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

Coordinated Entry Policies & Procedures v.4

November 2020

The current version of this document will be published on Kentucky Housing Corporation's (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

In consultation with recipients of Emergency Solutions Grants (ESG) program funds within the geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-Victim Service Providers (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 Coordinated Entry System

CPD Notice 17-01 regarding implementation of a Coordinated Entry system
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 who are working to end homelessness and concerned with the development and coordination of homeless assistance programs in 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 directors and a maximum of 15. These 12-15 individuals collectively shall be known as the Advisory Board for the BOS Continuum of Care. The Advisory Board will convene at least quarterly, at a date and time convenient to the majority of board members.

The directors are elected as follows:

- Two representatives from each of the six 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:
- 1 director shall be an individual who is homeless or formerly homeless
- 1 director shall be from relevant subpopulations
- 1 director shall be from a non-profit/government organization representing the public interest

- The goal of the BOS CoC Advisory Board is to have representation of these relevant organizations and projects serving homeless subpopulations within the geographic area including: Emergency Solutions Grant funded agency, 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).

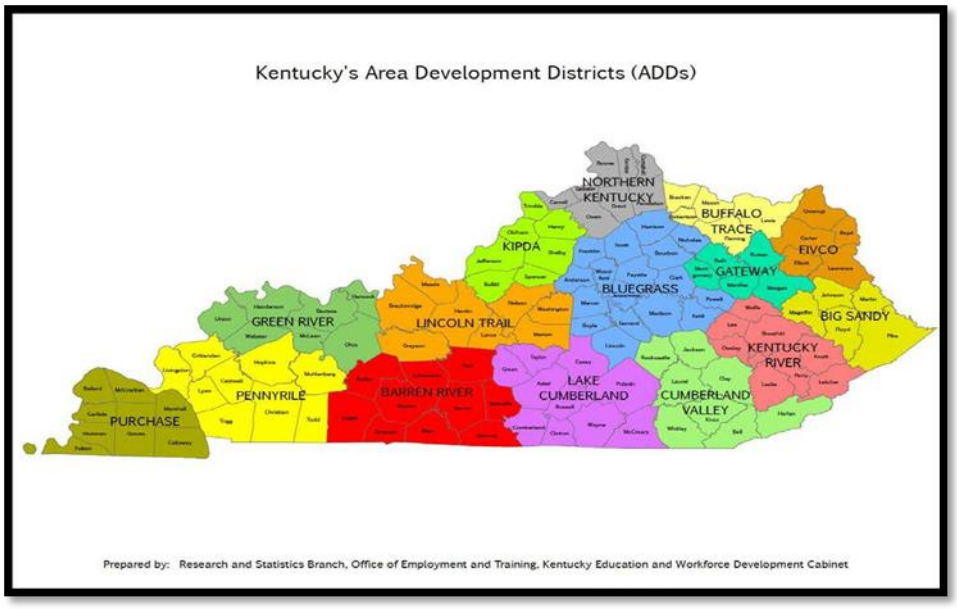
CoC Collaborative Applicant

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 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 to staff, coordinated and facilitate 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



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

Local Prioritization Communities (LPC)

The Local Prioritization Community (LPC) participates in the coordinated entry system 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:

1. Serve as an **access point** to the Any Door KY Coordinated Entry System.
2. Be present (virtually or face-to-face) for LPC meetings scheduled by the Lead Agency/KHC.
3. Commit to solution-focused conversations prior to shelter entry; utilize the BoS Diversion Project in HMIS.
4. If households/individuals are unable to be diverted from the homeless response system:

a) And will enter an Emergency Shelter, enter required data into the provider's specific shelter project in HMIS.
b) 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.

5. VSPs must submit Local Prioritization Inclusion to the KHC CoC Systems Specialist as people present at individual programs.
6. Triage the household/individual with the appropriate VI-SPDAT in the Housing Engagement Assessment within the KY BOS Coordinated Entry Project (2992).
7. Gather basic eligibility documentation immediately while household/individuals are active in the Housing Engagement Assessment.
8. Upload basic eligibility documentation in HMIS in order for household/individual to be added to the CES Housing Actionable & Prioritization list in which housing referral occurs.
9. Accept referrals for available permanent housing resources as prioritized and deemed eligible by the CoC Systems Specialist.
10. Take referrals for their housing programs solely from the CES Housing Actionable & Prioritization list.
11. Eliminate all side doors to the CES (such as an agency waiting list for housing).
12. Honor client choice in taking referrals.

CoC & ESG Project Accountability

All HUD Homeless Assistance (CoC, ESG) and Veterans Administration 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 CE System Performance Measures in ranking and funding awarded to individual projects.

Approval and 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 and Goals

We value:

- Programs with outcomes that demonstrate progress toward reducing and ending homelessness as quickly as possible with an ultimate goal of no more than 30 days
- 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 Coordinated Entry system 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 _____%
- 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.

Coordinated Entry (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:

1. Divert people who can solve their own homelessness away from the system. More specific information on this can be found later in this document.
2. Quickly move people from street to permanent housing
3. Create a more defined and effective role for emergency shelters and transitional housing
4. Create an environment for less time, effort, and frustration on the part of case managers through the targeting of resources
5. Use the correct housing intervention the first time for the household, particularly for chronic

and high-acuity populations

6. Reduce the length of time homeless by moving people quickly to the correct housing intervention
7. Increase housing stability by targeting the appropriate intervention to corresponding needs
8. 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.

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 Coordinated Entry System implementation.

Tools

Tool or Concept	Specific Solutions Adopted by KY BoS CoC
Common Assessment/Triage Tool	Individual, Family, and Youth VI-SPDATs
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 and 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

What Is Basecamp?

- Basecamp is an online communication platform that has been established to help participating agencies in the KY BoS CoC Any Door KY Coordinated Entry System (CES). Each of the 15 Local Prioritization Communities (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 as well as meeting recaps are posted on this platform. LPC Leads and KHC manage the Basecamp.
- LPC members can find helpful links to Kentucky Balance of State CoC documents, HUD guidance and resources as it relates to Coordinated Entry.

Who should have access to Basecamp?

- 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.
- All information is to be held confidential

How Does It 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 Local Prioritization Inclusion forms to Basecamp, please send them to the KHC CoC Systems Specialist.

Basecamp is NOT Facebook. Please be respectful and courteous to all Basecamp users and clients.

What Is the VI-SPDAT?

The Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) is the common assessment, prescreen, and triage tool adopted by the BoS CoC and designed to be used by all providers within the BoS CoC to quickly assess the health and social needs of homeless persons and match them with the most appropriate and available support and housing interventions.

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

What Is the Full SPDAT?

The SPDAT is an evidence-informed approach to assessing an individual's or family's acuity. The tool, across multiple components, prioritizes who to serve next and why, while concurrently identifying the areas in the person/family's life where support is most likely necessary in order to avoid housing instability.[2] It is used as a full assessment/progressive case management tool among trained providers and also provides an acuity score.

Training Requirements

Before using the VI-SPDAT as a triage tool with clients, program staff members in the BoS CoC are required to complete OrgCode's training module, which can be used online. By submitting a household into the regional CE project, staff members are acknowledging that they have completed the required training.

Training for the Individual VI-SPDAT v2.0 can be found here.

Training for the Family VI-SPDAT v2.0 can be found here.

A breakdown of what the differences are between a By-Name List, Coordinated Entry List and Priority List can be found here.

Program staff members must be trained by OrgCode or KHC staff prior to implementation of the Full SPDAT. KHC will offer a Full SPDAT Training at minimum annually. By requesting

permission to use a Full SPDAT score in the prioritization process, staff members are acknowledging that they have completed the required training.

Comparing the VI-SPDAT and Full SPDAT

- The VI-SPDAT is a triage tool; the SPDAT is a complete assessment.
- VI-SPDAT usage requires online training; SPDAT usage requires training provided by OrgCode or OrgCode trained individuals.
- Each question in the VI-SPDAT ties into the components of the SPDAT.
- The VI-SPDAT is a self-reported tool; the SPDAT uses multiple methods for capturing information.
- Do not use the terms interchangeably or as a verb.
- Do not change the script of either tool.
- Do not change the order of the questions.
- The BoS CoC requires the use of the VI-SPDAT among providers as the Common Assessment & Triage tool.
- The BoS CoC strongly recommends the use of the SPDAT as an on-going housing-focused case management tool once clients are housed.

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 but completion of ROI document is required.

For Victim Service Provider agencies (VSP): VSPs do not include client information in any shared database (i.e. KYHMIS) and as such should NOT utilize the standard KYHMIS ROI. Kentucky Coalition Against Domestic Violence (KCADV) Member Program Service Standards state that, "In the event of the use of computer-generated case notes or client records, it is the responsibility of each domestic violence program to assure confidentiality of information. Each program must maintain a written policy and accompanying procedures that reflect security measures."

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 Coordinated Entry System Components

1. Diversion

What is Diversion

As defined by 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."

How Does Diversion Work

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 longer-term. Some of these options may include:

- a negotiated return to their previous housing;
- short-term, non-shelter accommodation;
- apartments or homes, (including shared housing);
- returns to family.

What Staff Needs to Provide Diversion

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.

Why Do Diversion

The intent of diversion is to give someone who has become homeless a positive alternative to entering 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.

More Diversion best practices can be found here:

- Diversion: Making it Work
- Progressive Engagement and Coordinated Entry: Thoughts from OrgCode

When to do Diversion in the KY BoS: Using KYHMIS

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. If the client/household is facing a "love-eviction" for a residence for which they are not a legal resident, follow the guidance below.

When to complete a New BOS-Diversion Project Entry

- If client/household is seeking shelter assistance
- If client/household is entering into the homeless response system for the 1st time (or without an ES/TH entry in the past 2 years)
- If the client/household came into shelter in the middle of the night without a Diversion conversation with staff. It is recommended staff have a Diversion conversation with the client/household the following morning.
- If the client/household is unsheltered **for the first time** and their time unsheltered has been less than a week.
- If client/household is imminently at risk of homelessness without a legal residence to stay
- If the client/household is unstably housed (doubled up, living in hotel/motel paid for by the client) and they have identified no alternative place to stay that night

When to complete an additional Diversion from Homelessness Assessment and Attempt (within the current Project Entry)

- If the client/household has already had a diversion entry within the last 30 days and is seeking shelter assistance

When to exit from the BOS-Diversion Project

- Diversion attempt is unsuccessful, and client/household is entering shelter
- 30 days after project entry

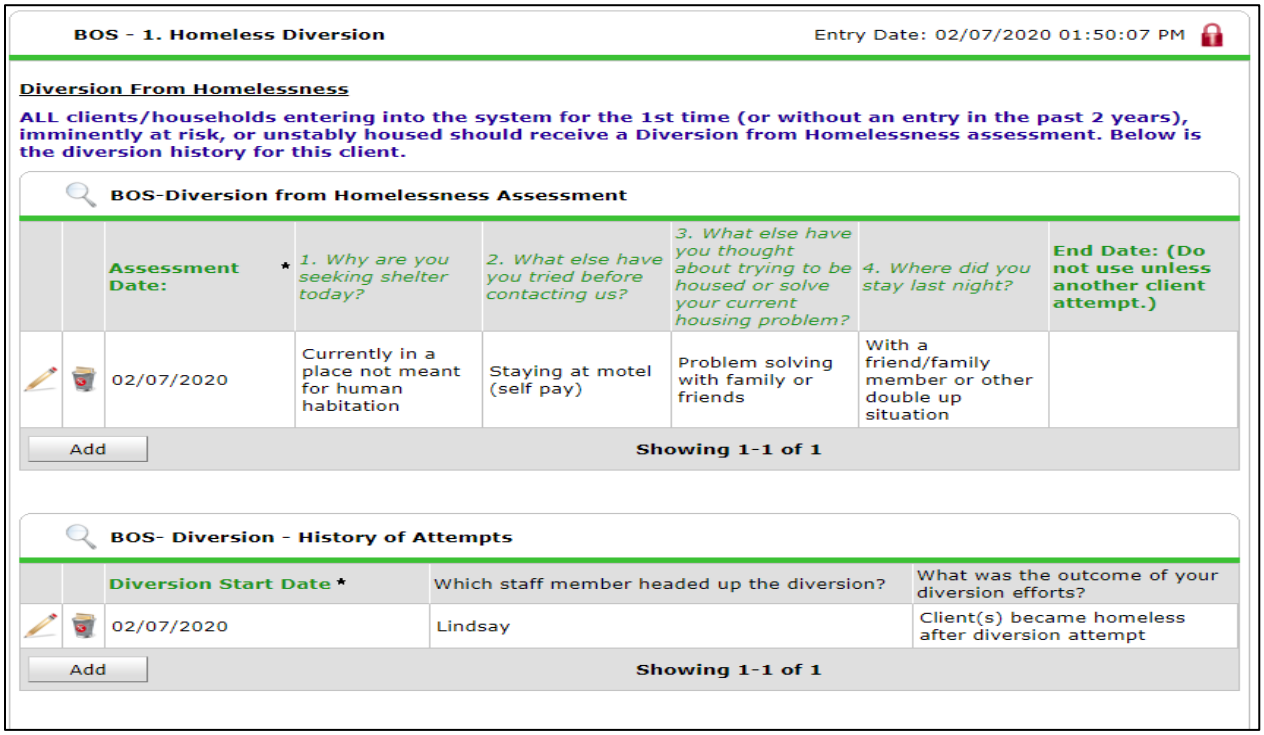
When not to do Diversion:

- If the client/household is unsheltered **for the first time** and their time unsheltered has been more than a week. These households should be engaged and offered access to shelter resources and access to CE for housing resources.
- If the client/household is unsheltered and this is not their first time being unsheltered. These households should be engaged and offered access to shelter resources and access to CE for housing resources.
- If the client/household is already in shelter as of November 1st, 2020 (implementation date of new CE P&P). These households should be engaged and offered access to CE for housing resources.
- If the client/household has entered into the homeless response system more than once in the last two years.

How to Complete Diversion in KYHMIS

Historically, Diversion data has not been collected in KYHMIS for the KY BoS CoC. In order to best serve the households seeking shelter assistance, KHC has created a BOS-Diversion Project (2991) in KYHMIS. Entry into this project is required to be completed by staff, with households seeking shelter assistance. It is the goal of the KY BoS CoC to divert households from the shelter system to safe and appropriate housing alternatives with these Diversion practices in order to reserve shelter space for those who truly need it.

Below is an overview of the BOS-Diversion Project (2991) in KYHMIS:



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Diversion From Homelessness

ALL clients/households entering into the system for the 1st time (or without an entry in the past 2 years), imminently at risk, or unstably housed should receive a Diversion from Homelessness assessment. Below is the diversion history for this client.

BOS-Diversion from Homelessness Assessment

		Assessment Date: *	1. Why are you seeking shelter today?	2. What else have you tried before contacting us?	3. What else have you thought about trying to be housed or solve your current housing problem?	4. Where did you stay last night?	End Date: (Do not use unless another client attempt.)
		02/07/2020	Currently in a place not meant for human habitation	Staying at motel (self pay)	Problem solving with family or friends	With a friend/family member or other double up situation	

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BOS- Diversion - History of Attempts

		Diversion Start Date *	Which staff member headed up the diversion?	What was the outcome of your diversion efforts?
		02/07/2020	Lindsay	Client(s) became homeless after diversion attempt

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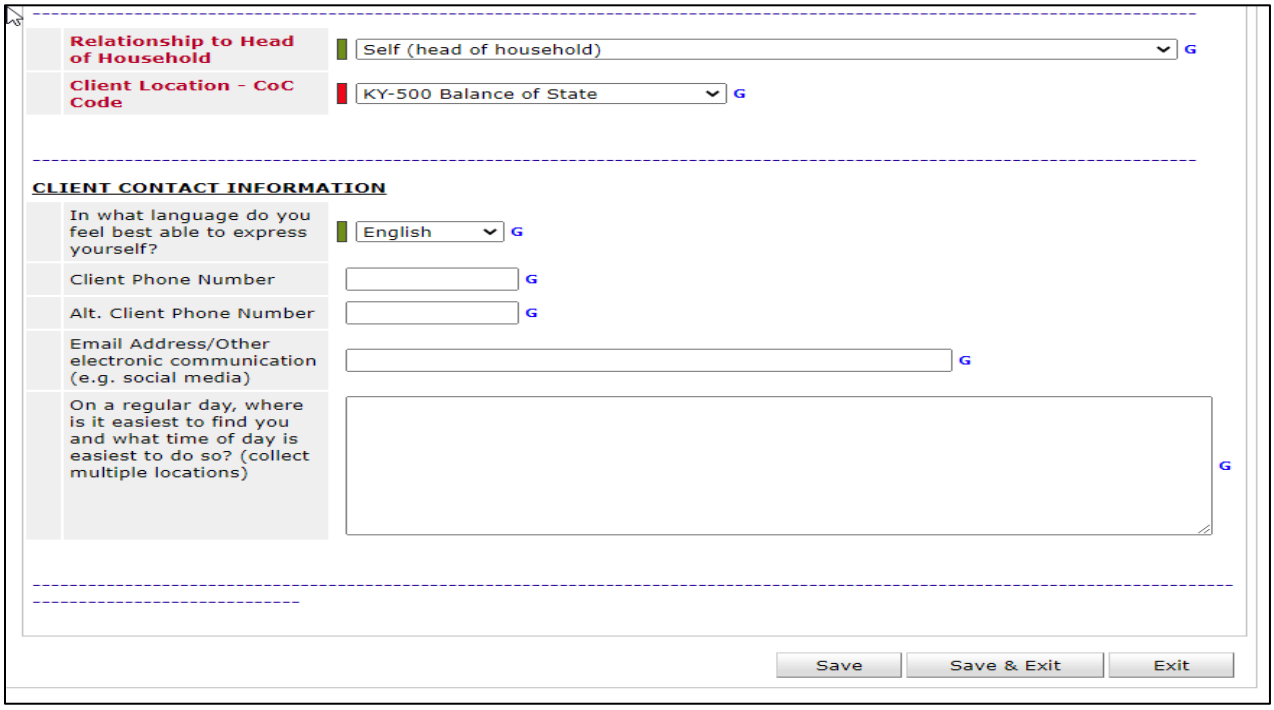


2. Coordinated Entry SSO Grantees

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. Projects must be designed in accordance with the applicable requirements and allowable activities for CoC SSO projects as authorized in 24 CFR 578.

With KHC facilitating the CE referral process, this 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 VI-SPDATs for participants being served by emergency shelters or service providers not participating in HMIS.
- Entering VI-SPDAT information and other client-level information into HMIS for inclusion on the prioritization list.
- Conduct 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.
- Facilitation of the sharing of information between the referring agency and housing provider to move people as quickly as possible into permanent housing.

3. 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.

More Street Outreach best practices can be found here:
- Impactful Outreach
- 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

4. Emergency Shelter

Emergency Shelter Best Practices

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. **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.

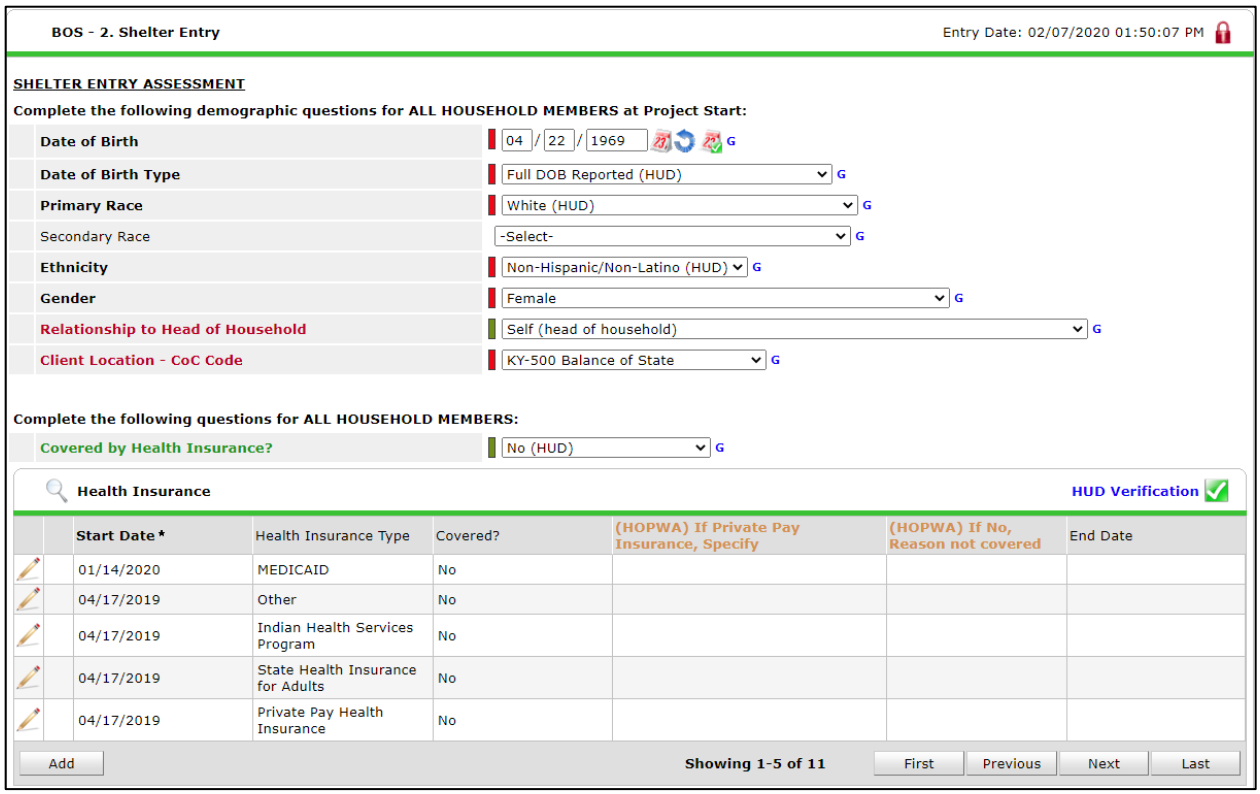
The Emergency Shelter Learning Series is a collection of webinars and resources from the NAEH focused on explaining the philosophy and practice of effective emergency shelter. KHC strongly encourages shelter providers to read and watch these materials, and to put these best practices in place within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

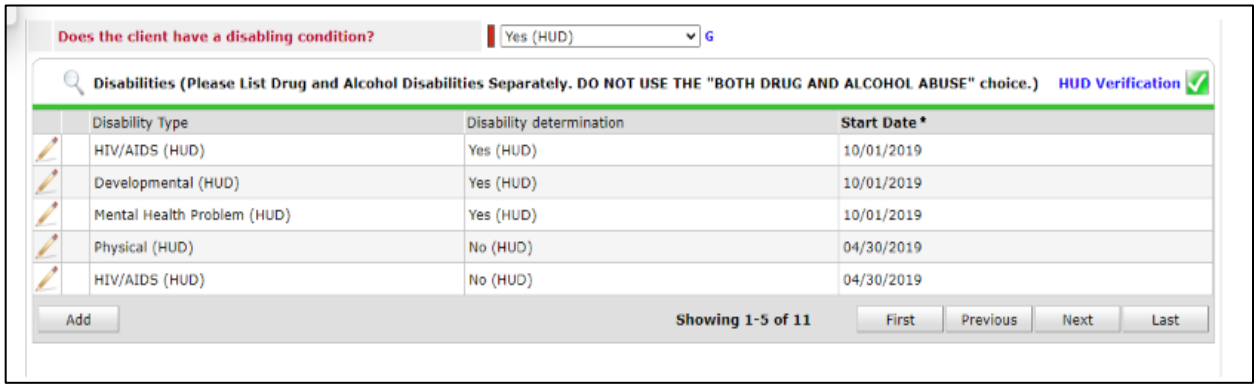
More Emergency Shelter best practices can be found here:
- Service Restrictions and Barring in Shelters
- So, You Think You're a Low Barrier Shelter… Let's Check
- Key Considerations for Implementing Emergency Shelter Within an Effective Crisis Response System

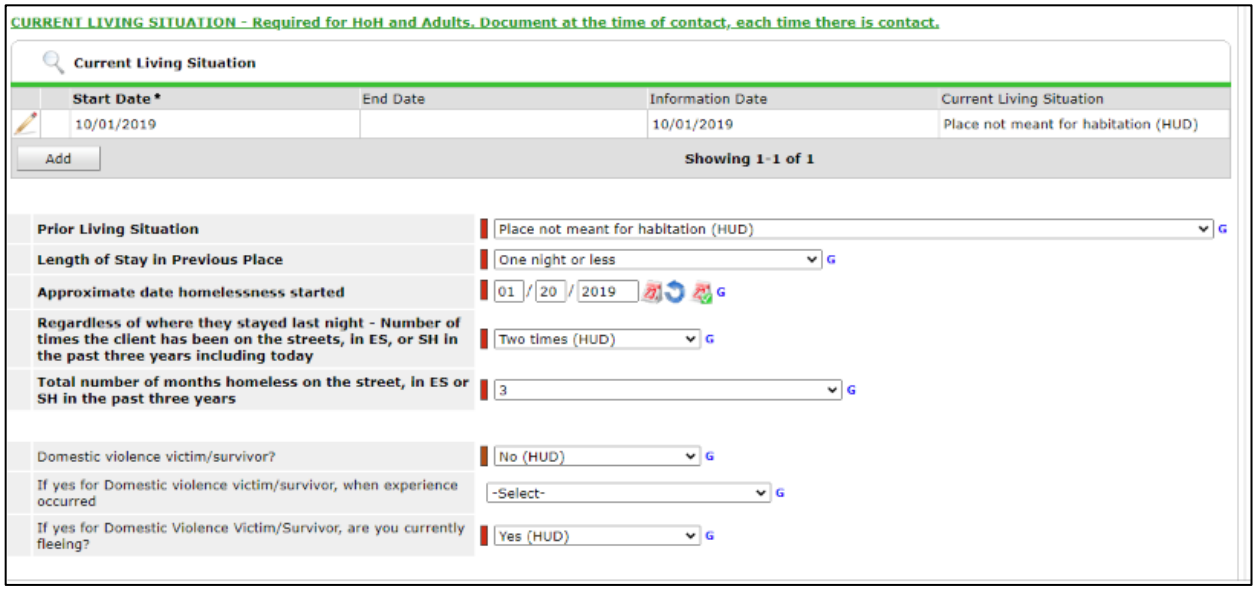
- Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation

Emergency Shelter Workflow in KYHMIS

- 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.







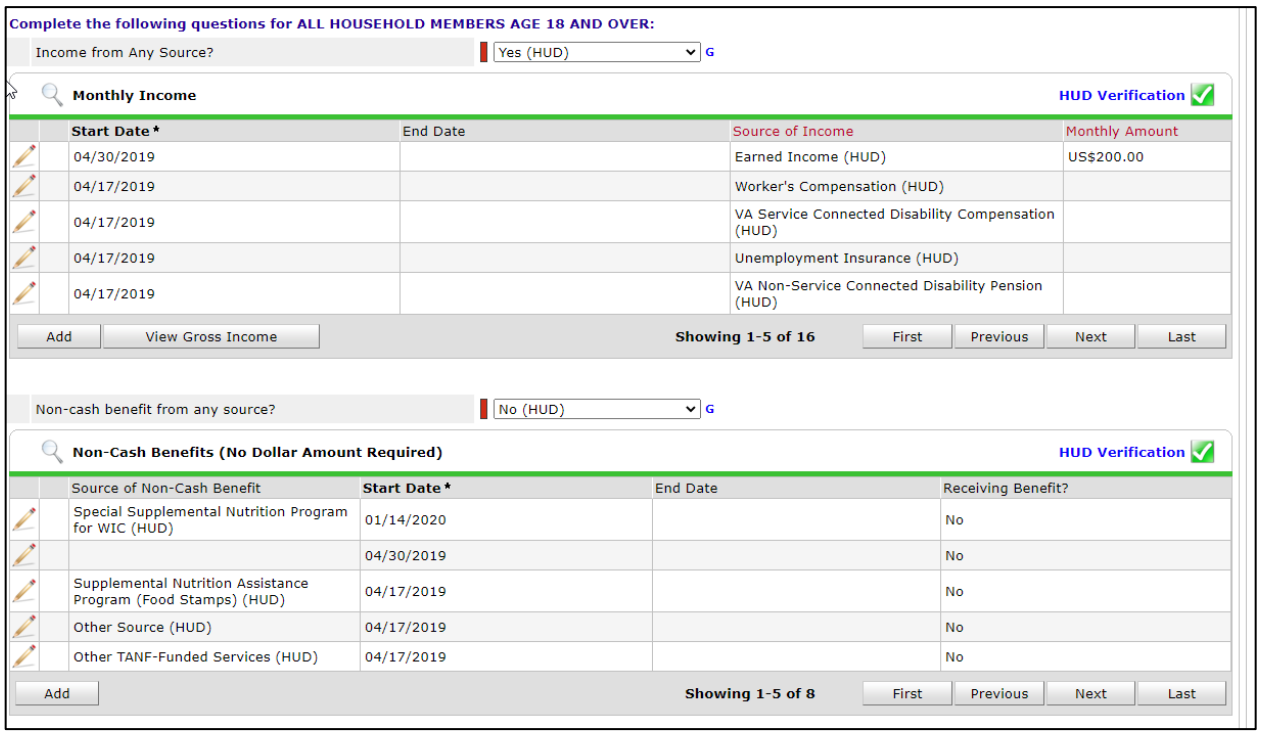
CURRENT LIVING SITUATION - Required for HoH and Adults. Document at the time of contact, each time there is contact.

Current Living Situation

	Start Date *	End Date	Information Date	Current Living Situation
	10/01/2019		10/01/2019	Place not meant for habitation (HUD)

Add — Showing 1-1 of 1

Prior Living Situation	Place not meant for habitation (HUD)
Length of Stay in Previous Place	One night or less
Approximate date homelessness started	01 / 20 / 2019
Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today	Two times (HUD)
Total number of months homeless on the street, in ES or SH in the past three years	3
Domestic violence victim/survivor?	No (HUD)
If yes for Domestic violence victim/survivor, when experience occurred	-Select-
If yes for Domestic Violence Victim/Survivor, are you currently fleeing?	Yes (HUD)



Complete the following questions for ALL HOUSEHOLD MEMBERS AGE 18 AND OVER:

Income from Any Source? — Yes (HUD)

Monthly Income — HUD Verification

	Start Date *	End Date	Source of Income	Monthly Amount
	04/30/2019		Earned Income (HUD)	US$200.00
	04/17/2019		Worker's Compensation (HUD)	
	04/17/2019		VA Service Connected Disability Compensation (HUD)	
	04/17/2019		Unemployment Insurance (HUD)	
	04/17/2019		VA Non-Service Connected Disability Pension (HUD)	

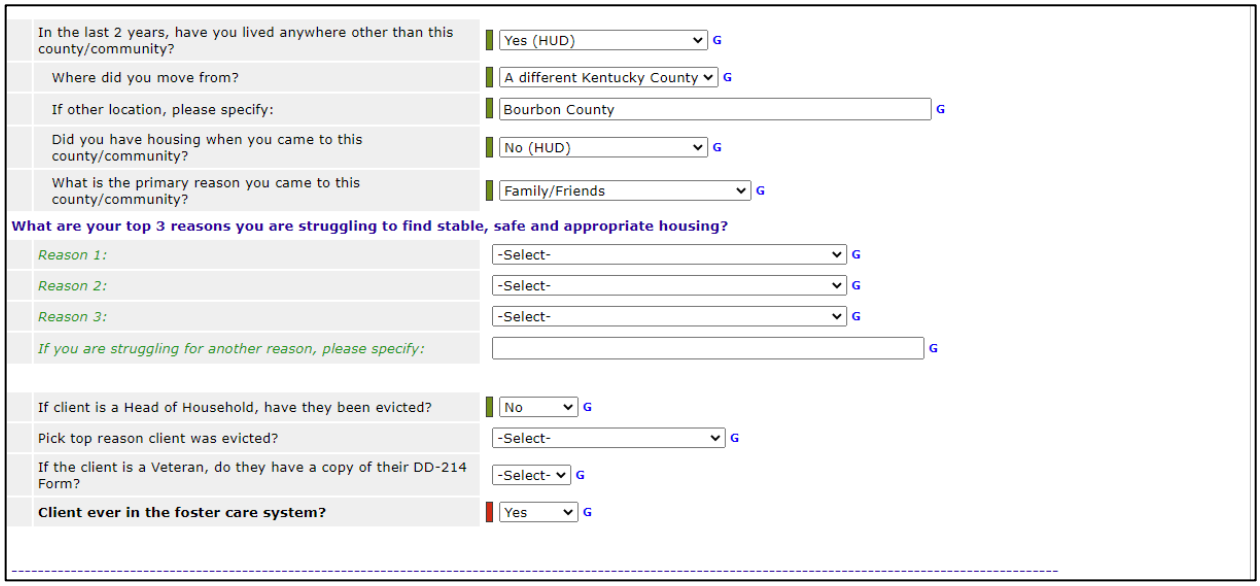
Add | View Gross Income — Showing 1-5 of 16 — First | Previous | Next | Last

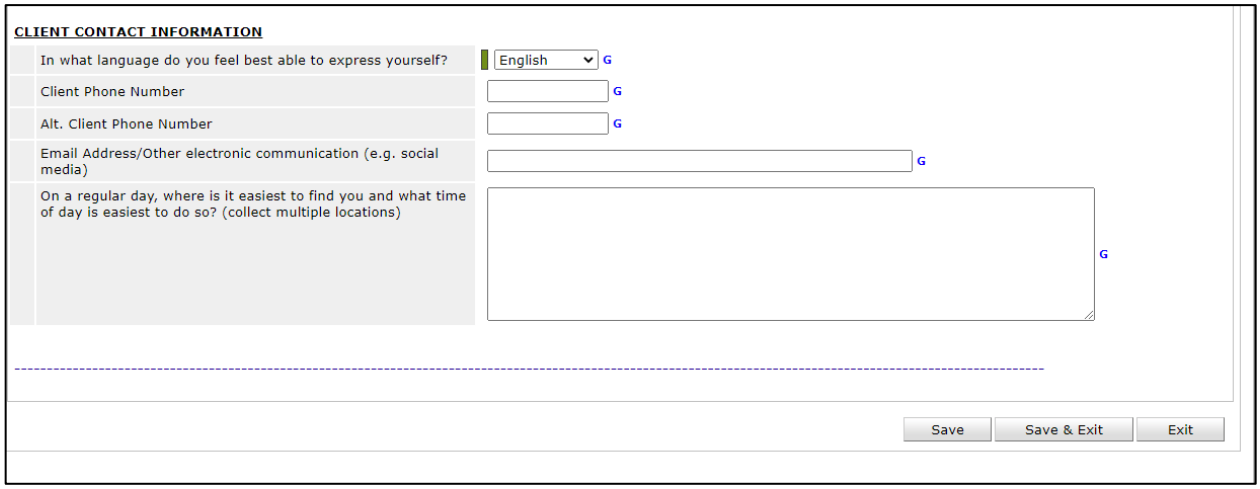
Non-cash benefit from any source? — No (HUD)

Non-Cash Benefits (No Dollar Amount Required) — HUD Verification

	Source of Non-Cash Benefit	Start Date *	End Date	Receiving Benefit?
	Special Supplemental Nutrition Program for WIC (HUD)	01/14/2020		No
		04/30/2019		No
	Supplemental Nutrition Assistance Program (Food Stamps) (HUD)	04/17/2019		No
	Other Source (HUD)	04/17/2019		No
	Other TANF-Funded Services (HUD)	04/17/2019		No

Add — Showing 1-5 of 8 — First | Previous | Next | Last





KY BoS CoC CE Project in KYHMIS

NEW in 2020

To best capture required system-wide CES data, KHC has created a single BoS Coordinated Entry Project in KYHMIS to be used for all LPC's. The KYHMIS Project is titled BOS-Coordinated Entry Project (2992). Within this project are two separate Assessments:

- BOS - 3. Housing Engagement
- BOS - 4. CES Housing Actionable & Prioritization

BOS – 3. Housing Engagement

- If the household has not resolved their homelessness within the first two weeks of being in shelter, is a long stayer, has returned to shelter multiple times or if the household is unsheltered, providers will Enter Data As (EDA) the BOS-Coordinated Entry Project (2992)

and complete the Housing Engagement Assessment, which includes the new CE Data Elements required by HUD.
- This Assessment also includes the section to complete the appropriate VI-SPDAT.

BOS – 4. CES Housing Actionable & Prioritization

- Once the Housing Engagement 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.
- Once all appropriate documentation is obtained, it will be added to the household's Client Profile in KYHMIS as a File Attachment.
- Providers will then complete the CES Housing Actionable & Prioritization Assessment within the BOS-Coordinated Entry Project (2992).
- By Selecting "Yes" to having all client paperwork and documentation uploaded in HMIS, clients will then appear on the CES Housing Actionable & Prioritization List.

When to Complete the VI-SPDAT

The CE process requires eligible referrals of 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). Categories 2 and 3 are not eligible.

Responsibilities of the agency entering the household to the KY BoS CoC CE Project:

1. Document the household's eligibility for homeless assistance using KHC's required program Toolkits.
2. 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
3. Maintain the ROI and privacy of all pertinent client information through KYHMIS or secure office location.
4. Do not complete the VI-SPDAT without the respondent's knowledge and explicit agreement.
5. Do not complete the VI-SPDAT through observation or other non-self-reported information.
6. If you cannot obtain a ROI as directed above, do not conduct the VI-SPDAT.
7. Emergency shelters should administer the appropriate VI-SPDAT with residents who have not solved their own homelessness approximately 2 weeks after shelter entry.
8. Other providers (including but not limited to street outreach, self-referrals to housing agencies, non-HUD-funded providers) should administer the appropriate VI-SPDAT immediately once rapport is established for people who are unsheltered.
9. Any provider conducting the appropriate VI-SPDAT is required to begin documentation for chronic homelessness (or homelessness) and disability immediately.

Which VI-SPDAT to Use?

The KY BoS currently uses Version 2 for Individuals and Families. The KY BoS will the most recent version (v3) whenever the KYHMIS vendor makes it available. All three versions of the

triage tool are available in KYHMIS and online.

VI- SPDAT Individuals

Recommended Intervention	Prescreen Score
PSH/Housing First	8+
Rapid Re-Housing	4-7
Diversion	0-3

- 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 2 separate VI-SPDATs and take the highest score as the acuity for prioritization purposes.
- For pregnant individuals, use the VI-SPDAT (Individual), unless woman has additional children in the household.

VI-FSPDAT Families

Recommended Intervention	Prescreen Score
PSH/Housing First	9+
Rapid Re-Housing	4-8
Diversion	0-3

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

VI- TAY-SPDAT Youth for singles <24

Recommended Intervention	Prescreen Score
PSH/Housing First	8+
Rapid Re-Housing	4-7
Diversion	0-3

- Providers should use the Youth VI-SPDAT for the any single adult under 24 years of age.

Use the Required Introductory Script

Once you have obtained the ROI, using the language in the respective forms, you can conduct the VI-SPDAT, beginning with:

"My name is [_____], and I work for a group called [name of organization]. I have a 7-minute survey 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 survey 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 Victim Service Provider 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 1-word answer. I'll be honest, some questions are personal in nature, but know 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."

Utilizing the full SPDAT for Coordinated Entry Purposes

To provide a safety net and deeper assessment for vulnerable households but score relatively low on the VI-SPDAT, referring providers may request permission from the LPC to conduct a full SPDAT. The LPC must grant permission, achieved by consensus, to use the full SPDAT for prioritization. This is the exception, rather than the rule. The Full SPDAT should only be utilized in extenuating circumstances for purposes of prioritization. The Full SPDAT can be used to better determine the acuity of clients whose acuity is more difficult to determine via the VI-SPDAT (borderline cases, persons not responsive to the VI-SPDAT, etc.) but is primarily used as an intensive ongoing case management tool.

The use of a full SPDAT or the request for review is not a side door to the process. This process is intended to be person-centric, not program-centric (i.e., the end result will not always be PSH placement, but rather to match a highly vulnerable person to the appropriate housing resource).

The only guarantee related to this process is that the individual will receive a review by the LPC and CoC Systems Specialist. The review will determine the individual's placement on the Prioritization List for housing.

Where to Complete the VI-SPDAT in KYHMIS

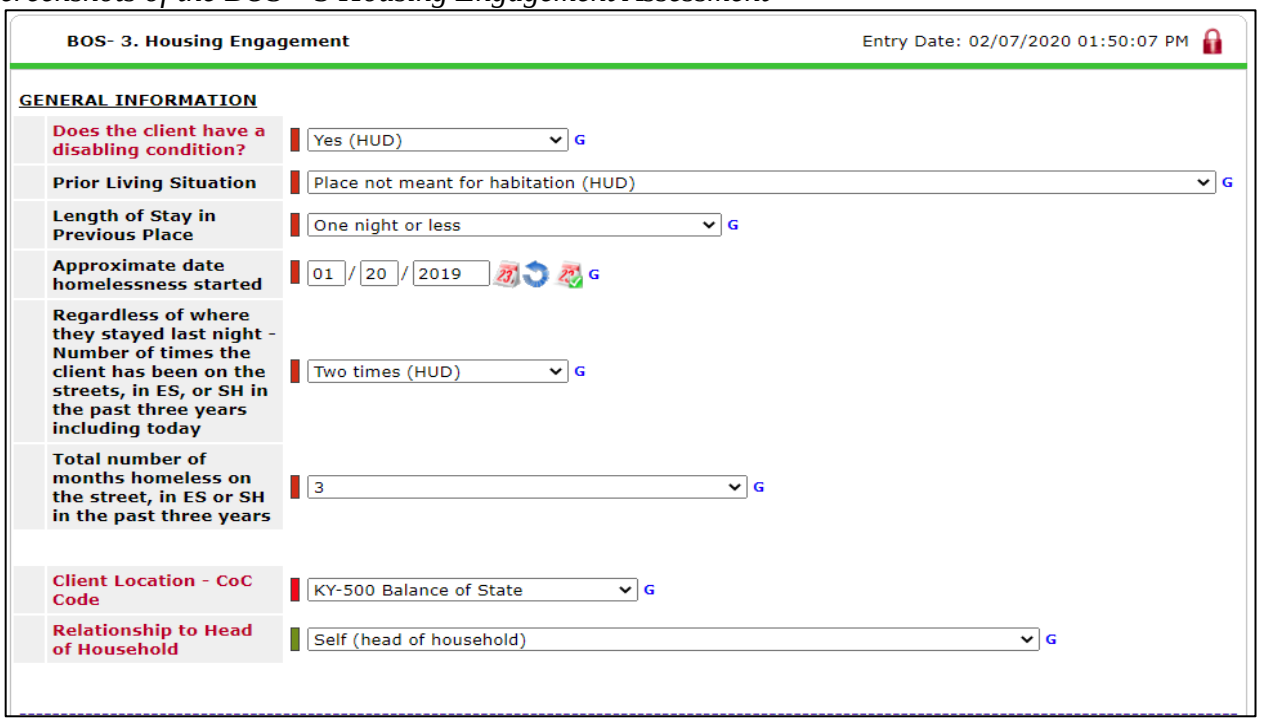
Providers Participating in KYHMIS: Whenever possible, the provider where the household sought assistance should complete the tool in KYHMIS, using the BOS-Coordinated Entry Project (2992). When not possible, the provider should complete the tool on paper and transfer

the information into the BOS-Coordinated Entry Project (2992) in KYHMIS.

VSPs: The provider where the household sought assistance should complete the tool on paper, Providers will then complete the updated Local Prioritization Inclusion Form (Appendix A) and will submit to the KHC CoC Systems Specialist via KHC's Secure File Share System.

Other Non-KYHMIS Providers: The provider where the household sought assistance should complete the tool on paper, Providers will then complete the updated Local Prioritization Inclusion Form (Appendix A) and will submit to the LPC Lead Agencies for entry into KYHMIS. LPC Lead Agencies may elect to complete the BOS-Coordinated Entry Project (2992) in real time with people accessing the system, rather than obtaining the Local Prioritization Inclusion Form.

Screenshots of the BOS – 3 Housing Engagement Assessment



CLIENT CONTACT INFORMATION

In what language do you feel best able to express yourself?	English 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 *	Bath G

HOUSING ENGAGEMENT INFORMATION

Housing Engagement Category? *	Individual G
When did client engage in Coordinated Entry CES conversation?	/ / G
Where is the client staying right now? *	Sheltered G
Agency *	khc G
Case Manager	G

HOUSING OPTION INFORMATION

Once an housing option is available, what size unit will be needed (# of bedrooms)?	1 G
If available, would the client be interested in a roommate option?	No G
Once an housing option is available, will the client require special accommodation (e.g. 1st floor, wheelchair access, ramp, bathroom facilities?)	Yes G
If yes for special accommodation, please specify:	First floor, or building with an elevator G

VI-SPDAT

ONLY complete the VI-SPDAT when a client/household is not able to be successfully diverted or has been a long stayer in the system. Complete the appropriate VI-SPDAT based upon household composition.

Follow the following text when conducting the VI-SPDAT:

We are here today to talk to you about your housing and service needs. If you give us permission, we will ask you some questions for about 10 minutes. These questions are about your health and housing and we will also ask for your social security number.

By participating in the interview you give permission to the Kentucky Homeless Management Information Systems to provide your information to homeless service providers for the purpose of furthering services and housing in this community.

The information that you tell us during the interview will be stored in the KY Homeless Management Information System (KYHMIS), which is a secure database that collects information about homelessness.

Identifying information will be kept confidential and will only be shared with outreach workers and case managers who will follow up with you for services.

Some of the questions we ask during the interview might make you feel uncomfortable or be upsetting. If you feel uncomfortable or upset during the interview, you may ask the interviewer to take a break or to skip any of the questions.

You can skip any questions you do not want to answer, end the interview at any point. Additional information about KYHMIS, and a list of participating agencies, is available from your surveyor or online at...

VI-SPDAT FOR INDIVIDUALS

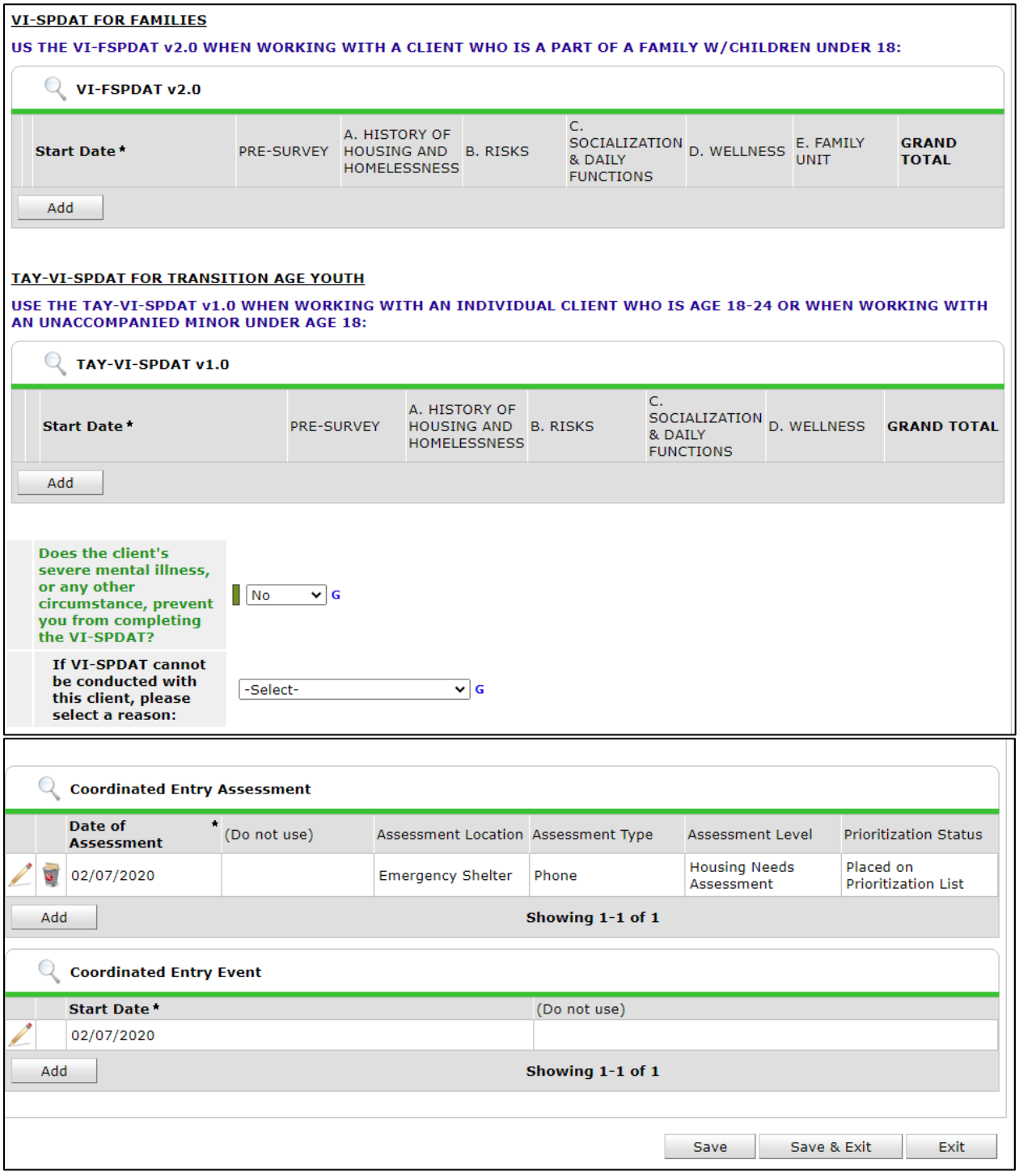
USE THE VI-SPDAT v2.0 WHEN WORKING WITH A CLIENT WHO IS AN INDIVIDUAL:

VI-SPDAT v2.0

		Start Date *	PRE-SURVEY	A. HISTORY OF HOUSING AND HOMELESSNESS	B. RISKS	C. SOCIALIZATION & DAILY FUNCTIONS	D. WELLNESS	GRAND TOTAL
		02/07/2020	0	1	2	3	1	7

Add

Showing 1-1 of 1



VI-SPDAT FOR FAMILIES

US 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

Does the client's severe mental illness, or any other circumstance, prevent you from completing the VI-SPDAT? No G

If VI-SPDAT cannot be conducted with this client, please select a reason: -Select- G

Coordinated Entry Assessment

Date of Assessment *	(Do not use)	Assessment Location	Assessment Type	Assessment Level	Prioritization Status
02/07/2020		Emergency Shelter	Phone	Housing Needs Assessment	Placed on Prioritization List

Add — **Showing 1-1 of 1**

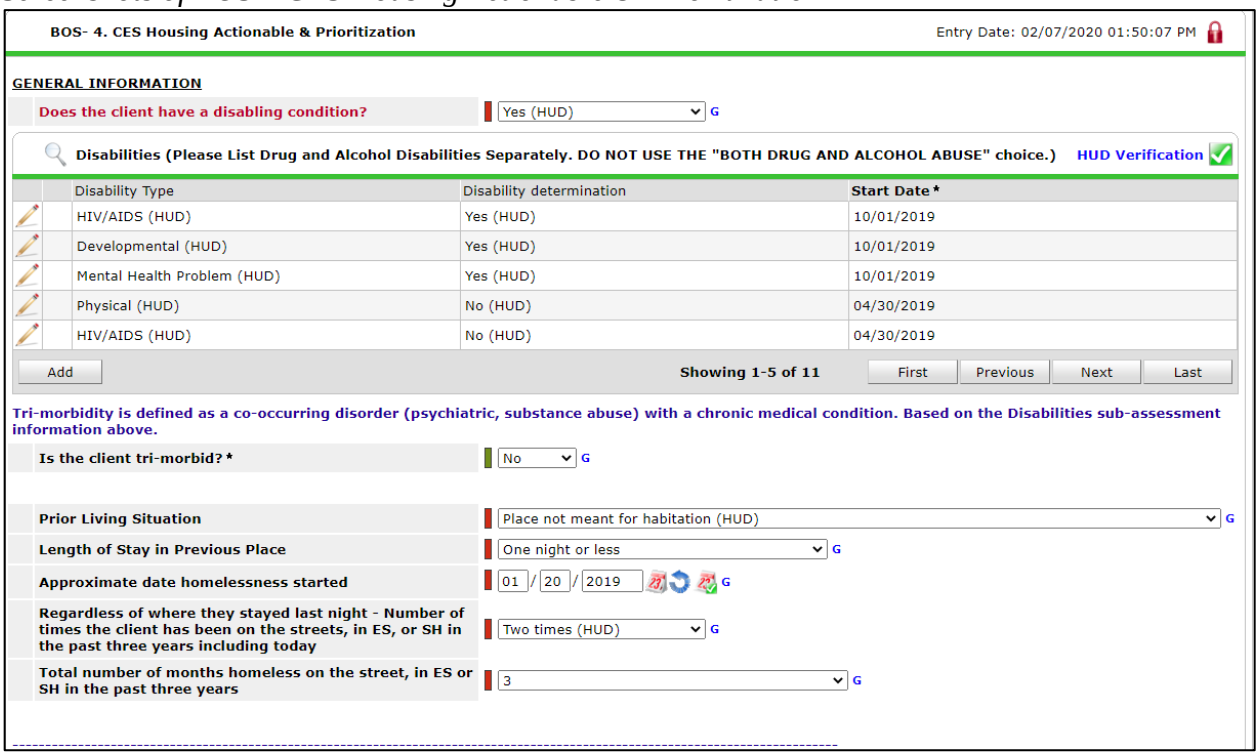
Coordinated Entry Event

Start Date *	(Do not use)
02/07/2020	

Add — **Showing 1-1 of 1**

Save | Save & Exit | Exit

Screenshots of BOS – CES Housing Actionable & Prioritization



BOS- 4. CES Housing Actionable & Prioritization Entry Date: 02/07/2020 01:50:07 PM

GENERAL INFORMATION

Does the client have a disabling condition? Yes (HUD) 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 *
HIV/AIDS (HUD)	Yes (HUD)	10/01/2019
Developmental (HUD)	Yes (HUD)	10/01/2019
Mental Health Problem (HUD)	Yes (HUD)	10/01/2019
Physical (HUD)	No (HUD)	04/30/2019
HIV/AIDS (HUD)	No (HUD)	04/30/2019

Add Showing 1-5 of 11 First Previous Next Last

Tri-morbidity is defined as a co-occurring disorder (psychiatric, substance abuse) with a chronic medical condition. Based on the Disabilities sub-assessment information above.

Is the client tri-morbid? * No G

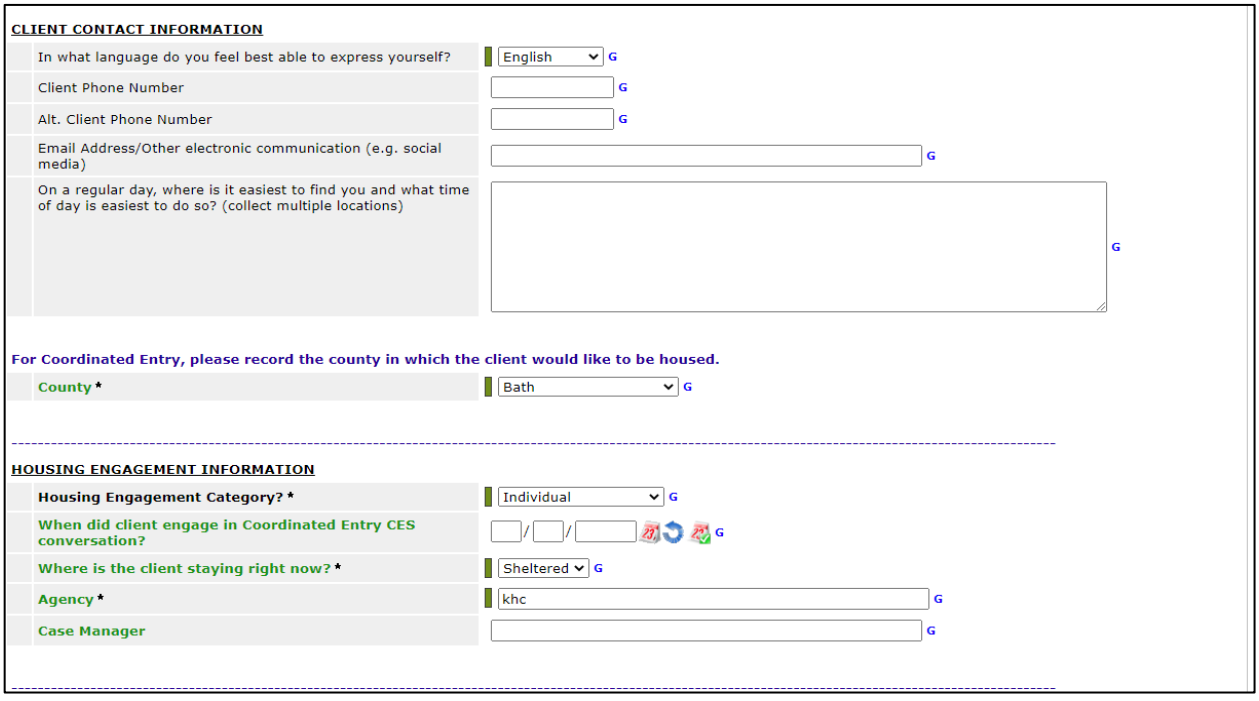
Prior Living Situation Place not meant for habitation (HUD) G

Length of Stay in Previous Place One night or less G

Approximate date homelessness started 01 / 20 / 2019 G

Regardless of where they stayed last night - Number of times the client has been on the streets, in ES, or SH in the past three years including today Two times (HUD) G

Total number of months homeless on the street, in ES or SH in the past three years 3 G



CLIENT CONTACT INFORMATION

In what language do you feel best able to express yourself? English 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 * Bath G

HOUSING ENGAGEMENT INFORMATION

Housing Engagement Category? * Individual G

When did client engage in Coordinated Entry CES conversation? / / G

Where is the client staying right now? * Sheltered G

Agency * khc G

Case Manager G

HOUSING OPTION INFORMATION

If available, would the client be interested in a roommate option?	No G
Once an housing option is available, what size unit will be needed (# of bedrooms)?	1 G
Once an housing option is available, will the client require special accommodation (e.g. 1st floor, wheelchair access, ramp, bathroom facilities?)	Yes G
If yes for special accommodation, please specify:	First floor, or building with an elevator G

VI-SPDAT

VI-SPDAT v2.0

Start Date *	PRE-SURVEY	A. HISTORY OF HOUSING AND HOMELESSNESS	B. RISKS	C. SOCIALIZATION & DAILY FUNCTIONS	D. WELLNESS	GRAND TOTAL
02/07/2020	0	1	2	3	1	7

Add — Showing 1-1 of 1

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 v1.0

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

Add

Does the client's severe mental illness, or any other circumstance, prevent you from completing the VI-SPDAT?	No G
If VI-SPDAT cannot be conducted with this client, please select a reason:	-Select- G

Coordinated Entry Event

Start Date *	(Do not use)
02/07/2020	

Add — Showing 1-1 of 1

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 from 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

Save | Save & Exit | Exit

CE Referral Process

Referral Process in the KY BoS

The KHC CoC Systems Specialist will maintain the Housing Engagement and CES 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 Coordinated Entry 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 will ONLY be made from the CES 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 agency accepting the referral from the CES Housing Actionable & Prioritization List are:

1. Work with referring agency to ensure eligibility is documented.
2. 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.
3. Provide or arrange for the provision of housing-focused case management and voluntary supportive services.

Victim Service Provider (VSP) Referrals

KCADV and partner VSP agencies will provide KY BoS CES information and obtain informed consent to survivors seeking mainstream housing referral in the system. Once consent is obtained, the VSPs as the trained trauma-informed care experts will complete the VI-SPDAT with clients. VSPs will then complete the updated Local Prioritization Inclusion Form and will submit to the CoC Systems Specialist via KHC's Secure File Share System. CoC Systems Specialist will add the Local Inclusion Form 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 location, contact information 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 fully into KYHMIS, KHC will follow the "Opt-out Option" noted below.

KCADV partner VSP agencies complete the VISPDAT with clients and fill out the Updated Local Prioritization Inclusion Form which includes the updated Coordinated Entry Data Elements required, with ALL client demographic information. VSP submits the completed documentation to CoC Systems Specialist via KHC's Secure File Share System who then adds the information to the BoS CoC Coordinated Entry Project as Anonymous clients. Only the client's DOB will be attached to the Anonymous Client profile to help determine potential Youth referrals. Client will be noted as a DV survivor for DV specific housing resources, but location, contact information and VSP they are working with will be kept on a separate spreadsheet only accessible by the CoC Systems Specialist.

Veteran Provider Referrals

KHC CoC Systems Specialist will make housing placement referrals to various veteran 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 CES Housing Actionable & Prioritization List for the next available resource.

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:

Permanent Supportive Housing (PSH)

1. Chronically Homeless + 2 or more years of homelessness + Tri-morbid + CV High-Risk + Acuity 13+
2. Chronically Homeless + 2 or more years of homelessness + Tri-morbid + CV High-Risk + Acuity 8/9-12 (I/F)
3. Chronically Homeless + 2 or more years of homelessness + Tri-morbid + CV Medium-Risk + Acuity 13+
4. Chronically Homeless + 2 or more years of homelessness + Tri-morbid + CV Medium Risk + Acuity 8/9-12 (I/F)
5. Chronically Homeless + 1-2 years of homelessness + Tri-morbid + CV High Risk + Acuity 8/9+ (I/F)
6. Chronically Homeless + 1-2 years of homelessness + Tri-morbid + CV Medium + Acuity 8/9+ (I/F)
7. Not Chronically Homeless + 1-2 years of homelessness + CV High Risk + Acuity 8/9+ (I/F)
8. Not Chronically Homeless + 1-2 years of homelessness + CV Medium Risk + Acuity 8/9+ (I/F)
9. Not Chronically Homeless + any length of homelessness + Unsheltered or Sheltered + Acuity 8/9+ (I/F)

Rapid Re-housing (RRH)

1. Chronically Homeless + 1+ years of homelessness + CV High/Medium-Risk +Acuity 8/9+ (I/F)
2. Not Chronically Homeless + any length of homelessness + CV High/Medium Risk + Acuity 8/9+ (I/F)
3. Chronically Homeless + 1+ years of homelessness + CV High-Risk + Acuity 4-7/8 (I/F)
4. Chronically Homeless + 1+ years of homelessness + CV Medium-Risk + Acuity 4-7/8 (I/F)
5. Chronically Homeless + 1+ years of homelessness + Unsheltered or sheltered + Acuity 4+
6. Not Chronically Homeless + 6-11 months of homelessness + CV High-Risk + Acuity 4-7/8 (I/F)
7. Not Chronically Homeless + 6-11 months of homelessness + CV Medium-Risk + Acuity 4-7/8 (I/F)
8. Not Chronically Homeless + 1 day-5 months of homelessness + CV High-Risk + Acuity 4-7/8 (I/F)
9. Not Chronically Homeless + 1 day-5 months of homelessness + CV Medium-Risk + Acuity 4-7/8 (I/F)
10. Not Chronically Homeless + any length of homelessness + Unsheltered or Sheltered + Acuity 4+

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

COVID-19 Risk Factors Criteria

Taking into consideration information from both 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 COVID-19 based on both Living Situation Criteria and Medical Factors Criteria as it pertains to Coordinated Entry Prioritization:

1. CV High Risk = 1+ Medical Factors + High Risk Living Situation
2. CV High Risk = 1+ Medical Factors + Medium Risk Living Situation
3. CV Medium Risk = 1+ Medical Factors +Low Risk Living Situation
4. CV Medium Risk = No Medical Factors + High Risk Living Situation
5. CV Low Risk = No Medical Factors + Medium Risk Living Situation
6. CV Low Risk = No Medical Factors + Low Risk Living Situation

Medical Factors Criteria

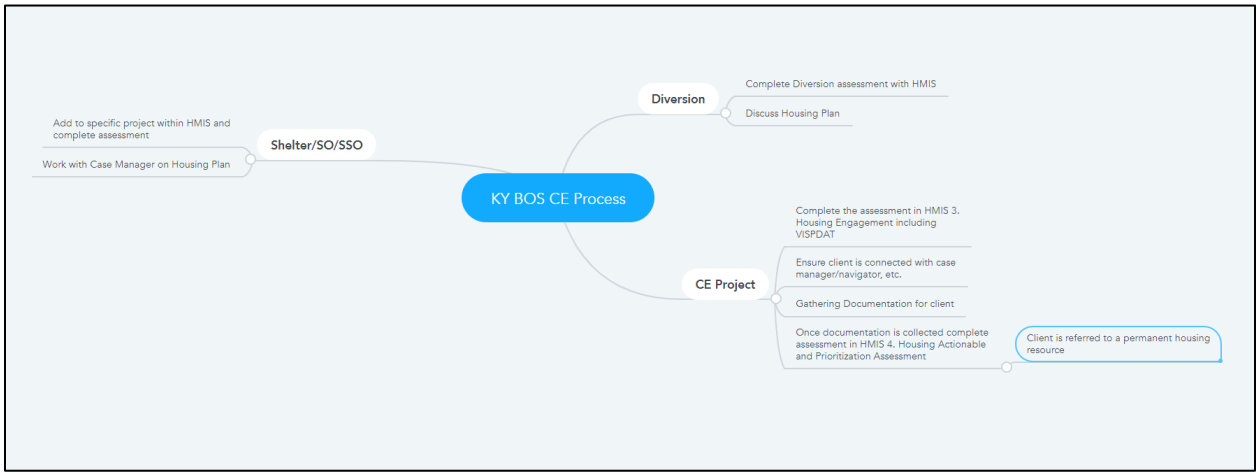
- Pregnant or breastfeeding women
- Individuals ages 55+
- One of the following pre-existing health conditions:
    - **Chronic lung disease or moderate to severe asthma**
    - **Serious heart conditions** (expected to be of long-continued and indefinite duration, and significantly inhibits ability 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 6 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 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)

CES Referral Visual Representation



Housing Search, Placement and Stabilization

Client Choice in Housing Search and Placement

Process

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.

Steps

1. In providing or arranging for housing, the project considers the needs of the household experiencing homelessness.
2. The project receiving the referral provides assistance in accessing suitable housing, guided by client choice.
3. Projects agree to accept 3 out of every 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

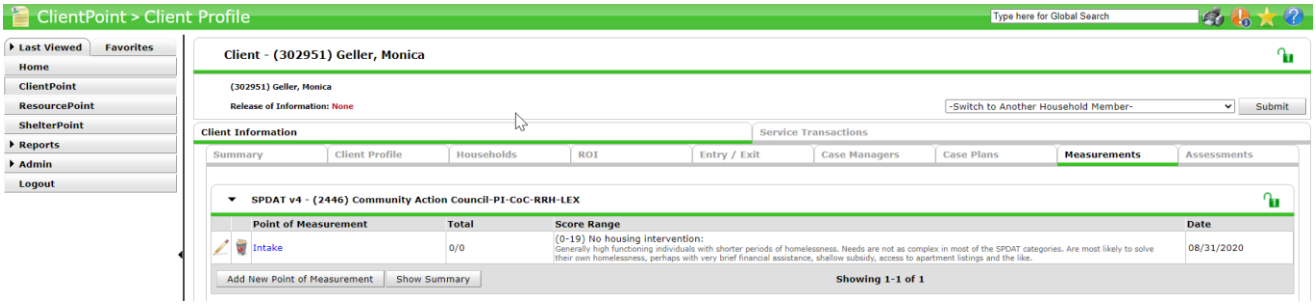
The CE process shall provide a continuity of Housing-Focused services to all participants once housed and their subsequent exit from the CES Housing Actionable & Prioritization List. These services may be provided by the housing provider or through partnerships with other agencies. KHC Strongly encourages 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 project, 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 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 6 months, for no more than 6 months after leaving transitional housing or homelessness, respectively, to assist their adjustment to independent living. 24 CFR 578.53(3)

Utilizing the Full SPDAT for Case Management purposes

To provide a comprehensive, evidence-based case management service to households that have been permanently housed through the Coordinated Entry System, housing providers are encouraged to utilize 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 utilize the Full SPDAT, the KHC Data Team can add the “Measurement” tab in KYHMIS; this is where the Full SPDAT can be documented in KYHMIS.



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 Placement

When a household refuses the housing resource offered (i.e. does not want to relocate), the housing provider will contact the CoC Systems Specialist. The household will be placed back onto the CES 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-Coordinated Entry Project (2992). The referring agency may consider providing counseling to the household on a voluntary basis to increase chances of successful housing placement.

Inactive Households

Referring agencies shall strive to maintain regular contact with households placed on the Housing Engagement and CES Housing Actionable & Prioritization Lists for documentation and referral updates. When a referring agency is unable to contact the household for 90 consecutive days, the Referring Agency or CoC Systems Specialist will exit the client from the BoS CoC CE Project.

Permanent Housing Interventions

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

What is Permanent Supportive Housing?

As defined by 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 utilize a Housing First approach in all of their ESG/CoC funded projects. However, this is especially important for households in Permanent Supportive Housing.

More Permanent Supportive Housing best practices can be found here:

- Housing First in Permanent Supportive Housing
- Supporting People that Have Complex Challenges and Have or are About to Lose their Accommodation
- Is Harm Reduction Enabling?
- Using Medicaid to Pay for Services in PSH

What is Rapid Re-housing?

As defined by 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 rapid re-housing 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.

More Rapid Re-Housing best practices can be found here:

- Rapid Re-Housing Performance Benchmarks and Program Standards
- Rapid Re-Housing Performance Evaluation and Improvement Webinar
- Using an Intensive Case Management Approach with Rapid ReHousing Resources
- Rapid Re-Housing Toolkit
- Rapid Re-Housing for Youth Toolkit

What is joint Transitional Housing-Rapid Rehousing?

As defined by 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. CoC's 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.

More joint Transitional Housing-Rapid Re-Housing best practices can be found here:

- 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!

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; and

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 Coordinated Entry System 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 to 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 Coordinated Entry System 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 Leade 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 Continuum of Care Coordinated Entry System. 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 Coordinated Entry System 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. The LPC Lead Agency

will arrange for recurring continuing education to LPC members on a quarterly basis to account for regional issues, staff turnover, and updates to the Policies and Procedures.

Evaluation of the CE System

Provider Evaluation

The LPC Lead Agencies will consult informally with participating projects to evaluate the CE prioritization, referral, and housing processes and inform the Coordinated Entry Committee of its findings. The System Performance Measures Committee of the BoS CoC Advisory Board will evaluate the CE System and LPC performance on an annual basis at a time to be designated by the Board Chair using data from KYHMIS. The System Performance Measures Committee will evaluate each LPC and the BoS CoC as a whole on the following measures:

1. Length of time persons remain homeless
2. Extent to which persons who exit homelessness to permanent housing destinations return to homelessness
3. Number of homeless persons
4. Number of persons who become homeless for the first time
5. Successful housing placement

Evaluation from Participants

The Coordinated Entry Committee will seek participant feedback in evaluating the system in tandem with KHC annually.

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, and Marketing of the CE System

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 way persons can access the CE system outside of regular business hours.

Appendix A: Local Prioritization Inclusion Form

Intake Date	Entry Date	ServicePoint (HoH) ID:
/ /	/ /	

Project Name

HoH Name First	Middle	Last

Suffix	Alias

Name Data Quality

- ☐ Full Name Reported
- ☐ Partial, Street or Code Name
- ☐ Client doesn't know
- ☐ Client Refused

Social Security Number	Date of Birth
	/ /
☐ Full SSN Reported (HUD) ☐ Approx or partial SSN reported (HUD) ☐ Client doesn't know (HUD) ☐ Client refused (HUD) ☐ Data Not collected (HUD)	☐ Full DOB Reported (HUD) ☐ Approx or partial SSN reported (HUD) ☐ Client doesn't know (HUD) ☐ Client refused (HUD) ☐ Data Not collected (HUD)

Gender

- ☐ Female
- ☐ Male
- ☐ Trans Female (MTF or male to female)
- ☐ Non-Conforming (not exclusively male or female)
- ☐ Client doesn't know
- ☐ Client refused
- ☐ Trans Male (FTM or female to male)

Race (select all that apply)

- ☐ American Indian or Alaska Native
- ☐ Native Hawaiian or Other Pacific Islander
- ☐ Asian
- ☐ White
- ☐ Black or African American
- ☐ Client doesn't know
- ☐ Client refused

Ethnicity

- ☐ Non-Hispanic/Non-Latino
- ☐ Hispanic/Latino
- ☐ Client doesn't know
- ☐ Client refused

Veteran Status	Relationship to HoH
☐ No ☐ Yes	☐ Self (Head of Household) ☐ HoH's child ☐ HoH's spouse or partner ☐ HoH's other relation member ☐ Other: non-relation member

Disability

Do you have a physical, mental or emotional Impairment, a post-traumatic stress disorder, or brain injury; a development disability, HIV/AIDS, or a diagnosable substance abuse problem?

☐ No ☐ Yes (indicate type(s) below) ☐ Client doesn't know ☐ Client refused

	Physical ☐	Mental Health ☐	Chronic Health Condition ☐	☐ Alcohol ☐ Drugs ☐ Both	Developmental ☐	HIV/AIDS ☐
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently:	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐	Yes ☐ No ☐

Client's Current Living Situation – current to project entry

(Select one Living Situation and **answer the corresponding questions in the order in which they appear**)

Start Date	End Date	Information Date	
/ /	/ /	/ /	

(Select one Living Situation and **answer the corresponding questions in the order in which they appear**)

Homeless Situation	Institutional Situation	Transitional/Permanent Housing Situation	Other
☐ Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside). ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher ☐ Safe Haven	☐ Foster care home or foster group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility ☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility	☐ Residential project or halfway house with no homeless criteria ☐ Hotel or motel paid for without emergency shelter voucher ☐ Transitional housing for homeless persons (including homeless youth) ☐ Host Home (non-crisis) Staying or living in a friend's room, apartment or house ☐ Staying or living in a family member's room, apartment or house ☐ Rental by client, with GPD TIP housing subsidy ☐ Rental by client, with VASH housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client, with RRH or equivalent subsidy	☐ Other: _____ ☐ Worker unable to determine ☐ Client doesn't know ☐ Client refused

	☐ Substance abuse treatment facility or detox center	☐ Rental by client, with HCV voucher (tenant or project based) ☐ Rental by client in a public housing unit ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client with other ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Owned by client, no ongoing housing subsidy	
Is client going to have to leave their current living situation within 14 days? ☐ Yes ☐ No	**If yes, answer the following questions.**		
Has a subsequent residence been identified? ☐ Yes ☐ No	Does individual or family have resources or support networks to obtain other permanent housing? ☐ Yes ☐ No	Has the client had a lease or ownership interest in a permanent housing unit in the last 60 days? ☐ Yes ☐ No	Has the client moved 2 or more times in the past 60 days? ☐ Yes ☐ No

Client's Prior Living Situation - Prior to Project Entry			
(Select one Living Situation and **answer the corresponding questions in the order in which they appear**)			
Literally Homeless Situation	**Institutional Situation**	**Transitional/Permanent Housing Situation**	**Other**
☐ Place not meant for habitation (e.g. a vehicle, abandoned building, bus/train/subway station, airport, anywhere outside). ☐ Emergency shelter, including hotel or motel paid for with emergency shelter voucher ☐ Safe Haven	☐ Foster care home or foster group home ☐ Hospital or other residential non-psychiatric medical facility ☐ Jail, prison or juvenile detention facility	☐ Residential project or halfway house with no homeless criteria ☐ Hotel or motel paid for without emergency shelter voucher ☐ Transitional housing for homeless persons (including homeless youth) ☐ Host Home (non-crisis) Staying or living in a friend's room, apartment or house ☐ Staying or living in a family member's room, apartment or house ☐ Rental by client, with GPD TIP housing subsidy	☐ Client doesn't know ☐ Client refused

	☐ Long-term care facility or nursing home ☐ Psychiatric hospital or other psychiatric facility ☐ Substance abuse treatment facility or detox center	☐ Rental by client, with VASH housing subsidy ☐ Permanent housing (other than RRH) for formerly homeless persons ☐ Rental by client, with RRH or equivalent subsidy ☐ Rental by client, with HCV voucher (tenant or project based) ☐ Rental by client in a public housing unit ☐ Rental by client, no ongoing housing subsidy ☐ Rental by client with other ongoing housing subsidy ☐ Owned by client, with ongoing housing subsidy ☐ Owned by client, no ongoing housing subsidy	
Length of Stay in Prior Living Situation (i.e. the literally homeless situation identified above)? ☐ One night or less ☐ Two to six nights ☐ One week or more but less than one month ☐ One month or more but less than 90 days ☐ 90 days or more but less than one year ☐ One year or longer	**Length of Stay in Prior Living Situation (i.e. the institutional situation identified above)?** ☐ One night or less ☐ Two to six nights ☐ One week or more but less than one month ☐ One month or more but less than 90 days ☐ 90 days or more but less than one year ☐ One year or longer **Did you stay in the institutional situation less than 90 days?** ☐ Yes (If YES – Complete SECTION III) ☐ No (If NO – End Homeless History Interview)	**Length of Stay in Prior Living Situation (i.e. the housing situation identified above)** ☐ One night or less ☐ Two to six nights ☐ One week or more but less than one month ☐ One month or more but less than 90 days ☐ 90 days or more but less than one year ☐ One year or longer **Did you stay in the housing situation less than 7 nights?** ☐ Yes (If YES – Complete SECTION III) ☐ No (If NO – End Homeless History Interview)	☐ Client doesn't know ☐ Client refused

☐ **N/A** (Complete SECTION IV Below)	**On the night before entering the institutional situation did you stay on the streets, in emergency shelter or a safe haven?** ☐ Yes (If YES – Complete SECTION IV) ☐ No (If NO – End Homeless History Interview)	**On the night before entering the housing situation did you stay on the streets, in emergency shelter or a safe haven?** ☐ Yes (If YES – Complete SECTION IV) ☐ No (If NO – End Homeless History Interview)	☐ Client doesn't know ☐ Client refused

On the night before your previous stay, was that on the streets, in an Emergency Shelter, or Safe Haven? ☐ No ☐ Yes	Approximate start of homelessness: __ __ / __ __ / __ __
Total number of times homeless on the street, in ES, or SH in the past three years ☐ One time ☐ Two times ☐ Three times ☐ Four times ☐ Client doesn't know ☐ Client refused	Total number of months homeless on the street, in emergency shelter, or SH in the past three years _____

Client Contact Information

In what language do you feel best to express yourself?	☐ English ☐ Arabic ☐ Chinese ☐ French ☐ German ☐ Hebrew ☐ Hindi ☐ Italian ☐ Japanese ☐ Korean ☐ Portuguese ☐ Russian ☐ Spanish ☐ Tagalog ☐ Vietnamese ☐ Other
Client Phone Number	
Alt. Client Phone Number	
Email address/other electronic communication (e.g. social media)	
On a regular day, where is it easiest to find you and what time of day is easiest to do so? (collect multiple locations)	

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

Housing Engagement Information

Housing Engagement Category?	☐ Individual ☐ Couple (no children) ☐ Family ☐ Transition Age Youth
When did client engage in Coordinated Entry CES conversation?	☐☐/☐☐/☐☐
Where is the client staying right now?	☐ Outdoors ☐ Shelter
Agency	
Case Manager	
What LPC are you in?	

Housing Option Information

Once a housing option is available, what size unit will be needed (# of bedrooms)?	
If available, would the client be interested in a roommate option?	☐ Yes ☐ No
Once a housing option is available, will the client require special accommodation (e.g. 1st floor, wheelchair access, ramp, bathroom facilities?)	☐ Yes ☐ No
If yes for special accommodation, please specify:	

VI-SPDAT

VI-SPDAT Score for Individual	
VI-SPDAT Score for Families	
TAY VI-SPDAT Score	
Tri-Morbid Questions from Vi-SPDAT	
Has your family ever had to leave an apartment, shelter program, or other place you are staying because of the physical health of you or anyone in your family?	☐ Yes ☐ No
Do you or anyone in your family have any chronic health issues with your liver, kidney, stomach, lungs, or heart?	☐ Yes ☐ No
If there was space available in a program that specifically assists people that live with HIV and AIDS, would that be of interest to you or anyone in your family?	☐ Yes ☐ No
Does anyone in your family have any physical disabilities that would limit the type of housing	☐ Yes ☐ No

you could access, or would make it hard to live independently because you'd need help?	
When someone in your family is sick or not feeling well, does your family avoid getting medical help?	☐ Yes ☐ No
Has drinking or drug use by you or anyone in your family led your family to being kicked out of an apartment or program where you were staying in the past?	☐ Yes ☐ No
Will drinking or drug use make it difficult for your family to stay housed or afford your housing?	☐ Yes ☐ No
Has your family ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program, or other place you were staying, because of:	
A mental health issue or concern?	☐ Yes ☐ No
A past head injury?	☐ Yes ☐ No
A learning disability, developmental disability, or other impairment?	☐ Yes ☐ No
Do you or anyone in your family have any mental health or brain issues that would make it hard for your family to live independently because help would be needed?	☐ Yes ☐ No

Coordinated Entry Assessment

Date of Assessment	☐☐/☐☐/☐☐
Assessment Location	☐ UnSheltered/Street Outreach ☐ Emergency Shelter ☐ Permanent Housing Provider ☐ Supportive Services Provider ☐ Transitional Housing Provider ☐ Victim Service Provider
Assessment Type	☐ Phone ☐ Virtual ☐ In person
Assessment Level	☐ Crisis Needs Assessment ☐ Housing Needs Assessment
Prioritization Status	☐ Placed on Prioritization List ☐ Not placed on Prioritization list

Coordinated Entry Event

Start Date	☐☐/☐☐/☐☐
Date of Event	☐☐/☐☐/☐☐

Event	**Access Event** ☐ Referral to Prevention Assistance project ☐ Problem Solving/Diversion/Rapid Resolution intervention or service ☐ Referral to scheduled Coordinated Entry Crisis Needs Assessment ☐ Referral to scheduled Coordinated Entry Housing Needs Assessment **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 ☐ Referral to Joint TH-RRH project/unit/resource opening ☐ Referral to RRH project resource opening ☐ Referral to PSH project resource opening ☐ Referral to Other PH project/unit/resource opening
If: Problem Solving/Diversion/Rapid Resolution intervention or service result:	
Client housed/re-housed in a safe alternative	☐ Yes ☐ No
If Referral to post-placement/follow-up case management result:	
Enrolled in Aftercare project	☐ Yes ☐ No
If Referral to an ES, TH, Joint TH-RRH, PSH, or Other PH opening:	
Location of Crisis Housing or Permanent Housing Referral	
Referral Result	☐ Successful referral: client accepted ☐ Unsuccessful referral: client rejected ☐ Unsuccessful referral: provider rejected
Date of Result	/ /

Covid-19 Risk Factors

Start Date	/ /

Due to COVID-19, 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?
	
	☐ Yes
	
	☐ No
	
	☐ Doesn't Know/Refused

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*	Is the client/household's Living Situation considered High, Medium, or Low Risk based on the above criteria? ☐ High ☐ Medium ☐ Low

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)*	

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	☐ No

Staff Completing (Printed Name):	Date:

Appendix B: Serving High Acuity Households with Available RRH Resources

Serving High Acuity Households with Available RRH Resources
(UPDATE from 2018 Bridge Policy)

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 KY BoS Order of Priority. LPC Lead Agencies will document the LPC decision in making referrals according to 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.
    - ❖ *For example, if a RRH provider houses an individual who is Chronically Homeless, has no income or benefits and has a VI-SPDAT score of 12, they will need much more intensive and regular housing stabilization services than a household who has been homeless for 6 months, marginally employed and scored a 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 provides will need to provide flexible rent assistance based on unique client circumstance, which is no different than if 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 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 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 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 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 C: Definitions

References: HUD; Corporation for Supportive Housing; Building Changes

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

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 CoC Coordinated Entry System. The BoS CoC has adopted the VI-SPDAT (Vulnerability Index Service Prioritization Decision Assistance Tool) as the Common Assessment Tool.

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

(1) A "homeless individual with a disability," who: (i) lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 12 months or on at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months
   - Occasions separated by a break of at least 7 nights
   - Stays in an institution of fewer than 90 days do not constitute a break

(2) An individual who has been residing in an institutional care facility for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraphs (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

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

Coordinated Entry – "A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The system covers the geographic area (designated by the CoC), is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool." 24 CFR Section 578.7. It is the responsibility of each CoC to implement Coordinated Entry in their geographic area.

Disabling Condition – (1) a condition that: (i) is expected to be long-continuing or of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by the provision of more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or (2) a development disability, as defined above; or (3) the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome, including infection with the Human Immunodeficiency Virus (HIV). 24 CFR 583.5.

Diversion – Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion programs can reduce the number of families becoming homeless, the demand for shelter beds, and the size of program prioritization lists. The main difference between diversion and other permanent housing-focused interventions centers on the point at which intervention occurs.
Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing/permanent supportive housing targets people who are already homeless.

Family - includes, but is not limited to the following, regardless of actual or perceived sexual orientation, gender identity, or marital status: (1) A single person, who may be an elderly person, displaced person, disabled person, near-elderly person, or any other single person; or
(2) A group of persons residing together, and such group includes, but is not limited to: (i) A family with or without children (a child who is temporarily away from the home because of placement in foster care is considered a member of the family); (ii) An elderly family; (iii) A near- elderly family; (iv) A disabled family; (v) A displaced family; and (vi) The remaining member of a tenant family. 24 CFR 5.403.

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 – means

1. **Category 1: Literally Homeless** An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
   - (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
   - (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, State, or local government programs for low- income individuals);
   - or (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution;

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

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

3. **Category 3: Homeless Under Other 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; or

4. **Category 4: Fleeing or Attempting to Flee Domestic Violence** Any individual or family who:
   - Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
   - (ii) Has no other residence; and
   - (iii) Lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other permanent housing. 24 CFR 578.3

Housing First – An approach to **quickly and successfully connect** individuals and families experiencing homelessness **to permanent housing *without preconditions* and barriers to program/housing entry**, such as sobriety, treatment or service participation requirements. Supportive services such as housing-focused case management are **offered** to maximize

housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

Kentucky Homeless Management Information System (HMIS) - The Kentucky Homeless Management Information System (KYHMIS) uses a software program from Bowman Systems called ServicePoint. The KYHMIS is a Client information database that provides a standardized assessment of Client needs, creates individualized service plans, and records the use of housing and services. Communities can use the data to determine the utilization of services of participating agencies, identify gaps in the local service continuum, and develop outcome measurements. The KYHMIS is designed to collect data and provide information on persons in compliance with all federal and state requirements regarding Client confidentiality and data security. The KYHMIS will meet the data collection specifications mandated by HUD, KHC, and/or other funders. The KYHMIS will provide a system for the collection of information on services and programs provided to Clients statewide, as well as provide referral capabilities and Client historical data. The KYHMIS can improve the services and programs offered to Clients in Kentucky by providing documented assurances of what service levels are met and in demand throughout the various types of agencies and programs in the state.

Local Prioritization Community (LPC) – Regional and/or geographical committees comprised of all CoC and ESG funded agencies 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 Continuum of Care from the client's perspective and is a system that is designed so that the client only has to go one place for a housing referral to the appropriate housing assistance. Any service or housing provider 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) – means community-based housing without a designated length of stay. Permanent supportive housing 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 appears below.

Prioritization List – A list generated by VI-SPDAT entry into the Kentucky Homeless Management Information System (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 LPC

prioritization and housing placement. CoC and ESG funded agencies must make and take referrals off of this list for their programs.

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

SPDAT – (Service Prioritization Decision Assistance Tool) the evidence-based assessment utilized by all trained CoC providers in either enacting more detailed determinations of acuity for housing placement and/or ongoing use in case management to ensure housing stabilization.
This is an ongoing case management tool suggested for your use. The SPDAT (or "Full SPDAT") has an individual and family tool. **Staff must be trained by OrgCode Consulting 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 - (a) 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 limitedto, emergency rooms, jails, and psychiatric facilities; and/or

ii. Significant health or behavioral health challenges, substance use disorders,or functional impairments which require a significant level of support in order to maintain permanent housing.

iii. For youth and victims of domestic violence, high risk of continued trauma or highrisk 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 costbeneficiaries.

(b) Severe service needs as defined in paragraphs i.-iv. above should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool and process and should be documented in a program participant's case file. The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual. The determination cannot be made based on any factors that would result in a violation of any nondiscrimination and equal opportunity requirements, see 24 C.F.R. § 5.105(a).

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

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.

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

Appendix D: Required Signage for CE Access Points

All Any Door KY Marketing Materials can be found here.

Are you homeless?

Any Door KY can help!

Any Door KY

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.

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, etc.), or are fleeing or attempting to flee domestic violence.

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

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:

Continuum of Care
KY Balance of State

KHC Kentucky Housing Corporation