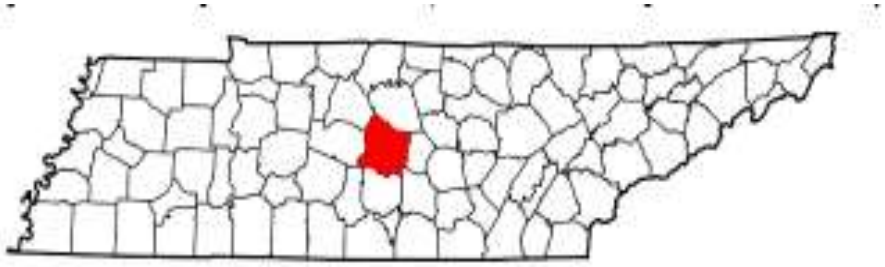
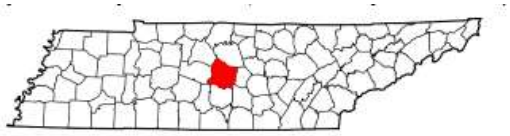
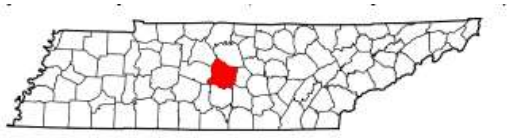
The Housing, Health and Human Services Alliance of Rutherford County (H^3ARC), TENNESSEE



Coordinated Entry Process (CEP)

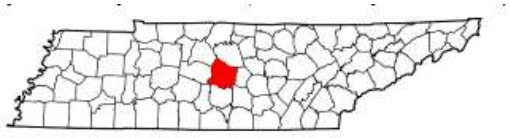
Operating Policies & Procedures – Written Standards





Approved By: H^{3}ARC Executive Committee Effective Date: 2/1/18 Review/Revise Date: 9/7/18	Website: www.murfreesborotn.gov/122/Homelessness Prepared By: H^{3}ARC Service Delivery Committee

Policy Authority:	This policy is adopted and approved by the H^{3}ARC Executive Committee, the local Continuum of Care (CoC) authority in Rutherford County, Tennessee.
Policy Statement:	• All Providers in Rutherford County receiving funding through Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) or a US Department of Housing & Urban Development (HUD) funded program are required to participate in the Coordinated Entry Process (CEP), must be live on the Homeless Management Information System (http://www.mha-tn.org/ProgramsServices/HMIS.aspx) system, and must maintain data which is inputted no later than within five business days of a service or outcome being achieved or rendered. • Providers must also submit written documentation to the H^{3}ARC Service Delivery Committee, a subcommittee of the H^{3}ARC Executive Committee, within five business days on why an applicant was denied entry into a program. (Refer to the Prioritization and Referral Section for additional direction on the appeal process.) • Training for Providers will occur at least annually. • Any individual administering the VI-SPDAT must have completed the training first.
Purpose:	In accordance with requirements established by HUD, the purpose of this policy is to define the population in Rutherford County that federal CoC and Emergency Solution Grant (ESG) programs are used to address the needs of the homeless and at-risk populations and to outline the standardized and coordinated process by which these needs are met.
Scope:	This policy addresses the CEP in the geographic area of Rutherford County, Tennessee, with the goal to provide a user-friendly, standardized, and outcome-based process for individuals and families in the county that are homeless or at-risk for homelessness.
Values:	All Rutherford County clients have the right to expect safe, stable and affordable housing and to be treated with respect and dignity. Services are provided without consideration of race, ethnicity, gender, sexual orientation, being a victim of domestic violence, age, socio-economic status, mental health diagnoses, physical abilities, religion, political beliefs, or criminal record. Program decisions and allocation of resources are driven by a culturally sensitive, equal access process, and evidence-based approach while maintaining client confidentiality.
Goals:	• Develop and consistently implement a systematic and coordinated response to clients experiencing pending or actual homelessness. • Intervene to prevent the loss of housing. • Provide immediate access to shelter and crisis services while permanent stable housing and supports are being secured. • Provide housing assistance and services tailored to client's unique needs. • Improve access to federally funded housing assistance by eliminating administrative barriers. • Implement Housing First model and end homelessness client by client.



Review/Revision:	As part of a commitment to monitor and enforce this policy, it will be reviewed at least annually with any change(s) documented in the appropriate H^3ARC Executive Committee and/or H^3ARC Service Delivery Committee minutes and on the Summary of Review/Revisions table at the end of this policy

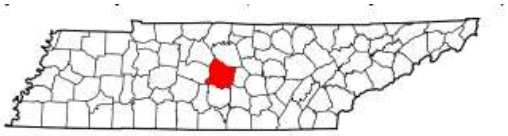
Introduction and Background Information

"Stable housing is the foundation upon which people build their lives—absent a safe, decent, affordable place to live, it is next to impossible to achieve good health, positive educational outcomes, or reach one's economic potential." (Opening Doors Plan, pg. 7). Researchers have focused on housing stability as an important ingredient for the success of children and youth in school; they are more likely to succeed socially, emotionally, and academically with stable housing. There are significant costs associated with family homelessness. The first is the high cost of the homeless system itself to support families in shelters or transitional housing. There are also costs borne by the education, health care, child welfare, and legal systems. Ending homelessness requires leveraging mainstream resources and programs in the areas of housing, employment, food, clothing, education, health care and income supports. This policy is focused only on providing housing.

National research has highlighted that a CEP is a key factor in the success of ending homelessness and can enhance the quality of client screening and assessment and better target program assistance where it can be most effective. Also, a CEP leads to better understanding of the causes and consequences of homelessness. For example, mental health disorders are a disproportionate percentage of homeless clients and therefore any framework needs to consider this. Because of a CEP, the system for preventing and ending homelessness is less fragmented and scarce resources are used more efficiently. The United States Interagency Council on Homelessness developed a federal strategic plan to prevent and end homelessness called Opening Doors which was launched in 2010 (amended in 2015) and continues to be updated as changes are incorporated. It is one of the critical, must read foundational documents required for each community to commit to its goals, using data to drive results, targeting resources strategically, and investing in the evidence-based practices proven to end homelessness.

A CEP must be established and implemented for agencies and organizations to obtain federal HUD funds. There are two phases for Rutherford County's CEP efforts. In Phase I (completed by February 1, 2018), the plan is focused solely on compliance by the Rutherford County agencies (Appendix A) that obtain City, County, and federal HUD funds. Phase II (February 2018 to February 2019) begins after Phase I is implemented and includes the county's additional organizations that provide various levels of housing assistance but do not receive federal or county funding. At the completion of Phase II, ALL organizations within the county providing any level of housing assistance will follow this policy.

Rutherford County is in the geographic center of Tennessee, approximately thirty (30) miles south of Nashville. With an estimated 2017 population of nearly 310,000, it has a mix of urban (83%) and rural (17%) residents. Tennessee in general is in a rapid state of growth, with the population consistently growing and Rutherford County is no exception. Rutherford County has had over 17% population growth since the 2010 Census (an over 50% population growth since the 2000 Census), second in the state only after neighboring Williamson County. According to US Census data, the number of housing units only increased 12% from 2010 (102,968 units) to 2016 (115,467 units). Affordable housing is insufficient to meet this rapid population growth, making it even more challenging to meet the housing needs of the homeless and at-risk populations.



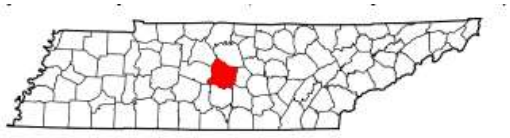
The CEP covers the entire geographic area of Rutherford County, is well-advertised, and is easily accessed by individuals and families seeking housing or services. The CEP is focused on providing a continuum of care that is client-centered, rather than focused on what is easier for the Provider program. The CEP should include assessments into coordinated entry that are based in part on clients' strengths, goals, risks, and protective factors. This includes a framework that seeks to be sensitive to clients' lived experiences in every aspect of coordinated entry, including the development of an assessment process and delivery protocols that are trauma informed, minimize risk and harm, and address potential psychological impacts. Communication about the assessment and referral process should provide clients with a clear understanding of recommendations, options, and expectations. CEP should include clients' choices in coordinated entry process decisions such as location and type of housing, level and type of services, and other program characteristics, as well as assessment processes that provide options and recommendations that guide and inform client choice, as opposed to rigid decisions about what individuals or families need when possible.

The CEP is a streamlined and consistent framework for determining the need and allocation of housing resources. The CEP is generally obtained in phases and includes the following core components:

- Information where clients know how to **ACCESS** intake for homeless prevention or housing services where several brief questions are asked to determine if the client simply requires a few resources (e.g. food, rent funds, etc.) to prevent an adverse situation is at risk for imminent homelessness, or literally homeless. The county CEP initial screening tool will be the VI-SPDAT, a pre-screening or triage tool, that is designed to be used by all Providers within the county to quickly assess the health and social needs of homeless clients and match them with the most appropriate support and housing interventions that are available. There are three (3) VI-SPDAT versions focused on https://d3n8a8pro7vhmx.cloudfront.net/orgcode/pages/315/attachments/original/1479851659/TAY-VI-SPDAT-v1.0-US-Fillable-Amended-July-13-2015.pdf?1479851659, VI-SPDAT for Single Adults, and VI-SPDAT for Families.
- The **ASSESSMENT** phase uses tools (i.e., Housing Crisis Screening [Appendix B], the appropriate VI-SPDAT, and the HMIS Assessment Tool) to gather and verify information about the client's housing needs and eligibility for assistance.
- After an assessment is completed and the client's eligibility for assistance is verified, the **PRIORITIZATION** phase ranks the client based on VI-SPDAT scores to determine where on the list of housing assistance the client sits.
- The **REFERRAL** phase is initiated after prioritization ranking is completed and the client is directed to the most appropriate program or agency such as transitional housing, rapid re-housing, assistance with rent, or permanent supportive housing services.

Additionally, the CEP incorporates the following characteristics:

- Collaboration with the Veterans Association and the Murfreesboro Housing Authority to assure that veterans are properly connected to the correct agency and resources.
- Collection and analysis of quality and uniform performance measurement data essential for targeting and evaluating interventions, tracking results, strategic planning and allocation of resources.
- Is a low barrier process that does not screen people out for assistance because of perceived barriers to housing such as lack of employment or income, drug or alcohol use, or having a criminal record.



- Does not jeopardize the safety of the client(s) seeking housing assistance.
- Is ADA Compliant and housing practices are nondiscriminatory and follow the Fair Housing Act, Section 504 of the Rehabilitation Act, Title II of the Americans with Disabilities Act , and Title VI of the Civil Rights Act of 1964 (https://www.hhs.gov/civil-rights/for-individuals/special-topics/needy-families/civil-rights-requirements/index.html.)
- Takes reasonable steps to ensure effective communication with individuals with disabilities and for clients with limited English proficiency.
- Participates in the collection of data for the annual Point in Time Count (PIT) required by HUD. The county follows HUD guidelines to conduct the PIT; this policy does not drive how this count is obtained.

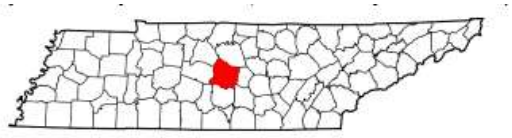
Key Terms and Definitions

Many key terms are subject to varying interpretations and thus are defined for purposes of this policy.

- 211 Hotline - http://www.211.org/ (Appendix C): a free and confidential service funded by United Way that is offered within the United States and parts of Canada that finds local resources that include: food, healthcare, housing and utilities, legal, disaster assistance, crisis (e.g. physical and/or emotional abuse, sexual assault) assistance, and jobs.
- **Access Points**: a) designated areas located within Rutherford County continuum where individuals or families can go to for intake and assessment of homeless prevention and housing services for which they may qualify or b) the 2-1-1 hotline that screens and directly connects callers to appropriate homeless housing and service providers in the area. Appendix D shows the routes for the Murfreesboro public transportation system (ROVER) and identifies the location of the key access points on the respective bus routes.
- **At-Risk Population:** individuals at higher risk for homelessness include mental or behavioral health conditions; substance abuse; victims of domestic violence or sexual abuse; lesbian, gay, bisexual, or transgender individuals; past history of incarceration; have chronic illnesses with high health care costs; youth aging out of foster care; youth that are parents; families and/or children who have been involved in the welfare system; and elderly and aging persons. Housing costs more than 30% of the client's income can also result in homelessness.

1.4 **By-Name List:** a holding list that all agencies use that contains the names of individuals or families that have been identified and assessed and need some type of housing intervention. This list assists in determining the clients that have met eligibility requirements and are awaiting housing placement.

1.5 **Chronic Homelessness**: a homeless individual with a disability who lives either in a place not meant for human habitation, a safe haven, or in an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days. In order to meet the ''chronically homeless'' definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven. Chronically homeless families are families with adult heads of household who meet the definition of a chronically homeless individual. If there is no adult in the family, the family would still be considered chronically homeless if a minor head of household meets all the criteria of a chronically homeless individual. A



chronically homeless family includes those whose composition has fluctuated while the head of household has been homeless.

1.6 **Client:** a single adult or family with a point person that is seeking information and/or assistance with temporary or permanent housing.

1.7 **Client-Centered Focus:** an approach that demonstrates the belief that every client is unique and knows themselves best and that optimal outcomes occur when providers work in partnership with the client.

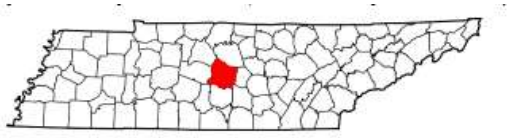
1.8 **Community Resource Booklet**: a booklet that outlines the information provided to the 2-1-1 call center for Rutherford County that includes resources for medical and dental assistance, medication, medical equipment, shelter and housing, rent and utility assistance, mental health services, food sources, household needs, transportation, and employment.

1.9 **Continuum of Care (CoC)**: federal housing program designed to promote a centralized and coordinated community wide commitment to the goal of ending homelessness and providing funding for efforts by nonprofit providers, State and local governments, to quickly rehouse homeless individuals.

- **Coordinated Entry Process (CEP)**: a centralized or coordinated process designed to coordinate program client intake, assessment, and provision of referrals across Rutherford County. The CEP is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.

2.1 **Crisis Response System**: an approach that shifts the community's response from simply ameliorating the immediate crisis of homeless to a systematic response that helps prevent and resolve homelessness by connecting clients swiftly to permanent housing opportunities.

- **Diversion:** a strategy to assist clients to explore all safe and appropriate alternative housing options and only enroll in crisis housing projects or emergency shelter after all other alternatives have been exhausted.
- **Emergency Shelter**: 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. Any project funded as an emergency shelter under a Fiscal Year 2010 Emergency Solutions grant may continue to be funded under ESG.
- **Emergency Solutions Grant** (ESG): federal program that provides funding related to addressing the problem homelessness that includes: street outreach, emergency shelter, homelessness prevention, rapid re-housing, and HMIS.
- **Homeless**: are grouped into four categories that include (1) individual(s) and families who lack a fixed, regular, and adequate nighttime residence, individual(s) who are exiting an institution where he/she resided for 90 days or less; or resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution; (2) individual(s) and families who will imminently lose their primary nighttime residence; (3) unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; or (4) individual(s) and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.
- **Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH)**: the federal act of 2009 that includes ESG and CoC grants.



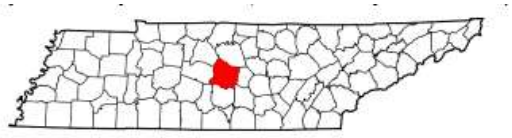
- **Homeless Management Information System (HMIS)**: central data management tool for gathering and recording characteristics and service needs for the homeless. In Rutherford County, Charity Tracker is our choice of a HMIS. Charity Tracker is a web-based program that helps record, track, and report on homeless persons. Charity Tracker will keep track of appointments, profiles, assessments, case plans, and service transactions.
- **Homelessness Prevention**: prevention of persons from becoming homeless and the assistance of participants in regaining stability in their current or other permanent housing.
- **Housing First**: a model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions for entry (such as sobriety or a minimum income threshold). HUD encourages all recipients of CoC Program-funded permanent supportive housing (PSH) to follow a Housing First approach to the maximum extent practicable.
- **Housing Ready**: case management/housing approach that places homeless households into permanent housing only when determined the household is ready. Until that time, households are placed into long-term shelter or transitional housing programs. The approach is being replaced by the Evidence Based Practice of Housing First and an approach known as "rapid re-housing."

2.11 **Housing Provider**: an individual or agency that provides housing and supportive services to clients.

2.12 **HUD**: United States Federal Department of Housing and Urban Development that administers the federal programs dealing with homelessness.

2.13 **Imminent Risk of Homelessnes** : individual or family who will imminently lose their primary nighttime residence, provided that the residence will be lost within 14 days of the date of application for homeless assistance; no subsequent residence has been identified; and the individual or family lacks the resources or support networks needed to obtain other permanent housing.

- **Intake**: general process between the client's first point of contact and the initial screening for eligibility. This step involves primary assessment of needs, strengths and resources to refer households into appropriate services.
- **Intake Specialist**: an intake worker, is Health Insurance Portability and Accountability Act (HIPPA) trained, whose responsibility is to provide coordinated intake and assessment for individuals or families seeking homeless prevention or housing services.
- **Lead Agency**: agency identified as the primary administrator of coordinated intake and assessment in Rutherford County which is the H3ARC Service Delivery Committee.
- **Literally Homeless**: individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning a primary nighttime residence not meant for human habitation; living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or is in an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
- **Outcome**: the specific result of what was provided from a specific activity or service; in relation to HUD, a specific result as detailed by HUD funding requirements.
- **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

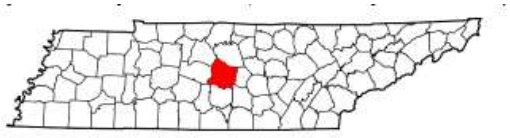


barriers to housing, and are unable to maintain housing stability without supportive services. This model has been shown to not only impact housing status, but also result in cost savings to various public service systems, including health care.

- **Prevention Housing Services**: an approach that focuses on preventing homelessness by helping households that otherwise would become homeless and end up in a shelter or on the streets.
- **Prioritization**: CEP by which all persons in need of housing assistance are ranked in order of priority and, to the maximum extent feasible, ensure that clients with more severe housing needs and levels of vulnerability are prioritized for housing and homeless assistance before those with less severe housing needs and lower levels of vulnerability.
- **Providers**: an individual or organization within the county that provides assistance with meeting housing needs for homeless or at imminent risk of homelessness clients.
- **Rapid Re-housing**: an approach that focuses on moving homeless individuals and families into appropriate housing as quickly as possible by providing the type, amount and duration of housing assistance needed to stabilize the household. Clients do not need to be considered "Housing Ready."
- **Referral**: directing or referring a client to a particular program for possible help.
- **Screening**: process by which eligibility for housing and services is determined at the initial point of contact to the Rutherford County coordinated entry system. Once screening determines eligibility, the intake and referral process follows.

2.25 **Shelter Plus Care:** is a program that provides rental assistance to homeless individuals/families with disabilities who are receiving continuing care for their disability; the respective agency must verify the continuing care. Disabilities primarily include mental illness, chronic problems with alcohol and/or drugs, and HIV/AIDS or related diseases. There is a waiting list for this program, and vouchers are limited.

- **Street Outreach**: engaging the homeless population living on the street or in parks, abandoned buildings, bus stations, campgrounds and in other such settings where unsheltered persons are staying, and providing needed resources and assistance.
- **System Change:** process by which Rutherford County's CoC has altered the way homeless and at-risk households engage with the homeless and housing providers within the community. The purpose of system change is to implement practices that have shown to decrease the incidence and length of time in homelessness, with a long-term goal of reducing and ending homelessness.
- **Tailored Programs and Services**: an approach to case management services that matches the services to the individual's or family's needs rather than using a one-size-fits-all approach.
- **Targeting**: process of determining the population to whom assistance will be directed, that is, the target population. The targeting process can occur at both the system and the program levels.
- **Trauma Informed Care**: is a structure and treatment framework that involves understanding, recognizing, and responding to the effect of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumer and providers, and helps survivors rebuild a sense of control and empowerment.
- **Transitional Housing**: housing assistance generally for a limited time that can be as little as a few days or up to 24 months
- **Verification**: the gathering and review of information to substantiate the applicant's/client's situation and support program eligibility and priority determination.



- **Vulnerability Index (VI) & Service Prioritization Decision Assistance Tool (VI-SPDAT**): is a pre-screening or triage tool, that is designed to be used by all Providers within the county to quickly assess the health and social needs of homeless clients and match them with the most appropriate support and housing interventions that are available. The VI-SPDAT has three versions that includes (1) Pre-Screen Tool for Homeless Youth, (2) Pre-Screen Tool for Families, and (3) Pre-Screen Tool for Single Adult. The tools also include helpful 'scripts' for each section to aid the interviewer.

Responsibilities

2.1 **Clients** in need of homeless prevention or housing services:

2.1.1 Sign the Release of Information (Appendix E) form.

2.1.2 Keep their contact information current in order to be notified of available housing opening in a timely manner or provide a HIPPA protected method to get in touch with them.

- Wait until the system has the capacity to assist them, and to get help from through diversion or other resource available to them.

2.2 **All Providers**:

2.2.1 Answer the initial client phone call requesting assistance within three (3) business days.

2.2.2 Schedule an in-person intake and assessment that is entered in HMIS, no later than within five (5) business days.

2.2.3 Match client's unique needs and priority status to an appropriate program(s).

2.2.4 Sign the standardized, HIPPA compliant Release of Information form (Appendix E).

2.2.5 Ensure adequate privacy protections are extended to all clients from the first point of access through referral.

2.2.6 Sign a H^3ARC Memorandum of Understanding (Appendix F).

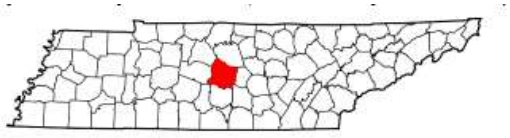
2.2.7 Assure that information in the 2-1-1 database is current.

2.3 **Lead Agency**:

2.3.1 Update and maintain information on program vacancies/opening. This must be done at least on a weekly basis regardless of whether there are new openings to report.

2.3.2 Regularly update and make current all programs eligibility guidelines and program contact information so that Intake Specialist can make the best referrals possible.

- Ensure that when a referral is made, the Intake Specialist confirms within three (3) business days whether the referral is accepted, declined by provider, declined by client, pending, or the provider is unable to contact the client.
- Bring problems and suggestions to the monthly H^3ARC Service Delivery Committee meeting.
- Oversee referral of homeless diversion and prevention housing services for eligible clients.
- Ensure that all points of entry will use the same screening and assessment tool, data collection forms, policies on eligibility verification and referral/information-sharing systems.
- Use the appropriate VI-SPDAT, or additional tools as designated by H^3ARC, as a standardized vulnerability index assessment. The tool(s) is not used to provide a diagnosis, assess current risk or be a predictive index for future risk, or take the place of other valid and reliable instruments used in clinical research and care.



- Does not screen out applicants based on rental, credit, criminal histories, sobriety, income, or other factors that typically prevent affordable, safe and stable housing.
- Implement the characteristics of Trauma Informed Care when conducting client screening and assessment phases; understanding that clients may not have all the desired paperwork.
- Develop relationships with relatives or individuals involved in the housing process.

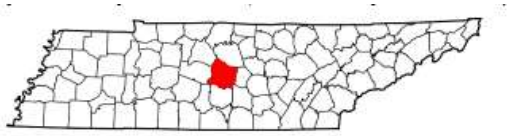
Access Procedures

Access refers to how people experiencing a housing crisis access the county's crisis response system. The process for accessing help will be widely advertised, provide fair and equal access, and is easily accessed whether in person, by phone, or the City of Murfreesboro' website: http://www.murfreesborotn.gov/122/Homelessness. The first contact that most people have is through a city access point location (Appendix A) but information could also be through the city/county website or the 2-1-1 system (Appendix C). Access points play a critical role in engaging people to address their most immediate needs through referral to emergency services. Obtaining information may be sufficient for some clients but most will require some directive assistance to emergency housing or referral to a more permanent housing solution.

The CEP may, but not required to, include separate access points and variations in assessment procedures to the extent necessary to meet the needs of the following five populations: 1) adults without children, 2) adults accompanied by children, 3) unaccompanied youth, 4) households fleeing domestic violence, and 5) persons at risk of homelessness. The H^3ARC may not establish a separate process for veterans; however, a CEP may allow the Veterans Administration partners to conduct the assessment and make direct placements into homeless assistance programs. The 'no wrong door' approach is applied; meaning a client/household can present at any access point and obtain assistance.

The table below identifies county access points and their respective communicated hours of business. Clients who need homeless prevention or housing services information or assistance during nonbusiness hours and need to have an intake performed, call 2-1-1 or visit The Salvation Army (see Appendix D, ROVER Tan Route for location of Salvation Army). All clients (except for households in domestic violence situations) must be assessed and screened prior to program entry; or, in the case of households in emergency shelters that admit same day, the assessment must occur as soon as possible after entry, and before being referred to another program.

Access Points for Phase I	**Days and Hours of Operation**
The Doors of Hope	Monday thru Thursday 9 am - 4:30 pm Friday 9 am - 12:30 pm
The Domestic Violence Shelter	Monday thru Friday 8 am – 4:30 pm. The emergency number for domestic violence is 615-896-2012 and for sexual assault, 615-494-9262.)
Journey Home	Monday through Friday 8 am to 3 pm
Green House Ministries	Tuesday thru Friday 9 am - 4 pm Thursday 5 pm to 8 pm
Murfreesboro Housing Authority	Monday through Friday 7:30 am to 4:30 pm



Upon initial contact with a Rutherford County CEP agency, a quick and simple diversion/screening process is conducted to determine the suggested path of services appropriate for the client needs as outlined in the flowchart (Appendix G). This quick screening is designed to capture the necessary information in a manner that is age appropriate (i.e., unaccompanied youth), where the questions are conducive to understanding by all potential clients regardless of their primary language, and sufficient information is collected to make prioritization decisions. Though it is desirable for clients to answer all questions, the CEP must allow clients presenting to the crisis response system to refuse to answer questions, and to reject offered housing options, without hindering their access to assistance. When this occurs, Providers need to inform the client that the lack of supplied information may limit the available housing options open to them.

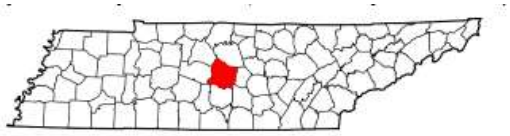
- Conduct the quick screening questions per the HCS (Appendix B) to assess the current client situation. The overall goal of the screening questions is to determine the criticality of the client's housing status.
    - Appendix G flowcharts four possible client housing scenarios: Stable, Vulnerable, Pending Loss of Housing, or Literally Homeless.
    - Each scenario suggests the next step(s) to assist the client with an appropriate housing option.
    - If a client has declined to answer some or all the necessary questions, the Intake Specialist needs to complete a CEP Denial Form (Appendix H) and forward the completed form to the H^3ARC Service Delivery Committee.
- Individuals and families that are literally homeless or at imminent risk of homelessness are eligible for housing/shelter assistance. For purposes of CEP eligibility, imminent risk of homelessness means individuals and families can document that they must leave their current nighttime residence within 3 days, and include a household that:
    - Have received a court notice of eviction or foreclosure,
    - Are staying with family or friends AND can document that they must leave within 3 days. Documentation must include a third-party verification of violation; for example, a lease that states that anyone other than occupants in the lease constitutes a lease violation, and.
    - Other, as determined by Provider.

3.4 Applicants not eligible for services will be referred to other appropriate community resources based on their eligibility.

3.5 **NOTE**: the needs of a household fleeing or attempting to flee, domestic violence, dating violence, sexual assault or stalking, may be different than the needs of non-victims. Intake Specialists will be trained on sensitivity regarding a victim's situation and referrals will only be made to domestic violence providers. In addition, the data of victims will continue to be treated with the highest level of confidentiality and victims' data will not be shared with other Providers (except those designated as Domestic Violence Providers).

Assessment Procedures

Assessment is heavily focused on the client's immediate housing challenge and includes questions regarding client demographic data (i.e., name, social security number, date of birth, race/ethnicity, gender, veteran status, disability), household composition, current housing situation, homelessness history, rental history, evictions, criminal history and/or active warrants, physical and mental health, domestic violence



issues, disabling conditions, and current barriers to obtaining and successfully maintaining permanent housing. This information is collected in order to match the client to eligibility requirements and appropriate services and housing. For example, applicants for permanent supportive housing must have a disabling condition and lack the resources to obtain housing. Assessment methods need to be used to distinguish between those clients that can resolve their homeless situation on their own with just the provision of information versus those that require short-term or long-term housing assistance.

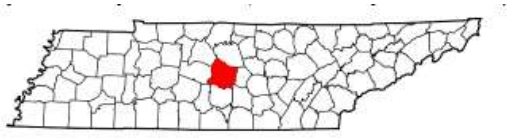
In HUD's 9 Criteria for Choosing a Standardized Assessment Tool, the importance of using a tool that is evidence-based, criteria-driven, tested to ensure that people are appropriately matched to the right interventions and levels of assistance, responsive to the needs presented by the individual or family being assessed, and make meaningful recommendations for housing services is strongly encouraged. H^3ARC has chosen to use the VI-SPDAT because the tool meets these criteria. Most Intake Specialists will use a hard copy of the appropriate VI-SPDAT tool when conducting the initial screening, but the information must be entered into HMIS within five (5) business days.

A triage tool like the VI-SPDAT allows homeless service providers to similarly assess and prioritize the universe of people who are homeless in their community and identify whom to treat first based on the acuity of their needs. It is a brief survey that service providers, outreach workers, and even volunteers can use to determine an acuity score for each homeless person who participates. The scores can then be compared and used to identify and prioritize candidates for different housing interventions based upon their acuity**.** Using the VI-SPDAT, providers can move beyond only assisting those who present at their particular agency and begin to work together to prioritize all homeless people in the community, regardless of where they are assessed, in a consistent and transparent manner.

The VI-SPDAT combines the strength of a prescreening tool that covers medical risk factors (VI) with social risk factors (SPDAT). The tool is backed by years of rigorous testing and research. To maintain valid and reliable results regardless of who is administering the test, it is critical that anyone administering the VI-SPDAT use the same script (Appendix I) with each client and ask the questions exactly as written. Do **not** share VI-SPDAT 2.0 Scores with Client, do **not** share VI-SPDAT 2.0 Recommendation, do **not** share possible outcomes, do **Not** Suggest a Time Frame.

Sometimes the VI-SPDAT is confused with or used interchangeably with the SPDAT. Whereas the VI-SPDAT is a triage tool (also referred to as a pre-screen tool), the SPDAT is an assessment tool. The SPDAT digs deeper into the context, history, environment and severity of an issue in a more nuanced manner than the VI-SPDAT. To return to the metaphor of a hospital emergency department, the VI-SPDAT is the triage station asking a series of questions to confirm what is occurring and to understand a particular patient's needs in comparison to all other patients; the SPDAT is what happens when the doctor sees the patient, rounds out the understanding of the issue, and advises the appropriate treatment protocol for that individual.

The VI-SPDAT is designed to determine the presence and acuity of an issue and identify clients to refer for assessment for specific housing interventions, but it is not intended to provide a comprehensive assessment of each person's needs. It is recommended that the VI-SPDAT be used together with the SPDAT, as they are complementary tools. However, H^3ARC will start using only the VI-SPDAT and referring clients directly to different housing interventions based on their VI-SPDAT scores.



Prioritization and Referral Procedures

The Assessment Process is standardized for use by all H[3]ARC members and obtained using the principles of Trauma Informed Care. The tools are used with the understanding that each applicant has a unique set of circumstances that the trained Navigator can address. Providers can obtain additional assessment information that is dictated by their respective client populations but minimally must obtain the Release of Information form (Appendix E), prioritizing the client's needs via the appropriate VI-SPDAT tool, and completing a more thorough assessment using the HMIS Assessment tool. At each phase, only enough client information is obtained to adequately determine available housing and support services.

- Complete a hard copy of the Release of Information form (Appendix E).

4.2 Complete the appropriate VI-SPDAT tool for Single Adult, Youth, or for Families, and the HMIS, no later than seven business days after entry into CEP. The VI-SPDAT score should NOT be shared with the client.

4.3 Review the scoring criteria in preparation for the Prioritization and Referral process outlined in Section 5.

4.4 Assure the client begins to gather all required documents as outlined in Appendix J.

4.5 Each access point will make proper referrals utilizing a wide range of resources such as Charity Tracker, the Murfreesboro website (http://www.murfreesborotn.gov/122/Homelessness), and/or the Community Resource Booklet.

4.6 The Housing Provider will run an updated By-Name List within the CEP, including active, inactive, and housed consumers, as needed.

4.6.1 The By-Name List is the main tool that is used in conjunction with CE to assist in determining prioritization and eligibility for referral from CE to housing placement.

4.6.2 Newly identified clients will fall into the existing By-Name List based on the prioritizations listed in the Prioritization & Referral Section. A consumer's prioritization will not be based solely on the date that the assessment was completed.

4.6.3 The By-Name List prioritizes every client using HUD Notice CPD-016-11: https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf which factors vulnerability, length of homelessness, severity of need, crisis utilization, veteran status, fleeing domestic violence, and/or risk of victimization.

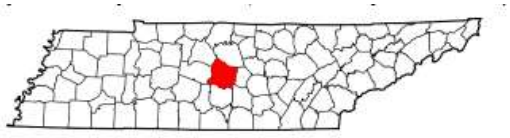
4.6.4 The By-Name List will consist of the following information for each client:

4.6.4.1 HMIS Unique Identifier
4.6.4.2 The appropriate VI-SPDAT score
4.6.4.3 The individual or organization that entered client into CE
4.6.4.4 Veteran Status
4.6.4.5 Homeless Status
4.6.4.6 Disability Status
4.6.4.7 Additional info can be pulled from the database as needed such as organization working with individual or where the individual can be found.

4.7 Pull a By-Name List by logging into HMIS by looking for the link *Enter Data As*, clicking on it. (Or search for the Coordinated Entry program or simply look at the list you have access to and click on the green plus to the left of the Coordinated Entry program.)

4.7.1 On the left side of the screen, look for *Reports*, click on the arrow to let down the menu of reports. Look for *Report Writer* and click on it. There will be two (2) saved reports: Housing Crisis report and VI-SPDAT Grand Totals report.

4.7.2 Click on the magnifying glass to the left of VI-SPDAT and the report will build.



4.7.3 Change the date to reflect the current week's clients. Look for the *Filters* tab and click on it.

4.7.4 Look for the *VI-SPDAT Start Date* and change it to the desired date range. Click *Save*. And the system will return to the report.

4.7.5 Look for the *Preview* tab and click on it; the report will build to reflect the current clients for the week.

4.7.6 To download the report, click on the *Download* button and a *Cancel* button will come up. Click on *Download* again which will put the report in a file that needs to be unzipped. *Unzip the* report.

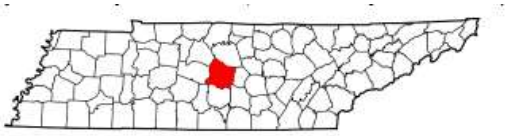
4.7.7 The report must be saved to be able to edit or change it. To save the report, look for *File* at the top of the screen. Choose *Save As*. Give the report a file name and the file type must be changed from CSV to Excel and save it to your computer in your desired location.

4.8 In addition to the Housing Provider pulling a By-Name List, a list will be pulled by Providers for specific housing placement and monthly for the Executive Committee and the Housing Service Delivery Committee Chairs.

There are some services or programs that are not prioritized, such as providing food or emergency shelter; however, most housing services are prioritized. Though housing prioritization and referral can occur at any point, it generally occurs after the Assessment component has been completed. Historically, housing assistance has been provided on a 'first-come, first-serve' approach. One of the main purposes of CEP is to ensure that people with the most severe service needs and levels of vulnerability are prioritized first for housing and homeless assistance. Rutherford County follows HUD guidelines: https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf and seeks to establish a recommended order of priority for permanent supportive housing so that those most in need are prioritized first.

In addition to prioritizing chronic homelessness, CEP identifies people who are more likely to need some sort of form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness. HUD has released the following criteria to consider how to prioritize individuals and families for housing and homeless assistance: significant health or behavioral challenges or functional impairments which require a significant level of support in order to maintain permanent housing; high utilization of crisis or emergency services including emergency rooms, jails, and psychiatric facilities to meet basic needs; the extent to which households, especially pregnant women and children, are unsheltered; vulnerability to illness or death; risk of continued homelessness; vulnerability to victimization, including physical assault or engaging in trafficking or sex work; or significant challenges or functional impairment including any physical, mental, and/or behavioral health disabilities that require significant support to maintain permanent housing.

Once it is determined which prioritization category the client falls into, it generally dictates which housing option the client is referred (Appendix G). The referral process is a uniform and coordinated approach to include all county beds and services and has standardized criteria for rejecting a referral. County agencies used as referral sites include the Murfreesboro Housing Authority and the Veterans Medical Center. If a client has been turned down for any Rapid Re-housing option, all individuals have the right to appeal any CEP placement assignment decision or referral.



Review and Evaluation

The Assessment and Prioritization process determines the most appropriate housing program type the client should be referred to; however, the Intake Specialist's judgment and familiarity with the county's resources plays a critical role in determining the most appropriate solution.

5.1 Determine whether the client meets the housing specific criteria for the option being considered or referred; assure the client meets eligibility criteria. If the client has been turned down for assistance, the individual may appeal in writing. The appeal will be addressed at the next available H^3ARC Service Delivery Committee meeting.

- 5.1.1 If an individual is unable to write their own appeal, assistance will be given to file the appeal.
- 5.1.2 Appeals may be turned in at all intake agencies, to any outreach worker, or to the participating program that the individual has been assigned.
- 5.1.3 The Committee will give due consideration to each complaint on an individual basis. If more information gained through the appeals process changes the CE decision, the individual shall be referred to a program as appropriate.
- 5.1.4 If an individual chooses to appeal, and their appeal is denied, their referral status and CE prioritization will remain unchanged.

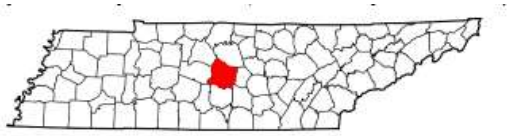
5.2 Review the VI-SPDAT score to identify housing options that are the best match for clients seeking housing assistance. Clients must be able to demonstrate episodes of homelessness by producing documentation history of homelessness. The following scores are the recommended prioritization guidelines to determine the type of housing option that the client should be prioritized for.

- 5.2.1 **Score 9+ and above**: Permanent Supportive Housing options for chronically homeless clients that have the most severe needs.
  - 5.2.1.1 Homeless and living in a place not meant for human habitation, a safe-haven, or in emergency shelter continuously for at least one year or on at least four separate occasions in the last three years.
  - 5.2.1.2 Can be diagnosed with one or more the following diagnoses: substance use disorder, serious mental health illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury or chronic physical illness.
  - 5.2.1.3 Client has been residing in an institutional care facility such as a jail, substance abuse or mental health treatment facility, hospital for less than 90 days, and meets 5.3.1.1, 5.3.1.2, and 5.3.1.3 criteria.
  - 5.2.1.4 Family with a client who meets the above criteria.
- 5.2.2 **Score 4-8**: Rapid Re-Housing or Transitional Housing.
- 5.2.3. **Score 0-3**: Prevention/Diversion and Other Community Resources

5.3 Pull eligible clients from the County's "By Name List" by running a report in HMIS document. Assign client to housing based on eligibility.

5.4 In the case several clients have a tie score, but the housing options are limited, the following factors are considered by the Housing Provider to determine the most qualified client: length of time homeless and/or chronically homeless; where are they sleeping (on the streets, shelter, family/friends); medical vulnerability; age; and individual versus family or youth.

5.5 As dictated, coordinate with Education for Homeless Children and Youth (EHCY) program, local schools and educational agencies to identify and respond to the housing, developmental, educational needs of children and youth.



5.6 The Housing Provider is responsible for coordinating services for the eligible individual. This includes the housing referral intake, documentation, and move-in commitment. It also includes ensuring that the individual receives clear information regarding the project they are referred to, what participants can expect from the project, and the project's expectations for the consumer.

5.7 Declining or canceling a program referral can only occur in the following instances:

5.7.1 Participating programs may only decline an HMIS Coordinated entry referral if the client is ineligible for program services and has been incorrectly referred from the CEP.

5.7.2 A program referral may be cancelled in HMIS if the eligible client is noncompliant and refuses services from the program.

5.7.3 A program referral may be cancelled by the Housing Provider if the assigned individual is unable to be located within seven (7) days, especially in the instance where other consumers on the By-Name List have comparable vulnerability and needs. In the event a client cannot be located, the individual will remain in the CEP system. It is imperative that coordinated entry be used to place consumers quickly; rarely holding units for any extended period of time.

5.7.4 The H3ARC Service Delivery Committee Chair is to be notified immediately if a participating program intends to cancel or decline a referral.

Revision of this policy is based on what was learned about what worked and what didn't, using data to drive changes and to establish best practices that have proven to be most effective. Data analysis also identifies gaps in services and might suggest additional data that needs to be collected. Adoption of proven solutions and evidence-based practices, adapted and tailored to the conditions in Rutherford County, significantly contributes to the resolution of the complex problem of homelessness.

6.1 The Lead Agency will provide a system of care that allows clients and providers to give feedback on suggestions and improvements of the CEP on a quarterly basis. This process will be posted in common areas of "Access Points" and made available on-line as part of the Web-based system.

6.2 The following data will be tracked, with impact of numbers to be evaluated for areas that need improvement and/or areas that are evolving in a positive manner.

6.2.1 # HCSs completed
6.2.2 # of VI-SPDATs completed
6.2.3 # of Prioritization categories
6.2.4 # of clients housed
6.2.5 # of clients that don't meet eligibility criteria
6.2.6 # of clients referred
6.2.7 # of denials by housing programs
6.2.8 which access point was used

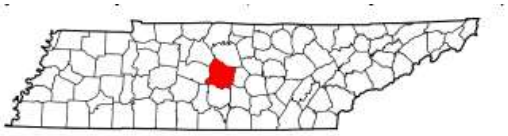
6.3 At least annually or with any new changes, each organization is responsible for updating their respective information in the nation-wide 2-1-1 call center by going to http://211tn.org/.

6.3.1 Click "Add Your Agency" which then shows the Inclusion/Exclusion criteria in the database. Acknowledge this which will reveal the Agency Survey Form.

6.3.2 Complete the form and hit submit which forwards the information to the 2-1-1 Resource Specialist who builds the listing in the database.

6.3.3 The Resource Specialist contacts the submitter to ask additional questions and obtain final approval on the listing.

6.3.4 Once approval has been obtained, the data will be updated on the http://211tn.org website.



Training

The purpose of training is to ensure consistency across the county for implementing the CEP. Training will occur annually and consist of: reviewing any changes to the policy, updating any new county and/or HUD requirements, evaluating what worked and what didn't regarding the prior year's CEP implementation process, and reviewing data from the CEP process that can be used to drive changes.

7.1 Initial training will involve a "live" training session and consist of the policy review, highlights of key documents that informs the trainee about the overall CoC process such as the HUD Coordinated Core Elements; HEARTH Act, Housing First and Opening Doors; instruction on key tools used in the CEP such as HCS, HMIS, and VI-SPDAT. Key points emphasized are:

7.1.1 CE is a process through which people experiencing homelessness access the crisis response system in a streamlined way, the client's strengths and needs are quickly assessed, and are quickly connected to appropriate, tailored housing and mainstream services within the community or designated region.

7.1.2 Standardized assessment tools are used across the CoC. The assessment provides the ability for households to gain access to the BEST options to address their NEEDS, incorporating participant's choice, rather than being evaluated for a single program within the system. The most intensive interventions are prioritized for those with the highest needs.

7.1.3 The overall goals of H^3ARC's CEP are to: reduce unnecessary duplication of efforts and services while increasing the focus on improving client outcomes; quickly identifying and responding to gaps in services; matching households with the most appropriate housing and service intervention; prioritizing limited resources based on level of need and vulnerability; prevent households from becoming homeless by supporting them through a housing crisis; reduce the length of homelessness by moving people quickly into the appropriate housing option; and increase housing stability by targeting the appropriate housing intervention to the corresponding needs of the household.

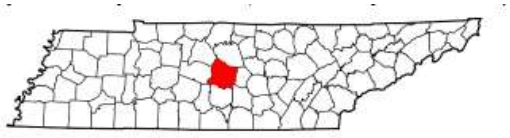
7.1.4 CEP will also help clients have fewer screenings thereby avoiding having to repeatedly tell their story.

7.2 Subsequent sessions can involve on-line or video training depending on the complexity of changes and updates from the previous year. The major focus of re-training is to provide all changes and updates that have occurred over the previous year.

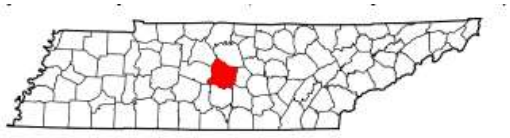
7.3 Training on the VI-SPDAT can occur anytime by watching a 22-minute video offered by the tool's creator, Org Code Consulting, Inc.

References and Resources

- Continuum of Care Program.
- HEARTH, Housing and Urban Development Act of 2009.
- United States Department of Housing and Urban Development (HUD).
- Homeless Management Information System (HMIS).
- Emergency Solutions Grant (ESG).



- Opening Doors.
- VI-SPDAT for Homeless Youth.
- VI-SPDAT for Single Adults.
- VI-SPDAT for Families.
- Fair Housing Act,
- Section 504 of the Rehabilitation Act,
- Title II of the Americans with Disabilities Act
- Title VI of the Civil Rights Act.
- Rutherford County Community Resource Booklet.
- United States Interagency Council on Homelessness, Crisis Response.
- Homeless Definition.
- Housing First.
- National Healthcare for the Homeless Council, Permanent Supportive Housing.
- Rapid Re-Housing.
- Trauma Informed Care.
- City of Murfreesboro.
- Tennessee Housing Authority.
- HUD Office of Community Planning and Development, CPD-16-11, Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing.
- Coordinated Core Elements.



- HUD Office of Community Planning and Development, CPD-17-01, Notice Establishing Additional Requirement for a Continuum of Care Centralized or Coordinated Assessment System.

- Northeast Florida Continuum of Care, Written Standards of Operating Policies HYPERLINK "http://endhomelessness.org/wp-content/uploads/2017/04/25.-07-2015-Revised-North-Florida-Continuum-of-Care-for-Intake-and-Assessment.pdf"& HYPERLINK "http://endhomelessness.org/wp-content/uploads/2017/04/25.-07-2015-Revised-North-Florida-Continuum-of-Care-for-Intake-and-Assessment.pdf" Procedures for Coordinated HYPERLINK "http://endhomelessness.org/wp-content/uploads/2017/04/25.-07-2015-Revised-North-Florida-Continuum-of-Care-for-Intake-and-Assessment.pdf"& HYPERLINK "http://endhomelessness.org/wp-content/uploads/2017/04/25.-07-2015-Revised-North-Florida-Continuum-of-Care-for-Intake-and-Assessment.pdf" Assessment.

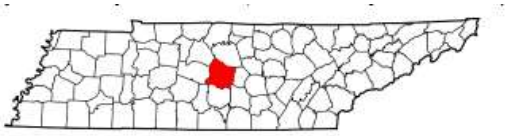
- Memphis and Shelby HYPERLINK "https://cafth.memberclicks.net/assets/CE%20MANUAL%20FINALIZED%20JAN%2023%202018_finalforwebsite.pdf" Counties HYPERLINK "https://cafth.memberclicks.net/assets/CE%20MANUAL%20FINALIZED%20JAN%2023%202018_finalforwebsite.pdf", Tennessee, Coordinated Entry Manual, 2018.

- HUD's 9 Criteria for Choosing a Standardized Assessment Tool

- Org Code Consulting (administrator of VI-SPDAT).

Summary of Policy Review/Revision(s)

Date	Policy Section	Highlights of Revision(s)
9/6/18	N/A	Update with organization name change



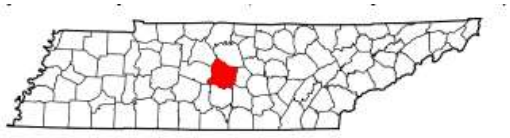
APPENDIX A: RUTHERFORD COUNTY CEP PROVIDER NETWORK

PHASE 1: Agencies that Receive funding from the city, county, and/or HUD.

- Domestic Violence Program (Shelter)
- Doors of Hope (Shelter)
- Greenhouse Ministries (Rapid Re-Housing)
- Murfreesboro Housing Authority.
- The Journey Home (Shelter for Coldest Nights)
- The Salvation Army (Shelter)

PHASE II: Other city organizations that assist with housing

- Barnabas Vision
- Cold Patrol
- Family & Child Services
- PATH/SOAR
- Rutherford County Schools
- Stepping Stones
- Way of Hope
- Local partners such as Emergency Responders, hospitals, jails, courts, etc.



APPENDIX B: HOUSING CRISIS SCREENING

"To help direct you to the most appropriate services I will ask you a few basic questions about your situation. I may ask you to repeat information or slow down so I do not miss any information AND so I can direct you to the best solution for your situation. If you need me to slow or repeat something, please let me know. I will be entering your information into our data system, but I will ask for your consent prior to sharing or referring you to another agency. OK, let's begin."

"Are you in need of shelter, in a housing crisis, or seeking housing assistance in Rutherford County today?"

• **NO (end interview and make referral to appropriate city/state**	• **YES (continue interview)**

"What is your first and last name?" _____
"Are there additional family members with you that are also in need of shelter?" **NO** **YES**
"First & last Name of 2nd Adult" _____ *"How many persons under 18?"*

- *"Are you seeking housing due to concern for your safety, or fear of violence or abuse from another person staying with you?"* **NO** **YES** (IF YES, skip to Question 6.)

- *"Where did you stay last night?"* (check one)

	Outside/Park/Campground		Emergency or DV Shelter		Own apartment/house/trailer
	Shed/Garage or Building		Motel paid by agency		With a family member or friend
	Vehicle		Hospital or Treatment Facility		Motel paid by self, family, friend
			Jail, Prison or Detention		Other:
Skip to Question 6		**Skip to Question 3**		**Continue with screening**	

- *"How long are you able to stay at your current housing situation?"*

	I can no longer stay there		2-7 days		Indefinite/Unknown
			2-3 weeks		Other
If checked, Go to Question 5		**If checked, go to Question 4**			

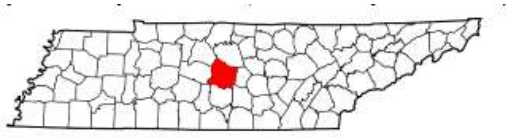
- *"What are the reasons you need to leave your current housing situation?"*

	Late Rent		Utility shut-off	If checked, refer to appropriate mainstream or prevention resources to divert from entry to homeless system.
	3 day notice to expire		Problems with landlord	
	Court eviction/foreclosure		Overcrowded (staying w/ someone & asked to leave)	
	Other			

- *"Is there anyone else you could stay with for the next 3-7 days if you were able to receive other supports (i.e., case management, transportation assistance, food basket, limited financial support, etc.)"*

	NO		YES
If NO, refer to Question 6	Other housing options:		
	What resources would you need to stay there?		

- EMERGENCY SHELTER SCREEN ONLY:
  DV: *"Given that you are concerned for your immediate safety due to a recent domestic violence (sexual assault or stalking) situation, I would like to make a referral to the Domestic Violence and Sexual Assault Center by contacting their hotline at 615-896-2012. The Center will be able to evaluate your needs and work with you on accessing an immediate but temporary safe place*



to stay. They can also help you access other resources for domestic violence and sexual assault services."

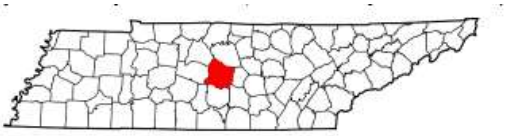
NON-DV*: "Based on the information you provided, you may be eligible for emergency shelter services. However, I first need to assess whether you are eligible for emergency shelter or voucher services. Do you give me permission to share your household data to make a referral?* **YES NO**

If YES*, "Prior to making the referral I will need some additional household information."*

What is the first name of all household members seeking shelter?	Gender	What are the ages of all members?	Are you a US veteran?	Does anyone in your family have a verifiable disability?	Have you been home-less 4x in the past 3 yrs or for 1 yr or longer?
HH:			YES NO	YES NO	YES NO
2nd Adult:			YES NO	YES NO	YES NO
# of Dependents				YES NO	

NON-DV SITE BASED SHELTER ONLY

- *"Are you restricted from staying in any shelters due to a past stay?"* NO YES
- *"Is there any member of your household a registered sex offender?"* NO YES
- *"Do you have a pet with you?"* NO YES If yes, *"do you have a plan for your pet if you are accepted into shelter?*
- *"Does any member of your household have a compromised immune system (i.e., cancer, HIV, AIDS, hepatitis, etc.)?* NO YES
- *"The possession or use of alcohol or drugs is not allowed by most shelters. If I referred you to a shelter right now, would you be able to pass*



APPENDIX C: 2-1-1 INFORMATION

Dial 2-1-1

Get help. Give help.

NEED HELP?

Get connected. Get answers.

2-1-1 is a free service that connects you to local resources – from financial, legal, and counseling help to healthcare, employment, and youth programs.

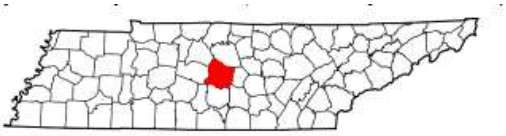
Go to uw211.org now!

United Way LIVE UNITED

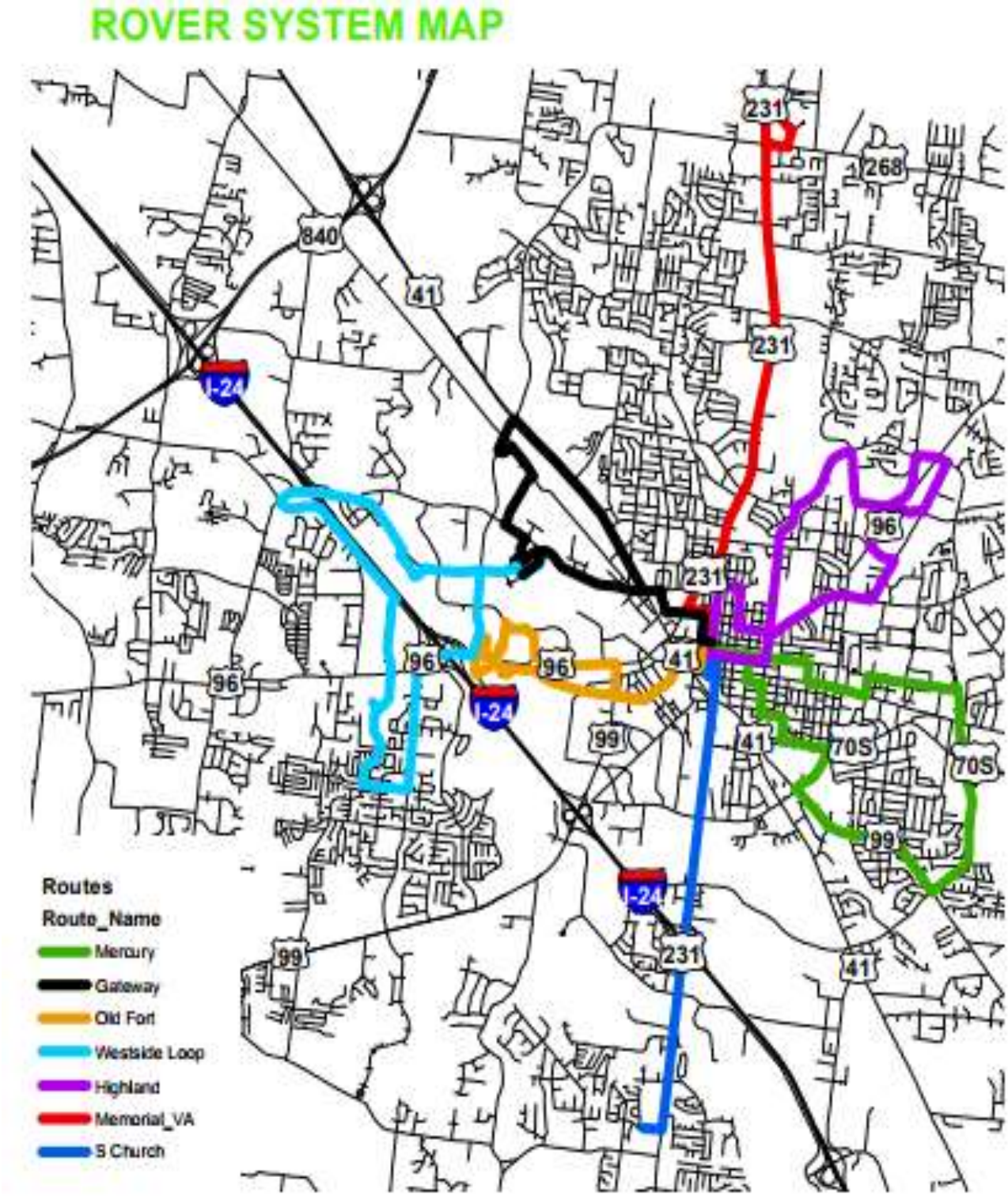
CALL
DIAL 2-1-1 OR
1-800-318-9335

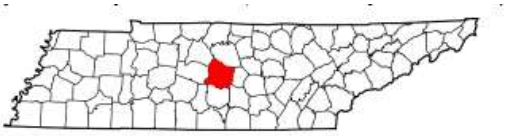
TEXT
YOUR ZIP CODE
TO 898-211

CHAT
GO TO
211CHAT.ORG



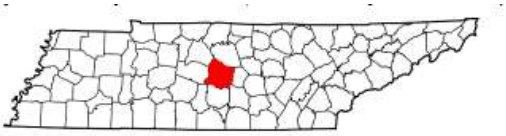
APPENDIX D: RUTHERFORD COUNTY CEP PROVIDER NETWORK
All Routes



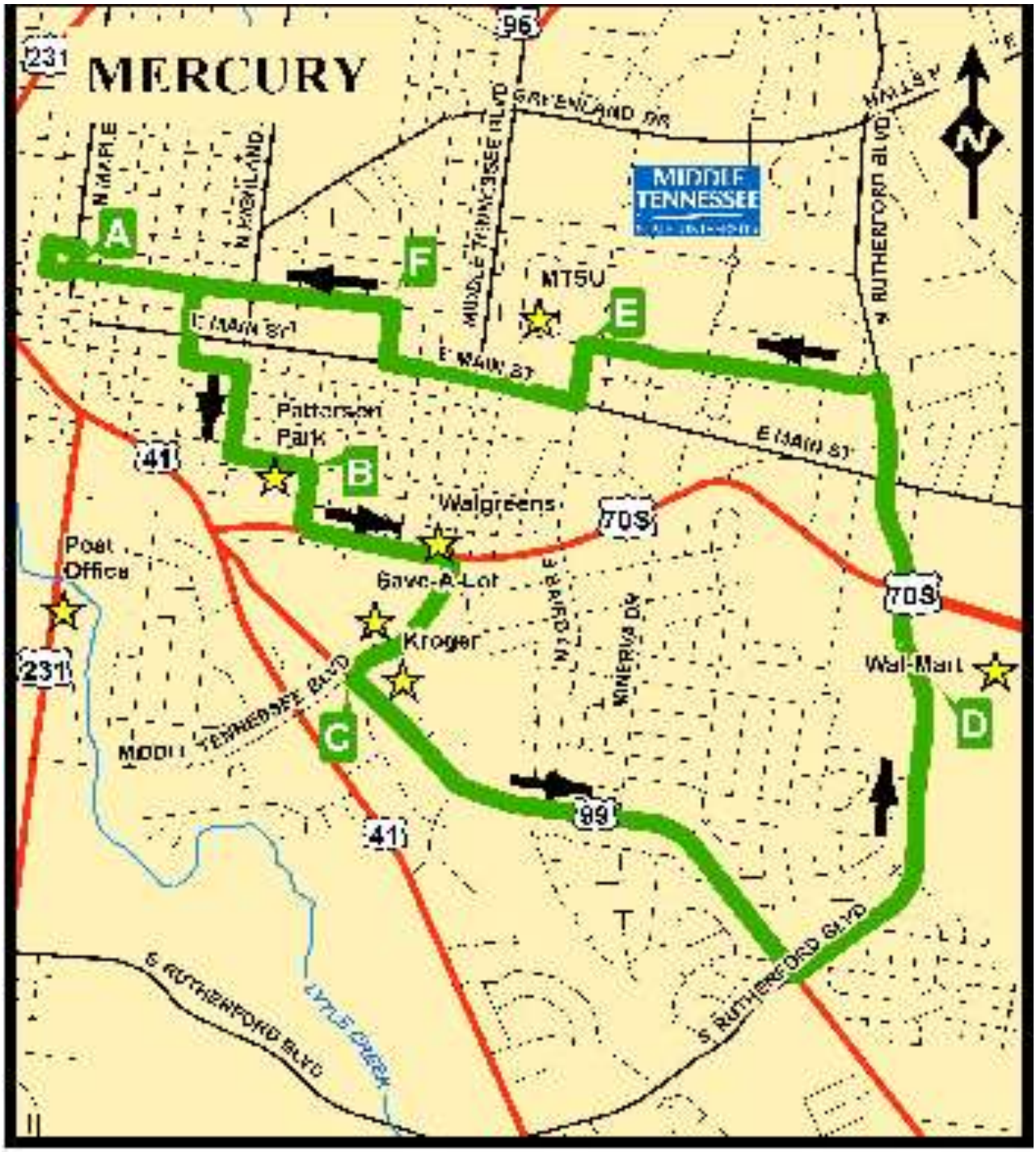


Memorial "Red" Route

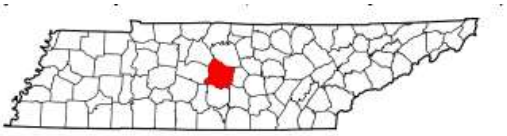
MURFREESBORO HOUSING AUTHORITY
415 North Maple Street



Mercury "Green" Route



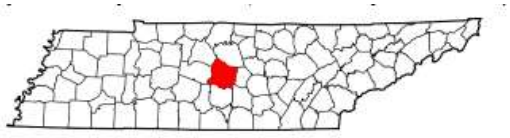
GREENHOUSE MINISTRIES
309 South Spring Street



Old Fort "Tan"

SALVATION ARMY
1137 West Main Street

JOURNEY HOME
308 West Castle Street



APPENDIX E: RELEASE OF INFORMATION
Homeless Alliance of Rutherford County
Multi-Agency Consent for the Release of Confidential Information

_____ _____ _____ _____-_____-_____
(Name of Consumer) (Record #) (DOB) (SSN)

The purpose of this form is to allow me to choose how my services are coordinated. I understand that this is my decision to make and that I can change my mind. If I change my mind, I need to make a written request to cancel this consent. I also understand that I can ask a staff member to assist me with this process. If I have a legal guardian, my guardian may sign or cancel this consent on my behalf.

By checking yes, I am allowing these providers to communicate, and exchange information needed to coordinate and continue care, treatment and services. If I check no, I do not want the information exchanged with that provider.

Yes	No	Provider/Agency Name
❒	❒	The Journey Home
❒	❒	Greenhouse Ministries
❒	❒	Door of Hope
❒	❒	The Salvation Army
❒	❒	Domestic Violence Program
❒	❒	H^3ARC Executive Committee
❒	❒	Service Delivery Committee
❒	❒	HMIS
❒	❒	Charity Tracker
❒	❒	Other:

Yes	No	Types of Information	Yes	No	Types of Information
❒	❒	Demographic	❒	❒	Criminal Background
❒	❒	Assessments	❒	❒	Admit/Discharge Dates
❒	❒	Physical Exam	❒	❒	Release/Discharge Summary
❒	❒	Treatment Plan(s)	❒	❒	Housing Information
❒	❒	Medications	❒	❒	Employment History
❒	❒	Education Records	❒	❒	Financial Records
❒	❒	Mental Health Records	❒	❒	
❒	❒	Other: Please describe:			

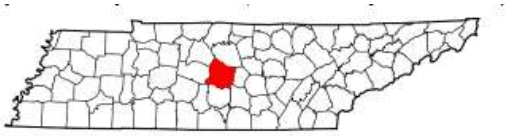
Date, Event or Condition when Consent Expires: _____. In the event no date/event/or condition is specified, this consent expires on year from the date of signing.

I understand that services are NOT contingent upon or influenced by my decision to permit the information release.

I understand that the information and records disclosed pursuant to this consent may be protected under 42 CFR Part 2, governing Alcohol and Drug Abuse patient records, the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and 45 CFR parts 160 and 164, State Confidentiality laws and regulations, and cannot be released without my consent unless otherwise provided for by the regulations. State and Federal regulations prohibit any further disclosure of such information and records without my specific written consent unless otherwise permitted by such regulation.

The information I authorize for release may include records that may indicate the presence of a communicable or venereal disease, which may include, but is not limited to diseases such as hepatitis, syphilis, gonorrhea, and the human immunodeficiency virus, also known as acquired immune deficiency syndrome (AIDS)

_____/_____ _____/_____
Signature of Consumer Date Witness (optional) Date



APPENDIX F: H^{3}ARC MOU

Housing, Health and Human Services Alliance of Rutherford County

MEMORANDUM OF UNDERSTANDING

The Homeless Alliance of Rutherford County (H^{3}ARC), and partner agencies responsible for providing diverse housing and homeless supportive services in the community are collaborating to develop a central access and case management system for persons experiencing homelessness. This Memorandum of Understanding, hereinafter referred to as "MOU," shall stand as evidence that _____, hereinafter referred to as AGENCY, agrees to work with H^{3}ARC, which serves as the lead entity for the Murfreesboro/Rutherford County Continuum of Care, and the Service Delivery Committee which serves as the lead Agency for the Coordinated Entry System. To this end, each entity, agency and/or organization agrees to participate in an exchange of services and coordinating efforts to improve effective access to services in support of housing stability. Under 24 CFR Part 578, Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act): Continuum of Care Program Interim Regulations issued in 2012, a centralized or coordinated assessment system (what in Rutherford County is referred to as **Coordinated Entry**) is defined as:

A centralized or coordinated process designed to coordinate program participant initial screening, assessment, and provision of referrals. As defined by HUD, centralized or coordinated assessment system must:
1. Cover the geographic area,
2. Be easily accessed by individuals and families seeking housing or services,
3. Be well advertised, and
4. Include a comprehensive and standardized assessment tool.

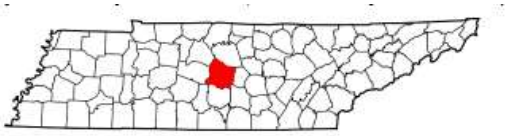
These are the minimum requirements for H^{3}ARC's centralized or coordinated assessment system.

RESPONSIBILITIES

H^{3}ARC is required to establish and operate a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services.

The Service Delivery Committee will be the Coordinated Entry service provider ensuring professionally competent and responsive practices, which may include, but are not limited to:
- Serving as the centralized access point for individuals and families seeking housing assistance;
- Conducting standardized initial assessments, identifying individual / family needs, and providing support and referral to individuals / families as appropriate;
- Providing system management and oversight;
- Maintaining a thorough, accurate, and updated resource database;
- Collecting and disseminating community needs data, and
- Communicating and collaborating with partner agencies

As the Lead Agency, the Service Delivery Committee will respond to AGENCY concerns, advocate for system improvement, and ensure the Coordinated Entry System remains efficient and effective, distributing updates and communication to AGENCY in a timely fashion or when the need arises.



The Service Delivery Committee will oversee and lead efforts of the Coordinated Entry System; sharing revisions with H^{3}ARC's Executive Board/Full Body, as needed.

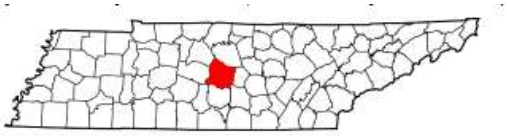
In compliance with 24 CFR Part 578, HEARTH Act and the objectives of H^{3}ARC, by signing this MOU, AGENCY agrees to participate in H^{3}ARC's Coordinated Entry System. Participation, includes, but is not limited to:

- Supporting efforts to centralize housing and homeless supportive services into a coordinated system;
- Demonstrating "good faith" efforts to improve cross-system collaboration and sustain inter-agency cooperation;
- Evidencing "good faith" efforts to identify and publicize the benefits of centralized screening and assessment that include, but are not limited to:
- freeing housing staff time for more direct services,
- improving access to services for individuals with higher needs,
- sharing responsibility and challenges to meet the needs of hard-to-serve clients across agencies, and
- centralizing community data to identify gaps that affect the system and streamline improvement efforts;
- Actively engaging in "good faith" efforts to resolve any and all program implementation challenges;
- Supporting the transition from *first come – first served* to a needs-based service access approach and philosophy;
- Supporting the transition to a Housing First approach and philosophy;
- Addressing concerns from funders and regulators regarding program outcomes and requirements;
- Clearly articulating concerns to the Service Delivery Committee about agency expectations;
- Clearly articulating concerns to the Service Delivery Committee about the interface with other systems (health care, behavioral health, foster care, corrections, basic needs resources, etc.);
- Referring individuals/families who contact their organization and who are homeless or in jeopardy of being homeless to IMPACT, Inc. for housing and homeless supportive service assessment screening; as such, IMPACT, Inc. will assess the need of the individual/family for housing and homeless supportive services;
- Providing the Service Delivery Committee with updated and accurate information about AGENCY capacity and service delivery and programmatic changes;
- Participating in program evaluation activities, where possible;
- Adhering to policies and procedures as identified within the most recent Coordinated Entry manual;
- Supporting the central access approach to housing referrals being provided by the Service Delivery Committee with the understanding that those referrals will match agencies' criteria, making bed/program reservations based on agencies' approval with the expectation that agencies will honor appropriate referrals;
- Understanding that participation is required by the Continuum of Care with funding sources backing up the requirement in their funding/program evaluation criteria, and
- Participating in regularly scheduled Continuum of Care Best Practices to End Homelessness trainings

<u>TERM</u>

The MOU is an agreement which does not have an ending date but which will continue for as long as certain other conditions, as identified in this agreement, exist.

The executed Memorandum of Understanding "MOU" and the Coordinated Entry System Manual will be provided to AGENCY's Board of Director's and adopted annually by its Board.



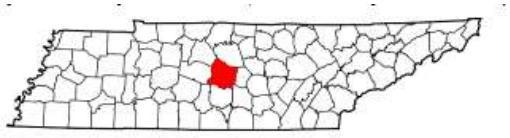
AUTHORIZED SIGNATURES

AGENCY:
(Print) Name: _____
Title: _____

Signature: _____Date: _____

H^3ARC:
(Print) Name: _____
Title: _____

Signature: _____Date: _____



APPENDIX G: CEP DENIAL FORM

This form should be completed by Housing Provider whenever they are denying a referral that has been made by a Rutherford County CEP. Forms should be returned to the H^{3}ARC Service Delivery Committee.

DATE:	**REFERRAL DATE:**
AGENCY NAME:	**PROGRAM NAME:**
STAFF CONTACT	**EMAIL:** **PHONE:**
CLIENT SERVICE POINT NUMBER:	

Reason for denial (please check a box and you MUST explain in detail below.

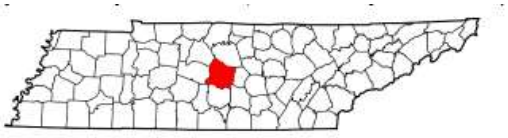
•	Client/household refused further participation (or client move out of Rutherford County.
•	Client/household does not meet required criteria for program eligibility.
•	Client/household unresponsive to multiple communication attempts.
•	Client resolved crisis without assistance.
•	Client/household safety concerns. The client's/household's health or well-being or the safety of current program participants would be negatively impacted due to staffing, location, or other programmatic issues.
•	Client/household needs cannot be addressed by the program. The program does not offer the services and/or housing supports necessary to successfully serve the household.
•	Program at bed/unit/service capacity at time of referral.
•	Property management denial (include specific reason cited by property manager).
•	Conflict of interest.

Please describe why you are unable to accept this referral.

Is this due to policy or procedure created by a funder, board, staff, property management, landlord or other entity? If yes, please explain.

If you were unable to contact client regarding this referral, please indicate the dates of attempted communication, to whom, and in what form (i.e., phone, email, etc.).

If you feel this was an inappropriate referral, please indicate that below with an explanation.



APPENDIX H: THE VI-SPDAT SCRIPT

(BEFORE ASKING QUESTIONS) My name is *[interviewer name]* and I work for a group called *[organization name]*. I have a 10-minute survey that I would like to complete with you. The answers will help us determine how we can go about supporting and housing you. Most questions only require a Yes or No. Some questions require a one-word answer. I'll be honest, some questions are personal in nature, but know you can skip or refuse any question. The information collected goes into the Connecticut Homeless Management Information System, a shared database that all of our shelters and housing providers can access, and once it is there, other providers in the community will not make you complete this survey multiple times.

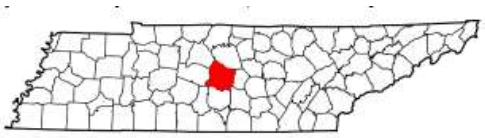
If you do not understand a question, let me know and I would be happy to clarify. If it seems to me that you don't understand a question I will also do my best to explain it to you without you needing to ask for clarification.

One last thing we should chat about. I've been doing this long enough to know that some people will tell me what they want me to hear rather than telling me – or even themselves – the truth. It's up to you, but the more honest you are, the better we can figure out how best to support you.

(WHEN COMPLETED) Thank you for taking the time to complete this assessment with me. It has helped us to determine what level of support you may need. As a community we are trying to assist clients with finding housing options as quickly as possible with the limited resources that are available."

REMEMBER:

Do **not** share VI-SPDAT 2.0 Scores with Client.
Do **not** share VI-SPDAT 2.0 Recommendation.
Do **not** share possible outcomes.
Do **Not** suggest a time frame.



APPENDIX I: REQUIRED CLIENT DOCUMENTS

415 N. Maple Street
Murfreesboro, TN 37130
www.mha-tn.org

Telephone: (615)893-9414
Fax: (615)893-9436
TN Relay Service (800)848-0298

Dear Applicant:

We will need the following information to make your file complete.

1. Original Application – all pages signed by all adults in household, including the supplement to application (Contact person) – bring to interview.
2. Income verifications for all household members including a letter from your employer stating wages and hours worked per week, TANF, Social Security, SSI, pensions or retirement, VA benefits, child support, and any other form of income received including family support. Verifications cannot be more than 60 days old.
3. Birth Certifications (naturalization and/or immigration documents if applicable) for all family members. We must view original documents.
4. Social Security cards for all family members. We must view original documents.
5. Driver's License or Identification Card with picture for all adult family members.
6. Marriage certificate, divorce papers or legal separation papers, or death certificate. (If more than one marriage/divorce, we will need all verifications).
7. Childcare verification if you pay for daycare.
8. Last 6 months of bank statements (including checking & savings, CD's, etc.).
9. Whole Life insurance policies – has a cash surrender value.
10. High School or College verification for full-time enrollment including financial aid. This applies to anyone 18 or older other than the head of household or spouse that is enrolled in high school or college.
11. Out of pocket medical expenses if head is disabled or elderly. These may include bills that are paid for dental, eye doctor and glasses/contacts, medical doctors, hospital or diagnostic tests, printouts for prescriptions, medical insurance premiums.

It is the policy of this housing authority that no certifications will be completed until all verifications are in your file. **All verifications must be current (no more than 60 days old).** It is very important that your file be complete. If you have any questions, please call me at (615) 225-9470.

Sincerely,

Deborah L. Fox
HCV Administrator