POLK COUNTY CONTINUUM OF CARE

CENTRALIZED INTAKE SYSTEM FOR HOMELESS ASSISTANCE

POLICIES AND PROCEDURES

OVERVIEW

Purpose

In establishing a Centralized Intake System, the Polk County Continuum of Care seeks to provide a single "front door" for homeless individuals and families seeking shelter and assistance. The System will include common intake, assessment, and prioritization tools and processes, referrals and placement decisions based on client needs, inventory of resources for housing and services, and consistent opportunities for prevention or diversion to appropriate resources, supportive services, and permanent housing. When situations require emergency shelter, Centralized Intake will employ rapid rehousing resources to minimize the trauma of homelessness and achieve stable housing as quickly as possible.

Additional expected benefits of the Centralized Intake System include:

- Creation of a common language and message from the homeless assistance system
- Elimination of multiple triages, intakes, and referrals for clients to multiple shelters and/or housing
- Creation of a single voice for available beds for shelter and housing
- Demonstration of efficiencies in matching homeless clients with appropriate community resources

Measurable Outcomes

The Centralized Intake System is expected to work toward measurable outcomes that will be set by the Performance Committee of the Polk County Continuum of Care Board (CoCB). The Performance Committee will periodically review the measures to determine if any changes need to be made. If so, the Committee will make recommendations to the CoCB.

Guiding Principles

The primary goal of the Centralized Intake System is effective allocation of assistance and easy accessibility no matter where or how people present. The Centralized Intake System will assist the Polk County Continuum of Care (CoC) in prioritizing assistance based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. Centralized Intake is also Housing First oriented, such that people are housed quickly without preconditions or service participation requirements.

The Polk County CoCB has developed the following guiding principles for the operation of the Centralized Intake System:

- Right resources - right time
- Client centered
- Prevent and divert when possible
- Real-time data and inventory

- Sustainable system: continuous evaluation and redesign as needed

Nondiscrimination

The CoC will operate a Centralized Intake System that permits recipients of Federal and State funds to comply with applicable civil rights and fair housing laws and requirements. Nondiscrimination and equal opportunity housing provisions include the following:

- Fair Housing Act prohibits discriminatory housing practices based on races, color, religion, sex, national origin, disability, or familial status
- 24 CFR Part 5 2016 Equal Access in Accordance with an Individual's Gender Identity in Community Development and Planning
- Section 504 of the Rehabilitation Act prohibits discrimination of the basis of disability under any program or activity receiving Federal assistance
- Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance
- Title II of the Americans with Disabilities Act prohibits public entities, which includes State and local governments, and special purpose districts, from discrimination against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance
- Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which includes shelters, social service establishments, and other public accommodations providing housing, from discrimination on the basis of disability

The Polk County Continuum of Care Board Nondiscrimination Policy appears as Appendix I to this document.

CENTRALIZED INTAKE SYSTEM

Designated Operating Agency

Policy:

1. Through a Request for Proposals (RFP) process, the Polk County CoCB will select an organization to operate the Centralized Intake System.
2. The selected organization will be required to enter into a Memorandum of Understanding with the CoCB.

Procedure:

1. An initial RFP was released on August 30, 2013 with a proposal submission deadline of September 23, 2013.
2. Submissions to the RFP were reviewed by the Centralized Intake Committee, which made a recommendation to the Polk County CoCB for discussion and approval.
    a. On November 15, 2013, the Centralized Intake Committee recommended that the Centralized Intake provider be awarded the contract to be the Centralized Intake provider and the recommendation was approved by the Polk County CoCB.
3. Subsequent contacts will be considered on an annual basis with final determination being made through the process as described above.

Community Education and Marketing

Policy:

Community education and marketing strategies will be designed to ensure that the Centralized Intake System includes all subpopulations, including people experiencing chronic homelessness, veterans, families, youth, and people fleeing domestic violence. Materials will include statements that ensure access points that are accessible to individuals with disabilities.

Procedure:

Community education and marketing strategies shall include the following

1. Informational flyers shall be developed and distributed across agencies in the CoC, meal sites, and food pantries, as well as public locations such as libraries, DART Central Station, Greyhound bus depot, and hospital emergency rooms.
2. Announcements and presentations shall be made at community meetings such as the CoCB, Director's Council, and Service Council meetings.
3. Programs to educate mainstream service providers and public schools will be provided.
4. In adherence with CoC interim rule at 24 CFR 578.93(c), along with any CoC-funded program, Centralized Intake (CI) will affirmatively market the system to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to apply in the absence of special outreach and maintain records of those marketing activities.
5. All housing assisted by or as a result of CI must be made available to individuals and families without regard to actual or perceived sexual orientation, gender identity, or marital status in accordance with 24 CFR 5.105(a)(2).

System Entry

Policy:

Entry into the Polk County CoC's CI shall reflect the following characteristics:

1. Full Coverage
    a. CI must offer full coverage of the CoC's geographic area.
    b. CI must offer the same assessment approach at all access points.
    c. CI must be usable by all people who may be experiencing homelessness or at-risk of homelessness.
    d. CI provides the same assessment approach, including standardized decision making, at all access points.
2. Fair and Equal Access
    a. All people in the CoC's geographical area have fair and equal access to the CI process, regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status as well as where or how they present for services.
    b. People in all populations and subpopulations in the CoC's geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence are assured to have fair and equal access to the CI process.
    c. Fair and equal access means that people can easily access the CI process, whether in person, by phone, or some other method, and the process for accessing help is well known.

d. If the entry point includes one or more physical locations, they are accessible to persons with disabilities and easily accessible by public transportation, or there is another method by which people can easily access them.
e. The CI process is able to serve people who speak languages commonly spoken in the community and takes reasonable steps to offer CI material and participant instruction in multiple languages to meet the needs of minority groups, ethnic groups, and people with Limited English Proficiency (LEP).
f. Efforts will be taken to ensure effective communication with individuals with disabilities including the provision of auxiliary aids and services necessary to ensure effective communication (e.g. Braille, large type, assistive listening devices, and sign language interpreters). A list of resources to call will be at hand.

3. Safety Planning
    a. The CI process has protocols in place to ensure the safety of the individuals seeking assistance
    b. The protocols ensure that people fleeing or attempting to flee domestic violence and victims of domestic violence have safe and confidential access to the CI process and victim services, including access to the comparable process used by victim service providers, as applicable, and immediate access to emergency services such as domestic violence hotlines and shelter.
        i. All data collection must adhere to the Violence Against Women Act (VAWA).
        ii. Victim service providers funded by CoC and ESG program funds are not required to use the CoC's CI process but are allowed to do so.
4. Access to Emergency Services
    a. The CI process does not delay access to emergency services, including all domestic violence and emergency services hotline, drop-in service programs, and emergency shelters, including domestic violence shelters and other short-term crisis residential programs, to operate with as few barriers to entry as possible
    b. Access points provide connections to mainstream and community-based emergency assistance services such as supplemental food assistance programs and applications for income assistance.
    c. The process includes a method for people to access emergency services at all hours independent of the operating hours of the CI intake and assessment processes.
5. Outreach
    a. The CI process is linked to street outreach efforts to that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through the CI process.
    b. All participating street outreach staff, regardless of funding source, ensure that persons encountered by street outreach workers are referred to the organization contracted to implement CI so that unsheltered persons are offered the same standardized process as persons who access CI through site-based access points.
6. Low Barrier
    a. The CI process does not screen people out for assistance because of perceived barriers to housing or services, including but not limited to, lack of employment or income, drug or alcohol use, or having a criminal records

Procedure:

1. All subpopulations including chronically homeless families and individuals, veterans, youth, individuals, families with children, transgender persons, and persons who are fleeing, or attempting to flee, domestic violence,

dating violence, sexual assault, or stalking, shall be provided access to all components of the Centralized Intake System for which they are eligible independent of the characteristics and attributes of their specific subpopulations

2. The staff composition of the organization to operate the Centralized Intake System will include a program manager, case managers, and a program support specialist sufficient to effectively maintain high standards of implementation but within resources allocated by the community through the CoCB.
    a. Duties of the program manager include, but are not limited to, being responsible for the overall supervision of the Centralized Intake System; providing quality control oversight to ensure intake information is correctly entered into ServicePoint; making and facilitating the referrals for services/housing programs to best fit the needs of the households requesting assistance; facilitating monthly meetings of Centralized Intake staff to discuss process improvement and case conferencing; and assisting in the triage of households with complex housing needs. The program manager will continually identify ways to improve the system for the benefit of the population being served.
    b. The CI case managers will be responsible for completing on-site intakes and community based intakes when outreach staff is not available; making referrals for prevention/diversion services, housing interventions, and shelter; providing transportation to housing and shelter interviews; and assisting with telephone intakes as needed. The program support specialist will be responsible for staffing the CI phone line and returning calls left on the CI voicemail.
3. Entry into the Centralized Intake System will either be by phone or in person at the CoC's contracted CI provider's outreach center. The physical location of the outreach center is accessible by three local DART routes and is handicap accessible. To prevent language from being a barrier to accessing CI, persons who have LEP will be assisted in one of two ways
    a. If the person is more comfortable speaking a language other than English, the case manager will use Language Line services to communicate with the person.
    b. The CI provider will maintain a contact list of other resources so that barriers to communication are eliminated to the extent that resources can be identified.
4. Persons experiencing homelessness will also be engaged to enter the Centralized Intake System by partnering area homeless outreach teams. System entry for persons engaged by identified outreach teams may be by transporting the person to the contracted CI provider's outreach center if the person is interested. These same system entry options shall be available to persons engaged by additional partnering outreach teams by the respective team making a referral directly to the CI location.
5. All agencies participating in the Centralized Intake System who are contacted by a person or their representative seeking homelessness assistance services shall provide the CI number and/or directions to the CI provider's outreach center. Two exceptions to this rule are:
    a. Individuals and families fleeing, or attempting to flee domestic violence, dating violence, sexual assault, or stalking. To ensure the continued safety and privacy of victims of domestic violence, the individual or family seeking services will be given a choice about potential referral to CI or to Children and Families of Iowa's (CFI) domestic violence services. CFI will be the central point of contact for victims of domestic violence for persons making that choice. If CI staff or outreach workers engage a person self-identifying as needing domestic violence services, the staff will offer to help contact CFI's domestic violence services. If necessary, CI shall provide transportation to the domestic violence shelter. If CFI's domestic violence shelter is full, CFI and CI staff shall work together to identify and transport the household to another area domestic violence shelter or safe place.

    b. Persons presenting at Central Iowa Shelter and Services (CISS). In keeping with the Guiding Principle of the Centralized Intake System being client-centered, individuals presenting at CISS will be immediately accepted into shelter with follow-up assessment occurring at a later date by CI staff either on-site or at the CI provider's outreach center.
6. CI will receive calls and take walk-in referrals from 8am-5pm, Monday through Friday. In instances where the program support specialist is on the phone and the case managers are engaged with other clients, the caller will be transferred to an answering machine that will convey a message provided directions for leaving a message or stopping by the CI provider's outreach shelter for an intake. The answering machine shall be checked by the program support specialist once a day.
    a. Calls received from families after 5pm or on weekdays, or anytime on weekends, will be referred to United Way's 211 to determine potential eligibility for an overnight or weekend motel stay (until CI is next open).
    b. Calls from single individuals or couples without children received after 5pm on weekdays, or anytime on weekends, will be referred to CISS and to United Way's 211 for additional resources.
7. If individuals or families require transportation to the CI access point, the CI provider will arrange for transportation. If necessary, case managers or identified outreach workers will go to the caller and complete the intake at the caller's location.

Initial Intake and Assessment

Policy:

All methods of system entry (i.e., phone, in-person) shall offer the same standardized assessment tool and referrals using the uniform decision-making processes in order to achieve fair, equitable, and equal access to services within the community. The Centralized Intake system is prohibited from screening people out of the process due to perceived barriers to housing or services, including but not limited to: too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations, history of not being a leaseholder, or criminal record.

To ensure an effective assessment process, the assessment tool shall reflect the following principles;

1. Phased Assessment
    a. The assessment tool will employ a series of situational assessments that allow the assessment process to occur over time and only as necessary.
    b. The successive assessments shall build on each other so a person does not have to repeat their story.
2. Necessary Information
    a. The assessment process only seeks information necessary to determine the severity of need and eligibility for housing and services and is based on evidence of the risk of becoming or remaining homeless.
3. Participant Autonomy
    a. The protocol for filling out assessment tools provides people receiving the assessment the opportunity to refuse to answer questions without retribution or limitation to their access to assistance
4. Person-centered

a. The assessment process provides options and recommendations that guide and inform client choices, as opposed to rigid decisions about what individuals or families need.
b. The process also incorporates participants' strengths, goals, and protective factors to recommend options that best meet the needs and goals of the people being assessed.
c. Participants must be informed of their right to file a complaint using the participant rights form.

5. Cultural Competence
    a. Staff administering assessments use culturally competent practices, tools containing culturally competent questions, and offer options and recommendations that reflect the population's specific needs.
6. User-friendly
    a. Tools are brief, easily administered by non-clinical staff including outreach workers, minimize the time required to utilize, and are easy for those being assessed to understand.
7. Privacy Protections
    a. Privacy protections are in place to ensure proper consent and use of client information.
8. Meaningful Recommendations
    a. Tools are designed to collect the information necessary to make meaningful recommendations and referrals to available housing and services.
    b. Participants being assessed should know exactly to what program they are being referred, what will be expected of them, and what they should expect from the program
    c. The CI process should avoid placing people on long waiting lists.
9. Sensitive to Lived Experiences
    a. The tool's questions are worded and asked in a manner that is sensitive to the lived and sometimes traumatic experiences of people experiencing homelessness.
    b. The tool minimizes risk and harm and provides individuals or families with the option to refuse to answer questions.
    c. Agencies administering the assessment have and follow protocols to address and psychological impacts caused by the assessment and administer the assessment in a private space, preferably a room with a door, or, if outside, away from others' earshot.
    d. Those administering the tool are training to recognize signs of trauma or anxiety.
10. The CoC may use Homeless Management Information Systems (HMIS) to collect and manager data associated with assessments and referrals.
11. The CoC along with the CI contractor provides training opportunities at least once annually to organizations and/or staff persons at organizations that serve as access points or administer assessments. The CoC updates and distributes training protocols at least annually. The purpose of the training is to provide all staff administering assessments with access to materials that clearly describe the method by which assessments are to be conducted with fidelity to the CoC's coordinated entry written policies and procedures. Training curricula include the following:
    a. Review of the CoC's written CI policies and procedures, including any adopted variations for specific subpopulations.
    b. Adherence to the stipulations, within both the HMIS Confidentiality and Responsibility Certification as well as the Polk County Coordinated Intake Network Memorandum of Understanding and Interagency Data Sharing and Coordinated Services Agreement documents.
    c. Requirements for use of assessment information to determine prioritization.
    d. Criteria for uniform decision making and referrals.

e. All assessment staff are trained on safety planning and other next step procedures if safety issues are identified in the process of participant assessment.

Procedure:

The intent of the ServicePoint-based initial intake and assessment process is a.) to gather pertinent information necessary to identify persons who are literally homeless, or in need of diversion or prevention assistance; b.) to match appropriate levels of housing and services to the individual's or family's needs; and c.) to prioritize the referral to housing and services to ensure those individuals and families with the greatest need are served first.

1. The initial intake and assessment will be completed with persons calling or walking into the Centralized Intake System administering organization's outreach center as well as with adults and youth who are engaged by the administrative organization's homeless outreach teams.
    a. Identified staff shall be trained in asking appropriately worded questions reflecting their understanding of the culture of the person seeking assistance and to avoid causing the person to relive difficult experiences.
    b. Outreach staff will offer adults and youth with whom they engage the option to return to the administering organization's outreach center to complete the initial intake and assessment.
    c. The initial intake and assessment shall be completed in a private setting that maintains the confidentiality of the person seeking assistance and prevents the person's answers from being overheard. If the initial intake and assessment is completed outside of the CI provider location, precautions will be taken to ensure the necessary distance from others is observed to maintain the privacy of the person seeking assistance.
2. Prior to beginning the initial intake and assessment, the person seeking assistance will be given the options to sign a Release of Information (ROI) – Appendix A – as well as be informed that they may choose not to answer any question asked during the initial intake and assessment process.
    a. The information gathers in the initial intake process will not be shared with the participating CI Network agencies (Appendix B) if the person seeking assistance does not wish to sign the ROI.
    b. Each person seeking assistance will be assured that they will not be denied assistance should they refuse to sign the ROI or answer specific questions.

Initial Intake

The Initial Intake is comprised of five phases: Pre-screening, Shelter Screening, Diversion Screening, Prevention Screening, and the Iowa Basic Entry.

1. All intakes include the Iowa Basic Entry, which asks date of birth, income level, homelessness history, income/education information, and domestic violence history
2. All phases of the intake are accessible to the case management staff of participating CI Network agencies in the CoC, to prevent the person seeking assistance from having to repeat their story, should the person sign the ROI and agree to it.
3. The other four phases of the initial intake build on each other so a person seeking assistance will only have to answer the questions for a particular screening based on their specific need for assistance (for example, a person living unsheltered would not have to answer anything in the Prevention Screening).

4. The questions in each phase are brief and request rudimentary information to ensure ease of understanding by the person seeking assistance, cultural competence, and to minimize the risk of re-traumatizing the person.

Pre-screening Questions

Each household who walks in or contacts CI shall be asked a series of pre-screening questions to determine if their immediate personal safety is threatened or if they should go through the CI process.

1. Personal safety questions include:
    a. Are you fleeing from domestic violence?
        i. Persons fleeing domestic violence will be referred to CFI's domestic violence services. No information about the person will be entered into the initial intake and assessment. If legal assistance is needed, the person will be referred to Iowa Legal Aid by CFI's domestic violence services.
    b. Are you in immediate danger?
    c. Do you have urgent health issues – bleeding, trauma, chest pains, nausea, etc.?
    d. Acute suicidal/homicidal/medical issues?
        i. Persons who are in immediate danger, have urgent health issues, or have acute issues will be further assessed for immediate intervention by police and/or medical personnel. If needed, 911 will be called.
2. Current living situation: a series of pre-screen questions shall be asked to gather information about the type and size of the household and the household's current living situation.
    a. If the household is made up of people between the ages of 16 until their 18th birthday, CI staff will attempt to contact the guardians involved in order to obtain consent for intake to be completed. See b. of this section.
        i. If the household is a family unit made up of pregnant/parenting minors, the only housing intervention options are through the Lighthouse emergency beds and from there the Lighthouse TH/RRH project.
        ii. If the household is made up of an unaccompanied youth, the only housing intervention is the emergency bed reserved for minors at Lighthouse.
    b. In the event that a client identifies having a guardian at any age, CI staff will attempt to contact the guardian to obtain consent for the intake to be completed. The guardian can give consent in two ways: written or verbal. In the event that a guardian is unable to provide written consent, they may give verbal consent, via phone, with two staff present to document such consent. If CI staff are unable to contact the guardian via writing or phone, the intake will not be completed as the client is unable to provide consent for intake, releases of information, or homeless verification.
        i. CI staff will attempt to contact a guardian twice during a fourteen day period. The first will be attempted on the day the client presents for CI and provides guardian information. CI staff will then wait seven days, and with no response, will reach out again. If a guardian fails to contact CI during the second seven days, no intake will be completed until the guardian contacts CI.
    c. If the household is "literally homeless", "at imminent risk of homelessness", or "fleeing domestic violence" as defined by HUD, CI staff will continue to the Shelter Screening.
    d. If the household does not meet the aforementioned HUD standards of homelessness in part c. of this section, CI staff will continue with the next series of pre-screening questions to gather information

about the household's eviction and utility arrears history, whether the household can stay where they stayed the night prior and under what conditions, and if the lease is in the person's name.

i. If the lease is in the person's name, the Prevention Screening will be completed.
ii. If the lease is not in the person's name, the Diversion Screening will be completed.

Shelter Screening

The Shelter Screening will assess any unique housing barriers (e.g., restrictions on where the household can live, parole/probation, no contact orders, sex offender registry), the household's past shelter history, any physical or mobility issues to be considered for shelter placement, and any supports the household currently has in place.

1. Physical or mobility issues as well as individual disabilities shall be recorded in the Polk County Disability Detail Assessment.
2. If the household includes minor children and family shelters are full, the case manager will work with the family on prevention and/or rapid resolution options and coordinate with Polk County General Assistance/ family shelters about upcoming openings if possible. The case manager will look at all possible safe housing options for a family, including calling Youth Emergency Services and Shelter (YESS) to keep the children in youth shelter until a family shelter opening is available if the family is unable to identify any other safe place for the children to stay.
3. Households that are successfully referred to shelter will end their engagement with CI.
4. The case manager shall complete the Coordinated Intake Disposition noting which, if any, CoC project to which the household was referred and the assessment disposition.

Prevention Screening

The Prevention Screening assesses if the household can stay in the unit where they currently have a lease. The CI case manager will utilize the information from this screening to assess whether the household is eligible for any prevention services.

1. If prevention programs are available, the household will be referred based on the program's criteria.
2. If no prevention programs are available, the household will be referred to Iowa Legal Aid and/or Home Inc. for prevention services and given a community resource guide.
3. Households that are referred to prevention services will end their engagement with CI.
4. The case manager shall complete the Coordinated Intake Disposition noting which, if any, CoC project to which the household was referred and the assessment disposition.

Diversion Screening

The Diversion Screening assesses if the household can stay with the person/family where they are currently living, or if there is another place they could stay as well and what it would take to remain out of the CI system. Assistance offered by the case manager may include dispute resolution, referrals to resources to contribute to the operation of the household such as groceries, referrals to resources for rent/utility assistance so the household can move into their own housing, and/or referrals to mainstream resources the household has not accessed.

1. If diversion programs are available, the household may be referred based on program criteria.
2. Households will also be given a community resource guide with different agencies that may be able to assist with financial assistance.

3. Households that are successfully referred to diversion services will end their engagement with CI.
4. The case manager shall complete the Coordinated Intake Disposition noting which, if any, CoC project to which the household was referred and the assessment disposition.

Assessment Process

VI-SPDAT

1. The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT, F-VI-SPDAT, and TAY-VI-SPDAT) 2.0 will be administered to individuals, families, and transition age youth, respectively, to assess various health and social needs and then match them to the most appropriate housing interventions available (e.g., permanent supportive housing, rapid-rehousing, or affordable housing). The VI-SPDAT and its versions will be administered by case managers during CI.
    a. The VI-SPDAT in all versions has a built-in scoring mechanism that will recommend the family/individual/transition age youth for referral to housing interventions.
2. The F-VI-SPDAT will be administered to families with minor children in their care or families with minor children who are DHS involved but able to seek services as a family unit (with a plan for reunification).
    a. On occasion, the F-VI-SPDAT may be used by the case manager to assess a household without minor children due to a member of the household being a dependent adult unable to answer questions on their own or to facilitate the ease of referral and reduce trauma for the household. In such instances, the portion of the F-VI-SPDAT about minor children will be omitted.
3. The TAY-VI-SPDAT will be administered to transition age youth from 16 up to their 25th birthday.
4. The VI-SPDAT will be administered to individuals age 25 and older.
5. VI-SPDATs are reissued only in the case of a major life change. Major life changes include:
    a. Birth of a child
    b. Death of a family member (who was part of the household in HMIS)
    c. Loss of limb(s)
    d. A household meeting the standard for chronic homelessness as verified by CI staff
    e. Having been housed with a signed lease for at least 90 days and then homeless again
    f. Aging out of the TAY-VI-SPDAT range after previously having been issued a TAY-VI-SPDAT
    g. Having been awarded SSI/SSDI (determined to be disabled by the federal government)
    h. director

Due Diligence

Policy:

Each referral programs requires verification of homelessness at program entry. Upon intake with the Centralized Intake Program, intake/case management staff seek verification of housing status using one of three prioritized methods: 1) third party verification, 2) staff observation, and 3) client self-certification. Staff must exercise due diligence in obtaining third party verification. Lack of third-party verification should not be a barrier to clients entering emergency shelter. Homeless verification must be obtained prior to entering programs.

Procedure:

1. Centralized Intake utilizes HUD's order of priority for obtaining verification of homelessness. The following is the order of priority used for documenting homelessness:
    - Third party verification
    - HMIS documentation
    - Staff observation
    - Client self-certification.
2. Centralized Intake will exercise due diligence in obtaining homeless verification. Staff will document the request for verification of homelessness using the homeless verification form. Staff will obtain a release of information prior to requesting verification of homelessness from the third party.
    - **Clients placed on prioritization list:** Staff will request verification of homelessness from a third party identified by the client during or immediately following the client's Centralized Intake. For clients who complete a Centralized Intake and will be placed on a prioritization list, only one attempt at third party verification will be made. Staff will wait 10 calendar days. A new attempt at third party verification will be made when the client is referred off the priority list to a housing project.
    - **Clients being referred to housing:** For clients who are being referred to a housing/shelter project, staff will request third party verification at the time of intake/referral. If staff do not receive any information from the third party within 4 calendar days, they will send a second request. After the second request, if staff have not received third party verification within 3 calendar days, they may move on to staff observation.
3. Staff must then make one attempt to observe where the client has reported staying. Staff observation of homeless status is documented through a written declaration by the case manager who observed where the client was staying.
4. If staff are not able to find the client to observe where they are staying, then staff may utilize client self-certification. Self-certification is documented by a written statement from the client. There is space provided on the homeless verification form.
5. All documentation of homeless verification will be kept in the client's file.
6. When a client is referred to a case management program by Centralized Intake, the case manager will receive a copy of the Centralized Intake and assessment that includes the homeless verification. The case manager is responsible for ensuring that homeless verification is correct at program intake. If it has been more than 30 days since a client's Centralized Intake, case management staff will request an updated homeless verification form from the client. If the client is no longer literally homeless, (s)he will not be admitted into the case management programs at PHC.
7. If a client chooses not to sign a release of information form for verification of homelessness or housing status, referral time may take additional time as homeless verification is a requirement of many programs. The client will be given direction about the type of verification needed from a third party and will be responsible for providing it. If the client does not provide homeless verification from a third party within 7 days, a second request from the client will be made. If no verification is provided within 7 days of the second request, Centralized Intake will move to staff observation.
8. Third party verification cannot be accepted from a person who will be a part of the client's household or who is planning to be housed with the client. Centralized Intake will then ask for a different source of third party verification from an agency or someone outside the household.

Basis for Referral

Policy:

Centralized Intake makes referrals to:

1. All projects receiving Emergency Solutions Grant (ESG) and CoC Program funds, including emergency shelter, Rapid Rehousing (RRH), Permanent Supportive Housing (PSH), and transitional housing (TH), as well as other housing and homelessness projects.
2. CoC and ESG Program funded projects are required to use CI as the only source from which to consider filling vacancies in their CoC and ESG funded housing/services programs and to accept those referrals except on rare occasions (see Referral Rejection Policy).
3. Projects in the community that are dedicated to serving people experiencing homelessness fill all vacancies through referrals from CI, while other housing and services projects determine the extent to which they rely on referrals from the CI process.

Procedure:

1. Referrals to housing, shelter, and services will be made based on the following:
    a. Results of the initial intake
    b. Chronic homeless status
    c. Most severe service needs (VI-SPDAT/F-VI-SPDAT/TAY-VI-SPDAT score)
    d. Veteran status
    e. Degree of vulnerability
    f. Availability of a housing unit by program type (i.e. PSH, RRH, or TH), size of priority list by program type and unit size
    g. Availability of shelter beds by family composition and size
    h. Program eligibility admission criteria, including populations served and services offered
    i. Homelessness due to eviction/foreclosure and other legal action that results in homelessness
2. The CI program manager or designated staff will regularly check the availability of housing units with ESG and HUD CoC-funded housing programs, as well as other housing intervention stakeholders in the community accepting referrals from CI.
    a. These programs will notify the program manager as soon as they receive funding for new housing units of the approximate time they will be accepting referrals for new units. The program manager will use this information to keep an up-to-date inventory of available housing intervention resources.

Prioritization for Referral

Policy:

1. HUD has determined that an effective coordinated entry process ensures that people with the greatest needs receive priority for any type of housing and homeless assistance available in the CoC.
2. HUD's policy is that people experiencing chronic homelessness should be prioritized for PSH.
3. In addition to prioritizing people experiencing chronic homelessness, the coordinated entry process prioritizes people who are more likely to need some form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness.
4. Communities should take care to ensure that their prioritization does not allow people who are more vulnerable or who have more severe service needs to languish in shelters or on the streets because more intensive types of assistance are not available.
    a. This means that if a person is assessed as being highly vulnerable, that person may be prioritized for PSH, but if PSH is not available or PSH has a long waiting list, that person should be prioritized for other

types of assistance such as RRH or TH. CoCs should not assume that because a person is prioritized for one type of assistance, they could not be served well by another type of assistance.

i. CoCs should be aware that placing a household in TH can affect their eligibility for other programs (e.g. lose eligibility for RRH and affect chronic homeless status).

5. The priority list report is compiled from data existing in HMIS., There are three methods to cause a client to appear on the priority list report:
    a. Any client who has an active entry in an emergency shelter project
    b. Any client who has an active entry in a project designed to count unsheltered clients
    c. Any client who has an active entry in a project for clients staying at a non-HMIS shelter who also has an evaluation with CI. CI will record the entries for clients who are 1) checked into a non-HMIS shelter and 2) follow up for evaluation with CI.
6. Process for removing people from the priority list:
    a. Because the priority list is based on active records for clients in a shelter or unsheltered project, when a client is exited from an eligible project, they will automatically drop from the report
7. The CI agency will make referrals from the list based on criteria stated in the policy and procedure document.
    a. When a referral is made, the referral will be recorded in HMIS.
    b. The agency to which the client is referred will record the outcome of the referral.
    c. Reports will be compiled of referral and referral outcome statistics.
8. Many clients who have at one point appeared on the priority list will not be referred on to another project for a variety of reasons including exiting from shelter on their own, disappearing from shelter, or becoming unable to locate.

Procedure:

1. A priority list shall be maintained by CI staff for each housing intervention type and emergency shelter.
    a. Priority ranking on each list shall be done by VI-SPDAT/F-VI-SPDAT/TAY-VI-SPDAT score, highest to lowest.
    b. Priority and security protections are consistent with those prescribed by HUD for HMIS practices in the HMIS Data and Technical Standards.
    c. Data collected from the assessment process will not discriminate or prioritize households from housing services on a protected basis, such as race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identification, or marital status.
2. The total score from the VI-SPDAT/FI-VI-SPDAT/TAY-VI-SPDAT will determine if a household will be prioritized to a housing intervention and to what type:
    a. Individuals:
        i. Score equaling or greater to 8 is recommended to PSH
        ii. Score of 4-7 is recommended to RRH, Tenant Based Rental Assistance (TBRA), or TH
        iii. Score equaling or less than 3 is not recommended for any housing intervention
    b. Families:
        i. Score equaling or greater to 9 is recommended to PSH
        ii. Score of 4-7 is recommended to RRH, TBRA, or TH
        iii. Score equaling or less than 3 is not recommended for any housing intervention
    c. Transition Age Youth:
        i. Score equaling or greater to 8 is recommended to PSH

ii. Score of 4-7 is recommended to RRH, Tenant Based Rental Assistance (TBRA), or TH
iii. Score equaling or less than 3 is not recommended for any housing intervention

3. Referral for PSH
    a. Prioritizing Chronically Homeless Persons in PSH Dedicated or Prioritized for Occupancy by Persons Experiencing Chronic Homelessness
        i. First Priority: This category consists of chronically homeless individuals and families with the longest history of homelessness and the most severe service needs (defined as the highest VI-SPDAT/F-VI-SPDAT/TAY-VI-SPDAT score).
        ii. Should there be no chronically homeless individuals or families, referrals to PSH will be made by following the order of priority in Section b.
    b. Prioritizing Chronically Homeless Persons in PSH NOT Dedicated or Prioritized for Occupancy by Persons Experiencing Chronic Homelessness
        i. First Priority: Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs. This category consists of an individual or family that is eligible for PSH who has experienced fewer than four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter but where the cumulative time is at least 12 months and has been identified as having severe service needs.
        ii. Second Priority: Homeless Individuals and Families with a Disability with Severe Service Needs. This category consists of an individual or family that is eligible for PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.
        iii. Third Priority: Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter without Severe Service Needs. This category consists of an individual or family that is eligible for PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified has having severe service needs. The length of tie in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.
        iv. Fourth Priority: Homeless Individuals and Families with a Disability Coming from Transitional Housing. This category consists of an individual or family that is eligible for PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing project had lived in a place not meant for human habitation, a safe haven, or an emergency shelter. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking, and prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, a safe haven, or an emergency shelter prior to entry in the transitional housing.
    c. Referrals to PSH should follow the order of priority above while also considering the goals and any identified target populations served by the project to which the referral is being made.
    d. While due diligence should be exercised when conducting outreach and assessment to ensure chronically homeless individuals and families are prioritized for assistance based on their total length of

time homeless and/or the severity of their needs, SH units should not be allowed to remain vacant indefinitely while waiting for an identified chronically homeless person to accept an offer of PSH. If the chronically homeless individual or family with the highest VI-SPDAT is not located or does not respond within fourteen days, the unit will be offered to the next highest ranked chronically homeless individual or family.

e. A person experiencing chronic homelessness should not be forced to refuse an offer of PSH if they do not want to participate in the project's services, nor should the PSH project have eligibility criteria or preconditions to entry that systematically exclude those with severe service needs.
f. Street outreach providers partnering with CI should continue to make attempts to engage those persons that have been resistant to accepting an offer of PSH. These chronically homeless persons must continue to be prioritized for PSH until they are housed.

4. Referral for TH
    a. First priority: Individuals choosing and eligible for Grant and Per Diem (GPD) who are living in a place not meant for human habitation, a safe haven, or an emergency shelter, score highest for this intervention based on their VI-SPDAT/F-VI-SPDAT/TAY-VI-SPDAT score.
        i. If an individual has the same VI-SPDAT score, the household with the longest history of homelessness will be referred first.
    b. Second priority: imminent risk of homelessness, highest VI-SPDAT score.
5. Referral for RRH and TBRA
    a. Individuals and families who are living in a place not meant for human habitation, a safe haven, or an emergency shelter, score highest for RRH/TBRA based on their VI-SPDAT/F-VI-SPDAT/TAY-VI-SPDAT score.
        i. Households eligible for referral to a program are determined by unit size available through that program.
        ii. If an individual and/or family has the same VI-SPDAT score, unsheltered households shall be prioritized first.
        iii. If an individual and/or family has the same VI-SPDAT score and are residing in the same type of location, the household with the longest length of homelessness shall be prioritized first.
        iv. TBRA programs funded by HOME funds and not CoC/ESG may set aside specific criteria that diverge from the traditional CI referral process of the next best housing intervention.
6. Referral for TH/RRH (joint component)
    a. First priority: individuals and families who meet the standard for category I or category IV under HUD guidelines and who score highest for TH based on their VI-SPDAT/F-VI-SPDAT/TAY-VI-SPDAT score AND meet at least one of the criteria listed below will be eligible for referral to TH:
        i. Transition age youth – pregnant, unaccompanied youth ages 16.5 – 24 without children.
        ii. Transition age youth parents – youth ages 16.5-24 who are the parents of at least one child, whether that child is residing in the household or the household is DHS involved with plans for reunification.
            1. If households have the same VI-SPDAT score, the household with minor children will be referred first based on the vulnerability of the children.
                a. If households have the same F-VI-SPDAT score, the household with the youngest children will be referred first.

2. If no households have minor children on the prioritization list and households have the same VI-SPDAT score, the household with the longest history of homelessness will be referred first.

b. Second priority: individuals and families who meet the standard for category II homelessness under HUD guidelines and who score highest for TH based on their VI-SPDAT/F-VI-SPDAT/TAY-VI-SPDAT score AND meet at least one of the criteria listed below will be eligible for referral to TH:
    i. Transition age youth – pregnant, unaccompanied youth ages 16.5 – 24 without children.
    ii. Transition age youth parents – youth ages 16.5-24 who are the parents of at least one child, whether that child is residing in the household or the household is DHS involved with plans for reunification.
        1. If households have the same VI-SPDAT score, the household with minor children will be referred first based on the vulnerability of the children.
            a. If households have the same F-VI-SPDAT score, the household with the youngest children will be referred first.
        2. If no households have minor children on the prioritization list and households have the same VI-SPDAT score, the household with the longest history of homelessness will be referred first.

7. Referral for Family Shelter
    a. First Priority: Literally homeless, greatest vulnerability (living in a car or a place not meant for human habitation).
        i. If a family's vulnerability is the same in terms of their living situation, the family with the youngest children shall be prioritized first
        ii. If the children in the households are the same ages, the family with the highest VI-SPDAT score will be prioritized first
    b. Second Priority: literally homeless in shelter
        i. If a family's vulnerability is the same in terms of their living situation, the family with the youngest children shall be prioritized first
        ii. If the children in the households are the same ages, the family with the highest VI-SPDAT score will be prioritized first
    c. Third Priority: imminent risk of homelessness, prioritized in order of date having to exit their housing situation: i.e. 3 day notice prioritized above 7 day notice, etc.
        i. If the family's vulnerability is the same in terms of their living situation, the family with the youngest children will be prioritized first
        ii. If the children in the households are the same ages, the family with the highest VI-SPDAT score will be prioritized first
    d. Families in shelter but asked to leave due to rules violation shall be ranked at the bottom of the prioritization list.
8. The CI case manager will inform the individual or family of the next step for their household, whether that is an immediate referral, a referral to a waiting list, or a referral to mainstream resources.

Referrals

Policy:

1. Referral Protocols
    a. Programs that participate in the CoC's CI process accept all eligible referrals unless the CoC has a documented protocol for referring referrals that ensures that such rejections are justified, rare, and that participants are able to identify and access another suitable project.
    b. Individual programs, including CoC funded projects, may restrict access to people with a particular disability or characteristic due to a targeted population being served. In these cases, the CI process should ensure that people are only referred to projects for which they are eligible.
    c. Providers should ensure that eligibility criteria are limited to those required by Federal or local statute or by funding sources.
        i. Providers limiting access due to specific client attributes or characteristics must provide documentation to the Coordinated Services Committee providing justification for their eligibility criteria.
        ii. Providers offering prevention and/or short term RRH assistance (i.e. 0-6 months of financial assistance) may choose to apply some income standards for their enrollment determination.
2. Person-centered
    a. The CI process incorporates participant choice. Choice can include location and type of housing, level of services, and other options about which households can participate in decisions.
3. Nondiscrimination
    a. When entering shelter, the CoC will ensure that emergency shelters, TH, RRH, and PSH providers within the CoC do not deny admissions to or separate any family members from other members of their family based on race, color, religion, national origin, age, sexual orientation, gender identity, familial or marital status, disability, type or amount of disability, or disability related services or support required.
    b. The CoC's CI referral process is informed by Federal, state, and local fair housing laws and regulations and ensures participants are not "steered" toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children.

Procedure:

Making Referrals:

1. Referrals will be based on each programs' admission eligibility criteria, including populations served. Programs participating in CI shall submit their eligibility criteria to the CI program manager. Any changes to a program's targeted population or eligibility criteria should be immediately conveyed to the CI program manager.
2. For households prioritized for a housing intervention, CI staff will describe how the referral process will work:
    a. Client choice, if more than one unit, program, or location are available within the intervention category;
    b. If no units are available, placement on the prioritization list;
    c. How they will be contacted once a unit is open; and
    d. How much time they will have to respond and the consequences of not responding within the given time frame.
3. For households not prioritized for a housing intervention, or who lack shelter while waiting for an opening, CI staff will describe the referral process for shelter:
    a. Options available for shelter, admission criteria, and program requirements
    b. Client choice, if more than one program is available and the household is eligible for both programs
    c. If no units are available, placement on the prioritization list;
    d. How they will be contacted once a unit is open; and

    e. How much time they will have to respond and the consequences of not responding within the given time frame.
4. When a shelter opening becomes available, CI staff will select the household at the top of the priority list for the respective shelter opening and notify the household of the opening.
    a. In the case of family shelter and the Lighthouse's emergency beds, if the household has not responded to the offer within six hours, the spot will be made available to the next household on the priority list.
    b. In the case of the emergency beds at Iowa Homeless Youth Center's (IHYC) Youth Opportunity Center, if the household has not responded to the offer within two hours, the spot will be made available to the next household on the priority list.
5. When a housing program has an opening, the program manager or appropriate staff will select the household at the top of the priority list for the respective housing intervention and provide their information to the program requesting referral,
    a. The program manager/CI staff may contact the household to facilitate the connection between the program and participant. In the case of a participant being housed in shelter, the program manager/CI staff may not contact the participant in order to facilitate ease of referral and reduce the burden on the client to respond to CI, instead providing the referral directly to the program for the program to contact the client.
    b. If the household has not responded within 72 hours, the spot will be made available to the next household on the priority list for that particular housing intervention.
6. At the time of referral, the program manager will also ensure:
    a. The household has a way to be contacted, whether that be through a shelter they are residing in, phone, or email; and
    b. Active releases of information are in place for the household and the program they are referred to; and
    c. Homeless verification is present for the household, whether that is a letter uploaded to HMIS from CI or an open shelter entry present in HMIS.
7. The referred to program should contact the program manager if the household fails to enter the program and the program needs a new referral.
8. Waiting lists:
    a. Shelter: if 90 days has passed since contact with CI or if there have been three attempts to offer shelter to a family/transition age youth and the family/transition age youth has not responded for shelter, the family/transition age youth will be taken off the list. The family/transition age youth can be added back to the list after contact with CI stating continued need for shelter.
    b. Housing Programs: Households not responding to contact attempts will remain on the priority list for 90 days. If no agency in the Continuum has had contact with the household within 90 days, the household will be removed from the priority list.
        i. All attempts at contact for shelter and housing programs during the 90 day period will be documented in HMIS.
        ii. If at a later date, the household re-engages with CI, a new intake will be completed and the household's information will be updated to reflect their living situation at the time of their new intake.
9. Families who enter a second (or third) shelter within 12 months are required to participate in staffing that will include CI staff, staff from the previous and current shelter entry, and any other support the family would like to bring.

Referral Rejection Policy

Either CoC providers or program participants may deny or reject referrals from CI, though service provider denials should be infrequent and must be documented in HMIS.

1. Program Declining Referral
    a. Emergency shelters, TH, PSH, and RRH providers within the CoC are prohibited from denying admission to or separating any family members from other members of their family based on age, sex, gender, or disability when entering shelter and housing.
    b. All agencies must submit basic program denial criteria to the CoC for the use of CI referrals.
    c. Denials are acceptable only in certain situations, including:
        i. Client/household does not meet required criteria for program eligibility
        ii. Client/household safety concerns. The client's/household's health or well-being or the safety of current program participants would be negatively impacted due to staffing, location, or other programmatic issues.
        iii. Client's/household's needs cannot be addressed by the program. The program does not offer the services and/or housing supports necessary to successfully serve the household.
        iv. Property management denial (include specific reason cited by property manager).
        v. For emergency shelter, the client/household is on the shelter's "banned list" for previous program infractions.
    d. Clients would not be referred only in certain situations, including:
        i. Program is at bed/unit/service capacity at time of referral.
        ii. For emergency family shelter, 12 months have not passed since the household exited shelter.
    e. The program declining the referral should immediately contact the CI staff person who referred the client/household.
    f. The Centralized Intake Referral Denial Form (Provider) – Appendix C – should be completed within 24 hours by the program staff person denying the referral and returned by fax or secure email to the CI program manager.
    g. Provider will also complete the HMIS referral entry consistent with the established protocol.
    h. The specific criteria for denying a referral must be shared with client/household.
    i. If a program consistently refuses referrals, (more than 25%) they must meet with the CI program manager and the Coordinated Services Committee to discuss the issues that cause the refusals.
    j. In instances where the client/household has been denied all available housing, shelter, and/or services to which they've been referred due to failure to previously comply with program requirements, the client with the CI program manager and/or the CI case manager making the referrals and representatives of the Coordinated Services Committee shall meet to develop a housing plan.
2. Client/Household Refuses Referral
    a. Denials are acceptable only in certain situations, including:
        i. Client/household refused further participation or client/household moved out of CoC area.
        ii. Client/household unresponsive to multiple communication attempts.
        iii. Client/household resolved crisis without assistance.
        iv. Client/household safety concerns. The client/household believes their health or well-being would be negatively impacted due to staffing or location.
        v. Client/household not satisfied with the location or type of housing offered.

vi. Client/household not satisfied with the level of services (either not enough or too stringent).

b. The Centralized Intake Referral Denial Form (Client) – Appendix D – should be completed immediately by the client/household declining the referral. If the client/household cannot be reached or refuses to complete the form, the CI staff person making the referral should complete the form noting the reason it is being completed by the household.
c. The completed Centralized Intake Referral Denial Form (Client) should be given to the Centralized Intake program manager within 24 hours.
d. A client who denies three sequential referrals will be asked to participate in a case conference with the Centralized Intake program manager, CI staff making the referral (if applicable), and representatives of the Coordinated Services Committee to develop a housing plan.

Client and Provider Grievances

1. Client Grievances
    a. The CI staff member working with the client/household should address any complaints by the client/household.
    b. If the client/household's complaint is not resolved, the client/household should be given the opportunity to speak with the Centralized Intake program manager.
    c. Complaints that should be addressed by the CI program manager or staff include:
        i. How clients were treated by the CI staff member
        ii. Physical conditions of the CI facility
        iii. Violation of confidentiality agreements
        iv. Denial from shelter or from programs
    d. If the grievance is not resolved by the CI program manager or the Homeless Support Services program director, complaints that are related to CI and not to the CI provider should be referred to the chair of the Coordinated Services Committee or the Executive Director of the CoC, whichever party is available first.
        i. The CI program manager will provide the client with the information about the party to contact and send, via secure email, a summary of the grievance and the steps taken to the chair of the Coordinated Services Committee or the Executive Director of the CoC.
        ii. The committee chair or the Executive Director will take steps to resolve the grievance; if needed, the grievance may be brought to the Coordinated Services Committee for further discussion.
2. Provider Grievances
    a. The provider should contact the CI program manager with any concerns about the CI process.
    b. If the provider does not feel like the concern has been resolved, they should forward, via email, a summary of their grievance to the chair of the Coordinated Services Committee.
    c. The committee chair should schedule for the CI program manager and the provider or their representative to come to the next Coordinated Services Committee meeting so the issue can be resolved.
    d. If the grievance needs more immediate resolution, the committee chair will be in charge of determining the best course of action to resolve the issue.
    e. If the grievance is being submitted by the committee chair, the Executive Director of the CoC should become involved to resolve the issue.

Monitoring Shelter Referrals

Policy:

1. Housing First orientation
    a. The CI process is Housing First oriented, such that people are housed quickly.

Procedure:

1. To ensure the shortest amount of time in shelter, various shelter staff and CI staff will meet on a regular basis to conduct case reviews and pool knowledge about resources that may assist households in exiting shelter as quickly as possible.
    a. These meetings will also provide a forum for shelter staff to provide up to date information about pending bed availability and for CI staff to provide information about priority lists.
2. Family shelter staff and CI staff will meet at least two times monthly.
3. IHYC youth program staff and CI staff will meet monthly.

Data Collection and Client Confidentiality

Policy:

1. Using HMIS and other systems for CI
    a. The CoC may use HMIS to collect and manage data associated with assessments and referrals or they may use another data system or process, particularly in instances where there is an existing system in place into which the CI process can easily be incorporated
2. Privacy Protections
    a. Privacy protections are in place to ensure proper consent and use of client information.

Procedure:

The CI system will use software solutions that are currently built into the existing HMIS software for client intake and tracking requirements. The development of these tools and training of agency staff will be conducted by the CoC's lead HMIS, the Institute for Community Alliances (ICA).

Intake, Assessment, and Prioritization Tools

1. The initial intake, assessment, and prioritization tools used in the CI process shall be built into HMIS. CI staff shall utilize these tools to enter data as they are conducting the initial intake, assessment and prioritization for referral with the household.
2. This will allow for the real-time evaluation of client needs, the electronic sharing of the intake and assessment information with the program/agency receiving the client placement, and the creation of a comprehensive client record that will eliminate the need for clients to be repeatedly asked the same questions and will include the appropriate service and housing plan for the client's household.

Data Entry Training

1. All CI staff as well as program/agency staff receiving client placements through the CI system must be trained in utilizing all HMIS-based tools pertaining to their role in the CI process. This shall include an initial training for exist and new staff as well as ongoing trainings as deemed necessary by the HMIS lead.
2. ICA will produce and provide all training materials on completion of the electronic intake assessment, and VI-SPDAT forms, use of the electronic referral tool, use of the bed registries, and producing performance/outcome measurement reports.

Data Sharing and Confidentiality

1. All CI staff as well as program/agency staff receiving client placements through the CI system will be required to comply with the User Confidentiality and Responsibility Certification – Appendix E – that will be signed at the time they were granted a license to use HMIS.
2. The sharing of the data from the intake, assessment, and VI-SPDAT tools will not only require client consent via a signed release of information (ROI) but also agency consent via a signed data sharing agreement (DSM) – Appendix F – Memorandum of Understanding to the program/agency receiving the client.
3. The HMIS lead shall develop the appropriate memoranda of understanding and client release of information forms as well as train all partner agencies on the information in the documents and on their use as part of the CI process.
4. The CI staff shall be responsible for reviewing with the client/household the ROI and explaining what data will be requested, how it will be shared, with whom it will be shared, and what the client/household's rights are regarding the use of their data.
    a. CI staff shall be responsible for ensuring the client/household understands their rights as far as ROI and data confidentiality.
    b. Clients/households should be offered a list of agencies in the data sharing network.
5. Regardless of whether the client/household signs the ROI, the CI staff will begin the initial intake and assessment process.
    a. When the ROI is not signed by the client/household, this will be noted in the intake and the client/household's information will not be shared within the data sharing network.
6. A household will not be denied services if they decline to sign the ROI.
    a. However, it may take longer for the client/household to access the services since the assessment form will have be filled out again by subsequent agencies from which the household is seeking assistance.
7. Clients who want domestic violence specific services only should never be entered into HMIS.
    a. A referral to CFI's domestic violence program should be immediately completed. The client's information then may be entered into an HMIS-comparable database.
    b. Should a client choose to contact CFI for shelter and services but also choose to continue with CI, appropriate releases should be signed for CFI so CI staff can communicate that CI was completed and the VI-SPDAT score.

Informing Local Planning

Policy:

Information gathered through the CI process is used to guide homeless assistance planning and system change efforts in the community.

Procedure:

The designated operating agency of the CI process, with assistance from the HMIS lead, shall report on performance objectives related to CI utilization, efficiency, and effectiveness. Monthly, the following elements will be reported to the CoCB by the Coordinated Services Committee:

1. Monthly narrative description of the status of CI's implementation, barriers, and challenges experience as well as recommendations for expansion and improvements in the future.
2. A report, submitted quarterly, may include but is not limited to the following:
    a. Number of families and individuals completing intakes
    b. Number of families and individuals determined eligible for shelter and the outcome of CI intervention (i.e. number entering shelter, number not entering shelter and reason for doing so)
    c. Number completing the diversion screen
    d. Number completing the prevention screen
    e. Number completing the VI-SPDAT/F-VI-SPDAT/TAY-VI-SPDAT
    f. Number completing the comprehensive assessment (families only)
    g. Percent of declined referrals (provider)
    h. Percent of declined referrals (client)
    i. Number of complaints filed with the Coordinated Services Committee or Executive Director (provider)
    j. Number of complaints filed with the Coordinated Services Committee or Executive Director (client)
3. Number of persons and individuals by VI-SPDAT score.
4. Number of persons receiving referrals to the following housing intervention types:
    a. Self-resolve
    b. Permanent Supportive Housing
    c. Rapid Rehousing
    d. Tenant-Based Rental Assistance
    e. Transitional Housing
    f. Emergency shelter, families
    g. Emergency shelter, individuals
    h. Emergency shelter, transition age youth
5. Destination of persons to each of the following intervention types as a result of referral:
    a. Permanent Supportive Housing
    b. Rapid Rehousing
    c. Tenant-Based Rental Assistance
    d. Transitional Housing
    e. Emergency shelter, families
    f. Emergency shelter, individuals
    g. Emergency shelter, transition age youth
6. Semi-annually, the length of time from completion of intake/assessment to program entry will be reported.
    a. Average length of time from intake/assessment to referral for each intervention type by family or individual
    b. Average length of time waiting on prioritization list for each intervention type by family or individual.
7. Semi-annually, the number of individuals and families who waited for each intervention type for greater than 30 days will be reported.

Evaluation

Policy:

1. Ongoing planning and stakeholder consultation.
    a. The CoC engages in ongoing planning with all stakeholders participating in the CI process to address the quality and effectiveness of the entire CI experience.
    b. This planning includes evaluating and updating the CI process at least annually with feedback from each participating project and project participants.
    c. Feedback from individuals and families experiencing homelessness or recently connected to housing through the CI process is regularly gathered through surveys and other means and is used to improve the process.
    d. The CoC will ensure privacy protections for all participant information collected in the course of the annual CI evaluation.

Procedure:

1. The CI assessment process will be evaluated on a regular basis to ensure that it is operating at maximum efficiency. Evaluation will be carried out primarily by the Centralized Intake Work Team (CIWT), who then recommends any change to the Coordinated Services Committee along with any consultants or third parties and reported to the CoCB. Evaluation mechanisms will include the following:
    a. The CIWT will meet monthly to evaluate the CI process and establish if there are any policy or procedural changes needed. If so, the recommendation will be presented to the Coordinated Services Committee and from there, will be presented to the CoCB for review and action.
        i. See Appendix N for urgent or emergent situations requiring policy or procedural action within 14 days.
    b. A quarterly review of performance measures for the CI assessment process.
    c. A survey of clients who receive services will be conducted every six months. The procedure for this is outlined in Appendix G.
    d. A report issued by the CoC to the community every six months on the CI will consist of a month-to-month analysis of CI data, as well as the total number of assessments and referrals made, successes to be shared, and system-wide progress. Major findings from this report should be presented at the CoCB and Homeless Coordinating Council meetings the month in which it is released by the CoCB Executive Director. The CoCB Executive Director will assist in writing and producing this report. The contents of this report will be included in the annual report.
    e. An annual report on the homelessness assistance system with a section devoted to CI. Within the annual report of the CoCB, there will be an overview of the CI process, concerns, and successes. Major findings from this report should be presented at the CoCB and Homeless Coordinating Council meetings the month in which it is released by the CoCB Executive Director or a member of the Coordinated Services Committee. The CoCB Executive Director will assist in writing and producing this report.

APPENDIX A: Coordinated Intake Network Releases of Information (Individuals, Families, and Minors)

Des Moines/Polk County Coordinated Intake Network

Client Informed Consent and Release of Information - Individual

AGENCY NAME

PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES
Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency participates in the Polk County Coordinated Services Network (the "Network"). The Network is administered by Primary Health Care, Inc. with technical support provided by the Institute for Community Alliances. The Network collects information on individuals experiencing, or at risk of, homelessness, to assist in coordinating and improving services provided to these individuals. The Network is maintained in compliance with the privacy and security standards required by the U.S. Department of Housing & Urban Development. A list of the agencies participating in the Network is available upon request by contacting us or at www.icalliances.org.

Because this Network is made up of many service providers in Polk County, you have the option to share your information with other service providers from whom you might be seeking services**.** If you choose to consent to the sharing of your information, your identity, case manager information, incident history and information collected in the *Polk County Coordinated Assessment* will be shared between collaborating agencies. The *Polk County Coordinated Assessment* includes your demographic information and other essential personal information needed to best determine your service needs. Please note that in some cases your information may be shared with agencies that participate in the Network that are not part of the web enabled system. This is done only when a participating agency may be able to provide you housing or services. At any time, you may request a list of agencies that are part of this service provision network, both through the web enabled system or outside of it. The information that will be shared with your permission:

Name & Household Information	Social Security Number	Demographic Information

Program Entry and Exit Dates	Service Needs/Referrals	Case Manager Name
Assessment Questions (Income, Length of Time Homeless, Disabilities, Health Insurance, Etc.)		
VISPDAT Score (Assessment Score to Determine Housing Placement)		

This process can benefit you by eliminating duplicate intakes and may reduce the time spent answering basic questions regarding your situation and allow that agency to focus on meeting your unique service needs. Sharing your information will also allow faster access to the Coordinated Services Network, which supports for better coordinated and streamlined services.

The information you provide will be shared with this agency, the participating agencies in the Polk County Coordinated Services Network, and limited staff of the Institute for Community Alliances. Information in the Network may also be disclosed as required by law or to third parties for research, funding, administrative and other purposes as allowed by applicable federal and/or state confidentiality laws and consistent with the Network's goal of improving the services provided to individuals experiencing, or at risk of experiencing, homelessness. For more information about the Network and the privacy and security of the personal information you provide in connection with the Network, please see the attached Privacy Notice.

You will be provided with the list of participating providers in the Polk County Network for your review. This list may change, and the most up to date list can be obtained by request from this agency. The list can also be found at www.icalliances.org.

Please note; if you grant permission for your information to be shared, that agreement will be in effect from that point on. If you do decide to share information at this time, but change your mind, you may end your agreement in writing and your personal and service information will no longer be shared from the date you end your permission going forward.

If you do not give permission for this agency to release your information, no other service provision agency will have access to it. As long as you are receiving services from this agency, our staff will reconfirm your permission to share on an annual basis.

Please indicate your choice regarding data sharing:

☐ **Yes**, I give my permission for this agency to share my information with the agencies participating in the Polk County Coordinated Intake Network. **Please complete Page 2 of this document;**

☐ **No**, I do not give my permission for this agency to share my information with the agencies participating in the Polk County Coordinated Intake Network.

Client's Printed Name_____

Client's Signature_____Date_____

Witness Signature_____Date_____

Des Moines/Polk County Coordinated Intake Network

Client Informed Consent and Release of Information – Family

AGENCY NAME

PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES
Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency participates in the Polk County Coordinated Services Network (the "Network"). The Network is administered by Primary Health Care, Inc. with technical support provided by the Institute for Community Alliances. The Network collects information on individuals experiencing, or at risk of, homelessness, to assist in coordinating and improving services provided to these individuals. The Network is maintained in compliance with the privacy and security standards required by the U.S. Department of Housing & Urban Development. A list of the agencies participating in the Network is available upon request by contacting us or at www.icalliances.org.

Because this Network is made up of many service providers in Polk County, you have the option to share your information with other service providers from whom you might be seeking services**.** If you choose to consent to the sharing of your information, your identity, case manager information, incident history and information collected in the *Polk County Coordinated Assessment* will be shared between collaborating agencies. The *Polk County Coordinated Assessment* includes your demographic information and other essential personal information needed to best determine your service needs. Please note that in some cases your information may be shared with agencies that participate in the Network that are not part of the web enabled system. This is done only when a participating agency may be able to provide you housing or services. At any time, you may request a list of agencies that are part of this service provision network, both through the web enabled system or outside of it. The information that will be shared with your permission:

Name & Household Information	Social Security Number	Demographic Information
Program Entry and Exit Dates	Service Needs/Referrals	Case Manager Name
Assessment Questions (Income, Length of Time Homeless, Disabilities, Health Insurance, Etc.)		
VISPDAT Score (Assessment Score to Determine Housing Placement)		

This process can benefit you by eliminating duplicate intakes and may reduce the time spent answering basic questions regarding your situation and allow that agency to focus on meeting your unique service needs. Sharing your information will also allow faster access to the Coordinated Services Network, which supports for better coordinated and streamlined services.

The information you provide will be shared with this agency, the participating agencies in the Polk County Coordinated Services Network, and limited staff of the Institute for Community Alliances. Information in the Network may also be disclosed as required by law or to third parties for research, funding, administrative and other purposes as allowed by applicable federal and/or state confidentiality laws and consistent with the Network's goal of improving the services provided to individuals experiencing, or at risk of experiencing, homelessness. For more information about the Network and the privacy and security of the personal information you provide in connection with the Network, please see the attached Privacy Notice.

You will be provided with the list of participating providers in the Polk County Network for your review. This list may change, and the most up to date list can be obtained by request from this agency. The list can also be found at www.icalliances.org.

Please note; if you grant permission for your information to be shared, that agreement will be in effect from that point on. If you do decide to share information at this time, but change your mind, you may end your agreement in writing and your personal and service information will no longer be shared from the date you end your permission going forward.

If you do not give permission for this agency to release your information, no other service provision agency will have access to it. As long as you are receiving services from this agency, our staff will reconfirm your permission to share on an annual basis.

Please indicate your choice regarding data sharing:

☐ **Yes,** I give my permission for this agency to share my information and my children's information with the agencies participating in the Polk County Coordinated Intake Network. **Please complete page 2 of this document.**

☐ **No**, I do not give my permission for this agency to share my or my children's information with the agencies participating in the Polk County Coordinated Intake Network. **Please complete the signature section at the top of page 2 of this document.**

Client's Printed Name_____

Minor Child's/Children's Printed Name(s)_____

_____

_____

Client's Signature_____Date_____

Witness Signature_____Date_____

Protected Health Information Release of Information to Secure Necessary Services

Federal and/or State law specifically require that any disclosure of substance use, alcohol or drug, mental health, or AIDS related information must be accompanied by the following statement:
This information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR Part 2): The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Par2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug use patient.

As part of the process of being admitted to this program, you will be asked questions about disabilities or health conditions that you and your family members may or may not have. You will have the option to answer that you have the health condition, do not have the health condition, do not know, or refuse to answer.

My signature below directs the disclosure of the specific information listed below to the participating agencies of the Polk County Coordinated Intake Network as I have indicated here:

Please select "Yes" or "No" for the following question:

1. Regardless of whether or not you or your children have any existing disabilities or health conditions, including but not limited to**; HIV/AIDS, substance use, and mental health conditions**, do you give us permission to share the information you tell us about these conditions for you and children with the Polk County Coordinated Intake Provider Network?

_____Yes _____No

Client's Printed Name_____

Client's Signature_____Date_____

Witness Signature_____Date_____

Des Moines/Polk County Coordinated Intake Network – AGENCY NAME

Client Informed Consent and Release of Information - Youth

PERMISSION TO SHARE CONFIDENTIAL INFORMATION TO SECURE NECESSARY SERVICES
Please read the following notice and authorization (or ask to have it read to you) before signing.

This agency participates in the Polk County Coordinated Services Network (the "Network"). The Network is administered by Primary Health Care, Inc. with technical support provided by the Institute for Community Alliances. The Network collects information on individuals experiencing, or at risk of, homelessness, to assist in coordinating and improving services provided to these individuals. The Network is maintained in compliance with the privacy and security standards required by the U.S. Department of Housing & Urban Development. A list of the agencies participating in the Network is available upon request by contacting us or at www.icalliances.org.

Because this Network is made up of many service providers in Polk County, you have the option to share your information with other service providers from whom you might be seeking services**.** If you choose to consent to the sharing of your information, your identity, case manager information, incident history and information collected in the *Polk County Coordinated Assessment* will be shared between collaborating agencies. The *Polk County Coordinated Assessment* includes your demographic information and other essential personal information needed to best determine your service needs. Please note that in some cases your information may be shared with agencies that participate in the Network that are not part of the web enabled system. This is done only when a participating agency may be able to provide you housing or services. At any time, you may request a list of agencies that are part of this service provision network, both through the web enabled system or outside of it. The information that will be shared with your permission:

Name & Household Information	Social Security Number	Demographic Information
Program Entry and Exit Dates	Service Needs/Referrals	Case Manager Name
Assessment Questions (Income, Length of Time Homeless, Disabilities, Health Insurance, Etc.)		
VISPDAT Score (Assessment Score to Determine Housing Placement)		

This process can benefit you by eliminating duplicate intakes and may reduce the time spent answering basic questions regarding your situation and allow that agency to focus on meeting your unique service needs. Sharing your information will also allow faster access to the Coordinated Services Network, which supports for better coordinated and streamlined services.

The information you provide will be shared with this agency, the participating agencies in the Polk County Coordinated Services Network, and limited staff of the Institute for Community Alliances. Information in the Network may also be disclosed as required by law or to third parties for research, funding, administrative and other purposes as allowed by applicable federal and/or state confidentiality laws and consistent with the Network's goal of improving the services provided to individuals experiencing, or at risk of experiencing, homelessness. For more information about the Network and the privacy and security of the personal information you provide in connection with the Network, please see the attached Privacy Notice.

You will be provided with the list of participating providers in the Polk County Network for your review. This list may change, and the most up to date list can be obtained by request from this agency. The list can also be found at www.icalliances.org.

Please note; if you grant permission for your information to be shared, that agreement will be in effect from that point on. If you do decide to share information at this time, but change your mind, you may end your agreement in writing and your personal and service information will no longer be shared from the date you end your permission going forward.

If you do not give permission for this agency to release your information, no other service provision agency will have access to it. As long as you are receiving services from this agency, our staff will reconfirm your permission to share on an annual basis.

☐ **Yes,** I give my permission for this agency to share this child's information with the agencies participating in the Polk County Coordinated Intake Network. **Please complete Page 2 of this document.**

☐ **No**, I do not give my permission for this agency to share this child's information with the agencies participating in the Polk County Coordinated Intake Network;

Client's Printed Name_____

Parent/Guardian's Signature_____Date_____

Relationship to Client_____

Witness Signature_____Date_____

Des Moines/Polk County Coordinated Intake Network

Client Informed Consent and Release of Information – Youth

AGENCY NAME

Protected Health Information Release of Information to Secure Necessary Services

Federal and/or State law specifically require that any disclosure of substance use, alcohol or drug, mental health, or AIDS related information must be accompanied by the following statement: This information has been disclosed to you from records protected by the federal confidentiality rules (42 CFR Part 2): The Federal rules prohibit you from making any further disclosure of information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Par2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of information to criminally investigate or prosecute any alcohol or drug use patient.

As part of the process of being admitted to this program, you will be asked questions about disabilities or health conditions that you may or may not have. You will have the option to answer that you have the health condition, do not have the health condition, do not know, or refuse to answer.

My signature below directs the disclosure of the specific information (on behalf of the minor child) listed below to the participating agencies of the Polk County Coordinated Intake Network as I have indicated here:

Please select "Yes" or "No" for the following question:

1. Regardless of whether or not you have any existing disabilities or health conditions, including but not limited to**; HIV/AIDS, substance use, and mental health conditions**, do you give us permission to share the information you tell us about these conditions with the Polk County Coordinated Intake Provider Network?
   _____Yes _____No

Client's Printed Name_____

Parent/Guardian's Signature_____Date_____

Relationship to Client_____

Witness Signature_____Date_____

APPENDIX B: Participating Agencies

1. **Anawim Housing, Inc., Des Moines, IA;**
2. **Broadlawns CAP Service Coordination, Des Moines, IA;**
3. **Catholic Charities Emergency Family Shelter, Des Moines, IA;**
4. **Central Iowa Shelter and Services, Des Moines, IA;**
5. **Family Promise of Greater Des Moines, Des Moines, IA;**
6. **Hawthorn Hill, New Directions Shelter, and Home Connections, Des Moines, IA;**
7. **House of Mercy Permanent Supportive Housing, Des Moines, IA;**
8. **Iowa Homeless Youth Centers, Lighthouse Transitional Living, Des Moines, IA;**
9. **Joppa Outreach, Des Moines, IA;**
10. **Primary Health Care, PATH, Rapid Rehousing and Supportive Services for Veteran Families programs, Des Moines, IA;**
11. **West Des Moines Human Services, West Des Moines, IA**

Polk County Coordinated Intake Network utilizes a computerized record keeping system that captures information about people experiencing homelessness that is administered by the Institute for the Community Alliances. This system allows programs, if they agree, to share information electronically about clients, including their service needs, who have been entered into the software, in order to better coordinate services.

Client level information can only be shared between agencies that have established an Interagency Data Sharing Agreement and have received written consent from particular clients agreeing to share their personal information with another agency. The agency receiving the written consent has the ability to “share” that client’s information electronically through the system with a collaborating agency. This process can benefit clients by eliminating duplicate intakes. Intake and exit interviews can be shared, with written consent, between collaborating agencies.

APPENDIX C: Centralized Intake Referral Denial Form (Provider)

Polk County Continuum of Care

Centralized Intake Referral Denial Form (Provider)

This form should be completed by the provider agency whenever they are denying a referral that has been made by a centralized intake staff person. Forms should be returned to the centralized intake program manager by fax/email within 24 hours of denial.

Referral Date: _____

Agency Name:_____ Program name:_____

Staff contact:_____Email:_____

Phone: _____

Client ServicePoint Number:_____

Reason for denial (please check a box, and you must explain in detail below)

□ Client/household does not meet required criteria for program eligibility
□ Client/household safety concerns. The client's/household's health or well-being or the safety of current program participants would be negatively impacted due to staffing, location, or other programmatic issues.
□ Client/household needs cannot be addressed by the program. The program does not offer the services and/or housing supports necessary to successfully serve the household.
□ Property management denial (include specific reason cited by property manager)
□ For emergency family shelter, 12 months have not passed since the client/household exited the shelter.

□ For emergency shelter for individuals/couples, the individual or couple is on the shelter's "banned list" for previous program infractions.

Please describe why you are unable to accept this referral.

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

Please explain:

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

Provider Staff Signature: _____ Date: _____

Centralized Intake Use Only

Follow up from previous page:

Centralized Intake Staff Signature: _____ Date: _____

APPENDIX D: Centralized Intake Referral Denial Form (Client)

Polk County Continuum of Care

Coordinated Entry Referral Denial Form (Client)

This form should be completed by clients whenever they refuse a referral that has been made by a centralized intake staff person. Forms should be turned in to the Centralized Intake Program Manager within 24 hours of refusal.

Referral Date: _____

Agency Name: _____

Program name: _____

Centralized Intake Staff person: _____

Client ServicePoint Number:_____

Reason for refusal (please check a box, and you must explain in detail below)

□ Client/household refused further participation (or client moved out of CoC area)
□ Client/household unresponsive to multiple communication attempts
□ Client resolved crisis without assistance
□ Client/household safety concerns. The client/household believes their health or wellbeing would be negatively impacted due to staffing or location.
□ Client/household not satisfied with the location or type of housing offered.
□ Client/household not satisfied with the level of services (either not enough or too stringent).

Please describe why you refused this referral.

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

Client Signature: _____ Date: _____

CI Staff Signature: _____ Date: _____

Centralized Intake Use Only

Follow up from previous page:

CI Staff Signature: _____Date: _____

APPENDIX E: User Confidentiality and Responsibility Certification

I-COUNT ServicePoint™ NETWORK
IOWA'S CONTINUUM OUTCOME AND UNIVERSAL NEED TOOLKIT
USER CONFIDENTIALITY AND RESPONSIBILITY CERTIFICATION

Iowa's Homeless Information Management System

Provider Name: **Project Name:**

Contract Fiscal Year:

USER CONFIDENTIALITY AND RESPONSIBILITY AGREEMENT

Your User ID and Password give you access to the statewide ServicePoint™ software of the I-COUNT Network. **Initial each item below to indicate your understanding and acceptance of the proper use of your User ID and password and your intention to comply with all elements of the Homeless Management Information System Data and Technical Standards Notice – published in the Federal Register on July 30, 2004 and revised July 2015 by the U. S. Department of Housing and Urban Development.** Failure to uphold the confidentiality and security standards set forth below is grounds for immediate termination from the Iowa Homeless Information Management System and forfeiture of grant funds if applicable.

____An I-COUNT Network "Notice of Data Collection" sign will be posted at any location that client intake activity occurs that is entered or will be entered into the ServicePoint™ system.

____This agency has a written privacy policy that includes the allowable uses and disclosures of protected personal information by this agency and it will be made available to the client upon request.

____If applicable, this agency has their privacy policies posted on their agency internet website.

____My ServicePoint™ User ID and Password are for my use only and must not be shared with anyone, including coworkers within my own agency.

____I will take all reasonable means to keep my User ID and Password physically secure.

____I understand that the only individuals who can view information in the ServicePoint™ system are authorized users and the Clients to whom the information pertains.

____I may only view, obtain, disclose, or use the database information that is necessary to perform my job.

____If I am logged into ServicePoint™ and must leave the work area where the computer is located, I **must log-off** of ServicePoint before leaving the work area.

____I will attend any and all HMIS and related topic training sessions as required to ensure accurate and appropriate data entry and use of the I-COUNT Network.

____Any computer that has ServicePoint™ "open and running" shall never be left unattended.

____Any computer used to access ServicePoint™ must be located in a secure area that is not available for public access and use.

____Any computer that is used to access ServicePoint™ must be equipped with locking (password protected) screen savers.

____Any computer that is used to access ServicePoint™ must have virus protection software installed with auto-update functions.

____Any computer that is used to access ServicePoint™ must have software and/or hardware firewall protection.

____Failure to log off ServicePoint™ appropriately may result in a breach in client confidentiality and system security.

____Hard copies of Iowa ServicePoint information must be kept in a secure file.

____When hard copies of Iowa ServicePoint™ information are no longer needed, they must be properly destroyed to maintain confidentiality.

____If I notice or suspect a security breach, I must immediately notify the System Administrator - Institute for Community Alliances (ICA).

I understand and agree to comply with all the statements listed above. I further understand that at the time of program site visits conducted under the direction of Iowa Finance Authority or other applicable funder, our agency will be monitored for compliance with the I-COUNT Network management elements listed above.

ServicePoint™ User (License Holder) Signature Date

Agency Executive Director Date

APPENDIX F: Polk County Data Sharing Agreement

Polk County Coordinated Intake Network Memorandum of Understanding and Interagency Data Sharing & Coordinated Services Agreement

The following agencies hereby enter into an "Interagency Data Sharing and Coordinated Services Agreement" as of 12/2/16.

1. **Anawim Housing, Inc., Des Moines, IA;**
2. **Beacon of Life, Des Moines, IA;**
3. **Broadlawns Medical Center, Des Moines, IA;**
4. **Catholic Charities, Des Moines, IA: St. Joseph's Family Shelter;**
5. **Central Iowa Shelter & Services, Des Moines, IA;**
6. **Family Promise of Greater Des Moines, Des Moines, IA;**
7. **Hawthorn Hill, Des Moines, IA;**
8. **HOME, Inc., Des Moines, IA;**
9. **House of Mercy, Des Moines, IA;**
10. **Institute for Community Alliances (Network Technical Managers), Des Moines, IA;**
11. **JOPPA, Des Moines, IA;**
12. **Polk County General Assistance (Emergency Solutions Grant; ESG funding only), Des Moines, IA;**
13. **Polk County Health Services, Des Moines, IA;**
14. **Primary Health Care, Des Moines, IA;**
15. **VA Central Iowa Health Care System Community Resource & Referral Center (CRRC), Des Moines, IA;**
16. **West Des Moines Human Services, West Des Moines, IA;**
17. **YMCA Residential Housing Program, Des Moines, IA;**
18. **Youth and Shelter Services, Inc. - Iowa Homeless Youth Centers, Des Moines, IA;**

The Polk County Coordinated Intake Network utilizes a computerized record keeping system that captures information about people experiencing homelessness that is administered by the Institute for Community Alliances. In addition to creating an unduplicated count of the homeless population and developing aggregate information that will assist in developing policies to end homelessness, the system allows programs if they agree, to share information electronically about clients, including their service needs, who have been entered into the software, in order to better coordinate services.

Client level information can only be shared between agencies that have established an Interagency Data Sharing Agreement and have received written consent from particular clients agreeing to share their personal information with another agency. The agency receiving the written consent has the ability to "share" that client's information electronically through the system with a collaborating agency.

This process can benefit clients by eliminating duplicate intakes. Intake and exit interviews can be shared, with written consent, between collaborating agencies. By establishing this agreement, the

collaborating agencies agree that within the confines of the Polk County Coordinated Intake Network and the HMIS software:

1. Acknowledge that in transmitting, receiving, storing, processing or otherwise dealing with any consumer protected information, they are fully bound by state and federal regulations governing confidentiality of patient records, including the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 ('HIPAA', 45 CFR, Parts 160 & 164), and cannot use or disclose the information except as permitted or required by this agreement or by law.
2. Acknowledge that they are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by state and federal regulations governing confidentiality of patient records, including the Federal Law of Confidentiality for Alcohol and Drug Abuse Patients, (42 CFR, Part 2) and the Health Insurance Portability and Accountability Act of 1996 ('HIPAA', 45 CFR, Parts 160 & 164), A general authorization for the release of information is **NOT** sufficient for this purpose.
3. Agree to use appropriate safeguards to prevent the unauthorized use or disclosure of the protected information.
4. Agree to notify each of the other participating agencies, within one business day, of any breach, use, or disclosure of the protected information not provided for by this agreement.
5. Agree to adhere to the standards outlined within the Health Insurance Portability and Accountability Act of 1996 ('HIPAA', 45 CFR, Parts 160 & 164) which provides consumers access to their protected information, (164.524), the right to amend protected information (164.526), and receive an accounting of disclosures of protected information (164.528).
6. Information that is shared with written consent will not be used to harm or deny any services to a client.
7. The Agency shall not solicit or input information from Clients into the Coordinated Assessment database unless it is essential to provide services.
8. Clients have the right to request information about who has viewed or updated their Polk County Coordinated Intake Network record.
9. Agree to notify each of the other participating agencies of their intent to terminate their participation in this agreement.
10. Agree to resist, through judicial proceedings, any judicial or quasi-judicial effort to obtain access to protected information pertaining to consumers, unless expressly provided for in state and/or federal regulations.
11. Agree to complete the individual agency's Authorization to Release Information in addition to the Polk County Coordinated Intake Network Release, if any protected personal information is released to any service provider outside of this coordinated service group as outlined above.
12. A violation of the above will result in immediate disciplinary action.
13. Whereby the above named agencies agree to share where applicable the following protected personal information via the Polk County Coordinated Intake Network (electronic, web-enabled):

Client First Name	Client Last Name
Client Social Security Number	Client Birth Date
Entry/Exit Information	Case Manager Information
Incident History	Client's "Iowa Basic Assessment"
Client's Services History	Client's Program Goals
Client Photo	Client's "Polk County Coordinated Assessment"

Client's "Vulnerability Index -Service Prioritization Decision Assistance Tool" (VI – SPDAT)

The signatures below constitute acceptance of the "Memorandum of Understanding" and "Data Sharing and Coordinated Services Agreement":

Agency
Name
Street
Address
City, State
Zip

Name & Title of Authorized Signature:

_____ _____

APPENDIX G: Centralized Intake Client Survey Procedures and Questions

Centralized Intake: Client Survey Procedures

Centralized Intake clients will be offered an opportunity on a regular basis to evaluate the program and services. The survey will be administered immediately following intake during the weeks of the January and July Point-In-Time Count. Individuals will be made aware that they may complete the survey at other times during the year.

A. The survey will be offered online.
    - Clients will be offered the option to complete the survey with assistance from someone outside of the Centralized Intake Staff.
    - Language assistance will be offered as appropriate.
B. Survey results will be collected and analyzed by the Institute for Community Alliances.

Centralized Intake: Client Survey Questions

1. Where have you completed the intake process?
    a. Primary Health Care
    b. Central Iowa Shelter and Services
2. How easy was it for you to get to Primary Health Care's location?
    a. I received clear information about the location.
    b. I had to figure out where PHC is located, but found information easily.
    c. Finding PHC was a challenge.
3. How easy was it for you to get transportation to Primary Health Care?
    a. I have my own car
    b. I was able to come by bus
    c. Someone brought me
    d. Other
4. Which of the following describes your household?
    a. Single person
    b. Household with children 18 years old or under
    c. Household with only adults
5. Age
    a. 18-24
    b. 25 or older
6. Gender
    a. Female
    b. Male
    c. Transgender Female
    d. Transgender Male
    e. Gender Non-Conforming
    f. I don’t know
    g. I refuse to answer
7. Race
    a. American Indian or Alaska Native

b. Asian
c. Black or African American
d. Native Hawaiian or other Pacific Islander
e. White
f. Multiple Races
g. I don't know
h. I refuse to answer

8. Ethnicity
    a. Hispanic/Latino
    b. Non-Hispanic/Non-Latino
    c. I don't know
    d. I refuse to answer
9. How did you first hear about Centralized Intake?
    a. Corrections
    b. Department of Human Services
    c. A Shelter
    d. A hospital
    e. From 211
    f. Family or friends
    g. Other (please specify)
10. Please Answer (Responses: Yes, No, NA)
    A. Do you know why you came to do an intake?
    B. Did someone explain the reason for intake and what would occur during intake?
    C. Did you understand the intake process?
    D. During intake, did someone talk to you about immediate shelter or housing options?
    E. Did staff offer to help you determine your eligibility for benefits?
    F. Did they offer to help you apply for benefits? For instance Medicaid, food stamps….
    G. Did you feel that you could answer the quests you were asked honestly?
    H. Did you feel comfortable asking questions during the intake process?
    I. At the intake did you feel like you were able to present the information you thought was relevant?
11. When you started, what did you expect would happen as a result of intake?
12. What referrals did you receive as a result of intake?
    a. Emergency shelter
    b. Community resources (rental assistance, transportation, food…)
    c. Waiting list for emergency shelter or housing
    d. Support to stay with a family/friend
    e. No referral
13. Where do you plan to stay tonight?
14. Is there anything else that you would like to tell us about the intake process?

APPENDIX H: Commonly Used Terminology

Homeless – An individual or family is considered "homeless" if they meet the criteria in one of the four following categories:

Literally Homeless

1. Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:
   - (i) Has a primary nighttime residence that is a public or private place not meant for human habitation;
   - (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
   - (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

Imminent Risk of Homelessness

2. Individual or family who will imminently lose their primary nighttime residence, provided that:
   - (i) 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 needed to obtain other permanent housing

Homeless under other Federal statutes

3. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
   - (i) Are defined as homeless under the other listed federal statutes;
   - (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
   - (iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and
   - (iii) Can be expected to continue in such status for an extended period of time due to special needs or barriers

Fleeing/ Attempting to Flee DV

4. Any individual or family who:
   - (i) Is fleeing, or is attempting to flee, domestic violence;
   - (ii) Has no other residence; and
   - (iii) Lacks the resources or support networks to obtain other permanent housing

Chronically Homeless -

1. A ''homeless individual with a disability,'' who:
   - (i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
   - (ii) Has been homeless and living as described in paragraph (1)(i) of this

definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2. 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 in paragraph (1) of this definition, before entering that facility; or
3. 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 in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Centralized or Coordinated Assessment System - a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment system 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 goal is to increase efficiency of local crisis response systems and improve fairness and ease of access to resources, including mainstream resources.
- The system is intended to help communities prioritize people who are most in need of assistance.
- The system also provides CoCs and other stakeholders about service needs and gaps to help communities strategically allocate their current resources and identify the need for additional resources.

Coordinated Entry or Coordinated Entry Process – CoC and ESG Program interim rules use the terms "centralized or coordinated assessment" and "centralized or coordinated assessment system." HUD and its Federal partners have begun using the terms "coordinated entry" and "coordinated entry process." "Centralized or coordinated assessment system" remains the legal term.

Continuum of Care Programs (CoC Program) – HUD funds that may be used to pay for costs used to establish and operate projects under five program components: permanent housing; transitional housing; supportive services only; HMIS; and, in some cases, homelessness prevention. Funds may be used for homelessness prevention only in High Performing Communities (HPC), since HUD only allows designated HPCs to carry out homelessness prevention activities through the CoC program.

Coordinated Services Committee – A standing committee of the Continuum of Care Board whose responsibilities include 1.) Developing a plan to coordinate and maintain a centralized intake system in Polk County; and 2.) Developing community strategies of improving service delivery, efficiencies and cost effectiveness in reducing homelessness.

Diversion – The use of community resources to divert from shelter an individual or family requesting shelter because they have no place to stay. Typically, diversion includes linking the person to community resources for child care, auto repairs, motel stay or mediation with a landlord, friend or family member so they can return to their previous living environment. Follow up typically occurs to assist the individual or family in developing a permanent housing plan.

Emergency Shelter - any facility, the primary purpose of which is to provide a temporary shelter for the homeless in general or for specific populations of the homeless and which does not require occupants to sign leases or occupancy agreements.

Emergency Solutions Grant (ESG) – These HUD funds may be used for five program components: street outreach, emergency shelter, homelessness prevention, rapid re-housing assistance, and HMIS; as well as administrative activities.

High Performing Communities (HPC) - In order to qualify as an HPC, a Continuum must use their HMIS data to demonstrate the following measures:

1. That the mean length of homelessness must be less than 20 days for the Continuum's geographic area, or the Continuum's mean length of episodes for individuals and families in similar circumstances was reduced by at least 10 percent from the preceding year;
2. That less than 5 percent of individuals and families that leave homelessness become homeless again any time within the next 2 years, or the percentage of individuals and families in similar circumstances who became homeless again within 2 years after leaving homelessness was decreased by at least 20 percent from the preceding year; and
3. For Continuums of Care that served homeless families with youth defined as homeless under other federal statutes, that 95 percent of those families did not become homeless again within a 2-year period following termination of assistance and that 85 percent of those families achieved independent living in permanent housing for at least 2 years following the termination of assistance.

HMIS - Homeless Management Information System (HMIS) means the information system designated by the Continuum of Care to comply with the HUD's data collection, management, and reporting standards and 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.

HMIS Lead means the entity designated by the Continuum of Care to operate the Continuum's HMIS on its behalf.

HOME Investment Partnerships Program (HOME) - provides formula grants to States and localities that communities use - often in partnership with local nonprofit groups - to fund a wide range of activities including building, buying, and/or rehabilitating affordable housing for rent or homeownership or providing direct rental assistance to low-income people. HOME is the largest Federal block grant to state and local governments designed exclusively to create affordable housing for low-income households.

Housing First – a model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions (such as sobriety or a minimum income threshold).

Permanent Supportive Housing (PSH) - permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently.

Prevention - The use of community resources to prevent an individual who is at imminent risk of losing housing (i.e. precariously housed and not yet homeless) from losing their housing. Typically, these community resources include legal assistance, landlord/tenant mediation and cash assistance to pay rent or utility arrears.

Rapid Rehousing (RRH) - housing assistance in the form of short-term (up to 3 months) and/or medium-term (for 3 to 24 months) tenant-based rental assistance, as necessary to help a homeless

individual or family, with or without disabilities, move as quickly as possible into permanent housing and achieve stability in that housing. Supportive services may be provided as well.

Safe Haven - for the purpose of defining chronically homeless, supportive housing that meets the following:

1. Serves hard to reach homeless persons with severe mental illness who came from the streets and have been unwilling or unable to participate in supportive services;
2. Provides 24-hour residence for eligible persons for an unspecified period;
3. Has an overnight capacity limited to 25 or fewer persons; and
4. Provides low-demand services and referrals for the residents.

Tenant-Based Rental Assistance (TBRA) - rental assistance in which program participants choose housing of an appropriate size in which to reside. In the Polk County CoC, TBRA is typically paid with HUD HOME funds passed through to the State of Iowa and administered by the Iowa Finance Authority (IFA). Typically, IFA holds an application round for HOME funds annually.

Transitional Housing (TH) - housing, where all program participants have signed a lease or occupancy agreement, the purpose of which is to facilitate the movement of homeless individuals and families into permanent housing within 24 months. Typically, TH targets special populations such as youth, pregnant women, Veterans, domestic violence victims and people with substance abuse and/or mental health issues. Services are also provided that are necessary to support the individual or family to successfully transition to permanent housing.

VA Grant and Per Diem Program (GPD) - allows community agencies to apply for grants from the VA to provide housing and other services (vocational assistance, case management, etc.) to encourage Veterans to learn the skills needed for them to achieve financial stability and independent housing

Veterans Affairs Supportive Housing (VASH) - combines HUD Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA). VA provides these services for participating Veterans at VA medical centers (VAMCs) and community-based outreach clinics.

APPENDIX I: Nondiscrimination Policy

Polk County Continuum of Care Board

Non-Discrimination Policy

Purpose: The Polk County Continuum of Care Board (CoCB) has established a non-discrimination policy for actions of the Board of Directors and all programs funded by the CoCB. This policy is in place regardless of the source of funding including Federal, State or private funds to comply with applicable civil rights and fair housing laws and requirements.

Policy: It shall be the policy of the CoCB that actions and deliberations of the board will not discriminate against individuals or families seeking services within the geographic area served by the Polk County Continuum of Care (PCCoC). This policy applies to programs funded through actions of the board.

Application of the CoCB Non-Discrimination Policy requires fair and equal access.

1. All people in the PCCoCB's geographic area have fair and equal access to CoCB's funded programs regardless of race, color, creed, national origin, ethnicity, religion, sex, age, familial status, physical or mental disability, actual or perceived sexual orientation, gender identity, or marital status as well as where or how individuals present for services.
2. People in all populations and subpopulations in the PCCoCB's geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence are assured to have fair and equal access to CoCB's funded programs.
3. Physical locations of the CoCB's funded programs will insure accessibility to people with disabilities.
4. The CoCB's funded programs will make every effort to serve individuals or families who speak languages commonly spoken in the community and take reasonable steps to offer program materials and participant instruction in multiple languages to meet the needs of minority, ethnic, and groups with Limited English Proficiency.
5. CoCB's funded programs will make every effort to ensure effective communication with individuals with disabilities including the provision of appropriate auxiliary aids and services necessary to ensure effective community (e.g. Braille, large type, assistive listening devices, and sign language interpreters.

Nondiscrimination and equal opportunity provisions include the following:

- Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability or familial status
- 24 CFR Part 5 2016 Equal Access in Accordance with an Individual's Gender Identity in Community Development and Planning.
- Section 504 of the Rehabilitation Act of 1973, as amended by the ADA Amendment Act of 2008 which prohibits discrimination on the basis of disability under any program or activity receiving Federal assistance.
- Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving Federal financial assistance.
- Title II of the Americans with Disabilities Act prohibits public entities, which includes State and

local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance.

- Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which includes shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

Approved (9-11-17)

APPENDIX J: Memorandum of Understanding: Coordinated Intake Network Partner-Polk County Continuum of Care

This Memorandum of Understanding (MOU) is made between the Polk County Continuum of Care Board ("CoCB") acting on behalf of the Polk County Continuum of Care ("PCCoC"), and the Centralized Intake Network Partner set forth below (the "CI Network Partner").

I. Background

Provisions in HUD's Continuum of Care Program and Emergency Solutions Grant Program interim rules require that all Continuums of Care establish a coordinated entry system. The PCCoC has established a Centralized Intake (CI) system meeting the applicable requirements. In addition, other Polk County funders of homeless and housing assistance have adopted the CI system requirement for their grantees.

The CI system represents a PCCoC-wide process for facilitating access to all homeless designated resources, identifying and assessing the needs of persons experiencing a housing crisis, and referring clients to the most appropriate service strategy or housing intervention. The PCCoC's CI system will enable the PCCoC and the community at large to document needs and enable comparison and analysis to allocate limited resources to achieve the most effective results.

II. Guiding Principles of the Polk County Continuum of Care

- Right resources – Right time
- Client-centered
- Prevent and divert when possible
- Real-time data and inventory
- Sustainable system with continuous evaluation and redesign as needed

III. Agreement

The CoCB and the CI Network Partner (together, the "Parties") agree as follows:

- To implement and operate the CI system as established by the PCCoC.
- To read and adhere to the policies and procedures established by the CoCB for the CI system.
- To prioritize clients based on "vulnerability" as the primary factor among many considerations to direct limited resources to the most "vulnerable" as defined by HUD's Continuum of Care Programs' *Housing First* orientation.

- To recognize CI as the single point of entry as referral for individuals or families who are homeless or at risk of being homeless with exceptions for those fleeing from domestic violence, youth under the age of 18 and veterans.
- To promote client-centered practices treating all clients with respect and kindness
- To accept referrals established through the CI system.
- To follow the denial procedures established through the CI system.
- To provide all related program eligibility criteria to the CoCB.
- To provide up-to-date availability information within the guidelines of each related program.
- To use available client information obtained during the CI system and discourage staff from administering any assessments that duplicate questions asked during the CI system's assessment.
- To exercise continuous quality improvement efforts by actively engaging with PCCoC partners to evaluate and improve the CI system.
- To the extent allowed by each organization, to join with other partners of the PCCoC to advocate for expanded affordable housing and needed resources for homeless individuals and families in our community.

IV. Terms of the Agreement

This MOU shall be effective upon execution and adoption by each CI Network Partner and will remain in effect unless terminated by either Party under the following conditions:

1. Upon 90 days written notice by one Party to the other Party;
2. Immediately upon mutual consent of both Parties;
3. For good cause by either Party if the other Party breaches the terms of the MOU. However prior to any such unilateral termination of good cause, the Party wishing to terminate must give the other Party written notice of the alleged breach and an opportunity to cure the alleged breach within 30 days before termination becomes effective; or
4. Upon filing of bankruptcy, liquidation, or cessation of operations by any Party.

Amendments

This MOU may be amended only in writing signed by the Parties. The Parties agree to make a good faith effort to agree on any amendments as may be necessary to achieve the goals and purposes set forth herein.

Notices

All notices required herein must be in writing and served on the other Party at the current mailing address for each Party.

Non-exclusive

All Parties agree that this MOU is non-exclusive in that each Party retains the right to provide services to other entities and receive services from other entities independent of the CI system

Confidentiality

The Parties agree to comply with any and all applicable laws and regulations concerning confidentiality of client records, files or related confidential communications in connection with participation in the CI system.

Nondiscrimination

All Parties agree to operate the CI system in compliance with applicable law, including laws concerning civil rights, fair housing and equal access laws and requirements as stated in the CoCB's policies and procedures governing the CI system.

CI Network Partner Signature: _____
Print Name: _____
Title: _____
Date: _____

Board President Signature: _____
Date: _____

Polk County Continuum of Care Signature:_____
Print Name: _____
Title: _____
Date: _____

APPENDIX K: VI-SPDAT Script

THE FOLLOWING SCRIPT IS TO BE READ TO ALL INDIVIDUALS WHO ARE COMPLETING THE VI-SPDAT ASSESSMENT.

The next part of the intake is intended to assess some of your current needs and to help determine if there are any additional referrals that Centralized Intake can make for you today.

As we go through the assessment, please feel free to stop me at any time if you have questions, would like clarification, or need a break. Please know there are no right or wrong answers and you can refuse to answer a question if you choose. It does benefit you to answer as honestly as possible because accurate information only works in your favor and you are not able to retake this assessment.

Based on the needs identified through the assessment, you may be placed on a prioritization list for housing that would meet your household's needs or receive information about steps you can take towards housing.

Approved by Coordinated Services Committee (12-20-2017)

APPENDIX L: Family Shelter Staffing Form

Date _____

Family Name:_____

Agencies/Staff in Attendance:

_____

_____

Location/date of shelter stay in last 12 mo: _____

Location at previous shelter discharge: _____

_____

Challenges of previous housing location: _____

_____

_____

Housing Barriers and Description:

□ Evictions □ Criminal Background □ Credit □ Income

_____

_____

_____

_____

_____

_____

_____

Support Systems:

_____

_____

_____

_____

Plan for new shelter stay and housing:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

APPENDIX M: IHYC Emergency Bed Program Eligibility, Referral Process, Waitlist, and Prioritization

Eligibility

The Youth Opportunity Center (YOC) Emergency Beds are available to youth ages 18 through 24 years, targeting runaway, homeless, and at-risk youth. The Emergency Bed Program is voluntary. Youth must request services.

The youth must fall into one of the below 4 categories of HUD's homeless definition:

- **Category 1-Literal Homelessness**
  - Individuals and families who live in a place not meant for habitation (including the streets or in their car), emergency shelter, transitional housing, and hotels paid for by a government or charitable organization.
- **Category 2-Imminent Risk of Homelessness**
  - Individuals or families who will lose their primary nighttime residence within 14 days and has no other resources or support networks to obtain other permanent housing.
- **Category 3-Homeless Under Other Statutes**
  - Unaccompanied youth under 25 years of age, or families with children and youth, who do not meet any of the other categories but are homeless under other federal statutes, have not had a lease and have moved 2 or more times in the past 60 days and are likely to remain unstable because of special needs or barriers.
- **Category 4-Fleeing Domestic Violence**
  - Individuals or families who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking and who lack resources and support networks to obtain other permanent housing.

The YOC is a safe place for all youth, where staff are committed to youth, their safety and well-being and their hard work to achieve independence and self-sufficiency. The YOC emphasizes "Respect for Yourself, for Staff & Other Youth and the Youth Opportunity Center." The following are indicators that eligibility to the Emergency Bed Program may not be appropriate:

- Youth with recent/recurrent extreme aggressive behavior directed toward self or others including destruction of property, or current suicidal or homicidal ideations or attempts.
- Youth who have drugs or alcohol in their possession and will not dispose of them.
- Youth whose behavioral history indicates that they are in need of a heavily structured and/or restrictive environment as evidenced by chronic hospitalization or recommendations by qualified professionals.
- Previous youth who were involuntarily discharged from another IHYC program due to extreme aggressive behavior directed towards self or others.

- Previous participants must wait two weeks before being eligible to ask for an Emergency Bed.
- Youth on the sex offender registry must be given prior approval through agency leadership before being put on the waitlist.

Exceptions can be made to this on an individual basis with the approval of the IHYC Director, IHYC Associate Director or YOC Program Manager. If it has been determined that a young person is not appropriate to stay in our Emergency Bed Program, a Denial Form will be sent into PHC.

IHYC Emergency Bed Program Referral, Waitlist, and Prioritization Process:

Step 1: All youth looking to participate in the Emergency Bed program must first meet with Primary Health Care staff, unless entry into the program is not during PHC operating hours. Youth will be taken to or given transportation assistance to Primary Health Care (PHC) offices for the Coordinated Intake and homeless verification process.

Step 2: PHC will maintain an updated waitlist of youth needing a program bed. PHC will prioritize the waitlist based on housing status and VI (vulnerability Index) SPDAT score.

Step 3: When a bed is available, PHC will reach out to the next person on the waitlist and give them two hours for that individual to respond to the offer of a bed. If the participant does not get back to PHC in that time frame, PHC will move down to the next person on the prioritized waitlist. If a person on the waitlist does not respond after three attempts to reach them, they will be taken off the waitlist until they reconnect and make contact again with PHC. If an opening occurs on a weekend or holiday, YOC staff will access the waiting list on ServicePoint to fill the bed with the first person on the list. We will communicate the response of the participant with PHC.

If a participant leaves the Emergency Bed program and needs another bed, they will be directed back to PHC to get back on waitlist.

How IHYC communicates emergency bed openings to PHC: All program openings will be communicated by email or phone call to PHC by IHYC staff as soon as a bed becomes available.

APPENDIX N: Expedited Centralized Intake Approval Process

When an emergent or urgent situation arises requiring a change in the Centralized Intake operational policies within a period of 14 days, the standard approval process will be unable to be followed due to time constraint.

Therefore, in such cases when an urgent issue is identified, the process will be as follows:

1. The issue will be forwarded to the Centralized Intake Work Team for review and recommendation.
2. The recommendation from the Centralized Intake Work Team is forwarded to the Polk County Continuum of Care Board's Executive Committee for review and approval. Any approval by this body will be effective for three months only.
3. During this three month period, the operational policy change made by the Executive Committee will be referred to the Coordinated Services Committee allowing for that body to review and then, following established procedure, will then be graduated to the CoCB for review and board approval.
4. If the standard approval process is unable to take place due to crisis circumstances causing the policy change to be unresolved within the initial three month period, the Executive Committee may approve an additional three month period.