South Carolina Upstate Continuum of Care

# Coordinated Entry System Policies and Procedures

Focusing resources and expertise based on need to effectively end homelessness throughout the community

Policies and procedures outlining a collaborative approach to ending homelessness

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# Overview

## Background

Coordinated Entry is a process designed to coordinate participant intake, assessment, provision of referrals and housing placement. It covers a geographic area, is easily accessed by individuals and families seeking housing services, is well advertised and includes a comprehensive and standardized entry tool.

Coordinated Entry is possible regardless of the geography, available housing and services or unique community characteristics. Coordinated Entry can be molded to fit almost any community or situation and – with patience, persistence, testing and tweaking – can be successful.

When implemented correctly, Coordinated Entry moves beyond the “first come, first served” approach to one that looks across the community to serve those in most need.

This document acts as the policies and procedures for the Coordinated Entry System (CES) for the South Carolina Upstate Continuum of Care service area which includes the counties of:

* Abbeville
* Anderson
* Cherokee
* Edgefield
* Greenville
* Greenwood
* Laurens
* McCormick
* Oconee
* Pickens
* Saluda
* Spartanburg
* Union

The Upstate Continuum of Care (CoC) has four designated chapters within its geography:

* Greenville/Laurens Chapter.
* Tri-County chapter (consisting of Anderson, Oconee, and Pickens counties);
* CUS chapter (consisting of Cherokee, Union, and Spartanburg counties); and
* GAMES chapter (consisting of Greenwood, Abbeville, McCormick, Edgefield, and Saluda counties)

This document will be a living document that is subject to change as our communities grow and change, learning what works well and what should be changed to work better.

## Intention

In implementing a process of Coordinated Entry, the Upstate CoC’s aim is to end homelessness in the community by changing the system to improve how we assign housing opportunities based on appropriate common tools and effective targeting efforts.

The intention of Coordinated Entry is to:

* **Divert** people who can solve their own homelessness away from having to enter the system.
* **Target** the most appropriate housing intervention to the correct individual and/or family, particularly for those with high acuity and high need
* Greatly **reduce the length of time people are experiencing homelessness** by quickly moving people into available housing opportunities
* Significantly **improve the likelihood of housing stability** by targeting the appropriate housing intervention to the corresponding needs

Coordinated Entry brings together the strength of community services and resources. When communities come together to implement a coordinated entry system, programs, participants, and the community at large can benefit:

##### Better referrals/eligible participants

* + Programs receive referrals for participants whose basic eligibility and basic housing needs have been determined through the entry assessment process.
  + The autonomy and unique nature of programs as they operate within the system become a strength, not a hindrance.

##### Administrative obstacles and traditional barriers to services are reduced

* + The most vulnerable in our community are prioritized for available housing assistance programs.
  + There is a shift in focus from housing readiness to Housing First principles (please see

**Appendix B** for a description of these principles).

##### Case Managers can concentrate on providing effective case management

* + Every program in a community is sharing the work of intake and entry.

##### Service providers are joined into a more unified network

* + Different programs across a community all follow the same process for entry.
  + Programs are aware of each other and cooperate in the provision of services.

##### Communities readily see what additional resources they need most

* + Many participants with mid-level acuity may signal a need for more rapid re-housing.
  + Many participants with high-level acuity may mean a need for more permanent supportive housing.

##### Community success in ending homelessness is significantly increased

* + Targeting our limited community resources in a more deliberate way leads to quicker and more effective long-term housing outcomes.

## Target Population

The Coordinated Entry System is intended to serve individuals and households currently experiencing literal homelessness, **as defined in accordance with the official HUD definition of this term.**

The CES process is intended to quickly triage people in a housing crisis to available resources. Individuals and households experiencing literal homelessness will enter the system, be assessed, and be referred

to available housing options as quickly as possible.

Individuals and households who are at imminent risk of homelessness will be referred to available community resources to help prevent a homeless episode.

## Requirements

All projects funded through Continuum of Care (CoC) and Emergency Solutions Grant (ESG) sources must participate in the Upstate Continuum of Care’s Coordinated Entry System. To develop a true community-wide response system, we welcome and will continue to invite all housing programs that serve people experiencing homelessness to join the system.

Please reach out to United Housing Connections ([info@uhcsc.org](mailto:info@uhcsc.org)), the lead agency for the Upstate Continuum of Care, if your agency and projects would like to participate

# Coordinated Entry Process

## Basic Process

Coordinated Entry follows this basic process:

#### Access

* + Provide entry points into the homeless crisis response system for housing needs

#### Assess

* + Uniform assessment(s) for all persons requesting assistance:
  + VI-SPDAT assessment to determine prioritization order

#### Assign with Participant-Centered Choice

* + Prioritization of individuals and households for available housing assistance programs.

#### Accountability

* + Acceptance of referrals, adherence to the process, measurement of time, outcomes and needs data

Please see **Appendix C** for a more detailed summary of the Coordinated Entry process for individuals and families.

## Access Points for Housing

***Access points*** are locations where people experiencing homelessness or at risk of becoming homeless go to determine eligibility for housing opportunities across the Continuum of Care.

In the South Carolina Upstate CoC, certain providers and programs may serve as an access point for participants to assist with emergency housing and other service needs. These access points work in partnership with a person’s existing community providers to complete the CES assessment process. Please refer to **Appendix D** for a current list of agencies and programs serving as access points into the Upstate CoC Coordinated Entry System.

Most street outreach teams and emergency shelters in the CoC serve as CES access points. Resources and information about CES are available via homeless service providers, emergency shelters, hospitals, hot meal providers, and homeless outreach efforts. Information about CES is also available via SC 211 – a statewide resource for finding assistance in communities across South Carolina. In addition, each access point is encouraged to explore various outreach activities such as hosting a booth at local community events, resource fairs, festivals, and county fairs to provide information and resources.

Street outreach workers and providers not actively participating in HMIS may refer participants to UHC Intake and Referral staff to complete a VI-SPDAT and be entered into HMIS for consideration for a housing assistance program offer through the community-wide prioritization list.

All persons experiencing literal homelessness – including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence – have fair and equal access to the coordinated entry process, regardless of the location or method by which they first present to the system.

## Common Assessment Process

#### Screening for Diversion and Prevention

Diversion and Prevention occurs when a client presents themselves as not literally homeless or if they would prefer to not participate in CES and would like resources outside of the CES process. When a client has been identified as someone who needs diversion and prevention assistance, the

access point would not conduct an intake or VI-SPDAT but would instead offer the client services and resources in their area as well as SC-211 for additional resources.

#### Shelter and other Emergency needs

Emergency shelters are not required to follow the established prioritization criteria to place persons in emergency or seasonal beds. If the offered prevention and diversion resources do not resolve a person’s need for housing, access point staff should connect the participant to local emergency shelter resources to solve their immediate housing crisis while longer term resources (rapid rehousing, transitional, permanent supportive housing) are explored.

#### Evaluating Vulnerability

The Vulnerability Index and Service Prioritization Decision Assessment Tool (VI‑SPDAT) is the prioritization assessment instrument used by all participating programs for people who enter the homelessness system.

#### Development and Revision of Tools

In collaboration with other Continuums of Care in South Carolina, the Upstate CoC has opted to use the Vulnerability Index and Service Prioritization Decision Assessment Tool (VI‑SPDAT, Version 2.0) as the primary tool for gauging participant vulnerability. The Coordinated Entry Committee solicits formal feedback from providers and participants on an ongoing basis to inform any necessary revisions to use of the VI-SPDAT and/or additional assessment and screening questions.

The VI-SPDAT provides each point of entry the ability to determine – across dimensions – the acuity of an individual or family who is experiencing homelessness.

*Acuity* speaks to the severity of a presenting issue(s). In the case of an evidence-informed common entry tool like the VI-SPDAT, acuity is expressed as a single score with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability. The VI-SPDAT shows the presence of these issues and indicates the potential best fit for housing and service intervention, based on scores across the following dimensions:

* + **Wellness**: Chronic health issues and substance use
  + **Socialization and Daily Functioning**: Meaningful daily activities, social supports and income
  + **History of Housing and Homelessness**: Length of time experiencing homelessness and cumulative incidences of homelessness
  + **Risks**: Crisis, medical, and law enforcement interdictions. Coercion, trauma, and most frequent place the individual has slept
  + **Family Unit** (Family VI-SPDAT Only): School enrollment and attendance, familial interaction, family makeup and childcare

The VI-SPDAT assessment form is located within the CoC HMIS software (WellSky’s ServicePoint) and is accessible to all projects with a user license. Paper copies can also be obtained from the assessment developer’s website (<http://www.orgcode.com/product/vi-spdat/>)..

All assessments completed using the VI-SPDAT are stored in ServicePoint HMIS, building a community - wide prioritization list for housing. When a VI-SPDAT assessment is completed for anyone entering the homeless services system, ServicePoint users can tag the VI-SPDAT to be included in their local prioritization list.

In HMIS, the VI-SPDAT is located as a sub-assessment in the UHC- Upstate CoC Coordinated Entry System entry, which can be opened via the Entry/Exit tab. (Insert screenshot) In order for the VI-SPDAT score to be included on the local prioritization list, ServicePoint users must answer "yes" to the question, "Include client in VI-SPDAT prioritization list?"

Graphical user interface, text

Description automatically generated with medium confidence

A script for conducting the initial CES entry and the VI-SPDAT assessment is included in Appendix E. All information recorded in the UHC-Upstate CoC Coordinated Entry System entry must be saved before navigating away from the entry for the responses and score to be saved within HMIS and attached to the client's record.

Participants have the right to refuse to provide any requested information in the coordinated entry process. However, the access point staff conducting the intake should ensure that the participant understands that incomplete information could result in an inaccurate assessment of the participant’s housing needs and can contribute to a longer wait time for a housing assistance program referral.

The VI-SPDAT should not be administered more than once every six months for the purposes of placement on the housing prioritization list.

Access points should use the Case Notes section of the entry to provide any other knowledge of a client's situation - employment information, access to reliable transportation, location preferences- that may contribute to the referral process but was not already surveyed by the VI-SPDAT. However, be aware that the information you enter in Case Notes will be visible to all HMIS-users across the statewide HMIS implementation.

Graphical user interface, text, application, chat or text message

Description automatically generated

If a participant experiences a change in circumstances that may significantly impact his or her vulnerability score, these changes should be noted in via Interim review in HMIS by the most current service provider:

As the initial point of contact for participants in the coordinated entry system, access points are likely to get questions from participants inquiring about their status on the prioritization list and when they will be referred to housing. In these instances, access points should be able to:

* Check the HMIS to determine if the individual or household has a VI-SPDAT completed within the past six months
  + If yes, communicate to the individual or household that they are current in the system and will be contacted if appropriate housing or services become available
  + If no, work with them to complete a standard intake process and VI-SPDAT assessment
  + If older than 6 months, work the individual/household to complete an update
  + Confirm that the living situation and contact information for the individual/household is current.

***Providers should not communicate the individual’s or household’s number or placement on the prioritization list as this status may change frequently as new assessments are entered into the system****.* To help ensure that placement on the list is not communicated to the client, the detailed and ranked prioritization list will not be shared electronically to any specific individual or agency. If an individual or agency would like to view the prioritization list, it will be viewable in-person at HDC meetings or at other pre-arranged meetings scheduled with the CES Manager present. In all cases, the CES Manager will not share an electronic copy of the detailed prioritization list.

Participants may provide updates on their housing status or change in circumstances to their case manager but do not need to check in to inquire about bed/housing availability or their status on the prioritization list. However, it is strongly recommended that participants notify a participating access point if there are changes to their contact information to ensure that they can be located quickly should the participant be matched with an available housing opportunity. (Please see **Appendix G** for more information about participant rights and responsibilities in the Coordinated Entry process.)

A client’s VI-SPDAT will expire after a period of six months. At that point, the client will be removed from the prioritization list and not be considered for housing resources unless they have another VI- SPDAT in HMIS that has been completed within the past six months. A process has been developed to re-contact clients with expiring VI-SPDATs to understand if they are still in need of housing and, if so, they would like to complete a new VI-SPDAT. To do this, a list of clients whose VI-SPDATs will expire during the next seven days is updated monthly by the CES Manager and Intake Specialist. Assessments conducted by access points familiar with client’s due for renewal may be sent to said access points for renewal in scenarios where client accessibility is limited.

Participants with multiple VI-SPDAT scores over a six-month period are assessed for housing using their most recent VI-SPDAT Score, unless a VI-SPDAT Discrepancy Form has been submitted on behalf of the participant (see **Appendix H**). The VI-SPDAT Discrepancy Form is to be used only when there is reasonable evidence or additional knowledge regarding the individual or household that would impact the VI-SPDAT score (either positively or negatively), potentially changing the category of housing for which the individual or household is recommended. The VI-SPDAT Discrepancy Form is to be completed only by trained CES Access Point staff who understand the scoring mechanism of the tool and can accurately indicate how scoring would be affected by the change in participant circumstances. The individual preparing the VI-SPDAT Discrepancy Form should submit the completed form by 5pm Tuesday and then be prepared to discuss the specifics of their discrepancy form at the Discrepancy Form Meeting/HDC meeting. If the VI-SPDAT Discrepancy Form is accepted, and a modification to the specific client’s VI-SPDAT score is required, the CES Manager/HMIS System Administrator will make the necessary changes within HMIS.

Training is **strongly encouraged** and available from CoC and UHC staff. New access points are expected to receive training prior to completing their first intakes and VI-SPDATs for CES. CES data quality will be monitored by the HMIS Department and remedial training will be assigned when data quality issues arise. We request that each project have a point person to train new project staff who will be completing the VI-SPDAT forms.

## Special Considerations for Persons Fleeing Domestic Violence

Individuals and households who are actively fleeing domestic violence, dating violence, sexual assault, or stalking (henceforth referred to under the general term “domestic violence”) may present at any designated access point for assessment and entry into the Coordinated Entry process. The VI-SPDAT is available in both the main and the DV-dedicated HMIS databases (accessible only to DV service providers) for consistency across the assessment process.

Communications regarding victims of domestic violence should refer to the individual/head of household only by their HMIS identification number, not by name or any other personal identifying information.

When an individual actively fleeing domestic violence presents at a non-victim service organization, the organization should make every effort to connect the individual with a victim’s services provider. The services provided may be shelter, but may also be advocacy, safety planning and peer counseling. If, when an assessment is being conducted, a household is determined to be at imminent risk of harm due to domestic violence, access point staff should (with the household’s permission) immediately connect the household to Domestic Violence Services by calling the local domestic violence hotline (see **Appendix I**) or SC 211 and tending to their immediate transportation and security needs. Defined access points must provide directly – or decide through other means to ensure universal access to

* crisis response services for participants seeking emergency assistance during operating hours.

If it is after hours, the following should occur:

* + People presenting at an emergency shelter are offered a bed in the emergency shelter where they arrived (if they are population-appropriate). If they are not population-appropriate, they are referred to a shelter that is population-appropriate or has available space.
    - If no shelter has available space, the presenting participant is sent to any available crisis housing (churches, hotels, or motels, etc.).
    - If the participant does not initially present at an emergency shelter, he/she is referred to

a population-appropriate one.

* + All physical access points must maintain after-hours answering services that provide information on accessing emergency shelters. The next available day that assessment hours are open, the participant is asked the pre-screening questions and, if needed, referred to a designated access point for assessment.

## Prioritization Process, Criteria and List

For the purposes of coordinated entry, one prioritization list is maintained for the entire CoC. Referrals can be made across chapters based on the availability of services within an area, as well as participant preferences and needs.

A Housing Determination Committee (HDC), comprised of representatives from the identified access point agencies and other housing and service providers, is responsible for reviewing the CoC-wide prioritization list and making referrals to available housing vacancies. Staff and professionals from homeless service providers are invited to participate in the weekly HDC meetings. Expertise from a broad variety of homeless service providers (housing, supportive services, hospitals/mental health) is encouraged. Together, this group coordinates across chapters to match participants on the prioritization list to available housing assistance program opportunities regardless of geography.

To help ensure the confidential nature of the HDC meetings, all attendees who are not active end-users of the Homeless Management Information System (HMIS) will need to sign a confidentiality form (**Appendix I**). This form spells out the attendee’s obligation to keep the information displayed in HMIS and the content of the conversations confidential.

This group coordinates across chapters to match persons on the prioritization list to available housing opportunities regardless of geography. Internal transfers within an agency DO NOT require HDC approval. However, agencies do not have discretion to switch between RRH, TH, and PSH during placement unless the assignment is verified by the Committee.

The HDC has a standing weekly meeting – either in person or via conference call. The committee reviews the priority list and determines the next prioritized and potentially eligible person to be referred to any vacancy. The HDC also reviews any instance where referral is made but does not happen. The client has the right to refuse a referral. Refusing a referral will not impact a client’s eligibility for a future housing referral. In no way will the HDC impose punitive consequences to participants if they choose not to accept a referral. If a referral is not accepted by the client, the provider submitting the vacancy will be responsible for adding an interim note to the client's CES entry, detailing their reason for refusal to help guide future referrals for that specific client.

Agencies and programs with housing vacancies should notify the HDC by electronically submitting a Housing Assistance Vacancy Form (Appendix K) by 5pm Wednesday for consideration at the next HDC meeting. The case manager who submitted the housing vacancy is required to attend the meeting in which referrals are identified. This reduces the likelihood of inappropriate referrals (e.g., if a participant is banned from a particular project or property, or if a participant has previously been deemed ineligible for the offered vacancy). It also allows the case manager to understand the process through which participants are identified and selected for referral. If the receiving case manager is not in attendance, The housing assistance vacancy will not be discussed and will be postponed until the next HDC meeting where case manager is present. consideration of the vacancy will be postponed until the next week’s HDC.

Case managers for participants may attend the weekly prioritization list review meetings to provide additional information to the group but do not have a vote in the group’s final decision for housing interventions and placements. **Under no circumstances is it appropriate for participants on the prioritization list to attend any portion of the weekly HDC meetings.**

Participants are assessed for prioritization in accordance to the U.S. Department of Housing and Urban Development (HUD) prioritization notice for chronic homelessness, consisting of four main criteria:

#### Vulnerability

* 1. **Severity of service needs**

#### Chronic homeless status

* 1. **Length of time homeless**

The Upstate has adopted HUD CPD Notice 16-11 along with the Final Rule on Defining “Chronically Homeless”. As such, the HDC is permitted to move to the next level of vulnerability in the event no persons meeting all eligibility criteria to qualify as chronically homeless are identified at the time of a vacancy.

In the event a participant scores for PSH but no such resource is available, the HDC may offer Rapid Rehousing or targeted Transitional Housing to quickly move the participant from homelessness until an appropriate PSH opportunity becomes available. Using case conferencing, the HDC will make such referrals based on current inventory of resources. In such cases the participant would remain active on the prioritization list for consideration for PSH.

In instances that a participant scores for PSH but is not deemed chronic (either because they do not have length of time homeless or do not have a qualifying disability), HDC may opt to offer Rapid Re- housing or targeted Transitional Housing, based on the provider’s ability to meet the participant’s assessed level of need.

Figure 1 (see next page) documents the sequence of prioritization criteria by program type.

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**Figure 1: Upstate CoC Coordinated Entry System Prioritization Criteria for Specific Housing Types**

#### PERMANENT SUPPORTIVE HOUSING (PSH)

PSH unit becomes available

**↘**Determine number of Bedrooms in PSH unit

**↘**Determine all Chronically Homeless that need same Bedroom size for unit available

**↘**Determine who of those Chronically Homeless have qualifying disability type (if applicable)

**↘**Determine who of those Chronically Homeless has the highest VI-SPDAT score

**↘**Longest Length of Homelessness

↘Fewest Number of Homeless Episodes

↘Oldest VI-SPDAT within 6-month period

#### TRANSITIONAL HOUSING (TH)

TH unit becomes available

**↘**Determine number of Bedrooms in TH unit

**↘**Determine highest VI-SPDAT score in Range (4-7) individuals (4-11) families - that need same Bedroom size for unit available

**↘**Longest Length of Homelessness

↘Fewest Number of Homeless Episodes

↘Those That Have a Disability

↘Oldest VI-SPDAT within 6-month period

#### RAPID REHOUSING (RRH)

RRH funds become available to support rental assistance

**↘**Determine highest VI-SPDAT score in Range (4-7) individuals (4-11) families

**↘**Longest Length of Homelessness

↘Fewest Number of Homeless Episodes

↘Those That Have a Disability

↘Oldest VI-SPDAT within 6-month period

## Referrals and Resources

Making a referral is the process by which a participant is placed into housing. Participant choice should be at the center of any referral and placement, with the participant fully understanding the next steps in their journey toward stable housing.

In the interest of fairness to all participants, and to maximize utilization rates for the limited local housing inventory, beds/units are held a maximum of seven (7) days after the Housing Determination Committee has identified an appropriate participant for that housing intervention. This does *not* mean the placement is completed in that time. It means that those being offered have been contacted and their intent regarding the resource is known. At the same time as reaching out to the offer, **every back- up will be contacted** per the prioritization list. Every outcome of these contacts (both offer and back- ups) will be recorded as an interim note on the client’s CES Entry. In either instance, both the offer and the back-ups will be informed as outlined in the “Offering a resource” document **Appendix L** or “Back-Up for a resource” document **Appendix M.**

If the participant offered cannot accept the referral within seven days (either through direct refusal or cannot be contacted), the participant’s name is returned to the prioritization list and the bed/unit is offered to the next appropriate participant identified as a back-up referral.

A referral from HDC shall be considered “in process” only if contact has been made directly to the participant AND they have accepted the offer but are getting paperwork, they have accepted the offer but are looking for a unit or they have accepted the offer and are awaiting property management approval. In those instances, the placing agency must give an update for every HDC meeting. Waiting to hear back, waiting for an answer to a voice mail, attempting to locate the participant etc. is NOT considered to be “in process.” Resources therefore return to HDC next meeting.

All participants identified as referrals or approved as back-ups in the HDC meetings are documented (See Coordinated Entry Event Documentation section below) discussed in the case management portion of HDC meetings are also documented. Meeting minutes are circulated to the HDC members and agencies that have housing vacancies by next business day. Hard copies of the minutes are kept on site at UHC offices.

HDC recognizes the value of “organic” relationships that participants may have with service providers and other members of their community. Provided the individual / head of household is next on the prioritization list, HDC will make all efforts to offer participants housing opportunities in their current geography in an effort to keep those relationships intact.

There is no limit to the number of times that a participant or household may decline a referral. Should a participant decline a referral, their name remains on the prioritization list and the HDC offers the available bed/unit to the next appropriate participant on the prioritization list. The original participant is

given equal consideration when the next bed/unit becomes available but cannot be guaranteed top priority based on vulnerability scores. If a participant declines a resource because of desiring housing in a different area/county, they will be informed that limiting their geographical preference for Housing assistance may reduce their number of potential housing assistance opportunities. Also, it should be communicated that if their geographical housing preferences change at any time, they can contact any access point to update their information in HMIS.

Individual housing providers participating in the coordinated entry process have the discretion to determine their own guidelines for addressing participants that do not follow through with referred appointments to a program. However, these guidelines should be clearly established and communicated both to participants and to the Coordinated Entry Committee so that all cases are handled consistently and fairly.

#### Coordinated Entry Event Documentation

For efficiency and accurate record-keeping, offers and back-up offers designated by the Housing Determination Committee are recorded in HMIS on a week-by-week basis by the CES Manager. This allows for systematic recording of who has been prioritized for housing, what the outcome of that prioritization was, and if relevant, more information about why a housing opportunity was declined or why a client was found to be ineligible for a specific vacancy.

Within the “Coordinated Entry Event Documentation” section, we record the following information:

* + 1. The date the HDC prioritized a client for a specific housing vacancy
    2. The type of prioritization the client received (primary offer or back-up)
    3. The vacancy - agency and name of the project
    4. The county where the vacancy is located
    5. The date the client was contacted by the case manager
    6. The outcome of the offer
    7. (Via Interim Note) The reason the client declined the housing vacancy – specific reason and text box
    8. (Via Interim Note) The reasons why the client was ineligible – specific reason(s) and text box

**Grievances**

There may be rare instances in which programs decide not to accept a referral from the coordinated entry process. Refusals are acceptable only in certain situations, including but not limited to:

* The person does not meet the program’s established eligibility criteria.
* The person would be a danger to themselves or others if allowed to remain in a particular program.
* The person has previously caused serious conflicts within the program (e.g., was violent toward another participant or program staff)

If the program determines that a participant is not eligible for their program after receiving a referral from the coordinated entry process, the participant should be returned to the HDC to determine the best next housing option for the participant. Any cases that are unable to be resolved to the participant’s satisfaction will be referred to the CoC’s Coordinated Entry Committee to be addressed as soon as possible. Any program that is consistently refusing referrals without appropriate reason will be called to meet with the Coordinated Entry Committee to discuss the issue that is causing the refusals. Any denials for eligibility reasons will be documented via interim notes in. HMIS and the local Housing Determination Committee will update eligibility criteria charts as necessary based on this information.

#### Provider Grievances

Providers should address any concerns about the coordinated entry process to the CoC’s Coordinated Entry Committee, unless they believe a participant is being put in immediate or life-threatening danger, in which case they should deal with the situation immediately. A summary of concerns should be provided via email to the chair of the Coordinated Entry Committee. The chair of the committee should then arrange for a representative of that provider to attend the next scheduled monthly Coordinated Entry Committee meeting so the issue can be presented and discussed, and a resolution proposed. If the issue requires more immediate resolution, the chair will be responsible for determining the best of course of action to address the issue. ***Grievances will not be presented or discussed during the weekly HDC meetings.***

#### Participant Grievances

The assessment staff member or assessment staff supervisor should address any participant grievances as best they can as they arise. Grievances that should be addressed directly by the assessment staff include grievances about how the participant was treated by assessment/program staff, assessment center conditions or violation of confidentiality agreements. Any other grievances should be referred to the chair of the Coordinated Entry Committee via email to be addressed in a process like the one described above for providers. Any grievances filed by a participant should note their name and contact information so that the committee chair may contact them and ask them to appear before the committee to discuss the issues of concern.

## Next Steps for Coordinated Entry

* + Continue weekly Housing Determination Committee meetings to focus on literally homeless (not doubled up)
  + Continue Technical Assistance as needed
  + Adjust access points as needed
  + Develop Memorandum of Understanding (MOU) for coordinated entry and participating agencies, regardless of participation in HMIS
  + Offer further trainings on using the VI-SPDAT, Priority List, and Eligibility Module in ServicePoint as needed
  + Develop tools to assess and evaluate the process including regular feedback meetings
  + Adjust policy and procedure (minor changes or clarification only) as needed

## Appendix A: Glossary of Terms

* + **Provider:** Organization that provides Housing assistance programs or services to people experiencing literal homelessness as defined by HUD.
  + **Program:** A specific set of services or a housing intervention offered by a provider.
  + **Participant:** People experiencing literal homelessness as defined by HUD being served by the coordinated entry process.
  + **Housing interventions**: Programs and subsidies that allow participants to become sheltered; these include transitional housing, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs.

## Appendix B: Housing First Principles

Housing First is an approach to connect individuals and families experiencing homelessness quickly and successfully 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 prior to permanent housing entry.

Housing First yields higher housing retention rates and lower returns to homelessness, and significantly reduces the use of crisis services and institutions.

The key principles of this approach to housing are:

* + Safe and affordable housing
  + All people can achieve housing stability in permanent housing, but the supports may look different
  + Everyone is “housing ready”
  + Improved quality of life, health, mental health and employment can be achieved through housing
  + Right to determination, dignity, and respect
  + Configuration of housing and services are based on participants’ needs and preferences.

## Appendix C: Coordinated Entry Process for Individuals and Families

* 1. Individual or family requests housing assistance in-person or by phone through 211, emergency shelter, street outreach teams, or other service organization
  2. Access point staff completes basic screening questions to divert and prevent homelessness, if possible, and gathers basic information needed to make initial crisis services referral
  3. Diverted if another option exists (friends, family, other housing situations)
  4. If client is determined to be experiencing literal homelessness, VI-SPDAT assessment... assessment completed at shelter, service organization, or by outreach worker and entered into HMIS
  5. CES Manager generates the local prioritization list from HMIS to determine next eligible households for rapid placement into housing
     1. Based upon participant choice, participant is referred based upon chronic homeless status, acuity/vulnerability score, veteran status, street/shelter status, income status, and program eligibility with the following recommendations by VI- SPDAT score:
        1. Permanent Supportive Housing/Housing First
           + 8 or above Individuals 12 or above Families
        2. Rapid Re-Housing or Transitional Housing
           + 4-7 Individuals (4-11) Families
        3. No Housing Support Recommendation (Diversion)
           + 0-3
  6. Program receiving referred participant completes offer process within seven (7) days
  7. Participant moves into housing or is rereferred to Coordinated Entry if eligibility requirements were not met.
  8. Case management and other services are offered to participant to help household find path to stability

## Appendix D: Access Points into the Upstate CES

|  |  |  |
| --- | --- | --- |
| **County** | **Program** | **Phone Number** |
| **Abbeville** | Alston Wilkes Society – Veterans Services  Meg’s House – Domestic Violence Services  UHC Intake and Referral | (864) 942-8726  (864) 227-1890  (864) 241-0462 |
| **Anderson** | Alston Wilkes Society – Veterans Services  Safe Harbor – Domestic Violence Services  UHC Intake and Referral | (864) 760-8072  (864) 467-1177  (864) 241-0462 |
| **Cherokee** | UHC Intake and Referral  United Way of the Piedmont | (864) 241- 0462  (864) 582-7556 |
| **Edgefield** | Meg’s House – Domestic Violence Services  UHC Intake and Referral | (864) 227-1890  (864) 241- 0462 |
| **Greenville** | Alston Wilkes Society – Veterans Services  First Impression of South Carolina  Greenville Mental Health Center  New Horizons Family Health Services  Pendleton Place- Youth Services  Safe Harbor – Domestic Violence Services  Salvation Army  SHARE  UHC Intake and Referral  United Ministries | (864) 242-0808  (864) 520-1500  (864) 241-1040  (864) 729-8330  (864) 467-3650  (864) 467-1177  (864) 235-4803  (864) 269-0700  (864) 241-0462  (864) 232-6463 |
| **Greenwood** | Alston Wilkes Society – Veterans Services  Meg’s House – Domestic Violence Services  Pathway House  UHC Intake and Referral | (864) 942-8726  (864)227-1890  (864) 223-4460  (864) 241-0462 |
| **Laurens** | Laurens Safe Homes – Domestic Violence Services  UHC Intake and Referral | (864) 682-7270  (864) 241-0462 |
| **McCormick** | Meg’s House – Domestic Violence Services  UHC Intake and Referral | (864) 227-1890  (864) 241-0462 |
| **Oconee** | Our Daily Rest  UHC Intake and Referral | (864) 482-2040  (864) 241-0462 |
| **Pickens** | UHC Intake and Referral | (864) 241-0462 |
| **Saluda** | Alston Wilkes Society – Veterans Services  Meg’s House – Domestic Violence Services  UHC Intake and Referral | (864) 242-0808  (864) 227-1890  (864) 241-0462 |
| **Spartanburg** | Spartanburg Opportunity Center  The Haven  UHC Intake and Referral | (864) 384-4131  (864) 582-6737  (864) 241-0462 |
| **Union** | UHC Intake and Referral | (864) 241-0462 |

**Appendix E: Access Point’s Conversation Guide for Intake Assessment**

This guide is intended to be used after a client has been determined to be experiencing literal homelessness per HUD definition.

The main purpose of the Conversation Guide is to ensure that all CES clients are receiving standardized and realistic information about how CES can provide them with the tools needed to help resolve their situation of literal homelessness.

**Initial conversation:**

*[Introduce your agency, inform client that housing assistance is available and that you will be providing them with more information to gauge their interest.]*

“This housing assistance program is funded by HUD, and to be eligible, you must currently be in a situation of literal homelessness, which- in accordance with the official HUD definition of this term- would be living on the streets, in an emergency shelter, or in a place not meant for habitation, such as a car or an abandoned building. Since you are \_\_\_\_\_\*client’s current living situation\*\_\_\_\_\_\_, you would meet those eligibility requirements at this time.

The first thing we’ll need to do is conduct an Intake Assessment, which is just a conversation over the phone and a chance to ask you some more questions about your circumstances. After we complete that assessment, you’ll be an active client in our housing needs database.

Once a week, \_\_\_\_\*your agency name\*\_\_\_\_ meets with other service providers across the Upstate. We discuss funding availability and refer clients from the database to housing assistance programs.

Due to the current number of clients in our database and limited funding availability, I cannot provide a definitive timeline as to when we will be able to refer you to housing assistance. It can take anywhere from a couple months or even years.

Once we can refer you to a service provider for housing assistance, they will be able to tell you more specifically about the program. All our programs offer clients temporarily subsidized rent- some are short term and other continue longer for special populations. Our most common program is called Rapid Rehousing.

With Rapid Rehousing, you- as the client- will be responsible for finding a place to rent. So, you will have to search for apartments within your financial means and get approved to move in. Once you have an apartment lined up, the service provider will help get you moved in and set up with utilities. The program will then subsidize your rent for a limited timeframe based on your current needs and income level.

I know that was a lot of information, but in summary, I cannot determine how long it would be before we refer you to assistance, but when we do, you will be responsible for finding a place to rent before a service provider will temporarily subsidize your rent. Did you have any questions about the program?”

**If a client is interested and would like to proceed:**

“Our Intake Assessment takes about 15-20 minutes, and I will need the Date of Birth and Social Security number for yourself and any other members of your household. The rest of the assessment is a questionnaire. I can do that assessment for you now, or I can schedule another time to call.”

**Before conducting an Intake Assessment:**

“On our Intake Assessment, some of the questions are more personal or sensitive information. However, the information that you share with us is stored in a secure database and is only visible to \_\_\_\_\_\_\*your agency name\*\_\_\_\_\_\_\_ and other homeless service providers. Also, we encourage clients to be honest in their responses, as there is nothing that could prohibit you from our assistance in any way—however, some responses may alter where you can be assisted. Are you comfortable to proceed?”

**After conducting an Intake Assessment:**

**“**Alright, that is all the information that I need from you today, and you are now an active client in our database. From here, you will be contacted when we are able to refer you to housing assistance program with one of our service providers. Please know that that call might come from someone other than myself. They will want to meet with you in person, and they will need to see your government-issued photo ID, your birth certificate, and your social security card. If you do not have those, I encourage you to work on replacing them. You must also still be in a situation of literal homelessness at the time of referral to be eligible. You will also need a letter from an unrelated third-party that can verify that you have been experiencing literal homelessness. Did you have any questions for me today?

Later today, I’ll be sending you an email that recaps all this information. I also wanted to let you know that the assessment we conducted today has a 6-month lifespan, and if you are still experiencing literal homelessness, we will need to be in contact to renew this assessment in 6 months. But, if you ever have any questions for me, of if anything changes about your living situation, income, or- most importantly- your contact information, please just let me know. Thank you very much for your time.”

\*\* Be sure to send standardized email (See Appendix F) that recaps eligibility, wait time, and client responsibilities\*\*

**Appendix F: Post Assessment Email**

The Post-Assessment Email should be sent to all CES clients who have access to email after completing their initial intake. This email is intended to be a summary of the CES process that clients can easily look back on to refresh their memory. It also provides clients with contact information for any questions, a reminder about renewing their assessment, and community resources for replacing personal documentation. Additional resources may be added to this standard message, but all CES clients who have access to email should receive the message below.

Hello, this is \_\_\_\_\* provider’s name and organization\*\_\_\_\_.

I am reaching out because on \_\_\_\_\_\*date of Intake Assessment\*\_\_\_\_\_\_, you and I completed an Intake Assessment to enroll you in our housing assistance program. This program is funded by HUD and is for people who are currently in a situation of literal homelessness (living on the streets, in an emergency shelter, or in a place not meant for habitation, such as a car or an abandoned building, or fleeing domestic violence.)

Now that we have conducted your assessment, you are in our housing needs database and will be contacted once we are able to refer you to housing assistance. I cannot provide a definitive timeline for this process- it can take anywhere from a couple of months to even years. It’s highly recommended that you explore other opportunities for housing due to the potential wait time for receiving a housing assistance referral.

When we do refer you to a service provider for housing assistance, they will be giving you call. If at any time your contact information changes, please let me know. At the time of the call, the service provider will be able to give you more information about the type of assistance and talk to you about the next steps to take. However, with our most common program (Rapid Rehousing), you will then be responsible for finding a place to rent that works with your financial means. So, while you are waiting to be referred to assistance, I encourage you to familiarize yourself with the counties that you mentioned that you were interested in living in, collect information about affordable rentals, secure transportation if needed, and search for employment or apply for disability benefits if you do not have a stable source of income.

At the time of referral, we will need to verify that you are still experiencing literal homeless or actively fleeing domestic violence. You will also need to provide personal documentation (photo ID, birth certificate, social security card) and a letter from an unrelated third party that can verify your situation of homelessness (such as a letter of residency from a shelter or a note from your doctor or counselor).

If you have any questions about this program, please reach out to me at \_\_\_\_\*contact information\*\_\_\_\_ or you can also contact an Intake Specialist with United Housing Connections at 864-241-0462. It will help your case if you keep me up to date with any changes in your income, your preferred counties for assistance, or your contact information. We will also need to be in contact 6 months from now if you are not housed by then, as the assessment we completed has a 6-month lifespan.

**Key Points to Remember:**

* This program is not emergency or immediate assistance. You will be referred to the housing assistance that best addresses your indicated needs, but the timeframe is based on the availability of federal funds.
* This is not a wait list for an apartment. When we refer you to assistance, you will most likely be responsible for finding a place to rent before your rent will be temporarily subsidized.
* You would no longer be eligible for this assistance if you move into permanent housing, or staying with family or friends, or are paying for a hotel.
* We will need to renew your assessment in 6 months if you are not housed by then.

**Resources for Replacing Personal Documentation**

* <https://www.vitalrecordsgov.com/>
* <https://www.ssa.gov/ssnumber/>
* If you are experiencing literal homelessness, you may be eligible for financial assistance with replacing your documentation.
  + Greenville County: United Ministries Place of Hope 864-232-6463
  + Anderson County: HOPE Missions 864-359-2396

## Appendix G: Participant Rights and Responsibilities

**Participants Rights and Responsibilities**

### As a participant in coordinated entry, you have the right…

* To be treated with respect, dignity, consideration, and compassion.
* To receive services free of discrimination based on race, color, sex/gender, ethnicity, national origin, religion, age, sexual orientation, physical or mental ability.
* To be informed about services and options available to you.
* To withdraw your voluntary consent to participate in coordinated entry (doing so will exclude you from access to some housing programs).
* To have your personal information treated confidentially.
* To have information released only in the following circumstances:
  + When you provide verbal or written consent for release of information.
  + When a clear and immediate danger to you or others exists.
  + When there is possible child or elder abuse.
  + When ordered by a court of law.
* To file a grievance about services you are receiving or denial of services.
* To not be subjected to physical, sexual, verbal, and/or emotional abuse or threats.

### As a participant in Coordinated Entry you have the responsibility …

* To treat other participants and staff in the Continuum of Care with respect and courtesy.
* To actively participate in obtaining documents, searching for appropriate housing, and other actions necessary to obtain permanent housing.
* To let your case manager know any concerns you have about the process or changes in your needs.
* To make and keep appointments to the best of your ability, or if not possible, to phone to cancel or change an appointment time.
* To stay in communication with your case manager by informing him/her of changes in your location or phone number and responding to the case manager’s calls, letters or emails to the best of your ability.
* Logo, company name

  Description automatically generatedTo not subject agency case managers, staff, or other clients to physical, sexual, verbal, and/or emotional abuse or threats.

## What you will need to do…….

**If you feel you have been discriminated against during the housing process…**

If you feel that you have been discriminated against under the Federal Fair Housing Act such as Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act of 1964, Section 109 of the Housing and Community Development Act, or the Age Discrimination Act of 1975, among others, you may file a grievance with the South Carolina Human Affairs Commission by calling (803) 737-7800.

**If you would like to file a grievance about the Coordinated Entry Process…**

If you feel you have been treated unfairly in the coordinated entry process and would like to file a grievance:

Please submit your complaint in writing within 30 days of the event to:

Coordinated Entry Systems Manager United Housing Connections

135 Edinburgh Court

Greenville, SC 29607

- or -

<https://www.cognitoforms.com/unitedhousingconnections1/cesgrievance>

**If you would like to revoke your HMIS consent…**

The intention and purpose of collecting and sharing participant information is to help HMIS Partner Agencies is to better understand and assist the needs of persons experiencing homelessness, and to produce non-identifying, aggregate reports to the federal government that can be used to track the program performance of these agencies. This authorization will remain in effect for a period of up to 7 years or until a participant revokes it in writing. A participant may revoke authorization at any time by returning to any previously visited HMIS Partner Agency and signing a new consent form using the “I do not agree” option. If a participant revokes authorization or this authorization expires, all information about the participant already in the database will remain to retain usage history; however, it will be inactive and not updated. Participants should further understand that any revocation of this consent will not affect the waiver of confidentiality as to information already disclosed.

## Appendix H: VI-SPDAT Discrepancy Form

The VI-SPDAT Discrepancy Form is to be completed when there is reasonable evidence or additional knowledge regarding a participant that would impact their VI-SPDAT score if the participant had fully disclosed or had the insight to provide such information during their initial assessment. This form can be found online at the link provided and is to be completed only by trained CES Access Point staff.

VI-SPDAT Discrepancy Form: <https://www.cognitoforms.com/UnitedHousingConnections1/discrepancyform>

This form must be submitted no later than 5pm Tuesday to be considered the following Thursday during a scheduled meeting with the Coordinated Entry Systems Manager.

## Appendix I: Local Domestic Violence Hotlines

|  |  |  |
| --- | --- | --- |
| **Agency** | **Phone** | **Areas Served** |
| South Carolina Office of Victim  Assistance (SOVA) | 1-800-220-5370 | Statewide |
| Laurens County Safe Home | 1-866-598-5932 or 864-682-7270 | Abbeville, Laurens, Saluda  counties |
| MEG’s House | (864) 227-1890 | Edgefield, McCormick,  Greenwood counties |
| Safe Harbor | 1-800-291-2139, option “1” | Anderson, Greenville, Oconee,  Pickens counties |
| Project R.E.S. T | 1-800-273-5066  (864) 583-9803 | Cherokee, Spartanburg, Union  counties |

**Logo, company name

Description automatically generatedAppendix J: Housing Determination Committee Confidentiality Agreement for Non-HMIS Users**

# CONFIDENTIALITY AGREEMENT

## for Upstate CoC Housing Determination Committee

***Non-HMIS Personnel attending the Upstate CoC Housing Determination Committee meetings are required to sign this agreement. Meeting attendees agree to protect anonymity and any other information about prioritization list participants (name, Social Security number, service history, disability status, etc.) that may be obtained when participating in the case conferencing discussion pertaining to housing offers.***

I, \_, acknowledge that as a staff member of

*(print name)*

in my attendance at the Upstate CoC Housing

*(name of agency)*

Determination Committee meeting, am aware of the legal necessity of protecting the privacy and confidentiality of each participant/client. I am either aware of or have been advised that in accordance with Federal confidentiality rules for HMIS implementation (24 CFR Part 580), I agree not to disclose any information learned or observed during my attendance to any third parties or persons outside the meeting. I am subject to the penalties of any breach of confidentiality, including but not limited to suspension from future Housing Determination Committee meetings.

\_

Meeting Attendee Signature Date

\_

HDC Chair Signature Date

## Appendix K: Housing Assistance Vacancy Form

**Upstate Coordinated Entry System – Housing Vacancy Form**

Agencies and programs with housing assistance vacancies should notify the HDC by electronically submitting a completed Vacancy Form, which can be found in the link provided.

Housing Assistance Vacancy Form: <https://www.cognitoforms.com/UnitedHousingConnections1/hdcvacancyform>

This form must be submitted no later than 5pm Wednesday for the vacancy to be considered at the next HDC meeting.

**Updates from Housing Determination Committee**

This form will be used for any updates to or from HDC. Providers will use the form below to submit updates on outcomes from HDC and for clients who are housed. Providers will need to fill out multiple forms if there are updates on multiple clients. The "Client was Housed?" question will determine what questions will show. If no client was housed and you are only submitting updates on referrals, you will select "No" and answer the required questions. If a client was housed through your program, you will select "Yes" and answer the required questions.

<https://www.cognitoforms.com/UnitedHousingConnections1/UpdatesFromHDC>

## Appendix L: Script for Offering a Housing Resource

##### PERSON ANSWERS:

My name is and I am calling from *(agency)*. May I speak with please?

I am calling because the Upstate Housing Determination Committee has referred you for a housing opportunity that you might be interested in. They would like to offer you *(pick one):*

* 1. Permanent Housing in *(county)*
  2. Transitional Housing in *(county)*
  3. Rapid Rehousing which can help you secure permanent housing in *(county or counties)*

If you are interested, let’s set up a time to meet. Are you able to meet with me?

Time Date Location

Do you have a way to get to that meeting?

If you are interested, you would need to get your photo ID or birth certificate, Social Security card, something that shows where you have been staying and proof of a disability (if you have one).

Again my name is and my phone # is .

If you have questions or concerns, or if you are not able to make our appointment for any reason, please contact me right away. I look forward to seeing you then.

##### VOICEMAIL:

My name is and I am calling from *(agency)*. I am calling to speak with .

I am calling because the Upstate Housing Determination Committee has referred you for a housing opportunity that you might be interested in. They would like to offer you *(pick one):*

1. Permanent Housing in *(county)*
2. Transitional Housing in *(county)*
3. Rapid Rehousing which can help you secure permanent housing in *(county or counties)*

Please call me as soon as you get this message at *(phone number)* so I can tell you more.

Again my name is and my phone # is . I look forward to speaking with you soon.

## Appendix M: Script for Contacting a Backup for a Housing Resource

##### PERSON ANSWERS:

My name is and I am calling from *(agency)*. May I speak with please?

I am calling because the Upstate Housing Determination Committee has referred you for a **possible**

housing opportunity that you might be interested in. They would like to offer you *(pick one):*

1. Permanent Housing in *(county)*
2. Transitional Housing in *(county)*
3. Rapid Rehousing which can help you secure permanent housing in *(county or counties)*

This housing has also been offered to someone else, and they will get the first chance to accept or decline the offer. If they do not accept, is this a housing opportunity that you would be interested in?

If you are interested, you would need to get your photo ID or birth certificate, Social Security card, something that shows where you have been staying and proof of a disability (if you have one).

Again my name is and my phone # is . I will be back in touch within 3 days to let you know what happened.

If you have questions or concerns, or if you are not able to make our appointment for any reason, please contact me right away. I look forward to seeing you then.

##### VOICEMAIL:

My name is and I am calling from *(agency)*. I am calling to speak with .

I am calling because the Upstate Housing Determination Committee has referred you for a **possible**

housing opportunity that you might be interested in. They would like to offer you *(pick one):*

1. Permanent Housing in *(county)*
2. Transitional Housing in *(county)*
3. Rapid Rehousing which can help you secure permanent housing in *(county or counties)*

Please call me as soon as you get this message at *(phone number)* so I can tell you more.

Again my name is and my phone # is . I look forward to speaking with you soon.