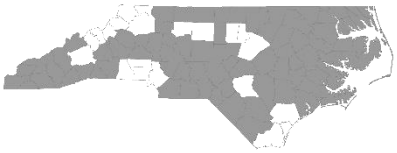

North Carolina
Balance of State Continuum of Care

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NC Balance of State Continuum of Care System Standards
Coordinated Assessment

Overview

The NC Balance of State Continuum of Care has developed these system standards to give specific guidelines for how best to operate regional coordinated assessment systems to achieve the goal of ending homelessness. These guidelines create consistency across the Balance of State regions, protect our mutual clients by putting their needs first, and provide a baseline for holding all CoC coordinated assessment systems to a specific standard of care.

The Department of Housing and Urban Development (HUD) requires every Continuum of Care to evaluate outcomes of projects funded under the Emergency Solutions Grants program and the Continuum of Care program and report to HUD (24 CFR 578.7(a)7). In consultation with recipients of ESG program funds within the geographic area, CoCs must establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individual and families for housing and services.

- In consultation with recipients of ESG and CoC program funds within the geographic area, CoCs must establish and consistently follow written standards for providing CoC assistance. At a minimum, these standards must include: Policies and procedures for evaluating individuals' and families' eligibility for and determining the process for prioritizing eligible households in ~~emergency shelter,~~ transitional housing, rapid rehousing, and permanent supportive housing programs.
- Policies and procedures for coordination among emergency shelters, transitional housing programs, essential service providers, homelessness prevention programs, rapid rehousing programs, and permanent supportive housing programs.
- Definitions for participation in the CoC's Homelessness Management Information System (or comparable database for domestic violence or victims' service programs).

The Balance of State Continuum of Care developed coordinated assessment system standards to ensure:

- System accountability to individuals and families experiencing homelessness, specifically populations at greater risk or with the longest histories of homelessness
- System compliance with the Department of Housing and Urban Development
- Consistency across regional coordinated assessment systems
- Adequate staff competence and training, specific to the target population served

COORDINATED ASSESSMENT

Coordinated assessment systems allow CoCs to coordinate program participant intake, assessment, and provision of referrals. The system covers a set geographic area, can be easily accessed by individuals and families experiencing homelessness or at-risk of homelessness seeking housing and services, is well advertised, and includes a comprehensive and standardized assessment tool.[1]

Any community can implement a coordinated assessment system regardless of geography, housing resources, service availability, or unique community makeup. Communities can successfully create and operate coordinated assessment with patience, persistence, testing, and revisions.

Whether a CoC, community or region uses the terms "coordinated assessment," "coordinated access," "centralized intake," or "coordinated intake," the substance behind the name remains the same: transitioning from a "first come, first served" mentality to one that prioritizes the most vulnerable individuals and families in a community for the most intensive interventions and sets a course of services that meets the needs of all individuals and families experiencing homelessness or at-risk of homelessness.

Coordinated assessment, when implemented correctly, prioritizes individuals and families who need housing the most across communities. This type of system moves beyond programs to create a collaborative environment across all services and program types in the community that can provide an informed way to target housing and supportive services to:

- Divert people away from the system who have other safe options for housing.
- Quickly move people from homelessness to permanent housing by connecting them to the most appropriate housing program available.
- Create a more effective and defined role for emergency shelters and transitional housing.
- Save time, effort, and frustration on the part of service providers through targeting and engagement efforts.
- Focus on efforts of ending homelessness as a community.
- Reduce the length of time homeless by moving people quickly into the appropriate housing.
- Increase the likelihood of housing stability by targeting the appropriate housing intervention to corresponding needs.
- Provide a picture of current system gaps in the community that need to be filled in order to end homelessness for all households
- Be good stewards of limited resources.

Traditionally, communities did not have an organized, transparent system for entry and referral to housing and support services. Individual programs served only people presenting themselves at their front doors, taking clients on a "first come, first served" basis. While many communities still operate in this manner, years of research, re-thinking, and commitment to

[1] https://www.gpo.gov/fdsys/granule/CFR-2013-title24-vol3/CFR-2013-title24-vol3-part578/content-detail.html

moving away from this linear approach, has shifted communities towards a collaborative systematic approach.[2] These changes include:

Historic Practice is Program-Centric	Coordinated Assessment is Client-Centric
Should we accept this person into our program?	What housing and service intervention is the best fit for each individual or family?
Clients must tell their information to every program that they enter for services	Standard forms, assessment, and intake processes across all programs in the community
Uneven knowledge about existing programs, eligibility, and purpose in communities	Accessible information about housing and service options in the CoC, community or region

Building a strong coordinated assessment system builds on and enhances the strengths of the community's programs. When communities come together to implement coordinated assessment, each program realizes success in multiple ways:

- *Programs receive eligible clients:* Programs receive appropriate referrals for participants whose needs and eligibility have already been determined.
- *Case managers can do case management:* When every program does their own intake, case managers often share most of this burden. When communities use a common assessment to share this workload, staff can realize real efficiencies in housing placement and case management.
- *Communities understand the resources they need most:* When communities coordinate the front door of their system, they begin to see who is accessing homeless and housing services and what their needs are. With this understanding, communities can begin to right-size their system to insure that programs are there to meet the needs of households accessing the system.
- *Time, red-tape, and barriers are significantly reduced:* When community programs follow the same process and understand one another's roles, workload is reduced for everyone.

NC BALANCE OF STATE COORDINATED ASSESSMENT GUIDING PRINCIPLES

Across the NC BoS, all locally designed and operated coordinated assessment systems will be:

- *Sustainable:* Regional Committees identify the resources required to operate a coordinated assessment system now and for the foreseeable future.
- *Flexible:* Communities customize their coordinated assessment system based on community needs, resources, and services available.
- *Transparent and accountable:* Participants understand what coordinated assessment is doing and why. Agencies publish and make available their program rules and have a clear, fair grievance and appeals process for both participants and services agencies.

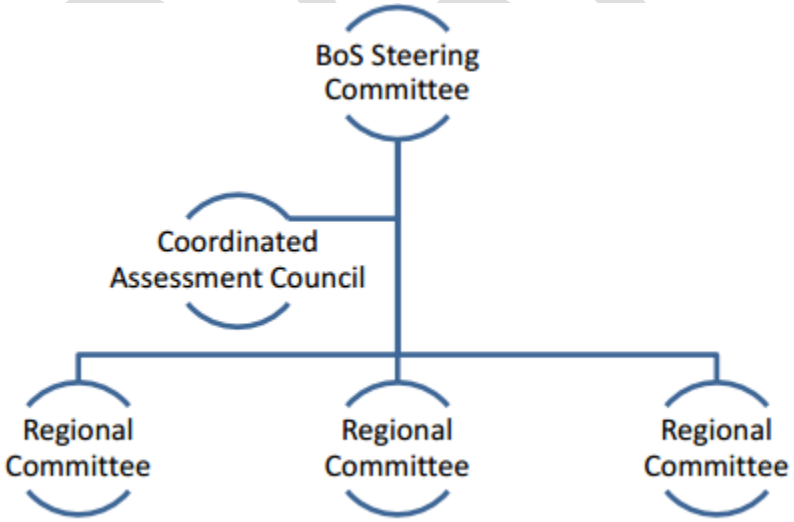
[2] http://www.endhomelessness.org/library/entry/one-way-in-the-advantages-of-introducing-system-wide-coordinated-entry-for-

- *Housing-focused:* Individuals and families experiencing homelessness return to permanent housing within an average of 30 days, in compliance with HEARTH.
- *Client-focused:* The coordinated assessment system is easily accessible, leaves no one behind, and accommodates participant choice and needs.
- *Collaboration-focused:* Regional Committees operate their systems with broad-based consensus and manage system responsibilities through strong partnerships where integrity is key and service providers hold one another accountable and exhibit a willingness to cooperate.
- *Easy-to-use:* System is well-advertised and known throughout the community. It does not inhibit providers from doing their job of ending homelessness.
- *Accessible:* The coordinated assessment system is accessible to every individual and family experiencing homelessness or at-risk of homelessness, regardless of race, color, national origin, religion, sex, age, familial status, disability, or sexual orientation, gender identity or marital status.

GOVERNANCE

General Structure

Local Regional Committees will design and administer coordinated assessment in their communities with standards and governance provided by the NC BoS Steering Committee. The Steering Committee will appoint a standing Coordinated Assessment Council (CAC) to approve new Regional Committee coordinated assessment plans and significant ongoing changes. The CAC will have representatives from across the Balance of State and other state-level experts.



Role of Coordinated Assessment Council (CAC)

The BoS Steering Committee appoints members to the Coordinated Assessment Council. The CAC provides oversight of the full CoC's coordinated assessment system to ensure regional coordinated assessment plans meet the standards set forth in this document. The CAC approves significant plan changes and provides ongoing oversight of the full system to meet Department of Housing and Urban Development priorities and mandates.

Role of Regional Committees

Each Regional Committee will design and implement a local coordinated assessment system within the parameters of the system standards provided. The standards give Regional Committees a supportive framework to use when implementing local systems as well as standardized assessment tools that will be uniform across the BoS CoC. These tools include: the Prevention and Diversion screening tool, the Individual and Family VI-SPDAT Screening Tools, and the Case Management Tool. This document describes these assessments in the definitions section and demonstrates their use throughout the document.

DEFINITIONS

Acuity: When using the VI-SPDAT prescreens, acuity means the presence of a presenting issue based on the prescreening score. Acuity on the prescreening tool is expressed as a number with the higher score representing more complex, co-occurring issues likely to impact overall stability in permanent housing. When using the Case Management Tool acuity refers to the severity of the presenting issue and the ongoing goals to addressing these issues.

Case Management Tool: A standardized tool for case management to track participant progress in programs in the coordinated assessment process. Housing programs administer this tool at program entry, housing entry, and every six months thereafter until program discharge. Upon discharge from the program, housing case managers administer the tool one final time 12 months later, when possible, to ensure the household continues to make progress.

Chronically Homeless: (1) an individual with a disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)) who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) had been homeless and living as described in (i) continuously for at least 12 months or on at least 4 occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating occasions included at least 7 consecutive nights of not living as described in (i). Stays in institutional care facilities for fewer than 90 days will not constitute a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the care facility; (2) an individual who has been residing in an institutional care facility, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or (3) a family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in (1) or 2) of this definition, including a family whose composition had fluctuated while the head of household has been homeless. (24 CFR 578.3)

Comparable Database: HUD-funded providers of housing and services (recipients of ESG and /or CoC funding) who cannot enter information by law into HMIS (victim service providers as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) must operate a database comparable to HMIS. According to HUD, "a comparable database . . . collects client-level data over time and generates unduplicated aggregate reports based on the data." The recipient or subrecipient of CoC and ESG funds may use a portion of those funds to establish and operate a comparable database that complies with HUD's HMIS requirements. (24 CFR 578.57)

Coordinated Assessment: "A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The . . . system covers the geographic area (designated by the CoC), is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool" (24 CFR 578.3). CoCs have ultimate responsibility to implement coordinated assessment in their geographic area.

Developmental Disability: As defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002): (1) A severe, chronic disability of an individual that (i) is attributable to a mental or physical impairment or combination of mental and physical impairments; (ii) is manifested before the individual attains age 22; (iii) is likely to continue indefinitely; (iv) results in substantial functional limitations in three or more of the following major life activities: (a) self-care; (b) receptive and expressive language; (c) learning; (d) mobility; (e) self-direction; (f) capacity for independent living; (g) economic self-sufficiency; (v) reflects the individual's need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. (2) an individual from birth to age 9, inclusive, who has a substantial developmental disability or specific congenital or acquired condition, may be considered to have a developmental disability without meeting three or more of the criteria in (1)(i) through (v) of the definition of "developmental disability" in this definition if the individual, without services or supports, has a high probability of meeting these criteria later in life. (24 CFR 578.3)

Disabling Condition: According to HUD: (1) a condition that: (i) is expected to be of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by providing more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or a developmental disability, as defined above; or the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from AIDS, including infection with the Human Immunodeficiency Virus (HIV). (24 CFR 583.5)

Diversion: Diversion is a strategy to prevent homelessness for individuals seeking shelter or other homeless assistance by helping them identify immediate alternate housing arrangements, and if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion practices and programs help reduce the number of people becoming homeless and the demand for shelter beds.

Family: A family includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) a single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person: or (2) a group of persons residing together, and such group includes, but is not limited to: (i) a family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family); (ii) an elderly family; (iii) a near-elderly family; (iv) a disabled family; (v) a displaced family; and (vi) the remaining member of a tenant family. (24 CFR 5.403)

Homeless:
Category 1: an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals); or (iii) an individual who exits an institution where he/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: an individual or family who will immediately lose their primary nighttime residence, provided that: (i) the primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) no subsequent residence has been identified; and (iii) the individual or family lacks the resources or support networks (e.g. family, friends, faith-based or other social networks) needed to obtain other permanent housing; or

Category 4: any individual or family who: (i) is fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or family member, including a child, that has either taken place within the individual's or family's primary nighttime residence; (ii) had no other residence; and (iii) lacks the resources or support networks (e.g. family, friends, and faith-based or other social networks) to obtain other permanent housing. (24 CFR 578.3)

Housing First: A national best practice model that quickly and successfully connects individuals and families experiencing homelessness to permanent housing without preconditions such as sobriety, treatment compliance, and service and/or income requirements. Programs offer supportive services to maximize housing stability to prevent returns to homelessness rather than meeting arbitrary benchmarks prior to permanent housing entry.[3]

Prevention and Diversion Screening Tool (aka Emergency Response Screening): A tool used to reduce entries into the homeless service system by determining a household's needs upon initial presentation to shelter or other emergency response organization. This screening tool gives programs a chance to divert households by assisting them to identify other permanent housing options and, if needed, providing access to mediation and financial assistance to remain in housing.

Rapid Rehousing: A national best practice model designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve long-term stability. Like Housing First, rapid rehousing assistance does not require adherence to preconditions such as employment, income, absence of criminal record, or sobriety. Financial

[3] http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1448313/pdf/0940651.pdf

assistance and housing stabilization services match the specific needs of the household. The core components of rapid rehousing are housing identification/relocation, short- and/or medium-term rental and other financial assistance, and case management and housing stabilization services. (24 CFR 576.2)

Transitional Housing: Temporary housing for participants who have signed a lease or occupancy agreement with the purpose of transitioning participants into permanent housing within 24 months.

VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool): An evidence-based tool used by all regions in the Balance of State to determine initial acuity and set prioritization and intervention for permanent housing placement.

ORDER OF PRIORITY FOR CoC-FUNDED DEDICATED OR PRIORITIZED CHRONICALLY HOMELESS BEDS

STANDARD: Programs receiving CoC-funded permanent supportive housing which have dedicated or prioritized their beds to serve individuals and families experiencing chronic homelessness must follow the order of priority in accordance with the Order of Priority section in Notice CPD-16-11[4] when selecting participants for housing. Grantees must exercise due diligence when conducting outreach and assessment to ensure the program serves people in the order of priority as adopted by the Balance of State Continuum of Care.

Benchmarks

- *First Priority:* Chronically homeless individuals and families as defined in 24 CFR 578.3 with the longest histories of homelessness AND the most severe service needs (as found through the acuity score on the VI-SPDAT with information from community stakeholders).
    - The chronically homeless individual or head of household of a family has experienced homelessness, living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and
    - The chronically homeless individual or head of household of a family has severe service needs as assessed through the VI-SPDAT. This person has a history of high utilization of crisis services, including, but not limited to, hospital emergency departments, jail, or psychiatric facilities; or significant health and behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.
- *Second Priority*: Chronically homeless individuals or families with the longest history of homelessness that meet the following:
    - The chronically homeless individual or head of household of a family has experienced homelessness, living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at least 12 months either continuously or on

[4] https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf

at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months; and
    - The chronically homeless individual or head of household of a family has not been identified to meet the severe service needs described in priority one.
- *Third Priority:* Chronically homeless individuals or families with the most severe service needs.
    - The chronically homeless individual or head of household of a family has experienced homelessness, living in a place not meant for human habitation, a safe haven, or in an emergency shelter on at least four separate occasions in the last 3 years, where the cumulative total length of the four occasions equals at least 12 months but less than others identified in the community needing permanent housing; and
    - The chronically homeless individual or head of household of a family has severe service needs as assessed through the VI-SPDAT. This person has a history of high utilization of crisis services, including, but not limited to, hospital emergency departments, jail, or psychiatric facilities; or significant health and behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.
- *Fourth Priority*: All other chronically homeless individuals or families.
    - The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter on at least four separate occasions in the last 3 years, where the cumulative total of the four separate occasions is less than 12 months; and
    - The program has not identified the chronically homeless individual or head of household of a family, who meets all of the criteria of a chronically homeless person or family, as having severe service needs.

ORDER OF PRIORITY FOR CoC-FUNDED NON-DEDICATED OR NON-PRIORITIZED CHRONICALLY HOMELESS BEDS

STANDARD: Programs receiving CoC-funded permanent supportive housing that do not dedicate or prioritize their beds for individuals and families experiencing chronic homelessness must first follow the order of priority as mentioned in the section above: Order of Priority for CoC-Funded Dedicated or Prioritized Chronically Homeless Beds. However, if the community does not have any chronically homeless individuals or families or someone meeting the priority listing above cannot be identified within 30 days, programs will prioritize their beds in accordance with the Order of Priority section in Notice CPD-16-11[5] for non-dedicated or non-prioritized beds when selecting participants for housing.

Benchmarks

- *First Priority:* Priority listing under section: Order of Priority for CoC-Funded Dedicated or Prioritized Chronically Homeless Beds.

[5] https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf

- *Second Priority:* Homeless individuals and families with a disability with long periods of episodic homelessness and severe service needs.
    - An individual or family that is eligible for CoC Program-funded PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months and has been identified as having severe service needs.
- *Third Priority:* Homeless individuals and families with a disability with severe service needs.
    - An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.
- *Fourth Priority:* Homeless individuals and families with a disability coming from places not meant for human habitation, safe haven, or emergency shelters without severe service needs.
    - An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.
- *Fifth Priority:* Homeless individuals and families with a disability coming from transitional housing.
    - An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing had lived in a place not meant for human habitation, in an emergency shelter or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

CLIENT INTAKE PROCESS THROUGH COORDINATED ASSESSMENT

PROCESS: Regional Committees determine whether their coordinated assessment system will be *centralized* (designated agency or agencies within their community to handle intake and referrals) or *decentralized* (all agencies will employ the common assessment and referral system for intake). All programs will actively participate in their Regional Committee's coordinated assessment system. Programs will minimize their entry requirements to ensure that the most vulnerable individuals and families experiencing homelessness are served. CoC and ESG housing programs will not accept referrals for housing outside of their community's coordinated assessment system. Communities will use the Prevention and Diversion screening tool prior to entry into shelter and emergency housing programs. Once entered into shelter or emergency housing after a length of time to be determined in the community, programs will

administer the VI-SPDAT Screening Tool to determine the most appropriate housing intervention based on the individual's or family's specific needs and acuity.

STEPS:

1. All adult program participants must meet eligibility requirements by appropriate program.
2. Programs may require participants to meet only additional program eligibility requirements as they relate specifically to federally, state-guided, and Continuum of Care eligibility in writing.
3. The only reasons programs may disqualify an eligible individual or family from program entry are:
    a. All programs beds are full.
    b. If the housing has in residence at least one family member with a child under the age of 18, the program may exclude registered sex offenders and person with a criminal record that includes violent crime from the program so long as the child resides in the same housing facility (24 CFR 578.93).
4. Programs cannot disqualify an individual or family from program entry for lack of income or employment status.
5. Programs cannot disqualify an individual or family because of prior evictions, poor rental history, criminal history, or credit history.
6. Programs cannot disqualify an individual due to the type or extent of disability-related services or supports that are needed or due to active or a history of substance use.
7. Programs explain available services and encourage each adult household member to participate in program services, but do not make service usage a requirement or the denial of services a reason for disqualification or eviction.
8. All client information should be entered in the NC HMIS in accordance with data quality, timeliness, and additional requirements found in the agency and user participation agreements. At a minimum, programs must record the date the client enters and exits the program, HUD required data elements, and an update of client's information as changes occur.

TOOLS

Having the standardized tools to operate a coordinated assessment is necessary to successfully implement the system. The following list shows the necessary tools and the specific ones used by all Regional Committees in the NC Balance of State Continuum of Care.

Tool of Concept	Specific solution used by the NC BoS CoC
A common prevention tool at entry prior to entry in the homeless service system	Prevention and Diversion Screening Tool
A common assessment tool at entry to determine the best housing intervention	Individual and Family VI-SPDATs V.2
A common process for prioritization for housing	Regional Committees determine their scoring ranges for the various housing interventions

A common referral mechanism across programs	Regional Committees determine the common mechanism used within their communities *Future: ServicePoint in HMIS for the VI-SPDAT*
A common community-level process for housing placement	Regional Committees determine the community-level process which may include local prioritization meetings and shared prioritization lists
A common tool for case management and housing stabilization	Case Management Tool
A common method to measure results of the process	Quarterly Coordinated Assessment Reports

ASSESSMENT

PROCESS: All programs will actively participate in their Regional Committee's coordinated assessment system by sharing responsibilities for implementing the system and closing side doors that circumvent the coordinated assessment process. All Regional Committees will use the Prevention and Diversion screening tool as the initial triage assessment for coordinated assessment. Whenever possible, Regional Committees want to work to divert any individual or family from the homeless service system by providing problem-solving, mediation, and diversion financial assistance to presenting households. When diversion is not possible, programs administering the Prevention and Diversion screen should refer clients to appropriate emergency services to meet their needs. Once in the shelter or emergency housing system communities will then administer the Individual or Family VI-SPDAT after the Regional Committee's agreed-upon waiting period. Programs should submit their VI-SPDAT scores through the agreed-upon method so that individuals and families can be evaluated, prioritized, and slated for the appropriate housing intervention.

STEPS:

1. All staff and/or volunteers administering the Prevention and Diversion screening tool, the Individual and Family VI-SPDAT Screening Tools, and the Case Management Tool should participate in training prior to direct work with individuals and families presenting for services.
    a. The Prevention and Diversion Screening Tool can be found at: https://prezi.com/3swi9bhzxszd/prevention-and-diversion-screen-version-2/
    b. The VI-SPDAT Screening Tools can be found at: https://prezi.com/ebmxox_3qwqd/vi-spdat-version-2/
2. The coordinated assessment system must not screen out anyone due to perceived barriers related to housing or services, including, but not limited to, too little or no income, active or a history of substance use, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record–with exceptions for state or local restrictions that prevent projects from serving people with certain convictions.
3. All Regional Committees will use the Prevention and Diversion screening tool as the initial triage assessment, diverting households as possible using problem-solving,

mediation, and/or financial assistance. If a household cannot be assessed with the Prevention and Diversion screen immediately, though, they should not be prevented from entering shelter or receiving other emergency services.

4. Once individuals and families enter the homeless service system, programs should administer the Individual or Family VI-SPDAT to households that have reached the agreed-upon community time limit with a suggested waiting period of two weeks. Once complete, the VI-SPDAT provides programs with the ability to determine, across dimensions, the acuity of an individual or family. Street outreach programs may choose to administer the VI-SPDAT on a different timeline to unsheltered households, as needed.
5. The VI-SPDAT, like all evidence-informed common assessment tools, expresses acuity of an individual or family through a numeric score, with a higher number representing more complex, co-occurring disorders likely to impact overall housing stability. In administering the VI-SPDAT, communities cannot require the disclosure of specific disabilities or diagnoses. The VI-SPDAT score shows the *presence* of these issues and indicates the potential best intervention for housing and services. The assessment tool bases the score on the following:
    a. Wellness: Chronic health issues and substance abuse
    b. Socialization and Daily Functioning: Meaningful daily activities, social supports, and income
    c. History of Housing and Homelessness: Length of time experiencing homelessness and cumulative incidences of homelessness
    d. Risks: Crisis, medical and law enforcement interdictions. Coercion, trauma, and most frequent places the individual or family has slept
    e. Family Unit (Family VI-SPDAT only): School enrollment and attendance, familial interaction, family makeup, and childcare
6. Regional Committees must have a process by which they operate prioritization lists within their coordinated assessment system that eliminates a "first come, first served" status quo and prioritizes individuals and families based on acuity and NC BoS CoC prioritization policies. Within acuity, when participants have the same score, Regional Committees should have a written schedule of priorities based on length of time homeless, vulnerability, and community needs (i.e. unsheltered before sheltered, families before individuals, or fleeing domestic violence before non-domestic violence). Prioritization lists may not prioritize households based on a diagnosis or particular disability or another other protected status.
7. Scores on the VI-SPDAT populate the local prioritization list, allowing Regional Committee agencies, providers, case managers, and others with housing resources to decide who enters housing next by acuity. Length of time homeless should also be tracked by Regional Committees in order to follow the prioritization listing above. Communities may also track eligibility factors that can determine referrals (e.g. veteran status). Communities may track specific diagnosis or disability information if it is necessary to determine eligibility, and as long as eligibility information is not being used as part of the prioritization or ranking.
8. Regional Committees may use additional prioritization factors such as high utilization of crisis or emergency services, unsheltered status, risk of continued homelessness, or vulnerability to victimization. Regional committees may not use other factors that would discriminate based on race, color, religion, national origin, sex, age, familial status,

disability, type or amount of disability, disability-related services or supports required or actual or perceived sexual orientation, gender identity, or marital status.

Regional Committees determine the VI-SPDAT score range under which individuals and families experiencing homelessness go into various housing interventions based on community needs. However, the score ranges below are recommended for communities and serve as a good starting point for any community initially implementing coordinated assessment.

VI-SPDAT Individuals V.2

Intervention Recommendation	VI-SPDAT Prescreen Score for Individuals
Permanent Supportive Housing	10-20
Rapid Rehousing	5-9
Basic Case Management	0-4

VI-SPDAT Families V.2

Intervention Recommendation	VI-SPDAT Prescreen Score for Families
Permanent Supportive Housing	12-20
Rapid Rehousing	6-11
Basic Case Management	0-5

ASSIGN WITH CLIENT CHOICE

PROCESS: Programs will provide safe, affordable housing meeting participants' needs in accordance with the coordinated assessment process and prioritization schedule, based on acuity and eligibility. Programs will provide rapid and successful entry into permanent housing for each eligible household, by acuity, with as few barriers as possible. The coordinated assessment system will focus its attention on the ability of all clients in the community to access the appropriate housing intervention.

STEPS:

1. In providing or arranging for housing, programs consider the specific household needs of the individual or family experiencing homelessness.
2. Programs assist households in finding suitable housing quickly and effectively and do so guided by client input and choice.
3. Programs agree to only accept referrals through the coordinated assessment system, closing all side doors to permanent housing placement.

Client choice should remain at the center of any referral and placement, with the client being completely informed of the steps and processes necessary to move from homelessness to permanent housing. Local Regional Committees decide how the referral process

will work in their communities. However, the process should include, whenever possible, a warm hand-off of the client to the referred agency, which could include either a phone call or email with a method for transmitting intake materials including the completed prevention and diversion screen and/or the VI-SPDAT. If a client rejects the program to which they are referred, they should maintain their place on the community-wide waitlist. Communities should take into consideration resources for transportation to get clients from screening site to referred agency.

FOLLOW-UP AND HOUSING STABILIZATION

PROCESS: To reduce returns to homelessness, programs should provide a continuity of services to all participants following their exit from a program. These services may be provided directly by the program or through referrals to other service providers.

STEPS:

1. Programs prioritize the development of exit plans for each participant to ensure continued permanent housing stability and connection to community resources, as desired.
2. Programs routinely check in with PSH participants to identify those households whose acuity scores are low enough to maintain permanent housing stability in market rate or subsidized housing outside the permanent supportive housing program.
3. Programs develop a plan, in conjunction with the participating household, for effective, timely exit of individuals and families whose acuity scores are low enough to maintain permanent housing stability in market rate or subsidized housing outside the permanent supportive housing program.
4. Programs should attempt to follow up with participants through verbal or written contact at least once 6 months after the client exits the program. A program may provide follow-up services to include identification of additional needs and referral to other agency and community services in order to prevent future episodes of homelessness.
5. For HUD CoC PSH grants, programs may provide services to formerly homeless individuals and families for up to six months after their exit from the program.

Programs will use the Case Management Tool, a standardized tool for case management, to track household progress in meeting key needs and determine ongoing acuity of the participant household. Programs begin administering the Case Management Tool at program entry, at housing entry, and every 6 months thereafter until program discharge. Programs should use this tool during the follow-up with participants 6 months after program exit to ensure that the household continues to thrive in permanent housing and can assist with service referral if the acuity score indicates ongoing needs.

Programs should train all staff members who will administer the Case Management Tool or who will supervise case management staff who administer the tool. An online video training can be found at: https://prezi.com/adwfkc2xzig_/case-management-tool-version-2/.

Regional Committees determine the Case Management Tool score range under which individuals and families in permanent housing programs should be considered for exit to another permanent housing program or housing subsidy based on community resources,

keeping in mind that some households may experience ongoing challenges at program exit.

ACCOUNTABILITY

PROCESS: Programs should actively contribute to their local coordinated assessment system and prioritization process. Both HUD and VA programs must participate and only accept referrals from the local system. When potential participants contact programs, according to their system, they should assess the household at a point of entry into the system or refer the household to the designated coordinated assessment agency in their community. All coordinated assessment systems must have a grievance process for participants and agencies using the system to formally bring their concerns to the Regional Committee.

STEPS:

1. Regional Committees must ensure that all providers serving individuals and families experiencing homelessness or at-risk of homelessness have been invited to participate in the local coordinated assessment system. For providers unwilling to play a role, Regional Committees must consistently outreach and engage these providers to reconsider their role with coordinated assessment.
2. Regional Committees should ensure that all counties under their purview play a role in the coordinated assessment system either through a central system for the entire area or individual county systems that coordinate with one another on participant referral and service/permanent housing access.
3. Programs should make every effort to take as many referrals from their local prioritization process as possible within federal and state eligibility criteria. If programs exhibit a consistent history of turning down referrals, the coordinated assessment system should reach out to said programs to encourage them to lower barriers to entry. Communities are able to set a limit of the number of referrals that participating programs can deny.
4. Regional Committees must submit quarterly outcome reports to the BoS Coordinated Assessment Council. These reports are due on the 15th of the month after quarter end: April 15th, July 15th, October 15th, and January 15th. The quarterly report can be accessed at: http://bit.ly/29UYXuR.
5. Regional Committees must create a grievance process for participants and agencies using the system when they have a concern with decisions made by the coordinated assessment system or agencies operating under said system. Local grievance procedures will handle the majority of issues. For issues that the local system cannot resolve, participants and/or agencies can appeal their concern to the BoS Coordinated Assessment Council for resolution. Documentation about the grievances filed and resolved should be kept by the community.
6. Regional Committees should evaluate the effectiveness of their coordinated assessment systems on a regular basis, using their own data and the reflection of the quarterly visual report provided from the BoS Coordinated Assessment Council (CAC). Regional Committees should make changes to their system that can make them more effective. Some changes require CAC approval, which include:
    a. Referral mechanism/process
    b. Waitlist mechanism/process
    c. Stop/start using HMIS for coordinated assessment
    d. Changes to assessment tools

Regional Committees should request to make these changes through the following form: http://bit.ly/29Ym8ID

Privacy Protections

All participants in Coordinated Assessment must be informed of how their information collected during the Coordinated Assessment process would be shared and used and must provide consent before that information is shared. Each Regional Committee should establish a community-wide release of information that each participant signs before their information is shared.

Participants in Coordinated Assessment must be allowed to refuse to have their information shared or refuse to disclose certain information. Regional Committees cannot deny services to participants if participants refuse to share or disclose information, unless Federal statute requires collection, use, storage, and reporting of a participant's personally identifiable information (PII) as a condition of program participation.

The assessment and prioritization process cannot require disclosure of specific disabilities or diagnoses. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.

Safety Planning

The coordinated assessment system must ensure the safety of people fleeing or attempting to flee domestic violence, dating violence, stalking, sexual assault, and victims of trafficking.

People administering the Prevention and Diversion Screening must always follow the domestic violence protocol, which directs agencies to refer clients directly to victim service providers immediately if they indicate they may be fleeing or attempting to flee domestic violence, dating violence, stalking, sexual assault or are victims of trafficking.

If victim service providers are participating in the Regional Committee's coordinated assessment process, their clients must be tracked confidentially, without divulging any information that could put their safety at risk, including, but not limited to, personally identifying information.

Victim service providers may instead use an alternative coordinated assessment system, as long as it meets all of HUD's minimum requirements. If victim service providers would like to use an alternative system, they should contact their regional coordinated assessment lead as well as NCCEH staff to help design that system.

Non-Discrimination and Equal Access

Participants may not be denied access to the coordinated assessment process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault, stalking, or human trafficking.

The coordinated entry process must be available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.

All populations and subpopulations in the CoC's geographic area, including people experiencing chronic homelessness, Veterans, families with children, youth, and survivors of domestic violence, must have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the system.

Regional Committees should take reasonable steps to ensure effective communication with individuals with disabilities, including providing information in appropriate accessible formats as needed (e.g., Braille, audio, large type, assistive listening devices, and sign language interpreters).

Regional Committees should take reasonable steps to ensure the coordinated entry process can be accessed by persons with Limited English Proficiency (LEP).

Participants must be informed of the ability to file a nondiscrimination complaint. Participants may file a fair housing complaint:

- With HUD by calling 1-800-669-9777 or online using this link https://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/online-complaint.
- With the North Carolina Department of Administration using this link https://files.nc.gov/ncdoa/documents/files/HousingDiscriminationComplaint.pdf