Coordinated Entry & Referral System

History of Coordinated Entry

- Defining a Continuum of Care
  - A CoC is a regional or local planning body that coordinated housing and services for homeless families and individuals.
  - Our local CoC (CA-506) is comprised of Monterey and San Benito Counties
- HEARTH Act
  - Homeless Emergency Assistance & Rapid Transition to Housing Act
  - Amended and reauthorized McKinney-Vento Act
  - Mandated Coordinated Entry System

What is CARS?

- A federally mandated change in the way homeless services are provided
- Also known as Coordinated Entry
- A centralized or coordinated process designed to coordinate program intake, assessment and provision of referrals
- Covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.
- The Coalition of Homeless Services Providers maintains a Master List of clients for the CA-506 Continuum of Care and provides referrals into homeless housing programs

How CARS is Different

Homeless Services Before:

- Each individual program maintained their own waitlist
- First-come first-served basis
- Programs were only able to serve their target population
- Clients had to go to each program to sign up for their services

Coordinated Entry:

- There is one centralized wait list for all homeless housing programs
- Prioritized by vulnerability
- All participating agencies are able to assess clients regardless of which programs they qualify for
- Clients only need to complete one assessment to be considered for all participating programs

CARS Participating Agencies

- Access Support Network
- Central Coast Center for Independent Living
- Coalition of Homeless Services Providers
- Community Homeless Solutions
- Community Human Services
- County of San Benito Health & Human Services
- CSUMB Chinatown Learning Center
- Franciscan Workers (Dorothy's Place)
- Housing Authority of the County of Monterey
- Interim, Inc.
- The Housing Resource Center of Monterey County
- The Veterans Transition Center
- Sun Street Center
- Veterans Resource Centers of America

Receiving Agencies & Programs

- Central Coast Center for Independent Living (CCCIL):
  - Emergency Solutions Grant (ESG)
- Community Homeless Solutions:
  - Homeward Bound
  - Men in Transition
  - Lexington Court - Intact Families
- Community Human Services:
  - Safe Passage
- County of San Benito - Health & Human Services:
  - Helping Hands
- Dorothy's Place
  - House of Peace
- Housing Authority of the County of Monterey:
  - Pueblo Del Mar
- Interim Inc.:
  - MCHOME
  - Shelter Plus Care
- Veterans Transition Center
  - Coming Home Program (GPD)
- Veterans Resource Centers of America:
  - SSVF

How It Works

- You (Case Managers, Receptionists, Outreach Workers, etc.) provide assessments to homeless clients who seek housing. CA-506 chose to use the VI-SPDAT as our assessment.
- The VI-SPDAT is administered via the HOME app
- All clients are put onto a Master List
- When a housing opportunity presents itself, the client who fits the unit best and has the highest assessment score is matched to the unit, and a referral is made
- The receiving agency performs their usual intake process to see if the client is eligible for program
- If all goes well, the client is then housed

The Assessment Process

- Prescreening:
  - As a first step, the individual or family should be asked basic pre-screening questions to determine if they need homelessness assistance, whether they have already received the VI-SPDAT, and whether they are a member of special population requiring specialized assistance.
  - If the individual or family is not homeless, the assessment process should not be continued.
- Special Populations:
  - Victims of Domestic Violence
  - Veterans
  - Youth Under Age 18
- If the individual or family does need homelessness assistance, staff should check the HOME app to see if they have already received the VI-SPDAT in the past year. If not, or if it seems their situation has changed significantly since the last time, the assessment can proceed.

Before the Assessment

The assessment should be conducted in a setting that promotes safety, privacy, and confidentiality. Staff conducting the assessment should follow community guidelines below for explaining the assessment process and benefits. Key points that may be covered include:

- That the collected information will be entered into the HOME app, which will help ensure that they will only need to compete the assessment once, that they will go onto the master list, and that they will not have to go around to different agencies getting on separate waiting lists.
- That the assessment will help result in a recommended housing intervention but it is not guaranteed.
- That due to limited housing availability, it is unlikely that the recommended intervention will be available immediately, and it is important provide up-to-date contact information for when the intervention does become available, and to immediately call Coalition staff at **831-883-3080** to inform staff of any contact information changes.
- That the assessment is voluntary, but that completing it will make it easier to provide the assistance needed and will allow them to be placed on the master list for referrals.
- Information will be entered into the HOME app only if a Release of Information (ROI) is signed.

The VI-SPDAT

- As mentioned before, CARS uses the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) as the standard assessment tool. The VI-SPDAT is built into the HOME app.
- The VI-SPDAT is completed in the HOME app with all individuals and families who are homeless under HUD’s definition of homelessness.
- The VI-SPDAT can only be conducted by agency staff (or volunteers who are connected to the agency) who have successfully completed training and been authorized by the Coalition as the CARS lead agency.
- More training later…

Determining Which VI-SPDAT to Use

Singles VI-SPDAT	Family VI-SPDAT	TAY-VI-SPDAT
Single Adult 25 or older with no children	Single adult with children	Single TAY individual (18-24 years old)
Married or non-married couple with no children	Married or non-married couple with children	TAY individual living in parents household
Step-parent or grandparent in a family with children	TAY individual with children	

Conducting the Assessment

If the ROI has been signed the assessment can be conducted. The assessment usually is entered directly into the HOME app, may be completed on paper where possible and more comfortable for the client, or may only be completed on paper in the case of a victim service provider. If completed on paper, the VI-SPDAT score must be entered into the HOME app within 24 hours of the assessment.

The assessment process should adhere to the following rules:

- Clients may be asked to answer the questions as accurately as possible.
- The order of questions should not be changed.
- All questions should be asked, including all linked questions.
- The wording used should not be changed (unless authorized).
- The information gathered and entered should only be through client self-report (not through staff opinion or guesses or third-party information).

More Training on Assessments Later!

The Master List

The Coalition of Homeless Services Providers and Community Technology Alliance (CTA) jointly maintain a “Master List” in the Home app that includes:

- A sortable list of clients prioritized by VI-SPDAT score and local population/subpopulation factors in the Prioritization Matrix.
- An inventory and basic eligibility information for each participating housing program, including transitional housing, rapid rehousing, and permanent supportive housing.
- A listing of beds/units that are currently availability or expected to become available.

Making a Referral

- When a PSH or TH bed/unit or RRH financial assistance becomes available, the master list will be sorted by both priority score AND eligibility criteria to identify the highest priority individual or family who is also eligible for the particular housing opportunity.
- This means that a person with a higher overall priority score will not be the one referred if he/she is not otherwise eligible for the housing.
- For example, a high scoring individual will not be referred family housing, and only Veterans will be referred to a program targeting Veterans.

Standard Referral Steps

	Step	Timeliness Standard
Step 1	Once the referral is made, the receiving program attempts to contact the client to schedule an appointment.	3 business days
Step 2	Once the client is contacted, the receiving program schedules the intake appointment.	3 business days
Step 3	If the client misses the appointment, the receiving program attempts to schedule a 2nd appointment. Absent extenuating circumstances, a client missing 2 appointments will be removed from the Master List and placed on a separate list; CoC staff may later reassign the client to the Master List.	3 business days
Step 4	Absent extenuating circumstances, the client has 3 business days after the intake interview to provide any missing application materials.	3 business days
Step 5	The receiving program provides the client with a written eligibility/acceptance determination.	3 business days or when application materials complete
Step 6	If the client is accepted, the receiving program works with the client to arrange move in.	30 calendar days latest
Step 7	The receiving program records program entry into HMIS (or uses the Master List to refer back to the CoC if the client was rejected.)	Immediately

Acceptance / Denials

- To ensure system efficiency and the best possible client service, receiving programs are generally expected to accept every referral received from CARS.
- Receiving programs may decline an individual or family referred through CARS if any of the following exceptions are demonstrated:
  - There is no appropriate vacancy available
  - Household presents with more or fewer people than the unit is designed for in line with housing standards
  - The individual or family is not eligible under funding source or local eligibility requirements for the program in question
  - For recovery-based housing programs only: if an individual indicates unwillingness to comply with sober program requirements
  - The program provides documentation that it lacks the resources needed to effectively or safely serve and support the individual or family in question
  - For transitional housing programs only: if the client has already graduated from a transitional housing program within the previous two years
  - Client misses two or more intake appointments within a 48-hour period of time
  - Clients may decline a referral because of program requirements that are inconsistent with their needs or preferences. There are no limitations on this decision
  - There is a conflict of interest as defined in writing by the receiving agency, e.g., where the client is related to a staff or Board member of the receiving agency.

Accessing the HOME App

- The HOME app can be accessed on the Coalition's website
- Each user will have their own login to access the HOME app
- All information regarding the CARS program and/or HOME is accessible on the Coalition's website.

Post-Assessment Wrap Up

- Let the client know that they are now on the Master List
- They can contact the Coalition if their contact information changes
- If they are unreachable when a referral is available for them, they will be removed from the Master List
- Referrals have very strict timelines, so they will be contacted as soon as we are able to offer them a referral
- It is just about impossible for us to provide them with their "place" on the Master List
- They are now the Coalition's client!

Questions?