Coordinated Assessment System

Policies and Procedures

06/07/17 (amended 9/18/17)

Background

Under the interim rule for the U.S. Department of Housing Urban Development's (HUD) Continuum of Care (CoC) program, each Continuum of Care must establish and operate 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 are, 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 receiving HUD CoC and Emergency Solutions Grant (ESG) funds (Burlington County does not currently receive ESG funding).

Burlington County's Continuum of Care has been actively engaged in a community wide strategic planning and implementation process to alleviate homelessness in Burlington County. A valuable tool in this endeavor is Coordinated Assessment (CA). Coordinated Assessment (or Coordinated Entry) is a consistent, community wide process to match people experiencing homelessness to community resources that are the best fit for their situation including homeless prevention, housing and other services.

Coordinated Assessment works by requiring homeless individuals and families who 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 clients to traverse the county seeking assistance a every provider separately. When participating programs do not have enough space to accept all referrals from the system, clients are prioritized for services based on need.

The Burlington County CA implementation phase started with a small group of providers who tested the effectiveness of using a standardized CA process that connected households with a wide range of services to respond to their assessed needs. The service delivery system that piloted featured:

1. Prevention strategies aimed at keeping households who were on the edge of homelessness housed and linked with appropriate services.
2. Diversion services targeted to those clients that could be successfully diverted from more intensive housing assistance
3. A standardized, uniform CA aimed at providing consistent, effective and swift access to needed services.

4. Rapid Re-housing aimed at helping homeless households quickly exit homelessness and stabilize in permanent housing.
5. Tailored services to provide services at the appropriate level and time to meet households' needs.
6. Economic opportunities that include aggressive engagement with employment services systems to help households advance toward self-sufficiency.
7. Data and evaluation enhancements to inform planning and decision-making.

The experiences of the pilot partners and households served as a catalyst for making changes to the CA tool to better serve the CoC community,

The goal of the Coordinated Assessment system is the implementation of a standardized assessment and that all emergency shelter, transitional housing, permanent supportive housing, and rapid rehousing placements are made through that system. Coordinated Assessment should serve all populations, prioritize, and place clients effectively and efficiently, quickly matching people to the housing type that is most likely to transition them to permanent housing.

Coordinated Assessment benefits the community by:

- Using existing resources effectively by connecting people to the housing program that is the best fir for their situation
- Reducing the need for people to call around to multiple housing programs and fill out multiple applications to join waitlists. Community Development 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 Burlington County need different types of housing. This information will help the CoC advocate for more resources to provide housing and supportive services for Burlington County's homeless.

Coordinated Assessment is NOT a stand-alone solution to end homelessness or a solution to the shortage of affordable housing stock. It is, instead, a system to promote access to an effective utilization of mainstream programs by homeless individuals and families and to optimize self-sufficiency among individuals and families experiencing homelessness by identifying and prioritizing the most vulnerable, disabled, and/or chronically homeless individuals and families.

System Overview

The Burlington County Coordinated Assessment system requires that all homeless individuals and families will complete a standard triage assessment survey that considers the household's situation and identifies the best type of housing intervention to address their situation. The standard triage assessment survey used by Burlington County is a modified version of the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT). The VI-SPDAT version will be integrated into the standard HMIS intake for people who are homeless and conducted at HMIS partner agencies, including

shelters, 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 CA scores to ensure that those with the greatest need are housed first. This coordinated process should reduce the need for people to seek assistance at every county provider separately.

Non-discrimination and Equal Opportunities

Burlington County operates the coordinated assessment system in accordance with all federal statutes including, but not limited to: the Fair Housing Act, Title VI of the Civil Rights Act, Section 504 of the Rehabilitation Act, and Title II and Title III of the Americans with Disabilities Act. All service providers where assistance is provided must ensure equal access in accordance with all general HUD Program requirements.

The Burlington County CoC requires service providers to incorporate participant choice and inclusion of all homeless subpopulations present in Burlington County, including homeless veterans, youth, and families with children, individual adults, seniors, victims of domestic violence, and Lesbian, Gay, Bi-sexual, Transgender, Queer or Questioning, and Intersex (LGBTQI) individuals and families. All CoC funded service providers must ensure that all people have fair and equal access to the coordinated assessment process and all forms of assistance regardless of race, ethnicity, national origin, age, sex, familial status, religious preference, disability, type or amount of disability, gender identity, perceived gender identity, marital status, sexual orientation, or perceived sexual orientation.

General Process

The CA system provides multiple points for access (locations) where people experiencing homelessness can complete the assessment survey to participate in coordinated assessment and is the first step assessment for all households seeking housing services throughout the county. Currently, all HMIS partner agencies will serve as access points and the triage assessment survey is incorporated in the standard HMIS intake. Additionally, Providence House, the domestic violence service provider in Burlington County will serve as the access point for domestic violence survivors. All of these social service providers reach Burlington County residents by providing services including outreach, shelter, drop-in services, and emergency housing providing a built-in network for reaching homeless people throughout the county.

In order to serve as a CA location, the 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. Maintain at least one staff person who is trained and authorized to conduct the Coordinated Assessment and allow only those trained and authorized staff or volunteers to conduct the assessment
3. Agree to follow the community guidelines for completing the assessment and communicating about the coordinated assessment system.
4. Agree to provide additional referrals to other community services, as appropriate, to people completing the assessment.

As the original point where people connect with the coordinated assessment system, the CA location should be able to respond to inquiries regarding status for a housing referral and be able to:

1. Check HMIS to determine if the individual or household has a current (less than one year old) assessment entered in HMIS
2. If the individual/household is current, respond by indicating that contact will be made if services are available and are a good fit
3. If the individual/household does not have an assessment in HMIS, work with them to complete one.
4. If the assessment is over a year old, an annual update should be initiated to insure that the individual/household's contact information is current and correct.

The Coordinated Assessment is covered under the standard HMIS Release of Information that authorizes HMIS partner agencies to conduct the HMIS intake and assessment, enter the information in HMIS, and share the individual's/household's information with other participating organizations in order to facilitate connecting the household with housing and services. The Release of Information MUSA be completed and uploaded into HMIS before any other information, including the assessment, can be entered into HMIS.

Conducting the Assessment

The Coordinated Assessment tool 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 on paper and then entered into HMIS.

The assessment should be conducted in a setting that promotes privacy and confidentiality. The staff member or volunteer conducting it must follow the CoC's guidelines for explaining what the assessment is and how coordinated assessment works.

All or the questions on the assessment 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 assessment 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 scarcity of available housing options in Burlington County. It is, therefore, important to provide information about resources that can meet immediate needs, such as emergency shelter, food , and health care.

Individuals and households that score in the in the low range should be provided with referrals to other resources to meet their housing needs, since they will not be matched with permanent supportive housing or rapid rehousing. Referrals should be based on the individual's/household's specific situation, and could include referrals to the Burlington County Board of Social Services, emergency shelters, or transitional housing programs.

Updates to Assessments

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

Wait List

Burlington County maintains a Wait List in HMIS based on the assessment 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.

1. **Housing Program Inventory**

   All participating housing providers will enter their program inventory and eligibility criteria in HMIS. Program staff will work with the HMIS system administrator to make sure program information stays up to date. Additional eligibility criteria will be used to pre-screen individuals and households on the wait list for basic eligibility.

2. **Program Determination for Wait List**

   The Coordinated Assessment Tool is used to determine the best type of housing intervention for the individual or household being assessed. Those who are identified with a high score are referred to permanent supportive housing. Those scoring in the moderate range are referred to rapid rehousing. People who are assessed with a low score are most likely able to resolve their homelessness without a housing intervention. Since Burlington County has limited housing capacity, housing interventions will be prioritized for those who most need it. Individuals an households with low scores will be referred to other, non-permanent housing interventions, where appropriate.

3. **Prioritization**

There is a shortage of housing opportunities in Burlington County in comparison to the need. The Coordinated Assessment system is intended to 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 in emergency shelter for at least a year and with the highest score, resulting in serving those who are most in need and most at risk.

Using the Coordinated Assessment 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:

Permanent Supportive Housing Prioritization Criteria

a. Coordinated Assessment 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 score will be served first
b. Length of Time Homeless – Among those with the same score, individuals/households who have been homeless the longest will be prioritized first.
c. High use of Services – among those with the same score and the same length of time homeless, individuals/households will be prioritized based on the level of utilization of County services, with those with the highest utilization served first.

To reflect the 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

a. Coordinated Assessment Score – Those with the highest score within the rapid rehousing range will be served first.
b. Risks Score – Among those with the same assessment score, individuals/households with the highest Risks sub-score in the assessment will be prioritized first.
c. Length of time on the Wait List – Among those with the same score, and the same Risks score, individuals/households will be served in the order they completed the assessment.

<u>Housing Referrals</u>

1. **Matches to Housing Opportunities**

Matches are facilitated by a Housing Navigator. When a permanent housing program has a space available, the designated Navigator will use the Wait List in HMIS to identify the household or individual to be referred by:

a. Filtering the wait list 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.
b. Filtering the wait list based on the eligibility criteria of the housing program.
c. Prioritizing the wait list based on the prioritization methodology described above.

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

The Navigator will provide his/her own judgment and discretion in making referrals based upon the prioritization and match-making methodology laid out these policies and procedures. Discretion may include taking into account a client's known preferences when making matches, 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. Any match that requires some flexibility outside the methodology described here requires approval from senior management.

2. Provider Responsibilities

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

a. *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 the 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. All attempt to find the individual/household must be documented in HMIS.
b. *Verify eligibility*: Information in the individual's/household's HMIS account (including the Coordinated Assessment) is primarily self-reported. Providers will need to conduct their own program intake and documentation of eligibility.
c. *Enter the individual/household into the program in HMIS.*

If the individual/household cannot be located, the provider will notify the Navigator who made the match. Together, the Navigator and the provider will determine if additional attempts should be made. If the individual/household still cannot be located, they will be referred back to the wait list and the Navigator will initiate a new match.

If the individual/household turns out to be ineligible for the program, they will be referred back to the wait list and the Navigator 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, the Navigator mat initiate a review of the client's information and/or request tha

the client complete an updated assessment (for example, if inaccurate or out of date information on the assessment led the Navigator to believe the client would be eligible).

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

a. The Navigator 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 Burlington County.
b. If an individual/household declines 3 referrals, the Navigator will wait three months before making the next referral.
c. If an individual/household declines 6 referrals, the Navigator will communicate with the individual/household that they will not be given any new referrals until they inform the Navigator that they are interested in receiving a new referral.

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 CoC wait list. However, some projects have requirements from their funders that may conflict with coordinated assessment. In those situations, the Navigator will work with the provider to determine the best possible way to participate in coordinated assessment.

Confidential Process for Domestic Violence Survivors

A separate, confidential process is available for domestic violence survivors who are receiving services form the designated domestic violence provider in Burlington County. 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.

Administrative Structure

System Oversight

Oversight of the coordinated assessment system, including implementation of the assessment tool, waiting list, prioritization and match-making will be provided by the Burlington County Office of Human Services. The Human Services office serves as the administrative liaison and HMIS Lead and staffs the CoC Governance Board and the CoC Coordinated Assessment Sub-Committee. The CoC board delegated authority to the Human Services office, as the collaborative applicant, to approve and implement operational policies for coordinated assessment, although input from the CoC is always factored into any decisions. Regular reports by representatives of the Human Services department will be provided at both the CoC Governance Board and CoC meetings.

Grievance Procedures

Any person participating in the coordinated assessment process has the right to file a grievance. Grievances related to a particular service provider (e.g., 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 (e.g., a grievance related to the match making process), should be forwarded to the Burlington County Human Services department.

Revisions to Policies and Procedures

The Policies and Procedures will be reviewed, and, if necessary, updated at least annually by the Coordinated Assessment sub-committee and the Human Services staff responsible for implementing the Coordinated Assessment.

Participating Providers

All CoC 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 waiting list. The CoC strongly encourages all other permanent housing providers with housing dedicated to people who are homeless to participate, as well.

Definitions

- **Access points** – Locations where people can complete the triage assessment (Coordinated Assessment) survey to participate in the coordinated assessment process. Access points can include emergency shelters and any social services providers.
- **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 three years; and
    - ❖ Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, development disability, 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 met 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 the CoC planning funds on behalf of the CoC. The Collaborative Applicant for Burlington County is the Burlington County Human Services Department.
- **Continuum of Care (CoC)** – The Burlington 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 Burlington County. CoC membership is open to all interested parties, and includes representatives from organizations within Burlington County. The over-arching 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.
- **Coordinated Assessment Tool** – an assessment tool designed to help guide case management and improve housing stability outcomes and that can be conducted to quickly determine whether a client has high, moderate, or low acuity.
- **Emergency Solutions Grant (ESG)** – ESG is a grant program of HUD that funds emergency assistance for people who are homeless or at risk of homelessness. Burlington County does not, however, receive ESG funds at present.
- **Homeless** – HUD's definition of homelessness (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)** – an information technology system used to collect data on the provision of housing and services to homeless individuals and families.
- **Housing Navigator** – Individual responsible for engaging and preparing a client for housing placement and serves as primary point of contact for the homeless individual/family after assessment. The Housing Navigator will match the assessed homeless individual/family with the appropriate housing placement.
- **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 publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by charitable organizations or federal, state, or local government programs), or the individual is exiting an institution where he/she 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.
- **Office of Human Services** – office within Burlington County, Department of Human Services. Serves as the collaborative applicant for the Burlington County Continuum of Care, staffs the

Coordinated Assessment Sub-committee, and serves as the lead for implementation of coordinated assessment in Burlington County.

- **Permanent Supportive Housing (PSH)** – 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)** – permanent housing program that provides short-term financial assistance and intensive support to quickly re-house households in their own independent households. The goal of Rapid Rehousing is to quickly move households out of homelessness and back into permanent housing, providing the level of service necessary to assist the household.
- **Release of Information** – the consent form that individuals/households complete and sign to grant consent for their personal information to be entered into HMIS and used for coordinated assessment. Signing the release of information is required to enter information into HMIS>
- **Transition Age Youth** – Young adults ages 18-24 years old