Topeka/Shawnee County Continuum of Care
Coordinated Assessment System

Policies & Procedures

Rev. 8/9/2017
# TABLE OF CONTENTS

1. Background
2. System Overview
3. Access Points
4. Assessments
5. Community Queue
6. Housing Referrals
7. Confidential Process for Domestic Violence Survivors
8. Transition Process
9. Administrative Structure
10. Definitions
1. **Background**

   a) **What is Coordinated Assessment?**

   Coordinated Assessment (also known as Coordinated Entry) is a consistent, community process to match people experiencing homelessness to community resources that are the best fit for their situation. In a community using coordinated assessment, homeless individuals and families complete a standard triage assessment survey that identifies the best type of services for that household. Participating programs accept referrals from the system, reducing the need for people to traverse the county seeking assistance at every provider separately. When participating programs do not have enough space to accept all referrals from the system, people prioritized for services based on need.

   In Topeka Shawnee County we plan to start phase one of coordinated assessment with permanent housing programs (permanent supportive housing and rapid rehousing), and in later phases add other resources, such as emergency shelter.

   b) **HUD Requirement**

   Under the interim rule for the U.S. Department of Housing and Urban Development’s (HUD) Continuum of Care (CoC) program, each Continuum of Care (CoC) must establish and operate a centralized or coordinated assessment system (24 CFR 578.7(a)(8)). HUD defines a centralized or coordinated assessment system as “a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool” (24 CFR 578.3).

   Participation in the coordinated assessment system is required for grantees HUD CoC and Emergency Solutions Grant (ESG) funds.

   c) **Community Vision**

   Our community vision for coordinated assessment is that we all have a fully engaged coordinated assessment system with standardized assessment and all emergency shelter, transitional housing, permanent supportive housing, and rapid rehousing placements made through system. Coordinated assessment will encompass all populations and prioritize and place people effectively and efficiently, quickly matching people to the housing type that is most likely to get them permanently housed.

   In phase one, the coordinated assessment process will provide referrals for permanent housing interventions, including permanent supportive housing and rapid rehousing. Later phases of implementation will add assessment and referral processes for emergency shelter and transitional housing.
d) Benefits of Coordinated Assessment

Coordinated assessment will benefit our community by:

- Using existing resources effectively by connecting people to the housing program that is the best fit for their situation.
- Reducing the need for people to call around to multiple housing programs and fill out multiple applications to join waitlists. Coordinated assessment will assess people for all participating permanent housing programs at the same time.
- Providing clear communication about what housing is available.
- Collecting information about how many people in Topeka/Shawnee County need different types of housing. This information will help us advocate for more resources to provide housing and services to homeless people in Topeka/Shawnee County.

2. System Overview

In Topeka/Shawnee County’s Coordinated Assessment system, all homeless individuals and families will complete a standard triage assessment survey that considers the household’s situation and identifies the best housing intervention to address their situation. The standard triage assessment survey that will be used in Topeka Shawnee County is the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). The VI-SPDAT will be integrated into the standard HMIS intake for people who are homeless and conducted at HMIS partner agencies, including service centers, transitional housing programs, and outreach programs: anywhere that people who are homeless first encounter our system of care.

Permanent housing programs, including permanent supportive housing and rapid rehousing, will fill spaces in their programs from a community queue of eligible households generated from HMIS. The queue will be prioritized based on length of time homeless and VI-SPDAT scores to ensure that we house those with the greatest need first. This coordinated process will reduce the need for people to traverse the county seeking assistance at every provider separately.

3. Access Points

  a) Requirements for Access Points

Access points are locations where people who are homeless can complete the assessment survey to participate in coordinated assessment. To ensure access to emergency services during hours where the collaborative applicant is not operating, the survey will be available on the website. In Topeka/Shawnee County, all CoC and ESG funded partner agencies will serve as access points and the triage assessment survey (VI-SPDAT) will be incorporated into the standard HMIS intake.
In order to participate as an access point, organizations must have a current, signed HMIS partner agency agreement and meet the following requirements:

1) Participate in HMIS and follow all HMIS user agency requirements (domestic violence victim service providers are exempt from this requirement).

2) Agree to follow the community guidelines for completing the assessment and communicating about the coordinated assessment system.

3) Agree to provide additional referrals to other community services, as appropriate, to people completing the assessment.

b) Communication and Frequently Asked Questions

As the original point where people connect with the coordinated assessment system, access points are also likely to get questions from people asking about their status on “the list” and when they will get referred to housing. Organizations should be able to:

1) Check HMIS to determine if the individual or household has a current (less than one year old) VI-SPDAT entered in HMIS.
   a. If so, communicate to the individual or household that they are current in the system and will be contacted if services that are good fit for them become available.
   b. If the individual / household do not have any record of a VI-SPDAT in HMIS, work with them to complete the standard HMIS intake and VI-SPDAT.
   c. If the individual’s/ household’s VI-SPDAT is over one year old, have them complete an annual update.

2) Check to make sure that the individual’s/household’s contact information is current and up to date if needed.

Organizations should not communicate the individual’s or household’s number or place in the community queue in HMIS as this placement may change frequently as new assessments are entered into the system.

c) Outreach and Marketing

An outreach strategy will be developed to reach all individuals and families who are homeless within Topeka Shawnee County. This strategy will be implemented in phases to facilitate a more manageable transition to the new system.

- Phase One – Late 2017: HMIS partner agencies will serve as access points, providing a diverse, countywide network of service providers that are easily accessible to homeless individuals and families throughout the country. Additionally, domestic violence providers will serve as access points for domestic violence survivors. Together, these organizations reach tens of thousands of individuals each
year and provide services including outreach, shelter, drop-in services, and transitional housing providing a built-in network of reaching homeless people throughout the community.

- **Phase Two – Early 2018:** Additional outreach will be developed to spread information about coordinated assessment to non-CoC member organizations that serve people that are homeless, including schools, hospitals, libraries, and government offices. This phase of outreach will be delayed to avoid overwhelming the new system in the beginning when organizations will be assessing all of their current clients.

4. **Assessments**
   
   a) *The VI-SPDAT*

   Topeka Shawnee County uses the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) as the standard triage assessment tool. This assessment will be used for all homeless individual and households in Topeka/Shawnee County. There are three versions of the VI-SPDAT in use for different populations:

   - Individuals
   - Families
   - Transition Age Youth

   The VI-SPDAT is to be completed by all individuals and families who are homeless under Category 1 (Literally Homeless) and Category 4 (Fleeing Domestic Violence) of HUD’s definition of homelessness. The VI-SPDAT will be conducted as part of the standard HMIS intake.

   b) *Training and Authorization of Users*

   The VI-SPDAT can only be conducted by staff or volunteers who have successfully completed training and been authorized by COT.

   COT staff will monitor the quality and consistency of assessments entered into HMIS and provide feedback, training, and adjustments to policies and procedures as necessary to address issues that may arise.

   c) *Confidentiality and Releases of Information*

   The VI-SPDAT is covered under the standard HMIS Release of Information (ROI). The ROI authorizes HMIS partner agencies to conduct the HMIS intake and the VI-SPDAT, enter the information in HMIS, and share the individual’s or household’s information with other...
participating organizations in order to facilitate connecting the household with housing and services. The ROI MUST be completed and uploaded into HMIS before any other information, including the VI-SPDAT, including the VI-SPDAT, can be entered into HMIS.

\[ d) \quad \text{Conducting the Assessment} \]

The VI-SPDAT will be conducted as part of the standard intake for HMIS and as part of annual updates in HMIS. It may be directly entered into HMIS or completed or paper and then entered into HMIS.

The VI-SPDAT should be conducted in a setting that promotes privacy and confidentiality. The staff member or volunteer conducting it must follow the community guideline for explaining what the assessment is and how coordinated assessment works.

All of the questions on the VI-SPDAT are designed to be answered with one-word “yes” or “no” answers. There is no need for respondents to go into detail describing their situation or past history. Respondents should be told that it is important to answer the questions honestly and accurately in order to match them to the best services for them.

The VI-SPDAT and HMIS standard intake must be conducted in person and the release of information must be uploaded into HMIS.

After completing the assessment, the volunteer or staff member should provide the individual/household with referrals to meet immediate needs. It is very unlikely that a housing placement will be available immediately or even in the near term, due to the overwhelming need in our community. Thus, it is important to provide information about resources that can meet immediate needs, such as shelter, food, and health care.

Individuals and households that score in the low acuity range should be provided with referrals to other resources to meet their housing needs, since they will not matched with permanent supportive housing or rapid rehousing. Referrals should be based on the individual’s/household’s specific situation.

\[ e) \quad \text{Updates to Assessments} \]

As long as individuals/families remain homeless, they should complete the VI-SPDAT annually to capture changes in their circumstances. In addition, individuals/households may complete an update whenever they experience a significant change their circumstances. The update would include an HMIS update and a new VI-SPDAT.

5. Community Queue

Topeka/Shawnee County maintains a community queue in HMIS based on the VI-SPDAT scores and intake records in HMIS. HMIS also contains the inventory and eligibility criteria for each
permanent housing provider, including permanent supportive housing and rapid rehousing programs.

\textit{a) Match to Program Type}

Topeka/Shawnee County uses the VI-SPDAT to determine the best type of housing interventions for the individual or household being assessed. Those who are identified to have high acuity are referred to permanent supportive housing. Those with moderate acuity are referred to rapid rehousing. People who are assessed to be low acuity most likely will be able to resolve their homelessness without a housing intervention. Since Topeka Shawnee County has limited housing capacity, housing interventions will be prioritized for those who most need it. Individuals and households with low acuity will be referred to other, non-permanent housing interventions. This could include deposit assistance and/or make sure they are connected to public benefits, and referring to other services in the community.

\textit{b) Prioritization}

Topeka/Shawnee County has a significant shortage of housing opportunities compare to the need. Thus, the coordinated assessment system will triage people and house those who are most in need first. Permanent Supportive Housing placements will be prioritized for those who have been homeless on the streets or emergency shelter for at least a year and with the highest acuity, thus serving those who are most in need and most at risk if they remain on the streets, first. Persons doing street outreach will screen individuals in the same manner as any other person who is assessed with coordinated entry. All individuals can abstain from disclosing and sharing information.

Using VI-SPDAT scores, individuals/households are assigned to the most appropriate type of housing intervention (permanent supportive housing, rapid rehousing, or no housing intervention). Within those groups, individuals and households will be prioritized based on:

\textbf{Permanent Supportive Housing Prioritization Criteria:}

1) \textbf{VI-SPDAT Score} – Those who have been on the street, in emergency shelter, and/or places not meant for human habitation for at least a year with the highest acuity will be served first.
2) \textbf{Length of Time Homeless} - Among those with the same VI-SPDAT score, individuals, households who have been homeless the longest will be prioritized first.
3) \textbf{High Use of Services} – Among those with the same VI-SPDAT score and the same length of time homeless, individuals/households will be prioritized based on those with the highest utilization served first.

To reflect our commitment to serve those most in need and most at risk, the CoC will work with all CoC funded permanent supportive housing projects to phase in turnover beds to be dedicated or prioritized for the chronically homeless.
Rapid Rehousing Prioritization Criteria:

1) VI-SPDAT Score – Those with the highest score within the rapid rehousing range will be served first.
2) Risks Score – Among those with the same VI-SPDAT score, individuals/households with the highest Risks sub-score in the VI-SPDAT will be prioritized first.
3) Length of Time on the Community Queue - Among those with the same VI-SPDAT score and the same Risks score, individual/households will be served in the order they completed the assessment.

6. Housing Referrals

   a) Matches to Housing Opportunities

Matches are facilitated by staff in the City of Topeka (COT). When a permanent housing program has space available, the designated COT representative will use the community queue in HMIS to identify the household or individual to be referred by:

   1) Filtering the community queue based on the type of housing intervention (permanent supportive housing or rapid rehousing) so that it pulls a list of individuals/households that have matched to that type of housing.
   2) Filtering the community queue based on the eligibility criteria of the housing program.
   3) Prioritizing the community queue based on the prioritization methodology described above.

The COT representatives will then make a referral in HMIS to the permanent housing program.

COT staff will provide human judgment and discretion in making referrals based upon the prioritization and match-making methodology laid out in this document. Discretion may include taking into account a client’s known preferences when making matched, avoiding referrals to programs where an individual/household has had a serious violation in the past and addressing inconsistencies or concerns in the assessment or eligibility information entered in HMIS.

   a) Provider Responsibilities

When a permanent housing program receives a referral in HMIS, the provider will follow these steps:

   1) **Locate the Individual/household:** It is expected that the provider will make at least 3-5 reasonable attempts to find the individual/household. In addition to trying to contact information in the person’s HMIS account, attempts should include seeking the person out in locations and at other service providers that they are known to frequent.
Topeka Shawnee County Continuum of Care

Coordinated Assessment Policies and Procedure

a. All attempts to find the individual/household must be documented in HMIS.

2) **Verify eligibility:** Information in the individual’s/household’s HMIS account (including the VI-SPDAT) is primarily self-reported. Providers will need to conduct their own program intake and documentation of eligibility.

3) **Enter the individual/household into the program in HMIS.**

If the individual/household turns out to be ineligible for the program, they will be referred back to the community queue and COT staff will initiate a new match. The program should provide information regarding why the individual/household was not eligible and a note will be made in HMIS. Depending on the reason for ineligibility, COT staff may initiate a review of the client’s information and/or request that the client complete an updated assessment (for example, if inaccurate or out of date information on the assessment led COT to believe the client would be eligible).

If the individual/household declines a referral, they will be referred back to the community queue and COT staff will initiate a new match. Individuals/households have the right to decline any and all referrals. COT staff will continue to offer referrals as many times as it takes to match the individual/household with housing. However, COT will follow some basic guideline:

1) COT staff will not re-refer an individual or household to the same program multiple times if the person/household has communicated that they are not interested in that program. Instead, the individual/household will be referred to other programs in the community.

2) If an individual/household declines 3 referrals, COT staff will wait three months before making the next referral.

3) If an individual/household declines 6 referrals, COT staff will communicate with the individual/household that they will not be given any new referrals until they inform COT that they are interested in receiving a new referral.

c) **Project Specific Wait Lists**

One of the benefits of coordinated assessment is that it simplifies the path to housing by replacing the multitude of existing project specific wait lists with a shared community queue. However, some projects have requirements form their funders that may conflict with coordinated assessment. In those situations, COT will work with the provider to determine the best possible way to participate in coordinate assessment.

7. **Confidential Process for Domestic Violence Survivors**

A separate, confidential process is available for domestic violence survivors who are receiving services form designated domestic violence service providers in the community. This process allows service providers to maintain confidentiality and safety for their clients, while also ensuring that homeless survivors have access to the full array of housing opportunities in the
The YWCA- Center for Safety and Empowerment has a hotline to ensure safety planning and protections to victims of domestic violence not staying at the shelter.

a) **Assessment**

The participating domestic violence service providers will conduct the VI-SPDAT triage assessment with the individuals and families staying in their shelters and transitional housing programs. These service providers are prohibited by law from using HMIS, so the VI-SPDAT and additional eligibility criteria that is usually included in the HMIS standard intake will be completed on a paper form. This modified intake form will only include the minimum information necessary to determine eligibility and prioritization and it will specifically exclude personally identifying information, including: name, date of birth, social security number, and last permanent address. The service provider completing the form will include the name of the agency, the appropriate staff contact, and an alternate staff contact. All communication about the assessment and any possible placements will be conducted through the service provider to maintain client confidentiality. The domestic violence service provider will include an internally generated ID number that the agency can associate with the client, but that cannot otherwise be identified with the client. COT staff will use the number to identify the client when communicating with the service provider.

b) **Community Queue**

COT will maintain a separate Community Queue outside of HMIS for survivors referred by domestic violence service providers. No client data will be entered into HMIS, in order to maintain confidentiality and safety for survivors and compliance with federal law. Anytime there is an opening in a permanent housing program, COT staff will reference both the HMIS community queue outside of HMIS to determine the most highly prioritized eligible individual/household.

c) **Housing Referrals**

When an anonymous client from a domestic violence service provider receives a housing referral, OSH staff will contact the service provider. It is the responsibility of the service provider to reach out to the client and connect them with the permanent housing provider. The standard policies regarding the length of time to look for someone and the individual’s/household’s right to decline a referral still apply.

8. **Transition Process - Existing Project Specific Wait Lists**

COT will work with projects that have existing project-specific wait lists to transition to using coordinated assessment to fill program spaces. Transition plans will be made on a project-by-project basis and will take into account funding and regulatory requirements specific to each project. Some possible transition plans include:
1) **One-Time Transition** – The project notifies every individual or household on their wait list that they will change the method for accepting applicants. Everyone on the wait list is directed to complete the VI-SPDAT at an access point organization. The wait list is disbanded and the project begins filling all units from community queue referrals.

2) **Phased Transition** – The project designates some portion of their units to be filled utilizing coordinated assessment, while continuing to fill the remaining units from the existing wait list until it is gone. No new individuals or households should be added to the project specific wait list.

9. **Administrative Structure**

   a) **System Oversight**

   Oversight of the coordinated assessment system, including implementation of the VI-SPDAT, community queue, prioritization and match-making, will be provided by the City of Topeka (COT). COT serves as the Topeka/Shawnee County CoC’s collaborative applicant and is a member of the CoC Board and the CoC Coordinated Assessment Work Group.

   b) **Grievance Procedures**

   Any person participating in the coordinated assessment process has the right to file a grievance. Grievances related to a particular service provider (for example, a grievance related to how an assessment was conducted at a particular provider) should be resolved through that provider’s grievance procedure. Grievances specific to the coordinated assessment system (for example, a grievance related to the match making process), should be forwarded to COT.

   c) **Revisions to Policies and Procedures**

   The Policies and Procedures document will be reviewed and, if necessary, updated at least annually by Coordinated Assessment Work Group and COT staff.

   d) **Participating Providers:**

   All CoC and ESG funded service providers must participate in the coordinated assessment system. For permanent housing providers (both rapid rehousing and permanent supportive housing) that means working with the coordinated assessment system to take referrals from the community queue. The CoC strongly encourages all other permanent housing providers with housing dedicated to people who are homeless to participate as well.

10. **Definitions**
**Chronic Homelessness** – HUD’s definition of chronically homeless is an individual (or a family with an adult head of household) who:
  - Is homeless and lives in a place not meant for human habitation, a safe haven, or an emergency shelter;
  - 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 one year or on at least four separate occasions in the last three years; AND
  - Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, and developmental disability, and post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

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 who meet all of the criteria above before entering that facility is also considered chronically homeless (24 CFR 578.3).

**Collaborative Applicant** – The eligible applicant that has been designated by the Continuum of Care to apply for a grant for Continuum of Care planning funds on behalf of the Continuum. The collaborative applicant for Topeka Shawnee County is the Office of Supportive Housing.

**Community Queue** – A prioritized list in HMIS of people who have completed the triage assessment survey and are in need of permanent housing. The list can be sorted by basic eligibility criteria and is prioritized so that individuals and families with the greatest need are housed first.

**Continuum of Care (CoC)** – The Topeka Shawnee County Continuum of Care carries out the responsibilities required under HUD regulations, set forth at 24 CFR 578 – Continuum of Care Program. The CoC is comprised of a broad group of stakeholders dedicated to ending and preventing homelessness in Topeka Shawnee County. CoC membership is open to all interested parties and included representatives from organizations within Topeka Shawnee County. The overarching CoC responsibility is to ensure community-wide implementation of efforts to end homelessness and ensuring programmatic and systemic effectiveness of the local continuum of care program.

**Emergency Solutions Grant (ESG)** – ESG is a grant program of the U.S. Department of Housing and Urban Development (HUD) that funds emergency assistance for people who are homeless or at-risk of homelessness. ESG grantees are required to participate in Coordinated Assessment.
- **Homeless** – HUD’s definition of home (24 CFR 578.3) has four categories:
  - **Category 1** – Literally homeless individuals/families
  - **Category 2** – Individuals/families who will imminently lose their primary nighttime residence with no subsequent residence, resources, or support networks.
  - **Category 3** – Unaccompanied youth or families with children/youth who meet the homeless definition under another federal statute.
  - **Category 4** – individuals/families fleeing or attempting to flee domestic violence.

- **Homeless Management Information System (HMIS)** – a local information technology system used to collect data on the provision of housing and services to homeless individual and families.

- **Housing and Urban Development (HUD)** – The United States Department of Housing and Urban Development.

- **Literally Homeless** – Category 1 of HUD’s definition of homelessness. Literally homeless means an individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning the individual or family has a primary nighttime residence that is a public or private place not meant for human habitation, the individual or family is living in a public or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by charitable organization or federal, state, or local government programs), or the an emergency shelter or place not meant for human habitation immediately before entering that institution.

- **Permanent Supportive Housing (PSH)** – a type of permanent housing designed for chronically homeless and other highly vulnerable individuals and families who need long-term support to stay housed. Permanent supportive housing provides housing linked with case management and other supportive services. Permanent supportive housing has no time limitation, providing support for as long as needed and desired by the resident.

- **Rapid Rehousing (RRH)** – The consent form that individuals/households complete and sign to grant consent for their personal information to be entered into HMID and used for coordinated assessment. Signing the release of information is not required to participate in coordinated assessment and receive referrals for housing; however, it is required that information be entered into HMIS.
• **Service Prioritization Decision Assistance Tool (SPDAT)** – an assessment tool that is designed to help guide case management and improve housing stability outcomes.

• **Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)** – a pre-screening tool that can be conducted to quickly determine whether a client has high, moderate, or low acuity.