



# ATLANTA HOMELESS CONTINUUM-OF-CARE

Policies and Procedures Manual for Coordinated  
Entry

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## Introduction

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Provisions in the CoC Program interim rule at 24 CFR 578.7(a)(8) require that CoCs establish a Centralized or Coordinated Assessment System. In accordance with this interim rule, the City of Atlanta (City) and the Atlanta Homeless Continuum of Care (CoC) have developed the following policies and procedures for Coordinated Entry. These standards will apply to all projects that receive Atlanta Continuum of Care (CoC) and Emergency Solutions Grants (ESG).

The goal of coordinated entry is to ensure those experiencing homelessness or those at risk of experiencing homelessness are matched with services, interventions, and housing in the most efficient and effective ways possible. In accordance with the HEARTH Act, the Atlanta Homeless Continuum of Care will adopt policies and procedures that include:

- A standardized access and assessment process for all people experiencing homelessness or are vulnerable to the effects of homelessness.
- A coordinated referral process for clients to receive service linkage, prevention services, housing, and/or other related homeless services.
- Program uniformity and common client expectations
- Policies and procedures for determining and prioritizing clients who are eligible for permanent supportive housing assistance
- Policies and procedures for determining and prioritizing clients who are eligible for rapid rehousing assistance and/or other permanent supportive housing placement options.

## Definitions

The following terms will be used throughout this manual:

### **Chronically Homeless (HUD Definition)**

- (1) An individual who:
  - i. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
  - ii. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 1 year or on at least four separate occasions in the last 3 years; and
  - iii. Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.
- (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) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

**Disability (HUD Definition):** A Physical, Mental or Emotional Impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that is expected to be long-continuing or of indefinite duration, substantially impedes the individual's ability to live independently, and could be improved by the provision of more suitable housing conditions; includes:

**Developmental Disability** Defined in §102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 USC 15002). Means a severe, chronic disability that is attributable to a mental or physical impairment or combination AND is manifested before age 22 AND is likely to continue indefinitely AND reflects need for a combination and sequence of special, interdisciplinary, or generic services, individualized supports, or other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated. An individual may be considered to have a developmental disability without meeting three or more of the criteria listed previously, if individual is 9 years old or younger AND has a substantial developmental delay or specific congenital or acquired condition AND without services and supports, has a high probability of meeting those criteria later in life.

**HIV/AIDS Criteria** Includes 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).

**Literally Homeless (HUD Homeless Definition Category 1):**

- (1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
- (i) Has a primary nighttime residence that is a public or private place not meant for human habitation;
  - (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
  - (iii) Is exiting an institution where

**At imminent risk of homelessness (HUD Homeless Definition Category 2)**

- (1) Individual or family who will imminently lose their primary nighttime residence, provided that:
- (i) Residence will be lost within 14 days of the date of application for homeless assistance;
  - (ii) No subsequent residence has been identified; and
  - (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing

**Homeless under other Federal statutes (HUD Homeless Definition Category 3)**

- (1) Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
- (i) Are defined as homeless under the other listed federal statutes;
  - (ii) have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance; (iii) Have experienced persistent instability as measured by two moves or more during the 60- day period immediately preceding the date of applying for homeless assistance; and

(iv) can be expected to continue in such status for an extended period of time due to special needs or barriers

**Fleeing domestic abuse or violence (HUD Homeless Definition Category 4)**

- (1) Any individual or family who:
  - (i) Is fleeing, or is attempting to flee, domestic violence;
  - (ii) Has no other residence; and
  - (iii) Lacks the resources or support networks to obtain other permanent housing

**VI-SPDAT:**

A combination of two tools – the Vulnerability Index (VI) survey created by Community Solutions for use in street outreach, which helps to determine the chronicity and medical vulnerability of homeless persons, and the Service Prioritization Decision Assistance Tool (SPDAT). This is the tool that will be used to prioritize homeless populations by a numbered score. The Atlanta CoC will adopt the 2.0 version of the VI-SPDAT as part of the coordinated entry system.

**VI-SPDAT Scoring Criteria:**

Each person experiencing literal homelessness is assessed with the VI-SPDAT as a way to determine their vulnerability. A chronically homeless individual or family scoring an 8 or higher is eligible for Permanent Supportive Housing. A non-chronically homeless individual or family scoring between 3-7 is considered for rapid rehousing. After the initial assessment, an individual is placed on the housing queue and prioritized based on their VI-SPDAT score. Clients scoring higher than 8 who are not chronically homeless will be placed on the housing queue and be screened for rapid rehousing once a vacancy becomes available

**Permanent Supportive Housing (PSH):**

Provides permanent housing and support services to individuals and families with a disability, prioritizing those who are chronically homeless. The program is designed to reintegrate this highly vulnerable population into the community by addressing their basic needs for housing and providing ongoing support.

**Rapid Rehousing (RRH):**

Provides an immediate permanent housing situation for moderately vulnerable individuals. Common types of Rapid Re-Housing include HUD CoC Rapid Re-Housing for Families with Children, Emergency Solutions Grant funded Rapid Re-Housing (ESG), and Supportive Services for Veteran Families (SSVF)

**Homeless Management Information System (HMIS):**

A Homeless Management Information System (HMIS) is a database used to record and track client-level information on the service needs and demographic information of homeless persons throughout the Atlanta CoC.

The Georgia Department of Community Affairs as the lead agency, has selected Client Track at the HMIS system the Atlanta CoC will use. Each agency that participates in coordinated entry is required to utilize Client Track and also adhere to the guidelines for data management to maintain privacy and accuracy.

## Clear Path:

The City of Atlanta's Coordinated Entry System.

## Coordinated Entry Overview

The Atlanta Homeless Continuum of Care's coordinated entry process is designed to be able to help homeless individuals and family's access services and housing resources no matter where or how they present. Through coordinated entry, long wait times for access to resources and homeless individuals and families being screened out for services are eliminated. Coordinated entry processes prioritizes assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. The gaps in homeless service needs are identified and filled with necessary resources through coordinated entry..

The Atlanta CoC Coordinated Entry system includes the following:

- **A uniform and standard Assessment Process.** The VI-SPDAT is used to give each client a vulnerability score that is used in determining prioritization for permanent supportive housing (PSH) and Rapid Rehousing (RRH) as well as shelter and transitional housing
- **Housing Queue.** Homeless families and individuals are recorded on the housing queue in the order of their vulnerability score to prioritize housing.
- **Coordinated Access Point.** Clients throughout our community have access to a stationary access point that is open to homeless individuals and families in need of housing and/or services.
- **Mobile Access Points.** For those unable to visit the stationary access point, outreach workers in the community have access to the VI-SPDAT assessment and the option to submit the clients' information into the housing queue.

## Housing First

Housing First is an approach that offers permanent housing as quickly as possible for people experiencing homelessness. The approach begins with an immediate focus on helping individuals and families get housing. Income, sobriety and/or participation in treatment or other services are not required as a condition for getting housing. All services are voluntary and are not a condition for retaining housing. Housing provides people with a foundation from which they can pursue goals. Tenants are assisted in developing or improving skills for independent living while they live in permanent housing instead of requiring them to complete a transitional residential program first.

Housing First permanent supportive housing programs often work to minimize barriers to housing access by simplifying the application process for housing or subsidies. Housing First programs work to "screen in" people with significant challenges who might be screened out of housing because of poor credit or prior evictions. If the program uses

tenant-based rent subsidies, assistance is provided to help people locate a rental unit and negotiate lease agreements with landlords.

The following requirements are NOT part of the Housing First approach:

- Sobriety and/or commitment to be drug free
- Requirement to take medication if the client has a mental health diagnosis
- Participation in drug treatment services (including NA/AA)
- Marriage license

Coordinated Access Points provide low barrier access to all housing interventions including PSH, RRH, and interim housing options.

## Coordinated Access Points

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Homeless individuals and families have access to Clear Path (Coordinated Entry) through multiple access points, stationary points and outreach teams. Assessors are trained in the coordinated entry process and the utilization of the assessment tool. All access to perform the assessment is approved through the Atlanta Continuum of Care.

### Staffing Roles and Expectations

**Coordinated Entry Implementation Committee:**

Responsible for providing feedback and oversight on the policies and procedures around coordinated entry. The committee convenes by the Atlanta Continuum of Care and held monthly or as needed.

**Director of Housing Resources for the Atlanta Continuum of Care:**

Provides oversight and leadership to overall functioning of coordinated entry. Supervises the Coordinated Entry Manager. Secures additional interim bed options and resources to build capacity for the Coordinated Access Point.

**Coordinated Entry Manager:**

Responsible for the day to day functioning of coordinated entry. Maintains the housing queue and makes referrals as vacancies become available. Responsible for ensuring the stationary and mobile access points are fully functional and easily accessible to consumers.

**Coordinated Access Point (CAP):**

Agencies that are selected to serve as assessment centers for those experiencing homelessness. The access points are responsible for using the VI-SPDAT and submitting the information of those in need of housing to the housing queue. Though coordinated access points can specialize in specific populations, each access point must see anyone that comes and wants to be assessed for housing. See below for more details on specific access points.

**Housing Assessors:**

Responsible for conducting the VI-SPDAT. Assessors are vital to the success of coordinated entry

and providing a welcoming and safe environment for those that are experiencing homelessness.

**Housing Navigators:**

Assist clients in getting housing ready. Clients who are high scoring are assigned to a housing navigator who will assist in getting clients all documentation needed to go into housing. The housing navigator works jointly with the housing assessor to fill out housing applications once a client has been matched to a housing vacancy.

**System Overview and Workflow**

This gives an overview of the process for accessing coordinated entry throughout our continuum. This provides a brief description of the path a household would take to access permanent housing or rapid rehousing. The Clear Path to housing is:

- Step 1: Connect with a housing assessor through our stationary CAP or through one of our mobile assessors. Detailed information regarding the hours of operation for our Coordinated Access Point can be found on our website or by calling the access point directly.
- Step 2: Housing and VI-SPDAT- once someone has connected with a housing assessor, the assessor will begin to inquire about the client's homeless status. At this point a VI-SPDAT will be given.
- Step 3: Match with a housing navigator- Once a client's score has been determined, if the client meets the definition of literal homelessness, the client's name will go on the housing queue. If the client is not literally homeless, they will be given help with accessing the services they need for their situation. Once the client's name has been submitted to the housing queue, they will be matched with a housing navigator who will help them become housing ready. Matching a client with a housing navigator will be based on vulnerability score and capacity. Those highest on the housing queue will be matched first. The Housing Assessor will identify a temporary housing placement option for the client(s) that will serve as stabilization for 30-90 days (based on need and availability)
- Step 4: Housing Match- information obtained during the VI-SPDAT will be used to put the household or individual on the housing intervention that is most appropriate. (Permanent supportive housing or rapid rehousing). Matches will be made based on availability and program eligibility.
- Step 5: Housing referral- Once the best housing intervention has been identified, the coordinated entry program manager will make the referral to the agency providing the permanent supportive housing or rapid rehousing. The housing assessor who performed the VI-SPDAT for that household as well as the housing provider will each be copied on the referral.
- Step 6: Housing provider will follow up with Atlanta Continuum of Care if any issues arise with the referral for housing. Housing provider will also report when client has moved into permanent housing in order to keep housing queue up to date and accurate.

**Clear Path Access Point Policies and Procedures**

**Locations and Hours**

Assessments are conducted between 9:00 am and 4:00 pm at the Clear Path location offered by the city of Atlanta's designee(s). Access to mobile assessors is available by contacting the Coordinated Entry Manager for assistance.

**Eligibility**

The coordinated access system is designed to facilitate the most appropriate housing intervention while making sure that the most vulnerable and/or those who have been homeless the longest are being prioritized. Clear Path uses the following criteria to match needs to the most appropriate housing intervention:

PSH	1	Veterans	Chronic veterans
			Prioritization score
			Date of assessment
			Length of time homeless
	2	Chronic Families	Chronic Veteran families
			Prioritizations Score
			Date of Assessment
			Length of time homeless
	3	Chronic Youth	Chronic veteran
			Prioritizations Score
			Date of Assessment
			Length of time homeless
	4	Chronic Singles	Chronic veterans
			Prioritization score
			Date of assessment
			Length of time homeless
RRH	1	Families	Veteran Families
			Prioritization Score
			Date of Assessment
			Length of time Homeless
	2	Youth	Veteran youth
			Prioritization Score
			Date of Assessment
			Length of time homeless
	3	Non-Chronic Singles scoring over 10	Veteran
			Prioritization Score
			Date of Assessment
			Length of time homeless
	4	Non-Chronic Singles Scoring 3-10	Veteran
			Prioritization Score
			Date of Assessment
			Length of time homeless

**Assessment:** Clients who meet Category 1 homeless definition as defined by HUD are assessed by the housing assessor at the Coordinated Access Point. Those who are not literally homeless are offered resources for those facing housing insecurity or for those who are in need of immediate shelter. Clients are instructed to return to Coordinated Access if they become literally homeless.

**CAP closures:** The Coordinated Access Point will be closed on all major holidays and during times that the designated agency is closed. If it is necessary for the access point to close at other times, it will be posted and made available via the Partners for Home website.

## Record Keeping and Client files

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All client files for the Clear Path program are kept at the Coordinated Access Point. All client information is entered and managed in HMIS. Clients have access their files and information through scheduled appointments with the housing navigator. Access to client records and information by any other agency can only be granted with a signed release of information by the client.

The housing navigator is responsible for sending over all client file information and applications for housing to the housing provider that the client has been referred.

## Time-Lines for Coordinated Entry

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**Vacancies:** Each housing provider for both HUD funded PSH and HUD funder RRH are required to submit using the housing vacancy report by close of business of every Monday.

**Housing Matches:** The coordinated entry manager offers the housing vacancy to a referring case-manger within 24 hours of the vacancy being submitted. The case-manager has 48 hours to make an attempt to locate the client. If the client can't be reached and the case-manager doesn't request more time, the vacancy is deemed available to the next highest scoring person on the housing queue.

**Housing Provider:** Once a client has accepted a vacancy, the coordinated entry manager immediately makes the referral to the housing provider. The housing provider has 48 hours to reply to the referral with the information they need from that client in order to move the referral forward.

**Referring Case-manager:** The referring case-manager is expected respond to the housing match and start working with the client to get all information needed by the housing

provider. The case-manger must respond within 48 hours to set up an intake appointment with the housing provider. This appointment does not need to take place within 48 hours but all efforts need to be made to get an appointment schedule. Referring case-manager has 5 days to get all required documents for client (this includes verification of disability and verification of homelessness).

## **Case-Conferencing**

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Case-conferencing will be done on an as needed basis between the Coordinated Entry Manager and the agency(ies) conducting the assessment. The assessor will send a detailed email to the coordinated entry manager outlining why they are advocating to change the initial score. Detailed examples are needed to explain the additional information needed to increase an individual or families vulnerability. As needed, these emails will be reviewed by a peer review team via conference call. The peer review team will be comprised of 3-4 individuals that are knowledgeable on the vulnerability index as well as aware of the needs of the homeless population. This will ensure the ability to find housing for populations with specific and specialized needs.

## **Interim Beds**

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Through collaborative partnerships, interim beds are secured and available as immediate housing solutions for homeless individuals and/or families that are high scoring and are next in the pipeline for permanent supportive housing placement. The referring agency is expected to continue case management services to individuals or families placed in interim beds to assist with documentation necessary to deem them housing ready. Referrals to interim beds are contingent on eligibility for permanent supportive housing, however should not be limited to permanent supportive housing. If other housing solutions are available, the individual or family should be referred to ensure that the time spent in interim housing is brief.

## **Denials and Termination**

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All referrals made through Clear Path to HUD funded projects are expected to be accepted by the housing provider. The provider may refuse up to four (4) referrals over the course of one (1) year with a written explanation of the decision to the Atlanta CoC. The validity of all denials submitted will be discussed and determined through case conferencing with the Provider, Coordinated Entry Manager, and the Deputy Director of Housing and Resource Coordination.

Any Authorized User Agency may terminate their participation in the Coordinated Access System by giving written notice. Housing programs that are required to participate due to HUD guidelines will need HUD approval to terminate participation which may affect HUD funding.

**Permanent Supportive Housing**

Provides permanent housing and support services to individuals and families with a disability, prioritizing those who are chronically homeless. The program is designed to reintegrate this highly vulnerable population into the community by addressing their basic needs for housing and providing ongoing support.

Program Description	Essential Program Elements	Time Frame	Population	Desired/Expected Outcomes
<p>Rental Assistance with supportive services for persons who are coming from the street or shelter/interim housing. Majority of programs serve households with a disabled head of household, but disability requirement will be based on subsidy source requirements.</p> <p>Projects can operate on a project-based or scattered site model.</p>	<p><b>Case-Management</b></p> <ul style="list-style-type: none"> <li>• Assistance with lease process</li> <li>• Provision of or linkage to mainstream resources, community building, peer to peer and all other services that assist a person in remaining stably housed</li> <li>• Services are voluntary to the clients and are not a condition of the lease</li> </ul> <p><b>Rental Subsidy</b></p> <ul style="list-style-type: none"> <li>• Provides rental subsidy to make the unit affordable</li> <li>• Provides assistance in accessing housing relocation resources/supports (security deposits, utilities, furnishings, etc)</li> <li>• Ensure coordination between property owner and landlord</li> </ul> <p><b>Health Care Access</b></p> <ul style="list-style-type: none"> <li>• Wellness services</li> <li>• Physical and mental health</li> </ul> <p><b>Harm Reduction and Housing First</b></p> <ul style="list-style-type: none"> <li>• All supportive housing embraces practices of housing first and harm reduction</li> <li>• Incorporates proven best practices and evidenced-based practices</li> <li>• Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention</li> </ul>	<p>No time limits</p>	<ul style="list-style-type: none"> <li>• Any high needs individual with multiple barriers to housing this is literally homeless</li> <li>• Specialized eligibility requirements for subsidies including veterans, disabled, long term homeless, or domestic violence</li> </ul> <p>Prioritizing: Disabling condition and long-term, multiple episodes of homelessness (Vulnerability index score of 8 or higher) and veterans</p> <p>Unique Populations:</p> <ul style="list-style-type: none"> <li>• Families with children</li> <li>• Unaccompanied youth</li> </ul>	<p><b>Outcomes: Clients will remain in permanent housing and will not return to homelessness</b></p>

**Rapid Rehousing**

Provides permanent housing and support services to individuals and families with a disability, prioritizing those who are chronically homeless. The program is designed to reintegrate this highly vulnerable population into the community by addressing their basic needs for housing and providing ongoing support.

Program Description	Essential Program Elements	Time Frame	Population	Desired/Expected Outcomes
<p>Provides an immediate permanent housing situation for moderately vulnerable individuals. Common types of types of Rapid Re-Housing include HUD CoC Rapid Re-Housing for Families with Children, Emergency Solutions Grant funded Rapid Re-Housing (ESG), and Supportive Services for Veteran Families (SSVF)</p>	<p><b>Case-Management</b></p> <ul style="list-style-type: none"> <li>• <b>Housing location</b></li> <li>• <b>Employment assistance</b></li> <li>• <b>Linkage to mainstream benefits</b></li> <li>• <b>Linkage to mental health services as needed</b></li> <li>• <b>Linkage to medical services as needed</b></li> <li>• <b>Linkage to substance abuse treatment as needed</b></li> <li>• <b>Financial management</b></li> </ul> <p><b>Temporary Financial Assistance</b></p> <ul style="list-style-type: none"> <li>• Rental Assistance based on lease and individual service plan</li> <li>• Utility assistance</li> <li>• Deposit assistance</li> </ul> <p><b>Housing Relocation</b></p> <ul style="list-style-type: none"> <li>• Linkage to community supports and wrap around services</li> <li>• Temporary Financial Assistance</li> <li>• Housing referrals and placement services through partnership or informal landlord relationships</li> </ul> <p><b>Harm Reduction and Housing First</b></p> <ul style="list-style-type: none"> <li>• All supportive housing embraces practices of housing first and harm reduction</li> <li>• Incorporates proven best practices and evidenced-based practices</li> <li>• Programs do not require sobriety or medication/treatment compliance as a condition of housing attainment or retention</li> </ul>	<p>Determined by agency and grant awarded</p>	<p>Literal Homeless households or those residing in shelters. Households that show the ability to become self-sufficient in a short period of time as evidence by: having income potential, and do not need intensive services to remain housed; recently became homeless; no serious known disabilities that would prevent independent living.</p> <p>Prioritizing: Households with children that meet category 1 homelessness. Veterans who are not eligible for other VA-funded rapid rehousing.</p>	<p><b>Outcomes: Clients will remain in permanent housing and will not return to homelessness</b></p>