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The West Virginia Balance of State Continuum of Care developed the following Coordinated Entry standards to ensure:

- program accountability to promote consistent services for all population groups experiencing homelessness; specifically, those who are experiencing chronic homelessness or are high-need/high-acuity,
- program compliance with HUD Rules and guidance,
- provision of resources in a uniform and transparent manner across the CoC geographic area,
- standardization of assessment, prioritization, and housing placement consistency,
- coordination among federal, state, and locally-funded partners serving persons experiencing homelessness, including the integration of mainstream resources and faith-based organizations into the system, and
- adequate program staff competence and training to create an environment, locally and CoC-wide, of coordination, consistency and speed in housing placement.

Introduction to Coordinated Entry

Coordinated Entry is defined as a process designed to coordinate program participant intake, assessment, and provision of referrals. It covers the entire geographic area served by the CoC, is readily available to all population groups seeking housing and services, is well advertised, and includes a comprehensive and standardized assessment tool.

The process of Coordinated Entry can be implemented regardless of geography, housing stock, service availability, or community characteristics. Almost any model of Coordinated Entry can be applied to any community or situation, and can be successful with patience, persistence, testing, and modification.

Coordinated Entry, when implemented correctly, can help to prioritize individuals and families who need housing the most across communities. Beyond program confinement, and beyond silos, Coordinated Entry can create a collaborative, objective environment across a community that can provide an informed way to target housing and supportive services to:

1. Divert people away from the system who can solve their own homelessness.
2. Quickly move people from street to permanent housing.
3. Create a more defined and effective role for emergency shelters and transitional housing.
4. Create an environment of less time, effort, and frustration on the part of case managers.
5. End homelessness across communities, versus program by program.

Traditionally, the system of entry and referral to housing and service supports was based on a “first-come, first-served” basis and in some places still is; however, we have shifted the way we do business after years of research, re-thinking, and a commitment to moving away from the linear approach to housing placement and moving toward quickly placing people into appropriate housing.

The intention of Coordinated Entry is to:

1. Target the appropriate housing intervention to each population group particularly for those with high acuity and high need.

2. Divert people away from the system who can solve their own homelessness.
3. Ensure all population groups have the same assessment criteria applied utilizing an evidence-based assessment tool through the identified system entry point in each region. If a particular population group(s) shows up at the wrong place, there must be a process identified in each region for getting them linked to the right place.
4. Greatly reduce the length of homelessness by removing red tape and conducting ongoing assessments of efficiency to move people quickly into the appropriate housing.
5. Greatly increase the possibility of housing stability by targeting the appropriate housing intervention to the corresponding needs.
6. Promote empowerment of local and regional service providers to either divert households away from the homeless services system or provide support to quickly end their homelessness through local resources.

Applying coordinated entry to a community brings together the strength of programs across a community, offering a menu of services across programs. When communities come together to implement a coordinated services model, each program realizes success in a myriad of ways:

- Programs Receive Eligible Clients: Programs receive referrals for participants whose needs and eligibility have already been determined. The autonomy and unique nature of programs as they operate within a coordinated framework becomes a strength, not a hindrance.
- Case Managers can concentrate on Case Management: With every program in a community providing assessment, case managers share the burden of intake and assessment. When working across case managers in a community, real efficiencies can be realized in housing placement and case management when a common assessment is employed and agencies share the workload.
- Communities readily see what additional resources they need most: Lots of clients with mid-level acuity (definition of *acuity* below) signal a need for more Rapid Re-housing resources. Lots of clients with high-level acuity signal a need for more supportive housing.
- Time, red tape, and barriers are significantly reduced: When different programs in a community follow the same process and are aware of one another, workload is significantly reduced and service provision is improved.
- Community homelessness is significantly decreased: Targeting limited resources as a community leads to fast and effective interdictions that lead to long-term housing stability.

Prioritization for Chronic Homelessness: HUD has released (updated from the July 2014 document) guidance for the prioritization of chronically homeless individuals and families, which is outlined after the "definitions" section of this document. For a look at the full notice, please go here: https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf

HUD Updated Guidance on Coordinated Entry (January 23, 2017): https://www.hudexchange.info/resources/documents/Notice-CPD-17-01-Establishing-

Additional-Requirements-or-a-Continuum-of-Care-Centralized-or-Coordinated-Assessment-System.pdf

The WVCEH website includes a list of resources for Continuum of Care-funded programs, and all other homeless programs, to utilize in their staff trainings, strategic planning, and goal setting, while continuing to follow best practices and new developments within the field. These resources are a guide and not an exhaustive list or intended to replace existing documents at your organization which already capture all required information. All participating providers should be utilizing the WV Balance of State (BoS) Continuum of Care (CoC) forms for the following four components: documentation of homelessness status, documentation for length of time homeless (chronic verification), verification of disabling condition and documentation of disabling condition, which can be found here: https://wvceh.org/monitoring/

Definitions

Acuity – When utilizing the VI-SPDAT Prescreens, acuity speaks to the presence of a presenting issue based on the prescreen score. In the context of the Full SPDAT assessments, acuity refers to the severity of the presenting issues. In the case of an evidence-informed common assessment tool like the SPDAT, *acuity* is expressed as a number with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability.

Assessment – Gathering of information at various phases in the coordinated entry process for different purposes by standardized, trained assessors.

Balance of State (BoS) – Geographical areas designated by HUD throughout a state that are not covered by other metropolitan continuums.

Chronically Homeless – An individual who:

1) Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter;
2) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions totaling 12 months or more in the last 3 years; and
3) Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000. 42 U.S.C. 15002.), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;
4) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria (*listed above)* of this definition [as described in 24 CFR Parts 91 & 578 of the CoC Final Rule], before entering that facility;

5) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria (*listed above)* of this definition [as described in 24 CFR Parts 91 & 578 of the CoC Final Rule], including a family whose composition has fluctuated while the head of household has been homeless.

Comparable Database – HUD-funded providers of housing and services (recipients of ESG, CoC, or YHDP funding) who are not permitted, by law, to enter into HMIS (only Victim Service Providers (VSP) as defined under the Violence Against Women and Department of Justice Reauthorization Act of 2005) who must operate a database comparable to HMIS. The term "comparable" has yet to be defined in the HMIS Data Standards Manual or HMIS Data Dictionary, but was defined under the HEARTH Act and ESG Interim Rule as "a comparable database that collects client-level data over time (i.e. longitudinal data) and generates unduplicated aggregate reports based on the data." (page 32) (https://www.hudexchange.info/resources/documents/HEARTH_ESGInterimRule&ConPlanConformingAmendments.pdf) The recipient or subrecipient of Continuum of Care funds may use a portion of those funds to establish and operate a comparable database that complies with HUD's HMIS requirements. (§578.57 of the CoC Interim Rule)

Continuum of Care (CoC) – A regional or local planning body that coordinates housing and services funding for homeless families and individuals. A CoC is designed to:

1) Promote communitywide commitment to the goal of ending homelessness
2) Provide funding for efforts by nonprofit providers and State and local governments to quickly rehouse homeless individuals and families, while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness
3) Promote access to and effectively utilize mainstream programs by homeless individuals and families
4) Optimize self-sufficiency among individuals and families experiencing homelessness

CoC Collaborative Applicant – Agency that is designated to carry out the activities of the CoC grant, including fiscal and compliance activities. Regular administrative tasks may include, but are not limited to: management of the annual HUD application, coordination of other funding opportunities, project and system monitoring, meeting management, etc. WV Coalition to End Homelessness is the CoC Lead Agency for the BoS CoC.

Coordinated Entry System (CES)– "A centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals across a geographic area. The Coordinated Entry System covers the geographic area (designated by the CoC), is easily usable by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool." [as described in 24 CFR Section 578.3 and further detailed in CPD-17-01.] It is the responsibility of each CoC to implement Coordinated Entry in their geographic area.

Crisis Response System – All of the services and housing available to persons who are at imminent risk of experiencing literal homelessness and those who are homeless.

Department of Housing and Urban Development (HUD) – The Federal Agency that oversees the CoC, YHDP, and ESG Programs.

Disabling Condition – (1) a condition that: (i) is expected to be long-continuing or of indefinite duration; (ii) substantially impedes the individual's ability to live independently; (iii) could be improved by the provision of more suitable housing conditions; and (iv) is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury; or (2) a development disability, as defined above; or (3) the disease of Acquired Immunodeficiency Syndrome (AIDS) or any conditions arising from the etiologic agent for Acquired Immunodeficiency Syndrome, including infection with the Human Immunodeficiency Virus (HIV). 24 CFR 583.5 – Title 24: Housing and Urban Development; Part 583: Supportive Housing Program; Section 583.5 Definitions.

Diversion – Diversion is a strategy that prevents homelessness for people seeking shelter, or other homeless assistance, by helping them identify immediate alternate housing arrangements and, if necessary, connecting them with services and financial assistance to help them return to permanent housing. Diversion programs can reduce the number of families becoming homeless, the demand for shelter beds, and the size of program wait lists.

Emergency Services – Services typically utilized by a person experiencing a housing crisis. They include, but are not limited to, homelessness prevention assistance, domestic violence and emergency services hotlines, drop-in service programs, domestic violence shelters, emergency shelters and motel voucher programs, and other short- term crisis residential programs.

Emergency Shelter (ES) – A place for people to live temporarily when they cannot live in their previous residence. This includes programs that provide motel vouchers to persons experiencing homelessness. Emergency shelters assist persons experiencing homelessness in regaining permanent housing.

Emergency Solutions Grant (ESG) – A Federal grant program that funds street outreach, homelessness prevention, emergency shelters, and rapid re-housing activities.

Entry Point – The engagement point for persons experiencing a housing crisis. Also refers to how a person enters the Coordinated Entry System.

Homeless – Defined by the McKinney-Vento Homeless Assistance Act as:

- Category 1 - An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) an individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping

accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; (ii) an individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, State, or local government programs for low- income individuals); or (iii) An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

- Category 2 - An individual or family who will imminently lose their primary nighttime residence, provided that: (i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, needed to obtain other permanent housing;
- Category 4 - Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous, traumatic or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; (ii) Has no other safe residence; and (iii) Lacks the resources or support networks, e.g., family, friends, and faith- based or other social networks, to obtain other safe permanent housing. 24 CFR 578.3.
    - Persons who are fleeing or attempting to flee human trafficking may qualify as homeless under paragraph (4) of the homeless definition at 24 CFR 578.3 or section 103(b) of the McKinney-Vento Homeless Assistance Act and may be eligible for certain forms of homeless assistance under the CoC Program, subject to other restrictions that may apply. HUD considers human trafficking, including sex trafficking, to be "other dangerous or life-threatening conditions that relate to violence against the individual or family member" under paragraph (4) of the definition of homeless at 24 CFR 578.3 and "other dangerous, traumatic, or life-threatening conditions related to the violence against the individual or a family member in the individual's or family's current housing situation, including where the health and safety of children are jeopardized" under section 103(b) of the McKinney-Vento Homeless Assistance Act.

Homeless Management Information System (HMIS) – A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. The information system designated by the Continuum of Care must comply with the HMIS requirements prescribed by HUD in 24 CFR 578.7(b). The HMIS used in West Virginia Statewide HMIS Implementation, which includes all four CoCs, is Community Services.

Household – Covers any configuration of persons seeking services (e.g. Households with children, Households without children, Households with only children)

Housing Interventions – Housing programs and subsidies; these include transitional housing, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs (e.g. Housing Choice Vouchers).

Housing with Supports – An approach that connects individuals and families experiencing homelessness to permanent housing as quickly as possible, while also providing supportive services that promote housing stability and overall well-being. Services may include assistance with health care, employment, or other needs identified by the household. The focus is on ensuring that people are not only housed, but also have access to the supports necessary to maintain long-term stability and reduce the likelihood of returning to homelessness.

Housing Opportunities for Persons with Aids (HOPWA) – Federal grant program fund by the Department of Housing and Urban Development (HUD) as part of the Community Development Block Grant. HOPWA was established to help those with low-income, living with HIV/AIDS, and their families establish and/or maintain stable housing, reduce risk of homelessness, and improve access to health care and other needed support services.

Housing Prioritization Guide – A guide of persons experiencing homelessness in the CoC who are prioritized for housing. This guide is maintained in HMIS and divided into the 8 CoC regions to promote regional coordination of services. Coordinated Entry staff oversee the guide along with a larger list of individuals engaged in services who may need additional information before connecting with appropriate housing interventions. Emergency Shelter and Street Outreach staff should work closely with Coordinated Entry to engage those not yet connected and to maintain contact with those already on the list.

Joint TH and PH-RRH Component Project – A project type that includes two existing program components, TH and PH-RRH, in a single project to serve individuals and families experiencing homelessness. Recipients or subrecipients must be able to provide both components, including the units supported by the TH component and the tenant-based rental assistance and services provided through the PH-RRH component, to all program participants up to 24 months as needed by the program participants.

Non-HMIS Housing Prioritization Guide – A Housing Guide that uses anonymous, unique identifiers in order to accommodate the needs and confidentiality of survivors of violence and other households that do not consent to sharing their information in HMIS.

Permanent housing (PH) – Community-based housing without a designated length of stay in which formerly homeless individuals and families live independently with supports tailored to household needs. Under PH, a program participant must be the tenant on a lease (or sublease) for an initial term of at least one year that is renewable and is terminable only for cause. Further, leases (or subleases) must be renewable for a minimum term of one month. The CoC Program funds two types of permanent housing: permanent supportive housing (PSH) for persons with disabilities and rapid re-housing (RRH). Permanent supportive housing is permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability. Rapid re-housing emphasizes housing search and relocation services and short- and medium-term rental assistance to move homeless persons and families (with or without a disability) as rapidly as possible into permanent housing.

Permanent Supportive Housing (PSH) – Community-based housing in which supportive services are provided to assist homeless persons with a disability to live independently. This project type equips participants with services tailored to their disability-related needs, enabling sustainable independent living. This assistance is subject to the definitions and requirements set forth in 24 CFR 578.3.

Program Standards – A set of expectations and policies developed by program funders/grant recipients across the state for each project type, based on HUD guidance and best practices, that the YHDP and CoC-funded agencies, and other agencies funded through federal partners, are required to follow.

Project – Housing and/or supportive services intended to help people exit homelessness and sustain housing.

Provider – Organizations that serve program participants in projects funded by the CoC, YHDP, ESG Program grants, and other federal partners (e.g. SAMSHA). This includes grant recipients and sub-recipients.

Rapid Re-Housing (RRH) – An intervention designed to help individuals and families exit homelessness as quickly as possible, return to permanent housing, and achieve stability in that housing. Services provided are tailored to the needs of each household and focused on achieving financial independence, promoting community connection, and enhancing overall well-being. The core components of a rapid re-housing program are housing identification and relocation, short- and/or medium-term rental assistance and move-in (financial) assistance, and case management and housing stabilization services. This assistance is subject to the definitions and requirements set forth in 24CFR§576.2 “Homeless” paragraph (1) and paragraph (4) who are residing in a place set forth in (1), 24CFR§576.105, 24CFR§576.106 and 24CFR§576.400.

(24CFR§576.104 *& Core Components of Rapid Re-Housing,* National Alliance to End Homelessness)

Service Prioritization Decision Assistance Tool (**SPDAT)** – An evidence-based assessment utilized by all trained CoC providers in either enacting more detailed determinations of acuity for housing placement and/or ongoing use in case management to ensure housing stabilization. The SPDAT (or "Full SPDAT") has an individual and family tool. Staff must be trained by OrgCode Consulting or Balance of State CoC staff on the SPDAT. The SPDAT can be completed on paper or in HMIS and attached to a client record.

Street Outreach – A project type that meets people experiencing homelessness where they live and provides supportive services, linkage to life-saving services and emergency housing, and connection to permanent housing.

Supportive Services for Veteran Families (SSVF) – A federal program by the U.S. Department of Veterans Affairs that awards grants to private non-profit organizations and consumer cooperatives who can provide supportive services to very low-income Veteran families at-risk or experiencing homelessness.

Transitional Housing (TH) – A form of temporary housing in which participants sign a lease or occupancy agreement. Transitional Housing is designed to provide supportive services and interim stability to individuals and families experiencing homelessness, with the primary objective of assisting households in successfully transitioning to permanent housing as quickly as possible, and within a maximum of 24 months 24 CFR 578.3. There are not stand-alone TH projects currently funded through the CoC. However, there are several **joint TH-RRH** projects funded to support youth and survivors of domestic operated throughout the BoS.

Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) – An evidence-based Prescreen utilized by all projects in the WV Balance of State CoC to determine initial acuity and utilized for housing triage prioritization and housing placement.

Youth – Persons aged 24 and younger.

1) Unaccompanied Youth – persons who are age 24 or younger, who are not part of a family with children, and who are not accompanied by their parent or guardian during their episode of homelessness. This also includes two or more youth age 24 or younger who are presenting together as a family without children.
2) Pregnant or Parenting Youth – persons who are 24 and younger who are the parents or legal guardians of one or more children who are present with or sleeping in the same place as that youth parent, or who are pregnant.
3) Transition Age Youth – persons between age 18 and 24 who are transitioning from childhood to adulthood.

Youth Homelessness Demonstration Program (YHDP) – YHDP is an initiative designed to reduce the number of youth experiencing homelessness. The goal of the YHDP is to support selected communities, including rural, suburban, and urban areas across the United States, in the development and implementation of a coordinated community approach to preventing and ending youth homelessness. This funding is distributed to community agencies through a competitive funding process and is used to operate youth-specific HMIS, CES, RRH and TH-RRH programs in the BoS.

Coordinated Entry Roles

Continuum of Care (CoC)	The CoC is the responsible entity for building a system of care throughout its geography in order to end homelessness while also acting as the monitor for CoC funds, and realization of HUD Performance Outcome Measures. The CoC itself and the agencies within it, hold the responsibility for creating and maintaining a functional Coordinated Entry System.
CoC Steering Committee	The WV BoS CoC Steering Committee, and its sub-committees, serve as the governance structure for the BoS CoC. See details on the WV BoS CoC Governance Structure at https://wvceh.org/governance/.
Coordinated Entry System (CES) Staff	WVCEH employs five staff to act as 'navigators and investigators' to ensure people move quickly and effectively from street or shelter to housing. The CES staff supervisor oversees the housing guide and make referrals utilizing the HMIS to the appropriate housing intervention in each region.
Emergency Shelters	Shelters are very often the 'first door' for people experiencing homelessness, and thus vital as a system entry point for CES.
Outreach Providers	Street Outreach services are a critical component of the CES, functioning as a primary system entry point for individuals who may not actively seek assistance or who face barriers to engaging with crisis housing or emergency shelter programs.
HMIS Lead Agency	WVCEH is the Lead Agency for HMIS and therefore works in tandem with CES efforts to ensure that a proper intake, resource prioritization, and housing referral process is in place, via HMIS, for the entirety of the CoC.

Participating Provider	An agency or organization who has agreed to provide homelessness assistance, on behalf of the CoC, YHDP, and ESG State Grantee, or through local philanthropic resources. A participating project must execute a CES participation agreement with the CoC. The Participation Agreement outlines the standards and expectations for the project's participation in and adherence to the policies and procedures governing CES operations.
Referral Agency	A type of participating project that receives referrals for its projects from the CES. The referral process will be tracked in HMIS.
Non-traditional Provider	An agency or organization who does not traditionally provide homeless services and has agreed to provide Diversion Services and/or Supportive Services in their community/region.

Coordinated Entry Process Overview

PROCESS:

Each participating agency, with its respective projects, will be an active member of the CoC Coordinated Entry System (CES). The four entry points for the WV BoS CoC CES are Emergency Shelter (including hotel/motel paid for by a charitable organization), Street Outreach, CES Intake Line, and Supportive Services for Veteran Families (SSVF) providers. Some areas throughout the BoS also have Transitional Housing (TH)/Rapid Re-Housing (RRH) Joint Component projects funded through the U.S. Department of Housing and Urban Development and transitional living resources funded through other private and public resources that should also communicate directly with CES staff to ensure these households are connected with appropriate housing resources. The BoS is divided into eight regions where persons experiencing homelessness are prioritized by region for the appropriate intervention. All CES, Emergency Shelter, Street Outreach, and SSVF programs will utilize Diversion as a service to connect people with other mainstream resources and divert them away from the system who can solve their own homelessness. The VI-SPDAT Prescreen will be utilized as the primary triage assessment for Coordinated Entry when the household is unable to be diverted away from the system. Whenever possible, the VI-SPDAT should be completed in HMIS. When not possible, the VI-SPDAT should be completed in its paper form and then entered into HMIS for each client. For providers not using HMIS, or not permitted by law to utilize HMIS (Victim Service Providers), they may provide the client seeking housing resources the direct contact information for the Domestic Violence (DV) CES point of contact. The survivor seeking housing assistance may reach out directly to the DV CES point of contact who will record their information in HMIS, just like any other client who would be seeking housing services with no indicators that they are currently or previously being served by a Victim Service Provider (VSP) or residing in a DV shelter. In order to ensure continuity

of services and flexibility in the process, the survivor may also be assessed directly by the VSP and de-identifiable assessment criteria can be added to an outside housing prioritization guide that is managed by the DV CES Point of Contact and their supervisor. The WV BoS CoC CES team reviews the regional housing guides (Individual, Family, Veteran, Youth) weekly and has a separate secure housing guide for persons fleeing Domestic Violence, Dating Violence, Sexual Assault, Stalking, and other dangerous, traumatic or life-threatening conditions that is only reviewed by the DV CES point of contact and their supervisor. No person should ever be denied housing if they choose not to disclose Personally Identifiable Information (PII) due to safety risks.

Steps:

1. **CES and Emergency Shelter Personnel, Outreach Personnel and SSVF Personnel**, will be practicing Diversion as a service with all persons/families at-risk of homelessness or entering into the system for the first and/or second time within a two-year period. If a person/family is a frequent user of the homeless services system (three or more times in a two-year period) Diversion may still be an effective tool for them, but the entry point personnel may choose to skip directly to Step 2. *Entry point personnel are encouraged to use their best judgement in cases such as these as not every situation can be written into policy.*
2. **CES, Emergency Shelters, Street Outreach, and SSVF Personnel** will use one of the VI-SPDAT Prescreen Tools as the initial assessment for people experiencing homelessness entering the system, when previous Diversion attempts to connect with other community/housing resources are unsuccessful. Diversion attempts should be documented in the household's file in the HMIS or comparable database.
3. There is a specific VI-SPDAT for **Individuals**, one for **Families**, one for **Youth** housed in Community Services HMIS.
4. The Prescreen, provides **CES, Emergency Shelters, Street Outreach, and SSVF Personnel** with the ability to determine, across dimensions, the acuity of an individual, family, and youth.
5. Scores on the VI-SPDAT populate to the CoC-wide housing prioritization guide broken down further by CoC region in HMIS allowing the **CoC CES staff** to assign appropriate, eligible persons to community agencies, case managers, and others with housing resources. Housing individuals, families, and youth is done by acuity, while taking into account other eligibility and vulnerability criteria, such as living situation, length of time homeless, and tri-morbidity.
6. The Housing Prioritization Guide is broken down into a two-part process with one larger list of every household in the CoC who is enrolled into a literally homeless project in HMIS (CES, Street Outreach, Emergency Shelter, SSVF- CES access provider ONLY, Transitional Housing programs). The second part of the guide is a shorter list by CoC Region that includes households who are entered into a project in HMIS and engaged with a case

manager, intake staff, or outreach worker regarding the development of a housing plan and gathering their vital documents to sign a lease and move into a unit. *This does not mean that the inability to obtain a document should cause someone to remain outside, or ever be a reason not to move quickly when a person is highly vulnerable on the street. System entry points should be assisting clients with moving the documentation gathering process along at the front-set, so case managers may begin to focus on stabilization at initial move-in.*

7. Monthly regional provider calls are held for both entry points and housing providers to review the individuals and families housing guides. A separate monthly call is held by the DV CES Specialist and Victim Service Providers across the CoC to ensure the confidentiality and rapid housing placement of persons fleeing or attempting to flee Domestic Violence, Dating Violence, Sexual Assault, Stalking, and other dangerous, traumatic or life-threatening conditions. CES staff pull the guides weekly to review individual client needs and identify information that needs to be updated in HMIS to reflect which households are currently enrolled and working with the direct service provider to develop a housing plan. The guide is shared weekly with providers and CES staff should be communicating regularly with both entry points and housing providers in between monthly calls to determine which household is next to be referred and which housing provider has an open unit. Participating providers should be prepared for monthly calls in regards to accurately updating HMIS records, information on client specific needs and location, knowledge of barriers to housing, and the housing location process/unit availability. Unit availability should be updated weekly in HMIS and housing providers should be communicating these updates and program capacity to CES staff each week. While the focus of these calls should be primarily on households with the highest acuity or needs in each region, participating providers should also be communicating with CES at a minimum monthly regarding households with less complex needs to ensure they are also connected with housing resources or diverted to less-intensive resources.
8. IMPORTANT NOTE: **CES staff** in the WV Balance of State Continuum of Care will refer households to beds/units in CoC, ESG, and YHDP Rapid Re-Housing; CoC and YHDP Joint Transitional Housing and PH-Rapid Re-Housing Component, and CoC Permanent Supportive Housing programs. Programs that operate population specific vouchers may also be required to participate in the CoC's CES referral process contingent on federal requirements for each program. Street Outreach providers must be linked to Coordinated Entry, regardless of funding source, in order to prioritize the most vulnerable persons experiencing homelessness in the CoC to appropriate housing interventions. Faith-based and privately funded outreach, shelter and housing programs are encouraged to participate in the CES process. CES does not make direct referrals to emergency shelters yet serves as an information and referral source to emergency services when appropriate.

The WV BoS CoC Coordinated Entry System Intake Line number is 304-842-9522 x1 and email is ces@wvceh.org.

Compliance with Civil Rights Laws

The CES must operate in accordance with all applicable civil rights and fair housing laws and regulations within its jurisdiction. Recipients of federal and state funds must meet these legal requirements. Recipients and sub-recipients of CoC, YHDP, and ESG Program funding are obligated to comply with the nondiscrimination and equal opportunity provisions established under federal law, as specified in 24 CFR 5.15(a).

Personal Responsibility and Work Opportunity Act of 1996 (PRWORA) and HUD's Homeless Assistance Programs. Congress restricted immigrant access to certain federal public benefits but also recognized exceptions to protect life or safety, based on a 3-part test. The link below covers the types of assistance funded through the Emergency Solutions Grants (ESG) and the Continuum of Care (CoC) Programs that are covered by the life or safety exceptions to the Act. https://www.hudexchange.info/resources/documents/PRWORA-Fact-Sheet.pdf

Accountability

STANDARD:

All participating providers should be contributing to and answering referrals in HMIS from the WV BoS CoC CES. HUD-funded programs (CoC, ESG, and YHDP) are required to participate in the process. For YHDP and CoC-funded Projects, participation is directly tied to performance measurements and funding in the WV BoS CoC. The CoC should be reviewing system performance data and soliciting feedback at minimum on an annual basis, creating an opportunity for participating providers and program participants to partake in the biennial evaluation of the CES processes.

CRITERIA:

1. *CoC Responsibility:* The WV BoS CoC is responsible for identifying and coordinating homeless services and mainstream resources across each CoC region. Efforts are directed toward ensuring that providers deliver services effectively, manage resources responsibly, and meet accountability standards for the use of federal and state funding. The CoC supports providers in strengthening local capacity to address homelessness in their communities through consistent coordination and compliance with program requirements.
2. *CES Background and Development:* In March 2018, the CoC was divided into seven regions, with bi-monthly planning meetings conducted in each region. In January 2019, the regional structure was revised, and an eighth region was established. For the next year and a half, quarterly planning meetings were held to review proposed improvements to the CoC-wide CES. These meetings provided a forum to identify

providers and community representatives who were subsequently invited to participate in the WV BoS CoC Steering Committee.

3. *Current CoC Governance Structure:* The WV BoS CoC Steering Committee is comprised of representatives from eight regions, established through the CoC's coordination with CES across participating communities. In alignment with HUD requirements, this decision-making body includes members from various service sectors to ensure appropriate representation within the CoC. The Steering Committee serves as the governing body responsible for overseeing the implementation of the CoC Interim Rule (24 CFR 578) in the WV BoS CoC and for advising WVCEH CoC staff on policy and operational matters. https://wvceh.org/download/wv-bos-coc-bylaws-and-governance/

   The CoC Steering Committee define areas of CoC performance improvement and build system capacity through:

   a. Collaboration with Public Housing Authorities, landlords, private developers to prioritize homelessness and other vulnerable populations, establish set-aside units for households experiencing homelessness, and expand housing stock.
   b. Refining CoC Performance Criteria to rank and rate funded projects including reducing the length of time homeless, degree to which people exited programs for permanent housing, and increases in participant income.
   c. Expanding system outreach coverage to speed up the documentation, prioritization and referral to permanent housing process.
   d. Improving system coordination for Unaccompanied and Transition Age Youth, Veterans, and Persons Fleeing Domestic Violence (DV), Dating Violence, Sexual Assault, Stalking, and other dangerous, traumatic or life-threatening conditions.
   e. Coordination between justice, health care and behavioral health systems to improve discharge planning coordination and policies, enhance local treatment options, develop new affordable housing resources, and reduce recidivism.
   f. Biennial review and update of CoC policies and guidance. CoC Guidance, including this document and all other guidance for other CoC or YHDP funded programs, are considered to be all living documents that change as the needs of the communities within the CoC changes.
   g. Establish and oversee various subcommittees to conduct the day-to-day business of the CoC, which includes, but is not limited to the following – frontline trends and community needs, HMIS and reporting, staff development and training, monitoring and performance, and CES. Subcommittees make recommendations to the Steering Committee on emergent issues and need for policy reform.

CoC Lead, ESG Recipient, & State Partner Coordination

The WV BoS CoC is committed to aligning and coordinating CoC governance, eligibility determinations and prioritization for administering CoC/YHDP, ESG, and other private and publicly funded homeless programs. The WV BoS CoC works closely with the State ESG Grantee, the WV Department of Economic Development (WVDED) Office and the administrative oversight body for state contracted shelter funding to review performance of shelters, outreach projects, and permanent housing projects receiving federal or state funding. These entities coordinate

regularly and meet a minimum quarterly to develop, promote, and evaluate mutually agreed-upon expectations for all homeless programs as it relates to the established WV BoS CoC CES process, enumerated by regional and community input, and communicated in this document. It is a primary goal among parties to also align monitoring and project performance requirements for ESG, CoC, YHDP and state shelter funding, when applicable, and within the parameters of the federal and state regulations for funding streams, to enhance service delivery across the BoS CoC, regarding overall system performance standards, consistency, and compliance across programs.

Prevention and Diversion Services

The WV BoS CES must ensure access for all program participants who are potentially eligible for homelessness prevention assistance and should also have knowledge of community mainstream resources in each CoC region. All CES entry points should ensure staff have ongoing training on offering Diversion services prior to entering a household into the homeless services system. Staff at all entry points (Intake Line, Emergency Shelter, Outreach, SSVF) should have knowledge of mainstream resources throughout their designated coverage area, such as Section 8, Public Housing, UDSA properties, Low Income Housing Tax Credit properties, and emergency assistance (DHHR, local churches, etc.) to assist persons in connecting with resources prior to entering into the homeless services system.

1. A household who is at risk of homelessness is assessed, and provided referrals to mainstream low-income housing resources and/or emergency assistance resources in their area. Communication with family and/or friends they are staying with may be necessary to assist in this process.
2. A household who is at imminent risk of losing housing (14 days or less), will be provided referrals to mainstream low-income housing resources and/or emergency assistance resources in their area. The household will also be assessed and connected with prevention resources in their area, when available. The household may also be connected with legal services regarding evictions, when appropriate.
3. All households contacting the intake line will first be assessed and provided Diversion services, connecting to mainstream low-income housing resources and/or emergency assistance resources in their area, when appropriate. When a household cannot be successfully diverted or the safety of the household is in question, the assessor should work to connect the household quickly to temporary housing. If the household is not able to self-resolve within 14 days, they should then be assessed, utilizing the VI-SPDAT, to determine the appropriate permanent housing intervention. If this is the second diversion attempt, the timeframe to allow for the household to self-resolve should reduce 7 days. (*Please note that when an individual or family is a frequent user of the homeless services system, Diversion can still be successfully practiced but may need to be skipped altogether depending on the household's specific circumstances.).*
4. A household presenting at an Emergency Shelter should be assessed and provided Diversion services, connecting to mainstream low-income housing resources and/or emergency assistance resources in their area, when appropriate. A household should be diverted back to where they were previously staying if it is safe. Communication with family and/or friends they are staying with will be necessary to assist in this process. There

should be an agreement with where they are temporarily staying for how long they can remain, with permanent housing being the ultimate goal. When a household cannot be successfully diverted or safety of the household is in question, the Emergency Shelter should offer immediate shelter and assist the household over the next 14 days with self-resolving. If the household is not able to self-resolve within 14 days, they should then be assessed, utilizing the VI-SPDAT, to determine the appropriate permanent housing intervention. If this is the second diversion attempt, the timeframe to allow for the household to self-resolve should reduce 7 days. The Emergency Shelter should coordinate with the CES to arrange a possible hotel/motel voucher when no shelter bed is available. Hotel/motel funding is prioritized for households with children, older adults over 60, or households who have a member that is medically vulnerable. Vulnerability should be assessed on a case-by-case basis and factors such as severe physical, mental health and intellectual disabilities that limit a person's daily functioning should be considered. It is important for both Emergency Shelters and Street Outreach staff to maintain ongoing communication with local community partners that may be willing to assist in the effort of developing an effective after-hours plan (transport to another shelter, hotel/motel when appropriate, etc.).

5. Diversion can also be successfully utilized by Street Outreach staff for persons currently living in a place not meant for human habitation.
6. As noted above, it should be a common practice for all entry points to practice diversion. However, it is important to also note that when a person self-identifies as a veteran, it is vital that they are connected with the local VA and/or SSVF provider in their service area, so eligibility for all veteran programs can be verified.
7. It is important to note that the timeline for supporting self-resolution should be shortened for Transition Age Youth to a maximum of 7 days, and youth presenting at shelter or engaged through outreach should be quickly connected with safe, temporary housing when available to reduce harm and decrease the likelihood of ongoing use of homeless services as older adults. When an unaccompanied minor is identified or presents for services, it is important for the entry point to connect them with safe temporary housing and coordinate with local child advocacy programs, youth providers, school systems, and the Public Child Welfare Agency to develop a plan to best meet the young person's needs.
8. It is important for entry points and housing providers to acquire annual training to assess for lethality risks and safety needs when a household is fleeing violence. Households should never be diverted back to an unsafe housing situation. Households fleeing violence should be provided information for the local Victim Service Provider to ensure immediate safety needs are met.

Emergency Services

Initial live screening through the CES Intake Line is available during normal business hours on Monday - Friday from 8:00am- 5:00pm, excluding holidays and weekends. Program participants and participating agencies also have an opportunity to leave a message or send an email to schedule a time for a call back. CES Intake Line staff are required to return all calls and emails within 3 business days. High priority calls (e.g. medically vulnerable and unsheltered) must be

returned within 1 business day. CES will triage calls and emails to determine the following basic elements:

1. Safety of the caller.
2. The nature of the crisis, individualized household needs, and current housing status: literally homeless, at-risk of homelessness, or needing housing or homeless services information.
3. Household composition, size, and current location/region.
4. A clear, understood and action-oriented resolution, referral, or next stage routing to coordinated entry prevention diversion.

When program participants present during non-business hours, the homeless services system should be set up to allow them to enter their local Emergency Shelter, or an opportunity to be assisted through a local provider for temporary shelter in a motel/hotel, when appropriate, until connection with the CES Intake Line and/or Outreach in that region can be made on the following business day. If the program participant has been temporarily provided motel/hotel assistance, it is that participating provider's responsibility who provided the hotel/motel assistance to connect them the following business day with the CES. If your community does not currently have an emergency shelter or any system set up with local organizations to assist with housing crises after regular business hours, this system gap should be discussed at local community meetings and at regional planning meetings in the effort of developing an effective after-hours plan, which is a notable challenge in isolated, rural communities.

It is important to note that all Emergency Shelters required to participate in HMIS should be tracking bed utilization **daily** to ensure accuracy of vacancies. This information is fundamental for CES to know which Emergency Shelter has an open bed when clients call for information on accessing emergency shelter resources across a 44-county coverage area. Accuracy of this information reduces the participant and provider burden of calling around to multiple shelters.

Coverage and Outreach Integration

CES in the WV Balance of State CoC covers all of the 44 counties in the Balance of State, through various means. The CoC provides a CES Intake Line (304-842-9522 x1) operated by dedicated CES Specialists and overseen by the Director of CES. The CES staff can also be contacted by email at ces@wvceh.org. The monthly regional providers calls are utilized to assess community resources and service gaps, as well as speed up the process of connecting people to housing by identifying needs of particular households through direct communication from Street Outreach providers and other system entry points. CES staff also pull the regional guides weekly to review individual households' needs and identify information that needs to be updated in HMIS to reflect which households are engaged in services and working toward a housing plan with their outreach worker. Since areas assigned to Street Outreach providers are often quite large in a rural BoS CoC, this ongoing communication during monthly calls, and weekly as the guides are being reviewed, allows identification of where any available resources should be allocated.

Shelters, Outreach programs, SSVF, and the Intake Line will use the HMIS, or Comparable Database, to ensure full coverage of CES throughout the CoC, serving as key entry points for

households experiencing homelessness to be assessed and prioritized for housing options. A crucial component of this approach is the integration of Street Outreach with CES. Street Outreach connects with individuals, families, and youth who are living on the streets, in wooded areas, or in locations not intended for habitation. Outreach is designed to engage with those living unsheltered who may not engage with traditional agency settings, shelters, or intake lines. By positioning Outreach as a core entry point, access is centralized for those who might otherwise remain disconnected from housing and services, reinforcing the commitment of Outreach providers to conduct consistent, proactive engagement with individuals who may not otherwise seek support.

The WVCEH BoS CoC Lead Agency, HMIS, and CES staff are responsible for working with system entry points (Intake Line, Street Outreach, Emergency Shelters, SSVF), providing technical assistance and education on best practices to these designated providers on their respective roles while concurrently identifying system coverage gaps. The WV BoS CoC collaborates directly with ESG and PATH recipients, as well as privately funded and medical outreach programs, to ensure that all street outreach providers within the WV BoS CoC:

1. Understand and Implement Best Practices: Providers are knowledgeable about the concepts, strategies, and proven practices that define effective street outreach or receive the necessary training to gain this expertise.
2. Integrate with the Coordinated Entry System (CES): Providers fully align their street outreach efforts with the CES process, including a clear understanding of roles, responsibilities, and designated service areas.
3. Commitment Through Formal Agreements: Agencies enter into Memoranda of Understanding (MOUs) with the WV BoS CoC to ensure their outreach efforts are part of the CES process, that staff receive required training, and that services remain housing-oriented through ongoing outcome measurement.

The WV BoS CoC Outreach subcommittee meets monthly and focuses on outreach coverage in rural areas, implementing and training on best practices, and assists the CoC with targeting resources to high needs areas. Street Outreach program development and policy changes are vetted by the Outreach subcommittee prior to submission to the CoC Steering Committee. Details on Street Outreach best practices, data collection, engagement, service delivery, and community collaboration can be found in the WVCEH Street Outreach Standards at https://wvceh.org/guidance/.

Entry Points for System Participation

The WV BoS CoC CES process covers the CoC's entire 44-county geographic area, which has been divided into eight regions to provide broad access. The WV BoS CoC uses a CES model with four main access points for housing placement throughout the CoC: Emergency Shelter (including hotel/motel accommodations paid for by charitable organizations), Street Outreach, SSVF providers, and the CES Intake Line. Some areas within the BoS also have CoC/YHDP Joint Transitional Housing (TH) Rapid Re-Housing (RRH) or other TH resources funded by local, state, and federal partners. These providers are expected to coordinate with Coordinated Entry staff at

least monthly to ensure that transitional housing options are available when emergency shelter is not and to connect households in TH with permanent housing resources as appropriate.

The CES supported by a comprehensive advertising strategy that includes social media outreach, a dedicated page on the WVCEH website, and email communications. These materials are distributed to community partners and organizations throughout the CoC. All CES advertising materials adhere to the formatting requirements outlined in the Americans with Disabilities Act to ensure availability for all audiences. The WV BoS CoC staff collaborate with its partner organizations to build rapport with individuals experiencing homelessness, those who are formerly homeless, community members, local government, social service agencies, and faith-based providers. These partnerships help raise awareness of available resources and ensure that information about the CES is widely distributed across the CoC. All CES participating agencies should post, or otherwise make publicly available, the CES advertising material. There should also be identified staff at each agency who can explain the CES process to program participants seeking services.

The WV BoS CoC continuously evaluates service gaps and implements improvements to promote ongoing awareness of homeless assistance and housing resources across local communities. Additionally, the CoC and its partners maintain strong relationships with legal services and adult protective services, making regular referrals to address client rights issues. These include tenancy disputes related to improper eviction processes, concerns about client capacity and safety, and instances of negligence or maltreatment by service providers.

Persons Fleeing Domestic Violence, Dating Violence, Sexual Assault, Stalking, and other Dangerous, Traumatic, or Life-Threatening Conditions

1. It is incumbent upon providers participating in the WV BoS CoC CES regardless of project type, to offer safety and accommodation to persons fleeing Domestic Violence (DV), Dating Violence, Sexual Assault, Stalking, and other dangerous, traumatic, or life-threatening conditions while safeguarding privacy and confidentiality. All system entry points shall be trained to conduct initial screening for risk of lethality, exploitation and potential harm (including the use of the Dangerousness Lethality Assessment Guide – DLAG). When present risk is identified, the participant should be referred immediately to available Victim Service Provider (VSP) services. The CoC will coordinate with the WV Coalition Against Domestic Violence (WVCADV), to offer annual training on DLAG to homeless service providers.
2. In order to provide a safe and effective way to prioritize and house survivors fleeing from Domestic or Partner Violence, Sexual Violence, and Human Trafficking, the WVCEH, WVCADV, WV Foundation for Rape and Services (FRIS), and their partner agencies have developed a VSP subcommittee which serves as a part of the larger WV BoS CoC Governance and structure. The purpose of this partnership is to provide an opportunity for coordination with the licensed DV programs and other VSPs within the WV BoS CoC

to coordinate housing services and referrals of survivors, dissemination of information about trainings on the intersection of domestic violence and homelessness, participation in statewide collaborative efforts to promote homeless services for survivors, and working with HMIS and comparable data base coordinators to integrate survivor's needs. The WVCEH DV CES Specialist (DV CES point of contact) will work in tandem with the WVCADV Human Trafficking and Housing Coordinator and the VSP subcommittee to educate and prepare domestic violence programs in the WV BoS CoC on the process for applying for HUD funding and improve and coordinate triage, referral, and housing placement processes for survivors in the CoC. The WVCEH DV CES Specialist will also ensure that the DV Housing Prioritization Guide (Outside List) is securely maintained. The VSP subcommittee will work with the HMIS and Comparable Database coordinators to disaggregate data for the purposes of analyzing population needs, identifying service coordination gaps, and improve housing resources for persons fleeing violence.

3. Individuals fleeing Domestic Violence (DV), Dating Violence, Sexual Assault, and Stalking, and other dangerous, traumatic, or life-threatening conditions are defined as homeless under HUD guidance. Due to VAWA privacy protections, providers who offer services for those fleeing violence are not permitted to enter data into HMIS, nor are providers permitted to reveal personally identifiable information on survivors. Providers not using HMIS, or not permitted by law to utilize HMIS (Domestic Violence Providers), will utilize the VI-SPDAT housing triage tool and enter VI-SPDAT information into a secure Google Doc which will feed an ID number and score to the Housing Prioritization Guide (Outside List). The DV CES Specialist will maintain contact with the VSP, and with client consent assist households with obtaining documents for housing and inform them of when the next household on the outside list is to be housed. The DV CES Specialist will review the list weekly. If the person seeking housing assistance reaches out to the DV CES Specialist directly, they will record their information in HMIS with no indicators that they are currently or previously being served by a DV provider or residing in a DV shelter. Since assessment data related to housing placement can be collected by the DV CES Specialist or VSP and inputted securely into an outside list, this allows for a flexible and confidential assessment, prioritization, and referral process and ensures that persons fleeing violence have equitable access to housing resources without having to repeat their story to multiple agencies. Prioritization calls will be conducted monthly with VSPs to address client needs and system barriers, and review housing resource availability. The WVCADV Human Trafficking and Housing Coordinator will participate in the prioritization calls to assist with coordination between housing providers and VSPs when housing is available.
4. When a housing opportunity becomes available in the area of the client's choice, the DV CES Specialist will either coordinate directly with the client, or VSP with the de-identified number, and with client consent, coordinate with the housing provider they are referring

to and make that connection. All appropriate releases of information must be in place prior to communicating with the VSP and housing provider. If the client does not want to be referred to a local VSP, the DV CES Specialist should still work with the client to identify safe, appropriate housing options in their area. No person should ever be denied a housing opportunity if they do not want their information shared or entered into the HMIS and alternative measures must be provided on a case-by-case basis. To ensure housing resources are not being overlooked for survivors or that all survivors are being steered to only DV-specific housing projects, the CES DV Specialist coordinates with the CES Director to assess all available housing options and work with the program participant to determine what housing option would best fit their needs.

5. All VSP housing program development and policy changes are vetted by the VSP subcommittee prior to submission to the CoC Steering Committee.

Veterans

1. The process for prioritization of veterans through the CES was developed by the CoC's Veterans subcommittee to ensure that veterans are connected with the appropriate resources. While all Veteran Administration Medical Centers (VAMC) are encouraged to participate in coordination discussions, there is one point-person charged as the lead CES contact for all four of the VAMCs in West Virginia. The Veterans Subcommittee, comprised of the VAMC representative, the WV BoS CoC, and Supportive Services for Vetern Families (SSVF) Grantees is charged with ongoing assessment of veteran housing needs and updating guidance when appropriate regarding the coordination and prioritization of SSVF, Grant and Per Diem (GPD), Health Care for Homeless Veterans (HCHV), and HUD-Veteran Affairs Supportive Housing (HUD-VASH) resources within the WV BoS CoC. The goal of the subcommittee is thorough integration and effective prioritization of Veteran resources in the WV BoS CoC CES. VAMC's and SSVF providers also participate in the monthly regional prioritization calls with the WV BoS CoC CES.
2. In regards to SSVF programs exclusively, **SSVF providers will act as fourth system entry point**. It is important to understand that in rural communities the veteran may seek out the SSVF agency directly. At that time, the following steps should be completed by the SSVF provider:
    a. **Practice Diversion/Rapid Resolution as a service with all at-risk and homelessness veterans** for the first and/or second time within a two-year period. If a veteran is a frequent user of the homeless services system, (three or more times in a two-year period) diversion may still be an effective tool for them, but the entry point personnel may choose to skip directly to Step b.
    b. Complete one of the VI-SPDAT Prescreen Tools as the initial assessment for people experiencing homelessness entering the system when previous Diversion attempts to connect with other community/housing resources are unsuccessful.

c. There is a specific VI-SPDAT for **Individuals**, one for **Families**, and one for **Youth** in Community Services HMIS. This Prescreen tool provides the ability to determine, across dimensions, the acuity of the veteran.
d. Scores on the VI-SPDAT populate to the CoC-wide housing prioritization guide, broken down further by CoC region and veteran subpopulation in HMIS. This allows the **CoC CES staff** to assign the next veteran household to the next available housing resources in the area of their choice by acuity, while taking into account other eligibility and vulnerability criteria, such as living situation, length of time homeless, and tri-morbidity.
e. Eligibility for the SSVF program is always determined by the SSVF provider; however, the CES provider maintains the integrity of the housing guide and oversees the referral process. CES staff in the WV BoS CoC will be responsible for prioritizing and referring the next eligible veteran to the SSVF program in that region, as the SSVF provider(s) in that area are simultaneously gathering documentation for eligible households and locating units. It is the SSVF provider's responsibility to keep open communication with CES staff regarding program capacity and unit availability. For regions with multiple SSVF programs, all parties will be responsible for maintaining open communication with CES staff regarding pending, current, and outstanding referrals during the monthly calls to maintain transparency.
f. Upon assessment, if the veteran is found to be ineligible for SSVF resources, they should be referred to CES by the SSVF provider for connection with housing intervention.
g. When a veteran contacts the CES Intake Line first, CES will complete the initial assessment, connect with emergency housing when appropriate, and refer the veteran directly to the SSVF provider in that area to assist with gathering documentation for eligibility. In areas where there are more than one SSVF provider, the CES will use an every-other referral system.
h. VAMCs will also practice Diversion/Rapid Resolution services for at-risk and homeless veterans. When a veteran enters into a VAMC and is identified as literally homeless, the VAMC staff will immediately refer the Veteran to SSVF provider and communicate with CES for proper referral tracking.
**Please reference the WV BoS CoC Veteran CES policies for further details.*

3. All veteran housing program development and policy changes are vetted by the veteran subcommittee prior to submission to the CoC Steering Committee.

Youth

1. The WV BoS CoC CES affirms that unaccompanied and transition-age youth experiencing or at risk of homelessness must be rapidly stabilized in housing through a dedicated

youth-specific prioritization process. To prevent youth from being passed over in the standard system, CES has established a separate process for prioritization. In communities with youth-specific housing and support services, referrals are made directly by an Outreach Worker, Emergency Shelter, or CES to a Youth Navigator, who assists in connecting the youth to safe temporary and, ultimately, permanent housing. In communities without youth-specific resources, the CoC directs that for every five adults housed, one youth is also housed, reinforcing a balanced approach to housing resources in each CoC region. This approach helps ensure youth spend less time in shelters or on the streets, reducing the risk of chronic homelessness and providing the supportive services needed to move from instability to permanent housing

2. When a youth presents at a shelter for the first time, it is advised to wait no longer than seven days to conduct a TAY VI-SPDAT. If the youth returns to the shelter, then a VI-SPDAT may be done immediately upon entry.
3. The youth subcommittee (WV BoS CoC Youth Action Board), comprised of youth with lived experience of homelessness and/or system involvement, frontline staff, and state entities, has developed the following criteria for prioritizing youth for housing resources:
    a. Current Living Situation (sheltered vs. unsheltered, safety in current living situation)
    b. Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing
    c. High utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities to meet basic needs
    d. Parenting and/or pregnant
    e. Multi-system involvement (foster care, justice, behavioral health)
4. Though there are youth-specific housing resources through YHDP funding in targeted regions across the state, youth should be assessed for all programs in order to be connected with the most appropriate housing intervention of their choice. It is important to avoid steering youth to only youth-specific programs when another intervention may best fit the individual youth's needs.
5. When an unaccompanied minor presents for services, data may be collected in HMIS but not shared. Providers must contact the HMIS staff to lock down the visibility of the record in the data system. Homeless services providers should coordinate with local child advocacy programs, youth providers, school systems, and the Public Child Welfare Agency to develop a plan to meet the unaccompanied minors' housing and service needs.
6. WV BoS staff coordinate with youth with lived experience, the Bureau for Children and Families, Bureau for Juvenile Services, Department of Education, Behavioral Health providers, Public Housing Authorities, and other youth providers across the CoC, to develop methods for sharing data to identify needs, expand youth street outreach and

housing programs, and build system capacity to serve unaccompanied youth under 18 and transition age youth 18-24. While all CES staff are trained on youth resources, there is one CES Youth Specialist. When a youth is being discharged from a juvenile facility or state's custody without a stable housing plan, facilities should work with both the youth and CES staff to develop a housing plan.

7. The CoC and its partners will evaluate system performance based on the four core outcomes identified by the United States Interagency Council on Homelessness (USICH) as benchmarks to end youth homelessness:
    a. Stable housing
    b. Permanent connections
    c. Education and employment
    d. Social-emotional wellbeing

    These outcomes reflect the understanding that youth experiencing homelessness have varied and unique needs that require a wide array of interventions and pathways to help them achieve outcomes they have identified as most critical to their success.
8. All youth program development and policy changes are vetted by the youth subcommittee (WV BoS CoC Youth Action Board) prior to submission to the CoC Steering Committee.

For additional guidance and resources for preventing and ending youth homelessness, see the WV BoS CoC Coordinated Community Plan: https://wvceh.org/coc-yhdp/.

Persons with Disabilities

The WV BoS CoC will ensure that all participating providers deliver services that are available to individuals with mobility limitations and are offered without distinction to individuals seeking services who may have one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act 2000, 42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability. Documentation of any of these conditions may be used to establish eligibility for certain housing assistance programs, such as CoC Permanent Supportive Housing (PSH), population specific vouchers through local Public Housing Authorities, and other HUD or USDA properties designated to be utilized to serve persons with disabilities. However, documentation of disability is not required for access to other forms of housing assistance provided through the WV BoS CoC such as Transitional Housing-Rapid Re-Housing (TH-RRH) or Rapid Re-Housing (RRH).

Evidence of diagnosis with one or more of the following conditions; substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability, must include one of the following forms of documentation for PSH projects:

a. Written verification of the condition from a professional licensed by the state to diagnose and treat the condition;
b. Written verification from the Social Security Administration;
c. Copies of a disability check (e.g., Social Security Disability Insurance check or Veteran Disability Compensation); or
d. Intake staff (or referral staff) observation that is confirmed by written verification of the condition from a professional licensed by the state to diagnose and treat the condition that is confirmed no later than 45 days of the application for assistance and accompanied with one of the types of evidence above.

It is also important to note here that the housing prioritization guide is to be utilized just as it is titled, as a "guide". When a household is eligible for a particular PSH program in their area and the resource is not available or will not be available in a reasonable amount of time, the CES staff should work with the available housing resources in that area (e.g. RRH) to ensure the household is connected quickly to housing. In respect to households who meet the eligibility criteria of CoC-funded PSH, but of which there is no PSH resource available in the community or region of the client's choice, RRH resources may be utilized as "bridge housing" until a PSH unit is available or the client may remain in RRH if that intervention demonstrates it is meeting their housing stability needs. Since CES is the primary referral entity throughout the BoS, staff should be trained on standardized assessment techniques to avoid steering a protected class to a particular housing program as outlined in Section 804 of the Fair Housing Act. Although a household meets eligibility requirements for a specific program, it is important to ask assessment questions in such a way that a household is not being steered toward a particular program. When assessing for eligibility of the HOPWA program, the assessor should gather information obtained from the VI-SPDAT question — "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?," along with all other necessary information, in order to make an informed decision on the most appropriate housing intervention for each household. The way the VI-SPDAT question is worded in the previous example helps to eliminate steering the household toward a particular program due to their disability status and allows the household to have options which is in compliance with Fair Housing law.

Client Intake Process Through Coordinated Entry

STANDARD:

The program will be an active member of the CoC CES and one of the four types of identified system entry points: Emergency Shelter (including hotel/motel paid for by a charitable organization), Street Outreach, SSVF, and the CES Intake Line. The program will have minimal entry requirements to ensure the most vulnerable of the population are being served. The program will ensure active client participation and informed consent. All programs identified as a system entry point will utilize the VI-SPDAT as the initial Prescreen for the CES when households are unable to be successfully diverted to other mainstream and/or community resources.

CRITERIA:

1. All adult program participants must meet the eligibility requirements by appropriate program.
2. **Programs may require participants to meet additional program eligibility requirements as they relate specifically to federal or state law, not local or agency-mandated additional assessments, criteria, or stipulations.**
3. Programs should maintain ongoing communication with CES regarding vacancy rates, and may have the option to restrict program entry due to any of the following criteria:
    a. All program beds are full.
    b. Household does not meet eligibility requirements for the program as outlined in specific program regulations. The issue of ineligible clients being referred to programs should be reduced significantly, since all referrals will go through CES.
    c. Household make-up, provided it does not violate HUD's Fair Housing and Equal Opportunity requirements (Singles-Only programs can disqualify households with children, Families-Only programs can disqualify single households, etc.)
    d. Rental subsidy money has been exhausted. If a program has exhausted funding for the year, CES staff should be notified immediately, and the household should be referred back to CES to be connected with another housing option.
    e. If the housing has in residence at least one family with a child under the age of 18, the housing may exclude registered sex offenders and persons with a criminal record that includes a violent crime from the project, so long as the child resides in the same housing facility. (CFR 578.93).
    f. Specific programs may assess income limits.
4. Though it is prudent to connect each household with income during their project stay to promote long-term stability, programs should not disqualify an individual or family from program entry for lack of income or employment status.
5. Programs should be designed to not disqualify an individual or family because of evictions or poor rental history.
6. Programs should explain the purpose and structure of the program and detail supportive services that are available through the program to each adult household member. Upon agreement of enrollment into the project, both the provider and participant should complete a mutual expectations agreement which clearly outlines the role and expectations of all involved parties.
7. The program should maintain records of a Release of Information, case notes, and all pertinent demographic and identifying data in the HMIS or comparable database. Paper files may also be kept as long as they are stored in a secure location.

Client Assessment and Screening

Common Assessment Tool

The Suite of VI-SPDAT products (Individual, Family, and TAY-Youth) are used as the common assessment tools for entry into the CES. The use of the VI-SPDAT triage tools populates the CoC Housing Prioritization Guide (by CoC region), supplying the most critical component of assessment and prioritization. All assessments are available within HMIS. For Diversion and Prevention, specific questions are programmed in the HMIS to guide the CES staff with assisting clients to develop a safe, alternative housing plan.

The program will utilize the Individual, Family, and Transition Age Youth (TAY) VI-SPDATs in Community Services HMIS for all clients, thereby populating a housing prioritization guide per CoC region by acuity, showing clients who most likely need:

1. Supportive housing (longer-term housing with high service intensity);
2. Temporary rental assistance (time-limited housing with moderate service intensity);
3. Diversion (no or very little housing supports, and connections to other mainstream housing resources).

Victim Services Providers, who are prohibited by law to input data into HMIS, will utilize the paper version of the VI-SPDAT and input the score in a secure Google Doc, thereby populating an external confidential prioritization guide of survivors in each region who are in need of housing resources.

The VI-SPDAT is an evidence-informed common assessment tool and acuity is expressed as a number with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability. The VI-SPDAT score shows the *presence* of these issues, and indicates the potential best fit for housing and service intervention, based on scores across the following dimensions:

Wellness: Chronic health issues and substance use.

Socialization and Daily Functioning: Meaningful daily activities, social supports, and income.

History of Housing and Homelessness: Length of time experiencing homelessness, and cumulative incidences of homelessness.

Risks: Crisis, medical, and law enforcement interdictions. Coercion, trauma, and most frequent place the individual has slept.

Family Unit (Family VI-SPDAT Only): School enrollment and attendance, familial interaction, family makeup, and childcare.

VI-SPDAT

Based upon the Prescreen Acuity Score of the VI-SPDATs, the CoC can arrive at best possible housing intervention that applies, as follows:

VI-SPDAT V.2 Individuals

Intervention Recommendation	VI-SPDAT Prescreen Score for **Individuals**
Permanent Supportive Housing	9+
Rapid Re-Housing	4-7
Diversion	0-3

VI-SPDAT V.2 Families

Intervention Recommendation	VI-SPDAT Prescreen Score for **Families**
Permanent Supportive Housing	9+
Rapid Re-Housing	4-8
Diversion	0-3

VI-SPDAT V.1 Transition Age Youth

Intervention Recommendation	VI-SPDAT Prescreen Score for **Youth**
Permanent Supportive Housing	8+
Rapid Re-Housing	4-7
Diversion	0-3

When a VI-SPDAT Prescreen is performed for a client who was not successfully diverted and entered the system for assistance, Community Services Users from delegated entry points can tag the VI-SPDAT to be included in the CoC-wide housing prioritization guide. Likewise, the WV BoS CoC CES will provide an intake line, connecting regularly with Emergency Shelter and Outreach providers, to provide assessment and follow up for all clients entering the system. All entry points must provide participant autonomy to freely refuse assessment questions. In cases where a person's severe mental illness impedes their ability to complete the VI-SPDAT assessment, the full SPDAT may be completed to develop a more accurate picture of a person's particular needs. The VI-SPDAT was created to be a triage tool to assist with prioritizing housing resources, and an individual's inability to complete the assessment will be addressed through alternative methods to ensure their needs are understood.

Full SPDAT

The Full SPDAT (Individual, Family, and TAY) are more intensive assessments that use many of the same dimensions as the VI-SPDAT to determine the acuity of clients. The Full SPDATs require formalized training from OrgCode or the WVCEH/BoS CoC Staff. The Full SPDATs can be used to better determine the acuity of clients whose acuity is more difficult to determine via the VI-SPDAT (borderline cases, "ties" on the Housing Prioritization Guide, persons not responsive to the VI-SPDAT, etc.) but is primarily a value as an intensive ongoing case management tool. Plainly put, the VI-SPDATs are used as triage and prioritization tools, and the Full SPDATs are used after

program intake to measure acuity over time in order to focus case management, and as a benefit to the community for service planning.

Use of the Full SPDATs primarily comes into play once a client is securely established in housing, after the Housing Prioritization Guide and Housing Placement Phase, and right as Case Management begins in earnest.

The Acuity measure of the Full SPDATs, is calculated differently than the VI-SPDATs due to the nature of the more comprehensive assessment and the depth of questions. Acuity via the Full SPDATs is:

Full SPDAT Acuity Scale for Individuals V. 4.0

Intervention Recommendation	SPDAT Score for **Individuals**
Permanent Supportive Housing	35-60
Rapid Re-Housing	20-34
Diversion	0-19

Full SPDAT Acuity Scale for Families V. 2.0

Intervention Recommendation	SPDAT Score for **Families**
Permanent Supportive Housing	54-80
Rapid Re-Housing	27-53
Diversion	0-26

Full SPDAT Acuity Scale for Youth V. 1.0

Intervention Recommendation	SPDAT Score for **Youth**
Permanent Supportive Housing	35-60
Rapid Re-Housing	20-34
Diversion	0-19

ASSESSMENT STEPS:

1. **CES, Emergency Shelters, Outreach Personnel, and SSVF Providers** will utilize the VI-SPDAT, Family VI-SPDAT, or TAY VI-SPDAT for entrance into the housing and homelessness assistance system when a household is not successfully diverted.
2. Once a client is engaged in services by one of the identified system entry points, every effort will be made to provide suitable triage for persons living in a place not meant for human habitation through identified entry points. Triage would include emergency shelter or hotel/motel vouchers. Triage is any temporary housing situation that can be utilized until more permanent housing placement can be made (e.g. RRH, PSH, TH/RRH, other federally-subsidized housing, mainstream housing).
3. Street Outreach, Emergency Shelter, SSVF and CES Intake Line staff should be working intensely to assist engaged clients with obtaining required documentation for housing (ID, birth certificate, documentation for length of time, etc.). It is important to note that documentation should never become an obstacle to housing a high acuity, vulnerable client. Clients must also be provided informed consent regarding the information they

share, and should never feel pressured to disclose personal detail beyond what they voluntarily consent to provide.

4. As provided by the Consolidated Appropriations Act, 2019, youth aged 24 and under must not be required to provide third-party documentation that they meet the homeless definition in 24 CFR 578.3 as a condition for receiving services. Additionally, any youth-serving provider funded by the CoC or serving as a youth access point may serve unaccompanied youth aged 24 and under (or families headed by youth aged 24 and under) who have an unsafe primary nighttime residence and no safe alternative to that residence. HUD interprets "living in unsafe situations" as having an unsafe primary nighttime residence and no safe alternative to that residence. These youth-related requirements supersede any conflicting requirements under this policy.
5. In accordance with the HUD Homeless Definition Final Rule, persons fleeing violence must not be required to provide third-party documentation that they meet the homeless definition in 24 CFR 578.3 as a condition for receiving services. Persons fleeing violence may be provided a self-certification stating that they are fleeing, have no subsequent residence and lack the financial resources and support networks to obtain other permanent housing.
6. CES staff will follow the order of priority by program type, prioritizing by acuity score, while assessing a multitude of factors such as program eligibility criteria, barriers to access housing, length of time homeless, disabling conditions, street homelessness, client location and unit availability by region to identify and refer each household to the appropriate housing intervention.
7. The CES staff oversees the housing prioritization guide and makes referrals utilizing the HMIS, or outside housing guide when applicable, to the appropriate housing intervention in each region. Details on the referral process are outlined below in the *Referrals and Assigning Units with Client Choice section.*

Prioritization and Core Components of Housing Assistance

Program eligibility does not drive placement in the WV BoS CoC; rather, placement is driven by acuity and need via prioritization. The WV BoS CoC CES and its partners work to ensure households are quickly connected to housing resources in their community by relying on rapid prioritization that considers clientele across various aspects of the Continuum simultaneously.

All population groups experiencing homelessness are prioritized on a common list (housing prioritization guide) by CoC region utilizing the latest versions of the VI-SPDAT for Singles, the VI-SPDAT for Families, and the VI-SPDAT for Transition Age Youth, respectively. Households are matched to units based on acuity, need, client choice, and availability of units. As a first step, Diversion should be performed for all persons initially seeking resources, exhausting all other

mainstream housing and income options before placement into the narrow band of HUD homeless assistance resources, if at all possible.

Transitional Housing Assistance

Prioritization and housing placement for Transitional Housing (TH) in the BoS CoC comes in three basic categories:

1. "Bridge Housing" for high acuity people being "spring-boarded" into other types of permanent housing. It is also important to note that if a client enters into TH chronically homeless, they are still eligible for homeless housing assistance post exit, but are no longer eligible for Dedicated Permanent Supportive Housing beds.
2. Interventions for subpopulations such as Youth and Persons Fleeing Violence who may need additional supports initially to thrive in regular modes of permanent housing (PSH, RRH, or Public and Market Rate Housing).
3. Persons in shelter or from the street with no immediate access to permanent housing.

Placements into TH should be of moderate to high acuity (generally, 8-12 on the VI-SPDATs) and be awaiting document-readiness for placement from the housing prioritization guide. TH should NOT be considered a destination or a measure that exhausts its length of stay requirements (generally, 18-24 months).

Rapid Re-Housing Assistance

Order of Priority for Rapid Re-Housing:

Utilizing a standardized assessment tool, eligibility criteria for all Rapid Re-Housing (RRH) programs throughout the CoC by region and consideration of client choice, the CoC has set guidelines for CES to prioritize the following households for RRH assistance.

1) A household who is chronically homeless and living in a place not meant for human habitation.
2) A household whose length of time homeless is longer than a year, but not chronically homeless, and living in a place not meant for human habitation.
3) A household who is chronically homeless and living in emergency shelter.
4) A household whose length of time homeless is longer than a year, but not chronically homeless, and living in emergency shelter.
5) A household whose length of time homeless is less than a year and living in a place not meant for human habitation.
6) A household whose length of time homeless is less than a year and living in an emergency shelter.

Other criteria to assess when prioritizing for RRH assistance:

- Household member with multiple disabling conditions (tri-morbidity/co-morbidity) and currently living in a place not meant for human habitation.

- Household member over the age of 60 and currently living in a place not meant for human habitation.
- Households with children.
- Household consisting of unaccompanied youth.
- Household currently fleeing domestic violence.

The application of RRH resources will vary greatly by geography, availability, and community need. RRH is housing created for the purpose of providing an immediate permanent housing situation for moderately vulnerable individuals. Common types of RRH include HUD CoC RRH, Emergency Solutions Grant (ESG) funded RRH, Youth Homelessness Demonstration Program (YHDP) funded RRH, and Supportive Services for Veteran Families (SSVF) funded RRH. Contemporary research has shown RRH to be one of the most effective types of housing in the fight to end homelessness from both a cost and housing stability perspective.

RRH programs should have minimal barriers to entry, ensuring basic needs are met in order to successfully focus on community reintegration, managing tenancy, increasing household income and improving health and wellness of the household. enrolled in the program. RRH projects have tremendous latitude in determining the type of population the project will serve, and a great degree of flexibility in how subsidies are applied, in duration and amount, to house and stabilize individuals and families. Many RRH projects are utilized to end homelessness among youth and family populations, while a host of others design their services to specifically target the needs of families, survivors of domestic violence, and persons experiencing chronic or episodic homelessness.

Joint TH and PH-RRH

The Joint TH and PH-RRH component project combines two existing program components, transitional housing and permanent housing-rapid rehousing, in a single project to serve individuals and families experiencing homelessness. Program participants may only receive up to 24-months of total assistance. The type of housing proposed, including the number and configuration of units, must fit the needs of the program participants (e.g., two or more bedrooms for families). The project should work with the mainstream rental market to increase access to RRH assistance, ensuring that at any given time a program participant may move from TH to permanent housing. This may be demonstrated by identifying a budget that has twice as many resources for the RRH portion of the project than the TH portion, by having twice as many PH-RRH units at a point in time as TH units, or by demonstrating that the budget and units are appropriate for the population being served by the project. The ultimate goal of the program is to connect clients with permanent and stable housing, while ensuring client choice throughout this process. Joint TH and PH-RRH programs are required to be an active participant in the CES referral process. Please reference the previous sections—*Transitional Housing Assistance* and *Rapid Re-Housing Assistance* which outline the prioritization process for each component.

Permanent Supportive Housing Assistance

Order of Priority for Permanent Supportive Housing:

Permanent Supportive Housing (PSH) is housing created for the purpose of keeping highly vulnerable individuals and families with complex issues from dying on the streets by providing them with a safe, stable place to live coupled with intensive case management. It is, by definition, a potentially permanent type of housing that seeks to provide a stable place for persons who otherwise would not succeed in remaining stably housed with a Housing Choice Voucher, Public Housing, market rate housing, or homeownership. PSH is a housing type designed for persons with prolific mental health, physical health, and/or substance use issues, including persons who are chronically homeless. Types of PSH include HUD CoC PSH and HOPWA Tenant Based Rental Assistance, in addition to, other types of housing created specifically at a state or local level to house this population.

Successful PSH programs emphasize reducing obstacles to entry so that households can move into stable housing as quickly as possible. Once housed, individuals and families receive intensive and ongoing supportive services tailored to their needs. These services are designed to promote community reintegration, support management of complex and chronic physical and mental health conditions, increase household income, and assist with tenancy management to reduce eviction risks. By combining housing with long-term support, PSH helps households achieve stability and work toward greater independence.

CoC-Funded DEDICATED Chronically Homeless Beds

A critical role of any Coordinated Entry System is to provide the quickest entry to housing with supportive services for persons who are most likely to die on the streets. In the WV BoS CoC, people would be considered those individuals and families who meet the criteria for chronic homelessness, have the longest length of time homeless, severe service needs, and highest acuity scores on the VI-SPDAT. Given the questions asked on the VI-SPDAT as to length of time homeless, residence prior, the presence of mental health and acute health conditions, and risk factors, the VI-SPDAT tool is an excellent tool for the WV BoS CoC to use for the prioritization of people for housing. The following is the priority by which all Chronically Homeless individuals and families will be prioritized for PSH projects with dedicated beds for those experiencing chronic homelessness. Dedicated PSH beds are those which are required through their grant agreement to only serve persons experiencing chronic homelessness unless there are no persons within the CoC's geographic area that meet that criteria. If there are no persons experiencing chronic homelessness at the time of a bed vacancy, CES staff will follow the Order of Priority listed below to make a referral to the next available Dedicated bed. Once a new Dedicated bed becomes vacant again, the CES staff will assess to determine if there is a chronically homeless individual or family throughout the CoC (by region) at the time.

CoC-Funded NON-DEDICATED Chronically Homeless Beds

PSH beds that are not designated for a specific population and can serve other eligible households with disabilities according to a CoC's established order of priority, which usually prioritizes those most vulnerable.

CoC-Funded DEDICATEDPLUS Chronically Homeless Beds

During the FY2017 NOFA, the concept of DedicatedPLUS Permanent Supportive Housing (PSH) beds was introduced, allowing for households who are highly vulnerable, but not currently experiencing chronic homelessness, to be served in a timely manner. The concept of DedicatedPLUS was created to eliminate the barriers to services for the following areas:

- The challenge of working with an individual who likely meets the definition of chronically homeless and is highly vulnerable, yet adequate third-party verification is not readily available.

- Household who had met the eligibility criteria for Permanent Supportive Housing, but then resided in Transitional Housing because there were no other options available at the time.

- Households experiencing chronic homelessness that the initial permanent housing situations did not work, and they ended back on the street. However, they were in the unit long enough to count as a break and affect their status.

- Persons who had been residing on the street for several years, and recently had a stay longer than 90 days in an institutionalized setting. However, they were discharged back to the street or shelter.

- Households whose length of time homeless equals 12 months or longer in the past three years, but the number of episodes is less than four.

A DedicatedPLUS project is a CoC-funded PSH project where the entire project will serve individuals and families that meet one of the following criteria at project entry:

1) Experiencing chronic homelessness as defined in 24 CFR 578.3;
2) Residing in a transitional housing project that will be eliminated and meets the definition of chronically homeless in effect at the time in which the individual or family entered the transitional housing project;
3) Residing in a place not meant for human habitation, emergency shelter, or safe haven; but the individuals or families experiencing chronic homelessness as defined at 24 CFR 578.3 had been admitted and enrolled in a permanent housing project within the last year and were unable to maintain a housing placement;
4) Residing in transitional housing funded by a Joint transitional housing (TH) and rapid re-housing (PH-RRH) component project and who were experiencing chronic homelessness as defined at 24 CFR 578.3 prior to entering the project;

5) Residing and has resided in a place not meant for human habitation, a safe haven, or emergency shelter for at least 12 months in the last three years, but has not done so on four separate occasions; or
6) Receiving assistance through a Department of Veterans Affairs (VA)-funded homeless assistance program and met one of the above criteria at initial intake to the VA's homeless assistance system.

Recipients of CoC Program funding for PSH designated as DedicatedPLUS are required to document eligibility of all program participants served at the time of program enrollment. HUD requires that recipients obtain the following documentation for all program participants assisted in a DedicatedPLUS project:

- Evidence that the head of household has a qualifying disability as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)).
- Evidence that the program participant is currently residing in a location that makes them eligible.
- History of homelessness that demonstrates that the household meets any of the DedicatedPLUS eligibility criteria.

For DedicatedPLUS PSH, the qualifying household member must be either an adult head of household or minor head of household when no adults are present. When there are multiple adults in the presenting household, or multiple minors in a family with no adult, HUD does not specify which adult or minor must be identified as head of household for determining eligibility purposes. When an unaccompanied minor is identified or presents for services, it is important for the entry point to connect them with safe temporary housing and coordinate with local child advocacy programs, youth providers, school systems, and the Public Child Welfare Agency to develop a plan to best meet the young person's needs.

When documenting Homeless Status and Length of Time Homeless for Dedicated PLUS, recipients and subrecipients must document both where the household is currently residing as well as their history of homelessness. https://files.hudexchange.info/resources/documents/Overview-of-DedicatedPLUS-Eligibility-and-Recordkeeping-Requirements.pdf

STANDARD:
CoC-funded PSH projects which have beds that are dedicated to serve individuals and families who are identified as chronically homeless are required to follow the order of priority in accordance with the Order of Priority section of Notice CPD-16-11, and per the agreed-upon Order of Priority as established by the WV Balance of State CoC when accepting referrals and enrolling participants in housing programs. The WV BoS CoC utilizes a Coordinated Entry Model with four primary entry points for connection to PSH throughout the CoC. The four entry points for Coordinated Entry— Emergency Shelter (including hotel/motel paid for by a charitable organization), Street Outreach, SSVF and the CES Intake Line (operated by the WVCEH)— must

exercise due diligence when conducting outreach and assessment to ensure that persons are served by the established Order of Priority, as adopted by the BoS CoC. When it has been determined by system entry points that no household in the designated BoS CoC region meets the definition of Chronically Homeless with regards to length of time homeless as defined by 24 CFR 578.3, the Director of CES will follow the established Order of Priority and then refer the next most vulnerable household with a disabling condition to PSH in this region. The CES Director will upload the redacted housing prioritization guide at the time of referral to the client file in HMIS along with a referral form stating the household was the next to be housed in accordance to the CoC's established Order of Priority for PSH.

When documenting disability for all PSH programs, written disability documentation should be dated at any point during the timeframe in which the individual was experiencing homelessness or in one of the following circumstances: (1) while the household is residing in RRH but will need PSH and (2) while the household is residing in PSH and within 45 days of having been enrolled in the program.

Chronic Homeless status and other established prioritization criteria are clearly indicated on the CoC-wide housing prioritization guide, making adherence to the following priority simple and straightforward. The prioritization process by CoC region allows CES staff to work with local entry points to assess and evaluate each household's needs when referring to a PSH bed.

CRITERIA:
The following is the Order of Priority by which all Chronically Homeless individuals and families will be prioritized for PSH resources for projects with Dedicated, Non-Dedicated, and DedicatedPLUS beds throughout the WV BoS CoC. Youth, Domestic Violence, and HOPWA housing programs are also advised to utilize this Order of Priority, with the understanding that clients who may be eligible for these population-specific services, and who meet the highest priority, will also be prioritized concurrently for CoC-funded PSH resources in their area.

First Priority – Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 for which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Most Severe Service Needs (tri-morbidity)
- Residing in a Place Not Meant for Human Habitation
- VI-SPDAT acuity score is 13 or above

Second Priority – Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Most Severe Service Needs (tri-morbidity)
- Residing in a Place Not Meant for Human Habitation
- VI-SPDAT acuity score is 8-12

Third Priority – Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Most Severe Service Needs (tri-morbidity)
- Residing in an Emergency Shelter (or Safe Haven if applicable to your area)
- VI-SPDAT acuity score is 13 or above

Fourth Priority – Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Most Severe Service Needs (tri-morbidity)
- Residing in an Emergency Shelter (or Safe Haven if applicable to your area)
- VI-SPDAT acuity score is 8-12

Fifth Priority – Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Less Severe Service Needs
- Residing in a Place Not Meant for Human Habitation
- VI-SPDAT acuity score is 8+

Sixth Priority – Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (3 or more years)
- Less Severe Service Needs
- Residing in an Emergency Shelter (or Safe Haven if applicable to your area)
- VI-SPDAT acuity score is 8+

Seventh Priority – Chronically Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- Longest History of Homelessness (1-3 years)
- VI-SPDAT acuity score is 8+

Eighth Priority – Literally Homeless Individuals and Families as defined in 24 CFR 578.3 which all of the following are true:

- VI-SPDAT acuity score is 8+

The following outlines the criteria that CES staff are to follow once they are down to the **8th priority** for any CoC region that does not currently have any chronically homeless households on their guide, or in a CoC region with highly vulnerable households that has DedicatedPLUS beds available. For situations when a highly vulnerable household without the length of time homeless as defined in 24 CFR 578.3 is referred to PSH, the CES staff will save the weekly housing

prioritization guide in the WVCEH secure filing system at the time of referral for documentation purposes demonstrating they were the next most vulnerable household in need of housing within the established BoS CoC region. The redacted housing prioritization guide and letter from the CES Director will also be uploaded to the client's HMIS file. Weekly housing prioritization guides will be stored for monitoring purposes.

Eighth Priority Households:

1. Longest History of Homelessness:
    a. Household whose length of time homeless equals 12 months or longer in the past three years, but the number of episodes is less than four.
    b. Length of time homeless just shy of one year and is about to age into chronicity.
2. Most Severe Service Needs (tri-morbidity)
3. Residing in a Place Not Meant for Human Habitation
4. Household member over the age of 60
5. Person is currently residing in a literally homeless situation; but the individuals or families experiencing chronic homelessness had been admitted and enrolled in a permanent housing project within the last year and were unable to maintain a housing placement.
6. Persons who have been residing on the street for several years, and now currently residing in an institutionalized setting with no current facility discharge plan. The person still must meet the HUD definition of literally homeless, so this current stay in the institutionalized setting must have been less than 90 days, and they must have entered the institution from a homeless situation.
7. Persons who had been residing on the street for several years, and recently had a stay longer than 90 days in an institutionalized setting long enough to count as a break and affect their status. However, they were discharged back to the street or shelter.
8. Household who had met the eligibility criteria for PSH, but then resided in Transitional Housing because there were **no other options available at the time**. There must be documentation in the client file for why PSH is the best housing intervention now for this client. *Household cannot be transferred from Transitional Housing to a Dedicated PSH bed.*

IMPORTANT NOTE: When observing the Eighth Priority, it is important to note that the eligibility requirements for ALL CoC-funded PSH programs, require that the head of household must have a documented disabling condition, as defined in 24 CFR 583.5.

For <u>DEDICATED</u> CHRONICALLY HOMELESS BEDS only, CoC-funded projects may only serve the Eighth Priority in regions where there are no other chronically homeless individuals or families have been identified by CES.

Referrals and Assigning Units with Client Choice

STANDARD:
The program will provide safe, affordable housing that meets participants' needs in accordance with the CES and Prioritization process, based on acuity and eligibility. The program will also provide low barrier, rapid, and successful entry into housing for each eligible client, by acuity and coordinate with local providers to increase availability of units. The program will assess eligibility factors for specific programs, identify obstacles to housing, and coordinate with local providers to connect households with safe and appropriate housing. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals. Clients should always have the option to access housing resources, as available, in the area of their choice and are not confined to resources to a particular region.

The CES is tasked with demonstrating transparency of the process and how and why some referral decisions are made. When the housing prioritization guides are pulled from HMIS by CES to be reviewed weekly, they are shared with regional entry points and housing providers. CES staff should be reviewing the housing prioritization guide weekly and communicating this information to entry points and housing providers in each region. Ongoing communication and transparency around the guide are meant to strengthen collaboration during warm hand-offs between providers and to enhance overall understanding of the outcomes when clients are referred to CES.

Notification of Vacancies

Participating programs are required to notify the WV BoS CES when they have permanent housing units becoming available or vacant. The CES staff can be contacted via phone at 304-842-9522 x1 or contacted by email at ces@wvceh.org. CES will provide all referrals throughout the WV BoS CoC to participating programs by region. At this time, vacancies in YHDP and CoC-funded programs can be tracked in HMIS, and providers should be doing so to ensure utilization of resources CoC-wide. Other participating programs, such as ESG-funded and SSVF-funded programs, should also maintain ongoing communication with the WV BoS CoC CES regarding notification of upcoming vacancies in their programs in an effort to reduce vacancy rates. As previously discussed, CES staff will host regional monthly calls with system entry points and housing providers to ensure that the weekly process for notification of unit vacancies, sending referrals, accepting referral, unit location and move-in is reviewed on a regular basis, as households enter and exit the system. The goal of monthly calls and weekly guide communication with individual providers is to speed up the process of connecting people with housing through identifying needs of particular households, increasing knowledge of when units are available, and also working together to ensure HMIS information and documentation is up-to-date and as accurate as possible.

In the same approach of having focused discussion on complex cases, there should be focused discussions on filling difficult program beds. Client choice should be a primary focus of any referral and placement, including the household in the next steps of their journey from street

into housing, and promoting awareness of the processes to get them there. However, location and availability of resources may limit options, particularly in the most rural areas of the CoC. Consideration should be made around transfers when households have ties to the community such as employment or children, and if the household is agreeable to moving to another area, providers in both areas are expected to assist with the relocation. It is important to remember in this process that a vacant unit should be held vacant for no more than 30 days awaiting a verification of eligibility match from any region in the CoC. If no match is identified, the referral can be made from moving down the prioritization list for that project type. Please reference the WV BoS CoC prioritization process details in the above section – *Prioritization and Core Components of Housing Assistance.*

The CoC staff will review Annual Performance Reports (APR) and Consolidated Annual Performance and Evaluation Reports (CAPER) on a quarterly basis to monitor open and unused beds. The CES staff must work with providers to verify within a region there was no match, and that persons throughout the CoC were offered the housing option. The CES staff and housing providers receiving referrals must also document the rejection of the housing offer and demonstrate due diligence to the fidelity of the prioritization, unit match, and referral process within the client record.

All referral procedures from the WV BoS CoC CES will be performed through Community Services (WV Statewide HMIS Implementation) for those providers utilizing HMIS. For providers not using HMIS, a traditional mode of phone/email referral will be performed per the protocol outlined by the individual participating partner. For VSPs, CES will complete and send a form with a de-identified client number to document the date of the referral to that CoC-funded DV service provider.

CRITERIA:

Referrals to Transitional Housing

All funding streams of Transitional Housing programs will be an active member of the CES throughout the WV BoS CoC. Transitional Housing may act as an entry point in specific communities, but will also accept referrals directly from the CES. This referral process will be tracked in HMIS. As mentioned previously, placements into Transitional Housing should be of moderate to high acuity (generally, 8-12 on the VI-SPDATs) and be awaiting document-readiness for placement from the housing prioritization guide. It is also important to note that if a client enters into Transitional Housing chronically homeless, they are still eligible for homeless housing assistance post exit, but are no longer eligible for Dedicated Permanent Supportive Housing beds. Transitional Housing should NOT be considered a destination or a measure that exhausts its length of stay requirements (generally, 18-24 months).

All Joint TH-RRH projects funded under CoC or YHDP are required to participate in the WV BoS CoC CES. Clients should have the choice of utilizing either component, and when a CES referral is made, the housing provider should enroll the client in both TH and RRH components on the same project start date in HMIS. When the client moves from TH to RRH, the client should be exited

from the TH component and a housing move-in date should be recorded. If the client chooses not to use the TH component, then only a RRH entry in HMIS is required.

Referrals to Rapid Re-Housing

All funding streams of Rapid Re-Housing programs will be an active member of the CES throughout the WV BoS CoC. Rapid Re-Housing programs will act as a referral point for the CES who will utilize the Order of Priority (listed below), knowledge of all program eligibility criteria, client need and location, and unit availability to identify and refer the household to the appropriate Rapid Re-Housing program. This referral process will be tracked in HMIS, or via referral form for CoC-funded DV providers. There is an expectation for all Rapid Re-Housing programs that once a household is referred from CES to a particular program, the assigned staff at the agency will be directed by the program supervisor to follow up with the appropriate entry point— CES, Street Outreach, Emergency Shelter, or SSVF— where the household is residing. This is done in order to make contact to begin the housing process with the goal of project start date/enrollment to move-in being within 20 days or less. It is important to note here that for sheltered households, the housing case manager is responsible for making initial contact with the shelter provider and referred client, allotting 5 days from CES referral, to answering referral, to project enrollment. For unsheltered households, the CES may refer directly to outreach, when appropriate, allotting 10 days to locate and refer to the permanent housing project. It is the expectation of the CoC that outreach referrals are accepted within 3 business days. Once the client is engaged and document gathering is initiated, the outreach provider is expected to update the client record in HMIS and communicate the client's housing needs to CES. Once a referral is made to a Rapid Re-Housing program for an unsheltered person, the housing provider is expected to connect with the outreach provider to coordinate a client meeting, allotting 10 days from CES referral, to answering referral, to project enrollment. The process from referral to housing in its entirety should be less than 30 days for Rapid Re-Housing projects.

In an CoC-wide effort to ensure the most vulnerable households are being served, referrals to Rapid Re-Housing providers will be tracked in HMIS, and during the annual review process, providers are monitored to ensure they have 10% or less denial rate. Any projects that do not meet this criteria will not obtain maximum points regarding participation with the CES during annual CoC ranking and rating.

Denial rates will also be tracked in HMIS for all participating providers and information will be provided to funders upon request. All programs will ensure active client participation and informed consent. If the client is not located by a minimum of three documented attempts to make contact within a three-week period, they will be exited from the Rapid Re-Housing project and the referral will be canceled. The Rapid Re-Housing project will notify the CES that the referral is being cancelled, and this referral cancellation will not count toward the overall denial rate.

Referrals to Permanent Supportive Housing

All types of Permanent Supportive Housing programs will be active members of the Coordinated Entry system throughout the WV BoS CoC. Permanent Supportive Housing programs will act as a

referral point for the CES who will utilize the Order of Priority (listed above), knowledge of all program eligibility criteria, client need and location, and unit availability to identify and refer the household to the appropriate Permanent Supportive Housing program. This referral process will be tracked in HMIS. There is an expectation for all Permanent Supportive Housing programs that once a household is referred from CES to a particular program, that the assigned staff at the agency will be directed by the program supervisor to follow up with the appropriate entry point— CES, Street Outreach, Emergency Shelter, or SSVF— where the household is residing in order to make contact to begin the housing process with the goal of project start date/enrollment to move-in being within 50 days or less. It is important to note here for sheltered households, the housing case manager will be responsible for making initial contact with the shelter provider and referred client, allotting 10 days from CES referral to answering referral to project enrollment. For unsheltered households, the CES may refer directly to outreach when appropriate, allotting 10 days to locate and refer to the permanent housing project. It is the expectation of the CoC that outreach referrals are accepted within 3 business days. Once the client is engaged and document gathering is initiated, the outreach provider is expected to update the client record in HMIS and communicate the client's housing needs to CES. Once a referral is made to a Permanent Supportive Housing program for an unsheltered person, the housing provider is expected to connect with the outreach provider to coordinate a client meeting, allotting 10 days from CES referral to answering referral to project enrollment. The process from referral to housing in its entirety should be less than 60 days for Permanent Supportive Housing projects, and all participating providers should ensure active client participation and informed consent during this process.

In an CoC-wide effort to ensure the most vulnerable households are being served, referrals to Permanent Supportive Housing providers will be tracked in HMIS, and during the annual review process, providers are monitored to ensure they have 10% or less denial rate. Any projects that do not meet this criteria will not obtain maximum points regarding participation with the CES during annual CoC ranking and rating. Denial rates will also be tracked in HMIS for all participating providers and information will be provided to funders upon request. All programs will ensure active client participation and informed consent. If the client is not located by a minimum of three documented attempts to make contact within a three-week period, they will be exited from the Permanent Supportive Housing project and the referral will be canceled. The Permanent Supportive Housing project will notify the CES that the referral is being cancelled, and this referral cancellation will not count toward the overall denial rate. Though, repeated cancellations will be brought to the attention of the CoC Team to address with the individual agency.

Program to Program Transfer Policy

A sound and successful CES considers the need for transfers between program types to better meet the needs of a household. A key component to any transfer process is an on-going assessment of a household to determine whether the levels of service are appropriate or need to be increased or reduced. A household may need to transfer to another program within the CES for a myriad of reasons including, though not limited to, changes to family composition, the defunding of an agency or program, or criminal record for state-mandated restrictions. Providers are often confronted with scenarios in which a household may need the most intensive services and require a move from rapid re-housing to permanent supportive housing. The WV BoS CoC

CES program transfer policies are focused on providing a flexible strategy to structure assistance to meet a household's needs and employing ongoing assessment to determine those needs.

Transfers between Programs within the Same Program Model

When a current household must transfer to another program within the same program model (Rapid Re-Housing to Rapid Re-Housing or Permanent Supportive Housing to Permanent Supportive Housing), the provider should contact the CES staff to assist in connecting with the receiving provider in the CoC region that the household is being transferred. The receiving provider will review the request and decide on whether the transfer is available and feasible within one week and communicate this decision with the referring provider. If the transfer is approved, the referring provider will be responsible for arranging moving assistance with the new provider. If the request is not accepted, the referring provider may contact the CES again to assist with locating other options.

Transfers from One Program Model to Another

Rapid Re-Housing is a model for helping individuals and families who are experiencing homelessness to obtain and maintain permanent housing, and it can be appropriate to use as a bridge to other permanent housing programs. Program transfers may be made from Rapid Re-Housing to Permanent Supportive Housing, so long as the household meets the eligibility criteria under the specific program and the requirements for the Permanent Supportive Housing project in the Notice of Funding Opportunity (NOFO) for the year the project was awarded. Requests for transfers from Rapid Re-Housing to Permanent Supportive Housing should be offered (when the resource is available) to households who were experiencing chronic homelessness prior to entry into Rapid Re-Housing and are requiring additional supports that Rapid Re-Housing is unable to provide.

Households CANNOT be transferred between the following Program Models:

- Permanent Supportive Housing to Rapid Re-Housing
- Transitional Housing to Permanent Supportive Housing (Dedicated beds)
- Rapid Re-Housing to Transitional Housing
- Rapid Re-Housing (when the household was not chronically homeless prior to entry) to Permanent Supportive Housing

CoC Emergency Transfer Plan

The CoC Emergency Transfer Plan includes procedures that prioritize safety for victims of domestic violence, dating violence, sexual assault, stalking and other dangerous, traumatic, or life-threatening conditions when requesting a transfer. This plan identifies tenants who are eligible for a transfer, the documentation needed to request a transfer, confidentiality protections, transfer process, and guidance to tenants on safety and security. This plan details steps for funded projects when transferring internally/externally and highlights the importance of client choice. If a unit is not available internally, the DV CES Specialist may assist the client with accessing other housing resources in or outside the CoC. If the client is not already connected with a VSP, and interested in doing so, this plan also provides contact information for resources.

Housing providers must provide reasonable accommodations for individuals with disabilities per ADA requirements and detailed in the CoC's Emergency Transfer policy. All funded providers are informed of the plan and the process for participants to request a transfer. The tenant may request a transfer utilizing the HUD 5382 form and coordinate with their case manager to provide documentation that the tenant's current housing situation presents a threat of imminent harm from further violence if the tenant were to remain in the same dwelling unit, or that the tenant was a SA victim and that the SA occurred on the premises during the 90-calendar-day period preceding the request for a transfer. With client consent, this information will be released to the DV CES Specialist to assist with locating an available unit. If the client does not want PII shared, the housing provider may internally assist with unit relocation or coordinate with the DV CES Specialist utilizing de-identified information to locate an available unit. Since landlords accepting federal subsidies must adhere to the VAWA Lease Addendum requirements, landlords are notified by the tenant or case manager (with consent) with the reason for breaking the lease but not provided information on the details of the situation or relocation. Details for the process of requesting and responding to a transfer request can be found in the WV BoS CoC RRH & PSH Guidance VAWA Emergency Transfer Plan at https://wvceh.org/guidance/.

Annual Training for Agency Staff

STANDARD:

The WV BoS CoC is committed to ensuring that all staff who assist with the daily operations of the CES receive sufficient training to implement their daily tasks in a manner consistent with the mission and framework of the WV BoS CoC CES, as outlined in this document.

CRITERIA:

1. Annual review of the WV BoS CoC's written CES guidance, including any adopted variations for specific sub-populations.
2. Requirements for use of assessment information to determine prioritization.
3. Protocol for uniform decision-making and referrals.
4. Intensive training for new staff on the use of the assessment tools, along with annual reviews for current staff who work at all identified system entry points.
5. Technical Assistance on an as-needed basis in regard to any changes to HMIS as it pertains to the CES.
6. On-going assessment and oversight of advertising efforts, service delivery and resource connection.

Data Systems- Privacy and Protections

The WV BoS CoC and all participating providers contributing data to the CES must ensure participants' data are secured regardless of the systems or locations where participant data are collected, stored, or shared, whether on paper or electronically. Additionally, participants must be informed how their data are being collected, stored, managed, and potentially shared, with whom, and for what purpose.

1. All CoC, YHDP, ESG, and PATH funded programs are required to report client level data in HMIS. The following VA funded programs are also required to report client level data in HMIS— SSVF, GPD, and HCHV. HOPWA and RHY funded programs are also required to report in HMIS, but the client level data is locked down to those providers only for confidentiality of the program participant receiving the services. All non-funded Emergency Shelters are encouraged to participate in HMIS to create a more accurate picture of the need in each community, and in order to connect those households more quickly to housing.
2. For providers not using HMIS, or not permitted by law to utilize HMIS (Victim Service Providers), the VI-SPDAT can be completed outside of HMIS. Assessment data related to housing placement is collected without Personally Identifiable Information (PII) and can be inputted securely by the staff person at that agency, where it is then managed in an outside housing prioritization guide by the WV BoS CoC DV CES Specialist via a secure GoogleDoc. The DV CES Specialist will review the guide weekly and contact the VSP to assist each household with obtaining documents for housing and when the next household on the guide is to be housed.
3. Any data collection methods at it relates to the CES must adhere to the Violence Against Women Act. For additional guidance regarding the 2022 reauthorization of VAWA, reference: https://www.federalregister.gov/documents/2023/01/04/2022-28073/the-violence-against-women-act-reauthorization-act-of-2022-overview-of-applicability-to-hud-programs.
4. Data may not be collected without consent from the participant. All intake line staff are required to obtain verbal release from the client, and record the Release of Information in HMIS. All Street Outreach staff are allotted time to build rapport with the client and may obtain verbal consent for Release of Information in HMIS, until a written release is able to be obtained. HMIS data may be collected while building rapport, but no PII should be shared until the client verbally permits. This means that Street Outreach project records in HMIS can be built over time, and once the client is engaged, the appropriate releases should be obtained at this time. All other providers participating in HMIS, should be obtaining a written Release of Information from the program participant which identifies what data will be collected, what data will be shared, which agencies data will be shared with and what the purpose of the data sharing is. Participants should always have the option to decline signing the consent without making them ineligible for services.
5. HMIS should also be utilized by the CES to track bed and unit vacancies. This should be done with all participating Emergency Shelters and YHDP and CoC-funded programs. For ESG-funded and SSVF programs, units may also be tracked in HMIS. However, since ESG

and SSVF do not apply for a set number of beds, agency staff should be in communication with CES staff regarding capacity and upcoming vacancies.

6. Participant Assessment Information in HMIS should be updated at a minimum once a year and also during any significant household changes (e.g. increase income, new health insurance) if the participant is served by any provider within the CES for more than 12 months. Staff should be updating any new information in the client record as it becomes known.

Evaluation

STANDARD:

Regular and ongoing evaluation of the CES will be conducted to ensure that improvement opportunities are identified, that results are shared and understood, and that the CES is held accountable.

CRITERIA:

1. The CES will be evaluated biennially using HMIS data. The following results will be published on the WVCEH website and reviewed by the WV BoS CoC Steering Committee including, but not limited to, reduction in the length of time homeless, reduction in the number of persons experiencing first time homelessness, increase in the number of placements into permanent housing, and reduction in the length of time it takes to move from street to housing.
2. The WV BoS CoC will seek feedback from participating providers and community stakeholders. Providers and community stakeholders have the opportunity to complete an anonymous survey to evaluate their experience with the CES.
3. The WV BoS CoC will work with frontline staff to collect feedback from program participants annually regarding overall system function. WV BoS CoC staff have contracted with the company, Pulse for Good, to develop a program participant survey to collect feedback from clients regarding their full experience from beginning to end with the CES. Pulse for Good creates simple surveys that are easily accessible on iPads, where customized kiosks can also be set up at different agencies across CoC, and the survey results are automatically tabulated. The purpose of the program participant survey is to collect meaningful feedback, while utilizing data to assess system successes and failures, allocate resources, and identify service gaps to make program/system-wide improvements.

Appeal Process

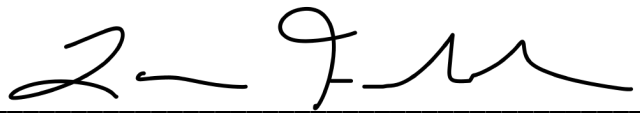
STANDARD:

If a program participant or participating provider is dissatisfied with a service, decision, action or situation involving WV BoS CoC Coordinated Entry System, or wishes to file a complaint against a perceived incidence of unfair treatment, the following procedures may be followed:

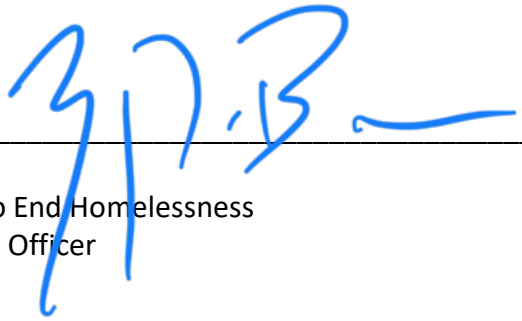
CRITERIA:

1. The program participant or participating provider may make a verbal complaint to WVCEH CES Director at the WVCEH Main Office by phone at 304-842-9522.
2. If contact with the WVCEH CES Director does not resolve the problem or if the program participant or participating provider does not feel comfortable making the complaint to the WVCEH CES Director, they may contact the CoC Director at 304-842-9522. An attempt to resolve the complaint will be made within 5 business days.
3. If contact with the CoC Director does not resolve the problem or if the program participant or participating provider does not feel comfortable making the complaint to the CoC Director, they may contact the WVCEH Chief Executive Officer at 304-842-9522. An attempt to resolve the complaint will be made within 5 business days.
4. If the program participant or participating provider is unhappy with the resolution and would like to file a formal written complaint, they may submit a written grievance via mail or email to the WV BoS CoC Steering Committee.
5. Within 30 days of receipt, the WV BoS CoC Steering Committee will review the formal complaint and determine the best course of action. Complaints regarding the program acceptance or denial process will be reviewed closely on a case by case basis. The committee may require the individual or agency issuing the complaint to meet with the committee to discuss the need for reconsideration for a particular individual or to obtain additional information from the agency filing the appeal.
6. Within 7 business days after review of the written complaint, the WV BoS CoC Steering Committee will inform the program participant or participating provider of the resolution of the complaint. The decision will be a written letter documenting the original complaint, all measures taken to resolve the complaint, and the final decision. This letter will be issued to the person or agency making the complaint via the CES email ces@wvceh.org and signed by the committee Chair. All decisions made by the committee will be final.

The above steps are provided in sequence; however, some steps may be eliminated if the program participant or participating provider wishes. The program participant or participating provider may also at any time complete a formal complaint or an anonymous complaint and return it to a staff member or via mail. After each step in the process, the program participant or participating provider will receive notice of the actions taken as a result of their complaint. All complaints reported will be documented and kept on file at the WVCEH main office and written copies will be available upon request.



Lauren Frederick
WV Coalition to End Homelessness
WV Balance of State Continuum of Care Director



Zach Brown
WV Coalition to End Homelessness
Chief Executive Officer

Appendix I:

Coordinated Entry System Prioritization during a Global Pandemic:

During a global pandemic, the goal will be to keep individuals under roof and in place as much as possible. At times when community transmission is high, the number of hotel stays across the WV BoS CoC will be higher than under normal circumstances to assist with sheltering in place, isolation, and quarantine. Hotel discharge will look different as more individuals are moved out of hotels into housing or shelter during times of lower community transmission. Individuals, families, and youth will be prioritized in accordance with the existing WV BoS CoC CES process with the goal of keeping households sheltered in both congregate and non-congregate sites based on acuity, vulnerability, etc., and will be prioritized for housing according to this existing guidance and following the established order of priority by project type. The following will be considered when prioritizing households during times a global pandemic:

- Prioritizing for housing by acuity and project type, taking into account when a household is part of a high-risk population for contracting disease.
- Discharging to shelter as beds become available at times when shelters are taking new intakes.
- Prioritizing for shelter or housing by group: those at high risk for contracting disease.