
Blue Ridge
Continuum of Care
Service Area
City of Covington
Alleghany County
Botetourt County
Craig County
City of Salem
City of
Roanoke
Roanoke County
N
W
E
S
0 2.5 5 10 15 20
Miles
Map prepared by the Blue Ridge Interagency Council on Homelessness, March 2016

Blue Ridge Continuum of Care
HOME-Link Best Practice Model

Our collective goal is to achieve and sustain a well-coordinated and efficient community system that assures homelessness is rare, brief and non-recurring and no person is forced to live in a homeless condition.

GUIDING PRINCIPLES

The Blue Ridge CoC HOME-Link team prioritizes and refers individuals and families experiencing homelessness to housing using Blue Ridge CoC guiding principles:

1. Transparent and data driven – the process must be transparent with expectations and outcomes communicated regularly to all stakeholders, including housing service providers and clients. We must use real-time data to drive our decision making, goal setting, and resource allocation.

2. Strength-based & Client-focused – our community supports a client-centered, low-barrier approach to housing that ensures that the needs and well-being of those experiencing homelessness are paramount, and increases self-determination for the client.

3. Easily Accessible – our system will operationalize a shared community vision across the seven-county metro area with clear priorities and community ownership.

4. Housing-focused – through coordination, our system targets appropriate resources by ensuring that every individual and family and youth is linked to the most relevant housing intervention.

5. Evolving Process – our collaborative effort focuses on long-term outcomes including sustainability and support for both providers and clients in housing retention.

ROLES

Chair
Team Coordinator
List Coordinator
Housing Navigators – Agency specific staff

BY NAME LIST

HOME-Link maintains a by-name list of all youth, family, chronic and veteran experiencing homelessness in Blue Ridge CoC. Our by-name list represents the biggest possible universe: everyone experiencing homelessness. A subset of that list -- our priority list -- represents a significantly smaller universe of people who have consented to our assistance, completed required surveys, collected essential documentation for housing, and now engage staff to locate units and enter permanent housing with supports.

How is someone added to the list?

- Providers enter intake questions, VI-SPDAT, and ROI for youth, family, chronic and veteran into HMIS.
- Team members email the List Coordinator the name and HMIS number of a youth, family, chronic and veteran to add the person to the list.
- Providers who do not use HMIS fax or deliver paper intake & VI-SPDAT to List Coordinator.

How do we track veterans on the list?

- The team tracks veterans using three categories:
  - Homeless: Veteran is "homeless" if s/he is unsheltered, in shelter or hospitalized for less than 30 days but came from the streets/shelter. S/he also remains homeless while working with a housing program until moved into permanent housing.
  - Housed: Veteran is "housed" if s/he has moved into permanent housing.
  - Inactive: Veteran is "inactive" if s/he moved out of Blue Ridge CoC, has been incarcerated, or if no contact has been made for 60 days. Team must show that reasonable attempts to locate the veteran prior deferring veteran. Designation should be made for clients who eat at Rescue Mission who may be housed vs clients who have **outreach/shelter** contact and should be identified on the BNL
- Once a veteran is added to the homeless list, s/he is assigned a housing navigator.
- The team matches client with appropriate housing and provides a warm hand-off to the housing provider.
- A new VI-SPDAT is conducted when housing status changes and/or every 6 months. If a client is actively homeless but no longer on the BNL, a new referral should be made.

CONDUCTING THE ASSESSMENT

Assessment Documents:

1. ROI
2. Intake Questions
3. VI-SPDAT

Suggested messaging:

"My name is [___] and I work with a group called [SPECIFY INITIATIVE]. I have a quick survey I would like to complete with you. The answers will help us determine how we may provide assistance. Most

questions only require a "yes" or "no." Some require a one-word answer. The information collected goes into the HMIS, the database for homeless services in Blue Ridge CoC. The primary benefit to doing the survey is that it will give you and me a better sense of your needs and what resources are available to assist you.

Client FAQs

When do I hear back?

- Continue to work with your case manager if you already have one.
- Continue to check in with your case manager.

How do I access services?

- Services may be access through any participating service provider or Central Intake.

DOs and DON'Ts for Explaining VI-SPDAT and Coordinated Assessment

- ✓ Do explain that [HOME-Link] is a collaboration of service providers working to streamline services to connect homeless individuals to resources and housing.
- ✓ Do explain the VI-SPDAT as an assessment that enables our network of service providers to understand needs, eligibility, and assist in matching them to resources.
- ✓ Do ask the client to sign the VI-SPDAT consent form prior to conducting the survey.
- ✓ Do encourage clients to seek out other housing opportunities.
- ✓ Do encourage clients to connect with their case managers.
- ✓ Don't do a VI-SPDAT if the person is not literally homeless.
- ✓ Don't mention a list.
- ✓ Don't mention that people will receive a score after participating in a VI-SPDAT, and don't give the score.
- ✓ Don't guarantee housing to a client or give them a timeframe in which they will be housed.
- ✓ Don't say what programs can offer (i.e. RRH can pay for a year) - offer general explanation of program so clients can be informed
- ✓ Don't tell a client that the most vulnerable are being prioritized for housing. Please remember that we are using the VI-SPDAT to match to appropriate housing.

CASE CONFERENCING MEETING

1. To ensure holistic, coordinated, and integrated assistance across providers for all persons experiencing homelessness in the community;
2. To review progress and barriers related to each person's housing goal;
3. To identify and track systemic barriers and strategize solutions across multiple providers;
4. To clarify roles and responsibilities and reduce duplication of services.

HOME-Link, a workgroup of the Blue Ridge CoC, consists of staff from multiple agencies directly working with youth, family, chronic and veterans experiencing homelessness, including: intake, outreach, shelters, SSVF, HUD-VASH, veteran organizations and employment providers within Blue Ridge CoC.

Case Conference meetings is a place to review cases of youth, family, chronically homeless and veterans. This provides a safety net for individuals where the tool did not reveal the full depth and/or urgency of the situation, not a side door to the process. HOME-Link members will have to demonstrate professional judgment in this process. Conferencing provides some element of individual attention and conversation in this process, but at the same time still maintains a uniform, transparent process. The process will be person-centric, not program-centric (i.e., the end result will not always be RRH or PSH placement, but rather to match a person to the appropriate housing resource).

MEETING PREPARATION

1. Members will work to complete intake form, VI-SPDAT, on each client to be presented. Each member will maintain a record of the completed form (along with the signed ROI) at their respective agency. If the case manager is unable to complete the form in its entirety, he/she should be prepared to discuss the key components of the report, including: History of Housing and Homelessness, Risks, Socialization and Daily Functions, and Wellness

    a. Each agency representative will forward to the Team Coordinator the number of cases to be presented at the next meeting 2 days before the scheduled date, including size of household and VISPDAT score (if applicable).

    b. Agency representatives are encouraged to also forward any previous cases that have been housed but require additional stabilization services.

2. Upon receipt, the **Chair** will establish an agenda for the meeting. The **Team Coordinator** will direct the case conferencing, including the number of cases to be presented, prioritizing clients based on the identified target populations. The **List Coordinator** will analyze and provide data for the meeting.

MEETING STRUCTURE

1. Previous Cases – The Team Coordinator will ask for any updates on clients who were discussed at the previous meeting to identify the successes of the service coordination as well as gaps within the system. This will include:

    a. Current status: For example: active in shelter, active unsheltered, missing and whether that status has changed since the last case conference review
    b. Critical Housing Placement Barriers: Review and problem-solve any barriers to housing placement.
    c. Critical Service Barriers: Review and problem-solve any challenges to connecting client to critical services.
    d. Current Safety: Make sure any unsheltered person has a safe place to stay tonight and in near term.
    e. Next Steps: Identify any immediate or critical action items related to the individual/family, including roles and timelines.

2. New Cases

    a. The Team Coordinator will call on case managers who have identified clients as youth, family, chronic and veteran, beginning with the client with the highest VI-SPDAT score.
    b. Case managers will state if the client has a signed Release of Information on file consenting to the sharing of basic information with members of the workgroup. If a copy is on file, the case manager will proceed to present basic information on the case for which they are seeking assistance. What information? ***The discussion should remain focused on the clients' needs as they relate to housing.***

3. After discussion, the Team Coordinator will conclude each case by summarizing a housing plan and identifying the parties responsible for each step required to place the client in housing. The Team Coordinator and List Manager will record the plan for each client presented so that updates may be given at the next meeting.

4. The List Coordinator will provide statistical data and number of clients housed, number inactive, etc.

After the Meeting

1. Providers will work together to complete steps provided by the housing plan established at the meeting.
2. Providers who accepted referrals at the meeting will email updates to the Chair regarding the successes and/or failures with the referral.
3. The Team Coordinator and List Manager will keep track of accomplishments as well as services still needed to acquire or maintain housing to be presented at the following meeting.

Dos and Don'ts of Case Presentation

DO present basic client information, including: Gender, Age, Location, Length of time of homelessness, Income, Barriers to housing.	DON'T use names or other client identifiers without a Release of Information.
DO present immediate client needs, including: Food, Employment, Shelter, and Housing.	DON'T present personal information that does not directly affect the housing and/or stabilization plan.
DO solicit input from participating providers to address barriers and immediate needs.	DON'T coordinate a housing and/or stabilization plan outside of meetings without opening a case with the Committee. Immediately open the case and then make housing plans as it will get a client housed faster)
DO identify a concrete service plan for each individual presented.	DON'T conclude a case without addressing solutions to housing barriers.
DO provide updates on clients discussed at previous meetings to track success and gaps.	DON'T forget to close cases as they are completed.

Dos and Don'ts for Updates

Do write an update for each veteran you are navigating	Don't not provide an update
Do include pertinent information including any changes in income, employment, location change, housing applications completed, etc.	Don't say "No update"
Do communicate attempts to contact veteran	
Do communicate "no change" in a veteran	
Do send an update when a veteran is housed- include date housed and how they were housed (HUD VASH, SSVF, Self-resolved)	
Do acknowledge that if the VI-SPDAT score is not reflective of the individual's case management needs. Communicate if a higher level of care is needed.	
Do look over the spreadsheet weekly and if are working with a veteran that is not on the spreadsheet, contact Lis	

PRIORITIZATION PROCESS

Assistance is prioritized based on vulnerability and length of homelessness to ensure that people who need assistance the most receive it in a timely manner.

Priority for Permanent Supportive Housing is given to:

- Chronically homeless with longest history of homelessness (determined by HMIS data and case manager input) and most service need (determined by VI-SPDAT score and case manager input).

Tie breakers:

- Unsheltered individuals will be prioritized for PSH.
- Older individuals will be prioritized for PSH.

Questions to ask when prioritizing:

- Where are they currently staying? How do you know?
- When did you last see them? How did they look? How are they doing?
- What is their case management need?

Priority for Rapid Rehousing is given to:

- Highest ViSPDAT of youth, family, chronic and veteran with medium level case management need.
- Supportive Services for Veteran Families has a different prioritization process based on program regulations. (See SSVF section below.)

Tie breakers:

- Unsheltered homeless.
- Homeless families.
- Families with school-age kids will be prioritized for RRH
- Individuals with steady income and low housing barriers (not allowable under SSVF)

Questions to ask when prioritizing:

- Where are they staying? Identify need for VOH.
- Does client have $650 per month minimum income? (not allowable under SSVF)
- Does client have more than $500 in assets (checking, savings, RM savings, cash on hand, deeds to property)?
- Does client have high barriers to housing (violent felony convictions, drug trafficking charges, Registered Sex Offender)?
- Is the client interested in rapid rehousing?
- Is the client willing to sign a lease?
- Does the client have the needed documents for housing? Photo ID, SS card, proof of income, assets verifiable.
- Will the client have the ability to meet with housing coordinator and search for housing?

- If the client does not have income, are they willing to look for employment? (Cannot refer until they do.) (except under SSVF)
- If needed, does the client have a payee or are the willing to get one?

MATCHING PROCESS

Procedures for PSH:

Prioritization using above priorities:

1. The team discusses the newly added youth, family, chronic and veteran and determines who should be prioritized for PSH based on length of homelessness and service needs (e.g. severity of health and behavioral health challenges, frequent interactions, difficulty engaging).

2. When a housing resource is available, the veteran who is prioritized as the most in need of PSH and has a completed application and documents will be selected.

Procedures for RRH:

1. The team discusses the newly added youth, family, chronic and veteran and determines who should be prioritized for RRH based on service needs (e.g. severity of health and behavioral health challenges, frequent interactions, difficulty engaging).

2. Once a person is identified as document-ready, they are eligible to be matched to housing resources. Shelters and HAT make direct referral to CHRC for RRH using provided form. Other agencies refer client to HAT for referral. Documents are provided and application and intake is completed, if eligible, housing assistance is provided.

Procedures for SSVF Prevention:

1. Referrals to other agencies must be made prior to initiating SSVF prevention intake.
2. SSVF Prevention Eligibility screening is performed.
3. If qualifies for SSVF eligibility, SSVF intake is competed. Physical, mental, substance abuse, domestic violence, and legal assessments are completed. Financial assessments and landlord/tenant rights are covered. All covered SSVF services will be explained to veteran. Exploration with veteran for increased income possibilities is completed. Intake packet is given to veteran.
4. Paperwork needed: 5 day pay or quit, unlawful detainer, or eviction notice. Veteran VA ID if has, Photo ID for all adults in the home, social security cards for everyone in the home. DD214 or regional service letter, letter for proof of income or last 3 paystubs, and letter from food stamps stating amount received if has food stamps.
5. SSVF will prioritize services for participants with service needs and SSVF funds available for that time frame.

6. Housing case manager will contact landlord to get all of the documents needed signed from landlord.
7. Check(s) will be sent to landlord.
8. SSVF case manager will follow up with veteran for at least 90 days to help support stabilization.

Procedures for SSVF Rapid Rehousing

1. Referrals are received from collaborative agencies.
2. Intake is completed. VI-SPDAT will be completed if veteran has not completed one. Physical, mental, substance abuse, domestic violence, and legal assessments are completed. Financial assessments and landlord/tenant rights are covered. All covered SSVF services will be explained to veteran. Exploration with veteran for increased income possibilities is completed. Intake packet is given to veteran.
3. Paperwork needed: verification of homelessness, Veteran VA ID if has, Photo ID for all adults in the home, social security cards for everyone in the home. DD214 or regional service letter, letter for proof of income or last 3 paystubs, and letter from food stamps stating amount received if has food stamps.
4. SSVF will prioritize based on VI-SPDAT scores and SSVF funds available for that time frame.
5. SSVF and veteran will begin housing search. Housing is per veterans' discretion.
6. Housing case manager will contact landlord to get all of the documents needed signed by landlord.
7. Check(s) will be sent to landlord.
8. SSVF case manager will follow up with veteran family for at least 90 days unless another viable case manager has been identified such as HUD/VASH case management.

Blue Ridge Continuum of Care
A Place to Call Home

HELPFUL INFORMATION

Definitions:

- **Homeless**: Person staying in a place not meant for human habitation (car, tent, bench, etc.), emergency shelter, or transitional shelter.

- **Chronically homeless (CH)**: Person with a disability that is staying in a place not meant for human habitation, in an emergency shelter, or a safe haven for the last 12 months continuously or four times in the last three years totaling at least 12 months.

- **Permanent Supportive Housing (PSH)**: Subsidized housing with support services for chronically homeless individuals and families.

- **Rapid Rehousing (RRH)**: Permanent housing with short-term financial assistance and case management for individuals and families experiencing homelessness.

- **Homeless Management Information System (HMIS)**: Bowman Service Point HMIS is a client-level database for homeless service providers.

- **Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)**: helps recommend individuals for housing interventions, moving the discussion from who is eligible to who is eligible and in greatest need of that intervention.

- **Supportive Services for Veteran Families (SSVF):** Rapid Rehousing assistance for youth, family, chronic and veteran, including single individuals and families.

- **HUD-Veterans Affairs Supportive Housing (HUD-VASH)**: This program combines Housing Choice Voucher (HCV) rental assistance for homeless Veterans with case management and clinical services provided by the Department of Veterans Affairs (VA).

Contact Info:

- **HOME-Link Co-Chairs:** Carol Tuning, City of Roanoke – carol.tuning@roanokeva.gov and Tanyia Jones – Salem VA Medical Center; Tanyia.Jones@va.gov
- **HOME-Link List Coordinator:** Susan Trout, Central Intake – susan.trout@roanokeva.gov