Palm Beach County Continuum of Care
Written Standards of Operating Policies & Procedures
For
Coordinated Intake & Assessment

TABLE OF CONTENTS

INTRODUCTION

National research has highlighted Coordinated Intake & Assessment as a key factor in the success of ending homelessness. Coordinated Intake & Assessment can enhance the quality of client screening and assessment and better target program assistance where it can be most effective. As a result, the system for preventing and ending homelessness is less fragmented and scarce resources are used more efficiently.

What is Coordinated Intake & Assessment?

Coordinated Intake & Assessment for Palm Beach County CoC is a centralized access point through the Homeless Resource Center (HRC), outreach, and telephone based centralized intake model. Initial screening can be conducted for all populations at one of the outreach locations or through a Navigator over the phone. Coordinated Intake & Assessment includes the following core components:

- Information so that people will know where or how to access intake for homeless prevention or housing services;
- A screening and assessment process and tools to gather and verify information about the person and his/her housing and service needs and program eligibility and priority;
- Information about programs and agencies that can provide needed housing or services;
- A process and tools for referral of the person to an appropriate program(s) or agencies; and assistance in making program admissions decisions.

While most housing and services are made available through other agencies, a variety of services may be provided on site at the “HRC” or by a “Navigator”. These services typically meet basic client needs and may include diversion services, showers, laundry, assessment, referral, shelter, bus pass and/or access to mainstream resources.

KEY TERMS

A number of key terms are subject to varying interpretations and thus should be defined for purposes of this document. They are as follows:

- **Acuity List –** A list that represents the prioritization of persons who are in need of homeless services or housing interventions, in rank order based on highest level of need to lowest.
- **Admission –** Process to admit a client into a program.
- **Access Point** – An approved entry point location where clients experiencing homelessness are able to access the homeless response system through Coordinated Entry.
- **Assessment –** A process that reveals the past and current details of an individual's/household's strength, and needs, in order to match the client to appropriate services and housing. For the purpose of this document, assessment will refer to a process (whether at primary screening and intake or at entry to a housing program) that reveals a client's eligibility, needs, barriers and strengths.
- **By-Name List –** A list that represents the persons or households who are in need of permanent housing.
- **Case Conference** – A regularly scheduled meeting where the ByName list is reviewed and coordinated entry referrals are made for emergency shelter, rapid re-housing, permanent supportive housing and CoC funded diversion.
- **Central Point of Access –** For the purpose of this document, Central Point of Access is the Homeless Resource Center where individuals or families can go to for intake and assessment of homeless and housing services for which they may qualify.
- **Chronic Homelessness –**. As defined by HUD in the final rule (https://www.govinfo.gov/content/pkg/FR-2015-12-04/pdf/2015-30473.pdf):
    - A homeless individual with a disability as defined in section 401(9) of the McKinney-Vento Assistance Act (42 U.S.C. 11360(9)), who:
        - Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and
        - Has been homeless and living as described for at least 12 months* or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described.
    - An individual who has been residing in an institutional care facility for less, including jail, substance abuse or mental health treatment facility, hospital, or

other similar facility, for fewer than 90 days and met all of the criteria of this definition before entering that facility**; or
    - A family with an adult head of household (or, if there is no adult in the family, a minor head of household) who meets all of the criteria of this definition, including a family whose composition has fluctuated while the head of household has been homeless.
- **Coordinated Assessment –** Relates to the utilization of the same assessment tool across multiple systems to connect clients to services as a means for a coordinated entry system. For the purpose of this document, that tool is the SPDAT (Service Prioritization Decision Assistance Tool) based on population, Individual, Family, or Transition Age Youth.
- **Coordinated Intake Provider Network –** is a consortium of partners that includes homeless service providers, advocacy groups, government agencies, and homeless individuals who are working together to address the housing and support needs of the homeless in Palm Beach County.
- **Coordinated Systems –** Within our community, coordinated systems is defined as interconnected network of systems that services homeless and at risk households, and consists of coordinated intake and assessment, diversion, prevention, rapid re-housing, transitional housing, permanent supportive housing and other tailored programs and services, and linkages to mainstream resources.
- **Diversion**- An approach that supports individuals and families by assisting them in identifying immediate alternative housing arrangements and, if necessary, connecting them with financial and other services to help them return to permanent housing.
- **Document Ready –** This term indicates that an individual's status has been documented through verification of homelessness and/or chronic homelessness through HMIS data, letters from outreach providers or shelters, confirmation documents provided by hospitals or treatment programs, or self-certification up to 30 days and/or verification of disability through SHP form, disability income, or psychiatric and/or medical diagnosis.
- **Fiscal Agent –** For the purpose of this document, the entity that coordinates funding and provides oversight to the coordinated intake and assessment system.
- **FUSE –** Palm Beach County FUSE (Frequent User System Engagement): A multiple systems approach to housing unsheltered community members who have high rates of criminal justice contacts, homeless service utilization, and admission to detox and crisis stabilization services. This small subpopulation consists of the top utilizers of services that result in high public costs.
- **HEARTH ACT –** The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) act of 2009 that includes Emergency Solutions Grant (ESG) and Continuum of Care (CoC) grants.

- **HMIS –** Homeless Management Information System is a centralized database designated to create an unduplicated accounting of homelessness that includes housing and services. This is referred to in Palm Beach County as the Client Management Information System (CMIS).
- **Homeless –** HUD definition as of January 2012
    - **Category 1** (Literal Homeless) is an individual or family who lacks a fixed regular, and adequate nighttime residence, which includes a primary nighttime residence of: a place not designed for or ordinarily used as a regular sleeping accommodation (including car, park, abandoned building, bus/train station, airport or camping grounds); a publicly or privately operated shelter or transitional housing, including a hotel or motel paid for by government or charitable organizations. In addition, a person is considered homeless if he or she is being discharged from an institution where he or she has been a resident for 90 days or less and the person resided in shelter (but not transitional housing) or place not meant for human habitation immediately prior to entering the institution.
    - **Category 2** (Imminent Homeless) is an individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing
    - **Category 4** (fleeing/attempting to flee DV) is any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing
- **Homeless Resource Center –** The agency identified as the primary administrator of coordinated intake and assessment. For the purpose of this document, that is the Philip D. Lewis Homeless Resource Center and the partners administering the coordinated assessment process; Gulfstream Goodwill Industries, Adopt-A-Family and all Homeless Outreach Teams.
- **Homeless Response System –** The network of homeless services providers in our community working to respond to the crisis of homelessness.
- **Housing First –** Evidence-Based programming for housing homeless individuals and families according to the provisions of a standard lease without requiring services other than case management in order to attain and retain housing.
- **Housing Ready –** A case management/housing approach that places homeless households into permanent housing only when determined the household was ready. Until that time, households are placed into long-term shelter or transitional housing

programs. The approach is being replaced by the Evidence Based Practice of Housing First and "rapid re-housing."

- **Housing Stability (formerly Prevention) –** Assistance that can aid households in preserving their current housing situation by providing assistance to households that otherwise would become homeless.
- **HUD –** The Department of Housing and Urban Development; the United States federal department that administers federal program dealing with homelessness. HUD oversees HEARTH-funded programs.
- **Information –** Specific facts about a program, such as its location, services provided, eligibility requirements, hours of operation, and contact information.
- **Intake –** the general process between the client's initial point of contact and screening for eligibility. This step involves primary assessment of needs, strengths and resources to refer households into appropriate services. This step may also include documenting client eligibility.
- **Linkage or Access to Mainstream Resources –** An approach to help people stabilize their housing for the long term by linking them to resources for which they are eligible within their community.
- **Navigation –** The process of assessing eligibility in order to connect or refer individuals for services.
- **Navigator –** An intake worker whose responsibility is to provide coordinated intake and assessment for individuals or families seeking housing services.
- **Outcome –** The specific result of what was provided from a specific activity or service; in relation to HUD/HEARTH, a specific result as detailed by HUD/HEARTH funding requirements.
- **Prioritization –** The process of using service-specific evaluation criteria to determine which individuals are most urgently in need of homeless services or housing interventions.
- **Progressive Engagement –** refers to a strategy of providing a small amount of assistance to everybody who enters your homelessness system, then waiting to see if that works. If it does not, you provide more assistance and wait to see if that works. If not, you apply even more, until eventually; you provide your most intensive interventions to the few people who are left.
- **Rapid Re-housing –** An approach that focuses on moving homeless individuals and families into appropriate housing as quickly as possible by providing the type, amount and duration of housing assistance needed to stabilize the household. Clients do not need to be considered "Housing Ready".
- **Referral –** linking a client to a particular program for possible assistance.

- **Screening –** For the purpose of this document, the process by which eligibility for housing and services is determined at the initial point of contact through coordinated entry. Once screening determines eligibility, the intake and referral process follows.
- **Street Outreach –** The process of identifying individuals and families who are sleeping in places not meant for human habitation and engage with these individuals with the goal of connecting them to housing resources through coordinated intake and assessment.
- **Systems Change –** For the purpose of this document, the process by which our CoC has altered the way homeless and at-risk households engage with the homeless and housing providers within our communities. The purpose of system change is to implement practices that have shown to decrease the incidence and length of time in homelessness, with a long-term goal of reducing and ending homelessness.
- **Tailored Programs and Services –** An approach to case management services that matches the services to the particular individual's or family's needs rather than using a one-size-fits-all approach.
- **Targeting –** Process of determining the population to whom assistance will be directed. That is, the target population. The targeting process can occur at both the system and the program levels.
- **Verification –** The gathering and review of information to substantiate the applicant's /client's situation and support program eligibility and priority determination.
- **Veteran (HUD) / Veteran Grant Per Diem (GPD)/ Veteran Self Sufficiency Veteran Families (SSVF)** - Any individual that has served one day of active duty.
- **Veteran (VASH) & Healthcare for Homeless Veterans (HCHV)** – any individual that has served 24 months of active duty or is eligible for VAMC Healthcare and has a discharge or release from service under conditions other than dishonorable discharge.

ENTRY SYSTEM

Applicants and Clients:

- Clients who are in need of homeless prevention or housing services can access information and eligibility criteria through the HRC and/or Call Center, which serve as the Central Point of Access. Participants seeking assistance must be screened at an Access Point, including at the HRC by a Navigator or by the Homeless Outreach Teams during off-site outreach. Participants not eligible for services will be referred to other appropriate community resources as available.
- Eligibility: Individuals and families that are **"Literally Homeless"** (meeting HUD's Category 1 definition of homelessness).
- Eligibility for Youth: could include "**Category 2"** at imminent risk of homelessness
- Participation Requirement: All households (with the exception of households in domestic violence situations) must be screened prior to program entry.
- Eligible Clients can expect:
  - To be treated with respect and dignity
  - Their initial phone call for assistance to be answered live or returned within two business days & navigated to appropriate resources
  - For intake and assessment to be scheduled for eligible clients within seven to fourteen business days as capacity allows
  - To be matched to an appropriate program based upon their unique needs, and referred based on their priority status to opening in a program
  - To wait until the system has the capacity to assist them, and to get help through diversion or other resources available to them
- Responsibilities

  Client must:
  - Answer all questions truthfully and to the best of their ability
  - Bring all required documentation
  - Keep their contact information current in order to be notified of available openings, and referred in a timely manner

Providers:

- Participation Requirement
  - All providers receiving funding through HEARTH or a HUD funded program are required to participate in the coordinated intake and assessment process.
  - Providers must be live on the HMIS system and must maintain data which is inputted no later than within 24 hours of a service or outcome being achieved or rendered.

- Providers must have an appeal process for those applicants who have been denied service or entry into a program.

HRC Partners:

- It is the HRC Partner's responsibilities to:
  - Regularly update and make current all program eligibility guidelines and program contact information so that Navigators can make the best referrals possible.
  - Ensure that when a placement referral is made, to confirm within two business days whether the referral is accepted, declined by provider, declined by client, or pending, or the provider is unable to contact the client.
  - Bring problems and suggestions to the monthly Standard Policies & Procedures Committee meeting.
  - Oversee provision of homeless diversion and housing services for eligible clients.
  - Ensure utilization of the same screening and assessment tool, data collection forms, policies on eligibility verification and referral/information-sharing systems.

See Coordinated Entry Flow Charts for homeless services delivery system overview (Appendix B).

NOTE: *This system acknowledges that the needs of a household fleeing or attempting to flee, domestic violence, dating violence, sexual assault or stalking, may be different than the needs of non-victims. Navigators will be trained on sensitivity in regards to victim's assistance, and referrals will only be made to domestic violence providers.*

BY NAME LIST

The By Name List is defined in our community as a list that represents the persons or households who are in need of permanent housing. The goal of these procedures is to ensure our community has a complete list of all those who are currently experiencing homelessness including those who are category 1 or 4 homeless and youth who are category 2. In order to achieve this, all agencies participating in the homeless response system will have access to enroll clients into the By Name List project, titled CoC By Name List, in CMIS.

Clients should be enrolled into this project when they are identified as currently homeless. This identification can be from third party verification, self-report or worker observation. If from self-report, this status will need to be verified in order for the client to be eligible to receive services through Coordinated Entry. If the agency is or will be working with this client in their

own program (ex: street outreach, services only, emergency shelter), the client should be enrolled into the agency program prior to completing the By Name List enrollment.

Providers & HRC Partners

When **enrolling** into the CoC By Name List project, staff will need to:

1. Click on  Triage Assessment
2. Search to see if client exists in CMIS
3. Create or update the basic client information
    a. Similar to Street Outreach, not all information is needed to create the client in the system. If client is not yet ready to engage with services, they can still be added to this enrollment with minimal information that can be updated at a later date when the client is ready.
4. Indicate the assessment location (options based on agency)
5. Indicate if this contact is:
    a. Phone
    b. Virtual
    c. In Person
6. Identify what type of household this client is in.
7. If the client is enrolled in your agency program, identify this as the "verified by project."
8. Identify the client's current living situation and include any details in the comment box, in the event that an outreach worker will need to locate them for services.
    a. If you are a street outreach worker, you can also choose to record a contact on this screen.
9. Complete the Triage Assessment
    a. Are you a Palm Beach County resident? Yes or No
    b. Is there violence or conflict in the place you were staying last night? Yes or No
    c. Is your health or safety at risk in the place you were staying last night? Yes or No
    d. If yes to a & b, do you have another place to go? Yes or No
    e. If yes to d, how long could you potentially stay there:
        i. One night or less
        ii. Two to six nights
        iii. One week or more but less than one month
        iv. One month or more but less than 90 days
        v. 90 days or more but less than one year
        vi. One year or longer
    f. If no to d, assess DV risk and refer to DV system if appropriate before proceeding.
10. If agency completing is a Partner Agency:
    a. Indicate if this client needs to be referred to Coordinated Entry (CE) to receive a Housing Needs Assessment (VI-SPDAT). This will need to be completed in order

to determine if client is eligible for shelter and housing services through Coordinated Entry.

b. By creating a referral in CMIS, the CE contact will receive an email and reach out to the client to complete the Housing Needs Assessment. Contact information on the client information screen must be up to date. If this client does not have a phone, include information in the referral email on when/how the client can best be reached. Referrals for Housing Needs Assessments will be completed within 24-48 business hours of receipt by Homeless Resource Center Lewis Center Navigation Staff.

11. If agency completing is an Access Point:
    a. The Lewis Center (TLC) Navigation/Ryan White: Complete the Housing Needs Assessment (VI-SPDAT) at time of contact.
    b. Street Outreach/Drop-In Center: Complete the Housing Needs Assessment when the client is ready to engage with services.

Once the Housing Needs Assessment is complete, add the client's Acuity Detail if they score for services based on the list below:

- Individuals (25+): 6+
- Families (including parenting youth): 4+
- Youth (18-25): All scores

More information on the Acuity Detail Scoring can be found starting on page 13.

Required documentation should be uploaded to the client's file in CMIS. Required documents to be referred for diversion, shelter and/or housing programs include:

1. Homeless Verification
2. Birth Certificates (for minors)
3. Government Issued ID for all adults (proof of PBC residency). If no valid PBC ID, other acceptable proof of residency documentation may include any of the following:
    a. SSI/SSD Benefit letter with a Palm Beach County address
    b. Eviction notice in PBC within the past year
    c. Currently enrolled in school in PBC (children or the adult)
    d. Employment in PBC for at least 2 weeks
    e. Vehicle registration in PBC
    f. Voters Registration Card PBC
    g. Probation/Parole released to PBC

All forms of documentation must be current and not expired.

Clients will be prioritized and referred for services based on their Acuity Score. When there are openings for services (diversion, emergency shelter, rapid re-housing, permanent supportive housing) through Coordinated Entry, the CoC By Name List will be filtered to those who have an

Acuity Score and have not yet entered into that project type. When referring for emergency shelter, the Acuity List will be filtered to those who are unsheltered and further filtered by population type (male/female, individual/youth/family). When referring for rapid re-housing (RRH) programs, the Acuity List will be filtered to those who have not yet been enrolled in RRH. Referrals are made during regularly scheduled Case Conference Meetings and are based on program availability.

Clients will be **closed** from the CoC By Name List when:

1. They are housed
2. They become inactive – no contact for 90 days

It is possible for clients to remain open in the By Name List enrollment who are not eligible for services. This enrollment will remain active until the auto-exit time frame. If a client reaches back out to an Access Point and their circumstances have changed, a new Housing Needs Assessment may be completed under the same enrollment (if still open) rather than opening the client a new enrollment. If the client is now eligible for services through Coordinated Entry based on this score, their Acuity Detail should be added at this time.

If a client is housed in a Rapid Re-Housing project as a placeholder while waiting for Permanent Supportive Housing, they should be enrolled into the Rapid Re-Housing Placeholder project.

ASSESSMENT TOOLS & PROTOCOLS

The Coordinated Entry System focuses on providing a continuum of care including prevention, diversion, rapid re-housing, and permanent supportive housing approaches. For housing programs, the acuity list is utilized to ensure that those with the highest level of vulnerability and longest time homeless are prioritized for enrollment into housing services.

A Navigator assesses each household's eligibility for services. Prevention services target households at imminent risk of homelessness and may be referred to available homeless prevention programs. Diversion services will target participants as they are applying for entry into shelter. For housing programs, rapid re-housing services target literally homeless participants and the VI-SPDAT score indicates this type of housing. Housing first and permanent supportive housing targets chronically homeless participants and the VI-SPDAT score identifies this housing type.

Applicants and Clients:

- Each applicant is evaluated on a variety of criterion, including rental history, criminal history, domestic violence, mental health challenges, disabling conditions, language

barriers, educational attainment, employment status, and length of homelessness. Services are then assigned based on the VI-SPDAT score.

- The Assessment tool provides a procedure for determining which applicants are eligible and appropriate for the variety of housing and support services available in the community.

Providers:

- Each participant who is referred for housing or services will have been evaluated through an assessment based on their current barriers to obtaining and successfully maintaining permanent housing.
- The Assessment will be used as a guide, with the understanding that each applicant has a unique set of circumstances.

HRC Partners and CoC Partners:

- The Vulnerability Service Prioritization Decision Assistance Tool (VI-SPDAT) is the assessment tool utilized for this system.
- The VI-SPDAT will utilize 4 domains for individuals and 5 for families to determine an acuity score that will help inform Navigators and Providers about the following:
  - People who will benefit most from Permanent Supportive Housing
  - People who will benefit most from Rapid Re-Housing
  - People who are most likely to end their own homelessness with little to no intervention on your part
  - Which areas of the person's life that can be the initial focus of attention in the case management relationship to improve housing stability.
  - How individuals and families are changing over time as result of case management process.
- The VI-SPDAT will be integrated into the HMIS System and each agency will ensure data is being maintained and monitored.
- The HRC Partners will provide a system of care that allows clients to give feedback on suggestions and improvements of the Intake and Assessment Process.
- The HRC Partners will ensure that the VI-SPDAT is not used to:
  - Provide a diagnosis
  - Assess current risk or be a predictive index for future risk
  - Take the place of other valid and reliable instruments used in clinical research and care

CoC Partners that receive federal CoC and ESG funds and any local funds required by the funder must participate in the Coordinated Assessment process and track data in the Homeless Management Information System (HMIS). Only Domestic Violence providers are exempt from

the HMIS requirement as per Florida Statute and Federal regulations. CoC partners receiving federal CoC and ESG funds or any other local funds dedicated to homeless services must fill vacant beds based on acuity from highest to lowest as per CPD-16-11.

ACUITY DETERMINATION

Palm Beach County's Acuity list is formulated through the utilization of an index comprised of multiple indicators of vulnerability, as well as associated criteria for program and/or sub-population eligibility. Each indicator is weighted. The values of each indicator are calculated to identify a final score. This score determines ranking on the acuity list. The list is ordered from highest to lowest score. The highest scoring client receives priority for service/housing enrollment. Days homeless will be used as a tie breaker for those with the same score, followed by VI-SPDAT, or SPDAT for PSH, score.

Individual Acuity Criteria: (This criteria pertains to all adults age 25 and over, including Veterans and Individuals Fleeing DV)

The following indicators and associated scores are used to calculate an individual's final score for referrals to emergency shelter and/or rapid re-housing programs:

- Length of time for current episode of Homelessness (see chart) (LoH)
- VI-SPDAT Score (see chart)
- Special Population points (SP)
    - Chronic Mental/Health/Physical Illness: 1 point is given to any client who lives with a chronic mental/health/physical illness and is not currently engaged in care.
    - Current Exposure to Violence Home/Community: 1 point.
    - Experience Human Trafficking: 1 point
    - Veteran: 1 point
    - FUSE: 1 point

The Acuity Score is calculated using the following formula: (**LoH Acuity(*3)) + (VI-SPDAT Acuity(*2))** + **SP** = **Acuity Score** (see chart below)

The acuity list is ranked in order from highest score to lowest. The highest score is given priority for housing and shelter interventions. Days of homelessness will be used as a tie breaker for clients with the same score.

Single Adults (Ages 25+)
Shelter/RRH Acuity Scoring Legend

LoH (Current Episode)		
Min	**Max**	**Acuity**
-	365 days	0
366 days (1 yr)	730 days (2 yrs)	1
731 days (2 yrs)	1095 days (3 yrs)	2
1096 days (3 yrs)	1825 days (5 yrs)	3
1826 days (5 yrs)	2555 days (7 yrs)	4
2556+ days (8 yrs)	-	5

VI - SPDAT		
Min	**Max**	**Acuity**
0	5	0
6	-	1
7	8	2
9	10	3
11	13	4
14	17	5

Special Population (SP)	
Description	**Acuity**
Experience Human Trafficking	1
Chronic Mental/Health/Physical Issue - Not Engaged in Care	1
Current Exposure to Violence Home/Community	1
Veteran	1
FUSE	1

Weighted Criteria	
Length of Homelessness (Current Episode)	3
VI-SPDAT	2
Special Population	1

(**LoH Acuity(*3)) + (VI-SPDAT Acuity(*2))** + **SP** = **Acuity Score**

For permanent supportive housing (PSH), individuals will receive a full SPDAT when scoring an 8+ on the VI-SPDAT and have a disabling condition identified. Those that score a 40 and above will be included on the Permanent Supportive Housing Prioritization list (see Permanent Supportive Housing standards for more information on this eligibility). Individuals who meet the definition of chronic homelessness will receive priority. If there are no individuals that meet the Chronic Definition, individual with most days homeless will be prioritized.

The PSH Acuity Score will be calculated using the following formula: (**LoH Acuity(*3)) + (SPDAT Acuity(*2))** + **SP = Acuity Score**. Those who are chronically homeless will receive highest priority.

Single Adults (Ages 25+)
PSH Acuity Scoring Legend

LoH (Current Episode)

Min	Max	Acuity
-	365 days	0
366 days (1 yr)	730 days (2 yrs)	1
731 days (2 yrs)	1095 days (3 yrs)	2
1096 days (3 yrs)	1825 days (5 yrs)	3
1826 days (5 yrs)	2555 days (7 yrs)	4
2556+ days (8 yrs)	-	5

SPDAT

Min	Max	Acuity
-	40	0
41	42	1
43	44	2
45	47	3
48	50	4
51	60	5

Special Population (SP)

Description	Acuity
Experience Human Trafficking	1
Chronic Mental/Health/Physical Issue - Not Engaged in Care	1
Current Exposure to Violence Home/Community	1
Veteran	1
FUSE	1

Weighted Criteria	
Length of Homelessness (Current Episode)	3
VI-SPDAT	2
Special Population	1

(LoH Acuity(*3)) + (SPDAT Acuity(*2)) + **SP = Acuity Score**

Individuals waiting for a unit in PSH can be housed through RRH and will remain on the list until a PSH unit is available or it is determined the client is managing successfully in this housing option. If an individual is chronic, effort must be made to document this status prior to being housed in RRH placeholder in order to retain status. If RRH programming is deemed most appropriate, the client is moved to inactive on the PSH list at case closure.

Individuals will become inactive on the acuity list for the following reasons: permanently housed, have relocated out of state, Outreach and Navigation have been unable to make contact in last 90 days, or if person is deceased. Individuals can be active again following resuming contact with Navigation or Outreach.

Youth Prioritization Acuity Scoring: (This criteria pertains to Individual Youth ages 18-24, Parenting Youth are scored using Family Criteria)

The following indicators and associated scores are used to calculate an individual's final score:

- Length of time for current episode of Homelessness (see chart)
- TAY VI-SPDAT Score (see chart)
- Chronic Mental/Health/Physical Illness: 1 point is given to any client who lives with a chronic mental/health/physical illness and is not currently engaged in care.
- Current Exposure to Violence Home/Community: 1 point.
- Experience Human Trafficking: 1 point
- Veteran: 1 point
- FUSE: 1 point

The Acuity Score is calculated using the following formula: (**LoH Acuity(*3)) + (VI-SPDAT Acuity(*2))** + **SP = Acuity Score**

The youth acuity list is ranked in order from highest score to lowest. The highest score will have priority for housing intervention.

Days of homelessness will be used as a tiebreaker for clients with the same score.

Single Youth (Ages 18-24)
Shelter/RRH Acuity Scoring Legend

LoH (Current Episode)		
Min	**Max**	**Acuity**
0 days	60 days	0
61 days	120 days	1
121 days	180 days	2
181 days	240 days	3
241 days	270 days	4
271 days +	-	5

TAY - VI - SPDAT		
Min	**Max**	**Acuity**
0	3	0
4	-	1
5	6	2
7	8	3
9	12	4
13	17	5

Special Population (SP)	
Description	**Acuity**
Experience Human Trafficking	1
Chronic Mental/Health/Physical Issue - Not Engaged in Care	1
Current Exposure to Violence Home/Community	1
Veteran	1
FUSE	1

Weighted Criteria	
Length of Homelessness (Current Episode)	3
TAY-VI-SPDAT	2
Special Population	1

(**LoH Acuity(*3)) + (TAY-VI-SPDAT Acuity(*2))** + **SP** = **Acuity Score**

For permanent supportive housing (PSH), youth will receive a full Y-SPDAT when scoring an 8+ on the TAY-VI-SPDAT and have a disabling condition identified. Those that score a 35 and above will be included on the Permanent Supportive Housing Prioritization list (see Permanent Supportive Housing standards for more information on this eligibility). Youth who meet the definition of chronic homelessness will receive priority. If there are no youth that meet the Chronic Definition, youth with most days homeless will be prioritized.

The PSH Acuity Score will be calculated using the following formula: (**LoH Acuity(*3)) + (Y-SPDAT Acuity(*2))** + **SP** = **Acuity Score**. Those who are chronically homeless will receive highest priority.

Single Youth (Ages 18-24)
PSH Acuity Scoring Legend

LoH (Current Episode)		
Min	**Max**	**Acuity**
0 days	60 days	0
61 days	120 days	1
121 days	180 days	2
181 days	240 days	3
241 days	270 days	4
271+ days	-	5

Y - SPDAT		
Min	**Max**	**Acuity**
-	35	0
36	37	1
38	40	2
41	45	3
46	47	4
48	60	5

Special Population (SP)	
Description	**Acuity**
Experience Human Trafficking	1
Chronic Mental/Health/Physical Issue - Not Engaged in Care	1
Current Exposure to Violence Home/Community	1
Veteran	1
FUSE	1

Weighted Criteria	
Length of Homelessness (Current Episode)	3
TAY-VI-SPDAT	2
Special Population	1

(LoH Acuity(*3)) + (Y-SPDAT Acuity(*2)) + SP = Acuity Score

Youth waiting for a unit in PSH can be housed through RRH and will remain on the list until a PSH unit is available or it is determined the client is managing successfully in this housing option. If a youth is chronic, effort must be made to document this status prior to being housed in RRH placeholder in order to retain status. If RRH programming is deemed most appropriate, the client is moved to inactive on the PSH list at case closure.

Note that in the instance that a youth specific program is unavailable, youth should be included in prioritization for adult beds utilizing the youth acuity scoring.

Individuals will become inactive on the acuity list for the following reasons: Permanently housed, Relocated out of the State, Outreach and Navigation have been unable to make contact in last 90 days, or if person is deceased. Youth can be active again following resuming contact with Navigation or Outreach.

Family Prioritization Acuity Scoring: (This criteria pertains to Veterans, Parenting Youth, and Individuals with children Fleeing DV)

The **Family Acuity List** includes all families screened by the Lewis Center and meet the Category 1 Homeless (HUD) definition. These families are screened using the VI-F-SPDAT and Referral for services is given based on Score. Those who score a 4+ are scheduled for a Clearance & Assessment that includes bringing in documents to verify client's homeless status, PBC residency, custody of children, and income. This intake appointment also includes a short assessment to help gather any additional information regarding barriers to obtain permanent housing.

Clients are included in the **Shelter and Rapid Re-Housing Prioritization List** after intake appointment and prioritized for services based on the Acuity Score made up of the following factors: Length of Homelessness, VI-F-SPDAT Score, and Special Population. Clients are scored on a scale of 0-5 in the first two (2) categories and are awarded one (1) extra point if they are part of a special population. The scores are weighted (using key below) and then added together creating an Acuity Score. Clients will be prioritized based on this sum. Clients categorized as chronically homeless receive priority. Additional considerations are made for those who are about to give birth or just given birth, have chronic health issues, or have a reunification plan through DCF that requires them to be sheltered.

Referrals for Rapid Re-Housing are subject to funding availability and case manager capacity. Clients are closed if two (2) viable units are declined or if they choose to seek permanent housing on their own (i.e. diversion, HA voucher). Clients waiting for a unit in PSH can be housed through RRH and will remain on the list until a PSH unit is available or it is determined the client is managing successfully in this housing option. If RRH programming is deemed most appropriate, the client is moved to inactive on the PSH list at case closure.

Families with minor children
Shelter/RRH Acuity Scoring Legend

LoH (Current Episode)		
Min	**Max**	**Acuity**
0 days	30 days	0
1 month	3 months	1
3 months	6 months	2
6 months	9 months	3
9 months	12 months	4
12 months +	-	5

VI - F - SPDAT		
Min	**Max**	**Acuity**
0	3	0
4	-	1
5	6	2
7	8	3
9	12	4
13	22	5

Special Population (SP)	
Description	**Acuity**
Experience Human Trafficking	1
Chronic Mental/Health/Physical Issue - Not Engaged in Care	1
Current Exposure to Violence Home/Community	1
Veteran	1
FUSE	1

Weighted Criteria	
Length of Homelessness (Current Episode)	3
VI-SPDAT	2
Special Population	1

(LoH Acuity(*3)) + (VI-SPDAT Acuity(*2)) + SP = Acuity Score

A client scoring a 9 or more on the VI-F-SPDAT and who reports a disability, is scheduled for a F-SPDAT. Clients are included in the **Family Permanent Supportive Housing (PSH) Prioritization List** when they present with a disability and their F-SPDAT score is above a 54. Prioritization for PSH is based on a combined weighted PSH Acuity Score, see chart below. Clients categorized as chronically homeless receive higher priority. Clients remain active on the list for one year and then must be re-assessed to remain on the list.

Families with minor children
Shelter/RRH Acuity Scoring Legend

LoH (Current Episode)		
Min	**Max**	**Acuity**
0 days	30 days	0
1 month	3 months	1
3 months	6 months	2
6 months	9 months	3
9 months	12 months	4
12 months +	-	5

F - SPDAT		
Min	**Max**	**Acuity**
-	54	0
55	57	1
58	60	2
61	64	3
65	69	4
70	80	5

Special Population (SP)	
Description	**Acuity**
Experience Human Trafficking	1
Chronic Mental/Health/Physical Issue - Not Engaged in Care	1
Current Exposure to Violence Home/Community	1
Veteran	1
FUSE	1

Weighted Criteria	
Length of Homelessness (Current Episode)	3
VI-SPDAT	2
Special Population	1

(**LoH Acuity(*3)) + (F-SPDAT Acuity(*2))** + **SP** = **Acuity Score**

Clients will become inactive on the acuity list for the following reasons: permanently housed, relocated out of county/state, unable to contact within last 30 days, unable to complete program documentation, children taken out of custody, or if person is deceased.

Documentation of Priority and Chronic Homelessness

As chronic homeless beds become available, CoC Partners will follow the priority guidelines defined in **Appendix A** (page 28) which are in compliance with CPD-16-11. The CoC Partners must include in all case records an email from the HRC certifying the individual/family is the next on the list with the highest acuity and identify which priority category they meet. Since all CoC beds are funded for Chronic Homeless, the individual or family must meet the definition of Chronic Homelessness (Appendix A) and this must be documented according to Appendix A and included in each case record. For families only, the placement can initially be completed without the documentation, but it must be obtained within 45 days of admittance. Should the CoC Partner and/or family not be able to document chronic homelessness, the CoC Partner

Agency is still in compliance with CPD-16-11 since the CoC has adopted the policy of filling all beds with an individual or family with the highest acuity. If self-certification is required, a Self Certification of Homelessness and Chronic Homelessness is required (**Appendix A**). **All clients who are referred should have an active enrollment included the PBC ByName list at the time of referral.** This enrollment should remain active until the client is connected with the referring provider to ensure a warm transfer is provided and that the client continues to be homeless and in need of housing support during the transition period. Connection with referring provider will be confirmed by an open enrollment in the housing program.

HOMELESS PREVENTION & HOUSING STABILITY SERVICES

According to the National Alliance to End Homelessness, many people seeking homeless assistance still have an opportunity to remain in their current housing situation, whether it is their own housing or the housing of a friend, relative, acquaintance or coworker. In light of this, prevention and shelter diversion are key interventions in the fight to end homelessness. Immediate screening for these possibilities at entry is an important tactic, and can preserve emergency beds for individuals/households that truly have nowhere else to go. Access to rental subsidies and case management at entry is often enough to ensure the household successfully remains housed.

While prevention and diversion are two separate concepts, they are utilized almost interchangeably in this strategy, as they both focus on preventing homelessness. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing targets people who are already homeless.

COORDINATED ENTRY FOR HOUSING STABILITY (FORMERLY HOMELESS PREVENTION)

PBC's CoC is expanding the Coordinated Entry system to include services offered through Housing Stability offices formerly referred to as Prevention. Historically, when individuals and/or families at-risk of homelessness were experiencing a crisis, they sought services on their own. The process included calling a list of service providers in the community oftentimes receiving the same message (ie. no appointments available, no more funds, please call back at a specified time). The CoC determined that this was not a client-centered approach and thus decided to expand the Coordinated Entry process to include at-risk of homelessness (housed with imminent risk of losing housing evidenced by a 3-day notice or eviction notice) individuals and families.

Calls made to the Call Center will be directed to Navigation for housing stability services. Navigators are considered Subject Matter Experts and will follow a script when speaking with callers. Navigators will be well versed in diversion strategies. Navigators will also be well versed in the existing resources in the community to meet the needs of the callers. Callers will be assessed using a screening tool and those who score a 19+ qualify for services. Callers scoring less than 19 are referred to other community resources. When a navigator has determined the individual or family qualifies for services an appointment will be scheduled at the appropriate office and/or assist with an application through Online System for Community Access to Resource and Social Services (OSCARSS) to be assisted through Palm Beach County Community Services Community Action Program.

The goal of the CoC is to add additional Housing Stability/Prevention offices and other service providers in a manner that does not congest the system, rather ensures an efficient and effective process. Regular reporting will occur to ensure quality service delivery.

DIVERSION

Client:

To determine which individuals/households are appropriate for prevention/diversion, Navigators can ask applicants a series of questions during the assessment, such as those delineated below:

- Where did you sleep last night? *If they slept somewhere safe where they could potentially stay again, this might mean they are good candidates for diversion*
- What other options do you have for the next few days or week? *Even if there is an option outside of shelter that is only available for a very short time, it worth exploring if this housing resource can be used.*
- (If staying in someone else's housing) What issues exist with you remaining in your current housing situation? Can those issues be resolved with financial assistance, case management, etc? *If the issues can be solved with case management, mediation, or financial assistance (or all of the above), diversion is a good option.*
- (If coming from their own unit) Is it possible/safe to stay in your current housing unit? What resources would you need to do that (financial assistance, case management, mediation, transportation, etc.)? *If the individual or family could stay in their current housing with some assistance, providers should focus on a quick prevention-oriented solution that will keep the individual or family in their unit.*

Providers:

Referrals to prevention/diversion providers must be at imminent risk of homelessness AND meet the following threshold.

- No appropriate subsequent housing options have been identified;
- The household lacks the financial resources to obtain immediate housing or remain in its existing housing; and
- The household lacks support networks needed to obtain immediate housing or remain in its existing housing

HRC Partner Agency:

The attached prevention screening tool (Attachment D) includes some, but not all risk factors that may be considered when determining imminent risk of homelessness and barriers to remaining housed or quickly moving into housing.

Some participants may not be good candidates for diversion programs due to a lack of safe and appropriate housing alternative and require immediate admittance to shelter, e.g. client fleeing domestic violence. A client's safety should always be the top consideration when developing an individual /household referral to a program.

RAPID REHOUSING

Generally, rapid re-housing is intended to assist eligible participants to quickly obtain and sustain stable, permanent housing. Effective rapid re-housing requires case management and financial assistance, as well as housing search and locations services. Support and duration of service are tailored to meet the needs of each household and each household has a lease in their name and is connected to mainstream resources in the community in which they reside.

Clients:

Eligible households must:

- Be literally homeless as defined by HUD
- Be prepared to establish a reasonable plan that shows how they are going to maintain housing once housing assistance has ended, develop a budget, a financial worksheet and or a narrative description of changes in household circumstances that caused them to become homeless.
- Entry is based on Acuity Score (highest to lowest), then length of time homeless (longest to shortest), and then TAY/F/VI-SPDAT Score (highest to lowest).

Providers:

Providers who are funded for rapid re-housing:

- Will utilize the **"Progressive Engagement"** methodology; that is, providers will determine the amount of rent and utility assistance and/or supportive services that a household will receive using the progressive engagement approach. Household will be asked to identify the minimum amount and duration of assistance needed to achieve housing stability. If it becomes clear that a rapid re-housing intervention is insufficient and or inappropriate for a particular household, the provider will work with the Navigator and/or other housing provider to find a more suitable program.
- Households should be attempted to be housed within 30 days of acceptance into the program.
- Providers are expected to remain engaged with the household from first contact to program exit as per the CoC approved Rapid Re-Housing Standards.

CoC Partners:

The following process will be used to refer clients to any Rapid Re-Housing program. Providers will receive referrals from any of the following sources; provided they have been assessed by the Navigator and all eligibility and vacancy information is up to date in HMIS.

- Coordinated Access Point and/or Outreach Workers
- Shelters
- Transitional Housing Programs

All households being referred for Rapid Re-Housing must be assessed by a Navigator. While they may be identified through other resources, i.e., shelter or transitional housing providers, McKinney-Vento Liaisons in school districts, or other service providers, they will require screening and assessment through the HRC Coordinated Intake and Assessment System. School Liaisons can conduct the VI-SPDAT and provide this information to the Navigator to be included on Rapid Re-Housing Placement Priority List.

- Navigators are responsible for gathering documentation for verification of homeless status.
- All Rapid Re-Housing clients must be entered into HMIS by the Navigator once the provider has confirmed entry into the program. Information should include all HUD required data elements.

HOUSING AND/OR PROGRAM REFERRAL

Participants unable to be served by prevention, diversion or rapid re-housing programs will most likely need more intensive housing and service interventions, such as transitional housing or permanent supportive housing. Those fleeing domestic violence that are not eligible or appropriate for prevention, diversion, and rapid re-housing services may fall into this category of needing more intensive service intervention, and should be referred to a domestic violence provider prior to intake and/or HMIS data entry.

Table 1 below delineates the characteristics of Permanent Support Housing and Transitional Housing Programs.

Characteristics of Transitional Housing & Permanent Supportive Housing Programs

Programs & Characteristics	Transitional Housing	Permanent Supportive Housing	Other Permanent Housing
Length of Stay	Maximum stay 24 months	No time limit	No time limit
Occupancy Agreement or Lease	Participants are clients, not tenants and sign an occupancy or program agreement instead of a lease	Participants have a lease	Participants have an Occupancy Agreement or Lease
Service Requirements	Services are required	Services are optional	Services are optional
Eligibility	Applicant must meet HUD's definition of homeless	Applicant must meet HUD's definition of homeless and member of the household must have a disabling condition	Applicant must meet HUD's and/or other federal definition of homeless

Provider:

Transitional Housing: programs that provide housing to individuals and/or families, usually for a period of four to twenty-four months, along with supportive services to help them become self-sufficient. In addition to providing a place to live, transitional housing providers should help participants to increase their life management skills and resolve the problems that have contributed to their homelessness. Individuals/Households who are homeless and have two or more of the following barriers are appropriate for referral to Transitional Housing:

- Domestic Violence victims fleeing a domestic violent situation
- Youth (18-24)
- No income
- Poor rental history (i.e. current eviction, rent/utility arrears)
- Sporadic employment history
- No high school diploma or GED

- History of homelessness

Permanent Supportive Housing: Permanent Supportive Housing targets individuals/households who need services in order to maintain housing. Prioritization is given to chronic homeless and/or those with the highest level of vulnerability as per HUD. As a minimum, candidates for Permanent Supportive Housing must meet the following basic requirements:

- Literally homeless
- Chronic homelessness
- Lacks the resources to obtain housing
- Has a member of the household with a severe or significant disabling condition
- Qualifies as a high need based on the SPDAT

CoC Partner Agencies:

The navigator or other appropriate staff such as Outreach Workers or Diversion Specialist can provide: needed housing navigation services, frequent communication with the client and serves as the primary liaison between the client and the housing provider. The CoC Partner Agency is responsible for overseeing and ensuring that:

- Advocacy and services to collect required housing documentation are provided
- A climate of trust is created and maintained between clients and navigators.
- A current housing inventory is maintained within HMIS
- Clients are housed based upon a prioritization determination; that is, those who score according to the identified criteria as the most vulnerable will be prioritized for housing depending on the availability of housing and services. Legacy programs with beds not dedicated to Chronic Homeless must prioritize the beds for Chronic Homeless Individuals and Families as beds become available.

If the Partner Agency evaluates a client for their bed and questions whether their program fits the needs of the client, they must staff the case with the existing Housing First Providers and a consensus reached that the placement not accepted must be considered in another program. If this occurs, then the Housing First Program with the bed will accept the next person on the priority list and the first individual will be placed in the next available bed in Housing First Program deemed most appropriate.

Palm Beach County's Continuum of Care, by and through it various social service, public health, faith-based and governmental partners, in accordance with the federal Violence Against Women Act at 42 U.S.C. 13925 and 42 U.S.C. 14043e et seq. ("VAWA") and the implementing regulations for VAWA at 24 CFR part 5, subpart L (the "Implementing Regulations"), is required by law to extend special concerns and efforts to and on behalf of a certain class of tenants who

live in housing located within Palm Beach County, or under certain programs, a certain class of tenants who live in eligible housing located within Palm Beach County, an a certain class of homeless persons who live in Palm Beach County, each of who benefit from or are supported by funding provided by program of U.S. Department of Housing and Urban Development (HUD)(such persons, collectively, are Eligible Persons).

In the event that a client is in need of an emergency transfer as outlined in the Palm Beach County Emergency Transfer Plan (Attachment C), that client shall be prioritized for the first available bed.

UNACCOMPANIED YOUTH AND TRANSITION AGE YOUTH

Unaccompanied youth is a fast growing and underserved sub- population, in our community.

Clients:

Unaccompanied Youth (ages 13-17) and Transition Age Youth (ages 18-24) are defined as youth and transition age youth who are unaccompanied by a parent or guardian and are without shelter where appropriate care and supervision are available, whose parent or guardian is unable or unwilling to provide shelter and care, or who lack a fixed, regular and adequate nighttime residence. Undocumented unaccompanied youth and transition age youth may also be served under these provisions except where exclusions are noted. Unaccompanied youth may be encountered during outreach but would not enter the Homeless Resource Center due to their age. City provisions prevent anyone under 18 from entering the program unless they had legally been as an emancipated as an adult. Those under 18 would be connected to the appropriate program based on their age and circumstances.

Providers:

Providers of services for unaccompanied youth and transition age youth should be able to provide safe and high quality housing and supportive services (scattered-site independent apartments, host homes, and shared housing) to youth and transition age youth experiencing homelessness that involve integrated affordable housing, intensive strength-based case management, self-sufficiency services, trauma informed care, and positive youth development approaches.

HRC Agency:

All housing referrals for unaccompanied youth and transition age youth must be screened and assessed. The HRC Agency is responsible for overseeing and ensuring that:

- Transition Age Youth willingly engage with coordinated intake for a screening and when appropriate, a TAY-SPDAT.
- Low barriers of entry for this highly vulnerable population are necessary.
- Navigators consult with expert providers of this population when conducting intake to properly match clients and providers, and reduce the risk of flight for this highly vulnerable population.

PROGRAM EVALUATION

Coordinated Intake and Assessment is one of many projects within our community that addresses the needs of individuals and families that are at risk or experiencing homelessness within our communities. The HRC Partner Agencies will evaluate the effectiveness as well as required HEARTH Act outcomes by utilizing data from HMIS. As recommended by the National Alliance to End Homelessness, the HRC Partner Agencies will track progress in the following areas to evaluate the Coordinated Intake and Assessment process:

- Length of stay, particularly in shelter: If participants are referred to the right interventions and those interventions have the necessary capacity, fewer individuals and families should be staying in shelter waiting to be moved elsewhere. Also if clients are referred immediately to the right provider, over time, clients will likely spend less time jumping from program to program looking for help, which could reduce their overall length and/or repeated episodes of homelessness.
- New entries into homelessness: if every individual and family seeking assistance come through the front door and the front door has prevention and diversion resources available, more people should be able to access these resources and avoid entering a program unnecessarily.
- Repeat episodes of homelessness: If clients are sent to the intervention that is the best suited to meet their needs on the first time, families are more likely to remain stably housed.

To track the outcomes summarized above, the CoC Lead Agency will analyze the following Performance Measures annually.

1) PBC CoC will reduce the number of person experiencing homelessness.
    a. Reduction in the total number of persons experiencing homelessness
    b. Reduction in the total number of persons experiencing first time homelessness.
2) PBC CoC will reduce the length of homelessness episodes
    a. Reduction in the mean length of homelessness episode for individuals
    b. Reduction in the mean length of homelessness episode for families with children
    c. Reduction in the mean length of homelessness episode for youth

3) PBC CoC will reduce the number of persons returning to homelessness.
    a. Reduction in return to homelessness within one year following exit
    b. Increase in exits to permanent housing
    c. Increase in income at exit

Measuring the success of this system and transparency with the community and providers will be a key to the success of coordinated assessment process. The CoC Lead Agency will summarize the data annually. The performance measures are utilized for all CoC programs regardless of funding source. For CoC funded and ESG funded programs, these criteria will be utilized for consideration for renewal or new projects based on the program type.

Moving forward, the CoC Lead Agency will expand the evaluation of outcomes by establishing mechanisms to monitor the quality of service through system-wide monitoring. For example, once a client enters shelter an assessment is to be completed within 72 hours. Procedures will be built into the monitoring system to determine how often this goal is met. This will allow for ongoing monitoring of the quality of services and how the program and Providers are able to follow through with this goal.

As part of the evaluation process, as recommended by the National Alliance to End Homelessness, the CoC Lead Agency will set a goal to establish an integrated feedback loop that involves using information gained from these assessments to make any necessary program/process adjustments to the system. Additionally, the CoC Lead Agency will continue working to develop data tools to ensure overall system efficiency and effectiveness.

VERSION HISTORY

Updated & Ratified by Homeless & Housing Alliance Governance Board - February 2024
Reviewed & Updated by Homeless & Housing Alliance Coordinated Entry Workgroup – August 2023
Updated & Ratified by Homeless & Housing Alliance Governance Board – May 25, 2022
Updated & Ratified by Homeless & Housing Alliance Executive Committee – Nov 17, 2021
Updated & Ratified by Homeless & Housing Alliance Executive Committee – March 25, 2021 Reviewed & Updated by Standards Policies & Procedures Committee – July 9, 2019
Adopted by Homeless and Housing Alliance Membership – May 26, 2018
Adopted by Homeless and Housing Alliance Membership – August 24, 2017
Reviewed & Updated by Homeless & Housing Alliance Membership – March 23, 2016
Ratified by Homeless & Housing Alliance Executive Committee -February 23, 2015 Adopted by Homeless & Housing Alliance Membership - February 26, 2015

Appendix A

Palm Beach County Continuum of Care Chronic Homelessness Prioritization

(a) **First Priority–Homeless Individuals and Families with a Disability with Long Periods of Episodic Homelessness and Severe Service Needs**

An individual or family that is eligible for CoC Program-funded PSH who has experienced four occasions where they have been living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter or where the cumulative time homeless is at least 12 months and has been identified as having severe service needs.

(b) **Second Priority–Homeless Individuals and Families with a Disability with Severe Service Needs.**

An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or in an emergency shelter and has been identified as having severe service needs. The length of time in which households have been homeless should also be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

There are no chronically homeless households that meet the criteria for dedicated PSH beds in Order of Priority1.

(c) **Third Priority—Homeless Individuals and Families with a Disability Coming from Places Not Meant for Human Habitation, Safe Haven, or Emergency Shelter Without Severe Service Needs.**

An individual or family that is eligible for CoC Program-funded PSH who is residing in a place not meant for human habitation, a safe haven, or an emergency shelter where the individual or family has not been identified as having severe service needs. The length of time in which households have been homeless should be considered when prioritizing households that meet this order of priority, but there is not a minimum length of time required.

There are no chronically homeless households that meet the criteria for dedicated PSH beds in Order of Priority1 or 2.

(d) **Fourth Priority–Homeless Individuals and Families with a Disability Coming from Transitional Housing.**

An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing had lived in a place not meant for human habitation, in an emergency shelter, or safe haven. This priority also includes individuals and families residing in transitional housing who were fleeing or attempting

to flee domestic violence, dating violence, sexual assault, or stalking and prior to residing in that transitional housing project even if they did not live in a place not meant for human habitation, an emergency shelter, or a safe haven prior to entry in the transitional housing.
There are no chronically homeless households that meet the criteria for dedicated PSH beds in Order of Priority 1, 2 or 3.

CoC Program-funded PSH must follow the order of priority above, as adopted by the CoC, while also considering the goals and any identified target populations served by the project. For example, non-dedicated or non-prioritized CoC Program-funded PSH that is permitted to target youth experiencing homelessness should follow the order of priority as adopted by the CoC, to the extent in which youth meet the stated criteria.
CoC Grantees must exercise due diligence when conducting outreach and assessment to ensure that persons are prioritized for assistance based on their length of time homeless and the severity of their needs following the order of priority described in this Notice, and as adopted by the CoC. HUD recognizes that some persons–particularly those living on the streets or in places not meant for human habitation–might require significant engagement and contacts prior to their entering housing and recipients are not required to keep units vacant indefinitely while waiting for an identified eligible individual or family to accept an offer of PSH (see FAQ 1895). CoC Program-funded PSH must follow a Housing First approach to the maximum extent practicable. Street outreach providers should continue to make attempts to engage those persons that have been resistant to accepting an offer of PSH and where the CoC has adopted these orders of priority into their written standards, these individuals and families must continue to be prioritized until they are housed.

Chronic Homeless Definition
Chronically Homeless: The definition of" chronically homeless" currently in effect for the CoC Program is that which is defined in the CoC Program interim rule at 24 CFR 578.3, which states that a chronically homeless person is:

An individual who:

- Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
- Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and

- Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

An individual who:

- Has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days;
- Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and
- Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

A family with an adult head of household (or if there is no adult in the family, a minor head of household) including a family whose composition has fluctuated while the head of household has been homeless who:

- Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
- Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and

- Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

Severity of Service Needs

Individual or Family for whom at least one of the following is true:

- History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; or
- Significant health or behavioral health challenges or functional impairments which require a significant level of support in order to maintain permanent housing.

Severe service needs should be identified and verified through data-driven methods through the use of a standardized assessment tool that can identify the severity of needs such as the Vulnerability Index (VI), the Service Prioritization Decision Assistance Tool (SPDAT)

Documentation of Disability:

Evidence of diagnosis with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.

Evidence of this criterion must include one of the following:
1) Written verification of the condition from a professional licensed by the state to diagnose and treat the condition;
2) Written verification from the Social Security Administration;
3) Copies of a disability check (e.g., Social Security Disability Insurance check or Veterans Disability Compensation);
4) Intake staff (or referral staff) observation that is confirmed by written verification of the condition from a professional licensed by the state to diagnose and treat the condition that is confirmed within 45 days of the application for assistance and accompanied with one of the types of evidence above; or
5) HUD Verification of Disability Form from a MD, DO, LCPC, LCSW, APRN-BC, or NP.

Documentation of Chronic Homelessness

Chronic Homelessness: An individual or household must have had either one occasion that lasted continuously without a break for 12 months or over a period of at least four occasions, each separated by a break where cumulative length of time homeless totals at least 12 months.

Written Intake Procedures to ensure compliance with the definition of chronically homeless the order of priority for obtaining evidence as: (1) third-party documentation, (2) intake worker observations, and (3) certification from the person seeking assistance. Records contained in an HMIS or comparable database used by victim service or legal service providers are acceptable evidence of third-party documentation and intake worker observations if the HMIS retains an auditable history of all entries, including the person who entered the data, the date of entry, and the change made; and if the HMIS prevents overrides or changes of the dates entries are made.

Duration of homelessness:

Evidence that the homeless occasion was continuous, for at least one year: documentation that the homeless occasion was continuous, for a year period, without a break in living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter.

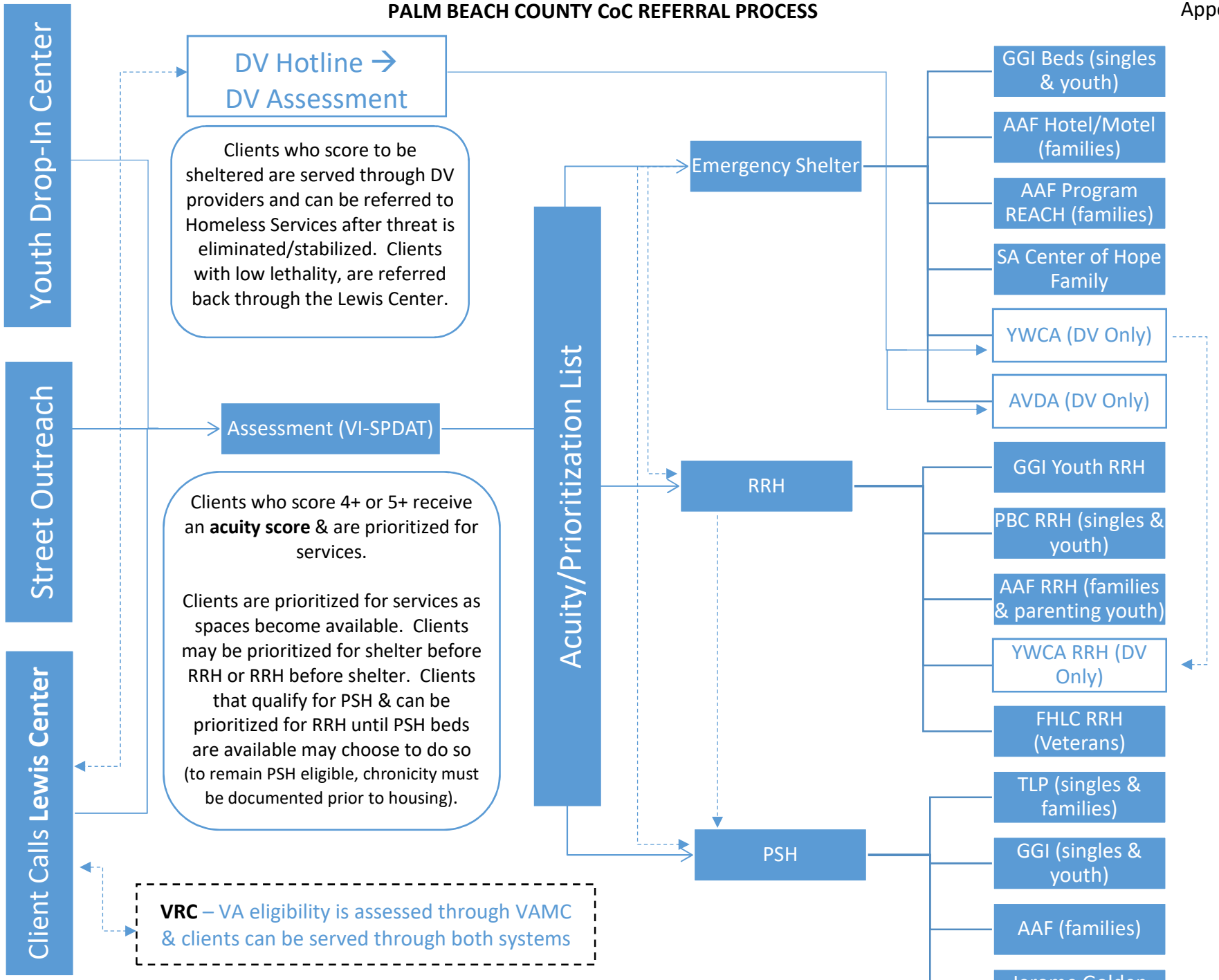
- A break is considered at least seven or more consecutive nights not residing in a place not meant for human habitation, in shelter, or in a safe haven.
- A single encounter with a homeless service provider on a single day within 1 month that is documented through third-party documentation is sufficient to consider an individual or family as homeless for the entire month unless there is any evidence that the household has had a break in homeless status during that month.

Evidence that the household experienced at least four separate homeless occasions over 3 years: evidence that the head of household or an individual experienced at least four, separate, occasions of homelessness in the past 3 years.

- Documentation preference is for at least three occasions to be documented by either: (1) HMIS data, (2) a written referral, or (3) a written observation. Any other occasion may be documented by a self-certification with no other supporting documentation.
- HUD will permit a certification from the individual or head of household seeking assistance in place of third-party documentation for the three occasions that must be documented by either: (1) HMIS data, (2) a written referral, or (3) a written observation. Where third-party evidence could not be obtained, the intake worker must obtain a certification from the individual or head of household seeking assistance, and must document efforts made to obtain third-party evidence, and document of the severity of the situation in which the individual has been living.

Is there a minimum number of days in which a person must be homeless in order for that period to count as an occasion? No**.** In order to provide the maximum extent of flexibility to communities, HUD has not required that a single occasion of homelessness must total a certain number of days. Instead, HUD would consider an occasion to be any period of homelessness where the household resided in a place not meant for human habitation, an emergency shelter, or a safe haven where that period was demarcated by a break, defined as at least 7 or more consecutive nights not residing in a place not meant for human habitation, in shelter, or in a safe haven.

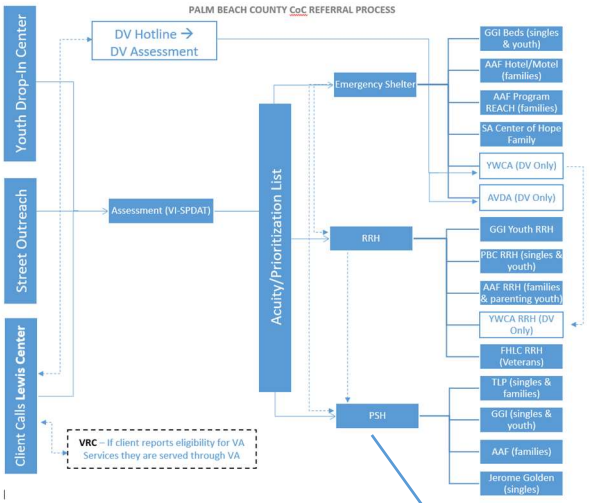
PALM BEACH COUNTY CoC REFERRAL PROCESS



Dashed lines indicate the movement clients can make when transferring/exiting to other programs. See the next charts for more details about the referral processes from the prioritization list to a program.

*See Coordinated Entry Standards for more information on how **acuity scores** are calculated based on population.

PALM BEACH COUNTY CoC REFERRAL PROCESS



Permanent Supportive Housing Referral Process

Clients can be referred to PSH from Outreach, Emergency Shelter & Rapid Rehousing.

Prioritization Meeting to staff client referrals based on acuity

- Partner agencies present
- Units identified by partner agencies
- Clients prioritized and doc readiness is discussed

→ Client is contacted by agreed upon staff to be notified of referral

Client is contacted by partner agency to schedule intake

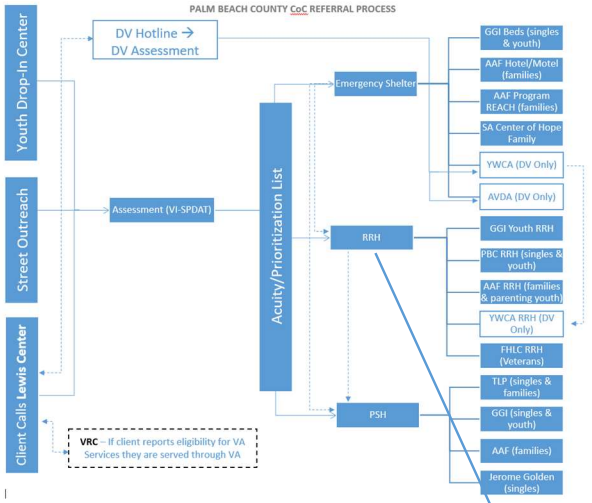
- For Single Adults/Youth client is offered space in LC Transitions until unit becomes available. If declined, client can be housed from streets.

→ Client is accepted into program

Client removed from PSH prioritization list during Prioritization Meeting

*See Coordinated Entry Standards for more information on how **acuity scores** are calculated based on population.

PALM BEACH COUNTY CoC REFERRAL PROCESS



Rapid Re-Housing Referral Process

Clients can be placed in RRH as a placeholder for PSH. In these instances Chronicity Documentation will need to be collected prior to referral.

Prioritization Meeting hosted by CE Managing Entities

- Clients from Emergency shelter & streets are included

Number of openings in RRH determined by funding and Case Management availability

Clients prioritized for referrals based on Acuity Score

Clients referred to RRH

- Based first on sub-population if for targeted funding (youth-specific)
- Then based on Acuity Score/Level

Clients notified of referral & paired with CM/HS to assist them with housing process

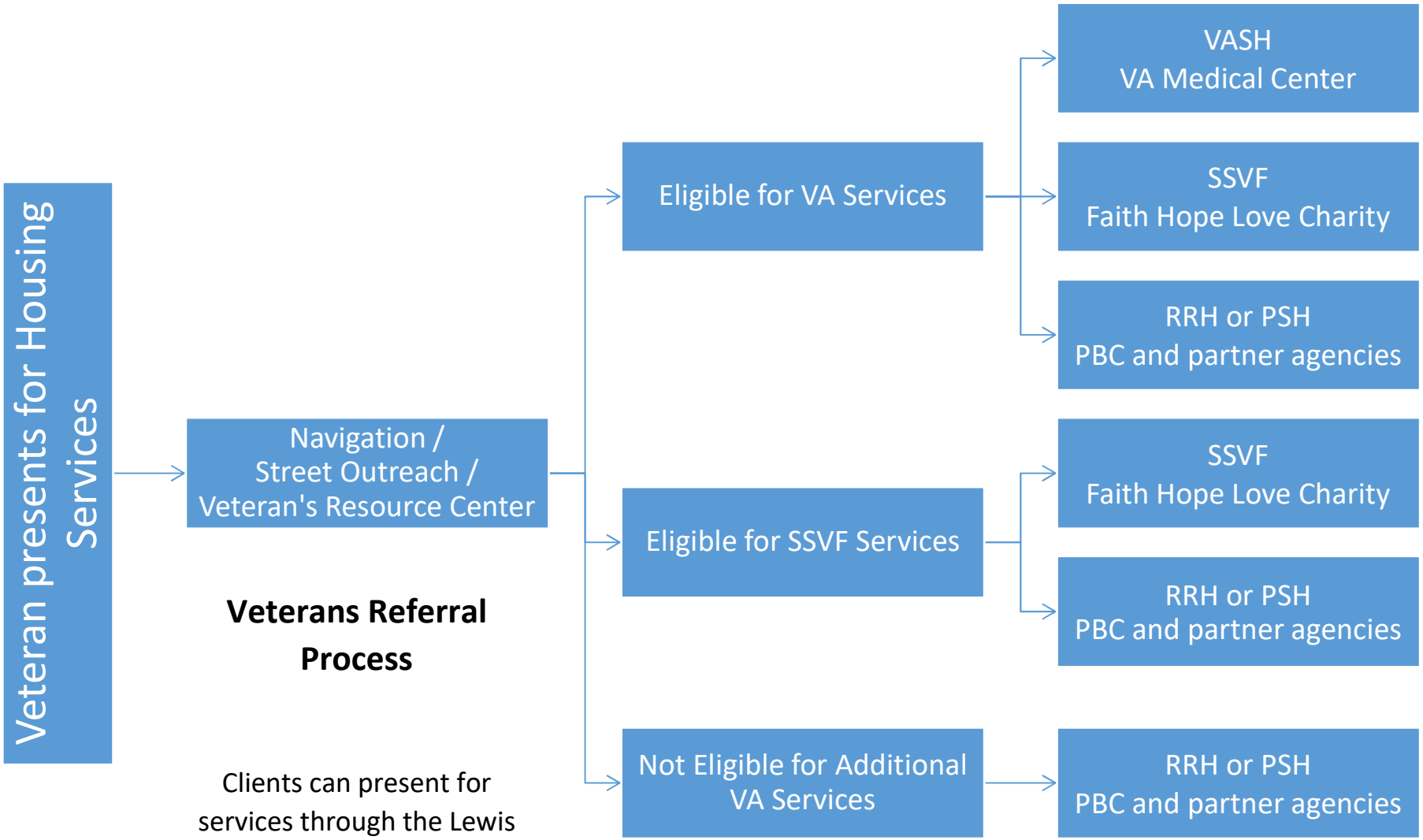
Client removed from RRH prioritization list

- Client works with HS/CM until housed or diverted

CM – Case Manager
HS – Housing Specialist

*See Coordinated Entry Standards for more information on how **acuity scores** are calculated based on population.

PALM BEACH COUNTY CoC REFERRAL PROCESS



Veterans Referral Process

Clients can present for services through the Lewis Center, Street Outreach, or Veteran's Resource Center. VAMC assesses for VA eligibility & clients can be served through both systems.

*See Coordinated Entry Standards for more information on how **acuity scores** are calculated based on population.

Appendix C

Palm Beach County Emergency Transfer Plan

For

Victims of Domestic Violence, Dating Violence,

Sexual Assault or Stalking

Effective August 23, 2018

This Plan is also available on the Homeless and Housing Alliance website as well as the Ending Homelessness website.

Palm Beach County's Continuum of Care, by and through it various social service, public health, faith-based and governmental partners, in accordance with the federal Violence Against Women Act at 42 U.S.C. 13925 and 42 U.S.C. 14043e et seq. ("VAWA") and the implementing regulations for VAWA at 24 CFR part 5, subpart L (the "Implementing Regulations"), is required by law to extend special concerns and efforts to and on behalf of a certain class of tenants who live in housing located within Palm Beach County, or under certain programs, a certain class of tenants who live in eligible housing located within Palm Beach County, an a certain class of homeless persons who live in Palm Beach County, each of who benefit from or are supported by funding provided by program of U.S. Department of Housing and Urban Development (HUD)(such persons, collectively, are Eligible Persons).

About VAWA

VAWA provides certain protections for victims of domestic violence, dating violence, sexual assault, or stalking. VAWA protections are not limited to only women but instead are available equally to all qualifying individuals regardless of sex, sexual orientation, or gender identity.

The relevant HUD programs for Palm Beach County purposes are:

1. The HOME Program
2. The Emergency Solutions Grant (ESG)
3. The Continuum of Care (CoC) program
4. HOPWA

For the purpose of this Plan, any housing programs that are supported by funding provided through any of these HUD programs shall be called HUD Program Supported Housing.

Eligibility for VAWA Emergency Transfer Plan

Under the Implementing Regulations, an Eligible Person who is a victim of domestic violence, dating violence, sexual assault, or stalking, as those terms are defined in the Implementing Regulations, is eligible for an emergency unit transfer or in the case of sexual assault, relocation to an appropriate housing provider. All requests must meet one of the following situations and each request must follow the procedures as stated in Documentation section.

1) The eligible person reasonably believes there is a threat of imminent harm from further violence if the Eligible Person remains within the same dwelling unit that the Eligible Person is currently occupying.

Or

2) In the case of an Eligible Person who is the victim of sexual assault, either the Eligible Persons reasonably believes there is a threat of imminent harm from further violence if the eligible Person remains within the same dwelling unit that the Eligible Person is currently occupying, or the sexual assault occurred on the premises during the 90-calendar-day period preceding the date of the request for transfer.

An eligible person who is not in good standing under the eligible person's HUD Program Supported Housing may still request emergency transfer if the eligible persons meets the eligibility requirement herein.

Emergency Transfer Request Documentation:

To request an emergency transfer or relocation, the eligible person shall submit a written request for a transfer to the property or program administrative offices. Each program or property administrative office will provide reasonable accommodations to the policy for persons with disabilities. The eligible person written request for an emergency transfer should include either:

1) A statement expressing that the eligible person reasonably believes that there is a threat of imminent harm from further violence if the eligible person were to remain in the same dwelling unit; OR
2) A statement that the eligible person was sexually assaulted on the premises during the 90-Day calendar period the proceeding the request for an emergency transfer.

*please note that each property or program administrator must maintain a confidential record of emergency transfer requests and their outcomes for three years.

Emergency Transfer Timing and Availability

The housing program cannot guarantee that a transfer request will be approved or how long it will take to process a transfer request. However, the housing program, will act as quickly as possible to move a tenant who is a victim of domestic violence, dating violence, sexual assault, or stalking to another unit, subject to availability and safety of a unit. If a tenant reasonably believes a proposed transfer would not be safe, the tenant may request a transfer to a different unit. If a unit is available, the transferred tenant must agree to abide by the terms and conditions that govern occupancy in the unit to which the tenant has been transferred. The housing program may be unable to transfer a tenant to a particular unit if the tenant has not or cannot establish eligibility for that unit. If the housing program has no safe and available units for which a tenant who needs an emergency transfer is eligible, the housing program with the client's permission will collaborate with the Prioritization Committee and present at the weekly case conference meetings to assist the tenant in identifying safe and available units to which the tenant could move. At the tenant's request, the housing program will also assist tenants in contacting the local organizations offering assistance to victims of domestic violence, dating violence, sexual assault, or stalking that are attached to this plan.

For households living in assisted units who qualify for an emergency transfer but a safe unit is not immediately available for an internal emergency transfer, the individual or family shall have priority over all other applicants for rental assistance, transitional housing, and permanent supportive housing projects funded under this part, provided that: 1. the individual or family meets all eligibility criteria required by Federal law or regulation or HUD NOFA; and 2. the individual or family meets any additional criteria or preferences established in accordance with 24 CFR 578.93(b)(1),(4),(6), or (7).

The individual or family shall retain their original homeless or chronically homeless status for the purposes of the transfer.

In cases where a household receiving assistance separates in order to effect an emergency transfer, the housing program, in consultation with the CoC, will determine appropriate actions with respect to the non-transferring family member(s). The Housing Provider, with the client's permission, will coordinate with the Lewis Center for placement in a Transition bed, if appropriate and available in an attempt to prevent a return to homelessness for the non-transferring family member.

Confidentiality:

Property or Program Administration will keep confidential any information that the eligible person submits in requesting an emergency transfer, and information about the emergency transfer, unless the eligible person gives a specific release of information that is time limited, or disclosure of the information is required by law or required for use in an eviction proceeding or hearing regarding termination of assistance for the covered program. This includes keeping confidential the new location of the dwelling unit of the resident, if one is provided, from the person(s) that committed an act(s) of domestic violence, dating violence, sexual assault or stalking against the resident.

This Does Not Replace Other Laws

This plan does not replace any Federal, State or local law that provides greater protection for victims of domestic violence, dating violence, sexual assault, or stalking. Eligible persons may be entitled to additional housing protections for victims of domestic violence, dating violence, sexual assault or stalking under other Federal laws, as well as under State and local laws.

Recordkeeping and Reporting:

The covered housing provider is required, under the Implementing Regulations, to keep certain information in its files. The covered housing provider must keep a record of all emergency transfer requests made and the outcomes of such requests and 1) retain records of such requests and outcomes for three years and 2) while not violating the confidentiality requirements listed above, report certain information to HUD annually.

Safety and Security of Eligible Persons:

Eligible persons who have been victims of domestic violence are encouraged to contact the National Domestic Violence Hotline at 1-800-799-7233, the Florida Domestic Violence Hotline at 1-800-500-1119, or a local domestic violence shelter (YWCA 561-640-8944) (AVDA 800-355-8547) (Palm Beach County Victim Services, Certified Rape Crisis Center 866-891-7273). For persons with hearing impairments, the National Domestic Violence Hotline cas be accessed by calling 1-800-787-3224 (TTY) and the State of Florida Domestic Violence Hotline can be accessed by calling 1-800-621-4202 (TTY).

Attachments:

Please see the attached Certification of Domestic Violence form.

CERTIFICATION OF DOMESTIC VIOLENCE, SEXUAL ASSAULT, OR STALKING, AND ALTERNATE DOCUMENTATION

U.S. Department of Housing and Urban Development

OMB Approval No. 2577-0286

Purpose of Form: The Violence Against Women Act ("VAWA") protects applicants, tenants, and program participants in certain HUD programs from being evicted, denied housing assistance, or terminated from housing assistance based on acts of domestic violence, dating violence, sexual assault, or stalking against them. Despite the name of this law, VAWA protection is available to victims of domestic violence, dating violence, sexual assault, and stalking, regardless of sex, gender identity, or sexual orientation.

Use of This Optional Form: If you are seeking VAWA protections from your housing provider, your housing provider may give you a written request that asks you to submit documentation about the incident or incidents of domestic violence, dating violence, sexual assault, or stalking.

In response to this request, you or someone on your behalf may complete this optional form and submit it to your housing provider, or you may submit one of the following types of third-party documentation:

(1) A document signed by you and an employee, agent, or volunteer of a victim service provider, an attorney, or medical professional, or a mental health professional (collectively, "professional") from whom you have sought assistance relating to domestic violence, dating violence, sexual assault, or stalking, or the effects of abuse. The document must specify, under penalty of perjury, that the professional believes the incident or incidents of domestic violence, dating violence, sexual assault, or stalking occurred and meet the definition of "domestic violence," "dating violence," "sexual assault," or "stalking" in HUD's regulations at 24 CFR 5.2003.

(2) A record of a Federal, State, tribal, territorial or local law enforcement agency, court, or administrative agency; or

(3) At the discretion of the housing provider, a statement or other evidence provided by the applicant or tenant.

Submission of Documentation: The time period to submit documentation is 14 business days from the date that you receive a written request from your housing provider asking that you provide documentation of the occurrence of domestic violence, dating violence, sexual assault, or stalking. Your housing provider may, but is not required to, extend the time period to submit the documentation, if you request an extension of the time period. If the requested information is not received within 14 business days of when you received the request for the documentation, or any extension of the date provided by your housing provider, your housing provider does not need to grant you any of the VAWA protections. Distribution or issuance of this form does not serve as a written request for certification.

Confidentiality: All information provided to your housing provider concerning the incident(s) of domestic violence, dating violence, sexual assault, or stalking shall be kept confidential and such details shall not be entered into any shared database. Employees of your housing provider are not to have access to these details unless to grant or deny VAWA protections to you, and such employees may not disclose this information to any other entity or individual, except to the extent that disclosure is: (i) consented to by you in writing in a time-limited release; (ii) required for use in an eviction proceeding or hearing regarding termination of assistance; or (iii) otherwise required by applicable law.

_____ _____

Client Signature **Date**

TO BE COMPLETED BY OR ON BEHALF OF THE VICTIM OF DOMESTIC VIOLENCE, DATING VIOLENCE, SEXUAL ASSAULT, OR STALKING

1. **Date the written request is received by victim: _____**

2. **Name of victim: _____**

3. **Your name (if different from victim's):_____**

4. **Name(s) of other family member(s) listed on the lease:_____**

_____

5. **Residence of victim: _____**

6. **Name of the accused perpetrator (if known and can be safely disclosed):_____**

_____

7. **Relationship of the accused perpetrator to the victim:_____**

8. **Date(s) and times(s) of incident(s) (if known):_____**

_____

10. **Location of incident(s):_____**

In your own words, briefly describe the incident(s):

_____

_____

_____

This is to certify that the information provided on this form is true and correct to the best of my knowledge and recollection, and that the individual named above in Item 2 is or has been a victim of domestic violence, dating violence, sexual assault, or stalking. I acknowledge that submission of false information could jeopardize program eligibility and could be the basis for denial of admission, termination of assistance, or eviction.

Signature _____Signed on (Date) _____

Public Reporting Burden: The public reporting burden for this collection of information is estimated to average 1 hour per response. This includes the time for collecting, reviewing, and reporting the data. The information provided is to be used by the housing provider to request certification that the applicant or tenant is a victim of domestic violence, dating violence, sexual assault, or stalking. The information is subject to the confidentiality requirements of VAWA. This agency may not collect this information, and you are not required to complete this form, unless it displays a currently valid Office of Management and Budget control number.

Appendix D

Adult-Homelessness Prevention Targeting Tool

Instructions:
The homelessness prevention targeting tool is designed to assist program staff with two functions: 1) verify eligibility for homelessness prevention assistance and 2) identify the most vulnerable adults who are most likely to experience literal homelessness if they do not receive assistance. In assisting with these two activities (verifying eligibility and targeting most vulnerable adults), the tool will support the goals of preventing the incidence of new cases of homelessness in Palm Beach County.

To administer the tool, agency staff should check each box for which the condition or attribute is present. Each checked box has a point value associated with it. After completing all questions, staff will add up the value of all checked boxes and assign a total score to the presenting household. As a screening tool the questions are designed to identify adults who are most likely to experience literal homelessness in the imminent future (within 1 month) and for whom the experience of homelessness will pose the greatest risk for increased trauma, severe health consequences, and/or greatest degree of instability. While no tool can precisely predict the future, this tool is based on national research and program evaluation data which identify conditions, characteristics, and attributes most closely associated with future incidence of literal homelessness.

Step 1. Determine if the presenting household is eligible for prevention assistance. Agency staff should document eligibility evidence by securing a copy of the eviction notice, 'pay or vacate' notice, or through written or oral communication with a friend/family member where the presenting adult is currently doubled up. In order to be eligible for prevention assistance, the presenting adult must provide third party documentation evidence and complete the Imminent Risk of Homelessness Certification Form.

Step 2. Determine targeting priority based on vulnerability of housing barriers. Agency staff will ask a series of questions of the prospective prevention participant to determine the presence of current or past conditions that are most closely correlated with the incidence of literal homelessness. Check each box where the condition is present or true for the adult.

Step 3. Determine targeting priority based on local policy priorities. Agency staff will ask a series of questions of the prospective prevention participant to determine whether they meet the criteria for local policy priorities. Check each box where the condition is present or true for the adult.

The prevention targeting tool is critical [because our community does not have sufficient resources to provide homelessness prevention services to every household that may be eligible for services]. An individual must score a 19 or higher on the targeting tool to receive homeless prevention services. This threshold will be evaluated throughout the system and may be altered depending on resource availability. Adults that are both determined eligible for prevention and score within the appropriate range on the prevention targeting tool may receive the full range of homelessness prevention services. These adults should be enrolled in the homelessness prevention program and tracked within HMIS.

Those adults who do not meet the threshold should be provided ***Light Touch Assistance***. *Light Touch Assistance* refers to the provision of all types of homelessness prevention assistance except temporary financial assistance. *Light Touch Assistance* is inclusive of mediation, case management, connection to community-based services and mainstream benefits, support accessing or maintain safe housing, and other forms of non-financial crisis response assistance, all which should not exceed more than 1 day of service. Households receiving *Light Touch Assistance* are considered enrolled in homelessness prevention program and are subject to the full requirements of client data collection and entry into HMIS.

Score Range	Possible Threshold Impact
0 – 18	Eligible for *Light Touch Assistance*
19 +	Scores of 19 and greater eligible for full homelessness prevention assistance

Determine if the household meets the Annual Gross eligible income requirement: All households must fall below 50% of the Area Median Income (AMI) to qualify for prevention services. If the individual is in subsidized housing AND currently or formerly under a homeless housing assistance program (i.e. Homeless Section 8), they can also qualify for prevention services with income up to 80% of the Area Median Income (AMI). See Income limit summary below (on referenced chart) or at the United States Department of Housing and Urban Development (HUD) link to determine the latest annual income limits.

FY 2020 Income Limits Summary: West Palm Beach-Boca Raton, FL HUD Medium Family Income $79,100. website more information https://www.huduser.gov/portal/elist/2020-April-14.html								
Income Limit	**Household Size**							
Area Median Income (AMI)	**1**	**2**	**3**	**4**	**5**	**6**	**7**	**8**
Extremely Low 0-30% AMI	$18,450	$21,100	$23,750	$26,350	$30,680	$35,160	$39,640	$44,120
Very Low 31%-50% AMI	$30,750	$35,150	$39,550	$43,900	$47,450	$50,950	$54,450	$57,950
Low 51%-80% AMI	$49,200	$56,200	$63,250	$70,250	$75,900	$81,500	$87,150	$92,750

Determine if the household meets the Age eligible requirement:
All households must be over the age of 18 in order to qualify for adult prevention services. If the individual or head of household is between the ages of 18-24 they can choose to be served by either a youth prevention provider or an adult prevention provider.

If the adult prevention provider is serving a youth between the ages of 18-24 they shall use the Youth Homelessness Prevention Targeting Tool.

First Name: _____ **Last Name:** _____ **HMIS #:** _____

Date of Birth: _____ **Age:** _____ **Contact Phone Number:** _____

Household Size: _____ **Number of Adults:** _____ **Number of Minors:** _____

Instructions: Check each applicable condition that is true for the prospective applicant (head of household). Each column (A- 0) has a question(s) with an attached point value. If a column has more than one question, please make sure to select one answer when asked to 'select only one below'. Next add the total number of points at the end of the tool to obtain the total score. Lastly, staff administering the tool shall ensure the Staff Certification section is completed, dated and signed.

STEP 1: Determine Eligibility & Priority for Homelessness Prevention Assistance

		Household is at imminent risk of literal homelessness. Without prevention assistance the household will experience literally homelessness within the immediately preceding month (i.e. either living in a place not meant for human habitation or residing in an emergency shelter or transitional housing facility intended for persons and households who are homeless).	Check if Applicable	Point Value
1.		Housing Status (Select ONLY one below)		
	1a.	If DOUBLED UP, the household has been told by the lease holder to vacate the unit. Program staff has verified with lease holder that prospective PRV participant is no longer welcome and must vacate. Prospective participant lacks the resources to secure alternative housing arrangements.	☐	5
	1b.	If LEASE HOLDER, the household has received an Unlawful Detainer ("Eviction") lawsuit by the property owner or manager. An Unlawful Detainer is a formal eviction action that is filed in justice court. Program staff has verified with property owner/manager that prospective PRV participant has received notice to vacate. Prospective participant lacks the resources to secure alternative housing arrangements.	☐	1
	1c.	Currently fleeing or attempting to flee domestic violence, dating violence, sexual assault, or other dangerous or life-threatening conditions that relate to violence against any household member.	☐	5
	1d.	Staying in a hotel in which adult is paying out of pocket, but can no longer sustain in the unit due to costs. Agency staff have verified with adult costs of increase in hotel, debt to cost ratio, applicable after a certain amount of days paying out of pocket. Prospective participant lacks the resources to secure alternative housing arrangements.	☐	5
2.		Imminent loss of current housing. Loss of housing means the prospective household will experience literal homelessness – either on the streets or staying in an emergency shelter. Imminent loss of current housing must be verified with a '*pay or vacate'* notice from landlord/property manager, lease holder or motel/hotel, ledger record of past due rent, or court paperwork showing the prospective PRV participant is at risk of losing housing. (Select ONLY one below)		
	2a.	Have failed to respond to the Unlawful Detainer notice within 5 days of the court hearing or have received a court ruling with a date the person must move out. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 24 hours.	☐	5
	2b.	Have been served an Unlawful Detainer requiring court response or have an already determined court date. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 48 hours.	☐	4
	2c.	Have received a 3-day pay or quit notice with more than one month of rent owed. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 3 days.	☐	3
	2d.	Have received a 3-day pay or quit notice with less than one month of rent owed. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 1 week.	☐	2
	2e.	Have received a 30-day Notice to vacate or experiencing a housing crisis that will lead to an expected loss of housing within 1 month. Or, lease holder (or motel/hotel management) has mandated prospective participant must leave within 1 month.	☐	1
		**If none of the items from STEP 1 are applicable and person scores less than 2, adult does not meet eligibility requirements. Refer to community resources.**	**SUBTOTAL:**	____

STEP 2: Determine Targeting Priority Based on Vulnerabilities or Housing Barriers

		Identify the barriers impacting household's ability to independently and quickly resolve housing issues and prevent literal homelessness from occurring in the imminent future.	Check if Applicable	Point Value
3.		Household Annual Gross Income Amount (Select ONLY one)		
	3a.	Household current income is $0	☐	5
	3b.	Income is less than 30% of Area Median Income (AMI) for household size (See chart)	☐	4
	3c.	Income is between 31-50% of AMI for household size (See chart)	☐	3
4.		Within the last 60 days, adult has experienced sudden and significant loss of income, including loss of employment and/or cash benefits AND/OR experienced an uncontrollable and significant increase in non-discretionary expenses	☐	3
5.		Prior rental evictions at any time in the past (Select ONLY one)		
	5a.	4 or more prior rental evictions	☐	5
	5b.	2-3 prior rental evictions	☐	4
	5c.	1 prior rental eviction	☐	3
6.		Required to register as a sex offender	☐	5
7.		History of literal homelessness for Head of Household. Literal homeless includes living in a place not meant for human habitation (e.g., street, sidewalk, vehicle, park, abandoned building), a safe haven, an emergency shelter, transitional housing and hotels and motels paid or by a charitable organization. An episode would include staying in and of the above-mentioned places. (Select ONLY one)		
	8a.	4 or more prior episodes OR total of at least 12 months within past three years	☐	5
	8b.	2-3 prior episodes in past three years	☐	4
	8c.	1 prior episode in past three years	☐	3
8.		Adult experienced adversity or housing disruptions during childhood. Examples of childhood adversity could include homelessness, placement in foster care, eviction, refugee or immigrant to the U.S., or frequent moves (>3 in 1 year)	☐	2
9.		Current involvement with Adult Protective Services (APS) or Child Protective Services	☐	2
10.		Recently (within last 6 months) experienced a major household trauma or event that directly affects ability to secure or maintain housing. Examples of trauma or event include death of family member, separation or divorce from adult partner, birth of a new child.	☐	3
11.		Recently (within last 6 months) discharged from an institution after stay of any length. Examples of institutions include hospital, jail, prison, psychiatric hospital or substance abuse treatment facility.	☐	3
		**Calculate Step 2 Subtotal.**	**SUBTOTAL:**	_____

STEP 3: Determine Targeting Priority Based on Local Policy Priorities

Identify the factors relevant to local policy priorities that increase the risk that the prospective prevention participant will experience literal homelessness.			Check if Applicable	Point Value
12.		Within the past two years (24 months), household was housed through a homeless housing assistance program in Palm Beach County. (i.e. Homeless Housing Assistance programs include CoC Permanent Housing, Homeless Section 8, Rapid Rehousing, etc.)	☐	5
13.		History of involvement in the foster care or criminal justice system.	☐	4
14.		Adult has a disability (i.e., a physical or mental impairment that substantially limits one or more major life activities; has a record of such impairment; or is regarded as having such an impairment)	☐	3
15.		Adult is 55 years old or older	☐	3
16.		Type of residence the adult is currently residing in (Select ONLY one)		
	17a.	Permanent Supportive Housing (PSH)	☐	5
	17b.	A unit using a Housing Choice Voucher (HCV) or under rent-control	☐	3
		**Calculate Step 3 Subtotal.**	**SUBTOTAL:**	_____
			TOTAL POINTS	_____

HEAD OF HOUSEHOLD CERTIFICATION

I certify that, to the best of my knowledge and belief, all the information presented is true, accurate and complete.

Head of Household's Name: _____ Head of Household's Signature: _____

Date Completed: _____

STAFF CERTIFICATION

I certify that, to the best of my knowledge and belief, all the information presented is true, accurate and complete.

Agency Name: _____

Agency Address: _____

Staff Name: _____ Staff Title: _____

E-Mail: _____ Phone: _____

Staff Signature: _____ Date Completed: _____