Policy: Coordinated Entry System HMIS Entries	**Date Issued: March 29, 2017**
Procedures: HMIS CES Entry, Assessment, Referral and Exit	**Effective Date: December 1, 2023**
	Review Date: January 30, 2023

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BACKGROUND

In 2012, the US Department of Housing and Urban Development required every Continuum of Care to implement a Centralized or Coordinated Entry System. With guidance from the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act), Housing and Urban Development (HUD) guidelines, regulations, and strategic agreement amongst partner agencies, the Ventura County Continuum of Care, Coordinated Entry System- Pathways to Home was designed.

POLICY

Provisions in the CoC Program interim rule at 24 CFR 578.7(a) (8) require that CoCs establish a Centralized or Coordinated Assessment System. Coordinated Entry must be easy for people to access services, it must also identify and assess their needs, and makes prioritization decisions based upon needs.

KEY TERMS

1. Housing First:

   A model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions for entry (such as sobriety or a minimum income threshold). HUD encourages all recipients of CoC Program-funded PSH to follow a Housing First approach to the maximum extent practicable.

2. Chronically Homeless:

   The definition of "chronically homeless", as stated in Definition of Chronically Homeless final rule is: (a) A "homeless 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. Has been homeless and living as described in paragraph (a)(i) continuously for at least 12 months or on at least four separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (a)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as 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 an institutional care facility; (b) An individual who has been residing in an institutional care facility, including a 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

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paragraph (a) of this definition, before entering the facility; (c) 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 paragraph (a) or (b) of this definition (as described in Section I.D.2.(a) of this Notice), including a family whose composition has fluctuated while the head of household has been homeless.

3. Severity of Service Needs

This Notice refers to persons who have been identified as having the most severe service needs. (a) For the purposes of this Notice, this means an individual for whom at least one of the following is true: i. History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; and/or 6 ii. Significant health or behavioral health challenges, substance use disorders, or functional impairments which require a significant level of support in order to maintain permanent housing. iii. For youth and victims of domestic violence, high risk of continued trauma or high risk of harm or exposure to very dangerous living situations. iv. When applicable CoCs and recipients of CoC Program-funded PSH may use an alternate criteria used by Medicaid departments to identify high need, high cost beneficiaries. (b) Severe service needs as defined in paragraphs i.-iv. Above should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool and process and should be documented in a program participant's case file. The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual. The determination cannot be made based on any factors that would result in a violation of any nondiscrimination and equal opportunity requirements, see 24 C.F.R. § 5.105(a).

4. Eligibility

Determining eligibility is a project level process governed by written standards as established in 24 CFR 576.400€ and 24 CFR 578.7 (a)(9). Coordinated entry processes incorporate mechanisms for determining whether potential participants meet project-specific requirements of the projects for which they are prioritized and to which they are referred.

5. Prioritization:

HUD has determined that an effective coordinated entry process ensures that people with the greatest needs receive priority for any type of housing and homeless assistance available in the VC CoC

6. Referrals:

The coordinated entry process makes referrals to all projects receiving Emergency Solutions Grants (ESG) and CoC Program funds, including emergency shelter, Rapid Re-housing (RRH), Permanent Supportive Housing (PSH), and Transitional Housing (TH), as well as other housing and homelessness projects.

- Referral Acknowledged: The receiving provider has acknowledged the referral in the system.
- Accepted Referrals: This means the receiving provider has accepted the

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referral, this does not mean the client has met eligibility for the program.

- Declined Referrals: Recipients must ensure that referral denials are justified (case noted) and rare, and that participant(s) is/are able to identify and access another suitable project.

WHEN AN INDIVIDUAL PRESENTS FOR SERVICES:

Access to coordinated entry process, whether in person, by phone, or some other method,

1. **Initial Triage** – resolve immediate crisis needs (BH, physical and/or food/shelter)
2. **Diversion/Prevention**– examination of existing resources and options instead of emergency shelter
3. **Safety Planning**: examination of safety concerns for participant currently experiencing any form of violence and provide general safety information to all participants, including referral to 211 and/or emergency service (if client does not agree to data sharing, please proceed to use paper forms for CES process)

   If unable to resolve item 1 and/or 2, proceed with Coordinated Entry System:

4. **Run a search** for client record in HMIS, *if a new client* or existing client, **Enter Data As (EDA**) under Pathways to Home CES.
   a. If a new Client, enter ALL Client Profile information and click **Add New Client with This Information**.
5. **Record PTH project entry:**
   a. Click on Entry/Exit Tab
   b. Click on Add Entry/Exit
   c. Complete an entry/exit for head of household only, click HUD (Pathways to Home CES assessment)

Eligibility Module:

6. **Run Eligibility Module in HMIS click Eligibility Search Criteria:**
   a. **Click Services Transaction** Tab
   b. Click **Eligibility Search**
   c. Under Eligibility Service Code Quick List, Click **Add all Eligibility Terms**
   d. Client will show eligible, potentially eligible and ineligible:
      i. Click on potentially eligible and complete assessments questions.

   STOP HERE and CHECK

   e. *If eligible* for Permanent Supportive Housing complete a Vulnerability Assessment Tool (*see below*)

Vulnerability Assessment Tool (PSH, PH, & TH):

Complete the Vulnerability Assessment Tool. If a client has an existing record with a Vulnerability score completed within the last 30 days (refer to client notes and attachment tab), then review the assessment and determine if anything has changed. If no changes, use the existing Vulnerability score for the case conference. If the client has had significant changes, complete a new Vulnerability Assessment Tool (can be found in the CES Teams Channel File Folder).

Review Existing Vulnerability Tool Score (PSH, PH, & TH) Cont.:	1. **Within the Client Profile Tab:** a. Click on Client Notes to identify if a previous Vulnerability Assessment Tool was completed b. Click on File Attachments to review the previous Vulnerability Assessment Tool c. If no previous Vulnerability Assessment Tool, **i.** Complete the Vulnerability Assessment Tool d. Complete a Client Note indicating date the Vulnerability Assessment Tool was completed **i.** Upload the Vulnerability Assessment Tool under File Attachments e. Review results and determine if client shows potentially eligible for Permanent Supportive Housing or Transitional Housing i. Vulnerability Assessment Tool Recommendations: i. 19+ (PSH Only) ii. 0-18 (PSH Only, No Supportive Housing option recommended) iii. PH & TH does not have a threshold A Case Conference Form, Vulnerability Assessments and homeless documentation is required to be completed prior to case conference submission f. Submit forms to CES Teams via HMIS CES Document Submission Portal, https://vchsa.org/hmis-submit/form/en along with complete Homeless Documentation by Wednesday noon for consideration to be presented at the Monday case conference meeting (see Homeless Documentation policy)
DIRECT REFERRALS FOR ES, RRHP, HPRP, SO or TH:	Complete direct referral via Eligibility module can be initiated *(no case conference is necessary) for e*mergency shelter *including Safe Haven*, Rapid Re-Housing, Homeless Prevention, Street Outreach and Transitional Housing: 1. Return to **Service Transactions** 2. Click **Eligibility Search** f. (if step 5 above has not been completed) Under Eligibility Service Code Quick List, Click **Add all Eligibility Terms**) 3. Click Green Cross on **Eligibility Search Criteria Results to eligible RRHP/HPRP/ SO/ES provider** a. choose program that client shows eligible for ▪ If eligible for RRHP, only choose one agency to refer to *4.* Click **Continue** *5.* Send direct referral (click **box** to notify receiving agency) 6. Follow up if referral has not been acknowledged w/in 24 business hours or accepted w/in 3-5 business days

POST CASE CONFERENCE REFERRALS FOR PSH, PH, & TH ONLY:	Complete referral once the case is conferenced, prioritized, and matched for Permanent Supportive Housing/ Permanent Housing or Transitional Housing: 1. Go to **Service Transactions Tab** 2. Click Tile for **Eligibility Search** 3. Under **Eligibility Service Code Quick List**, Click add **All Eligibility Terms** 4. Click on the **Eligibility Service Term** (PSH, PH or TH) 5. In **Eligibility Search Criteria Results,** Click the **Green Cross on the Eligible Provider** 6. Click **Continue** 7. Send direct referral (click **box** to send an email to notify receiving agency) then continue

SERVICE LEVEL COMMITMENT FOR REFERRALS	**The Receiving Agency** has 24-48 business hours to Acknowledge
	1. Return to **Service Transactions, View Entire Service History,** Click on **Referral tab,** click on the **referral pencil**
	2. Under **Referral Data**, click in **Referral Ranking box** and click **acknowledged**
	3. The Receiving Agency has 3-5 business days to accept/decline referral (**Click in Referral Data,** click in **Referral Outcome** and click **Accepted or Declined***)*
	    a. Document the justification as to why a referral has been declined. Follow-up with agency/ case manager working with client to communicate regarding decline
	4. The Receiving Agency has 5 business days to make contact with potential client and the potential client has 3 business days to make contact with the agency. If no contact after 8 business days, the referral may be declined.
	5. The Receiving Agency will change the **Outcome of Need Status** in **Services Transactions** if the need was **Fully Met**, or **Not Met** once successfully entered into the new program.
	    a. Document the justification as to why a referral has been declined. Follow-up with agency/ case manager working with client to communicate regarding decline
	6. Re-refer client
	*Recommendation: On the HMIS Dashboard, click **My Referrals to track incoming or outgoing** referrals

EXITS FROM CES:

Exits from CES are to be completed in HMIS if the following occurs:

A. The client is permanently housed (PSH/PH or RRH)
B. Client self-resolved the housing situation
C. Loss of contact with client after 90 days

A reason for leaving and destination must be selected for client upon exit:

D. Complete Coordinated entry Event
E. Complete Monthly Income (if changes occurred)
F. Complete non-Cash Benefits (if changes occurred)
G. Complete Health Insurance (if changes occurred)
H. Complete Disabilities (if changes occurred)
I. Housing Assessment exit questions

FORMS:

VCCoC Chronic Homeless Documentation Packet (HMIS/CES Document Submission Portal)

VCCoC Homeless Documentation Packet (HMIS/CES Document Submission Portal)

Vulnerability Assessment Tool (CES Teams Channel File)

PTH Case Conference Form (VCCoC Website)

REFERENCES

24 CFR 578.7 (a) (8)

CPD-17-11 /2017

CPD-16-11 /2016, 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), Coordinated Entry Self-Assessment, Coordinated Entry Policy Brief/ 2015

https://vchsa.org/hmis-submit/form/en