**Coordinated Entry Partnership – Balance of State Continuum of Care**

*Serving Veterans*

*Preparation for 9/28/15 Randolph Coordinated Entry Committee Meeting*

**WHAT IS IT THAT WE NEED TO CONSIDER?**

Does someone first identify as a Veteran? Or first identify as someone with a housing crisis/homeless?

At want point in our process are we screening for Veteran Status? How are screening?

What happens when we identify someone who is a Veteran? Where and when are we referring them to Veteran-specific resources, both VA-funded and otherwise? What if someone refuses a referral?

How do we ensure that Veteran’s have access to all the resources available to support their stable housing, not just Veteran-specific resources? Is this important? For example, Vermont Rental Subsidy

How will Vet-specific service providers, the local lead agencies, and the other assessment partners share information? Will certain providers be expected to use ServicePoint and share baseline information with others in the local Coordinated Entry Partnership in the same way assessment partners and local lead agencies will share information? Are these agencies participating or able to participate in local coordination of services, such as housing review teams?

How do we ensure that we are determining the level of need and duration of housing assistance in a way that is uniform (assessment, “matching”) – e.g., Permanent Supportive Housing, Short-term Rapid Re-housing, Medium-term RRH? And relatedly, prioritization for assistance? Is this important? (I would say “yes”, it seems to be an explicit requirement of coordinated entry)

**WHAT IS THE BALANCE OF STATE COORDINATED ENTRY PARTNERSHIP MODEL?**

Review the current Coordinated Entry Partnership flow chart. There is a 2-Step Housing Assessment Process:

* Step 1 is a Housing Status Screen, which also identifies some basic demographics and housing status. Step 1 is for any number of organizations or institutions within a CoC that need to make a referral for someone in housing crisis. Step 1 is sent to the local lead agency who follows up with the client for Step 2 (target: within 3 days of referral)
* Step 2 is a Housing Barriers Assessment, which collects the full HMIS data elements, and identifies housing barriers and level of need to direct a referral/service intervention, and prioritization for PSH. The local lead agency will accept most referrals and will complete most assessments. But, the CE Partnership can have multiple “assessment partners” who complete the “housing barriers assessment”, communicate/share information with the partnership (assessment partners and lead agency) to manage local waitlists, referrals and resources. HMIS will be key to this process, as will Housing Review Teams.

**WHAT ARE SOME WAYS WE HAVE ALREADY MADE VARIATIONS TO THE CE PARTNERSHIP PROCESSES?**

There can be variations on these processes to meet the needs of specific populations. Here are some ways that we have made changes to better serve victims fleeing domestic/sexual violence:

* Step 1 (Screen): at the start, asks if the person is fleeing DV/SV?
  + Yes? okay to contact local DV shelter/service provider?
    - Yes? A phone referral is immediate. The DV shelter becomes the lead provider.
      * The DV shelter may complete Step 2 (Assessment) and will advocate/make connections/refer in a way that meets the safety needs of the client
      * The DV shelter may refer the client to complete Step 2 with the local lead agency
    - No? The screen continues and the referral is made to the local lead agency
* All processes can occur outside of HMIS, or in HMIS (for non-victim service providers) with or without identifying information (depending on the release of information of the client and the safety plan in place)

**WHAT ARE SOME POSSIBILITIES WHEN SERVING VETERANS?**

1. Add it to the screen, Step 1: – Have you or anyone in your household served in the military or armed services? Yes
   * Can I refer you to the VA?
     + Yes: Refer to local VA worker. The VA is an assessment partner, completes Step 2, shares data, coordinates with local CE partnership
     + No (Declines VA referral): Can I refer you to X (pre-determined peer-based service or SSVF provider)?
       - Yes: This provider is an assessment partner and completes Step 2.
       - No: Refers to the local lead agency for Step 2. Completes assessment, makes service connections/referrals in the normal way, may still include Vet-specific resources

* In this variation, what happens to folks already being service by the VA or the pre-determined partner? These providers are assessment partners and complete Step 2.

1. Add it to Step 2, the Housing Barriers Assessment: Have you or anyone in your household served in the military or armed services? Yes
   * Can I refer you to the VA?
     + Yes: Local Lead Agency completes assessment, makes referral/handoff/shares assessment with VA provider
     + No (Declines VA referral): Can I refer you to X (pre-determined peer-based service or SSVF provider)?
       - Yes: Local Lead Agency completes assessment, makes referral/handoff/shares assessment with provider
       - No: Local Lead Agency completes assessment, makes service connections/referrals in the normal way, may still include Vet-specific resources

* In this variation, what happens to folks already being service by the VA or the pre-determined partner?
  + They could refer the client to the local lead agency for a housing barriers assessment and additional resources
  + They could be Assessment Partners and complete Step 2, the housing barriers assessment

1. Veterans could be identified and bypass the local CE Partnership entirely. For example, be referred by the hospital, 2-1-1, church, etc. directly to the VA or another provider.
   * What would this CE process look like? Would the assessment of need be done through coordinated assessment? How would they be referred, connected with, and prioritized for non-Vet specific housing resources?
   * We would still need to identify how the local CE Partnership is expected to make referrals.
2. What are some possibilities for co-location? Or providing onsite Step 2 assessment at partner agencies? How does this vary the model?