



Fredericksburg Regional Continuum of Care

Coordinated Entry Policies & Procedures

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I. Policy Intent

The CoC Program Interim Rule requires CoCs to establish coordinated entry systems. All projects of the CoC's homelessness response system are required to participate in coordinated entry.

The primary goals for coordinated entry are for assistance to be allocated as effectively as possible and to be easily accessible, no matter where or how people present. The priority of the coordinated entry system is to assess each situation and rule out other options before offering services designated for those experiencing or at imminent risk of homelessness.

The Fredericksburg Regional Continuum of Care (CoC) develops, implements, and refines a homelessness response system that ensures homelessness is prevented whenever possible and is otherwise rare, brief, and non-recurring. This policy governs the administration of the CoC's homelessness response system, including coordinated entry, outreach, diversion, prevention, emergency shelter, rapid re-housing, permanent supportive housing, and housing location. All projects of the CoC's homelessness response system are required to adhere to these guidelines.

II. Definitions

Ending Homelessness (local definition) – The CoC will have ended homelessness when the homelessness response system is right-sized to ensure that all persons experiencing homelessness have a path to permanent housing. Specifically, it means:

- Identifying all persons experiencing homelessness
- Providing immediate access to shelter for anyone experiencing unsheltered homelessness
- Ensuring that all persons experiencing homelessness have the opportunity to move back into permanent housing within 30 days of becoming homeless
- Preventing new episodes of homelessness whenever possible

At Imminent Risk of Homelessness (24 CFR 91.5) – An individual or family who will imminently lose their primary nighttime residence provided that:

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

Literally Homeless (24 CFR 91.5) – 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 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 and 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.

Chronically Homeless (24 CFR 91.5) –

- (1) A “homeless individual with a disability,” as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C 11360(9)), who:
 - (i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
 - (ii) Has been homeless and living as described in section (1)(i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months; and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in section (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility.
- (2) An individual who has been residing in an institutional care facility, including jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in section (1) of this definition, before entering the 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 paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Fleeing/Attempting to Flee Domestic Violence (24 CFR 91.5) – Any individual or family who:

- (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual’s or family’s primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
- (ii) Has no other residence; and
- (iii) Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing

III. Guiding Principles

Housing First

The CoC has adopted a Housing First approach to homeless services. Housing First is a whole-system orientation that centers on first helping households obtain permanent housing and then providing services as needed. A central tenet of the Housing First approach is that services to enhance household well-being can be more effective when people are in their own home.

Local partners have adopted a Housing First approach by reducing barriers to services and shifting project focus to helping participants create a housing plan and move into permanent housing as quickly as possible.

IV. Marketing

To ensure that stakeholders throughout the CoC coverage area are informed on the Coordinated Entry process, the CoC has developed numerous avenues for continuous communication on awareness, changes and updates on the Coordinated Entry System (CES).

Primary Target- Potential System Users

For community services to be successful, those in need of assistance must be aware how and when to access the homelessness response system; the CES must be well advertised across the CoC coverage areas. The CoC will use the following methods of communication to ensure that all persons in the region are aware of where to go for assistance when needed. The CoC affirmatively markets housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, handicap or who are least likely to apply in the absence of special outreach.

- **CoC website.** The Lead Agency maintains a website on behalf of the CoC. Key information and major updates will be posted on the website. The CoC's website includes information for persons in need of assistance and potential system users to learn about how to access the homelessness response system.
- **Partner websites.** Community partners will be asked to display information on their website about how to access homeless services in the CoC area.
- **Social Media.** The Lead Agency also maintains social media accounts on behalf of the CoC. These platforms will be used to inform potential system users on how to utilize system services.
- **Marketing materials.** Marketing materials such as brochures, fact sheets, posters, etc. will be created and distributed to community partners providing information to potential system users on the process of seeking assistance. Partners will be asked to display the information in lobbies and other areas frequented by potential system users. These materials will be distributed to partners throughout the CoC coverage area.

Secondary Target- Community Partners

Community partners play an integral part in marketing and advertising the CES for the community. As the first point of contacts for many of the system's potential users, community partners must be knowledgeable about the coordinated entry process so that system users are able to enter the system in the most effective and efficient methods possible. Therefore, there are a number of methods that will be utilized to ensure that community partners are educated on the coordinated entry process:

- **CoC website.** The Lead Agency maintains a website on behalf of the CoC to help inform CoC stakeholders of CoC business. Key information and major updates and system changes will be posted on the website. The website will also be a platform for partners to make comments or suggestions for any needed changes to the system.

- **Full CoC membership meetings.** Large system change items shall be presented at quarterly CoC meetings. Initially, this will involve presenting the completed Coordinated Entry Plan to the full CoC for comment. Following approval by the CoC Board, any updates will be shared with the full CoC at these meetings and through email blasts.
- **Cross Sector Trainings.** CoC staff will offer coordinated entry trainings to mainstream providers in order to educate and update community partners on their role within the CES.

For communication with community partners to be effective, each agency should ensure that key points of contacts for CoC information are current and up to date. It is the responsibility of each partner agency to inform CoC staff of any turnovers or changes in contact information that may impair their ability to receive important system information. CoC staff will maintain CoC contact lists, which will be used to keep community partners informed of any major changes within the homelessness response system.

V. Access

Access Points

Access points are avenues through which households in a housing crisis connect with trained assessors to complete the coordinated assessment and are referred to the most appropriate resource(s) for the current situation. The CoC has multiple access points to provide full coverage to the geographic region. Given the large geographic area that is being covered, there are multiple ways for these access points to be utilized:

- **Walk-in:** Households in need of assistance are able to walk in to any of the approved access point locations and complete an assessment.
- **Phone-based system:** All locations are accessible by phone and callers will be able to complete an assessment without having to physically be present at the location.
- **Street Outreach:** In order to target those that are least likely to access services on their own, the CoC provides street outreach services. Street Outreach staff connect with identified households on the street and assess their need for services in the same way as those that choose to connect to services via phone or walk-in.

The coordinated assessment process is provided in the same way throughout all of the approved access points, utilizing a standardized community assessment. Each staff member who comes into contact with a person experiencing homelessness is trained annually to offer access consistently and fairly. (A current list of approved access points can be found on the CoC website at www.fredericksburgcoc.org.)

Accessibility

The CoC works to engage people at risk of and experiencing homelessness who might encounter the greatest difficulty reaching an access point due to geography, physical or mental disability, or concerns about personal safety. All access points are handicap accessible for those with physical disabilities, such as persons with wheelchairs. Access points have resources in place to accommodate needs of those with vision and hearing impairments by providing audio, large type and sign language interpreters. The CoC has also taken steps to accommodate those with Limited English Proficiency (LEP) by providing materials in multiple languages as well as utilizing resources for language interpreters as needed. Physical

assessment areas are made safe and confidential to allow for individuals to identify sensitive information or safety issues in a private and secure setting.

After Hour Access

The CoC utilizes multiple access points with varying hours of operation. However, with the variance in hours, the CoC has been able to establish 24-hour access to assessment and referral. Regardless of the time, day or night, households experiencing a housing crisis are able to connect to a trained assessor for support and assistance.

Access for Domestic Violence

Per HUD guidelines, community domestic violence (DV) providers have set up a separate coordinated entry system outside of the CoC's system. However, this system meets all HUD requirements in CPD-17-01. All households will be screened to determine if the household is fleeing or attempting to flee domestic violence. If so, the household will be offered connection to the local domestic violence agency. If the participant does not wish to be connected to those services, he/she will be served at a non-domestic violence provider. Participants may not be denied access to the coordinated entry process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault or stalking. Non-DV providers will ensure that clients are provided with a safe and confidential space to complete assessments.

Providers Who Are Not Access Points

All mainstream providers within the CoC area have a full understanding of how individuals and families access shelter and housing in the region. CoC staff has provided information and training to providers on how to best connect households in need to needed services. All providers are expected to provide consistent information about the process and make proper referrals to access points once identifying a household that is homeless or at imminent risk of homelessness. If the provider provides homeless services, but is not an approved access point, providers are not to take referrals outside of the coordinated entry process and must send all households in need to an approved access point to be assessed. Providers are able to assist with providing a warm hand off to an access point by assisting households with connecting to an access point and providing information as needed. If the client is unable to physically access an access point, the provider is to assist the household with connecting to the access point by phone.

VI. Assessment

The assessment process is used to ensure that participants are provided with the intervention most useful given the current situation and that no unnecessary services are provided when other less intensive services are appropriate and available. However, CoC projects are prohibited from screening people out of the coordinated entry process due to perceived barriers to housing or services, including, but not limited to, too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record.

Standardized Assessments

The CoC uses a phased approach to assessment which progressively collects only enough participant information to prioritize and refer participants to available CoC housing and support services. Participants will be screened and assessed based on their current situation and referred to the most appropriate resources using the community decision tree.

Coordinated Assessment Tool

Participants who walk-in or call an access point will be assessed using a common coordinated assessment tool. The tool is designed to identify the participant's immediate needs and assess eligibility for emergency shelter, homelessness prevention resources, or referral to specialized services (e.g., veterans or domestic violence survivors). The assessor will conduct a brief 5-10 minute conversation with the participant in order to complete the tool and to determine what the appropriate next step is.

Diversion

Diversion is a strategy used to help people avoid using homeless services altogether. By helping individuals and families immediately identify alternative housing arrangements and connecting them with mainstream and community resources, some people are able to find permanent housing options without utilizing homeless services at all. All participants seeking assistance should be diverted if possible, safe, and appropriate. Utilizing the diversion questions built into the coordinated assessment tool, access points are able to work with participants on diversion options. If diversion is not successful, participants will be referred to the services needed to fit their situations.

Housing Barrier Assessment

The Housing Barrier Assessment is completed as soon as a participant is enrolled in emergency shelter or street case management and is used to assess possible barriers to housing as well as client preferences and needs in regards to housing. This is completed with all clients, regardless of housing options being perused. The information collected will allow case managers and participants to understand possible struggles with obtaining and maintaining housing.

VI-SPDAT

The VI-SPDAT is completed 14 days after enrollment into a shelter or street outreach project to determine prioritization for rapid re-housing and permanent supportive housing. Adults in households without children will complete the Individuals VI-SPDAT v2, and adults in households with children will complete the Families VI-FSPDAT v2. Adults who are not currently residing with their children but have custody and wish to be housed as a family will complete the Families VI-F-SPDAT v2. Results of VI-SPDAT assessments will be used in determining prioritization for rapid re-housing and permanent supportive housing.

Domestic Violence Assessment

Empowerhouse completes an assessment relevant to domestic violence experience.

Assessor Training

The CoC provides training opportunities at least once annually to staff persons at organizations that serve as access points or administer assessments. The CoC updates and distributes training protocols at least annually.

The purpose of the training is to provide all staff administering assessments with access to materials that clearly describe the methods by which assessments are to be conducted with fidelity to the CoC’s coordinated entry written policies and procedures. The CoC’s coordinated entry process training curricula includes the following topics:

- Review of the CoC’s written CE policies and procedures, including any adopted variations for specific subpopulations;
- How to use assessment information to determine eligibility and prioritization; and
- How to provide assessments in a safe and culturally competent way.

Client Protections and Autonomy

All information collected during the coordinated entry process is protected and held to the same standards of privacy as set out in the HMIS guidelines. No information collected during the coordinated entry process is able to be shared without formal consent from participants.

All participants are informed of the ability to file a discrimination complaint during the assessment process. All participants are provided instructions and information on how to file this complaint. When a discrimination complaint is received, the CoC Coordinator will complete an investigation of the complaint within 60 days by attempting to contact and interview a reasonable number of persons who are likely to have relevant knowledge, and by attempting to collect any documents that are likely to be relevant to the investigation. Within 30 days after completing the investigation, the CoC Coordinator will write an adequate report of the investigation’s findings, including the investigator’s opinion about whether inappropriate discrimination occurred and the action(s) recommended by the investigator to prevent discrimination from occurring in the future. If appropriate, the investigator may recommend that the complainant be re-assessed or re-prioritized for housing or services. The report will be kept on file for two years.

Participants are freely allowed to decide what information they provide during the assessment process, to refuse to answer assessment questions and to refuse housing and service options without retribution or limiting their access to other forms of assistance. Participants are not required to disclose specific disabilities or diagnoses. Specific diagnosis or disability information will only be obtained for purposes of determining program eligibility to make appropriate referrals.

VII. Eligibility and Prioritization

The current supply of homeless assistance resources in the CoC does not match demand. Therefore, the system must use a participant’s level of vulnerability to target limited resources to those who need them the most. The CoC manages a central, by-name prioritization list for the region, created using HMIS data. Participants are placed on the by-name list after their VI-SPDAT is completed. The list is prioritized by vulnerability using the factors outlined below to calculate an overall vulnerability score. HMIS data protection standards extend to the by-name list.

Vulnerability Factors Used to Prioritize Housing Resources	
Households without Children	Households with Children

<ul style="list-style-type: none"> • VI-SPDAT Score • Disabling Condition • Consecutive Time Homeless • Number of Homeless Episodes • Total Months Homeless in 3 years 	<ul style="list-style-type: none"> • VI-FSPDAT Score • Disabling Condition • Consecutive Time Homeless • Number of Homeless Episodes • Total Months Homeless in 3 years • Number of Children • Education Level • Monthly Income
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The individual or family who is most vulnerable will be at the top of the list and will be prioritized for housing openings as they become available.

Emergency Services

Based on the results of the coordinated assessment, assessors will make referrals to emergency services, including homelessness prevention, emergency shelter, or community resources. Agencies that receive referrals, however, will make the final eligibility determination.

Homelessness Prevention

A household must be at imminent risk of homelessness or fleeing /attempting to flee domestic violence (as defined in Section II) in order to be eligible for homelessness prevention resources. Grant guidelines may dictate additional eligibility requirements by funding source. Homelessness prevention eligibility is assessed through the coordinated assessment tool. Clients will not be required to have income before being re-housed, and will not be required to pay a portion of their rent to receive assistance.

Client Prioritization

The CoC prioritizes households eligible for homelessness prevention in the following order:

1. Households fleeing or attempting to flee domestic violence, labor trafficking, or sex trafficking
2. Households temporarily staying in a hotel or motel that is self, family, or friend paid and have to leave
3. Households temporarily staying with family or friends and have to leave
4. Households exiting hospital, jail, or other institution with no identified housing plan
5. Households being evicted within two weeks

Emergency Shelter

Emergency shelter serves as temporary, short-term crisis housing with services to alleviate immediate housing crisis as a first step towards being quickly and permanently rehoused. The role of emergency shelter is to support households in moving back into permanent housing as quickly as possible. A household must be literally homeless (as defined in Section II) or have nowhere else to sleep tonight in order to occupy an emergency shelter bed. Emergency shelter eligibility is assessed through the coordinated assessment tool. (Empowerhouse completes a separate shelter eligibility assessment for domestic violence shelter.)

Client Prioritization

There is no additional prioritization for shelter beds beyond ensuring that they only go to households who are literally homeless and cannot be diverted, allowing for an immediate crisis response.

Housing Resources

Households are prioritized for housing resources to ensure that those that are most vulnerable and least likely to self-resolve are provided with assistance first.

Rapid Re-Housing

Rapid re-housing is vital to ensuring that all persons experiencing homelessness move back into permanent housing within 30 days of becoming homeless. Rapid re-housing is an intervention designed to help individuals and families quickly exit homelessness and return to permanent housing. Rapid re-housing assistance is offered without preconditions — like employment, income, absence of criminal record, or sobriety — and the resources and services provided are tailored to the unique needs of the household. A household must be literally homeless (as defined in Section II) in order to be eligible for rapid re-housing resources. Grant guidelines may dictate additional eligibility requirements by funding source.

The core components of Rapid Re-Housing consist of:

- Housing Identification
- Rent and Move-In Assistance
- Rapid Re-Housing Case Management and Services

Financial assistance is time-limited and should provide the minimum amount necessary for each household to succeed. Providers will determine the level of rental subsidy needed for the upcoming month(s) through case management and home visits. Each rapid re-housing provider will employ the following financial assistance best practices, as appropriate:

- Progressive Engagement
- Graduated Subsidies

Clients will not be required to have income before being re-housed, and will not be required to pay a portion of their rent to receive assistance. Specific standards and benchmarks for all CoC RRH programs are outlined in the *FRCoC Rapid Re-Housing Policies and Procedures*.

Client Prioritization

The CoC has implemented a community process that prioritizes those least likely to self-resolve for housing resources. This process involves generating a community list of all persons who have been in an emergency shelter and/or on the street for at least 14 days. Households are prioritized for rapid re-housing based on position on the prioritization list and case conferencing. Households that are prioritized through the list are assigned to one of the rapid re-housing providers based on provider expertise with specific subpopulations and current caseloads.

The CoC has three prioritization lists, one for households without children, one for households with children, and one for survivors of domestic violence. Criteria and associated scoring are detailed on the *FRCoC Prioritization Criteria* sheet.

This process will adhere to the *FRCoC Prioritization Guidelines*.

Permanent Supportive Housing

Supportive housing is an evidence-based housing intervention that combines non-time-limited affordable housing assistance with wrap-around supportive services. Research has proven that supportive housing is a cost-effective solution to homelessness, particularly for people experiencing chronic homelessness. Permanent supportive housing clients contribute 30% of their overall income to housing costs; the remaining costs are covered by the project.

Permanent supportive housing beds within the CoC are prioritized for persons experiencing chronic homelessness. A household must be literally homeless (as defined in Section II) in order to be eligible for permanent supportive housing. Grant guidelines may further restrict eligibility requirements by funding source.

Client Prioritization

The CoC has adopted the recommended orders of priority for permanent supportive housing beds per Notice CPD-16-11.

In alignment with Notice CPD-16-11, the CoC has implemented a community process that prioritizes those least likely to self-resolve for housing resources. This process involves generating a community list of all persons who have been in an emergency shelter and/or on the street for at least 14 days. Households are prioritized for permanent supportive housing beds, when they are available, based on documented chronic homelessness status, position on the prioritization list, PSH flags, and case conferencing.

The CoC has three prioritization lists, one for households without children, one for households with children, and one for survivors of domestic violence. Criteria and associated scoring are detailed on the *FRCoC Prioritization Criteria* sheet.

This process will adhere to the *FRCoC Prioritization Guidelines*.

Nondiscrimination

The CoC does not use data collected from the assessment process to discriminate or prioritize households for housing and services on a protected basis, such as race, color, religion, national origin, sex age, familial status, disability, actual or perceived sexual orientation, gender identify or marital status. If at any time a participant feels that they have been treated unfairly, they are able to file a non-discrimination complaint. The complaint will be reviewed and investigated by the CoC Coordinator within 60 days. A full report will be made available within 30 days of the investigation's completion.

VIII. Referral

Referrals to emergency shelter or homelessness prevention are made directly to admission staff by submitting a completed referral form. Referrals to emergency services should be made immediately after completing the coordinated assessment so that clients can be notified of acceptance as quickly as possible and referred to other services if denied. The provider who completed the coordinated assessment is responsible for completing needed referrals for emergency services. All CoC and ESG program recipients and sub-recipients must use the coordinated entry process as the only referral

source from which to consider filling vacancies in housing and /or services funded by CoC and ESG programs.

The community's housing locator(s) will work with prevention, rapid re-housing, and permanent supportive housing providers to identify housing opportunities for clients being re-housed. The housing locator(s) will actively seek out and maintain relationships with local landlords and property managers, as well as provide training to staff and clients on housing opportunities and tenant/landlord roles and responsibilities. Providers shall make a housing locator referral by submitting a completed *Fredericksburg Regional CoC Needs Assessment Tool* to the housing locator(s).

If a housing provider requires a referral for admission, referrals will be submitted within 24 hours of prioritization meeting. Referrals should be sent electronically in order to ensure documentation of the referral is preserved. The shelter or street case manager working with the household is responsible for completing the referral to housing assistance.

Denials of Referrals

There may be instances where a program does not accept a referral from the coordinated assessment process. Refusals are acceptable only in certain situations, including:

- The person does not meet the program's eligibility criteria;
- Lack of availability; and
- The person would be a danger to others or themselves if allowed to stay at this particular program

If a program determines a client is not eligible for their program after they have received the referral from coordinated assessment, the client should be sent back to their initial assessment point for assessment staff to determine a place for them to sleep that night (if they do not already have one). If assessment hours are over for the day, the client should be referred to after-hours assessment staff for assistance.

Whenever a program rejects a referral, the program must document the time of the rejection and the reason for the rejection, and communicate that information to both the client and to the CES using appropriate channels. If a program is consistently refusing referrals, the program will need to meet with the CoC Coordinator and Systems Planning Committee to discuss the issue that is causing the refusals.

Client Choice

Clients must be made aware of any referrals that are being made on their behalf. Clients are to be explained referral options and to agree to all options prior to having information referred to another program. Clients who refuse or decline a referral option will maintain their place on the prioritization list and continue to be engaged until housing is accepted or an alternative housing option is found.

Nondiscrimination

The CoC and all agencies participating in the coordinated entry process comply with the equal access and nondiscrimination provisions of federal civil rights laws.

The CoC's referral process is informed by federal, state, and local Fair Housing laws and regulations and ensures participants are not "steered" toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children.

IX. Process for Victim Services

Victim service providers are not required to use the CoC's coordinated entry process. However, if victim service providers funded by CoC and ESG program funds choose not to use the CoC's coordinated entry process, the victim services providers must create an alternative coordinated entry process for victims of domestic violence, dating violence, sexual assault, and stalking that meets HUD's minimum coordinated entry requirements. CoC victim service providers have chosen to create an alternative, comparable system which is outlined below.

Victim Service Coordinated Entry Process

Access

Victims of domestic violence, dating violence, sexual assault, and stalking are able to access services by phone or in-person. Empowerhouse, the CoC's domestic violence provider, hosts a 24-hour hotline that allows victims to seek assistance at any time. Households are also able to connect with an advocate by walking into the Empowerhouse office during business hours. Any victim that comes through the CoC's coordinated system will be provided the option to go through the victim service process if desired.

Assessment

Upon initial contact, Empowerhouse staff assesses the needs of the client using a standardized intake form. The intake assesses victim safety and wishes in order to determine the most appropriate course of action. Based on the assessment, victims are referred to prevention services, shelter, or other community services. If the client does not pose a major safety risk or does not wish to come to shelter, the client will be diverted to other options through safety planning.

If the client goes to shelter, the client will be assessed for housing once able. Though most of the assessments occur within 14 days of shelter entry, the assessment time is flexible to accommodate the needs of the client and to be as trauma-informed as possible. The housing assessment scores the clients based on the following criteria to determine those that may be able to self-resolve and those that should be added to the prioritization list.

Prioritization

Empowerhouse manages a by-name prioritization list for domestic violence survivors. Created using housing assessment data, participants are placed on the by-name list based on their score from the assessment. Vulnerability is measured using the following criteria:

- Safety/Risk of Harm
- Length of Homelessness
- Documentation Status
- Disabling Condition
- Education
- Income
- Number of Children

Case conferencing meetings among Empowerhouse staff are used to discuss all cases on the prioritization list. Housing case managers and shelter staff meet to discuss each client's needs and determine who will be prioritized for housing services. Prioritization is based on client score and wishes for housing.

Referral

Clients that are prioritized for housing are referred to the domestic violence housing team, where they will receive assistance with housing search and placement. Victim services may also refer clients to the community housing locator to assist with the search process. If the client meets other criteria, they may be referred to other mainstream resources. For example, if the client is a veteran, they may be referred to the Homeless Veteran Working Group in order to explore veteran housing services before utilizing DV resources. However, all decisions about housing resources to be used are based on the wishes of the client.

X. Data Management

All providers, except domestic violence service providers and HOPWA providers, administering coordinated assessment, outreach, diversion, homelessness prevention, emergency shelter, rapid re-housing, permanent supportive housing, and housing location projects shall enter data into HMIS in accordance with the *Homeward Community Information System Policies and Procedures* and applicable HUD guidelines, including HMIS Data and Technical Standards.

Participants of any program that utilizes HMIS, including coordinated assessment, must give consent, either verbal or written, in order for the provider to share and store their information for the purpose of assessing and referring participants through the CES. The CoC prohibits the denial of services to participants for refusing to allow their data to be shared unless Federal statute requires collection, use, storage, and reporting of a participant's identifiable information (PII) as a condition of the program participation. Participants who refuse to disclose or share information must be made aware that some programs require certain information be provided in order to document program eligibility and, without disclosure of this information, the participant may not be eligible for those programs. However, if the participant continues to decline, the participant should be served in any other way possible.

All HMIS users are informed and understand the privacy rules associated with collection, management, and reporting of client data. Users will be explained these rules on an annual basis at HMIS training and as changes arise. All users are responsible for adhering to all privacy rules and standards as detailed in the *HCIS Policies and Procedures*.

All shared domestic violence clients (those served by both a DV provider and a non-DV provider) are assumed to receive confidential services and not be placed in HMIS.

Domestic violence service providers and HOPWA providers must, in lieu of HMIS, use a comparable system. Domestic violence service providers are responsible for meeting all HMIS data standards and reporting requirements regardless of the data collection system used.

XI. Evaluation

In creating a system that is focused on constant improvement and data-informed decision making, evaluation of community projects and the system as a whole becomes an integral piece of the CoC's work. The focus of these evaluations is to assess the quality and effectiveness of the entire coordinated entry experience for both consumers and participating projects. In order to do this thoroughly and effectively, numerous evaluation strategies will be used. All feedback collected through the course of the evaluation process will be private and must be protected as confidential information. Each strategy is outlined below, describing the methodology and aim of each method.

Participant Surveys

Upon exit from all projects, all participants will be provided with information to complete an anonymous electronic survey regarding their experiences in the program. The survey is optional and all completed surveys will be sent directly to CoC staff for analysis.

Focus Groups

Sub-population focus groups will be used to get more in-depth information on the system and its processes. These groups will focus on the experiences of specific sub-populations utilizing the CES and working with its participating providers. The sub-populations to be surveyed include:

- Adults with Children
- Adults without Children
- Youth (18-24)
- Veterans
- Domestic Violence
- Imminent Risk of Homelessness
- Street Homeless

The aim of the focus groups will be to evaluate 1) gaps and intersections in services, 2) access to services, 3) quality of services provided, and 4) flow of participants through the CES. Participants for the focus group will be selected by soliciting for volunteers at all provider locations. Flyers asking for participation in the focus groups will be posted and interested participants will be asked to register for each of the focus groups.

Provider Surveys

All homeless response system projects will be surveyed annually in order to evaluate the quality of the CES as a whole. Other community providers who work in partnership with the CES system will also be surveyed on an annual basis. The evaluation will be focused on the ease of use of the system for providers as well as the perceived usefulness and/or burden of each component of the system. Provider staff will be solicited for potential challenges and improvements.

All staff members will be asked to participate via electronic survey. All participation in these surveys will be anonymous and confidential. Survey participants will be provided with a CoC-created survey tool, focused on the detailed evaluation of each component of the CES. Data will be analyzed and used to inform system changes and improvements to system flow and process.



Fredericksburg Regional Continuum of Care

Rapid Re-Housing Policies & Procedures

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I. Purpose

This document is intended to serve as a guide to service providers implementing the Rapid Re-Housing (RRH) program in the Fredericksburg Regional Continuum of Care (FRCoC). The document promotes a unified understanding of the core elements and expectations of local RRH providers. As the local homeless response system continues to evolve and strengthen its ability to make homelessness rare, brief, and non-reoccurring, there is an increased need for system-wide alignment around common goals and outcomes, program models and activities, and performance standards. **All RRH providers within the FRCoC are expected to adhere to the RRH model outlined in this document.** Fidelity to this model will help ensure that all clients enrolled in RRH have similar experiences and opportunities to attain housing regardless of which service provider they work with.

II. Access and Prioritization

A household must be literally homeless (24 CFR 91.5) in order to be eligible for rapid re-housing resources. Grant guidelines may dictate additional eligibility requirements by funding source.

All referrals to the RRH program will be received through the coordinated entry process. Domestic violence (DV) providers are not required to be a part of the coordinated entry process, but must have their own coordinated entry process for persons fleeing domestic violence. Therefore, person fleeing or attempting to flee domestic violence would be connected to the community's rapid re-housing program through the DV specific coordinated entry process. To receive a referral for prioritization, a household has to meet the eligibility criteria for RRH and complete a VI- SPDAT. The FRCoC has implemented a community process that prioritizes those least likely to self-resolve for housing resources. This process involves generating a community list of all persons who have been in an emergency shelter and/or on the street for at least 14 days. A prioritization score for each adult is calculated to show the likeliness of the household to self-resolve. (Criteria and associated scoring are detailed on the *Fredericksburg Regional CoC Prioritization Criteria* sheet attached in Appendix A.) Those least likely to self-resolve will be prioritized for housing resources. Households are prioritized for rapid re-housing based on position on the prioritization list and case conferencing. Households that are prioritized through the list are assigned to one of the RRH providers based on provider expertise with specific subpopulations and current caseloads. The FRCoC has three prioritization lists, one for households without children, one for households with children, and one for survivors of domestic violence.

III. Core Components

Rapid re-housing is a time-limited intervention intended to house families and individuals experiencing homelessness as quickly as possible. RRH is a housing first, no-barrier intervention with no preconditions to enrollment other than homeless status. The level of case management and financial assistance is based on a progressive engagement model where the minimum amount of service is provided before increasing support to meet the household's needs. The RRH program includes three core components:

1) housing location, 2) financial assistance and 3) case management. Each of these core components of a RRH program are described below.

Housing Identification

The goal of housing identification is to quickly locate affordable housing options for the household experiencing homelessness. Activities under this core component are targeted for both landlords and participants:

1. Landlord Recruitment and Support
 - Engage landlords, homeowners, or renters with units, rooms or housing options
 - Negotiate with landlords or homeowners to facilitate household access, including households with rental barriers
 - Support landlords, homeowners or roommates in order to preserve and develop partnerships for current and future housing placements
2. Household Housing Search and Support
 - Assess tenant needs and barriers to housing placement
 - Set family or individual expectations on location, size and/or rent
 - Conduct a targeted housing search with housing affordability plan
 - Support households with completing rental applications
 - Provide tenant counseling (including education on how to speak with landlords, understanding rental applications and leases, securing utilities, and understanding tenant obligations)
 - Support households with setting up utilities and making moving arrangements

Staffing

The lead staff during the housing identification process is the Housing Locator (see Appendix B for copy of job description). The Housing Locator is a shared community position responsible for working collaboratively with rapid re-housing partners to identify housing opportunities for clients experiencing homelessness. Working across community agencies to assist in the identification of potential housing opportunities for RRH participants, the Housing Locator provides viable housing options to those that have been prioritized for the RRH program.

The Housing Locator works collaboratively with RRH case management staff at partner agencies throughout the housing identification process. Case managers are responsible for referring participants for the Housing Locator for services as well as updating the Housing Locator on changes that may impact the housing search process. All housing location services are provided by the Housing Locator, but case management staff should be in constant communication regarding progress toward housing and with additional tips for viable options. The Housing Locator should be trained in domestic violence in order to work with DV clients appropriately. Both the Housing Locator and the case managers assisting with the housing location process should receive training in Fair Housing and Landlord/Tenant Law.

Landlord Engagement Process

The Housing Locator builds and maintains a steady pool of partner landlords and property managers through regular recruitment and retention activities. Recruitment is achieved through a variety of methods, such as word of mouth, cold outreach, driving around prospective neighborhoods looking for 'FOR RENT' signs, references from partner agencies, Craigslist and other websites, and connections with landlord associations.

All potential RRH landlord partners are subject to a screening process. The Housing Locator uses a number of methods to identify patterns in landlord behavior that would suggest they should not be RRH program partners. These methods include:

- Contacting local tenant rights organizations to identify landlords who fail to comply with licensing/building requirements and/or fail to correct violations,
- Reviewing housing court records for past tenant issues with the landlord, and
- Surveying past program participants about their satisfaction with landlords.

The Housing Locator maintains the FRCoC Housing Directory which includes information on available units (location, rent, bedrooms, baths, pet policies, etc.) across the service region. This directory is used to maintain up-to-date information on housing vacancies in the area and facilitate the matching process for program participants.

Housing Search Process

Rapid Re-Housing participants are referred to the Housing Locator by case management staff using the *FRCoC Needs Assessment Tool*. This tool must be completed within 72 hours of assignment to RRH providers. The tool is used to identify potential barriers to housing and to provide projection of financial assistance that could be provided. The housing locator uses the information provided on the assessment to match participants to potential vacancies in the area using the housing directory and additional vacancy searches. Once potential options are found, the Housing Locator contacts the participant to schedule showings.

Once housing options have been identified and viewed, the housing locator and case management staff assist participants in making informed housing choices with the goal that the participant will be able to maintain in housing after program exit. While, participants ultimately chose their housing unit, the program should use housing and budgeting plans to help participants understand the likelihood of being able to pay rent and meet the requirements of the lease by the end of assistance. For extremely low income households, case managers should assist in creating reasonable projections, expectations, and goals for participants to secure income (through employment, public benefits, and/or on-going rental assistance) before program exit to ensure that they are able to assume the housing burden once financial assistance ceases.

Though the Housing Locator is responsible for housing search and location services, these services do not preclude program participants from conducting their own search and choosing housing they identify independently. The Housing Locator is responsible for providing support and resources in the housing search process, but participants are able to locate their own housing, which the housing locator can assist with securing. Some households may also decline assistance in finding housing. In these instances, the case managers are responsible for continuing to check on their progress and offer advice and/or direct assistance if the household encounters obstacles they cannot resolve independently.

Once the participant selects a housing option, the Housing Locator and the case manager will prepare the participant for the lease signing. The Housing Locator reviews leases with each participant and answers any questions that they may have. The case manager provides a pledge letter to the client showing a 3 month projection of assistance, including the amount of rent that the provider will pay and the amount that the participant will pay. This projection is provided to the both the resident and the landlord prior to lease signing. The Housing Locator accompanies the participant to the lease signing and the participant is able to move in. Assistance with move-in needs, including obtaining furniture, securing utilities, and scheduling mover services, is coordinated by the case manager.

Once the participant is housed, case managers are responsible for supporting landlords. Case managers should strive to respond to landlord needs that would risk participant tenancy and to maintain working relationship with the landlord for future participants. This includes:

- Responding quickly (within one business day) to landlord calls about serious tenancy problems,
- Seeking to resolve conflicts around lease requirements, complaints by other tenants, and timely rent payments, and
- When necessary and whenever possible, negotiating move-out terms and assisting households to quickly locate and move into another unit without an eviction.

Landlords should be provided detailed contact information for appropriate staff assigned to respond to landlord calls, mediate disputes between program participants and landlords, and assure rental payments are made on time for each RRH participant that the landlord agrees to rent to. When closing a case, the case manager should provide information to the landlord about how they can contact the RRH program again if needed and what kind of follow-up assistance may be available.

Financial Assistance

Financial assistance in RRH provides short-term support to households so they can quickly obtain housing. Financial assistance is based on the progressive engagement principle of offering the minimum amount of assistance necessary for households to move out of homelessness and stabilize in permanent housing. The role of the case manager is to prepare households for the end of the financial assistance by leveraging resources or working with them to increase household income. Programs should begin by assuming that households, even those with zero income or other barriers, will succeed with a minimal subsidy and support rather than a long subsidy, and extend services and support if/when necessary.

Staffing

Case managers are responsible for evaluating participant needs and making determination of the amount of assistance needed from the RRH program. Case managers are responsible for ensuring that both the landlord and the participant are informed of the supports that are being provided throughout the program participation. Training to case managers will be provided annually by the CoC Lead on financial assistance through the rapid rehousing program, including expenses to be covered through RRH financial assistance, determining financial need, and models of assistance (e.g. progressive engagement and graduated subsidies).

Financial Assistance Process

Each participant works with a rapid re-housing case manager to determine the amount and length of financial support to be provided. Participants are not required to pay any portion of their rent in order to be eligible for services, however, the case manager works directly with the participant to determine what amount they would be able to pay and what assistance they would need. Using budgeting tools, the case manager and the participant collaboratively determine the need for assistance. A three month projection is created detailing the amount to be paid by the provider and the amount to be paid by the participant. Reviews of the projection occur monthly with the participant to determine participant's ability to pay their housing expenses for the month. In cases where they are not able to make their housing expenses, case managers must work with the participant to find resources and to increase income so that they are able to do so in later months. Though a projection was created for three months, the amount that the client pays will be based on the monthly review and the projection is subject to changes as need changes month to month.

Reassessments must be completed every three months to determine need for continued assistance. Similar to the process for the initial projection, case managers will work with participants to determine their need for financial assistance over the next three months. Monthly reviews of projections will continue until client is able to assume total housing burden on their own.

Financial assistance should be provided using a progressive engagement and graduated subsidy model. Progressive engagement is where the minimum amount of financial assistance is provided before increasing support to meet the household's needs. Graduated subsidy is where participants are responsible for more and more of their housing cost as they progress through the program. Participants should be asked to contribute the most that they are able to pay from the beginning. If participants are expected to pay an amount toward their housing, the case manager will provide written notification to the participant. The case manager will also provide written notification if projection changes as a result of a monthly review.

Transition from financial assistance is coordinated with case management efforts to assist program participants to assume and sustain their housing costs. Participants that are not able to sustain housing without the RRH financial assistance should be assessed for more long term options such as permanent subsidies. For those that are in need of more intensive care, beyond the scope of RRH case

management, should be assessed for permanent supportive housing resources. In both cases, RRH may be a viable option to bridge participants into more permanent sustainable programs, but participants under these circumstances should be connected and provided a warm hand off as soon as possible and assistance under the RRH program must not exceed allowable timeframes.

These guidelines are flexible to respond to the varied and changing needs of program participants, including participants with zero income. A progressive approach is used to determine the duration and amount of rent assistance. Financial assistance is not a standard “package” and is flexible enough to adjust to households’ unique needs and resources, especially as participants’ financial circumstances or housing costs change. However, case managers must follow applicable grant guidelines for guidance on eligible activities and the requirements and limitation of each.

All participants receiving financial assistance must meet with the case manager monthly. The case manager is responsible for ensuring that all possible ways or methods to contacting the household are explored. If the case manager has not been able to complete a full monthly review with the household, but has had contact with the household and they are still in need of services, the case manager should continue to work with the household on their housing goals. If a household still needs and wants services, but missed appointments or communication is not regular, the case manager should have a discussion of the program scope and expectations with participants and assist in overcoming barriers to compliance. If there is no contact after 30 days of multiple attempts to reach the household, the case manager should exit the household from the program.

Case Management

The goals of RRH case management are to help households obtain and move into permanent housing, to support households to stabilize in housing, and to connect them to community and mainstream services and supports if needed.

Staffing

Case managers are responsible for

- Providing case management before, during and after housing placement,
- Linking participants to mainstream and community resources for stabilization,
- Helping participants identify strengths to retain housing and behaviors that contribute to housing instability, and
- Assisting client with assessing and overcoming housing barriers.

Case managers will receive training annually from the CoC Lead on RRH case management, including scope of case management and models for engagement.

Case Management Process

The case management process consists of three stages: 1) obtaining and securing housing, 2) stabilizing in housing, and 3) closing the case. Case management services include: housing planning, referrals, resources, financial assistance, job search, childcare, education, basic life skills development, transportation, and self-sufficiency. Throughout the case management process, participants will have regular contact with case managers. Participants are required to meet with case managers at least monthly to discuss program needs and expectations. Once housed, these contacts should take place within the home unless there is a safety concern for the worker to do so. In these instances, clients should be met in other safe places such as places of employment or other meeting place chosen by participant. Safety for case managers is of utmost concern when making home visits to participants. Each RRH provider should create safety protocols and train staff in safety needs in the field.

RRH case management should be client-driven and voluntary. Though case management is required in order to receive financial assistance, decisions regarding where, how and when case management is received should be made in collaboration with participants. RRH case management should be flexible in intensity so that only essential assistance is offered until or unless the participant demonstrates the need for or requests additional help. RRH case management should also use a strengths-based approach to empower clients.

Obtaining and Securing Permanent Housing

Case managers work closely with the Housing Locator to help households identify housing options. Financial assistance will be used to resolve or mitigate tenant screening barriers like rental and utility arrears or multiple evictions. Case managers will assist in obtaining necessary identification, support other move-in activities such as obtaining furniture, and prepare households for successful tenancy by reviewing lease provisions.

Case management meetings during this stage should focus on:

- Creating a housing plan
- Setting short-term goals (as identified by the participant) and assisting participants with identifying the steps that both the case manager and the participant need to take in order to achieve those goals
- Assessing ongoing, underlying housing barriers, including those that limit the participant's ability to get into housing and maintain housing
- Preparing participants for housing (e.g. providing education on landlord/tenant relations)
- Providing referrals and resources for basic needs to support housing (e.g. income)

All meetings should focus on the needs and goals of the participant, as set by the participant. Obtaining or maintaining stable housing should be the focus of many of the conversations during this phase, but other steps needed to achieve housing stability (such as employment or needed supports) should also be discussed. Participant contacts should happen frequently in this stage to assist client toward

achieving housing goals as quickly as possible. Plans must be developed with full involvement from household members and should start with a strengths assessment where strategies for increasing housing stability seek to leverage these strengths.

Stabilizing in Housing

Once participants are housed, case managers continue to work with clients to stabilize their housing situation and to ensure that they are able to continue to remain in housing once financial assistance has ceased. The main goal of this stage of case management is to provide participants with the needed resources and services in the community to be able to continue meeting housing needs on their own. RRH case management visits in this stage should be home-based and must occur at least once a month. Case management meetings during this stage should focus on:

- Ongoing monitoring of housing situation
- Setting goals for assuming full rent at end of subsidy, housing maintenance, debt reduction, increased income, budgeting, landlord/tenant relationship
- Identifying and resolving issues or conflicts that may lead to tenancy problems, such as disputes with landlords or neighbors
- Helping households develop and test skills they will use to retain housing once they are no longer in the program
- Identifying and accessing supports needed to retain housing including: family and friend networks, mainstream community services, and employment and income

Closing the Case

Financial assistance should end when the household is no longer at imminent risk of returning to homelessness, however, case management can continue after financial assistance has ceased to ensure that household is able to sustain in housing. Participants that require additional case management, beyond the scope of the RRH program, should be connected to mainstream and community-based services that will continue to assist them in maintaining housing as quickly as possible. Those that are in need of more permanent support should be connected to permanent supportive housing options and work to be bridged into those programs.

IV. HMIS and Data Collection

All rapid re-housing providers are required to enter data into the Homeless Management Information System (HMIS). For confidentiality reasons, DV and HOPWA providers are exempt from using the HMIS system, but must use comparable methods and/or database to collect data. Prompt and accurate data collection assists the homeless system to determine which services and programs clients are utilizing, evaluate the impact of RRH services, and make system improvements. It is the responsibility of the program staff to have accurate and complete data. Providers should refer to the latest version of HUD's *HMIS Data Dictionary* for detailed instructions on what is required to be collected.

V. Performance Standards

The RRH program strives to meet the performance standards as outlined by the National Alliance to End Homelessness (NAEH). The NAEH has set forth performance benchmarks for communities to strive for in order to effectively reach the goals of rapid re-housing. These goals are to:

- Reduce the length of time program participants spend homeless
- Exit households to permanent housing
- Limit returns to homelessness within a year of the program

The NAEH has established benchmarks that each community should strive for. However, when using these performance benchmarks NAEH is aware that a community may not have any programs that meet these benchmarks despite meeting the program standards, particularly in extremely expensive or low-vacancy housing markets or if programs are primarily serving households with zero income and/or higher housing barriers. While programs should continue to strive for the NAEH established benchmarks, communities are able to set alternate performance goals for the purposes of performance improvement while programs work to achieve these benchmarks.

Due to limited availability of affordable housing in the community and the large population of high barrier households being served, the FRCoC has established alternative performance goals to assess the improvement in performance of the RRH program. Each of the NAEH benchmarks are listed below along with the community performance goals in instances where the community is not able to meet the NAEH established benchmark at this time. Though alternative performance goals have been established, each of the RRH providers in the community will continue to strive to meet the NAEH benchmarks.

NAEH Benchmark #1: Households served by the program should move into permanent housing in an average of 30 days or less.

FRCoC Performance Goal: Households served by the program should move into permanent housing in an average of 50 days or less.

NAEH Benchmark #2: At least 80 percent of households that exit a rapid re-housing program should exit to permanent housing.

FRCoC Performance Goal: At least 80 percent of households that exit a rapid re-housing program should exit to permanent housing.

NAEH Benchmark #3: At least 85 percent of households that exit a rapid re-housing program to permanent housing should not become homeless again within a year.

FRCoC Performance goal: At least 85 percent of households that exit a rapid re-housing program to permanent housing should not become homeless again within a year.

Appendix A: FRCoC Prioritization Guidelines



Prioritization Guidelines

Prioritization Lists

FRCoC will have three prioritization lists for housing resources, one for households without children (individuals), one for households with children (families), and one for survivors of domestic violence (DV). These lists will be used to prioritize rapid re-housing and permanent supporting housing resources.

Criteria

Criteria and associated scoring are detailed on the *FRCoC Prioritization Criteria* sheet. The final prioritization score is calculated by averaging the scores assigned to each of the criteria. The lower the final prioritization score, the less likely the client is to self-resolve. Those least likely to self-resolve will be prioritized for housing resources.

VI-SPDAT: For individuals, this criterion is based on the client's actual prescreen score for the VI-SPDAT (version-2) assessment. For families, this criterion is based on the client's actual prescreen score for the VI-FSPDAT (version-2) assessment. When a client has multiple VI-SPDAT or VI-FSPDAT records, the most recent actual prescreen score will be used.

Disabling Condition: This criterion is based on whether or not the client has a disabling condition. If the client self-reports at intake that (s)he does not have a disabling condition, but it later becomes apparent to staff that the client does have a disabling condition, the HMIS data should be updated to reflect the disabling condition.

Consecutive Time Homeless: This criterion is based on the number of days the client has been homeless during his/her current episode. Consecutive time homeless is calculated based on the approximate start date of the current episode. If approximate start date is null, consecutive time homeless is calculated based on the project entry date. This criterion automatically updates as time goes on.

If the client moved continuously between the streets, shelters, or safe havens, the approximate start date of the current episode would go back as far as the first time (s)he stayed in one of those places. A break, constituting a new episode of homelessness, is considered at least 7 or more consecutive nights not residing in a place not meant for human habitation, shelter, or safe haven. This excludes an

institutional stay of less than 90 days, which is not considered a break and does not constitute a new episode of homelessness.

A break in time on the street, in shelters, or in safe havens that is under 7 nights should be included in the continuous time homeless. An institutional stay (i.e. jail, substance abuse or mental health treatment facility, hospital, or other similar facility) that is 90 days or less should also be included in the continuous time homeless.

Episodes: This criterion is based on the number of times the client was homeless in the past three years, as of his/her intake. This criterion does not update over time, but rather represents a snapshot of the information collected at intake. The previously-stated logic concerning breaks should be used in determining the number of separate episodes of homelessness.

Total Months Homeless in 3 Years: This criterion is based on the number of months the client was homeless in the past three years, as of his/her intake. This criterion does not update over time, but rather represents a snapshot of the information collected at intake.

Children: This criterion, used only for the family prioritization list, is based on the number of children in the household. If the mother is pregnant, an additional child is added.

Education: This criterion, used only for the family prioritization list, is based on the highest education level attained by the client.

Monthly Income: This criterion, used only for the family prioritization list, is based on the monthly income of the entire household. If there are two adults in the household, this amount should reflect their combined monthly income.

Flags

In some instances, a client may not fall within the prioritization for housing resources, but is given a flag to move him/her into the prioritization. Flags can be given for the following circumstances:

- Terminal Illness
- Serious Mental Illness
- Chronic Homeless Status
- Veteran Status

Creating the Prioritization Lists

Compiling the Lists: HMIS data will be exported via ReportWriter; DV data will be sent to CoC staff by Empowerhouse staff if the client agrees to have his/her information shared and has signed a release of information. All data is entered into the appropriate template (individuals or families), which automatically calculates the final prioritization score based on the above-listed criteria.

Removing Duplicate Client Records: Reasons for duplicate client records exported from HMIS are multiple entry/exit records or multiple VI-SPDAT records. When there are multiple, open entry/exit records for a client, any old records should be closed before the final prioritization list is pulled. When a client has multiple VI-SPDAT records, the most recent actual prescreen score will be used, and the other records will be removed from the prioritization list.

Housing Choice: Case managers will have a discussion with clients that are being included on the list regarding their housing choice. Clients will discuss the housing options that they are interested in being considered for with case manager. Case managers will email CoC staff when clients have accepted housing options. Information will be added to the list so that each list is divided into two sections: those that are interested in housing assistance and those that are declining or need to be engaged.

Clients Refusing Housing: If a client refuses housing, the shelter or street outreach case manager will continue to engage the client and email CoC staff if the client accepts housing options.

Ordering the Lists: The lower the final prioritization score, the more of a priority the client is. When multiple clients have the same final prioritization score, VI-SPDAT actual prescreen score is the tie-breaker. When multiple clients have the same final prioritization score and VI-SPDAT actual prescreen score, consecutive time homeless is the tie-breaker.

Each list is ordered by housing choice selection, then by final prioritization score (low-to-high), then by VI-SPDAT actual prescreen score (high-to-low), then by consecutive time homeless (high-to-low).

Fixing Errors on the Prioritization Lists

Fixing Data: In some cases, data errors prevent the template from calculating a client's final prioritization score. Case managers may also identify inaccurate data when reviewing the prioritization list. These errors must be corrected in the system for the changes to appear on the next prioritization list.

Fixing VI-SPDAT Scores: If the case manager believes the VI-SPDAT score is inaccurate because something has changed since the date of the assessment, the case manager can complete a new VI-SPDAT with the client. The most recent VI-SPDAT score will be used in the prioritization.

If the case manager believes the score is inaccurate because the client did not answer questions truthfully or refused to answer certain questions, the case manager can submit to CoC staff prior to the prioritization meeting an explanation of which answers she believes are incorrect, and what the final score should be.

Prioritization Meeting Process

All individual, family, and DV prioritization meetings will be held monthly. Executive directors and case managers will complete the following around each separate prioritization list.

Part One - Reviewing Snapshot: Prior to the prioritization meeting, all organizations are required to provide information on current caseloads for housing resources. The group will spend time reviewing the numbers provided, and organizations will determine the number of clients that are able to be assigned to them during that prioritization meeting. The number of spots available will depend on each organization's financial and case management capacity to take on new cases.

Part Two - Finalizing the Prioritization: The group will spend the first part of the list discussion determining which clients will be prioritized for housing. The group will start at the top of the list with

those clients that have discussed housing choices with case managers and work its way down until all available spots are filled.

Clients Not Assigned: The group may decide not to prioritize a client at the top of the list if that client is in the process obtaining housing through other means (self-resolving, family/friends, PATH, etc.), has pending criminal charges, or is a street outreach client that is believed to no longer be homeless.

Veterans: If the client is a veteran, staff will verify that (s)he is on the veterans by-name list. Veteran-specific funds will be used to rehouse veterans whenever possible. If veterans funding runs out at any point, the veterans working group may request that a veteran be prioritized for housing resources through the prioritization process.

Household Members/Roommates: A client who falls within the prioritization for housing resources can request to be housed with household members or other clients as roommates. When this happens, the household member/roommate can be moved up on the list to be prioritized.

Part Three - Case Conferencing: Once the clients within the prioritization are finalized, the group will go through and case conference around each client. This includes assigning each client to a housing case manager, but may also include assigning shelter, SOAR, DV, or other services.

Once the group has completed case conferencing for each client within the prioritization, the group can then case conference anyone else on the list.

Appendix B: FRCoC Prioritization Criteria

Individuals Criteria

less likely to
self-resolve

↑

↓

more likely to
self-resolve

Score	VI-SPDAT	Disabling Condition	Consecutive Time Homeless	Episodes	Total Months Homeless in 3 Years
1	12+	Yes	1000+	4+	13+
2	10 or 11		900-999	3	12
3	9		840-899	2	11
4	8		780-839	1	10
5	7	No	630-779		9
6	6		510-629		8
7	5		450-509		7
8	4		330-449		5 or 6
9	3		150-329		3 or 4
10	0, 1, or 2		0-149		1 or 2

Flags:
Terminal Illness
Serious Mental Illness
Chronic Homeless Status
Veteran Status

Families Criteria

less likely to
self-resolve

↑

↓

more likely to
self-resolve

Score	VI-FSPDAT	Disabling Condition	Consecutive Time Homeless	Episodes	Total Months Homeless in 3 Years	Children	Education Level	Monthly Income
1	9+	Yes	1000+	4+	13+	4+	Less than High School	\$0
2	8	No	900-999	3	12	3	GED	\$1-\$834
3	7		840-899	2	11	2	High School	\$835-\$1,667
4	6		780-839	1	10	1/Pregnant	Post-Secondary	\$1,668-\$2,500
5	5		630-779		9			\$2,501+
6	4		510-629		8			
7	3		450-509		7			
8	2		330-449		5 or 6			
9	1		150-329		3 or 4			
10	0		0-149		1 or 2			

Appendix C: FRCoC Housing Locator Job Description



Fredericksburg Regional Continuum of Care (CoC) Housing Locator Job Description

Position Summary:

The Housing Locator is a shared community position responsible for working collaboratively with local shelter, rapid rehousing, permanent supportive housing, and prevention case management staff to identify housing opportunities for clients experiencing or at imminent risk of homelessness. The Housing Locator works across community agencies, specifically Empowerhouse, Loisann's Hope House, Micah Ecumenical Ministries, and Thurman Brisben Center. This position is required to actively seek out and maintain relationships with local landlords and property managers. The Housing Locator provides training to staff and clients on housing opportunities and tenant/landlord roles and responsibilities. The Housing Locator is an integral member of the CoC's Homeless Response System.

Responsibilities:

- Proactively seek out new housing opportunities and resources to assist clients with obtaining housing.
- Maintain a Housing Directory to include information on available units (location, rent, bedrooms, baths, pet policies, etc.) and documentation of all contacts with landlords and property managers. Provide consistent updates on housing availability.
- Maintain ongoing relationships with landlords and property managers, including acting as a liaison between landlord and clients as needed.
- Maintain close working relationships with CoC case management staff and engage in frequent communication with partner agencies.
- Meet with clients and case managers to establish housing needs and understand client barriers to housing. Show clients potential units in collaboration with case managers.
- Conduct housing quality inspections and complete associated paperwork per grant guidelines. Advise and advocate for clients with regard to quality standards.
- Confirm that all rental properties are rent reasonable and complete associated paperwork per grant guidelines.
- Facilitate agency payment of application/holding fees for identified units.
- Review and negotiate leases on behalf of clients in collaboration with case managers and clients. Ensure leases meet fair housing and legal requirements. Assist clients in understanding their leases. Attend lease signings.
- In collaboration with case managers, mediate client/landlord conflicts as needed.
- Develop and facilitate training and workshops for clients and case management staff including tenant rights and responsibilities, housing discrimination, finding and securing rental housing, communications with landlords, and fair housing.
- Maintain understanding of grant guidelines and housing/homelessness best practices.
- Enter required data into the local Homeless Management Information System.
- Other duties as assigned.

Minimum Qualifications

- Bachelor's degree or combination of academic study and relevant experience required.
- Ability to work with diverse populations and persons experiencing a housing crisis.
- Strong interpersonal and communication skills.
- Exceptional problem solving skills. Ability to provide creative solutions.
- Ability to make independent decisions when circumstances warrant such actions.

- Flexibility and adaptability to changing needs.
- Ability to work in a fast-paced environment.
- Personal integrity and confidentiality.
- Proficiency in Microsoft Office Suite.

Preferred Qualifications

- A minimum of 3 years of experience in property management, housing management, and/or real estate preferred.
- Experience in conducting group training preferred.

Supervision:

The Housing Locator will be supervised by the hiring agency. Performance evaluations will be completed by the Continuum of Care Coordinator and the CoC's Pursuit of Housing Partners on a biannual basis.

Work Schedule:

This position is full-time salaried, 40 hours per week. A flexible schedule will be necessary to perform job duties including client appointments. Position will require night and weekend work.