Pinellas County Homeless Leadership Board Meeting  
August 3, 2018 10:00AM  
Empath Health/Hospice 5771 Roosevelt Blvd, Clearwater, FL

AGENDA

1. Welcome and Introductions: Amy Foster, Board Chair

2. Consent Agenda
   a. HLB Board Meeting Minutes July 2018
   b. HLB Executive and HMIS Governance Minutes June 2018
   c. Providers Council Minutes May 2018
   d. HLB Financials June 2018
   e. Committee Reports July 2018
   f. CEO Report
   g. Board Attendance through 7.13.18

2a. Items Removed from Consent Agenda (if applicable)

3. Public Comment/Good News

4. June 2018 Data Summary Report

5. FY 2017/2018 Third Quarter Data Presentation: HLB Staff

6. Revisions to the Prioritization Process for the Coordinated Entry Process: HLB Staff

7. Ad Hoc Advocacy Committee for Family Homelessness: Amy Foster

Adjourn

NEXT SCHEDULED MEETING:  
*** August 31st 10:00AM (MOVED FROM SEPTEMBER 7TH) ***  
Empath/Hospice – 5771 Roosevelt Blvd. Clearwater, FL
Summary of the June 2018 CoC performance reporting, per data within PHMIS. The data date range for the report was June 1, 2018 – June 30, 2018, with the data for the report being ran on July 5, 2018. The report provides a summary of the CoC’s current capacity, as per the Housing Inventory County; system entries and exits; exit destinations; and system flow from FY 2016-2017. The findings for June 2018 include:

- Compared to May 2018, were 77 additional entries and 140 additional exits within the Homeless Emergency Response System in June 2018.
- The Housing Placement Rate for June 2018 was 356 Positive Exits < 2,085 Entries. Housing Placement Rate need to reflect Positive Exits that are equal to or less than the Monthly Entries and to have a positive effect, the rate needs to increase. This rate increased by 5% in June 2018 from May 2018.

Overall Data Changes:
- The rate of women that entered into the Homeless Crisis Response System increased by 1.25%.
- There was a 1.75% increase in individuals aged 35 to 44 that entered into the Homeless Crisis Response System.
- There was a 1.38% decrease in individuals aged 62 and over that entered into the Homeless Crisis Response System.
- There were 35 additional individuals that entered the Homeless Crisis Response System from jail in June.
- The CoC reported the following changes in HIC for the month of June:
  - 14 less beds for individuals in Emergency Shelters
  - 4 less beds for individuals in Transitional Housing
  - 1 less bed for individuals in Permanent Supportive Housing
  - 20 additional beds for families in Emergency Shelters
4 additional beds for families in Permanent Supportive Housing

The Data and System Performance will be monitoring these changes for the next three months to determine if these are new data trends.

The committee conducted a follow up review of the April Special Data reporting on PHMIS entries with prior residence owned/rental by client with no subsidies and exits by clients owned/rental by client with no subsidies. The following is a summary of those reviews:

**PHMIS Entries Prior Residence Owned/Rental by Client No Subsidies**

<table>
<thead>
<tr>
<th>Data</th>
<th>April 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Entries</td>
<td>130</td>
<td>137</td>
</tr>
<tr>
<td>Data entry errors</td>
<td>63</td>
<td>43</td>
</tr>
</tbody>
</table>

- A decrease of 20 errors within two months.

**PHMIS Exits Owned/Rental by Client No Subsidies**

<table>
<thead>
<tr>
<th>Data</th>
<th>April 2018</th>
<th>June 2018</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exits</td>
<td>129</td>
<td>215</td>
</tr>
<tr>
<td>Data entry errors</td>
<td>7</td>
<td>11</td>
</tr>
<tr>
<td>Miscoded RRH exits</td>
<td>28</td>
<td>8</td>
</tr>
<tr>
<td>Return into Homeless System within 30 days of exit</td>
<td>8</td>
<td>11</td>
</tr>
</tbody>
</table>

- 86 additional individuals had positive exits the system in June.
- Same data error rate as in May.
- RRH miscodes dropped from 22% in April to 4% in June.
- Returns to homelessness dropped from 11% in April to 5% in June.

This report was reviewed and approved by the Data and System Performance Committee on July 12, 2018.

**Budget Impact (if any):** NA

**Staff Recommendation:** Approve the June 2018 Data Summary Report.

**CEO Approval:** Susan Myers, CEO – July 29, 2018
The first two charts represent the number of episodes during the month of June 2018.

The second two charts represent the number of unduplicated clients during the month of June 2018. Note these individuals may have also entered and exited the system of care during a previous month.
The below chart measures the total number of entries within PHMIS, the number of entries that were carried over from May 2018 and the number of exits from PHMIS. Entries refer to the "touches" made to the Homeless Emergency Response System by an individual. This data contains duplication, which is why the data differs from the previous four charts.
The Length of Stay (LOS) tracks individuals based upon the number of days an individual was open within a given project in HMIS. The LOS measure is a means to track trends in keeping homelessness brief within the CoC.

Emergency Shelter LOS continues to maintain at 60 days or less; Permanent Supportive Housing saw a slight increase in the exits within 365 days; Rapid Re-Housing saw an increase of exits within 365 days; Safe Haven's exits within 90 days or less decreased and Transitional Housing had an increase of exits after staying up to 180 days. Emergency Shelter and Street Outreach exits with more than 1,825 days were the result of HMIS not being updated at the time of an individual's closure.
There were 166 Rapid Re-Housing units added as of June 30, 2018, a decrease of 61 from May 2018.

Housing Inventory Adults Only June 2018

Housing Inventory Households with Children June 2018

Housing Inventory Children Only June 2018

There were 166 Rapid Re-Housing units added as of June 30, 2018, a decrease of 61 from May 2018.
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<thead>
<tr>
<th><strong>Meeting Name:</strong></th>
<th>Homeless Leadership Board</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Meeting Date:</strong></td>
<td>8/3/2018</td>
</tr>
<tr>
<td><strong>Agenda Item Number:</strong></td>
<td>5</td>
</tr>
<tr>
<td><strong>Item Title:</strong></td>
<td>FY 2017/2018 Third Quarter Data Presentation (April 1, 2018 – June 30, 2018)</td>
</tr>
<tr>
<td><strong>Name of Staff Member Submitting:</strong></td>
<td>Avery Slyker</td>
</tr>
<tr>
<td><strong>Background:</strong></td>
<td>The data for the third quarter of the current fiscal year covering April 1, 2018 – June 30, 2018 was extracted from PHMIS on July 24, 2018. The only statistical significance found between the third and second quarter is the rate of growth in the age demographics for individuals 25-61. This will be monitored by the committee during the fourth quarter. For the CoC approved benchmarks, the data used for Benchmark A2, Prevention is a very small sampling. Benchmark B shows a decline in the percentage of individuals that exited within 60 and 90 days; the decline may be attributed to RRH projects being at capacity at the end of the quarter. This determination cannot be made until the beginning of the fourth quarter data can be reviewed to confirm a data trend. Benchmark C show slight improvement in the percentages of returns into homelessness. The Rapid Re-Housing Benchmark reports are still being tested. They will be presented with the fourth quarter report.</td>
</tr>
<tr>
<td><strong>Budget Impact (if any):</strong></td>
<td>NA</td>
</tr>
<tr>
<td><strong>Staff Recommendation:</strong></td>
<td>Approve the Third Quarter Data Presentation.</td>
</tr>
<tr>
<td><strong>CEO Approval:</strong></td>
<td>Susan Myers, CEO – July 31, 2018</td>
</tr>
</tbody>
</table>
Quarterly Data Review
April - June 2018

Homeless Leadership Board
CoC-502

Data Source: Pinellas Homeless Management System
Extracted: July 24, 2018
### PHMIS Data Summary Report Qrt. III

#### New Entries - Unduplicated Client Count
- **March**: 1,290
- **April**: 1,393
- **May**: 1,357

#### Carryover from the Previous Months
- **March**: 2,228
- **April**: 2,140
- **May**: 2,185

#### Total Entries in Homeless Emergency Response System (Duplicated Clients)
- **March**: 1,932
- **April**: 2,025
- **May**: 2,110

#### Total Episodes in Homeless Emergency Response System
- **March**: 3,518
- **April**: 3,533
- **May**: 3,542

#### Exits - Unduplicated Client Count
- **March**: 1,421
- **April**: 1,384
- **May**: 1,481

#### Total Exits (Duplicated Clients)
- **March**: 2,020
- **April**: 1,980
- **May**: 2,168
Client Entries Qrt. III

These RRH individuals have not been housed.

PSH is not included in entries count.
New Entries Qrt. III
FY 2017/2018 Compared to FY 2016/2017

Exits FY 2017/2018 - FY 2016/2017 Qtr III

- FY 2017/2018:
  - April: 2,168
  - May: 1,980
  - June: 2,020

- FY 2016/2017:
  - April: 2,010
  - May: 2,027
  - June: 1,770
Exit Destinations

- Institutional Settings: 310
- Missed Curfew: 2,827
- Other Destinations: 411
- Permanent Destinations: 1,016
- Temporary Destinations: 869
- Unknown: 735
Exit Destinations by Project

**PSH**
- Institutional Settings: 6
- Other Destinations: 4
- Permanent Destinations: 19
- Temporary Destinations: 14
- Unknown: 2

**RRH**
- Institutional Settings: 3
- Other Destinations: 9
- Permanent Destinations: 280
- Temporary Destinations: 25
- Unknown: 10

**ES**
- Institutional Settings: 271
- Other Destinations: 380
- Missed Curfew: 2,824
- Permanent Destinations: 595
- Temporary Destinations: 633
- Unknown: 700

**TH**
- Institutional Settings: 18
- Other Destinations: 11
- Permanent Destinations: 86
- Temporary Destinations: 35
- Unknown: 19
Exit Destinations by Project

**SH**

- Institutional Settings: 8
- Other Destinations: 1
- Permanent Destinations: 4
- Temporary Destinations: 2

**SO**

- Institutional Settings: 3
- Other Destinations: 6
- Permanent Destinations: 6
- Temporary Destinations: 156
- Unknown: 2
Exit Data

Length of Stay for Exits

- 78.8%
- 0.1%
- 1.1%
- 4.4%
- 7.6%
- 4.4%
- 3.5%
- 1.1%
- 0.0%
- 0.0%
- 0.0%

Percentages are based on individuals and not counts of exits.
Demographics

**Client Gender**
- Male: 4,308
- Female: 1,752
- Trans Female: 3
- Trans Male: 3
- Unknown: 1

**Client Race**
- White: 4,146
- Black or African American: 1,799
- American Indian or Alaska Native: 34
- Unknown: 34
- Asian: 29
- Native Hawaiian or Other Pacific Islander: 12
- Client Doesn't Know: 9
- Client Refused: 4

**Client Age Range**
- Under 5: 138
- 5 to 12: 454
- 13 to 17: 1,074
- 18 to 24: 1,274
- 25 to 34: 1,067
- 35 to 44: 295
- 45 to 54: 104
- 55 to 61: 204
- 62 and Over: 2
- Unknown Age: 1

**Client Ethnicity**
- Non-Hispanic/Non-Latino: 5,682
- Hispanic/Latino: 345
- Unknown: 28
- Client Doesn't Know: 11
- Client Refused: 1

**Client Doesn't Know**: 3
**Client Refused**: 5
Demographics Year To Date

Client Race

- White
- Black or African American
- American Indian or Alaska Native
- Unknown
- Asian
- Native Hawaiian or Other Pacific Islander
- Client Doesn't Know
- Client Refused

Quarters:
- Qrt I
- Qrt II
- Qrt III
Demographics FY 2016/2017 to FY 2017/2018

Client Race

0 10,000 20,000

White

Black or African American

American Indian or Alaska Native

Unknown

Asian

Native Hawaiian or Other Pacific Islander

Client Doesn't Know

Client Refused

FY 16/17 FY 17/18
Benchmark A: Homelessness Will Be Rare

Benchmark A1: At any point in time, the number of individuals and households experiencing homelessness in Pinellas County will be no greater than the CoC’s average monthly, positive, housing placement rate for individuals and families.

Entries are going into shelter or a project. This is duplicate due to individuals having entries into shelter and into projects. Exits from the Homeless Emergency Response System that resulted in Permanent Housing.
 Benchmark A: Homelessness Will Be Rare

Benchmark A2: 80% of households referred to prevention with a housing crisis will have their homelessness prevented.

- Qrt II and III ESG Challenge Prevention Project: 100%
- Qrt II TANF Prevention Project: 100%
- Qrt III TANF Prevention Project (1 Client Exited without Exit Interview): 90%
Benchmark B: Homelessness Will Be Brief

50% of individuals and households in ES will be placed in PH within 30 days of program entry
75% of individuals and households ES will be placed in PH within 60 days of program entry

B1: Percentage of Emergency Shelter Entries Placed in Permanent Housing within 30 Days

- Individuals: 6.97% (Qrt I), 8.52% (Qrt II), 9.16% (Qrt III)
- Households: 7.37% (Qrt I), 9.20% (Qrt II), 7.27% (Qrt III)

B1: Percentage of Emergency Shelter Entries Placed in Permanent Housing within 60 Days

- Individuals: 8.61% (Qrt I), 10.18% (Qrt II), 8.86% (Qrt III)
- Households: 24.29% (Qrt I), 24.91% (Qrt II), 20.71% (Qrt III)
**CoC Benchmarks**

**Benchmark C: Homelessness Will Be Non-Recurring**

- **C1. Benchmark:** 95% will not re-enter system after exiting less than 6 months
  - Qrt II: 78%
  - Qrt III: 79%

- **C2. Benchmark:** 85% will not re-enter system after exiting less than 12 months
  - Qrt II: 71%
  - Qrt III: 72%

- **C3. Benchmark:** 80% will not re-enter system after exiting less than 24 months
  - Qrt II: 64%
  - Qrt III: 69%

*These are number of individuals that had positive exits and did not re-enter the Homeless Emergency Response System*
Data & System Performance Committee Quarter IV Goals

1. Racial Disparities
2. Providers Council Report Requests
3. Family Benchmarks
4. Updating Training Guidelines for PHMIS
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<th>Meeting Name:</th>
<th>Homeless Leadership Board</th>
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<tbody>
<tr>
<td>Date:</td>
<td>August 3, 2018</td>
</tr>
<tr>
<td>Agenda Item Number:</td>
<td>6</td>
</tr>
<tr>
<td>Item Title:</td>
<td>Language Revisions to the Prioritization Process for the Coordinated Entry Process</td>
</tr>
<tr>
<td>Name of Staff Member Submitting:</td>
<td>Susan Myers</td>
</tr>
<tr>
<td>Background:</td>
<td>Language Revisions to the Prioritization Process for the coordinated Entry Process to ensure that the language was an exact match to the U.S. Department of Housing and Urban Development Office of Community Planning and Development notice CPD-16-11, as required within the FY 2018 NOFA. Beginning on page 7 of the CEP Policies and Procedures, the definitions for Priorities one through four were updated to include the exact language from the priorities within notice CDP-16-11:</td>
</tr>
<tr>
<td></td>
<td>• First Priority – Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs;</td>
</tr>
<tr>
<td></td>
<td>• Second Priority – Homeless Individuals and Families with a Disability with Severe Service Needs;</td>
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<tr>
<td></td>
<td>• Third Priority – Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs; and</td>
</tr>
<tr>
<td></td>
<td>• Fourth Priority – Homeless Individuals and Families with a Disability Coming from Transitional Housing.</td>
</tr>
<tr>
<td>Budget Impact (if any):</td>
<td>NA</td>
</tr>
<tr>
<td>Staff Recommendation:</td>
<td>Approve the Language Revisions to the Prioritization Process for the Coordinated Entry Process.</td>
</tr>
<tr>
<td>CEO Approval:</td>
<td>Susan Myers, CEO – July 31, 2018</td>
</tr>
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Pinellas County CoC
Coordinated Entry System
Policy & Procedures
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ACKNOWLEDGEMENTS

In an effort to capitalize on the excellent work being done locally and nationally to improve homeless housing and service systems for individuals and families, this plan relies heavily on research and tools produced in our community and in communities across the county, especially the work of the National Alliance to End Homelessness. This plan has been influenced by several important resources including:

- The many homeless housing stakeholders of Pinellas County
- The Coordinated Entry System (CES) - Work Groups
- The Provider’s Council
- CSH
- The work of the 2015 Coordinated Intake and Assessment Committee; and,
- The National Alliance to End Homelessness
- The Pinellas County HLB System Redesign Committee

Thank you to the following organizations and agencies for your assistance in the planning and development of this process:

- 2-1-1 Tampa Bay Cares, Inc.
- Boley Centers, Inc.
- CASA
- Catholic Charities
- City of Clearwater
- City of St. Petersburg
- Directions for Living
- Homeless Empowerment Program
- Homeless Leadership Board
- Pinellas County Human Services
- Pinellas County Sheriff’s Office
- Religious Community Services (RCS)
- Saint Vincent de Paul St. Petersburg
- Salvation Army North
- Salvation Army South
- Westcare

For additional Information please contact:

The Pinellas County Coordinated Entry Staff at info@pinellow.org
**Pinellas County CoC Coordinated Entry Policy and Procedures**

**Overview:**

The housing system can feel like a maze for individuals experiencing homelessness. Trying to determine who to talk to, how to get there, and where to begin can be confusing and overwhelming. Coordinated Entry for Single Individuals and Families establishes a system where housing placement isn't a matter of talking to the right case manager, at the right agency, at the right time.

Instead, Coordinated Entry represents standardized access and assessment for all individuals, as well as a coordinated referral and housing placement process to ensure that people experiencing homelessness receive appropriate assistance with both immediate and long-term housing and service needs. The entire Coordinated Entry process uses “client centered” approach, while doing so through a standardized process from initial engagement to successful housing placement.

In a data-driven and evidence-informed manner, providers across Pinellas County are establishing strategic partnerships to better serve our fellow community members experiencing homelessness.

The following policy is an update to the June 10, 2016 policy guide to fully meet the HUD requirements outlined in 24 CFR 578.7(a)(8) for implementation by January 23, 2018.

**CES Marketing:**

These policies and procedures are intended to ensure the coordinated entry process is available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. The CoC will affirmatively market housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, handicap or who are least likely to apply in the absence of special outreach 24 CFR 578.93(c) & 24 CFR 576.407(a) and (b). Furthermore, the CoC will ensure all people in different populations and subpopulations in the CoC’s geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, have fair and equal access to the coordinated entry process.

CES will be marketed primarily through the Lead Agencies Social Media efforts including Facebook and Twitter. CES will have a tab on the Homeless Leadership Boards web site, and will encourage participating agencies to provide a link to the CES web page on their homepage. All Access points will provide a uniform message, providing an overview of CES and expectations for the process.
As part of the marketing process The System Redesign Committee developed a Value Statement for CES which was approved by the Board of Directors on December 1, 2017: “Coordinated Entry is for all those who need or will need services, Categories 1 through 4.”

**Access:**

The CoC offers the same CES assessment approach at all access points and all access points are usable by all people who may be experiencing homelessness or at risk of homelessness. If an access point is not able to meet the needs of the populations allowable by HUD’s Coordinated Entry Notice, initial screening at each access point allows for linkage to the appropriate subpopulation services. (e.g. unaccompanied youth who access CES at the access point will be directed into youth appropriate services).

- The CoC CES process provides the same assessment approach, including standardized decision-making, at all access points.
- The CoC CES process ensures participants may not be denied access to the coordinated entry process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault or stalking.
- The CoC CES access point(s) must be easily accessed by individual and families seeking homeless or homelessness prevention services.

The CES Access Points in Pinellas County cover the entire CoC geography and are the Homeless Outreach Teams, the Community Resource and Referral Agency (211 Tampa Bay Cares), Emergency Shelters, and the CES Navigators. All the access points receive the same training to uniform the CES message and ensure that an individual or family receives the same level of care at each access site.

The CoC’s CES process allows emergency services, including all domestic violence and emergency services hotlines, drop-in service programs, and emergency shelters, including domestic violence shelters and other short-term crisis residential programs, to operate with as few barriers to entry as possible. People are able to access emergency services, such as emergency shelter, independent of the operating hours of the CE system’s intake and assessment processes. People can access emergency services, such as emergency shelter, independent of the operating hours of the system’s intake and assessment processes.

All emergency shelters operate independently of CES for shelter admission. Once a client has been admitted to a shelter, the shelter staff will conduct the acuity assessment within 72 hours of entry and enter the assessment into HMIS. In an effort to ensure effective communication with individuals with disabilities. The CES Staff will work with recipients of Federal funds and to provide appropriate auxiliary aids and services necessary to ensure effective communication (e.g. Braille, audio, large type, assistive listening devices, and sign language interpreters.) CES staff will identify the providers that offer these services and direct clients as appropriate. Additionally, CES staff will take reasonable steps to offer CE process materials and participant
instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency with in Pinellas County by partnering with Federally Funded agencies to meet the need of individuals and families seeking assistance.

Individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers will be granted entry into the emergency services they are seeking. The Service provider will then work with available DV providers to provide a referral when resources are available. At a minimum, people fleeing or attempting to flee domestic violence and victims of trafficking will have safe and confidential access to the coordinated entry process through the DV providers and victim services, including access to the comparable process used by victim service providers, as applicable, and immediate access to emergency services such as domestic violence hotlines and shelter.

Assessment:

Anyone who has been trained to utilize Homeless Management Information System (HMIS) and conduct acuity assessments for the Pinellas County Coordinated Entry System may enter that score into the HMIS. This includes Coordinated Entry Staff, All Outreach Staff, Service Providers, and others utilize the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) as the common acuity assessment in Pinellas County to screen any single individual experiencing homelessness. Similarly, providers utilize the Family Vulnerability Index and Service Prioritization Decision Assistance Tool (F-VI-SPDAT) as the common acuity assessment in Pinellas County to screen any family experiencing homelessness. All assessment data (unless requested by the participant) is then entered in HMIS.

The use of the VI-SPDAT tools across the CoC is a way to ensure that the CES process is consistently applied throughout the CoC in order to achieve fair, equitable, and equal access to services within the community. The CoC will strictly prohibit the coordinated entry process from screening people out of the coordinated entry process due to perceived barriers to housing or services, including, but not limited to, too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of a disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record. All persons experiencing homelessness will be granted the opportunity to participate in CES.

CES will provide at a minimum 8 training opportunities annually to organizations and or staff persons at organizations that serve as access points or administer assessments. CES will update and distribute training protocols at least annually. All assessors will receive standardized messaging through training so that the assessment process and its results are communicated clearly and consistently across the community. The purpose of the training is to provide all staff administering assessments with access to materials that clearly describe the methods by which
assessments are to be conducted with fidelity to the CoC’s coordinated entry written policies and procedures. The coordinated entry process training curricula includes the following topics for staff conducting assessments:

- Review of CoC’s written CE policies and procedures, including any adopted variations for specific subpopulations;
- Requirements for use of assessment information to determine prioritization; and
- Criteria for uniform decision-making and referrals.
- Process for informing participants to file a nondiscrimination complaint.
- Ensuring participants know they are allowed to decide what information they provide during the assessment process, to refuse to answer assessment questions and to refuse housing and service options without retribution or limiting their access to other forms of assistance.
- Conditions for participants to maintain their place in coordinated entry prioritization lists when the participant rejects options.

Prioritization:

The coordinated entry process prioritizes homeless persons within the CoC’s geographic area. The following represents the uniform process to be used across the CoC for assessing individuals, matching them to an intervention, and within each category, prioritizing placement into housing. This will eliminate the need to complete multiple assessments with individuals, which is burdensome both for the person being assessed and conducting the assessment.

The VI-SPDAT will be the ONLY tool used to assess acuity for individuals and families at the point of entry (the triage tool (Policy Attachment 4) will be used prior to entry as part of the prevention/diversion process and to determine literal homelessness). The VI-SPDAT scores will be used to sort individuals into the category of the most appropriate housing intervention.

In accordance with HUD Notice CPD-016-11 (Policy Attachment 5), households scoring in the permanent supportive housing range will be prioritized in the following manner:

- **First Priority – Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs**

  An individual or family that is eligible for CoC Program-funded PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months and has been identified as having severe service needs.
• **Second Priority – Homeless Individuals and Families with a Disability with Severe Service Needs**

An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter and has been identified as having severe service needs. The length of time in which a households have been homeless should also be considered when prioritizing households that need this order of priority, but there is not a minimum length of time required.

Household’s length of time homeless will be determined by length of time as reported by homeless household during the VI-SPDAT assessment in combination with a review of their HMIS record. Households must be able to demonstrate history of homeless by producing required documentation.

• **Third Priority – Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs**

An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

Service needs will be identified by the acuity captured in the VI-SPDAT assessment. When applicable, portions of the SPDAT targeting the use of crisis services will be administered to the head of household if the household’s needs are not accurately captured by the VI-SPDAT.

• **Forth Priority – Homeless Individuals and Families with a Disability Coming from Transitional Housing.**

An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing lived in a place not meant for human habitation, in an emergency shelter, or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and prior to residing in that transitional housing project.
even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

- **First Priority — Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs**

  An individual or family that is eligible for CoC Program-funded PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months and has been identified as having severe service needs.

- **Second Priority — Homeless Individuals and Families with a Disability with Severe Service Needs**

  An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which a households have been homeless should also be considered when prioritizing households that need this order of priority, but there is not a minimum length of time required.

  Household’s length of time homeless will be determined by length of time as reported by homeless household during the VI-SPDAT assessment in combination with a review of their HMIS/TBIN record. Households must be able to demonstrate history of homeless by producing required documentation.

- **Third Priority — Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs**

  An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

  Service needs will be identified by the acuity captured in the VI-SDPAT assessment. When applicable, portions of the SPDAT targeting the use of crisis services will be administered to the head of household if the household’s needs are not accurately captured by the VI-SPDAT.
Forth Priority — Homeless Individuals and Families with a Disability Coming from Transitional Housing.

An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing lived in a place not meant for human habitation, in an emergency shelter, or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

Prioritization Process for PSH:

For individuals that score 8 or above on the VI-SPDAT (Families that score a 9 or above), which signals a need for permanent supportive housing, the following criteria (only going to the next level as needed) will be used to break a tie between two or more individuals or families:

1. Chronic Homelessness – Documentation of the HUD Definition of Chronic Homelessness
2. Veteran Status – Documented Veteran Status
3. Score on Section D Wellness of the VI-SPDAT/F-VI-SPDAT.
4. Score on Section B Risks of the VI-SPDAT/F-VI-SPDAT
5. Score on Section C Socialization of the VI-SPDAT/F-VI-SPDAT
6. Date of VI-SPDAT/F-VI-SPDAT Assessment: The final tie breaker will be the date of the individual’s assessment, giving priority to the earliest date of assessment.

Prioritization Process for Rapid Rehousing and Transitional Housing:

For individuals scoring 4-7 and families scoring 4-8 on the VI-SPDAT/F-VI-SPDAT, the following process will be used to prioritize for rapid rehousing placement (ESG, CoC, and Other RRH). Based on the quantity of available case management, rapid rehousing clients will be referred based on the acuity score and the same priorities of the PSH. Clients scoring in the PSH range may select the lower intervention of RRH.

Prioritization Process for Emergency Shelter:
In Accordance with HUD Coordinated Entry Notice: Section II.B.7 entry to emergency shelter **will not be prioritized** through CES, allowing for an immediate crisis response for individuals and families seeking emergency services.

**Full SPDAT Process:**

To provide a safety net for individuals that are presumed to be highly vulnerable but score too low on the VI-SPDAT to qualify for permanent supportive housing (ie, 7 individual and 8 families), those individuals would be recommended for full SPDAT assessment.

While the VI-SPDAT is a pre-screen or triage tool that looks to confirm or deny the presence of more acute issues or vulnerabilities, the SPDAT (or "full SPDAT") is an assessment tool looking at the depth or nuances of an issue and the degree to which housing may be impacted.

For those limited instances where an assessor determines that the VI-SPDAT score may warrant a more comprehensive assessment, they may elect to complete a SPDAT. Once the SPDAT has been recorded within HMIS, if the individual scores at least 40, the SPDAT score may be considered along with VI-SPDAT when prioritizing housing navigator assignments and/or housing placement. Those who have received a full SPDAT assessment will periodically be reviewed through the case conferencing and housing match processes.

*Note: In the first year of assessments following a very similar process in Washington D.C., only 2% of individuals were recommended for a full SPDAT assessment. By allowing for assessors to spend the time to complete this more in-depth analysis, the small set of individuals whose full depth of vulnerability may not be reflected within their VI-SPDAT assessment may still be considered for housing navigator assignments and/or housing placement. In a subset of these very limited instances, it is possible for a full SPDAT to produce different results than the VI-SPDAT because it is a multi-method assessment compared to the self-reported survey of VI-SPDAT.*

In instances where individuals have both a full SPDAT and VI-SPDAT assessment, whenever possible, referral for housing placement will prioritize the full SPDAT and not solely the VI-SPDAT score.

**Nondiscrimination:**

The CoC CES process does not use data collected from the assessment process to discriminate or prioritize households for housing and services on a protected basis, such as race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity or marital status. Anyone needing housing services will receive an assessment and be prioritized based on the acuity score. Clients will be matched for eligibility based on program funding (e.g. families will be referred to family programs and veterans to veteran programs). This nondiscrimination policy is extended to all agencies that
participate in CES and comply with the equal access and nondiscrimination provisions of Federal civil rights laws.

The CoC’s CES referral process is informed by Federal, State, and local Fair Housing laws and regulations and ensures participants are not “steered” toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children. This policy is extended to all agencies that participate in CES.

All participants have the right to file a nondiscrimination complaint with the CES Director. The complaint can be emailed to info@pinellashlb.org, mailed to the HLB at 647 First Avenue North, 2nd Floor St. Petersburg, Florida 33701 or Faxed to 727.582.7704. The complaint will be reviewed by the CES Director and the CoC Director and appropriate action will be taken. If there is no action that the CES Director and the CoC Director can take the issue will be elevated to the HLB CEO and/or the HLB Board of Directors.

**Prioritization List:**

Each Federally funded agency will be required to enter into a CES participation agreement (MOU). This agreement will show each agency is committed to following the process outlined in the CES Policy. This includes but is not limited to accepting referrals for the most vulnerable person or family eligible for the agency’s housing opportunity, closing “side door” entry to programs, and participating in case conferencing sessions. The CES By Name List will be maintained through HMIS. The CES reports will be run weekly (or more frequently if needed) from the HMIS system. A referral will be sent to providers based on capacity and program eligibility. Any CES participant that is not accepted into a program will be returned to the By Name List and will be referred again once capacity has been identified.

Because the CoC manages prioritization order using a “Prioritization List,” CoC extends the same HMIS data privacy and security protections prescribed by HUD for HMIS practices in the HMIS Data and Technical Standards.

**Data Management:**

CES utilizes the CoC’s HMIS to manage coordinated entry data, the CoC ensures adequate privacy protections of all participant information per the HMIS Data and Technical Standards at (CoC Program interim rule) 24 CFR 578.7(a)(8). CES utilizes the HMIS Release of Information (ROI) for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the coordinated entry process. The CoC CES process prohibits denying services to participants if the participant refuses to allow their data to be shared, unless Federal statute requires collection, use, storage, and reporting of a participant’s personally identifiable information (PII) as a condition of program participation and ensures all users of HMIS are informed and understand the privacy rules associated with collection, management, and reporting of client data.
**Evaluation:**

The CoC CES will consult with each participating project and project participants at least annually to evaluate the intake, assessment, and referral processes associated with coordinated entry. Solicitations for feedback will address the quality and effectiveness of the entire coordinated entry experience for both participating projects and households. This will be initially conducted as an electronic survey sent out each August beginning in August 2018.

Twenty CES participants will be selected at random and may be in various stages of the CES process, the CES director will obtain the email address from HMIS records or from the participants program manager. All responses will remain anonymous protecting the privacy of the participants providing feedback. The survey will ask participants to provide feedback. The results will be grouped into themes by CES staff and reviewed by the CoC System Redesign Committee. The System Redesign Committee will the make recommendations to the HLB Board of Directors for approval and inclusion in updated policies.

**CES Navigation:**

Each CES Navigator will serve as a point of contact when a high-priority (high acuity score) individual or family has been matched to housing. The CES Navigator will facilitate meetings between the individual or family and the assigned housing agency. The CES Navigator will also help case managers when necessary to obtain any documents needed for a housing placement or a housing voucher. Prior to and throughout the housing assignment process, the CES Navigator may also do regular outreach to an individual in an effort to build rapport with him or her and assist the case manager in locating appropriate housing based on the participant's choice.

When CES Navigators are unable to make contact with the individual or family following assignment, the individual or family placed on the inactive list until they are reengaged through CES, outreach, or shelter services.

**Housing Providers:**

Organizations that provide ESG/CoC funded housing to those experiencing homelessness and Providers that are not ESG/CoC funded but would like to dedicate all or some of their housing vacancies to the coordinated entry system will enter into a MOU and follow the process outlined below:

1. Identify if the housing is permanent supportive housing, rapid rehousing, or affordable/one-time assistance housing. All housing must be considered permanent.

2. The Housing Provider will fill out the eligibility requirements for each of their programs that they will be dedicating to the coordinated entry process.
3. The Housing Provider will notify the HLB CES Staff when they have open and currently available housing inventory unit, voucher, or case capacity. This will be communicated via email to CES staff.

4. The Housing Provider commits to following the Housing Matching Prioritization Process for Permanent Supportive Housing, Transitional Housing, Rapid Rehousing, and Homeless Prevention.

5. The matches will be made as soon as vacancies become available and at coordinated entry meetings where a Housing Provider can choose to be present or receive referrals following the meeting via email. Referrals will be made by the HLB CES staff and clients will be referred to the appropriate intervention based on acuity, eligibility, and prioritization.

6. Upon receiving the referrals, the Housing Provider first contacts the client based on information in HMIS. If they are not successful in reaching the client the CES Navigator will coordinate contact with the individual and set up intake appointments with the agency if necessary and possible.

7. The Housing Provider commits to working with the CES Navigator to locate the individual and engage with them to see if the housing referral provided is appropriate.

8. The Housing Provider commits to communicating with the HLB CES staff when each referral does not lead to successful program entry and providing reason(s) why they were not housed so that the individual can be unassigned from the Housing Provider in HMIS and returned to the Priority List as necessary.

9. The Housing Provider commits to communicating with the CES Staff when each referral does lead to successful program entry and providing the date the individual moves into housing.

**Homeless Diversion:**

A Strong Coordinated Entry System must allow for service interventions before a loss of housing has occurred. *Prevention* targets people at imminent risk of homelessness and *Diversion* targets people as they are applying for entry into shelter. All persons seeking shelter should have attempted at a minimum at least one diversion strategy.

The main difference between diversion and other permanent housing-focused interventions centers on the point at which intervention occurs. Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion programs can reduce the number of individuals and families becoming homeless, the demand for shelter beds, and the size of program wait lists. The services individuals and families are provided with when
being diverted are services that caseworkers in most poverty and homeless assistance organizations are already trained and funded to deliver. They include:

- a provision of financial, utility, and/or rental assistance;
- short-term case management;
- conflict mediation;
- connection to mainstream services (services that come from agencies outside of the homeless assistance system, such as welfare agencies) and/or benefits; and
- locating an affordable housing option, i.e. housing search assistance.

Once an individual or family is encountered, comes to, or calls any assessment point, they should be assessed to determine what housing needs they may have. To determine which individuals and families are appropriate for diversion, intake staff will need to ask a few specific questions, such as:

1. Where did you sleep last night? If they slept somewhere where they could potentially safely stay again, this might mean they are good candidates for diversion.

2. What other housing options do you have for the next few days or weeks? Even if there is an option outside of shelter that is only available for a very short time, it's worth exploring if this housing resource can be used.

3. (If staying in someone else’s housing) what issues exist with you remaining in your current housing situation? Can those issues be resolved with financial assistance, case management, etc.? If the issues can be solved with case management, mediation, or financial assistance (or all of the above), diversion is a good option.

4. (If coming from their own unit) is it possible/safe to stay in your current housing unit? what resources would you need to do that (financial assistance, case management, mediation, transportation, etc.)? If the family could stay in their current housing with some assistance, systems should focus on a quick prevention-oriented solution that will keep the family in their unit.

**Homeless Prevention:**

Homelessness prevention programs are usually designed to use available resources to offer time-limited assistance to a large number of families and individuals. The assistance may not be enough to cover all needs, but can often act as a means to leverage other income and supports and permit the recipients to remain housed. In some cases a homelessness prevention program is structured to provide deeper assistance to a defined population, such as persons being discharged from prisons, hospitals, or foster care, to prevent them from experiencing homelessness.

In Pinellas County prevention programs are based on a set of core strategy.
The majority of households that experience a housing crisis such as eviction, even those with very low incomes, will not end up experiencing homelessness. There is no proven way to reliably predict which at-risk households are most likely to become homeless without assistance. There are, however, strategies that the Pinellas County CoC has developed, including these:

1. By offering diversion services “at the front door” of shelter, households who would otherwise enter shelter maintain their current housing situation or, when that is not possible, quickly relocate to an alternate housing option. The implication of this targeting is that the response must be immediate to prevent loss of housing.

2. Housing focus. Housing stability is the primary goal of homelessness prevention. The key to successful prevention is identifying those barriers related to retaining existing housing and finding ways to eliminate or compensate for those barriers. Household problems that are not directly related to housing are addressed only if and when the participant chooses.

3. Housing negotiation, mediation, and counseling. When possible, prevention programs seek to help families remain in their existing housing if it is safe. This may include mediation to resolve conflicts with family members or friends with whom they are living or landlord-tenant mediation if the household is the primary tenant. Programs may offer counseling about other housing options that could provide alternatives to entering shelter. The goal is to try to negotiate the terms by which a household can stay in or return to housing, even for a limited period. As part of this process, the program may agree to provide the household with training in money management or other household skills, offer some financial assistance, or help to connect the household to needed services.

4. Financial assistance. Prevention programs often provide one-time financial assistance to help participants keep their housing or relocate to new housing. This may include payment of rent or utility arrearages, transportation for housing search, first and last month’s rent, security deposit, application fees, and help with moving costs and utility connections. Some programs provide financial incentives to landlords to rent to families with challenging rental histories, such as additional months of rent upfront or doubling the security deposit. Having at least one source of funds that can be used flexibly allows some prevention programs to adapt their assistance to the specific, immediate needs of each household. Funding Sources in Pinellas County.
   i. Emergency Solutions Grant (ESG)
   ii. Emergency Food and Shelter Program (EFSP)
   iii. Family Support Initiative (FSI)
   iv. OTHER

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5. Relocation assistance. When households cannot remain in their current housing, the prevention program works with the household to find housing in the private market with a focus on safety and proximity to the children’s school, support networks—including relatives, friends, church, and familiar surroundings, and employment opportunities. To streamline access to housing, prevention programs continuously search for the most affordable housing options in the community and cultivate relationships with landlords.

6. Housing stabilization supports. A prevention plan can include actions and supports to overcome or minimize recurrent, significant barriers to retaining housing. Development of this aspect of the plan between the household and the program’s case manager or advocate occurs only when desired and needed and after the immediate housing crisis has been resolved. Staff members ensure that households have a basic understanding of their rights and responsibilities as a tenant and those of the landlord.

The providers providing prevention services will use a threshold process to determine who receives priority for prevention services. Clients achieving the threshold score (set by the funder) will be screened for eligibility and enrolled by the service provider. Those who do not achieve the threshold score will be directed to 211 the community resource and referral service for any available services.

Special Populations:

Unaccompanied Street Youth

Unaccompanied youth are one of the fastest growing and most underserved subpopulations in the United States. It is also important to note that LGBT, as well as African American youth and young adults, are disproportionately impacted by homelessness when compared to other groups.

Unaccompanied Youth and Young Adults are defined as youth (ages 13-17) and young adults (ages 18-24) who are unaccompanied by a parent or guardian and are without shelter where appropriate care and supervision are available, whose parent or guardian is unable or unwilling to provide shelter and care, or who lack a fixed, regular and adequate nighttime residence.

Service providers for unaccompanied youth and young adults should be able to provide safe and high-quality housing and supportive services to youth and young adults experiencing homelessness that involve an integrated system of affordable housing, intensive strengths-based case management, self-sufficiency services, trauma-informed care, and positive youth development approaches. As part of CES providers serving
unaccompanied youth and young adults will be encouraged to adopt the use of the VI-SPDAT and adopt a method of prioritizing the most vulnerable for immediate shelter and housing. Unaccompanied young adults will be referred to the Housing Priority List for PSH and RRH opportunities following the process above.

**Survivors of Domestic Violence**

The safety of individuals and families fleeing DV is very important. CES will work with DV providers to ensure that a confidential and safe referral is made to CASA or RCS. CASA and RCS will work together to provide emergency shelter as necessary. CASA and RCS will conduct the initial VI-SPDAT to determine acuity. If a participant does not require the confidential nature of the DV providers they will be referred to the Housing Priority List. If they do need the confidential nature of DV services they will remain at CASA or RCS and be prioritized based on their acuity score. CASA has the ability to provide Rapid Rehousing to clients in their program. If PSH is required CASA will work with RCS and the CES lead agency to connect the participant to the appropriate program.

**Homeless Veterans**

CES access for Veterans will be through the Society of Saint Vincent de Paul, South Pinellas County (SVdP) as SSVF Priority 1 & 3 lead in Pinellas County. SVdP continues to provide necessary services and assist veterans with appropriate housing opportunities through RRH.

Veterans may be sheltered at any shelter recognized by the CoC while all efforts for housing are explored by SSVF and other Veteran opportunities. The Veteran population can access two additional assessment sites are located at:

- St. Vincent de Paul Center of Hope - 401 15th Street N. St Petersburg 33713
- St. Vincent de Paul Clearwater - 2735 Whitney Road Clearwater, FL 33760

**Revisions to CES Policy and Procedure**

Revisions to this **Policy and Procedure** document should be reviewed annually by the Pinellas County Homeless Leadership Boards Board of Directors. Staff will submit any proposed procedural changes to the Data and System Performance Committee for input prior to making a change. The CEO can amend any **procedures** as required.
Attachment 1

Definition of Homeless

On December 5, 2011, HUD published the final rule on the Definition of Homeless in the Federal Register and it went into effect on January 4, 2012.

The final rule on the Definition of Homeless establishes four categories under which an individual or family may qualify as homeless. The categories are:

1. **Literally homeless** - An individual or family who lacks a fixed, regular and adequate nighttime residence, meaning the individual or family has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately operated shelter designed to provide temporary living arrangements. This category also includes individuals who are exiting an institution where he or she resided for 90 days or less who resided in an emergency shelter or place not meant for human habitation immediately prior to entry into the institution.

2. **Imminent Risk of Homelessness** - An individual or family who will imminently lose (within 14 days) their primary nighttime residence provided that no subsequent residence has been identified and the individual or family lacks the resources or support networks needed to obtain other permanent housing.

3. **Homeless under other Federal Statutes** - Unaccompanied youth (under 25) or families with children and youth who do not otherwise qualify as homeless under this definition and are defined as homeless under another federal statute, have not had permanent housing during the past 60 days, have experienced persistent instability, and can be expected to continue in such status for an extended period of time.

4. **Fleeing/Attempting to Flee Domestic Violence** - Any individual or family who is fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking.
Attachment 2

Vulnerability Index -
Service Prioritization Decision Assistance Tool
(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.0

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1 (600) 395-0420 info@orgcode.com  www.orgcode.com
SPDAT Training Series
To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

**Current SPDAT training available:**
- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

**Other related training available:**
- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at [http://www.orgcode.com/product-category/training/spdat/](http://www.orgcode.com/product-category/training/spdat/)
# Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT)

## Administration

<table>
<thead>
<tr>
<th>Interviewer's Name</th>
<th>Agency</th>
<th>Team</th>
<th>Staff</th>
<th>Volunteer</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Survey Date</th>
<th>Survey Time</th>
<th>Survey Location</th>
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</thead>
<tbody>
<tr>
<td>DD/MM/YYYY</td>
<td><em>:</em> AM/PM</td>
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</tr>
</tbody>
</table>

## Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only “Yes,” “No,” or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

## Basic Information

<table>
<thead>
<tr>
<th>First Name</th>
<th>Nickname</th>
<th>Last Name</th>
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</thead>
</table>

In what language do you feel best able to express yourself?

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Age</th>
<th>Social Security Number</th>
<th>Consent to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD/MM/YYYY</td>
<td><em>:</em></td>
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</tr>
</tbody>
</table>

*If the person is 60 years of age or older, then score 1.*

**Score:**
A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)
   - [] Shelters
   - [] Transitional Housing
   - [] Safe Haven
   - [] Outdoors
   - [] Other (specify):
   - [] Refused

   IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.

2. How long has it been since you lived in permanent stable housing?
   _______  [] Refused

3. In the last three years, how many times have you been homeless?
   _______  [] Refused

   IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.

B. Risks

4. In the past six months, how many times have you...
   a) Received health care at an emergency department/room?  _______  [] Refused
   b) Taken an ambulance to the hospital?  _______  [] Refused
   c) Been hospitalized as an inpatient?  _______  [] Refused
   d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines?  _______  [] Refused
   e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along?  _______  [] Refused
   f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between?  _______  [] Refused

   IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR EMERGENCY SERVICE USE.

5. Have you been attacked or beaten up since you’ve become homeless?  [] Y  [] N  [] Refused

6. Have you threatened to or tried to harm yourself or anyone else in the last year?  [] Y  [] N  [] Refused

   IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF HARM.
VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

AMERICAN VERSION 2.0

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? □ Y □ N □ Refused

IF "YES," THEN SCORE 1 FOR LEGAL ISSUES.

SCORE:

8. Does anybody force or trick you to do things that you do not want to do? □ Y □ N □ Refused

9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? □ Y □ N □ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF EXPLOITATION.

SCORE:

C. Socialization & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? □ Y □ N □ Refused

11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? □ Y □ N □ Refused

IF "YES" TO QUESTION 10 OR "NO" TO QUESTION 11, THEN SCORE 1 FOR MONEY MANAGEMENT.

SCORE:

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? □ Y □ N □ Refused

IF "NO," THEN SCORE 1 FOR MEANINGFUL DAILY ACTIVITY.

SCORE:

13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? □ Y □ N □ Refused

IF "NO," THEN SCORE 1 FOR SELF-CARE.

SCORE:

14. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted? □ Y □ N □ Refused

IF "YES," THEN SCORE 1 FOR SOCIAL RELATIONSHIPS.

SCORE:
D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? □ Y □ N □ Refused

16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? □ Y □ N □ Refused

17. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you? □ Y □ N □ Refused

18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help? □ Y □ N □ Refused

19. When you are sick or not feeling well, do you avoid getting help? □ Y □ N □ Refused

20. **FOR FEMALE RESPONDENTS ONLY:** Are you currently pregnant? □ Y □ N □ N/A or Refused

**IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR PHYSICAL HEALTH.**

SCORE: [ ]

21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? □ Y □ N □ Refused

22. Will drinking or drug use make it difficult for you to stay housed or afford your housing? □ Y □ N □ Refused

**IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR SUBSTANCE USE.**

SCORE: [ ]

23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
   a) A mental health issue or concern? □ Y □ N □ Refused
   b) A past head injury? □ Y □ N □ Refused
   c) A learning disability, developmental disability, or other impairment? □ Y □ N □ Refused

24. Do you have any mental health or brain issues that would make it hard for you to live independently because you’d need help? □ Y □ N □ Refused

**IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR MENTAL HEALTH.**

SCORE: [ ]

**IF THE RESPONDENT SCORED 1 FOR PHYSICAL HEALTH AND 1 FOR SUBSTANCE USE AND 1 FOR MENTAL HEALTH, SCORE 1 FOR TRI-MORBIDITY.**

SCORE: [ ]
25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? □ Y □ N □ Refused

26. Are there any medications like painkillers that you don’t take the way the doctor prescribed or where you sell the medication? □ Y □ N □ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR MEDICATIONS.

SCORE:

27. YES OR NO: Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced? □ Y □ N □ Refused

IF "YES", SCORE 1 FOR ABUSE AND TRAUMA.

SCORE:

Scoring Summary

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Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so? place: ________ time: __:__ or Morning/Afternoon/Evening/Night

Is there a phone number and/or email where someone can safely get in touch with you or leave you a message? phone: (____) _______ _______ email: ________

Ok, now I’d like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so? □ Yes □ No □ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- legal status in country
- children that may reside with the adult at some point in the future
- ageing out of care
- income and source of it
- safety planning
- mobility issues
- current restrictions on where a person can legally reside

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Appendix A: About the VI-SPDAT

The HEARTH Act and federal regulations require communities to have an assessment tool for coordinated entry — and the VI-SPDAT and SPDAT meet these requirements. Many communities have struggled to comply with this requirement, which demands an investment of considerable time, resources and expertise. Others are making it up as they go along, using “gut instincts” in lieu of solid evidence. Communities need practical, evidence-informed tools that enhance their ability to be efficient in satisfying federal regulations, and quickly implement an effective approach to access and assessment. The VI-SPDAT is a first of its kind tool designed to fill this need, helping communities end homelessness in a quick, strategic fashion.

The VI-SPDAT

The VI-SPDAT was initially created by combining the elements of the Vulnerability Index which was created and implemented by Community Solutions broadly in the 100,000 Homes Campaign, and the SPDAT Prescreen Instrument that was part of the Service Prioritization Decision Assistance Tool. The combination of these two instruments was performed through extensive research and development, and testing. The development process included the direct voice of hundreds of persons with lived experience.

The VI-SPDAT examines factors of current vulnerability and future housing stability. It follows the structure of the SPDAT assessment tool, and is informed by the same research backbone that supports the SPDAT — almost 300 peer reviewed published journal articles, government reports, clinical and quasi-clinical assessment tools, and large data sets. The SPDAT has been independently tested, as well as internally reviewed. The data overwhelmingly shows that when the SPDAT is used properly, housing outcomes are better than when no assessment tool is used.

The VI-SPDAT is a triage tool. It highlights areas of higher acuity, thereby helping to inform the type of support and housing intervention that may be most beneficial to improve long-term housing outcomes. It also helps inform the order — or priority — in which people should be served. The VI-SPDAT does not make decisions; it informs decisions. The VI-SPDAT provides data that communities, service providers, and people experiencing homelessness can use to help determine the best course of action next.

Version 2

Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

You will notice some differences in Version 2 compared to Version 1. Namely:

- it is shorter, usually taking less than 7 minutes to complete;
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- medical, substance use, and mental health questions are all refined;
- you can now explicitly see which component of the full SPDAT each VI-SPDAT question links to, and;
- the scoring range is slightly different (Don’t worry, we can provide instructions on how these relate to results from Version 1).
Attachment 3

Vulnerability Index -
Service Prioritization Decision Assistance Tool
(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.0

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1 (603) 355-0420 info@orgcode.com www.orgcode.com
VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

HLB Board Approval 01/05/2018

SPDAT Training Series
To use the SPDAT training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 35 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:
- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:
- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at http://www.orgcode.com/product-category/training/spdat/

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June 10, 2016
Revised December 12, 2017
VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

Administration

Interviewer's Name
Agency

☐ Team
☐ Staff
☐ Volunteer

Survey Date
Survey Time
Survey Location

DD/MM/YYYY ___/___/____  ___:___ AM/PM

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only “Yes,” “No,” or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name
Nickname
Last Name

In what language do you feel best able to express yourself?

Date of Birth
Age
Social Security Number
Consent to participate

DD/MM/YYYY ___/___/____  ___:___ AM/PM  ☐ Yes  ☐ No

IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.
VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)
   - Shelters
   - Transitional Housing
   - Safe Haven
   - Outdoors
   - Other (specify):
   - Refused

   IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.

2. How long has it been since you lived in permanent stable housing?

3. In the last three years, how many times have you been homeless?

   IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.

B. Risks

4. In the past six months, how many times have you...
   a) Received health care at an emergency department/room?
   b) Taken an ambulance to the hospital?
   c) Been hospitalized as an inpatient?
   d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines?
   e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along?
   f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between?

   IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR EMERGENCY SERVICE USE.

5. Have you been attacked or beaten up since you’ve become homeless?
   - Y
   - N
   - Refused

6. Have you threatened to or tried to harm yourself or anyone else in the last year?
   - Y
   - N
   - Refused

   IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF HARM.
VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS

AMERICAN VERSION 2.0

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? □ Y □ N □ Refused

IF "YES," THEN SCORE 1 FOR LEGAL ISSUES. SCORE:

8. Does anybody force or trick you to do things that you do not want to do? □ Y □ N □ Refused

9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don’t know, share a needle, or anything like that? □ Y □ N □ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF EXPLOITATION. SCORE:

C. Socialization & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? □ Y □ N □ Refused

11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? □ Y □ N □ Refused

IF "YES" TO QUESTION 10 OR "NO" TO QUESTION 11, THEN SCORE 1 FOR MONEY MANAGEMENT. SCORE:

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? □ Y □ N □ Refused

IF "NO," THEN SCORE 1 FOR MEANINGFUL DAILY ACTIVITY. SCORE:

13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? □ Y □ N □ Refused

IF "NO," THEN SCORE 1 FOR SELF-CARE.

14. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted? □ Y □ N □ Refused

IF "YES," THEN SCORE 1 FOR SOCIAL RELATIONSHIPS. SCORE:
D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? □ Y □ N □ Refused

16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? □ Y □ N □ Refused

17. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you? □ Y □ N □ Refused

18. Do you have any physical disabilities that would limit the type of housing you could access, or would it make it hard to live independently because you’d need help? □ Y □ N □ Refused

19. When you are sick or not feeling well, do you avoid getting help? □ Y □ N □ Refused

20. FOR FEMALE RESPONDENTS ONLY: Are you currently pregnant? □ Y □ N □ N/A or Refused

**IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR PHYSICAL HEALTH.**

21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? □ Y □ N □ Refused

22. Will drinking or drug use make it difficult for you to stay housed or afford your housing? □ Y □ N □ Refused

**IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR SUBSTANCE USE.**

23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
   a) A mental health issue or concern? □ Y □ N □ Refused
   b) A past head injury? □ Y □ N □ Refused
   c) A learning disability, developmental disability, or other impairment? □ Y □ N □ Refused

24. Do you have any mental health or brain issues that would make it hard for you to live independently because you’d need help? □ Y □ N □ Refused

**IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR MENTAL HEALTH.**

**IF THE RESPONDENT SCORED 1 FOR PHYSICAL HEALTH AND 1 FOR SUBSTANCE USE AND 1 FOR MENTAL HEALTH, SCORE 1 FOR TRIPLE MORTALITY.**
VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

SINGLE ADULTS  AMERICAN VERSION 2.0

25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking?  □ Y  □ N  □ Refused

26. Are there any medications like painkillers that you don’t take the way the doctor prescribed or where you sell the medication?  □ Y  □ N  □ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR MEDICATIONS.

27. YES OR NO: Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced?  □ Y  □ N  □ Refused

IF "YES", SCORE 1 FOR ABUSE AND TRAUMA.

SCORE:

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Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?

place: ____________________________
time: __________ or Morning/Afternoon/Evening/Night

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phone: (_____)(____) ______ - ________
email: ____________________________

Ok, now I’d like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?

□ Yes  □ No  □ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

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June 10, 2016
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Appendix B: Where the VI-SPDAT is being used in the United States

Since the VI-SPDAT is provided completely free of charge, and no training is required, any community is able to use the VI-SPDAT without the explicit permission of Community Solutions or OrgCode Consulting, Inc. As a result, the VI-SPDAT is being used in more communities than we know of; it is also being used in Canada and Australia.
Attachment 4

Triage Tool

A. Which of the following best describes the Client's current living situation? (Meets definition of literal homelessness if 1, 2, or 3 below)
   1. Living in an emergency or transitional shelter
   2. Living in a place not designed as regular sleeping accommodations, such as a car, park, abandoned building, bus or train station (unsheltered)
   3. Living in a motel, hotel or trailer park paid for by an agency in lieu of shelter
   4. Living in a motel, hotel or trailer park paid for by another source including self-pay.
   5. Temporarily living with family or friends due to loss of housing, economic hardship or other similar reason (doubled up)
   6. Couch surfing
   7. Rent or own apartment, house, condo

B. If 1-3 (literally homeless), refer to shelter/homeless services as necessary.

C. If 4-7 (not literally homeless), can you remain at that location tonight?
   1. Yes (refer to prevention/diversion programs for screening)
   2. No

D. If No, is there another place you can stay tonight?
   1. Yes (After confirmation that this is feasible refer to prevention/diversion programs for screening)
   2. No

E. If No, would you be willing to stay in a shelter?
   1. Yes (make appropriate shelter referral)
   2. No

F. If No, explain options and confirm question D. and offer assistance in securing support services.
Attachment 5

HUD Notice: CPD-16-11 can be accessed at:
Attachment 6

Definition of Chronic Homelessness

HUD Released the Final Rule on Homeless Emergency Assistance and Rapid Transition to Housing: Defining “Chronically Homeless” on 12/4/15. The final rule defines chronic homelessness as follows:

(1) A “homeless individual with a disability”:
   i. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
   ii. Has been homeless and living as described in paragraph (1)(i) above continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i) above. Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

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

Definition of Disability

(1) A condition that:
   i. Is expected to be long-continuing or of indefinite duration;
   ii. Substantially impedes the individual’s ability to live independently;
   iii. Could be improved by the provision of more suitable housing conditions; and
   iv. Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;

(2) A developmental disability, as defined in this section; or

(3) The disease of acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome, including infection with the human immunodeficiency virus (HIV).
Attachment 7

Severity of Service Needs

This Notice refers to persons who have been identified as having the most severe service needs.

(a) For the purposes of this Notice, this means an individual for whom at least one of the following is true:

i. History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; or

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

Severe service needs as defined in paragraphs i. and ii. above should be identified and verified through data-driven methods such as an administrative data match or through the use of a standardized assessment tool that can identify the severity of needs such as the Vulnerability Index (VI), the Service Prioritization Decision Assistance Tool (SPDAT), or the Frequent Users Service Enhancement (FUSE). The determination must not be based on a specific diagnosis or disability type, but only on the severity of needs of the individual.

(b) In states where there is an alternate criteria used by state Medicaid departments to identify high-need, high cost beneficiaries, CoCs and recipients of CoC Program-funded PSH may use similar criteria to determine if a household has severe service needs instead of the criteria defined paragraphs i. and ii. above. However, such determination must not be based on a specific diagnosis or disability type.
At the July 16th Executive Committee, members discussed current lack of funding for homeless families and what actions might be taken as long or short-term interventions. Chair Foster suggested reaching out to Board members to sit on an ad hoc committee to create a common ask and common message for homeless families, including prevention and diversion. Several Board members have expressed interest in advocacy and defining common asks.

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<td>G. Keeter-Bodkin</td>
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<td>Background:</td>
<td>At the July 16th Executive Committee, members discussed current lack of funding for homeless families and what actions might be taken as long or short-term interventions. Chair Foster suggested reaching out to Board members to sit on an ad hoc committee to create a common ask and common message for homeless families, including prevention and diversion. Several Board members have expressed interest in advocacy and defining common asks.</td>
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<td>Budget Impact (if any):</td>
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<td>Board members volunteer time and expertise for a one or two meeting advocacy committee in the interest of homeless families.</td>
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<td>CEO Approval:</td>
<td>Susan Myers, CEO – July 31, 2018</td>
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