Coordinated Entry HMIS User Guide

The Coordinated Entry (CE) 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.

Responsibilities of the agency entering the household to the BoS-Coordinated Entry Project (2992):

- Document the household's eligibility for homeless assistance using the required program Toolkits from Kentucky Housing Corporation (KHC).

- Update the household's information as necessary between CE Project submission and housing referral/placement, using KYHMIS or by notifying the KHC CoC Systems Specialist via email or KHC's Secure File Share System.

- Maintain the ROI and privacy of all pertinent client information through KYHMIS or secure office location.

- Do not complete the BoS-Coordinated Entry Project entry without the respondent's knowledge and explicit agreement.

- Do not complete the BoS-Coordinated Entry Project entry through observation or other non-self-reported information.

- If you cannot obtain an ROI as directed above, do not conduct the BoS-Coordinated Entry Project entry.

- Emergency shelters should complete the BoS-Coordinated Entry Project entry with residents who have not solved their own homelessness approximately two (2) weeks after shelter entry, who are long stayer, or who have returned to shelter multiple times.

- Other providers (including but not limited to street outreach, self-referrals to housing agencies, non-HUD-funded providers) should complete the BoS-Coordinated Entry Project entry once rapport is established.

- Any provider completing the BoS-Coordinated Entry Project entry is required to begin documentation for homelessness/chronic homelessness and disability immediately.

To best capture required system-wide CES data, KHC has created a single BoS Coordinated Entry Project in KYHMIS to be used for all LPCs. The KYHMIS Project is titled BOS-Coordinated Entry Project (2992). Within this project is the BoS-CE Housing Engagement and Prioritization Assessment, as well as the BoS-CES Interim Assessment.

BOS-CE Housing Engagement and Prioritization

If the household has not resolved their homelessness within the first two (2) weeks of being in shelter, is a long stayer, has returned to shelter multiple times, or is unsheltered for the first time for less than a week, providers will Enter Data As (EDA) the BOS-Coordinated Entry Project (2992) and complete the entire Housing Engagement and Prioritization Assessment, which includes the new CE Data Elements required by HUD.

Below is an overview of the BOS-Coordinated Entry Project (2992) workflow in KYHMIS:

- Once you have obtained the ROI, using the language in the respective forms, you can complete the BoS-Coordinated Entry Project entry, beginning with the <u>Required Opening Script</u>:
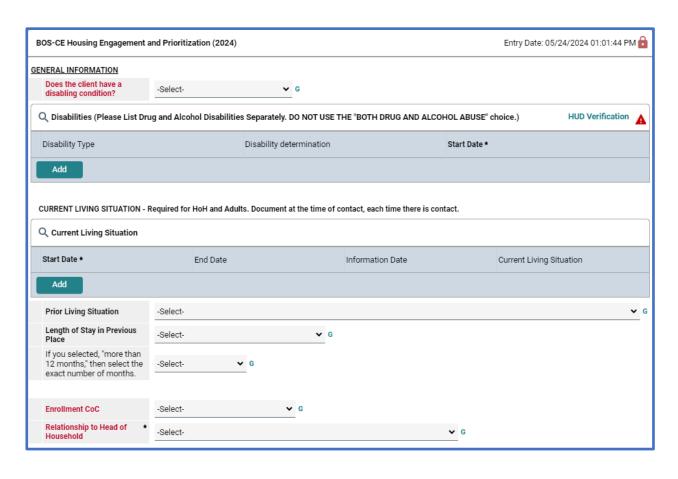
    > My name is [_____], and I work for a group called [<u>name of organization</u>]. I have a common assessment that I would like to complete with you. One thing I'd like to do before we begin is see if you'd like information about our local domestic violence program. So, for instance, if a partner has ever threatened to hurt you, or made you afraid, or hit, slapped, kicked, or otherwise physically hurt you or made you do something sexual you did not want to, it might be helpful for you to talk to someone confidentially. Our local domestic violence program can help you fill out this survey. The answers you give will be kept confidential and not become part of the shared database. This level of confidentiality could be really important at some point in the future, because some of these questions that must be asked are very personal.
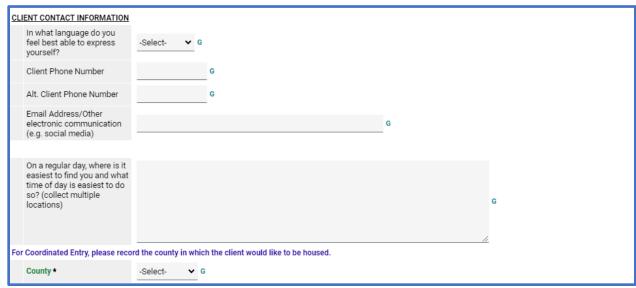
    > Would you like to speak to someone at that program and perhaps fill out this assessment with them?

    > > ➢ If the answer to question above is "yes," then the service provider will ask if they may make a referral to the regional <u>Victim Service Provider</u> so that the program can continue the survey in a manner that is sensitive to survivors' needs and offer additional services.

    > > ➢ If the respondent declines, the service provider will continue the survey:

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

- After reading the Opening Script and obtaining consent to proceed, staff will login to KYHMIS and will click "Enter Data As" and then select the BOS-Coordinated Entry Project (2992). Once the client has either been found or created, a new entry will be added to the Entry/Exit tab.

- Within the Coordinated Entry Project entry, the BoS-CE Housing Engagement and Prioritization Assessment will be completed. Below are screenshots of the workflow for this Assessment.

BOS-CE Housing Engagement and Prioritization (2024)   Entry Date: 05/24/2024 01:01:44 PM 🔒

GENERAL INFORMATION

Does the client have a disabling condition?	-Select- ▼ G

🔍 Disabilities (Please List Drug and Alcohol Disabilities Separately. DO NOT USE THE "BOTH DRUG AND ALCOHOL ABUSE" choice.)   **HUD Verification** ⚠️

Disability Type	Disability determination	Start Date *
Add		

CURRENT LIVING SITUATION - Required for HoH and Adults. Document at the time of contact, each time there is contact.

🔍 **Current Living Situation**

Start Date *	End Date	Information Date	Current Living Situation
Add			

Prior Living Situation	-Select- ▼ G
Length of Stay in Previous Place	-Select- ▼ G
If you selected, "more than 12 months," then select the exact number of months.	-Select- ▼ G
Enrollment CoC	-Select- ▼ G
Relationship to Head of Household *	-Select- ▼ G

CLIENT CONTACT INFORMATION

In what language do you feel best able to express yourself?	-Select- ▼ G
Client Phone Number	_____ G
Alt. Client Phone Number	_____ G
Email Address/Other electronic communication (e.g. social media)	_____ G
On a regular day, where is it easiest to find you and what time of day is easiest to do so? (collect multiple locations)	G

For Coordinated Entry, please record the county in which the client would like to be housed.

County *	-Select- ▼ G

HOUSING ENGAGEMENT INFORMATION

Housing Engagement Category? *	-Select- ▾	G
When did client engage in Coordinated Entry CES conversation?	___ / ___ / _____ 📅 ↺ 📅	G
Where is the client staying right now? *	-Select- ▾	G
Agency *		G
Case Manager		G
What LPC are you in? *	-Select- ▾	G

- -

HOUSING OPTION INFORMATION

Once a housing option is available, what size unit will be needed (# of bedrooms)?	___	G
If available, would the client be interested in a roommate option?	-Select- ▾	G
Once a housing option is available, will the client require special accommodation (e.g. 1st floor, wheelchair access, ramp, bathroom facilities?)	-Select- ▾	G
If yes for special accommodation, please specify:		G

VI-SPDAT FOR INDIVIDUALS

USE THE VI-SPDAT v2.0 WHEN WORKING WITH A CLIENT WHO IS AN INDIVIDUAL:

🔍 VI-SPDAT v2.0

Start Date *	PRE-SURVEY	A. HISTORY OF HOUSING AND HOMELESSNESS	B. RISKS	C. SOCIALIZATION & DAILY FUNCTIONS	D. WELLNESS	GRAND TOTAL
Add						

VI-SPDAT FOR FAMILIES

USE THE VI-FSPDAT v2.0 WHEN WORKING WITH A CLIENT WHO IS A PART OF A FAMILY W/CHILDREN UNDER 18:

🔍 VI-FSPDAT v2.0

Start Date *	PRE-SURVEY	A. HISTORY OF HOUSING AND HOMELESSNESS	B. RISKS	C. SOCIALIZATION & DAILY FUNCTIONS	D. WELLNESS	E. FAMILY UNIT	GRAND TOTAL
Add							

TAY-VI-SPDAT FOR TRANSITION AGE YOUTH

USE THE TAY-VI-SPDAT v1.0 WHEN WORKING WITH AN INDIVIDUAL CLIENT WHO IS AGE 18-24 OR WHEN WORKING WITH AN UNACCOMPANIED MINOR UNDER AGE 18:

🔍 TAY-VI-SPDAT v1.0

Start Date *	PRE-SURVEY	A. HISTORY OF HOUSING AND HOMELESSNESS	B. RISKS	C. SOCIALIZATION & DAILY FUNCTIONS	D. WELLNESS	GRAND TOTAL
Add						

Infectious Disease Factors

Due to Infectious Disease, KHC has established criteria to determine if a client/household is potentially High, Medium, or Low risk for prioritization purposes.

Answer the following questions based on the client/household's Medical Factors Criteria and Living Situation Criteria:

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/AIDS, and prolonged use of corticosteroids and other immune weakening medications

- Severe obesity (body mass index [BMI] or 40 or higher)

- Diabetes

- Chronic kidney disease and those who are undergoing dialysis

- Liver disease

Does the client/household have 1 or more of the above listed Medical Factors?	-Select- ⌄ G

Living Situations Criteria

- Individuals/Households sleeping outdoors or in other places not meant for regular human habitation in close proximity (less than 6 feet apart) to other not in the same household without regular access to hygiene facilities where frequent handwashing

possible. (Potentially High-Risk)

- Individuals/Households sleeping in emergency shelter 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 6 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 6 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
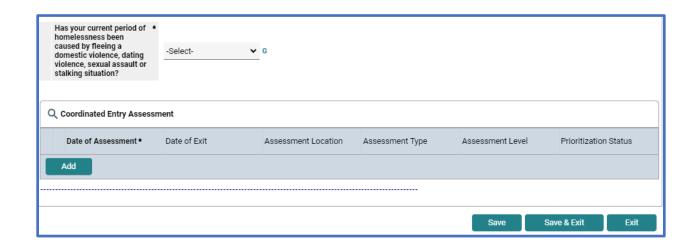
possible. (Potentially Medium-Risk)

- 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)

Is the client/household's Living Situation considered High, Medium, or Low Risk based on the above criteria?	-Select- ⌄ G

Has your current period of homelessness been caused by fleeing a domestic violence, dating violence, sexual assault or stalking situation? *	-Select- ⌄ G

🔍 **Coordinated Entry Assessment**

Date of Assessment *	Date of Exit	Assessment Location	Assessment Type	Assessment Level	Prioritization Status
Add					

- -

Save **Save & Exit** **Exit**

Triage Tools

SPDAT Individuals

- Providers should use the Individual VI-SPDAT as the appropriate assessment for any single adult.

- Providers should use the Individual VI-SPDAT when a childless couple presents; providers complete two (2) separate Individual VI-SPDATs.

- For pregnant individuals, use this VI-SPDAT unless they have additional children in the household.

VI-FSPDAT Families

- Providers should only administer a Family VI-SPDAT when there are minor children (under the age of 18) who are currently in the household at the time of assessment.

  - If the state has removed children from parental custody, the provider should perform an Individual VI-SPDAT. If the children are returned to the household while awaiting housing referral, the provider should administer the Family VI-SPDAT via an Interim Update.

TAY VI-SPDAT Youth

- Providers should use the Youth VI-SPDAT for the any single adult between the ages of 18 and 24.

Required Closing Script

Once the BoS CE Project entry has been completed in HMIS, staff should wrap up their CE engagement with clients using the following script:

> Thank you for allowing me to understand you [and your family] better. I know that those questions can sometimes be difficult to answer. But answering these questions honestly allows us to connect you with available permanent housing resources that may exist in your community of choice to assist in helping you end your homelessness.

> Now that I understand your strengths, we can make a coordinated plan together to help you resolve your housing crisis.

> Just so you understand next steps, the information you have provided to me will be placed into a system-wide database (KYHMIS) like we talked about before. Our limited housing resources are prioritized for individuals and families with the highest needs first much like how an Emergency Room operates, meaning it is not a first-come, first-serve basis. Instead, we look at the vulnerabilities and homeless histories of everyone in the system and will prioritize first those that are most vulnerable to death due to their homeless situation. This process does not guarantee you will receive financial assistance or a housing voucher but is one way to try to access housing resources in your area.

> Your information will be reviewed and if housing assistance becomes available that matches your needs, you will automatically be referred to that program. I will stay in touch with you regularly to keep you updated throughout this process. In the meantime, we are going to work with your strengths to address your needs while we look for alternative housing as well. I will also work with you to obtain documents you may need (such as an ID or social security card) to obtain housing whether through the CE process or not.

It is your responsibility to also stay in communication with me and to update me if any of your information changes, or if you'd like to live in a different community.

Once the Housing Engagement and Prioritization Assessment has been completed, providers are required to immediately start documenting the household's homelessness (and chronic homelessness, if applicable), as well as disability information if applicable.

After all appropriate documentation is obtained, it will be added to the household's Client Profile in KYHMIS as a File Attachment. Providers that use KYHMIS for Emergency Shelter and/or Street Outreach entries do no need to complete additional homeless verifications because their shelter or street outreach entries are sufficient homeless verification.

BOS-CES Interim

Providers will then complete the CES Interim Assessment via the CE Interim Updates guidance. When the client/household is considered document-ready with all appropriate homeless verifications, staff will add an Interim Update to mark the client/household as document-ready, and update any information as necessary:

- o By Selecting "Yes" to having all client paperwork and documentation uploaded in HMIS, clients will then appear on the CES Housing Actionable & Prioritization List.

- o Clients/households who are not marked as document-ready through an Interim Update will appear on the CES Engagement List.

PERMANENT HOUSING INFORMATION

Have you, the Engaging Agency or the client obtained ALL of the following paperwork? And, are copies of ALL ATTACHED TO THE CLIENT'S HMIS RECORD? This means ALL necessary paperwork is on file; not that the client has simply reported having the paperwork.

- Proof of Citizenship (for PSH Placement)

- Verification of Disability (for PSH Placement)

- Verification of Homelessness Form & Supporting Documentation (including HMIS records 3rd party verification from another agency or entity)

- Verification of Personal Identification (State Issued ID, Birth Certificate, or Social Security Card) most likely needed for Landlords/Property Management Agencies during Housing Search and Placement, but not required for CoC/ESG RRH Placement

Client is paperwork ready for housing, and all documents are uploaded in HMIS *   [Yes ▾] G

CES Interim Updates Policy

Effective April 1, 2024, 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. Clients who need an Interim Update will show on the LPC list as "Needs Interim." Clients who need an Interim Update will NOT be prioritized for referrals until an Interim Update is completed.

Rationale:

- Long stays on LPC list

- Clients ageing into CH

- High rate of unfulfilled referrals due to clients not being able to be located

- Homeless Verifications outdated

- Clients not being counted on the CE APR

At Interim, you <u>will</u> update the required information, including:

- Current Living Situation

- Prior Living Situation

- # of times and months homeless

You <u>can</u> also update any other information that has changed:

- Disability Status

- Client Contact Information

- County Preference

- Housing Engagement Information

- Housing Option Information

- VISPDAT (only if necessary)

- Infectious Disease Factors

*Updated Homeless Verifications should be added with each Interim Update unless ES/SO contacts are already recorded in HMIS

Partners no longer need to exit the client's BoS CE Project entry and add a new entry to record updates for the client's situation. Partners can add an Interim Update for a client who they DID NOT entry into the BoC CE Project if they've had recent contact with them. This includes when:

- Client relocates to a new shelter

- Client relocates to a different part of the state

- Client engages with a different partner organization

Partners should still exit clients from the BoS CE Project as they become housed or are inactive after 90 days of no contact.

Coordinated Entry Assessment

The Coordinated Entry Assessment MUST be completed at entry and at every Interim Update.

- When adding the first CE Assessment at entry, do not add a "Date of Exit."

- When adding additional CE Assessments at Interim Updates, add a "Date of Exit" for the day BEFORE the new CE Assessment.

- New CE Assessments will be for the SAME DAY as the Interim Update (auto generates).

		Date of Assessment *	Date of Exit	Assessment Location	Assessment Type	Assessment Level	Prioritization Status
✏	🗑	03/18/2024		Supportive Services Provider	In Person	Housing Needs Assessment	Placed on Prioritization List
✏	🗑	02/15/2024	03/17/2024	Supportive Services Provider	In Person	Housing Needs Assessment	Not Placed on Prioritization List
✏		06/01/2023	02/14/2024	UnSheltered/Street Outreach	In Person	Housing Needs Assessment	Placed on Prioritization List

Add   Showing 1-3 of 3

Coordinated Entry Referral

The Coordinated Entry Referral is located on the Interim Update.

- Permanent Housing Referrals will still be made by KHC.

- Other referrals can be recorded here as well:

— REFERRAL EVENTS —
Referral to post-placement/follow-up case management
Referral to Street Outreach project or services
Referral to Housing Navigation project or services
Referral to Non-continuum services: Ineligible for continuum services
Referral to Non continuum services: No availability in continuum services
Referral to Emergency Shelter bed opening
Referral to Transitional Housing bed/unit opening

Partners will be responsible for adding the Referral Result, Date of Result, and Date of Exit as they occur.

- For non-PH referrals, Referral Result, Date of Result, and Date of Exit can be added as the referral is completed with a new Interim Update.

- For PH referrals, Referral Result, Date of Result, and Date of Exit can be added through a new Interim Update at either of the below:

  o Client accepts PH referral and is exited from the CE Project for the day before Housing Move in Date—CE Referral Date of Exit is the same as the date of exit from the CE Project; or

  o Client declines PH referral—CE Referral Date of Exit is the day the client declined.

  *This affects their status on the LPC list

PH referrals will continue to be made and recorded by KHC.

Exiting Clients from the BoS-CE Project

The client can be exited from the BoS CE Project during the below situations:

- Once a client is housed with a RRH, PSH, or other Permanent Housing destination:

    - The Day Before the move in date.

- If a client has been inactive for 90+ days:

    - On the ninetieth day, or shortly after if you try to reach out to them again and are unsuccessful.

But the client cannot be exited on the day of or day before the RRH/PSH project entry.

Victim Service Providers Specific Information

The VSP Inclusion Process does not change for VSP CE Inclusion at entry. VSPs will need to send Interim Updates via the File Share with the below documents:

- BOS CE VSP Interim Update

- Updated Homeless Verification (ES Verification, Outreach Worker Observation, etc.)

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