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

Coordinated Entry Policies & Procedures v.4

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The current version of this document will be published on the Kentucky Housing Corporation (KHC) website and on the KHC Housing Contract Administration (HCA) Help Desk.

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24 CFR Part 578.7

Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act Responsibilities of the Continuum of Care (CoC)

In consultation with recipients of the Emergency Solutions Grant (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 CoC 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 (VSPs). This system must comply with any requirements established by the Department of Housing and Urban Development (HUD) by Notice.

Current Notices/Rules in Effect for KY BoS CoC CES

CPD Notice 17-01 regarding implementation of a Coordinated Entry System (CES)
CPD Notice 16-11 regarding prioritization of chronically homeless persons; supersedes 14-012 CPD Notice 14-012 regarding recordkeeping requirements
HEARTH Act Homeless Definition Final Rule
CoC Program Interim Rule
ESG Program Interim Rule
HUD Equal Access Final Rule
Coordinated Entry Policy Brief

KY BoS CoC Governance Structure

CoC Membership

Membership in the CoC shall be comprised of individuals and agencies working to end homelessness and concerned with the development and coordination of homeless assistance programs within the 118-county Kentucky Balance of State Continuum of Care (KY BoS CoC).

CoC Advisory Board

The leadership of the BoS CoC shall reside with a minimum of 12 and maximum of 15 directors. These 12–15 individuals collectively shall be known as the Advisory Board for the BoS CoC. The Advisory Board will convene at least quarterly at a date and time convenient to the majority of board members.

The directors elected will be as follows:

- Two (2) representatives from each of the six (6) geographic regions of the state for a total of twelve (12) directors.
- Three (3) members shall be nominated by a majority vote of the current Advisory Board and approved by a majority vote of the BoS CoC membership. These three (3) members must meet and serve within one of the following categories:
  - One (1) director shall be an individual who is homeless or formerly homeless;
  - One (1) director shall be from relevant subpopulations; and
  - One (1) director shall be from a non-profit/government organization representing the public interest.
- The goal of the Advisory Board is to have representation of these relevant organizations and projects serving homeless subpopulations within the geographic area, including ESG-funded agencies, persons with substance use disorders, persons with HIV/AIDS, Veterans, the chronically homeless, families with children, unaccompanied

youth, persons with serious and persistent mental illness, and victims of domestic violence.

- Two (2) non-voting Ex-officio members shall include representatives from the Homeless and Housing Coalition of Kentucky (1) and the Kentucky Coalition Against Domestic Violence (1).

CoC Collaborative Applicant

Through an annual Memorandum of Understanding, the Advisory Board designates the Collaborative Applicant to staff the CoC planning, system coordination, and application process for the geographic area. The Collaborative Applicant for the KY BoS CoC is Kentucky Housing Corporation (KHC).

CoC Coordinated Entry Committee

The Coordinated Entry Committee is a standing committee of the Advisory Board responsible for developing and implementing a coordinated assessment process for the entire CoC region, which works to meet the needs of clients from all jurisdictions in the CoC and which prioritizes local, state, and federal efforts. Each Local Prioritization Community (LPC) Lead Agency designee across the 15 regional LPCs serves on the Coordinated Entry Committee. Committee leadership must be a member of the Coordinated Entry Committee serving as a LPC Lead. When vacancy in leadership occurs, the Committee will nominate and vote on new leadership. Coordinated Entry Committee leadership will present an update of committee work at each Advisory Board meeting. KHC's CoC Systems Specialist is responsible for staffing, coordinating, and facilitating Coordinated Entry Committee meetings. The CoC Systems Specialist will serve as the liaison between the Coordinated Entry Committee, KHC, the Advisory Board, and CoC as a whole.

Geographic Area Covered by the BoS CoC

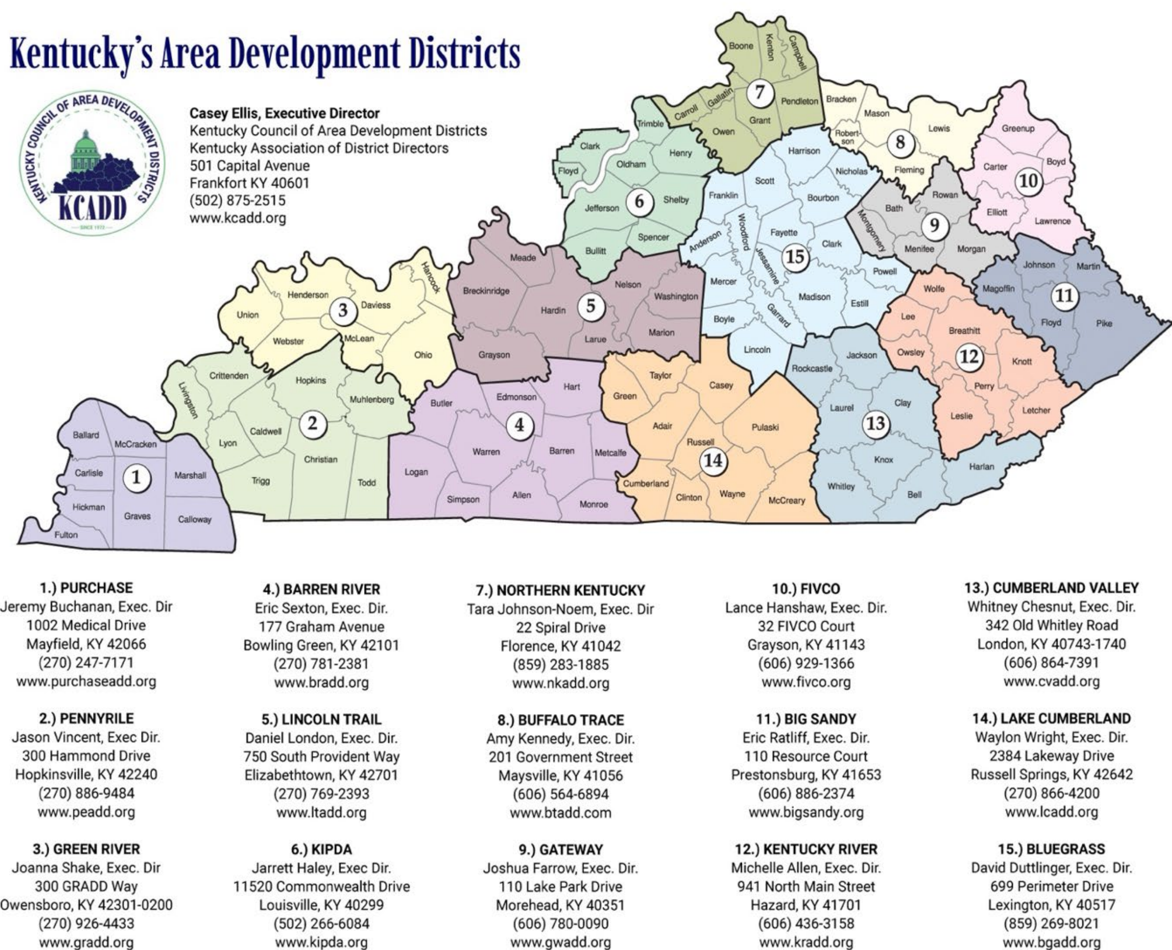

Figure 1. The BoS CoC covers 118 counties — all counties in Kentucky except for the urban areas of Lexington/Fayette County and Louisville Metro/Jefferson County. Kentucky is divided into Area Development Districts (ADD). Each LPC covers one ADD.

Local Prioritization Communities (LPCs)

LPCs participate in the CES in regions designated by the CoC. All agencies receiving CoC and/or ESG funding are required to actively participate in the LPC. LPCs are strongly encouraged to engage other key stakeholders to join the coordinated entry efforts locally. Examples of key stakeholders can include but are not limited to local health departments, local emergency management officials, local school systems, first responders, healthcare workers, local libraries, and business owners. Each LPC has a Lead Agency designee that will serve as the point person in the LPC and report its progress to the Coordinated Entry Committee by serving as a member of the committee.

LPC Lead Agencies

These agencies will serve as the point of contact for the regional LPC. They are responsible for communicating any policy changes to the regional LPC and, conversely, for reporting any issues with the LPC to the KHC CoC Systems Specialist and the Coordinated Entry Committee. Each Lead Agency will also be responsible for facilitating and assisting with Case Conferencing on an as-needed basis for specific client situations within the LPC.

CoC & ESG Project Responsibilities

Responsibilities of all CoC/ESG projects within the LPC are as follows:

- Serve as an access point to the Any Door KY Coordinated Entry System.
- Be present (virtually or face-to-face) for LPC meetings scheduled by the Lead Agency/KHC.
- Commit to solution-focused conversations prior to shelter entry; use the BoS Diversion Project in HMIS.
- If households/individuals are unable to be diverted from the homeless response system:
    - And will enter an Emergency Shelter, enter required data into the provider's specific shelter project in HMIS.
    - And will be unsheltered or living in another place not meant for human habitation, enter required data into KY BOS Coordinated Entry Project (2992) in HMIS.
- VSPs must submit Local Prioritization Inclusion to the KHC CoC Systems Specialist as people present at individual programs.
- Triage the household/individual with the appropriate assessment in the Housing Engagement Assessment within the KY BOS Coordinated Entry Project (2992).
- Gather basic eligibility documentation immediately while household/individuals are active in the Housing Engagement Assessment.
- Upload basic eligibility documentation in HMIS in order for household/individual to be added to the Coordinated Entry System Housing Actionable & Prioritization List in which housing referral occurs.
- Accept referrals for available permanent housing resources as prioritized and deemed eligible by the CoC Systems Specialist.
- Take referrals for their housing programs solely from the Coordinated Entry System Housing Actionable & Prioritization List.
- Eliminate all side doors to the CES (such as an agency waiting list for housing).
- Honor client choice in taking referrals.

CoC & ESG Project Accountability

All HUD Homeless Assistance (CoC, ESG) and Veterans Administration (VA) programs are required to participate in the

Coordinated Entry (CE) process. Participation will be measured by the KHC CoC Systems Specialist and communicated to the Coordinated Entry Committee of the BoS CoC Advisory Board. Application rounds of CoC and ESG from 2018 and on incorporate Coordinated Entry System Performance Measures in ranking and funding awarded to individual projects.

Approval & Amendment Process for the Policies and Procedures

These policies have been created by the Coordinated Entry Committee and approved by the BoS CoC Advisory Board. The Coordinated Entry Committee will review and revise the document as necessary by HUD Notice and/or at the request of the CoC Advisory Board, on an annual basis at minimum.

KY BoS CoC Values & Goals

Values

- 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
- Housing First principles, including commitment to serve people regardless of criminal background, rental history, substance abuse/use, mental illness and/or lack of income
- Innovative and diverse programming that addresses gaps in the homeless response system
- Quality programming that is consistent and accountable to the community and system as a whole through measured outcomes
- Effort to access the maximum amount of funding available to KY BoS CoC
- Commitment to serve all people who are in need of assistance regardless of age, race, color, creed, religion, sex, disability, national origin, familial status, marital status, sexual orientation, or gender identity
- Commitment to make the CES accessible to those least likely to apply for homeless assistance
- Client-driven services and client choice in housing and supports that meet their needs
- The resiliency and decision making of the clients we serve
- Program accountability to all individuals and families experiencing homelessness, specifically those who are experiencing chronic homelessness or have high-acuity
- Program compliance with current HUD rules and regulations
- System access, prioritization, and housing placement uniformity
- Adequate program staff competence and sufficient best practice training to create an environment, locally and throughout the BoS CoC, of coordination, uniformity, and speed in housing placement

Goals

- To create a system where homelessness is rare, brief, and nonrecurring
- To strive for reducing the length of time a household is homeless to 30 days or less
- To reduce the overall rate of returns to homelessness by 10% within a 12-month period
- To strive for reducing the number of households entering the homeless service system with no prior enrollments

in HMIS

Coordinated Entry

The terms Coordinated Access, Centralized Intake, Coordinated Intake, Common Assessment, and Coordinated Assessment are often used interchangeably, and mean the same thing (more or less): transitioning from a "first come, first served" standard operating procedure at the program level to a system of prioritizing highest need households first. For the purposes of implementation, the BoS CoC has chosen to refer to its system as Coordinated Entry (CE).

CE is defined as a process 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 involves a comprehensive and standardized triage tool.

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

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

- Divert people who can solve their own homelessness away from the system. (More specific information on this can be found later in this document.)
- Quickly move people from street to permanent housing.
- Create a more defined and effective role for emergency shelters and transitional housing.
- Create an environment for less time, effort, and frustration on the part of case managers through the targeting of resources.
- Use the correct housing intervention the first time for the household, particularly for chronic and high-acuity populations.
- Reduce the length of time homeless by moving people quickly to the correct housing intervention.
- Increase housing stability by targeting the appropriate intervention to corresponding needs.
- End homelessness across communities, as opposed within individual programs.

Traditionally, the system of entry and referral to housing and service supports was based on a "first come, first served" approach, and in some places, still is. But years of research and evidence-based practice has shifted the way we operate.

Table 1. Historic Practice Versus Coordinated Entry

Historic Practice is Program-Centric	Coordinated Entry 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, assessment forms, and eligibility requirements for each program	Standardized forms, assessment, and eligibility requirements
Uneven knowledge about existing programs, eligibility, and purpose in communities	Accessible information about housing and service options in the CoC

Applying CE to a community or region brings together the strength of the programs across a community. Each program realizes success in a myriad of ways:

- Programs receive eligible, actionable clients.
- Case managers can concentrate on case management.
- Communities see which additional resources they need most.
- Time, red tape, and barriers are significantly reduced.
- Community success in ending homelessness is significantly increased. Targeting limited resources as a community leads to fast and effective interactions that lead to long-term housing stability.

The KY BoS has chosen a "No Wrong Door" approach to CES implementation.

Tools

Table 2. Tools and Solutions

Tool or Concept	Specific Solutions Adopted by KY BoS CoC
Common Assessment/Triage Tool	HMIS BoS CoC Coordinated Entry Project (Engagement and Actionable & Prioritization Assessments)
Privacy protections for CE participants	Kentucky Homeless Management Information System (KYHMIS)
Adherence to HMIS Data Standards and Technical Standards	Current HMIS Data Dictionary and HMIS Data Standards Manual
KYHMIS Information and Processes	KYHMIS External Policies and Procedures
Common process for prioritizing for housing referral and placement	HMIS BoS CoC Coordinated Entry Project (Engagement and Actionable & Prioritization Lists)
Common referral mechanism across programs	KYHMIS BoS Coordinated Entry Project, LPC meetings, Basecamp platform
Common tool for on-going housing-focused case management and housing stabilization	Full SPDAT: choose tool appropriate to population
Common method to measure results of CE process	KYHMIS BoS Coordinated Entry Project reporting outputs, System Performance Measures Committee, Coordinated Entry Committee

Basecamp

Basecamp is an online communication platform established to help participating agencies in the KY BoS CoC Any Door KY CES. Each of the 15 LPCs have access to a Basecamp group. Basecamp provides a way for all the partners to communicate regarding the prioritization listing and successful (or unsuccessful) client referrals. Meeting reminders, real time prioritization, and meeting recaps are posted on this platform. LPC Leads and KHC manage the Basecamp. LPC members can find helpful links to KY BoS CoC documents, HUD guidance, and resources as it relates to CE. All

information is to be held confidential.

Basecamp is accessible to all CoC- and ESG-funded agencies in the LPC. All entities who work to end homelessness (school system, law enforcement, non-HUD funded agencies, community mental health providers, etc.) are encouraged to participate in their LPC and Basecamp.

How Does Basecamp Work?

- Everything posted on the Message Board is public to the Basecamp Group (the whole LPC).
- You will get email notification of each time someone posts in Basecamp.
- You may opt out of these notifications.
- If you respond to the email directly, it will also post publicly on Basecamp.
- LPC meeting login information and details are posted prior to each meeting.
- Do NOT post client names (use HMIS/Unique ID and/or Initials).
- Do NOT post any information that could violate the confidentiality of the client/referral.
- Do NOT post eligibility documentation to Basecamp.
- Do NOT post VSP CE Intake forms to Basecamp, please send them to the KHC CoC Systems Specialist via the secure File Share system.

Please be respectful and courteous to all Basecamp users and clients.

KYHMIS Requirements & Consent

Agencies must obtain informed consent from participating households prior to entering them into KYHMIS. For general population providers conducting the VI-SPDAT face-to-face or over the phone: complete the KY Homeless Management Information System (KYHMIS) ROI. Verbal ROI is sufficient for data collection as long as the "Verbal Consent" section is completed properly

VSPs do not include client information in any shared database (i.e. KYHMIS); however, they do submit client information to the KHC CoC Systems Specialist for inclusion into the CES, which includes completing the KYHMIS ROI. "In the event of the use of computer-generated case notes or client records," state the ZEROV Member Program Service Standards, "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."

ROIs are kept on file by the referring agency for one (1) year upon execution and must be renewed annually if the household is still receiving services.

KY BoS CES Components

Households experiencing a homelessness crisis can connect with one of the BoS CoC partners to determine if they are appropriate for CES access.

Coordinated Entry System Components

Diversion

Every person who has lost their housing and is seeking homelessness assistance should be immediately engaged in a diversion intervention/conversation, and the focus of that conversation should be on that person's housing options.

Access

- Coordinated Entry SSO Grantee
  - CE-SSO resources and staff will focus their efforts for housing navigation and street outreach for people experiencing homelessness.
- Street Outreach
  - Coordinated street outreach identifies and engages people living in unsheltered locations, such as in cars, parks, abandoned buildings, encampments, and on the streets.
- Emergency Shelter
  - Shelters can offer immediate and low-barrier access to anyone facing a housing crisis, including households who cannot be diverted as well as a safe alternative to households living in unsheltered locations.

Assessment

Households will be offered and included in the KY BoS CoC Coordinated Entry Project for possible homeless specific housing resources.

Prioritization

Households will be prioritized based on multiple factors including their current living situation, chronically homeless status, tri-morbidity, infections disease risk, and acuity.

Referral

Households will be referred to a homeless specific housing resources based on availability and priority status.

Housing

Households will work with permanent housing provider on housing search, placement, and stabilization.

Diversion

According to the National Alliance to End Homelessness:

> Diversion is a strategy that helps people experiencing a housing crisis quickly identify and access safe alternatives to emergency shelter. Diversion strategies can include: engaging in creative problem-solving conversations with clients; connecting them with community resources and family supports; providing housing search and placement services; and securing flexible financial assistance to help people resolve their immediate housing crisis.
>
> These strategies have a significant impact on a community's crisis response system, because they can reduce new entries into homelessness, cut down on shelter wait lists, decrease demand for limited shelter beds, and target more intensive homelessness interventions to those with higher needs.

Diversion is an intensive service intervention. Through an interactive problem-solving conversation with the client, staff seek to:

- understand what caused a person's housing crisis;
- explore what immediate solutions to the crisis may be possible; and
- help them pursue a solution(s).

The idea is to immediately get the client into a safe housing alternative, which may be short- or long-term. These options include:

- a negotiated return to their previous housing;

- short-term, non-shelter accommodation;
- apartments or homes, (including shared housing); and
- returns to family.

Diversion activities occur once an individual or family has legally lost their housing, but prior to shelter entry. Diversion should not be completed with a household seeking eviction-prevention assistance for a residence they legally reside in; instead, they should be connected with Homeless Prevention resources. If the client/household is facing a "love-eviction" for a residence for which they are not a legal resident, or if the client/household is unsheltered for the first time and their time unsheltered has been less than a week, follow the guidance listed in the Diversion HMIS User Guide.

Training

Staff should have training in skills like mediation, negotiation, conflict resolution, active listening, and strengths-based approaches. They should have access to flexible financial resources for things like rent arrears, transportation, utilities, and deposits. Staff also should have the ability to connect the client with community-based services (as needed).

Every person who has lost their housing and is seeking homelessness assistance should be immediately engaged in a diversion intervention/conversation, and the focus of that conversation should be on that person's housing options. However, those options are not always available or acceptable to the client. In these cases, diversion staff should be prepared to provide information on shelter options and take necessary steps to arrange shelter for the client (if it is available).

Diversion should not be a mechanism for denying access to available shelter, but rather one for finding a better alternative than shelter or the street (if possible).

Rationale

The intent of diversion is to give someone who has become homeless a positive alternative to entering an emergency shelter or being unsheltered.

Shelter can be traumatic, unhealthy, and unsafe. Some data show that people who enter shelter experience longer periods of homelessness than those who are diverted from it. No matter how well-run shelter is, clients prefer to be in housing, and housing is more likely to improve their well-being.

Likewise, being unsheltered has high risk of negative health outcomes and involvement with the criminal justice system (such as being ticketed or fined for sleeping on the streets).

Diversion is also a much more effective intervention from the perspective of homeless services systems and ending homelessness. Diversion stems the inflow into shelter; every person diverted makes a shelter bed available for someone else who needs it. It is considerably less costly, on average, than a shelter stay. Diversion avoids the emergency-related costs of unsheltered homelessness including ambulance use, sanitation, and interaction with law enforcement.

KHC understands that some shelters may struggle to know the fundamentals of diversion. We strongly encourage shelter providers to read and watch the materials included in the NAEH'S The Role of Emergency Shelter in Diversion to better understand these fundamentals.

Resources

Progressive Engagement and Coordinated Entry: Thoughts from OrgCode
The Three Cs of Diversion
What's the Role of Emergency Shelter in Diversion?
Prevention, Diversion, and Rapid Exit
Adopting Housing Problem-Solving Approaches with Prevention, Diversion, and Rapid Exit Strategies

Access

Agencies that have been awarded Coordinated Entry Supportive Services Only (CE-SSO) grants are to use these funds in accordance with KHC's 2017 CE SSO NOFA and HUD's 2021 NOFA. Projects must be designed in accordance with the applicable requirements and allowable activities for CoC SSO projects as authorized in 24 CFR 578.

KHC's facilitation of the CE referral process frees up current CE-SSO resources for housing navigation and street outreach efforts and moves CE-SSO grantees away from burdensome administrative work to provide more time and funds for direct client services.

All CE-SSO recipients are required to enter all clients they assist into their specific KYHMIS SSO project.

Below are examples of how these funds may be used. This list is only meant to serve as a sample and is not necessarily exhaustive.

- Coordinating the connection of persons to the appropriate and available housing and service intervention
- Conducting CE Intakes for participants being served by emergency shelters or service providers not participating in HMIS
- Entering CE information and other client-level information into HMIS for inclusion on the prioritization list
- Conducting Street Outreach to participants not otherwise accessing the coordinated entry system
- Working with service providers to obtain third party verification of participants' chronically homeless status or other necessary information to move people quickly into permanent housing
- Developing and distributing promotional materials to publicize the availability of and access to coordinated entry
- Participating in meetings relative to case coordination to move people into permanent housing
- Facilitating the sharing of information between the referring agency and housing provider to move people as quickly as possible into permanent housing

Street Outreach

Coordinated Street Outreach that identifies and engages people living in unsheltered locations, such as in cars, parks, abandoned buildings, encampments, and on the streets plays critical roles within systems for ending homelessness. Effective street outreach reaches people who might not otherwise seek assistance or come to the attention of the homelessness service system and ensures that people's basic needs are met while supporting them along pathways toward housing stability. Street Outreach may be funded through ESG funds or other funds designated specifically for providing services to people living in unsheltered locations.

All Street Outreach recipients are required to enter all clients they assist into their specific KYHMIS SO project.

Resources

Transgender Homeless Adults & Unsheltered Homelessness: What the Data Tell Us
Exploring the Crisis of Unsheltered Homelessness
Core Elements of Effective Street Outreach to People Experiencing Homelessness

Emergency Shelter

Emergency Shelter Best Practices

If a household cannot be diverted from the shelter system and will be admitted to shelter with a pre-determined housing plan, staff will then complete their specific shelter project entry. Emergency shelters play a critical role in ending homelessness. Effective shelters should embrace a Housing First approach, operating as a process to obtain permanent housing. Shelters should offer immediate and low-barrier access to anyone facing a housing crisis, and measure shelter performance in order to improve results.

The Emergency Shelter Learning Series is a collection of webinars and resources from the NAEH focused on explaining the philosophy and practice of effective emergency shelter. KHC strongly encourages shelter providers to read and watch these materials, and to put these best practices in place within their shelter systems.

If the household cannot be diverted from the shelter system and will be admitted to shelter with a pre-determined housing plan, staff will then complete their specific shelter project entry.

Victim Service Provider (VSP) Access

ZEROV and partner VSP agencies will provide KY BoS CES information and obtain informed consent to survivors seeking mainstream housing referrals in the CES. Once consent is obtained, the VSPs as the trained trauma-informed care experts will complete the BoS-Coordinated Entry Assessment with clients.

VSPs will use the 2024 Intake Form-VSP CE Intake Form along with applicable toolkit forms and will submit to the CoC Systems Specialist via KHC's Secure File Share System. CoC Systems Specialist will add the client information to the BoS CoC Coordinated Entry Project. The client's information will be visible within HMIS. Client will be noted as a DV survivor for DV specific housing resources, but their location, and VSP they are working with will be kept on a separate spreadsheet only accessible by the CoC Systems Specialist.

If consent is not obtained from the survivor to be entered into KYHMIS, The CoC Systems Specialist will follow the same data entry process and will request the client's profile be locked down in KYHMIS so other users are unable to locate the profile.

VSPs can find specific guidance for the Coordinated Entry System Process for their clients in the VSP Inclusion Process User Guide.

Other BoS CoC Partners

Any other BoS CoC Partner, regardless of whether they are funded by HUD or KHC, can also provide access to the BoS CoC CES for people experiencing homelessness. This can include but is not limited to:

- Community Mental Health Organizations
- Non-HUD/KHC funded Emergency Shelter or Street Outreach
- Housing Advocacy Organizations
- School/School Systems
- Health Care Organizations
- Permanent Housing Organizations

For more information about how your organization can provide access to CES for people experiencing homelessness, please submit a ticket to KHC's HCA Partner Agency Portal.

Resources

Key Considerations for Implementing Emergency Shelter Within an Effective Crisis Response System
Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation

Assessment

The CE assessment process is for people experiencing Category 1 or 4 of the HEARTH homeless definition (experiencing homelessness on the street or in shelter or fleeing/attempting to flee domestic violence, dating violence, sexual assault and/or stalking). Categories 2 and 3 are not eligible. For specific guidance on the CE assessment process, follow the guidance listed in the CE HMIS User Guide

Additionally, every client/household within the BoS CE project will require an Interim Update at least every 90 days to update their living situation, length of time homeless, and any other client information that has changed since the initial entry. More information about how to complete the interim updates can be found in the CE HMIS User Guide.

CE Annual Performance Report Requirements

The purpose of this policy is to ensure that all partners within the LPCs adhere to standardized procedures for collecting

Personally Identifiable Information (PII) and CE-specific data on all applicable household members participating in CE assessments. This policy is essential for accurate reporting in the CE Annual Performance Report (APR) as required by HUD.

This policy applies to all organizations and partners involved in conducting CE assessments within the BoS.

By collecting and reporting this information as specified below, organizations can meet the reporting requirements set forth by HUD for the CE APR, which is crucial for evaluating the effectiveness and impact of homelessness assistance programs.

All partners conducting CE assessments must collect the following PII for each household member:

- Name
- Social Security Number (SSN)
- Date of Birth
- Race and Ethnicity
- Gender
- Veteran Status

In addition to PII, partners must collect CE-specific information for only the Head of Household:

- Assessment Type (Coordinated Entry Assessment)
- Prioritization Status (Coordinated Entry Assessment)
- Access Events (Coordinated Entry Event—located on the interim or exit assessments)
- Referral Events (Coordinated Entry Event—located on the interim or exit assessments)

Data can be collected on all household members by using the Data Collection Forms for Coordinated Entry on the HCA Partner Agency Portal.

Inactive Households

Referring agencies shall strive to maintain regular contact with households placed on the Housing Engagement and Coordinated Entry System Housing Actionable & Prioritization Lists for documentation and referral updates. When a referring agency is unable to contact the household for 90 consecutive calendar days, the referring agency is responsible for exiting the client from the BoS CoC CE project, or they can contact the CoC Systems Specialist who will exit the client from the BoS CoC CE project.

Prioritization

KY BoS CoC Order of Priority

In accordance with CPD Notice 16-11 and the BoS CoC Interim Guidance for CE Prioritization during the COVID-19 Emergency along with CDC Guidance the BoS CoC has established the following order of priority for homeless assistance:

Priority 1: Unsheltered, CH, Trimorbid, and High Acuity

- Unsheltered + CH + Tri-morbid + Infectious Disease High Risk + Acuity 8/9+ (I/F) = 1.0
- Unsheltered + CH + Tri-morbid + Infectious Disease Medium Risk + Acuity 8/9+ (I/F) = 1.1
- Unsheltered + CH + Tri-morbid + Infectious Disease Low Risk+ Acuity 8/9+ (I/F) = 1.2

Priority 2: Sheltered, CH, Trimorbid, and High Acuity

- Sheltered + CH + Tri-morbid + Infectious Disease High Risk + Acuity 8/9+ (I/F) = 2.0

- Sheltered + CH + Tri-morbid + Infectious Disease Medium Risk + Acuity 8/9+ (I/F) = 2.1
- Sheltered + CH + Tri-morbid + Infectious Disease Low Risk+ Acuity 8/9+ (I/F) = 2.2

Priority 3: Unsheltered and High Acuity

- Unsheltered + CH + Infectious Disease High Risk+ Acuity 8/9+ (I/F) = 3
- Unsheltered + CH + Infectious Disease Medium Risk+ Acuity 8/9+ (I/F) = 3.1
- Unsheltered + CH + Infectious Disease low Risk+ Acuity 8/9+ (I/F) = 3.2
- Unsheltered+ Not CH + 1+ years of homelessness + Infectious Disease High Risk + Acuity 8/9+ (I/F) = 3.3
- Unsheltered+ Not CH + 1+ years of homelessness + Infectious Disease Medium Risk + Acuity 8/9+ (I/F) = 3.4
- Unsheltered+ Not CH + 1+ years of homelessness + Infectious Disease Low Risk + Acuity 8/9+ (I/F) = 3.5
- Unsheltered+ Not CH + 1 day-11 months of homelessness + Infectious Disease High + Acuity 8/9+ (I/F) = 3.6
- Unsheltered+ Not CH + 1 day-11 months of homelessness + Infectious Disease Medium + Acuity 8/9+ (I/F) = 3.7
- Unsheltered+ Not CH + 1 day-11 months of homelessness + Infectious Disease Low + Acuity 8/9+ (I/F) = 3.8

Priority 4: Sheltered and High Acuity

- Sheltered + CH + Infectious Disease High Risk+ Acuity 8/9+ (I/F) = 4
- Sheltered + CH + Infectious Disease Medium Risk+ Acuity 8/9+ (I/F) = 4.1
- Sheltered + CH + Infectious Disease low Risk+ Acuity 8/9+ (I/F) = 4.2
- Sheltered + Not CH + 1+ years of homelessness + Infectious Disease High Risk + Acuity 8/9+ (I/F) = 4.3
- Sheltered + Not CH + 1+ years of homelessness + Infectious Disease Medium Risk + Acuity 8/9+ (I/F) = 4.4
- Sheltered + Not CH + 1+ years of homelessness + Infectious Disease Low Risk + Acuity 8/9+ (I/F) = 4.5
- Sheltered + Not CH + 1 day-11 months of homelessness + Infectious Disease High Risk + Acuity 8/9+ (I/F) = 4.6
- Sheltered + Not CH + 1 day-11 months of homelessness + Infectious Disease Medium Risk + Acuity 8/9+ (I/F) = 4.7
- Sheltered + Not CH + 1 day-11 months of homelessness + Infectious Disease Low Risk + Acuity 8/9+ (I/F) = 4.8

Priority 5: Unsheltered and Low Acuity

- Unsheltered + CH + Infectious Disease High Risk + Acuity 4-7/8 (I/F) = 5.0
- Unsheltered + CH + Infectious Disease Medium Risk + Acuity 4-7/8 (I/F) = 5.1
- Unsheltered + CH + Infectious Disease Low Risk + Acuity 4-7/8 (I/F) = 5.2
- Unsheltered + Not CH + 1+ years of homelessness + Infectious Disease High Risk + Acuity 4-7/8 (I/F) = 5.3
- Unsheltered + Not CH + 1+ years of homelessness + Infectious Disease Medium Risk + Acuity 4-7/8 (I/F) = 5.4
- Unsheltered + Not CH + 1+ years of homelessness + Infectious Disease Low Risk + Acuity 4-7/8 (I/F) = 5.5
- Unsheltered + Not CH + 1 day-11 months of homelessness + Infectious Disease High Risk + Acuity 4-7/8 (I/F) = 5.6
- Unsheltered + Not CH + 1 day-11 months of homelessness + Infectious Disease Medium Risk + Acuity 4-7/8 (I/F) = 5.7
- Unsheltered + Not CH + 1 day-11 months of homelessness + Infectious Disease Low Risk + Acuity 4-7/8 (I/F) = 5.8

Priority 6: Sheltered and Low Acuity

- Sheltered + CH + Infectious Disease High-Risk + Acuity 4-7/8 (I/F) = 6.0
- Sheltered + CH + Infectious Disease Medium-Risk + Acuity 4-7/8 (I/F) = 6.1
- Sheltered + CH + Infectious Disease Low-Risk + Acuity 4-7/8 (I/F) = 6.2
- Sheltered + Not CH + 1+ years of homelessness + Infectious Disease High-Risk + Acuity 4-7/8 (I/F) = 6.3
- Sheltered + Not CH + 1+ years of homelessness + Infectious Disease Medium-Risk + Acuity 4-7/8 (I/F) = 6.4
- Sheltered + Not CH + 1+ years of homelessness + Infectious Disease Low-Risk + Acuity 4-7/8 (I/F) = 6.5
- Sheltered + Not CH + 1 day-11 months of homelessness + Infectious Disease High-Risk + Acuity 4-7/8 (I/F) = 6.6
- Sheltered + Not CH + 1 day-11 months of homelessness + Infectious Disease Medium-Risk + Acuity 4-7/8 (I/F) = 6.7
- Sheltered + Not CH + 1 day-11 months of homelessness + Infectious Disease Low-Risk + Acuity 4-7/8 (I/F) = 6.8

VISPDAT Scores <4 =7.0

KHC has issued guidance for serving high acuity households with Rapid Re-housing. That guidance can be found here (Appendix B).

Infections Disease Risk Factors Criteria

Taking into consideration information from the CDC and KHC's interim guidance, the following criteria have been established to determine if a household is considered potentially High, Medium, or Low risk for Infectious Diseases based on both Living Situation Criteria and Medical Factors Criteria as it pertains to CE Prioritization:

- High Risk = 1+ Medical Factors + High Risk Living Situation

- High Risk = 1+ Medical Factors + Medium Risk Living Situation
- Medium Risk = 1+ Medical Factors +Low Risk Living Situation
- Medium Risk = No Medical Factors + High Risk Living Situation
- Low Risk = No Medical Factors + Medium Risk Living Situation
- Low Risk = No Medical Factors + Low Risk Living Situation

Medical Factors Criteria

- Pregnant or breastfeeding women
- Individuals ages 55+
- One of the following pre-existing health conditions:
- Chronic lung disease or moderate to severe asthma
- Serious heart conditions (expected to be of long-continued and indefinite duration, and significantly inhibits ability of the individual to live independently)
- Conditions that can cause a person to be immunocompromised, including cancer treatment, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, and prolonged use of corticosteroids and other immune weakening medications
- Severe obesity (body mass index [BMI] of 40 or higher)
- Diabetes
- Chronic kidney disease and those who are undergoing dialysis
- Liver disease

Living Situations Criteria

- Individuals/Households sleeping outdoors or in other places not meant for regular human habitation in close proximity (less than six feet apart) to others not in the same household without regular access to hygiene facilities where frequent handwashing is possible. (Potentially High-Risk)
- Individuals/Households sleeping in emergency shelters where appropriate social distancing and isolation is not possible (e.g., sharing bedrooms or congregate sleeping spaces with people from other households where sleeping/general presence cannot consistently be six feet apart.) (Potentially High-Risk)
- Individuals/Households sleeping in emergency shelters where appropriate social distancing is being practiced for sleeping (e.g., individuals/households share separate sleeping areas from other households or where sleeping is at least six feet apart from others), but bathing/hand-washing facilities and common areas are shared with other people not in the same household. (Potentially Medium-Risk)
- Individuals/Households sleeping outdoors or in other places not meant for regular human habitation, but not in close proximity to others not in the same household yet still without regular access to hygiene facilities where frequent handwashing is possible. (Potentially Medium-Risk)
- Individuals/Households sleeping in emergency shelters where appropriate social distancing is being practiced

(e.g., individuals/households share separate sleeping areas from other households such as a separate bedroom with doors and bathing/handwashing facilities are separate from others not in the same household). This includes staying in hotel/motels or in other alternative locations arranged by the shelter. (Potentially Lower-Risk)

The KHC CoC Systems Specialist will maintain the Housing Engagement and Coordinated Entry System Housing Actionable & Prioritization Lists of people assessed within the geographic area, as well as across the BoS. The KHC CoC Systems Specialist will facilitate the CE meetings in partnership with LPC Leads with each LPC. As CoC/ESG permanent housing providers have available resources, they will request referrals during the LPC meetings, and the KHC CoC Systems Specialist will provide those referrals and will follow up on active referrals as needed. Referrals can also be requested in-between the LPC meetings via Basecamp.

Referrals will ONLY be made from the Coordinated Entry System Housing Actionable & Prioritization List in the order of priority, meaning clients are required to be “document ready” before they are able to receive a referral to an appropriate permanent housing resource. This is to ensure clients are housed quickly and efficiently as possible through the CES.

Responsibilities of the referring agency adding client to the Coordinated Entry System Housing Actionable & Prioritization List are as follows:

- Be present (virtually or face-to-face) for LPC meetings scheduled by the Lead Agency/KHC.
- Gather basic eligibility documentation immediately while household/individuals are active in the Housing Engagement Assessment.
- Upload basic eligibility documentation in HMIS in order for household/individual to be added to the Coordinated Entry System Housing Actionable & Prioritization List in which housing referral occurs.
- Continue regular communication and service provision with all individuals and households entered into CES throughout the entirety of the KY BoS CE Process from initial tirage to housing program hand-off. Eliminate all side doors to the CES (such as an agency waiting list for housing).
- Work with agency accepting the referral to assist with completing/submitting eligibility documentation and program applications as needed.

Responsibilities of the agency accepting the referral from the Coordinated Entry System Housing Actionable & Prioritization List are as follows:

- Work with referring agency to ensure eligibility is documented.
- Eliminate barriers to participation in the agency’s permanent housing program. This includes not requiring:
    - Income
    - Rental history
    - Criminal background
    - Sex offender status
        - Programs may disqualify registered sex offenders from the program if the housing location will place the client in violation of KRS 17.545, which prohibits registered sex offenders from living within 1000 feet of a school, publicly owned playground, or childcare facility.
- Provide or arrange for the provision of housing-focused case management and voluntary supportive services.
- Accept referrals for available permanent housing resources as prioritized and deemed eligible by the CoC Systems Specialist.

- Take referrals for their housing programs solely from the Coordinated Entry System Housing Actionable & Prioritization List.

Referrals

The KHC CoC Systems Specialist will make housing placement referrals to various providers in the community through the LPC Meeting. Veteran referrals identified will be referred to Veteran providers prior to being offered CoC/ESG housing resources. If a Veteran referral is not eligible for the resource due to program eligibility requirements, then the household will remain on the Coordinated Entry System Housing Actionable & Prioritization List for the next available resource.

KHC has determined that if a client in the CES has the means available to remain housed on their own without financial assistance, but still require move in assistance (security deposit, first month's rent etc.), providers are able to submit the CES Move In Assistance Form to the CoC Systems Specialist for approval. This form allows providers to skip the prioritization criteria in order to provide move in assistance with CoC/ESG/ERA funds for households only needing the up-front assistance.

Referral Results

Based on the KYHMIS Data Standards, the agency accepting the referral will follow the below guidelines when determining whether to consider the referral "Successful" or "Unsuccessful."

Successful Referral: Client Accepted

If a client was referred to an opening in a continuum crisis housing or permanent housing project, subsequent follow-up with the client or provider indicates the client was accepted into the project opening.

Unsuccessful Referral: Client Rejected

If a client was referred to an opening in a continuum crisis housing or permanent housing project, subsequent follow-up with the client or provider indicates the client decided to reject the referral to the project.

Unsuccessful Referral: Provider Rejected

If a client was referred to an opening in a continuum crisis housing or permanent housing project, subsequent follow-up with the client or provider indicates the client referral was rejected by the provider. A provider, after meeting with a client and reviewing eligibility for a project, may reject the referral. Or a provider may reject a client referral if the client failed to respond to the provider requests for eligibility information or otherwise failed to follow through with the requirements of the referral.

Housing

Client Choice in Housing Search & Placement

When housing resources are available, the project will provide safe, affordable housing that meets participants' needs in accordance with CE values and based on acuity and eligibility. Both referring and receiving agencies will work with clients to honor client choice in location and type of assistance:

- In providing or arranging for housing, the project considers the needs of the household experiencing homelessness.

- The project receiving the referral provides assistance in accessing suitable housing, guided by client choice.

- Projects agree to accept three (3) out of every four (4) referrals made through the LPC Prioritization List. The KHC CoC Systems Specialist will monitor this and report noncompliance to the Coordinated Entry Committee of the BoS CoC.

Housing Stabilization

The CE process shall provide a continuity of Housing-Focused services to all participants once housed and their subsequent exit from the Coordinated Entry System Housing Actionable & Prioritization List. These services may be provided by the housing provider or through partnerships with other agencies. KHC strongly encourages providers to use the Full SPDAT as a long-term case management tool (once staff have been trained by OrgCode or KHC staff) for participants housed through the CE process. Providers may wish to use additional Housing Stabilization case management

tools made available by [OrgCode](#) in tandem with the Full SPDAT and housing retention plan. Additionally, when clients are ready to exit CoC- or ESG-funded projects, the provider may continue to provide follow-up case management services based on the following regulations:

- For ESG RRH programs, housing stability case management assistance may not exceed 30 days during the period in which the program participant is seeking permanent housing and may not exceed 24 months during the period in which the program participant is living in permanent housing. ESG 576.105(b)(2)

- For CoC RRH programs, case managers can provide services for six (6) months after exit from the CoC RRH Program. Services may also be provided to former residents of transitional housing and current residents of permanent housing who were homeless in the prior six (6) months, for no more than six (6) months after leaving transitional housing or homelessness, respectively, to assist their adjustment to independent living. 24 CFR 578.53(3)

Full SPDAT for Case Management

To provide a comprehensive, evidence-based case management service to households that have been permanently housed through the CES, housing providers are encouraged to use the Full SPDAT. The Full SPDAT in intended to be used from assessment at program intake through to the time of program exit, informing support services and allowing for the measurement of changes in acuity over time.

Once providers have been trained by either OrgCode or KHC staff to use the Full SPDAT, the KHC Data Team can add the tab labeled "Measurements" in KYHMIS; this is where the Full SPDAT can be documented in KYHMIS.

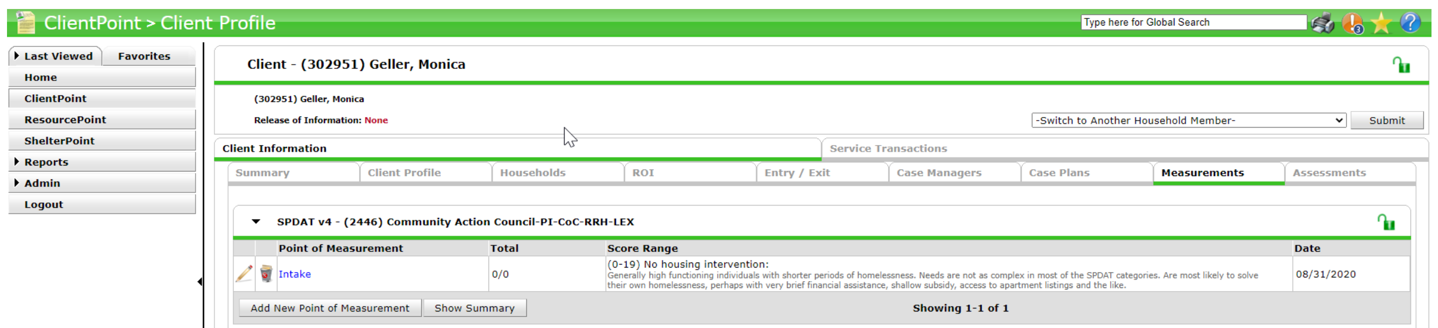

Figure 2. A screenshot of KYHMIS with the Measurements tab open.

The recommended increments of administration of the Full SPDAT are as follows:

- Intake
- Move In
- 30 days after move-in
- 60 days after move-in
- 90 days after move-in
- 180 days after move-in
- 270 days after move-in
- 365 days after move-in
- Every 90 days after 1 year
- Other appropriate time frames

- Any time after a rehousing, even if household did not return to homelessness
- When a significant life change has happened (new household member, loss of a household member, returns to homelessness etc.)

Unsuccessful Housing Referral or Placement

Housing providers accepting referrals from CES are required to make multiple attempts at contacting the client, with assistance from the referring housing provider if needed. It is the expectation that agencies remain in regular contact with each household connected to the CES to avoid unsuccessful referrals. If after two calendar weeks of attempted contacts the client is unable to be located or contacted, the housing provider accepting the referral should notify the KHC CoC Systems Specialist. The referral will be made inactive, and the client can remain on the Coordinated Entry System Housing Actionable & Prioritization List for consideration for the next available resource, assuming they have not reached 90 days of inactivity.

When a household refuses the housing resource offered (i.e. does not want to relocate or does not want to work with the housing provider), the housing provider will contact the CoC Systems Specialist. The household will be placed back onto the Coordinated Entry System Housing Actionable & Prioritization List for consideration for the next available resource. The household may reject up to three (3) housing referrals before being exited from the BOS-CE Project (2992). The referring agency may consider providing counseling to the household on a voluntary basis to increase chances of successful housing placement.

Permanent Housing Interventions

Table 3. Permanent Housing Projects

Permanent Supportive Housing (PSH)	Rapid Re-Housing (RRH)	Joint TH-RRH
Long-term assistance based on client-need	Short-Medium-term assistance (up to 24 months)	Combination of Temporary/Short-Medium-term assistance
• Chronically homeless (CH) • High-acuity • Documented disability • Supportive services offered	• Mid-acuity • Can be used to house high-acuity households when PSH is not available • Considered a homeless episode for the purposes of documenting CH status	• Mid-acuity • Can be used to house high-acuity households when PSH is not available • Considered a homeless episode for the purposes of documenting CH status • Provides up to 24 months of assistance total for TH and RRH

Permanent Supportive Housing

According to the National Alliance to End Homelessness:

> Permanent supportive housing is an intervention that combines affordable housing assistance with voluntary support services to address the needs of chronically homeless people. The services are designed to build independent living and tenancy skills and connect people with community-based health care, treatment and employment services.

Housing Providers are required to use a Housing First approach in all of their ESG/CoC funded projects. However, this is

especially important for households in PSH.

PSH Resources

Housing First in Permanent Supportive Housing
Using Medicaid to Pay for Services in PSH

Rapid Re-Housing

According to the National Alliance to End Homelessness:

> Rapid re-housing is an intervention designed to help individuals and families quickly exit homelessness, return to housing in the community, and not become homeless again in the near term.

The core components of RRH are:

- Housing identification
- Move-in and rent assistance
- Rapid re-housing case management and services

These core components represent the minimum that a program must provide to be considered a rapid re-housing program, but do not fully describe what constitutes an effective rapid re-housing program.

RRH Resources

Rapid Re-Housing Performance Benchmarks and Program Standards
Rapid Re-Housing Performance Evaluation and Improvement Webinar
Rapid Re-Housing Toolkit
Rapid Re-Housing for Youth Toolkit

Joint Transitional Housing-Rapid Re-Housing

According to HUD:

> A Joint transitional housing (TH) and rapid re-housing (PH-RRH) component project is a new project type in the FY 2017 CoC Program Competition that includes two existing program components–TH and PH-RRH–into a single project to serve individuals and families experiencing homelessness.

The joint component combines transitional housing and rapid re-housing into a single project. CoCs can consider reallocating current renewal projects to a project that, for the first time, can serve people in temporary housing and provide those same participants with a permanent housing exit paid for with rapid re-housing dollars.

While the joint component provides low-barrier and safe place for individual and families experiencing homelessness to stay temporarily, it is not CoC funding for more emergency shelter beds. Think of it as crisis housing coupled with financial assistance and services. Those services should be determined by participants and focused on moving people quickly to permanent housing.

Joint TH-RRH Resources

The Scoop on the Transitional Housing-Rapid Re-Housing Joint Component
Joint TH-RRH Component Projects
Are there time limits on the TH or PH-RRH portions of the Joint TH and PH-RRH component project?
The Joint Component Is for Homeless Youth, Too!

Emergency Housing Vouchers (EHV)

The KHC Emergency Housing Voucher (EHV) program is available through the American Rescue Plan Act (ARPA). The EHV program is a specialized Housing Choice Voucher (HCV) resource that targets the homeless population to select local Public Housing Authorities (PHAs), in this case, KHC, in order to assist households who are eligible obtain and maintain long term housing stability. The goal of the EHV program is to help households locate or sustain ongoing rental

housing and provides financial assistance to make their rent affordable. The EHV program is a permanent housing option that is currently funded through September 2030. HCA's Homeless Programs Team serves as the KY BoS CE referral source for this program, while KHC's HCV team serves as the EHV administrator (as they do for their other HCV programs).

Table 4. EHV Prioritization Criteria

Bracket	EHV Eligibility Category	Order of Priority
Tier 1	Recently Homeless	Rapid Rehousing (RRH) participants whose assistance will end within the next six (6) months and who face a return to homelessness or have a high-risk of housing instability without continued housing assistance.
		Rapid Rehousing (RRH) participants whose rental assistance will end in more than six (6) months and who face a return to homelessness or have a high-risk of housing instability without continued housing assistance.
Tier 2	Homeless—HUD Definition Category 1 (Literal Homelessness)	Coordinated Entry System (CES) Actionable List Based on Acuity/Severity of Needs: Living in a place not meant for regular human habitation, or in a publicly or privately operated sheltered designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels/motels paid for by a charitable or governmental organizations), or exiting an institution for 90 days or less who resided in an emergency shelter or place not meant for human habitation immediately before entering the institution.
Tier 3	Recently Homeless	Permanent Supportive Housing (PSH) participants with 62+ years of age head of household who qualifies for CoC's Moving On Program* and who face a return to homelessness or have a high-risk of housing instability without continued housing assistance.
		Emergency Solutions Grant (ESG) Prevention Program active participants with AMI of 30% or below who face a return to homelessness or have a high-risk of housing instability without continued housing assistance.
		HOME Tenant-Based Rental Assistance (TBRA) participants with AMI of 30% or below whose living situation prior to program entry was homeless who face a return to homelessness or have a high-risk of housing instability without continued housing assistance.
Tier 4	Homeless—HUD Definition Category 2 (Imminent Risk)	Will physically lose housing in 14 days or less, no subsequent housing has been identified, and household lacks resources and support network to prevent a move into shelter or another location identified in Category 1 of the HUD Homeless Definition.
Tier 5	At-Risk of Homelessness	At or below 30% AMI income and meets one of the other criteria for HUD "At-Risk" definition.
Tier 6	All eligible EHV categories	All other EHV-eligible households not meeting priority populations above.

A detailed description of the qualifying categories for EHV eligibility is outlined in Section 8 of Notice 2021-15 ("EHV Notice") and is based, in part, on the HUD Homeless Definition categories codified in the CoC Program regulations at 24 CFR 578.3 (At-risk of Homelessness; Category 1: Literal Homelessness; Category 2: Imminent Risk, Category 3: Unaccompanied youth under 25 years of age or families with children who do not otherwise qualify as homeless under the HUD homeless definition but who are defined as homeless under other federal regulations and meet the other requirements of Category 3; and 4) Fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, and human trafficking.

People who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or human trafficking can fall into any of the Tiers listed above. With consent of the person fleeing/attempting to flee, the person should be connected with a Victim Service Provider (VSP) so that an appropriate safety plan can be established.

RRH is a time-limited tenant-based rental assistance program for people who were experiencing literal homelessness (HUD Category 1 and/or HUD Category 4) upon program entry.

PSH provides housing assistance, most often in community-based apartments, for people with disabilities who were experiencing literal homelessness at program entry. PSH prioritizes people who are chronically homeless.

HOME Tenant Based Rental Assistance (TBRA) provides community-based rental assistance. While homelessness is not a required admission criterion under federal regulations for the HOME TBRA program, many TBRA programs target people who were experiencing literal homelessness at the time of program entry.

*The KY BoS CoC Moving On Program assists people currently being served in PSH and need ongoing housing assistance, but who no longer need the level of supportive services provided by that program, "move on" to a HCV. The Moving On Program is designed to keep the person stably and permanently housed but frees up the extremely limited PSH resources for other people experiencing chronic homelessness who need intensive supportive services.

Housing Stability Vouchers (HSV)

KHC was awarded a limited number of specialized rental assistance vouchers called Stability Vouchers (SV) for the KY BoS CoC. These vouchers operate just like a HCV except referrals made to the administering PHA (in this case KHC) must come through the CoC's CES and eligibility criteria requires people to meet one of the below situations:

- Homeless
- At-risk of homelessness
- Fleeing or attempting to flee domestic violence, dating violence, stalking and/or sexual assault
- Veterans and families that include a veteran that meet one of the preceding criteria

The goal of the SV program is to help households quickly locate or sustain ongoing rental housing and provides financial assistance to make their rent affordable, particularly when other resources such as PSH or RRH are not available or sufficient. HCA's Homeless Programs team serves as the KY BoS CE referral source for this program, while KHC's HCV team serves as the SV administrator (as they do for the EHV, Mainstream and other HCV programs).

Table 5. HSV Prioritization Criteria

Bracket	SV Eligibility Category	Order of Priority
Tier 1	Homeless-HUD Definition Category 1 (Literal Homelessness)	Unsheltered Homeless: Coordinated Entry System (CES) Actionable List Based on Acuity/Severity of Needs: Living in a place not meant for regular human habitation
		Sheltered Homeless: Coordinated Entry System (CES) Actionable List Based on Acuity/Severity of Needs: Living in a publicly or privately

		operated sheltered designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels/motels paid for by a charitable or governmental organizations), or exiting an institution for 90 days or less who resided in an emergency shelter or place not meant for human habitation immediately before entering the institution.
Tier 2	All eligible SV categories	All other SV-eligible households not meeting priority populations above.

A detailed description of the qualifying categories for SV eligibility is outlined in Section 8 of Notice PIH 2022-24 (HA) ("SV Notice") and is based, in part, on the HUD Homeless Definition categories codified in the Continuum of Care Program regulations at 24 CFR 578.3 (At-risk of Homelessness; Category 1: Literal Homelessness; Category 2: Imminent Risk, Category 3: Unaccompanied youth under 25 years of age or families with children who do not otherwise qualify as homeless under the HUD homeless definition but who are defined as homeless under other federal regulations and meet the other requirements of Category 3; and 4) Fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, and human trafficking.

People who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or human trafficking can fall into any of the Tiers listed above. With consent of the person fleeing/attempting to flee, the person should be connected with a VSP so that an appropriate safety plan can be established.

Veterans and their families can fall into any of the tiers listed above.

Non-Discrimination in the CE Process

All recipients of Federal and state funds are required to comply with applicable civil rights and fair housing laws and requirements. Recipients and subrecipients of CoC Program and ESG Program Funding must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws as specified at 24 CFR 5.15(a), including, but not limited to, the following:

- Fair Housing Act
  - prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status.
- Section 504 of the Rehabilitation Act
  - prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance.
- Title VI of the Civil Rights Act
  - prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance.
- Title II of the Americans with Disabilities Act
  - prohibits public entities, which includes state and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance. Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.
- HUD's Equal Access Rule

- at 24 CFR 5.105(a)(2) prohibits discriminatory eligibility.

- determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC Program, ESG Program, and HOPWA Program. The CoC Program interim rule also contains a fair housing provision at 24 CFR 578.93. For ESG, see 24 CFR 576.407(a) and (b), and for HOPWA, see 24 CFR 574.603.

Grievance Protocol

This protocol covers referral/system utilizer grievances regarding the CES only. If a referral has a grievance regarding an agency or representative of that agency, they should follow that agency's grievance procedure. The provider completing the VI-SPDAT should address any complaints by referrals as best as they can in the moment. Ideally, the person and the provider will try to work out the problem directly as a first step in the process. If this does not resolve the issue, the person may begin the grievance procedure. The person has the right to be assisted by an advocate of his/her choice (e.g., agency staff person, co-worker, friend, family member, etc.) at each step of the grievance process. The person has the right to withdraw his/her grievance at any time. Any grievance paperwork filed by a participant should note his/her name and contact information so the LPC Lead Agency can contact him/her to discuss the issues.

Level 1

The first person to review the grievance is the LPC Lead Agency. The person with the grievance should contact the LPC Lead Agency with a written statement describing the alleged violation of the CES policies and procedures, and any actions taken on behalf of the person or agency to resolve the issue. The LPC Leadership Agency will contact the KHC CoC Systems Specialist in order to jointly contact agency in question to request a response to the grievance. Once the LPC Lead Agency and KHC CoC Systems Specialist have gathered relevant information about the situation, they will decide if the grievance is valid and determine what, if any, action needs to be taken. If both the person and the provider agree, the process ends, and the resolution is implemented. If the person or the provider disagrees, the grievance moves to the next level.

Level 2

The KY BoS CoC Advisory Board Chair reviews the grievance if there is dissatisfaction with resolution. The Advisory Board Chair may designate one or more Board members or other entity to review the situation. After gathering relevant information, the KY BoS CoC Advisory Board Chair or designated Board member(s) or other entity will inform the person and provider what will happen to resolve the grievance. This is the final step in the process and the decision of the KY BoS CoC Advisory Board is final.

Provider Grievances

It is the responsibility of all boards, staff, and volunteers of CoC-funded and ESG-funded projects to comply with the rules and regulations of the KY BoS CoC CES. Anyone filing a complaint concerning a violation or suspected violation of the policies and procedures must be acting in good faith and have reasonable grounds for believing an agency is violating the Coordinated Entry System policies and procedures.

To file a grievance regarding the actions of an agency, contact the KY BoS CoC Advisory Board with a written statement describing the alleged violation of the CES policies and procedures, and the steps taken to resolve the issue locally. The KY BoS CoC Advisory Board will work in tandem with the Collaborative Applicant to contact the agency in question to request a response to the grievance. Once the KY BoS CoC Advisory Board and Collaborative Applicant have received all documentation they will decide if the grievance is valid and determine if further action needs to be taken. If the individual or agency filing the grievance, or the agency against whom the grievance is filed, is not satisfied with the determination they may file an appeal with the KY BoS CoC Advisory Board Chair. This must be done by providing a written statement regarding the reasons for the appeal. The KY BoS CoC Board Chair will bring the matter to the Board of Directors for discussion and a final decision.

Continuing Education

The BoS CoC will provide CE training on an annual basis through KHC.

Evaluation of the CES

Provider Evaluation

KHC will annually evaluate its CES via its standing BoS CoC Committees and/or contract work through an outside consultant or consultants.

Evaluation from Participants

The Coordinated Entry Committee will annually seek participant feedback in evaluating the system in tandem with its standing BoS CoC Committees and/or contract work through an outside consultant(s).

Privacy Protections

In its annual implementation of the Memorandum of Understanding with the HMIS Lead, the BoS CoC Advisory Board will ensure the privacy protections of CE participants.

Accessibility, Advertising, & Marketing of the CES

All marketing materials and outreach strategies utilized by the BoS CoC must ensure that all people in different Category 1 or 4 homeless populations and subpopulations in each of the LPCs, including people experiencing chronic homelessness, Veterans, families with children, youth, and survivors of domestic violence, have fair and equal access to the coordinated entry process, regardless of the location or method by which they access the system.

Additionally, the CE Committee will maintain a list of the LPC Lead Agencies to promote on KHC's website for CE marketing in a no-wrong-door approach. Each LPC is required to advertise, conduct outreach activities, and provide appropriate accommodations to ensure the coordinated entry process is available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.

LPCs must go one step further and ensure that they are affirmatively marketing the system in areas known to be frequented by people experiencing homelessness in the region through culturally competent methods. Additionally, LPCs must identify and promote the ways persons can access the CE system outside of regular business hours.

Appendix A

Serving High Acuity Households with Available RRH Resources

In the event Local Prioritization Community (LPC) agencies and statewide providers do not have any available Permanent Supportive Housing (PSH) funds to house new participants, LPCs should use (with group consensus) Rapid Re-housing (RRH) funds to serve high acuity individuals and households (e.g., VI-SPDAT scores of XYZ for individuals, XYZ for families, XYZ for unaccompanied youth) aligning Kentucky Balance of State (KY BoS) Order of Priority. LPC Lead Agencies will document the LPC decision in making referrals according to Coordinated Entry (CE) Compliance Standards and record this decision on HCA Compliance Form 190. RRH providers who house higher acuity individuals and households should ramp up intensive housing-focused case management services accordingly and should make rental support flexible to the client's unique needs in order to maintain housing stability and prevent returns to homelessness.

This means RRH providers will need to:

- **Increase home visit frequency and housing stabilization case management based on acuity.** An individual who is Chronically Homeless, has no income or benefits, and has a VI-SPDAT score of 12 will need much more intensive and regular housing stabilization services than a household who has been homeless for six (6) months, marginally employed, and scored a four (4) on the VI-SPDAT. RRH providers must provide housing-focused case management that ensures housing stabilization is achieved by the time financial assistance ends. RRH should continue housing-focused case management after financial assistance ends (for up to 90 days).

- **Increase duration of financial/rent assistance and provide flexibility based on unique needs.** RRH providers will need to provide flexible rent assistance based on unique client circumstance, which is no different from serving a person with a lower acuity. In considering the two examples above, it is likely the individual who scored a 12 will need more rental assistance (in terms of duration and amount) than the household who scored a four (4). RRH must ensure financial assistance meets the needs of the client and is flexible. As a best practice, RRH providers will need to reevaluate household income every three (3) months to allow for subsidy adjustment as needed (as housing-focused case management is offered and housing stabilization is achieved). It may be that income is gained and lost while receiving RRH assistance; thus providers should adjust subsidy accordingly to prevent returns to homelessness.

- **Treat the RRH project as the permanent housing intervention that will end the individual's or household's homelessness.** Due to scarce PSH resources and the uncertainty of a PSH resource becoming available while a higher acuity household has moved into RRH, accepting RRH providers should exit the individual or household from the LPC list. It is expected that RRH providers provide appropriate services and rental assistance to end the individual's or household's homelessness. It is expected that RRH providers conduct follow up services to prevent returns to homelessness.

- **Must be mindful of their program's capacity and funding availability.** If an RRH provider does not believe their program has the capacity to deliver RRH according to these guidelines, they must voice concerns to the LPC. Case conferencing will be essential in identifying the appropriate housing provider and resource to match to the high acuity individual or household.

Appendix B

Key Definitions

Acuity – When using the VI-SPDAT (Vulnerability Index Service Prioritization Decision Assistance Tool) 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.

Case Management – The overall coordination of an individual's use of services, which may include medical and mental health services, substance-abuse services, and vocational training and employment. Although the definition of case management varies with local requirements and staff roles, a case manager often assumes responsibilities for outreach, advocacy, and referral on behalf of individual clients.

Common Assessment Tool – A comprehensive and standardized assessment tool used for the purposes of housing prioritization and placement within a Continuum of Care (CoC) Coordinated Entry System (CES). The Balance of State (BoS) CoC has adopted the VI-SPDAT 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 four separate occasions in the last three years where the combined occasions must total at least 12 months.
    - Occasions are 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.

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 (CE) – "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 (CE) 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 AIDS, 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 whereas 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.

Harm Reduction – A model of substance-use intervention that focuses on helping people who use substances to better manage their use and reduce the harmful consequences to themselves and others.

Homeless –

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: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing.

3. Category 3: Homeless Under Other Statutes. 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.

4. Category 4: Fleeing or Attempting to Flee Domestic Violence. Any individual or family who: (i) 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 (KYHMIS) – 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 the U.S. Department of Housing and Urban Development (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. The KYHMIS uses a software program from Bowman Systems called ServicePoint.

Local Prioritization Community (LPC) – Regional and/or geographical committees comprised of all agencies funded by the CoC and Emergency Solutions Grant (ESG) and designated by the BoS CoC Advisory Board. 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 and families 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 CoC 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 administering the VI-SPDAT Common Assessment Tool to eligible community members presenting for housing and services must be trained online as outlined in this manual. 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 LPC across the CoC.

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

Prioritization List – A list generated by VI-SPDAT entry into the KYHMIS) and managed by the LPC Lead Agency. 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 prioritization and housing placement. CoC- and ESG-funded agencies must make and take referrals off this list for their programs.

Progressive Engagement (PE) – In a progressive engagement (PE) approach, a family seeking housing receives a small

amount of assistance, tailored to their most critical need, with a keen focus on quickly resolving the housing crisis. The family keeps in regular contact with their provider, mutually monitoring whether the initial support was successful. If needed, the provider can adjust the amount and intensity of tailored service until the family has obtained permanent housing. With PE, the family and provider work together to get the family into housing first and then may identify additional goals.

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. RRH assistance, operating in a CoC 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 RRH program are housing identification and relocation, short- and/or medium-term rental assistance, 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. See 24CFR§576.104 and Core Components of Rapid Re-Housing, National Alliance to End Homelessness.

Service Prioritization Decision Assistance Tool (SPDAT) – The evidence-based assessment used 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 or KHC staff 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 –

1. For the purposes of HUD 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.

    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 criterion used by Medicaid departments to identify high-need, high-cost beneficiaries.

2. 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.

Voluntary Services – The term "supportive" in supportive housing refers to voluntary, flexible services designed primarily to help tenants maintain housing. Voluntary services are those that are available to, but not demanded of, tenants/participants, such as service coordination/case management, physical and mental health, substance use management and recovery support, job training, literacy and education, youth and children's programs, and money management.

Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) – The evidence- based Common

Assessment or Prescreen Triage Tool used by all projects in the KY BoS CoC to determine initial acuity (the presence of an issue) and used for housing triage, prioritization, and housing placement. There are three versions of VI-SPDAT: Individual, Family, and Youth, all of which are available in KYHMIS.

Appendix C

Are you homeless?

Any Door KY can help!

Coordinated Entry is a system in which people experiencing homelessness may be connected to limited available housing resources and supportive services in their community. The Kentucky Balance of State Continuum of Care's Any Door KY system is accessible to eligible individuals and families by visiting local homeless service providers and shelters around the state.

Look for **Any Door KY** signs in your community — these organizations may be able to help!

Are you eligible? You may be eligible for Any Door KY access if your primary nighttime residence is in an emergency shelter, a public or private place not meant for human habitation (such as a car, park, bus station, bridge over pass), or are fleeing or attempting to flee domestic violence.

You don't need to be sober, you don't need to have income, and you don't need to have a perfect background to access Any Door KY. We welcome anyone experiencing homelessness, through any door.

Coordinated Entry Partner Agencies in this Area:

Appendix D

KHC Guidance for CoC PSH to PSH Transfers

Kentucky Housing Corporation (KHC) understands that, under rare circumstances, a program participant may need to transfer from one Continuum of Care (CoC) Permanent Supportive Housing (PSH) project to another, such as when another PSH project can better meet the service needs of the program participant or when a PSH project will no longer receive CoC funds and needs to find alternate housing for their program participants.

Under the CoC program, an individual or family may transfer from one PSH project to another so long as the participant met the eligibility criteria of the original PSH project, including a transfer to a PSH project dedicated to serving the chronically homeless if the household was originally chronically homeless. Under normal circumstances, PSH projects must accept referrals for new admissions through the Kentucky Balance of State (KY BoS) CoC Coordinated Entry System (CES) based on CES prioritization polices for people actively experiencing homelessness. In order for PSH projects to accept new admissions directly from other PSH projects, recipients or subrecipients must keep records on file demonstrating that the individual or family has all of the below documented:

1. transferring from another permanent supportive housing project;
2. reason for the transfer;
3. met the eligibility requirements for permanent supportive housing prior to entering the original permanent housing project; and
4. prior written approval from KHC staff via the HelpDesk to move forward with the transfer instead of filling the open unit with a household from the CES prioritization list.

Please note that this admission will most likely be flagged on your APR for "15. Living Situation" since the program participant will be transferring from a permanent housing situation (i.e. should be recorded in HMIS as "Other Locations: Permanent Housing [other than RRH] for formerly homeless persons"). Be prepared to provide documentation, upon request, for that APR as to why the admission occurred. This signed document serves as written documentation of KHC's approval of the transfer solely as it relates to the CES entry process.

____
Client Name and HMIS#

________________________________	________________________________
Project transferring from	Project transferring to
________________________________	________________________________
KHC Staff Signature	Date

Appendix E

Lead Agency Contact Information

Local Prioritization Community	Lead Agency	Contact	Email	Phone Number
Barren River	BRASS	Tori Henninger	tori@brassinc.org	270-781-9334
Big Sandy	Mountain Comp Care	Jackie Long	jackie.long@mtcomp.org	606-788-9789
Bluegrass	HHCK	Jenny Andrews	jandrews@hhck.org	502-223-1834
Buffalo Trace	Welcome House	Bruce Hill	bhill@welcomehouseky.org	606-802-4978
Cumberland Valley	KCEOC	Bonita Mason	bdmason@kceoc.com	606-546-3152
FIVCO	CAReS	Lynn Childers	lynn@boydcountycares.org	606-324-2949
Gateway	Gateway Homeless Coalition	Paul Semisch	psemisch@gatewayhouseky.org	606-784-2668
Green River	Welcome House	Lindsay Clark	lclark01@welcomehouseky.org	270-938-5309
Kentucky River	KRCC	Santana Keene	Santana_Keene@krccnet.com	606-207-3843
KIPDA	Volunteers of America	Danielle Cavanaugh	DanielleC2@voamid.org	502-785-9898
Lake Cumberland	Welcome House	Jessi Adams	jadams01@welcomehouseky.org	606-802-4004
Lincoln Trail	Volunteers of America	Danielle Cavanaugh	DanielleC2@voamid.org	502-785-9898
Northern Kentucky	Welcome House	Amanda Couch	acouch@welcomehouseky.org	859-292-9346
Pennyrile	Salvation Army of Hopkinsville	Alisa Barton	Alisa.Barton@uss.salvationarmy.org	270-885-9633
Purchase	Merryman House	Stephanie Hook	stephanie@merrymanhouse.org	270-448-8063