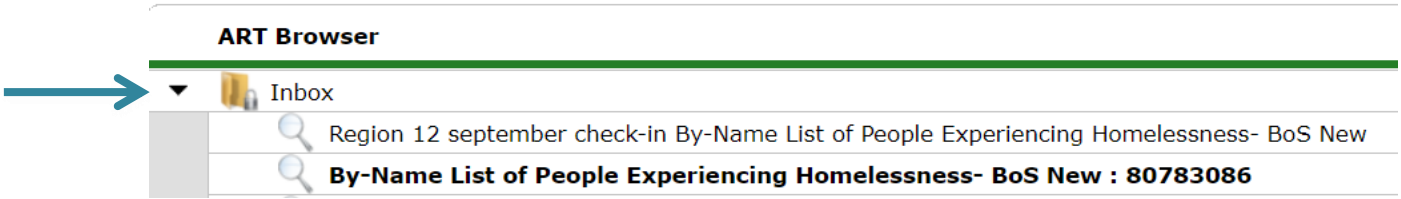
e. **Report End Date:** This is the same as your Effective Date, often the same date that you are running the report
f. **Enter CE Provider(s):** Find and select your CE project.
g. **Length of Stay Lookback Date:** This will populate the Cumulative Length of Stay column. Select a date that is 3 years in the past to highlight people/households that have become chronically homeless. This is dependent on visibility and how far back you can see the data for that client.

6. After all prompts are completed click Next. The schedule report box will pop up.

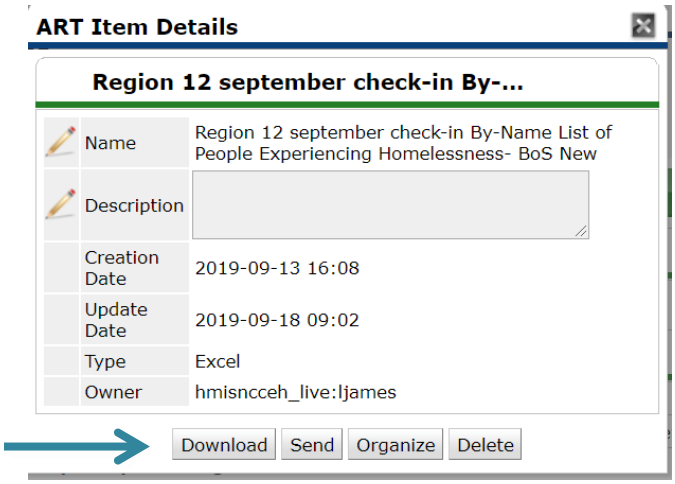


a. **Name:** Enter a name that will distinguish it from other reports that are the same type.
b. **Report Format:** Select Excel.
c. **Users Inbox:** Who's ART inbox should this report go to? Skip this step if inapplicable.
d. **Interval**: Select Once.
e. **Start Date**: When should the report start running? This is NOT the same as reporting dates**.**
f. **End Date**: When should the report stop running? This is NOT the same as reporting dates most often it's the same day as the start date. Change the end date time to one hour later than the start date time to give the report time to run.

7. Click Send. Once the report has finished running it will appear in your ART Inbox near the top of the screen. Click the magnifying glass next to the report name you want to view.



8. Click Download and then open the report that is downloaded.



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Report Columns on the By-Name List Report:

If fields are blank, then the information is missing, incomplete, or not visible on HMIS.

1. **HMIS ID:** Client ID for clients on the report.
2. **First and Last Name:** Taken from name fields on HMIS.
3. **Age:** Calculated from Date of Birth field on HMIS. If Age is blank DoB is not complete or not visible.
4. **Veteran? Y or N:** Taken from Veteran field on HMIS.
5. **HH Detail:** Relationship to Head of Household. Should pull only Heads of Household. If column is blank the relationship to head of household is not completed or visible on the project entry.
6. **# in Household:** Total number of people in the household.
7. **Is Client Chronically homeless? Y or N:** Taken from the Coordinated Entry form chronic homeless yes or no question. If this column is blank that item has not been completed by SSO grantee.
8. **Disability? Y or N:** Taken from the project entry if this column is blank that items has not been completed or is not visible.
9. **NC County of Service:** Taken from the project entry if this column is blank that items has not been completed or is not visible.
10. **CES Project? Y or N:** Indicates if client has an entry into the Coordinated Entry Project that was selected in the CE Provider prompt when the report was run.
11. **Current Provider:** Pulls the most recent HMIS service provider seen for the person/household. If blank, there is no project entry anywhere else other than the CE project.
12. **Project entry and exit date:** Pulls the entry and exit dates for the person/household's most recent HMIS service provider. If the client only has an entry into the CE project ***and*** the Current Provider column is blank, then it will pull the entry and exit dates for the CE project.
13. **Length of Stay:** Calculates the length of stay (or participation) for the people/households served by the provider listed in the Current Provider column.
14. **Length of Stay (cumulative):** Calculates the total lengths of stay (or participation) for the people/households served by the front door providers. This column utilizes the lookback period entered in report prompts. The lookback period impacts the lengths of stay by excluding dates

from the calculation that are prior to when HMIS sharing began. This means that if regional sharing in HMIS is new, then the "lookback" period will be small, but increase as time goes on.

15. **VI-SPDAT Date:** Pulls from the project entry/interim, if this column is blank the client has not yet has a VI-SPDAT entered into HMIS or it is not visible.
16. **Indv VI-SPDAT:** Pulls from the project entry/interim if this column is blank the client has not yet has this VI-SPDAT assessment entered into HMIS or it is not visible.
17. **Family VI-SPDAT:** Pulls from the project entry/interim if this column is blank the client has not yet has this VI-SPDAT assessment entered into HMIS or it is not visible.
18. **Case Conferencing Date:** Pulls from the Coordinated Entry form question. If this column is blank that item has not been completed by SSO grantee.
19. **Client Status:** Pulls from the Coordinated Entry form question. If this column is blank that item has not been completed by SSO grantee.
20. **Housing Assessment Disposition:** Pulls from the Coordinated Entry form question. If this column is blank that item has not been completed by SSO grantee.
21. **Date referred to a housing provider:** Pulls from the Coordinated Entry form question. If this column is blank that item has not been completed by SSO grantee.
22. **Referred to Provider:** Pulls from the Coordinated Entry form question. If this column is blank that item has not been completed by SSO grantee.
23. **Housing Move-in Date:** Pulls from the Coordinated Entry form question. If this column is blank that item has not been completed by SSO grantee.
24. **Date removed from By-Name List:** Pulls from the Coordinated Entry form question. If this column is blank that item has not been completed by SSO grantee.
25. **Reason removed from By-Name List:** Pulls from the Coordinated Entry form question. If this column is blank that item has not been completed by SSO grantee.

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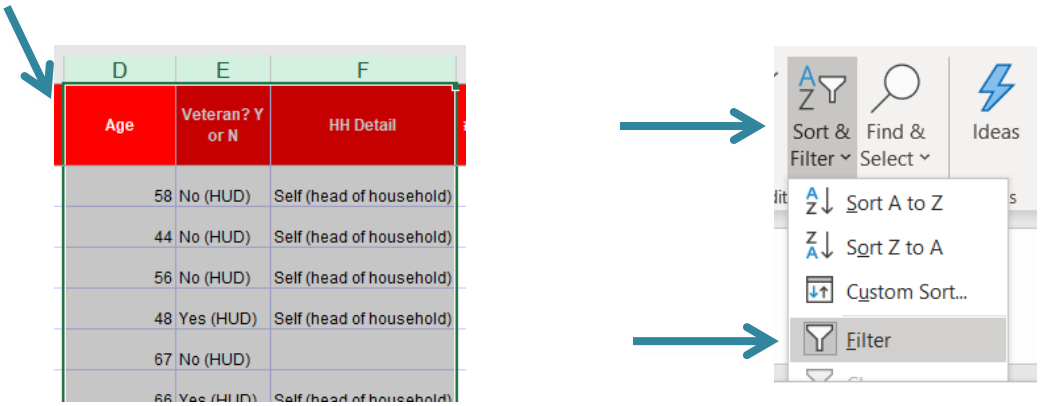
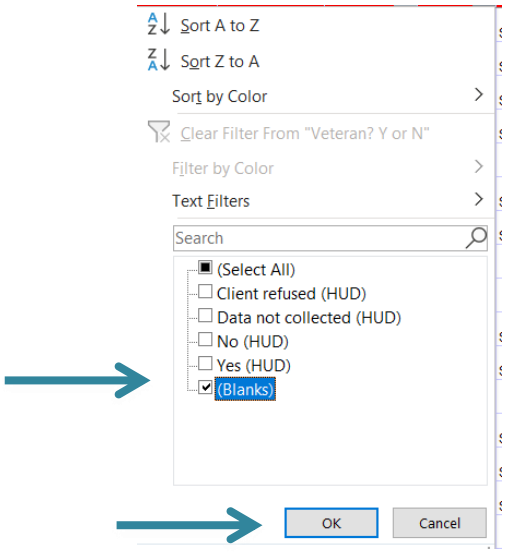
Reviewing the By Name List report for data quality checks:

Each column can be selected and filtered for blanks to check data quality or visibility issues.

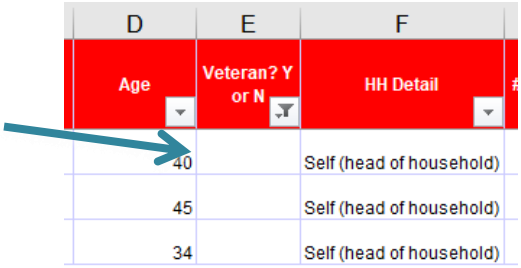
1. Select the columns that should be filtered, click Sort and Filter then Filter.



2. A little box with an arrow will appear in the top of the column, click that box to select which items to filter for then click OK.



3. Review rows that are blank for the selected data element. These people/household are either missing data or the CE project needs a visibility update. Please note that some people/households may filter out of the report due to their data being incomplete or missing in HMIS.



D	E	F
Age	Veteran? Y or N	HH Detail
40		Self (head of household)
45		Self (head of household)
34		Self (head of household)

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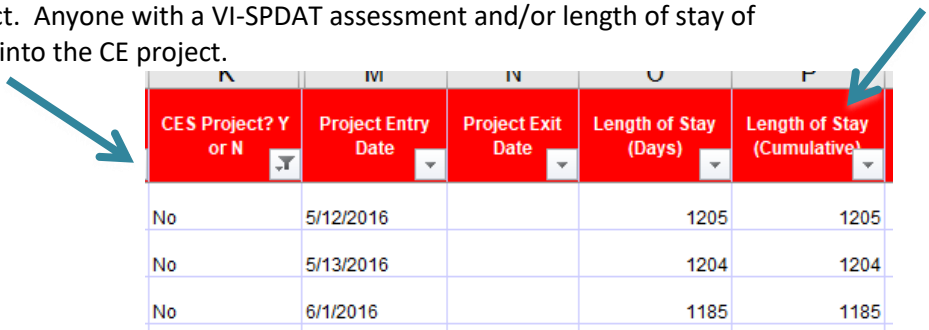
Reviewing the By Name List report for other information:

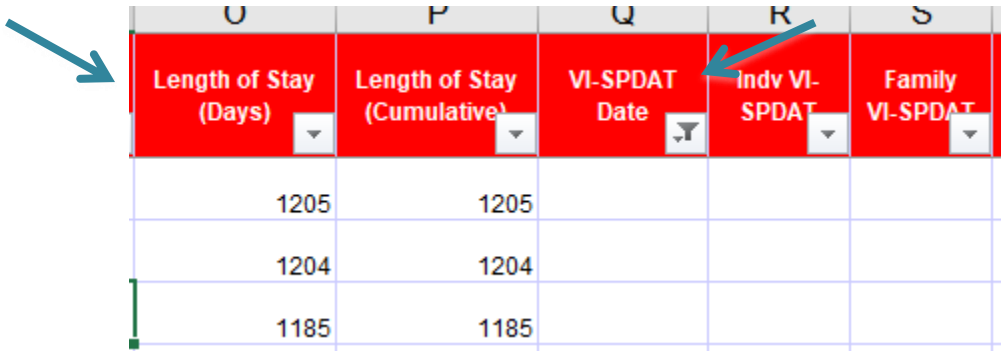
The By-Name List will be used for case conferencing. For specifics on how to sort, filter and review the list for case conferencing see the next sections of this guide.

1. Filter the "CE Project? Y or N" column to No to view people/households missing an entry into the Coordinated Entry Project. Anyone with a VI-SPDAT assessment and/or length of stay of over 14 days needs an entry into the CE project.



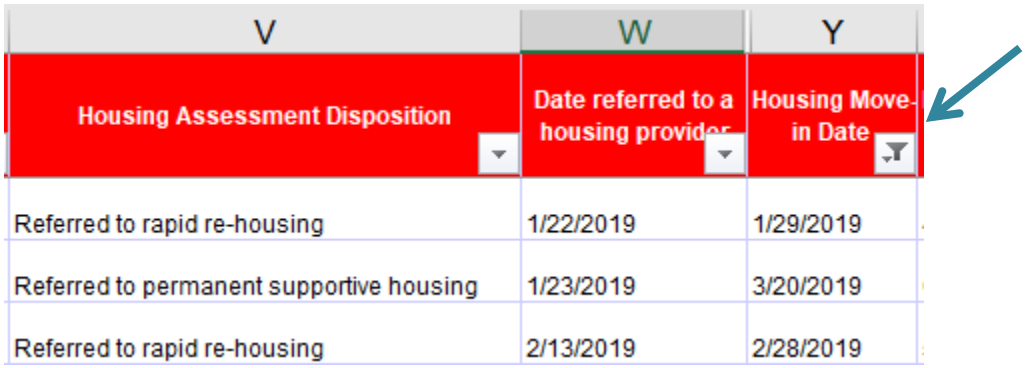
K	M	N	O	P
CES Project? Y or N	Project Entry Date	Project Exit Date	Length of Stay (Days)	Length of Stay (Cumulative)
No	5/12/2016		1205	1205
No	5/13/2016		1204	1204
No	6/1/2016		1185	1185

2. Filter the VI-SPDAT date column to view people/households missing a VI-SPDAT. If the cumulative length of stay is over 14 days, then administer the assessment and enter into HMIS.



O	P	Q	R	S
Length of Stay (Days)	Length of Stay (Cumulative)	VI-SPDAT Date	Indv VI-SPDAT	Family VI-SPDAT
1205	1205			
1204	1204			
1185	1185			

3. Filter the Housing Move-in date column to view people/households that have been housed for 90+ days. If they have not re-entered the homeless system, then exit them from the Coordinated Entry Project.



V	W	Y
Housing Assessment Disposition	Date referred to a housing provider	Housing Move-in Date
Referred to rapid re-housing	1/22/2019	1/29/2019
Referred to permanent supportive housing	1/23/2019	3/20/2019
Referred to rapid re-housing	2/13/2019	2/28/2019

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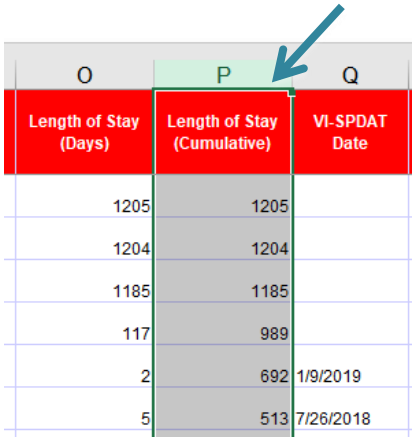
Sort and Filter By Name List Report for Long Stayers Not Yet Assessed

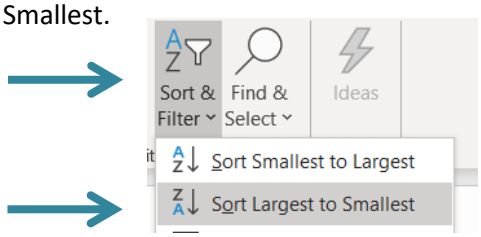
Every person/household that has been homeless for 14+ days without a VI-SPDAT assessment could lose a chance at a housing resource. Long Stayers that have not yet been assessed should be assessed as soon as possible. You can use the by-name list report to find who needs to be assessed.

1. Select the Length of Stay (Cumulative) column.

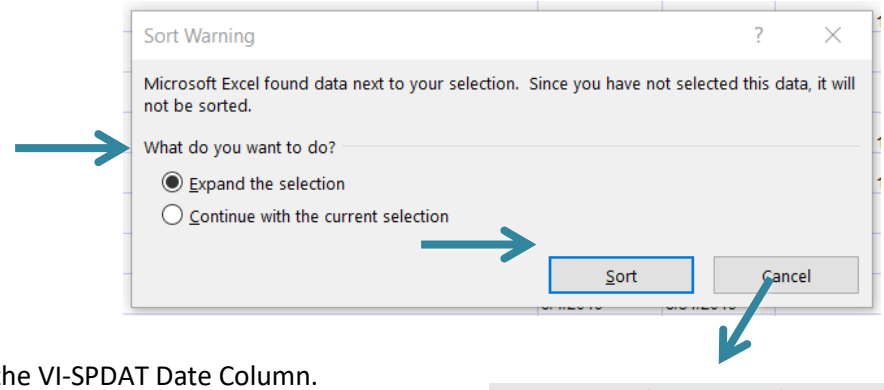


O	P	Q
Length of Stay (Days)	Length of Stay (Cumulative)	VI-SPDAT Date
1205	1205	
1204	1204	
1185	1185	
117	989	
2	692	1/9/2019
5	513	7/26/2018

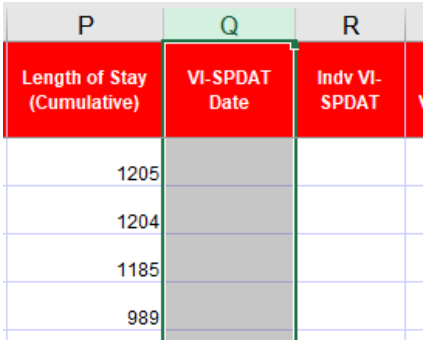
2. Click Sort and Filter and then Sort Largest to Smallest.



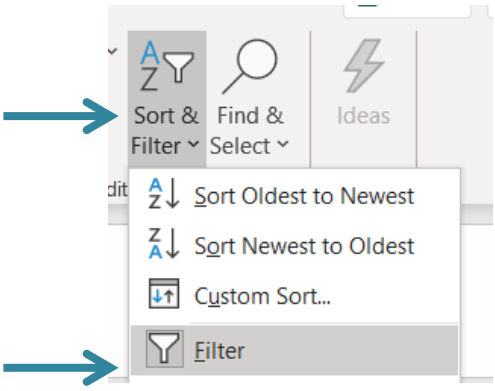
3. When the Sort Warning box pops up click Expand the selection and then click Sort. Longest Stayers should now be sorted to the top.



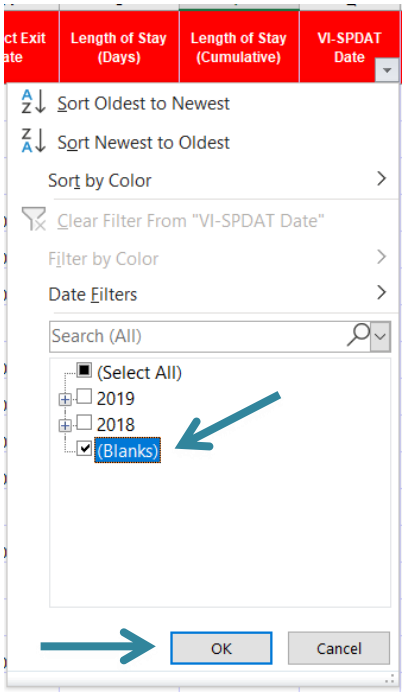
4. Select the VI-SPDAT Date Column.



5. Click Sort and Filter and then click Filter



6. Click the black arrow at the top of the column. Unselect all except blanks and click Ok.



7. Longest stayers without an assessment in HMIS are now at the top. Discuss clients to get them assessed or if assessment has been completed get it into HMIS. Create plan for assessment.

Project Entry Date	Project Exit Date	Length of Stay (Days)	Length of Stay (Cumulative)	VI-SPDAT Date	Indv VI-SPDAT	Family VI-SPDAT
5/12/2016		1205	1205			
5/13/2016		1204	1204			
6/1/2016		1185	1185			

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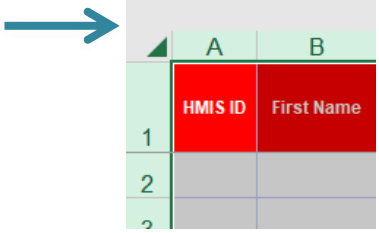
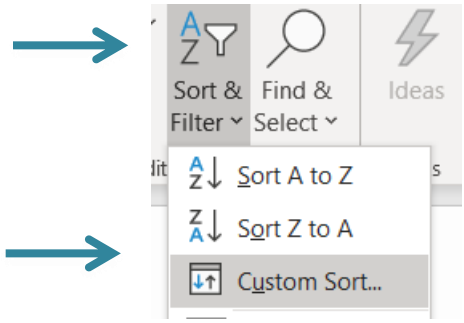
Ways to Sort and Filter for Prioritization

Housing referral prioritization is one of the most important jobs of the case conferencing meeting and can happen in a variety of ways. Those with a high VI-SPDAT score are prioritized first but other factors such as length of time homeless should be taken into account at the meeting.

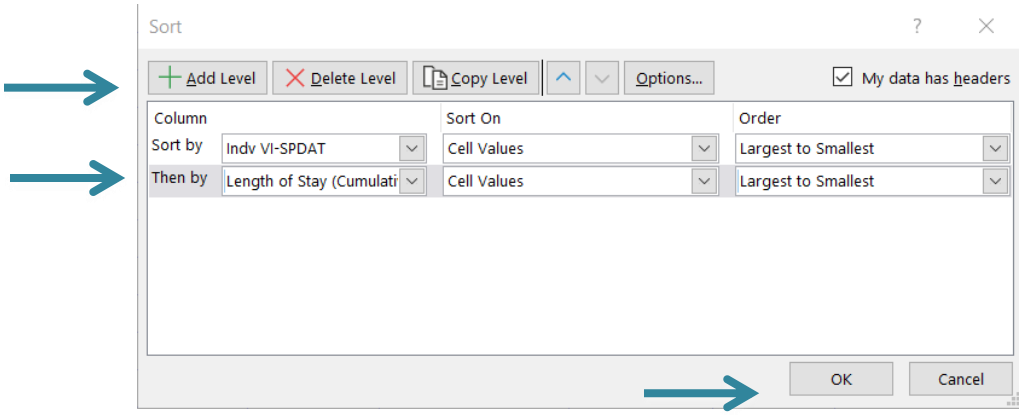
1. Click the triangle in the upper left corner of columns and rows to select the entire sheet.



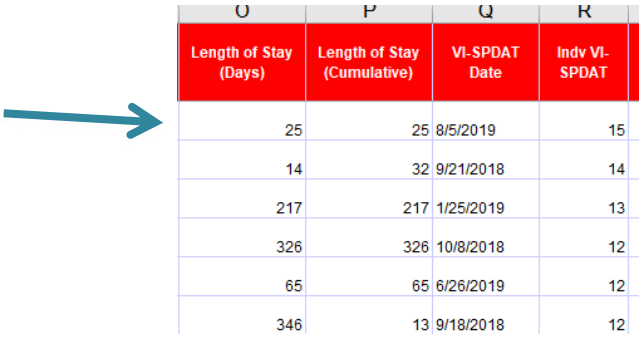
2. Click Sort & Filter and then Custom Sort.



3. Sort VI-SPDAT column by Largest to Smallest. Then click Add Level to sort Length of Stay (Cumulative) by Largest to Smallest and click OK.



4. Highest VI-SPDAT score with longest time homeless is now at the top and can be reviewed for appropriate referrals.



O	P	Q	R
Length of Stay (Days)	Length of Stay (Cumulative)	VI-SPDAT Date	Indv VI-SPDAT
25	25	8/5/2019	15
14	32	9/21/2018	14
217	217	1/25/2019	13
326	326	10/8/2018	12
65	65	6/26/2019	12
346	13	9/18/2018	12

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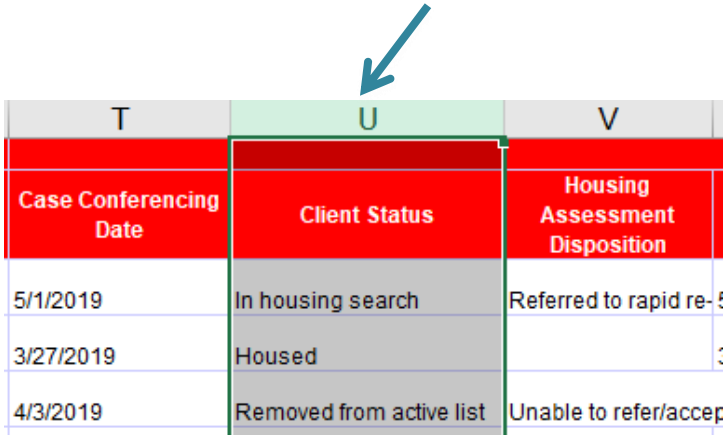
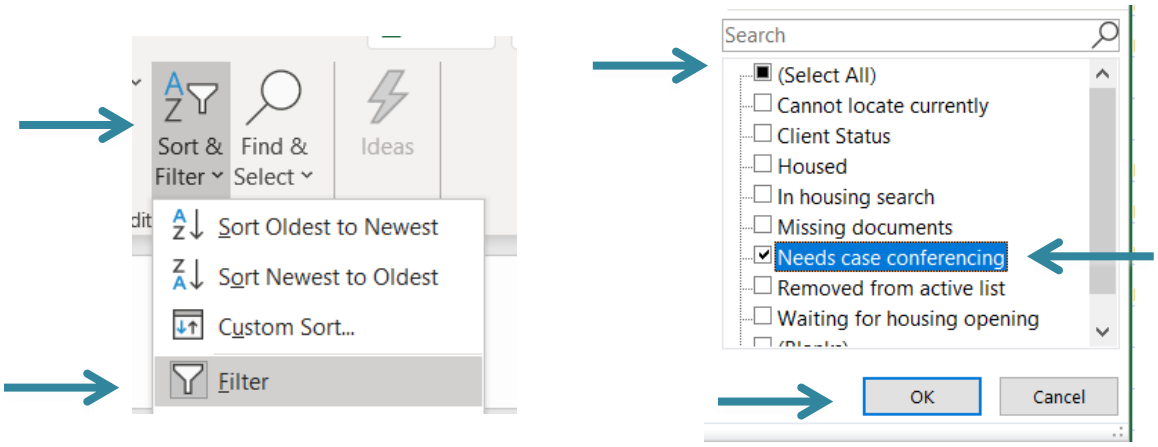
The By-Name List report tracks the progress of people through the Coordinated Entry system. It also highlights needed resources for sub-populations such as people/household who are chronically homeless, have disabilities, or are Veterans.

To track client's progress in CE, filter on Client Status

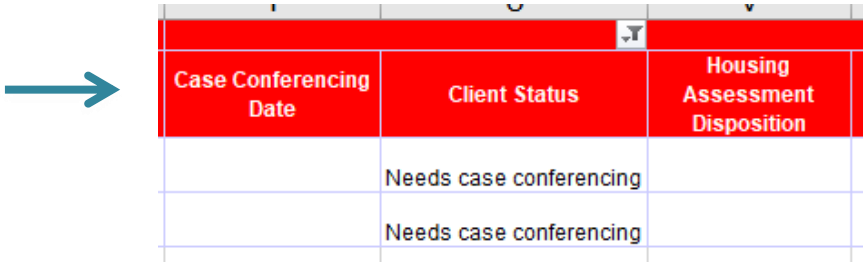
1. Select Client Status column.



2. Click Sort & Filter and then Filter. Click arrow in column to unselect everything except needs case conferencing then click OK.



3. Clients that are designated as needing case conferencing are now the only clients visible.



4. The same process can be used to filter on the other Client Statuses.
    a. **Clients that are designated as missing documents** can be discussed to ensure they receive assistance in getting needed documents.
    b. **Clients that are designated as cannot be located** can be discussed to ensure outreach attempts are made to find the client before removing from the by name list.
    c. **Clients that are designated as in housing search** can be discussed to ensure they have appropriate support in finding housing. The date they were referred to a housing provider can be checked as well to ensure they haven't been searching for housing for a very long time.

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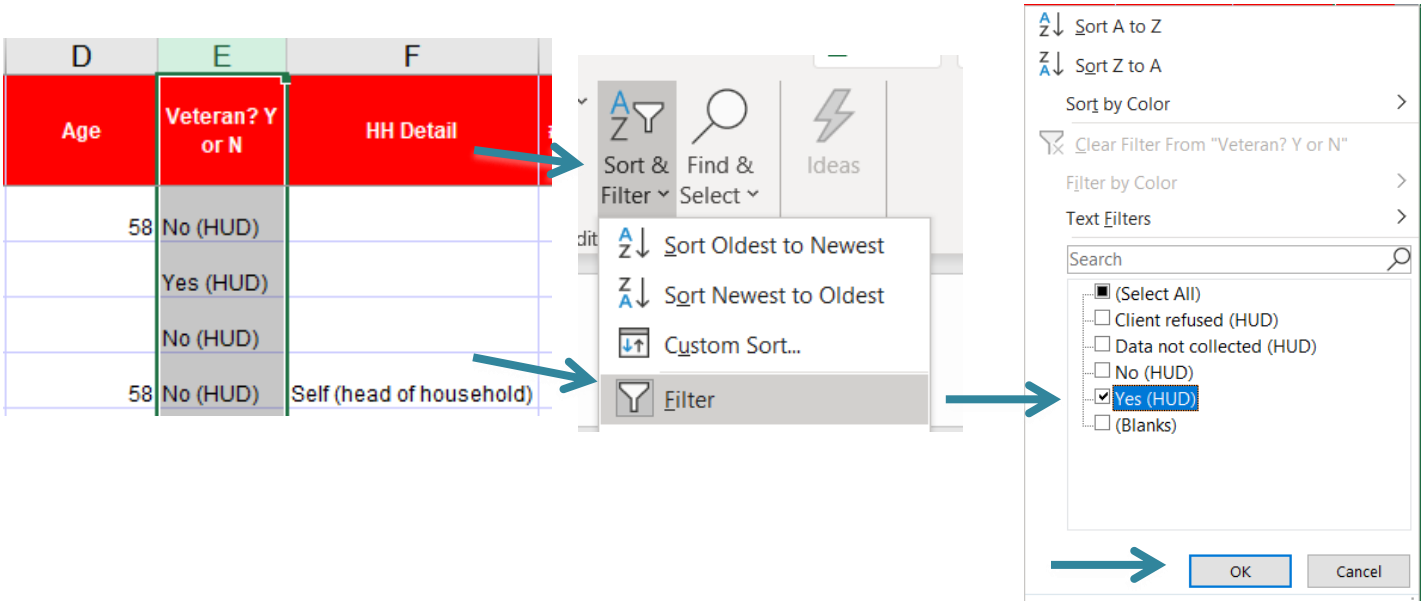
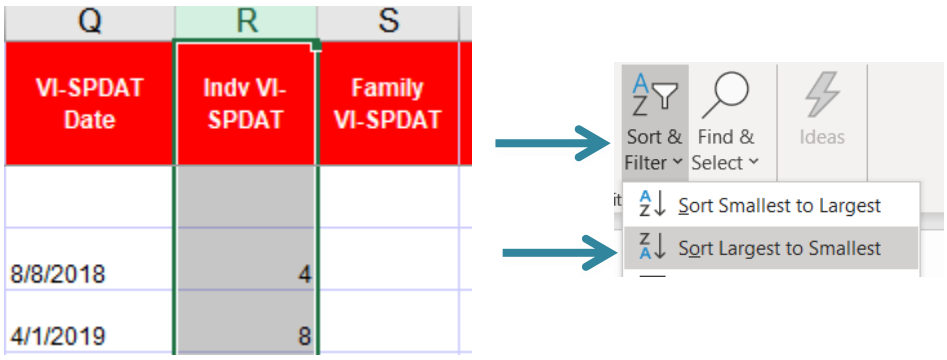
Filter for Veteran status

1. Filter to Veterans by Selecting Veteran column, clicking Sort & Filter and then Filter. Click arrow in column to unselect no and blanks then click OK.



2. Sort VI-SPDAT column to highest score by selecting VI-SPDAT columns, clicking Sort & Filter and then Sort Largest to Smallest. Select Expand Selection and Sort.



3. Veterans with the highest VI-SPDAT score are now sorted to the top.

Length of Stay (Cumulative)	VI-SPDAT Date	Indv VI-SPDAT
142	8/20/2019	10
303	4/1/2019	8
98	7/31/2019	8
182	5/8/2019	7
125	5/25/2019	7

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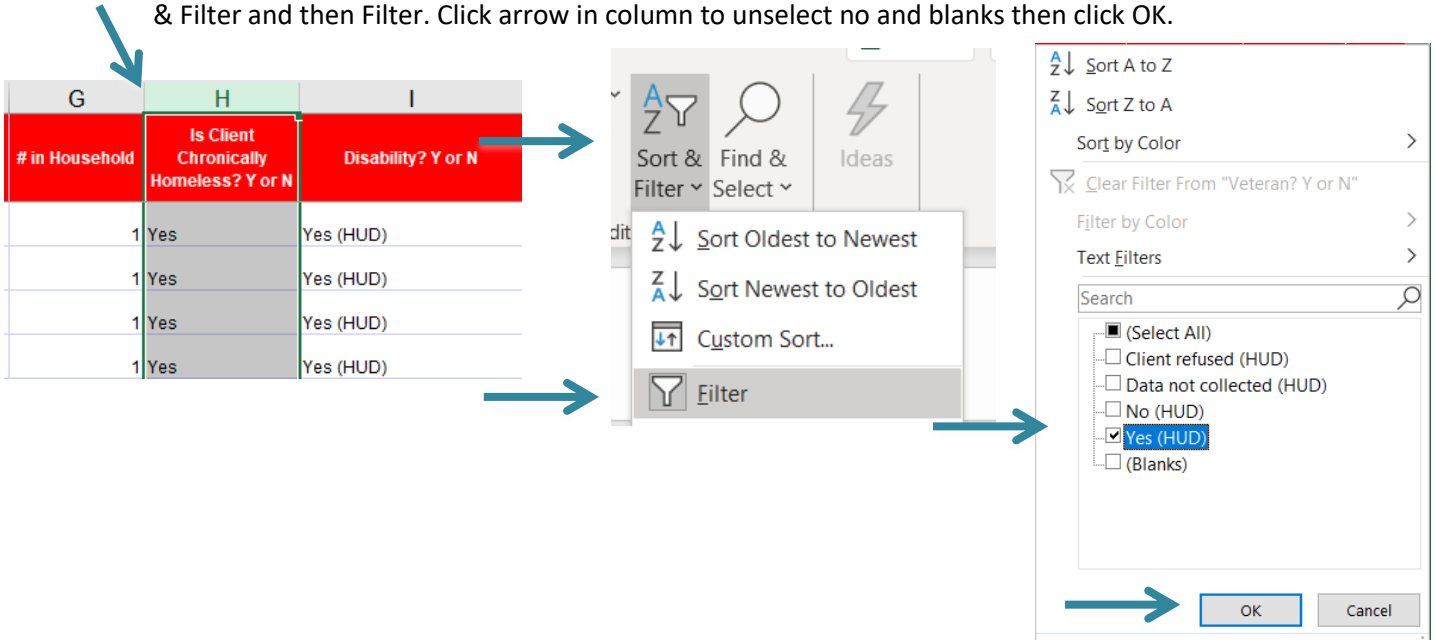
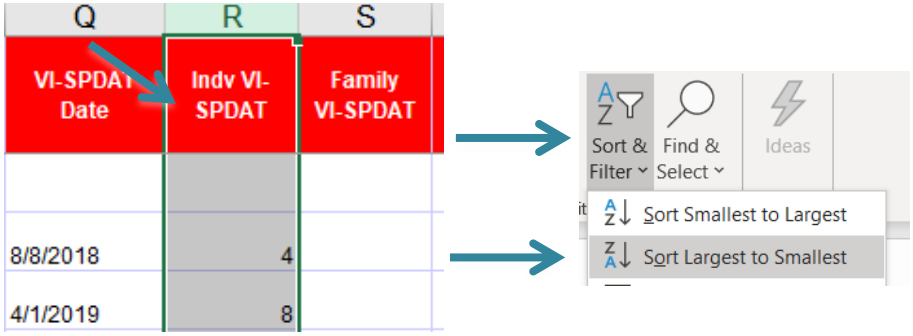
Filter for chronic homelessness

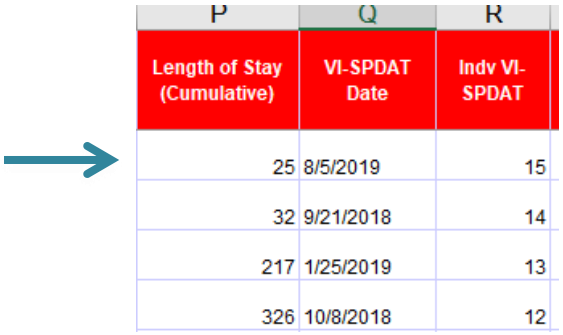
1. Filter to Chronically Homeless by selecting Is Client Chronically Homeless? column, clicking Sort & Filter and then Filter. Click arrow in column to unselect no and blanks then click OK.



2. Sort VI-SPDAT column to highest score by selecting VI-SPDAT columns, clicking Sort & Filter and then Sort Largest to Smallest. Select Expand Selection and Sort.



3. Chronically Homeless individuals with the highest VI-SPDAT score are now sorted to the top and can be reviewed for available Chronic specific resources.



P	Q	R
Length of Stay (Cumulative)	VI-SPDAT Date	Indv VI-SPDAT
25	8/5/2019	15
32	9/21/2018	14
217	1/25/2019	13
326	10/8/2018	12

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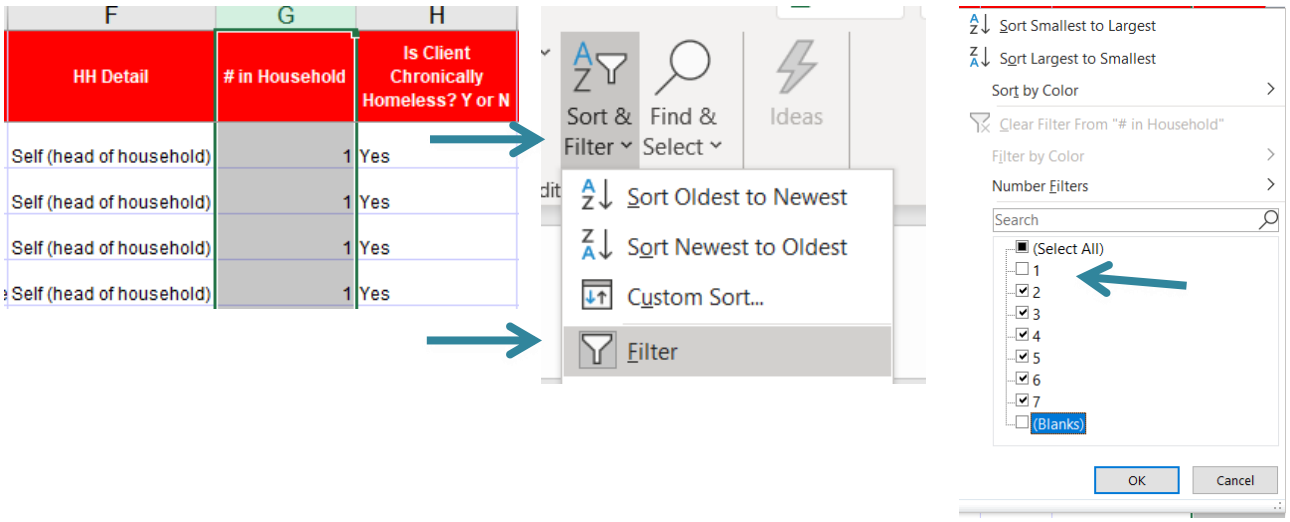
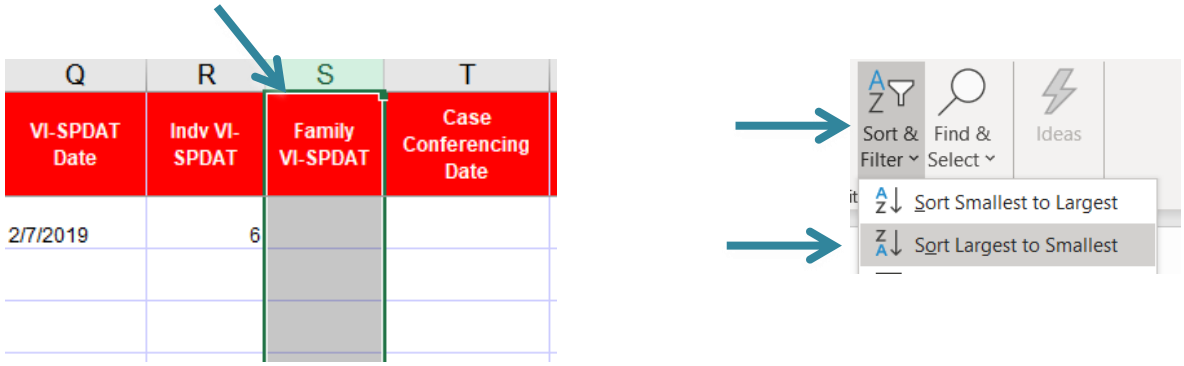
Filter for families

1. Filter to families only by Selecting # in Household column, clicking Sort & Filter and then Filter. Click arrow in column to unselect 1 and blanks then click OK.



2. Sort VI-SPDAT column to highest score by selecting the Family VI-SPDAT columns, clicking Sort & Filter and then Sort Largest to Smallest. Select Expand Selection and Sort.



3. Families with the highest VI-SPDAT score are now sorted to the top and can be reviewed for available Family specific resources.

Q	R	S
VI-SPDAT Date	Indv VI-SPDAT	Family VI-SPDAT
3/1/2019		17
2/25/2019		14
4/8/2019		13
7/30/2019		12

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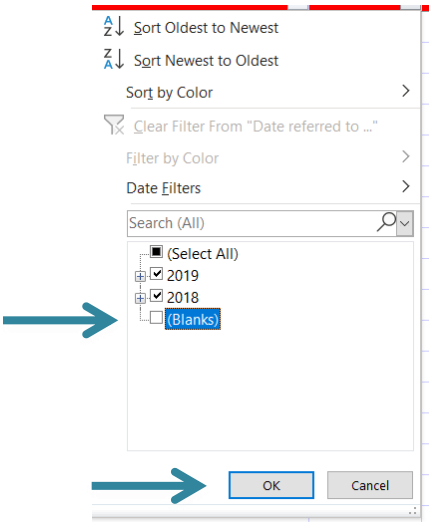
Sort and Filter By Name List Report for Referral Follow-ups

Updates should be provided on clients that have already been referred to a housing provider to see if they are housed yet or need additional supports.

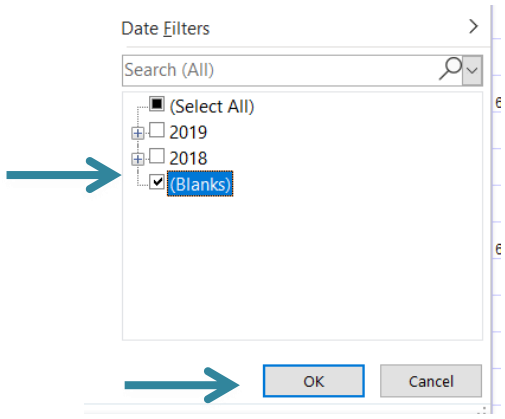
1. Select all columns and click Sort & Filter then click Filter

U	V	W	X	Y	Z	AA
Client Status	Housing Assessment Disposition	Date referred to a housing provider	Referred to Provider	Housing Move-in Date	Date removed from By-Name List	Reason removed from By-Name List
Waiting for housin	Referred to permanent supportive housing	8/7/2019				
Waiting for housin	Referred to permanent supportive housing	2/13/2019		3/4/2019	6/28/2019	Housed for 90 days o

2. Click arrow in Date referred to a housing provider column to unselect blanks then click OK.



3. Click arrow in Housing Move-in Date column to unselect all dates but leave blanks then click OK.



4. All clients that have been referred to a provider but not yet housed are now shown and can be reviewed for updates and next steps.

V	W	X	Y
Housing Assessment Disposition	Date referred to a housing provider	Referred to Provider	Housing Move-in Date
Referred to permanent supportive housing	8/7/2019		
Referred to permanent supportive housing	6/26/2019		
Referred to permanent supportive housing	3/13/2019		

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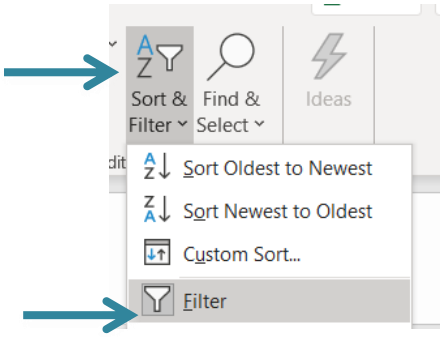
Sort and Filter By Name List Report to Review clients not yet referred

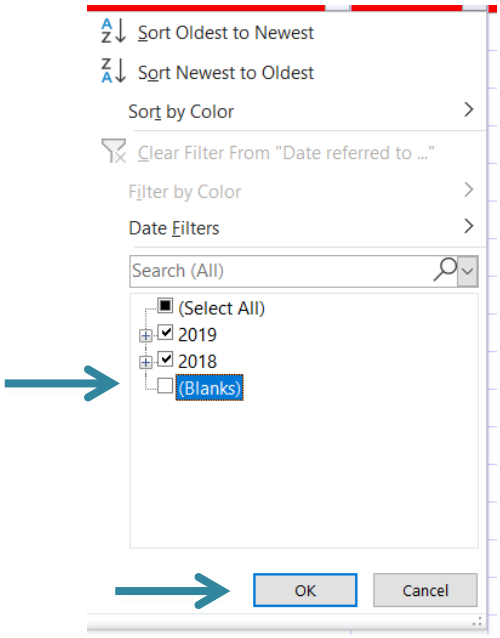
The By Name List report can be sorted and filtered to find and address clients that have been case conferences but not yet referred to a housing provider.

1. Select all columns and click Sort & Filter then click Filter

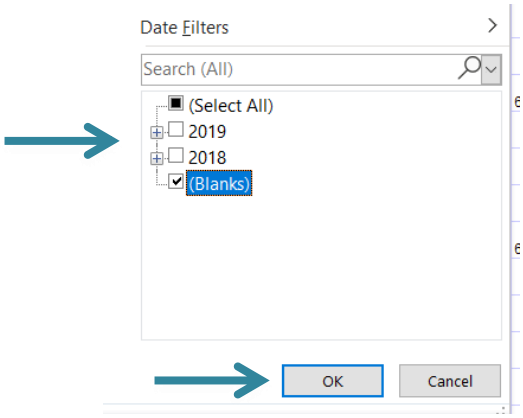
U	V	W	X	Y	Z	AA
Client Status	Housing Assessment Disposition	Date referred to a housing provider	Referred to Provider	Housing Move-in Date	Date removed from By-Name List	Reason removed from By-Name List
Waiting for housin	Referred to permanent supportive housing	8/7/2019				
Waiting for housin	Referred to permanent supportive housing	2/13/2019		3/4/2019	6/28/2019	Housed for 90 days o



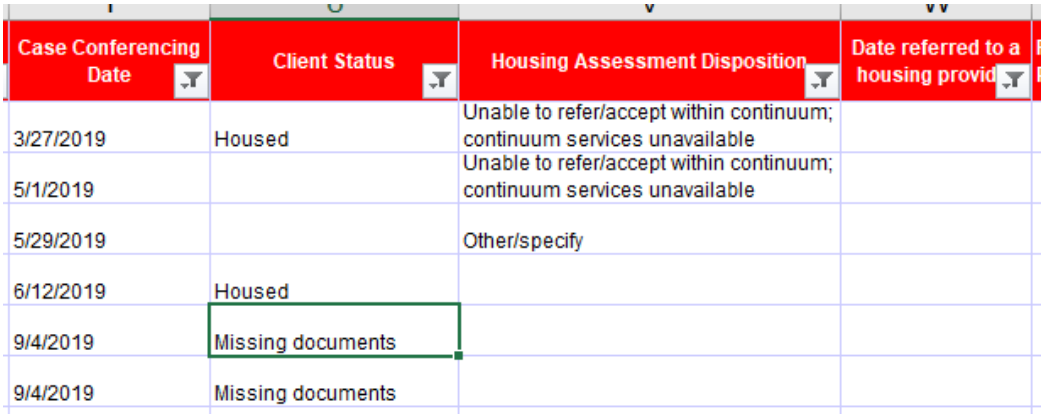
2. Click arrow in Case Conferencing date column to unselect blanks then click OK.



3. Click arrow in Date referred to a housing provider column to unselect all dates but leave blanks and then click OK.



4. All clients that have been case conferenced but not yet referred to a housing provider are now shown and can be reviewed for updates and next steps.



Case Conferencing Date	Client Status	Housing Assessment Disposition	Date referred to a housing provid
3/27/2019	Housed	Unable to refer/accept within continuum; continuum services unavailable	
5/1/2019		Unable to refer/accept within continuum; continuum services unavailable	
5/29/2019		Other/specify	
6/12/2019	Housed		
9/4/2019	Missing documents		
9/4/2019	Missing documents		

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Section: SSO Grant Reporting

SSO Grantees enter data into both the regional Coordinated Entry project and the Prevention and Diversion project to allow the grantee to pull a variety of reports. There are four reports that are particularly useful to evaluate program data:

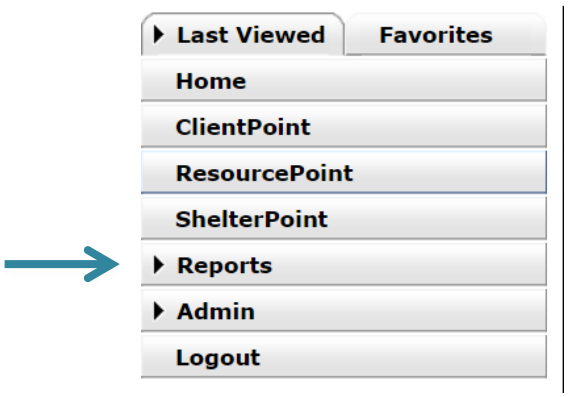
1. APR
2. By Name List
3. Service Transaction
4. 0640 – HUD Data Quality Report Framework

APR

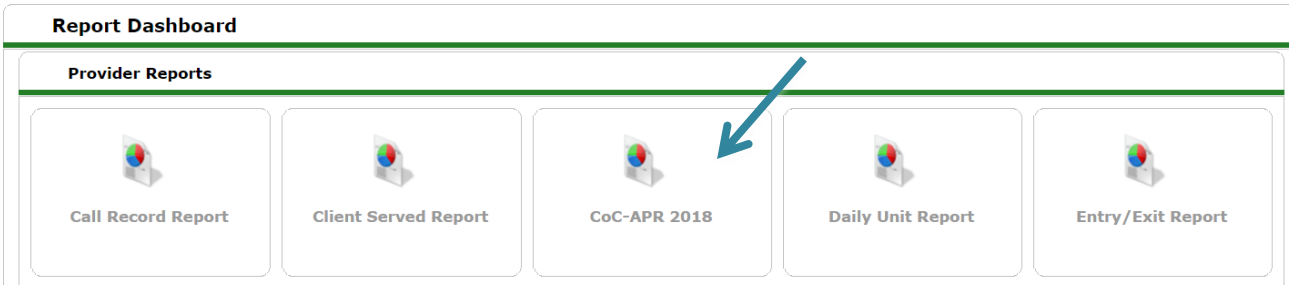
The APR is a dashboard report that provides both data quality checks and Coordinated Entry flow. It is important to be in the correct EDA mode prior to running this report for accurate results.

Running the APR report:

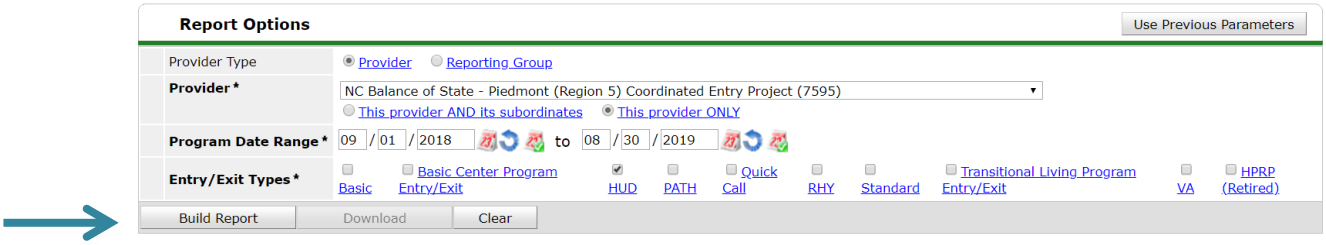
1. As with all dashboard reports EDA mode impacts the report so make sure you EDA for the SSO project you want to run the report for.
2. Click Reports on the left-hand side of the HMIS page.



3. Click on the CoC-APR in the Provider Reports section.



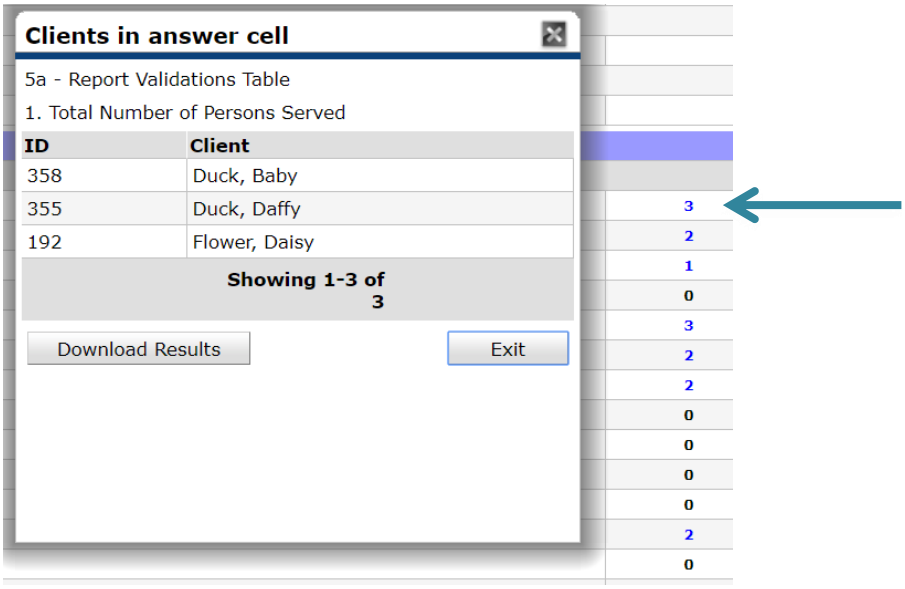
4. Complete report prompts.



a. **Provider Type:** Select Provider or Reporting Group depending on how you want to run the report. Usually it will be Provider.
b. **Provider:** This should auto populate with the project you are in EDA for if not check your EDA. If you select Reporting Group a field to search for the reporting group will come up. Search for and select the group you want.
c. **Program Date Range:** Select whatever dates you want.
d. **Entry/Exit Types:** Select HUD.

5. Click Build Report.

6. Report will build for a few minutes then appear. The blue hyperlinked numbers can be clicked to pull up a list of the clients included in that number.



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Reviewing the APR report for data quality checks:

1. **Does Total Number of Persons Served looks correct?**
2. **What is the total Number of Persons with Unknown Age?** These people are missing a Date of Birth in their HMIS record.
3. **What is the total Number of Child and Unknown-Age Heads of Household**? These are either children in households without an adult or households where at least one person has a missing or inaccurate Head of Household status. It could also mean at least one person is missing a Date of Birth.

5a - Report Validations Table	
Report Validations Table	
1. Total Number of Persons Served	198
2. Number of Adults (age 18 or over)	128
3. Number of Children (under age 18)	49
4. Number of Persons with Unknown Age	21
5. Number of Leavers	60
6. Number of Adult Leavers	34
7. Number of Adult and Head of Household Leavers	35
8. Number of Stayers	138
9. Number of Adult Stayers	94
10. Number of Veterans	14
11. Number of Chronically Homeless Persons	18
12. Number of Youth Under Age 25	6
13. Number of Parenting Youth Under Age 25 with Children	2
14. Number of Adult Heads of Household	109
15. Number of Child and Unknown-Age Heads of Household	6
16. Heads of Households and Adult Stayers in the Project 365 Days or More	1

4. **What is the % of Error Rate for Personally Identifiable Information?** Click the blue hyperlinked number to find out which person/household has Information Missing or Data Issues.

6a - Data Quality: Personally Identifiable Information

Data Element	Client Doesn't Know/Client Refused	Information Missing	Data Issues	% of Error Rate
Name (3.1)	0	0	7	4%
SSN (3.2)	1	21	4	13%
Date of Birth (3.3)	0	23	2	13%
Race (3.4)	0	28		14%
Ethnicity (3.5)	1	38		20%
Gender (3.6)	0	19		10%
Overall Score				**31%**

5. **What is the % of Error Rate for Universal Data Elements?** Click the blue hyperlinked number to find out which person/household is identified in Error Count.

6b - Data Quality: Universal Data Elements

Data Element	Error Count	% of Error Rate
Veteran Status (3.7)	8	6%
Project Start Date (3.10)	0	0%
Relationship to Head of Household (3.15)	57	29%
Client Location (3.16)	5	4%
Disabling Condition (3.8)	69	35%

6. **What is the % of Error Rate for Income and Housing Data Quality?** Click the blue hyperlinked number to find out which person/household is identified in Error Count.

6c - Data Quality: Income and Housing Data Quality

Data Element	Error Count	% of Error Rate
Destination (3.12)	20	34%
Income and Sources (4.2) at Start	44	38%
Income and Sources (4.2) at Annual Assessment	0	0%
Income and Sources (4.2) at Exit	10	29%

7. **Who is counted under Unknown Household Type for Number of Persons Served?** Click the blue hyperlinked number to find out which person/household is identified.

7a - Number of Persons Served

	Total	Without Children	With Children and Adults	With Only Children	Unknown Household Type
Adults	128	104	18		6
Children	49		42	7	0
Client Doesn't Know/Client Refused	0	0	0	0	0
Data not collected	21	0	0	0	21
Total	198	104	60	7	27

8. **Who is counted under Data not collected for Gender of Adults?** Click the blue hyperlinked number to find out which person/household is identified.

10a - Gender of Adults

	Total	Without Children	With Children and Adults	Unknown Household Type
Male	72	69	2	1
Female	54	33	16	5
Trans Female (MTF or Male to Female)	1	1	0	0
Trans Male (FTM or Female to Male)	0	0	0	0
Gender Non-Conforming (i.e. not exclusively male or female)	0	0	0	0
Client Doesn't Know/Client Refused	0	0	0	0
Data not collected	1	1	0	0
Subtotal	128	104	18	6

9. **Who is counted under Data not collected for Age?** Click the blue hyperlinked number to find out which person/household is identified.

11 - Age

	Total	Without Children	With Children and Adults	With Only Children	Unknown Household Type
Under 5	16		13	3	0
5 - 12	27		23	4	0
13 - 17	6		6	0	0
18 - 24	6	3	2		1
25 - 34	28	15	10		3
35 - 44	34	29	4		1
45 - 54	23	21	1		1
55 - 61	23	22	1		0
62 +	14	14	0		0
Client Doesn't Know/Client Refused	0	0	0	0	0
Data not collected	21	0	0	0	21
Total	198	104	60	7	27

10. **Who is counted under Data not collected for Race or Ethnicity?** Click the blue hyperlinked number to find out which person/household is identified.

12a - Race

	Total	Without Children	With Children and Adults	With Only Children	Unknown Household Type
White	33	30	2	0	1
Black or African American	129	64	54	7	4
Asian	1	1	0	0	0
American Indian or Alaska Native	2	0	2	0	0
Native Hawaiian or Other Pacific Islander	1	1	0	0	0
Multiple races	2	2	0	0	0
Client Doesn't Know/Client Refused	2	0	2	0	0
Data not collected	28	6	0	0	22
Total	198	104	60	7	27

12b - Ethnicity

	Total	Without Children	With Children and Adults	With Only Children	Unknown Household Type
Non-Hispanic/Non-Latino	157	97	48	7	5
Hispanic/Latino	2	1	0	0	1
Client Doesn't Know/Client Refused	1	1	0	0	0
Data not collected	38	5	12	0	21
Total	198	104	60	7	27

11. **Who is counted under Client Doesn't Know/Client Refused or Data Not Collected for Destinations?** Click the blue hyperlinked number to find out which person/household is identified.

Subtotal	17	16	0	0	1
Other Locations					
Permanent Housing (other than RRH) for formerly homeless persons	0	0	0	0	0
Owned by client, no ongoing housing subsidy	0	0	0	0	0
Owned by client, with ongoing housing subsidy	0	0	0	0	0
Rental by client, no ongoing housing subsidy	9	8	0	0	1
Rental by client, with VASH housing subsidy	0	0	0	0	0
Rental by client, with GPD TIP housing subsidy	0	0	0	0	0
Rental by client, with other housing subsidy (including RRH)	0	0	0	0	0
Hotel or motel paid for without emergency shelter voucher	3	1	2	0	0
Staying or living in a friend's room, apartment or house	13	13	0	0	0
Staying or living in a family member's room, apartment or house	14	14	0	0	0
Client Doesn't Know/Client Refused	0	0	0	0	0
Data not collected	14	9	2	1	2
Subtotal	53	45	4	1	3
Total	134	104	19	2	9

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Reviewing the APR report for Coordinated Entry flow/usage:

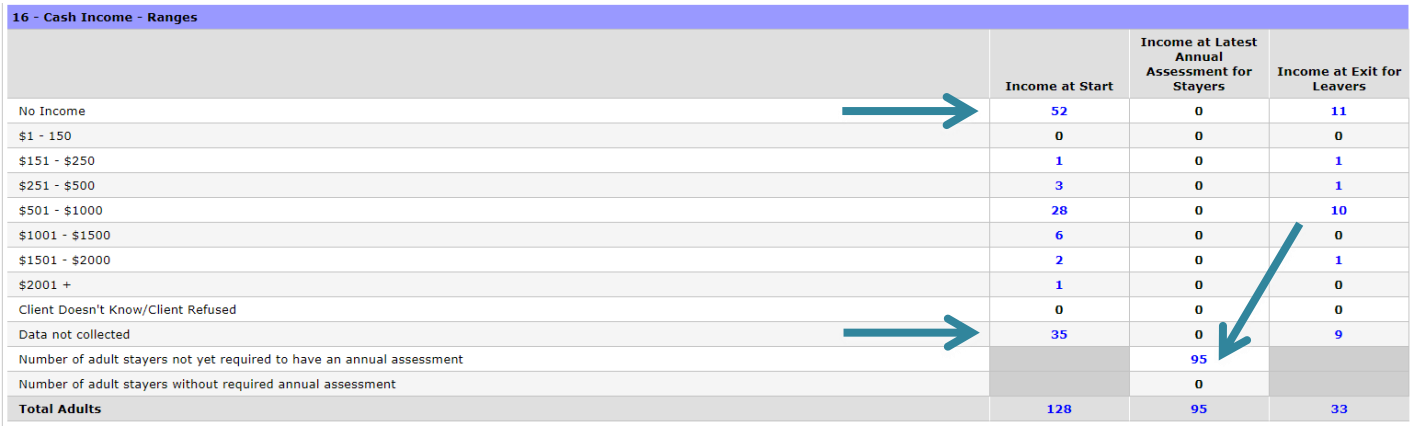
1. **Are the Number of Leavers from the Coordinated Entry system equal to the number of housed people?** Check flow out of the CE system and make sure all housed clients are exited.
2. **Have all the Veterans been connected to Veteran-dedicated providers?**
3. **What is the total Households and Adult Stayers in the Project 365 Days or More?** These clients should be prioritized for housing and will need an Annual Assessment on their project entry.

5a - Report Validations Table	
Report Validations Table	
1. Total Number of Persons Served	198
2. Number of Adults (age 18 or over)	128
3. Number of Children (under age 18)	49
4. Number of Persons with Unknown Age	21
5. Number of Leavers	60
6. Number of Adult Leavers	34
7. Number of Adult and Head of Household Leavers	35
8. Number of Stayers	138
9. Number of Adult Stayers	94
10. Number of Veterans	14
11. Number of Chronically Homeless Persons	18
12. Number of Youth Under Age 25	6
13. Number of Parenting Youth Under Age 25 with Children	2
14. Number of Adult Heads of Household	109
15. Number of Child and Unknown-Age Heads of Household	6
16. Heads of Households and Adult Stayers in the Project 365 Days or More	1

4. **Who is counted under Client Doesn't Know/Client Refused or Data Not Collected for Prior Living Situation?** Click the blue hyperlinked number to find out which person/household is identified to review prior living situations for homeless verification.

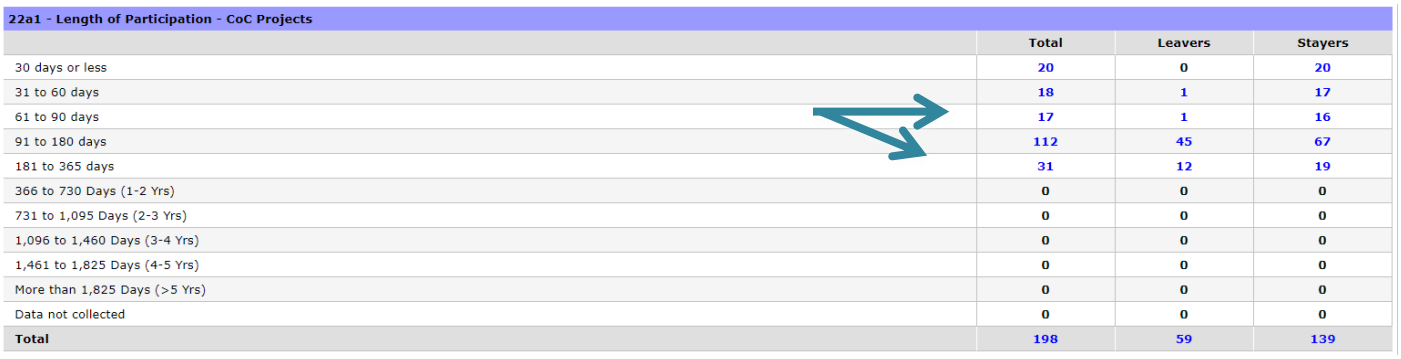
Subtotal	17	16	0	0	1
Other Locations					
Permanent Housing (other than RRH) for formerly homeless persons	0	0	0	0	0
Owned by client, no ongoing housing subsidy	0	0	0	0	0
Owned by client, with ongoing housing subsidy	0	0	0	0	0
Rental by client, no ongoing housing subsidy	9	8	0	0	1
Rental by client, with VASH housing subsidy	0	0	0	0	0
Rental by client, with GPD TIP housing subsidy	0	0	0	0	0
Rental by client, with other housing subsidy (including RRH)	0	0	0	0	0
Hotel or motel paid for without emergency shelter voucher	3	1	2	0	0
Staying or living in a friend's room, apartment or house	13	13	0	0	0
Staying or living in a family member's room, apartment or house	14	14	0	0	0
Client Doesn't Know/Client Refused	0	0	0	0	0
Data not collected	14	9	2	1	2
Subtotal	53	45	4	1	3
Total	134	104	19	2	9

5. **Who is counted under No Income or Data not collected for Cash Income?** Click the blue hyperlinked number to find out which person/household is identified. Check to review clients with No Income for possible referrals to SOAR and other services for income. This section also identifies people/households who are not due for an annual yet



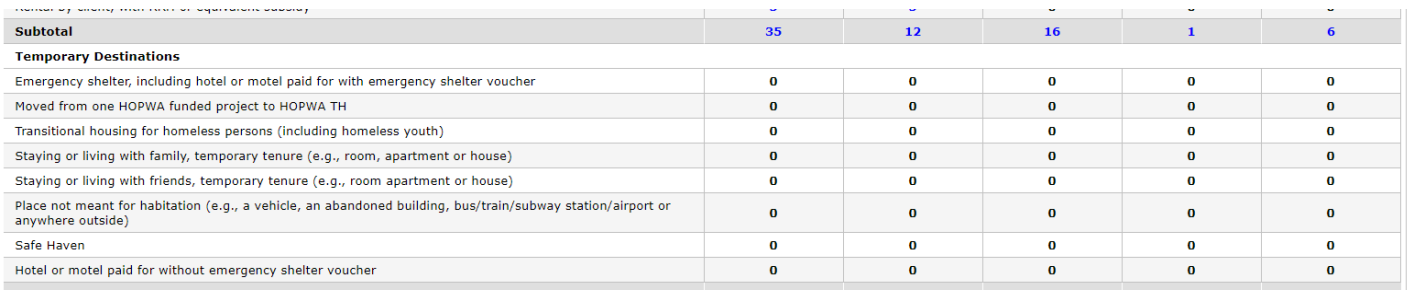
16 - Cash Income - Ranges			
	Income at Start	Income at Latest Annual Assessment for Stayers	Income at Exit for Leavers
No Income	52	0	11
$1 - 150	0	0	0
$151 - $250	1	0	1
$251 - $500	3	0	1
$501 - $1000	28	0	10
$1001 - $1500	6	0	0
$1501 - $2000	2	0	1
$2001 +	1	0	0
Client Doesn't Know/Client Refused	0	0	0
Data not collected	35	0	9
Number of adult stayers not yet required to have an annual assessment		95	
Number of adult stayers without required annual assessment		0	
Total Adults	128	95	33

6. **What is the Length of Participation for people/household in the Coordinated Entry project?** Click the blue hyperlinked number to find out which person/household has accidentally been left in the project after being housed, cannot be located and/or which person/household with long lengths of stay to discuss for prioritization.



22a1 - Length of Participation - CoC Projects			
	Total	Leavers	Stayers
30 days or less	20	0	20
31 to 60 days	18	1	17
61 to 90 days	17	1	16
91 to 180 days	112	45	67
181 to 365 days	31	12	19
366 to 730 Days (1-2 Yrs)	0	0	0
731 to 1,095 Days (2-3 Yrs)	0	0	0
1,096 to 1,460 Days (3-4 Yrs)	0	0	0
1,461 to 1,825 Days (4-5 Yrs)	0	0	0
More than 1,825 Days (>5 Yrs)	0	0	0
Data not collected	0	0	0
Total	198	59	139

7. **Who is counted under Homeless locations for Temporary Destinations?** Click the blue hyperlinked number to find out which person/household is identified



Subtotal	35	12	16	1	6
Temporary Destinations					
Emergency shelter, including hotel or motel paid for with emergency shelter voucher	0	0	0	0	0
Moved from one HOPWA funded project to HOPWA TH	0	0	0	0	0
Transitional housing for homeless persons (including homeless youth)	0	0	0	0	0
Staying or living with family, temporary tenure (e.g., room, apartment or house)	0	0	0	0	0
Staying or living with friends, temporary tenure (e.g., room apartment or house)	0	0	0	0	0
Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	0	0	0	0	0
Safe Haven	0	0	0	0	0
Hotel or motel paid for without emergency shelter voucher	0	0	0	0	0

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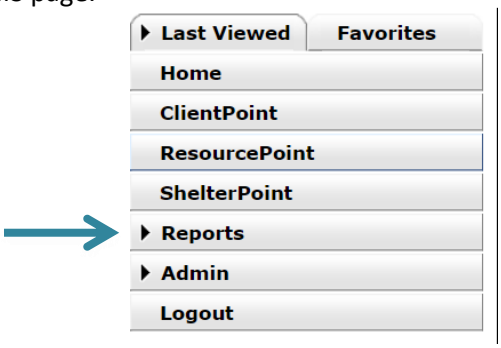
Service Transaction report

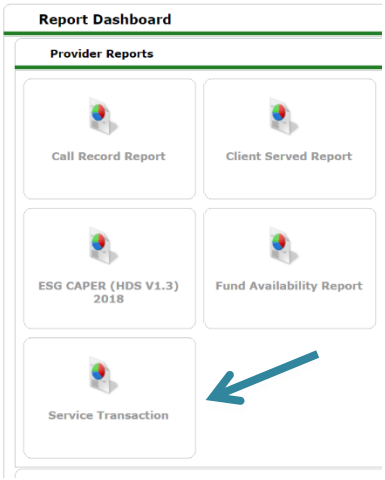
The Service Transaction report is a dashboard report that will pull the Service Transactions entered into HMIS. Grantees should also check this report against timesheets and reimbursement requests to make sure all services provided directly to clients are in HMIS.

Running the Service Transaction report:

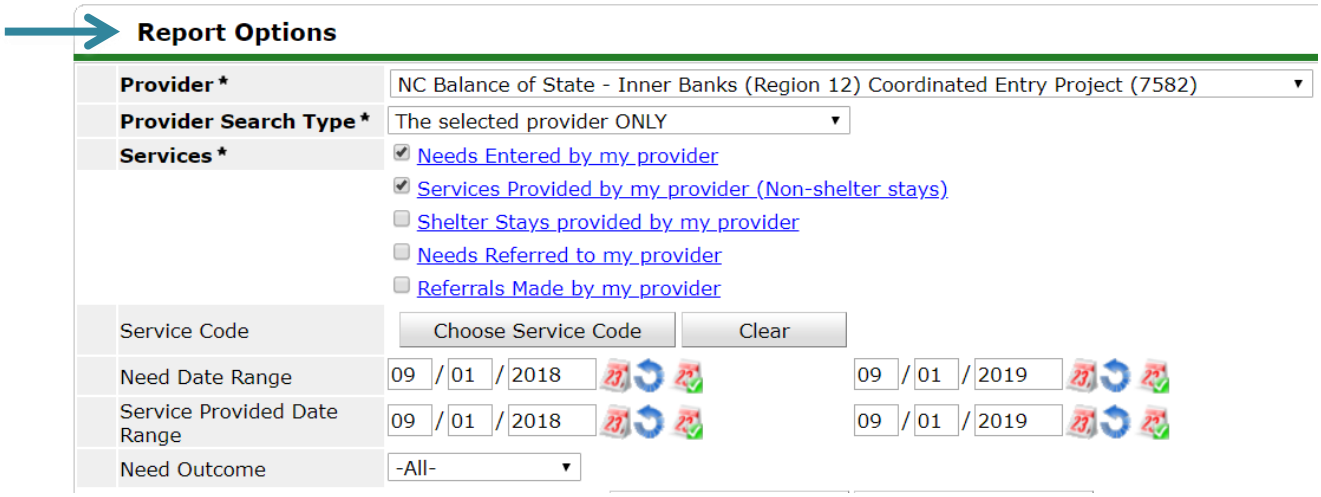
1. As with all dashboard reports EDA mode impacts the report so make sure you EDA for the SSO project you want to run the report for.
2. Click Reports on the left-hand side of the HMIS page.



3. Click on the Service Transaction report in the Provider Reports section.



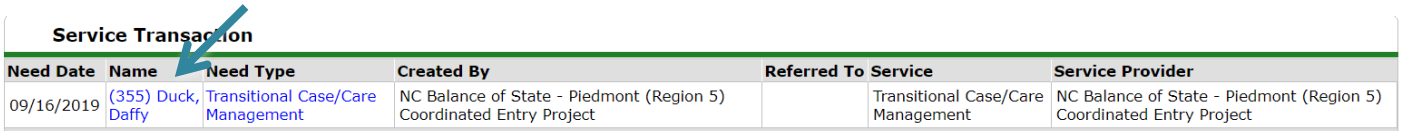
4. Complete report prompts.



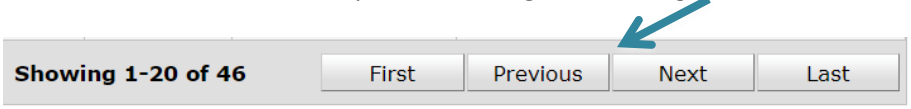
a. **Provider:** This should auto populate with the project you are in EDA for if not check your EDA.
b. **Provider Search Type:** Choose The selected provider ONLY.
c. **Services:** Select Needs Entered by my provider and/or Services Provided by my provider to see what services that provider has entered. Select Needs Referred to my provider and/or Referrals Made by my provider to check referrals made by that provider select.
d. **Service Code:** To search for a specific type of service click Choose Service Code and search for and select the service for the report.
e. **Need Date Range:** Select the dates cover the dates that needs were entered.
f. **Service Provided Date Range:** Select the dates cover the dates that services were entered.
g. **Need Outcome:** Select the outcome to search specifically or leave as All to search for all outcomes.

5. Click Build Report.

6. Report will build for a few minutes then appear. The blue hyperlinked Names and Need Types can be clicked to go directly to that client's profile or their service.



7. Navigate through the report with the Next and Previous buttons or click Download Results to download an excel version of the report for sorting and filtering.



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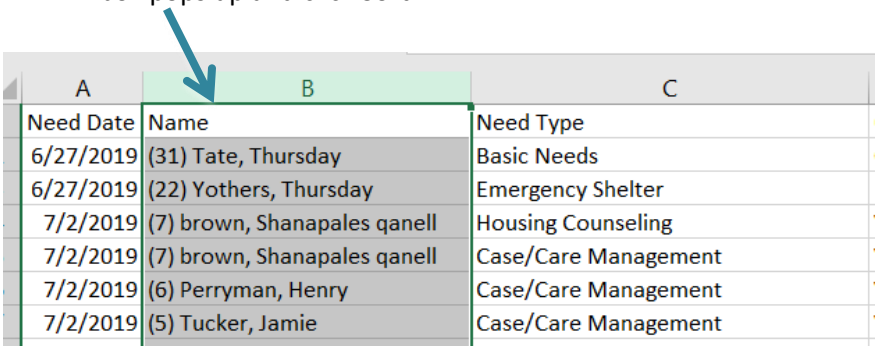
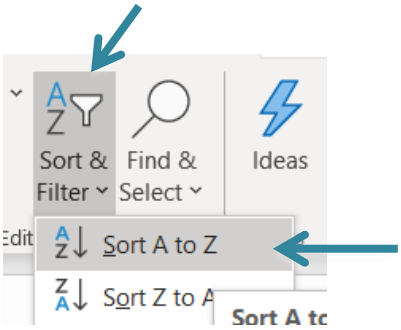
Reviewing the Service Transaction report for data quality checks:

1. Click Download Results to download an Excel version of the report for sorting and filtering.
2. Once you have an open the Excel document and widen the columns see all the information.
3. Select Name column and click Sort and Filter then sort A to Z or Z to A to check to ensure each client has the appropriate services recorded. Click Expand the Selection when the Sort Warning box pops up and click Sort.

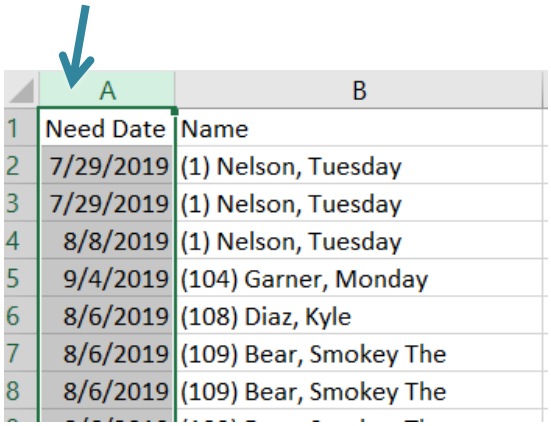


A	B	C
Need Date	Name	Need Type
6/27/2019	(31) Tate, Thursday	Basic Needs
6/27/2019	(22) Yothers, Thursday	Emergency Shelter
7/2/2019	(7) brown, Shanapales qanell	Housing Counseling
7/2/2019	(7) brown, Shanapales qanell	Case/Care Management
7/2/2019	(6) Perryman, Henry	Case/Care Management
7/2/2019	(5) Tucker, Jamie	Case/Care Management



4. Every person/household that received a direct service from the SSO grantee should have a service entered in HMIS including all full Prevention and Diversion Screens and all VI-SPDAT assessments.

5. Select the Need Date column and sort in the same way to check to make sure that dates you know direct services were provided to clients (outreach event etc) have services recorded for. Update HMIS if the dates are incorrect.

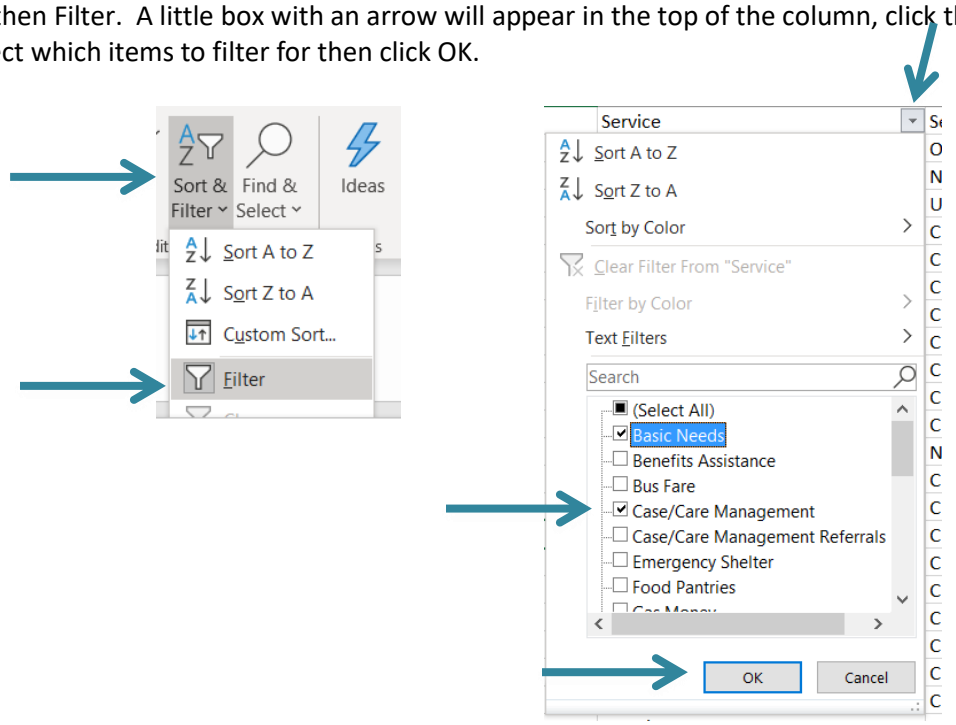


	A	B
1	Need Date	Name
2	7/29/2019	(1) Nelson, Tuesday
3	7/29/2019	(1) Nelson, Tuesday
4	8/8/2019	(1) Nelson, Tuesday
5	9/4/2019	(104) Garner, Monday
6	8/6/2019	(108) Diaz, Kyle
7	8/6/2019	(109) Bear, Smokey The
8	8/6/2019	(109) Bear, Smokey The

6. Select the Service column and sort in the same way to review the types of services codes used. This should accurately reflect activities and service codes that were used/billed. Make sure Prevention and Diversion activity specific codes were not entered into the CE Project.

E	F
Referred To	Service
	Case/Care Management
	Case/Care Management
	Case/Care Management
	Case/Care Management
	Case/Care Management
	Case/Care Management
	Case/Care Management
	Case/Care Management

7. Filter columns as needed for data review. Select the columns that should be filtered, click Sort and Filter then Filter. A little box with an arrow will appear in the top of the column, click that box to select which items to filter for then click OK.



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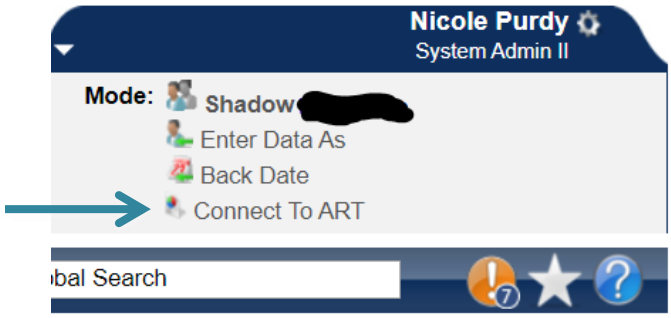
0640 – HUD Data Quality Report Framework

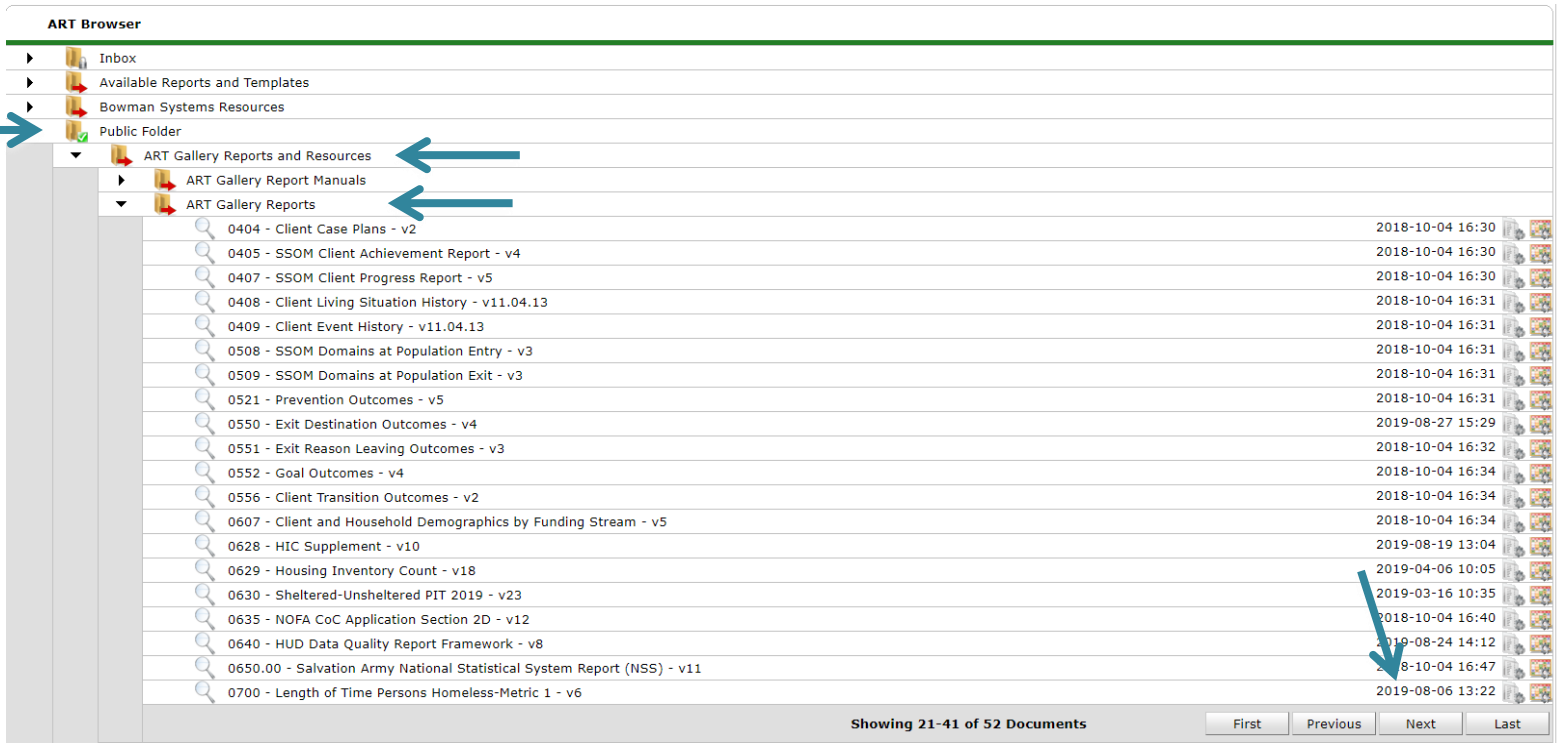
The 0640 – HUD Data Quality Report Framework is an ART report that can provider some data quality information as well as other project information. The 0640 report pulls some of the same data quality elements as the APR but since it's an ART report is pulls differently than the APR and can be pulled for multiple projects at once with better data visibility results.

Running the 0640 report:

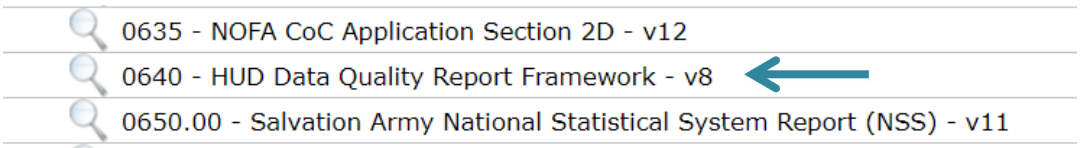
1. As with all ART reports you need to connect to ART to run report. Click Connect to ART in the upper right corner under EDA and Back Date.



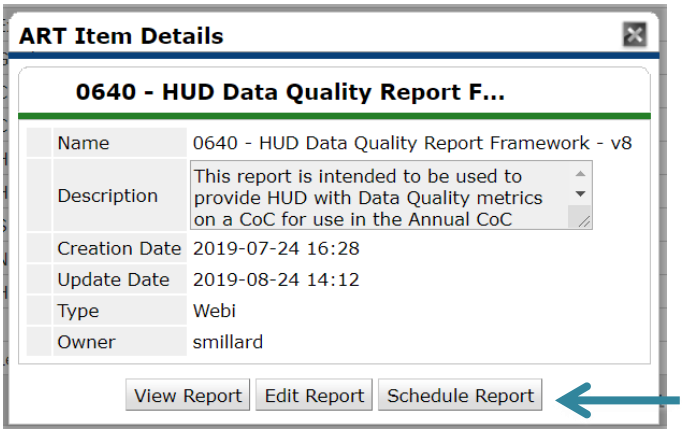
2. Navigate to the 0640 report by clicking the black triangle next to the Public Folder, then the black triangle next to ART Gallery Reports and Resources, then the black triangle next to ART Gallery Reports and then hit the Next button until you get to the 0640 report.



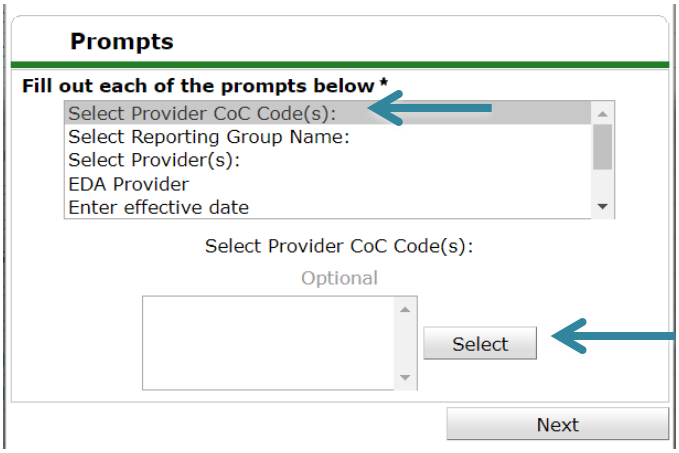
3. Click the magnifying glass next to the 0640 – HUD Data Quality Report Framework. Versions may change but the most updated version should be in the WellSky gallery.

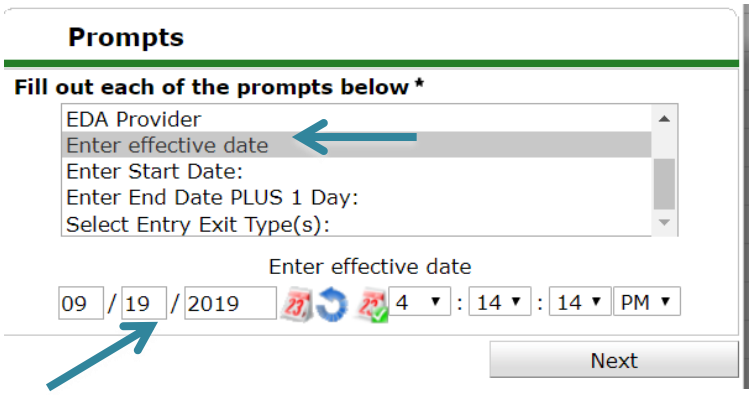


4. Click Schedule Report



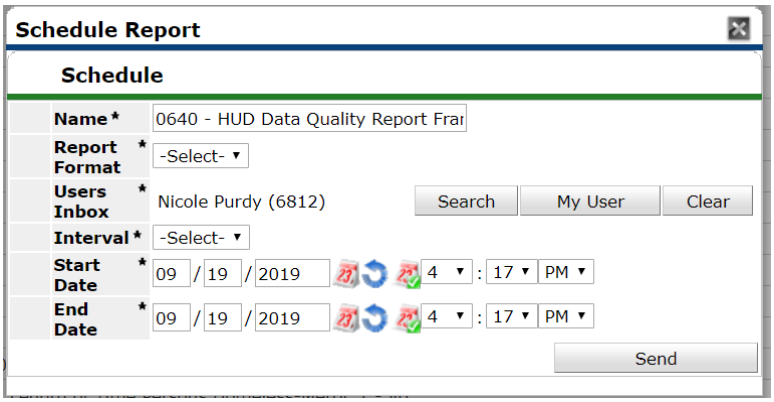
5. A prompts box will pop up. Complete each of the prompts by clicking on the prompt and hitting Select or completing the date fields. Do NOT hit the Next button until you have completed ALL of the required prompts.





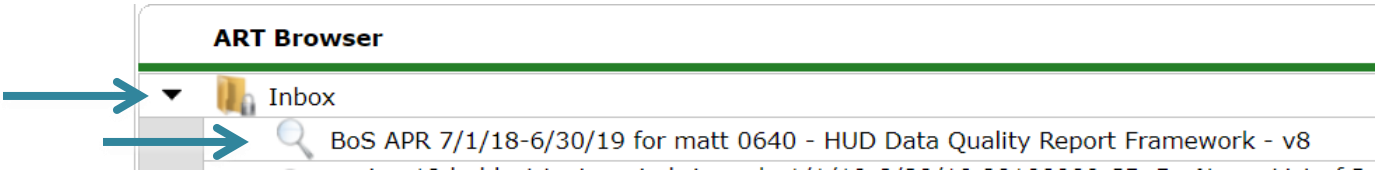
a. **Select Provider CoC Code:** Keep blank.
b. **Select Reporting Group Name:** Search and select reporting group if running by reporting group.
c. **Select Provider(s):** Search and select providers if running by providers.
d. **EDA Provider:** Search and select the correct provider.
e. **Enter effective date:** Same as your end date plus one, often the same date that you are running the report.
f. **Enter Start Date:** Enter the earliest date that you want the report to pull.
g. **Enter End Date Plus 1 Day:** Same as your Effective Date, often the same date that you are running the report.
h. **Select Entry Exit Type(s):** Keep it as HUD and VA.

6. After all prompts are completed click Next. The schedule report box will pop up.

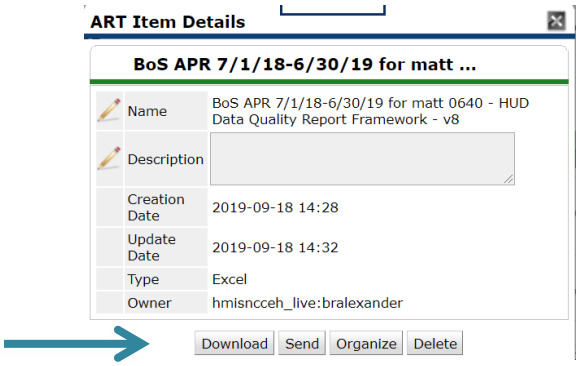


a. **Name:** Enter a name that will distinguish it from other reports that are the same type.
b. **Report Format:** Select Excel.
c. **Users Inbox:** Who's ART inbox should this report go to? Skip this step if inapplicable.
d. **Interval**: Select Once.
e. **Start Date**: When should the report start running? This is NOT the same as reporting dates**.**
f. **End Date**: When should the report stop running? This is NOT the same as reporting dates most often it's the same day as the start date. Change the end date time to one hour later than the start date time to give the report time to run.

7. Click Send.
8. The completed report will appear in your ART Inbox near the top of the screen. Click the magnifying glass next to the report name you want to view.



9. Click Download and then open the report that is downloaded.



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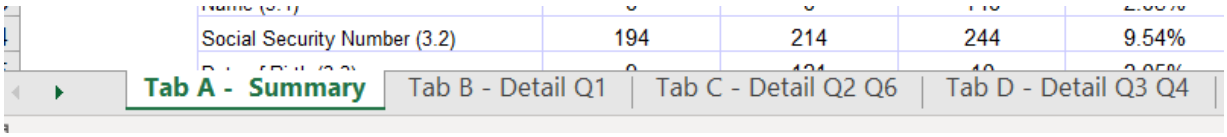
Reviewing the 0640 HUD Data Quality Framework report for data quality checks:

1. Go to Tab A which contains a high-level summary of the data contained throughout the report. Each table in Tab A corresponds to a specific detail tab in the report with more information.



Q1. Report Validation Table

Elements	Client Count
Total Number of Persons Served	6833
Number of Adults (age 18 or over)	4797
Number of Children (under age 18)	1971
Number of Persons with Unknown Age	65
Number of Leavers	1772
Number of Adult Leavers	1464
Number of Adult and Head of Household Leavers	1465
Number of Stayers	5061
Number of Adult Stayers	3333
Number of Veterans	519
Number of Chronically Homeless Persons	588
Number of Youth Under Age 25	372
Number of Parenting Youth Under Age 25 with Children	50
Number of Adult Heads of Household	4133
Number of Child and Unknown-Age Heads of Household	20
Heads of Household and Adult Stayers in the Project More Than 365 Days	1271

2. **Does the Total Number of Persons Served looks correct?**
3. **What is the total for Number of Persons with Unknown Age?** These people/households are missing a Date of Birth in their HMIS record.
4. **What is the total Number of Child and Unknown-Age Heads of Household?** These are either children in households without an adult or households where at least one person has a missing or inaccurate Head of Household status. It could also mean at least one person is missing a Date of Birth.

5. **What is the % of Error Rate for Personally Identifiable Information?** Click on the correct report tab to find out which person/household has Information Missing or Data Issues.

Q2. Personally Identifiable Information (PII)				
Data Element	Client Doesn't Know / Refused	Information Missing	Data Issues	% of Error Rate
Name (3.1)	0	0	140	2.05%
Social Security Number (3.2)	194	214	244	9.54%
Date of Birth (3.3)	9	121	10	2.05%
Race (3.4)	58	134		2.81%
Ethnicity (3.5)	48	140		2.75%
Gender (3.6)	1	80		1.19%
Overal Score				13.16%

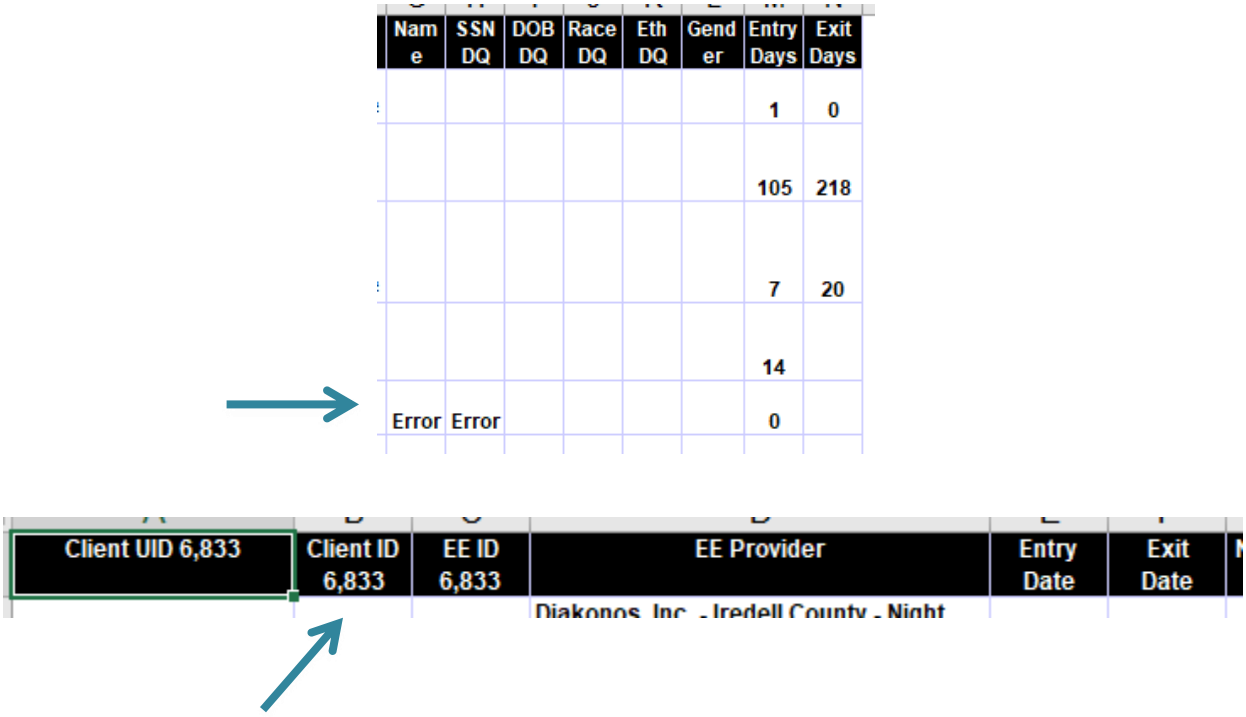
6. **What is the % of Error Rate for Universal Data Elements?** Click on the correct report tab to find out which person/household is identified in Error Count.

Q3. Universal Data Elements		
Data Element	Error Count	% of Error Rate
Veteran Status (3.7)	192	4.00%
Project Entry Date (3.10)	223	3.26%
Relationship to Head of Household (3.15)	737	10.79%
Client Location (3.16)	397	9.56%
Disabling Condition (3.8)	751	10.99%

7. **What is the % of Error Rate for Income and Housing Data Quality?** Click on the correct report tab to find out which person/household is identified in Error Count.

Q4. Income and Housing Data Quality		
Data Element	Error Count	% of Error Rate
Destination (3.12)	478	26.98%
Income and Sources (4.2) at Entry	630	13.08%
Income and Sources (4.2) at Annual Assessment	1079	84.89%
Income and Sources (4.2) at Exit	95	6.48%

8. Click on the appropriate tab that is the Detail tab for the Question you want to make corrections for.
9. Search for the appropriate error flag and client ID that the error is flagging for then data can be corrected in client profile or entry in HMIS.



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Section: Data Entry Summary Grid

Place for data entry	What it tracks	When to do it
Coordinated Entry Project Entry	All literally homeless clients in the community that need housing.	After opportunity to self-resolve (14+ days) and/or assessed for vulnerability (VI-SPDAT)
Coordinated Entry Form	People/household status throughout coordinated entry process and dates of key events.	1. At CE project start to get the form started 2. After the client/household is case conferenced. 3. After the client/household is referred to a housing provider. 4. After the client/household is housed. 5. After the client/household should be removed from the active by name list. 6. Any other time it is helpful for the SSO grantee to update a field.

Interim Assessment	Changes in information for people/households.	When a change in situation or information occurs.
Coordinated Entry Project Exit	Where people went and that they are no longer in the coordinated entry process.	1. After a someone has been housed for 90+ days 2. If someone disappears for a community specified amount of time 3. If that person enters an institution for a long period of time 4. If that person dies
Service transactions	Direct services provided by the SSO grantee to people/households	When providing any SSO grant approved service to a specific person/household
Prevention and Diversion Project limited Entry	Prevention and Diversion screens	On all people/households that are eligible for Prevention and Diversion services.
Prevention and Diversion Project full Entry	Full information on clients served with prevention and diversion services.	On only people/households that prevention and diversion support ie diversion assistance, self-resolution and shelter planning
Prevention and Diversion Project Exit	Where people went and what their status is after receiving prevention and diversion services.	After prevention and diversion is completed (usually same day as start)

Section: Reporting Summary Grid

Type of report	**What it tells you**	**How to use it**	**When you pull it**
By Name List Report	Everyone literally homeless in the community, basic information, CE information on them and current provider information.	Use for case conferencing meeting, to determine who needs entries and exits for the CE project and where people are at in the community.	At least every two weeks
Referrals Dashlet	Incoming and outgoing referrals	To do entries into CE project and keep track of referrals to housing providers	Whenever doing entries into the CE project

Service Transactions	All services provided by the CE project or P&D project	Track services for billing and reimbursement	At least with each reimbursement request
APR	Overall project statistics and information	For data quality checks, flow information and for reporting to the CoC and HUD	At least quarterly
0640	Overall project statistics and information	For data quality checks, flow information	At least quarterly

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