Pikes Peak Continuum of Care

Coordinated Entry
Policy, Implementation, and Procedures

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Policy

The Pikes Peak Continuum of Care (PPCoC) will use the Coordinated Entry Process to promote client choice and to demonstrate openness, inclusiveness, and transparency in homeless assistance. The PPCoC Coordinated Entry process will operate within the requirements of HUD Notice CPD-17-01 under the authority of HUD 24 CFR 578.7(a)(8), which mandates the coordinated entry process, be developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their individual strengths and needs.

The PPCoC adheres to HUD Notice CPD-016-11 prioritizing persons experiencing chronic homelessness in permanent supportive housing and requiring chronic homeless status documentation records. This policy is in fulfillment of Key Goal 3 of the PPCoC's Strategic Plan.

Overview

Coordinated Entry Purpose:

The Coordinated Entry process establishes a common tool for assessing individuals' housing needs and a single system for matching clients to available supportive housing. The common assessment tools are the Vulnerability Index & Service Prioritization Decision Assistance Tool and the Transitional Age Youth Service Prioritization Decision Assistance Tool, (VI-SPDAT version 2.0, F-VI-SPDAT version 2.0 and TAY-VISPDAT version 1.0), which examines and scores individual or family vulnerability. Individuals/families are prioritized for housing opportunities according to this score and other criteria from these assessments. HUD CoC funded housing programs and ESG funded housing programs are now required to use Coordinated Entry for placing clients into housing resources.

Vision:

The PPCoC Coordinated Entry (CE) Process will implement the PPCoC's vision to "have a durable system of places and programs to ensure that all people facing homelessness have access to housing and supportive services to sustain their quality of life." This process will provide timely access to appropriate resources through a centralized, equitable, person-centered process that preserves choice, dignity, and transparency.

Guiding Principles:

1. Our Continuum of Care, encompassing the entirety of El Paso County, supports a client-centered, low-barrier approach to housing, ensuring the needs and well-being of those experiencing homelessness are paramount while fostering self-determination for the client.

2. Our process will operationalize a shared community vision with clear priorities and community ownership.

3. We will use real-time key performance indicator data to inform decisions, goal setting, and resource allocation.

4. The process is transparent, with expectations and outcomes communicated regularly to all stakeholders, including housing service providers and clients.

5. The process is accessible to all and able to prioritize those most in need within different populations for available and appropriate services based on a common assessment tool.

6. Through coordination, our process targets appropriate resources by ensuring every individual, family and youth assessed is linked to the most relevant housing intervention.

7. Our collaborative effort focuses on long-term outcomes, including sustainability and support for both providers and clients in housing retention.

Process Components and Key Performance Indicators:

Identification: Through outreach and communications efforts, we will identify who needs help and who can provide help in our community. This information will be maintained and managed in the form of a "by-name" list and a list or database of housing programs.

- *Key Performance Indicator:* Number of individuals/families added to the By-Name List.
- *Key Performance Indicator:* Number of housing programs participating.

Assessment: In order to prioritize those most vulnerable and in need of help, we will use the VI-SPDAT version 2.0, F-VI-SPDAT and TAY-VISPDAT version 1.0 tools developed by OrgCode and Community Solutions. These tools will provide a starting point for case conferencing as a community. Other resources and information will be used in the process to prioritize individuals and families.

- *Key Performance Indicator:* Number of individuals and families with VI-SPDAT/f-VI-SPDAT/TAY-VISPDAT completed referred to resources.

Assistance: Community service providers will help individuals move toward housing solutions. This includes obtaining documents (see Document Ready Form, Attachment VI), development of client referral program application packet, developing a housing plan and providing case management.

- *Key Performance Indicator:* Number of individuals/families assisted with program application
- *Key Performance Indicator:* Number of individuals/families assisted with document readiness
- *Key Performance Indicator:* Number of individuals/families assisted with housing plans
- *Key Performance Indicator:* Number of individuals/families assisted with case management beyond the initial assessment.

If an individual does not score high enough to be matched to a housing resource, they will still receive assistance by being contacted by 211. Weekly the list of clients entered onto the By-Name List whose calculated score is low enough for "no housing resource", are compiled and sent to 211 for follow up. The 211 staff will initiate a call to these clients and ask them what

other types of assistance they might need and then give them ways to connect with people/agencies that can assist them. This is an important part of our service to the community.

- *Key Performance Indicator:* Number of individuals/families referred to 211.

Assignment: Service providers will meet for case conferencing and match (see Match Initiation Form, Attachment I) individuals with the appropriate housing resource or program.

- *Key Performance Indicator:* Number of individuals/families identified in case conferencing (PSH, SSVF, VASH, RRH, TH, etc.)
- *Key Performance Indicator:* Number of individuals/families accepted into a housing solution program (PSH, SSVF, VASH, RRH, TH, etc.)
  Key Performance Indicator: Number of individuals/families receiving rental assistance $$, leasing assistance $$, alternate funding for a housing solution program (PSH, SSVF, VASH, RRH, TH, etc.)
- *Key Performance Indicator:* Number of housing vacancies (See Housing Vacancy Form attachment II) brought to CE (PSH, SSVF, VASH, RRH, TH, etc.)
- *Key Performance Indicator:* Number of case conferencing meetings held to refer individual/family into a housing solution program (PSH, SSVF, VASH, RRH, TH, etc.)

Housing: Service providers will connect individuals with permanent housing units to move into and provide follow up services to ensure sustainability.

- *Key Performance Indicator:* Numbers of "move in"
- *Key Performance Indicator:* Length of time from reception of "referral acceptance" to "move in"
- *Key Performance Indicator:* Numbers of "referral acceptances" received that did not result in "move in"

Sustainability: Six months after "move-in" date, programs will follow up with individuals to determine success of program.

- *Key Performance Indicator:* Percentage of individuals still in housing

Roles and Responsibilities:

Requirement

The CE Process requires participation and support from agencies with resources committed to helping clients to attain housing and to retain housing.

Implementation

This will be accomplished through support of participating agencies and through centralized resources, as and when funding is secured. The following sections identify specific roles, responsibilities of these types of resources, including but not limited to: community coordination, housing navigation, and case management.

Community Coordinator *(to be hired when funding is secured)*

- Coordinate community efforts to follow the agreed upon CE Process and continue improvement initiatives

- Ensure assessment of individuals/families and work with agency case management staff to gather necessary documents
- Ensure individuals/families are added to the By-Name List
- Work with agency staff to coordinate initial client meetings and discuss program expectations
- Report numbers of individuals/families assessed, assigned, and placed monthly to the CE committee
- Coordinate outreach
- Coordinate community outreach efforts to reduce duplication and ensure comprehensive assessment of all individuals experiencing homelessness in El Paso County
- Lead outreach coordination meetings and facilitate communication between agency outreach efforts
- Identify outreach gaps and develop an annual plan to reduce the gaps
- Report monthly on community outreach performance
- Create training curricula for tools and processes used in CE with the support of the CoC.
- Supervise Housing Navigator Coordinator

Housing Navigator (*to be hired when funding is secured)*

The CE requires participation and support from resources committed to helping clients to attain and to retain housing. This will be accomplished through support of participating agencies and through centralized resources, as and when funding is secured.

- Coordinate community housing navigators to consolidate housing resources and engagement efforts
- Create and maintain housing resource list for inclusion in the CE Process
- Lead landlord engagement efforts
- Train and organize community housing navigators on community plan to coordinate and maintain housing placement portion of the CE Process
- Report the number of individuals housed each month to the CE Committee

Case Manager (applicable only in programs where the program has case management services in existence and client is assigned to case management)

- Upon Program Entry (Case Assignment):
    - Conduct an Assessment and Housing Stability Plan within seven calendar days
    - Assist with action planning in accordance with agency procedures
    - Assist with collection of any additional documents necessary for housing
    - Coordinate with housing navigator for housing match
- Upon Lease-Up: (Housing Stabilization Model)
    - Coordinate bed delivery
    - Coordinate furniture delivery
    - Provide access to treatment groups, therapy, and vocational services (if applicable)

    - Connect/enroll client with benefits including Medicaid, Food Stamps, SSI/SSDI, etc.
    - Visit client once per two weeks at the client's residence in accordance with agency procedures (recommended) but a minimum of one time after housed (compulsory).
- After initial 60 days of Case Management:
    - Coordinate case management transfer with Long-Term Case Managers (if possible)
    - Introduce client to new case manager (if applicable)
    - Update new case manager on client's case development regarding benefits, access to therapy, client goals, progression and relapse, etc.

Training

Requirement

PPCoC will provide training opportunities at least once annually to organizations and/or staff person(s) that serve as access points or administer assessments. The purpose of the training is to provide all staff administering assessments with access to materials that clearly describe the methods by which assessments are to be conducted (HUD Coordinated Entry notice: Section II.B.4). All street outreach staff are trained and required to use the same standardized process as if they were site based.

Implementation

Training in the Coordinated Assessment process and procedures is important for effective community coordination and standardization. CE Process training will cover, at a minimum, the following topics:

- Review of CE Policies, Implementation, and Procedures.
- Messaging. (the common community language used to introduce and clarify questions). All messaging complies with "Harm Reduction" philosophy.
- How to administer the VI-SPDAT
- Processes and procedures for submitting/entering the VI-SPDAT into CE system.

The CE System training and guiding materials will be approved by the CE Advisory Committee. All participating agency staff and volunteers will be trained using the approved CE System training prior to administering the VI-SPDAT and entering individuals into the CE System. The CE Advisory committee is the approval authority for suggested changes or improvements to training materials, the assessment tool, the referral process, and other components of the CE process. The CE Community Coordinator is responsible for implementation.

Access

Requirement

The Coordinated Entry Process is available to all who are eligible regardless of race, color, national origin, religion, sexual orientation, gender identity, age, familial status, disability, marital status, etc.

Individuals or families who fall into multiple populations for which an access point is dedicated (i.e. a parent accompanying a youth who is fleeing domestic violence) can be served at all access points for which they qualify. The same assessment approach is used. All physical access points are accessible to individuals and families with disabilities. For those individuals and families who are least likely to seek out homeless assistance, street outreach is provided. Information is available regarding where to access coordinated entry by internet through https://www.ppchp.org/ or in person by visiting one of the participating agencies. PPCoC requires all staff and volunteers participating in CE sign the VI-SPDAT and CE agreement (see Attachment III.)

Implementation

PPCoC is currently working with the Colorado School for the Deaf and Blind for available resources for ocular and/or auditory challenges. All points of entry have ADA accessible facilities. The VI-SPDAT (Housing Survey) has been translated into Spanish. For other languages, we have several local translation organizations that will provide interpreters to any access point.

- Marketing: All participating agencies have prominently posted notices/posters announcing points of entry information (address, phone and hours doing surveys). This information is updated any time there is a change. The Community Coordinator inspects sites to be sure posted notices are prominent.

Identify

Requirement

The initial step into the CE Process is the identification of persons experiencing homelessness. All agencies funded within the Pikes Peak Continuum of Care (PPCoC) must also participate in the outreach and identification of any people experiencing homelessness.

Implementation

There will be "no wrong door" for people in the Pike's Peak Region to enter the CE Process. This means that at all entry points (shelters, walk-in agencies, street outreach, etc.) staff and volunteers will be informed of this process and use the following steps to enter individuals into the system with the goal of leveraging community resources to most effectively make homelessness in the Pike's Peak region rare, brief, and non-recurring.

Procedure

An outreach/identification primary point of contact (POC) will be identified for each agency.

CE trained outreach workers are formal access points just as if the clients walked into an agency. The outreach worker will administer a Housing Survey wherever they find a client. This process ensures entrance into the CE process. The outreach/identification POC will agree to participate in the community coordinated outreach effort. The PPCoC will hire a community outreach coordinator to develop a coordinated community process of outreach to reduce redundancy and synergize efforts. Outreach POCs will be trained in the CE process and in administering the VI-SPDAT.

- *Key Performance Indicator:* The community outreach coordinator will report the number of individuals newly identified over the past month. This number will be based on the number of individuals added to the By-Name List[1] from various sources. This number will be compared to the number housed in the last month to determine community-housing capacity in the system.

Diversion and Prevention

Requirement

A process must be documented for persons seeking access to homelessness prevention services funded with ESG program funds through the Coordinated Entry process.

Implementation

All Emergency Solutions Grants funded programs or other homelessness prevention programs shall bring their resources to CE case conferencing for assignment of clients at highest risk (most vulnerable). PPCoC's intention is to prevent as many clients as possible from becoming homeless, to assign clients to the most appropriate housing resource (housing program: PSH, RRH, TH) when we first identify them, and to honor client choice in the process. This reduces the repeat numbers of homeless. Our CoC area currently has no ESG prevention funded programs. We continue to encourage agencies to apply for this funding. Applications from agencies have been submitted for homeless prevention services in the current year's ESG cycle. This diversion and prevention process will be developed and integrated into the Coordinated Entry process once funding is secured. Currently, clients identified as seeking homeless prevention are referred to 211 and are responsible for reaching out and connecting with 211.

Assess

Requirement

Before being assessed with the VI-SPDAT, the client must sign the CE Process Release of Information (Assessment Screening and Match Initiation Consent/MIC) form (see Attachment IV).

Implementation

The purpose of this release is to facilitate referrals for housing, treatment, case management, treatment planning, coordination of medical care, and other services. By signing, the client agrees that his or her VI-SPDAT responses can be exchanged among the organizations

[1] By-Name-List=VI-SPDAT list and exceptions to the process list.

participating in the CE Process. Only the minimum amount of information necessary at any point in time to assist either in the prioritization or referral process is disclosed. Specific diagnosis or disability information can only be obtained/shared for purposes of determining program eligibility to make an appropriate referral. Signing the MIC is not required for services within the PPCoC; however, it is required to participate in the routine weekly CE process described below. Without a signed MIC, the client's paperwork will be processed through the Alternate Placement Process described later in this document.

Procedure

Agencies will identify persons experiencing homelessness through outreach or walk-in requests for assistance. Once identified, the trained agency staff will complete the CE MIC, HMIS Central Intake Basic Information sheet, and appropriate VI-SPDAT with the client. The CE MIC which is available at https://www.ppchp.org/ must be uploaded into clients HMIS file and kept on file at the agency conducting the initial intake for seven years (electronic or hard copy, in accordance with agency procedures). If an individual refuses to sign the MIC, the staff member or volunteer should explain the benefits of being in the CE process. Staff members/volunteers should also refer to the "Alternate Placement Process", described later in this document, which recognizes that some of the most vulnerable in our community may not be willing to participate in a community-coordinated process.

The agency-trained staff with access to the HMIS CE Program module will enter the client into HMIS Central Intake (if not already completed). Once in central intake, the staff member will enter the VI-SPDAT Assessment in the HMIS. Ideally, the Document Ready Form (see Attachment V) which is available at https://www.ppchp.org/, will also be filled out so readiness can be better assessed when a housing resource becomes available.

After assessing an individual, he or she is provided the Client Housing Information Sheet hand-out (see Attachment VI) that lays out the next steps in their CE journey. Additionally, the client is reminded verbally that if they have received no contact regarding a housing resource in three months it is their responsibility to check in and be re-assessed to remain on the coordinated entry By-Name List. If no re-assessment takes place, the client is moved to inactive status.

By-Name Lists are pulled weekly so that all those in case conferencing can see who is most vulnerable. This ensures placement of the most vulnerable and coincides with a no waiting list approach. Clients who are identified but refuse a resource or who cannot be found are not removed from the list so that they still have a future opportunity. By-Name Lists are shredded following each case conferencing to preserve confidentiality of all whose names appear on list. Case conferencing is a transparent inner-agency forum that ensures proper identification of vulnerable clients into appropriate resources.

Denial of Referrals

Both PPCoC providers and program clients may deny or reject referrals. Service denials by providers may only occur within their requirements/policies. The specific allowable criteria for denying a referral must be established by the PPCoC, must be shared with each project and client, and reviewed annually. All participating projects must provide the reason for

service denial and the reason will be documented in HMIS. Denials outside of this must be brought to CE case conferencing for unanimous approval. Program clients may deny referrals for any reason and will remain on list for future referrals.

Criteria established for denial:

- Client refused further participation (or client moved out of PPCoC area)
- Client does not meet required criteria for program eligibility
- Client unresponsive to multiple communication attempts
- Client resolved crisis without assistance
- Client safety concerns, client's health or well -being or the safety of current program clients would be negatively impacted due to staffing, location, or other program issues
- Client needs cannot be addressed by the program
- Property management denial
- Conflict of interest

- *Key Performance Indicator*: Number of persons with newly completed VI-SPDAT scores and entered into the VI-SPDAT module in HMIS. (This should also be the same as the number of individuals newly "IDENTIFIED" within the last month.)

Alternate Placement Process:

Requirement

Together with the CE System, there is an alternate process for housing placement to ensure equal access for those individuals whose needs may not be fully addressed by the CE Process[2].

Implementation

This alternate process must be accessible to community members advocating for clients who fall into at least one of the following categories:

- Individuals who are unable because of mental health concerns to complete the VI-SPDAT
- The VI-SPDAT score seems incongruent with the actual vulnerability of the person assessed. Are there special circumstances not captured by the screening tool that could be generating additional vulnerabilities for this person?
- Duplicate VI-SPDATs have been completed by different community providers and the variance in scores is greater than 5 OR the scoring difference crosses a threshold of housing interventions (i.e., one score indicates rapid re-housing and one score permanent supportive housing) or vulnerability
- A housing resource comes available that necessitates out-of-the-ordinary qualifications (for example, only available for 90 days so quick expedition necessary-may have to take someone already document ready). Even in these

[2] All information obtained is under adequate privacy protection per the HMIS Data and Technical Standards HUD24 CFR 578.7(a) (8).

out-of-the ordinary qualifications, our referral process ensures clients are not steered toward a facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children

- Client is unwilling to sign MIC and must be conferenced anonymously (Share Anonymously form, see Attachment VII)-with no identifying information shared
- Client is using a victim service provider

For any individual/family in the above categories, agency representatives must bring these high priority individual/family cases to case conferencing meetings. Since there may not be a release of information, these situations must be referenced without revealing personal information in the community forum; however, such details as mental health diagnosis, physical health vulnerability, age, family status, criminal record, and financial resources must be discussed without association to a particular name. When first identified, the case conferencing facilitator will assign a reference number based on the agency associated such as SRM001 or RMHS002, etc. The case conference facilitator will add this number to the By-Name List and the committee will assign an objective assessment score to prioritize this individual/family in the list for future reference. The associated agency will maintain a "private" list which associates the "list" reference number to the actual name of the individual.

Grievance

Requirement

All individual's or family's concerns and grievances must be resolved promptly and fairly, in the most appropriate manner.

Implementation

Providers inform individuals and families of the process for filing a grievance. Each agency provides instructions for a grievance on a form given to client on completion of Housing Survey. The grievance form (see attachment VIII) and instructions are also provided on the Community Health Partnership website.

Procedure

Fair Housing Grievances should be made directly to:
https://portal.hud.gov/hudportal/HUD?src=/program_offices/fair_housing_equal_opp/online-complaint.
PPCoC has no further involvement in these particular grievances.

Agency Grievances: The agency completing the screening should address any complaints by clients as best as they can in the moment. Complaints that should be addressed directly by agency staff are agency conditions and/or violation of confidentiality agreements. Any other complaint should refer to process below. Any complaints filed by a client should note their name and contact information so the CE Community Coordinator can contact him/her to discuss the issues.

- Level 1: If client has a grievance regarding a particular agency or representative of that agency (general grievances such as customer service or services offered), they should follow that agency's grievance procedure. Agency grievance form is included with intake packet. If both the client and the agency come to a mutual resolution, the process ends and the resolution is implemented. If the client or the agency disagree on resolution, the grievance must be advanced to the next level by complainant. The process to advance grievance is found on Community Health Partnership's website (https://www.ppchp.org/).
- Level 2: The CE Community Coordinator is the first person to review the grievance and will gather relevant information about the situation, including but not limited to, communicating with the client and the agency in question. The CE Community Coordinator will inform the client and the agency in question of the resolution reached. If both the client and the agency mutually agree to the resolution, the process ends and the resolution is implemented. If the client or the agency disagree on resolution, the CE Community Coordinator will advance the grievance to the next level.
- Level 3: The PPCoC Governing Board Chair reviews the grievance or designates one or more Board members to review the grievance. After gathering relevant information, the Board Chair or designated Board member(s) will inform all parties of the resolution reached. This is the final step in the process, and the decision of the Governing Board of Directors is final.

Coordinated Entry Grievance: If the grievance is with the Coordinated Entry Process, the CE grievance form is provided on Community Health Partnership's website. The Coordinated Entry Grievance process begins at Level 2.

Emergency

Requirement

PPCoC CE process will allow services, including all domestic violence and emergency services hotlines, drop-in service programs, and emergency shelters to operate with as few barriers to entry as possible.

Implementation

PPCoC has a No Wrong Door Policy at all access points, regardless of whether that agency serves all individuals. This means that any individual presenting at an access point will be provided help to access a shelter (domestic violence or other shelter) or medical facility when they present with an emergency need outside of during business hours. Although Housing Surveys are not conducted 24 hours a day, all access points have staff available or posted notices directing to an emergency service to assist anyone presenting with an emergency. Individuals presenting outside of Housing Survey hours will then be offered the Housing Survey during Housing Survey hours. The Housing Survey hours are as robust as possible within staff limitations of each agency. Help in emergency situations; however, is always available, and clients will be referred/helped by staff to manage the emergency in best way available at the time. PPCoC only uses the standardized assessment tool for prioritizing PSH, TH, and RRH match and referral. Shelter services are not prioritized through CE. As hours

and locations for the Housing Survey administration vary and change frequently, the current VI-SPDAT schedule of locations and hours where the Housing Survey is being conducted is located on the Community Health Partnership website: https://www.ppchp.org/programs/continuum-of-care/ Scroll down to Coordinated Entry and click on VI-SPDAT Schedule.

Safety Planning

Domestic Violence:

Requirement

Individuals or families may not be denied access to the CE process if experiencing or fleeing from domestic violence, dating violence, sexual assault, and/or stalking (HUD Category 4 Homeless Definition). Victim service providers funded by the CoC and ESG program funds are not required to use CoC's coordinated entry process, but victim service providers are allowed to do so. Victim service providers may use an alternative coordinated entry process for victims of domestic violence, dating violence, sexual assault, and/or stalking.

Implementation

Individuals that present to any agency experiencing domestic violence, dating violence, sexual assault, and/or stalking will be referred to the CoC's Domestic Violence agency TESSA. TESSA will use their own coordinated entry process regarding RRH and other supportive services that are managed by TESSA. Individuals or families that present to TESSA needing community TH or PSH will be included in CoC case conferencing when the following is provided: VI-SPDAT completed by TESSA staff by Monday, but not entered into CO504; email sent to CE Community Coordinator stating that a new individual or family will be presented at case conferencing (email should include the following data: created reference ID#, age, gender, veteran status, household size, monthly income, date assessed, raw score, and # of children if any. DV names will not be presented, the only information that will be given is: created reference ID#, age, gender, veteran status, household size, monthly income, date assessed, raw score, and # of children if any). A TESSA case manager will need to be present at case conferencing to vet initial eligibility match for candidates.

Assist

Requirement

The core of the CE Process is a community effort to assist our neighbors experiencing homelessness. PPCoC requires that all CoC and ESG program recipients and sub-recipients use the coordinated entry process established by the CoC as the ONLY referral source to consider filling vacancies in the housing and/or services funded by CoC and ESG programs.

Implementation

The case conference process will organize the assistance phase. The next step is to assign the individual/family to an appropriate housing resource (housing program: PSH, RRH, TH). Individuals or families will not be steered toward any particular housing facility based on race, color, national origin, religion, sexual orientation, gender identity, disability, or the presence of children. Next, we will assist with developing and completing a plan with goals and action steps as well as gathering and storing required documentation. We will strive to keep client document requirements as low barrier as possible, recognizing the need for providers to have complete records for their programs and any audits that may ensue, along with the landlord's requirements for leasing. We recognize that there are different documentation requirements for different programs, but remain committed to achieving as much consistency as possible, while working toward a low barrier process.

Procedure

At least monthly, the community will have a CE Advisory/Planning meeting. The meetings are open and attended by stakeholders in the community interested in the work. The purpose of the meeting is to support case coordination, advancement of CE work, and problem-solving among service providers. The PPCoC will determine the CE Advisory/Planning meeting facilitator, participants and frequency, but will consist of no fewer than two stakeholders and no less frequent than once per month. The goals of the CE Advisory/Planning meeting are:

- To ensure holistic, coordinated, and integrated assistance across providers for all experiencing homelessness in the community.
- To review progress and barriers related to housing goals.
- To identify and track systemic barriers and strategize solutions across multiple providers.
- To clarify roles and responsibilities and reduce duplication of services.

At least weekly, the community will have a CE case conferencing meeting. These meetings are confidential and only participating agencies currently listed on the MIC (most current MIC with participating agency list located on Community Health Partnership website) are invited to attend. Staff who intersect with the clients at their respective agency are who generally attend case conferencing. The purpose of the meeting is to identify and match the most vulnerable (per the By-Names List) to available housing resources via the process detailed in this document. Participating Agency attendance is expected at every meeting per HUD 24 CFR 578.7. Agencies required to attend are those receiving HUD COC NOFA and HUD ESG funding. Meeting attendance will be recorded and could be a factor for future funding.

At a minimum, the CE case conferencing meeting agenda will include the following items:

- Update of Progress with case conferencing since last meeting
- Discussion of prioritization of most vulnerable clients-In addition to the VI-SPDAT score, length of time homeless, and number of times homeless in last three years the following priorities are considered if scores are equal:
    - Families with Children

    - Youth (ages 16-24) Currently unaccompanied youth under the age of 16 are not prioritized for housing resources as we do not have the means to house them independently.
    - Veterans
    - Tri-morbidity
- Review of housing resources available
- Match of most vulnerable clients to resources available
- Case Coordination/Action Assignments
- Report out of Key Performance Indicators
- Specifically. The case conferencing meeting will be held weekly as long as there is a housing resource available. The priority of this meeting is to allocate housing and service resources as effectively and timely as possible. Assistance is prioritized based upon vulnerability. Currently the VI-SPDAT, F-SPDAT and TAY-SPDAT scores are categorized to fit PSH, TH, RRH and (No Housing) Services Referral only.

The metric currently used to match clients into available housing categories for Permanent Supportive Housing (PSH), Transitional Housing (TH), Rapid Re-Housing (RH) and Service Referral Only based upon their raw score from the VI-SPDAT is:

- PSH= Individuals/TAY score of 8+, Families score of 9+. All compute to category 4.
- TH = Individuals/TAY score of 6-7, Families score of 7-8. All compute to category 3.
- RRH = Individuals/TAY score of 4-5, Families score of 4-6. All compute to category 2.
- Services Referral Only = Individuals/TAY/Families score of 0-3. All compute to category 1.

The deadline to have an agency's newly VI-SPDAT assessed client(s) appear on the active list to be discussed at that week's case conferencing meeting is Monday. If clients VI-SPDAT are not entered by Monday, they will be discussed the following week at case conferencing (unless using Alternate Placement Process, and in those cases names should not be shared…see Alternate Placement Process as described in this document).

Participation at case conferencing meetings are limited to staff from participating agencies as denoted on the current MIC. Confidentiality is a huge part of case conferencing and meetings must be secure with those attending. A confidential sign in sheet is used expressing the confidentiality of the meeting. Currently, technology is not in place to conduct these meetings with the degree of confidentiality needed for call ins and webinars, so attendance is in person. The Coordinated Entry meeting schedule is as follows:

- 1st Wednesday of the month: Housing first hour Case Conferencing second hour
- 2nd Wednesday of the month: Case Conferencing two hours
- 3rd Wednesday of the month: Planning first hour Case Conferencing second hour
- 4th Wednesday of the month Case Conferencing two hours
- 5th Wednesday of the month: Case Conferencing two hours

The facilitator will prepare for each meeting by organizing and updating the By-Name List and determining which clients will be discussed at the upcoming meeting. The facilitator will also organize the By-Name List, sort the list by VI-SPDAT score, then length of time homeless. The facilitator prepares and sends out the agenda for the conference.

The following is a list of documents considered important to housing:

- Colorado ID/Driver's License, or having proof that one has been ordered*
- Birth Certificate, or proof that one has been ordered*
- Social Security Card, or proof that one has been obtained*
- Proof of Income (within last 60 days)
- Proof of disability
- Documentation of chronic homelessness
- DD-214 (for Veterans*

** must be scanned into HMIS at "organization" level to protect the high level of confidentiality of document*

No documents are required to be in hand to be matched to a housing program; however, individuals/families will receive assistance to obtain these documents as quickly as possible since most housing resources will require them prior to move in.

Once an individual/family has been identified through case conferencing as the most vulnerable in the community for the housing resource available, the representative from the agency who conducted the VI-SPDAT/TAY-SPDAT, or a representative from one of the other agencies that is in touch with this individual, will be charged with locating the individual/family and making sure the Document Ready Form (see Attachment V) is completed. Those being sought are not guaranteed a housing resource, it means that we are trying to see if they are a match for the available housing resource. If a client has not been contacted regarding a housing resource in three months, the client is responsible for going to a participating agency to be assessed again. On initial assessment the client will receive the PPCoC Client information sheet with the date they need to be re-assessed. If client cannot be found and there are no leads on where they may be located after two weeks, the client will be moved back to active By-Name List. Once the client is found, if there is no update on client within 30 days, the identified client would be moved back to the active By-Name List, and another client would be identified to be found. Once client is found, they will then be given until the next case conference to accept or decline referral. If the client accepts the resource, **i**nitial eligibility is confirmed to determine a match with the available housing resource. Then client will be referred to the housing resource program for intake. In the event that two or more households within the same area are identically prioritized and eligible for the next available unit, the PPCoC selects the household that presented first.

When the accepted resource is a Rapid Re-Housing (RRH) resource, the client will be provided with the percentage (amount of rent) they will be responsible for while receiving RRH assistance. For RRH placements, clients will contribute 30% of their income to rent while receiving RRH assistance.

Assign

Requirement

The purpose of the CE Process is to allocate housing and service resources as effectively as possible in a manner that is easily accessible.

Implementation

Assistance is prioritized based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. Under no circumstances should an individual/family be screened out of the CE process based on perceived barriers, such as: too little or no income, active or history of substance abuse, domestic violence history, resistance to receiving services, criminal record, lease violations or history of not being a lease holder etc. Exceptions are a.) conviction for manufacturing Methamphetamine, b.) registered sex offender or c.) eviction from federally funded housing for drug – related criminal activity in the past 3 years. Individuals that have criminal records must be reviewed on a case-by-case basis.

Procedure

By-Name List

- Creating the Active List:
    - The By-Name List should be created from the CE Report in HMIS. This report should not be printed and shared with anyone, and confidential information on the By-Name active list should not be discussed outside of the Case Conferencing meeting. All confidential information should be secured at all times.
- Updating the Active list:
    - Print report from HMIS-CE program
    - Include any names from the Alternate Placement Process
    - Individuals will be removed from the Active By-Name"list by another designated person through the following process:
        - Run an HMIS report to list the individuals housed since the last time the list was updated
        - Change the "List Status" to "Exit" and add in the Move-In date for anyone on the "housed" list from HMIS
        - Sort the Active By-Name List by "Last Contact" and choose any dates 90 days or prior from current date.
        - If "Last Contact" is longer than 90 days, unless they are currently working with an agency case manager for a housing resource, client is moved off active list to inactive list status.

Housing Placement:

Requirement

All Continuum of Care grantee providers and ESG funded programs are required to fill vacancies using CE Process. In addition, providers outside the PPCoC funding stream are encouraged to use CE Process to identify candidates for housing vacancies.

Implementation

The PPCoC will ensure that applicants entering through CE shall not be denied admission to housing, nor will any family members be separated from other members of their family, based on age, sex, gender, gender identity or sexual orientation when entering housing.

In order to meet HUD's Continuum of Care Notice of Funding Availability grant requirements on turnover units and vouchers each time a PPCoC-funded supportive housing project has an opening, a Housing Vacancy Update form (see Attachment X) available on the Community Health Partnership website, needs to be completed to inform the PPCoC of each opening.

The Community Coordinator will create a list with submitted housing vacancies. The list will be brought to case conferencing where participating agency staff will match vacancies with vulnerability needs of individuals/families from the El Paso County area who meet the project's criteria. An Action List is generated, assigning agencies to help find identified clients. Once found, the client is connected to the agency with the open housing resource for eligibility confirmation. If eligible, a referral is made from Coordinated Entry to the open housing resource. The agency with the open housing resource assists with program application and acceptance of referral. Once referral is accepted, housing search commences. This ensures communication between the housing providers, the potential client and the person helping that client (Housing Navigator) to make a final determination on housing.

Evaluation

Requirement

PPCoC consults with participating projects and project staff at least annually to evaluate the intake assessment and referral processes associated with CE. Feedback must address the following for both participating projects and staff: quality of coordinated entry process for intake/includes posted signage, effectiveness of coordinated entry process for referrals, and Planning Committee evaluation meeting to inform changes.

Implementation

PPCoC technical/training staff do an annual site visit to evaluate the following:

- Security of client information
- Correct use of training procedures
- Utilization and consistency of CE for every individual, youth, or family
- Data quality

Staff then address concerns or issues agencies may have and provide feedback based on CE successes or concerns. Staff provides an annual report to the PPCoC Governing Board regarding KPI results.

Glossary

By-Name List-The weekly list of clients in PPCoC desiring housing, sorted by vulnerability.

CE- Coordinated Entry

CH-Chronic Homelessness

CHP-Community Health Partnership

DV- Domestic Violence

ESG-Emergency Solutions Grant

Extension-Term used when asking for an adjustment to a deadline. Most often associated with expiration of a resource (voucher).

HMIS- Homeless Management Information System

Homeless definition-HUD-Chart of HUD's homelessness definitions click here

Housing Survey-Community name for VI-SPDAT

HUD- Housing and Urban Development

KPI-Key Performance Indicator—Data that measures achievement as related to objectives.

MIC- VI-SPDAT Assessment Screening and Match Initiation Consent Form

POC-Point of Contact

PPCoC- Pikes Peak Continuum of Care

Prioritization List: A list kept, of sorting by vulnerability. After each use of list, the list is updated, re-pulled, and re-sorted thus always having those with the most vulnerabilities serviced first.

Progress List-The weekly progress list of clients that our agencies are actively working on housing.

PSH-Permanent Supportive Housing

RA-Reasonable Accommodation. A change, exception, or adjustment to a rule, policy, practice, or service to allow a person with disabilities to fully access the HUD programs or services.

RRH-Rapid Re-Housing

SSVF-Supportive Services for Veterans' Families

TESSA-The only confidential assistance agency for victims of domestic violence and/or sexual assault in El Paso and Teller counties

TH-Transitional Housing

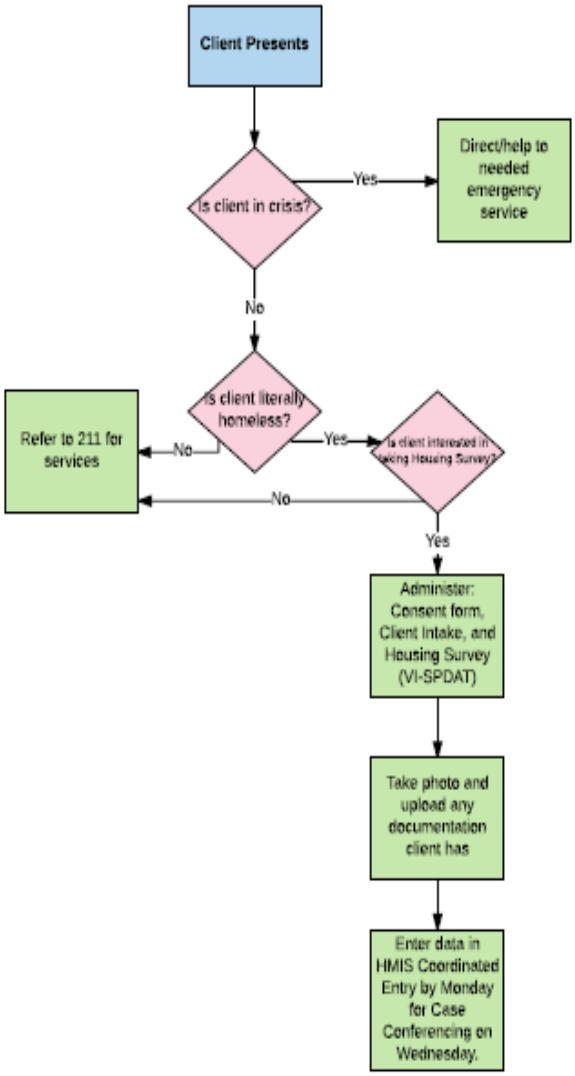
VASH-Veterans' Administration Supportive Housing

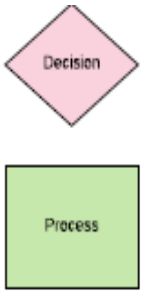
Glossary continued

VI-SPDAT- Vulnerability Index- Service Prioritization Decision Assistance Tool. Common assessment tool used in Coordinated Entry process. Commonly referred to in community as the "Housing Survey".

Wait List: A list that is kept by first come first serve basis. Once a client's name is placed on the list, the client keeps their position and are advanced as openings occur.

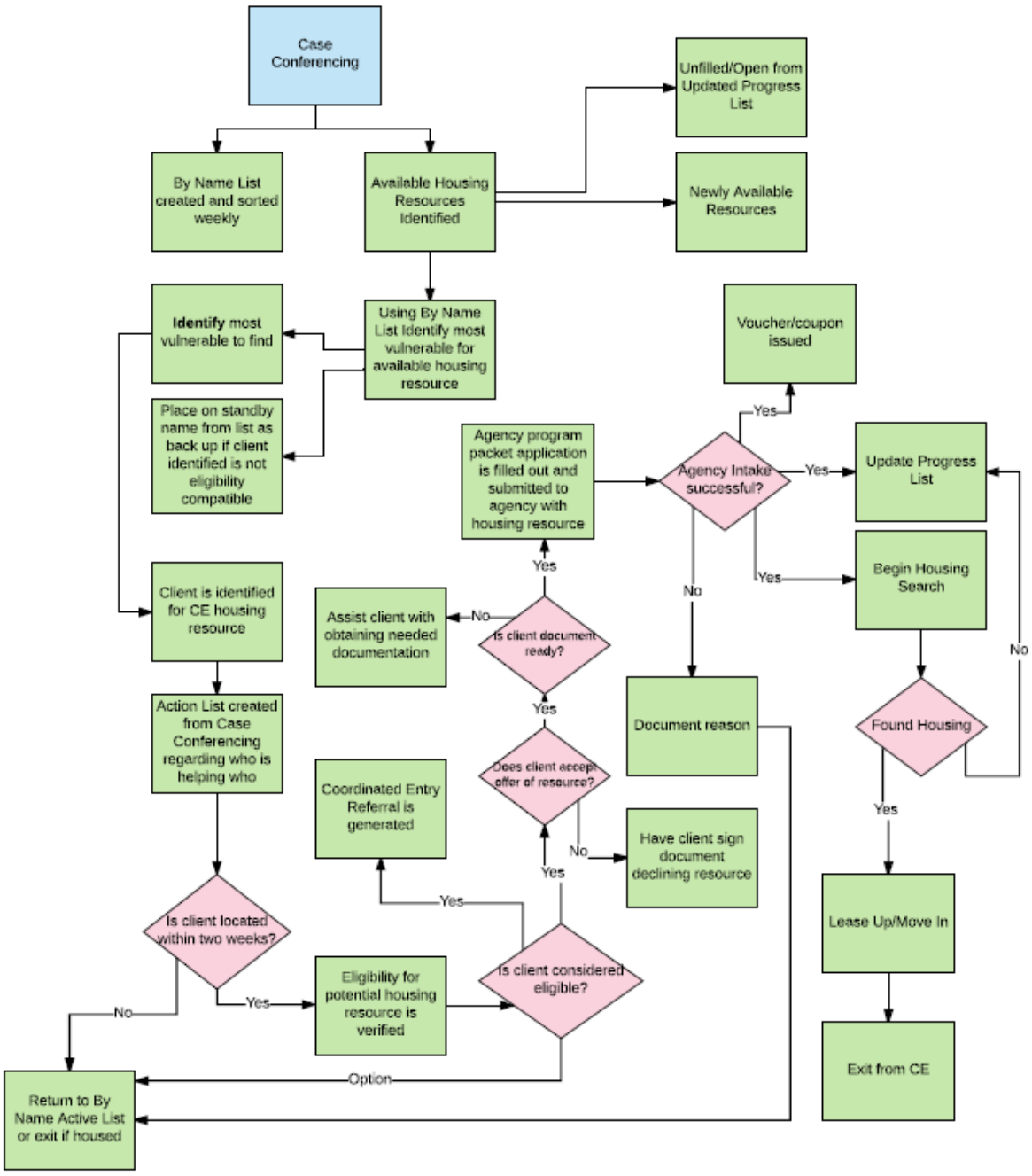
Coordinated Entry Client Assess flowchart





12-14-2017

Coordinated Entry Case Conferencing flow 12.2017



Attachment I

Pikes Peak Continuum of Care Match Initiation Form

This Match Initiation Form includes questions that will assist with making a match to a unit of Supportive Housing in your community. These questions will assess for basic eligibility requirements of these resources, making it possible to prioritize housing placements for those with the highest acuity as determined by the VI-SPDAT Screener. This form will also document client preference relative to where he/she would like to live in housing, making the unit match possible for their community of origin (where they are currently homeless) or their top two community preferences. The VI- SPDAT Survey, Family VI-SPDAT Survey, or TAY VI-SPDAT Survey must be filled out before this form, either administered at the same time as the Survey, or sometime thereafter. Scan completed form into the documents tab. * denotes required questions.

3. *First Name of Point of Contact (POC) working on housing this Client: *POC will be the person contacted to match this client with permanent supportive housing. In most cases, the POC will be the client's Navigator.*	4.* Last Name of Point of Contact (POC) working on housing this Client:
5. *Agency the POC is affiliated with:	6. *Phone number of POC:
7. *Email of POC:	8. *Has Client signed a Release of Information? *If not, the client must sign a release before the Housing Matching Process can begin.* ____*YES* *NO*

BACKGROUND INFORMATION

QUESTIONS TO ASSIST WITH HOUSING MATCH

9. *If a family unit is needed, how many children (under 18) for whom you have full legal custody will be living with you?	Not Applicable 1 child 2 children 3 children 4 children 5 children __6 children 7 children 8 children
10. *If a family unit is needed, are there any adults (18+) who will be living in the unit?	__Not Applicable Yes No
11. Who in addition to you will be living in the unit, please list each adult and his/her relation to you.	

12. *If a family unit is needed, how many bedrooms are required?	__Not Applicable-I need an individual unit. __1 bedroom __2 bedroom 3 bedroom __4 bedroom 5 or more bedrooms
13. *Do you need shared housing? *Two or more unrelated people share a 2 or more bedroom unit.*	Yes No
14. Do you need access to public transportation?	__Yes No
15. Do you live in El Paso County?	__Yes No
16. *Which of the following areas would be your FIRST choice for housing?	__Anywhere in El Paso County. (Wherever I will be placed into housing most quickly) __Downtown/Central Colorado Springs __North Colorado Springs/Monument __South Colorado Springs/Fountain __East Colorado Springs __West Colorado Springs/Manitou Springs
17. Which of the following areas would be your SECOND choice for housing?	__Anywhere in El Paso County. (Wherever I will be placed into housing most quickly) __Downtown/Central Colorado Springs __North Colorado Springs/Monument __South Colorado Springs/Fountain __East Colorado Springs __West Colorado Springs/Manitou Springs

FINAL QUESTIONS TO ASSIST WITH HOUSING MATCH

18. Which of the following documents do you have with you or have easily accessible?	__Colorado-Issued ID Card or Driver's License (or receipt of application) __Social Security Card (or receipt of application) __Birth Certificate
19. *What are your sources of income right now? *Select all that apply. Note: If Client refuses to answer, Housing Match cannot begin. If "other" is chosen for source of income please specify what the other source(s) are.*	__Refused to Answer __No Income General Relief (GR) __SSA __SSI/SSDI __VA

20. *How much income do you receive in total each month? *Answer can be rounded to the nearest $10 and should NOT include the value of Food Stamps. Please write without the "$" sign or commas.*	
21. What kind(s) of health insurance do you have, if any?	__None Medicaid Medicare Colorado Indigent Care Program (CICP)__Veterans Administration (VA) Medical Services Private Insurance State Health Insurance for Adults COBRA Employer-Provided Health Insurance Other:
22. *Are you already receiving supportive services that can/will follow you into supportive housing?	Yes No
23. If yes, what agency provides those supportive services?	
24. Have you ever been a patient at any of the following Hospitals and/or at an El Paso County Health Clinic? *If other, please state the name of the specific health facility.*	__No __Memorial Hospital __Penrose Hospital __Evans Hospital __Peak Vista
25. Are you currently or have you ever received treatment for mental health issues?	Yes No

26. If you selected "Yes" in question 26, what are the names of all clinics, hospitals and/or agencies that you are currently receiving treatment from?	
27. What is your citizenship status?	__Citizen __Permanent Legal Resident __Asylee, Refugee, or other Eligible Immigrant __Ineligible Immigrant (including Undocumented)

28. Do you have a permanent physical disability that limits your mobility?	Yes No
29. If yes, please describe the limits to your mobility:	
30. *Have you ever been evicted from housing or abandoned a unit, of which your name was on the lease?	__Yes No
31. If yes, approximate month and year of last eviction: *If you are unsure of the day, please write in "1" to indicate the first day of the month*.	Month: / Day: / Year:
32. *Were any of the evictions from Public Housing Authority units?	Yes No
33. If you've been evicted from a PHA unit, was it due to fraud?	Yes No
34. If yes, approximate month and year of the last eviction due to fraud: *If you are unsure of the day, please write in "1" to indicate the first day of the month.*	Month: / Day: / Year:
35. If you've been evicted from a PHA unit, was it due to unit damage?	Yes No
36. If yes, approximate month and year of the last eviction due to unit damage: *If you are unsure of the day, please write in "1" to indicate the first day of the month.*	Month: / Day: / Year:
37. *If you've been evicted from a PHA unit, do you owe money?	Yes No
38. *If you selected "Yes" in question 38, do you have a payment plan in place?	Yes No
39. *Have you ever been convicted of a felony?	__Yes No
40. If yes, please describe all felonies for which you have been convicted?	
41. If yes, when was the month and year of your last conviction? *If you are unsure of the day, please write in "1" to indicate the first day of the month.*	Month: / Day: / Year:

42. If you've been convicted, were any of the felonies considered violent?	Yes No
43. If yes, when was the month and year of your last violent felony conviction?	Month: / Day: / Year:
44. *Have you ever been convicted of manufacturing or producing methamphetamine?	__Yes No
45. Do you have a history of drug or alcohol use?	__Yes No
46. Do you currently use alcohol or drugs?	__Yes No
47. If yes, please list what you are using.	__Yes No
48. Are you interested in sober living?	__Yes No
49. *Have you ever been convicted of arson?	__Yes No
50. *Are you a registered sex offender?	__Yes No

51. If no; Have you ever been accused or charged with any sexual offense?	Yes No
52. *Are you currently, or have you in the past two years, been on parole, probation or in a diversion program?	__Yes No
53. When a background check is run will anything show up that hasn't been covered by these questions?	Yes No
54. If you are receiving disability benefits (Social Security, VA, or other), what is/are the disabling condition(s) for which you receive payments?	
55. *Do you need a smoking or non-smoking apartment?	__Smoking __Non-smoking
56. *Do you use an accompaniment (service) animal? *Please only specify "Yes" if the animal is required rather than just nice to have.*	__Yes No
57. If yes, what is the animal trained to do?	
58. *Do you have a pet? *Please only specify "yes" if this is a non-required pet.*	Yes No
59. If yes, what type of pet is it?	
60. Are there other requirements or requests around permanent housing that we need to be aware of (ADA compliant/Reasonable Accomodations)? If so, please list them. *Please include here details not covered elsewhere (e.g. needs ground-floor unit, has a dog/pet, etc.) to help ensure that the housing match meets the client's needs.*	ADA accessible Walk-in tub/shower __Grab bars __No stairs __Limited stairs
62. Date this Match Initiation Form is being submitted:	Month: / Day: /Year:

Attachment II

PPCoC Coordinated Assessment and Housing Placement

Parameters for Dwelling Resource Listing

_____	_____	_____
Resource Name	Status	Available Date

# Bedrooms	#People	# People
_____	_____	_____
Unit Size	Maximum	Minimum

Unit Description:

General Description of dwelling: type (house, condo, apt.), bedrooms, bathrooms, amenities etc.

School District _____

Blocks from Bus stop _ _____

Walkability: Proximity to grocery, medical, client services

ADA Accessibility _____

Rent Cap _____

Program eligibility requirements:

Attachment III

VI-SPDAT/CE Agreement

I_____ acknowledge that I attended training and received instruction on how to administer the Vulnerability Index – Standardized Prioritization Decision Assistance Tool (VI-SPDAT). To ensure compliance with HUD's notice CPD-17-01, I understand I will be held accountable for the following HUD requirements:

_____ I will not discriminate against: age, race, color, ethnicity, national origin, disability, sexual orientation, gender identity, marital status, etc.

_____ I will not steer any individual or family towards a particular housing facility based on: age, race, color, ethnicity, national origin, disability, sexual orientation, gender identity, marital status, etc.

_____ I understand that all information obtained during VI-SPDAT administration is confidential.

_____I will keep all confidential information obtained secure. This security includes but is not limited to immediate shredding/destruction of paper copies once no longer needed, storage of records in locked filing cabinets, removal of any personal information that is not necessary to support prioritization or referral processes of a household, etc.

I understand that if I am found in breach of this agreement, I will no longer be permitted to administer the VI-SPDAT, obtain documents or information regarding coordinated entry.

_____ _____/_____

Signature **Date**

_____

Print Name

_____

Agency

_____

Email

Attachment IV

Pikes Peak Continuum of Care

Regional Coordinated Entry System

VI-SPDAT Assessment Screening and Match Initiation Consent Form Authorization to Participate in Housing Eligibility Survey

Participant Last Name:	Participant First Name:	DOB (mm/dd/yyyy):
HMIS Client ID Number (If applicable): Social Security Number:		

We are here today to talk to you about your housing and service needs. If you give us permission, we will ask you questions about your health and housing for about 20-30 minutes. Participation in the VI-SPDAT Assessment and Match Initiation is completely voluntary. If you feel uncomfortable or upset during the interview, you may ask the interviewer to take a break, skip any of the questions, or stop the survey.

No one will be upset or angry if you decide not to be interviewed today. You will not be denied access to necessary services based on your refusal to participate in the assessment interview.

Please initial below if you agree with the following statements:

_____I agree to allow my responses to VI-SPDAT Assessment and Match Initiation to be disclosed and received by the organizations that participate in the Pikes Peak Continuum of Care Coordinated Entry System and to be used to determine if I am eligible for participating housing, service and related programs. These organizations include but are not limited to:

Ascending To Health	**Homeward Pikes Peak**
AspenPointe	**Catholic Charities**
Partners In Housing	**Greccio Housing**
Coalition for Compassion and Action	**Peak Vista Health Clinic**
Colorado Springs Housing Authority	**Pikes Peak United Way**
Colorado Division of Housing	**Rocky Mountain Human Services**
Community Health Partnership	**CSPD Homeless Outreach Team**
The Salvation Army	**Ecumenical Social Ministries**
Springs Rescue Mission	**Family Promise**
Tri-Lakes Cares	**Veterans Administration**

A complete list of participating agencies is provided online at https://www.ppchp.org/

_____I understand that the information from this survey will be entered into Pikes Peak Continuum of Care Regional Coordinated Entry database. My personal information will be kept

in accordance with all federal, state and local laws and regulations related to protecting personal information.

_____I understand that the Pikes Peak Continuum of Care Regional Coordinated Entry databases operate over the Internet and use many security protections to ensure confidentiality. The information collected may either be kept in separate databases or in a joint HMIS database, and may remain in the database or databases past the expiration of this consent or after consent is withdrawn.

_____I understand that the following information can be shared with participating agencies in the Pikes Peak Continuum of Care Region and other agencies as needed to help me find appropriate housing and/or services:

- **Birth date**
- **Gender**
- **Scanned copies of vital documents to assist with housing application requirements**
- **History of medical treatments**
- **History of mental health treatment**
- **Housing and homeless history**
- **Income**
- **Contact information**
- **Additional information used for matching me with suitable housing and/or services**
- **Alcohol and Drug Use History**
- **HIV/AIDS Status (only for targeted housing programs)**

_____I allow my case manager or outreach worker to enter my personal information to the interview questions into a secure database. My signature below signifies my permission.

_____I, or my outreach worker/case manager, may be contacted about my survey.

_____I understand that participating in the Pikes Peak Continuum of Care Regional Coordinated Entry System does not guarantee that I will be eligible for, or admitted into, a housing program.

_____I understand that the Pikes Peak Continuum of Care Regional Coordinated Entry System will act as the agency that matches my information against eligibility requirements of housing that becomes available and that I may be eligible for.

Important Rights and Other Required Statements You Should Know

- **You may revoke this authorization at any time. To do so, please contact the Pikes Peak Continuum of Care Regional Coordinated Entry at Community Health Partnership at 719-632-5094.**
- **All participating organizations of the Pikes Peak Continuum of Care Regional Coordinated Entry System agree to use information provided <u>for the sole purpose of linking clients with housing or supportive service options.</u>**

- **This authorization will expire one year after the date it is signed by you.**
- **This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.**
- **You have a right to a copy of this authorization once you have signed it. To obtain a copy, please contact the**

Pikes Peak Continuum of Care Coordinated Entry System 719-632-5094

SIGN BELOW IF AGREEING TO BE INTERVIEWED

Your signature (or mark) below indicates that you have read (or been read) the information provided above, have received answers to your questions, and have freely chosen to be interviewed. By agreeing to be interviewed, you are not giving up any of your legal rights.

_____

Date **Signature (or Mark) of Participant**

_____

Printed Name of Participant

_____

Date **Signature (or Mark) of Guardian**

_____

Printed Name of Guardian

updated 4/2018

Attachment V

Pikes Peak Continuum of Care

PSH Document Ready Form for Coordinated Entry

Fill out before scanning:

Date_____

Navigator_____

Other_____

_____

_____

Client Name_____

Please mark the appropriate box(es) for all documentation you can affirm the client has in their possession. Use the comment section for conveying additional pertinent information.

Photo ID, --State of Issue: _____

___Original (In Hand)

___Copy (In Hand)

___Applied For (With Receipt)

___No

Birth Certificate

___Original (In Hand)

___Copy (in Hand)

___Applied For (With Receipt)

___No

Social Security Card

___Original (In Hand)

___Copy (In Hand)

___Applied For (With Receipt)

___No

DD214

___Original (In Hand)

___Copy (In Hand)

___Applied For (With Receipt)

___No

Proof of Income (Within Last 2 Months)

___Yes

___No

___N/A

Homeless Verification (HUD Definition)

___Yes

___No

___N/A

Coments:_____

PPCoC Housing Client Information Sheet

El Paso County does not use waitlists. "First come first served" does not exist. If you are experiencing homelessness and seeking housing, you must complete the "housing survey", and be placed on the prioritization list. The VI-SPDAT is the "housing survey" used in El Paso County. In no way does taking, the "housing survey" guarantee you will receive housing.

IMPORTANT: You must check in every 3 months to remain on list for housing. If you have not been contacted regarding housing. It is your responsibility to check in by this

Date: _____, to be reassessed and remain on the housing list.

It is important that you keep any and all contact information current!

Important Information:

Agency where I was assessed: Agency Phone#_____

_____

Person who assessed me: _____

Client Name: _____ Agency Address:

Today's Date: _____ _____

VI-SPDAT (Circle One): Individual TAY Family _____

Below are the steps to being housed in El Paso County, with The Pikes Peak Continuum of Care.

1. Take the "Housing Survey" also called the VI-SPDAT; you only have to take it at one location.

2. Answers given on the "housing survey" are entered into the system and used to identify people for housing.
3. Weekly a new list is pulled with all "housing surveys" entered into the system. **If your score does not qualify you for housing assistance, you will receive a phone call from 211 offering you other potential resources.**
4. Weekly open housing slots are submitted
5. Weekly case conferencing occurs. Eligible person(s) are identified and matched to appropriate open housing slot.
6. Once identified for an opening, the identified person(s) will be looked for. If not found in 2 weeks the person is returned to the list. It is very important to keep your contact information up to date!!!
7. Once a person is found, the place where the "housing survey" was taken will verify your eligibility, and help you gather documents. Documents needed are:
   - -Disability paperwork (if disabled)
   - -Birth Certificate
   - -Veteran Paperwork (DD214)
   - -Colorado ID
   - -Proof of length of time homeless
   - -Proof of Income
   - -Social Security Card

8. Once all your documents are obtained, and it is verified that you are an eligible match for the open housing slot you will be referred to the program with the open housing slot.
9. If you have not been contacted about housing within 3 months, it is your responsibility to go and take a new "housing survey". See date written on the top of this sheet.
10. If you have a grievance pursuant to fair housing, contact the Dept. of Housing and Urban Development directly https://portal.hud.gov/hudportal/HUD?src=/program offices/fair housing equal opp/online-complaint. If you have a grievance with the agency you worked with-see the agency grievance procedure information form given to you upon completion of the housing survey. If you have a grievance with the coordinated entry process, you can access the grievance procedure and form on the Community Health Partnership website - https://www.ppchp.org/

Please call Community Health Partnership at 719-632-5094 for any other resources you may want information about.

On the reverse of this form is a schedule/locator where you can update your housing survey.

Attachment VII

Pikes Peak Continuum of Care
Regional Coordinated Entry System
Authorization to Share VI-SPDAT Information Anonymously

Participant Last Name:	Participant First Name:

DOB:	HMIS ID #:	SS #:

I have participated in the VI-SPDAT Assessment and Match Survey. I did not agree to allow my identification to be connected to my Survey. Rather, I am choosing to have my information shared anonymously through a representative.

Please initial below if you agree with the following statements:

___I agree to allow my responses to VI-SPDAT Assessment and Match Initiation to be disclosed anonymously only to organizations that participate in the Pikes Peak Continuum of Care Coordinated Entry System and to be used to determine if I am eligible for participating housing, service and related programs. These organizations include but are not limited to:

Ascending To Health	Family Promise	Rocky Mountain Human Services
AspenPointe	Greccio Housing	The Salvation Army
Catholic Charities	CSPD Homeless Outreach Team	Springs Rescue Mission
Coalition for Compassion and Action	Homeward Pikes Peak	Tri-Lakes Care
Colo. Springs Housing Authority	Partners in Housing	Veterans Administration
Colorado Division of Housing	Peak Vista	Urban Peak, Colo. Springs
Ecumenical Social Ministries	Pikes Peak United Way	Community Health Partnership

A complete list of participating agencies is provided online at https://www.ppchp.org/

___This agency (listed below) may represent me at Coordinated Entry Case Conferencing and contact me about my survey and possible housing.

The Name of Agency that did my survey: _____
Contact/Location _____
_____
_____

I am best reached at the following address, phone number, and/or e-mail:

_____
_____
_____
_____
_____
_____
_____

Attachment VIII
Pikes Peak Continuum of Care
Coordinated Entry Grievance Form

This form is to be filled out if you have a grievance with the Coordinated Entry Process, those grievances would include, any complaint against the Coordinated Entry policies and/or procedures.This form is also used if you have filed a grievance against one of the CE participating agencies, and the grievance needs to be escalated.

Name	Today's Date

Phone#: _____	Current Address:
Email: _____	

Brief Discription of Grievance / Attached Copy of Agency Grievance Form

For Coordinated Entry Use Only.

Coordinated Entry Director Resolution

CE Director Signature _____ Date _____

Client Signature _____ Date _____

Agree to Resolution	
Please Escalate to Next Level	

Updated 6/5/2017