Connect To Home:

Coordinated Entry System of Eastern PA

Policy Manual

Revised: December 18, 2019

For more information: http://www.pennsylvaniacoc.org/connecttohome

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TABLE OF CONTENTS

EASTERN PA COC COORDINATED ENTRY SYSTEM COMMITTEE 5

INTRODUCTION 6

About the Eastern Pennsylvania Continuum of Care 7
The Benefits of Coordinated Entry 8
HUD Coordinated Entry Requirements 10
Coordinated Entry and Housing First 10
Key Coordinated Entry System Terms and Definitions 12

GUIDING PRINCIPLES 16

COORDINATED ENTRY SYSTEM DESIGN 17

Integration of Veterans Service Organizations into CES 17
CES Governance 18
CES Regional Managers 18
Coordinated Entry Specialists 20
Coordinated Entry Referral Partners 21
Responsibilities of all Coordinated Entry System Partner Organizations 22

COORDINATED ENTRY SYSTEM ACCESS 23

CES Call Center 23
CES Access Sites 23
Street Outreach 28
Safety Planning 28
Access to Emergency Services 29
CES Marketing and Outreach Plan 29

COORDINATED ENTRY WRITTEN STANDARDS 32

Minimum Standards for Coordinated Entry Regional Managers, Specialists and Referral Partners 32
VI-SPDAT Score Community Queue Placement Guidelines 34
Prioritization Standards for Emergency Service Providers Receiving Referrals from Coordinated Entry 35
Prioritization Standards for Rapid Re-Housing Providers Enrolling Households from the Community Queue 36
Prioritization Standards for Permanent Supportive Housing Providers Enrolling Households from the Community Queue 37
Performance Benchmarks 39

COORDINATED ENTRY INTAKE PROCESS 41

Overview 41
Coordinated Entry Process Workflow in HMIS 41

Intake and Assessment 42
Client Intake 43
Client Search 43
Call/Visit History 45
Pre-Screening 45
Client Sharing 47
Zip Code / County 47
Slept Last Night / Length of Living Situation / Losing Housing in next 14 days 48
Homeless Category 48
Literally Homeless / Fleeing DV Status 50
Prevention / At-Risk Status 50
Military Service 50
Discrimination 51
Homeless / VI-SPDAT Path 52
Edit/View Household Members 52
VI-SPDAT 53
VI-SPDAT Assessment 54
Family Members 55
Follow-up Questions 56
Edit previous VI-SPDAT 58
VI-SPDAT Copy Feature 59
Eligibility and Referrals 59
Community Queue Placement 60
Has Immediate Housing Need 61
Placement on Community Queue 63
Prevention / Diversion Tool for Households At Risk of Homelessness 65
Direct Referrals 66
Emergency Housing/Service Referrals (HMIS Referrals) 66
Emergency Housing/Service Referrals (Non-HMIS Referrals) 70
Coordinated Intake Notes 71
Intake/Assessment Management 73
Intake and Assessment - DV / Anonymous Client Addendum 74
DV / Anonymous Client Intake 74
Pre-Screen | VI-SPDAT 76
Community Queue Placement 77
Community Queue Management 78
Community Queue Search 79
Community Queue Emergency Service Needs 81
Emergency Shelter/Service Referrals 81

Community Queue Statuses 82
Community Queue Days in Status 83
Community Queue Management Functions 84
Review Community Queue Record 84
Accept/Enroll from Queue 85
Change Queue Status 86
Community Queue Coordinated Intake Notes 87
Add/Create Intake Note 88
Intake Log Notes 88
Community Queue Housing Placement Process 88
Accept/Enroll from Queue 88
Service Acceptance 88
Non-Active / Closeout Process 89
Community Queue Status 89
Community Queue Referral Management 90
Accept/Reject Referral 91
Accepted Status 92
Rejected/Cancelled Status 92
Review Referral 93

CONNECT TO HOME: COORDINATED ENTRY SYSTEM OF EASTERN PA PARTNERSHIP AGREEMENT 94
I. Guiding Principles 94
II. Roles 95
III. Responsibilities 97
IV. Termination of Agreement 98
V. Expenses 98
VI. Agreement 99

CONNECT TO HOME: COORDINATED ENTRY SYSTEM OF EASTERN PA NOTICE AND CONSENT FORM FOR NON-HMIS PARTICIPANTS 100

APPENDICES 102

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POLICY MANUAL WRITING AND DESIGN

Capacity for Change, LLC

INTRODUCTION

The **Connect to Home: Coordinated Entry System of Eastern PA** (CES) coordinates and manages access, assessment, prioritization, referral to emergency services and enrollment into permanent housing from the Community Queue (CQ) in PA HMIS for any person(s) experiencing or at imminent risk of homelessness in the CoC service area. CES is accessible through a toll-free Call Center operated by PA 2-1-1, providing a 24/7 live voice as well as a texting option and dedicated language translation and Deaf/Hard of Hearing services. In addition, CES Access Sites are operated by a wide variety of providers that deliver face-to-face screening and referral. A list of current CES Access Site locations, hours of operation, policies and marketing materials are available online at https://pennsylvaniacoc.org/connecttohome. Five dedicated Regional Managers oversee implementation of CES across the CoC's regions (RHABs).

Call Center and Access Site Coordinated Entry Specialists (Specialists) provide uniform services for people experiencing homelessness or a housing crisis:

- Triage and Safety Planning to assure the person is eligible for Eastern PA CoC services and not in immediate danger. If the person is in immediate danger, they will be connected to 911, Domestic Violence (DV) Hotline, Human Trafficking hotline, etc.;
- PA HMIS record creation/update;
- Pre-Screen Interview to determine HUD Category of homelessness (1, 2, 3, 4 or At Risk) and identify appropriate intake process (Prevention or Literal Homeless);
- Prevention Intake, including the use of Diversion Tool, for Category 2, 3 or At Risk, leading to direct referral to appropriate Homeless Prevention and community services (e.g., food pantries, health clinics, legal aid, etc.); and,
- Literal Homeless Intake, including the use of VI-SPDAT Screening Tool and placement on the CQ for RRH or PSH, in addition to the use of Diversion Tool and, if necessary, direct referral to Emergency Shelter or Transitional Housing for Category 1 and 4.

Connect To Home: Coordinated Entry System of Eastern PA (CES) coordinates and manages access, assessment, prioritization and referral to housing and services for any person(s) experiencing or at imminent risk of homelessness in the following counties: Adams, Bedford, Blair, Bradford, Cambria, Carbon, Centre, Clinton, Columbia, Cumberland, Franklin, Fulton, Huntingdon, Juniata, Lebanon, Lehigh, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Schuylkill, Somerset, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming.

Participation in CES is required for all projects funded by HUD Continuum of Care or Emergency Solutions Grants (including those administered by the Commonwealth of Pennsylvania) and strongly encouraged for all other housing and service providers in order to ensure equitable and coordinated access for all. In order to participate in CES as an Operations and/or Referral Partner, an organization must simply agree to the terms and sign the Eastern PA CoC CES Partnership Agreement (see Appendix: Partnership Agreement).

This policy manual details the CoC-approved policies and procedures that must be followed by any organization participating in CES, either as Coordinated Entry providers and/or referral partners.

About the Eastern Pennsylvania Continuum of Care

The mission of the PA-509 Eastern Pennsylvania Continuum of Care is to end homelessness in a thirty-three county region of Eastern Pennsylvania. CoC membership is free and open to any individual or public, private or nonprofit organization that is committed to making homelessness rare, brief and non-recurring. Led by a member-elected Governing Board, the CoC advances its mission by:

1. Promoting effective and efficient community-wide solutions to ending and preventing homelessness for all persons;
2. Securing and administering funding from the U.S. Department of Housing and Community Development's (HUD) Annual Continuum of Care Grant Program;
3. Regularly convening cross-sector partners at both the CoC and regional levels;
4. Gathering, analyzing and distributing data from an Annual Homeless Point-In-Time Count and the CoC's Homeless Management Information System (HMIS);
5. Establishing and enforcing policies and procedures for CoC-funded housing and service projects; and,
6. Providing training and technical assistance to maximize system performance and outcomes.

Each year, the CoC secures approximately $12,000,000 from HUD and other public sources to support housing and services to help end homelessness in this thirty-three county region. HUD CoC Program grant funding is leveraged and braided with other federal, state, local and private funding sources to support a comprehensive housing crisis response system that includes Coordinated Entry, Homeless Prevention, Street Outreach, Emergency Shelter, Transitional Housing, Rapid Re-Housing, Permanent Supportive Housing and other support services.

The CoC is subdivided into five geographic regions overseen by Regional Homeless Advisory Boards (RHABs) that are responsible for locally identifying needs and operationalizing CoC goals, projects and policies. These five regions and their respective counties include:

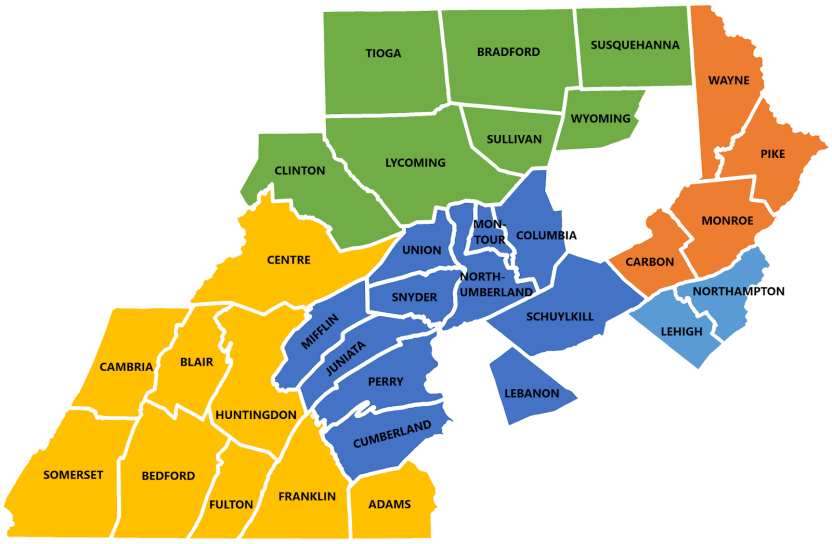
Central Valley – Columbia, Cumberland, Juniata, Lebanon, Mifflin, Montour, Northumberland, Perry, Schuylkill, Snyder, Union

Lehigh Valley – Lehigh, Northampton

Northern Tier – Bradford, Clinton, Lycoming, Sullivan, Susquehanna, Tioga, Wyoming

Pocono – Carbon, Monroe, Pike, Wayne

South Central – Adams, Bedford, Blair, Cambria, Centre, Franklin, Fulton, Huntingdon, Somerset



The Benefits of Coordinated Entry

Traditionally uncoordinated housing crisis response systems are commonly characterized as fragmented, duplicative, confusing and inefficient. In contrast, Coordinated Entry Systems connect more people to the right solution to end their housing crisis or homelessness as quickly and effectively as possible. It is important to note, however, that Coordinated Entry alone cannot address the lack of affordable housing or housing and shelter resources in any given community. Instead, Coordinated Entry will ensure limited housing and resources will be prioritized for the people who need them the most while generating more accurate data to make the case for appropriate levels of investment in the future.

Uncoordinated Entry Systems	Coordinated Entry Systems
For People Experiencing a Housing Crisis or Homelessness	
• Geography, transportation, language and/or culture are barriers to access • Navigating the system is difficult • Housing and services are often available on a “first come, first serve” basis • Referrals are often inappropriate • People in crisis often make/complete multiple calls, agency visits and assessments to obtain help • Assessment and referrals are project-centric, designed to meet program requirements	• Promotes easier, more fair and more equitable access • Streamlines system navigation • Prioritizes housing and services based on vulnerability and severity of need • Increases number of appropriate referrals • Reduces the number of times people must tell their story • Assessment and referrals are person-centric, taking into account consumer agency and goals, while also being uniformly guided by written CoC standards
For Service Providers	
• Significant amount of time spent on intake and referral (often unfunded) • Unreliable or missing client information • Inconsistent information on availability of housing and services • Lack of a common language and assessment tools among service providers • Inability to demonstrate need for additional investments in housing and services to meet community needs • Out of compliance with federal and state policy and funding requirements	• More time to focus on their mission of ending or preventing homelessness • Better access to client information and history • More complete knowledge of all available housing and services • Common language and assessment score to guide case management and communicate with other service providers • Systemic data to advocate for funding and programs to meet community needs • Alignment with federal and state policy and funding requirements
For Public and Private Funders	
• Inability to determine whether investments are making a difference • Lack of data to make informed planning, policy and budget decisions • Funding in silos	• Ability to assess community/collective impact of investments • Data-driven planning, policy and budget decisions • Funding aligned across sectors and sources

HUD Coordinated Entry Requirements

The 2009 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act consolidated several of HUD's separate homeless assistance programs into a single grant program, the Continuum of Care Program (CoC Program). The CoC Program interim rule requires that CoCs establish and operate a "centralized or coordinated assessment system" and defines coordinated entry as a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals (24 CFR part 578.3).

On January 23, 2017, HUD published Notice CPD-17-01: Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System.[1] The notice established the minimum requirements for Coordinated Entry and required them to be in place in every CoC by January 23, 2018. According to the notice, CoC Coordinated Entry Systems must:

- Cover the entire geographic area claimed by the CoC;
- Be easily accessed by individuals and families seeking housing or services;
- Be well-advertised;
- Include a comprehensive and standardized assessment tool;
- Provide an initial, comprehensive assessment of individuals and families for housing and services; and,
- Include a specific policy to guide the operation of the centralized or coordinated assessment system to address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim specific providers.

The Eastern PA CoC CES is fully compliant with these requirements.

Coordinated Entry and Housing First

Coordinated Entry supports a "Housing First" approach to ending homelessness. According to the United States Interagency Council on Homelessness:

"Housing First is a proven approach, applicable across all elements of systems for ending homelessness, in which people experiencing homelessness are connected to permanent housing swiftly and with few to no treatment preconditions, behavioral contingencies, or other

[1] https://www.hudexchange.info/resource/5208/notice-establishing-additional-requirements-for-a-continuum-of-care-centralized-or-coordinated-assessment-system/

barriers. It is based on overwhelming evidence that people experiencing homelessness can achieve stability in permanent housing if provided with the appropriate level of services. Study after study has shown that Housing First yields higher housing retention rates, drives significant reductions in the use of costly crisis services and institutions, and helps people achieve better health and social outcomes."[2]

Coordinated, unified and streamlined entry into a community's housing crisis response system is essential to a Housing First approach to ending homelessness. Once a family or individual in crisis is safe and in housing, it is easier for them to concentrate on their stability goals related to education, employment, health and economic self-sufficiency. Adopting a Housing First approach challenges housing and service providers to lower barriers to program entry and remove conditions attached to securing permanent housing. A Housing First approach ultimately achieves better outcomes at costs equal to or less than traditional approaches to ending homelessness.

According to the National Alliance to End Homelessness:

"A Housing First approach can benefit both homeless families and individuals with any degree of service needs. The flexible and responsive nature of a Housing First approach allows it to be tailored to help anyone. As such, a Housing First approach can be applied to help end homelessness for a household who became homeless due to a temporary personal or financial crisis and has limited service needs, only needing help accessing and securing permanent housing. At the same time, Housing First has been found to be particularly effective approach to end homelessness for high need populations, such as chronically homeless individuals.

What are the elements of a housing first program? Housing First programs often provide rental assistance that varies in duration depending on the household's needs. Consumers sign a standard lease and are able to access supports as necessary to help them do so. A variety of voluntary services may be used to promote housing stability and well-being during and following housing placement.

Two common program models follow the Housing First approach but differ in implementation. Permanent supportive housing (PSH) is targeted to individuals and families with chronic illnesses, disabilities, mental health issues, or substance use disorders who have experienced long-term or repeated homelessness. It provides long-term rental assistance and supportive services.

[2] United States Interagency Council on Homelessness Housing First Checklist: Assessing Projects and Systems for a Housing First Orientation, September 2016. https://www.usich.gov/resources/uploads/asset_library/Housing_First_Checklist_FINAL.pdf

A second program model, rapid re-housing, is employed for a wide variety of individuals and families. It provides short-term rental assistance and services. The goals are to help people obtain housing quickly, increase self-sufficiency, and remain housed. The Core Components of rapid re-housing—housing identification, rent and move-in assistance, and case management and services—operationalize Housing First principles."[3]

Connect To Home: Coordinated Entry System of Eastern PA incorporates Housing First into its system design while still providing local communities and organizations with the flexibility to operate a wide variety of housing interventions and homeless services that contribute to the goal of ending and preventing homelessness. Further, the CES is designed to align and connect with other mainstream systems of care, including child welfare, domestic violence, economic self-sufficiency, education, employment and job training, health, legal, mental/behavioral health, and public benefits access, among others. Coordinated Entry is the key to connecting these systems together in a person-centered, trauma-informed way.

The Eastern PA CoC requires all CoC-funded programs to comply with Housing First. See Appendix: Eastern PA Continuum of Care Policy Requiring the Use of a Housing First Approach.

Key Coordinated Entry System Terms and Definitions

Coordinated entry is an approach to coordination and management of a crisis response system's resources that allows users to make consistent decisions from available information to efficiently and effectively connect people to interventions that will rapidly end their homelessness.

Crisis response system denotes all the services and housing available to persons who are at imminent risk of experiencing literal homelessness and those who are homeless, whereas homeless system refers specifically to the services and housing available only to persons who are literally homeless.

Emergency services for a person experiencing homelessness or a housing crisis include, but are not limited to, homelessness prevention, domestic violence and emergency services hotlines, drop-in service programs, domestic violence shelters, emergency shelters, hotel/motel voucher programs, transitional housing and other short-term crisis residential programs.

An **Emergency Shelter** (ES) refers to any facility, the primary purpose of which is to provide a temporary shelter for the homeless in general or for specific populations of the homeless and which does not require occupants to sign leases or occupancy agreements.

[3] National Alliance to End Homelessness Housing First, April 2016. https://endhomelessness.org/resource/housing-first/

Homeless Management Information System (HMIS) is the database used to confidentially aggregate data on homeless populations. The system allows for a record of client-level information about the characteristics and services needs of homeless persons.

The term **household** is intended to cover any configuration of persons in crisis, whatever their age or number (adults, youth, or children; singles or couples, with or without children).

Homelessness Prevention includes financial assistance, rental assistance, and services provided to individuals and families who are at imminent risk, or at risk of homelessness.

Housing interventions are permanent housing programs and subsidies, including, Rapid Re-Housing and Permanent Supportive Housing programs, as well as permanent housing subsidy programs such as Housing Choice Vouchers.

People in a housing crisis who are accessing or being assessed by coordinated entry are referred to as **people** or **persons**; once they are referred to and enroll in housing or supportive services, they are **program participants** (or consumers).

HUD is the United States Department of Housing and Community Development whose mission is to create strong, sustainable, inclusive communities and quality affordable homes for all. HUD oversees the Continuum of Care (CoC) and Emergency Solutions Grant (ESG) programs that fund housing and services for people experiencing homelessness, including coordinated entry.

People who are literally homeless (HUD Category 1 Homeless Definition) include any individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

(i) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;

(ii) An individual or family living in a supervised 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, or local government programs for low income individuals); or

(iii) An individual who is exiting an institution where he or she 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 (24 CFR 578.3).

People imminently at risk of homelessness (HUD Category 2 Homeless Definition) include any individual or family who will imminently lose their primary nighttime residence, provided that:

(i) The primary nighttime 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, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing (24 CFR 578.3).

People who are homeless under other Federal statutes (HUD Category 3 Homeless Definition) include 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 during the 60 days prior to the homeless assistance application;

(iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and

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

People fleeing domestic abuse or violence (HUD Category 4 Homeless Definition) include any individual or family who:

(i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, trafficking, or other dangerous or life- threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;

(ii) Has no other residence; and

(iii) Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing (24 CFR 578.3).

A person who is **chronically homeless** is 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 one year or on at least four separate occasions totaling 12 months or more 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 (42 U.S.C. 15002)), 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 met all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice], before entering that facility; 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 [as described in Section I.D.2(a) of this Notice, including a family whose composition has fluctuated while the head of household has been homeless. (24 CFR 578.3).

Permanent Supportive Housing (PSH) is a model that combines low-barrier affordable housing, health care, and supportive services to help individuals and families lead more stable lives. PSH typically targets people who are homeless or otherwise unstably housed, experience multiple barriers to housing, and are unable to maintain housing stability without supportive services. This model has been shown to not only impact housing status, but also result in cost savings to various public service systems, including health care.

Rapid Re-Housing (RRH) provides short-term rental assistance and services. The goals are to help people obtain housing quickly, increase self- sufficiency, and stay housed. It is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the needs of the person. The core components of Rapid Re-Housing are housing identification, rent and move-in assistance, and rapid re-housing case management and services.

Transitional Housing (TH) has as its purpose facilitating the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months). Transitional housing includes housing primarily designed to serve deinstitutionalized homeless individuals and other homeless individuals with mental or physical disabilities and homeless families with children.

Veteran means a person who served in the active military, naval, or air service.

GUIDING PRINCIPLES

Connect To Home: Coordinated Entry System of Eastern PA is guided by the following principles:

- Every person experiencing homelessness should be treated with dignity, respect and kindness, and have their rights to privacy, confidentiality and safety honored.
- By coordinating entry to housing and services for people experiencing homelessness, more families and individuals can exit from homelessness to permanent housing with stability as quickly, efficiently and effectively as possible.
- Coordinated entry is inclusive of all populations experiencing homelessness, including families, youth, veterans, survivors of domestic violence, people with disabilities, people with mental illness, recent immigrants and people identifying as LGBTQIA.
- Coordinated entry protects the safety and confidentiality of people fleeing/attempting to flee and survivors of domestic violence while simultaneously providing them with access to housing and services.
- Coordinated entry embraces a housing first approach to ending homelessness in which people are housed as quickly as possible without preconditions or service participation requirements.
- People experiencing homelessness are prioritized for appropriate housing and services based on their vulnerability and severity of need using an evidence-based assessment tool rather than on a “first come, first served” basis.
- People experiencing homelessness are not denied access to coordinated entry assessment and referral based on perceived barriers to housing and services such as sobriety, income level, mental health status or other factors.
- Coordinated entry should be aligned with affordable housing, veterans affairs, child welfare, health, mental health, education, legal, judicial and other public systems to the greatest extent possible allowed by law and policy.
- Coordinated entry is a continually evolving system that requires a commitment to ongoing learning, evaluation and quality improvement.
- Ongoing coordinated entry planning efforts strive to incorporate diverse stakeholder voices and needs, including those of people with the lived experience of homelessness.
- The long-term financial sustainability of coordinated entry requires the commitment and alignment of federal, state, local and private funding sources.

COORDINATED ENTRY SYSTEM DESIGN

The Eastern Pennsylvania Continuum of Care housing crisis response system includes all of the housing and services available to persons who are literally homeless or at imminent risk of homelessness. **Connect To Home: Coordinated Entry System of Eastern PA** coordinates access, assessment, prioritization and referral into the housing crisis response system for all households and populations. The term household is intended to cover any configuration of persons in crisis, whatever their age or number (adults, youth, or children; singles or couples, with or without children). CES will also attempt to divert households from entering shelter if possible. Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternative housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing.

Households may access CES through either a toll-free Call Center or through designated Access Sites in each region (consumers will choose one or the other, not both). Dedicated Regional Managers will guide daily CES operations in each region of the CoC, provide technical assistance to providers, support to consumers, information to system leaders, and outreach to community members.

Participation in CES is required for all projects funded by HUD Continuum of Care or Emergency Solutions Grants (including those administered by the Commonwealth of Pennsylvania) and strongly encouraged for all other housing and service providers in order to ensure equitable and coordinated access for all. CES data will be entered, managed, saved and analyzed by the Eastern Pennsylvania CoC Homeless Management Information System (PA HMIS).

Integration of Veterans Service Organizations into CES

In addition to Veterans Affairs Medical Center (VAMC) integration into CoC initiatives, Supportive Services for Veteran Families (SSVF) program guidance expects grantees to be fully engaged with their local CoC to the fullest extent possible. Grantees must work in close partnership with their local CoC to establish a community-wide plan to prevent and end homelessness among Veterans. SSVF grantees are expected to engage as active members in each and every CoC where they are approved to provide assistance. In particular, SSVF grantees are expected to formally participate in the planning of local coordinated intake and assessment processes (i.e., "coordinated entry"), which each CoC establishes for itself. This system creates a centralized or coordinated means for all households experiencing homelessness to access homeless assistance services and matches them with the best fit shelter, housing, and relevant services. SSVF grantees are responsible for ensuring that SSVF is formally integrated into this local CoC

process and, where necessary, for taking a lead role in developing and implementing such processes for Veterans. This includes situations where a grantee's service area is covered by multiple CoCs, SSVF where providers are responsible for participating in each CoC's coordinated entry system and planning.

On October 17, 2017, the U.S. Department of Veterans Affairs (VA) Deputy Under Secretary for Health for Operations and Management released a memo to the VA Network Directors, VA Network Homeless Coordinators, and VA Medical Center (VAMC) staff which issued guidance regarding the roles and responsibilities of the VA medical center homeless programs in each of the local Continuum of Care (CoC) and the CoC's Coordinated Entry Systems (CES). This guidance from the VA to the VA medical centers is meant to support community planning and CES efforts within CoCs by clearly outlining the expectations of VA medical center involvement. In many ways, this guidance codifies what has already been occurring in local communities. Where new partnerships are needed, it provides the opportunity for engagement. Within the guidance, VA recognizes that coordinated entry systems are a critical element in our collective and continued efforts to end Veteran homelessness and homelessness for all populations. Coordinated Entry ensures coordination of community-wide services for Veterans experiencing homelessness, system-wide awareness of the availability of housing and services, and easy access to and appropriate prioritization for these resources by Veterans who are in critical need.[4]

CES Governance

The Eastern PA CoC Coordinated Entry Committee, a standing committee of the CoC, is responsible for CES planning, budgeting, policies and procedures, selection of operational partners, training, evaluation and oversight. The Committee solicits input from service providers, funders, community partners and consumers to ensure its recommendations and decisions are inclusive of diverse voices. The CoC Governing Board, which is elected by the CoC membership, has final approval of all CES policies.

CES Regional Managers

Coordinated Entry System Regional Managers are dedicated staff members employed and supervised by a public or nonprofit organization operating within each of the five regions that comprise the Eastern PA CoC. The CoC also have a CES Call Center Manager and a CES Domestic Violence Coordinated Entry Specialist. The responsibilities of CES Regional Managers include to:

[4] U.S. Department of Housing and Urban Development From Our Federal Partners: VA and Coordinated Entry Systems (CES) Memo, November 2017.
https://newsletterlog.com/from-our-federal-partners-va-and-coordinated-entry-systems-ces-memo/

- Manage the Community Queue prioritization list for housing
- Interpret and enforce Coordinated Entry policies and procedures
- Facilitate Community Queue By-Name-List (BNL) meetings
- Review and distribute PA HMIS CES reports
- Provide ongoing feedback to the CoC Governing Board and CES Committee
- Serve as liaisons to the HMIS administrator
- Conduct community outreach and education

Connect To Home: Coordinated Entry System of Eastern PA Managers

RHAB	CES Regional Manager Contact Information
Central Valley	Chris Kapp Coordinated Entry Regional Manager - Central Valley Region Redevelopment Authority of Cumberland County ckapp@cchra.com 717-980-1410
Lehigh Valley	Zenayda Alicea Coordinated Entry Regional Manager - Lehigh Valley Region Third Street Alliance for Women & Children ZAlicea@thirdstreetalliance.org 610.258.6271 x504
Northern Tier	Jackie Condor Coordinated Entry Regional Manager - Northern Tier Region Clinton County Housing Coalition, Inc. (570) 748.2955 jackie@clintoncountyhousing.com
Pocono	Maria Schramm Coordinated Entry Regional Manager - Pocono Region Pocono Mountains United Way Direct Line: 570-517-5362 maria@poconounitedway.org
South Central	Erica Matko Coordinated Entry Regional Manager - South Central Region Blair Community Action Program Office: 814-946-3651 ext: 114 Erica.Matko@blaircap.org
Call Center (all	Emily Aubele

RHABs)	211 Special Projects Manager United Way of Pennsylvania 814-221-1551 Emily@uwp.org
Domestic Violence Coordinated Entry Specialist	Kayla Gower Domestic Violence Coordinated Entry Specialist 570-217-6435 kayla_g@transitionsofpa.org

Coordinated Entry Specialists

Coordinated Entry Specialists are trained staff members employed by CES partner organizations to deliver uniform coordinated entry intake, assessment and referrals to people experiencing or at imminent-risk of homelessness. The major steps in coordinated entry include:

Triage, Safety Planning and Diversion: Asking basic questions to determine whether the person is fleeing/attempting to flee and survivors of domestic violence, is literally homeless or at imminent risk of homelessness, and, if homeless, whether they could be diverted from entering shelter.

HMIS Client Record Search/Creation: Creating or updating the person's data and information in the Pennsylvania Homeless Management Information System (PA HMIS).

Pre-Screen Interview: Obtaining client data sharing consent and asking questions about the person's current housing situation and veteran status.

VI-SPDAT Assessment: Determining the person's vulnerability and prioritization for appropriate housing interventions.

Referral: Making direct referrals to homeless prevention and emergency services (including Street Outreach, Safe Haven, Emergency Shelter and Transitional Housing) and placement on a Community Queue prioritization list for housing interventions, including Rapid Re-Housing and Permanent Supportive Housing.

Call Center Coordinated Entry Specialists are employed by 211 and provide coordinated entry services by telephone and text Monday through Friday from 9:00 AM to 4:00 PM EST except on federal holidays. After hours, on weekends and on federal holidays, anyone experiencing a housing crisis or homelessness can call or text 211 toll-free to receive direct referrals to emergency services, including emergency shelters.

Access Site Coordinated Entry Specialists are employed by public, private and nonprofit organizations to deliver coordinated entry services in-person Monday through Friday from 9:00 AM to 4:00 PM EST (unless otherwise noted in CES marketing materials) except on federal holidays. Access Sites are located throughout the CoC in as many communities as resources allow and need warrants.

Coordinated Entry Referral Partners

Coordinated Entry Referral Partners accept appropriate program referrals from the Coordinated Entry System. Coordinated Entry Specialists make direct referrals to homeless prevention and emergency services, including Emergency Shelter and Transitional Housing (both of the latter through HMIS). Rapid Re-Housing and Permanent Supportive Housing providers obtain their referrals from the Community Queue prioritization list in HMIS. The Community Queue has special protocols for veterans, people fleeing/attempting to flee and survivors of domestic violence, and people who do not consent to share their information in HMIS, to ensure they are connected to appropriate housing and services. These protocols are detailed in further sections of this Policy Manual.

Responsibilities of all Coordinated Entry System Partner Organizations

Connect To Home: Coordinated Entry System of Eastern PA partner organizations share the following responsibilities as agreed to upon signing the Connect To Home CES Partnership Agreement:

- Comply with all CES processes, policies and procedures detailed in the Eastern PA CoC Coordinated Entry System Policy Manual, including policies related to referral, grievance, prioritization, data sharing, and client confidentiality, among others.
- Comply with all PA HMIS privacy, security and data sharing processes, policies and procedures.
- Ensure that people experiencing or at imminent risk for homelessness understand how the CES system works.
- Make appropriate staff available for regular CES trainings and meetings.
- Distribute CES marketing and outreach materials.
- Maintain accurate and up-to-date agency and program information, including program eligibility requirements, in PA HMIS and the PA 211 database. (This information should be provided to the CES Call Center Manager and/or the appropriate CES Regional Manager).
- Comply with a non-discrimination policy which states that no discrimination of any person or group of persons on account of race, ethnicity, national origin, disability status, religion, marital status, sex, sexual orientation, actual or perceived gender identity, or age.

COORDINATED ENTRY SYSTEM ACCESS

Anyone experiencing a housing crisis or homelessness in the CoC's thirty-three county service region may contact **Connect To Home: Coordinated Entry System of Eastern PA** for a single, streamlined assessment and referral process for housing and related services from a CoC-designated Coordinated Entry Specialist.

CES Call Center

The **Connect To Home: Coordinated Entry System of Eastern PA** Call Center, operated by PA 211, is the virtual "front door" into the Eastern Pennsylvania Continuum of Care housing crisis response system. The Call Center accepts toll-free, inbound calls and text messages Monday through Friday between the business hours of 9:00 AM and 4:00 PM. Trained Call Center Coordinated Entry Specialists provide pre-screening, assessment and referral to any household in crisis as needed and appropriate.

After hours, including weekends and federal holidays, the Call Center answers in-bound calls and text messages live but will not be required to provide Coordinated Entry services, instead referring households directly to emergency services and/or instructing them to contact Coordinated Entry during business hours. The Call Center has language translation services available for people experiencing a housing crisis who speak English as a second language in addition to support for people who are hearing impaired.

CES Call Center Access (2018)

Call Center Service	Contact Information	Hours of Operation
Coordinated Entry Services	Call 211 or 855-567-5341 (toll-free) or Text Your Zip Code to 898-211	Monday - Friday 9:00 am - 4:00 pm
Emergency Help By Phone	Call 211 or 855-567-5341 (toll-free) or Text Your Zip Code to 898-211	24/7, 365 days per year

CES Access Sites

Connect To Home: Coordinated Entry System of Eastern PA Access Sites are the physical "front doors" into the Eastern Pennsylvania Continuum of Care housing crisis response system.

Access Sites provide Coordinated Entry services Monday through Friday, primarily between the hours of 9:00 AM and 4:00 PM. At each Access Site, trained Coordinated Entry Specialists provide pre-screening, assessment and referral to any household in crisis as needed and appropriate. The vast majority of Access Sites are both handicapped accessible and located near public transportation. The CoC aspires to have at least one Access Site in every county or community that has a concentration of need and/or services, resources permitting. Organizations seeking to operate an Access Site in a County or community lacking one should contact the Eastern PA CoC Coordinated Entry Committee Chair or consultant directly.

CES Access Points by County (as of December 1, 2019)

County	Access Points (Monday through Friday from 9:00 AM – 4:00 PM unless otherwise noted)
Adams	Call 211 (toll-free) or Text Your Zip Code to 898-211
Bedford	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Center for Community Action 195 Drive In Lane, Everett, PA 15537 Hours of Operation: M – F 8:00 AM – 4:00 PM
Blair	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Blair County Community Action 2100 6th Ave, Altoona, PA 16602 Hours of Operation: M – TH 8:00 AM – 4:30 PM & F 8:00 AM – 2:00 PM
Bradford	Call 211 (toll-free) or Text Your Zip Code to 898-211
Cambria	Call 211 (toll-free) or Text Your Zip Code to 898-211
Carbon	Call 211 (toll-free) or Text Your Zip Code to 898-211
Centre	Call 211 (toll-free) or Text Your Zip Code to 898-211
Clinton	Call 211 (toll-free) or Text Your Zip Code to 898-211

	UPMC Susquehanna Lock Haven 208 E Church St, Lock Haven, PA 17745
Columbia	Call 211 (toll-free) or Text Your Zip Code to 898-211
	CSO Community Action 16 Sherwood Drive, Bloomsburg, PA 17815 Hours of Operation: M – F 9:00 AM – 4:00 PM
Cumberland	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Community CARES 50 West Penn Street, Carlisle, PA 17013 Hours of Operation: T – SA 12:00 – 5:00 PM
Franklin	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Franklin County Human Services Access Center 425 Franklin Farm Lane, Chambersburg, PA 17202 Hours of Operation: T – W 9:00 AM – 4:00 PM. TH 1:00 – 4:00 PM
Fulton	Call 211 (toll-free) or Text Your Zip Code to 898-211
Huntingdon	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Center for Community Action, 207 5th Street Huntingdon, PA 16652 Hours of Operation: M – F 8:00 AM – 3:00 PM
Juniata	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Mifflin Juniata Human Service Mifflin County Courthouse, Mifflin Juniata Human Services Department 20 N Wayne Street, Lewistown, PA 17044 Hours of Operation: M – F 9:00 AM – 3:00 PM
Lebanon	Call 211 (toll-free) or Text Your Zip Code to 898-211
Lehigh	Call 211 (toll-free) or Text Your Zip Code to 898-211

	Lehigh County Information and Referral 17 S. 7th, Street, Allentown, PA 18101 Hours of Operation: M – F 8:30 AM – 4:15 PM
	Lehigh Conference of Churches 1031 Linden St., Suite 104, Allentown, PA 18102 Hours of Operation: M – TH 8:30 AM – 3:00 PM & F 8:30 AM – 12:00 PM
Lycoming	Call 211 (toll-free) or Text Your Zip Code to 898-211
	YWCA Northcentral PA 815 West 4th Street, Williamsport, PA 17701 Hours of Operation: M – F 9:00 AM – 4:00 PM
Mifflin	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Mifflin Juniata Human Service Mifflin County Courthouse, Mifflin Juniata Human Services Department 20 N Wayne Street, Lewistown, PA 17044 Hours of Operation: M – F 9:00 AM – 3:00 PM
Monroe	Call 211 (toll-free) or Text Your Zip Code to 898-211
	RHD Crossroads Street 2 Feet Outreach Center 130 N. First St, Suite 102, Stroudsburg, PA 18360 Hours of Operation: M – F 10:00 AM – 2:00 PM
Montour	Call 211 (toll-free) or Text Your Zip Code to 898-211
Northampton	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Third Street Alliance for Women and Children 41 North Third Street, Easton, PA 18042 Hours of Operation: M – TH 9:00 – 11:00 AM & 1:00 – 3:00 PM
Northumberland	Call 211 (toll-free) or Text Your Zip Code to 898-211
	CSO Community Action 2 East St, Shamokin, PA 17872 Hours of Operation: M – F 9:00 AM – 4:00 PM

	CSO Community Action 219 Filbert Street, Milton, PA 17847 Hours of Operation: M – F 9:00 AM – 4:00 PM
	CSO Community Action 228 Arch Street, Sunbury, PA 17801 Hours of Operation: M – F 9:00 AM – 4:00 PM
Perry	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Perry Housing Partnership 42 W. Main St., New Bloomfield, PA 17068 Hours of Operation: T – TH 8:00 AM – 4:00 PM
Pike	Call 211 (toll-free) or Text Your Zip Code to 898-211
Schuylkill	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Servants to All 4 South Centre Street, Pottsville, PA 17901 Hours of Operation M – F 9:30 AM – 1:00 PM
Somerset	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Tableland Services, Inc. 535 East Main St., Somerset, PA 15501 Hours of Operation: M – F 8:00 AM – 4:00 PM
Snyder	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Union-Snyder Community Action 713 Bridge Street Suite 10, Selinsgrove, PA 17870 Hours of Operation: M – F 8:30 AM – 4:00 PM
Sullivan	Call 211 (toll-free) or Text Your Zip Code to 898-211
Susquehanna	Call 211 (toll-free) or Text Your Zip Code to 898-211
Tioga	Call 211 (toll-free) or Text Your Zip Code to 898-211

Union	Call 211 (toll-free) or Text Your Zip Code to 898-211
	Union-Snyder Community Action 480 Hafer Road, Lewisburg, PA 17837
Wayne	Call 211 (toll-free) or Text Your Zip Code to 898-211
Wyoming	Call 211 (toll-free) or Text Your Zip Code to 898-211

Street Outreach

All Street Outreach projects funded by either HUD Continuum of Care Program grants or Emergency Solutions Grants must participate in **Connect To Home: Coordinated Entry System of Eastern PA**, and all others are strongly encouraged to do so. Unless a Street Outreach provider is formally designated as a CoC CES Access Site, it must ensure that people living in unsheltered locations are offered access to Coordinated Entry, either through the Call Center or the nearest Access Site. Street Outreach providers seeking to operate as a CES Access Site should contact the Eastern PA CoC Coordinated Entry Committee Chair or consultant directly.

Safety Planning

All providers, including non-victim service providers, must provide safe and confidential access to CES for all people, including those who are fleeing/attempting to flee and survivors of domestic violence (including dating violence, sexual assault, trafficking, and/or stalking). All persons accessing CES are asked if they are fleeing/attempting to flee domestic violence during the screening procedure. If a person or persons are identified as fleeing/attempting to flee domestic violence, the Coordinated Entry Specialist will offer an immediate referral to, and assistance accessing, emergency services, such as domestic violence hotlines and shelters. The person or persons has the right to decline any and all referrals to, or assistance with access to, these emergency services. Declining these referrals or assistance will not have a negative impact on the person's ability to obtain housing and services accessible via CES.

CES Regional Managers will maintain, and share with all Coordinated Entry operational partners, an up-to-date list of all domestic violence resources in their service area. Further, the Eastern PA CoC Coordinated Entry Committee will have at least one representative from the victims' services system at all times to provide policy and practice guidance on behalf of people who are fleeing/attempting to flee and survivors of domestic violence.

Access to Emergency Services

Access to emergency services is not prioritized through CES. Instead, CES makes direct referrals to emergency services for anyone experiencing a housing crisis upon their request. Emergency services include, but are not limited to:

- Domestic violence and other emergency service hotlines
- Street Outreach programs
- Emergency Shelters
- Transitional Housing programs
- Eviction prevention programs
- Food pantries
- Homeless drop-in centers
- Motel voucher programs
- Rental, mortgage and utility assistance programs
- Short-term crisis residential programs

Diversion is a strategy that prevents homelessness for people seeking shelter by helping them identify immediate alternative housing arrangements and, if necessary, connecting them with prevention services to help them return to permanent housing. In the event that beds are not available for people seeking access to Emergency Shelter or Transitional Housing, Coordinated Entry Specialists will be trained in and practice diversion.

After CES business hours and on federal holidays, access to emergency services for anyone experiencing a housing crisis in the CoC's thirty-three county region will be available by calling 211 toll-free or texting 211 via a computer, tablet or mobile device. Anyone can text 211 for free regardless of whether they have minutes on their mobile device.

CES Marketing and Outreach Plan

Connect To Home: Coordinated Entry System of Eastern PA is well-advertised through print and online materials where people may commonly seek assistance for a housing crisis or homelessness. Print materials include flyers, signage in public spaces, postcards and other handouts. Online materials include a dedicated page on the Eastern PA CoC website and social media tools utilized by CoC and other community providers. Marketing materials are widely available in Spanish as well as English. Current materials appear in the Appendix.

CES Regional Managers will conduct community outreach through meetings and presentations to increase public and service provider knowledge of how to access CES as either a consumer or referral partner.

CES marketing materials and community outreach efforts will be targeted to the following kinds of organizations:

- Campgrounds and state parks
- Child welfare agencies
- Churches, synagogues and mosques
- Colleges and universities
- County/municipal health and human service agencies
- Drop-in centers
- Early learning centers
- Emergency shelters
- First responders (police, fire and ambulance)
- Food pantries and cupboards
- Housing Authorities
- Public assistance offices
- Public schools and libraries
- Transitional Housing providers
- United Way agencies and partners
- Veterans organizations
- Victim service providers

The CoC will also conduct an ongoing marketing campaign to promote fair and equitable access to CES for all, regardless of their protected class status as defined in Fair Housing or other applicable civil rights laws and which include:

- Race
- Color
- Religion
- Sex
- National Origin
- Disability
- Familial Status
- Marital Status
- Sexual Orientation
- Gender Identity and Expression

Regular information about important CES milestones, policies, events, trainings, partnership opportunities and performance indicators will be made available through the CoC website, email, social media and online collaboration tools. CES updates will be made at all CoC general membership and Regional Homeless Advisory Board (RHAB) meetings. Finally, each RHAB will be encouraged to establish its own CES subcommittee to discuss local challenges and outreach efforts related to Coordinated Entry.

COORDINATED ENTRY WRITTEN STANDARDS

This section contains written standards for organizations delivering housing and services for people experiencing or at-risk for homelessness in a region of Pennsylvania defined by the United States Department of Housing and Urban Development (HUD) as the PA-509 Eastern Pennsylvania Continuum of Care (CoC). Compliance with these standards is required for all programs funded by HUD and the Pennsylvania Department of Community and Economic Development (DCED), including the HUD Continuum of Care and both HUD and DCED Emergency Solutions Grants (ESG) programs. Adherence to and successful implementation of these written standards is built into both contract monitoring and the project scoring and ranking process for annual CoC and ESG grant competitions.

The use of these standards is strongly encouraged for all programs funded through any federal, state, local and private grants to ensure an effective and coordinated systemic response to homelessness that is based on best practices in the sector and provides a uniform and equitable experience for all families and individuals experiencing homelessness or a housing crisis in every community.

Connect to Home CES operational and referral partners are required to comply with all current PA-509 Eastern Pennsylvania Continuum of Care Written Standards for Programs that End and Prevent Homelessness. The most current version of the Written Standards may be found here: https://pennsylvaniacoc.org/easterncoc/ under Documents and Resources.

The specific standards for Coordinated Entry that follow are excerpted from the full Written Standards document below for ease of reference.

Minimum Standards for Coordinated Entry Regional Managers, Specialists and Referral Partners

1. Specialists connect people in danger to appropriate police, fire, rescue, DV, child welfare, Human Trafficking and other emergency response services.
2. Specialists provide or connect participants to language translation and/or deaf and hard of hearing services if needed.
3. Specialists obtain written or verbal permission from participants to enter and share their data in PA HMIS.
4. If a participant is a Domestic Violence Survivor, the Specialist will ask if they prefer to be entered into PA HMIS anonymously to protect the confidentiality. If a non-DV Survivor requests anonymity, the CE Specialist will honor that request. Any participant enrolled in

PA HMIS anonymously will have a numeric ID to navigate the homeless system and a confidential password that the participant creates themselves.

5. Specialists use the CoC Diversion Tool and related problem-solving strategies to help participants avoid entering Emergency Shelter.
6. Specialists use the Pre-Screen Interview questions in PA HMIS to determine whether a participant qualifies for HP, ES, TH, RRH or PSH.
7. Specialists provide direct referral information to participants who meet the Category 2, 3 and At Risk categories to HP, SO and community services.
8. Specialists conduct the appropriate version of the VI-SPDAT Screening Tool (VI-SPDAT) and ask additional CoC screening questions related to mental health diagnosis and Chronic Homeless status in PA HMIS only on the Head of Household (the person who is presenting to Coordinated Entry as Category 1 or 4 and who would sign the lease if enrolled in an RRH or PSH housing program):
9. VI-SPDAT for Single Adults – Use this version with adults age 25 or older with no children in the household, regardless of whether they are presenting as a single person household or as the head of a household with one or more family members (e.g., spouses, partners, and/or adult children);
10. VI-SPDAT for Families – Use this version with households with at least one child under the age of 18, even if the Head of Household is aged 18 – 24; or,
11. TAY-VI-SPDAT – Use this version with transition age youth (age 18 – 24) and unaccompanied minors, regardless of whether they are presenting as a single person household or as the head of a household with one or more family members (e.g., spouses or partners) unless the youth Head of Household also has a child age 0 – 18 (in which case, use the VI-SPDAT for Families).
12. Specialists allow, with the participant's express verbal permission, Mental Health or Domestic Violence Case Managers to participate in the intake and assessment process but all questions must be answered by the participant, not the Case Manager.
13. Specialists add information about all other household members (e.g., spouses, partners, adult children, children aged 18 – 24) to the Head of Household's PA HMIS client record in accordance with the HUD Equal Access Rule definition of family.
14. Specialists place participants who meet the Category 1 and 4 definitions of homelessness on the Community Queue (CQ) in PA HMIS depending on their VI-SPDAT score.
15. Specialists inform all participants that CES is not a guarantee of housing or services.
16. HP, SO, ES and TH providers accept referrals from CES participants.
17. RRH and PSH providers enroll all eligible CES participants into their housing programs from the Community Queue and will only enroll other households in units restricted for use by other County or Municipal contracts.

18. RRH and PSH providers update participant PA HMIS CQ records when they engage, enroll, or move participants into housing, including the addition of detailed notes in the PA HMIS client record.
19. Regional Managers monitor the CQ daily to help ensure participants are enrolled in housing programs by priority (based on VI-SPDAT score) and length of time waiting for enrollment.
20. Regional Managers facilitate regular By Name List (BNL) meetings with housing providers and other community partners to case conference the highest priority participants currently on the CQ in their region.
21. Regional Managers and Coordinated Entry Specialist distribute CES marketing materials throughout their community with an emphasis on 1) populations in need that would otherwise not know about Coordinated entry and 2) places where people experiencing homelessness (e.g. encampments, day centers, etc.) or housing instability (e.g., food pantries, soup kitchens, public assistance offices, etc.) often gather.

VI-SPDAT Score Community Queue Placement Guidelines

The VI-SPDAT is intended to help Coordinated Entry Specialists and Referral Partners determine whether the recommended housing intervention for a family or individual is Rapid Re-Housing or Permanent Supportive Housing. RRH and PSH providers may enroll eligible program participants who score for a different housing intervention but should always prioritize the most vulnerable households who will succeed in their program. The VI-SPDAT score may also be a valuable tool for Emergency Shelter and Transitional Housing Case Managers receiving direct referrals from CES to guide program-level prioritization and enrollment.

VI-SPDAT score guidelines are as follows. If a housing Case Manager has a question about whether or not to enroll a participant in their program based on their CQ placement, they should contact their CES Regional Manager for guidance.

VI-SPDAT Score Range	**CQ Placement**
Family VI-SPDAT	
9+	Permanent Supportive Housing
4 – 8	Rapid Re-Housing
0 – 3	Do Not Place on CQ Except for DV Survivors (Category 4) and Veterans
Single Adult	

8+	Permanent Supportive Housing
4 – 7	Rapid Re-Housing
0 – 3	Do Not Place on CQ Except for DV Survivors (Category 4) and Veterans
Transitional Age Youth (TAY) VI-SPDAT	
8+	Permanent Supportive Housing
0 – 7	Rapid Re-Housing

Due to a lack of housing programs in the CoC, families and single adults who score 0 – 3 on the VI-SPDAT and do not have a DV Survivor, Veteran or TAY Head of Household are not placed on the CQ and instead should be given the Diversion Tool and direct referrals to HP, ES, TH and/or Supportive Services for Veterans Families (SSVF; Veterans only).

Prioritization Standards for Emergency Service Providers Receiving Referrals from Coordinated Entry

Prioritization standards for Emergency Service Programs (HP, SO, ES and TH) and Housing Programs (RRH and PSH) are aligned with the CoC's Strategic Plan and HUD policy guidance.

Every household must first meet the program eligibility criteria. Emergency Service Programs in general, and Emergency Shelter programs in particular, should regularly review their eligibility priorities with the goal of becoming as low barrier to entry as possible. According to the National Alliance to End Homelessness, Emergency Shelters should have policies and procedures that promote: 1) a Housing First approach, 2) safe and appropriate diversion, 3) immediate and low-barrier access to shelter, 4) housing-focused, rapid exit services and 5) data to measure performance.

If a household meets the program eligibility criteria, and the program is not at a "functional zero" (meaning there are more service units/slots/subsidies available than households in need of that service), then households should be enrolled using the following Order of Priority:

1. Veterans
2. Families
3. Unaccompanied youth
4. Single adults

For Emergency Shelter programs, households sleeping in unsheltered locations should always be prioritized over those who are not. For example, a chronically homeless Veteran sleeping outside should be prioritized over another who is sheltered. Likewise, an Unaccompanied Youth sleeping outside should be prioritized over a Veteran who is sheltered.

In the event that two or more households meet all of a given program's eligibility criteria and have the identical Order of Priority for their program type, service providers should use their judgement to prioritize households that have more of the following characteristics than any other:

- Families with children age 0 – 5
- High use of emergency services (e.g., Hospital Emergency Departments or police)
- Significant Intellectual or Developmental Disabilities
- Significant physical or behavioral health challenges
- Vulnerability to death or serious illness
- Vulnerability to victimization (e.g., trading sex for housing, human trafficking, Domestic Violence, sexual assault, criminal activity, etc.)
- Have a written judgement or Order of Possession from a Magisterial District Judge, not simply an eviction notice (for HP services)

Prioritization Standards for Rapid Re-Housing Providers Enrolling Households from the Community Queue

Rapid Re-Housing programs (RRH) enroll households from the Community Queue in PA HMIS. These households have already been prioritized based on the results of the VI-SPDAT Screening Tool used during the Coordinated Entry Homeless Intake process. Housing Programs may filter the CQ to identify the highest priority households that meet their eligibility criteria (e.g., Chronically Homeless, Veteran, DV Survivor, TAY, mental health issues, physical health issues, current County of residence, etc.). Like Emergency Shelter Programs, Housing Programs should strive to have a Housing First approach and be as low barrier as possible.

Anyone enrolled in a Transitional Housing program for any duration of time is ineligible for Rapid Re-Housing. While the HUD Category 1 definition includes people living in Transitional Housing, the annual HUD Continuum of Care Grant Application has not allowed CoC-funded Rapid Re-Housing to enroll people from TH for the past few years.

If a household on the CQ meets all of the program eligibility criteria, they should be enrolled in the following Order of Priority:

- Non-chronic households sleeping in unsheltered locations (on the CQ but not enrolled in ES)

- VI-SPDAT score (higher scores prioritized first)
- For households on the CQ with the same VI-SPDAT score, those who have more of the following characteristics as documented in their PA HMIS intake notes:
- Families with children age 0 – 5
- High use of emergency services (e.g., Hospital Emergency Departments or police)
- Significant Intellectual or developmental disabilities
- Significant physical or behavioral health challenges
- Vulnerability to death or serious illness
- Vulnerability to victimization (e.g., trading sex for housing, human trafficking, Domestic Violence, sexual assault, criminal activity, etc.)

Rapid Re-Housing Case Managers should use their judgement when deciding which household to enroll. For example, a family with a VI-SPDAT score of 6 who have two children under 5 and an adult household member with a significant intellectual disability may be prioritized over another family with a VI-SPDAT score of 7 who have none of the characteristics listed above. Case Managers unsure of which household to enroll should consult with their CES Regional Manager.

Prioritization Standards for Permanent Supportive Housing Providers Enrolling Households from the Community Queue

The CoC has adopted HUD Notice CPD-16-11 on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing in full. The overarching goal of this Notice is to ensure that those individuals and families who have spent the longest time in places not meant for human habitation, in emergency shelters, or in safe havens and who have the most severe service needs within a community are prioritized for PSH. All PSH programs must review and comply with this Notice.

PSH programs enroll households from the Community Queue in PA HMIS. Housing Programs may filter the CQ to identify the highest priority households on the CQ that meet their eligibility criteria (e.g., Chronically Homeless, Veteran, DV Survivor, TAY, Mental Health Issues, Physical Health Issues, current County of residence, etc.). Like Emergency Shelter Programs, Housing Programs should strive to have a Housing First approach and be as low-barrier as possible.

Both CoC-funded Permanent Supportive Housing Beds Dedicated or Prioritized for Occupancy by Persons Experiencing Chronic Homelessness and CoC-funded Permanent Supportive Housing Beds Not Dedicated or Not Prioritized for Occupancy by Persons Experiencing Chronic Homelessness should follow the same Order of Priority.

The four Orders of Priority are:

1. Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs.

An individual or family that is eligible for CoC Program-funded PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time homeless is at least 12 months and has been identified as having severe service needs.

2. Homeless Individuals and Families with a Disability with Severe Service Needs.

An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

3. Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs.

An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

4. Homeless Individuals and Families with a Disability Coming from Transitional Housing.

An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing had lived in a place not meant for human habitation, in an emergency shelter, or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee Domestic Violence, dating violence, sexual assault, or stalking and prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.

If there are no Chronically Homeless households currently on the CQ who meet the program's eligibility criteria, or because the PSH program has beds/units that are not intended for Chronically Homeless households, then the program should enroll households based on these additional Orders of Priority:

- Households sleeping in unsheltered locations (on the CQ but not enrolled in ES or TH)
- VI-SPDAT score (higher scores prioritized first)
- For households on the CQ with the same VI-SPDAT score, those who have more of the following characteristics as documented in their PA HMIS intake notes:
- Families with children age 0 – 5
- High use of emergency services (e.g., Hospital Emergency Departments or police)
- Significant physical or behavioral health challenges
- Vulnerability to death or serious illness
- Vulnerability to victimization (e.g., trading sex for housing, human trafficking, Domestic Violence, sexual assault, criminal activity, etc.)

Permanent Supportive Housing Case Managers should use their judgement when deciding which household to enroll. For example, a single adult with a VI-SPDAT score of 10 who has self-reported trading sex for housing may be prioritized over another single adult with a VI-SPDAT score of 11 who has none of the characteristics listed above. Case Managers unsure of which household to enroll should consult with their CES Regional Manager.

Performance Benchmarks

CES will be evaluated using HMIS data on an annual basis. Results will be published on the CoC website, after they have been reviewed by the CES Committee. The CES Committee has selected the following as key outcomes for CES:

1. Reduction in the length of time homeless (system and project level).
2. Reduction in the number of persons experiencing first-time homelessness (system and project level).
3. Increase in percentage of placements into permanent housing (system and project level).

The CES Call Center and Access Site performance standards include:

1. Percent of participants were satisfied with CE as measured by Customer Satisfaction question asked at the end of intake and entered into PA HMIS.
2. Percent of complete (all questions answered unless participant refuses) PA HMIS Coordinated Entry Intake Pre-Screen Interviews and VI-SPDATs.
3. Percent of participants who successfully avoid a referral to ES as a result of conducting the Diversion Tool.

COORDINATED ENTRY INTAKE PROCESS

Overview

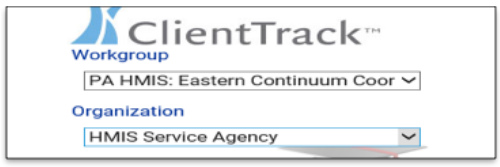
Intake is defined as the process by which Coordinated Entry Specialists decide whether people who contact the Call Center or an Access Site should be screened, assessed and referred to homeless prevention, emergency services, and/or housing programs. Through intake, Coordinated Entry Specialists determine a person's immediate safety needs, current housing status, and whether or not to conduct a VI-SPDAT assessment and place them on the Community Queue for housing programs. The major action steps of the intake process include asking initial triage questions about why the person is contacting Coordinated Entry, searching for/creating a client record in HMIS, obtaining client consent, and (if appropriate) conducting a Pre-Screen Interview.

This section provides guidelines for using the Connect to Home Eastern Coordinated Entry system through PA HMIS to intake clients, perform a Pre-Screening and then walk them through either a homeless workflow or a prevention workflow depending on how the household is classified by their housing/homeless status during the pre-screen. The intake considers the household's classification and needs and provides the ability to perform a VI-SPDAT assessment of their needs, and a combination of diversion techniques, the sending of immediate Emergency Housing/Services referrals and/or placing them on a Community Queue for the Continuum to assist in maintaining / achieving permanent housing.

For access to the Pennsylvania HMIS or access to the Coordinated Entry system within PA HMIS please contact ra-pahmis@pa.gov for user account information.

Coordinated Entry Process Workflow in HMIS

A specific Workgroup is available for all Coordinated Entry personnel in the Eastern PA CoC that allows for the collection of CE data and for its management of clients through the system. All Coordinated Entry data entered into the system will be through this Eastern PA CoC Coordinated Entry Workgroup. Please select this Workgroup when logging into the system to access the Coordinated Entry functions, especially when performing intakes as Call Center or Access Sites.



The Coordinated Entry process is broken down into two steps, the first step is the initial Intake and Assessment of the client/household performed at either an Access Site or through a United Way Call Center (2-1-1). An Assess Site is any organization or provider that is setup to perform the continuum's intake and VI-SPDAT assessment in a physical location in-person or over the phone and are placed throughout the continuum to meet regional demand; United Way (2-1-1) provides Call Center operations to perform over the phone intake and assessment across the entire continuum.

The second step occurs after emergency housing or prevention referrals and/or placement on the Community Queue is performed, and involves Service Providers actively reviewing and finding clients/households on the queue in which they can serve through their programs in the client's geographical region. Each of these steps or parts are separated and detailed in the rest of the guide.

Intake and Assessment

The Intake and Assessment process begins the process of entering clients into the Eastern CES, once the initial triage questions have been conducted and initial requirements and eligibility have been met. The CES begins with a Client Intake to identify the client in HMIS or create a new record, followed by a Pre-Screening Assessment which collects information to assist in determining the proper course of action(s) to take to best serve the household.

Please note that the system contains a method for recording Domestic Violence (DV) / Anonymous clients and its variations from the main process are detailed in the DV / Anonymous Intake Addendum below.

To begin the Intake and Assessment part of the process, within the Client tab, select the Coordinated Entry Intake option (circled below). This launches a workflow in PA HMIS that allows for the completion of the above listed intake and assessment steps. This is the option to use for every Call or Assessment Center client that wants to enter the CE system.

Client Intake

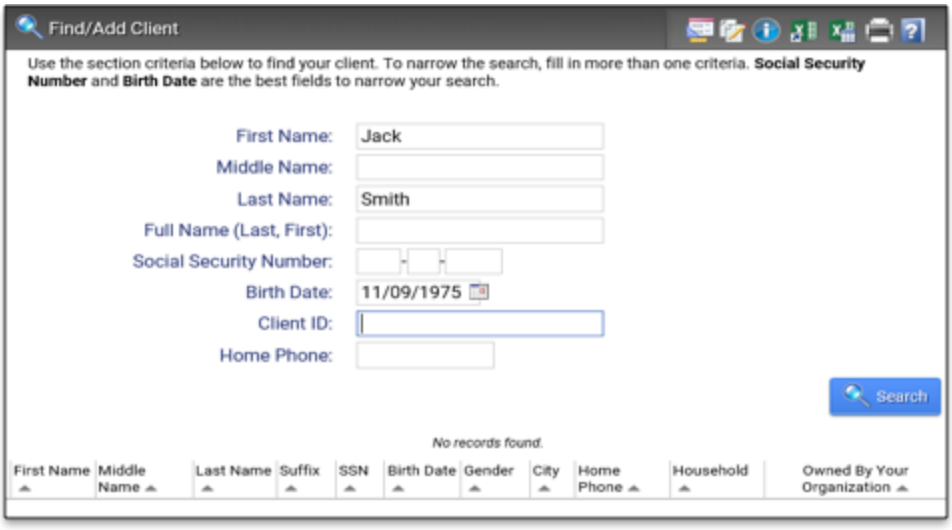
Client Intake will be the first step and will allow a user to search for / create a new client in the same step. A client will need to be selected (existing one) or created during this step before moving forward with the rest of the intake which includes the Pre-Screening, and VI-SPDAT steps.

Client Search

To begin the search, enter in the client's (head of household) First Name and Last Name into the appropriate fields. When you have finished entering the Last Name the system will automatically perform a search to find existing matches in the system through a new pop-up window.

The user can always force a search to appear by selecting/clicking the magnifying glass icon at the end of the Last Name or Home Phone fields.

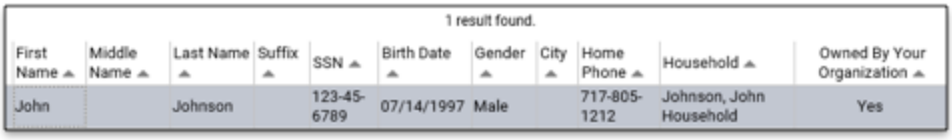
When the search window appears, it will search the system for any matches for the name information entered. We recommend entering in as much information as you have for the client, such as Date of Birth, Social Security Number into the appropriate fields and hitting the "search" button to better pinpoint or refine your matches.



You can run any many searches as you need in this window until you have found a matching client or determined that the client does not currently exist in the system.

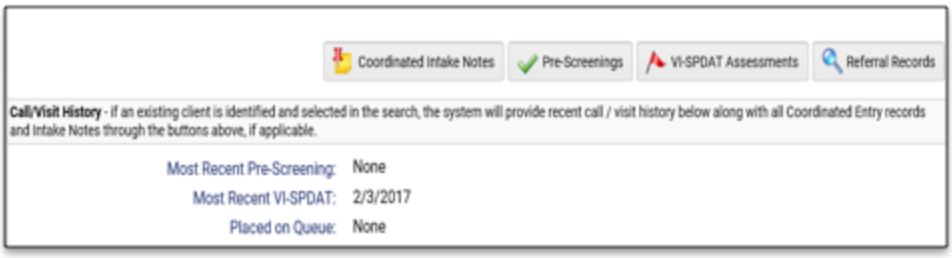
No Matches – if no matches are found within the search, you can hit the Cancel button at the bottom right of the pop-up window. When moving forward the system will create a new client in the system to use with the remainder of the intake and assessment process.

Existing Matches – if a match is located, the client should be selected from the search results section. By clicking directly on the record, the system will select this existing client and load them on the Client Intake screen and this existing client will be used when moving forward with the CE process and additional assessments.



If you select an existing client, the system will load that record on the current Client Intake screen and will display Coordinated Intake Notes, Pre-Screening, VI-SPDAT and Referral Records options on the top right of the page as circled below.

By selecting either option, the system will generate a new window that shows any previous Assessment or Note records collected or any previous Referrals sent for this client in HMIS. This information can be used to determine returning visitors to the Coordinated Entry system and adjust the intake process accordingly (as the client/household may just need any update on their status).



Call/Visit History

This section above the Client Search area can be used after selecting an existing client in the system and can be helpful for return visitors to the CE system or HMIS in general. Along with displaying historical records for Coordinated Intake Notes, Assessments and Referrals this section will display information about the client's most recent pre-screening, VI-SPDAT or placement on the queue.

This information can be helpful to decide on the next best course of action if the client has already entered the CE system. For new clients, since we have no history on their actions, the system will display "None" for each of those dates and hide the historical buttons.

Once the Client Search and Client Sharing sections are completed, select the Next Step option on the bottom of the screen to move forward with collecting the main assessment.

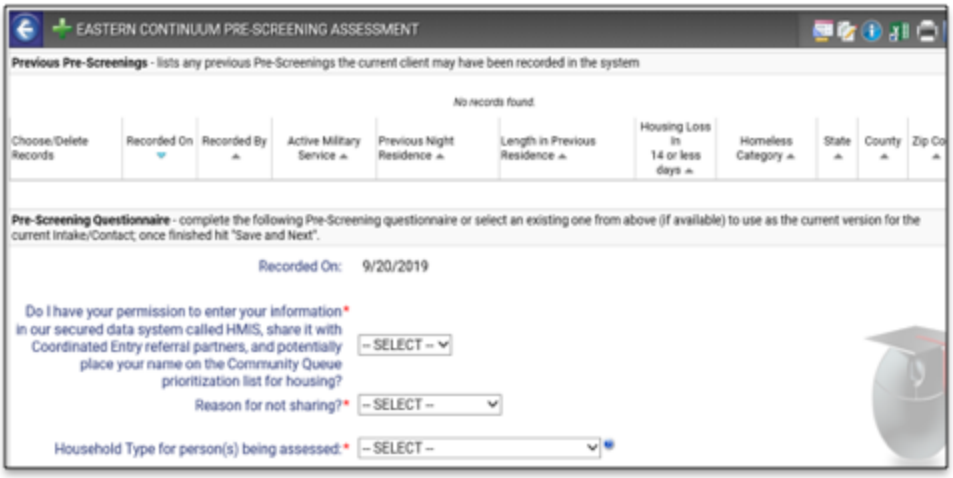
Please note that Close Intake will stop the process and not save any information from this step.

Pre-Screening

The Pre-Screening step is a short assessment that gathers a small amount of information about the person being assessed and collects information in terms of household type, where the client resided the previous night, length of time at previous residence, military service history and discrimination history.

A Pre-Screening is required to be completed for all clients prior to moving to the next step, and can be completed as new (for new or long returning clients) or an existing pre-screening can be selected for returning clients to use as their information of record when moving forward. The Pre-screen is very important in determining the potential course the client/household could take during the process based on their housing or homeless situation.

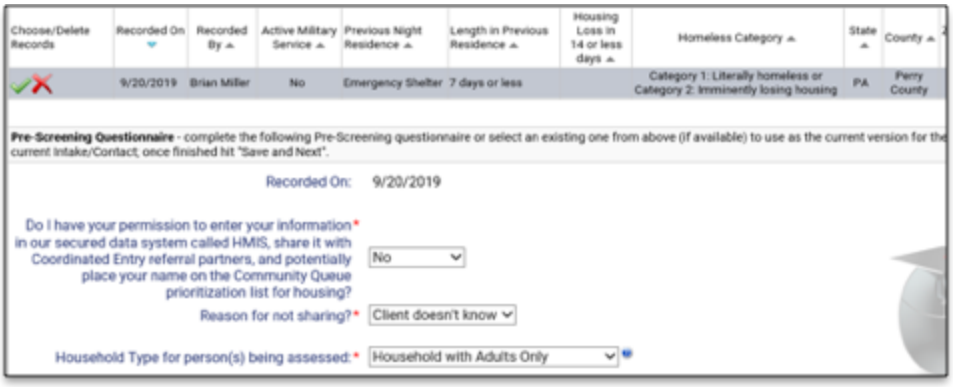
The Pre-Screening is separated into 2 sections, the top section is for Previous Pre-Screenings and will display all Pre-Screenings that have been recorded in HMIS for the client being assessed. The 2nd section, the Pre-Screening Questionnaire includes the questions that make up the actual assessment that can be completed to move forward in the process.



For existing clients, if a Pre-Screening or Pre-Screenings have been recorded, they will be listed in the top section in the available grid with the most recently recorded placed on top.

The user can either record a new Pre-Screening by entering a new questionnaire from the beginning, or they can select or load an existing Pre-Screening by clicking the “Choose Pre-Screening” icon at the beginning of the record.

When selecting an existing Pre-Screening record from the previous pre-screenings section, the screen will refresh and the questionnaire section will populate / load with the Pre-Screening information previously recorded.



The system will allow changes to be made to an older screening once it has been selected and loads into the bottom questionnaire section.

Before moving to the next step, the CE / Case specialists must either record a new Pre-Screening or select an existing one to use going forward and all questions are on Pre-screening are required. Each response does have a client doesn't know/refused type selection to allow for its completion without skipping the questions.

Once completed, use the Save and Next button on the bottom of the screen to save the current information entered the Pre-Screening Questionnaire and move to the next step of the process.

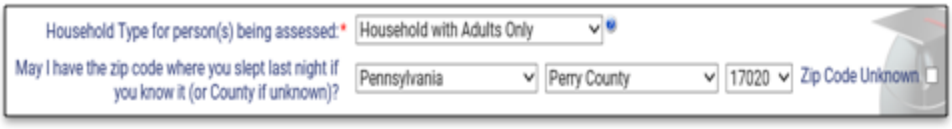
Client Sharing

When a client enters the Eastern CE system they can verbally share their client record and Coordinated Entry information with other Assessment Centers and Referral Partners within the continuum, this option is the first question on the Pre-Screening assessment. This option can be answered with a 'Yes' to share their data with other Assessment Centers directly, no to not share their data with other Assessment Centers directly; this is the only question required to be collected during the Pre-Screen.

Please note that even if the client does not agree to directly share their Coordinated Entry information directly with Assessment Centers they can still be provided with direct Referrals and with Placement onto the Community Queue with limited viewing from the continuum partners.

Zip Code / County

The Pre-screening collects the Zip Code or County of their previous night's residence and this information is helpful for reporting purposes. The questions allow for the entry of a State (or US Territory), County and Zip Code and each can be entered independent of each other, but the system narrows down the selects in each corresponding list based on a previous answer.



For times where neither a County or Zip Code can be collected, the Zip Code Unknown option can be used to show the information was not able to be obtained.

Slept Last Night / Length of Living Situation / Losing Housing in next 14 days

The Pre-screening collects their previous night's residence, and provides a list of options to best describe their location, along with a list of choices that best defines how long they have been staying at that residence.

For those residing in a homeless location based on the where did you sleep last night element, such as Emergency or Transitional Shelter, Safe Haven, On the Streets or in a Hotel/Motel Voucher paid for by charitable organization these are the only two questions that will prompt for answer.

For those residing in an institutional or temporary residential location the system will prompt with a follow up question "Are you losing your Housing in the next 14 days" and requires a Yes or No response. This information will help the system determine the client's housing / homeless status.

The pre-screen also collects the Days until housing loss and is highly recommended to collect for future providers to have this information when the client is not currently in a homeless location when entering coordinated entry.

Homeless Category

This element is used to help determine the client/household's housing or homeless status and the best course of action after the pre-screen. The system uses the information collected for "where did you sleep last night" and the follow-up "Are you losing your Housing in the next 14 days" to classify the client into one of the following categories:

- Category 1: Literally Homeless or Category 2: Imminently losing housing
- At-Risk of Homelessness

- Category 4: Fleeing a DV Situation

Literally Homeless / Fleeing DV Status

Those clients that entered directly from a homeless location or that answered Yes to losing their housing in the next 14 days are automatically classified as Category 1: Literally Homeless or Category 2: Imminently losing housing and are entered into the coordinated entry system within the Homeless Workflow/Path and given a VI-SPDAT assessment.

Those clients that are entered as DV/Anonymous are either classified as Category 1: Literally Homeless or Category 2: Imminently losing housing if they meet the above conditions or are classified as Category 4: Fleeing a DV Situation and should also be formally entered into the coordinated entry system within the Homeless Workflow/Path and given a VI-SPDAT assessment.

Prevention / At-Risk Status

Those clients that are not losing their housing in the next 14 days are classified as At-Risk of Homelessness and are entered into the coordinated entry system within the Prevention Workflow/Path and should not be given a VI-SPDAT assessment. Instead these clients may be provided with referrals for Prevention, Diversion and other community services based on their current needs and CE Specialists work with them using the Prevention/Diversion Tool and attempt to solve their housing crisis without additional resources.

CE Specialist Override for Homeless Category: while the above logic should work in most cases, eligibility can be complex and has an override that CE Specialists can use to manually determine the Homeless Category based on additional factors than the questions mentioned above.

Please note that one of the more common overrides may be those clients that are Fleeing a DV situation but do not require a full anonymous entry through coordinated entry, those clients may need to have their Homeless Category set to Category 4: Fleeing a DV Situation in this manner before continuing with the process.

Military Service

The Pre-Screening collects whether a client has served in the active military and any client that answers with a Yes is flagged as a Veteran in the system.

For those clients that do response with Yes, if they are also categorized as At-Risk of Homelessness through the above Homeless Category, the system will prompt for whether they are currently Enrolled in SSVF (i.e. working with an SSVF Provider).

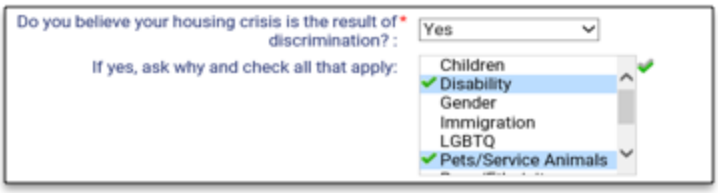
If the client is identified as having Military Service and NOT currently enrolled/working with a SSVF provider, upon completion of the Pre-screening the system will automatically launch an email referral window that will allow for the sending of a notification to all potential SSVF/VA resources in the client's immediate area about their housing/service needs.

Please note that the Veteran prevention notification only occurs for those that are currently At-Risk of Homelessness (not Literally or Imminently Homeless) and not currently working with an SSVF resource.

The veteran notification window should contain all pertinent information needed, including proper addressing emails and the CE Specialists can add additional information if needed to the message, either in the body or by adding additional email addresses, and hit Send Email to finish the process.

Discrimination

The pre-screen collects whether the client believes their housing crisis is a result discrimination. If the client answers Yes, collect the reasons why they believe this without any prompting and select one or more of the options available within the list.



The list of discrimination types available to choose from include:

- Children
- Disability

- Gender
- Immigration
- LGBTQ
- Pets/Service Animals
- Race/Ethnicity
- Religious Affiliation
- Other

Homeless / VI-SPDAT Path

Once the Pre-Screen is completed, by selecting the Save and Next option, system will rely on the Homeless Category to determine the appropriate path (Homeless vs Prevention). Those households classified as Literally Homeless / Fleeing DV (Category 1, 2, 4) will go through this Homeless path and be provided with a VI-SPDAT Assessment. The following covers the steps in the Homeless path in HMIS, which is automatically performed by the system.

Edit/View Household Members

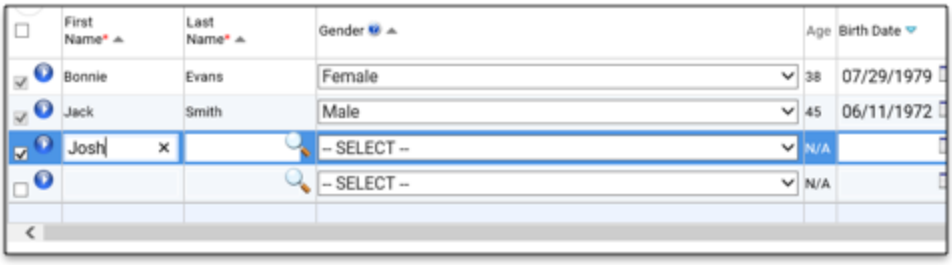
The intake will prompt the CE Specialist to view/edit household members before continuing with the intake. Selecting Yes will load a household members grid that allows for the adding of new household members as well as editing of existing households in terms of demographic data elements. Selecting No will skip the household members and continue to the next step in the process.

This step is recommended for new clients that have additional households and allows for their entry prior to additional assessment/referral steps, it can however be skipped for single person households and is not included for Domestic Violence/Anonymous intakes.

Upon selecting Yes, the Family Members grid will show the current client you are intaking along with any household or family members that may be associated with that client (if they were previously entered). As each row displays an individual member of the current household along with their current demographics such as Gender, Date of Birth, Race, Ethnicity and Veteran Status and Relationship to Head of Household.

You can update the demographic fields by entering or updating each of the fields for each client to collect any information that may be missing.

For new clients with households or for incomplete households on existing clients, the Family Members grid also allows you to enter in new clients by clicking on a blank row and entering in the client's information into each field. You can enter in all the family members directly into this grid, one in each row.



Please note that the Family Members has a scroll bar on the bottom of the grid, which can scroll right and left (<- ->) to show you all the individual elements for each client.

Once the Family Members grid is completed / reviewed the CE Specialist can continue with the intake by hitting Save on the screen.

VI-SPDAT

The system will prompt the CE /Case Specialist for the next step in the intake process, which for households on the Homeless Path is the recording of a VI-SPDAT assessment.

CE Specialists will be prompted with the following screen and can choose from the 3 official VI-SPDAT versions available based on the household configurations below:

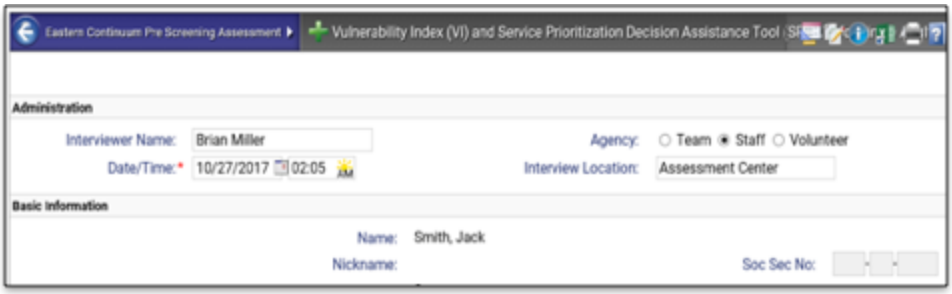
- Single Adults (ages 24+, with no minor children)
- Families (ages 18+ that include minor children in the household)
- Single Youth (ages 18-23, with no minor children)

Once the proper VI-SPDAT version is selected from this menu the system will load the appropriate assessment form for completion. All new homeless clients entering the coordinated entry system should be provided with a brand new VI-SPDAT assessment.

Please note that for existing or returning clients, if the system recognizes they have a previously recorded VI-SPDAT, the Edit previous VI-SPDAT option may be available in the menu in which to choose that allows for the editing of an existing assessment rather than the creation of a new one. Please see the Edit previous VI-SPDAT section below for more details.

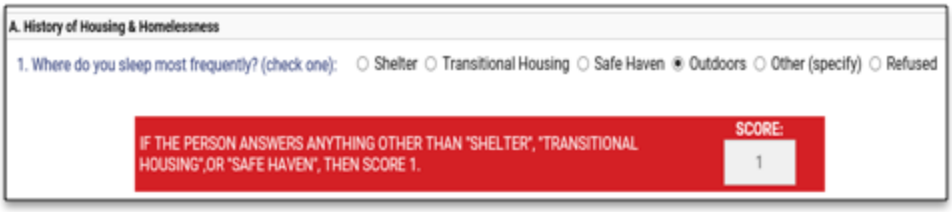
VI-SPDAT Assessment

Once a VI-SPDAT version is selected that assessment form will load on screen to allow the user to fill it out for the current client. All the questions and responses provided should match exactly the version the Eastern PA CoC has been trained on for all three versions. Please complete as much of the assessment as possible with the client by scrolling down the assessment, as most questions are answered with Yes/No toggles and lists and a few at the end allow for manual text entry.



The system currently contains and supports the following OrgCode, Inc. VI-SPDAT versions in PA HMIS, Single Adults – v2.01, Families – v2.0, and Single Youth – v1.0.

The electronic version will also automatically update the scoring for the domains in real-time as the questions and data are entered – be on the look-out for the red colored blocks which displays scores for specific sections, domains and the overall assessment which change as you answer each question.



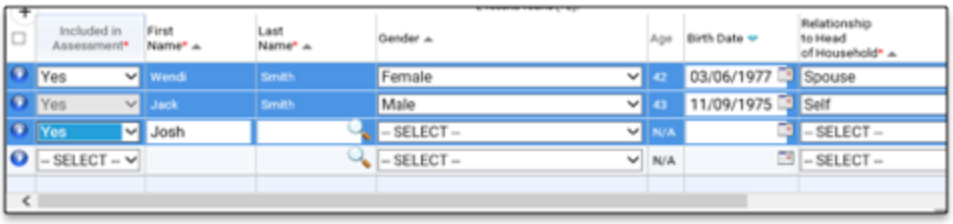
Once you have completed the Vi-SPDAT Assessment and have reviewed the final domain and assessment scores and are confident with them, select the “Save” option at the bottom of the screen to permanently save your data.

Family Members

The only section of the VI-SPDAT assessments that may vary from the OrgCode templates, other than our Additional Question section below, is the Family Members section / grid found near the top of each assessment. The Family Members grid will show the current client you are assessing along with any household or family members that may be associated with that client (if they were previously entered). As each row displays an individual member of the current household along with their current demographics such as Gender, Date of Birth, Race, Ethnicity and Veteran Status and Relationship to Head of Household.

Please note that the household/family grid detailed in the “edit/view household members” section is almost the same identical the one found in the VI-SPDAT assessment and uses the same data collection fields and rules to add and remove household members.

For new clients with households or for incomplete households on existing clients, the Family Members grid also allows you to enter in new clients by clicking on a blank row and entering in the client’s information into each field. You can enter in all the family members directly into this grid, one in each row.



Please note that the Family Members has a scroll bar on the bottom of the grid, which can scroll right and left (<- ->) to show you all the individual elements for each client.

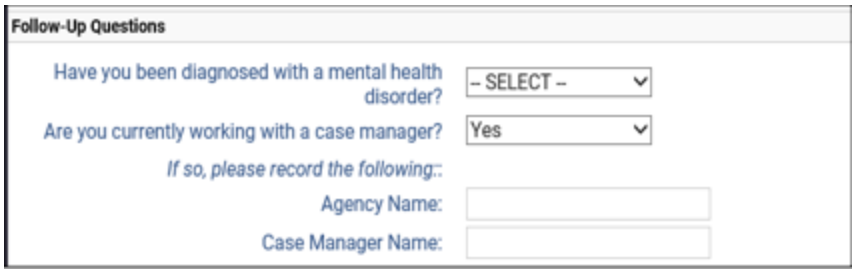
The Family Members Grid allows you to also identify or include specific Household Members as part of the current VI-SPDAT assessment or not, using the Included in Assessment setting. Each Household Member is required to have their status set to Yes, if they apart of the family during the intake or No if they are not.

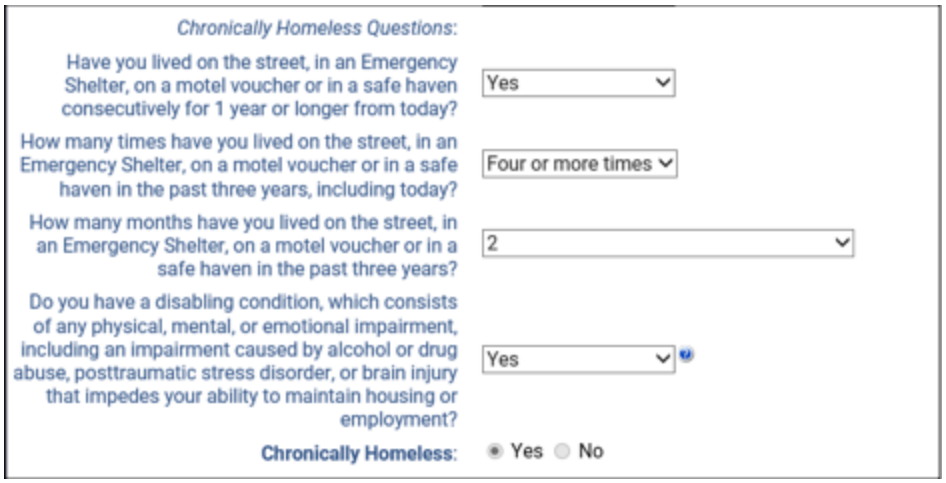
The Included in Assessment setting allows CE specialists to exclude Household Members from the assessment without having to change or configure the makeup of the household. And these settings can be changed when editing a VI-SPDAT assessment as well, providing additional flexibility to household configuration within the assessment itself.

Once the Family Members section is completed / reviewed the Case Specialists can continue with the VI-SPDAT Assessment. Any changes made to the household members information or any new clients added will be saved once the VI-SPDAT assessment form is saved.

Follow-up Questions

In addition to the standard VI-SPDAT assessment, the Connect to Home system has included several additional questions that collects information to help with the prioritization of the person's needs within the process and consists of an assessment based on their Mental Health Status and their Chronically Homeless Status; both of which are displayed below.





The system can use this information once the person is placed on the Community Queue to better prioritize their needs, along with providing more tools to focus on specific sub-populations.

The final section consists of collecting contact information, such as Phone Number, Email address and preferred contact method, along with asking the Survey response to the client and collecting their satisfaction rating of the experience.

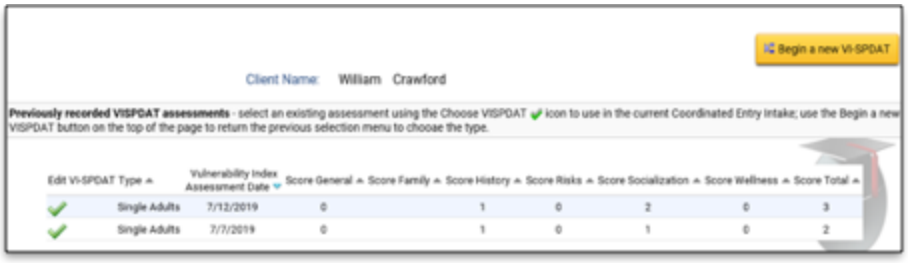
Once all questions are answered and reviewed, hitting the Save button will finalize and finish the VI-SPDAT assessment. Once saved, selecting the Eligibility and Referrals option will take the CE Specialist to the next step in the process.

Edit previous VI-SPDAT

For those persons that are returning the system and have a recorded VI-SPDAT the system can provide this option to select an existing assessment and edit/update that record instead of creating a brand new one.

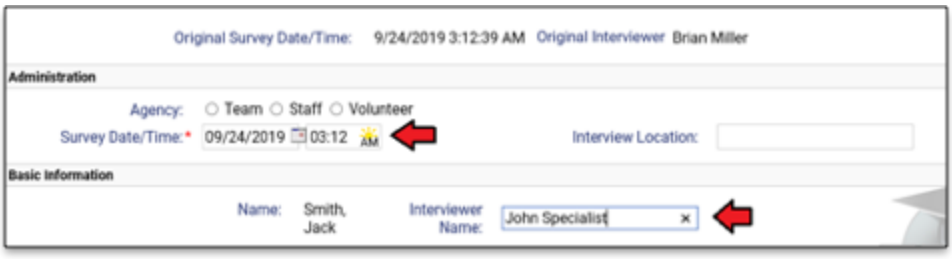
When selecting this option from the Homeless Path menu above, the system will provide the CE Specialist with a list of all VI-SPDATs for this person that have been originally recorded in the last 12 months

CE Specialists should choose the most recent of the available VI-SPDAT assessments by Assessment Date for the Type (i.e. Single Adult, Family, Single Youth) you plan to use with the current intake person.



By selecting the Edit VI-SPDAT option icon for a specific assessment shown, the system will load that assessment to allow the CE Specialist to edit/update and use that VI-SPDAT within the current intake without having to create a new VI-SPDAT.

When editing an VI-SPDAT assessment make sure the Survey Date is properly updated to the current assessment date to reflect the VI-SPDAT contains the most recent information available for use in the CE system, along with updating the Interviewer if needed. All existing VI-SPDATs will show the Original Survey Date and Interviewer at the top of the assessment for historical purposes.



Please note that VI-SPDAT assessments can only be re-used for up to 12 months from the time they were originally recorded. This 12 month time frame allows for the updating of assessment

information for recent return visits to the CE system. Once a VI-SPDAT assessment is over 12 months old, it cannot be re-used for returns and a new VI-SPDAT assessment should be created for those returning to the system after that timeframe.

VI-SPDAT Copy Feature

When recording a new VI-SPDAT for a person, and a previous assessment exists for that type, the system will provide a "COPY" button in which to auto-fill the current assessment with the most recent VI-SPDAT responses and scoring as a starting point for the new assessment. This is available for all 3 versions and the copy only looks at previous versions of its own type.

Once the VI-SPDAT assessment is saved, using the Save option at the bottom of the screen, the system will move to the next step of the intake process and determine based on the VI-SPDAT score and the household's sub-populations types on the next course of action automatically.

Completing / Saving a VI-SPDAT will start the last step of the Intake and Assessment phase labeled Eligibility and Referrals.

Eligibility and Referrals

The Eligibility and Referrals step determines from a household's most recent VI-SPDAT score, along with any identified special populations (sub-populations) whether or not they are eligible for placement on the Community Queue for Rapid Re-Housing or permanent housing services.

Single/Youth VI-SPDAT	Family VI-SPDAT	CQ Placement	Eligible Services
0-3	0-3	No*	Rapid Re-Housing*
4 – 7	4 – 8	Yes	Rapid Re-Housing
8+	9+	Yes	Permanent Supportive Housing
*Households that identify as Veteran, Fleeing Domestic Violence, Chronic or TAY and score less than 4 on the VI-SPDAT are still placed on the Community Queue for Rapid Re-Housing.			

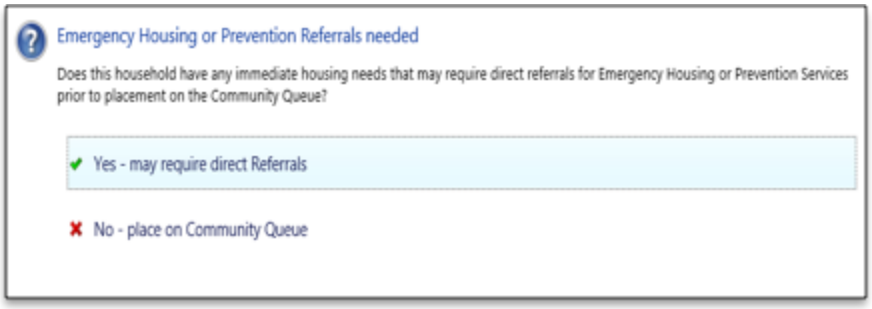
In terms of eligibility for the Community Queue the following VI-SPDAT Scoring is used along with an override or exception based on specific sub-populations as follows:

If a household is eligible for placement on the Community Queue for Rapid Re-Housing or permanent housing services through either VI-SPDAT score or specific a population (Veteran, Fleeing DV, Chronic or TAY), the next step in the process will continue through the Community Queue Placement route, those not eligible for placement for the Community Queue will continue through the Prevention/Diversion Tool route; both routes and their steps are detailed below.

Community Queue Placement

Once completing/saving the VI-SPDAT and the household is eligible for placement on the Community Queue, the next step is to determine if the household has any immediate housing or prevention service needs that may referral direct Referrals to be sent to Community partners prior to placement onto the queue.

The system will prompt the CE Specialist with the following Emergency Housing or Prevention Referral needs question/prompt to determine the next step in this route:



For those households that have an immediate housing need and may require direct Housing or Prevention services prior to placement on the Community Queue, CE Specialists should select the Yes – may require direct Referrals option. For those households that do not have an immediate housing need prior to placement on the Community Queue, CE Specialists should select the No – place on Community Queue.

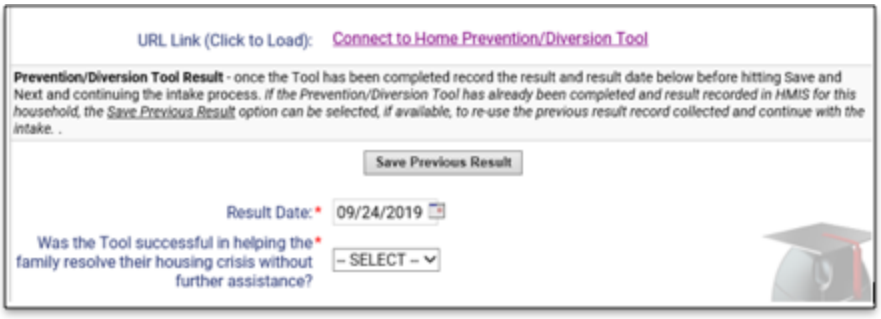
While all client/households within this route will be placed on the Community answering Yes to this question will require additional steps to attempt to assist with their current housing/service requirements.

Has Immediate Housing Need

For those identified as having an immediate housing need and may require direct Referrals for emergency housing or prevention, the system will prompt the CE Specialist to attempt to divert the household using the new Connect to Home Prevention/Diversion Tool. The Tool help to provide a guided conversation with the household that includes goal planning to assist in resolving their housing crisis without further emergency housing or prevention services.

The Connect to Home Prevention/Diversion Tool is not included in PA HMIS, it is a separate tool and is located at the following weblink/url: https://pennsylvaniacoc.org/connecttohome/prevention-and-diversion-tool/

The PA HMIS will load the Prevention / Diversion Tool screen and have the link available embedded within the screen, and when selected will load the Tool or the webpage with the Tool in a new window for use.



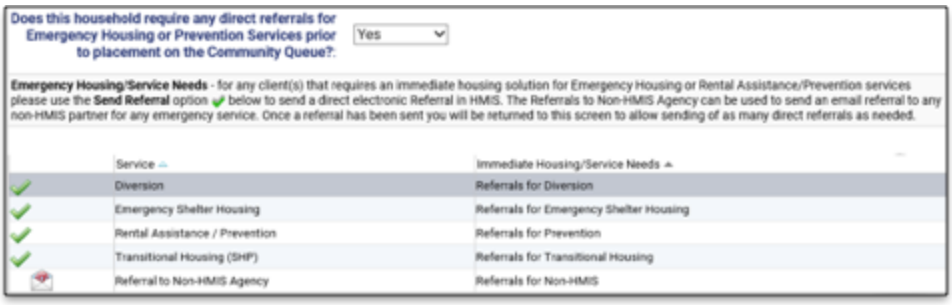
Once the tool has been covered and utilized with the client/household, the result of the diversion attempt should be recorded in this step. The Result Date and the result for “was successful in helping the family resolve their housing crisis without further assistance” is recorded (Yes or No) and based on the outcome upon hitting Save the system will determine the next step.

Please note that the system may have a Save Previous Result option on the screen if a previous result for a diversion attempt was recorded recently for the household. Using this option will load the most recent Prevention/Diversion Tool attempt result for a household and allow for it to be saved for the current intake.

Successful Diversion: For those households in which the tool provided for successful diversion and resolution from their housing crisis with no further assistance (Yes), upon saving the result on this step, the intake process will skip the need for direct Referrals and take the CE Specialist to the final step which is Placement on the Community Queue. Please refer to that section below.

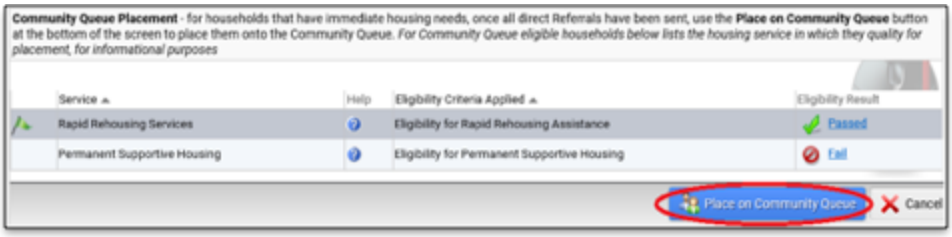
Unsuccessful Diversion: For those households in which the tool was not successful in providing diversion and resolution from their housing crisis with no further assistance (No), the intake process will take them to the direct Referrals screen to send out emergency referrals for Housing and/or Prevention as needed in HMIS.

The Direct Referrals screen will allow for the sending or Emergency Housing and/or Prevention referrals using the below referral grid. Please refer to the below Direct Referrals section for detailed steps and information on using the referrals screen/grid and sending individual emergency housing and prevention referrals.



Once all emergency service referrals have been sent, the household will need to then be placed onto the Community Queue directly from the Referrals screen using the Place on Community Queue button available at the bottom of the screen.

For those community queue eligibility households, the direct Referrals screen will display the above notification banner as well as provide the below eligibility service grid to highlight their need for placement onto the Community Queue.



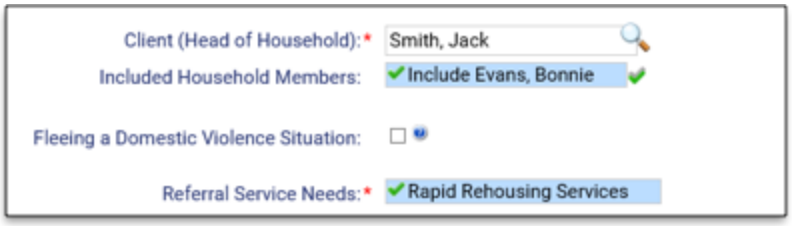
Using the **Place on Community Queue** option will begin the last step of the intake process to finalization their placement to the Community Queue with the service identified in the eligibility grid above.

Placement on Community Queue

The final step of the Intake and Assessment process, for those eligibility for the Community Queue involves completing the placement form to officially adding the client/household to the Eastern PA CoC's Community Queue.

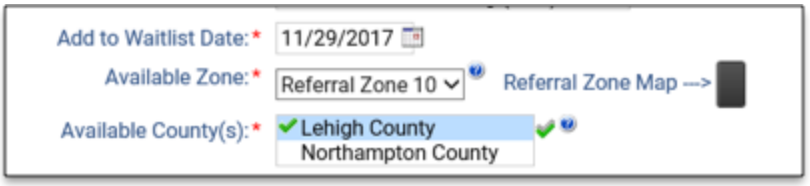
The placement form will load and will default to the current client and will include only the single service need determined by their eligibility for the Community Queue in previous steps (either Rapid Re-Housing or Permanent Supportive Housing). The three main areas to check are, additional household members, Available Zone and Available County(s); the rest of the fields are defaulted or optional.

The recommendation is to include any additional household members added during the VI-SPDAT so that the proper family dynamics are displayed from with the queue; you can add household members by selecting them from the list box. You can also include a client/household is Fleeing a Domestic Violence Situation on the CQ by checking that option below.



As noted, since only a single service can be assigned to each Community Queue placement, the system will automatically load and select the appropriate service based on their VI-SPDAT score. This can only be changed through a change within the score of the VI-SPDAT itself.

For Available Zone, you want to select the Referral Zone in which the client/household is available to relocate or receive housing services, along with selecting one or more of the Counties defined within the selected Zone within the Available County(s) selection box.

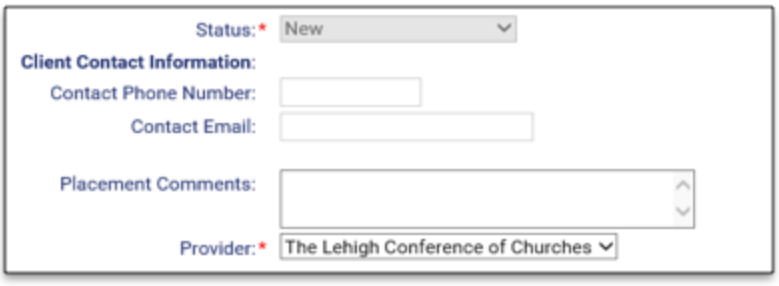


The Eastern PA CoC is separated into 10 Referral Zones (1 through 10) and each zone includes one or more counties to form that geographical zone. Depending on the Referral Zone selected, the system will build the available county(s) list and allow for the selection of one or more of the included counties.

The Available Zone and County(s) selections will be used for filtering on the Community Queue and for sending Queue Placement notifications based on the client/household's geographic preferences and housing situation.

Within the Queue Placement screen and within the Community Queue Record, the system provides a Referral Zone Map button after the Referral Zone field to display a window that shows the referral zone / county makeup within the continuum for reference purposes.

The placement form also provides the ability to enter in the client's contact information for phone and email to help providers searching the queue to more easily reach out these individuals, as well as a place to enter in placement comments.



The Placement Comments are only used during the initial placement and any notes added here are copied to the Coordinated Intake Notes for the person and can be viewed and edited with the other notes within that area. For those Organizations with multiple Providers, please ensure the correct Provider is selected during the placement for geographical reporting purposes; please note that most Organizations are setup with a single Provider entity and the system will default to the only one choice during placement.

Once the Community Queue placement screen has been completed and all elements configured to best fit the client(s) situation, select the "Add to Community Queue" option on the bottom of the screen to permanently save and initiate the placement.

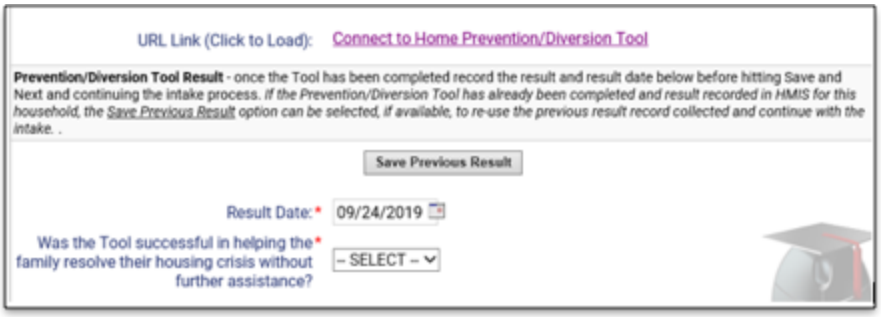
Once the placement occurs the client(s) are properly placed and identified on the Community Queue and all Eastern PA CoC Providers participating in the Coordinated Entry System (CES) in HMIS will have access to review and attempt to serve their housing needs.

Prevention / Diversion Tool for Households At Risk of Homelessness

For those identified as At-Risk of Homelessness, the system will prompt the CE Specialist to attempt to divert the household using the new Connect to Home Prevention/Diversion Tool. The Tool help to provide a guided conversation with the household that includes goal planning to assist in resolving their housing crisis without further emergency housing or prevention services.

The Connect to Home Prevention/Diversion Tool is not included in PA HMIS, it is a separate tool and is located at the following weblink/url: https://pennsylvaniacoc.org/connecttohome/prevention-and-diversion-tool/

The PA HMIS will load the Prevention / Diversion Tool screen and have the link available embedded within the screen, and when selected will load the Tool or the webpage with the Tool in a new window for use.



Once the tool has been covered and utilized with the client/household, the result of the diversion attempt should be recorded in this step. The Result Date and the result for “was successful in helping the family resolve their housing crisis without further assistance” is recorded (Yes or No) and based on the outcome upon hitting Save the system will determine the next step.

Please note that the system may have a Save Previous Result option on the screen if a previous result for a diversion attempt was recorded recently for the household. Using this option will load the most recent Prevention/Diversion Tool attempt result for a household and allow for it to be saved for the current intake.

Successful Diversion: For those households in which the tool provided for successful diversion and resolution from their housing crisis with no further assistance (Yes), upon saving the result on this step, the intake process will end.

Unsuccessful Diversion: For those households in which the tool was not successful in providing diversion and resolution from their housing crisis with no further assistance (No), the intake

process will continue and take them to the Referrals screen to send out direct referrals for Prevention and other services in HMIS.

For those households that are unable to be diverted using the tool please refer to the below Direct Referrals section for detailed steps and information on using the referrals screen and sending individual emergency housing and prevention referrals.

Direct Referrals

The system allows for the sending of electronic direct Referrals to Community Providers for emergency Housing and Prevention services to both HMIS and non-HMIS providers.

The default direct Referrals screen allows for the sending or referral request to community partners for service needs and can be accessed once a household has been unsuccessfully diverted using the community prevention/diversion tool.

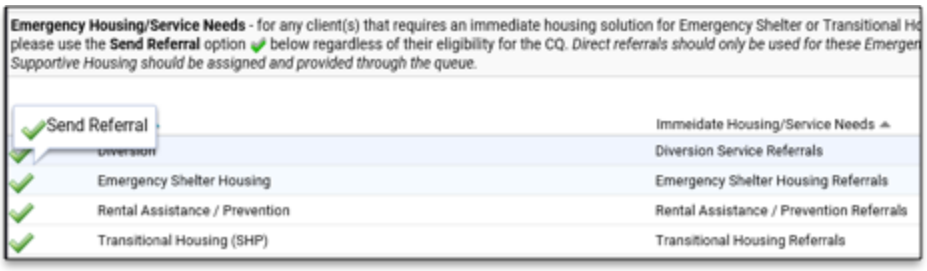
The below direct Referrals screen is the standard screen that is used to send all direct emergency housing and service referrals through the Connect to Home Coordinated Entry system for consistency purposes.

The next two sections detail using the Emergency Housing / Service Needs section to send out electronic referrals to HMIS providers and email referrals to non-HMIS providers within HMIS.

Emergency Housing/Service Referrals (HMIS Referrals)

This section allows for the sending of one or more Emergency Housing/Service referrals to shelter, transitional and prevention providers through HMIS for those client/households that have an immediate housing/service needs.

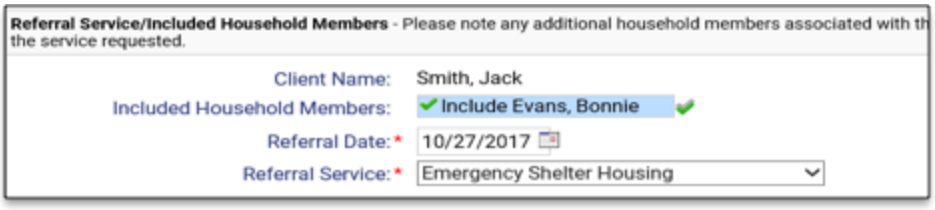
By selecting the icon, for Send Referral, the system will load an option to send a single referral to a single provider for that specific emergency service. Once completed the user will be returned to this screen to send additional referrals if needed until all emergency / immediate service requests have been met.



To send an Emergency Service Referral, select the icon and the system will launch into a referral process that allows the sending of an electronic referral requesting shelter assistance through HMIS.

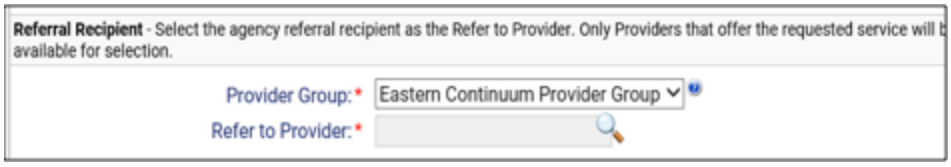
During the direct referral process, there are two sections to review and configure and include the Referral Service/Included Household Members and Referral Recipient sections.

Within the Referral Service/Included Household Members section, the screen displays the current client, the referral date and the referral service. Almost all this information is properly filled in by default and you want to check that the Referral Service shows the proper service (i.e. ES, TH, etc.) and that any additional household members added or reviewed in the VI-SPDAT step are added to the referral.

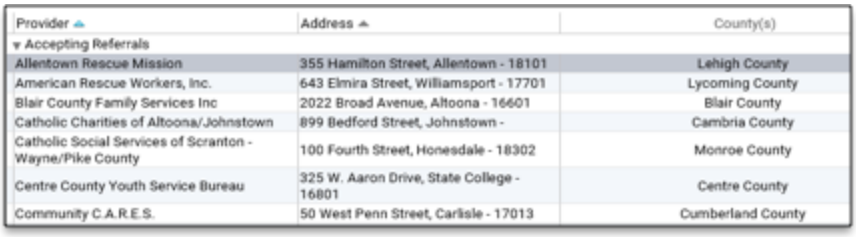


To add additional household members click them in the included household members list box shown below.

Within the Referral Recipient section, the Provider Group should default to your Eastern PA CoC Provider Group (i.e. CE Group). The Refer to Provider is the final element to complete and will be the provider in which the referral request will be sent. To begin the provider selection process, click the magnifying glass at the end of that field to load the search which will appear in a pop-up window.



Once the Available Providers window appears it will show all Providers within your continuum that have been setup as able to receive referral requests for emergency shelter housing services and have the service set to “Accepting”. Each provider will be listed along with their address and the County(s) in which they can serve.

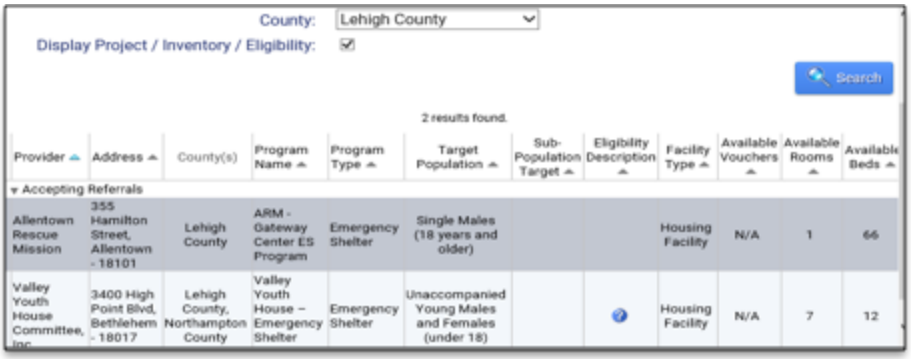


Provider	Address	County(s)
▾ Accepting Referrals		
Allentown Rescue Mission	355 Hamilton Street, Allentown - 18101	Lehigh County
American Rescue Workers, Inc.	643 Elmira Street, Williamsport - 17701	Lycoming County
Blair County Family Services Inc	2022 Broad Avenue, Altoona - 16601	Blair County
Catholic Charities of Altoona/Johnstown	899 Bedford Street, Johnstown -	Cambria County
Catholic Social Services of Scranton - Wayne/Pike County	100 Fourth Street, Honesdale - 18302	Monroe County
Centre County Youth Service Bureau	325 W. Aaron Drive, State College - 16801	Centre County
Community C.A.R.E.S.	50 West Penn Street, Carlisle - 17013	Cumberland County

The Refer to Provider also allows you to perform additional searching, by Provider Name, Address, Referral Zone and/or County as shown below. You can enter the text name or address fields or simply select a Referral Zone and/or County from the list.

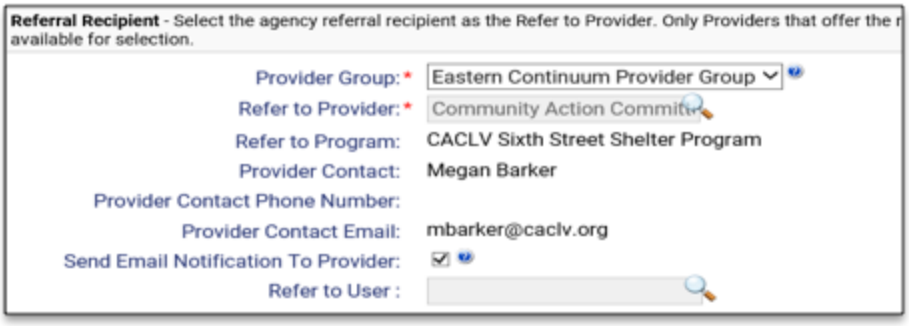
The Display Project / Inventory /Eligibility option allows a more in-depth look at each provider and includes each individual program and their target population(s), program eligibility description and inventory information on available slots/beds to help CE Specialists decide on the best match for client referrals. It is highly recommended to use this option to further review potential referral matches.

For the Eligibility Description field, any program that displays the icon can provide basic eligibility information; hovering over this icon will display this information in a pop-up text box.



Once a Provider has been identified as the referral recipient, select them from the grid by clicking on their record (you can select anywhere within that provider's row on any field).

Once Refer to Provider is selected, the screen will refresh and be updated with your choice. The system will update the provider contact information if it has been setup in the system (Providers can be setup to have a primary contact for referrals).

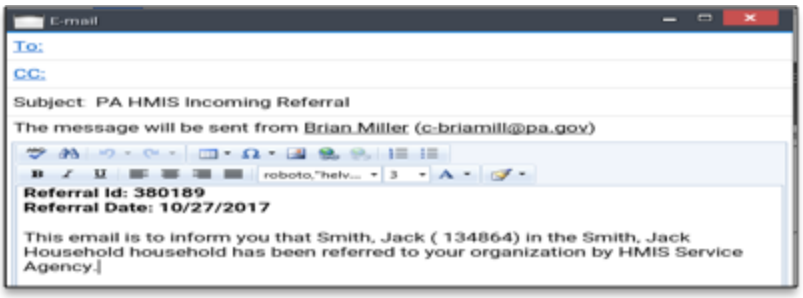


While not required, Case Specialists can also use the Refer to User option to associate the referral to a specific user/case manager at the recipient provider. By clicking the magnifying glass, a search screen will load that shows all users at that provider and their contact information; select a user to add them to the referral.

Once these 2 sections are completed, you can finish the process and send the electronic referral by selecting the "Finish" option on the bottom of the screen.

Once the referral is sent it will be electronically placed into the recipient provider's referral queue (i.e. referral inbox) and the system will provide the opportunity to send an email along with the referral.

An email dialog box will appear that contains information about the current referral and can be sent to specific persons at both the recipient and source provider. The email dialog works like any email application and you can manually type in email addresses or add in email addresses into the "To" and "CC" spots. Additional text may also be added to both the subject and body of the email.

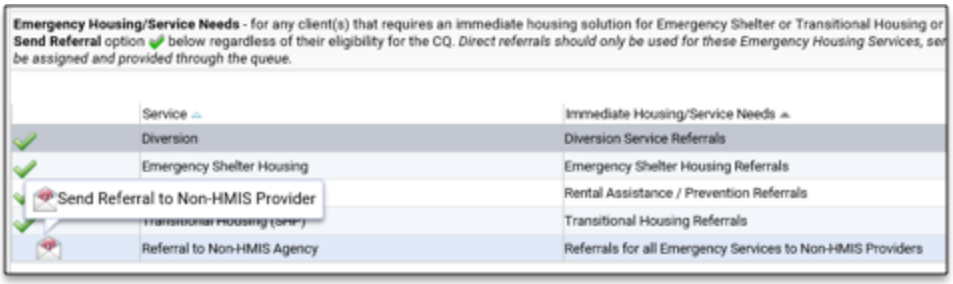


When sending a referral, the system attempts to automatically complete the “To” and “CC” email address of the email notification based on predefined setup. By default, the “To” email address is either the Primary contact of the recipient provider or **Refer to User** if one is selected during the process. By default, the “CC” email address is completed by using the Secondary contact of the recipient provider and if a specific program was selected in the referral request the user setup as that program’s referral contact.

Please note that the email is only a notification for the electronic referral transaction, all users with access to the recipient Provider in HMIS will have the ability to access, view and respond to any incoming referrals whether it not included in the email or the “refer to user” field.

Emergency Housing/Service Referrals (Non-HMIS Referrals)

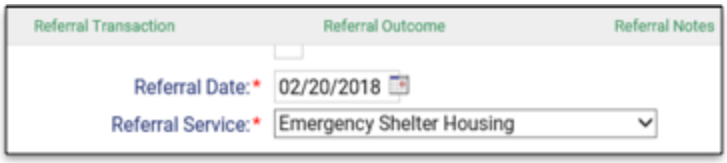
The system also contains the ability to record referrals sent to Providers/Agencies that currently do not participate with the Pennsylvania HMIS using the Referral to Non-HMIS Agency option. This will allow a referral to be recorded in the HMIS and an email to be sent to the requesting Provider for additional communication methods.



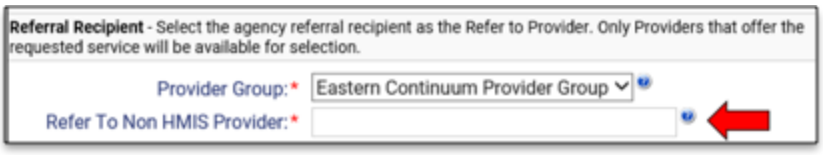
To send a Referral to a Non-HMIS Agency, select the icon and the system will launch into a referral process that allows the recording of a referral and the sending of an email to the entered Providers requesting emergency housing or service assistance.

While much of the same referral step(s) are used in recording a Non-HMIS referral as noted above, there are a few differences which are highlighted below.

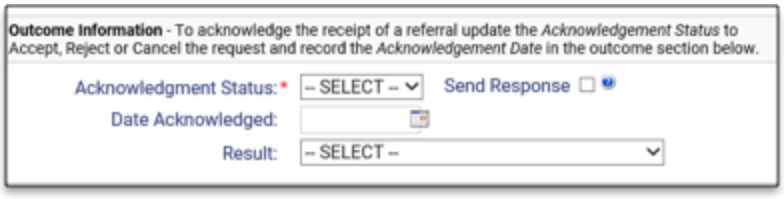
Referral Service: the emergency service included in the referrals will need to be manually selected from the list of options available in the Referral Service element; all emergency services are available from which to choose from in the list.



Refer to Non-HMIS Provider: the Provider/Agency in which the referral request is being recorded / sent will need to be manually entered the text box.



Outcome Information: since Non-HMIS Referrals are not directly sent to any other party (except with an email), its request cannot be responded to and recorded in the system by the refer to Provider. This outcome or acknowledgement information should be entered by the sending Provider to record its eventual status. This can be done during its initial recording or the referral can be revisited and updated after its status is known to the sender.

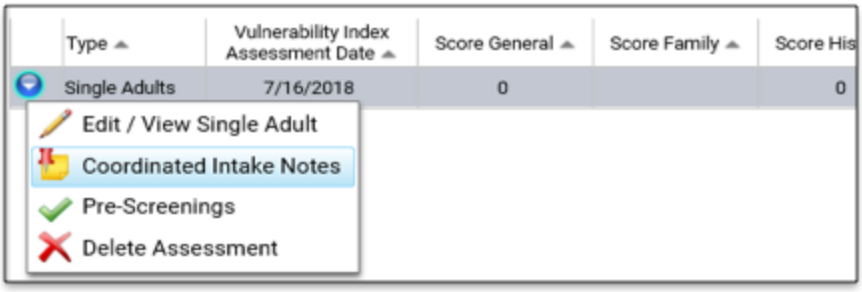


By default, the Acknowledgement Status is set to 'Pending' when initially sent, accepted infers the service was provided to the client while refused or cancelled infers that it was not.

Coordinated Intake Notes

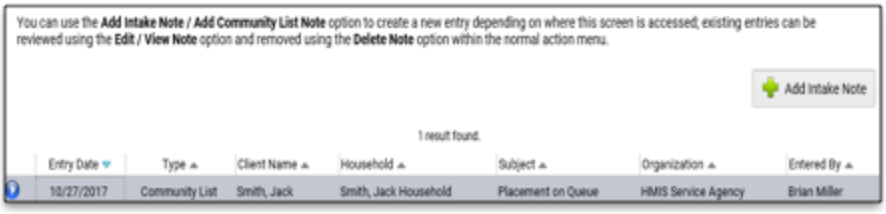
The Coordinated Intake Notes are an integrated note system within HMIS built specifically for Coordinated Entry and allows all participating members to view and enter all notes entered by all providers for all clients in the system. It is highly recommended to enter in a Coordinated Intake Note every time you contact or work with a specific client/household and update the entry will any relevant information on their needs, status or pending actions.

Once the VI-SPDAT and Community Queue Placement is completed the system automatically loads the VI-SPDAT screen, which lists all assessments for the current client/household and provides a number of actions. By selecting the action menu for a VI-SPDAT assessment (blue ball) you can Edit / View the VI-SPDAT, as well as load the Coordinated Intake Notes.

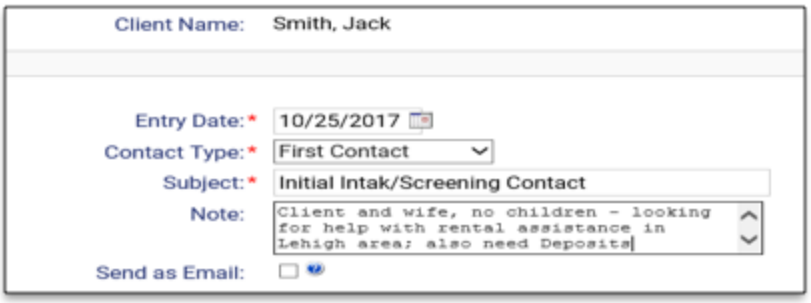


By selecting the Coordinated Intake Notes option after the initial assessment / placement you can enter additional information about the current client/household to pass along to other providers that may view this client and their needs in the future.

Once loading this option the system will display all the notes entered by the community for this client and can be reviewed for information. For initial clients, it is recommended to enter in a new note by selecting the Add Intake Note option at the top right of the screen.



When creating a new note, you enter in the Entry Date, Contact Type, Subject and Note into the appropriate fields. You can enter multiple notes if needed to provide as much relevant information to the community to help them locate and serve this client/household on the Community Queue.

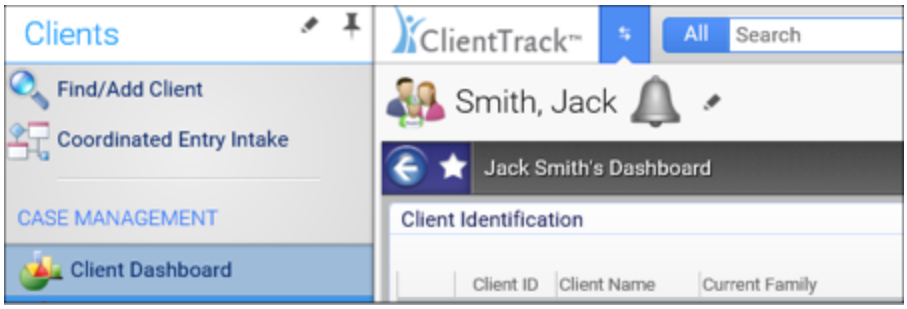


Once entered, hit save and the note will be recorded and displayed for all community partners to view for this client/household. Each note will be listed as their own record and shows which organization and user recorded and can be viewed using the Edit/View Note option as shown below.

Intake/Assessment Management

Once a person has gone through the Connect to Home Intake process and provided referrals and/or placed on the Community Queue, there are several areas within the Eastern PA CoC Coordinated Entry Workgroup to locate their information if needed whether for a call-back, return visit or informational purposes.

To locate a person that was entered into the HMIS for CES you can use either the Find/Add Client, which is the system's general client search feature or you can use the Coordinated Entry Intake option. Both options will allow you to search for the client and select them on your screen and load their Client Dashboard.

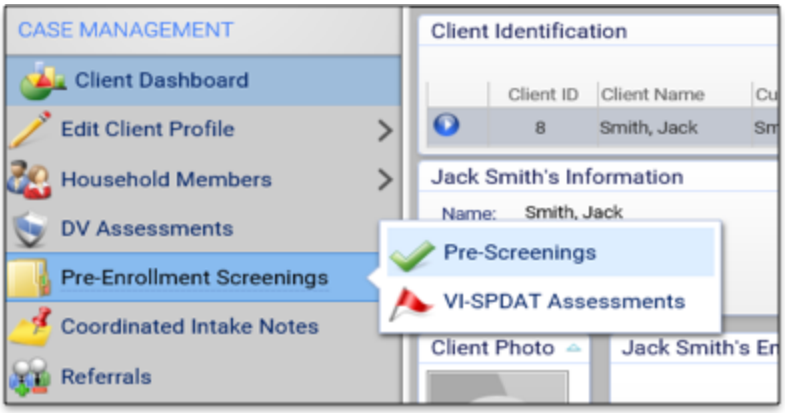


Using Find/Add Client, you select this option, perform a search and select the client from the result grid to be placed on their Client Dashboard. Within the Coordinated Entry Intake, locate the client in the 1st step of the process (Client Intake), go to the Pre-Screening and then hit Cancel Intake in the bottom right of the screen; this will also place you on the Client's Dashboard.

The Client Dashboard in HMIS is a home screen for a client that shows basic demographic information and provides a menu in which to locate different CES screenings, assessments and notes.

Within the Client Dashboard, the menu on the left-hand side will provide the following sections that will allow access to their history in terms of data collected for the Connect to Home CES in HMIS.

- Pre-Enrollment Screenings -> Pre-Screenings and VI-SPDAT Assessments
- Coordinated Intake Notes
- Referrals



These sections should provide the information recorded for the client in HMIS for the Intake and Assessment steps of the process and all are available to Assessment/Call Centers and Referral Partners for those persons that have shared their data on their Pre-Screening.

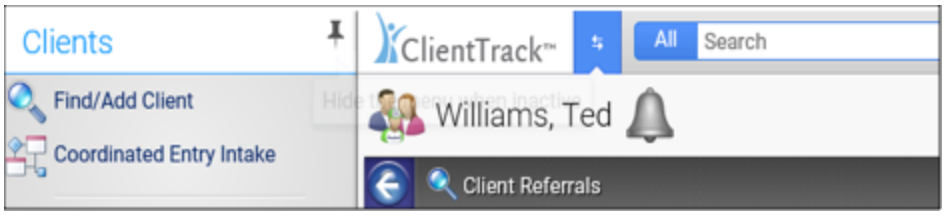
Intake and Assessment - DV / Anonymous Client Addendum

The DV / Anonymous Client Intake and Assessment process works in almost the same manner as depicted in the Intake and Assessment section above with some slight variations to ensure no personally identifiable information is collected or stored for any person entering this process.

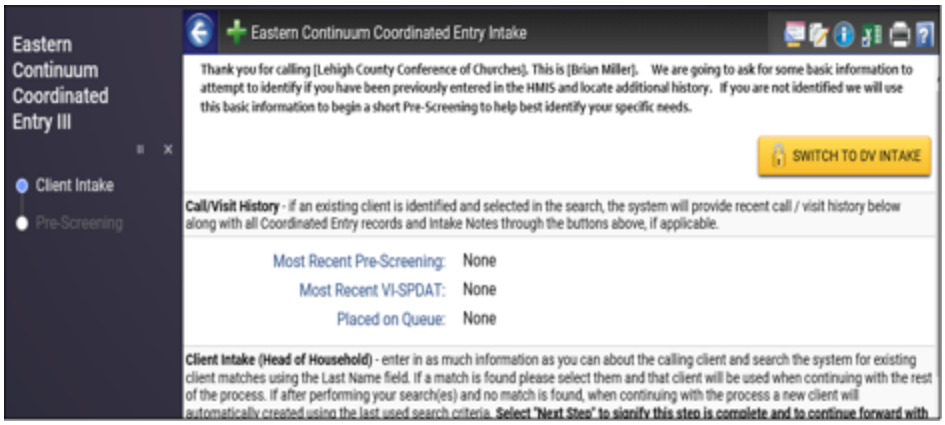
Each Call and Assessment Center currently has this intake available and can use it when working with those clients that need any additional layer of privacy protection. The below steps point out the main differences in the screens for the standard Intake and Assessment process shown above.

DV / Anonymous Client Intake

To access the DV / Anonymous Intake part of the process, begin by using the Coordinated Entry Intake option (circled below) to launch the standard Connect to Home CES Intak workflow in PA HMIS.



Once the Coordinated Entry Intake process in HMIS has been started, on the initial Client Intake screen the system will display a “SWITCH TO DV INTAKE” option on the top of the screen.

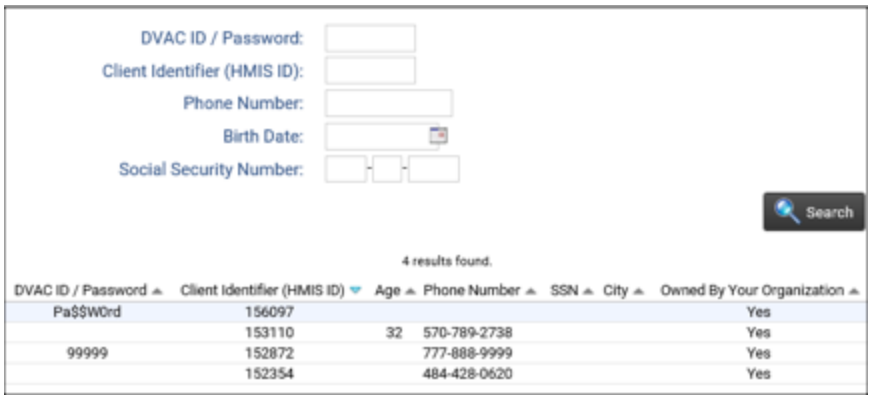


When entering in general clients, this option can be ignored and regular data entry should be performed using the familiar steps shown above. When entering a client referred/served from VAWA/DV organization or one that requires an extra layer of protection, this option can be selected to switch the process over to the DV / Anonymous Client Intake Process.

Once selecting the “SWITCH TO DV INTAKE” option, the current screen switches to an anonymous entry form that allows for searching for existing clients by entering in either an HMIS ID, Consumer Password or Phone Number. It also allows for an easier way to create a new anonymous client in HMIS – as you can enter a specific Consumer Password for the client or Phone Number for future tracking.

A “Switch to General Intake” option is also available at the top of the screen to switch back to the general entry mode if a mistake was made and you need to switch back for a general client.

This Client Intake/Search screen works like the general client intake in that you can search for existing clients using the DV ID field and can search by HMIS ID, Consumer Password or by Phone Number. The main difference from the general client process is no personal identifying information for a client can be recorded and the three elements mentioned above are the identifiers used for entering and tracking them.



If an existing client is found you can select them and use them for the rest of the process. If an existing client is not found/selected during the intake, a new anonymous client will be created when moving forward in the process.

Please note that the DV Intake is built for privacy and security and in most cases, the Assessor will be creating a new anonymous client during this process. The few times where an existing client is selected during a DV Intake will be for known returning clients that have their HMIS ID available or have been assigned a Consumer Password by the agency.

The HMIS ID is the unique identifier that is automatically created for each client (and DV client) entered in PA HMIS and this can be used for tracking in the future. The Consumer Password is an identifier that can be entered by the Assessor manually and can relate to an ID or Number (can be alphanumeric and up to 12 characters) used by the DV/VAWA provider for cross-tracking. If it is not initially entered it will be left blank, but can be updated later once obtained.

Pre-Screen | VI-SPDAT

Once saving a DV client at this step, the rest of the intake will be labeled as a DV Intake and you will be moved through the basic steps as the general client intake, collecting the Pre-Screen and then be prompted to record one of the 3 VI-SPDAT versions as the client/household is

automatically identified as Category 4 – Fleeing DV, unless manually changed/overridden by a CE Specialist.

Collecting the VI-SPDAT will be the same as with a general client, with the main difference being any personally identifying fields will be hidden, which includes the VI-SPDAT Family Member grids (only single anonymous clients should be entered during the DV Intake). The VI-SPDAT can be completed to provide the score needed to determine Community Queue placement.

Please note that since dv/anonymous clients do not allow household members, the edit/view household member step is also skipped for the DV/Anonymous intake.

Once the VI-SPDAT assessment is saved, using the Save option at the bottom of the screen, the system will move to the next step of the intake process and determine based on the VI-SPDAT score and the household's sub-populations types on the next course of action automatically.

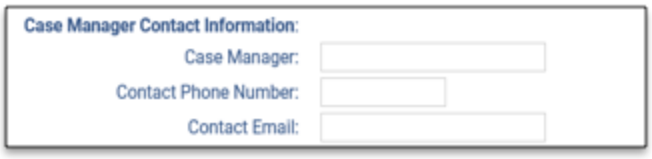
Completing / Saving a VI-SPDAT will start the last step of the Intake and Assessment phase labeled Eligibility and Referrals. Since all DV/anonymous clients are eligibility for placement onto the Community Queue the DV/Anonymous Intak will follow the same steps as described above for a household heading through the Community Queue Placement Route.

Community Queue Placement

The Community Queue placement will be the same as a general client and the same questions will need to be completed for Available Zone and Available Counties; the system will also automatically load and select the appropriate service based on the person's VI-SPDAT score.

The Community Queue record will be flagged as 'Fleeing a Domestic Violence Situation' and can be filtered through the Domestic Violence subpopulation filter on the queue. As with all other forms during the DV Intake, no personal information is displayed, only the HMIS ID and Consumer Password are present for tracking purposes.

One main difference between a general client placement and a DV placement is the contact information section. For general clients, there is a section for Client Contact Information and a Phone Number and Email address. For DV clients this is changed to be Case Manager Contact Information, and includes the Case Manager name, phone number and email address.

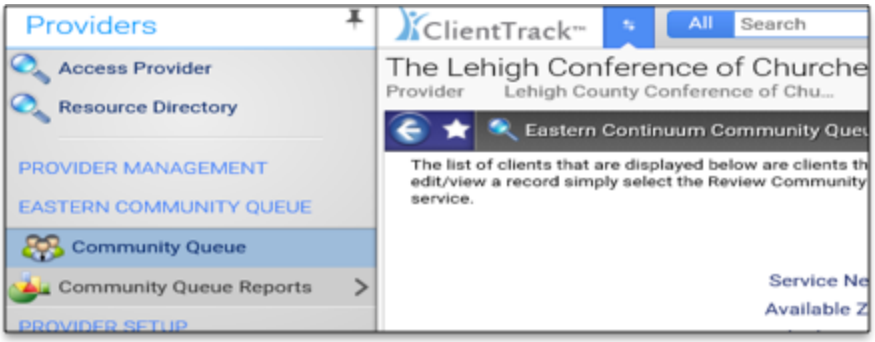


This will allow for partners to contact the DV client's Case Manager directly to get in contact with the client through them and further protects the client from having their information on the system.

Community Queue Management

The Community Queue is available within the Provider tab and located within the Eastern Community Queue folder. By selecting that folder, the system will display the Community Queue option (circled below) and when selected will load all clients that have been assessed and placed from the Intake and Assessment step.

Community Queue Management is assisted by Regional Coordinated Entry Managers to facilitate periodic region and referral zone reviews and help provide assistance to Providers working to provide housing and services to households that are active in the queue in their respective areas.



When loading the Community Queue each client/household placed will be identified as a single row and will display summary information about that person(s). Each list record includes the client, household demographics, screening information, service needs, status and more.

Added to Waitlist	HMIS ID	Client (Head of Household)	Adult Males	Adult Females	Child Males	Child Females	Household Size	Available Zone	Available County(s)	SPDAT Type	SPDAT Score	Sub-Populations	Chronically Homeless
07/10/2018	6	Johnson, John	1	0	0	0	1	Referral Zone 7	Cumberland County,	Single Adults	1		No

By using the below Community Queue Search and the Community Queue Management functions, community providers can search, locate, examine, note and match client/households to their own available resources for housing placement opportunities.

Community Queue Search

By default when loading the Community Queue all active clients are displayed on the screen and are sorted automatically with the person(s) with the highest Screening Tool score on top, followed by those with the highest needs determined by sub-populations (i.e. Veteran, Chronic Homelessness, Fleeing DV, Youth, etc.).

The Community Queue provides several search options to help community providers search through the list to attempt to locate matching clients/household in which to attempt to offer housing resources. Each of these filters can be used alone or in conjunction with one another by providers to assist in managing the overall list.

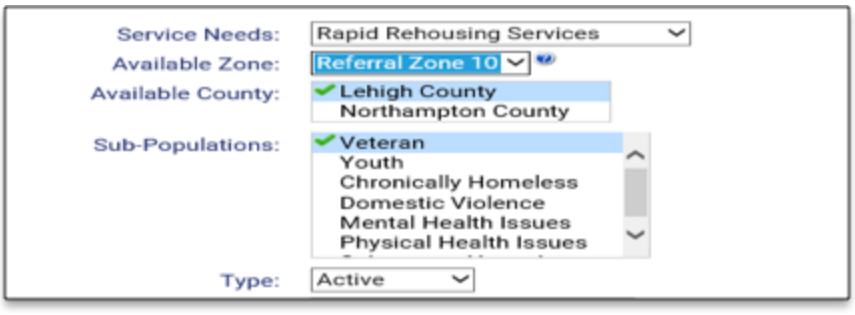
The current “active” list includes all persons on the Community Queue that are still awaiting Permanent Housing / Permanent Housing assistance and includes those records with a status of New, Verifying, Engaging and Reviewed. Those persons on the Community Queue with a status of Closed or Enrolled are no longer active and have been moved to the “historical” list. The Type filter shown below can move between the Active and Historical lists as needed, but always defaults to Active queue when initially loaded.

Please note that the filters in the Community Queue for Service Needs, Available Zone and Available County coincide with the selections and settings entered for clients during the placement process.

As each filter is chosen the system will automatically rebuild the list of available clients on the screen and most community providers should be reviewing clients/households that have service needs that match their program(s) within their geographic region (Zone and/or County).

The subpopulation filter can also be used to further filter available clients for specialized programs that serve specific demographics and include: Veteran, Youth, Chronically Homeless, Domestic Violence (i.e. Fleeing DV) and Mental Health, Physical Health and Substance Abuse issues. All subpopulation identifiers for each Queue record is derived from information collected during the person's Intake, within their Pre-Screen, standard VI-SPDAT and VI-SPDAT additional questions.

As an example, if a provider that has available Rapid Re-Housing resources for Veterans, that are Chronically Homeless within Lehigh County can use the following search filters to locate persons on the list that have similar service needs and are within the geographic region to contact for a potential meeting to determine eligibility for enrollment.

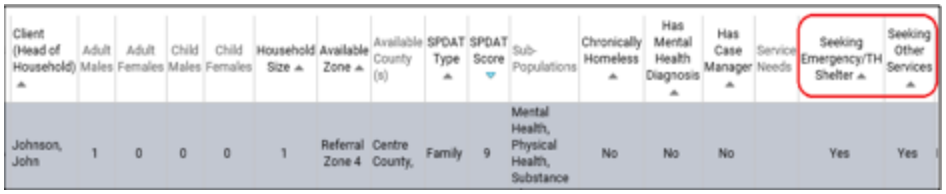


Once a client(s) are located within the list the following options can be used to further review the client and work toward enrolling them into your project and letting the community know through the Coordinated Intake Notes.

Please note that both Available County and Sub-Populations allow for multiple criteria to be included in the search at the same time and while the County search only requires a client to be associated with any of the areas selected, the Sub-Populations search requires the client to be identified with all the issues selected.

Community Queue Emergency Service Needs

The Community Queue incorporates any emergency service needs for any associated persons and displays this information in two separate categories, one for shelter needs and one for service needs. Those persons that have a current shelter or service need based on pending or unanswered referrals are denoted with a 'Yes' in the appropriate column.



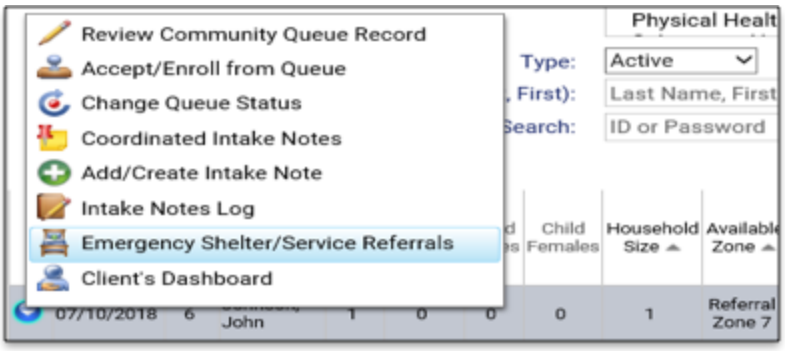
Client (Head of Household)	Adult Males	Adult Females	Child Males	Child Females	Household Size	Available Zone	Available County (s)	SPDAT Type	SPDAT Score	Sub-Populations	Chronically Homeless	Has Mental Health Diagnosis	Has Case Manager	Service Needs	Seeking Emergency/TH Shelter	Seeking Other Services
Johnson, John	1	0	0	0	1	Referral Zone 4	Centre County,	Family	9	Mental Health, Physical Health, Substance	No	No	No		Yes	Yes

Seeking Emergency/TH Shelter – displays the current service need status for Emergency Shelter or Transitional Housing/Shelter services.

Seeking Other Services – displays the current service need status for Rental Assistance (Homelessness Prevention) or Diversion services.

Emergency Shelter/Service Referrals

When either of these columns are labeled with 'Yes', the system has identified the person has 1 or more referrals that have not been accepted for the specific service type. Those referrals and the person's service needs can be viewed within the Emergency Shelter/Service Referrals menu option of the Community Queue Record as shown below.



Selecting this option will load an information screen that displays all Shelter and Service referrals for the client, along with the details of each request. The referral records include the source and destination Providers, the service and their statuses (i.e. Pending, Declined, etc.).

Providers can directly respond to referrals sent to them from with this screen and can create new referrals using the Send Referral option to send a service request to a Provider with a potential opening or to themselves if they have an opening.

Community Queue Statuses

Each Community Queue record is associated with a Status that helps provide information on where in the process the associated person/household is on the queue. The following provides an overview of each Community Queue Status and what each represents:

New – this is the status all Community Queue records receive when initially placed on the queue and show a record that has not yet been touched by any Providers. Once a status has been moved from new, in most cases it should not been returned to that original status

Engaging – this status is used when attempting to contact a person for verification and potential enrollment. Changing a CQ record to this status will identify this record as being actively communicated with to provide service, but only reflects that communication is ongoing. Other Providers interested in contacting or reaching out to this person should continue to do so under this status.

Enrolled – this status indicates an active queue record, but identifies the person as being enrolled and currently served by a program and awaiting placement into a permanent housing unit. Once a person is served and enrolled they should be set to this status. Community providers should not actively pursue contacting or working with a person of this status as they are being served by a community housing program.

Housed- this status indicates a non-active queue record and represents a positive outcome as the person has been enrolled and confirmed to be placed into a permanent housing unit. This status should be used to remove a person from the active queue and identify them as being placed into housing.

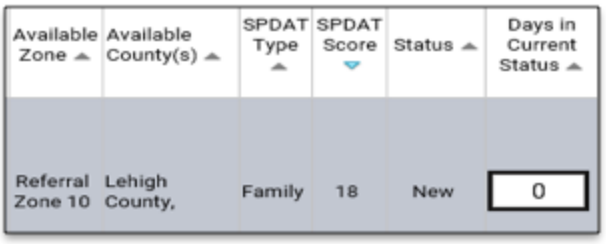
Closed – this status indicates a non-active queue record and represents that the person is either no longer is need of permanent housing or has lost contact with the community for services. This status should be used to remove a client from the active list based on the current community rules (i.e. at least 90 days of attempted contact, person refused further service or contact, person was found to not be literally homeless).

Self-Resolved – this status indicates a non-active queue record and represents that a person self-resolved their housing situation and no longer requires assistance or services from the community.

The Community Queue Status can be manually changed using the various functions listed below in the management section.

Community Queue Days in Status

The Days in Status field accompanies the Status and denotes the number of days from the current day that the Status of a record was last changed (or manually reset). This Days in Status field helps the community when reviewing Community Queue records identify persons that have been recently reviewed and which ones have a need to be contacted for review.



Available Zone	Available County(s)	SPDAT Type	SPDAT Score	Status	Days in Current Status
Referral Zone 10	Lehigh County,	Family	18	New	0

The general policy is for each record to be reviewed within a 7-day period and any record with a Days in Status over 7 days should be a priority to review during Community Queue reviews. The Days in Status has the following color coding:

White = record Status updated in last 7 days (or record is not active), no urgency

Green = record Status is Enrolled/Engaging in last 14 days, provider is most likely actively working with this client, record can be skipped in review

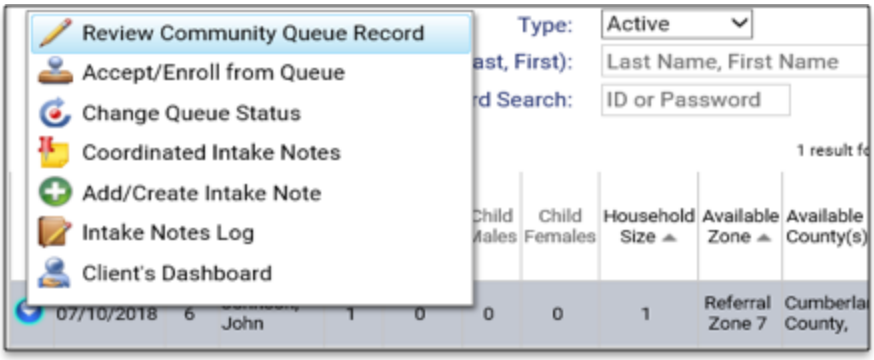
Yellow = record Status for Enrolled/Engaging is over 14 days, may be to be reviewed for reason additional status changes have not been warranted

Red – record Status has not been updated in predefined time frame, high urgency for review

The Status and Days in Status options can be updated directly within the Prioritization List record, which is accessible using the Review Prioritization List record feature which is detailed in the management functions below.

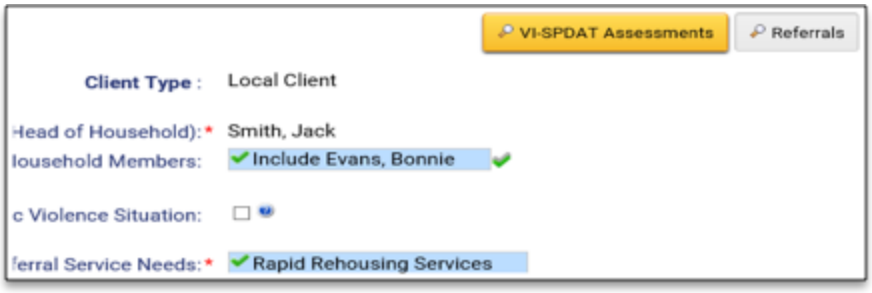
Community Queue Management Functions

Each Community Queue record has a menu of options for use during the review / contact stage after they have been identified from the initial search and includes options for reviewing and editing the Community Queue record to reviewing and adding notes regarding their contacts and progress.



Review Community Queue Record

This is the option to review and edit not only the Community Queue record but the service outcomes section as well. The review list record displays options at the top of the page to display the client's recorded VI-SPDAT Assessments and Referrals for information purposes.



The Community Queue Record also can set the client/household's overall Status on the list, as well as provide an option to record a Housing Placement through a Service Acceptance process

to provide official housing services. These options will be covered in more detail in the “Housing Placement” section below.

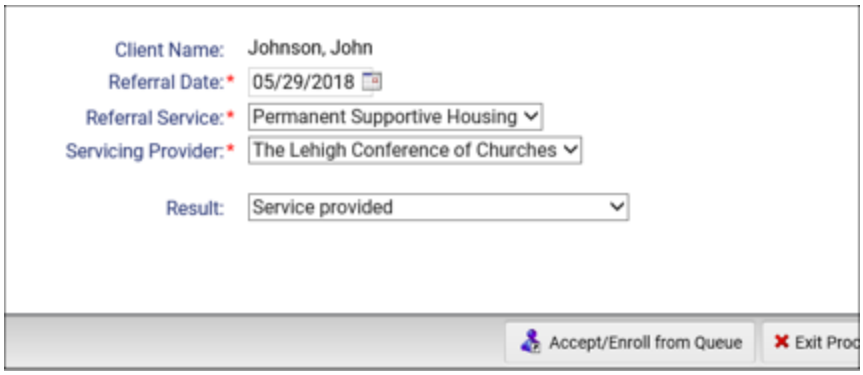
VI-SPDAT Assessments: by using this option within the Community Queue record you can view all VI-SPDATs collected for this person along with any Pre-Screens that have been recorded as well. This option will display each VI-SPDAT record, and using the action menu you can Edit / View the individual assessment and Pre-Screenings using directly within this area.

Please note that only Call and Assessment Centers have access to edit existing VI-SPDAT assessments, however all Providers with access to the Community Queue will have at least read-only access to VI-SPDAT assessment data through this method.

Accept/Enroll from Queue

This option allows for a Rapid Re-Housing or Permanent Supportive Housing service / enrollment to be recorded for the person by the accepting Provider. This option also allows for the CQ record to be set to Enrolled and pulled off the Active list in a single easy to perform step.

When selecting this option, the system will load a new window to record the service accept / enrollment and includes the date, service, and the Provider. The result is an optionally data element which can also be included.



Once completed, select the Accept/Enroll from Queue option and the service will be recorded and the CQ record will be set to the “Enrolled” status by default. When set to Enrolled the person

will be kept on the active queue until they have been confirmed to have received permanent housing through the program.

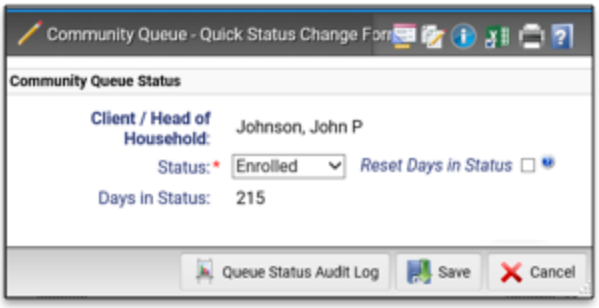
The system will also allow you to update the status to “Housed” during the Accept/Enroll from Queue process and once completed will remove the person from the active queue. You only want to set the status to “Housed” if the person has been confirmed to have been placed into permanent housing and can be removed from the active queue.

Please note that these are the same steps for going through the Service Acceptance option from within the CQ record, with the exception that this action menu process automatically sets the record to Enrolled for Rapid Re-Housing and Permanent Supportive Housing services. The Service Acceptance option is detailed below in the Record Housing Placement section.

Change Queue Status

This option allows for the changing of the status of a Community Queue record without having to load the full record using the above Review Community Queue Record option. When selecting this option a new window will appear that will allow for the changing of the status to an intermediate status such as New, or Engaging.

The new option will appear and will default to the person’s status and can be changed to either New, Engaging, or Enrolled. Once changed, hit save and the window will close automatically without entering the CQ record or losing your place within the queue.

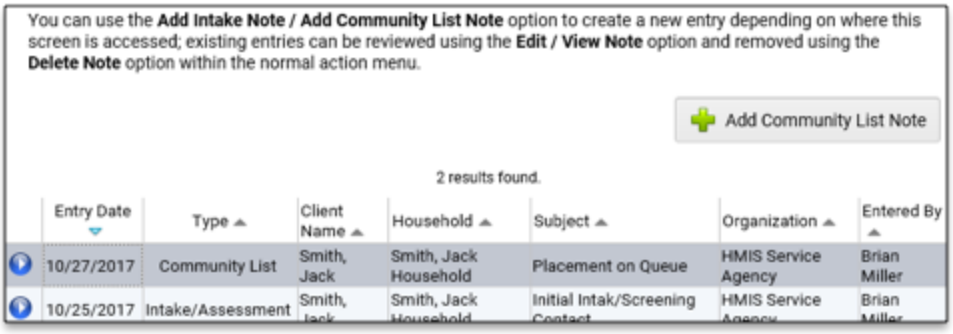


With the Change Queue Status, the ability to “Reset Days in Status” is also available and will record when a status change has occurred. The Community Queue has a Queue Status Audit

Log that records an entry every time a record's Status was changed or reset and can be run using this option. The Audit tracks the agency, user along with the date and time the status was changed; it provides for a historical audit review of all changes by users in the system.

Community Queue Coordinated Intake Notes

The Community Queue has access to the same Coordinated Intake Notes described in the Intake and Assessment section and displays all shared notes entered by community providers working / contacting this client/household. By selecting this option a new window will load that displays all notes for the client that can edit/viewed individually and new notes can be entered using the Add Community List Note option. The same rules for viewing, editing and creating new notes remain the same whether you access these notes in the assessment or prioritization list steps.



Once a client has been reviewed a new Coordinated Intake Note should be entered that provide information on whether the provider plans to pursue connecting with the client/household for potential services or whether a connection is not going to be made.

It is important to use the Coordinated Intake Notes from the Community Queue side to record all actions with an active client/household, this provides other providers with information on whether another provider is working with them or not and whether to begin actively working with the client or to move to the next one on the list.

Add/Create Intake Note

This option allows for the creation of a new Coordinated Intake Note directly from the main Community Queue search screen. When selecting this option, a new window will appear that will allow for the recording of a new Community Queue note using the standard process, as detailed above using the “Add Community List Note”.

Please note that once the new note has been entered, the window does need to be closed manually by hitting cancel or the red X in the top corner.

Intake Log Notes

This option produces a pop-up report that combines all the Coordinated Intake Notes entered for the Prioritization List record and displays them on a single report in reverse chronological order. The log report can be used to quickly run and scan all intake notes for the most recent entries and to locate trends when seeing all information together on the same page.

Community Queue Housing Placement Process

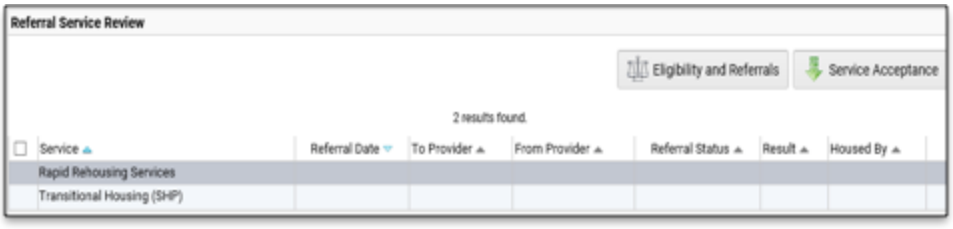
After reviewing a client/household and matching their service needs with an opening or available housing resources, the next step is to record this Housing Placement and remove the record from the active queue. This can be done by using either the Accept/Enroll from Queue option or the Service Acceptance option located within the Community Queue Record; both are almost identical and can be used to complete the housing placement process.

Accept/Enroll from Queue

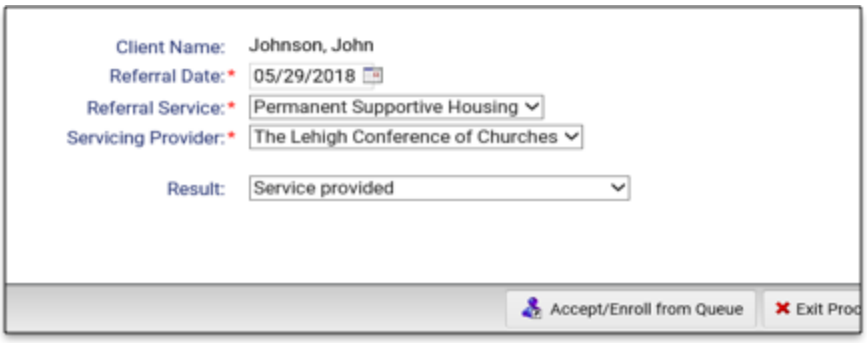
The recommended way to record a proper Housing Placement is to use the Accept/Enroll from Queue option located within the Community Queue record menu options as described above.

Service Acceptance

The Service Acceptance option is within the Community record (using Review Community Queue Record function) and found within the bottom Referral Service Review or Outcomes section and is circled below.

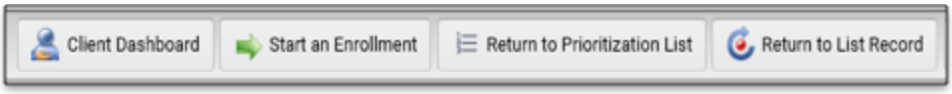


By selecting this option the system will load a screen that will allow you to record the Service and the Provider that provided it for an enrollment to the current Community Queue client/household.



Once you have selected the service you are providing to the client, select the Accept from Queue option to complete the process. This option automatically sets the person's status to "Enrolled", but also allows for the Provider to set the person's status to "Housed" to remove the person from the active queue in a single step (only set to "Housed" if the person is in permanent housing and should be removed from the active queue).

Once the Service Acceptance is performed (or the Accept/Enroll from List), the system refreshes the screen and provides a navigation menu to load the Client's Dashboard, Start an Enrollment, Return to the Community Queue or even Return to the List Record if desired.



Please note that the Service Acceptance step should only occur once your agency is going to provide the client/household with a housing service.

Non-Active / Closeout Process

Once a client/household on the Community Queue has been determined that they either no longer require any housing services, is deemed ineligible, or declines further contact from the community (i.e. disappears) the community can remove them from the active list.

Community Queue Status

To officially mark the Community Queue record as "Closed", which indicates a neutral housing outcome, requires a provider to manually update the Community Queue Record's Status and enter in a Non-Placement Reason. Once the status is updated, save the Community Queue record to complete the process.

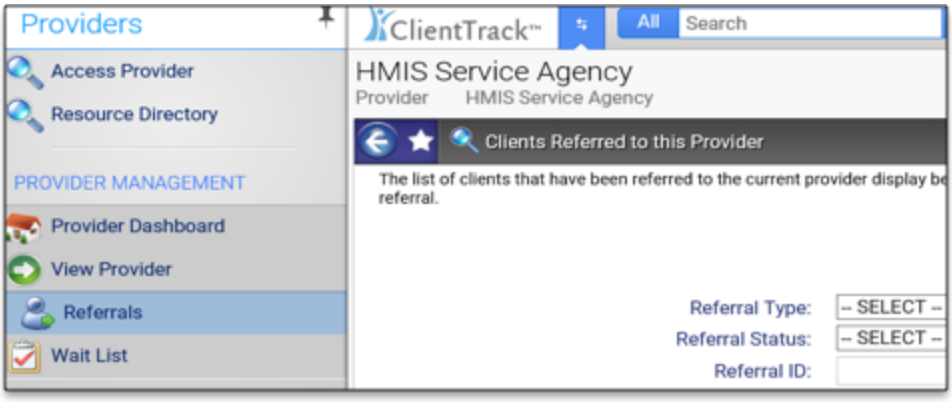
Once this step is performed, the client/household will be moved from the active to the historical side of the Community Queue.

Please note that you only want to close out a Community Queue record to a non-housing placement when the client/household's situation no longer fits the requirements of the system or they have refused further services directly or through inaction. When a provider reviews a client/household and does not find them to be a match for their own program(s) only record that within the Coordinated Intake Notes and let the client/household remain active on the list for other providers to review for potential matches.

When closing out a Queue record from the active list, for either Enrolled or Closed, the system will prompt with the following message which indicates the record is being removed from the active list and no longer requires assistance. Selecting save again will place / close out the Queue record to the historical list.

Community Queue Referral Management

Referral Management covers the process of reviewing your referral queue includes the actions of accepting/rejecting referral requests. All referrals that have sent or received are located within the Provider tab, within the Provider Management -> Referrals area highlighted below.



If your agency is not listed at the top of the Provider tab, please select Access Provider at the top of the menu to load your organization provider.

When selecting the Referrals option, this will load your agency's referral "queue" and this screen includes all the referrals sent by you (outgoing) and sent to you (incoming) in the system. The referrals screen has several filters that can be used to assist in finding the exact referrals you are looking to review and process.

The filters include type (incoming vs. outgoing), status (pending vs. accepted vs. rejected...), referral ID and by client name. For standard referral management, the main filters to use will be to view incoming and pending referrals as these are the referrals that a Provider needs to immediately review and act upon.

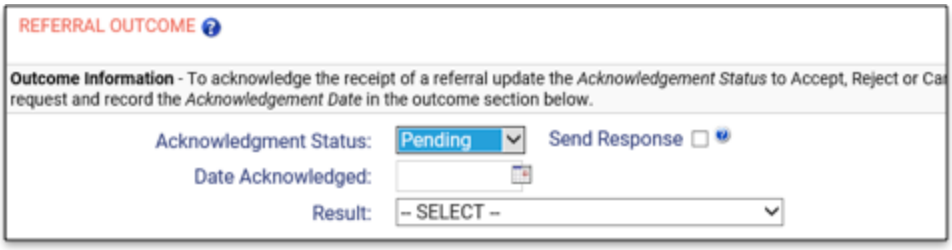
Each referral will be listed in its own row and includes information about the request, such as the Refer to Provider and Refer from Provider, the Client, the Service and the Status.

Each referral has a couple of actions that can be used to review, process and report on each transaction and are listed below:

Accept/Reject Referral

Any pending referral, which is a referral that has been sent but not yet received a response from the receiving provider, will have this action available to allow the referral to be processed.

Once this action is selected, the referral will be loaded on screen and one data element that affects the overall status of the request is the Acknowledgement Status located within the Referral outcome section near the bottom of the page. This is the only element that needs to be updated to process the referral, as both the date acknowledged and results are optional.



The Acknowledgement Status allows for the receiving Provider to update the referral request to be either Accepted or Rejected/Cancelled. Once a referral's acknowledgement status has been updated, select "Finish" on the bottom of the screen to permanently update the referral request.

Accepted Status

A referral should only be updated to Accepted when a provider can 100% provide the client/household with the service included in the referral. This status will inform the sending provider or assessment center that the client's needs have been met; in terms of Coordinated Entry this means providing Emergency Shelter housing.

When a referral is accepted, the client and associated household members are automatically imported into the recipient provider's agency in HMIS and will have full data access to perform enrollments into their program(s).

Rejected/Cancelled Status

A referral should be rejected or cancelled when a provider is unable to provide the services requested through the referral. This status will inform the sending provider / assessment center that the client's needs have not been met by this request.

When a referral is rejected/cancelled, the client and household members are not imported into the provider's agency in HMIS and any temporary sharing provided through the referral request is cancelled.

When rejecting or cancelling referrals from Coordinated Entry Assessment Centers, the system will require the entry of a Coordinated Entry Referral Note to include the reason the referral was cancelled. To enter a note, select the Enter Referral Note option shown below to enter in the reason.

Please note that all responses to referrals, whether accepted or rejected/cancelled, prompt the system to automatically send an email to the sending provider (sending user) that informs them of the final status and includes any referral notes.

Review Referral

Once a referral has been processed as either accepted or rejected/cancelled the status is permanent and cannot be changed. However, the referral can still be viewed for historical information and note purposes. All processed referrals will have the Review Referral access that will load the referral screen and provide access to the information entered and noted recorded.

CONNECT TO HOME: COORDINATED ENTRY SYSTEM OF EASTERN PA PARTNERSHIP AGREEMENT

The Eastern Pennsylvania Continuum of Care (CoC) Coordinated Entry System (CES) coordinates and manages access, assessment, prioritization and referral to housing and services for any person(s) experiencing or at imminent risk of homelessness in the following counties: Adams, Bedford, Blair, Bradford, Cambria, Carbon, Centre, Clinton, Columbia, Cumberland, Franklin, Fulton, Huntingdon, Juniata, Lebanon, Lehigh, Lycoming, Mifflin, Monroe, Montour, Northampton, Northumberland, Perry, Pike, Schuylkill, Somerset, Snyder, Sullivan, Susquehanna, Tioga, Union, Wayne and Wyoming.

Participation in CES is required for all projects funded by HUD Continuum of Care or Emergency Solutions Grants (including those administered by the Commonwealth of Pennsylvania) and is strongly encouraged for all other housing and service providers in order to ensure equitable and coordinated access for all.

By signing this agreement, CES partners agree to work with other CES funders, service providers and referral partners throughout the thirty-three county CoC region under a shared set of guiding principles, roles, and responsibilities as follows.

I. Guiding Principles

The Eastern Pennsylvania Continuum of Care (CoC) Coordinated Entry System (CES) is guided by the following principles:

- Every person experiencing homelessness should be treated with dignity, respect and kindness, and have their rights to privacy, confidentiality and safety honored.
- By coordinating entry to housing and services for people experiencing homelessness, more families and individuals can exit from homelessness to permanent housing with stability as quickly, efficiently and effectively as possible.
- Coordinated entry is inclusive of all populations experiencing homelessness, including families, youth, veterans, survivors of domestic violence, people with disabilities, people with mental illness, recent immigrants and people identifying as LGBTQIA.
- Coordinated entry protects the safety and confidentiality of people fleeing/attempting to flee and survivors of domestic violence while simultaneously providing them with access to housing and services.

- Coordinated entry embraces a housing first approach to ending homelessness in which people are housed as quickly as possible without preconditions or service participation requirements.
- People experiencing homelessness are prioritized for appropriate housing and services based on their vulnerability and severity of need using an evidence-based assessment tool rather than on a “first come, first served” basis.
- People experiencing homelessness are not denied access to coordinated entry assessment and referral because of perceived barriers to housing and services such as sobriety, income level, mental health status or other factors.
- Coordinated entry should be aligned with affordable housing, veterans affairs, child welfare, health, mental health, education, legal, judicial and other public systems to the greatest extent allowed by law and policy.
- Coordinated entry is a continually evolving system that requires a commitment to ongoing learning, evaluation and quality improvement.
- Ongoing coordinated entry planning efforts strive to incorporate diverse stakeholder voices and needs, including those of people with the lived experience of homelessness.
- The long-term financial sustainability of coordinated entry requires the commitment and alignment of federal, state, local and private funding sources.

II. Roles

Each Eastern Pennsylvania Continuum of Care (CoC) Coordinated Entry System (CES) partner organization has one or more of the following roles. All Operations Partner roles (Call Center, Access Sites and Regional Managers) have been assigned through competitive RFP processes, approved by the CoC’s elected Governing Board, and implemented to the greatest extent that funding resources and/or partner organization in-kind contributions allow.

Coordinated Entry Specialists:

Coordinated Entry Specialists are trained staff members employed by CES partner organizations to deliver uniform coordinated entry intake, assessment and referrals to people experiencing or at imminent-risk of homelessness. The major steps in coordinated entry include:

1. **Triage, Safety Planning and Diversion:** Asking basic questions to determine whether the person is fleeing/attempting to flee and survivors of domestic violence, is literally

homeless or at imminent risk for homelessness, and, if homeless, whether they could be diverted from entering shelter.

2. **HMIS Client Record Search/Creation:** Creating or updating the person's data and information in the Pennsylvania Homeless Management Information System (PA HMIS).
3. **Pre-Screen Interview:** Obtaining client data sharing consent and asking questions about the person's current housing situation and veteran status.
4. **VI-SPDAT Assessment:** Determining the person's vulnerability and prioritization for appropriate housing interventions.
5. **Referral:** Making direct referrals to emergency services (including homeless prevention, Emergency Shelter, Transitional Housing and others) and placement on a Community Queue prioritization list for housing interventions, including Rapid Re-Housing and Permanent Supportive Housing.

Call Center Coordinated Entry Specialists are employed by 211 and provide coordinated entry services by telephone and text Monday through Friday from 9:00 AM to 4:00 PM EST except on federal holidays. After hours, on weekends and on federal holidays, anyone experiencing a housing crisis or homelessness can call or text 211 toll-free to receive direct referrals to emergency services, including emergency shelters.

Access Site Coordinated Entry Specialists are employed by public, private and nonprofit organizations to deliver coordinated entry services in-person Monday through Friday from 9:00 AM to 4:00 PM EST (unless otherwise noted in CES marketing materials), except on federal holidays. Access Sites are located throughout the CoC in as many communities as resources allow.

Coordinated Entry Regional Managers:

Coordinated Entry System Regional Managers are dedicated staff members employed and supervised by a public or nonprofit organization operating within each of the five regions that comprise the Eastern PA CoC. The responsibilities of CES Regional Managers include:

- Managing the Community Queue prioritization list for housing
- Interpreting and enforcing Coordinated Entry policies and procedures
- Facilitating Community Queue By-Name-List (BNL) meetings
- Reviewing and distributing PA HMIS CES reports
- Providing ongoing feedback to the CoC Governing Board and CES Committee
- Serving as liaisons to the HMIS administrator
- Conducting community outreach and education

Coordinated Entry Referral Partners:

Coordinated Entry Referral Partners accept appropriate program referrals from the Coordinated Entry System. Coordinated Entry Specialists make direct referrals to homeless prevention and emergency services, including Emergency Shelter and Transitional Housing. Housing providers accept referrals from the Community Queue prioritization list in HMIS. The Community Queue has special protocols for both veterans and survivors of domestic violence to ensure they are connected to appropriate housing and services.

III. Responsibilities

Eastern Pennsylvania Continuum of Care (CoC) Coordinated Entry System (CES) partner organizations share the following responsibilities:

- Compliance with all CES processes, policies and procedures detailed in the **Eastern PA CoC Coordinated Entry System Policy Manual**, including policies related to referral, grievance, prioritization, data sharing, and client confidentiality, among others.
- Compliance with all PA HMIS processes, policies and procedures.
- Ensure that people experiencing or at imminent risk for homelessness understand how the CES system works.
- Make appropriate staff available for regular CES trainings and meetings.
- Distribute CES marketing and outreach materials.
- Compliance with all applicable civil rights and fair housing laws and requirements. Recipients and subrecipients of CoC Program and ESG Program-funded projects must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws as specified at 24 C.F.R. 5.105(a), including, but not limited to the following:
    - Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status;
    - Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance;
    - Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color or national origin under any program or activity receiving Federal financial assistance; and
    - Title II of the Americans with Disabilities Act prohibits public entities, which includes state and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance. Title III of the Americans with Disabilities

Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

In addition, HUD's Equal Access Rule at 24 CFR 5.105(a)(2) prohibits discriminatory eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC Program, ESG Program, and HOPWA Program. The CoC Program interim rule also contains a fair housing provision at 24 CFR 578.93. For ESG, see 24 CFR 576.407(a) and (b), and for HOPWA, see 24 CFR 574.603.

IV. Termination of Agreement

Any party may terminate their participation in this agreement with written notification to the appropriate CES Regional Manager and the Eastern PA CoC Coordinated Entry Committee Chairperson. Referral partners must give at least 30 days notice of termination. Access Sites must give at least 60 days notice before ceasing operations. Organizations employing Regional Managers must give at least 90 days notice in order for the CoC to identify and select a new organization to employ a Regional Manager.

Participation in the Eastern PA CoC Coordinated Entry System is a requirement of certain funders, including HUD's CoC and ESG programs. Termination of this agreement may negatively impact the Partner's ability to obtain and/or retain funding.

V. Expenses

Unless the CoC has provided grant funding to a CES Operations Partner organization through separate contract, any and all expenses incurred by the participants of the Eastern PA Coordinated Entry System are the responsibility of the Partner.

VI. Agreement

The signature of the Executive Director/Chief Executive Officer or designee of the Partner Organization indicates agreement with the terms set forth in this Partnership Agreement.

By signing this Agreement, I understand and agree to the terms within on behalf of my organization.

Name of Organization:

Name and Title of Signer:

Signature **Date**

Agreed to and accepted on behalf of the Eastern Pennsylvania Continuum of Care.

President, Eastern Pennsylvania Continuum of Care Board **Date**

CONNECT TO HOME: COORDINATED ENTRY SYSTEM OF EASTERN PA NOTICE AND CONSENT FORM FOR NON-HMIS PARTICIPANTS

I, _____ [print first and last name], understand that the Eastern PA Coordinated Entry System (CES) is a partnership of agencies sharing information to provide a more coordinated homeless response system. I authorize that my information can be shared by CES partners to improve services for me. I also authorize that my information can be viewed by the CES Regional Managers for the purpose of system evaluation, which will help improve services offered to me and others in the CES region.

By initialing "yes" below and affixing my signature, or, when meeting via phone and permitting a CES Partner Agency staff to sign on my behalf, I agree that my information may be shared with other CES partners and System Administrators. I understand that agencies participating in CES may change from time to time and that a copy of the current list of agencies is available upon request.

Yes:___ (please initial)

Participant Signature: _____ Date: _____

OR Verbal Consent obtained by phone
CES Agency Staff Signature: _____ Date: _____

DESCRIPTION OF INFORMATION THAT CAN BE SHARED

This form authorizes identifying assessment information, including but not limited to the items listed below, to be routinely shared in the CES to better help me and/or my family.

- Family/Household Information (Names, Date of Birth, Race, Gender)
- Income and Benefits Information
- Education and Employment History
- Housing History and Barriers
- Homeless Status and History
- Veteran Status
- Program and Service Involvement and Contacts
- Health Information, including Physical Health and Behavioral Health (but not Case Records)
- Photo

INFORMATION FROM CES SCREENING AND ASSESSMENT MAY BE SHARED WITH:

- Social Service Agencies
- Housing Providers
- Veterans Services
- Shelter Programs
- Housing and Redevelopment Authorities
- Victim Services (including Domestic Violence) Agencies

PURPOSE OF SHARING

Information from the CES screening and assessments will be shared for the purpose of:

- Assessing my program eligibility
- Prioritizing my need for services
- Linking me to the most appropriate services
- Evaluating CES services and system performance
- Evaluating service gaps, needs and duplication in CES

This authorization is voluntary and strictly for sharing information needed for entering and moving through the Coordinated Entry System and may NOT be used for any other purpose. The information collected, maintained and stored by Eastern PA Continuum of Care, and shared with service providers, may include records relating to your behavioral and/or mental health, alcohol and drug abuse treatment, HIV/AIDS, and genetics.

This information is necessary for determining your eligibility for housing and services.

You will not be denied help if you do not want to sign this form or if you do not want to allow CES to share your personal information. You have the right to revoke this authorization at any time by giving verbal or written notice of revocation to the CES. Revoking this authorization will not affect any action taken or information shared prior to notice of revocation. You may have a copy of this authorization.

APPENDICES

The following Appendices are available for download separately:

- Connect to Home CES Flyers and Business Cards (English and Spanish)
- Connect To Home: Coordinated Entry System of Eastern PA Referral Zone Map
- PA-HMIS Inter-Agency Data Sharing Agreement
- HUD Notice CPD-16-11 Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing
- Eastern PA Continuum of Care Policy Requiring the Use of a Housing First Approach
- Eastern Pennsylvania Continuum of Care Written Standards for Programs that End and Prevent Homelessness
- Eastern PA CoC - VAWA Emergency Transfer Plan Policy
- VI-SPDAT for Families 2.0
- VI-SPDAT for Individuals 2.0
- VI-SPDAT for Youth 1.0
- VI-SPDAT for Families 2.0 (Spanish Translation)
- VI-SPDAT for Individuals 2.0 (Spanish Translation)