**Continuum of Care**

and

**Emergency Solutions**

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**St. Louis County CoC - MO-500**

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# Guiding Principles of Coordinated Entry Flow Chart

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# Definitions and Acronyms

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## Client

For this manual, “client” refers to any individual or family seeking services from the homeless services system.

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## ESG: Federal Emergency Solutions Grant

ESG is the term utilized to refer to Emergency Solutions Grant funding provided through the St. Louis County Department of Human Services and Missouri Housing Development Commission. ESG can also refer to emergency funding such as ESGVCV (Emergency Solutions Grant Coronavirus).

## 

## Housing First Philosophy

“Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals before permanent housing entry.”

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## HRC: Housing Resources Commission

HRC is a funding source that is available through the St. Louis County Department of Human Services.

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## MESG: MHDC Emergency Solutions Grant (if available)

MESG is the term utilized to refer to Emergency Solutions Grant (ESG) funding provided through the Missouri Housing Development Commission.

PATH: Projects for Assistance in Transition from Homelessness (if available)

The PATH program is operated by the U.S. Department of Health and Human Services Department. It is designed to assist individuals experiencing homelessness or at-risk homelessness and have a severe mental illness.

Point-of-Contact (POC)

All St. Louis County Homeless Service System agencies must designate at least two Point-of-Contact (PoC). This individual will be responsible for receiving correspondence from the front door lead and List Manager. Additionally, the PoC will be the person in the organization who can request an acuity review panel meeting. All review panel requests must be coordinated through the PoC for the agency. The shelter, street outreach, or housing provider is welcome and encouraged to designate a second PoC to function as a back-up if the primary PoC is unavailable.

Qualified Minor

Qualified minors are unaccompanied youth ages 16 and 17 who are homeless or domestic violence victims who are legally competent to contract for shelter, housing, and other essential services prescribed in RSMo 431.056.

## 

## Warm Referral

For this manual, a “warm referral” is when one agency contacts another agency or service on behalf of the client to ensure that the agency can assist the client quickly before sending the client to the agency or service.

Project Enrollment / Engaged

The day the client becomes active in an agency project. An agency can have multiple projects. Once a client is entered into the project, they are “engaged.”

Client Advocate

Term used for housing navigator, case manager, outreach worker, or any person who is an authorized representative from the agency representing the client's best interest and responsible for assisting the client with their housing goal.

Housing Navigation

The process by which homeless clients that have entered the CES system are provided ongoing engagement, document collection, and case management services to facilitate a match to an appropriate housingresource.

Coordinated Entry Enrollment List (CEL)

The project enrollment list is a prioritization of all the clients enrolled into a St. Louis County HMIS project. This list is used to create the Housing Prioritization List. The CEL will be distributed to all agency point-of-contacts. The list should be utilize to confirm enrollment into a project and data accuracy. This list should not be used in conjunction with case management or to determine the time frame for housing placement.

Housing Prioritization List (HPL)

The housing prioritization list created by utilizing the CEL report. Those with the highest level on needs will be referred to project openings. Clients pulled onto the HPL are pulled based on their acuity score AND housing units available AND project availability.

# Preamble

The St. Louis County Continuum of Care (CoC) mission is to promote a collaborative community-wide response to prevent, respond, and end homelessness in Saint Louis County by offering a full array of housing and support services to persons experiencing a housing crisis. Prevention resources; emergency, transitional, and permanent housing options; trauma-informed case management; legal services; and other support options are strategically woven together to provide the stabilizing assistance needed to resolve their homelessness.

This policy and procedure manual institutes consistent and uniform assessment processes to determine the most appropriate response to each individual or family’s immediate short- and long-term housing needs.

The CoC developed guiding principles to inform the design, implementation, and oversight of the homeless service system of care for persons experiencing a housing crisis in St. Louis County. The Continuum of Care members and homeless service providers will work to:

* Rapidly exit people from their homelessness to stable housing
* Ensure that the hardest to serve, with the greatest needs, are served
* Serve clients as efficiently and effectively as possible
* Ensure transparency and accountability throughout the referral and assessment process

Background and Purpose

HUD requires Continuum of Cares’ to establish and operate a coordinated entry system to increase efficiency of crisis response systems and improving ease of access to resources (including mainstream resources). Both CoC and ESG regulations require participation in coordinated entry for projects receiving funding from the Continuum of Care (CoC) program and the Emergency Solutions Grant (ESG) program. Coordinated Entry is designed to help communities prioritize clients who need assistance and allow CoCs to identify gaps in services and resources.

Governance

The Executive Board must approve changes to this policies and procedures manual before it’s submitted to the CoC general body for review. The general CoC body will be given 30 days to review the manual before a vote occurs to finalize any updates to the coordinated entry policy and procedure manual. It may take an additional 30 days to implemented after the final approval is received.

# 

# Section 1: Guiding Principles of Coordinated Entry

Coordinated entry intends to provide individuals and families at risk of or experiencing homelessness with need-based access to services and supports to resolve their housing crisis. The following principles are present throughout the coordinated entry process.

## Nondiscrimination

The CoC believes that the most effective response to homelessness results from a service delivery system that values diversity and recognizes the inherent dignity of individuals and families of all backgrounds. As such, the CoC and their member agencies shall not discriminate or withhold services based on race, color, religion, national origin, ancestry, disability or health-related condition, familial status, marital status, sex, gender identity, gender expression, sexual orientation, veteran status, or source of income. Additionally, the CoC will ensure that the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, Title II of the Americans with Disabilities Act, and HUD's Equal Access Rule at 24 CFR 5.105(a)(2) will be followed. Individuals or families fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, human trafficking, or other life-threatening situations shall not be prohibited from receiving services from non-victim service providers.

Service Animals

Service animals are animals trained to perform tasks for people with disabilities such as guiding people who are blind, alerting people who are deaf, pulling wheelchairs, alerting and protecting a person who is having a seizure, or performing other individual tasks. Service animals are working animals, not pets.

While Emotional Support Animals or Comfort Animals are often used as part of a medical treatment plan as therapy animals, they are not considered service animals under the ADA. These support animals provide companionship, relieve loneliness, and sometimes help with depression, anxiety, and specific phobias, but do not have special training to perform tasks that assist people with disabilities. Even though some states have laws defining therapy animals, these animals are not limited to working with people with disabilities and therefore are not covered by federal laws protecting service animals' use.  Therapy animals provide people with therapeutic contact, usually in a clinical setting, to improve their physical, social, emotional, and cognitive functioning.

Agencies are not required to provide care, food for the service animal, or a unique location to relieve itself.

Those with a service animal will need to:

* Maintain control of the animal.
* Keep the animal with them at all times.
* Pick up all bowel movements inside and outside.
* If applicable, animals are required to be housebroken.
* A service animal may be asked to leave the property if:
* The service animal is out of control, and the animal's owner does not take effective action to control it (for example, a dog that repeatedly barks after lights out).
* The service animal poses a direct threat to the health or safety of others.
* The service animal is not housebroken.

When there is a legitimate reason to remove a service animal, agencies should offer the participant with the disability the opportunity to obtain services without the animal's presence. Allergies and fear of animals are generally not valid reasons for denying access or refusing service to people with service animals.

For additional info, you may request a copy of a booklet containing information about the federal law, the Americans with Disabilities Act of 1990 (ADA), and the 2010 Revised Regulations.

If an agency needs help sheltering a pet or emotional support animal while providing services to a household, client advocate can call the APA, Animal Protection Association, at (314) 645-4610 or visit their website at www.apamo.org

## Affirmative Marketing and Outreach

The coordinated entry system and services available within are affirmatively marketed to "eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to apply in the absence of special outreach, and will maintain records of those marketing activities. Housing assisted by HUD and made available through the CoC must also be made available to individuals and families without regard to actual or perceived sexual orientation, gender identity, or marital status in accordance with 24 CFR 5.105 (a)(2)."

## Access

The coordinated entry system must be easily accessed by individuals and families seeking services to address housing crises. Access points will be available via walk-in and telephone. Additionally, the CoC will establish access points accessible via walk-in throughout the geographic region to the greatest extent possible. Access points for protected classes, i.e., VSP, youth, HIV/AIDS, or veterans, will not be required to provide walk-in services. Access points must provide reasonable accommodation for disabilities upon request. The assessments at each access point must follow this manual's requirements to ensure that clients are provided with the same assessment regardless of where they seek services. If the access point is unable to serve a client, the front door agrees to provide a warm referral to another front door to the greatest extent possible.

## Low Barrier

The coordinated entry system prohibits the "screening out" of clients "due to perceived barriers relating to housing or services, including, but not limited to, too little or no income, active or a history of substance use, 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 records – with exceptions for state and local restrictions that prevent projects from serving people with certain convictions."

## Client Choice

Clients are provided with information about the coordinated entry system, including which programs are available to them, so they decide about their housing goals. Clients are free to determine what information they provide during the assessment process. Clients may not be denied services if the client refuses to provide certain pieces of information unless the information is required to establish or document program eligibility for the project or compliance with state and federal laws.

## Collaboration

Coordinated entry is a system-wide process, and therefore all agencies within the network must collaborate to ensure the system functions smoothly and effectively. To have the most effective coordinated entry system, the CoC recognizes that partnerships from across sectors will help our region best provide services for all persons experiencing or at risk of homelessness and invite non-HUD funded programs and agencies to participate in the Homeless System Coordinated Entry Process.

## Data

An essential function of coordinated entry is collecting data regarding each client's housing crisis and needs to provide clients with the most appropriate housing interventions available. The data gathered is also utilized to reveal gaps in services and inform funding decisions. Clients may not be denied services if they refuse to allow their personally-identifying information to be shared unless required by local, state, or federal statute as a condition of program participation.

## Housing First

Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment, or service participation requirements. Housing First is a philosophy that values flexibility, individualized supports, client choice, and autonomy. It has never been housing only, and it never should be. Agencies who participate in coordinated entry voluntarily are strongly encouraged to follow the Housing First approach.

## Prioritization

Coordinated entry will ensure that those clients with the highest needs are provided with services first. A uniform assessment process is utilized for all clients experiencing housing crises to ensure needs-based access to housing interventions. Prioritization may not be based on any of the following: race, color, religion, national origin, sex, age, familial status, disability, type or amount of disability or disability-related services or supports required, actual or perceived sexual orientation, gender identity, or marital status.

## Privacy Protections

Participating agencies will only gather information deemed necessary to provide quality services, and assessments cannot require the disclosure of specific disabilities or diagnoses unless otherwise required to determine eligibility.

Clients must be notified of their HMIS-related privacy rights per the notification requirements included in the HMIS Policies and Procedures Manual. Staff and volunteers of agencies participating in coordinated entry will access client information only as necessary to provide services and referrals. No identifiable client information may be released to any individual, agency, organization, or government entity unless written consent is obtained from the client or is otherwise required by law.

## 

## Safety Planning

When a non-victim service provider is sheltering, housing, or otherwise providing services to an individual or family fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, human trafficking, or other life-threatening situation, that service provider shall follow the safety protections in the Violence Against Women Act (VAWA) and HUD Protections Against Survivors of Violence (16-159). Agencies will give the survivor the safety and confidentiality rights the highest priority and ensure the survivor’s autonomy, self-determination, and safety are respected.

Non-victim service access points responding to domestic or sexual violence victims will provide a private location and assistance in contacting local shelters for victims of violence. Should a victim of violence choose to seek refuge with a program that does not provide victim-specific services, they cannot be discriminated against due to the violence. They must be offered the same confidentiality of services provided through victim service providers, including but not limited to data collection, privacy, and sharing.

Housing providers must have emergency transfer plans in place that allow for a survivor to move immediately to a safe and available unit if the survivor fears for their life and safety. Such programs enable a survivor to self-certify their need for the transfer, do not require the survivor to undergo an application process as a new tenant, and allow the survivor to determine a safe unit for purposes of the transfer.

Non-victim service providers are encouraged to consult and collaborate with victim service providers and familiarize themselves with safety planning resources available through the Missouri Coalition Against Domestic and Sexual Violence website [https://www.mocadsv.org/resources/.](https://www.mocadsv.org/resources/)

Grievance Policy

Before a grievance can be brought before the Coordinated Entry Committee, the client must exhaust all grievance procedures within the agency project guidelines.

Only grievances related to the Coordinated Entry process should be brought to the committee. Clients with concerns about the coordinated entry process can file a complaint via email with the CE Chair, Jacki MacIntosh, at [jacki@loavesandfishes-stl.org](mailto:jacki@loavesandfishes-stl.org) or the CE Vice-Chair, Linda Huntspon, at [lhuntspon@stlouisco.com](mailto:lhuntspon@stlouisco.com).

Crisis Management - In draft form

Section 2: Access to Housing Crises Services

## 

## Prevention and Diversion

## **Prevention** - Homelessness prevention strategies represent a wide array of efforts to prevent housing crises from occurring and to prevent people who face such crises from experiencing homelessness. Homelessness prevention requires a multi-sector approach and an active focus on reducing the prevalence of housing crises. Prevention strategies as described by Housing and Urban Development and U.S. Interagency Council of Homelessness define prevention into the following categories:

1. Activities that reduce the prevalence of risk of housing crises within communities;
2. Activities that reduce the risk of homelessness while households are engaged with or are transitioning from systems; and
3. Activities that target assistance to prevent housing crises that do occur from escalating further and resulting in homelessness.

**Diversion -** Strategies and practices that assist people to resolve their immediate housing crisis by accessing alternatives to entering emergency shelter or the experience of unsheltered living. This typically occurs when people request emergency services, such as entry into emergency shelter, or could take place in a day center or through outreach before a person spends a night unsheltered.

Diversion occurs at a “front door” of the homelessness service system (e.g., coordinated entry access point, services center, emergency shelter) but before the person spends a night at a shelter, in a motel with a voucher, in a place not meant for human habitation, or unsheltered. In diversion, there is a focused conversation to help the person identify an immediate housing arrangement that is a safe alternative to shelter or sleeping unsheltered. This housing arrangement may be temporary, allowing time to identify a permanent housing option while avoiding the immediate trauma of homelessness, or it may allow those involved to explore the possibility of extending a temporary arrangement into a permanent one.

Approaching diversion from a client-centered service perspective is critical. Diversion is not a process of turning people away or declining to provide needed services. Instead, diversion offers a valuable service that helps people avoid the experience of being in a shelter or unsheltered. Integrating diversion practices into the system helps ensure that scarce resources are better utilized. More importantly, good diversion processes focus on serving the household in crisis by helping them find positive alternatives to entering the shelter system or staying outdoors.

Coordinated Entry Manager (CEM)

## St. Louis County Homeless Services will be the Coordinated Entry Manager. The CEM’s responsibilities include, but are not limited to:

1. Oversee the operations of the Housing Prioritization List and Project Enrollment List.
2. Monitors the inactive policy and ensures clients that have not been engaged in 90 days are moved to the inactive list.
3. Coordinates with the HMIS lead and the HMIS committee to address any data issues, concerns, or changes.
4. Ensures that housing openings are being paired with qualifying clients.
5. Contacts housing project regarding referrals.
6. Provides monthly reporting to St. Louis County CoC Executive Boards and Coordinated Entry Committee.
7. Coordinates with all access points.

## Access Points

Any agency within the St. Louis County CoC that share the goal of ending and preventing homelessness is allowed to be an access point but must agree to all responsibilities of an access point as defined in this manual, including the signing of an agreement

All individuals and families at risk of or experiencing homelessness must be offered the opportunity to be assessed at an access point agency. An access point is responsible for gathering or completing all coordinated entry assessments required to enroll clients into an HMIS project.

All access points have the following responsibilities:

* Designate two individuals to function as the primary contacts for communication with the Coordinated Entry Manager.
* To the greatest extent possible, provide a warm referral to clients in need of emergency services (e.g., emergency shelter, victim service provider, medical care, meal programs) to ensure the most basic needs are met. This includes referring or connecting clients to applicable emergency services and other mainstream resources.
* Screen for prevention and diversion before making a referral to the homeless services.
* Verify that the client meets HUD’s definitions of homelessness or at-risk of becoming homeless before completing an assessment. Suppose a client does not meet HUD’s definition of homelessness or at-risk of homelessness. In that case, access points must provide a warm referral to a prevention and diversion project or other agency that may be able meet their needs.
* Access points may choose to work exclusively with special populations if that’s their agency’s primary mission (e.g., veterans, VSP, youth, persons with HIV/AIDS) but must agree to make a warm referral to an appropriate access point for any individuals seeking services who are not in their unique population.
* Assess each housing crisis and gather all required information for prioritization and input into HMIS for enrollment into an HMIS project or refer those at-risk of homelessness to appropriate prevention and diversion services. This includes gathering documentation of homelessness or at-risk of homelessness per HUD guidance to the greatest extent possible.
* Function as a client advocate for the clients they enroll into an HMIS project or refer clients to another front access point who has agreed to provide the client with housing navigation services. (if applicable)
* Agency is a member in good standing with the St. Louis County CoC per their governance chart.

All access points must sign an agreement with the Continuum of Care before providing coordinated assessment services. Suppose an access point is designated for a protected population(s). In that case, the agreement must outline the particular population(s) it will serve and any specific requirements needed to ensure safe and effective participation in coordinated entry (e.g., access points for victims of domestic violence will not enter data into the HMIS per the Violence Against Women Act, nor will the physical location of domestic violence front doors or other victim services providers be disclosed publicly).

No access point may function as the only access point for a protected population. All special populations must be able to access a minimum of two access points.

### Emergency Shelters

All referrals to shelters must come through coordinated entry. Access points include, but are not limited to, the St. Louis Regional Housing Helpline (2-1-1) and street outreach providers who participate in HMIS. All shelter referrals must be documented within the HMIS (victim service agencies are exempt) to track referral sources. Access points are permitted to make referrals to open shelter spaces at any time, including nights and weekends, if the shelter accepts new clients during the night and over weekends.

1. All access points are expected to complete a prevention and diversion assessment to determine the most appropriate referral for their housing crisis and make a referral based upon their housing needs to available resources in the community.
2. All emergency shelters receiving ESG or HRC funding are access points for clients living in their shelter projects and must provide the opportunity for assessment and enrollment into their project within 24 hours unless the client declines to participate in coordinated entry.

### Street Outreach

All street outreach providers receiving ESG or PATH funding are access points for clients who have been determined to be engaged with their project. Outreach workers must provide assessment and enrollment into an HMIS project within seven (7) days of contact or immediately after evaluation unless the client declines to participate in coordinated entry. In addition, street outreach must call 2-1-1, youth twenty-four hours hotline, or victim services providers twenty-four-hour hotline for placement before a direct referral to a shelter or other emergency housing program.

1. Youth Access Points

Youth agencies will operate their own youth access point and housing referral process. This referral process should work laterally to all other access points and adhere to all policies outlined in this manual. (1) A member of the youth access process must be a member of the St. Louis County CoC and in good standing. (2) Have a representative from the referring agency on the Coordinated Entry Committee. (3) For oversight and transparency purposes, the agency making housing referrals must submit an aggregated monthly report to the Coordinated Entry Committee. Reports should include agency openings, the number of referrals, and the agency that referrals were made. Monthly reports will be submitted to the Executive Committee for final review and shared with the CoC general body. No personal client data should be on any report.

1. Victim Service Providers / Protected Classes

VSP will operate their access point and, in some cases, housing referral process. These referrals should work laterally to all other access points and adhere to all policies outlined in this manual. If a VSP or protected class agency is making housing project referrals: (1) The agency must be a member of the St. Louis County CoC and in good standing. (2) Have a representative from the agency on the Coordinated Entry Committee. (3) For oversight and transparency purposes, the agency making housing referrals must submit an aggregated monthly report to the Coordinated Entry Committee. Reports should include agency openings, the number of referrals, and the agency those referrals were made. Monthly reports will be submitted to the Executive Committee for final review and shared with the CoC general body. No personal client data should be on any report.

“After Hours” Access to Services In Draft Form

Our “After Hour” policy was created to provide 24-hour access to emergency services through a collaboration with funded shelters located in St. Louis County. Shelters will be asked to assist with the following:

1. Work in collaboration with shelters to take responsibility for “after-hour” emergency calls for shelter placement.
   1. Ask each shelter to designate a point of contact each night to help with after-hour phone calls.
   2. Ensure diversion attempts are made before referral to a shelter.
   3. Provide funding to shelters for “after-hour” transportation.
2. Work with CIT officers who are trying to locate access to emergency services.
3. Utilize 211 -
   1. The 211 Navigator will reach out to the on-call shelter to connect the caller.
4. Have a walk-up location to provide triage.
5. Have an after-hours virtual number accessible on the CcC website, on 211 website, and 211 database for the after-hours 211 Navigator to provide via phone.
6. Hotel vouchers for extreme cases; no-repeat users (never utilized vouchers)
   1. Overnight only; the person(s) go into available shelter vacancy on the next day.

Full utilization of HMIS to track the persons, for accountability and having a transparent system that all triage locations can/will access/ identify the needs

# Section 3: Program Standards and Policy By Service

The Saint Louis County CoC practices a person-centered model that strongly incorporates participant choice and inclusion, including, but not limited to, persons experiencing chronic homelessness, veterans, youth ages 18-24, households with children, and victims services or other life-threatening interpersonal violence.

For a more in-depth description of our program standards, please visit our website: www.stlcountycoc.com for a copy of the St. Louis County Service Delivery Standards Manual.

## Homeless Assistance Services Available

|  |
| --- |
| **ELIGIBILITY BY COMPONENT** |

|  |  |  |  |  |
| --- | --- | --- | --- | --- |
| Component\*\* | Funding | Homeless Status  Category \* | Target Population | Income |
| Homelessness  Prevention | ESG | At-risk: 1,2,3  Homeless: 2,4 | See "ESG Homeless Prevention" Section  for further eligibility criteria | At or below  30% AMI |
| Emergency  Shelter | ESG | 1,2,4 | N/A | N/A |
| Transitional Housing | CoC | 1,4 | Youth ages 18-24 | N/A |
| Rapid Re-Housing | ESG  CoC | 1,4 | People with VI-SPDAT Scores 4-7 People with the longest history of homelessness  People with VI-SPDAT scores 9+ who do not qualify for PSH | N/A |
| Permanent Supportive Housing \*\*\* | CoC | 1,4 | Dedicated to households experiencing chronic homelessness, as defined by HUD, or meeting the eligibility criteria for DedicatedPLUS | N/A |

\*\* All components: Eligible households must have a head of household that is 18 years of age or older; if not 18 years old, they must provide documentation of legal emancipation.

\*\*\* PSH component: Eligible households must have one household member (adult OR child) with a disability

\*\*\*\* RRH Income: Client income must be at or below 30% AMI at annual evaluation. COMPONENT

## 

## HMIS Participation

Projects receiving CoC or funding through St. Louis County Human Service are required to participate in the Saint Louis County CoC's Homeless Management Information System (HMIS). Only victim service providers (VSP) are prohibited from entering participant information into HMIS under federal guidelines, and therefore will use a comparable database to report data as necessary. The CoC strongly encourages non-CoC/ESG funded organizations to participate in HMIS.

## Housing Navigation Services

Available to single adults (25+), qualified minors (age 16-17), youth (18-24), and families.

All clients experiencing homelessness are eligible to receive housing navigation services regardless of any other circumstances, including clients otherwise ineligible for assistance due to an acuity score of 0-3.

Prevention

## Available to single adults (25+), qualified minors (age 16-17), youth (18-24), and families.

ESG homelessness prevention is housing relocation and stabilization services and short-and/or medium-term rental assistance as necessary to prevent the household from entering homeless services, a place not meant for human habitation, or another location described in paragraph (1) of HUD’s homeless definition.

## The costs of homelessness prevention are only eligible to the extent that the assistance is necessary to help the program participant regain stability in their current housing or move into other permanent housing and achieve stability in that housing.

## Minimum Standards

* Participants are eligible to receive rental assistance up to 18 months
* Participants receiving more than one month of rental assistance must meet with their housing stabilization specialist/social worker at least once per month. (requirement waived during pandemic)
* Participants are required to contribute 30% of their adjusted monthly income or 10% of their monthly income (higher of the two amounts) towards rent. Client household incomes are recertified every three months: monthly household income at or below 30% AMI. Participants must make payments directly to the housing owner (or their agent, such as a property manager).
* Participants must have a written lease to receive rental assistance.
* Rental assistance will only be provided if the unit's total rent does not exceed the fair market rent established by HUD and complies with HUD’s standard of rent reasonableness.
* When providing rental assistance under the homelessness prevention component of the ESG program, service may only be provided when a rental assistance agreement is in place between the provider and owner that sets forth the terms under which the rental assistance is being provided. It must *at least* include the following:
  + A provision requiring the owner to give the provider a copy of any notice to the program participant to vacate the housing unit, or any complaint used under state or local law to commence an eviction action against the program participant, as indicated in §576.106(e)).
  + The same payment due date, grace period, and late payment penalty requirements as the program participant’s lease, as indicated in §576.106(f)).
  + For project-based rental assistance, the initial term of the rental assistance agreement must be one year. For tenant-based rental assistance, recipients/sub-recipients should establish the rental assistance agreement's duration for the period they anticipate assisting.
  + All protections for domestic violence victims, dating violence, sexual assault, or stalking that apply to tenants and applicants under 24 CFR part 5, subpart L, as supplemented by § 576.409.

## Emergency Shelters

The CoC interim establishes minimum standards for safety, sanitation, and privacy in funded emergency shelters and minimum habitability standards for permanent housing funded under the Rapid Re-housing and Homelessness Prevention components of ESG.

## Minimum Standards

## DHS and its contracted emergency housing agencies should provide the following services to facilitate self-sufficiency and independence:

* Safe, temporary emergency shelter;
* Housing-focused, person-centered, strengths-based case management services;
* Assistance with obtaining housing;
* Referrals to supportive services for special subpopulations such as children, people with disabilities such as severe mental illness or substance use disorder, veterans, etc.; and
* The guiding principles of the CoC’s Emergency Housing Standards ensure individuals and families living in emergency housing:

1. a safe environment
2. treatment with dignity and respect; and
3. provision of housing and related services without regard to race, ethnicity, age, gender, disability, or sexual orientation.

## Requirements (Including Non-HMIS shelters)

### Assess clients and enroll them into an HMIS project per the client assessment process for HMIS participating shelters.

### Non HMIS participating shelters should refer clients to appropriate access points for assessment and enrollment into the HMIS system.

### Provide housing navigation services

* Be a member of the St. Louis County CoC and in good standing per the CoC governance.
* Send shelter openings to access points by 7:00 am daily. Shelter openings should only be submitted if the bed or unit is ready for immediate occupancy. If a client is declined or does not show up, notify the referring access point. In the event of a change in availability during the day, notify the access point. At least 100% of referrals from access points must be accepted if the project is mandated to participate in coordinated entry.
* Advocate on behalf of any clients going through the acuity review process.

## Assessment

For clients living in emergency shelters to access the prioritization list (when space is available), the following steps will be completed for each household. This process is intended to align with HMIS data collection requirements.

#### Complete project enrollment - Gather all required data to complete project enrollment and record in HMIS. The emergency shelter must offer the opportunity for assessment and enrollment into have HMIS project within two business days of shelter move-in.

#### Prescreen for Interest- Briefly explain the coordinated entry system and determine if the client wishes to proceed with an assessment. If the client does want to proceed, continue. Otherwise, provide the client with other applicable referrals to mainstream resources and services available via the emergency shelter project.

#### Gather Client Consent - Have the client sign the Coordinated Entry Participation Agreement.

#### Complete Applicable Coordinated Entry Assessment(s) - Complete the Coordinated Entry Assessment, including prevention and diversion screening (if not already completed) and the VI-SPDAT. If a VI-SPDAT has previously been recorded in the HMIS, a new VI-SPDAT will be conducted only if one or more of the following circumstances exist:

* + The VI-SPDAT on file is the wrong type for the current housing crisis (e.g., PR-VI-SPDAT on file when a VI-SPDAT is required).
  + The client has had a significant change in their life that will most likely result in an increase or decrease of at least one point on the VI-SPDAT (e.g., attacked or beaten up, change in employment status, new medical diagnosis).
  + The VI-SPDAT present in the database was completed during a different episode of homelessness.
  + It has been more than six months since the most recent VI-SPDAT was completed.
  + The household composition has changed (household members have joined or left, including a child's birth).

#### Verify Eligibility - Verify that the clients VI-SPDAT score is within the applicable range to receive services, and no information has been disclosed during the assessment that results in the client being ineligible for services (e.g., stably housed). Unless information has been disclosed that determines the client is ineligible for services, the assessor records the placement onto the prioritization list.

#### Client Participant Rights and Expectations Packet - make available upon clients request.

## Victim Service Provider - Emergency Shelters

### Follow individual agency procedures regarding shelter openings.

### Assess clients and enroll them in the HMIS project.

### Provide housing navigation services.

### Maintain contact with the Coordinated Entry Manager at least once a week to identify housing matches and ensure collaboration.

### Advocate on behalf of any clients in the shelter going through the acuity review process.

* Be a member of the St. Louis County CoC and in good standing per the CoC governance.

## Assessment

For clients living in a victim service project who are mandated to participate in Coordinated Entry, the following steps will be completed for each household.

#### Complete Project Enrollment - gather all required data to complete project enrollment and record it in their HMIS-comparable database. The victim service provider must offer the opportunity for assessment and enrollment into a project within two business days of shelter move-in.

#### Prescreen for Interest - Briefly explain the coordinated entry system and determine if the client wishes to proceed with an assessment. If the client does want to proceed, continue. Otherwise, provide the client with other applicable referrals to mainstream resources and services available via the victim service project.

#### Gather Client Consent - While victim service providers are exempt from utilizing the CoC-mandated Coordinated Entry Participation Agreement, each victim service provider must ensure that clients are notified about the type of information that will be disclosed to enroll the client into an HMIS project and that the client consents to the disclosure of that information. The victim service provider must have procedures that ensure that client consent is documented in a manner that meets HUD’s requirements as found in CPD-17-01.

#### Complete Applicable Coordinated Entry Assessment(s) - Complete the Coordinated Entry Assessment, including prevention and diversion screening (if not already completed) and the VI-SPDAT. If a VI-SPDAT has previously been recorded in the HMIS, a new VI-SPDAT will be completed only if one or more of the following circumstances exist:

1. The client has had a significant change in their life that will most likely result in an increase or decrease of at least one point on the VI-SPDAT (e.g., attacked or beaten up, change in employment status, new medical diagnosis).
2. The VI-SPDAT available was completed during a different episode of homelessness.
3. It has been more than six months since the most recent VI-SPDAT was completed.
4. The household composition has changed (household members have joined or left, including a child's birth).

#### Verify Eligibility - Verify that the client’s VI-SPDAT score is within the applicable range to receive services and that no information has been disclosed during the assessment process that results in the client being ineligible for services (e.g., stably housed). Unless information has been disclosed that clearly determines the client is ineligible for services, the assessor sends the de-identified prioritization information to the HMIS lead for placement onto the prioritization list.

#### Client Participant Rights and Expectations Packet - make available upon clients request.

## Street Outreach Providers

### Assess clients utilizing the prevention and diversion screening tool and enroll them into an HMIS project if applicable.

### Provide housing navigation services.

* Be a member of the St. Louis County CoC and in good standing per CoC governance.

### Advocate on behalf of any clients in the shelter going through the acuity review process.

## Assessment

For clients working with street outreach providers to be enrolled in a project, the following steps will be completed for each household. This process is intended to align with HMIS data collection requirements.

#### Record Project Start Information in HMIS - At first contact with an individual living in a place not meant for habitation, the street outreach provider will gather information and put information provided by the client into the HMIS.

#### Complete Project Enrollment - Once the client has been deemed “engaged,” the outreach provider will gather any remaining data to complete project enrollment and record it in the HMIS. When a client is deemed engaged, the street outreach provider must offer the opportunity for assessment and placement into a program within seven days.

#### Prescreen for Interest - Briefly explain the coordinated entry system and determine if the client wishes to proceed with an assessment. If the client does want to proceed, continue. Otherwise, provide the client with other applicable referrals to mainstream resources and services via the street outreach project.

#### Gather Client Consent - Have the client sign the Coordinated Entry Participation Agreement.

#### Complete Applicable Coordinated Entry Assessment(s)

Complete the Coordinated Entry Assessment, including the Prevention and Diversion Screen and VI-SPDAT. Suppose a Prevention and Diversion screening or VI-SPDAT has previously been recorded in HMIS. In that case, a new screening will only need to be completed if one or more of the following circumstances exist:

* 1. The VI-SPDAT on file is the wrong type for the current housing crisis.
  2. The client has had a significant change in their life that will most likely result in an increase or decrease of at least one point on the VI-SPDAT (e.g., attacked or beaten up, change in employment status, new medical diagnosis).
  3. The VI-SPDAT present in the database was completed during a different episode of homelessness.
  4. It has been more than six months since the most recent VI-SPDAT was completed.
  5. The household composition has changed (household members have joined or left, including a child's birth).

#### Verify that the client’s VI-SPDAT score is within the applicable range to receive services and that no information has been disclosed during the assessment that results in the client being ineligible for services (e.g., stably housed). Unless information has been disclosed that clearly determines the client is ineligible for services, the assessor records the placement onto the prioritization list.

#### Client Participant Rights and Expectations Packet - make available upon clients request.

## Transitional Housing for Youth

Transitional housing is temporary supportive housing used to facilitate the movement of youth experiencing homelessness to permanent housing. All referrals to transitional housing must come through the Coordinated Entry System (excluding RHY-funded projects).

Eligibility

To receive assistance through transitional living programs, households must be headed by an individual 16 to 24 years of age with an acuity score of 8 or higher (singles and youth) or nine or higher (families). Mandated transitional living programs must follow the housing first philosophy.

## Minimum Standards

* + The primary objective of transitional housing is to move a household from homelessness to permanent housing as quickly as possible; assistance in transitioning to permanent housing must be made available/provided as promptly as possible from transitional housing program entry.
  + Supportive services must be offered throughout the stay in transitional housing.
  + Participants in transitional housing must enter into a lease, sublease, or occupancy agreement for a term of at least one month. The lease, sublease, or occupancy agreement must be automatically renewable upon expiration, except on prior notice by either party, for up to twelve months.
  + The maximum length of stay cannot exceed 12 months. When households need assistance beyond 12 months, OHS approval is required. This standard applies to all households who enter a TH project on or after October 1, 2018.
  + Unless otherwise prohibited by other project funding sources, transitional housing projects are required to use a low barrier Housing First Approach (i.e., not have services participation requirements or preconditions to entry, such as sobriety or minimum income threshold) and must prioritize rapid placement and stabilization in permanent housing.

## Rapid Re-Housing (RRH)

Rapid Re-Housing is available to help those who are experiencing homelessness be quickly and permanently housed. RRH projects provide temporary financial assistance combined with housing location and housing stability case management services to help homeless individuals and families obtain permanent housing and achieve stability. The model is consumer-driven, and the services and housing options provided will be tailored to a clients’s needs and priorities as much as possible. Project participants will be assisted to locate housing of their choice in the private rental market.

Eligibility

* Those eligible for RRH should be literally Homeless (referred to as Category 1 in the Homeless Definition Final Rule. An individual or family is defined as “literally homeless” if (1) living in a public or private place not meant for human habitation, (2) living in temporary shelter, which includes congregate shelters and transitional housing, or (3) exiting an institution where the individual or family has resided for 90 or fewer days and was living in shelter or in a place not meant for habitation before entering the institution.
* Fleeing or attempting to flee domestic violence if they are **also** literally homeless.

## Minimum Standards

The following minimum standards will be applied to all rapid re-housing projects:

1. All projects must document eligibility according to HUD recordkeeping requirements for the CoC Program.
2. Maximum participation in a rapid re-housing program cannot exceed 24 months in any three-year period.
3. Supportive services must be offered throughout the stay in the program.
4. Agency client advocates will assist participants in identifying potential housing options and selecting suitable landlords.
5. Agency client advocates are required to make appointments with participants not less than once per month to assist the participant in ensuring long-term housing stability.
   1. Though appointments are required to be set by program staff, the participant reserves the right not to attend the meetings or to be consistently engaged in services
6. Participants must enter into a lease agreement for a term of at least 366 days, which is terminable for cause.
7. The lease must be automatically renewable upon expiration for terms that are a minimum of one monthlong, except on prior notice by either party. Rental assistance will only be provided if the unit's total rent does not exceed the fair market rent established by HUD and if it complies with HUD’s standard of rent reasonableness.
8. Any lease, sublease, and occupancy agreement with a client must include a provision that includes all requirements that apply to tenants, the owner, or the lease under federal protections for victims of domestic violence, dating violence, sexual assault, or stalking, including the prohibited bases for eviction and restrictions on construing a lease. The lease, sublease, and occupancy agreement may specify that the protections apply only during the period of assistance.
9. When CoC Program grant funds are used for assistance that is not tenant-based, any lease, sublease, or occupancy agreement with a client must permit the client to terminate the lease, sublease, or occupancy agreement without penalty if the program participant qualifies for an emergency transfer under the CoC Emergency Transfer Plan.
10. Must re-evaluate quarterly that the participant lacks sufficient resources and support networks necessary to retain housing without assistance.
11. When providing rental assistance under the rapid re-housing component of the ESG program, service may only be provided in cases where a rental assistance agreement is in place between the agency and owner that sets forth the terms under which the rental assistance is being provided. It must *at least* include the following:
    1. A provision requiring the owner to give the provider a copy of any notice to the program participant to vacate the housing unit or any complaint used under state or local law to commence an eviction action against the program participant.
    2. The same payment due date, grace period, and late payment penalty requirements as the program participant’s lease.
    3. For project-based rental assistance, the initial term of the rental assistance agreement must be one year. For tenant-based rental assistance, recipients/sub-recipients should establish the rental assistance agreement's duration for the period they anticipate assisting.
    4. All requirements apply to tenants, the owner, or the lease under federal protections for domestic violence victims, dating violence, sexual assault, or stalking.
12. When CoC Program grant funds are used for tenant-based rental assistance, the provider must enter into a contract with the owner or landlord of the housing that:
    1. Requires the owner or landlord of the housing to comply with Federal protections for victims of domestic violence, dating violence, sexual assault, or stalking;
    2. Requires the owner or landlord of the housing to include a lease provision that contains all requirements that apply to tenants, the owner, or the lease under federal protections for victims of domestic violence, dating violence, sexual assault, or stalking, including the prohibited bases for eviction and restrictions on construing lease.

## Permanent Supportive Housing (PSH)

## Permanent supportive housing (PSH) for persons with disabilities is permanent housing with ongoing leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or children member with a disability achieve housing stability. (Continued services are contingent on renewal of funding)**.**

## PSH projects have the following additional NOFA limitations on eligibility within Category 1:

* Individuals and Families coming from TH must have originally come from the streets, emergency shelter, or safe haven
* Projects that are dedicated to serving households experiencing chronic homelessness, including those that were originally funded as Samaritan Bonus Initiative Projects, must continue to serve chronically homeless persons exclusively

## Projects funded under the Permanent Supportive Housing Bonus must continue to serve the homeless population outlined in the NOFA under which the project was originally awarded.

* Projects that are DedicatedPLUS must serve households who meet HUD’s eligibility criteria for DedicatedPLUS, prioritizing those households experiencing chronic homelessness, as defined by HUD

Eligibility (in priority order)

1. First Priority –– Individuals and families with a disability who meet HUD’s definition of chronic

homelessness

1. Second Priority – Individuals and families with a disability residing in a place not meant for human habitation, emergency shelter, or safe haven who experienced chronic homelessness as defined by HUD, had been admitted and enrolled in a permanent housing project within the last year but were unable to maintain the housing placement
2. Third Priority – Individuals and families with a disability residing in a place not meant for human habitation, a safe haven, or emergency shelter for at least 12 months in the last 3 years, but has not done so on four separate occasions.
3. Fourth Priority –Individuals and families with a disability residing in a transitional housing project that will be eliminated and meet the definition of chronically homeless at the time the individual or family entered the transitional housing project
4. Fifth Priority – Individuals and families with a disability receiving assistance through a Department of Veterans Affairs (VA) – funded homeless assistance program and met one of the above criteria at initial intake to the VA’s homeless assistance system.

## Minimum Standards

1. There can be no predetermined length of stay for a PSH project.
2. Supportive services designed to meet the client's needs must be made available to the clients throughout their PSH stay.
3. Clients in PSH must enter into a lease (or sublease) agreement for an initial term of at least one renewable year and is terminable only for cause. Leases (or subleases) must be renewable for a minimum period of one month.
4. Any lease, sublease, and occupancy agreement with the client must include a provision that includes all requirements that apply to tenants, the owner, or the lease under federal protections for victims of domestic violence, dating violence, sexual assault, or stalking, including the prohibited bases for eviction and restrictions on construing lease. The lease, sublease, and occupancy agreement may specify that the protections apply only during the period of assistance.
5. When CoC Program grant funds are used for assistance that is not tenant-based, any lease, sublease, or occupancy agreement with a client must permit the client to terminate the lease, sublease, or occupancy agreement without penalty if the program participant qualifies for an emergency transfer under the Saint Louis County CoC Emergency Transfer Plan.
6. Agencies must enter into a contract with the owner or landlord for which assistance is being provided that:
   1. Requires the owner or landlord of the housing to comply with Federal protections for victims of domestic violence, dating violence, sexual assault, or stalking; and
   2. Requires the owner or landlord of the housing to include a lease provision that contains all requirements that apply to tenants, the owner, or the lease under federal protections for victims of domestic violence, dating violence, sexual assault, or stalking, including the prohibited bases for eviction and restrictions on construing lease.
7. Agencies that provide permanent supportive housing for hard-to-house populations of homeless persons must exercise judgment and examine all extenuating circumstances in determining when violations are severe enough to warrant termination so that a client’s assistance is terminated only in the most severe cases.
8. Agencies must allow tenants due process when terminating assistance. Clients should exhaust the agency’s grievance policies before filing a concern with the Coordinated Entry Committee. Only grievances about coordinated entry will be reviewed at a committee level. To file a grievance regarding the coordinated entry process, you can email your concerns to CE Chair Jacki MacIntosh at [jacki@loavesandfishes-stl.org](mailto:jacki@loavesandfishes-stl.org) or CE Vice Chair Linda Huntspon[lhuntspon@stlouisco.org](mailto:lhuntspon@stlouisco.org).

# Section 4: Expectations of Housing Projects

Housing projects are defined as programs that provide transitional youth housing, rapid rehousing, permanent supportive housing, permanent housing only, and permanent housing with services. Housing projects mandated to participate in coordinated entry must follow the rules and expectations below, while projects not mandated to participate in coordinated entry are strongly encouraged to do so.

## Notification of Housing Availability

Housing projects must respond within the twenty-four hours from when the Coordinated Entry Manager (CEM) sends a request for housing openings every week, including how many units are available with and without pending referrals. If a housing provider does not have any openings, they must still respond to the request to notify the CEM of no openings. If a sponsor-based unit is listed, the project must indicate whether the unit is currently available or when it will be available. Each notification of housing availability shall be deemed to override any previously submitted housing openings.

## Program Information Sheet

HMIS projects that are not HUD-funded must submit a detailed list of eligibility criteria, an outline of the enrollment process, and projects in addition to housing (if any) for each housing project. The information submitted will be made publicly available for review by service providers, clients, and other community members. HMIS projects that are not HUD-funded include, but are not limited to, HHS youth, MHDC Housing Trust Fund, and MHDC MoHip.

All acuity reviews should be noted in HMIS (or comparable database if a Victim Service Provider)

Project Acceptance Expectations

Referrals will only be provided when a project notifies the Coordinated Entry Manager (CEM) that it has openings. Projects mandated to participate in coordinated entry will fill 100% of their openings from the CEL.

When a referral is made, the housing project must work with the client’s advocate to ensure that an eligibility appointment is scheduled to occur within seven business days of receiving the referral (assuming no extenuating circumstances). After the eligibility appointment, the housing project has two business days to notify the client of the determined (1) eligible, (2) eligible pending receipt of required documentation, or (3) ineligible. If the client was deemed eligible pending documentation, the housing project must work with the client and the client’s advocate to gather all required documentation. The client and advocate must be allowed a minimum of ten business days to gather required documentation AND no communication of progress from the client or client advocate before a housing project may cancel the referral due to lack of documentation.

A housing program shall be deemed to have “declined” a referral if all of the following criteria are met:

* The client has been referred to the housing project by coordinated entry.
* The client meets the eligibility criteria as defined in the program standards.
* The client has expressed interest in working with the housing project.
* The client has agreed to follow all requirements of the housing provider.
* The housing provider has notified the Coordinated Entry Manager of an available, applicable unit for the client
* The housing provider does not make a housing offer to the client

If a project declines a referral, the next applicable client will be referred to the housing opening.

A housing project may “cancel” a referral in the following circumstances. A canceled referral shall be excluded from calculating the rate of acceptance for each project as long as the appropriate requirements are met.

* The client has rejected the housing opportunity. Housing projects are required to document the client’s reason for rejecting the housing opportunity and submitted for recordkeeping. When reasonably possible, the documentation will include the client’s signature. The client will be removed from the prioritization list, and the next applicable client will be referred to the opening. Clients may reject an unlimited number of housing opportunities but must be aware that there may not be another opening, or the next opening may be significantly delayed. In addition, if a client rejects a housing opportunity, the client advocate is strongly encouraged to work with the client to determine what the client is seeking in a housing opportunity to ensure that the housing opportunities offered are meeting the client’s needs.
* The client cannot be contacted or located. The housing project must document a minimum of three attempts to contact the client via the client’s advocate, directly via the available contact information, or through the CEM, and the client has been provided at least 24 hours to respond to any messages (e.g., voicemails, emails, or text messages). Multiple attempts to contact the client on the same day, while encouraged, may only be counted as one attempt. Documentation of a minimum of three failed attempts to reach the client must be recorded in the HMIS system, and flag for community projects should the client show up. If a client cannot be contacted via three contact attempts, they will be deemed “disappeared” and will be moved to an inactive list. They will not be considered for additional openings unless they return to an access point and are reactivated.
* The client does not meet the eligibility criteria. An explanation of why the client does not meet the eligibility criteria must be submitted to the CEM for record-keeping purposes. The client will be removed from the list, and the next applicable client will be referred to the opening.
* The client’s acuity score has been reevaluated using a full SPDAT, and the coordinated entry committee has agreed that the client is not an appropriate fit for the housing project. The client will be returned to the list, and the next applicable client will be referred to the opening.
* The client and advocate have not produced the minimum required documentation within ten business days **AND** has not communicate progress with the housing project. In that case, the client will be removed from the prioritization list, and the next applicable client will be referred to the opening.

# Section 5: Expectations of Other Groups

## HMIS Lead

The HMIS lead has the following responsibilities:

* Provide training to all applicable HMIS users to ensure that the coordinated entry system within the HMIS is appropriately recorded.
* As possible, setup and customize the HMIS to gather and report on data needed for HUD compliance, coordinated entry, gaps analysis, and other community needs as directed by the CoC Executive Board.
* Ensure the HMIS prioritizes clients per the defined prioritization criteria.
  + Provide monthly reports on coordinated entry

Crisis Management Team In draft form

## 

Coordinated Entry Monitoring

An review of our Coordinated Entry System will be the responsibility of an independent consultant(s) selected by the St. Louis County Planning Consultant with the Executive Committee and the Coordinated Entry Committee's assistance. Areas of review will include

* HUD Compliance
* HMIS software
* Data collection
* Coordinated entry efficiency
* Client experience

\*\* The St. Louis County Coordinated Entry Policy and Procedure Manual will be reviewed annually by CE Committee. Any changes will be given to the CoC body once it has been approved by the Executive Committee.

# Section 6: Assessment Procedures

Per CPD-17-01: *Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System*, “[t]he assessment and prioritization process cannot require disclosure of specific disabilities or diagnoses. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals”.

## Designated Assessment Tools

The VI-SPDAT and the full SPDAT are the designated assessment tools for the coordinated entry system.

|  |  |  |  |
| --- | --- | --- | --- |
| **Population** | **VI-SPDAT Tool** | **Prevention/**  **Diversion** | **Full SPDAT Tool** |
| Unaccompanied individuals at-risk of homelessness | N/A | TBD | Not applicable |
| Households with two or more individuals at-risk of homelessness | N/A | TBD | Not applicable |
| Unaccompanied individuals ages 25 and above who are homeless | VI-SPDAT | TBD | SPDAT |
| Unaccompanied individuals ages 24 and under who are homeless | TAY-VI-SPDAT | TBD | Y-SPDAT |
| Households with two or more individuals, regardless of age, who  are homeless | VI-F-SPDAT | TBD | F-SPDAT |

## Client Assessment Process for All Access Points (walk-in and virtual)

To be enrolled in an HMIS-bases project, become eligible for the HPL, or referred to appropriate prevention services, the following steps will be completed for each household. Clients working with street outreach or emergency shelters that do not participate in HMIS must be informed of the ability to go to walk-in access points for assessment and enrollment into an HMIS project.

#### Prescreen for Eligibility and Interest

Determine if the client is eligible for prevention/diversion or other homeless services. If potentially eligible, briefly explain the coordinated entry system and determine if the client wishes to proceed with an assessment. If the client wants to proceed and is part of the access point's population, continue. If the client wants to proceed but is not part of the access point's population, make a warm referral to an appropriate access point. Otherwise, provide the client with other applicable referrals to mainstream resources.

#### Gather Client Consent

* + 1. Have the client sign the Coordinated Entry Participation Agreement. Agencies screening for prevention services may gather verbal consent and document it on the form if necessary, though written consent should be collected to the greatest extent possible. However, agencies assessing for enrollment into an HMIS project must gather written consent.

or

* + 1. Gather Verbal Client Consent - Explain the Coordinated Entry Participation Agreement and ask for verbal consent. Document the verbal consent appropriately by writing “verbal consent” on the form.

#### Complete Project Intake and Gather Minimum Required Demographics

If required by funding source(s), the access point will conduct a standard intake into the project before completing the coordinated entry assessment. If the funding source does not require a standard project intake or the standard project intake does not gather all minimum required demographics and consent forms, the access point will gather the needed minimum demographics.

#### Complete Applicable Coordinated Entry Assessment(s)

Complete the coordinated entry Assessment, including the VI-SPDAT. If a VI-SPDAT has previously been recorded in the HMIS, a new VI-SPDAT will be completed only if one or more of the following circumstances exist:

* 1. The VI-SPDAT on file is the wrong type for the current housing crisis (e.g., PR-VI-SPDAT on file when a VI-SPDAT is required).
  2. The client has had a significant change in their life that will most likely result in an increase or decrease of at least one point on the VI-SPDAT (e.g., attacked or beaten up, change in employment status, new medical diagnosis).
  3. The VI-SPDAT present in the database was completed during a different episode of homelessness.
  4. It has been more than six months since the most recent VI-SPDAT was completed.
  5. The household composition has changed (household members have joined or left, including a child's birth).

1. **Enroll Client into a County HMIS Project or Make a Referral to Prevention Project** Verify that the client’s VI-SPDAT score is within the applicable range to receive services and that no information has been disclosed during the assessment that results in the client being ineligible for services (e.g., stably housed). Unless information has been disclosed that clearly determines the client is ineligible for services, the assessor records the enrollment. The HMIS project refers the household to an appropriate prevention project.

#### Client Participant Rights and Expectations Packet – made available upon request

#### 

# Section 7: Housing Referral Process

## Preparation for Housing Referrals

### **Gathering List of Housing Openings**

Housing projects must submit available housing units to Coordinated Entry Manager (CEM) by 9:00 am each Tuesday. The CEM will compile submitted housing openings and make referrals within 48 hours of the openings.

### **Generation of the Coordinated Entry Enrollment List (CEL) Review with DH**

The HMIS lead will generate an updated CEL report on Monday mornings and merge in the de-identified information provided by victim service providers by 10:00 am each Monday. The list is reviewed by the agency PoC and approved by 12:00 pm.

1. **Generating the Housing Prioritization List (HPL) Reports from HMIS**

St. Louis County CoC HPL will reflect housing availability, referrals to housing projects, and the status of the referral. Clients referred to the HPL for housing will be selected by the Coordinate Entry Manager based on clients placement on the CEEL **AND** unit size **AND** project availability. The de-identified reports should be brought to the coordinated entry meetings for transparency and oversight.

### **Confidentiality Agreement**

All meeting attendees, facilitators, and others present in any CoC sanctioned meetings where client details are discussed will be required to sign a confidentiality agreement before entering discussions. Any individual who violates the confidentiality agreement may be subject to penalties including, but not limited to, permanent prohibition from attending future meetings.

### Matching Clients to Housing Openings and Ensuring Collaboration

The Coordinated Entry Manager will present the HPL at monthly Coordinated Entry meetings. The HPL must match the reported number of housing openings. No clients may be added or removed from the list except if a client is known to be not currently in need of housing assistance (e.g., housed, incarcerated, or institutionalized for a significant period, deceased) or disappears and is unable to be located. If a client is removed from the HPL because they are not currently in need of housing assistance, the CEM shall add clients who are next for housing openings to the list. Once clients have been matched to openings, the client advocate is expected to work with the client and the potential housing project to ensure an eligibility interview is scheduled within seven days.

After A Housing Referral

### Scheduling Eligibility Interview and Updating Referral Status

The housing project has two business days from the receipt of the referral to work with the client advocate and the client to schedule the eligibility interview. The interview should take place within seven days of the referral receipt (assuming no extenuating circumstances). The referral status will be documented using one of the following options (shown in the order they are available in the HMIS system):

* **– Select –**: The agency has not yet scheduled the eligibility interview.
* **Accepted:** The project has housed the client.
* **Accepted on HPL:** Clients should have this status from the point that the housing project has scheduled an eligibility interview with the client to the point they are housed or the referral is canceled or declined.
* **Canceled:** *Cancelations are on the part of the client.* The housing project has contacted the client **AND** the clients advocate **AND** has determined that the client does not want or need housing assistance from their agency, OR the agency has made multiple attempts to contact the client and has been unable to do so. The reason for cancelation is recorded within the HMIS. The housing project must notify the Coordinated Entry Manager.
* **Declined:** *Declinations are on the part of the agency.* The housing project has determined that they cannot serve this particular client. The reason for the declined referral must be recorded within the HMIS and the CEM must be informed.

### Closing Prioritization List Referral at Housing Move-In

The **housing project** will take the client off the HPL when they move into the permanent housing unit. Suppose the housing provider cannot see the placement onto the prioritization list due to visibility settings within the HMIS. In that case, they must send an email to the HMIS lead’s helpdesk and CEM containing the client ID, the date the client moved into the unit, and the project that housed the client so that the client may be correctly removed from the prioritization list by the HMIS lead’s helpdesk.

### Review of Outstanding Referrals to Ensure Accountability

The Coordinate Entry Manager will ask each housing project for status updates on any clients who meet the following criteria:

1. A referral for a client who has no status update within the HMIS was referred at least seven days ago.
2. A referral for a client who is not yet recorded as housed within the HMIS but was referred at least 30 days ago.

Examples of status updates that will be shared at coordinated entry, executive, and general meetings include:

* “We have not been able to contact client 1234 to schedule an eligibility interview. We have contacted the client advocate, who is also unable to contact or locate the client. We would appreciate any help to find client 1234.”
* “Client 14567 has multiple barriers to housing, and we are having difficulty finding a landlord who will accept them due to their criminal record and poor credit history. We continue to look for landlords who are willing to work with the client.”
* “We have been working with client 54320 to identify housing options but have not found any units at this time that are within walking distance of the client’s workplace. We continue to work with the client to search for housing options.”

These updates will be part of the report to the CE committee.

## Acuity Review

## The acuity review process will take place monthly at the coordinated entry meetings on the third Friday of the month at 10:00 am. This meeting can be more frequent should the need arise.

The acuity review is designed to address issues that arise for clients with the most difficult/challenging barriers and the accuracy of the assessment process in making an appropriate referral. Members of the Coordinated Entry Committee will complete the acuity review.

The acuity review is designed to review the following cases:

* The assessor has determined that the client is not competent to complete the VI-SPDAT assessment or has refused due to what is believed to be mental illness or cognitive delays. (clients do have the right to decline Coordinated Entry)
* The assessor believes that the client’s VI-SPDAT score does not correctly reflect the client’s situation.
* A client is placed in a housing program, and it is determined that the client needs to go to another program option, including lateral moves between permanent housing projects. This does not include lateral movements between shelters.\*
* A housing provider rejects a client

\* If a client scores for PSH but is not chronically homeless and does not have a documented disability, the case does not have to be brought to review for recommendation adjustment to RRH. The client’s advocate may email the change request to the CEM (using the client ID number). The request must state that the client should be adjusted from PSH to RRH and must explain why the client does not meet the minimum eligibility criteria for any PSH projects (e.g., not disabled and not chronic). If a client is chronically homeless and has a disability that is not documented, reasonable steps should be offered to obtain disability documentation before changing the recommendation for housing.

Before an acuity review, the client’s client advocate must complete a full SPDAT. The client’s advocate representative should provide the committee members with background and information regarding the client’s situation. Any documentation supplied to the committee, including the full SPDAT, must have the client’s name and any other identifying information redacted to ensure client confidentiality and prevent biased decisions. Using the completed full SPDAT and additional information provided by the housing navigator and caseworkers, the coordinated entry committee will develop a list of possible next steps, which the client’s housing navigator will review with the client. Suppose the CE Committee is meeting to consider changing the placement of an individual on the prioritization list. In that case, the panel will vote whether to utilize the full SPDAT score to determine the acuity score in place of the acuity score determined based upon the VI-SPDAT score. A simple majority is required to use the full SPDAT score to determine the acuity score in place of the VI-SPDAT determined acuity score in the prioritization list.

Suppose the committee is considering changing the placement of an individual on the CEL. In that case, the panel will vote whether to utilize the full SPDAT score to determine the acuity score in place of the acuity score determined based upon the VI-SPDAT score. A simple majority is required to use the full SPDAT score to determine the acuity score in place of the VI-SPDAT determined acuity score in the prioritization list.

*Note:* If a client scores for PSH but does not have a disability, the case does not have to be brought to the Coordinated Entry Committee to have the recommendation adjusted to RRH. The client’s advocate may email the change request to the List Manager (using the client ID number). The request must state that the client should be adjusted from PSH to RRH and explain why the client does not meet the minimum eligibility criteria for any PSH projects (e.g., not disabled). Suppose a client is being adjusted from PSH to RRH due to a lack of a documented disability. In that case, the assessing agency must have taken reasonable steps to provide the client with the opportunity to be examined for or receive documentation of a disability before submitting the request to the CE Manager. Upon receipt, the CE Manager will change the housing recommendation within HMIS, but the acuity score will not be changed because the acuity score may only be changed with approval from the Coordinated Entry Committee after reviewing a full SPDAT.

The CE Manager will document the outcome of all acuity reviews within the HMIS, except for clients added to the Project Enrollment List by victim services providers.

# Section 8: Uniformed Service Guidelines

## Housing Services

The client advocate is the primary point-of-contact for each homeless individual or family. When necessary, the client advocate will complete the full SPDAT and advocate for the client during the acuity review process.

The client advocate has the responsibility of working with the client to gather all required documentation so that the client can be deemed “document ready.” The client advocate will also provide support and referrals, including but not limited to: coordination of services, in-person support for clients with mental or physical health concerns, and benefits enrollment.

The client advocate will assist the client in searching for housing opportunities both inside and outside of the homeless service system, including affordable housing units, market-rate housing, and financial assistance from other providers (e.g., one-time assistance or ongoing rental assistance programs) as needed to obtain and maintain stable housing. The client advocate will provide additional support to clients once a housing placement ensures a smooth transition to the new housing placement.

Documentation that client advocates will help clients gather or obtain includes, but is not limited to:

* Birth certificate(s)
* Social Security card(s)
* Government-issued photo identification
* Documentation of disabilities (if applicable)
* Proof of income or zero income statement
* Verification of homelessness
* Veterans only: DD-214

The client advocate also has the responsibility to identify possible housing barriers and work to address them when reasonably possible. Housing barriers that the advocate may identify and work to address include, but are not limited to:

* Poor rental history (including history of evictions)
* Poor credit history
* Criminal history
* Lack of employment or other income
* Rental and utility arrears

Housing projects may not use the criteria above to deny services to a client unless required by law.

Following the Housing First philosophy, clients have the option to decline case management services. Housing projects are required to document if a client refuses case management services within the client’s record.

# Section 9. Training Opportunities

The St. Louis County Coordinated Entry Committee is dedicated to providing additional training. While most training will be optional to CoC members, there may be some roles and responsibilities within coordinated entry that require training to participate. Training about the coordinated entry system will be posted on the St. Louis County CoC website and other social media outlets (if applicable).

## Trainings

### Annual Coordinated Entry updates

### Motivational Case Management

### Mental Health

### Prioritization and Prevention Assessment

### VI-SPDAT / SPDAT

### Cultural Sensitivity

### Qualified Minors

### Understanding HUD’s definition of homelessness

### Other training as recommended by the CoC or identified through gap analysis

# Section 10: Prioritization

The St. Louis County Coordinated Entry system and housing projects that participate in coordinated entry make every attempt to meet our community participants' needs. We hope that our services are a period of growth and a step toward ending homelessness. Services are based on availability and prioritized by those with the greatest needs first. We do not operate as a first-come, first-served housing system.

## Non-Prioritized Housing Crisis Interventions

### Emergency Shelter

Emergency shelter beds are not prioritized. All beds function on a first-come, first-served basis, but all clients must be screened by an access point to see if prevention or diversion is possible before entering homeless services.

### Street Outreach

Street outreach projects will not be prioritized. All clients who are identified as living in places not meant for habitation may be served by street outreach projects if they meet the project’s minimum eligibility requirements.

### Safe Havens

At the time of the revision of this manual, the region does not have any safe-havens. However, if a safe haven project begins operating within the region, it will not be prioritized.

## Prioritized Housing Crisis Interventions

Note: The project types listed below are required to follow the prioritization policies for their intervention if required by their funding sources, including, but not limited to: Continuum of Care (CoC) funds, Emergency Solutions Grant (ESG) funds, Missouri Housing Trust Fund (MHTF) funds, Missouri Housing First Program (HFP) funds, and Housing Resource Commission (HRC) funds. Additional funders may require participation in coordinated entry. Projects that are not required to participate in coordinated entry are strongly encouraged to follow these prioritization criteria and participate fully in coordinated entry.

### **Homelessness Prevention** In draft form

Homelessness prevention funds will be prioritized using minimum eligibility criteria (e.g., income under defined limits, eviction, or disconnect notice) and minimum prevention and diversion score. Any client who meets the minimum standards will be referred to a prevention services provider who will verify eligibility and provide services as applicable.

### **Rapid rehousing, independent living programs, permanent supportive housing, transitional living programs, and transitional housing programs**

Rapid rehousing, independent living programs, permanent supportive housing programs, transitional living programs, and transitional housing programs will receive all clients through the applicable prioritization process.

## Contents of the Coordinated Entry Enrollment List (CEL)

The project enrollment prioritization list includes the following information.

### HMIS Client ID (or identifier assigned by the VSP shelter) - This functions as the sole client identifier on the list and is assigned by the HMIS system or by the victim service provider.

### Referring agency- This is utilized to facilitate collaboration between the agency who assessed the client and enrolling them into an HMIS project.

### Chronic status- Indicates whether the client appears to meet the federal definition of chronically homeless according to the information entered into the HMIS database (or gathered by the victim service provider).

### Acuity score and assessment type - This shows the household's acuity score and the assessment type utilized to determine the acuity score.

### Risk/medical frailty score - This shows the total of the risk/medical frailty score as calculated by the HMIS (or as calculated by the victim service provider).

### Approximate date homelessness started - This is the date entered into the system for the client’s approximate date homelessness started. If the approximate date homelessness started is missing or not applicable, the date the client or household was assessed will be utilized.

### Date client/household assessed - This was when the client was assessed and enrolled in an HMIS project.

### Household size - This is utilized to identify appropriately sized households for sponsor-based units that can hold only a specific number of clients.

### Age range of head of household - The list indicates whether the head of household is between the ages of 16 and 24 to determine if the client may be eligible for youth-only projects.

### Disability status of the head of household - The list includes whether the head of household reported a disabling condition during intake. The CEL contains only a “yes” or “no” and no specific disability information. The list includes this information to identify appropriate clients for projects that require a disabling condition.

### Gender of the head of household - The CEL includes the gender of the head of household. Clients who report being “transgender male to female” will be listed as “female,” clients who report being “transgender female to male” will be listed as “male,” and clients who report being “gender non-conforming” or do not provide a gender will be listed as “other” on the CEL. The list contains this information to identify appropriate clients for congregate living environments that have specific gender requirements.

### Veteran status of the head of household - The enrollment list shows the head of household's reported veteran status to identify clients for projects that serve only households that contain a veteran. Information regarding branch of service, discharge status, or length of service is not included on the list.

### Preferred geographic location of housing - The enrollment list includes the preferred geographic location that clients indicate during assessment for potential housing opportunities. If the client does not indicate a preference, they will be housed in St. Louis County. All efforts will be made to accommodate the client in their preferred location.

## Housing Prioritization List (HPL) - The housing prioritization list will be developed by the Coordinated Entry Manager. The list shall be maintained in an encrypted format and may be distributed at monthly meetings in aggregate form. The list shall be created by pulling names from the project enrollment list based on their acuity score and placement on the CEL **AND** unit size **AND** project availability. Include all additional information, as described below, only if the client has agreed to share additional eligibility information as indicated on a completed Coordinated Entry Participation Agreement. Clients who have not agreed to share additional information on the Coordinated Entry Participation Agreement or have been referred by victim service providers will not have any other data added when the enrollment list is compiled.

### Head of household’s first and last name

If the client consents to allow their name to be utilized during housing matching meetings, the first and last name of the head of household will appear on the detailed prioritization list.

### Mental health problem

The CEL will indicate “yes” or “no” regarding the client’s reported mental health diagnosis. A “yes” will indicate that the client has indicated they (or a member of their household) do have a mental health problem. The information will be determined utilizing information gathered in the Special Needs Assessment for the head of household, as well as information gathered within the VI-SPDAT. At no point shall the CEL indicate specific diagnoses.

### Current or past substance abuse

The CEL will indicate “yes” or “no” regarding the client’s reported current or past substance abuse. A “yes” will indicate that the client has indicated they (or a member of their household) have or have had a history of substance abuse. The information will be determined utilizing information gathered in the Special Needs Assessment for the head of household, as well as information gathered within the VI-SPDAT. At no point shall the CEL indicate specific diagnoses.

### Developmental disability/traumatic brain injury diagnosis

The CEL will indicate “yes” or “no” regarding the client’s developmental disability/traumatic brain injury status. A “yes” will indicate that the client has indicated they (or a member of their household) have a developmental disability or traumatic brain injury. The information will be determined utilizing information gathered in the Special Needs Assessment for the head of household, as well as information gathered within the VI-SPDAT. At no point shall the CEL indicate specific diagnoses.

### HIV/AIDS status

The CEL will indicate “yes” or “no” regarding the client’s self-reported HIV/AIDS status. A “yes” will indicate that the client has indicated they (or a member of their household) have been diagnosed with HIV/AIDS. The information will be determined utilizing information gathered in the Special Needs Assessment for the head of household and information gathered within the VI-SPDAT. At no point shall the CEL indicate specific diagnoses.

Housing Intervention Prioritization Sorting Criteria

|  |  |
| --- | --- |
| **Criterion** | **Sorting Method** |
| Chronic homeless status | Yes -> No |
| Acuity score (as defined) | Highest -> Lowest |
| Risk/Frailty Score | Highest -> Lowest |
| Approximate date homelessness started | Oldest -> Newest |
| Date client/household assessed | Oldest -> Newest |

## Risk/Frailty Score Matrix

*The Risk Frailty Score will focus* on the following bases:

1. Risk/Frailty Score Matrix
2. Chronic Status
3. VI-SPDAT Score
4. Length of Time Homeless
5. Length of Time on Prioritization List

Because our community has committed to the Orders of Priority as outlined in Notice CPD-14-012: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status, all PSH referrals will consist of households that meet the Chronic Homeless Definition.

By approving of these recommendations, all RRH projects would be open to taking the top person most at risk of COVID-19 complications and most frail, which would mean both Chronic and Non-chronic households would be referred to RRH openings until the Coordinated Entry Committee is directed to end or re-evaluate this Prioritization change. In addition, and though used to break ties among categories of people, the VI-SPDAT score will not be a predictor of which type of housing program a household should be referred to, with this new Prioritization Criteria Recommendation.

**Risk/Frailty Scoring Matrix**

Answers to the below questions will score specific points to come up with a final or total Risk/Frailty Score, where the higher the score, the more risk or frailty a person exhibits. There are 5fivecategories with a series of questions within each category, which totals 18 total questions. The scale of points will range from 0-40 points.

**AGE** (**up to 4 points**). As indicated by the CDC those that are 65 and older, if diagnosed with COVID-19 are at a much greater risk of developing severe health complications.

1. Are you or anyone in your household age 65 or older?
   1. Yes = 4 points
   2. No = 0 points

**HIGH-RISK HEALTH CONDITIONS** (**up to 12 points**). As outlined by the CDC, these conditions, when present in a person diagnosed with COVID-19, have the potential to develop more severe health complications.

1. Do you or anyone in your household have any of the following high-risk health conditions? (Points equal to number of conditions present in household, 0-8 points possible)
2. Chronic Lung Disease Yes/No
3. Severe Asthma Yes/No
4. Serious Heart Condition Yes/No
5. Severe Obesity (BMI 40 or higher) Yes/No
6. Diabetes Yes/No
7. Chronic Kidney Disease undergoing dialysis Yes/No
8. Liver Disease Yes/No
9. Immunocompromised (includes: cancer treatment, smoking, bone marrow or organ transplantation, immune deficiencies, poorly controlled HIV or AIDS, prolonged use of corticosteroids and other immune weakening medications) Yes/No
10. If you are prescribed medication for any of the conditions above, are you taking them as prescribed?
    1. Yes = 1 point
    2. No = 2 points
    3. No Medications Prescribed = 0 points
11. Are you seeing a doctor for any of the above conditions?
    1. Yes = 1 point
    2. No = 2 points
    3. Not Recommended = 0 points

**UTILIZATION OF MEDICAL SERVICES** (**up to 4 points**). Indication of vulnerability as a medical/ER high utilizer.

1. In the past six months, how many times have you (and/or your household) been to an emergency room to receive healthcare services?
   1. times = 0 points
   2. times = 1 point
   3. 3-4+ times = 2 points
2. In any of the times above, did you ride in an ambulance to get to the hospital?
   1. Yes = 1 point
   2. No = 0 points
3. In any of the times above, did you stay in the hospital for more than 24 hours?
   1. Yes = 1 point
   2. No = 0 points

**HOMELESSNESS (up to 10 points).** Those in congregate shelters and those on the streets are most at risk of contracting COVID-19, per the CDC.

1. Where did you sleep most frequently during this period of homelessness?
   1. Congregate Shelter (connection to services/hygiene) = 3 points
   2. On the streets (possibly no connection to services/hygiene) = 3 points
   3. Individual Room in a Shelter/Motel = 1 point
   4. Transitional Housing = 0 points
2. Have you or any other adults in the household experienced homelessness or unstable housing in your life?
   1. Yes = 1 points
   2. No = 0 points
3. How long has it been since you and your household lived in stable permanent housing?
   1. 0-6 months= 0 points
   2. 6-12 months= 1 point
   3. 12 months or more= 2 points

**OTHER VULNERABILITIES** (**up to 10 points**). Per the CDC’s guidance: “Black people and people of color also experience disproportionate impacts of COVID-19. These health and housing disparities represent high vulnerabilities that CE assessment and prioritization processes should be actively addressing. Although CoCs cannot set prioritization based solely on protected classes, CoCs can and should prioritize the vulnerabilities created by the compounding effect of other systems’ inequities that contribute to people of color experiencing homelessness and impacts of COVID-19 at higher rates. Consider, for instance, housing barriers such as criminal records, poor credit histories, and histories of evictions—all of which disproportionately impact people of color—as vulnerabilities, as these factors often contribute to difficulties accessing and maintaining housing (COVID-19 Homeless System Response: Changes to Coordinated Entry Prioritization to Support and Respond to COVID-19).”

1. Have you or anyone in your household been effected by the justice system making it difficult to rent a home?
   1. Yes = 1 point
   2. No = 0 points

1. Have you or anyone in your household ever been evicted?
   1. Yes = 2 points
   2. No = 0 points
2. Have you or anyone in your family experienced trauma related to law enforcement encounters. (Police/Immigration)
   1. Yes = 2 points
   2. No = 0 points
3. Does your household have a support network that can able help you with your kids or anything else if it comes up?
   1. Yes = 1 points
   2. No = 0 points
4. Does anyone in the household have a poor credit history, making it hard to rent a home?
   1. Yes = 1 point
   2. No = 0 points
5. Is any member of the household pregnant?
   1. Yes = 1 point
   2. No = 0 points
6. Are you or any other adults in the household responsible for a child living outside of the current household
   1. Yes = 1 point
   2. No = 0 points
7. Have you or anyone in your household been in the Foster Care System?
   1. Yes = 1 point
   2. No = 0 points

## Prevention and Diversion Pre-Screen Questions In draft Form

**St. Louis County Continuum of Care Prevention/Diversion Pre-Screen**

Head of Household Name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date Completed: \_\_\_\_\_\_\_\_\_\_\_

Phone Number: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Household Size: \_\_\_\_\_\_\_\_\_\_\_\_\_\_

**Immediate Safety question:**

Are you currently safe where you are staying? □Yes □No

(If the client indicates **NO** above) Why is it not safe? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Depending on answer, refer client to the DV Hotline or other resources, or continue with the assessment.

**Diversion from Homelessness:**

Where did you sleep last night? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Is your household doubled up at a location where you don’t own the lease? □Yes □No

Why did you have to leave the place you stayed last night? Could you stay tonight at the same location?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

(If the client indicates **NO** above) If we sign you up for a resource, so you are contributing to the household, would you be able to go back to your housing? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If a resource would assist, which resource(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Could your household find other housing options with family or friends?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Could your household find other financial resources to obtain immediate housing or remain in existing housing?

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Was the diversion attempt successful? □Yes □No

(If **YES**, please stop here.)

**Prevention from Homelessness**

Does your household have:

1. Young Adults (18-24)? □Yes □No
2. Young children (5 and under)? □Yes □No
3. Children attending school? □Yes □No

If **YES**, at which school(s)? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. A large family (5 or more people)? □Yes □No
2. A previous period of homelessness? □Yes □No

If **YES**, how many times? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. A previous eviction? □Yes □No

If **YES**, how many times? \_\_\_\_\_\_\_\_\_

1. A monthly gross income (for all adults in the household) below 15% of 20xx AMI?

(use chart below) □Yes □No

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1 person | 2 persons | 3 persons | 4 persons | 5 persons | 6 persons | 7 persons | 8 persons |
| □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx |

If **YES** to the above prevention questions, the household should be scheduled for an intake appointment to determine if they are eligible for a program. If **NO** to all of the questions, **STOP**. The household does not qualify for assistance.

1. Are you a St. Louis County resident? □Yes □No

If no, where: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

1. What is your household’s monthly income? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Your source of income?\_\_\_\_\_\_\_\_\_\_\_\_\_\_

If $0 income, will the household have income in the next 2 months? □Yes □No

If **YES**, what will be the source of income? \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

10. Is your household’s monthly gross income (for all adults in the households) below 30% of 20xx AMI?

□Yes □No

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1  person | 2 persons | 3 persons | 4 persons | 5 persons | 6 persons | 7 persons | 8 persons |
| □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx |

11. Is your household’s monthly gross income (for all adults in the households) below 50% of 20xx AMI?

□Yes □No

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1  person | 2 persons | 3 persons | 4 persons | 5 persons | 6 persons | 7 persons | 8 persons |
| □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx |

12. If the household is above 50% AMI, **STOP**. The household does not quality for services.

13. Does your household’s monthly gross income (for all adults in the households) exceed 20xx FMR?

□Yes □No

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| 1  person | 2 persons | 3 persons | 4 persons | 5 persons | 6 persons | 7 persons | 8 persons |
| □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx | □$xxx |

If the household exceed FMR, **STOP**. The household does not quality for services.

14. Does your household have an eviction notice or other qualifying documentation? □Yes □No

15. Would your household immediately lose your primary residence with 14 days? □Yes □No

16. Does your household have no appropriate subsequent housing options identified? □Yes □No

17. Does your household lack financial resources and support networks needed to obtain immediate housing or remain in existing housing? □Yes □No

\*\*If **NO** to any of these three questions, stop. The household does not qualify for assistance.

1. Would the household fall into homelessness even if assistance is provided? □Yes □No

The above information was obtained from the household listed above, and it is true and complete to the best of my knowledge.

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Name of the person completing the form Signature

Final outcome. Please note if the household qualified for an intake appointment. If they did not qualify,

why and what resources were given:

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

## VI-SPDAT/SPDAT to Acuity Score Conversion Chart

All clients will be assigned an acuity score using the appropriate tool in the VI-SPDAT Tools section unless use of the full SPDAT score is approved by the Acuity Review Panel, in which case the appropriate tool in the full SPDAT section will be used to determine the acuity score.

|  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- |
| VI-SPDAT Tools | | | Full SPDAT Tools | | | Acuity Score |
| VI-SPDAT 2.0 | VI-F-SPDAT 2.0 | TAY-VI-SPDAT 1.0 | SPDAT 4.0 | F-SPDAT 2.0 | Y-SPDAT 1.0 |
| 0 | 0 | 0 | 0-3 | 0-4 | 0-3 | 0 |
| 1 | 1 | 1 | 4-9 | 5-12 | 4-9 | 1 |
| 2 | 2 | 2 | 10-15 | 13-21 | 10-15 | 2 |
| 3 | 3 | 3 | 16-19 | 22-26 | 16-19 | 3 |
| 4 | 4 | 4 | 20-22 | 27-29 | 20-22 | 4 |
| 5 | 5 | 5 | 23-27 | 30-35 | 23-27 | 5 |
| 6 | 6 | 6 | 28-32 | 36-42 | 28-32 | 6 |
| 7 | 7 | 7 | 33-34 | 43-48 | 33-34 | 7 |
| 8 | 8 | 8 | 35-36 | 49-53 | 35-36 | 8 |
| 9 | 9 | 9 | 37-39 | 54 | 37-39 | 9 |
| 10 | 10 | 10 | 40-42 | 55-56 | 40-42 | 10 |
| 11 | 11 | 11 | 43-45 | 57-58 | 43-45 | 11 |
| 12 | 12 | 12 | 46-47 | 59-60 | 46-47 | 12 |
| 13 | 13 | 13 | 48-50 | 61-62 | 48-50 | 13 |
| 14 | 14 | 14 | 51-53 | 63-64 | 51-53 | 14 |
| 15 | 15 | 15 | 54-56 | 65-66 | 54-56 | 15 |
| 16 | 16 | 16 | 57-59 | 67-68 | 57-59 | 16 |
| 17 | 17 | 17 | 60 | 69-70 | 60 | 17 |
|  | 18 |  |  | 71-72 |  | 18 |
|  | 19 |  |  | 73-74 |  | 19 |
|  | 20 |  |  | 75-76 |  | 20 |
|  | 21 |  |  | 77-78 |  | 21 |
|  | 22 |  |  | 79-80 |  | 22 |

The acuity score may not be used in place of a VI-SPDAT or full SPDAT score, nor should it be considered to be a VI-SPDAT or full SPDAT score.

Section 12: Evaluation and Planning

Evaluation and planning shall be the responsibility of the Executive Committee in partnership with the St. Louis County CoC committees outline in the Governance Charter. The CoC will also utilize independent contractors for reviews of system efficiency and HUD compliance.

## Stakeholder Consultation

The CoC will solicit feedback at least once annually from participating projects and clients who participated in coordinated entry during the time period. A combination of the following feedback gathering methods will be used to ensure sufficient information is gathered to assess the quality and effectiveness of the coordinated entry system:

* Surveys provided to all participating service providers.
* Surveys, focus groups, or individual interviews to gather information from enough clients to approximate the diversity of participating clients. For the purpose of evaluation, a client is defined as an individual currently engaged in the coordinated entry system or clients who have participated to some extent within the last year.

## Coordinated Entry Committee

The coordinated entry committee meets monthly. Monthly meeting will include (1) Overseeing elements of the CE process, (2) Ensuring HUD compliance, (3)Review reports for housing, and (3)acuity review, if needed. The reports will include project-level information where appropriate, housing outcome, and referrals. Any recommendations approved by the Coordinated Entry Committee will be taken to CoC Executive Board for approval.

In addition, copies of the report(s) will be made available to the Rank and Review Committees, any funders (upon request) who may choose to utilize the information to make decisions regarding compliance with grant agreements and/or future funding decisions.

Reports reviewed by the coordinated entry committee each month will include, at minimum:

* Status of the HPL (length of time on list, number of households on the list, etc).
* Review of referral process functioning.
* Review of appropriate HMIS report(s) regarding clients served, length of stay, outcomes, etc.
* Review of rates of acceptance, cancelations, and declines by participating providers.
* Review of rates of referrals to acuity review by participating providers.
* Review of the Coordinate Entry Enrollment list.

# Section 13: Forms, Packets, and Agreements

## Coordinated Entry Participation Agreement

The coordinated entry participation agreement must be completed by all clients prior to being enrolled in and HMIS project. The agreement explains the basic purpose and design of coordinated entry, and then allows the client to determine (1) if they wish to participate, (2) how much information they authorize to be disclosed, and (3) whether their name may be utilized in meetings.

Victim service providers are not required to use this form, but must have internal procedures that guarantee that the client has consented to participating in coordinated entry prior to placement onto the CEL.

## Agreement for Access Points (including VSP and protected classes)

This agreement is utilized to determine what services will be provided by each access point and which population(s) the access point will serve. The agreement must also contain a written narrative explaining the anticipated steps a client will take when seeking coordinated assessment services and any special requirements or processes that will be in place to serve their populations appropriately. The agreement must be signed by a representative of the agency and the St. Louis County CoC Chair before the access point may begin offering assessment services.

Coordinated Entry Assessment

Coordinated Entry Assessment is programmed into the HMIS software and is designed to gather all information required to enroll a client into an HMIS project. While the form must be completed within the HMIS (victim service providers exempt), a paper version of the assessment is available on the CoC website for use in the event that the information must be gathered while access to the HMIS is not available.

## Rapid Rehousing Rental Assistance Calculation Worksheet

This worksheet takes into consideration the following when determining the appropriate amount of rental assistance that is provided to each participant in rapid rehousing: annual income, income exclusions, dependent allowances, child care allowances, disabled assistance allowances, medical expenses allowances, elderly family allowances, and utility allowances.

## Participant Rights and Expectations Packet

All participants shall be provided a copy of the Participant Rights and Expectations Packet (up request) at the time they are assessed and enrolled in an HMIS project or referred to an appropriate prevention services provider. The packet must describe, at minimum:

* The purpose of coordinated entry
* What to expect as a participant in coordinated entry
* Requirements of participants in coordinated entry
* How to file a grievance or nondiscrimination complaint

The packet is included on the CoC website.

# Section 13: HUD’s Homeless Definition

Table

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