St. Louis City and County Continua of Care

Coordinated Entry Policies and Procedures

Approved January 17, 2018

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Definitions and Acronyms

Client

For the purpose of this manual, "client" refers to any individual or family seeking services from the homeless services system.

FESG: Federal Emergency Solutions Grant

FESG is the term utilized to refer to Emergency Solutions Grant (ESG) funding provided through the St. Louis County Department of Human Services.

HESG: HEARTH Emergency Solutions Grant

HESG is the term utilized to refer to Emergency Solutions Grant (ESG) funding provided through the St. Louis City Department of Human Services.

Housing First Philosophy

"Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry."[1]

HRC: Housing Resources Commission

HRC is a funding source that is available through the St. Louis County Department of Human Services.

MESG: MHDC Emergency Solutions Grant

MESG is the term utilized to refer to Emergency Solutions Grant (ESG) funding provided through the Missouri Housing Development Commission.

PATH: Projects for Assistance in Transition from Homelessness

The PATH program is operated by the U.S. Department of Health and Human Services Department and is designed to provide assistance to individuals experiencing homelessness or who are at-risk of homelessness and have a serious mental illness.

Point-of-Contact

All shelter, street outreach, and housing providers who participate in the St. Louis Homeless Service Delivery System must designate at least one Point-of-Contact (PoC). This individual will be responsible for receiving correspondence from the front door lead. Additionally, the PoC will be the person in the organization who can request an acuity review panel meeting. All review panel requests must be funneled through the PoC for the agency. The shelter, street outreach, or housing provider is welcome and encouraged to designate a second PoC to function as a back-up in the event that the primary PoC is unavailable.

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[1] Quoted from *Housing First in Permanent Supportive Housing Brief* published by the U.S. Department of Housing and Urban Development in July 2014.

Qualified Minor

Qualified minors are unaccompanied youth ages 16 and 17 who are homeless or victims of domestic violence who are legally competent to contract for shelter, housing, and other essential services as prescribed in RSMo 431.056.

Warm Referral

For the purpose of this manual, a “warm referral” involves the agency contacting another agency or service on behalf of the client to ensure that the agency is able to provide services in a timely fashion to the client prior to sending the client to the agency or service.

Preamble

The mission of the St. Louis City and St. Louis County Continuums of Care (CoCs) is to provide access to housing and support services for families and individuals who experience or are at great risk of homelessness throughout the St. Louis region. This policy and procedure manual institutes consistent and uniform assessment processes to determine the most appropriate response to each individual or family's immediate short- and long-term housing needs.

The CoCs developed guiding principles to inform the design, implementation, and oversight of the homeless service system of care for persons experiencing a housing crisis in St. Louis City and County. The Continua of Care members and homeless service providers will work to:

- Rapidly exit people from their homelessness to stable housing
- Ensure that the hardest to serve, with the greatest needs, are served
- Serve clients as efficiently and effectively as possible
- Ensure transparency and accountability throughout the referral and assessment process

Background and Purpose

HUD requires each Continuum of Care to establish and operate a coordinated entry system with the goal of increasing efficiency of crisis response systems and improving ease of access to resources (including mainstream resources). Both CoC and ESG regulations require participation in coordinated entry for projects receiving funding from the Continuum of Care (CoC) program and the Emergency Solutions Grant (ESG) program. Coordinated entry is designed to help communities prioritize clients who are most in need of assistance, and to allow CoCs to identify gaps in services and resources.[2]

Joint Coordinated Entry System

The St. Louis City Continuum of Care (MO-501) and St. Louis County Continuum of Care (MO-500) have agreed to operate a joint coordinated entry process. This coordinated entry process is available to the entire geographic region within these to Continua of Care, and projects in each continuum must serve clients regardless of last permanent residence unless specifically prohibited by funders.

Governance

Changes to this policies and procedures manual must be approved by the executive boards of both continua prior to going into effect, and may take up to 30 days to be implemented after the final approval is received.

[2] Adapted from CPD-17-01: *Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System.* Published January 23, 2017, page 2.

Section 1: Guiding Principles of Coordinated Entry

The intent of coordinated entry is to provide individuals and families at risk of or experiencing homelessness with need-based access to services and supports to resolve their housing crisis. The following principles are present throughout the coordinated entry process.

Nondiscrimination

The CoCs believe that the most effective response to homelessness results from a service delivery system that values diversity and recognizes that inherent dignity of individuals and families of all backgrounds. As such, the CoCs and their member agencies shall not discriminate or withhold services on the basis of race, color, religion, national origin, ancestry, disability or health-related condition, familial status, marital status, sex, gender identity, gender expression, sexual orientation, veteran status, or source of income. In addition, the CoCs will ensure that the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, Title II of the Americans with Disabilities Act, and HUD's Equal Access Rule at 24 CFR 5.105(a)(2) will be followed. In addition, individuals or families fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, human trafficking, or other life-threatening situations shall not be prohibited from receiving services from non-victim service providers.

Affirmative Marketing and Outreach

The coordinated entry system and services available within it will be affirmatively marketed to "eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to apply in the absence of special outreach, and will maintain records of those marketing activities. Housing assisted by HUD and made available through the CoC must also be made available to individuals and families without regard to actual or perceived sexual orientation, gender identity, or marital status in accordance with 24 CFR 5.105 (a)(2)."[3]

Access

The coordinated entry system must be easily accessed by individuals and families seeking services to address housing crises. Emergency services entry points will be accessible via walk-in and via telephone. Additionally, the CoCs will establish, to the greatest extent possible, front doors that are accessible via walk-in throughout the geographic region. Funded front door providers must provide reasonable accommodation for disabilities upon request. The assessments at each front door must follow the requirements of this manual to ensure that clients are provided with the same assessment regardless of the front door from which they seek services. In the event that the front door is unable to serve a client, the front door agrees to ensure that the client is provided with a warm referral to another front door to the greatest extent possible.

Low Barrier

The coordinated entry system prohibits the "screening out" of clients "due to perceived barriers relating to housing or services, including, but not limited to, too little or no income, active or a history of substance use, domestic violence history, resistance to receiving services, the type or extent of disability-related services or

[3] Quoted from CPD-17-01: *Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System.* Published January 23, 2017, page 3.

supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal records – with exceptions for state and local restrictions that prevent projects from serving people with certain convictions."[4]

Client Choice

Clients are provided with information about the coordinated entry system, including which programs are available to them so that they may make an informed decision regarding in which programs they wish to participate, if any. Clients are also free to decide what information they provide during the assessment process, and clients may not be denied services if the client refuses to provide certain pieces of information unless the information is required to establish or document program eligibility for the applicable project.

Collaboration

Coordinated entry is a system-wide process, and therefore all providers within the network must collaborate to ensure the system functions smoothly and effectively. The use of weekly housing matching meetings is intended to facilitate regular, in-person collaboration to the greatest extent possible. To have the most effective coordinated entry, the CoCs recognize that partnerships from across sectors will help our region to best provide services for all persons who are experiencing or at risk of homelessness and invite non-HUD funded programs and agencies to participate in the Homeless System Coordinated Entry Process.

Data

A key function of coordinated entry is the collection of data regarding each client's housing crisis and needs in order to provide clients with the most appropriate housing interventions available. The data gathered is also utilized to reveal gaps in services and inform funding decisions. Clients may not be denied services if they refuse to allow their personally identifying information to be shared unless required by local, state, or federal statute as a condition of program participation.

Housing First

The coordinated entry system is based upon a Housing First approach. Providers mandated to participate in coordinated entry agree to prioritize housing placement over supportive services. Providers who participate in coordinated entry voluntarily are strongly encouraged to follow the Housing First approach.

Prioritization

Coordinated entry will ensure that those clients with the highest needs are provided with services first. A uniform assessment process is utilized for all clients experiencing housing crises to ensure needs-based access to housing interventions. Prioritization may not be based on any of the following: race, color, religion, national origin, sex, age, familial status, disability, type or amount of disability or disability-related services or supports required, actual or perceived sexual orientation, gender identity or marital status.[5]

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[4] Quoted from CPD-17-01: *Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System.* Published January 23, 2017, page 11.

[5] Adapted from CPD-17-01, page 10. While the factors above may not be used to prioritize, they may be used as eligibility criteria unless otherwise prohibited by federal, state, or local civil rights laws.

Privacy Protections

Participating agencies will only gather information that is deemed necessary to provide quality services, and assessments cannot require the disclosure of specific disabilities or diagnoses unless otherwise required in order to determine eligibility.

Clients must be notified of their HMIS-related privacy rights in accordance with the notification requirements included in the HMIS Policies and Procedures Manuals of each CoC. Staff and volunteers of agencies participating in coordinated entry will access client information only as necessary to provide services and referrals. No identifiable client information may be released to any individual, agency, organization, or government entity unless written consent is obtained from the client or is otherwise required by law.

Safety Planning

When a non-victim service provider is sheltering, housing or otherwise providing services to an individual or family fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, human trafficking, or other life-threatening situation, that service provider shall follow the safety protections in the Violence Against Women Act (VAWA) and HUD Protections Against Survivors of Violence (16-159). Service-providers will give the safety and confidentiality rights of the survivor the highest priority and will ensure the survivor's individual autonomy, self-determination and safety are respected.

Non-victim service front doors responding to a victim of domestic or sexual violence will provide a private location and assistance in contacting local shelters for victims of violence. Should a victim of violence choose to seek shelter with a program that does not provide victim specific services, they cannot be discriminated against due to the violence and must be offered the same confidentiality of services offered through victim service providers including but not limited to data collection, privacy, and sharing.

Housing providers must have emergency transfer plans in place that allow for a survivor to move immediately to a safe and available unit if the survivor fears for their life and safety. Such plans allow a survivor to self-certify their need for the transfer, do not require the survivor to undergo an application process as a new tenant, and allow the survivor to determine what is a safe unit for purposes of the transfer.

Finally, non-victim service providers are encouraged to consult and collaborate with domestic violence service providers and familiarize themselves with safety planning resources available through the Missouri Coalition Against Domestic and Sexual Violence website at https://www.mocadsv.org/resources/.

Section 2: Access to Housing Crises Services

Emergency Services Entry Points

All shelter referrals for shelters funded with FESG, HESG, MESG, or HRC funding must come from an Emergency Services Entry Point. Emergency Services Entry Points include, but are not limited to, Biddle Housing Opportunities Center, the St. Louis Region Housing Helpline, and all street outreach providers who participate in HMIS. All shelter referrals must be documented within the HMIS (domestic violence victim services exempted) in order to track referral sources. Emergency Services Entry Points are permitted to make referrals to open shelter spaces at any time, including nights and weekends, if the shelter accepts new clients during the night and over weekends.

Emergency Services Entry Points are expected to complete a triage assessment for those experiencing a housing crisis to determine the most appropriate referral for their housing crisis (e.g., shelter, prevention, diversion) and make a referral based upon their housing crisis and available resources in the community.

Front Doors

All individuals and families at risk of or experiencing homelessness must be offered the opportunity to be assessed at an appropriate front door provider. A front door is responsible for gathering or completing all coordinated entry assessments required to place clients onto the prioritization list.

All front doors have the following responsibilities:

- Designate one or two individuals to function as the primary contacts for coordinated entry for communication from the front door lead.
- To the greatest extent possible, provide a warm referral to clients in need of emergency services (e.g., emergency shelter, domestic violence shelter, medical care, meal programs) to ensure the most basic needs are met, including referring or connecting clients to applicable emergency services entry points and other mainstream resources.
- Verify that the client appears to meet the definitions of homeless or at-risk of becoming homeless in accordance with HUD's regulations prior to completing a coordinated entry assessment. If a client does not meet HUD's definition of homeless or at-risk of homelessness, the front door must provide a warm referral to other agencies who may be able to meet their needs.
- Front doors may choose to work exclusively with special populations if the agency's primary mission is to focus on an exclusive population (e.g., veterans, persons with HIV/AIDS) but must agree to make a warm referral to an appropriate front door for any individuals seeking services who are not in their special population to ensure the client receives a proper assessment as soon as possible.
- Assess each housing crisis and gather all required information for prioritization and input it into the HMIS for the purpose of adding clients who meet HUD's definition of homelessness onto the prioritization list or referring those who are at-risk of homelessness to appropriate prevention services. This includes gathering documentation of homelessness or at-risk of homelessness in accordance with HUD guidance to the greatest extent possible.
- Function as a housing navigator for the clients they place onto the prioritization list who are not otherwise provided with housing navigation services by another service provider, or refer clients to another front door provider who has agreed to provide the client with housing navigation services.
- Participate in least 80% of weekly housing matching meetings.

- Remove clients they added to the prioritization list from the prioritization list when they become housed and/or disappear.

All voluntary front doors (as defined below) must sign an agreement with both Continua of Care prior to providing coordinated assessment services.[6] If a front door is designated for specific population(s), the agreement must outline the special population(s) it will serve and any specific unique requirements that the special population requires to ensure safe and effective participation in coordinated entry (e.g., front doors for victims of domestic violence will not enter data into the HMIS in accordance with the Violence Against Women Act, nor will the physical location of domestic violence front doors or other victim services providers be disclosed publicly).

No front door may function as the exclusive access point for any special population. All special populations must be able to access a minimum of two front door providers.

Funded Front Doors

Any provider who receives funding through any ESG, CoC, or HRC grant for the purpose of providing coordinated assessment services is a front door. Their population may be specialized if it is stipulated in their grant agreement or contract. They may not otherwise specialize the population(s) to which they provide coordinated assessment services. Funded front doors must offer housing navigation services to clients who are not able to receive housing navigation services from any other providers.

Emergency Shelters

All emergency shelters receiving FESG, HESG, MESG, or HRC funding are front doors for clients who are living in their shelter projects and must provide the opportunity for assessment and placement onto the prioritization list for their shelter residents within 7 days of shelter move-in unless the client declines to participate in coordinated entry. In addition, shelters must provide housing navigation services to clients living in their shelters unless the client declines to participate.

Street Outreach

All street outreach providers receiving FESG, HESG, MESG, or PATH funding are front doors for clients who have been determined to be engaged[7] with their project and must provide assessment and placement onto the prioritization list within 7 days of engagement unless the client declines to participate in coordinated entry. In addition, street outreach providers must provide housing navigation services to their engaged clients unless the client declines to participate.

"Voluntary" Front Doors

Any agency within either CoC that shares the goal of ending and preventing homelessness is allowed to be a front door, but must agree to all responsibilities of a front door as defined above, including the signing of an agreement. Voluntary front doors must provide housing navigation services or refer clients to other service providers who provide housing navigation services unless the client declines to participate.

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[6] Any voluntary front doors already in operation at the time this manual goes into effect must have an agreement signed within 60 days of this manual going into effect or they must stop providing coordinated assessment services.

[7] A client is deemed "engaged" with a street outreach project when the client has indicated interest in receiving services from a street outreach project and agrees to participate in a deliberate client assessment (i.e., completes program intake).

Section 3: Expectations of Emergency Services

Emergency services are defined as emergency shelters, domestic violence shelters, and street outreach providers.

HMIS-participating Emergency Shelters

Point-of-Contact

Emergency shelters must designate one or two individuals to function as the primary contacts for coordinated entry for communication from the front door lead.

Shelter Openings

Maintain "live" shelter openings within HMIS. In the event a client is declined, document reason for rejection within the HMIS and notify the referring emergency services entry point. At least 75% of referrals from emergency services entry points must be accepted.

Assessment and Prioritization List Placement

Assess clients and place them onto the prioritization list in accordance with *Client Assessment Process for HMIS-participating Emergency Shelters* in section 6 of this manual.

Housing Navigation Services

Provide housing navigation services in accordance with the expectations outlined in section 8.

Participation in Weekly Housing Matching Meetings

Participate in a minimum of 80% of Weekly Housing Matching Meetings. See section 7 for details.

Advocacy at Acuity Review Panel Meetings

Advocate on behalf of any clients in the shelter going through the acuity review process. See section 7 for details.

Non-HMIS-participating Emergency Shelters (excluding DV shelters)

Point-of-Contact

Emergency shelters must designate one or two individuals to function as the primary contacts for coordinated entry for communication from the front door lead.

Shelter Openings

Send openings to emergency services entry points by 7:00am daily. Shelter openings should only be submitted if the bed or unit is ready for immediate occupancy. In the event a client is declined or does not show up, notify the referring emergency services entry point. In the event of a change in availability during the day, notify emergency services entry points. At least 75% of referrals from emergency services entry points must be accepted if the project is mandated to participate in coordinated entry.

Assessment and Prioritization List Placement

Refer clients to appropriate front door providers for assessment and placement onto the prioritization list.

Housing Navigation Services

Provide housing navigation services in accordance with the expectations outlined in section 8.

Participation in Weekly Housing Matching Meetings

Participate in a minimum of 80% of Weekly Housing Matching Meetings. See section 7 for details.

Advocacy at Acuity Review Panel Meetings

Advocate on behalf of any clients in the shelter going through the acuity review process. See section 7 for details.

Domestic Violence Emergency Shelters

Point-of-Contact

Emergency shelters must designate one or two individuals to function as the point-of-contact for coordinated entry for communication to and from the front door lead.

Shelter Openings

Follow individual agency procedures regarding shelter openings.

Assessment and Prioritization List Placement

Assess clients and place them onto the prioritization list in accordance with *Client Assessment Process for Domestic Violence Emergency Shelters* in section 6 of this manual.

Housing Navigation Services

Provide housing navigation services in accordance with the expectations outlined in section 8.

Participation in Weekly Housing Matching Meetings

Attendance at Weekly Housing Matching meetings poses a significant confidentiality and safety risk for domestic violence survivors receiving services from domestic violence emergency shelters. In lieu of participation in Weekly Housing Matching Meetings, domestic violence emergency shelters are required to maintain contact with the front door lead at least once a week in an effort to identify housing matches and ensure collaboration.

Representatives of domestic violence emergency shelters may attend housing matching meetings to provide feedback and input regarding the provision of services to clients who are fleeing or attempting to flee domestic violence while receiving services from non-victim service providers, but may not disclose information about clients they are serving or have served in their projects during housing matching meetings.

Advocacy at Acuity Review Panel Meetings

Advocate on behalf of any clients in the shelter going through the acuity review process. See section 7 for details.

Street Outreach Providers

Point-of-Contact

Street outreach providers must designate one or two individuals to function as the point-of-contact for coordinated entry for communication to and from the front door lead. The point-of-contact is the sole individual who can request a client's case be reviewed by the acuity review panel.

Assessment and Prioritization List Placement

Assess clients and place them onto the prioritization list in accordance with *Client Assessment Process for HMIS-participating Street Outreach Providers* in section 6 of this manual.

Housing Navigation Services

Provide housing navigation services in accordance with the expectations outlined in section 8.

Participation in Weekly Housing Matching Meetings

Participate in a minimum of 80% of Weekly Housing Matching Meetings. See section 7 for details.

Advocacy at Acuity Review Panel Meetings

Advocate on behalf of any clients in the shelter going through the acuity review process. See section 7 for details.

Section 4: Expectations of Housing Providers

Housing providers are defined as programs that provide transitional housing, rapid rehousing, permanent supportive housing, permanent housing only, and permanent housing with services. Housing providers mandated to participate in coordinated entry must follow the rules and expectations below, while providers not mandated to participate in coordinated entry are strongly encouraged to do so.

Notification of Housing Availability

Housing providers must respond within the allotted timeframe when the front door lead sends a request for housing openings on a weekly basis, including how many units are available with and without pending referrals. If a housing provider does not have any openings, they must still respond to the request to notify the front door lead of no openings. If a sponsor-based unit is listed, the provider must indicate whether the unit is currently available or when it will be available if it is not currently available. Each notification of housing availability shall be deemed to override any previously submitted housing openings.

Program Information Sheet

Each housing provider must submit a detailed list of eligibility criteria, an outline of the enrollment process, and services provided in addition to housing (if any) for each housing project. The information submitted will be made publicly available for review by service providers, clients, and other members of the community. The front door lead, in consultation with the City CoC's Service Delivery Committee and the County CoC's Planning Committee, shall develop a questionnaire that housing providers must complete and submit to the front door lead at least once annually, as well as any time eligibility criteria, the outline of the enrollment process, or services change. Completed program information sheets must be available online and must be made available in printed format upon request. In addition, a copy of the completed program information sheet will be provided to clients when they are offered a potential housing opportunity to allow them to make an informed decision regarding whether to accept the housing opportunity.

Acuity Reassessment by Housing Providers

Housing providers are permitted, but not required, to complete the full SPDAT assessment with clients who are not yet housed by their project if they believe the referred client may not be an appropriate fit for their project. If the results of the full SPDAT suggest that a different housing intervention is more appropriate, the housing provider may bring the case to the acuity review panel to request that the individual be updated or placed back onto the list with a SPDAT-determined acuity score.

Program Acceptance Expectations

Programs that are mandated to participate in coordinated entry must accept at least 75% of referrals for clients who meet the basic eligibility criteria as defined in the program information sheet each grant cycle. Referrals will only be provided when a program notifies the front door lead that it has openings.

When a referral is made, the project must work with the client's housing navigator to ensure that an eligibility appointment is scheduled to occur within the first week of receiving the referral (assuming no extenuating circumstances). After the eligibility appointment, the project has 2 business days to notify the housing navigator if the client has been determined (1) eligible, (2) eligible pending receipt of required documentation, or (3) not eligible. The housing navigator must notify the client as quickly as possible, and if the client was deemed eligible pending documentation, must work with the client and the housing project to gather all required

documentation. The client and housing navigator must be allowed a minimum of 10 business days to gather required documentation before a project may cancel the referral due to lack of documentation.

A program shall be deemed to have "declined" a referral if all of the following criteria are met:

- The client has been referred to the project by coordinated entry
- The client meets the eligibility criteria as defined on the program information sheet
- The client has expressed interest in being housed by the project
- The client has agreed to follow all requirements of the housing project
- The housing provider has notified the front door lead of an available, applicable unit for the client
- The project does not make a housing offer to the client

In the event a program declines a referral, the client will be returned to the prioritization list, and the next applicable client will be referred to the housing opening.

A program may "cancel" a referral in the following circumstances. A canceled referral shall be excluded from the calculation of the rate of acceptance for each project as long as the appropriate requirements are met.

- The client has rejected the housing opportunity. Agencies are required to document the client's reason for rejecting the housing opportunity and submitted for recordkeeping. When reasonably possible, the documentation will include the client's signature. The client will be returned to the prioritization list and the next applicable client will be referred to the opening. Clients may reject an unlimited number of housing opportunities, but must be made aware that there may be not be another offer, or the next offer may be significantly delayed. In addition, if a client rejects a housing opportunity, the housing navigator is strongly encouraged to work with the client to determine what the client is seeking in a housing opportunity to ensure that the housing opportunities offered are meeting the client's needs.
- The client cannot be contacted or located. The housing provider must document a minimum of 3 attempts to contact the client via the housing navigator, directly via available contact information, or through the weekly housing matching meeting (if the client has agreed to allow their name to be used during the weekly housing matching meeting) and that the client has been provided at least 24 hours to respond to any messages (e.g., voicemails, emails, or text messages). Multiple attempts to contact the client on the same day, while encouraged, may only be counted as one attempt. Documentation of a minimum of three failed attempts to reach the client must be submitted for recordkeeping. If a client is unable to be contacted for three different housing offers, they will be deemed "disappeared" and will be moved to an inactive list and will not be considered for additional openings unless they return to a front door and are reactivated.
- The client does not meet the eligibility criteria as defined on the program information sheet. An explanation of the reason the client does not meet the eligibility criteria must be submitted for recordkeeping. The client will be returned to the list and the next applicable client will be referred to the opening.
- The client's acuity score has been reevaluated using a full SPDAT and the acuity review panel has agreed that the client is not an appropriate fit for the housing project. The client will be returned to the list and the next applicable client will be referred to the opening.
- The client and housing navigator have not produced minimum required documentation within 10 business days of being notified that the client has been determined eligible pending receipt of required documentation. A list of the documentation required that was not received must be submitted for recordkeeping. If the client and housing navigator are not able to produce the minimum required

documentation within 10 business days, the client will return to the prioritization list and the next applicable client will be referred to the opening.

Section 5: Expectations of Other Groups

Front Door Lead

The front door lead has the following responsibilities:

- Organize and lead Weekly Housing Matching Meetings, including setting a location and ensuring that participating agencies are given the date, time, and location of each meeting a minimum of 24 hours in advance.
- Develop potential matches for housing openings and bring them to the weekly housing matching meeting for discussion, adjustment, and approval.
- Solicit feedback from clients participating in coordinated entry at least once each year in accordance with section 12 of this document.
- Provide quarterly narratives regarding the status of coordinated entry as defined in *Quarterly Reports and Recommendations* in accordance with section 12 of this document.

HMIS Lead

The HMIS lead has the following responsibilities:

- Provide training to all applicable HMIS users to ensure that functions of the coordinated entry system within the HMIS are recorded properly.
- As possible, setup and customize the HMIS to gather and report on data needed for coordinated entry.
- Ensure the HMIS generates the prioritization list in accordance with the defined prioritization criteria.
- Provide quarterly reports on coordinated entry within HMIS as defined in *Quarterly Reports and Recommendations* in section 12 of this document.

Prioritization List Review Team

The prioritization list review team is responsible for reviewing the combined prioritization list to ensure that it has been combined and sorted by the HMIS lead in accordance with this manual.

The prioritization list review team is made up of one representative from each of the following:

- The front door lead
- The HMIS lead
- A domestic violence victim services provider
- A service provider in the St. Louis City CoC
- A service provider in the St. Louis County CoC
- A youth services provider

Acuity Review Panel

The acuity review panel is designed to address issues that arise for clients with the most difficult/challenging barriers and the accuracy of the assessment process in making an appropriate referral. Acuity review panel members will be nominated by the Service Delivery Committee. The terms will run from October 1 through September 30 of each year. Individuals may be appointed and confirmed for an unlimited number of consecutive terms if nominated each year by the Service Delivery Committee.

The members of the panel will be made up of 2 to 5 representatives from each of the following provider types.

- Youth services provider
- Domestic violence victim services provider
- Street outreach provider
- Emergency shelter provider
- Transitional housing or rapid rehousing provider
- Permanent supportive housing, permanent housing only, or permanent housing with services provider
- Veteran services provider

Coordinated Entry Monitoring Workgroup

The coordinated entry monitoring workgroup is responsible for carrying out the duties listed in Section 12 of this manual. The workgroup's membership will include, but is not limited to, representatives of the following:

- The lead front door
- Each funded front door (as defined in section 2)
- The HMIS lead agency
- The St. Louis City CoC (appointed/selected by City CoC's Executive Board)
- The St. Louis County CoC (appointed/selected by the County CoC's Executive Board)

In addition, representatives of other participating agencies are permitted to participate.

Section 6: Assessment Procedures

In accordance with CPD-17-01: *Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System*, "[t]he assessment and prioritization process cannot require disclosure of specific disabilities or diagnoses. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals" (p. 14).

Designated Assessment Tools

The VI-SPDAT and the full SPDAT are the designated assessment tools for the coordinated entry system.

Population	VI-SPDAT Tool	Full SPDAT Tool
Unaccompanied individuals at-risk of homelessness	PR-VI-SPDAT 1.0 for Single Adults	Not applicable
Households with two or more individuals at-risk of homelessness	PR-VI-SPDAT 1.0 for Families	Not applicable
Unaccompanied individuals ages 25 and above who are homeless	VI-SPDAT 2.0	SPDAT 4.0
Unaccompanied individuals ages 24 and under who are homeless	TAY-VI-SPDAT 1.0	Y-SPDAT 1.0
Households with two or more individuals, regardless of age, who are homeless	VI-F-SPDAT 2.0	F-SPDAT 2.0

Client Assessment Process for Walk-in Front Doors

In order to be placed onto the HMIS-based prioritization list or referred to appropriate prevention services, the following steps will be completed for each household. Clients working with street outreach providers or emergency shelters that do not participate in HMIS must be informed of the ability to go to walk-in front doors for assessment and placement onto the prioritization list.

1. **Prescreen for Eligibility and Interest**
   Determine if client is eligible for prevention or other housing services available in the CoCs. If potentially eligible, briefly explain the coordinated entry system and determine if the client wishes to proceed with an assessment. If the client does wish to proceed and is part of the population served by the front door, continue. If the client does wish to proceed but is not part of the population served by the front door, make a warm referral to an applicable front door. Otherwise, provide client with other applicable referrals to mainstream resources.
2. **Gather Client Consent**
   Have the client sign the Coordinated Entry Participation Agreement.[8] Providers screening for prevention services may gather verbal consent and document it on the form if absolutely necessary, though written consent should be gathered to the greatest extent possible. However, providers assessing for placement onto the prioritization list must gather written consent.
3. **Complete Project Intake and/or Gather Minimum Required Demographics**
   If required by funding source(s), the front door will conduct a standard intake into the project prior to completing the coordinated entry assessment. If the funding source does not require a standard project intake, or if the standard project intake does not gather all minimum required demographics and consent forms, the front door will gather the minimum required demographics.
4. **Complete Applicable Coordinated Entry Assessment(s)**

[8] In accordance with CPD-17-01, page 13, section 12a.

Complete the St. Louis Front Door/Coordinated Entry Assessment, including the VI-SPDAT. If a VI-SPDAT has previously been recorded in the HMIS, a new VI-SPDAT will be completed only if one or more of the following circumstances exist:

- The VI-SPDAT on file is the wrong type for the current housing crisis (e.g., PR-VI-SPDAT on file when a VI-SPDAT is required).
- The client has had a significant change in their life that will most likely result in an increase or decrease of at least one point on the VI-SPDAT (e.g., attacked or beaten up, change in employment status, new medical diagnosis).
- The VI-SPDAT present in the database was completed during a different episode of homelessness.
- It has been more than 6 months since the most recent VI-SPDAT was completed.
- The household composition has changed (household members have joined or left, including birth of a child).

5. **Verify Eligibility and Place Client onto Prioritization List or Make Referral to Prevention Project**
   Verify that the client's VI-SPDAT score is within the applicable range to receive services and that no information has been disclosed during the assessment that results in the client being ineligible for services (e.g., stably housed). Unless information has been disclosed that clearly determines the client is ineligible for services, the assessor records the placement onto the prioritization list or refers the household to an appropriate prevention project.
6. **Provide Client with Participant Rights and Expectations Packet**

Client Assessment Process for HMIS-participating Street Outreach Providers

In order for clients working with street outreach providers to be placed onto the HMIS-based prioritization list, the following steps will be completed for each household. This process is intended to align with HMIS data collection requirements.

1. **Record Project Start Information in HMIS**
   At first contact with an individual living in a place not meant for habitation, the street outreach provider will begin gathering information and will put information provided by the client into the HMIS.
2. **Complete Project Enrollment**
   Once the client has been deemed "engaged," the outreach provider will gather any remaining data to complete project enrollment and record it in the HMIS. At the point that a client is deemed engaged, the street outreach provider must offer the opportunity for assessment and placement onto the prioritization list within 7 days.
3. **Prescreen for Interest**
   Briefly explain the coordinated entry system and determine if the client wishes to proceed with an assessment. If the client does wish to proceed, continue. Otherwise, provide client with other applicable referrals to mainstream resources and services available via the street outreach project.
4. **Gather Client Consent**
   Have the client sign the Coordinated Entry Participation Agreement.[9]
5. **Complete Applicable Coordinated Entry Assessment(s)**
   Complete the St. Louis Front Door/Coordinated Entry Assessment, including the VI-SPDAT. If a VI-SPDAT has previously been recorded in the HMIS, a new VI-SPDAT will be completed only if one or more of the following circumstances exist:

[9] In accordance with CPD-17-01, page 13, section 12a.

- The VI-SPDAT on file is the wrong type for the current housing crisis (e.g., PR-VI-SPDAT on file when a VI-SPDAT is required).
- The client has had a significant change in their life that will most likely result in an increase or decrease of at least one point on the VI-SPDAT (e.g., attacked or beaten up, change in employment status, new medical diagnosis).
- The VI-SPDAT present in the database was completed during a different episode of homelessness.
- It has been more than 6 months since the most recent VI-SPDAT was completed.
- The household composition has changed (household members have joined or left, including birth of a child).

6. **Verify Eligibility and Place Client onto Prioritization List**
   Verify that the client's VI-SPDAT score is within the applicable range to receive services and that no information has been disclosed during the assessment that results in the client being ineligible for services (e.g., stably housed). Unless information has been disclosed that clearly determines the client is ineligible for services, the assessor records the placement onto the prioritization list.
7. **Provide Client with Participant Rights and Expectations Packet**

Client Assessment Process for HMIS-participating Emergency Shelters

In order for clients living in emergency shelters to be placed onto the HMIS-based prioritization list, the following steps will be completed for each household. This process is intended to align with HMIS data collection requirements.

1. **Complete Project Enrollment**
   During intake, the emergency shelter will gather all required data to complete project enrollment and record it in the HMIS. The emergency shelter must offer the opportunity for assessment and placement onto the prioritization list within 7 days of shelter move-in.
2. **Prescreen for Interest**
   Briefly explain the coordinated entry system and determine if the client wishes to proceed with an assessment. If the client does wish to proceed, continue. Otherwise, provide client with other applicable referrals to mainstream resources and services available via the emergency shelter project.
3. **Gather Client Consent**
   Have the client sign the Coordinated Entry Participation Agreement.[10]
4. **Complete Applicable Coordinated Entry Assessment(s)**
   Complete the St. Louis Front Door/Coordinated Entry Assessment, including the VI-SPDAT. If a VI-SPDAT has previously been recorded in the HMIS, a new VI-SPDAT will be completed only if one or more of the following circumstances exist:
   - The VI-SPDAT on file is the wrong type for the current housing crisis (e.g., PR-VI-SPDAT on file when a VI-SPDAT is required).
   - The client has had a significant change in their life that will most likely result in an increase or decrease of at least one point on the VI-SPDAT (e.g., attacked or beaten up, change in employment status, new medical diagnosis).
   - The VI-SPDAT present in the database was completed during a different episode of homelessness.
   - It has been more than 6 months since the most recent VI-SPDAT was completed.

[10] In accordance with CPD-17-01, page 13, section 12a.

- The household composition has changed (household members have joined or left, including birth of a child).

5. **Verify Eligibility and Place Client onto Prioritization List**
   Verify that the client's VI-SPDAT score is within the applicable range to receive services and that no information has been disclosed during the assessment that results in the client being ineligible for services (e.g., stably housed). Unless information has been disclosed that clearly determines the client is ineligible for services, the assessor records the placement onto the prioritization list.
6. **Provide Client with Participant Rights and Expectations Packet**

Client Assessment Process for Domestic Violence Emergency Shelters

In order for clients living in domestic violence shelters who are mandated to participate in coordinated entry to be placed onto the prioritization list, the following steps will be completed for each household.

1. **Complete Project Enrollment**
   During intake, the domestic violence emergency shelter will gather all required data to complete project enrollment and record it in their HMIS-comparable database. The domestic violence emergency shelter must offer the opportunity for assessment and placement onto the prioritization list within 7 days of shelter move-in.
2. **Prescreen for Interest**
   Briefly explain the coordinated entry system and determine if the client wishes to proceed with an assessment. If the client does wish to proceed, continue. Otherwise, provide client with other applicable referrals to mainstream resources and services available via the domestic violence emergency shelter project.
3. **Gather Client Consent**
   While domestic violence victim service providers are exempt from utilizing the CoC-mandated Coordinated Entry Participation Agreement, each domestic violence victim service provider must ensure that clients are notified about the type of information that will be disclosed in order to place the client onto the prioritization list, and that the client consents to the disclosure of that information. The domestic violence emergency shelter must have procedures that ensure that client consent is documented in a manner that meets HUD's requirements as found in CPD-17-01, page 13, section 12a.
4. **Complete Applicable Coordinated Entry Assessment(s)**
   Complete the St. Louis Front Door/Coordinated Entry Assessment, including the VI-SPDAT. If a VI-SPDAT has previously been completed with the domestic violence victim service provider, a new VI-SPDAT will be completed only if one or more of the following circumstances exist:
   - The VI-SPDAT on file is the wrong type for the current housing crisis (e.g., PR-VI-SPDAT on file when a VI-SPDAT is required).
   - The client has had a significant change in their life that will most likely result in an increase or decrease of at least one point on the VI-SPDAT (e.g., attacked or beaten up, change in employment status, new medical diagnosis).
   - The VI-SPDAT available was completed during a different episode of homelessness.
   - It has been more than 6 months since the most recent VI-SPDAT was completed.
   - The household composition has changed (household members have joined or left, including birth of a child).
5. **Verify Eligibility and Place Client onto Prioritization List**
   Verify that the client's VI-SPDAT score is within the applicable range to receive services and that no information has been disclosed during the assessment that results in the client being ineligible for

services (e.g., stably housed). Unless information has been disclosed that clearly determines the client is ineligible for services, the assessor sends the de-identified prioritization information to the HMIS lead for placement onto the prioritization list.

6. **Provide Client with Participant Rights and Expectations Packet**

Client Assessment Process for Virtual Front Doors

Virtual front doors, which include front doors where clients call in or use another method of electronic or written communication, are only permitted for assessing clients for prevention services at this time.

1. **Prescreen for Eligibility and Interest**
   Determine if client is eligible for prevention services available in the CoCs. If potentially eligible, briefly explain the coordinated entry system and determine if the client wishes to proceed with an assessment. If the client does wish to proceed and is part of the population served by the front door, continue. If the client does wish to proceed but is not part of the population served by the front door, make a warm referral to an applicable front door. Otherwise, provide client with other applicable referrals to mainstream resources.
2. **Gather Verbal Client Consent**
   Explain the Coordinated Entry Participation Agreement[11] and ask for verbal consent. Document the verbal consent appropriately.
3. **Complete Project Intake and/or Gather Minimum Required Demographics**
   If required by funding source(s), the front door will conduct a standard intake into the project prior to completing the coordinated entry assessment. If the funding source does not require a standard project intake, or if the standard project intake does not gather all minimum required demographics and consent forms, the front door will gather the minimum required demographics for prioritization list placement.
4. **Complete Applicable Coordinated Entry Assessment(s)**
   Complete the St. Louis Front Door/Coordinated Entry Assessment, including the VI-SPDAT. If a VI-SPDAT has previously been recorded in the HMIS, a new VI-SPDAT will be completed only if one or more of the following circumstances exist:
   - The VI-SPDAT on file is the wrong type for the current housing crisis (e.g., PR-VI-SPDAT on file when a VI-SPDAT is required).
   - The client has had a significant change in their life that will most likely result in an increase or decrease of at least one point on the VI-SPDAT (e.g., attacked or beaten up, change in employment status, new medical diagnosis).
   - The VI-SPDAT present in the database was completed during a different episode of homelessness.
   - It has been more than 6 months since the most recent VI-SPDAT was completed.
   - The household composition has changed (household members have joined or left, including birth of a child).
5. **Verify Eligibility and Make Referral to Prevention Project**
   Verify that the client's PR-VI-SPDAT score is within the applicable range to receive services and that no information has been disclosed during the assessment that results in the client being ineligible for services (e.g., stably housed). Unless information has been disclosed that clearly determines the client is ineligible for services, the assessor refers the household to an appropriate prevention project.

[11] In accordance with CPD-17-01, page 13, section 12a.

6. **Provide Client with Participant Rights and Expectations Packet**
   Provide the client with the website address where information about coordinated entry, including a downloadable version of the *Participant Rights and Expectations Packet,* may be found, or send the *Participant Rights and Expectations Packet* via email to the client.

Section 7: Housing Matching Process

Preparation for Housing Matching Meetings

Gathering List of Housing Openings

The front door lead will email all PoCs a request for all available housing units by 9:00am each Monday. Housing providers must respond by 9:00am each Tuesday in accordance with the *Notification of Housing Availability* policy in section 4. The front door lead will compile submitted housing openings and bring them to the weekly housing matching meeting each Wednesday.

Generation of the Prioritization List

The HMIS lead will generate an updated prioritization list from the HMIS on Tuesday morning and merge in the deidentified information provided by domestic violence service providers by 10:00am each Tuesday. The list is then reviewed by the prioritization list review team and approved by 12:00pm for submission to all designated prioritization list recipients by 3:00pm each Tuesday. The HMIS lead will also generate and bring the approved detailed prioritization list to the weekly housing matching meeting each Wednesday (see section 10).

Running/Updating Client List Reports from HMIS

Each participating emergency services provider and housing provider must run applicable coordinated entry reports from the HMIS (domestic violence victim services providers exempted) and must verify that the information in the report is accurate. Any inaccurate information must be updated in a timely manner. The updated reports should be brought to the meeting in order to facilitate quick use of client ID numbers during meetings, but must not be shared with other providers at the meeting.

Weekly Housing Matching Meetings

The front door lead will organize and coordinate weekly housing matching meetings, which will occur each Wednesday from 12:00pm to 1:00pm. At least one staff member from each agency with a funded shelter, street outreach project, or housing project is required to attend at least 80% of the weekly housing matching meetings each grant cycle. In the rare event that there are no housing openings and no referrals to follow-up on, the front door lead may cancel the weekly housing matching meeting for the week. The front door lead may cancel or reschedule the meeting for holidays, special events, or emergencies; but is urged to do so rarely. No more than 2 consecutive meetings may be canceled or rescheduled.

Confidentiality Agreement

All meeting attendees, facilitators, and others present in the room (e.g., maintenance workers, technical support) will be required to sign a confidentiality agreement before entering the meeting each week. Any individual who violates the confidentiality agreement may be subject to penalties including, but not limited to, permanent prohibition from attending weekly housing meetings.

Matching Clients to Housing Openings and Ensuring Collaboration

The front door lead will present a list of clients who are next for housing openings. The list of clients must have the same number of openings reported. The front door lead will present possible housing matches to the individuals at the meeting. The meeting attendees may request to “swap” clients between openings to ensure the best possible match for each client’s needs. However, no clients may be added or removed from the list except in the event that a client is known to be not currently in need of housing assistance (e.g., housed, incarcerated or institutionalized for a significant period of time, deceased). In the event a client is removed from the list because they are not currently in need of housing assistance, the front door lead shall add clients who

are next for housing openings to the list. Once clients have been matched to openings, the housing navigator for the client is expected to work with the client and the agency providing the potential housing opportunity to ensure an eligibility interview is scheduled as quickly as reasonably possible.

Review of Outstanding Referrals to Ensure Accountability

The front door lead will ask each housing provider to present status updates on any clients who meet the following criteria:

1) A referral for a client who has no status update within the HMIS but was referred at least 7 days ago.
2) A referral for a client who is not yet recorded as housed within the HMIS but was referred at least 30 days ago.

Examples of status updates that may be shared at weekly housing matching meetings include:

- "We have not been able to contact client 1234 to schedule an eligibility interview. We have contacted the housing navigator who is also unable to contact or locate the client. We would appreciate any help to find client 1234."
- "Client 14567 has multiple barriers to housing and we are having difficulty finding a landlord who will accept them due to their criminal record and poor credit history. We continue to look for landlords who are willing to work with the client."
- "We have been working with client 54320 to identify housing options, but have not found any units at this time that are within walking distance of the client's workplace. We continue to work with the client to search for housing options."

These updates will be provided in order to allow housing providers to notify the attendees at the weekly housing matching meeting if they are having any difficulties in locating or housing clients who have been referred to them. Those in attendance may be able to offer additional support or ideas when challenges are disclosed, such as landlords who are willing to work with those with criminal records or agreeing to help search for a client.

Acuity Review Panel Meeting

The acuity review panel will meet at 1:00pm each Wednesday in the same location as the Weekly Housing Matching Meeting if there are cases to review. The acuity review panel is designed to review the following cases:

- A client VI-SPDAT refusal takes place
- The assessor has been determined the client is not competent to complete the VI-SPDAT assessment
- The assessor believes that the client's VI-SPDAT score does not properly reflect the client's situation
- A client is placed in a housing program and it is determined that the client needs to go to another program option, including lateral moves between permanent housing projects
- Two housing providers reject the same client
- Involuntary termination[12]

[12] If a client is to be involuntarily terminated from a program, the agency must notify the front door lead. The review panel will discuss appropriate placement and follow up. In cases where the client poses an immediate threat to self or others, the provider will seek emergency removal as needed to ensure safety. In cases where the client will not be returned to the program, the front door lead will be notified of the removal within 24 hours and the case will be referred to the housing review panel. The program exiting the client from services will refer the client back to the front door lead for housing/shelter planning/referral.

Before a case can be reviewed by the acuity review panel for adjusting or setting placement on the prioritization list (e.g., refusal to complete VI-SPDAT, inability to complete VI-SPDAT, or VI-SPDAT does not accurately reflect client's situation) or for lateral moves between housing, the client's primary housing navigator must complete a full SPDAT. If the agency has access to ServicePoint, it must be recorded in ServicePoint. After completed, the housing navigator or case manager must contact their agency's PoC to request that the acuity panel review the case. If the review panel is meeting because a client has been rejected for two referrals or due to an involuntary termination, a full SPDAT is recommended but not required.

Only one representative from each of the listed provider types will vote at each acuity review panel meeting (see section 5). A minimum of five voting representatives must be present in order to take votes. Those nominated to serve on the panel for the same provider type must coordinate together to ensure that one representative will be present for each meeting to the greatest extent possible.

The client's housing navigator may meet with the acuity review panel to provide background and information regarding the client's situation or may submit a request that explains the client's situation in writing. Any documentation provided to the panel, including the full SPDAT, must have the client's name and any other identifying information redacted to ensure client confidentiality and to prevent biased decisions. The panel, using the completed full SPDAT and other information provided by the housing navigator and case workers, will develop a list of possible next steps which the client's housing navigator will review with the client.

In the event that the review panel is meeting to consider changing the placement of an individual on the prioritization list, the panel will vote whether to utilize the full SPDAT score to determine the acuity score in place of the acuity score determined based upon the VI-SPDAT score. A simple majority is required to utilize the full SPDAT score to determine the acuity score in place of the VI-SPDAT determined acuity score in the prioritization list.

Note: If a client scores for PSH but does not have a disability, the case does not have to be brought to the Acuity Review Panel to have the recommendation adjusted to RRH. The client's housing navigator may email the change request to the front door lead (using the client ID number). The request must state that the client should be adjusted from PSH to RRH and must include an explanation as to why the client does not meet the minimum eligibility criteria for any PSH projects (e.g., not disabled). In the event that the reason a client is being adjusted from PSH to RRH due to a lack of a documented disability, the assessing agency must have taken reasonable steps to provide the client with the opportunity to be examined for or receive documentation of a disability prior to submitting the request to the front door lead. Upon receipt, the front door lead will change the housing recommendation within the HMIS, but the acuity score itself will not be changed because the acuity score may only be changed with approval from the Acuity Review Panel after reviewing a full SPDAT.

The front door lead will document the outcome of all acuity review panel meetings within the HMIS, with the exception of clients added to the prioritization list by domestic violence victim services providers.

After the Weekly Housing Matching Meetings

Scheduling Eligibility Interview and Updating Referral Status

The housing provider has 48 hours from the receipt of the referral at the weekly housing matching meeting to work with a provider who is currently working with the client to schedule the eligibility interview with the client, which should take place within 7 days of the receipt of the referral (assuming no extenuating circumstances). The referral status will be documented using one of the following options (shown in the order they are available in ServicePoint):

- **– Select –** : The agency has not yet scheduled the eligibility interview.
- **Accepted:** The client has been housed by the project.
- **Accepted on Waitlist:** Clients should have this status from the point that the housing provider has scheduled an eligibility interview with the client to the point they are housed or the referral is canceled or declined.
- **Canceled:** *Cancelations are on the part of the client.* The housing provider has contacted the client and has determined that the client does not want or need housing assistance from their agency, OR the agency has made multiple attempts to contact the client and has been unable to do so. Reason for cancelation is recorded within the HMIS. The housing provider must notify the front door lead.
- **Declined:** *Declinations are on the part of the agency.* The housing provider has determined that they cannot serve this particular client. The reason for the declined referral is recorded within the HMIS. The housing provider must notify the front door lead.

Closing Prioritization List Referral at Housing Move-In

The housing provider will take the client off of the prioritization list when the client moves into the permanent housing unit. If the housing provider is unable to see the placement onto the prioritization list due to visibility settings within the HMIS, they must send an email to the HMIS lead's helpdesk containing the client ID, the date the client moved into the unit, and the project that housed the client so that the client may be correctly removed from the prioritization list by the HMIS lead's helpdesk.

Section 8: Minimum Service Standards

Housing Navigation Services

The housing navigator is the main point-of-contact for each homeless individual or family. When necessary, the housing navigator will complete the full SPDAT and advocate on behalf of the client during the Acuity Review Panel process.

The housing navigator has the responsibility of working with the client to gather all required documentation so that they client can be deemed "document ready." In addition, the housing navigator will provide support and referrals, including but not limited to: coordination of services, in-person support for clients with mental or physical health concerns, and benefit enrollment.

The housing navigator will assist the client in searching for housing opportunities both inside and outside of the homeless service system, including affordable housing units, market rate housing, and financial assistance from other providers (e.g., one-time assistance or ongoing rental assistance programs) as needed to obtain and maintain stable housing. The housing navigator will provide additional support to clients once a housing placement is made to ensure a smooth transition to the new housing placement.

Documentation that housing navigators will help clients gather or obtain includes, but is not limited to:

- Birth certificate(s)
- Social Security card(s)
- Government-issued photo identification
- Documentation of disabilities (if applicable)
- Proof of income or zero income statement
- Verification of homelessness
- Veterans only: DD-214

The housing navigator also has the responsibility of identifying possible housing barriers and working to address them when reasonably possible. Housing barriers that the housing navigator may identify and work to address include, but are not limited to:

- Poor rental history (including history of evictions)
- Poor credit history
- Criminal history
- Lack of employment or other income
- Rental and utility arrears

Housing projects may not use the criteria above to deny services to a client unless required by law.

Case Management Services

The case manager provides services to clients currently in transitional and permanent housing programs to assist them in maintaining their housing or transitioning to permanent housing. If the client may need to be moved between housing projects, the case manager will complete the full SPDAT and advocate on behalf of the client during the Acuity Review Panel process.

Case managers also provide support and referrals, including but not limited to: coordination of services, in-person support for clients with mental or physical health concerns, benefit enrollment, and landlord/tenant mediation.

Case managers also utilize the full SPDAT to guide case management services. Certified case managers are responsible for completing the full SPDAT within 7 days of move-in to housing, and updating the full SPDAT every 6 months. Projects that are mandated to enter data into the HMIS must record the scores for each domain of the full SPDAT within the HMIS software for community-wide reporting.

In accordance with the Housing First philosophy, clients have the option to decline case management services. Housing projects are required to document if a client declines case management services within the client's record.

Section 9. Required Training

In accordance with HUD guidelines, individuals performing the following functions of the coordinated entry system must complete required trainings for each role and receive a refresher training each year. The certification will be deemed valid for one year from the date of the training. The required trainings will be offered a minimum of once each year, and will also be made available in a self-study format (e.g., recorded webinars, online classes) to the greatest extent possible.

In the St. Louis Coordinated Entry system, there are multiple roles for which individuals may be certified: certified assessor, certified housing navigator, certified case manager, and certified acuity panel review member. Each role and applicable trainings are defined below. Individuals may be certified in one or more of the following. In addition, certifications are transferable in the event an individual changes organizational affiliation.

Roles

Coordinated Entry-Certified Assessor

Assessors are the individuals responsible for completing the initial assessment of clients who are believed to meet minimum eligibility requirements for programs that serve individuals who are at risk of or experiencing homelessness. They are responsible for completing applicable assessments and providing appropriate mainstream referrals at front doors. All front doors must have at least one certified assessor, as must shelters and street outreach providers who are mandated to participate in coordinated entry. Only certified assessors may complete assessments for prevention or prioritization.

Coordinated Entry-Certified Housing Navigator

The housing navigator is the main point-of-contact for each homeless individual or family. The housing navigator has the responsibility of helping clients gather documentation, navigate the process of searching for housing opportunities, and ensure clients are aware of available benefits. Each shelter and street outreach provider who is mandated to participate in coordinated entry must have at least one certified housing navigator. Individuals who are not certified housing navigators may provide housing navigation services under the guidance of a certified housing navigator.[13]

Coordinated Entry-Certified Case Manager

Once a client is in housing, the case manager is responsible for working with clients to ensure they are able to maintain their housing. Each transitional, rapid rehousing, or permanent supportive housing project that is mandated to participate in coordinated entry must have a minimum of one certified case manager. Individuals who are not certified case managers may provide case management services under the guidance of a certified case manager.[14]

Coordinated Entry-Certified Acuity Reviewer

Acuity reviewers are individuals authorized to vote on the Acuity Review Panel. In addition to the training requirements below, acuity reviewers must also be appointed by the Service Delivery Committee.

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[13] Utilizing the full SPDAT requires specialized training. The full SPDAT may not be completed by an untrained individual, even under guidance of a certified housing navigator.

[14] Utilizing the full SPDAT requires specialized training. The full SPDAT may not be completed by an untrained individual, even under guidance of a certified case manager.

Trainings

Prioritization and Prevention Assessment Training

Required for certified assessors, certified housing navigators and certified acuity reviewers.
Recommended for certified case managers.

Full SPDAT training

Required for certified housing navigators, certified case managers and certified acuity reviewers.
Recommended for certified assessors.

Cultural and Linguistic Competency Training

Required for certified assessors, certified housing navigators, and certified case managers.
Recommended for certified acuity reviewers.

Trauma-informed Care and Safety Planning

Required for certified assessors, certified housing navigators, and certified case managers.
Recommended for certified acuity reviewers.

Section 10: Prioritization

Non-Prioritized Housing Crisis Interventions

Emergency Shelter

Emergency shelter beds are not prioritized. All beds function on a first-come, first-served basis, but all clients must be screened by an emergency services entry point to see if diversion is possible before being offered a bed (if available).

Street Outreach

Street outreach projects will not be prioritized. All clients who are identified as living in places not meant for habitation may be served by street outreach projects if they meet the project's minimum eligibility requirements.

Safe Havens

At the time of the revision of this manual, the region does not have any safe havens. However, if a safe haven project begins operating within the region, it will not be prioritized.

Prioritized Housing Crisis Interventions

Note: The project types listed below are required to follow the prioritization policies for their intervention if required by their funding sources, including, but not limited to: Continuum of Care (CoC) funds, Emergency Solutions Grant (ESG) funds, Missouri Housing Trust Fund (MHTF) funds, Missouri Housing First Program (HFP) funds, and Housing Resource Commission (HRC) funds. Additional funders may require participation in coordinated entry. Projects that are not required to participate in coordinated entry are strongly encouraged to follow these prioritization criteria and participate fully in coordinated entry.

Homelessness Prevention

Homelessness prevention funds will be prioritized using minimum eligibility criteria (e.g., income under defined limits, eviction or disconnect notice), and a minimum PR-VI-SPDAT score. Any client who meets the minimum criteria will be referred to a prevention services provider who will verify eligibility and provide services as applicable.

Rapid rehousing, independent living programs, permanent supportive housing, transitional living programs, and transitional housing programs

Rapid rehousing, independent living programs, permanent supportive housing programs, transitional living programs, and transitional housing programs will receive all clients through the applicable prioritization process described in section 11.

Housing Intervention Prioritization Sorting Criteria

Criterion	Sorting Method
Chronic homeless status	Yes -> No
Acuity score (as defined)	Highest -> Lowest
Risk/Frailty Score	Highest -> Lowest
Approximate date homelessness started	Oldest -> Newest
Date client/household assessed	Oldest -> Newest

Risk/Frailty Score Matrix

Question	Scoring method	VI-SPDAT S/F/TAY #
Where do you sleep most frequently?	If anything other than "shelter," "transitional housing," or "safe haven," score 1.	1/5/1
In the past six months, how many times have you received health care at an emergency department/room?	If 3 or greater, score 1	4a/8a/4a
In the past six months, how many times have you taken an ambulance to the hospital?	If 3 or greater, score 1	4b/8b/4b
In the past six months, how many times have you been hospitalized as an inpatient?	If 3 or greater, score 1	4c/8c/4c
Have you been attacked or beaten up since you've become homeless?	If yes, score 1	5/9/5
Have you threatened to or tried to harm yourself or anyone else in the last year?	If yes, score 1	6/10/6
Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that?	If yes, score 1	9/13/10
Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted?	If yes, score 1*	14/18/15*
Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	If yes, score 1	16/20/17
If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?	If yes, score 1	17/21/18
Is any member of the household pregnant?	If yes, score 1	Not applicable

*TAY-VI-SPDAT only: If yes to one or more of the prompts in question 15; score 1.

VI-SPDAT/SPDAT to Acuity Score Conversion Chart

All clients will be assigned an acuity score using the appropriate tool in the VI-SPDAT Tools section unless use of the full SPDAT score is approved by the Acuity Review Panel, in which case the appropriate tool in the full SPDAT section will be used to determine the acuity score.

VI-SPDAT Tools			Full SPDAT Tools			Acuity Score
VI-SPDAT 2.0	VI-F-SPDAT 2.0	TAY-VI-SPDAT 1.0	SPDAT 4.0	F-SPDAT 2.0	Y-SPDAT 1.0	
0	0	0	0-3	0-4	0-3	0
1	1	1	4-9	5-12	4-9	1
2	2	2	10-15	13-21	10-15	2
3	3	3	16-19	22-26	16-19	3
4	4	4	20-22	27-29	20-22	4
5	5	5	23-27	30-35	23-27	5
6	6	6	28-32	36-42	28-32	6
7	7	7	33-34	43-48	33-34	7
8	8	8	35-36	49-53	35-36	8
9	9	9	37-39	54	37-39	9
10	10	10	40-42	55-56	40-42	10
11	11	11	43-45	57-58	43-45	11
12	12	12	46-47	59-60	46-47	12
13	13	13	48-50	61-62	48-50	13
14	14	14	51-53	63-64	51-53	14
15	15	15	54-56	65-66	54-56	15
16	16	16	57-59	67-68	57-59	16
17	17	17	60	69-70	60	17
	18			71-72		18
	19			73-74		19
	20			75-76		20
	21			77-78		21
	22			79-80		22

The acuity score may not be used in place of a VI-SPDAT or full SPDAT score, nor should it be considered to be a VI-SPDAT or full SPDAT score.

Contents of the Standard Prioritization List

The standard prioritization list includes the following information. This is the list that is emailed to designated representatives once the prioritization list is approved by the prioritization list review committee.

ServicePoint Client ID (or identifier assigned by the domestic violence shelter)

This functions as the sole client identifier on the list, and is assigned by ServicePoint or by the referring domestic violence shelter.

Referring program

This is utilized to facilitate collaboration between the agency who assessed the client and placed them onto the prioritization list.

Chronic status

This indicates whether the client appears to meet the federal definition of chronically homeless according to the information entered into the HMIS database (or gathered by the domestic violence victim service provider).

Acuity score and assessment type

This shows the acuity score for the household and the assessment type utilized to determine the acuity score.

Risk/medical frailty score

This shows the total of the risk/medical frailty score as calculated by the HMIS (or as calculated by the domestic violence victim service provider).

Approximate date homelessness started

This is the date that was entered into the system for the client's approximate date homelessness started. In the event that the approximate date homelessness started is missing or not applicable, the date the client or household was assessed will be utilized.

Date client/household assessed

This is the date the client was assessed and referred to the prioritization list.

Household size

This is utilized for the purpose of identifying appropriately sized households for sponsor-based units that can hold only a specific number of clients.

Age range of head of household

The list indicates whether the head of household is between the ages of 16 and 24 to determine if the client may be eligible for youth-only projects.

Disability status of the head of household

The list includes whether or not the head of household reported a disabling condition during intake. The standard prioritization list contains only a "yes" or "no", and no specific disability information. The list contains this information for the purpose of identifying appropriate clients for projects that require a disabling condition.

Gender of the head of household

The standard prioritization list includes the gender of the head of household. Clients who report being "transgender male to female" will be listed as "female," clients who report being "transgender female to male" will be listed as "male," and clients who report being "gender non-conforming" or do not provide a gender will

be listed as “other” on the standard prioritization list. The list contains this information for the purpose of identifying appropriate clients for congregate living environments that have specific gender requirements.

Veteran status of the head of household

The standard list shows the reported veteran status of the head of household for the purpose of identifying clients for projects that serve only households that contain a veteran. Information regarding branch of service, discharge status, or length of service is not included on the list.

Preferred geographic location of housing

The standard prioritization list includes the preferred geographic location that clients indicate during assessment for potential housing opportunities. Options available include “city only”, “county only”, or “city or county.” In the event that the client does not indicate a preference, they will be assumed to be open to housing opportunities in city or county. This information is included so that clients may be referred only to projects that can place them in their preferred geographic area.

Detailed Prioritization List

The detailed prioritization list will be developed by the HMIS lead agency and brought to housing matching meetings each week. The additional information will be added to the approved standardized prioritization list. The list shall be maintained in an encrypted format, and may not be distributed to any other entities unless the HMIS lead is unable to attend the housing matching meeting, in which case it can be provided to the front door lead.

The list shall include additional information, as described below, only if the client has agreed to share additional eligibility information as indicated on a completed Coordinated Entry Participation Agreement. Clients who have not agreed to share additional information on the Coordinated Entry Participation Agreement or have been referred by domestic violence victim service providers will not have any additional information added when the detailed prioritization list is compiled.

Head of household’s first and last name

If the client consents to allow their name to be utilized during housing matching meetings, the first and last name of the head of household will appear on the detailed prioritization list.

Mental health problem

The detailed prioritization list will indicate “yes” or “no” regarding the client’s reported mental health diagnosis. A “yes” will indicate that the client has indicated they (or a member of their household) do have a mental health problem. The information will be determined utilizing information gathered in the Special Needs Assessment for the head of household, as well as information gathered within the VI-SPDAT. At no point shall the detailed prioritization list indicate specific diagnoses.

Current or past substance abuse

The detailed prioritization list will indicate “yes” or “no” regarding the client’s reported current or past substance abuse. A “yes” will indicate that the client has indicated they (or a member of their household) have or have had a history of substance abuse. The information will be determined utilizing information gathered in the Special Needs Assessment for the head of household, as well as information gathered within the VI-SPDAT. At no point shall the detailed prioritization list indicate specific diagnoses.

Developmental disability/traumatic brain injury diagnosis

The detailed prioritization list will indicate “yes” or “no” regarding the client’s developmental disability/traumatic brain injury status. A “yes” will indicate that the client has indicated they (or a member of their household) have a developmental disability or traumatic brain injury. The information will be determined utilizing information gathered in the Special Needs Assessment for the head of household, as well as information gathered within the VI-SPDAT. At no point shall the detailed prioritization list indicate specific diagnoses.

HIV/AIDS status

The detailed prioritization list will indicate “yes” or “no” regarding the client’s self-reported HIV/AIDS status. A “yes” will indicate that the client has indicated they (or a member of their household) have been diagnosed with HIV/AIDS. The information will be determined utilizing information gathered in the Special Needs Assessment for the head of household, as well as information gathered within the VI-SPDAT. At no point shall the detailed prioritization list indicate specific diagnoses.

Section 11: Eligibility Standards

All projects mandated to participate in coordinated entry must follow the minimum standards as described below. Projects may have additional eligibility criteria as long as the additional criteria align with the Housing First philosophy and do not violate any nondiscrimination policies in this manual; nondiscrimination policies adopted by the CoCs; or any local, state, or federal civil rights laws.

Any projects participating voluntarily in coordinated entry are strongly encouraged to utilize the eligibility standards provided below, but may set special eligibility requirements based upon criteria collected during the coordinated entry assessment process.

Housing Navigation Services

Available to single adults (25+), qualified minors (age 16-17), youth (18-24), and families.

All clients experiencing homelessness are eligible to receive housing navigation services regardless of any other circumstances, including clients otherwise ineligible for services due to an acuity score of 0-3. Housing navigation services are defined in section 8.

Prevention Services

Available to single adults (25+), qualified minors (age 16-17), youth (18-24), and families.

To receive financial assistance through prevention programs, the household must have a PR-VI-SPDAT (single adults or families) score of 4 or higher. Funded prevention programs may utilize additional eligibility criteria as defined by the funder, but may not establish additional eligibility criteria without prior authorization from the Service Delivery Committee.

Rapid Rehousing

Available to single adults (25+), qualified minors (age 16-17), youth (18-24), and families.

To receive assistance through rapid rehousing programs, households must have acuity scores of 4 to 7 (singles and youth), or an acuity score of 4 to 8 (families). In addition, households without a disabled head of household who score 8 or above (singles and youth), or 9 and above (families) are eligible for rapid rehousing. Mandated rapid rehousing programs must follow the housing first philosophy.

In addition, mandated rapid rehousing providers must utilize the set formula established in the Rapid Rehousing Rental Assistance Calculation Worksheet to determine the amount of rental assistance that may be provided to each household while participating in rapid rehousing. The criteria for determining amount of financial assistance is explained in Section 13.

Independent Living Programs

Available to individuals 16 to 24 years of age, and households headed by individuals 16 to 24 years of age.

To receive assistance from an independent living program, households must have acuity scores of 4 to 7 (singles and youth), or an acuity score of 4 to 8 (families). Mandated independent living programs must follow the housing first philosophy.

Permanent Supportive Housing

Available to single adults (25+), qualified minors (age 16-17), youth (18-24), and families.

To receive assistance through permanent supportive housing programs, households must have a head of household with a disabling condition and must have acuity scores of 8 or higher (singles and youth), or 9 or higher (families). In addition, households who score 8 or above (singles and youth), or 9 and above (families) but do not have one or more disabled client are eligible for rapid rehousing. Mandated rapid rehousing programs must follow the housing first philosophy.

Transitional Living Program

Available to individuals 16 to 24 years of age, and households headed by individuals 16 to 24 years of age.

To receive assistance through transitional living programs, households must be headed by an individual 16 to 24 years of age with an acuity score of 8 or higher (singles and youth), or 9 or higher (families). Mandated transitional living programs must follow the housing first philosophy.

Transitional Housing

Available to single adults (25+), qualified minors (age 16-17), youth (18-24), and families.

Transitional housing programs shall be utilized to provide short-term, service-intensive temporary housing to clients who are at the top of the prioritization list who have been determined eligible for rapid rehousing or permanent supportive housing, but have not been stably housed due to the lack of available rapid rehousing or permanent housing openings. While in transitional housing, the client shall be considered homeless and will be on the prioritization list. Clients in transitional housing projects will be considered for rapid rehousing and permanent supportive housing projects in the same manner as an individual receiving services from an emergency shelter or street outreach project.

Section 12: Evaluation and Planning

Evaluation and planning shall be the joint responsibility of the Service Delivery Committee through the Coordinated Entry Monitoring Workgroup, the advocacy committees and consumer councils of the CoCs.

Stakeholder Consultation

The CoCs will solicit feedback at least once annually from participating projects and clients who participated in coordinated entry during the time period. A combination of the following feedback gathering methods will be used to ensure sufficient information is gathered to assess the quality and effectiveness of the coordinated entry system:

- Surveys provided to all participating service providers.
- Surveys, focus groups, or individual interviews to gather information from enough clients to approximate the diversity of participating clients. For the purpose of evaluation, a client is defined as an individual currently engaged in the coordinated entry system or clients who have participated to some extent within the last year.
- Comment/concern forms will be available at all front door locations and from all front door providers at all times. Completed comment/concern forms will be submitted to the Coordinated Entry Monitoring Workgroup.

Quarterly Reports and Recommendations

The HMIS lead shall provide the CoCs with updates regarding the operating status of coordinated entry according to the HMIS database at least once each quarter. In addition, the front door lead will submit to the CoCs a narrative outlining successes, challenges, and recommendations for coordinated entry each quarter. All other participating providers, CoC members, clients, and community members may also submit narratives or reports each quarter. Reports and recommendations must be submitted to the Coordinated Entry Monitoring Workgroup no later than January 15, April 15, July 15, and October 15 or the following business day.

Coordinated Entry Monitoring Workgroup

The coordinated entry monitoring workgroup must meet at least once each quarter shortly after January 15, April 15, July 15, and October 15 to review the comment/concern forms, reports and recommendations submitted each quarter and shall make a report to the Service Delivery Committee to modify or retain the current edition of the Coordinated Entry Policies and Procedures Manual, along with any concerns about participation (or lack thereof) by mandated providers. The report will include project-level information where appropriate. Any recommendations approved by the Service Delivery Committee will be taken to both CoC Executive Boards for approval.

In addition, copies of the report will be made available to the Rank and Review Committees of each CoC and any funders (upon request), who may choose to utilize the information to make decisions regarding compliance with grant agreements and/or future funding decisions.

Reports reviewed by the coordinated entry monitoring workgroup each quarter will include, at minimum:

- Status of the prioritization list (length of time on list, number of households on the list, etc)
- Review of referral process functioning
- Review of appropriate HMIS report(s) regarding clients served, length of stay, outcomes, etc.
- Review of VI-SPDAT refusal rates

- Review of rates of acceptance, cancelations, and declines by participating providers
- Review of rates of referrals to the acuity review panel by participating providers
- Review of number of project entries without a coordinated entry referral

Section 13: Forms, Packets, and Agreements

Coordinated Entry Participation Agreement

The coordinated entry participation agreement must be completed by all clients prior to being placed onto the prioritization list. The agreement explains the basic purpose and design of coordinated entry, and then allows the client to determine (1) if they wish to participate, (2) how much information they authorize to be disclosed, and (3) whether their name may be utilized in weekly housing matching meetings. The form is included in the appendix.

Domestic violence victim service providers are not required to use this form, but must have internal procedures that guarantee that the client has consented to participating in coordinated entry prior to placement onto the prioritization list.

Agreement for Voluntary Front Door Providers

This agreement is utilized to determine what services will be provided by voluntary front doors and which population(s) the front door will serve. The agreement must also contain a written narrative explaining the anticipated steps a client will take when seeking coordinated assessment services from the voluntary front door, and any special requirements or processes that will be in place to serve their populations appropriately. The agreement must be signed by a representative of the agency, a representative of the City CoC, and a representative of the County CoC before the voluntary front door may begin offering assessment services. The form is included in the appendix.

St. Louis Front Door/Coordinated Entry Assessment

The St. Louis Front Door/Coordinated Entry Assessment is programmed into the HMIS software and is designed to gather all information required to place a client onto the prioritization list. While the form must be completed within the HMIS (domestic violence victim service providers exempted), a paper version of the assessment is included in the appendix for use in the event that the information must be gathered while access to the HMIS is not available.

Rapid Rehousing Rental Assistance Calculation Worksheet

This worksheet takes into consideration the following when determining the appropriate amount of rental assistance that is provided to each participant in rapid rehousing: annual income, income exclusions, dependent allowances, child care allowances, disabled assistance allowances, medical expenses allowances, elderly family allowances, and utility allowances. The worksheet is attached to this manual in the appendix.

Participant Rights and Expectations Packet

All participants shall be provided a copy of the Participant Rights and Expectations Packet at the time they are assessed and placed onto the prioritization list or referred to an appropriate prevention services provider. The packet must describe, at minimum:

- The purpose of coordinated entry
- What to expect as a participant in coordinated entry
- Requirements of participants in coordinated entry
- How to file a grievance or nondiscrimination complaint

The packet is included in the appendix of this document, and must also be made available online.