Kentucky Balance of State Continuum of Care
(KY BoS CoC)

Coordinated Entry Policies and Procedures

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The most up-to-date version of this document will be published on Kentucky Housing Corporation's (KHC) website, under "Specialized Housing, Continuum of Care" and on the KHC Housing Contract Administration (HCA) Help Desk under "Coordinated Entry".

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Kentucky Balance of State Continuum of Care (KY BoS CoC) Values, Priorities and Goals

KY BoS CoC Values

- *We value programs with outcomes that demonstrate progress toward reducing and ending homelessness as quickly as possible with an ultimate goal of no more than 30 days.*
- *We value innovative and diverse programming that addresses gaps in community services.*
- *We value quality programming that is accountable to the community through outcomes measurement.*
- *We value the effort to access the maximum amount of funding available to the KY BoS CoC.*
- *We value the commitment to serve all people who are in need of assistance regardless of regardless of age, race, color, creed, religion, sex, handicap, national origin, familial status, marital status, sexual orientation or gender identity*
- *We value and respect the decisions and choices of those who find themselves homeless and seek to optimize self-sufficiency.*

The KY BoS CoC developed the following Coordinated Entry standards to ensure:

- Program accountability to individuals and families experiencing homelessness; specifically those who are experiencing chronic homelessness or are high-need/high-acuity.
- Program compliance with current HUD rules and regulations
- System access, prioritization, and housing placement uniformity
- Adequate program staff competence and training to create an environment, locally and CoC-wide, of coordination, uniformity, and speed in housing placement

24 CFR Part 578.7 Homeless Emergency Assistance and Rapid Transition to Housing: Responsibilities of the Continuum of Care

In consultation with recipients of Emergency Solutions Grants (ESG) 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.

COORDINATED ENTRY

Coordinated Entry– "Coordinated Entry" is defined as a process designed to coordinate program participant intake, assessment, and provision of referrals. It covers the geographic area, is easily accessed by individuals and families seeking housing and services, is well advertised, and includes a comprehensive and standardized assessment tool.

The process of Coordinated Entry can be implemented regardless of geography, housing stock, service availability, or unique community makeup. Almost any model of Coordinated Entry applied to any community or situation with patience, persistence, testing, and tweaking, can be successful.

The terms "Coordinated Access", "Centralized Intake", "Coordinated Intake", "Coordinated Entry" and "Coordinated Assessment" are often used interchangeably, and with the exception of "Centralized Intake", more or less mean the same thing: transitioning from a "first come, first served" mentality to a mentality that says "now that you are here, let's determine, together, what might be your next step". **The BoS Continuum of Care will refer to the system as "Coordinated Entry."**

Coordinated Entry, when implemented correctly, can help to prioritize individuals and families who need housing the most across communities. Coordinated Entry can create a collaborative, objective environment across a community that can provide an informed way to target housing and supportive services to:

1. Divert people away from the system who can solve their own homelessness.
2. Quickly move people from street to permanent housing.
3. Create a more defined and effective role for emergency shelters and transitional housing.
4. Create an environment for less time, effort, and frustration on the part of case managers by targeting efforts.
5. End homelessness across communities, versus program by program.

Traditionally, the system of entry and referral to housing and service supports was based on a "first-come, first-served" basis and in some places still is. But years of research, re-thinking, and a commitment to moving away from the linear approach to housing placement and moving toward quickly placing people into appropriate housing, has shifted the way we do business.

The intention of Coordinated Entry is to:

1. **Target** the correct housing intervention to the correct individual (family), particularly for those with high acuity and high need.
2. **Divert** people away from the system who can solve their own homelessness.
3. **Greatly reduce the length of homelessness** by moving people quickly into the appropriate housing.
4. **Greatly increase the possibility of housing stability** by targeting the appropriate housing intervention to the corresponding needs.

Historic Practice is **Program** Centric	Coordinated Access/Entry/Assessment is **Client** Centric
Should we accept this family into our program?	What housing and service intervention is the best fit for each family and individual?
Unique entry and assessment forms for each individual program.	Standard forms, assessment, and entry processes across all programs.
Uneven knowledge about existing programs, eligibility, and purpose in communities.	Accessible information about housing and service options in the CoC.

Applying Coordinated Entry to a community or region brings together the strength of programs across a community, offering a menu of services across programs. When communities come together to implement a Coordinated Entry model, each program realizes success in a myriad of ways:

- Programs Receive Eligible Clients: Programs receive referrals for participants whose needs and eligibility have already been determined. The autonomy and unique nature of programs, as they operate within a coordinated framework become a strength, not a hindrance.
- Case Managers can concentrate on Case Management: With every program in a community providing assessment, case managers often share the burden of intake and assessment.
- Communities readily see what additional resources they need most: Lots of clients with mid-level acuity signal a need for more Rapid Re-housing resources. Lots of clients with high-level acuity signal a need for more permanent supportive housing/housing first.
- Time, red tape, and barriers are significantly reduced: When different programs in a community follow the same process across and are aware of one another, workload is significantly reduced.
- Community success in ending homelessness is significantly increased: Targeting limited resources as a community in a laser-like way leads to very fast and effective interactions that lead to long-term housing stability.

DEFINITIONS

Acuity – When utilizing the VI-SPDAT Prescreens (triage tool), acuity speaks to the presence of a presenting issue based on the prescreen score. In the context of the Full SPDAT assessments, acuity refers to the severity of the presenting issues. In the case of an evidence-informed common assessment tool like the VI-SPDAT (Single), Family VI-SPDAT, Full SPDAT, *acuity* is expressed as a number with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability.

Common Assessment Tool – A comprehensive and standardized assessment tool used for the purposes of housing prioritization and placement within a CoC Coordinated Entry System. The BoS CoC has adopted the VI-SPDAT (Vulnerability Index Service Prioritization Decision Assistance Tool) as the Common Assessment Tool.

Chronically Homeless (Final Definition 24 CFR 578.3, effective January 15, 2016) –

(1) A "homeless individual with a disability," 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 or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 12 months or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months
    - Occasions separated by a break of at least 7 nights
    - Stays in an institution of fewer than 90 days do not constitute a break
(2) An individual who has been residing in an institutional care 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 paragraphs (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Disability is described as: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 USC 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability 24 CFR 578.3.

Coordinated Entry – "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 Section 578.7. It is the responsibility of each CoC to implement Coordinated Entry in their geographic area.

Disabling Condition – (1) a condition that: (i) is expected to be long-continuing or of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by the provision of 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 (2) a development disability, as defined above; or (3) the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome, including infection with the Human Immunodeficiency Virus (HIV). 24 CFR 583.5.

Diversion – Diversion is a strategy that prevents homelessness for people seeking shelter 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 programs can reduce the number of families becoming homeless, the demand for shelter beds, and the size of program prioritization lists. The main difference between diversion and other permanent housing-focused interventions centers on the point at which intervention occurs. Prevention targets people at imminent risk of homelessness, diversion targets people as they

are applying for entry into shelter, and rapid re-housing/permanent supportive housing targets people who are already homeless.

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 – means

1. **Category 1: Literally Homeless→** 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 is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

2. **Category 2: Imminent Risk of Homelessness→** An individual or family who will imminently lose their primary nighttime residence, provided that:
   - 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;

3. **Category 3: Homeless Under Other Statues→** Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
   - (i) Are defined as homeless under section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), section 637 of the Head Start Act (42 U.S.C. 832), section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e 2), section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), section 3 of the Food and Nutrition Act of 2008

(7 U.S.C. 2012), section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a);

- (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance;
- (iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
- (iv) Can be expected to continue in such status for an extended period of time because of chronic disabilities; chronic physical health or mental health conditions; substance addiction; histories of domestic violence or childhood abuse (including neglect); the presence of a child or youth with a disability; or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or

4. **Category 4: Fleeing or Attempting to Flee Domestic Violence→** Any individual or family who:

- Is fleeing, or is 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 a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
- (ii) Has 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 – An approach to **quickly and successfully connect** individuals and families experiencing homelessness **to permanent housing *without preconditions* and barriers to program/housing entry**, such as sobriety, treatment or service participation requirements. Supportive services such as housing-focused case management are **offered** to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

Kentucky Homeless Management Information System (HMIS) - The Kentucky Homeless Management Information System (KYHMIS) uses a software program from Bowman Systems called ServicePoint. The KYHMIS is a Client information database that provides a standardized assessment of Client needs, creates individualized service plans, and records the use of housing and services. Communities can use the data to determine the utilization of services of participating agencies, identify gaps in the local service continuum, and develop outcome

measurements. The KYHMIS is designed to collect data and provide information on persons in compliance with all federal and state requirements regarding Client confidentiality and data security. The KYHMIS will meet the data collection specifications mandated by HUD, KHC, and/or other funders. The KYHMIS will provide a system for the collection of information on services and programs provided to Clients statewide, as well as provide referral capabilities and Client historical data. The KYHMIS can improve the services and programs offered to Clients in Kentucky by providing documented assurances of what service levels are met and in demand throughout the various types of agencies and programs in the state.

Local Prioritization Committee (LPC) – Regional and/or geographical committees comprised of all CoC and ESG funded agencies. It is best practice to invite as many service providers and non CoC and ESG funded agencies to the table in order to identify and serve as many individuals experiencing homelessness as possible, (i.e community mental health providers, veteran providers, law enforcement, non HUD funded shelters, faith based organizations, McKinney-Vento school district representatives, etc.…). The regional LPC **makes and takes referrals** to/from the Prioritization List of eligible, high acuity individuals and families seeking CoC and ESG funded housing interventions (such as Rapid Re-Housing and Permanent Supportive Housing). LPCs must adhere to priorities set forth by HUD and this document.

No Wrong Door Approach – Describes the experience of accessing the housing assistance and service system in a Continuum of Care from the client's perspective and is a system that is designed so that the client only has to go one place for a housing referral to the appropriate housing assistance. Any service or housing provider may be trained to administer the VI-SPDAT Common Assessment Tool to eligible community members presenting for housing and services. Presently, agencies who receive CoC and/or ESG funds serve as agents of the Coordinated Entry system by administering the Common Assessment Tool to those experiencing homelessness who present for housing and/or services. It is the goal of the KY BoS Continuum of Care to work toward a strategy to achieve a state-wide access to a Common Assessment initiative (such as a call system), however currently the No Wrong Door Approach will be utilized through each Local Prioritization Committee across Continuum of Care.

Permanent Supportive Housing (PSH) – means community-based housing without a designated length of stay, and includes both permanent supportive housing. Permanent supportive housing means long term permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently. 24 CFR 578.3. The definition of rapid re-housing appears below.

Prioritization List – A list generated by VI-SPDAT entry into the Kentucky Homeless Management Information System (KYHMIS). The prioritization List is thought of as a universal registry within KYHMIS. Each LPC will receive access via KYHMIS to enter completed VI-SPDATs for inclusion on the list for purposes of LPC prioritization and housing placement. CoC and ESG funded agencies must make and take referrals off of this list for their programs.

Rapid Re-Housing (RRH) –An intervention designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve stability in that

housing. Rapid re-housing assistance, operating in a Continuum of Care and/or Housing First model, is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. The core components of a rapid re-housing program are housing identification and relocation, short-and/or medium term rental assistance and move-in (financial) assistance, and case management and housing stabilization services. This assistance is subject to the definitions and requirements set forth in 24CFR§576.2 "Homeless" paragraph (1) and paragraph (4) who are residing in a place set forth in (1), 24CFR§576.105, 24CFR§576.106 and 24CFR§576.400. (24CFR§576.104 *& Core Components of Rapid Re-Housing,* National Alliance to End Homelessness).

SPDAT – (Service Prioritization Decision Assistance Tool) the evidence-based assessment utilized by all trained CoC providers in either enacting more detailed determinations of acuity for housing placement and/or ongoing use in case management to ensure housing stabilization. **This is an ongoing case management tool suggested for your use.** The SPDAT (or "Full SPDAT") has an individual and family tool. **Staff must be trained by OrgCode Consulting prior to administering the tool.** The SPDAT can be completed on paper or in HMIS and attached to a client record.

Severity of Service Needs - (a) For the purposes of Notice(CPD-16-11), 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

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)

Transitional Housing (TH) – housing to facilitate the movement of individuals and families experiencing homelessness into permanent housing within 24 months. 24 CFR 578.3.

VI-SPDAT – (Vulnerability Index-Service Prioritization Decision Assistance Tool) the evidence-based Common Assessment or Prescreen Triage Tool utilized by all projects in the KY Balance of State Continuum of Care to determine initial acuity (the presence of an issue) and utilized for housing triage, prioritization and housing placement. Note there are two versions of VI-SPDAT, the Individual and Family, both of which are available in KYHMIS. There is a Youth VI- SPDAT

that was recently released for use specifically with youth and is available on the OrgCode website, with anticipation of KYHMIS release in the near future.

- ***PLEASE NOTE the VI-SPDAT is a different tool than the Full SPDAT; do not use these terms interchangeably as they are different***
- ***The VI-SPDAT is the Common Assessment Tool, or Prescreen Triage Tool***
- ***The Full SPDAT can be used as an ongoing case management tool***

Types of CoC Housing

Permanent Supportive Housing (PSH)	Rapid Re-housing (RRH)	Transitional Housing (TH)
Permanent Housing	**Permanent Housing**	**Temporary Housing**
Long Term Assistance *May be permanent	Temporary Assistance	Temporary Assistance
Once the individual/family is placed in PSH it is intended that both the housing and supportive services are permanent. HIGH Acuity * Must have a documented disability to qualify. * Supportive Services are offered to support housing stability.	Assistance is temporary but it is intended that the assistance will allow the individual/family to stay in housing permanently. MEDIUM Acuity *Intended for lower barrier individuals/families **AND/OR** to get harder to serve individuals/families out of the shelter or off the street and rapidly re-housed until a more permanent assistance can be found.	Both the housing and supportive services are limited to 24 months, at which time the individual is required to leave both.

What is the VI-SPDAT?

The VI-SPDAT is a pre-screening, or triage tool that is designed to be used by all providers within a community to quickly assess the health and social needs of homeless persons and match them with the most appropriate support and housing interventions that are available.

Emergency Room Scenario:

Compare homelessness in your community to a mass casualty event that sends many people to the hospital emergency department: there will be some serious injuries that require immediate intervention, while others may be able to wait to be treated, and some injuries may not need medical attention at all. The emergency department staff will need to identify whom to treat first and why, based upon the best available evidence. For example, an emergency room medical team will triage an individual with a fatal gunshot wound before treating an individual with a broken wrist, despite the fact that the individual with the broken wrist had been in the waiting room longer than gunshot victim. The emergency room medical team triages patients and provides care based on severity of the medical emergency.

A triage tool like the VI-SPDAT allows homeless service providers to similarly assess and prioritize the universe of people who are homeless in their community and identify who to treat first based on the acuity (severity) of their needs. It is a brief survey that service providers, outreach workers, and even volunteers can use to determine an acuity score for each homeless person who participates. The scores can then be compared and used to identify and prioritize candidates for different housing interventions based upon their acuity. Using the VI-SPDAT, providers can move beyond only assisting those who present at their particular agency and begin to work together to prioritize all homeless people in the community, regardless of where they are assessed, in a consistent and transparent manner.

Sometimes the VI-SPDAT is confused with or used interchangeably with the Full SPDAT. Whereas the VI-SPDAT is a triage tool (also referred to as a pre-screen tool), the SPDAT is an assessment tool. The Full SPDAT digs deeper into the context, history, environment and severity of an issue in a more nuanced manner than the VI-SPDAT. To return to the metaphor of a hospital emergency department, the VI-SPDAT is the triage station asking a series of questions to confirm what is occurring and to understand a particular patient's needs in comparison to all other patients; the Full SPDAT is what happens when the doctor sees the patient, rounds out the understanding of the issue, and advises the appropriate treatment protocol for that individual. The VI-SPDAT is designed to determine the presence and acuity of an issue and identify clients to refer for assessment for specific housing interventions, but it is not intended to provide a comprehensive assessment of each person's needs.

It is recommended that the VI-SPDAT be used together in a community with the Full SPDAT, as they are complementary tools. However, communities may start with using only the VI-SPDAT and referring clients directly to different housing interventions based on their VI-SPDAT scores, although this approach is less precise than using a more comprehensive assessment. Please note, use of the Full SPDAT is not mandated under the BoS Continuum of Care Coordinated Entry System for housing referral.

Where there is flexibility in the wording/content, and where there is not…

Each question in the VI-SPDAT ties into one or more of the components of the Full SPDAT. The inclusion of each question is supported by an extensive body of evidence from peer-reviewed studies and government documents, and/or extensive data from program operations.

Each word and phrase within the tool has been carefully and rigorously tested. Some questions permit adjustments to the wording to allow for differences in the local context: for example, in Question 3, "emergency room" may be changed to "emergency department" in communities where the latter is more commonly used. As you go through this course, you will see where you

have some flexibility to alter a word or phrase without it having a bearing on the intent of the tool, and where you cannot change the wording.

Making changes to the wording of a question, other than those that are identified, may mean that the question will no longer be grounded in evidence and may not elicit the information for which it was designed. Permission is required from Community Solutions and OrgCode Consulting, Inc. to make amendments because they own the intellectual property of the tool.

Unlike the Full SPDAT assessment, which uses multiple methods for information capture, the VI-SPDAT is designed and structured to only use self-report. A person who is being surveyed using the VI-SPDAT should be able to complete it with anyone, not just the people who know her/his case history or have other information from other circumstances or sources.

The order of the VI-SPDAT cannot change. As a self-reported tool, the sequence is vitally important and links it back to the SPDAT for those communities that are using both tools.

Your community may choose to **add** more questions to the VI-SPDAT, as long as they are **not used for scoring** in any way. For example, it is common for communities to add screening questions that capture information that may be important for understanding local needs or to meet funding requirements, such as experience of domestic/intimate partner violence, military service and nature of discharge, and whether the individual meets the federal definition of chronic homelessness. Additionally, some demographic information can be gathered that may be required for HMIS entry.

VI-SPDAT and COORDINATED ENTRY CONSENT

An individual **must** provide informed consent prior to the VI-SPDAT being completed, (KYHMIS Release of Information Form, see page 12). You **cannot** complete a VI-SPDAT with a client without that person's knowledge and explicit agreement. You also **canno**t complete the VI-SPDAT solely through observation or using known information within your organization.

VI-SPDAT Current Intervention Recommendation Ranges

VI-SPDAT Version 2 Individuals (Now available in HMIS)

Intervention Recommendation	VI-SPDAT Prescreen Score for **Individuals**
Permanent Supportive Housing/Housing First	8+
Rapid Re-Housing	4-7
Diversion	0-3

VI-SPDAT Version 2 Families (Now available in HMIS)

Intervention Recommendation	VI-SPDAT Prescreen Score for **Families**
Permanent Supportive Housing/Housing First	9+
Rapid Re-Housing	4-8
Diversion	0-3

RELEASE OF INFORMATION FORM: The KYHMIS Release of Information (ROI - located online on the KHC Housing Contract Administration Help Desk; https://kyhmis.zendesk.com) is utilized by all providers to input VI-SPDAT assessments within the HMIS. Individuals who do not sign the release of information do not complete the assessment. Individuals who are not able to complete either a VI-SPDAT or full SPDAT may be referred to the Local Prioritization Committee.

Victim Service Provider (VSP) RELEASE OF INFORMATION - VSPs do not include client information in any shared database (such as HMIS) and as such should NOT utilize the standard KYHMIS Release of Information. KCADV Member Program Service Standards state that, "In the event of the use of computer-generated case notes or client records, it is the responsibility of each domestic violence program to assure confidentiality of information. Each program must maintain a written policy and accompanying procedures that reflect security measures.

Coordinated Entry in Practice

COMMON ASSESSMENT: Administering the VI-SPDAT

PROCESS: The CoC/ESG program will be an active member of the BoS Continuum of Care Coordinated Assessment Entry system as it is locally implemented via the Local Prioritization Committee. All programs will utilize the VI-SPDAT Prescreen as the initial triage assessment for Coordinated Entry. Whenever possible, the VI-SPDAT should be completed in HMIS. When not possible, the VI-SPDAT should be completed in its paper form and then entered into HMIS for each client. **Please note that you should conduct the VI-SPDAT no more than once annually for any client – unless there has been a qualifying event (such as pregnancy, death in the household, etc.….) that would warrant performing the assessment again.**

- For providers not using HMIS, or not permitted by law to utilize HMIS such as Victim Service Providers (VSP), the VI-SPDAT can be completed on paper and staff can communicate acuity scores and basic characteristics to the Local Prioritization Committee for inclusion in the Coordinated Entry system without divulging name and identifying information. KHC and the Kentucky Coalition Against Domestic Violence (KCADV) have created a ***VSP Local Prioritization Inclusion Form*** **(page 25**) that should be used in order to include those experiencing domestic violence in the Coordinated Entry System, while maintaining victim/survivor confidentiality to the strictest degree.

- KCADV and BoS CoC Approved Common Assessment Procedure for DV Survivors on page 14.

STEPS:

1. Providers will obtain a KYHMIS Release of Information and Consent (or comparable document for VSPs)
2. Providers will utilize the VI-SPDAT as the Common Assessment Tool, to screen individuals and families experiencing homelessness.
3. There is a specific VI-SPDAT for Individuals and Families in HMIS. Providers should use the most up to date version available in HMIS (currently, Version 2 is available for both Individuals and Families).
4. The assessment takes approximately 7 minutes to administer, and can be conducted by any provider who has been introduced to the tool through a 30 minute video (or attended a training by its creator, OrgCode Consulting, Inc.), see below for more training details.
5. The VI-SPDAT, as a first assessment at entry, provides each program with the ability to determine, across dimensions, the acuity of an individual or family.
6. In the case of an evidence-informed common assessment tool like the VI-SPDAT, acuity is expressed as a number with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability. The VI-SPDAT score shows the *presence* of these issues, and indicates the potential best fit for housing and service intervention, based on scores across the following dimensions:

   Wellness: Chronic health issues and substance use.
   Socialization and Daily Functioning: Meaningful daily activities, social supports, and income.
   History of Housing and Homelessness: Length of time experiencing homelessness, and cumulative incidences of homelessness.
   Risks: Crisis, medical, and law enforcement interdictions. Coercion, trauma, and most frequent place the individual has slept.
   Family Unit (Family VI-SPDAT Only): School enrollment and attendance, familial interaction, family makeup, and childcare.

7. Based upon the Prescreen Acuity Score of the VI-SPDATs, programs and communities can arrive at best possible housing intervention that applies, as follows:

VI-SPDAT Individuals

Intervention Recommendation	VI-SPDAT Prescreen Score for **Individuals**
Permanent Supportive Housing/Housing First	8+
Rapid Re-Housing	4-7
Diversion	0-3

VI-SPDAT Families

Intervention Recommendation	VI-SPDAT Prescreen Score for **Families**
Permanent Supportive Housing/Housing First	9+
Rapid Re-Housing	4-8
Diversion	0-3

8. Scores on the VI-SPDAT populate the local Prioritization List once entered into KYHMIS, and at weekly Local Prioritization Committee meetings all the partners and others with housing resources decide who enters available housing (RRH and PSH) next by acuity and HUD priorities.

While no formal training is required for the VI-SPDAT to be used, program or staff person requires training or assistance in utilizing the VI-SPDAT should use the following resources as a training material:

VI-SPDAT (Individual and Family) Manual: https://app.box.com/s/ov9p80o826h5ebgsv9qi

Common Assessment Procedure for DV Survivors

Additionally, KHC, Kentucky Coalition Against Domestic Violence (KCADV) and the KY BoS CoC Advisory Board recognize and understand the highly sensitive nature of information gathered from individuals experiencing domestic or intimate partner violence. As such these groups have worked together to include a non-scoring statement and question at the beginning of the VI-SPDAT to identify these individuals and refer them to the appropriate victim service providers (VSP) and have developed a procedure regarding how a referral from a VSP will be handled for the sake of the victims' inclusion in the local prioritization process. Shelters and other agencies funded through the Balance of State Continuum of Care Coordinated Entry System will make the Pre-screening Statement (page 15-16) in an attempt to divert survivors to victim service providers, which would then administer the surveys and record the score on the VSP Local Prioritization Inclusion Form with a client identification number. The form would be signed by the administering staff member and another staff member or volunteer attesting that the tool was completed and the score is accurate and true.

The completed tool will then be destroyed so as not to keep sensitive data about a client on file (when it is not directly related to service goals mutually identified by a client and advocate). The score will be presented by a VSP representative to the Local Prioritization Committee and placed on the Prioritization List for future housing placement accordingly.

SETTING UP THE VI-SPDAT – YOUR INTRODUCTORY SCRIPT

It is recommended that everyone in your community use the same introductory script. Create one that explains how your community is using the VI-SPDAT, how the information is stored, and what happens with the information collected from the VI-SPDAT. In your script, you should relay the following:

- The name of the surveyor and the organization that he or she is affiliated with;
- That the survey takes 7 minutes or less to complete (although the addition of non-scoring questions will increase this time)
- That you are looking for yes, no or one word answers, not their full story;
- Some questions are of a sensitive nature, and they may choose to refuse to answer any question;
- If they do not understand what a particular question is asking, or if the surveyor thinks that the question may not have been understood, that clarification can and will be provided;
- Information collected goes into your community's data system/HMIS;
- Consent to participate in the survey;

• The importance of honest responses;
• What happens with the information and how they can request access to the results?

SAMPLE SCRIPT:
My name is [interviewer name] and I work for a group called [organization name]. I have a 7-minute survey that I would like to complete with you. The answers will help us determine how we can best support you with available resources. Most questions only require a Yes or No. Some questions require a one-word answer. I'll be honest, some questions are personal in nature, but know you can skip or refuse any question. The information collected goes in to KYHMIS. If you do not understand a question, let me know and I would be happy to clarify. If it seems to me that you don't understand a question I will also do my best to explain it to you without you needing to ask for clarification. One last thing we should chat about. I've been doing this long enough to know that some people will tell me what they want me to hear rather than telling me – or even themselves – the truth. It's up to you, but the more honest you are, the better we can figure out how best to support you. If you are dishonest with me, really you are just being dishonest with yourself. So, please answer as honestly as you feel comfortable doing.

***Pre-Screening Statement* (Common Assessment Procedure for DV Survivors in Kentucky):** Before beginning the VI-SPDAT please ask the following question:

"One thing I'd like to do before we begin is see if you'd like information about our local domestic violence program? So, for instance, if a partner has ever threatened to hurt you, or made you afraid, or hit, slapped, kicked or otherwise physically hurt you or made you do something sexual you did not want to, it might be helpful for you to talk to someone confidentially. ***Our local domestic violence program can help you fill out this survey, the answers you give will be kept confidential and not become part of the shared database.*** *This level of confidentiality could be really important at some point in the future, because some of these questions that must be asked are very personal.*

Would you like to speak to someone at that program, and perhaps fill out this survey with them?"

If the answer to the question above is "yes" then the service provider will ask if they may make a referral to a regional domestic violence program so that the program can continue the assessment in a manner that is sensitive to survivors' needs and offer additional services. If the person declines, the service provider will continue assessment.

If the answer to the question above is "no" then the service provider will continue the assessment.

UNIVERSAL REGISTRY IN KYHMIS

Whether the VI-SPDAT is first conducted on paper or directly inputted within KYHMIS, all Non-VSP VI-SPDATs must be recorded into KYHMIS within **2-3 business** days of when the information was first collected for inclusion on the LPC Prioritization List. Each LPC will have access to their universal registry, or Coordinated Entry Project in KYHMIS. This access will help facilitate and streamline the Coordinated Entry System at the LPC level and statewide level. The BoS CoC will be working with KHC to develop these regional projects as LPCs develop.

COORDINATED ENTRY: CoC & ESG Programs

PROCESS: The CoC/ESG program will be an active member of the BoS Continuum of Care Coordinated Entry system as it is locally implemented via the Local Prioritization Committee. The CoC/ESG program will have minimal entry requirements to ensure the most vulnerable of the population are being served. The CoC/ESG program will ensure active client participation, client-center practices and informed consent. All programs will utilize the **appropriate and current** VI-SPDAT as the initial Prescreen/Common Assessment Tool for the KY BoS Coordinated Entry system for inclusion on the Prioritization List via KYHMIS or VSP Local Inclusion. All CoC/ESG programs will make and take referrals from the Prioritization List for housing referral and placement with available CoC/ESH housing resources via Local Prioritization Committee Meetings.

STEPS:

1. All adult program participants must meet the *program* eligibility requirements and properly document this eligibility as required (Kentucky Housing Corporation (KHC)/HUD funded ESG and CoC Programs are required to use the ESG/CoC Toolkits by appropriate program) for housing placement.

2. Programs may require participants to meet only additional program eligibility requirements as they relate specifically to federally and state-guided eligibility in writing. For example, your Grant Agreement from KHC states that you will serve specific populations. Programs are strongly encouraged to create or amend program standards to Low-Barrier standards for client entry.

3. Programs may disqualify registered sex offenders from the program if the location of housing will place the client in violation of KRS 17.545 which prohibits registered sex offenders from living near schools, daycare facilities and publicly owned playgrounds. These offenders are prohibited from living within 1,000 feet of a high school, middle school, elementary school, preschool, publicly owned playground, or licensed day care facility. The measurement is taken in a straight line from the nearest property line of the school to the nearest property line of the registrant's place of residence. Additionally, under 24 CFR 578.93 (b)(4), if the program housing has in residence at least one family with a child under the age of 18, the housing may exclude registered sex offenders and persons with a criminal record that includes a violent crime from the project so long as the child resides in the housing.

4. Additionally, programs **may not** 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 evictions or poor rental history.

6. The program explains the services that are available and encourages each adult household member to participate in program services, but does not make service usage a requirement or the denial of services a reason for disqualification or eviction. Please note that it is acceptable to require your program participants to participate in housing-

focused case management, but it is not acceptable to require participation in any other supportive services. It is important to note that the purpose of any required housing-focused case management should be to engage the program participant to assist them in **maintaining** their housing.

7. The program will maintain an annual Release of Information and annual income verification, Case notes, and all pertinent demographic and identifying data in HMIS, or a comparable database. Paper files can also be kept as long as they are stored in a secure location.

TOOLS

Several tools are available in the successful implementation of a coordinated access process. Important tools and concepts in the process are follows, with the specific tool that is utilized in the KY Balance of State Continuum of Care:

Tool or Concept	Specific Solution Used by KY BoS CoC
A Common Assessment Tool at entry into the Coordinated Entry system.	Individual and Family VI-SPDATs.
A common process for prioritization for housing referral and placement.	KYHMIS Regional LPC Prioritization List
A common referral mechanism across programs.	Local Prioritization Committee (LPC) Meetings, KYHMIS and BaseCamp
A common community-level process for housing placement.	Local Prioritization Committee (LPC) Meetings
A common tool for housing-focused case management and housing stabilization.	Individual and Family Full SPDATs.
A common method to measure results of the process.	KYHMIS (in accordance with HUD's Performance Measures).

PRIORITIZATION FOR HOUSING PLACEMENT: KY BoS CoC Priorities

The following represents the uniform process to be used across the community for assessing individuals, matching them to an appropriate housing intervention (Diversion, RRH, PSH), and within each category, prioritizing placement into housing. This will eliminate the need to complete multiple assessments with individuals, which is burdensome both for the person being assessed and those conducting the assessment.

The VI-SPDAT will be the ONLY tool used to assess individuals at the point of entry. The VI-SPDAT scores will be used to triage individuals into the appropriate category of intervention.

Also, please note that the Continuum of Care has developed the policy that pregnant individuals will be given the individual VI-SPDAT until which time the baby is born and then a VI-SPDAT-F, or Family VI-SPDAT, can be given to them.

HUD has released specific guidance for the prioritization of chronically homeless individuals and families, which was adopted by the Continuum of Care upon it's release is outlined in the following notice: Notice CPD 16-11: Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing. This Notice supersedes Notice CPD-14-012 and provides guidance to Continuums of Care (CoC) and recipients of Continuum of Care (CoC) Program (24 CFR part 578) funding for permanent supportive housing (PSH) regarding the order in which eligible households should be served in all CoC Program-funded PSH. This Notice reflects the new definition of chronically homeless as defined in CoC Program interim rule as amended by the Final Rule on Defining "Chronically Homeless" (herein referred to as the Definition of Chronically Homeless final rule) and updates the orders of priority that were established under the prior Notice.

The goal of this notice is to ensure that homeless individuals and families with the most severe service needs within a community are prioritized in PSH, eventually ending chronic homelessness.

As such the KY BoS CoC has established the following order of priority for individuals and families:

1.) CH (longest episodic homelessness) + Highest Acuity (most severe service needs) + Disability
2.) Highest Acuity (most severe service needs) + Longest time Homeless (Non CH) + Disability
3.) Acuity Score (not the most severe service needs)+ Homeless + Disability
4.) Exiting TH (those who were homeless prior to entry) + Disability

For individuals that score (8+) and families that score (9+) on the VI-SPDAT signals the need for **permanent supportive housing**, they will be prioritized based on the following criteria:

1. Chronic Homeless Status: The first prioritization factor is serving those with a disability with long periods of episodic homelessness and severe service needs.

2. Severe Service Needs: The second prioritization factor is serving those with a disability experiencing homelessness with severe service needs.

3. Disability: The third prioritization factor is serving those with a disability who are experiencing homelessness, but not identified as having severe service needs.

4. Transitional Housing Exit: The fourth prioritization factor is serving those who have a disability and were experiencing homeless or fleeing DV prior to TH entry.

For individuals that score 4 -7 and families scoring 4 - 8 on the VI-SPDAT, signals the need for **Rapid Re-Housing**, individuals and families will be prioritized based on the following criteria:

1. Severe Service Needs: The first prioritization factor is the highest acuity, or most severe service needs of those experiencing homelessness

2. Length of Time Homeless: The second prioritization factor is the length of time an individual or family has experienced homelessness, giving priority to the person that has experienced homelessness the longest (based on question 1 of the VI-SPDAT).

3. Date of VI-SPDAT: The third prioritization criteria will be the date of VI-SPDAT, serving those who have been on the list the longest.

In the event of "tie-breaking" among priorities, those referrals who are document-ready will be offered the available housing.

FULL SPDAT PROCESS: **Please note, providers MUST be trained by Orgcode Consulting to administer the Full SPDAT**

On occasion, to provide a safety net for individuals that are presumed to be highly vulnerable but score too low on the VI-SPDAT to qualify for PSH (ie, 7 or below), those individuals would be recommended for Full SPDAT assessment. In this situation the leadership of the Local Prioritization Committee (LPC) should be contacted for permission for the full SPDAT assessment score to be considered.

While the VI-SPDAT is a pre-screen or triage tool that looks to confirm or deny the presence of more acute issues or vulnerabilities, the Full SPDAT is an assessment tool looking at the depth or nuances of an issue and the degree to which housing may be impacted.

For those limited instances where an assessor determines that the VI-SPDAT score may warrant a more comprehensive assessment, they may elect to complete a Full SPDAT. Once the Full SPDAT has been completed, if the individual scores at least 36 or the family scores at least a 54, the Full SPDAT score may be considered along with VI- SPDAT if approved by the leadership of the LPC.

In instances where individual/families have both a Full SPDAT and VI-SPDAT assessment, whenever possible, referral for housing placement will prioritize the full SPDAT and not solely the VI-SPDAT score.

Please note, the purpose of this policy inclusion, is to provide a safety net for individuals where the tool did not reveal the full depth and/or urgency of the situation, not a side door to the process. Assessors/case managers will have to demonstrate professional judgment in this process. Those that repeatedly refer a large percentage of individuals in these situations to the LPC may be subject to additional training and/or other measures.

This process is intended to be person-centric, not program-centric (i.e., the end result will not always be PSH placement, but rather to match a highly vulnerable person to the appropriate housing resource). The only guarantee related to this process is that the individual will receive a review. Not all cases will have immediate placement. In some instances, the LPC may determine that the initial score and position on the list is correct given the severity of other cases. In other situations, the LPC may determine that a higher score is warranted, though immediate placement is still not feasible.

Full SPDAT Acuity Scale for Individuals

Intervention Recommendation	VI-SPDAT Prescreen Score for **Individuals**
Permanent Supportive Housing/Housing First	35-60
Rapid Re-Housing	20-34
Diversion	0-19

Full SPDAT Acuity Scale for Families

Intervention Recommendation	VI-SPDAT Prescreen Score for **Families**
Permanent Supportive Housing/Housing First	54-80
Rapid Re-Housing	27-53
Diversion	0-26

LOCAL PRIORTIZATION COMMITTEE (LPC) MEETINGS: Referrals for Housing Placement

Each Local Prioritization Committee (LPC) will make contact with local providers within their local homelessness housing and services system to create local prioritization groups for all homelessness and housing programs (HUD, VA, Community Mental Health, etc.). Each LPC will hold regular meetings for housing referral and placement. CoC/ESG funded programs and organizations that provide non CoC or ESG housing to those experiencing homelessness and would like to dedicate all or some of their housing vacancies to Coordinated Entry follow the process outlined below:

1. Identify if the housing is permanent supportive housing (PSH), rapid rehousing (RRH), or affordable/one-time assistance housing. All housing must be permanent.

2. The Housing Provider will follow the eligibility requirements (KHC/HUD funded CoC and ESG programs are required to use the KHC provided toolkits for their program) for each of their programs that they will be dedicating to the Coordinated Entry system and will submit paperwork documenting this eligibility requirements to the leadership for the LPC.

3. The Housing Provider will notify the leadership of the LPC when they have open and currently available housing inventory. Typically housing availability is discussed at the beginning of each LPC Meeting.

4. The Referring Agency, (the agency who administers the VI-SPDAT and adds the referral to the Prioritization List) will be responsible to ensure the referral is "**document-ready"** for housing placement. This means it is the responsibility of the Referring Agency to make sure all client eligibility documentation has been completed as soon as possible for rapid housing placement as Housing Providers have available resources.

5. The Housing Provider commits to following the processes outlined directly below for Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH).
    - Assuming client eligibility (refer to KHC Toolkits when applicable) clients are placed into permanent housing, by acuity, as rapidly as possible on a community-by-community basis.
    - The community then houses the next, most acute individual or family on the list according to HUD priorities.

6. Referrals for housing placement will be made live in LPC Meetings in person (recommended) or if in an emergency, via conference call participation or listserv participation based on the Prioritization List.

7. Upon receiving the referrals, the Housing Provider commits to working with the Referring Agency to locate the individual/family and engage with them to see if the housing referral provides a good match. The Housing Provider commits to completing necessary housing documentation needed for program entry.

8. The Housing Provider commits to communicating with the LPC when a referral does not lead to successful program entry and providing reason(s) why they were not housed so that the individual can be unassigned or reassigned to the LPC Prioritization List.

9. The Housing Provider commits to communicating with the LPC when each referral does lead to successful program entry and providing the date the individual moves into housing.

Unsuccessful Housing Placement

When a referral is unsuccessful due to reasons such as a client not willing to relocate to the area in which the housing resource is available then the client will be placed back on the LPC Prioritization List for consideration for the next most appropriate PSH resource while being housed as appropriate under the Housing First model.

Veteran Provider Referrals

LPCs will work with and make housing placement referrals to various Veteran Providers in the region. It is highly recommended that LPCs develop strong working partnerships with the Veteran Providers in their region via LPC Meetings and participation. Veteran referrals identified through the LPC Meeting should be referred to Veteran Providers for housing placement prior to being placed into CoC/ESG funded housing. If a Veteran referral is not eligible for Veteran specific housing resources, then may remain on the LPC Prioritization List for possible housing placement.

Referral Transfer from Region to Region

Considerations when an individual/family would like to transfer from one Region/LPC to the next. The individual family will be placed on the Region they want to transfer into Prioritization List via LPC leadership. This request does not automatically move them to the top of the Prioritization list for the Region they would prefer to be housed in.

PLEASE NOTE: LPC Meetings are for the purpose of housing referral and placement only. These meetings are not intended for case-conferencing, but rather must focus on making successful housing referrals and placements from the regional Prioritization List.

ASSIGN WITH CLIENT CHOICE- Housing Search & Placement

PROCESS: *When housing resources are available*, the CoC/ESG program will provide safe, affordable housing that meets participants' needs in accordance with the Coordinated Entry and system, based on acuity and eligibility. The CoC/ESG program will also provide the most barrier-free, rapid, and successful entry into housing for each eligible client, by acuity, with as few barriers to housing as possible. The CoC/ESG program will not concentrate on only the clients eligible for their specific program, but the ability of all clients in a community to access the appropriate housing.

STEPS:

1. In providing or arranging for housing, the program considers the needs of the individual or family experiencing homelessness.
2. The program provides assistance in accessing suitable housing and is guided by client choice.
3. Housing location is completed quickly, and effectively, with client participation.
4. **Programs agree to accept 3 out of 4 of every referrals from their local Prioritization List. Accountability to the housing placement process by each program will be paramount**.

Making a referral is the process by which programs, once they have prioritized their clients, place clients into housing interventions and service programs. Client choice should be at the center of any referral and placement, with the client being completely sure of the next steps of their journey from street into housing, and aware of the processes to get them there.

FOLLOW-UP AND HOUSING STABILIZATION: Housing-Focused Case Management

PROCESS: The program shall provide a continuity of services to all participants following their exit from the program. These services can be provided directly and/or through referrals to other agencies or individuals. CoC-funded PSH may provide up to six months of follow-up case management under the funded program after client exit. The program develops exit plans with the participant to ensure continued housing stability and connection with community resources, as necessary.

Your program may consider utilizing The Full SPDATs (Individual and Family) as a long term case management tool for your clients. The Full SPDAT (Individual and Family) are more intensive assessments that use many of the same dimensions as the VI-SPDAT to determine the acuity of clients. The Full SPDATs require formalized training from OrgCode – visit their site for more details. The Full SPDATs can be used primarily as an intensive ongoing case management tool. Plainly put, the VI-SPDATs are used as triage and prioritization tools, and the Full SPDATs are used after program intake to measure acuity over time in order to focus case management, and as a benefit to the community for service planning.

Use of the Full SPDATs comes into play once a client in securely established in housing, after the Prioritization List and Housing Placement phase, and right as Case Management begins in earnest.

ACCOUNTABILITY: Participation in the Coordinated Entry System

PROCESS: All CoC/ESG programs should be contributing (by making and taking referrals) to their Coordinated Entry system via the Local Prioritization Committee (LPC). **HUD programs (CoC and ESG-funded) are required to participate in the process 24 CFR Part 578.** Veterans Administration Programs (SSVF, GPD, HCHV) are also required to participate. For CoC and ESG projects, participation in Coordinated Entry will be directly tied to performance measurement and funding in the KY Balance of State Continuum of Care.

STEPS:

1. If a LPC in your region exists, providers are expected to participate (contact KHC for contacts in your community).
2. If a LPC in your region does not yet exist, HUD and VA-funded providers are expected to take responsibility for assisting the KY Balance of State Continuum of Care with the implementation in their area.

3. Every community has the ability to begin the process as all components are in KYHMIS. If an agency is utilizing the KYHMIS, then they have the ability to participate in the process, even in extremely rural areas.
4. Programs should make every effort to take as many referrals from their local Prioritization List as possible, assuming that federal and state eligibility criteria are met.
5. **If programs with open slots/available resources are not taking 3 of every 4 referrals** from their Prioritization List, justification will have to be made to the Local Prioritization Committee and to the BoS Continuum of Care if the program is CoC or ESG-funded.

The Kentucky Balance of State (BoS) Continuum of Care (CoC) Coordinated Entry Policies and Procedures have been created and approved by the CoC Advisory Board. These Policies and Procedures can be amended at any time by comment from a CoC member and/or issue of HUD notice upon review and approval from the CoC Advisory Board.

VSP Local Prioritization Inclusion Form

Kentucky Housing Corporation (KHC), the Kentucky Coalition Against Domestic Violence (KCADV), and the KY Balance of State CoC Advisory Board recognize the highly sensitive nature of information gathered from individuals experiencing domestic or intimate partner violence. These groups have worked together to develop the following protocols that ensure Victim Service Providers (VSPs) and their clients are included in the Coordinated Entry/Assessment process while adhering to the strict confidentiality requirements mandated by federal laws protecting victims of intimate partner violence.

- A statement is read to clients at the point of entry into the housing/ homeless services system in order to offer referrals to regional VSPs for individuals who may be experiencing domestic violence. (For more information on this topic please see the Kentucky Balance of State Program Standards for Coordinated Access/Entry/ Assessment located on KHC's HCA Help Desk.)
- Housing referrals from VSPs will be handled differently by regional Coordinated Assessment teams. DV clients will be given one VI-SPDAT at entry, and the assessment is completed on paper. After the VI-SPDAT is completed by VSP, a Client/Family Identifying Number should be assigned, and this form should be completed and submitted for inclusion on the local/regional prioritization list. The acuity score from the VI-SPDAT must be verified as accurate by at least two employees of the VSP.
- When the Coordinated Assessment Team determines that a VSP referral is the next appropriate match for available housing, the referring agency and housing provider will coordinate services using the time-limited Release of Information used by the VSP.

Client/Family Unique Identifying Number:_____

Is this an Individual of Family SPDAT score?:_____

Pre-Screen Total VI-SPDAT (or F-VI-SPDAT) Score:_____

Program Entry Date:_____

Is the client or head of household a (please check all that apply):

☐ **Disabled** ☐ **Chronically Homeless** ☐ **Veteran**

VSP Provider Name:_____

Employee Performing VI-SPDAT/F-VI-SPDAT Signature:_____

Employee attesting to accuracy of the VI-SPDAT/F-VI-SPDAT Pre-Screen Total Score

Signature:_____