ATLANTA HOMELESS CONTINUUM-OF-CARE

Policies and Procedures Manual for Coordinated Entry

December 2019

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Introduction

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).

Coordinated entry written policies and procedures ensure that that the coordinated entry process is available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.

All procedures outlined in the policies and procedures manual will be reviewed and voted on by the CES (Coordinated Entry System) policy and monitoring committee. This committee is comprised of members of the CoC who actively participate in CES. All policy changes to CES will first be approved by the policy and monitoring committee and then approved by the governing council for the Atlanta CoC.

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.

Advertising

The coordinated entry system for the City of Atlanta Continuum of Care is advertised through the Partners for HOME website. Additional information is provided at each Coordinated Access Point for hours of operation. The Coordinated Access point at The Gateway Center also provides printed material for distribution. The CoC affirmatively markets housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, handicap or who are least likely to apply in the absence of special outreach.

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 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):

(1) 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:

(2) Developmental Disability:
   i. 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.

(3) HIV/AIDS Criteria:
   i. 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 (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

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 adopted 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 2.0 as a way to determine their vulnerability. A family experiencing homelessness will be assessed using the F-SPDAT. An unaccompanied transitioning age youth will be assessed with the TAY-SPDAT. 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 4+ is considered for rapid rehousing or transitional housing. Priority is also given to those who score an 8 or above but are not chronically homeless for rapid rehousing or transitional housing. After the initial assessment, an individual is placed on the housing queue and prioritized based on a combination of their VI-SPDAT score and length of since original assessment. Length of time is also used to determine intervention type.

Permanent Supportive Housing (PSH- see Appendix A for program model):

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- see Appendix A for program model):

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)

Transitional Housing (TH- see Appendix A for program model):

Transitional housing (TH) is designed to provide homeless individuals and families with the interim stability and support to successfully move to and maintain permanent housing. Transitional housing may be used to cover the costs of up to 24 months of housing with accompanying supportive services.

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 adhere to the guidelines for data management to maintain privacy and accuracy.

The Atlanta CE Housing queue will be housed in the ClientTrack system and will be the primary way to assess those participating in coordinated entry.

Clear Path:

The Named program for Coordinated Entry from the City of Atlanta. This will be the advertised name for the coordinated entry system and will be the name referred to when speaking on coordinated entry

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. The coordinated entry processes prioritize 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 2.0, the F-SPDAT, and the TAY-SPDAT is used to give each household 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.
    - CoC participants are freely allowed to decide what information they will provide during the assessment process. They have the right to refuse to answer any questions. Participant can choose to remove themselves from the coordinated entry system at any point.
    - Participant will also be informed before the assessment that they have the ability to file a nondiscriminatory complaint- Jimiyu will assist; ask providers to provide a copy of that for each agency doing assessment.

- **Housing Queue**: Homeless families and individuals are recorded on the housing queue in the order of their vulnerability score to prioritize housing.

    - Households experiencing literal homelessness are added to the housing queue through the Coordinated Entry Workflow housed within the HMIS system, ClientTrack.
    - Information collected is connected to program eligibility. The information that is entered into the workflow for prioritization and eligibility is: disability information, age, gender, income, household composition, and veteran. This information is not used to screen out but to match with the appropriate housing solution.
    - The full housing queue is only seen by those with Coordinated Entry Manager permissions turned on within HMIS. Each agency can see the clients that their agency added to the housing queue.
    - Individuals and families will be discharged from the housing queue when they move into permanent housing, are enrolled in a permanent housing program, or after they have not touched the Atlanta Continuum of Care system in HMIS system for 90 days or more.
    - After 90 days of inactivity, the assessor that added the client to the housing queue is responsible for their discharge. If a client comes back into the system and engages with an assessor, they will be added back to the housing queue and backdated to their original enrollment date on the queue if they have not been housed since their original enrollment date.
    - Assessors who are continuing to work with a client will enter a service every 90 days for the client to remain on the housing queue.

Training

The Atlanta Homeless Continuum of Care's coordinated entry process is designed to be utilized by those who have received training specific to Coordinated Entry. The Atlanta Continuum of Care provides monthly training for all those participating in the Coordinated Entry System as an assessor. Quarterly training will be provided to those who are receiving referrals through Coordinated Entry and access to the Atlanta Coordinated Entry Provider workgroup. The purpose of the assessor trainings is to provide all staff administering assessments with access to materials that clearly describe the methods by which assessments are to be conducted with fidelity to the CoC's coordinated entry written policies and procedures. The purpose of the provider training is to ensure compliance with the referral process and filling vacancies through the Housing First approach. The trainings will also provide updates to the coordinated entry system as adjustments are being made. If an assessor is unable to attend training at least once per quarter, they will lose access to the CE workflow in HMIS and will not able to gain access until they complete an assessor training. As part of the monthly trainings, each assessor will receive ClientTrack training and updates to the workflow in ClientTrack every 6 months. Each housing provider using CES in ClientTrack will participate in mandatory training quarterly to ensure compliance and data integrity.

- **Curriculum for assessor training will include:**

    - A review of the CoC's policies and procedures, including any adopted variations for specific subpopulation
    - Requirements for use of assessment information to determine prioritization
    - Criteria for uniform decision making
    - Refresher training for VI-SPDAT tool and any updates to the tool
    - This training will be held monthly for all those with assessor access in ClientTrack.

- **Curriculum for provider training will include:**

    - A review of the CoC's policies and procedures, including any adopted variations for specific subpopulation

- An overview of requirements for following a low-barrier approach to housing first
- Detailed review of the Atlanta CE provider workflow
- A review of current system issues and tickets related to those issues
- Updates on changes to the Atlanta CE Provider workflow.

- **New User Training (assessor and provider):**

  - If an agency that participates in coordinated entry hires a new staff, the staff member will be trained in the entire coordinated entry system by the PFH Coordinated Entry Manager.
  - This training will be held bi-monthly as an in-person training.
  - Each agency is responsible for reaching out to the Coordinated Entry Manager at PFH once a new staff has been on boarded. Agencies commit not to share the housing queue link with staff who have not been trained.

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 coordinated entry process will prohibit screening out for following perceived barriers:

- 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)
- Criminal record
- Service resistance
- Type or extent of disability
- Marriage license
- Little to no Income
- History of domestic violence

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

Coordinated Access Points

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 Policy and Monitoring Committee:

Responsible for providing feedback and oversight on the policies and procedures around coordinated entry. The committee convened by the Atlanta Continuum of Care and held quarterly. The committee is comprised of members of the community who can speak to the effectiveness of the coordinated entry system. Members of this committee will include a representative from a permanent supportive housing project, a rapid rehousing provider, a PATH outreach worker, a clinical social worker, a member of our coordinated access point team, a service provider for permanent supportive housing, and staff from Partners for Home.

PFH Senior Project Manager:

Provides oversight and leadership to overall functioning of coordinated entry. Supervises the Coordinated Entry Manager. Responsible for capacity building within the coordinated entry system and all HUD compliance for Coordinated Entry. Provides oversite and leadership for existing Coordinated Access Points and the expansion of Coordinated Access Points across the city.

Coordinate Entry Project 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:

Serves a key role in the system-wide assessment of homeless persons in determining appropriate housing intervention. The housing assessor will input all information necessary into the Coordinated Entry Workflow needed to determine the participants' eligibility for housing. This includes but is not limited to the administration of the VI-SDPAT.

Essential Duties and Responsibilities:

1. Triage all clients experiencing homeless to determine eligibility to move forward with a coordinated entry assessment
2. Enter all information accurately into the coordinated entry workflow
3. Complete training to conduct the VI-SPDAT assessment on all populations (Single, Family, and Tay-SPDAT)
4. Upload any documents that client currently has available into ClientTrack into the CE workflow
5. Uses DCA form to determine chronic homelessness and documents information in client's file

6. Attend all mandatory assessor trainings for updates to the workflow and to the coordinated entry system
7. Update client's information if any changes need to be made
8. Discharge client if client is housed or moves outside of the City of Atlanta geography
9. Follow all entrance and exit scripts as determined by the Coordinated Entry Policy and Monitoring Committee to ensure message consistency
10. Enter case-note at assessment completion with client history and chronic information included. Can include relevant information on this current episode of homelessness, special circumstances, or additional disability information.

Housing Navigators:

Serves a key role in the system-wide assessment of homeless persons to match them to the appropriate housing intervention. The Housing Navigator will accompany clients from the housing queue to the lease-up process. The Housing Navigator will also collaborate with other system partners. See appendix A for navigation program model.

Essential Duties and Responsibilities:

1. Pull housing referral from HMIS and begins the next step process to enrollment
2. Develops/fosters partnerships with community resources
3. Assists individuals that are homeless in gathering all documents necessary in order to begin a housing program enrollment.
4. Ensure all data is entered accurately into HMIS
5. Attends all Housing Navigator and HMIS training in order to fully utilize the Coordinated Access system accurately
6. Accompanies clients to all housing appointments and services as clients' primary advocate
7. Completes in-depth assessments with clients to ensure proper supportive services are provided
8. Manage assigned caseload to include monitoring visits, community referrals, collaboration with team members, and advocacy in accordance with the Housing First and Harm Reduction models.
9. Work together with other community agencies to jointly serve clients enrolled in multiple programs.

Street Outreach:

The goal of street outreach for CES is to connect anyone experiencing homelessness who is unsheltered to housing and resources. See Appendix A for the outreach program model.

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:

- Access: this is the point of engagement with the coordinated entry/crisis response system. Persons experiencing homelessness will connect with a housing assessor through our stationary CAP, a mobile CAP or through street outreach. Detailed information regarding the hours of operation for our Coordinated Access Point can be found our website or by calling the access point directly.
- Assessment: This progressive assessment process will be layered and will allow the assessor to determine

clients needs. If the client is literally homeless in the City of Atlanta (category 1 or 4), the assessor will put their information into the CE workflow in ClientTrack. Part of the workflow includes the VI-SPDAT. Client will be made aware that the assessment is optional and will not prevent them from being housed. If a client does not complete assessment, case-conferencing will be used with additional support from a licensed clinician if a HUD McKinney is needed to verify disabling condition.

- Prioritization: Once enrolled in the workflow, the client will immediately go on the housing queue. If case-conferencing is needed, the case-manager or assessor can send the form to the CE manager at that time. Once the client's information has been submitted to the housing queue and the client has been determined to be chronically homeless and appropriate for system navigation, they will be matched with a housing navigator (if they are not already working with a navigator/case-manager) who will help them become document 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 through system navigation.
- Referral: information obtained in the CE workflow will be used to match the household or individual to the housing intervention that is most appropriate (permanent supportive housing or rapid rehousing). Matches will be made based on availability and program eligibility. 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 through ClientTrack (based on need and availability). The housing assessor that entered the client into the CE workflow will be responsible for follow-up with that client to see if they want the intervention being offered. The assessor is responsible for accepting the CE referral within 72 hours or the referral will go back into the system to be matched to another client. Housing provider will update the referral in 72 business hours to either approve or reject the referral. If the provider rejects the referral, they will need to note the rejection in ClientTrack and follow up with an email to the coordinated entry manager on why they are denying client. Coordinated entry manager is responsible for approving or denying all rejections. Housing provider will send all intake packets and information to navigator/case-manager/assessor within 72 business hours of acceptance.

Access Point Times and Locations

All access points are open to anyone experiencing homelessness unless they are for a specific subpopulation. This includes youth and households fleeing domestic violence. Changes to the access point locations can be adjusted as needed by approval from the Coordinated Entry Policy and Monitoring Committee.

- **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. The stationary access point is at *The Gateway Center at 275 Pryor St. Atlanta, GA 30310*. The hours of operation are *Monday-Friday from 9:00 am till 4:00 pm*. In addition, evening hours were added to the stationary site once per week to accommodate those unable to come during the day. In the event that the Coordinated Access Point needs to close for training or staffing, the closure will be posted in advance and advertised on the Partners for Home and Gateway website. Signage will be posted at least 3 days prior to closure inside the Client Engagement Center. In the event of an emergency such as staff illness or a weather emergency, the Gateway Center will alert Partners for Homes staff of closure.

- **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. Additionally, mobile access points have been identified by the Coordinated Entry Policy and Monitoring Committee Team. A request for an outreach team to visit a client can be made by contacting the Coordinated Entry Manager at Partners for Home.
    - Mobile sites hours will vary by location but will be advertised at each location, on the PFH website, and on the website of the agency contracted to carry out the mobile sites contract.
    - For those fleeing domestic violence, the participant can access the coordinated entry system through the Partnership Against Domestic Violence, a victim service provider agency. PADV will be trained in the

assessment tool and Coordinated Entry system. PADV will attend all required CE trainings. Information will be shared directly with the Coordinated Entry Manager through a password protected housing queue. Those fleeing domestic violence also have the same ability to access Coordinated Entry through the Coordinated Access point. Staff at the Coordinated Access point will receive safety training from PADV to assist those feeling domestic violence.

- Mobile Sites will be determined by the Coordinated Entry Policy and Monitoring Committee and will change based on need and geographic coverage. A triage assessment will be done at each site that requests a coordinated access point location to determine need at that site.

- **Youth Access Points:** Access points have been designed specially to meet the needs of transitional age youth. Coverage has been designed to have youth assessments conducted every day of the week Monday-Friday.
  - Tuesday, Wednesday, and Thursday from 11 am- 1pm at The Spot, 1976 Flat Shoals Rd SE Atlanta, GA 30316.
  - Fridays 10 am- 12 pm at Lost n Found Youth Center, 729 Lambert Drive NE Atlanta, GA 30324.
  - Monday- Thursday 9 am- 1 pm and evenings as needed from 6 pm- 8 pm at Covenant House Community Service Center 1559 Johnson Road NW, Atlanta, GA 30318

Emergency Services

Referrals to emergency intervention such as shelter, behavioral health, or crisis response will be made as needed and as available. These interventions will not be based on a prioritization scoring.

Clear Path Access Point Policies and Procedures

Locations and Hours:

Assessments are conducted between 9 am and 4 pm at the Clear Path location offered by the city of Atlanta's designee(s). Mobile sites operate on a rotating schedule that is advertised in advance. Access to an outreach assessor 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**	Chronic Families	Prioritization score
			Date of assessment
			Length of time homeless
			Veteran family
			High Utilizer of other systems (jail, hospital, institution)
	2	Chronic Singles	Prioritization Score
			Date of assessment
			Length of time homeless
			Chronic veteran
			High Utilizer of other

			systems (jail, hospital, institution)
	3	Chronic Youth	Prioritizations Score
			Date of Assessment
			Length of time homeless
			Chronic veterans
			High Utilizer of other systems (jail, hospital, institution)
RRH	**1**	Families	Prioritization Score
			Date of Assessment
			Length of time Homeless
			Veteran youth
	2	Youth	Prioritization Score
			Date of Assessment
			Length of time homeless
			Veteran
	3	Non-Chronic Singles scoring over 8	Prioritization Score
			Date of Assessment
			Length of time homeless
			Veteran
	4	Non-Chronic Singles Scoring 3-7	Prioritization Score
			Date of Assessment
			Length of time homeless

Assessment:

Each client that enters a CAP will be assessed using a triage assessment. This triage assessment will determine if the client is literally homeless and in the CoC resource geography. Clients who meet Category 1 or 4 homeless definition as defined by HUD are assessed by the housing assessor at the Coordinated Access Point or at one of the mobile access points. Those who are not literally homeless are offered diversion or prevention 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

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 to 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.

The CoC does not use data collected from the assessment process to discriminate or prioritize households for housing and services on a protected basis, such as race, color religion, nation origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identify or marital status. Information will be used to determine eligibility (in line with housing first) but not prioritization. In some instances, some projects may use disability status or other protected class information to limit enrollment but only if Federal or State statute explicitly allows (e.g. HOPWA-Funded projects may only serve participants with HIV+/Aids).

Time-Lines for Coordinated Entry

Vacancies: Each housing provider for both HUD funded PSH and HUD funded RRH and ESG are required to submit vacancies using ClientTrack. These vacancies are added in real time. Emergency shelter vacancies are able to be seen and referred to by the case-manager/assessor. Permanent housing resources are matched through the CE manager.

Housing Matches: The coordinated entry manager offers the housing vacancy to a referring case-manger the same week the vacancy being submitted. The case-manager has 72 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 expires and is able to be matched to the next eligible person.

Housing Provider: Once a client has accepted a vacancy, the housing provider will accept the referral within 72 hours. It is then the responsibility of the housing provider and case-manager to work together to move the client into housing.

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 referring case-manager will work with client to fill out necessary applications and obtain needed documentation. Referring case-manager will respond to all correspondence from the housing provider in 72 hours.

Case-Conferencing

Case conferencing can be utilized for those who have a VI-SPDAT score entered into the Coordinated Entry Workflow in ClientTrack, but their vulnerability is not clearly reflected in the standard VI-SPDAT assessment. Case-conferencing will be used in cases where a change in the client score would impact the type of housing intervention they are eligible to be referred into.

Process:

The assessor that administered the initial coordinated entry assessment or the system navigator will fill out a

standard case-conferencing form that will be submitted to the Atlanta Continuum of Care lead agency, Partners for Home. Assessor or navigator may work jointly with client's case management team to get the most accurate and clear information on the client. Partners for Home will hold a weekly case conferencing meeting on Monday of each week via conference call. The assessor or navigator will be notified within 48 hours of that case conferencing meeting if the request was approved. If the request is denied, the assessor, navigator, or case management team can appeal the decision by contacting the coordinated entry manager at Partners for Home.

Case conferencing committee:

The case conferencing committee will be made up of the following roles:

- Outreach worker
- Clinical social worker
- Housing provider for PSH and RRH
- Administrator from Partners for Home

Case Conference Denials through Coordinated Entry

If a housing provider rejects a referral for a client through Coordinated Entry, the housing provider will follow up with the Coordinated Entry manager and the assessor/navigator both through ClientTrack and through an email communication informing both parties that they are not going to move forward with this client. Housing providers can reject 3 clients per year. The client will then be case-conferenced to determine what program will meet the client's needs. The assessor who enrolled the client into coordinated entry or the system navigator will be responsible for filling out the case conferencing document for the client.

If in the event a rapid rehousing provider determines that the client requires a higher level of care, the RRH provider will case-conference the client and "provider reject" with a note that says "case-conference for higher level of care."

Non-Assessed Priority List Policy

To assess anyone who is unsheltered (not including winter warming shelter) and not able to participate in the traditional coordinated entry process with navigation and housing resources.

Requirements to enter client on list:

- Unable to complete assessment due to one of the following:
  - Impaired state of mind;
  - Does not want to share their information;
  - refuses to consent in the HMIS process.
- Outreach worker has made 3 or more attempts to gather information in the assessment process and has not been able to do so.
- Clinical provider will engage client and will provide a diagnosis and confirmation that the client is unable to complete the assessment.
- Once above criteria is met, outreach team will submit a google doc to PFH who will maintain the list and verify above met criteria.

Navigation Elements:

- Unable to complete assessment due to one of the following:
- Impaired state of mind
- Does not want to share their information
- refuses to consent in the HMIS process
- Outreach worker has made 3 or more attempts to gather information in the assessment process and has not been able to do so.

- Clinical provider will engage client and will provide a diagnosis and confirmation that the client is unable to complete the assessment.
- Once above criteria is met, outreach team will submit a google doc to PFH who will maintain the list and verify above met criteria.

Time Frame:

- 3 interactions with Outreach Worker and a clinical recommendation prior to adding client to priority listing
- Client will remain on the non-assessed priority list for as long as an agency is able to maintain contact. If no services or contacts for 6 months, the client will move off the list (client can always return to NAPL once located)

Population:

- Unsheltered
- Chronic
- Not able to complete traditional coordinated entry assessment

System Transfers

Transfers within the Coordinated Entry System provides flexibility to programs and households and can help to prevent a return to homelessness. A household may need to transfer to another program for several reasons, such as needing an increased or decreased level of services, change in family composition, the closure of a program, a pending eviction from a master leased property, or others. While there are many reasons a transfer may be in the best interest of a household it is recommended that referring programs consult closely with the household to ensure a successful transfer.

Transfers Between HUD CoC PSH Programs:

When a transfer is deemed necessary from one HUD CoC PSH program to another, the transfer request will be prioritized within the CES upon approval. Transfer requests must be submitted by the current PSH provider and communicated via email to the CES team. A completed PSH to PSH Transfer Form detailing the specific issues that are prompting the transfer must be included. Approved transfers will be processed in a timely manner but may be affected by PSH availability.
While the CES refers households to PSH programs with a variety of funding sources, transfers are only allowable between HUD CoC funded PSH programs.

Transfers from RRH to PSH:

Transfers from a RRH program to a PSH program are allowable if the household met all requirements for chronic homelessness when entering the RRH program. Households do not accrue time toward chronic homelessness while enrolled in the RRH program. Transfer requests must be submitted by the current RRH program and be submitted to the CES team via email. A completed RRH to PSH Transfer Form detailing the specific reasons for the transfer request and documentation of chronic homelessness must be included. Approved transfers will be processed in a timely manner based on PSH availability and the need within CES. For instance, if a household is currently housed in a RRH program, and is not at imminent risk of a return to homelessness, a literally homeless household may be prioritized.

Emergency Transfers:

In compliance with the Violence Against Women Act (VAWA), the CES allows emergency transfers for

households that are victims of domestic violence, dating violence, sexual assault, or stalking. The ability to request a transfer is available regardless of sex, gender identity, or sexual orientation.
HUD 24 CFR Part 5 states that a household qualifies for a VAWA emergency transfer when the household requests a transfer, reasonably believes there is a threat of imminent harm from further violence if the tenant remains in the same unit, or a sexual assault occurred on the property within 90 days preceding the emergency transfer request.

When an emergency transfer has been requested from the household the RRH or PSH program will submit the request via email to the CES Team with a PSH to PSH Transfer form detailing the reasons for the emergency transfer request. The transfer request will be processed as quickly as possible. In the meantime, the program will evaluate the need for an internal transfer to a new unit based on need and availability.

Shelter Beds

A limited number of Shelter bed vacancies are entered into the Coordinated Entry workflow in HMIS. Shelter beds are not prioritized based on the vulnerability score but are matched on a first come first serve basis. Shelter beds are reserved directly by the CE assessor in Client Track and are not matched by the Coordinated Entry Manager.

Denials and Termination

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.

Program Models

See Appendix A

Evaluation

The Coordinated Entry Policy and Monitoring Committee will provide performance monitoring on a quarterly basis. They will also vote on all procedural changes to the CES system as needed. In the event a policy change is needed for CES, the policy addition or change will be sent to the governing council for approval. The policy and monitoring committee will evaluate the number of CE assessments per access point, the number of housing referrals each quarter and the number of housing placements each quarter. A performance evaluation of CES will be performed annually. The CoC will contract an evaluator who is not currently a participating agency or provider to conduct the Annual Evaluation. The following will be used to measure the effectiveness and impact of CES across the CoC:

- Participant survey and interview (housed and unhoused at various stages in process)
- Policies and Procedures Review
- Interviews with key stakeholders

- Data Integrity
- Referral Effectiveness
- Gaps in current system
- Data review on how the system is functioning- CE Score card review
- Agency interaction with CE overall and interaction with agencies participating in CE

Revisions Log 12-2-2019

CE Policy and Procedures Updates and Additions:

- Definition
  - Update: VI-SPDAT Scoring Criteria
- Coordinated Entry Overview
  - Uniform and Standard Assessment Process
    - Update: 2nd bullet point
  - Housing queue
    - Update: 5th bullet point
- Coordinated Access Point and Mobile Access Point
    - Moved sections
- Training
  - Update: overview
  - Update: Curriculum for assessor training will include
  - Addition: Curriculum for provider training will include
  - Update: New User Training (assessor and provider)
- Staffing Roles and Expectations
  - Update: Coordinated Entry Implementation Committee
  - Updated: Coordinated Entry Manager
  - Housing assessor
    - Update: role overview
    - Addition: Essential duties and responsibilities
  - Housing Navigator
    - Update: Role Overview
    - Addition: Essential duties and responsibilities
- System overview and workflow
  - Update: reduced to 4 bullet points and all edited
  - Addition/move: access point times and locations
  - Update: Coordinated Access Points
  - Addition: Youth Access Points
- Clear Path Access Point Policies and Procedures
  - Update: PSH and RRH eligibility charts
- Time-lines for coordinated entry
  - Update: referring case manager
- Case Conference
  - Update: Overview
  - Addition: Process
  - Addition: Case Conference Committee
  - Addition: Case Conference Denials through Coordinated Entry
- Non-Assessed priority List policy
  - Addition: full policy (already approved)
- System Transfers
  - Addition: full policy
- Shelter Beds
  - Section addition
- Evaluation
  - Update: needs policy approval