

# **Vermont Balance of State Continuum of Care**



## **Vermont Balance of State Continuum of Care (VT BoS CoC) Coordinated Entry Policies and Procedures**

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## SECTION 1: OVERVIEW

In accordance with 24 CFR 578.7 and as required by the US Department of Housing and Urban Development (HUD), the Vermont Balance of State CoC (VT BoS CoC), in partnership with the Vermont Office of Economic Opportunity, has established a Coordinated Entry system.

Policies and procedures for the VT BoS CoC Coordinated Entry system are established in this document. These policies and procedures will govern the implementation of the Vermont Balance of State Continuum of Care (CoC) Coordinated Entry system. Policies will be reviewed annually in accordance with the Vermont Balance of State CoC Governance Charter. The VT BoS CoC Coordinated Entry Committee is responsible for Coordinated Entry evaluation and oversight of implementation.

Coordinated Entry (CE) is a set of processes to ensure that people experiencing a housing crisis are quickly identified, assessed for, referred and connected to housing assistance based on their strengths and needs. At a minimum, Coordinated Entry is required to:

- Cover the geographic area of the CoC,
- Be easily accessed by individuals and families seeking housing or services,
- Be well advertised, and
- Include comprehensive and standardized assessment.

Coordinated Entry also helps ensure the success of homeless assistance and homeless prevention programs in communities. In particular, Coordinated Entry can help communities systematically assess the needs of individuals and families, and effectively match each individual or family with the most appropriate resources available to address that individual or family's particular needs.

### 1.1 Geographic Area & Population

The Vermont Balance of State Continuum of Care includes all the counties in Vermont *except* for Chittenden County. Within these 13 counties, there are 11 Local Housing Coalitions operating as part of the Balance of State CoC. VT BoS CoC has defined a Local Coordinated Entry Partnership model as key to Coordinated Entry implementation.

Coordinated Entry is intended to serve all households (adults only, adults with children, children only) experiencing a housing crisis, defined as: **Homeless** or **At-risk of Homelessness**, using the definitions adopted by HUD and the Vermont Agency of Human Services:

[https://www.hudexchange.info/resources/documents/HomelessDefinition\\_RecordkeepingRequirementsandCriteria.pdf](https://www.hudexchange.info/resources/documents/HomelessDefinition_RecordkeepingRequirementsandCriteria.pdf)

[https://www.hudexchange.info/resources/documents/AtRiskofHomelessnessDefinition\\_Criteria.pdf](https://www.hudexchange.info/resources/documents/AtRiskofHomelessnessDefinition_Criteria.pdf)

### 1.2 Goals of Coordinated Entry

Most communities lack sufficient resources to meet all the needs of people experiencing homelessness. This combined with the lack of well-developed process for accessing resources has resulted in severe hardships for people experiencing homelessness. Coordinated Entry is intended to increase and streamline access to housing and services for households experiencing homelessness, match appropriate levels of housing and services based on their needs, and prioritize persons with complex service needs for the most intensive interventions.

HUD's primary goals for Coordinated Entry processes are:

1. Assistance will be allocated as effectively as possible
2. Assistance is easily accessible no matter where or how people present

In Vermont, the primary goal of Coordinated Entry is to provide and improve consumer information, referral, assistance and access to housing and services for individuals and families experiencing or at risk of homelessness.

In Vermont, Coordinated Entry will:

- Improve referral appropriateness and coordination
- Increase understanding among partners of what resources are available
- Decrease the time that people experience homelessness
- Help people move in and out of the "homeless system" as quickly as possible
- Support community-wide or system level planning and outcomes

VT BoS CoC further defines effective Coordinated Entry as client-focused, linking the household to an intervention to resolve the housing crisis, based on a standard assessment of needs and strengths and the knowledge of housing and services available.

VT BoS CoC will work to ensure that in policies and practice all clients in all permanent housing programs, regardless of their funding source, can be connected to high intensity supports (as needed), bridge to a permanent affordable housing placement as appropriate, and pursue mainstream housing resources.

### 1.3 Guiding Principles (from the Local Partnership Agreement)

1. **Reorient service provision**, creating a more client-focused environment.
2. **Recognizes the inherent dignity of persons in need of housing**, and honors their right to confidentiality, safety, respect, and choice.
3. **Identify which strategies are best for each household** based on knowledge of and access to a full array of available services.
4. **Link households to the most appropriate program** that will assist the household to quickly resolve their housing crisis and regain housing stability.
5. **Provide timely access and appropriate referrals** to housing programs and support services.
6. **Shorten the number of days** between onset or threat of homelessness and access to assistance needed to re-establish stable housing.
7. **Protects the safety of victims fleeing domestic/sexual violence** and simultaneously helps victims to access housing resources.
8. **Provide immediate access to information** regarding housing and support services.
9. **Establishes consistent referral protocols and uniform assessment** so that no matter where a person or family presents in need, they can have access to needed housing programs and support services.
10. **Reduces duplicate collection of household information** to streamline referral and access to needed resources.
11. **Provide for ongoing participation** by consumers and stakeholders in the development and evaluation process of Coordinated Entry.
12. **Commitment to continuous improvement** through ongoing evaluation of Local Coordinated Entry Partnerships and VT BoS CoC.

## 1.4 Associated Regulations

### **HUD Continuum of Care (CoC) Interim Rule**

<https://www.hudexchange.info/resources/documents/CoCProgramInterimRule.pdf>

578.7 (a) (8) In consultation with recipients of Emergency Solutions Grants program funds within the geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. This system must comply with any requirements established by HUD by Notice.

The VCEH is the primary decision-making body for the Balance of State Continuum of Care.

### **HUD Emergency Solutions Grant (ESG) Interim Rule**

[https://www.hudexchange.info/resources/documents/HEARTH\\_ESGInterimRule&ConPlanConformingAmendments.pdf](https://www.hudexchange.info/resources/documents/HEARTH_ESGInterimRule&ConPlanConformingAmendments.pdf)

576.400 (d) Centralized or coordinated assessment. Once the Continuum of Care has developed a centralized assessment system or a coordinated assessment system in accordance with requirements to be established by HUD, each ESG-funded program or project within the Continuum of Care's area must use that assessment system. The recipient and subrecipient must work with the Continuum of Care to ensure the screening, assessment and referral of program participants are consistent with the written standards required by paragraph (e) of this section. A victim service provider may choose not to use the Continuum of Care's centralized or coordinated assessment system.

The Vermont Office of Economic Opportunity is the ESG recipient for the state of Vermont. ESG funds are administered as part of the Housing Opportunity Grant Program (HOP).

### **HUD Coordinated Entry Policy Brief (2015)**

<https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf>

### **HUD Coordinated Entry Notice CPD-17-01 – Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System (2017)**

<https://www.hudexchange.info/resource/5208/notice-establishing-additional-requirements-for-a-continuum-of-care-centralized-or-coordinated-assessment-system/>

### **HUD Prioritization Notice CPD-16-11 – Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing (2016)**

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

### **HUD Equal Access rule: 24 CFR 5.105(a)(2) and 5.106(b)**

<https://www.hudexchange.info/resource/1991/equal-access-to-housing-final-rule/>

### **VT BoS CoC Governance Charter**

<http://helpingtohousevt.org/wp-content/uploads/2012/11/VT-BoS-CoC-VCEH-Governance-Charter-Revised-07.17.pdf>

## SECTION 2: LOCAL COORDINATED ENTRY PARTNERSHIP

The Vermont Balance of State CoC is diverse in its local needs and has a large geography therefore, access to the Coordinated Entry process occurs through many local providers as well as through 2-1-1 statewide.

- A client can seek housing assistance through any of the participating providers<sup>1</sup> and will have access to the Coordinated Entry process.
- Clients will have equal access to information and advice about the housing assistance for which they are eligible to assist them in making informed choices.
- Providers participate in one of three roles: a local Lead Agency, an assessment partner or a referral partner. Departments or divisions within large agencies may have different roles.
- Participating housing providers will work collaboratively to achieve responsive and streamlined access services and cooperate to use available resources to achieve the best possible housing outcomes for clients, particularly for those with high, complex or urgent needs.

### 2.1 Designated Local Lead Agency

Each Local Housing Coalition will designate a local Lead Agency to lead Coordinated Entry locally, including but not limited to management the local Master List and contact for the VT BoS CoC Coordinated Entry Committee.

### 2.2 Agencies Providing Housing and Services

All agencies that administer Continuum of Care (CoC)-funded programs, Housing Opportunity Grant Program (HOP)-funded programs, or Supportive Services for Veteran Families (SSVF) are required to participate in their Local Coordinated Entry Partnership. Other organizations and programs are encouraged and welcome to join; they can join by contacting the Lead Agency, establishing what role they will serve within the Local Coordinated Entry Partnership, and signing the Partnership Agreement.

Providers participate in one of three roles as follows and departments or divisions within large agencies may have different roles:

- a local Lead Agency,
- an Assessment Partner or a
- Referral Partner.

Participating housing providers will work collaboratively to achieve responsive and streamlined access services and cooperate to use available resources to achieve the best possible housing outcomes for clients, particularly for those with high, complex or urgent needs.

### 2.3 Partnership Agreement

VT BoS CoC will provide a Local Coordinated Entry Partnership Agreement template that will include the following:

- Identify the participating providers and their role in the Local Coordinated Entry Partnership: the Local Lead Agency, an Assessment Partner(s) or a Referral Partner(s)
- Describe the Purpose and Guiding Principles of VT BoS CoC Coordinated Entry
- Describe Coordinated Entry Core Components and Activities
- List shared responsibilities and partner responsibilities that relate to: advertisement, training,

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<sup>1</sup> Participating Providers: Referral Partners, Assessment Partners, and the Lead Agency

outreach, planning, evaluation, joint-problem solving and communication, confidentiality, client grievance, safety protocols, and nondiscrimination policies.

- Confidentiality Principles and Policies, including optional staff certification to use with partner staff.

**The Local Coordinated Entry Partnership Agreement is in Appendix B. This template is considered part of the VT BoS CoC written policies and procedures for Coordinated Entry.**

Local Housing Coalitions may only alter the Partnership Agreement with approval of the VT BoS CoC Coordinated Entry Committee.

## 2.4 Outreach and Advertisement

### Agency Outreach

At least once annually, each local Coordinated Entry Partnership is required to contact local agencies and community partners who come in contact with persons who are experiencing homelessness or at risk of experiencing homelessness to provide them with education on the Coordinated Entry process and how to participate.

### Client Outreach

Participating providers will coordinate with existing street outreach programs to receive referrals to ensure that people in unsheltered locations are prioritized for assistance in the same manner as other clients accessing Coordinated Entry.

Participating providers will take steps to ensure that coordinated entry is available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, actual or perceived gender identity, or marital status. Partners will work to make access points accessible to individuals with disabilities, including wheelchair accessibility and auxiliary aids and services to assist communication. All partners will take reasonable steps to offer materials and instruction in other languages to meet the needs of people with limited English proficiency.

### Advertisement

The Local CE Partnership will advertise the Coordinated Entry process in order to inform people how to get connected to housing resources for people experiencing homelessness or at-risk of homelessness. At a minimum, advertisement will include: flyers posted at locations where clients may present (*e.g.*, hospitals, clinics, local Economic Services office, WIC offices, community meal sites, churches, food shelves, check cashing locations, *etc.*) The Local CE Partnership is encouraged to explore other venues of advertising such as during the Point in Time Count, a booth at local events, newspaper ads, participating provider websites, or radio. Local CE Partnerships will use plain language to advertise, such as “Look for help to get or keep housing? Contact <Lead Agency> to get connected”.

The Local CE Partnership is responsible for actively working to ensure all persons, regardless of language or disability, know how to access help through the Coordinated Entry process. This includes but is not limited to physical accessibility of access sites, provision of appropriate auxiliary aids and services necessary to ensure effective communication such as Braille, audio, large type, assistive listening devices and sign language interpreters and reasonable steps to offer material in multiple languages. Auxiliary aids and services can be provided through a third-party that is accessible to staff performing Coordinated Entry duties.

VT BoS CoC will include information on accessing Coordinated Entry on its website, [hhav.org](http://hhav.org)



## SECTION 3: COORDINATED ENTRY STEPS

ACCESS → ASSESSMENT → MASTER LIST → PRIORITIZATION → REFERRAL TO HOUSING INTERVENTION

### 3.1 Screening and Assessment

VT Bos CoC uses two standardized tools for screening and assessment:

#### **VT BoS CoC Housing Crisis Referral (Screening and Access)**

Referral partners will triage by conducting a housing screening using the VT BoS CoC Housing Crisis Referral Form to refer households for housing crisis help. This initial screen reviews for basic eligibility (e.g., housing status) and offers a referral to the local Domestic Violence Service Provider, if appropriate.

Referral Partners:

- Complete the VT BoS CoC Housing Crisis Referral Form for households identified as experiencing homelessness or at-risk of experiencing homelessness.
- All individuals and families experiencing or at risk of homelessness and served by a Referral Partner must be offered the opportunity to participate in Coordinated Entry.
- Submit the Housing Crisis Referral Form to the local Lead Agency within one business day.

A DV provider or youth provider who is contacted by a client from another subpopulation should complete this form and forward to the Local Lead Agency for assessment.

Any participating provider may complete the Housing Crisis Referral form, but it is not required for anyone but referral only partners.

#### **VT BoS CoC Housing Assessment**

If an individual or family contacts an Assessment Partner or local Lead Agency, or if a Referral Partner submits a Housing Crisis Referral Form, the Lead Agency and Assessment Partner will reach out to the client as soon as possible to schedule an appointment to complete the Housing Assessment.

It is the goal of VT BoS CoC that all individuals and families have the opportunity to complete the assessment process as quickly as possible. To this end, VT BoS CoC has set the following

Assessment Partners and Lead Agencies will aim to:

- Reach out to all households referred through the Coordinated Entry process to schedule a housing assessment within three days of referral receipt.
- Provide clients the opportunity to complete the housing assessment within one week of referral or “walk-in”.
- Place all individuals and families to who have completed the assessment on the Master List within three days of completion.

The Housing Assessment:

- Will be offered to all individuals and families experiencing homelessness and served by an Assessment Partner or Lead Agency.
- Will only be conducted by a trained assessor.
- May be conducted in an office or community-based setting, such as through outreach.
- Includes the Homeless Management Information System (HMIS) Universal Data Elements, which may be updated for returning clients.

- Collects all the information needed to determine prioritization for housing interventions.
- Screens for whether a household would be served well by short-term, medium-term or long-term assistance to regain stability in permanent housing. This division of short-term, medium-term or long-term assistance is referred to as “level of assistance”.
- Includes some optional sections and provides instructions to the assessor on how to conduct the interview.
- May be first recorded on paper or directly inputted within HMIS.

Participating assessment partner providers are responsible to respond to the range of client needs and act as the primary contact for clients who complete the Housing Assessment with their organization, unless or until another provider assumes that role. This includes providing proactive help to facilitate the client applying for assistance or accessing services from other providers.

If a participant becomes homeless after losing housing obtained through Coordinated Entry, the Local Coordinated Entry Partnership is required to conduct a Housing Assessment and put forth an effort to connect them with appropriate housing interventions, which may be placement in the same program type (RRH or PSH) again.

### **Best Practice for Consideration**

As part of a client-centered approach, VT BoS CoC believes that each individual or family experiencing or at-risk of homelessness should have an individualized housing plan developed jointly by housing staff and the client. A housing plan should be based on the strengths, needs and desires of the household, and guided by the Housing Assessment. A housing plan outlines the type, amount and length of services and assistance for a household, as well as housing preferences. Each Local Coordinated Entry Partnership will determine the protocol for ensuring that all participants receive the help necessary to develop an individualized housing plan.

Once on the Master List, households should be connected to housing navigation services when available. Housing navigation services include support for the following:

- Development of a housing stability plan.
- Close work with housing providers regarding eligibility documentation/verification.
- Follow-up on referrals to housing to support enrollment.
- Completion of housing applications.
- Assistance with submitting rental applications and understanding leases.
- Housing search and placement, sometimes in conjunction with local Landlord Liaisons.
- Education and training on the role, rights and responsibilities of the tenant and landlord.
- Finding resources to support move-in (security deposit, moving costs, furnishings, other one-time costs).
- Ensuring living environment is safe and ready for move in (facilitate inspections).
- Assistance in arranging for/supporting move (set up utilities, moving arrangements, etc)
- Work to address barriers to project/housing admissions (e.g., criminal record, credit report, utility arrears, unfavorable references).
- Development of a housing support crisis plan that includes early prevention/intervention when housing is jeopardized.
- Identification of other service needs/ongoing retention support needs and connect/refer to these mainstream services and benefits.

## **3.2 Master List**

Each Local Coordinated Entry Partnership will maintain a local Master List that includes all households (individuals and families) experiencing homelessness that have participated in the assessment process. Households who meet with an assessment partner, even if they do not complete the full assessment are considered to be participating and will be added to the Master List.

The Master List guides referrals to the following housing interventions:

- Rapid Re-housing (RRH)
- Permanent Supportive Housing (PSH)
- Transitional Housing for Youth (THY)

A Master List that is local recognizes that entrance into a program is based on both eligibility and availability for both the rental subsidy/unit and services. Service capacity is inherently local and thus necessitates a local list.

The local Master List:

- Will be populated by assessment partners and the local Lead Agency using the Coordinated Entry process— e.g., housing assessment will be completed. Only assessment partners and the local Lead Agency can refer directly to the list.
- Is the responsibility of the Lead Agency and they will manage the list(s).
- May be generated in and exported from HMIS, and other households can be added to the list manually, outside of HMIS (e.g., those working with a victim service provider).
- May have households added to it prior to and at a monthly review meeting.
- Will be (re)generated/updated and reviewed at least monthly by all relevant providers (e.g. shelters, PSH providers, etc.).
- May use unique IDs in place of names, etc., for confidentiality purposes
- May be included in the generation of a state Master List, as needed.
- May only be accessed if a Local CE Partnership Agreement is in place. Respective agencies who are part of the Local CE Partnership will have signed the agreement.
- Will only include households who have executed a Client Release of Information form.

Participating Providers:

- Will use the local Master List to fill all openings in housing programs that elect or are required to use the Coordinated Entry process and prioritization policy.<sup>2</sup>
- Will review the Master List to match households with openings in a Rapid Re-housing, Permanent Supportive Housing program and Youth Transitional Housing based on prioritization AND eligibility for services and housing subsidy.
- Will review the Master List to assess how agencies can work together to enroll a client quickly.
- May and should enroll households from the Master List in between meetings, as needed.
- Will develop systems to anticipate openings in services and vouchers availability, and review list prior to program opening and identify priority client(s).
- Will review of the Master List at least monthly to provide updates on household status.
- Are part of a system of shared accountability for enrolling households into a Permanent Supportive Housing, Rapid Re-housing or Youth Transitional Housing project according to the prioritization policy.

The HMIS Lead will work with local Lead Agencies to create the local Master List. Lead Agencies and Assessment Partners that use ServicePoint will be able to “refer” to the ServicePoint Master List using the “Referrals” feature. Households do not need to be enrolled in a program at the agency that refers them to the Master List. For additional guidance on using the Master List in ServicePoint, a pre-recorded training is available.

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<sup>2</sup> *Projects that receive the following funding must enroll households from the Master List:* Continuum of Care (CoC) Program-funded: Shelter+Care, Rapid Re-housing, Housing Opportunity Grant Program (HOP)-funded: Rapid Re-housing, Supportive Services for Veteran Families (SSVF): Rapid Re-housing

Agencies making referrals to the Master List are responsible for following up with the households they refer to determine whether they are still in need of permanent or transitional housing, until another provider has assumed this responsibility. Follow-up contact will occur at a minimum every 90 days. If still in need of housing, the agency should update contact information if needed. If they no longer need housing, the agency can close the referral to remove the individual or family from the Master List.

Providers that contact an individual or family to offer services and find out the household is no longer in need, can close the referral to the Master List in ServicePoint, even if that provider did not make the referral to the Master List.

### 3.3 Active and Inactive Lists

Maintaining an active Master List ensures that a Coordinated Entry Partnership is able to contact and connect with households as soon as a housing opportunity is available. Loss of contact means that it is difficult to determine whether households on the Master List are still in need of housing. In some situations these households may have self-resolved their housing crisis or relocated to another area. Without a policy, the Local Coordinated Entry Partnership can experience delays in housing referral procedures due to the time spent searching for households in the community who they have not been able to reach through multiple attempts, often for many months.

#### Moving a Household to the Inactive List

If a household has had no contact with any Coordinated Entry Partner AND they have had no services or shelter stays in HMIS for the past 90 days, the household will be removed from the Active List and placed on the Inactive List. In HMIS, the household is not “exited” from Coordinated Entry.

Master List Inactive/Active status updates will be done at least once a month to ensure the Active List is accurate. For households who have not been contacted within the last 90 days, the assigned Housing Navigation Provider, or the agency where the household completed an assessment in cases where there is no Housing Navigator, will make three attempts to contact the household to inquire about housing status before moving the household to Inactive. The Housing Navigator or the agency where the household was assessed will update the household’s Active/Inactive status.

If a household on the Inactive list makes contact with any Coordinated Entry Partner, they are moved from the Inactive list to the Active list and can be referred to housing services and resources. The household may be re-assessed at this time in order to update household information, including housing and service needs. The date of the initial housing assessment remains the date used in any determination of prioritization.

### 3.4 Prioritization

The goal of prioritization is to get the next available housing resource to the client with the highest needs and greatest barriers to obtaining and maintaining housing on their own.

The clients on the master list have all started and/or completed the Coordinated Entry assessment. This information includes but is not limited to: homeless status, length of homelessness and assessment score that assists coordinated entry staff in prioritizing people on the list for available housing resources. See below and in the “Referral” Section for prioritization factors for each project type.

The **Order of Priority**<sup>3</sup> is:

1. Chronic Homelessness + Complex Service Needs (Points)

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<sup>3</sup> This prioritization policy follows guidance from HUD on the prioritization of permanent supportive housing. <https://www.hudexchange.info/resource/5108/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh/>

2. NonChronic Homelessness + Disability, then
  - a. Unsheltered or living in an emergency shelter/safe haven
    - i. Then, homeless at least 12 months + Complex Service Needs (Points)
    - ii. Then, homeless for less than 12 months + Complex Service Needs (Points)
  - b. Living in transitional housing (meeting homeless definition prior to entry) + Complex Service Needs (Points)
3. NonChronic Homelessness without Disability + Complex Service Needs (Points)

Where households are equally ranked on the list, priority will first be given to those who are unsheltered, then those in emergency shelter/safe haven. If there are equally ranked households with the same living situations, (e.g. two households in unsheltered living) the priority will be given to the household that presented for assistance first.

All households receive points for Complex Service Needs, as outlined in the Housing Assessment.

Prioritization is different than eligibility verification. For the purposes of prioritization, self-reported information is sufficient.

Among eligible participants, VT BoS CoC has not chosen to prioritize sub-populations such as individual or families. Some programs may only serve a specific sub-population and referral will be made according to program eligibility criteria.

Engagement in services is something that is negotiated at the point of enrollment, it is not to be considered in the context of prioritization.

### 3.5 Referral to Participating Housing Programs<sup>4</sup>

Projects that receive the following funding for homelessness assistance may only enroll individuals and/or families experiencing homelessness or who are at imminent risk of homelessness if they are on the Master List:

- Continuum of Care (CoC) Program-funded: Shelter+Care, Rapid Re-housing, Youth Homelessness Demonstration Program Transitional Living and Rapid-Rehousing
- Housing Opportunity Grant Program (HOP)-funded: Rapid Re-housing
- Supportive Services for Veteran Families (SSVF): Rapid Re-housing

Other Rapid Re-housing, Transitional Housing and Permanent Supportive Housing Programs are encouraged utilize the Master List as their sole referral source and to participate formally in Coordinated Entry by signing the Local Partnership Agreement.

**Permanent Supportive Housing** providers use the Order of Priority and program-specific eligibility requirements (e.g., disability, youth, CRT eligibility, etc.) to enroll the highest prioritized individual or family on the Master List.

**Rapid Re-housing** referrals are made as follows:

- Short-term Rapid Re-housing is provided on a first-come, first-serve basis to all households that screen for a short-term level of assistance determined by the Housing Assessment.
- Medium-term Rapid Re-housing is for households that screen for a medium-term level of assistance determined by the Housing Assessment. Rapid Re-housing providers then use the Order of Priority on the Master List.

**Transitional Housing** referrals are made as follows:

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<sup>4</sup> Participating Housing Programs/Projects/Providers refers to those that are required or elect to enroll participants ONLY through the CE process; program refers to the statewide program, project refers to a specific local project, and provider refers to the agency that is administering the local project

- Households that screen for long-term or medium-term level of assistance as determined by the Housing Assessment, then by Complex Service Needs (points). If there are equally ranked households with the same living situations, (e.g. two households in unsheltered living) the priority will be given to the household that presented for assistance first.

HOWEVER, a participant is not excluded from accessing any housing resource solely based on the Housing Assessment determined level of assistance, such that, if resources are limited, households need not be prevented from exiting homelessness.

In these cases, a household identified as needing long-term assistance, may be reviewed and referred to a medium-term Rapid Re-housing program if their individual housing plan clearly demonstrates a reasonable and adequate plan for maintaining stable housing once the program ends. This is achieved by demonstrating:

- Reasonable expectation for increased income as indicated by tenure in current employment, expected completion of education/vocational programs, achievement of skills and training certifications, or pending military, retirement, social security benefits, alimony or child support.
- Documented opportunity of receiving subsidized housing or an assisted living placement before rental assistance would end.

In a similar way, a household identified as needing medium or long-term assistance, may be reviewed and referred to a short-term Rapid Re-housing program if their housing plan meets the above criteria. This is referred to as a documented "Housing Sustainability Plan".

### 3.6 Example of Master List Prioritization<sup>5</sup>

NAME or ID#	Chronic Homeless Status	Disability	Homeless Status	Length of Current Homeless Episode	Complex Service Needs	Level of Assistance	Housing Sustainability Plan Documented	Date Assessment Completed
RW	Y	Y	Shelter	5 months	24	L	N	5/15/2017
Doug	Y	Y	Unsheltered	24 months	15	L	N	7/18/2017
Osnum58	Y	Y	Shelter	2 months	12	L	N	8/15/2017
Brian	Y	Y	Unsheltered	3 months	10	L	N	10/15/2017
AK	Y	Y	Shelter	13 months	10	L	N	9/20/2016
Emily	N	Y	Shelter	7 months	12	L	Y	3/3/2017
Daniel	N	Y	Unsheltered	9 months	8	L	N	9/28/2017
Dawn	N	Y	Transition'l Hous.	3 months	18	L	N	6/27/2017
JD	N	N	Unsheltered	3 months	22	M	Y	8/28/2017
Osnum243	N	N	Shelter	13 months	18	L	N	9/14/2016
Pete	N	N	Unsheltered	1 month	12	M	N	10/19/2017
Osnum612	N	N	Shelter	3 months	12	M	N	7/5/2017
Deb	N	N	Shelter	1 month	7	S	N	10/3/2017
Amos	N	N	Shelter	6 months	5	M	Y	4/11/2017
Sarah	N	N	Shelter	1 month	4	S	N	10/14/2017

If Agency A has an opening in its Permanent Supportive Housing Project, they would offer this opening to RW because she meets the definition of chronically homeless and has the highest complex service needs score, so long as RW met the basic eligibility requirements for the project and chooses to participate. The next opening would be offered to Doug, and so on.

If Agency B has four openings in its Rapid Re-Housing Project which offers 12 months of rental assistance (medium-term), they would offer these openings to Emily, JD, Pete and Osnum612. Although Emily has been identified as being a good candidate for long-term housing assistance, she has met the documentation requirements for housing plan sustainability. JD, Pete and Osnum612 are the candidates next highest on the list that have been identified as candidates for medium-assistance.

If Agency C has funding available to support short-term Rapid Re-housing Assistance for four clients this month. Providing short-term rental assistance to these households would be done on a first-come, first-serve basis. They would offer financial or rental assistance to Amos, JD, Deb, and Sarah. Short-term rapid re-housing is provided on a first-come, first-serve basis. Deb and Sarah have both been identified as good candidates for short-term housing assistance. Josh and Amos have been identified as good candidates for medium-term assistance, but have both met the documentation requirements for housing plan sustainability.

#### Maintaining a Local Inventory

Each Coordinated Entry Partnership should maintain an inventory of local homeless assistance projects, including the number of beds or subsidies available, open slots or vacancies, and eligibility criteria. Maintaining this knowledgeable inventory is key to expediting referrals and assisting clients with documentation to support eligibility verification. It will also reduce the occurrence of clients having to be referred back to the Coordinated Entry Master List for alternate referral.

<sup>5</sup> The Master List report may not contain other data fields that are not included in this example, such as Veterans status, family type, primary contact person, and the date of the ROI execution.

## 3.7 Declined Referrals

### Agency Declining Referral

There are few legitimate reasons that can be considered when not enrolling the highest priority household, such as eligibility requirements or the household choice/preference does not match available project opening.

If a program does not take the highest prioritized individual or family from the Master List to fill an available opening, the agency that operates that program must document the reason for not accepting that referral in the ServicePoint client file. In cases where two or more agencies must accept a client, the documentation requirement applies to either agency in the case of a declined referral. If that client does not have a ServicePoint file, the agency must provide a written explanation to the provider. It is the responsibility of the agency not taking the highest prioritized individual or family to ensure that the individual or family has a new referral to the Master List, if needed. The individual or family remains on the Master List to access the next available program opening, as long as the individual or family needs housing.

### Client Declining Referral

One of the guiding principles of the VT BoS CoC Coordinated Entry Process is client choice. Individuals and families will be given information about the programs available to them and have choice about which programs they want to participate in. If an individual or family declines a referral to a housing program, their name remains on the Master List until the next housing opportunity is available.

## 3.8 Information & Data Sharing

The Local CE Partnership Agreement (Appendix A) and the Client Release of Information (Appendix D), provide the specific details on when and how client data is collected in the Coordinated Entry System.

### Housing Crisis Referral Form

The Housing Crisis Referral Form includes a client release of information in order to allow the Referral Partner to share the form with the local Lead Agency. Staff completing the form will review the “Permission to Share Personal Information to Help with Housing” with the client so they understand what information will be shared with the Lead Agency. Information from the Housing Crisis Referral Form will not be inputted into HMIS.

### Housing Assessment

As part of the Housing Assessment process, staff will review the Coordinated Entry Release of Information (ROI) with clients after the Housing Assessment is completed. Staff will be responsible for ensuring clients understand their rights as far as release of information and data confidentiality, as outlined in the Release of Information, and the Confidentiality Principles & Policies of the Coordinated Entry Partnership Agreement. VT BOS CoC has provided a staff ROI explanation tool (<http://helpingtohousevt.org/wp-content/uploads/2017/01/ROI-Staff-Form-Draft.docx>). On the ROI, clients may request that none of their information be shared with one or more agencies, or that certain types of information not be shared.

### Respecting Client Consent

Sharing of client information and data occurs both “in” and “out” of VT HMIS as part of Coordinated Entry. It is the responsibility of all Partners to ensure that client permission is reviewed and followed. The Partner who initially collects the Release of Information from the client is responsible for tracking the expiration date of the release and renewing, as needed.



Any client whose name is on the Master List must have signed the ROI that guides the information shared on the list. The Local Coordinated Entry Partnership is required to include a list of agencies with the Release of Information. All Assessment Partners and the local Lead Agency should be included in this list. As agencies within the local Coordinated Entry Partnership change, or as Referral Partners elect to participate in a Master List review process, it is incumbent on the Lead Agency and all Partners, to ensure that client releases are honored with respect to the permission provided by the client regarding both the specific agencies and information allowed (or to update the client release). For this reason, it is recommended that attendance at any group review of the Master List include a regular group of partners that is closely monitored by the Lead Agency. This may include asking staff from one or more organizations to exit a meeting when a specific case is reviewed. Master List review meetings (e.g., Housing Review Team) should include only those agencies that have signed a Local Partnership Agreement. The date of the ROI execution for each client will be included on the Master List.

All Partners participating in VT HMIS are required to meet the VT HMIS Security Standards and all users are required to complete the annual security training.

Victim service providers<sup>6</sup> must never enter information into ServicePoint about survivors of domestic or sexual violence served by their agency. There may be other times when it is not in the best interest of the client (e.g., safety) to have their data in VT HMIS or shared with others. It is the responsibility of participating providers to support clients in making their own informed consent.

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<sup>6</sup> "Victim service provider" refers to the local domestic and sexual violence organizations. To find the domestic or sexual violence organization that serves your area go to: <http://vtnetwork.org/get-help/>

## SECTION 4: EMERGENCY SHELTER

Emergency shelter refers to any temporary shelter for people experiencing homelessness in general or for a specific population of people experiencing homelessness. Emergency shelter is sometimes provided in a facility, scattered site apartments, host homes for youth, or through a publicly-funded motel stay. By design, emergency shelter programs work to help individuals and families move into permanent or transitional housing as quickly as possible.

The VT BoS CoC Coordinated Entry system does not interfere with the current process for individuals or families to seek emergency shelter or services, including domestic violence shelters and other short-term crisis residential programs, outside of the Coordinated Entry operation hours. The VT BoS CoC Coordinated Entry system also allows for a triage of needs to ensure that all individuals and families have access to emergency services and shelter, regardless of whether they have first completed the Housing Crisis Referral Form or Housing Assessment.

If someone is seeking shelter immediately, a referral should be made to:

- Local Shelter(s), Economic Services District Office or 2-1-1

In cases of a person fleeing domestic or sexual violence, a referral should be made to:

- Local Domestic/Sexual Violence Shelter
  - Domestic Violence Hotline, 800-228-7395, or
  - Sexual Violence Hotline, 800-489-7273, or
  - Online: <http://vtnetwork.org/get-help/>

For unaccompanied minors, a referral should be made to:

- Local Vermont Coalition of Runaway & Homeless Youth Program (VCRHYP)
  - Online: <https://vcrhyp.org/find-your-local-agency.html>
  - 2-1-1

### 4.1 Coordinated Access to Local Emergency Shelters

In each Local Housing Coalition, there is a written protocol for coordination and communication between local shelter providers, the Economic Services District Office, and 2-1-1 (developed by these parties) to ensure streamlined access to emergency shelter.

- An optional template is provided by the VT BoS CoC Coordinated Entry Committee.
- At a minimum, the protocol must include:
  - contact info for each agency,
  - intake hours,
  - shelter hours,
  - population(s) served, and
  - the intake process for each agency.
- Protocols should emphasize ease of access for those seeking emergency shelter.
- Local emergency shelter coordinated access protocols are submitted to and reviewed by the VCEH Coordinated Entry Committee.

## 4.2 Emergency Shelter Programs and Housing Assessment

### **If an emergency shelter provider is a referral partner:**

- They must make a referral to the local Lead Agency within 3 calendar days.

It is strongly recommended that referrals occur as soon as possible after entry into the emergency shelter program. This includes General Assistance Emergency Housing Program, and 2-1-1 as the after-hours General Assistance Emergency Housing provider.

### **If an emergency shelter provider is a Local Lead Agency or an Assessment Partner:**

- They provide an opportunity for the client to complete the Housing Assessment within one week of entry into shelter program.

## 4.3 Emergency Shelter Prioritization for Programs with Waiting Lists

When an emergency shelter program operates with a waiting list for entry into shelter, the order of priority is:

- Unsheltered
- Literally Homeless (Category 1), including those fleeing domestic or sexual violence, AND staying in a motel (not paid for by self)
- Literally Homeless (Category 1), including those fleeing domestic or sexual violence – staying some place other than a motel
- Imminently Homeless (Category 2), including those fleeing domestic or sexual violence

The order of priority does not override admission requirements or eligibility that may exist for an emergency shelter.

# SECTION 5: DOMESTIC VIOLENCE, SEXUAL VIOLENCE, DATING VIOLENCE, AND STALKING

## 5.1 Policies

VT BoS CoC is committed to ensuring survivors of domestic violence, dating violence, sexual violence and stalking who are fleeing or attempting to flee have access to homeless assistance through the Coordinated Entry process.<sup>7</sup> To ensure the process works best for survivors, VT BoS CoC adheres to the following policies:

### Access

- The Coordinated Entry process will be voluntary and trauma-informed, and have an option for survivors to remain anonymous.
- Victim service providers and non-victim service providers work together to ensure that all survivors have fair and equal access to the Coordinated Entry process.
- Participants may not be denied access to Coordinated Entry on the basis that the participant is or has been a survivor of domestic violence, sexual violence, dating violence or stalking.
- Individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault or stalking will have the option of working with and seeking services from both victim service providers and non-victim specific providers.

### Victim-Service Provider Involvement

- Victim service providers will continue to be included in the design and implementation of the VCEH Coordinated Entry system.
- Victim service providers are included in all Local Coordinated Entry Partnerships. Victim service providers will work with their Local Housing Coalition to determine the best role (i.e., Referral Partner, Assessment Partner) for their organization within the partnership.

### Safety

- The VT BoS CoC Coordinated Entry system does not in any way interfere with the current process for homeless survivors seeking emergency shelter outside of the Coordinated Entry operation hours. The VT BoS CoC Coordinated Entry system also allows for a triage of needs in order to ensure that survivors have access to emergency services such as domestic violence hotline and shelter.
- Non-victim service providers will be trained in the Coordinated Entry process for survivors as well as safety planning for survivors who disclose domestic violence, sexual violence, dating violence or stalking in order to ensure that services are inclusive and trauma-informed.

## 5.2 Procedures

The VT BoS CoC, Vermont Network Against Domestic and Sexual Violence and its member programs worked together to create a Coordinated Entry process that is inclusive, safe and accessible for survivors fleeing or attempting to flee domestic violence, sexual violence, dating violence and stalking.

The following procedures aim to allow survivors to enter into the Coordinated Entry system through multiple entry points, make informed decisions about how they would like to navigate through the system and the level of personal information they choose to share.

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<sup>7</sup> References to domestic violence survivors or victims means all survivors of domestic violence, dating violence, sexual violence and stalking who are fleeing or attempting to flee. The terms survivors and victims are used interchangeably.

A survivor may enter the Coordinated Entry system in one of two ways, either starting with a victim service agency or starting with a non-victim service agency.

## **Referral Partners**

Non-victim service providers - Referral partners within the Coordinated Entry Partnership will offer a referral first to the local domestic/sexual violence agency, if the survivor discloses that they are fleeing or attempting to flee domestic violence, sexual violence, dating violence or stalking. The referral form will be sent to the assessment partner chosen by the survivor.

*\*Note: DV/SV providers are the only ones with expertise to determine eligibility for their services. Even if a non-victim service provider refers someone to a DV/SV organization, it is still up to that organization to determine if the participant is a survivor and is eligible for their services. If it is found that the participant is not eligible, the DV/SV provider will refer them to the local Lead Agency.*

Victim service providers - If a DV/SV agency is a referral partner they may complete the referral form and attach with it a unique ID for the survivor, generated in Osnum (a database used by victim service providers). They will explain the Coordinated Entry Process and their choices around confidentiality and anonymity. The referral form will be sent to the assessment partner. If the local victim service provider is an Assessment Partner, the survivor may choose to continue the Coordinated Entry process with the victim service provider or they may choose to continue the process with another (non-victim service provider) assessment partner. The referral form will be sent to the assessment partner chosen by the survivor.

## **Assessment Partners**

### Non-victim service providers-

1. The Local Lead Agency and Assessment partners will offer a referral first to the local domestic/sexual violence agency, if the survivor discloses that they are fleeing domestic violence, sexual violence, dating violence or stalking. If the local victim service provider is an assessment partner, it will be presented to the survivor as an option do the assessment with the local DV/SV agency or to choose to continue with the organization that they have begun the assessment with. It will be explained to the survivor, the difference between assessment and sharing of information within the two options.
2. If the survivor chooses to continue with the non-victim service provider, they would complete the assessment and refer to the Master List for prioritization.

### Victim service providers-

1. Complete assessment with survivor.
2. Refer to the Master List for prioritization.

## **Confidentiality and the Master List**

### Non-Victim service providers-

- Providers will explain the confidentiality forms and survivors may choose if they wish to have their information shared in HMIS, or not. Survivors may also choose who they would like to share their information with, within the Coordinated Entry Partnership.
- If survivors were referred to the assessment partner by a DV/SV agency, the provider will explain what the Master List is and offer to use the anonymous unique ID for the survivor if they choose, instead of adding their name to the list/sending their name to the Local Lead Agency to add to the list.
- If the survivor chooses, their name will be added to the Master List for housing intervention.

#### Victim Service providers-

- Providers will explain the confidentiality forms. Survivors may choose who they would like to share their information with, within the Coordinated Entry Partnership. DV/SV agencies do not use HMIS.
- The provider will generate a unique ID for the survivor using Osnum and send it to the Local Lead Agency with their prioritization information and any additional needed information.

#### **Referral to Housing Program**

- If a survivor is listed by name on a Master List and they are next for a referral to an opening in a housing program, they will be contacted by the housing program.
- If a survivor's unique ID number comes to the top of a Master List, the Local Lead Agency will contact the victim service provider or the Assessment Partner to connect the survivor with the housing program.
- The organizations involved will work to ensure that the survivor is connected to housing navigation and other support as needed.

## **COMING in 2019: REFERRAL PROTOCOL FOR UNACCOMPANIED YOUTH**

## **COMING in 2020: HOMELESSNESS PREVENTION**

## SECTION 6: VETERANS COORDINATED ENTRY

### 6.1 OVERVIEW

The Vermont Veterans Committee is a statewide organization that serves both federally recognized Continua of Care. Vermont Balance of State CoC (VT BoS CoC) is the organization that represents the Balance of State Continuum of Care (VT 500). The Chittenden County Homeless Alliance (CCHA) is the organization that represents the Chittenden County Continuum of Care (VT 501). This policy is specific to the VT BoS CoC.

This section outlines the process Lead Agencies and Assessment Partners with VT BoS CoC will use to assist Veterans in gaining access to Veteran specific resources. Referral Partners will follow VT BoS CoC policy and procedures to refer Veterans, like all persons, to the local Lead Agency to participate in coordinated entry.

The stated goal of the Veteran's Homeless programs is to end homelessness among Veterans. The resources available are federal, state, local and private funded programs. Connecting Veterans experiencing homelessness to resources available through Veteran's homeless programs allows Local Housing Coalition providers to use non-Veteran specific funds to assist non-Veteran households in their communities.

The Vermont Veterans Committee will follow the VT BoS CoC Coordinated Entry policies and procedures in the Balance of State, unless there is a required variance outlined by the U.S. Department of Veterans Affairs or HUD, specific to Veteran resources.

### 6.2 DEFINITIONS

**Veteran:** A person who served in the active Military, Naval, Air Service, regardless of length of service, and who was discharged or released there from, excluding any one who received a dishonorable discharge or was discharged or dismissed by reason of a General court-martial (PL 114-315; 38 USC § 2002(b)).

- Active duty means full time duty in the active military service of US Title 10. Hence, the National Guard and Reserve Members must have been called into Federal Service, by the President.

**Veteran family:** A Veteran who is a single person or a family in which the head of household, or the spouse/guardian of the head of household, is a Veteran.

**Vermont Veterans Committee:** The Vermont Veterans Committee is a joint committee of the Chittenden Homeless Alliance and the VT BoS CoC. It is an all-volunteer committee made up of representation from Veteran service providers and other Veteran specific organizations. The Vermont Veterans Committee provides the organizational structure to help Veterans access all of the Veteran specific homeless assistance resources available. The Vermont Veterans Committee serves to ensure homelessness among Veterans is rare, brief and non-recurring.

**Veterans Committee Representative:** This position will be a full-time paid position housed in SSVF@UVM initially. The primary role of this position will engage with the Veteran and facilitate access into the Coordinated Entry System.

- VT Veteran's Committee Representative: Will Vilaro
- VT Veteran's Committee Representative's email: [wvilaro@uvm.edu](mailto:wvilaro@uvm.edu)
- VT Veteran's Committee Representative's phone number: **802-656-2834**

**Coordinated Entry Housing Assessments:** Initially the existing VT BoS CoC Housing Assessment from VT BoS CoC (VT-500, the Balance of State) will be used to determine order of priority and guide housing referrals.

**Federal Benchmark Generation Tool:** The FBGT is a statewide Master List used by the Veterans Committee. It provides data to help determine how successful the Veterans Committee and Vermont Balance of State Continuum of Care are in meeting the federally mandated benchmarks of achieving an end to Veteran homelessness. It is only used by the Veteran Service providers.

### 6.3 Available Veteran Resources

Veterans, who qualify, will be eligible for assistance with housing in four main categories:

- HUD-VASH (Veterans Affairs Supportive Housing) is permanent supportive housing. This program is administered by the U.S. Department of Veterans Affairs in partnership with local Public Housing Authorities.
- GPD (Grant Per Diem) is a service-enriched transitional housing program. Veterans who are enrolled in GPD are still considered homeless and should be added to the Local Master list. GPD is administered by the U.S. Department of Veterans Affairs in partnership with local homeless service provider agencies.
- SSVF (Supportive Services for Veteran Families) is primarily a Rapid Re-Housing program. Funding is also available for Homelessness Prevention on a case by case basis only. SSVF is grant funded through the U.S. Department of Veterans Affairs.
- Other Veteran Housing Partners, specifically Dodge House

### 6.4 Referral Process

- Veterans will be referred to a Lead Agency of the Local Coordinated Entry Partnership by referral partners to complete the assessment.
- Lead Agencies and Assessment Partners will follow the Coordinated Entry process as outlined in the VCEH Coordinated Entry Policies and Procedures.
- If the initial point of contact for a Veteran is a CE Assessment Provider (Lead Agency or Assessment Partner), that provider will follow the VT BoS CoC Coordinated Entry process – i.e., place the household on the local Master List, etc.
- Lead Agency or Assessment Partner will make a referral to the Veterans Committee in HMIS (or the equivalent in cases where DV/SV are present).
- Veterans Committee Representative (VCR) will accept the referral in HMIS.
- VCR will place the Veteran on the FBGT, determine what resource will best serve the Veteran (& their family, if applicable) based on the VT BoS CoC Housing Assessment and prioritization policy.
- VCR will refer the Veteran to a Veteran service provider within 3 business days.
- VCR will manage the FBGT and work with the Veteran Service Providers and Local Housing Coalitions to ensure no Veterans are missed.
- **It is the responsibility of the Veteran Service Provider to update the FBGT weekly.**
- For Veterans who present at a non-HMIS Referral Partner, that Referral Partner will follow the policies and procedures outlined in the VT BoS CoC Policies and Procedures for Referrals.
- Clients who report to be Veterans but don't meet eligibility requirements for any Veteran specific program will be referred by the VCR back to the Lead Agency of the Local Housing Coalition.



- VCR will oversee case conferencing phone meetings with the Veterans Committee – on behalf of the Chairperson of the Veterans Committee.
- VA Homeless program staff will actively participate (either by phone or in person) in the case conferencing process that takes place amongst the community partners within Local Housing Coalitions (commonly referred to as Housing Review Team/HRT or Housing Solutions Team/HST).

## **6.5 Domestic Violence, Sexual Violence, Dating Violence and Stalking**

The VCR will work closely with the Victim Service Provider in the Local Housing Coalition based on client choice, to ensure personal information is de-identified and all policies and procedures related to safety and access are followed. Each Veteran Service Provider will also follow their specific policies and procedures in regards to Veterans fleeing domestic/sexual violence.

## **6.6 Inactive List**

Each Veteran Service Provider, during their weekly updates of the FBGT, will check current clients start dates to ensure a Veteran who has reached 90 days with no contact will be manually entered in the FBGT as inactive (Unknown/Missing). The VCR will work closely with the Local Lead Agencies to ensure no Veteran is inadvertently placed on the Local Master list as inactive. The VCR will also provide feedback to the Lead Agencies to add Veteran's name to the Local Master List when needed.

## **6.7 Non-Participation**

A Veteran who wishes to not participate in coordinated entry, Veteran-specific services or with a specific agency/provider will still be eligible for services based on his/her eligibility. The VCR will work closely with the Local Lead Agency and the network of Veterans Service Providers to de-identify the Veteran and provide the Veteran access to the resources that will best suit them.

## SECTION 7: TRAINING

This section details the annual training plan; additional training will be provided as part of start-up implementation and on an as needed basis.

- **Overview of VT BoS CoC Coordinated Entry Process**
  - Content:
    - What is Coordinated Entry and the VT BoS CoC Local CE Partnership
      - Roles and Responsibilities of Lead Agency, Assessment Partners, Referral Partners
      - The Coordinated Entry Committee and Master List Review Process
    - Coordinated Entry Policy and Procedures for: Referral to CE, Assessment, Master List, Prioritization, Referral to Housing Program
    - Confidentiality
    - Safety Planning and a Trauma-Informed Process
    - Fair Housing, Equal Access, Americans with Disabilities Act (ADA) and other Nondiscrimination Requirements
    - Evaluation Process
  - Method:
    - Training for Lead Agencies to provide Overview of VT BoS CoC Coordinated Entry Process
      - Training materials provided
    - Recorded Webinar for staff and available in person, by request
  - Audience:
    - Required for all Key Coordinated Entry Partner staff (Local Lead Agency, Assessment Partner, and Referral Partner)
- **Housing Assessment Training**
  - Content:
    - Assessment Tool and Process
    - How to conduct a Trauma-Informed assessment
    - Safety Planning
    - Release of Information
  - Method:
    - Training for Lead Agencies to provide Assessment Training
    - Recorded Webinar for staff and one in-person training annually
  - Audience:
    - Required for all Coordinated Entry Partner staff administering the assessment including Lead Agency
- **HMIS ServicePoint and Coordinated Entry Referral Process Overview**
  - Content:
    - How to access HMIS and technical instructions for making referrals
  - Method:
    - Provided by Institute for Community Alliances (ICA), the CoC HMIS Lead Agency, to each region, as needed
    - Web-based recording
  - Audience:
    - Coordinated Entry Partner staff including Lead Agency staff
    - Required for HMIS Coordinated Entry Users

Providing training and training materials is the responsibility of the VT BoS CoC Coordinated Entry Committee, in partnership with the ICA, the VT HMIS Lead Agency.

## SECTION 8: EVALUATION

Once the Local Coordinated Entry Partnership has been implemented, the Local Housing Coalition and the VT BoS CoC will regularly evaluate its effectiveness. Lessons derived from these evaluations will be used to further improve the coordinated entry process. VT BoS CoC will evaluate the coordinated entry process primarily through Local Housing Coalition implementation, but will also consider aggregate data.

At least annually, each Local CE Partnership will:

- Survey all local Partners to solicit feedback on how well the Local CE Partnership is being implemented, and
- Collect feedback on the coordinated entry process from consumers through a focus group or survey.

The VT BoS CoC will establish uniform questions to support this evaluation process.

Every 6 months, the VT BoS CoC Coordinated Entry Committee will review the following data points for each Local Housing Coalition and the aggregate Balance of State CoC:

- The number of Coordinated Entry Partners, and type (by services provided, not unduplicated: Outreach, Prevention, Emergency Shelter, Transitional Housing, Rapid Re-housing, Permanent Supportive Housing; and by Coordinated Entry Role: Lead, Assessment, Referral);
- # of referrals received by the Lead Agency
  - #/% of households with an initial outreach date within 3 days
  - Average # of days between referral and initial outreach
- The number of assessments completed (e.g, the number of households placed on the Master List during the time period), including:
  - #/% of assessments completed by Lead Agency
    - Average # of days between referral to Lead Agency and assessment
  - #/% of assessments completed by Assessment Partners
  - the number who were literally homeless (category 1)
  - the number of households returning to the Master List;
- The number of households on the Master List, including the number that are unsheltered (point in time);
- The number (and %) of households on the Master List more than 3 months, including
  - the # who are chronically homeless
  - the # who were rejected or not referred to a project and a summary of the reasons;
- The average length of time a household (HH) is on the Master List (date of assessment to date exit due to being inactive or housed) during the reporting period for: (LEAVERS)
  - all HH
  - all HH, compared as identified as needing long-term, medium-term or short-term assistance
  - all HH, compared by race, family status, age (head of household), disability status
- The average length of time a household is on the Master List (date of assessment to date of report) during the reporting period for” (STAYERS)
  - all HH
  - all HH identified as needing long-term assistance
  - all HH identified as needing medium-term assistance
  - all HH identified as needing short-term assistance
  - all HH, by comparison of race, family status, age and disability status
- The number of households exiting coordinated entry:
  - To a Permanent Housing Destination
  - Removed to the inactive list, and a summary of the reasons
  - Removed self from list
  - Transferred to another Continuum of Care

The VT BoS CoC Coordinated Entry Committee will provide an annual summary report and analysis to the VT BoS CoC Board.

## APPENDIX A – Key Terms & Definitions

**Rapid Re-housing** – A housing intervention that provides time-limited rental assistance and support services to individuals and families who are experiencing homelessness. In Vermont there are multiple funding sources for Rapid Re-housing and each program has their own eligibility criteria, policies and procedures; specific eligibility for each Rapid Re-housing Program varies depending on funding source, including the category of homelessness.

**Short-term rental assistance** – Tenant-based rental assistance and housing stability services for up to three months

**Medium-term rental assistance** – Tenant-based assistance and housing stability services for more than three months and up to 24 months

**Participating Housing Programs/Providers/Projects** – Housing programs that are required or elect to enroll participants ONLY through the coordinated entry process; program refers to the statewide program, project refers to a specific local project, and provider refers to the agency that is administering the local project

**Victim Service Provider** – Local domestic and sexual violence organizations

**Youth Provider** – Local youth service provider, as part of the Vermont Coalition of Runaway & Homeless Youth Programs

## APPENDIX B – Local Partnership Agreement Template

## APPENDIX C – VT BoS CoC Housing Crisis Referral Form

## APPENDIX D – VT BoS CoC Housing Assessment

## APPENDIX E – VT BoS CoC Release of Information

## APPENDIX F – Emergency Shelter Coordinated Access Protocol Template (Coming Soon)

## APPENDIX G – Client Complaint Notice Template

## APPENDIX H – Transfer Form

## Revision History

July 2018	Section 7: Evaluation: Technical changes by VT BoS CoC Coordinated Entry Committee based on available information.
August 2018	Added Section 3.3: Active and Inactive Lists; subsequent Section renumbering. Approved by VT BoS CoC Board.
December 2018	Added Section 6 on Veterans Coordinated Entry; subsequent Section renumbering. Approved by VT BoS CoC Board.
September 2019	Changes to Section 8, Evaluation; Added Appendix H, Transfer Form
November 2019	Inclusion of Youth Transitional Housing and Youth Homelessness Demonstration Projects. Removal of detail for Complex Service Needs (reference Assessment only); Updates to the Assessment