Coordinated Entry System
Policies and Procedures

Focusing resources and expertise based on need to effectively end homelessness throughout the community

Policies and procedures outlining a collaborative approach to ending homelessness

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Background

Coordinated Entry is a process designed to coordinate participant intake, assessment, provision of referrals and housing placement. It covers a geographic area, is easily accessed by individuals and families seeking housing services, is well advertised and includes a comprehensive and standardized entry tool.

Coordinated Entry is possible regardless of the geography, available housing and services or unique community characteristics. Coordinated Entry can be molded to fit almost any community or situation and – with patience, persistence, testing and tweaking – can be successful.

When implemented correctly, Coordinated Entry moves beyond the "first come, first served" approach to one that looks across the community to serve those in most need.

This document acts as the policies and procedures for the Coordinated Entry System (CES) for the South Carolina Upstate Homeless Coalition Continuum of Care service area which includes the counties of:

- Abbeville
- Anderson
- Cherokee
- Edgefield
- Greenville
- Greenwood
- Laurens
- McCormick
- Oconee
- Pickens
- Saluda
- Spartanburg
- Union

The Upstate Continuum of Care (CoC) has four designated chapters within its geography:

- Greenville/Laurens chapter;
- Tri-County chapter (consisting of Anderson, Oconee, and Pickens counties);
- CUS chapter (consisting of Cherokee, Union, and Spartanburg counties); and
- GAMES chapter (consisting of Greenwood, Abbeville, McCormick, Edgefield, and Saluda counties)

This document will be a living document that is subject to change as our communities grow and change, learning what works well and what should be changed to work better.

Intention

In implementing a process of Coordinated Entry, our CoC's aim is to end homelessness in the community by changing the system to improve how we assign housing opportunities based on appropriate common tools and effective targeting efforts.

The intention of Coordinated Entry is to:

- **Target** the correct housing intervention to the correct individual and/or family, particularly for those with high acuity and high need
- **Divert** people who can solve their own homelessness away from the system
- Greatly **reduce the length of time people are experiencing homelessness** by quickly moving people into the appropriate housing
- Significantly **improve the possibility of housing stability** by targeting the appropriate housing intervention to the corresponding needs

Coordinated Entry brings together the strength of community services and resources. When communities come together to implement a coordinated entry system, programs, participants and the community at large can benefit:

- Better referrals/eligible participants
    - Programs receive referrals for participants whose basic eligibility and basic housing needs have been determined through the entry assessment process.
    - The autonomy and unique nature of programs as they operate within the system become a strength, not a hindrance.
- Administrative obstacles and traditional barriers to services are reduced
    - The most vulnerable in our community are prioritized for available housing.
    - There is a shift in focus from housing readiness to Housing First principles (please see **Appendix B** for a description of these principles).
- Case Managers can concentrate on providing effective case management
    - Every program in a community is sharing the work of intake and entry
- Service providers are joined into a more unified network
    - Different programs across a community all follow the same process for entry.
    - Programs are well aware of each other and cooperate in the provision of services to participants.
- Communities readily see what additional resources they need most
    - Numerous participants with mid-level acuity may signal a need for more rapid re-housing.
    - Numerous participants with high-level acuity may mean a need for more permanent supportive housing.

- Community success in ending homelessness is significantly increased
    - Targeting our limited community resources in a more deliberate way leads to quicker and more effective long-term housing outcomes.

Target Population

In the first year of implementation, the Coordinated Entry System is intended to serve individuals and households currently experiencing homelessness, as defined in accordance with the official HUD definition of this term. The CoC plans to expand its target population in the second year of CES implementation, to include those who are at *imminent risk of homelessness*.

The CES process is intended to quickly triage people in a housing crisis to available resources.

Individuals and households experiencing homelessness will enter the system, be assessed and referred to available housing options.

Individuals and households who are at imminent risk of homelessness will be referred to available community resources to help prevent a homeless episode.

Requirements

All Continuum of Care (CoC) and Emergency Solutions Grant (ESG) funded projects must participate in the Upstate Homeless Coalition's Coordinated Entry System. In order to develop a true community-wide response system we welcome and will continue to invite all housing programs serving people experiencing homelessness to join the system.

Please reach out to United Housing Connections (info@unitedhousingconnections.org), the lead agency for the Upstate Homeless Coalition CoC, if your agency and projects would like to participate.

Basic Process

Coordinated Entry follows this basic process:

1. **Access**
    a. Provides entry points into the homeless crisis response system for housing needs

2. **Assess**
    a. Uniform assessment(s) for all persons requesting assistance:
        i. Housing Barrier Questions
        ii. Diversion and prevention activities to minimize entries into the crisis response system
        iii. VI-SPDAT assessment to determine prioritization order

3. **Assign with Participant-Centered Choice**
    a. Prioritization of individuals and household for available housing openings and rapid placement into housing

4. **Accountability**
    a. Acceptance of referrals, adherence to the process, measurement of time, outcomes and needs data

Please see **Appendix C** for a more detailed summary of the Coordinated Entry process for individuals and families.

Access Points

Access points are locations where people who are experiencing homelessness or at risk of becoming homeless go to determine eligibility for emergency services.

In the South Carolina Upstate Continuum of Care, certain providers and programs may serve as an access point for participants to help with emergency housing needs. These access points work in partnership with a person's existing community providers to complete the CES assessment process. Please refer to **Appendix D** for a current list of agencies and programs serving as access points into the Upstate SC Coordinated Entry System.

All street outreach teams and emergency shelters serve as CES access points. Resources and information about the CES is provided to 24 hour establishments, restaurants, hospitals, hot meal programs, churches, schools, check cashing locations and other places known to be frequented by the target population. In addition, each access point is encouraged to explore various outreach activities such as hosting a booth at local community events, resource fairs, festivals and county fairs to provide information and resources.

When an individual actively fleeing domestic violence presents at a non-victim service organization, the organization should make every effort to connect the individual with a victim's services provider. The services provided may be shelter, but may also be advocacy, safety planning and peer counseling. If, when an assessment is being conducted, a household is determined to be at imminent risk of harm due to domestic violence, the CES assessor should immediately connect the household to Domestic Violence Services by calling the local domestic violence hotline (see **Appendix E**) or 211 with the household and tending to their immediate transportation and security needs. Defined access points must provide directly – or make arrangements through other means to ensure universal access to – crisis response services for participants seeking emergency assistance during operating hours.

If it is after hours, the following should occur:

- People presenting at an emergency shelter are offered a bed in the emergency shelter where they arrived (if they are population-appropriate). If they are not population-appropriate, they are referred to a shelter that is population-appropriate or has available space.
    - If no shelter has available space, the presenting participant is sent to any available crisis housing (churches, hotels or motels, etc.).
    - If the participant does not initially present at an emergency shelter, he/she is referred to a population-appropriate one.
- All physical access points and the hotline must maintain after-hours answering services that provide information on accessing emergency shelters.

The next available day that assessment hours are open, the participant is asked the pre-screening questions and, if needed, referred to a designated access point for assessment.

As the initial point of contact for participants in the coordinated entry system, access points are likely to get questions from people asking about their status of the prioritization list and when they will be referred to housing. In these instances, organizations should be able to:

- Check the HMIS to determine if the individual or household has a VI-SPDAT completed within the past six months
    - If yes, communicate to the individual or household that they are current in the system and will be contacted if appropriate housing or services become available
    - If no, work with them to complete a standard intake process and VI-SPDAT assessment
    - If older than 6 months, work the individual/household to complete an updated assessment
- Confirm that the living situation and contact information for the individual/household is current and up-to-date.

Providers should not communicate the individual's or household's number or placement on the prioritization list as this placement may change frequently as new assessments are entered into the system.

When supportive housing is not immediately available, individuals and households seeking these resources may be connected with United Housing Connections' Intake and Referral department to be assisted in identifying more readily available temporary housing options.

Common Assessment Process

A. Development and Revision of Tools

In collaboration with the other Continuums of Care in South Carolina, the Upstate CoC has opted to use the Vulnerability Index and Service Prioritization Decision Assessment Tool (VI-SPDAT) as the primary tool for gauging participant vulnerability. The selected set of Housing Barrier Questions was adopted from a local housing provider. These two tools will remain in place for the first year of CES implementation (through June 30, 2017), after which time the Program/Coordinated Entry Committee will solicit formal feedback from providers and participants to inform any necessary revisions.

B. Screening for Diversion and Prevention

- Initial practice (the first year of CES implementation) – All shelters assist households to prevent entry into homelessness whenever possible by connections with prevention and diversion resources available in the community.
- Advance practice – All shelters utilize the CoC Diversion and Prevention tool during the initial contact with households seeking shelter.

C. Shelter and other emergency needs

In the first year of implementation, emergency shelters are not required to follow the established prioritization criteria to place persons in emergency or seasonal beds. If the offered prevention and diversion resources do not resolve a person's need for housing, access point staff should connect the participant to local emergency shelter resources to solve their immediate housing crisis while longer term resources (rapid rehousing, transitional, permanent supportive housing) are explored.

D. Housing Resources and Barriers

Access point staff work with persons in need of housing to complete a series of questions to identify potential barriers that might prevent them from entering or maintaining housing. This questionnaire is administered either at shelter entry or through linkage with outreach team, or within 3 days to help identify housing challenges that may be resolved without financial assistance (please sees **Appendix F** for a detailed list of Housing Barrier Questions).

E. Evaluating Vulnerability

The Vulnerability Index and Service Prioritization Decision Assessment Tool (VI-SPDAT) Prescreen tool is the prioritization assessment used by all participating programs for people who enter the homelessness system.

The VI-SPDAT Prescreen provides each point of entry, shelter, outreach and transitional housing program the ability to determine – across dimensions – the acuity of an individual or family who is experiencing homelessness.

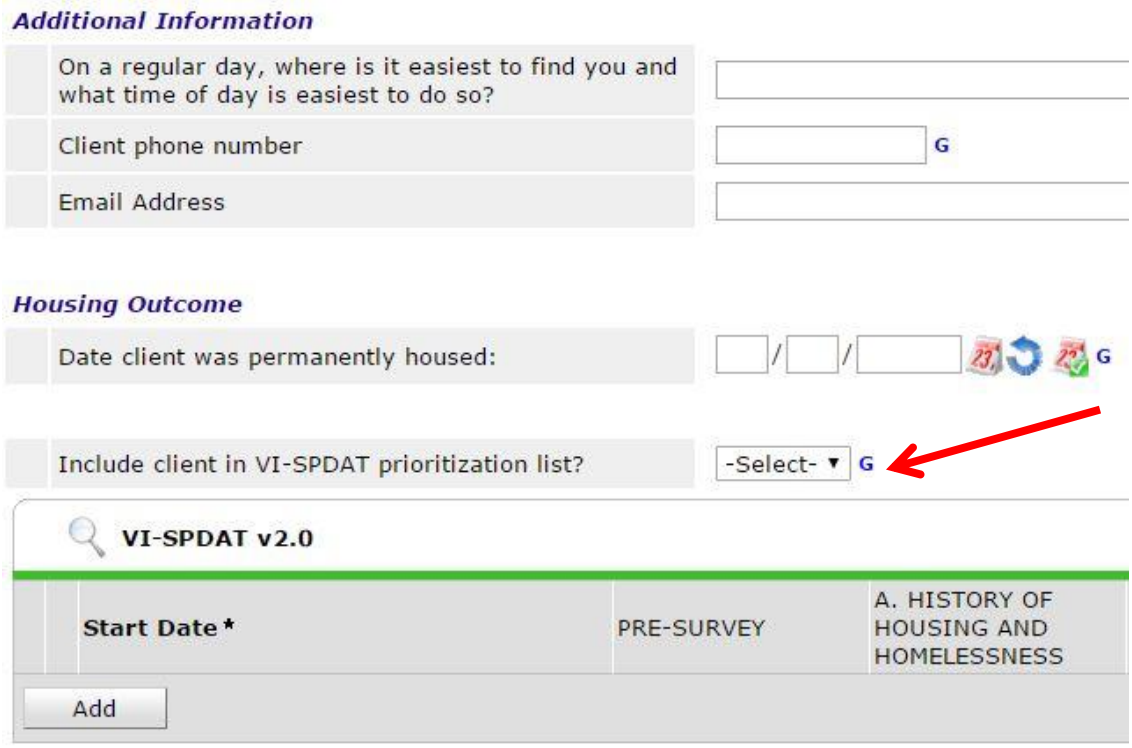
Acuity speaks to the severity of a presenting issue(s). In the case of an evidence-informed common entry tool like the VI-SPDAT, acuity is expressed as a single score with a higher number representing more complex, co-occurring issues that are likely to impact overall housing stability. The VI-SPDAT shows the presence of these issues and indicates the potential best fit for housing and service intervention, based on scores across the following dimensions:

- **Wellness**: Chronic health issues and substance use
- **Socialization and Daily Functioning**: Meaningful daily activities, social supports and income
- **History of Housing and Homelessness**: Length of time experiencing homelessness and cumulative incidences of homelessness
- **Risks**: Crisis, medical, and law enforcement interdictions. Coercion, trauma and most frequent place the individual has slept
- **Family Unit** (Family VI-SPDAT Only): School enrollment and attendance, familial interaction, family makeup and childcare

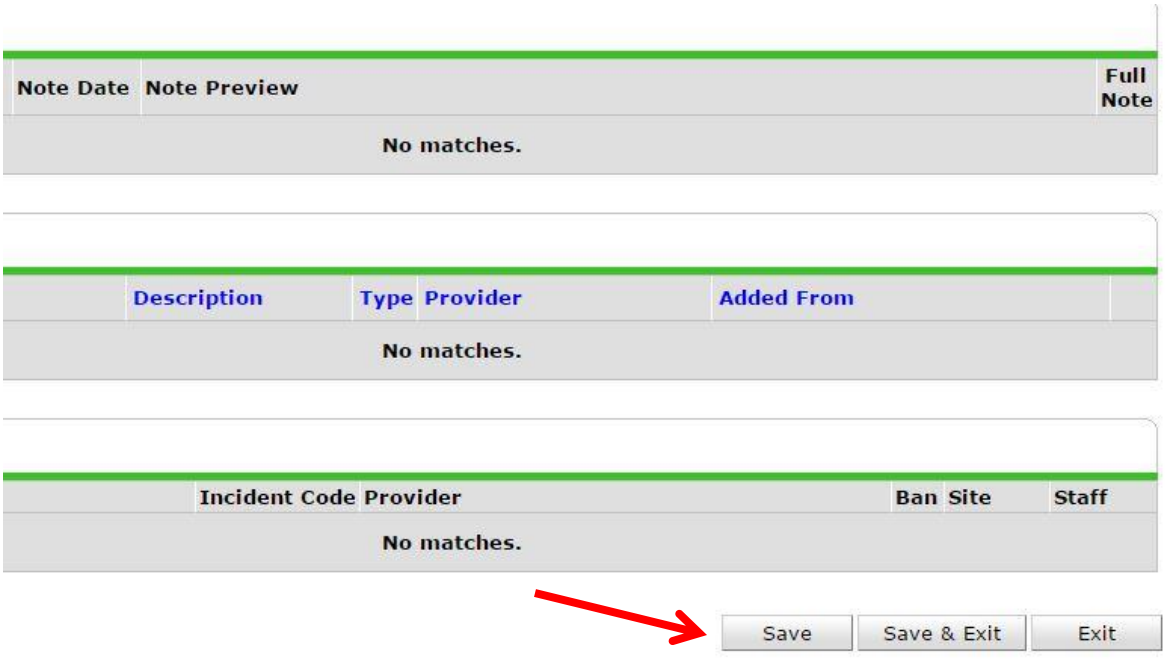
The VI-SPDAT assessment form is located in the CoC HMIS software (ServicePoint) and is accessible to all projects with a user license. Paper copies can also be obtained from the assessment developer's website (http://www.orgcode.com/product/vi-spdat/).

All assessments completed using the VI-SPDAT are stored in ServicePoint HMIS, building a community-wide prioritization list for housing. When a VI-SPDAT prescreen assessment is completed for anyone entering the homeless services system, ServicePoint users can tag the VI-SPDAT to be included in their local prioritization list.

In HMIS, the VI-SPDAT is located as a sub-assessment within the UHC-Coordinated Entry assessment on the Client Profile tab. In order for the VI-SPDAT score to be included on the local prioritization list, ServicePoint users must answer "yes" to the question "Include client in VI-SPDAT prioritization list?":



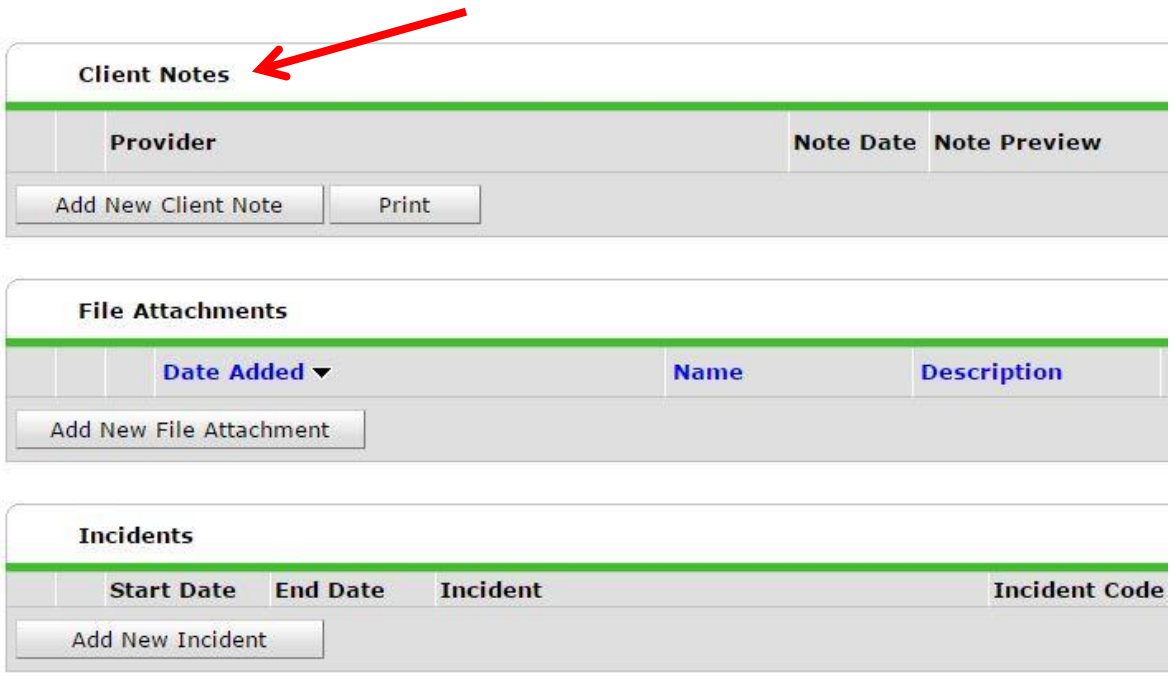
All responses to the UHC-Coordinated Entry assessment must be saved when navigating away from the Client Profile tab in order for the scores to be saved within the HMIS and attached to the client record:



Street outreach workers and providers not actively participating in HMIS may refer participants to the UHC Intake and Referral team to complete a VI-SPDAT and be entered into HMIS for consideration of the community-wide prioritization list.

Participants have the right to refuse to provide any requested information in the coordinated entry process. However, the case manager or staff person conducting the intake should ensure that the participant understands that incomplete information could result in an inaccurate assessment of the participant's housing needs and vulnerability, potentially lowering their placement on the prioritization list.

The VI-SPDAT should not be administered more than once every six months for the purposes of placement on the housing prioritization list. If a participant experiences a change in circumstances that may significantly impact his or her vulnerability score, these changes should be noted in the Client Notes section of HMIS by the most current service provider:



Participants with multiple VI-SPDAT scores over a six-month period are assessed for housing using the earliest score within that timeframe.

Training is strongly encouraged and provided as requested, but projects may utilize the form without formal training. We request that each project have a point person to train new project staff who will be completing the VI-SPDAT forms.

VI-SPDAT Training Resources:
http://100khomes.org/resources/vi-spdat-prescreen-tool-training
http://www.orgcode.com/course/vi-spdat-v1-training/

Prioritization Process, Criteria and List

For the purposes of coordinated entry, one prioritization list is maintained for the entire CoC. Referrals can be made across chapters based on the availability of services within an area, as well as participant preferences and needs. The Upstate has adopted HUD CPD Notice 16-11 along with the Final Rule on Chronically Homeless. As such it is acceptable to move down the vulnerability order in the event no chronically homeless persons are identified at the time of a vacancy.

A Housing Determination Committee (HDC), composed of representatives from the identified access point agencies, is responsible for managing the CoC-wide prioritization list. Each CoC chapter must designate at least one member to the Housing Determination Committee, for a minimum total membership of four persons and a maximum membership of eight persons. This group coordinates across chapters to match persons on the prioritization list to available housing opportunities regardless of geography. Internal transfers within an agency DO NOT require Housing Determination Committee approval. However, agencies do not have discretion to switch between RR, TR and PSH during placement unless the assignment is verified by the Committee.

The Housing Determination Committee has a standing weekly meeting – either in person or via conference call. They review the priority list and determine the next prioritized and potentially eligible person to be referred to any vacancy. Agencies and programs with housing vacancies should notify the Housing Determination Group by forwarding the CES vacancy form (appendix G) to CES@unitedhousingconnections.org
Housing Determination Committee also reviews any instance where referral is made but does not happen. There is no consequence to participants choosing not to accept a referral.

Case managers for participants may attend the weekly prioritization list review meetings to provide additional information to the group but do not have a vote in the group's final decision for housing interventions and placements.

Participants may provide updates on their housing status or change in circumstances to their case manager but do not need to check in to inquire about bed/housing availability or their status on the prioritization list.

Participants are assessed for prioritization in accordance to the U.S. Department of Housing and Urban Development (HUD) prioritization notice for chronic homelessness, consisting of four main criteria:

A. Vulnerability
B. Severity of service needs
C. Chronic homeless status
D. Length of time homeless

In the event a client scores for PSH, but no such resource is available, the HDC may offer Rapid Rehousing or targeted Transitional Housing. Using case conferencing the HDC will match to the resource as appropriate.

Where necessary, in rare cases, the HDC may decide to use RR as a bridge only. In such cases the client would remain active for prioritization consideration for PSH.

Where a client scores for PSH but is not deemed chronic (either because they do not have length of time homeless or do not have a disability) HDC may opt to offer Rapid Re-housing or where appropriate targeted Transitional Housing.

Figure 1 documents the sequence of prioritization criteria by program type:

Figure 1: Upstate CoC Coordinated Entry System
Prioritization Criteria for Specific Housing Types

PERMANENT SUPPORTIVE HOUSING (PSH)

PSH unit becomes available
- ↘Determine number of Bedrooms in PSH unit
  - ↘Determine all Chronically Homeless that need same Bedroom size for unit available
    - ↘Determine who of those Chronically Homeless has the highest VI-SPDAT score
      - ↘Veteran Status = Yes
        - ↘Longest Length of Homelessness
          - ↘Select homeless living in Streets vs. living in Shelter

TRANSITIONAL HOUSING (TH)

TH unit becomes available
- ↘Determine number of Bedrooms in TH unit
  - ↘Determine highest VI-SPDAT score in Range (4-7) that need same Bedroom size for unit available
    - ↘Veteran Status = Yes
      - ↘Longest Length of Homelessness
        - ↘Select homeless living in Streets vs. living in Shelter

RAPID REHOUSING (RRH)

RRH funds become available to support short-term rental assistance
- ↘Determine highest VI-SPDAT score in Range (4-7)
  - ↘Veteran Status = Yes
    - ↘Longest Length of Homelessness
      - ↘Select homeless living in Streets vs. living in Shelter

Referrals and Resources

Making a referral is the process by which a participant is placed into housing. Participant choice should be at the center of any referral and placement, with the participant fully understanding the next steps in their journey toward stable housing.

All referrals can be processed using ServicePoint HMIS functionality. For those agencies not participating in the HMIS implementation, referrals must be processed over the phone. For HMIS-implemented agencies, communication outside of HMIS is not required.

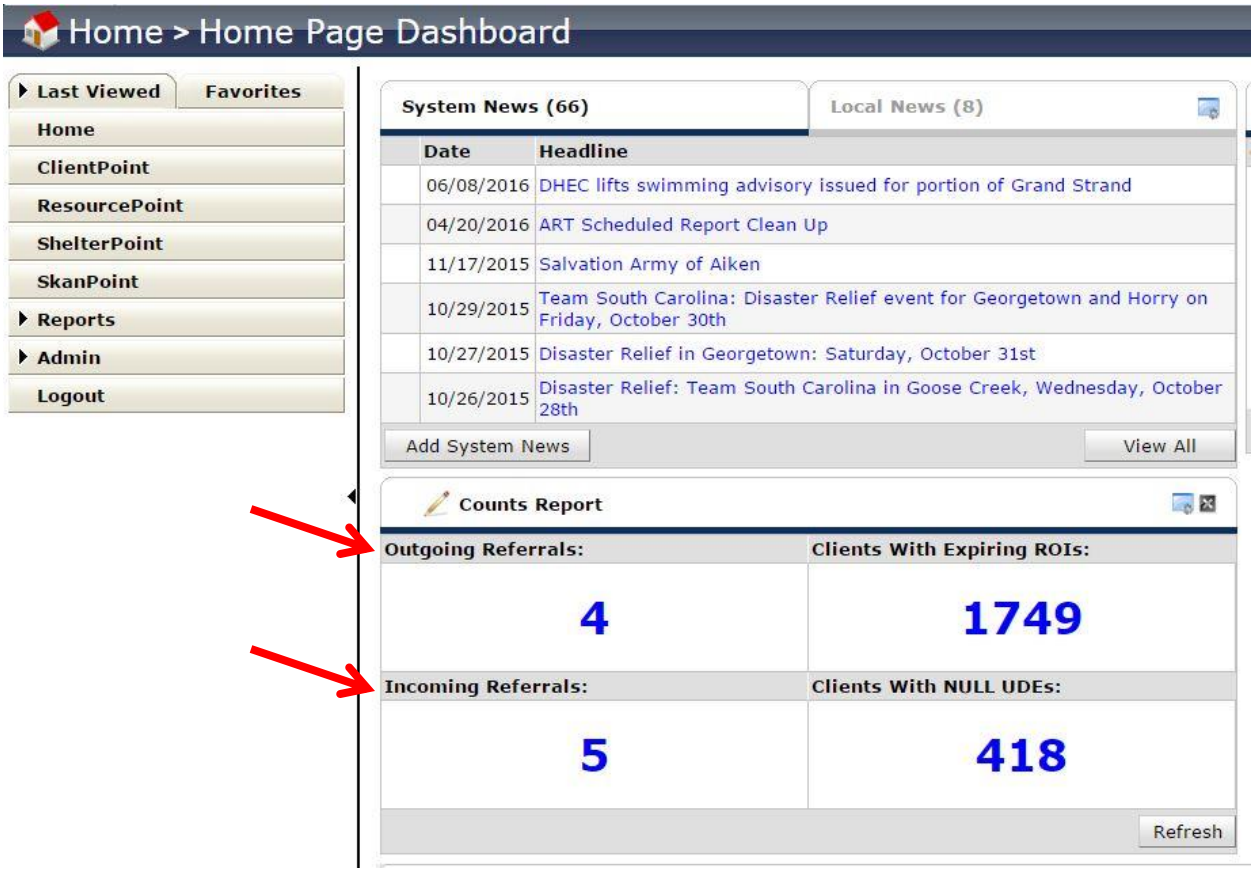
To process a referral in ServicePoint, an HMIS user would:

1. Navigate to the “Client Profile”
2. Click on the “Service Transactions” tab
3. Click on the “Add Referral” tab
4. Select the household member(s) to be included in the referral
5. Add service codes associated with the participant’s need(s)
6. Search for provider by need type or target population
7. Select the desired service provider
8. Attach an individual or family VI-SPDAT score
9. Select “Save ALL” to send referral and save documented need(s)

All outgoing and incoming referrals are documented using HMIS.

HMIS-Participating Program to HMIS-Participating Program

Programs that are active users of HMIS are responsible for monitoring the status of both outgoing and incoming referrals and ensuring they are addressed in an appropriate timeframe. ServicePoint HMIS users should select the “Outgoing Referrals” and “Incoming Referrals” dashlets on the Counts Report section of the Home Page Dashboard to check the status of referrals each time the user accesses HMIS:



HMIS-Participating Program to non-HMIS Participating Program

HMIS-participating agencies wishing to make a referral to an agency not on HMIS should document the referral in HMIS; this will allow service providers to follow the participant's service history across providers and allow for consistent tracking of referrals. The referring (sending) agency should then notify the receiving agency by telephone of the referral. Non-HMIS programs that receive referrals from HMIS-participating programs should call the referring agency to confirm that the referral was followed up on and processed; the HMIS user at the referral (sending) agency is responsible for updating the status of the referral in the system for the purposes of communicating within the coordinated entry system.

Non-HMIS Participating Program to HMIS-Participating Program

Non-HMIS participating programs wishing to make a referral to a program that participates in HMIS should contact an identified CES access point to receive assistance in entering an electronic referral into the HMIS. The access point will then submit the electronic referral to the designated receiving agency or program.

In the interest of fairness to all participants, and to maximize utilization rates for the limited local housing inventory, beds/units are held a maximum of three (3) days after the Housing Determination Group has identified an appropriate participant for that housing intervention. This does *not* mean the placement is completed in that time. It means that those being offered have been contacted and their intent regarding the resource is known. At the same time as reaching out to offer a resource, multiple back- ups will be contact per the prioritization list. In both instance they will be informed as outlined in the "Offering a resource" document APPENDIX I or "Back-Up for a resource" document APPENDIX J.
If the participant offered cannot accept the referral within three days (either through direct refusal or cannot be contacted), the participant's name is returned to the prioritization list and the bed/unit is offered to the next appropriate participant.
A referral from HDC shall be considered "in process" only if contact has been made directly to the client AND they have accepted the offer but are getting paperwork / they have accepted the offer but are looking for a unit / they have accepted the offer and are awaiting property management approval. In those instances the placing agency must give an update for every HDC meeting.
Waiting to hear back, waiting for an answer to a voice mail, attempting to locate the client etc. is NOT considered to be "in process." Resources therefore revert back to HDC next meeting.

All participants discussed, offered resources or approved as back up in the Housing Determination Committee meetings are documented. Minutes are circulated to the HDC members and agencies who have housing vacancies by next business day. Hard copies of the minutes are kept on site at UHC offices.

HDC recognizes the value of "organic" relationships. Provided the individual / head of household is next on the prioritization list, HDC will make all efforts to keep those relationships intact.

There is no limit to the number of times that a participant or household may decline a referral. Should a participant decline a referral, their name remains on the prioritization list and the Housing Determination Group offers the available bed/unit to the next appropriate participant on the prioritization list. The original participant is given equal consideration when the next bed/unit becomes available but cannot be guaranteed top priority based on vulnerability scores. If a participant declines a resource because of wanting a different area, they may be offered a non-preferred location two times. If they decline for a second time they will be informed of the ramifications – i.e. this may drastically effect the length of time they remain homeless. Also, they should be told that if their geographical preference broadens at any time, they can contact UHC Intake and Referral to update their information.

Individual agencies participating in the coordinated entry process have the discretion to determine their own guidelines for addressing participants that do not follow through with referred appointments to a program. However, these guidelines should be clearly established and communicated both to participants and to the Program/Coordinated Entry Committee so that all cases are handled consistently and fairly.

Grievances

There may be rare instances in which programs decide not to accept a referral from the coordinated entry process. Refusals are acceptable only in certain situations, including:

- The person does not meet the program's established eligibility criteria;
- The person would be a danger to themselves or others if allowed to remain in a particular programs; or
- The person has previously caused serious conflicts within the program (e.g., was violent toward another participant or program staff)

If the program determines that a participant is not eligible for their program after receiving a referral from the coordinated entry process, the participant should be redirected back to the Housing Determination Group to determine the best next step for the participant. Any cases that are unable to be resolved to the participant's satisfaction will be referred to the CoC's Program/Coordinated Entry Committee to be addressed as soon as possible. Any program that is consistently refusing referrals or refusing referrals without appropriate reason will be called to meet with the Program/Coordinated Entry Committee to discuss the issue that is causing the refusals.

Any denials for eligibility reasons will be stored in the HMIS and the local Housing Determination Group will update eligibility criteria charts as necessary based on this information.

Provider Grievances

Providers should address any concerns about the coordinated entry process to the CoC's Program/Coordinated Entry Committee, unless they believe a participant is being put in immediate or life-threatening danger, in which case they should deal with the situation immediately. A summary of concerns should be provided via email to the chair of the Program/Coordinated Entry Committee. The chair of the committee should then arrange for a representative of that provider to attend the next scheduled Program/Coordinated Entry Committee meeting so the issue can be presented and discussed, and a resolution proposed. If the issue requires more immediate resolution, the chair will be responsible for determining the best of course of action to address the issue.

Participant Grievances

The assessment staff member or assessment staff supervisor should address any participant grievances as best they can as they arise. Grievances that should be addressed directly by the assessment staff include grievances about how the participant was treated by assessment/program staff, assessment

center conditions or violation of confidentiality agreements. Any other grievances should be referred to the chair of the Program/Coordinated Entry Committee to be addressed in a process similar to the one described above for providers. Any grievances filed by a participant should note their name and contact information so that the committee chair may contact them and ask them to appear before the committee to discuss the issues of concern.

Next Steps for Coordinated Entry

- Continue weekly Housing Determination Committee to focus on literally homeless (not doubled up.)
- Continue Technical Assistance as needed.
- Adjust access points as needed.
- Develop Memorandum of Understanding (MOU) for coordinated entry and participating agencies, regardless of participation in HMIS
- Offer further trainings on using the VI-SPDAT, Priority List, and Eligibility Module in ServicePoint as needed.
- Develop tools to assess and evaluate the process including regular feedback meetings.
- Adjust policy and procedure (minor changes or clarification only) as needed.

Appendix A: Glossary of Terms

- **Provider:** Organization that provides housing or services to people experiencing or at risk of homelessness
- **Program:** A specific set of services or a housing intervention offered by a provider
- **Participant:** Person or household unit at risk of or experiencing homelessness, or someone being served by the coordinated entry process
- **Housing interventions**: Programs and subsidies that allow participants to become sheltered; these include transitional housing, rapid re-housing, and permanent supportive housing programs, as well as permanent housing subsidy programs

Appendix B: Housing First Principles

Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

Housing First yields higher housing retention rates and lower returns to homelessness, and significantly reduces the use of crisis services and institutions.

The key principles of this approach to housing are:

- Safe and affordable housing
- All people can achieve housing stability in permanent housing, but the supports may look different
- Everyone is “housing ready”
- Improved quality of life, health, mental health and employment can be achieved through housing
- Right to determination, dignity and respect
- Configuration of housing and services are based on participants’ needs and preferences.

Appendix C: Access Points into the Upstate CES

County	Program	Phone Number
Abbeville	Alston Wilkes Society	(864) 942-8726
Anderson	AIM AOP Mental Health Alston Wilkes Society Safe Harbor School District 5 UHC Intake and Referral Upstate Warrior Solution	(864) 226-2273 (864) 260-2220 (864) 242-9510 (864) 6223633 (864) 260-5000 (864) 908 -3699 (864) 722-2073
Cherokee	UHC Intake and Referral	(864) 908- 3699
Edgefield	UHC Intake and Referral	(864) 908- 3699
Greenville	Alston Wilkes Society Greenville Mental Health Center Piedmont Center - Mental Health Safe Harbor Salvation Army SHARE UHC Intake and Referral	(864) 242-0808 (864) 241-1040 (864) 963-3421 (864) 467-1177 (864) 235 4803 (864) 269-0700 (864) 908- 3699
Greenwood	Alston Wilkes Society Meg's House Pathway House School District 50	(864) 942-8652 (864) 227-1890 (864) 223-4460 (864) 941-5400
Laurens	Alston Wilkes Society Laurens Co. Safe Homes UHC Intake and Referral	(864) 260 9510 (864) 682-7270 (864) 908- 3699
McCormick	UHC Intake and Referral	(864) 908-3899
Oconee	Our Daily Rest UHC Intake and Referral	(864) 482-2040 (864) 908-3699
Pickens	UHC Intake and Referral	(864) 908 3699
Saluda	Alston Wilkes Society	(864) 242-0808
Spartanburg	SPIHN The Haven UHC Intake and referral	(864) 597-0699 (864) 582-6737 (864) 908- 3699
Union	UHC Intake and Referral	(864) 908 -3699

Appendix D: Local Domestic Violence Hotlines

Agency	Phone	Areas Served
South Carolina Office of Victim Assistance (SOVA)	1-800-220-5370	Statewide
Laurens County Safe Home	1-866-598-5932	Abbeville, Laurens, Saluda counties
MEG's House	(864) 227-1890	Edgefield, McCormick, Greenwood counties
Safe Harbor	1-800-291-2139, option "1"	Anderson, Greenville, Oconee, Pickens counties
SAFE Homes Rape Crisis Coalition	1-800-273-5066 (864) 583-9803	Cherokee, Spartanburg, Union counties

Appendix E: Coordinated Entry Process for Individuals and Families

1. Individual or family requests housing in-person or by phone through 2-1-1, emergency shelter, street outreach teams, or other service organization
2. Provider completes basic screening questions to divert and prevent homelessness, if possible, and gathers basic information needed to make initial crisis services referral
3. Diverted if another option exists (friends, family, other housing situations)
    a. Triaged into shelter if no option exists
4. Housing Barrier assessment completed
5. VI-SPDAT Prescreen completed at shelter, service organization, or by outreach worker and entered into HMIS
6. Communities generate the local prioritization list from HMIS to determine next eligible household for rapid placement into housing
    a. Based upon participant choice, participant is referred based upon chronic homeless status, acuity/vulnerability score, veteran status, street/shelter status, income status, and program eligibility with the following recommendations by VI-SPDAT score:
        i. Permanent Supportive Housing/Housing First
            - 8 or above
        ii. Rapid Re-Housing or Transitional Housing
            - 4-7
        iii. No Housing Support Recommendation (Diversion)
            - 0-3
7. Program receiving referral program completes admission process within three (3) days
8. Participant moves into housing or is referred back to Coordinated Entry if eligibility requirements were not met
9. Case management and other services are offered to participant to help household find path to stability

Appendix F: Housing Barrier Questions

Client Name: _____ Date:_____

RENTAL HISTORY

_____ No rental history
_____ Evictions, Unlawful Detainers and/or Judgments 1 2-3 4-5 6+
_____ Landlord References: ____good _____some problems _____poor
_____ Owes current landlord money, amount $_____
_____ Owes public housing money, amount $_____
_____ Owes large utility bill, utility _____ amount $ _____

CREDIT HISTORY

_____ No credit history
_____ Credit History shows unpaid rent and/or utility bills

CRIMINIAL HISTORY

_____ One of more misdemeanors – DV, assault type charges may be a higher barrier
_____ One or more felonies – drug convictions, sex crimes, assault and arson may be a higher barrier
_____ Pending Court Dates

INCOME BARRIERS

_____ Needs temporary assistance to obtain or maintain housing
_____ No income
_____ Part-time or seasonal work
_____ Works for a temp agency
_____ Monthly income $_____ 0-30% 31-50% 51-80%
_____ Low income – not enough income to afford open market rent – 0 to 30%
_____ High Percentage of Income Spent on Housing: _____
_____ Unemployed family members
_____ Education level a barrier employment
_____ Does not have a high school diploma or GED
_____ Physical or mental disability affects ability to work
_____ Transportation Issues – no reliable transportation, high car repair bills, uses public transportation
_____ Needs day care
_____ Child support pending – has filed court papers
_____ Not receiving court ordered child support
_____ Temporary not working due to medical condition – has job to return to
_____ Not working due to an accident – workman's comp pending
_____ Not working due to an accident – compensation pending
_____ Disability Application Pending Date filed: _____
_____ Denied disability, appealed decision

Appendix G: Housing Vacancy Form

Name of Agency:

_____

Agency Contact:

Name: _____

Phone:

_____

Email: _____

Population
Served_____

Available resource as of date: ☐

Rapid Rehousing: ☐

Transitional Housing: ☐

Permanent Supportive Housing: ☐

Location of resource (where applicable):

_____

_____

_____

Number of bedrooms (where applicable): _____

Other_____

_____

_____

_____

Appendix H: CES Intake

Thank you for calling ----------. My name is ---------- how may I help you today?

Looking for rental assistance, alternate housing or doubled up refer per resources or offer 211.

Shelter, street, place not meant for human habitation, institutional care facility fewer than 90 days - non- access points refer to UHC Intake and Referral staff (864) 908 3699. Access Points per below:

I am so sorry to hear that you are living in those conditions. What I need to do is get some information to complete an Intake. Every Friday a group meets to see what housing resources are available in all of the Upstate. If you qualify they would get in touch with you. Would you like me to proceed?

Can I get your name and social security number please?

Where possible complete the information / VI-SPDAT for the individual or head of household in HMIS while on the phone with them. Do not share the number scored on the VI- SDAT nor the resource indicated. Do not refer to the "prioritization list" as that implies waiting list.

0-4. Thank – you. Per our system's data, unfortunately, all I would be able to offer at this time is shelter or affordable housing resources. You may also call 211 for information on available services.

4-20.Per our system's data you may qualify for some services. I can refer you to -------- *shelter, agency* ----for now. If your name comes up at one of the Friday meetings they will be in touch with you by the Monday after. They will need you to have copies of your disability letter, if you have, plus you will need any ids, social security cards and anything that shows where you have been staying. If you do not have them you should try to get these documents. In meantime you are welcome to call me back to let me know how you are doing.

Again my name is ----------My number _____

Anything else I can help you with? Thank you for calling I am glad to assist you.

Appendix I: Offering a Resource

PERSON ANSWERS -

My name is ---------- I am calling from ----------.

I need to speak with ---------- please?

I am calling because the Upstate Housing Determination Committee has a housing opening *right now* that you might be Interested in -

They would like to offer you (pick one)

1. Permanent Housing in (county.)
2. Transitional Housing in (county.)
3. Rapid Rehousing which can help you secure permanent housing in (county or counties.)

If you are interested let's set up a time to meet. Are you able to meet with me

Time ---------- Date _____

Location ----------

Do you have a way to get to that meeting?

If you have them I need you to bring your disability letter, id, social security cards and anything you may have that shows where you have been staying.

Again my name is ---------- My phone # is----------

If you have questions or concerns please contact me right away. I look forward to seeing you then.

VOICEMAIL –

My name is ---------- I am calling from ----------.

I need to speak with ---------- please.

I am calling because the Upstate Housing Determination Committee has a housing opening for you right now. It is for – (pick one)

1. Permanent Housing in (county.)
2. Transitional Housing in (county.)
3. Rapid Rehousing which can help you secure permanent housing (county.)

Please call me as soon as you get this message at ----------so I can tell you more.

Again my name is ---------- from ---------- my number is----------.

Appendix J: Backup for Resource

PERSON ANSWERS –

My name is ---------- I am calling from ----------.

I need to speak with ---------- please?

I am calling because the Upstate Housing Determination Committee has a housing possible opening for you if the person they offered it to does not work out. It is for - (pick one)

4. Permanent Housing in (county.)
5. Transitional Housing in (county.)
6. Rapid Rehousing which can help you secure permanent housing (county.)

If you are interested you would need to get your disability letter, id and anything that shows where you have been staying.

Again my name is----------

My phone # is----------

I will be back in touch within 3 days to let you know what happened.

If you have questions or concerns please contact me right away.

VOICEMAIL -

My name is ---------- I am calling from ----------.

I need to speak with ---------- please.

I am calling because the Upstate Housing Determination Committee has a possible housing opening for you if the person they offered it to does not work out. It is for - (pick one)

4. Permanent Housing in (county.)
5. Transitional Housing in (county.)
6. Rapid Rehousing which can help you secure permanent housing (county.)

Please call me as soon as you get this message at ----------so I can tell you more.

Again my name is ---------- from ---------- my number is----------.