2017

Blue Ridge
Continuum of Care
A Place to Call Home

Coordinated Assessment & Entry Process

Policies, Standards and Procedures

www.endhomelessnessblueridge.org

TABLE OF CONTENTS

BLUE RIDGE COC PLANNING PROCESS

The Blue Ridge Continuum of Care has a service area with a population of 311,814. The area includes the cities of Roanoke, Salem and Covington as well as the counties of Alleghany, Botetourt, Craig and Roanoke. The CoC planning agency assists our community in successfully implementing strategies consistent with Opening Doors and to reach our goal of ending homelessness while remaining compliant with HUD regulations. CoC planning helps our community to improve program outcomes, strengthen housing first strategies, measure system performance and strengthen our community's coordinated entry system.

In accordance with Title 24 of the Code of Federal Regulations (24 CFR) governing the Continuum of Care Program (24 CFR 578) and the Emergency Solutions Grants Program (24 CFR 576) as well as HUD's final rule on defining chronically homeless and homeless (24 CFR 91) and HUD Notice CPD-14- 012 on prioritizing persons experiencing chronic homelessness and other vulnerable homeless persons in permanent supportive housing, the City of Roanoke and the Blue Ridge Continuum of Care (BRCoC) have developed the following written standards for the Coordinated Entry System (CES). All projects that receive HUD Continuum of Care (CoC), Department of Housing and Community Development Virginia Homeless Solutions Program (DHCD-VHSP) funding, Emergency Solutions Grants (ESG) funding as well as other local government funding are required to participate in the CES system, and are therefore subject to complying with these basic minimum standards. In addition, other homeless service providers not receiving CoC or ESG funding located within the BRCoC geographic area are encouraged to participate in the CES.

The BRCoC is committed to ending homelessness and seeks to coordinate and support community agencies within its geographic boundaries that offer services to homeless persons through dissemination of best practices; training; planning; monitoring; and technical assistance. An important role of the BRCoC is to ensure that all projects providing services to the homeless as well as homeless prevention/retention services throughout the entire BRCoC geographic area utilize a single coordinated entry process that allows for coordinated screening, assessment and referrals to those seeking services.

The goal of these standards is to synthesize key elements of the HUD regulations with the processes and priorities of the BRCoC and ensure that the CES system is administered fairly and methodically. The City and the BRCoC will continue to build upon and refine this document.

The purpose of this document is to set forth policies, standards and procedures to govern the centralized or coordinated assessment system. This coordinated assessment system shall be known as the Coordinated Entry System (CES) and will be referred to as such throughout this document.

COORDINATED ENTRY SYSTEM OVERVIEW

The Coordinated Entry System (CES) is a BRCoC-wide process for facilitating access to all resources designated for homeless individuals and families, identifying and assessing needs in a transparent and consistent way, and referring clients to the most appropriate service strategy or housing intervention. In doing so, CES ensures the BRCoC's limited resources are allocated to achieve the most effective results. The BRCoC's CES combines centralized intake with multiple community based access points. All access points utilize a common assessment tool, methodology and electronic information management system thus creating a No Wrong Door approach that functions as a community-wide coordinated entry system for everyone who is experiencing or at risk of becoming homeless. The system ensures that people experiencing homelessness have equitable, coordinated and timely access to housing resources in a person-centered approach that preserves choice and dignity.

GUIDING PRINCIPLES FOR THE BLUE RIDGE COC MODEL

The CES throughout the CoC's geographic area is governed by the following guiding principles:

- **Prioritization of the Most Vulnerable People**. The CoC's limited resources are directed first to individuals and families who are the most vulnerable and in need of assistance.

- **Low-barrier and Easily Accessible.** The CES process does not screen out people for assistance because of perceived barriers to housing or services. Barriers could include, but are not limited to, conditions such as income or drug addiction set as eligibility requirements.

- **Housing First Orientation.** The CES process is Housing First oriented, such that people are housed quickly without preconditions or service participation requirements.

- **Person-Centered.** Every person experiencing homelessness is treated with dignity, offered at least minimal assistance, and participate in their own housing plan. Participants should be made aware of their options and offered choice whenever possible.

- **Standardized Access and Assessment.** All people in the Blue Ridge CoC can easily access the CES and are assessed using a universal assessment tool, either the Vulnerability Index Service Prioritization Decision Assistance Tool for individuals (VI-SPDAT) or the family version of the assessment, the F-VI-SPDAT.

- **Inclusive.** Through its No Wrong Door Approach, the coordinated entry process for the Blue Ridge CoC includes all subpopulations, including people experiencing chronic homelessness, Veterans, families, youth, survivors of domestic violence, persons with mental illness, LGBTQ persons, and disabled persons.

- **Facilitated access to mainstream services**. In addition to the core services to address housing crises, CES help clients access a range of "mainstream" services -- those not specifically limited or targeted to people who are homeless or experiencing a housing crisis but that are important to address issues that impact housing stability such as child care, employment services, legal services, public benefits, education, health care, etc.

- **Shared outcomes:** Outcome expectations are similar for each HRC and results are reported in a consistent way, either through the use of a shared data system, or the ability to merge and de-duplicate data from multiple systems.

- **Informed by Local Planning.** The Blue Ridge CoC and its governing body, the Blue Ridge Interagency Council on Homelessness (BRICH) engage in ongoing planning with all stakeholders participating in the coordinated entry process. This planning includes evaluating and updating the coordinated entry process at least annually and using data to drive decision making and resource allocation

ELIGIBILITY

CES serves all individuals and families who are literally homeless according to the Category 1 HUD definition of homelessness. Households that are not literally homeless are connected with homeless prevention programs and/or encouraged to reach out to family and friends as well as alternative community resources, such as their places of worship, for assistance.

Literally Homeless Definition (HUD Category 1)

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning they have either:
1) Have a primary nighttime residence that is a public or private place not meant for human habitation; or
2) Are living in a publicly or privately operated shelter designated to provide temporarily 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
3) Are exiting an institution where s/he has resided for 90 days or less and who resided in emergency shelter or place not meant for human habitation immediately before entering that institution.

CES PROCESS

The City of Roanoke administers the local coordinated entry system in partnership with the Blue Ridge CoC. As can be seen in the Blue Ridge Continuum of Care Homeless Services Flow Chart (Attachment I), our system is a hybrid of centralized and coordinated assessment and entry representing a No Wrong Door approach to assist families or individuals who are at imminent risk of becoming homeless. Our entry system allows entry through Street Outreach, Central Intake (CI) and/or through shelters. Its design facilitates immediate access to temporary housing and is strengthened by shared data in our Homeless Management Information System (HMIS) and use of the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) at any and all points of entry. Evident in the Homeless Services Flow Chart is that our coordinated assessment and entry system provides individuals and families at risk of homelessness with access to relevant and appropriate prevention, housing, and other services. The coordinated entry system also works closely with 2-1-1 Virginia to ensure that all parts of the CoC are listed in the data base and that agency contact information and hours of operation are up to date to ensure that referrals from DHCD, other communities, and providers link to the coordinated entry system. 2-1-1 Virginia operates as the community's after-hours CES for individuals and families in urgent need of emergency shelter or other crisis services by screening and referring individuals to the most appropriate resource.

Depending on circumstance, clients can enter the system of care through shelters, street outreach, or through Central Intake to access temporary housing. Clients are administered the VI-SPDAT to determine level of need and data is entered into the HMIS. Those in crisis typically access our emergency crisis response system through one of three ways:

- Street outreach provided by the Homeless Assistance Team (HAT); PATH through the local Community Services Board (CSB); the Salem VA Medical Center Healthcare for Homeless Veterans Outreach Program
- Central Intake physical offices
- Community Providers (shelters)

Real time data entry is the agreed upon community wide standard, which allows staff at participating community providers to assess current services and needed referrals for clients. The Blue Ridge CoC adopted the No Wrong Door approach, in part, because of the robust nature of its current HMIS system and its ability to provide and share real-time data for all service providers within the CoC. This robust system allows for improved data collection and reporting, critical to establishing the most efficient use of resources to better move the needle on ending homelessness.

As families and individuals experiencing a housing crisis access services through the No Wrong Door approach, staff assesses their vulnerability using the VI-SPDAT. Once the assessment is complete, staff enters the results of the VI-SPDAT into the HMIS system to allow community wide access and facilitate referrals to services. The VI-SPDAT has proven to be an effective tool.

It plays a critical role in the By Name List (BNL) case conferencing, piloted as part of the Mayors Challenge to End Veteran Homelessness. Due to the pilot's success, community partners, now utilize the best practice of VI-SPDAT assessment combined with BNL case conferencing in other populations including youth; families; and the chronically homeless.

ASSESSMENT TOOL

CES utilizes the Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT) as the common assessment tool to screen single individuals experiencing homelessness. Families receive the family version of the assessment, the F-VI-SPDAT.

Currently utilized by more than 130 communities nationwide, the VI-SPDAT and F-VI-SPDAT allow for prioritization based on vulnerability across five components: (a) history of housing and homelessness (b) risks (c) socialization and daily functioning (d) wellness – including chronic health conditions, substance usage, mental illness, and trauma and (e) family unit (if applicable). The assessment takes approximately 10 minutes to administer and can be conducted by any provider who has been introduced to the VI-SPDAT tool through a brief training session provided by the BRCoC's Homeless Management Information System (HMIS) Coordinator. All VI-SPADAT scores are entered into the CoC's HMIS system.

PARTICIPATION REQUIREMENTS

The Department of Housing and Urban Development (HUD) has recently established guidance that instructs all Continuum of Care (CoC) projects to participate in their CoC's coordinated assessment system. Any project that receives HUD funding (CoC Program or Emergency Solutions Grant) or funding from the Virginia Department of Housing & Community Development (DHCD) must comply with the participation requirements as established by the corresponding CoC jurisdiction. The City of Roanoke is the Blue Ridge CoC lead agency and has developed a coordinated entry system with the following expectations for participation:

CoC, ESG and DHCD permanent housing (PH) projects, including Rapid Re-Housing (RRH), Permanent Supportive Housing (PSH), and Homelessness Prevention (HP) must follow the CoC-approved written standards for service provision (Attachment II - Homelessness Prevention & Rapid Re-housing Standards and Best Practices Manual for Permanent Supportive Housing Programs)

CoC, ESG and DHCD PH projects must submit project vacancies, including bed/unit-specific information to the by-name list committees at their regular committee meetings.

CoC, ESG and DHCD PH projects must enroll only those clients referred through CES except in special circumstances (as detailed below).

CoC, ESG and DHCD PH projects must hold turnover beds open for the next individual on the prioritization list. Open spots will be filled by majority vote of the appropriate committee (i.e. the Chronically Homeless (CH) By-Name List Committee will fill all slots for dedicated CH beds).

The CES agency lead (City of Roanoke) is responsible for maintaining by-name lists of the priority populations (families with children, chronically homeless, veterans and youth) as well as an updated list of project vacancies and overseeing the match process.

Single households experiencing a housing crisis must access services and housing through Central Intake, a CES shelter access point, by calling 2-1-1 VIRGINIA for referral or through the City of Roanoke Street Outreach Team.

Families experiencing a housing crisis must access CoC services and housing through Central Intake, a CES shelter access point or by calling 2-1-1 VIRGINIA.

Survivors of Domestic Violence who come to a CES site or who are approached through street outreach will be asked if they are attempting to flee domestic violence (DV) or experiencing intimate partner violence. If a participant indicates they are a victim of domestic violence, none of the participant's information will be entered into HMIS, and referrals will immediately be made to domestic violence-specific resources, including hotlines and shelter. Survivors of DV are de-identified and placed on our community's by-name lists for housing resource prioritization.

Veterans who come to a CES site or who are approached through street outreach will be assessed using the VI-SPDAT. The Veteran by-name list committee will identify Veteran-specific resources such as HUD-VASH or Supportive Services for Veteran Families (SSVF) providers or general homeless assistance. If a veteran chooses not to be referred to those services, he or she will be assigned a housing navigator. In alignment with federal, state and local priorities, CoC, DHCD and ESG program-funded projects, including PSH and RRH prioritize veterans and their families.

DOCUMENTATION

Once a household has been assessed, the next step is documenting their homeless status. All clients will need to be document ready or nearly document ready in order to be matched with a permanent housing placement. In order to be document ready, the client must have one of the following types of documentation (See attachment IV for forms):

- Chronic homelessness verification form and supporting documentation
- Homeless verification form and supporting documentation

In addition, clients generally also need a Birth Certificate, ID, Social Security Card and income documentation prior to housing placement.

HOUSING NAVIGATION

Individuals or families with the highest priority are assigned a Housing Navigator to assist them in preparing to be referred to an available housing resource and move in after a referral is made. This Housing Navigator provides support throughout the process, which may include accompanying them to all housing related appointments and other necessary social service or benefit acquisition appointments until such time that they are permanently housed. Depending on the capacity of the assessment agency, the housing navigator role may alternatively be filled by an outreach worker or case manager.

MATCH & PRIORITIZATION FOR HOUSING PLACEMENT

CES is a uniform process through which the most vulnerable homeless residents within the Blue Ridge CoC are prioritized to be matched with available and appropriate housing resources in a systematic and efficient manner. The following represents the uniform process used across the CoC for matching and prioritizing placement into housing through the client prioritization lists based on VI-SPDAT score. It is important to note that the order of prioritization established below will be followed with consideration of agency goals and target populations (e.g. mental illness, veterans).

BNL COMMITTEES

Referrals to housing interventions are made only through the by-name list committees, with the maintainer of the list making the referral to the housing provider by consensus vote of the appropriate committee. By name list committees are appointed by the Chair of the CoC and are composed of CoC homeless service providers, mental health providers and other community agency representatives as appropriate. BNL committees will meet on an as needed monthly basis. Committee members will review names and assessment scores to make determinations on how best to serve the needs of clients on their lists. Decision on placements will adhere to guidelines set forth in this CES policy and standards handbook. Housing placements will be made by consensus vote of Committee members with a housing navigator being assigned as needed. The Chair of the CoC sits on all by-name list committees. BNL committees and their composition will change over time based on needs in the Blue Ridge CoC geographic area and federal and state priorities. Designated housing navigators lead the housing search process through meetings of the CoC's BNL committees. Currently the following committees are in place:

- Veterans
- Chronically Homeless
- Families
- Youth

BNL committees will hold periodic case conferencing meetings to review special cases of households that cannot complete the assessment due to their level of vulnerability, or whose

responses do not reflect what an assessor observes. The case conferencing process provides a safety net for households whose level of vulnerability may not be accurately reflected through the assessment process.

The following represents a uniform assessment and housing prioritization process to be used across the Blue Ridge CoC for matching individuals and families with housing interventions:

VI-SPDAT or F-VI-SPDAT Score	Single Individuals	Families
≥8	Permanent Supportive Housing (PSH)	PSH or Medium-Term RRH
4-7	Rapid Re-Housing (RRH)	Short & Medium-Term RRH
≤3	Homelessness Prevention (HP) or Self-Resolve	HP or Self-Resolve

Permanent Supportive Housing (PSH)
Individuals and families that score an 8 or above on the VI-SPDAT and who are chronically homeless are recommended for permanent supportive housing and are prioritized based on the following criteria (only go to the next level as needed to break a tie between two or more households):

1) Chronically homeless individuals and families with the longest history of homelessness and most severe service needs (those with highest VI-SPDAT score).
2) Chronically homeless individuals and families with longest current episode of homelessness (to be used as a tie breaker for those in category 1 with the same VI-SPDAT score).
3) All other chronically homeless individuals and families.
4) If no chronically homeless individual or family is identified, follow the order of priority for beds not dedicated or prioritized for chronically homeless.

PSH Beds Dedicated and Prioritized for Persons Experiencing Chronic Homelessness
All turnover beds for CoC funded PSH are prioritized for persons experiencing chronic homelessness and should use the following order of priority for filling vacancies:

1) Chronically homeless individuals and families with longest history of homelessness and most severe service needs (based on VI-SPDAT score)
2) Chronically homeless individuals and families with longest history of homelessness
3) Chronically homeless individuals and families with most severe service needs
4) Chronically homeless individuals and families with longest current episode of homelessness
5) All other chronically homeless individuals and families
6) If no chronically homeless individual or family is identified, the order of priority for filling vacancies is:

- Homeless individuals and families with a disability and most severe service needs
- Homeless individuals and families with a disability and longest continuous or episodic homelessness
- Homeless individuals and families with a disability and coming from a place not meant for human habitation, safe haven, or emergency shelter
- Homeless individuals and families with a disability and coming from transitional housing

Rapid Re-Housing (RRH)
Individuals and families with a score between 4 and 8 on the VI-SPDAT may be recommended for rapid re-housing (RRH). Households that are recommended for rapid re-housing will be prioritized based on the following criteria (only go to the next level as needed to break a tie between two or more households):

1	**Non-Chronic Youth Scoring 4-8**	1. Veteran (not eligible for VA-RRH) 2. VI-SPDAT Score 3. Length of Homelessness
2	**Non-Chronic Families Scoring 4-8**	1. Veteran (not eligible for VA-RRH) 2. VI-SPDAT Score 3. Length of Homelessness
3	**Non-Chronic Singles Scoring 4-8**	1. Veteran (not eligible for VA-RRH) 2. VI-SPDAT Score 3. Length of Homelessness

In an effort to ensure all populations have access to housing resources, rapid re-housing slots will be assigned monthly through the by-name list maintainer to singles and families using the prioritization process outlined above. Available funding governs the number of families and individuals referred to rapid re-housing. Current 2017 funding allows for 4 families and 2 singles to be referred to rapid re-housing resources monthly. The rapid re-housing coordinator and coordinated entry supervisor will coordinate placements directly from the community's by-name lists.

Homelessness Prevention (HP)
Households meeting the minimum eligibility requirements outlined in the Blue Ridge Continuum of Care's homelessness prevention standards (Attachment III) will be prioritized for services based on the level of risk each household faces in experiencing homelessness. Households are placed in the following tiered categories:

- Tier 1: households at "imminent" risk of homelessness are defined as those staying with family or friends who must vacate the unit within 14 days or those that have been to court and have an eviction scheduled within ten days or the household is residing in housing that has been condemned by a housing official and the unit must be vacated

within ten days or the household is living in a hotel/motel and must vacate within 14 days. Households at imminent risk fall into the tier one category and are served first.

- Tier 2: "high risk" households are defined as those that have a pending court date for an eviction documented through an unlawful detainer. High risk households fall into the tier two category and are served as funding allows after all households in the first tier category have been served.

- Tier 3: the lowest tiered category are "at-risk" households that are defined as those with a five day pay or quit notice issued by the landlord, but with no scheduled court date. These households meet the minimum requirements for service but are only served if funding remains after all households in the first and second tier priorities have been served.

Households that have experienced a homeless episode in the past are prioritized for services within each tier.

HOUSING REFERRAL

The CES makes referrals to all projects receiving ESG, CoC and VHSP Program funds within the Blue Ridge CoC geographic area. By-name list committees and the CoC Lead Agency lead the housing referral process, with the help of the client prioritization lists. When a permanent housing unit becomes available, BNL committees identify the next eligible households on the client prioritization list and referrals for that opening based on:

1) **Appropriate/best match:** unit eligibility and available services are the right fit to client need.

   Referrals will be made by the lead agency and the relevant BNL committee based on standardized eligibility criteria and contract requirements. For example, programs that serve only male-identified single adults will only receive referrals for male-identified single adults. The CES will follow eligibility and screening criteria based on agreed upon requirements with the agency and funder(s). Agencies participating in CES must submit all of their eligibility criteria to the lead agency. If there is a concern that a program's requirements may be contributing to "screening out" or excluding households from services, it may request to meet with the provider to discuss their criteria. If a provider is unwilling to modify the criteria, the CoC may de-prioritize the provider for CoC, ESG or VHSP funding.

2) **Client availability:** not in jail, able to contact, document ready / nearly ready to move in so as to reduce vacancy times.

3) **Client choice:** When appropriate and not without including client choice, clients are referred to the most restrictive or most abundant housing resource for which they are eligible. For example, a Veterans Affairs Supportive Housing (VASH) eligible Veteran would be unlikely to be prioritized for ARCH PSH program.

BEST PRACTICE SUPPORTS CES

The Blue Ridge CoC has co-located its largest street outreach effort with Central Intake. The CoC also co-locates and centralizes prevention and rapid-rehousing resources to the extent possible. The CoC's centralized prevention provider partners with a provider in the CoC's rural areas to provide on-site intake and services for individuals at imminent risk of homelessness in these communities.

As part of our continuous quality improvement and to increase efficiencies, the Blue Ridge CoC consolidates prevention services and houses those services within the Council of Community Services' Community Housing Resource Center (CHRC) as part of the best practice of co-location. The CHRC manages a number of prevention resources and the decision to make it the sole prevention provider creates efficient layering of resources to meet varying client needs. The co-location of Central Intake; the CHRC; and the largest street outreach program forms a one-stop shop to ensure successful diversion from homelessness; and decreases in the length of time people spend homeless while strengthening the capacity of the CES.

CES OPERATING GUIDELINES

HMIS

CES is a system that operates within the Homeless Management Information System (HMIS). As such, all VI-SPDAT and F-VI-SPDAT assessments must be recorded into the Blue Ridge CoC HMIS. If the VI-SPDAT is conducted on paper, the HMIS administrator can offer assistance to agencies that need help inputting the information into the HMIS.

RELEASE OF INFORMATION

Any household who agrees to participate in the CES process is asked to sign a consent form before proceeding with the assessment. The consent form informs individuals that assessment information will be shared with housing and service providers through a secure database (HMIS) so that s/he does not need to complete the assessment multiple times. Clients are also informed that they may revoke their permission to share their information at any time. Households that do not sign the consent are entered into HMIS with only limited information being made available to partner agencies for the purpose of ensuring records are not duplicated.

LOW BARRIER POLICY

CES participating programs will make enrollment determinations on the basis of limiting barriers to enrollment in services and housing. No client may be turned away from homeless designated housing due to lack of income, lack of employment, disability status, or substance use.

CONFLICTS OF INTEREST
In the event that a conflict of interest occurs between a household and CES staff or housing provider staff, the staff must inform their supervisor, who will assign another staff to work with the household as appropriate or refer the client to another provider.

AGENCY DENIALS
A housing provider can deny a referral that is ineligible for the program based on program eligibility requirements. Any denial must be documented and reported to the CoC lead. The CoC lead may follow-up with the housing program and the household referred in order to understand the circumstances of the returned referral. Housing providers are responsible for assuring that a household meets the contractually required eligibility requirements for their program.

EXTERNAL FILL
The External Fill Policy allows a housing provider to fill available housing units external of a CES referral when CES is unable to identify an eligible household. Housing providers must hold turnover beds open for a period of 15 days while the CoC lead and the appropriate by-name committee consult the existing client prioritization list. If an individual or family cannot be found within the 15-day time period, the turnover bed may be filled by the normal agency process. This policy is intended to be the last effort to ensure CES is making the best use of available housing resources. Communication during an external fill request is required to allow CES and housing providers to work together to understand challenges of the CES referral process and support continuous system improvement.

GRIEVANCE POLICY
Client concerns and grievances should be resolved promptly and fairly. Grievances about experience(s) with homeless housing programs should be directed to the program and follow the grievance policies and procedures of that organization. Agencies should maintain internal documentation of all complaints received. Grievances about CES policies and procedures or a participating program's screening or program participation practices which appear to have a discriminatory impact should be directed to the Blue Ridge CoC Lead Agency.

A first-person written and/or documented complaint will be considered a grievance. A verbal, second-hand or hearsay complaint will be considered a complaint. Each situation will be treated seriously and with sensitivity, and will be documented for the record with date, time, program name, and nature of the complaint, as well as with any action taken towards resolution. All complaints or grievances involving vulnerable adults or children will be immediately turned over to the appropriate authorities.

HOUSEHOLD REFUSAL
The Coordinated Entry System (CES) values client choice in the housing process. CES also strives to maintain low vacancy rates for the variety of housing programs available. In an effort to balance these values, the Refusal Policy, while flexible, has specific constraints to maintain the

CES system. Eligible households are not limited in the number of resources they can refuse, but will not be considered for a program that is outside of their recommended housing type match based on their VI-SPDAT or F-VI-SPDAT score. The CES lead will document refusals in order to better understand why eligible households refuse resources and identify changes that would support the needs of our community.

INACTIVE HOUSEHOLDS

To ensure the client prioritization list reflects the most current information regarding eligible households who are in need of housing, eligible households may be made inactive after they have been contacted for two (2) unique attempts to make a housing referral with no response from the household or gone 90 days without contact/service provision. If a household is made inactive and later reestablished contact with CES and are still eligible for CES, they will be given the opportunity to make updates to their assessment and be referred to the client prioritization list again.

MOBILITY REQUESTS

Eligible households are prioritized for transfer to another housing program if they experience an imminent safety issue, require a geographic change, have a change in service need, are aging out of their current program with no other housing options, or if their household size changes. Mobility requests should be sent through the housing provider to the CES lead.

HARASSEMENT

In accord with federal, state, and local laws, to prohibit all forms of harassment and discrimination of or by clients, employees, visitors, and volunteers, including harassment and discrimination based on actual or perceived gender identity and expression, or based on an individual's association with a person or group with one or more of these actual or perceived characteristics. Retaliation against an individual who files a complaint of harassment or discrimination against (agency) employees, visitors, volunteers, or other clients, or who participates in an investigation of such a complaint, is strictly prohibited

FAIR HOUSING, EQUAL ACCESS & ACCESSIBILITY

The CES Lead and planning agency take all necessary steps to ensure the CES is administered in accordance with the Fair Housing Act by promoting housing that is accessible to and usable by persons with disabilities, including accessible physical locations for individuals who use wheelchairs, as well as people in the CoC who are least likely to access homeless assistance. The CES complies with the non-discrimination requirements of the Fair Housing Act, which prohibits discrimination in all housing transactions on the basis of race, national origin, sex, color, religion, disability status and familial status. This also includes protection from housing discrimination based on source of income.

It is recognized that the Fair Housing Act recognizes that a housing provider may seek to fulfill its "business necessity" by narrowing focus on a subpopulation within the homeless population.

The CES may allow the targeting of subpopulations while preventing discrimination against protected classes.

The CES and all publically-funded projects provide access to individuals with limited English proficiency through a language line and assistive technology tools including Google translator. Marketing and program materials are available upon request in large type and Braille for individuals with visual impairments.

The CES and all HUD and state-funded projects abide by the Equal Access to Housing Final Rule entitled "Equal Access in Accordance with an Individual's Gender Identity in Community Planning and Development Programs". This ensures equal access to shelter and services to individuals in accordance with their gender identity, and in a manner that affords equal access to the individual's family.

Compliance with Fair Housing, Equal Access and accessibility is monitored annually by the CoC Lead and planning agency for all CoC, DHCD and ESG-funded projects.

EVALUATING AND UPDATING CES POLICIES AND PROCEDURE

To help ensure that the CES will be effective and manageable for homeless and at-risk households and for the housing and service providers tasked with meeting their needs, the Blue Ridge Continuum of Care anticipates adjustments to the processes described in this manual. To inform those adjustments, the CES will be periodically evaluated, and there will be ongoing opportunities for stakeholder feedback, including but not limited to soliciting provider feedback through the annual strategic planning process. Consumer feedback will be solicited through annual surveys as part of the Point-in-Time Count and through focus group meetings as needed. Specifically, the CoC Lead and planning agency are responsible for:

- Establishing an identified committee to review CES periodic evaluation efforts to ensure that the CES is functioning as intended; such evaluation efforts shall happen at least annually
- Leading efforts to make periodic adjustments to the CES as determined necessary; such adjustments shall be made at least annually based on findings from evaluation efforts
- Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders
- Ensuring that the CES is updated as necessary to maintain compliance with all state and federal statutory and regulatory requirements

GLOSSARY

Coordinated Entry System (CES): The process whereby any single individual or family experiencing homelessness received coordinated entry into the homeless serves system through a common assessment (the VI-SPDAT), followed by targeted assistance through By-name committees, Housing Navigators and Case Managers who obtain essential documentation for housing in order to facilitate the coordinated exit to permanent housing through either Permanent Supportive Housing or Rapid Rehousing.

CES Lead Agency: The CoC Lead Agency, the City of Roanoke is the CES Lead Agency.

CES Participating Program: Any program that is required by its funding source to participate in coordinated entry, or has opted into the system to receive its referrals through coordinated entry.

Eligible Household: CES serves all individuals and families who are literally homeless according to Category 1 HUD definition of homelessness. See "eligibility" section for details.

Emergency Solutions Grant (ESG): A program grant operated by The City of Roanoke's HUD Office of Community Planning and Development that is designed to help improve the quality of existing emergency shelters for the homeless, to make additional shelters available, to meet the costs of operating shelters, to provide essential social services to homeless individuals, and to help prevent homelessness. ESG also provides short-term homeless prevention assistance to persons at imminent risk of losing their own housing due to eviction, foreclosure, or utility shutoffs.

Healthcare for Homeless Veterans: This program offers outreach, case management and residential treatment services to help Veterans transition from living on the street or in institutions to stable housing situations. Clinically trained providers locate Veterans who are living in precarious situations and connect them with VA bridge housing, health care and case management services that promote safe, stable living arrangements.

Homeless Management Information System (HMIS): A Homeless Management Information System is a web-based software application designed to record and store person-level information on the characteristics and service needs of homeless persons through a Continuum of Care (CoC) jurisdiction. Usage of the HMIS is mandated by the U.S. Department of Housing and Urban Development (HUD).

Housing Opportunities for Persons With AIDS (HOPWA): A Federal program dedicated to the housing needs of people living with HIV/AIDS.

Housing Navigator: A Housing Navigator serves as the primary point of contact for an individual or family after they have been assessed, and provides assistance in obtaining the documents

needed for that individual or family to enter housing. The housing navigator role may alternatively be filled by an outreach worker or case manager.

Family Vulnerability Index and Service Prioritization Decision Assistance Tool (F-VI-SPDAT): The Family Vulnerability Index and Service Prioritization Decision Assistance Tool (F-VI-SPDAT) is utilized for families (and not single individuals) to recommend the level of housing supports necessary to resolve the presenting crisis of homelessness. Within those recommended housing interventions, the F-VI-SPDAT allows for prioritization based on presence of vulnerability across five components: (a) history of housing and homelessness (b) risks (c) socialization and daily functioning (d) wellness – including chronic health conditions, substance usage, mental illness, and trauma and (e) family unit.

Rapid Re-Housing (RRH): A type of intervention, informed by a Housing First approach, that connects families and individuals experiencing homelessness to permanent housing through a tailored package of assistance that may include the use of time-limited financial assistance and targeted supportive services.

Street Outreach Teams: Teams that can provide assessment of individuals who are unable or unwilling to visit a CES assessment site.

Supportive Services for Veteran Families (SSVF): For very low-income Veterans, SSVF provides case management and supportive services to prevent the imminent loss of a Veteran's home or identify a new, more suitable housing situation for the individual and his or her family; or to rapidly re-house Veterans and their families who are homeless and might remain homeless without this assistance. Through referrals and direct outreach, nonprofit agencies and community cooperatives use SSVF funding to quickly house Veterans and their families who are homeless and keep others from slipping into homelessness by providing time-limited supportive services that promote housing stability.

Veterans Administration Housing Support (VASH): This collaborative program between HUD and VA combines HUD housing vouchers with VA supportive services to help Veterans who are homeless and their families find and sustain permanent housing. Through public housing authorities, HUD provides rental assistance vouchers to Veterans who are eligible for VA health care services and are experiencing homelessness.

Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT): The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) is utilized for single individuals (F-VI-SPADAT for families) to recommend the level of housing supports necessary to resolve the presenting crisis of homelessness. Within those recommended housing interventions, the VI-SPDAT allows for prioritization based on presence of vulnerability across four components: (a) history of housing and homelessness (b) risks (c) socialization and daily functioning and (d) wellness – including chronic health conditions, substance usage, mental illness, and trauma.

CONCLUSION

This initial design and framework for our community's CES will be posted and sent out to the CoC Board and CoC membership for review and modifications. Over the next several months after adoption, detailed implementation plans including policies and procedures for all aspects of coordinated entry will be finalized. The CoC Board and other community partners will continue to seek funds to ensure the coordinated entry system is centrally managed, well-coordinated, and continually improving.

Please contact the following individuals with questions or requests for further information:

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Matt Crookshank
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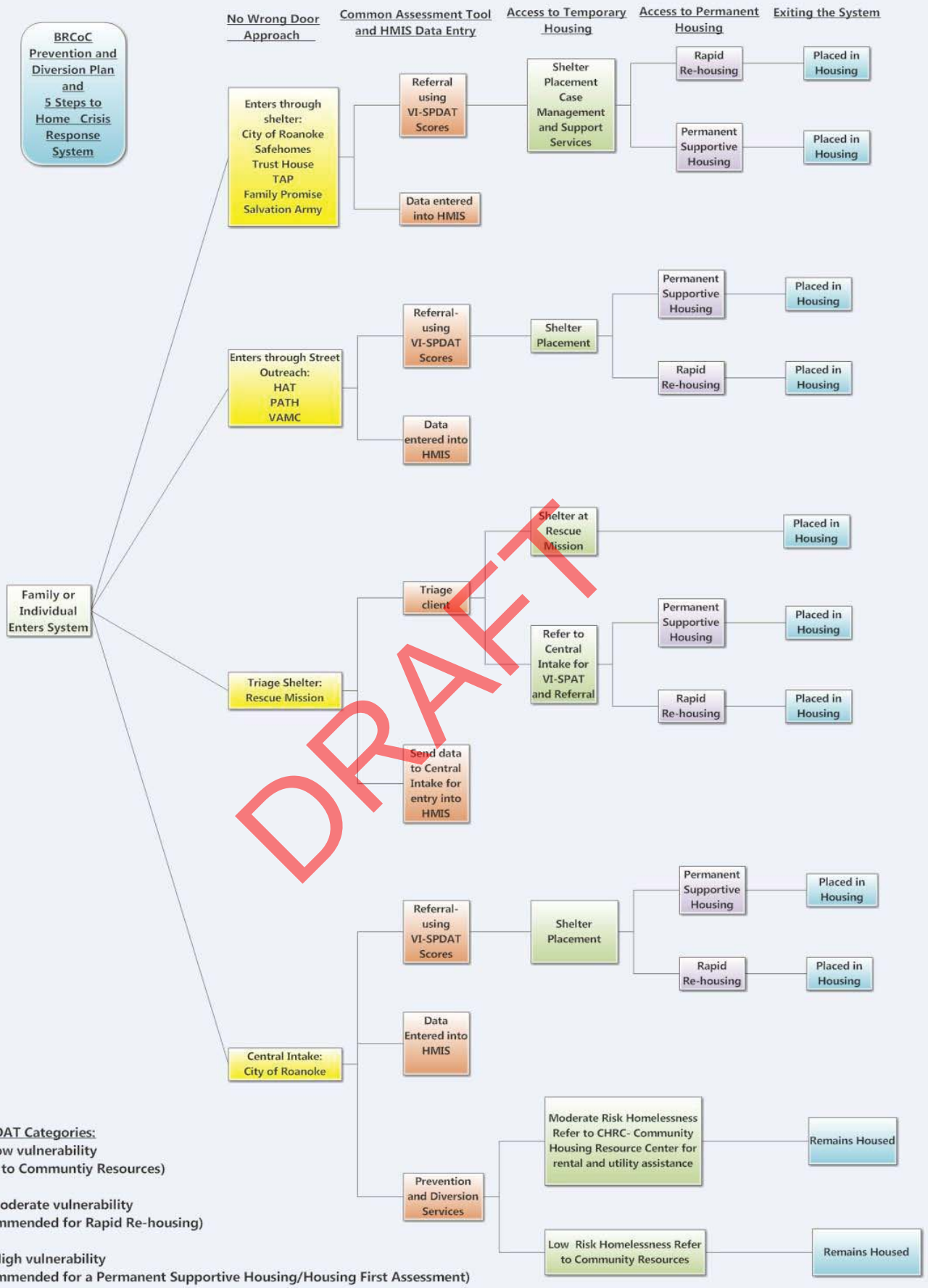
ATTACHMENTS

1. CONTINUUM OF CARE FLOW CHART
2. HOMELESS PREVENTION AND RAPID REHOUSING STANDARDS
3. CHRONIC HOMELESS VERIFICATION
4. HOMELESS VERIFICATION
5. HOUSING BARRIERS ASSESSMENT
6. PSH DISABILITY DOCUMENTATION
7. VI SPDAT V2.0 FOR SINGLES
8. VI SPDAT V2.0 FAMILY
9. PREVENTION RRH WRITTEN STANDARDS
10. PSH MANUAL – www.endhomelessnessblueridge.org
11. HOMELINK MANUAL – www.endhomelessnessblueridge.org
12. CoC CLIENT AUTHORIZATION FORM
13. ROI FOR VETERANS

Blue Ridge Continuum of Care Coordinated Assessment Housing Placement and Crisis Response System Access Flow Chart



VI-SPDAT Categories:
0-4: Low vulnerability
(Refer to Communtiy Resources)

5-9: Moderate vulnerability
(Recommended for Rapid Re-housing)

10 + High vulnerability
(Recommended for a Permanent Supportive Housing/Housing First Assessment)

Placed in Housing: Private Landlord

Rapid Re-housing: CHRC

Permanent Supportive Housing: TAP, TRUST, City of Roanoke, VA

Self-Sufficiency Support Services and Case Management is provided by shelter providers

Blue Ridge
Continuum of Care

Homelessness Prevention & Rapid Re-Housing Standards

March 2016

Homelessness Prevention

Individuals and families who meet the following criteria are eligible for homelessness prevention assistance.

- Household gross income limit must be below the limit of the individual program (ESG: below 30% of AMI, VHSP: below 30% of AMI, CDBG: below 50% of AMI). Clients must provide documentation for all income sources, including a zero income affidavit for clients with no income.
- The household must lack the financial resources and support networks needed to prevent them from becoming literally homeless; and must meet one of the following risk factors of imminent homelessness with acceptable documentation:
  1) Housing loss within 14 days – client has been notified of their right to occupy their current housing or their living situation will be terminated within 14 days after the date of application for assistance. Notification must be written and from a third party source. Documentation must be from one of the following:
     - If tenant: eviction notice, court order to leave within 14 days; or
     - If living in doubled up arrangement: eviction letter from tenant/homeowner; or
     - If living in a hotel/motel: letter from hotel/motel manager and cancelled checks to verify costs covered by the participant
  2) Residency in housing that has been condemned by a housing official and is no longer meant for human habitation. Documentation must include letter from housing official.
- No appropriate subsequent housing options have been identified
- The household lacks the resources and support networks needed to maintain housing
- Total household assets cannot exceed $500
- Proof of residence within the Blue Ridge Continuum of Care service area. This includes the counties of Alleghany, Botetourt, Craig and Roanoke and the cities of Covington, Roanoke and Salem.

Client Prioritization

Households meeting the minimum eligibility requirements outlined above will be prioritized for services based on the level of risk each household faces in entering the shelter system. Households are placed in the following tiered categories:

- Tier 1: households at "imminent" risk of homelessness are defined as those staying with family or friends who must vacate the unit within 14 days or those that have been to court and have an eviction scheduled within ten days or the household is residing in housing that has been condemned by a housing official and the unit must be vacated within ten days or the household is living in a hotel/motel and must vacate within 14 days. Households at imminent risk fall into the tier one category and are served first.

- Tier 2: "high risk" families are defined as households that have a pending court date for an eviction documented through an unlawful detainer. High risk households fall into the tier two category and are served as funding allows after all households in the first tier category have been served.

- Tier 3: the lowest tiered category are "at-risk" families that are defined as those with a five day pay or quit notice issued from the landlord, but no scheduled court date. These households meet the minimum requirements for service but are only served if funding remains after all households in the first and second tier priorities have been served.

Households that have experienced a homeless episode in the past are prioritized for services within each tier.

Coordinated Assessment and Diversion

Households that are housed but at-risk of homelessness should be diverted from literal homelessness whenever possible. All diversion services are coordinated centrally through the City of Roanoke's Central Intake program. Emergency shelter staff shall refer all households seeking a shelter placement that are currently in permanent housing to Central Intake for a diversion assessment.

Central Intake staff shall use the CoC's common diversion tool (Attachment A) to divert households from homelessness. If it is determined that the only diversion option for the household is financial assistance, then Central Intake will connect the client to the Community Housing Resource Center's centrally coordinated homelessness prevention services.

All households assessed for homeless prevention services must be screened with the CoC's Homelessness Prevention Screening Worksheet (Attachment B). The Worksheet will screen the household for basic eligibility requirements and place them into one of the three prioritization categories.

Duration and Amount of Financial Assistance

In order to maximize the number of households served, homelessness prevention services will generally be provided on a "one-time" basis. The amount of financial assistance provided will be determined by the case manager using the following standards:

- Household will be assessed to determine financial need through a budget analysis
- Case manager sets a financial assistance plan after completing the intake and financial needs assessment
- Client files must be reviewed and approved by the program director once a financial assistance plan has been set
- No maximum or minimum amounts of assistance will be set at intake
- Households will only receive the minimum amount of assistance necessary to stabilize in permanent housing

Case Management & Caseloads

Case managers should maintain an average case load of 20 clients or less. This will allow case managers to provide quality case management and ensure that services are targeted to individuals most in need of homelessness prevention resources. Case managers are expected to use motivational interviewing techniques and use a strengths-based approach in all client interactions.

Inspections and Landlord Agreement

Any unit that receives financial assistance through homelessness prevention must pass a basic habitability inspection. Units built prior to 1978 with a household that includes a child under the age of six must pass a lead-based paint visual assessment. Inspections must be completed by adequately trained staff. Individuals conducting lead-based paint assessments must have documentation on file of being a HUD-certified lead-based paint visual assessor.

Any unit that receives rental assistance payments through homelessness prevention must have an agreement in place between the provider and the property owner or manager. The rental assistance agreement details the terms under which rental assistance will be provided.

Rapid Re-Housing

Individuals and families who meet the following definitions of literal homelessness are eligible for rapid re-housing assistance.

- Persons sleeping in a place not meant for human habitation, such as cars, parks, abandoned buildings, streets/sidewalks
- Persons living in a shelter designed to provide temporary living arrangements (congregate/scattered site emergency shelters, transitional housing, hotels/motels paid for by a charitable organization or government program)
- Persons exiting an institution where they resided for 90 days or less and resided in a place not meant for human habitation immediately before entering the institution

Third party documentation must be obtained to certify homeless status.

Individuals and families must also meet the following minimum requirements to qualify for rapid re-housing services:

- Households cannot be receiving tenant or project-based rental assistance through another source for the same time period and cost type that rapid re-housing assistance is being provided
- No appropriate subsequent housing options have been identified
- The household lacks the resources and support networks needed to obtain immediate housing

Coordinated Assessment

All clients must have an assessment completed to assess their level of vulnerability and to determine the most appropriate housing intervention. The Blue Ridge Continuum of Care uses the Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) as its primary coordinated assessment tool. Households scoring between 5 and 7 on the VI-SPDAT are targeted for a rapid re-housing intervention.

Households must be assessed by a trained assessor on-site at all shelter and street outreach providers within 7 days of intake. Households scoring between 5 and 7 are referred to the Community Housing Resource Center for intake, housing search assistance, placement, move-in assistance and on-going rapid re-housing services. Community Housing Resource Center staff will coordinate all housing search and placement, and on-going services with referring agency staff.

Duration and Amount of Financial Assistance

The Blue Ridge Continuum of Care has adopted the declining rental subsidy model for its rapid re-housing programs in order to promote client self-sufficiency and to maximize the number of households served. The case manager providing initial intake services will determine the amount of initial assistance provided to the household using the following standards:

- Household will be assessed to determine initial need through a budget analysis
- case manager sets a financial assistance plan after completing the intake and financial needs assessment
- Client files must be reviewed and approved by the program director once a financial assistance plan has been set
- No maximum or minimum amounts of assistance will be set at intake
- All requests for re-certification must be approved by the program director
- Households will only receive the minimum amount of assistance necessary to stabilize in permanent housing

Households cannot exceed 24 months of rapid re-housing assistance in a 36 month period.

Participant Share

Because the Blue Ridge Continuum of Care has adopted the declining rental subsidy model for its rapid re-housing programs, households will be expected to contribute a portion of their income to their rental costs. The case manager will develop a financial assistance plan with the client at intake, after completing a household budget analysis. Clients will collaboratively participate with their case manager the development of their individualized housing plan. Case managers will use the housing plan to determine the client contribution based on monthly income and necessity expenses. All financial assistance plans must be reviewed and approved by the program director.

Case Management & Caseloads

Rapid re-housing case managers should maintain an average case load of 20 clients or less. This will allow case managers to provide quality case management and ensure that services are targeted to individuals most in need of a rapid re-housing intervention. As rapid re-housing resources available in the continuum continues to expand, this number may increase.

Case management includes home and office visits determined by client need and supported by the housing plan. Case managers are expected to use motivational interviewing techniques and use a strengths-based approach in all client interactions. Case management meetings must be held at least once per month. More frequent meetings are encouraged for clients with higher levels of need.

Inspections and Landlord Agreement

Any unit that receives financial assistance through rapid re-housing must pass a basic habitability inspection. Units built prior to 1978 with a household that includes a child under the age of six must pass a lead-based paint visual assessment. Inspections must be completed by adequately trained staff. Individuals conducting lead-based paint assessments must have documentation on file of being a HUD-certified lead-based paint visual assessor.

Any unit that receives rental assistance payments through rapid re-housing must have an agreement in place between the rapid re-housing provider and the property owner or manager. The rental assistance agreement details the terms under which rental assistance will be provided.

Re-Certifications

All case managers must re-certify clients at three month intervals. The household must meet income eligibility guidelines at the time of re-certification to continue to qualify for services. The case manager may decide to extend, decrease or discontinue providing assistance. All re-certifications must be reviewed and approved by the program director. At re-certification, the following conditions must be met:

- Household income must be at or below 30% of the Area Median Income (AMI)
- Household must lack sufficient resources and support networks necessary to retain housing without rapid re-housing assistance
- Household must not have assets that exceed $500

Blue Ridge Continuum of Care
A Place to Call Home

Chronic Homelessness Certification

Chronic Homelessness Documentation Checklist

An individual is defined by HUD as "Chronically Homeless" if they have a disability and have lived in a shelter, safe haven, or place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last three years (must total 12 months). Breaks in homelessness, while the individual is residing in an institutional care facility will not count as a break in homelessness. Additionally, an individual who is currently residing in an institutional care facility for less than 90 days and meets the above criteria for chronic homelessness may also be considered chronically homeless. Lastly, a family with an adult/minor head of household who meets the above mentioned criteria may also be considered chronically homeless, despite changes in family composition (unless the chronically homeless head of household leaves the family).

Client Name:	**Date of Birth:**
Number in Household:	**Client Head of Household:** ☐ Yes ☐No

Part 1: Current Housing Status

Client must currently be in one of these locations in order to be considered chronically homeless.

Client is currently residing:

☐In Emergency Shelter
☐On the Streets/Place not Meant for Human Habitation
☐In the Safe Haven
☐In an Institutional Care Facility (Where they have been for fewer than 90 days)

Start Date: _____	**End Date:** _____

Location Name/Address:

Current Housing Status Notes:

Part 2: Housing History

	Month # 1	Month # 2	Month # 3	Month # 4	Month # 5	Month # 6	Month # 7	Month # 8	Month # 9	Month # 10	Month # 11	Month # 12
Mo./Yr.	(Current Month)											
Location *Check all that Apply*	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)	☐ Streets ☐ Shelter ☐ Safe Haven ☐ Inst. (<90 days)
Doc. Type *Check One* *(Except Self-Cert. select both)*	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence
Doc. Att.	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No	☐Yes ☐No

Break Mo./Yr. & Descr. or N/A	Break 1: Break 2: Break 3: If there are additional breaks please detail and attach.
Notes	
Self-Cert. Check	Does the documentation include more than 3 Months of Self-Certifications? * ☐ Yes ☐ No ** Please be advised that if you answered **YES**, that for at least 75% of the households assisted by a recipient in a project during an operating year, no more than 3 months can be self-certified. **Please check with you project administrator to ensure your project has not exceeded its self-certification cap.***
Key	*Mo. = Month, Yr. = Year, Inst. = Institution, Doc. = Documentation, Obsv. = Observation, Comp. = Comparable, Cert. = Certification, Descr. = Description*

Part 3: Disability Status

The term homeless individual with a disability' means an individual who is homeless, as defined in section 103, and has a disability that

- *Is expected to be long-continuing or of indefinite duration;*
  - *Substantially impedes the individual's ability to live independently;*
  - *Could be improved by the provision of more suitable housing conditions; and*
  - *Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;*
- *Is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or*
- *Is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.*

The head of household has been diagnosed with one or more of the following (check all that apply):

☐ Substance use disorder

☐ Serious mental illness

☐ Developmental disability

☐ Post-traumatic stress disorder

☐ Cognitive impairments resulting from brain injury

☐ Chronic physical illness or disability

☐ Other:

Documentation Attached:

☐ Written verification of the disability from a licensed professional;

☐ Written verification from the Social Security Administration;

☐ The receipt of a disability check; or

☐ Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, accompanied by supporting evidence.

Disability Notes:

Part 4: Staff and Client Certifications

Client Certification:

To the best of my knowledge and ability, all the information provided in this document is true and complete. I also understand that any misrepresentation or false information may result in my participation being cancelled or denied, or in termination of assistance. It is my responsibility to notify _____ of any changes in my housing status or address in writing during program participation and I understand that my application may be cancelled if I fail to do so.

Client Name: (Printed)	Client Signature:	Date:

Staff Certification:

To the best of my knowledge and ability, all of the information and documentation used in making this eligibility determination is true and complete.

Staff Name: (Printed)	Staff Signature:	Date:
Staff Role:	**Agency:**	

Notes:

Blue Ridge CoC: Verification of Homelessness

Name of person being referred: _____

This is to certify that the above named individual or household is currently homeless based on the check mark, other indicated information, and signature indicating their current living situation.

Living Situation: A place not meant for human habitation (e.g., cars, parks, abandoned buildings, streets/sidewalks) or a domestic violence situation:

☐ The person(s) named above is/are currently living in a public or private place not designed for, or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus station, airport, or camp ground.

Description of current living situation:

_____

_____

_____

_____

_____

☐ The person(s) named above is/are fleeing from a domestic violence situation and has no subsequent appropriate residence that has been identified and lacks the resources and support networks needed to obtain housing.

Living Situation: Eviction

☐ The person(s) named about is/are facing eviction within 7 days from current housing

☐ Copy of eviction notice is attached (required)

Living Situation: Emergency Shelter

☐ The person(s) named above is/are currently living in a supervised publicly or privately operated shelter as follows:

Emergency Shelter Program Name: _____

Living Situation: Transitional Housing

☐ The person(s) named above is/are currently living in a transitional housing program for persons who are homeless. The persons(s) named above is/are graduating from or timing out of the transitional housing program:

Transitional Housing Program Name: _____

Living Situation: Institution (hospital, prison or other)

☐ The person named above is being discharged from an institution after a stay of **less than** 30 days and was homeless immediately prior to admission in _____Hospital/jail/prison

☐ The person is being discharged within a week from an institution in which the person has been a resident for **more than** 30 consecutive days and no subsequent residence has been identified and the person lacks the resources and support networks to obtain housing.

Self Declaration of Housing Status

☐ I [and my children] am/are currently homeless and living on the street (i.e. a car, park, abandoned building, bus station, airport, or camp ground).

☐ I [and my children] am/are the victim(s) of domestic violence and am/are fleeing from abuse

---

I certify that the information above and any other information I have provided in applying for housing assistance is true, accurate and complete.

☐ A place not meant for human habitation (see above definition)
☐ A domestic violence situation (see above definition)
☐ An emergency shelter (see above definition)
☐ Living situation: Institution, Hospital, Correctional Facility, Other

Client Signature: _____ Date: _____

Agency Staff Signature: _____ Date: _____

Blue Ridge CoC Homelessness Prevention Screening Worksheet

Screening Date: _____

Screening Time: _____ ☐ **In-person** ☐ **Telephone**

Name of Agency and Person Completing Screening: _____

Name of head of household: _____

Contact phone number for head of household: _____ **Address: _____**

1. **In what locality do you live? _____**
2. **Where did you stay last night?** ☐ In own housing – rented ☐ In own housing – owned With friend or family member
   ☐ In an institution (specify): _____ ☐ Hotel/Motel _____ ☐ Other (Specify)_____
3. **Do you have:**

☐ **An eviction notice from the court (must have been to court and/or have notice to vacate within 10 days)**

☐ **A property that has been condemned by a housing official** ☐ **An eviction statement from a friend or family member**

☐ **Hotel/Motel receipts not paid by an agency or institution** ☐ **Proof of foreclosure on rental property and eviction within 14 days**

If yes, what is the date you must vacate? _____ ☐

4. **Have you been literally homeless in the past?** ☐ Yes ☐ No If yes, number of times: _____ When?_____ Where? _____
5. **Have you served in the military?** ☐ Yes ☐ No If yes, what was your discharge status? _____
6. **How many people are in your household?** Total: _____ Adults: _____ Children: _____ Ages of children: _____
7. **Does your household have income?** ☐ Yes ☐ No
8. **What are your household's income sources (must include income for all household members that are not full-time students)?**

   ☐ Social Security: $_____ ☐ Unemployment: $_____ ☐ TANF: $ _____

   ☐ Employment: Hourly wage: _____ Number of hours worked per week: _____

   ☐ Employment: Hourly wage: _____ Number of hours worked per week: _____

   ☐ Child support: $_____ ☐ Veteran's benefits: $_____ ☐ other (specify): $_____

   Total projected gross annual income: _____ _Gross Current Income (Fiscal Year): _____ ___DOH _____
9. **How many months are you behind on your rent? _____ Total amount owed: _____**
10. **Total Deposit needed for move in and First Month's Rent_____**
11. **How much is your monthly rent? _____** **Amount you can pay towards balance: _____**
12. **How many bedrooms are in your home**? _____
13. **Do you have a written, legal lease or deed?** ☐ Yes ☐ No
14. **Do you live in public housing or receive a Section 8 voucher?** ☐ Yes ☐ No
15. **Have you received rental or utility assistance from another source in the last 6 months?** ☐ Yes ☐ No

    If yes, list type of assistance and the period for which it was received: _____

Household is below: ☐ 30% AMI ☐ 50% AMI Referred to: _____ Date of referral: _____

Blue Ridge Continuum of Care Housing Barriers Assessment

Name: _____Assessment type: ☐ New ☐ Recertification Date: _____

This form is intended to assess household needs and to plan case management services accordingly. For each category, check only one level that most closely reflects the household's current situation.

Homelessness	
☐	(5) Multiple evictions or chronically homeless (homeless consecutive 1 year or more, or 4 times in the past 3 years total 12 months minimum, and disabled.)
☐	*(4) One episode of homelessness six months or longer, or one eviction*
☐	(3) Currently homeless less than six months or at imminent risk of becoming homeless, for first time
☐	(2) In transitional, temporary or substandard housing or current housing is unaffordable
☐	(1) Adequate housing, or never been homeless
Housing	
☐	(5) Judgments for past rental expenses
☐	(4) Multiple bad references, or owes past rent and utility bills
☐	(3) One bad reference, or owes for one past bill
☐	(2) No rental history
☐	(1) Good rental references, no rental debt
Income	
☐	(5) History of no income
☐	(4) Inadequate or sporadic income
☐	(3) Able to meet basic needs but not all bills
☐	(2) History of meeting needs, but experienced sudden loss of income or increase in expenses
☐	(1) Income is sufficient, little or no debt
Employment	
☐	(5) Unable to work, or inadequate job skills
☐	(4) History of temporary or seasonal work, or minimal job skills
☐	(3) Receiving disability or unemployment, or not working due to education or training program
☐	(2) Employed but inadequate pay, or adequate job skills
☐	(1) Employed with adequate pay, or good job skills
Education	
☐	(5) No high school diploma/GED
☐	(4) Enrolled in GED program or has high school diploma/GED
☐	(3) Enrolled in other education/training program, expect to finish within 18 months
☐	(2) Some college or certification
☐	(1) College graduate or advanced certification
Transportation	
☐	(5) No access to transportation, public or private
☐	(4) Transportation is available but unreliable or unaffordable
☐	(3) Transportation is available but limited, or driver's license is restricted
☐	(2) Transportation is generally accessible to meet basic needs
☐	(1) Transportation is readily available and affordable
Legal	
☐	(5) Ex-offender and non-compliant with probation/parole
☐	(4) Ex-offender but compliant with probation/parole
☐	(3) Outstanding warrants or current charges/trial pending
☐	(2) Prior arrests but no felony record
☐	(1) No criminal history
Child Care (Score only if children under 13)	
☐	(5) No child care available or affordable

☐ (4)	Child care is unaffordable, or inadequate
☐ (3)	Child care is affordable but not available in time needed
☐ (2)	Child care is affordable and available but on a limited basis
☐ (1)	Reliable, affordable child care is available

Add numbers, divide by total used categories. (5=Highest, 4=High, 3=Medium, 2=Low, 1=Lowest) **Barrier Level**_____

Part 2: Service Needs Assessment (check one box per section)	
Substance Abuse	
☐	Actively using/abusing drugs/alcohol, or avoids/neglects essential life activities due to use
☐	Evidence of persistent or recurrent social, occupational, emotional, physical problems due to use
☐	Actively involved in substance abuse treatment/self help program
☐	Completed treatment and no drug/alcohol use in last six months
☐	No history of substance abuse
Mental Health	
☐	Experiencing severe difficulty in essential life activities, or very unstable
☐	Suspected but undiagnosed mental illness, and persistent difficulty functioning
☐	Current mental health diagnosis with mild to moderate difficulty functioning
☐	Mental health symptoms being managed through treatment, good functioning in wide range of activities
☐	No history of mental illness
Physical Health	
☐	Multiple disabilities/chronic health concerns
☐	Some household members suffer from chronic health conditions/disabilities
☐	Some health issues untreated or currently being addressed
☐	Health issues are treated or have been addressed
☐	No disabilities or health conditions
Health Care	
☐	No medical coverage
☐	Great difficulty accessing medical care when needed
☐	Some members of household have access to health care
☐	All members of household have medical coverage but struggle to cover unreimbursed costs
☐	All members are covered by adequate and affordable health care
Domestic Violence	
☐	History of abuse with multiple partners
☐	Recent or current victim of abuse
☐	Currently undergoing or completed domestic violence counseling
☐	Free from abuser
☐	No history of abuse
Life Skills	
☐	Unable to meet the demands and challenges of daily living
☐	Can meet a few but not all of the demands of daily living without assistance
☐	Can meet most but not all of the challenges of daily living without assistance
☐	Able to meet most of the demands of daily living with or without assistance
☐	Has adaptive and positive behaviors needed to deal effectively with the challenges of daily living
Literacy	
☐	No command of the English language, literacy problems are serious barrier to employment
☐	Enrolled in literacy or English as Second Language programs
☐	Completed literacy or ESL program, developing effective usage
☐	Minimally proficient, language/literacy is a minimal barrier to employment
☐	Full proficiency, can read, write and speak well, no barriers to employment

HOUSING PLAN: INDIVIDUALIZED SERVICE PLAN (ISP)

Goals:

- ☐ Maintain all appointments with medical providers
- ☐ Engage in mental health treatment
- ☐ Take all medications as prescribed
- ☐ Engage in substance abuse treatment
- ☐ Access primary health care services
- ☐ Maintain current employment
- ☐ Increase income through additional employment
- ☐ Enroll in specialized education program
- ☐ Maintain housing by avoiding eviction through prevention funds
- ☐ Apply or re-address for SNAP benefits
- ☐ Access food pantries
- ☐ Apply for WIC
- ☐ Increase income by applying for financial assistance
- ☐ Decrease expenses through identifying areas of over-spending and budgeting
- ☐ Learn how criminal history can affect housing
- ☐ Learn how to explain criminal history to prospective landlords/employers
- ☐ Establish credit history
- ☐ Repair credit history
- ☐ Housing search and placement

Other : _____

Other : _____

REFERRALS PROVIDED:

Referral 1: _____

Referral 2: _____

Referral 3: _____

Referral 4: _____

CASE MANAGER'S NOTES:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Client: _____ Date: _____

Signature of Case Manager: _____ Date: _____

HOUSING PLAN: INDIVIDUALIZED SERVICE PLAN (ISP)

Goals:

- ☐ Maintain all appointments with medical providers
- ☐ Engage in mental health treatment
- ☐ Take all medications as prescribed
- ☐ Engage in substance abuse treatment
- ☐ Access primary health care services
- ☐ Maintain current employment
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- ☐ Maintain housing by avoiding eviction through prevention funds
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- ☐ Apply for WIC
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- ☐ Learn how criminal history can affect housing
- ☐ Learn how to explain criminal history to prospective landlords/employers
- ☐ Establish credit history
- ☐ Repair credit history
- ☐ Housing search and placement

Other : _____

Other : _____

REFERRALS PROVIDED:

Referral 1: _____

Referral 2: _____

Referral 3: _____

Referral 4: _____

CASE MANAGER'S NOTES:

_____

_____

_____

_____

_____

_____

_____

_____

_____

_____

Signature of Client: _____ Date: _____

Signature of Case Manager: _____ Date: _____

Permanent Supportive Housing (PSH)

DISABILITY CERTIFICATION

In order to be eligible for participation in the PSH Program, an applicant must have at least one of targeted disabilities established by HUD for this program **and** must meet HUD's definition of disability. Please verify that the person named below meets these requirements by completing Sections I and II.

Name of Applicant to PSH Program:_____

Section 1: Targeted Disabilities

The applicant has one or more of the following targeted S+C disabilities (please check all that apply)

- ❒ a. SMI – Serious Mental Illness
- ❒ b. CSA – Chronic Substance Abuse
- ❒ c. SMI & CSA
- ❒ d. PWA - AIDS or Related Diseases
- ❒ e. Other – Physical Disability

Section 2: Verification of Disability

I have verified that the applicant is disabled by determining that: (please check only one box)

- ❒ a. The applicant is eligible to receive Supplemental Security Income (SSI) benefits for the targeted disability or disabilities checked above.

  If you checked box (a), a copy of the applicant's SSI determination letter with diagnosis code must be attached.)

- ❒ b. The applicant is not receiving SSI benefits, but has one or more of the targeted disabilities checked above **AND** meets the following definition of disability:

  "Has a physical, mental, or emotional impairment which is expected to be of long-continued and indefinite duration; substantially impedes his or her ability to live independently; and is of such nature that such ability could be improved by more suitable housing conditions."

  If you checked box (b.), this certification must be signed by a professional who is licensed by the state to diagnose the condition and make such a determination.

Signature: _____ Date: _____

Printed Name and Title: _____

Agency/Organization: _____

Administration

Interviewer's Name	Agency	
_____	_____	☐ Team ☐ Staff ☐ Volunteer
Survey Date	**Survey Time**	**Survey Location**
DD/MM/YYYY ____/____/_____	__ __ : __ __	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

PARENT 1

First Name	Nickname	Last Name
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	Age	Social Security Number	Consent to participate
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes ☐ No

PARENT 2

☐ No second parent currently part of the household

First Name	Nickname	Last Name
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	Age	Social Security Number	Consent to participate
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes ☐ No

IF EITHER HEAD OF HOUSEHOLD IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE: 0

Children

1. How many children under the age of 18 are currently with you? _____ ☐ Refused
2. How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed? _____ ☐ Refused
3. *IF HOUSEHOLD INCLUDES A FEMALE:* Is any member of the family currently pregnant? ☐ **Y** ☐ N ☐ Refused
4. Please provide a list of children's names and ages:

First Name	Last Name	Age	Date of Birth

IF THERE IS A SINGLE PARENT WITH 2+ CHILDREN, AND/OR A CHILD AGED 11 OR YOUNGER, AND/OR A CURRENT PREGNANCY, THEN SCORE 1 FOR **FAMILY SIZE**.

IF THERE ARE TWO PARENTS WITH 3+ CHILDREN, AND/OR A CHILD AGED 6 OR YOUNGER, AND/OR A CURRENT PREGNANCY, THEN SCORE 1 FOR **FAMILY SIZE**.

SCORE: 0

A. History of Housing and Homelessness

5. Where do you and your family sleep most frequently? (check one)
   - ☐ Shelters
   - ☐ Transitional Housing
   - ☐ Safe Haven
   - ☐ **Outdoors**
   - ☐ **Other (specify):** _____
   - ☐ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.

SCORE: 1

6. How long has it been since you and your family lived in permanent stable housing? ___ Years ☐ Refused
7. In the last three years, how many times have you and your family been homeless? _____ ☐ Refused

IF THE FAMILY HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.

SCORE: 0

B. Risks

8. In the past six months, how many times have you or anyone in your family...

   a) Received health care at an emergency department/room? ____ ☐ Refused

   b) Taken an ambulance to the hospital? ____ ☐ Refused

   c) Been hospitalized as an inpatient? ____ ☐ Refused

   d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? ____ ☐ Refused

   e) Talked to police because they witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told them that they must move along? ____ ☐ Refused

   f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR **EMERGENCY SERVICE USE.**	**SCORE:** 0

9. Have you or anyone in your family been attacked or beaten up since they've become homeless? ☐ **Y** ☐ N ☐ Refused

10. Have you or anyone in your family threatened to or tried to harm themself or anyone else in the last year? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF HARM.**	**SCORE:** 0

11. Do you or anyone in your family have any legal stuff going on right now that may result in them being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **LEGAL ISSUES.**	**SCORE:** 0

12. Does anybody force or trick you or anyone in your family to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused

13. Do you or anyone in your family ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone they don't know, share a needle, or anything like that? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION.**	**SCORE:** 0

C. Socialization & Daily Functioning

14. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you or anyone in your family owe them money?	☐ **Y**	☐ N	☐ Refused
15. Do you or anyone in your family get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that?	☐ Y	☐ **N**	☐ Refused

IF "YES" TO QUESTION 14 OR "NO" TO QUESTION 15, THEN SCORE 1 FOR **MONEY MANAGEMENT.**	**SCORE:** 0

16. Does everyone in your family have planned activities, other than just surviving, that make them feel happy and fulfilled?	☐ Y	☐ **N**	☐ Refused

IF "NO," THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.**	**SCORE:** 0

17. Is everyone in your family currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that?	☐ Y	☐ **N**	☐ Refused

IF "NO," THEN SCORE 1 FOR **SELF-CARE.**	**SCORE:** 0

18. Is your family's current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because other family or friends caused your family to become evicted?	☐ **Y**	☐ N	☐ Refused

IF "YES," THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS.**	**SCORE:** 0

D. Wellness

19. Has your family ever had to leave an apartment, shelter program, or other place you were staying because of the physical health of you or anyone in your family?	☐ **Y**	☐ N	☐ Refused
20. Do you or anyone in your family have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ **Y**	☐ N	☐ Refused
21. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you or anyone in your family?	☐ **Y**	☐ N	☐ Refused
22. Does anyone in your family have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused
23. When someone in your family is sick or not feeling well, does your family avoid getting medical help?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH.**	**SCORE:** 0

1 (800) 355-0420 info@orgcode.com www.orgcode.com

24. Has drinking or drug use by you or anyone in your family led your family to being kicked out of an apartment or program where you were staying in the past?	☐ **Y**	☐ N	☐ Refused	
25. Will drinking or drug use make it difficult for your family to stay housed or afford your housing?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.**				**SCORE:** 0
26. Has your family ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:				
a) A mental health issue or concern?	☐ **Y**	☐ N	☐ Refused	
b) A past head injury?	☐ **Y**	☐ N	☐ Refused	
c) A learning disability, developmental disability, or other impairment?	☐ **Y**	☐ N	☐ Refused	
27. Do you or anyone in your family have any mental health or brain issues that would make it hard for your family to live independently because help would be needed?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.**				**SCORE:** 0
28. *IF THE FAMILY SCORED 1 EACH FOR PHYSICAL HEALTH, SUBSTANCE USE, AND MENTAL HEALTH:* Does any single member of your household have a medical condition, mental health concerns, **and** experience with problematic substance use?	☐ **Y**	☐ N	☐ N/A or Refused	
IF "YES", SCORE 1 FOR **TRI-MORBIDITY.**				**SCORE:** 0
29. Are there any medications that a doctor said you or anyone in your family should be taking that, for whatever reason, they are not taking?	☐ **Y**	☐ N	☐ Refused	
30. Are there any medications like painkillers that you or anyone in your family don't take the way the doctor prescribed or where they sell the medication?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.**				**SCORE:** 0
31. *YES OR NO:* Has your family's current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you or anyone in your family have experienced?	☐ **Y**	☐ N	☐ Refused	
IF "YES", SCORE 1 FOR **ABUSE AND TRAUMA.**				**SCORE:** 0

E. Family Unit

32. Are there any children that have been removed from the family by a child protection service within the last 180 days?	☐ **Y**	☐ N	☐ Refused
33. Do you have any family legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY LEGAL ISSUES.**	**SCORE:** 0

34. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation?	☐ **Y**	☐ N	☐ Refused
35. Has any child in the family experienced abuse or trauma in the last 180 days?	☐ **Y**	☐ N	☐ Refused
36. *IF THERE ARE SCHOOL-AGED CHILDREN:* Do your children attend school more often than not each week?	☐ Y	☐ **N**	☐ N/A or Refused

IF "YES" TO ANY OF QUESTIONS 34 OR 35, OR "NO" TO QUESTION 36, SCORE 1 FOR **NEEDS OF CHILDREN.**	**SCORE:** 0

37. Have the members of your family changed in the last 180 days, due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that?	☐ **Y**	☐ N	☐ Refused
38. Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY STABILITY.**	**SCORE:** 0

39. Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a family movie, or anything like that?	☐ Y	☐ **N**	☐ Refused
40. After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult...			
a) 3 or more hours per day for children aged 13 or older?	☐ **Y**	☐ N	☐ Refused
b) 2 or more hours per day for children aged 12 or younger?	☐ **Y**	☐ N	☐ Refused
41. *IF THERE ARE CHILDREN BOTH 12 AND UNDER & 13 AND OVER:* Do your older kids spend 2 or more hours on a typical day helping their younger sibling(s) with things like getting ready for school, helping with homework, making them dinner, bathing them, or anything like that?	☐ **Y**	☐ N	☐ N/A or Refused

IF "NO" TO QUESTION 39, OR "YES" TO ANY OF QUESTIONS 40 OR 41, SCORE 1 FOR **PARENTAL ENGAGEMENT.**	**SCORE:** 0

Scoring Summary

DOMAIN	SUBTOTAL	RESULTS
PRE-SURVEY	0 /2	
A. HISTORY OF HOUSING & HOMELESSNESS	1 /2	**Score:** **Recommendation:**
B. RISKS	0 /4	0-3 no housing intervention
C. SOCIALIZATION & DAILY FUNCTIONS	0 /4	4-8 an assessment for Rapid Re-Housing
D. WELLNESS	0 /6	9+ an assessment for Permanent Supportive Housing/Housing First
E. FAMILY UNIT	0 /4	
GRAND TOTAL:	1 /22	

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: __ : ____ or Night
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the adult at some point in the future
- safety planning

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.0

1 (800) 355-0420 info@orgcode.com www.orgcode.com

COMMUNITY SOLUTIONS

ORG CODE

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or types of users. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front-line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

Administration

Interviewer's Name	Agency	
_____	_____	○ Team ○ Staff ○ Volunteer
Survey Date	**Survey Time**	**Survey Location**
DD/MM/YYYY ____/____/_____	__ __ __ __	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	Nickname	Last Name
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	Age	Social Security Number	Consent to participate
DD/MM/YYYY ____/____/_____	_____	_____	○ Yes ○ No

IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE: 0

A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)

- ◯ Shelters
- ◯ Transitional Housing
- ◯ Safe Haven
- ◯ **Outdoors**
- ◯ **Other (specify):** _____
- ◯ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.	SCORE: 1

2. How long has it been since you lived in permanent stable housing? ___ Years ☐ Refused
3. In the last three years, how many times have you been homeless? _____ ☐ Refused

IF THE PERSON HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.	SCORE: 0

B. Risks

4. In the past six months, how many times have you...
   a) Received health care at an emergency department/room? ____ ☐ Refused
   b) Taken an ambulance to the hospital? ____ ☐ Refused
   c) Been hospitalized as an inpatient? ____ ☐ Refused
   d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? ____ ☐ Refused
   e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? ____ ☐ Refused
   f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR **EMERGENCY SERVICE USE.**	SCORE: 0

5. Have you been attacked or beaten up since you've become homeless? ☐ **Y** ☐ N ☐ Refused
6. Have you threatened to or tried to harm yourself or anyone else in the last year? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF HARM.**	SCORE: 0

7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **LEGAL ISSUES.**	**SCORE:** 0

8. Does anybody force or trick you to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused

9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION.**	**SCORE:** 0

C. Socialization & Daily Functioning

10. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? ☐ **Y** ☐ N ☐ Refused

11. Do you get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? ☐ Y ☐ **N** ☐ Refused

IF "YES" TO QUESTION 10 OR "NO" TO QUESTION 11, THEN SCORE 1 FOR **MONEY MANAGEMENT.**	**SCORE:** 0

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.**	**SCORE:** 0

13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **SELF-CARE.**	**SCORE:** 0

14. Is your current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because family or friends caused you to become evicted? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS.**	**SCORE:** 0

D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?	☐ **Y**	☐ N	☐ Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ **Y**	☐ N	☐ Refused
17. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you?	☐ **Y**	☐ N	☐ Refused
18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused
19. When you are sick or not feeling well, do you avoid getting help?	☐ **Y**	☐ N	☐ Refused
20. *FOR FEMALE RESPONDENTS ONLY:* Are you currently pregnant?	☐ **Y**	☐ N	☐ N/A or Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH.**	**SCORE:** 0

21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?	☐ **Y**	☐ N	☐ Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.**	**SCORE:** 0

23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:

a) A mental health issue or concern?	☐ **Y**	☐ N	☐ Refused
b) A past head injury?	☐ **Y**	☐ N	☐ Refused
c) A learning disability, developmental disability, or other impairment?	☐ **Y**	☐ N	☐ Refused
24. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.**	**SCORE:** 0

IF THE RESPONENT SCORED 1 FOR **PHYSICAL HEALTH** AND 1 FOR **SUBSTANCE USE** AND 1 FOR **MENTAL HEALTH**, SCORE 1 FOR **TRI-MORBIDITY**.	**SCORE:** 0

25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? ☐ **Y** ☐ N ☐ Refused

26. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.**	**SCORE:** 0

27. *YES OR NO:* Has your current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you have experienced? ☐ **Y** ☐ N ☐ Refused

IF "YES", SCORE 1 FOR **ABUSE AND TRAUMA.**	**SCORE:** 0

Scoring Summary

DOMAIN	SUBTOTAL	
PRE-SURVEY	0 /1	
A. HISTORY OF HOUSING & HOMELESSNESS	1 /2	
B. RISKS	0 /4	
C. SOCIALIZATION & DAILY FUNCTIONS	0 /4	
D. WELLNESS	0 /6	
GRAND TOTAL:	0 /17	

RESULTS	
Score:	**Recommendation:**
0-3:	no housing intervention
4-7:	an assessment for Rapid Re-Housing
8+:	an assessment for Permanent Supportive Housing/Housing First

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ____ or Night
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the adult at some point in the future
- safety planning

Appendix A: About the VI-SPDAT

The HEARTH Act and federal regulations require communities to have an assessment tool for coordinated entry - and the VI-SPDAT and SPDAT meet these requirements. Many communities have struggled to comply with this requirement, which demands an investment of considerable time, resources and expertise. Others are making it up as they go along, using "gut instincts" in lieu of solid evidence. Communities need practical, evidence-informed tools that enhance their ability to to satisfy federal regulations and quickly implement an effective approach to access and assessment. The VI-SPDAT is a first-of-its-kind tool designed to fill this need, helping communities end homelessness in a quick, strategic fashion.

The VI-SPDAT

The VI-SPDAT was initially created by combining the elements of the Vulnerability Index which was created and implemented by Community Solutions broadly in the 100,000 Homes Campaign, and the SPDAT Prescreen Instrument that was part of the Service Prioritization Decision Assistance Tool. The combination of these two instruments was performed through extensive research and development, and testing. The development process included the direct voice of hundreds of persons with lived experience.

The VI-SPDAT examines factors of current vulnerability and future housing stability. It follows the structure of the SPDAT assessment tool, and is informed by the same research backbone that supports the SPDAT - almost 300 peer reviewed published journal articles, government reports, clinical and quasi-clinical assessment tools, and large data sets. The SPDAT has been independently tested, as well as internally reviewed. The data overwhelmingly shows that when the SPDAT is used properly, housing outcomes are better than when no assessment tool is used.

The VI-SPDAT is a triage tool. It highlights areas of higher acuity, thereby helping to inform the type of support and housing intervention that may be most beneficial to improve long term housing outcomes. It also helps inform the order - or priority - in which people should be served. The VI-SPDAT does not make decisions; it informs decisions. The VI-SPDAT provides data that communities, service providers, and people experiencing homelessness can use to help determine the best course of action next.

Version 2

Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

You will notice some differences in Version 2 compared to Version 1. Namely:

- it is shorter, usually taking less than 7 minutes to complete;
- subjective elements through observation are now gone, which means the exact same instrument can be used over the phone or in-person;
- medical, substance use, and mental health questions are all refined;
- you can now explicitly see which component of the full SPDAT each VI-SPDAT question links to; and,
- the scoring range is slightly different (Don't worry, we can provide instructions on how these relate to results from Version 1).

1 (800) 355-0420 info@orgcode.com www.orgcode.com

OMB Number: 2900-0260
Estimated Burden: 2 minutes

Department of Veterans Affairs

REQUEST FOR AND AUTHORIZATION TO RELEASE MEDICAL RECORDS OR HEALTH INFORMATION

Privacy Act and Paperwork Reduction Act Information: The execution of this form does not authorize the release of information other than that specifically described below. The information requested on this form is solicited under Title 38, U.S.C. The form authorizes release of information in accordance with the Health Insurance Portability and Accountability Act, 45 CFR Parts 160 and 164, 5 U.S.C. 552a, and 38 U.S.C. 5701 and 7332 that you specify. Your disclosure of the information requested on this form is voluntary. However, if the information including Social Security Number (SSN) (the SSN will be used to locate records for release) is not furnished completely and accurately, Department of Veterans Affairs will be unable to comply with the request. The Veterans Health Administration may not condition treatment, payment, enrollment or eligibility on signing the authorization. VA may disclose the information that you put on the form as permitted by law. VA may make a "routine use" disclosure of the information as outlined in the Privacy Act systems of records notices identified as 24VA19 "Patient Medical Record - VA" and in accordance with the VHA Notice of Privacy Practices. You do not have to provide the information to VA, but if you don't, VA will be unable to process your request and serve your medical needs. Failure to furnish the information will not have any affect on any other benefits to which you may be entitled. If you provide VA your Social Security Number, VA will use it to administer your VA benefits. VA may also use this information to identify veterans and persons claiming or receiving VA benefits and their records, and for other purposes authorized or required by law. The Paperwork Reduction Act of 1995 requires us to notify you that this information collection is in accordance with the clearance requirements of section 3507 of the Paperwork Reduction Act of 1995. We may not conduct or sponsor, and you are not required to respond to, a collection of information unless it displays a valid OMB number. We anticipate that the time expended by all individuals who must complete this form will average 2 minutes. This includes the time it will take to read instructions, gather the necessary facts and fill out the form.

ENTER BELOW THE PATIENT'S NAME AND SOCIAL SECURITY NUMBER IF THE PATIENT DATA CARD IMPRINT IS NOT USED.

TO: DEPARTMENT OF VETERANS AFFAIRS (Print or type name and address of health care facility)

Salem VA Medical Center
1970 Roanoke Blvd, Salem, VA 24153

PATIENT NAME (Last, First, Middle Initial)

SOCIAL SECURITY NUMBER

NAME AND ADDRESS OF ORGANIZATION, INDIVIDUAL OR TITLE OF INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

Blue Ridge Continuum of Care (CoC)/ Veterans Boot Camp Team

VETERAN'S REQUEST: I request and authorize Department of Veterans Affairs to release the information specified below to the organization, or individual named on this request. I understand that the information to be released includes information regarding the following condition(s):

☒ DRUG ABUSE ☒ ALCOHOLISM OR ALCOHOL ABUSE ☒ TESTING FOR OR INFECTION WITH HUMAN IMMUNODEFICIENCY VIRUS (HIV) ☒ SICKLE CELL ANEMIA

INFORMATION REQUESTED (Check applicable box(es) and state the extent or nature of the information to be disclosed, giving the dates or approximate dates covered by each)

☐ COPY OF HOSPITAL SUMMARY ☐ COPY OF OUTPATIENT TREATMENT NOTE(S) ☒ OTHER (Specify)

VI-SPDAT Assessment: Housing history, daily functioning, health and wellness, family unit, mental health and substance abuse history, benefits payments, military service information

PURPOSE(S) OR NEED FOR WHICH THE INFORMATION IS TO BE USED BY INDIVIDUAL TO WHOM INFORMATION IS TO BE RELEASED

For housing coordination and placement purposes.

NOTE: ADDITIONAL ITEMS OF INFORMATION DESIRED MAY BE LISTED ON THE BACK OF THIS FORM

AUTHORIZATION: I certify that this request has been made freely, voluntarily and without coercion and that the information given above is accurate and complete to the best of my knowledge. I understand that I will receive a copy of this form after I sign it. I may revoke this authorization, in writing, at any time except to the extent that action has already been taken to comply with it. Written revocation is effective upon receipt by the Release of Information Unit at the facility housing the records. Redisclosure of my medical records by those receiving the above authorized information may be accomplished without my further written authorization and may no longer be protected. Without my express revocation, the authorization will automatically expire: (1) upon satisfaction of the need for disclosure; (2) on 1-30-2016 (date supplied by patient); (3) under the following condition(s):

Verbal and written communication between VAMC and above named organizations.

I understand that the VA health care practitioner's opinions and statements are not official VA decisions regarding whether I will receive other VA benefits or, if I receive VA benefits, their amount. They may, however, be considered with other evidence when these decisions are made at a VA Regional Office that specializes in benefit decisions.

DATE

SIGNATURE OF PATIENT OR PERSON AUTHORIZED TO SIGN FOR PATIENT (Attach authority to sign, e.g., POA)

FOR VA USE ONLY

IMPRINT PATIENT DATA CARD (or enter Name, Address, Social Security Number)

TYPE AND EXTENT OF MATERIAL RELEASED

VI-SPDAT (Vulnerability Index-Service Prioritization Decision Assistance Tool)

DATE RELEASED

RELEASED BY

Blue Ridge Continuum of Care (CoC)
Authorization for Release of Information

When you request or receive services from _____ (agency), we collect information about you and your household that is entered into a computerized database called Blue Ridge Community Assistance Network (BRCAN). This agency and other area agencies that provide services to people who are homeless or at risk of homelessness use this information to identify services and resources that may be of interest to you. This information is also used to improve service coordination and to produce reports.
This form is provided for you to give your permission for your information that is entered in BRCAN to be shared with Partner Agencies. Below is a description of the information that is being collected, how it is shared (with your permission), the purpose for sharing, and how your information is protected.

What information is collected?

Depending on your situation, you may be asked for some or all of the following for you and your household:

- Basic identifying information (examples: name, SSN, driver's license number, date of birth);
- Demographic information (examples: gender, race, ethnicity, veteran status, disability status, household relationships);
- Housing information (examples: prior housing, homeless status, reasons for homelessness);
- Income & Benefit information (examples: sources and amounts of household income, enrollment in benefit programs, employment information); and
- Health-related information (examples: mental and physical health conditions, substance abuse history, HIV status).
- We may add photo(s) of you and any minors for whom you are legally responsible to BRCAN and print photo ID card(s) that can be scanned for services at Partner Agencies.

How is information protected?

- Partner Agencies must abide by relevant state or federal laws protecting client data;
- BRCAN Policies and Procedures establish additional protections for client data including requirements for hardware, software, security, confidentiality, and training;
- Data is entered into BRCAN via a secure and encrypted internet connection; and
- BRCAN data is encrypted and stored in a secured facility.

Why is information collected and how is it used or disclosed?

- To better assess your needs and the needs of others in the community;
- To make it easier for clients to receive services from several agencies;
- To track whether your needs, and the needs of others, are being met;
- To improve the quality of care and service for people who are homeless or at risk of homelessness;
- To better provide or coordinate services among local service providers;
- To perform functions related to payment or reimbursement of services;
- To carry out administrative functions (such as legal, audits, personnel, oversight, and management functions); and
- To conduct research on issues and programs related to homelessness (either on de-identified (anonymous) data or with parties who have signed an agreement to protect your privacy).

Partner Agencies offer a variety of services of interest to our clients. Connecting these agencies through BRCAN makes referrals easier, and decreases duplicative intakes through many programs. By sharing your information with Partner Agencies, you will help them:

- Identify other services or programs you may be eligible for;
- Make it less time-consuming and more convenient for you to access services;
- More accurately count the number of homeless persons, the services available and what other services are needed; and
- Show the people who fund homeless programs that the services are needed and help the agencies to obtain other funding for programs that serve homeless persons.

More rarely, disclosure of BRCAN data may also be permitted:

- As required by law, including in response to lawful court order, court-ordered warrant, subpoena, or summons;
- To avert a serious threat to health or safety; or
- As required by law, to report abuse, neglect, or domestic violence to a governmental authority.

How is information shared?

- Once you sign the Release of Information or provide a verbal release, your record (and the record(s) of any minors for whom you are legally responsible) will be made available to Partner Agencies. If you choose not to sign the Release of Information or provide verbal consent to share your information, only limited information will be made available to Partner Agencies in BRCAN for the purpose of ensuring your record is not duplicated. However, your specific interaction with this Agency will not be available to other Partner Agencies.
- Once your Release of Information expires, your information will not be shared with Partner Agencies, but will be retained indefinitely by the originating agency and the BRCAN administrator (Council of Community Services).
- Other agencies that do not use BRCAN may access your information to assist with coordination of services if they sign an agreement to protect your privacy. At any time, you may revoke your permission to share your information and this will prevent further sharing with all Partner Agencies.
- This policy may be amended at any time and amendments may affect information obtained before the date of the change.
- You may obtain a copy of the information we have about you and any minors for whom you are legally responsible (unless we are unable to provide one due to legal proceedings), as well as request corrections be made to your information.
- A current list of Partner Agencies and the requirements for participation is available by request from BRCAN, and online at: http://www.councilofcommunityservices.com/programs/brcan/participating-agencies
- If you have questions or complaints regarding the privacy or security of your information, you may write directly to:
  Blue Ridge Community Assistance Network, 339 Salem Ave SW, Roanoke, VA 24016
  email: brcan@chrcblueridge.org

Consent

Please review all of the preceding statements and provide your signature if you agree.

_____	_____
Signature of Client or Guardian	Date
_____	_____
Printed name of Client or Guardian	Date of Birth
_____	_____
Signature of Agency Witness	Date
_____	_____
Printed Name of Agency Witness	Expiration Date (7 years from start)

COUNCIL OF COMMUNITY SERVICES

Blue Ridge Continuum of Care
A Place to Call Home

Blue Ridge Continuum of Care (CoC)
Authorization for Release of Information - Family Consent Addendum

Please specify a head of household, and the names and dates of birth for any and all minor children for whom you are legally responsible, below.

Head of Household
Please review all of the preceding statements and provide your signature if you agree.

Signature of Head of Household	Date
Printed Name of Head of Household	Date of Birth
Signature of Agency Witness	Date
Printed Name of Agency Witness	Expiration Date (7 years from start)

Minors' Names and Dates of Birth (please print):

Name	Date of Birth
Name	Date of Birth
Name	Date of Birth

(more listings on the next page)

COUNCIL OF COMMUNITY SERVICES

Blue Ridge Continuum of Care
A Place to Call Home

Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth
Name	Date of Birth