Coordinated Entry System
Policy & Procedures

Pinellas County
Continuum of Care

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Introduction and Overview

The housing system can feel like a maze for individuals experiencing homelessness. Trying to determine who to talk to, how to get there, and where to begin can be confusing and overwhelming. Coordinated Entry (CE) improves access to resources through standardized assessments and coordinated referrals to ensure people experiencing homelessness receive appropriate assistance with immediate and long-term needs. This document describes the data-driven and evidence-informed strategies the Pinellas County Continuum of Care (CoC) utilizes to serve those experiencing homelessness in the most effective way possible.

All CoC and Emergency Solutions Grant (ESG) funded projects are required to participate in CE. The CoC will work with all local projects and funders to facilitate their participation in the CE.

Guiding Principles

The CoC establishes the following guiding principles for its CE:

1. CE will operate with a person-centered approach, and with person-centered outcomes.
2. CE will ensure that participants receive access to the most appropriate services and housing resources available.
3. CE will reduce the stress of the experience of being homeless by limiting assessments and interviews to only the most pertinent information necessary to resolve the participant's immediate housing crisis.
4. CE will incorporate cultural and linguistic competencies and will focus on equity in all engagement, assessment, and referral coordination activities.
5. CE will integrate mainstream service providers into the system.
6. CE will utilize HMIS for the purposes of managing participant information.
7. CE will ensure that participants do not stay on the prioritization waiting list for any longer than necessary.

Revision History

The CoC's Board of Directors shall be responsible for the revision, review, and approval of the CE Policies & Procedures. The revision process will be completed at least once annually, and anyone who is interested in submitting suggestions for revisions to the document should submit them to SBoylan@HLAPpinellas.org.

- June 10, 2016 – Original
- January 18, 2018
- August 3, 2018
- December 8, 2018
- October 22, 2020
- February 24, 2021 – Three COVID-19 related amendments
- November 4, 2022

Key Definitions

See Attachment A for a full list of acronyms and definitions.

Full Geographic Coverage

The CoC's CE system covers the CoC's entire geographic area of Pinellas County.

CoC and ESG Coordination

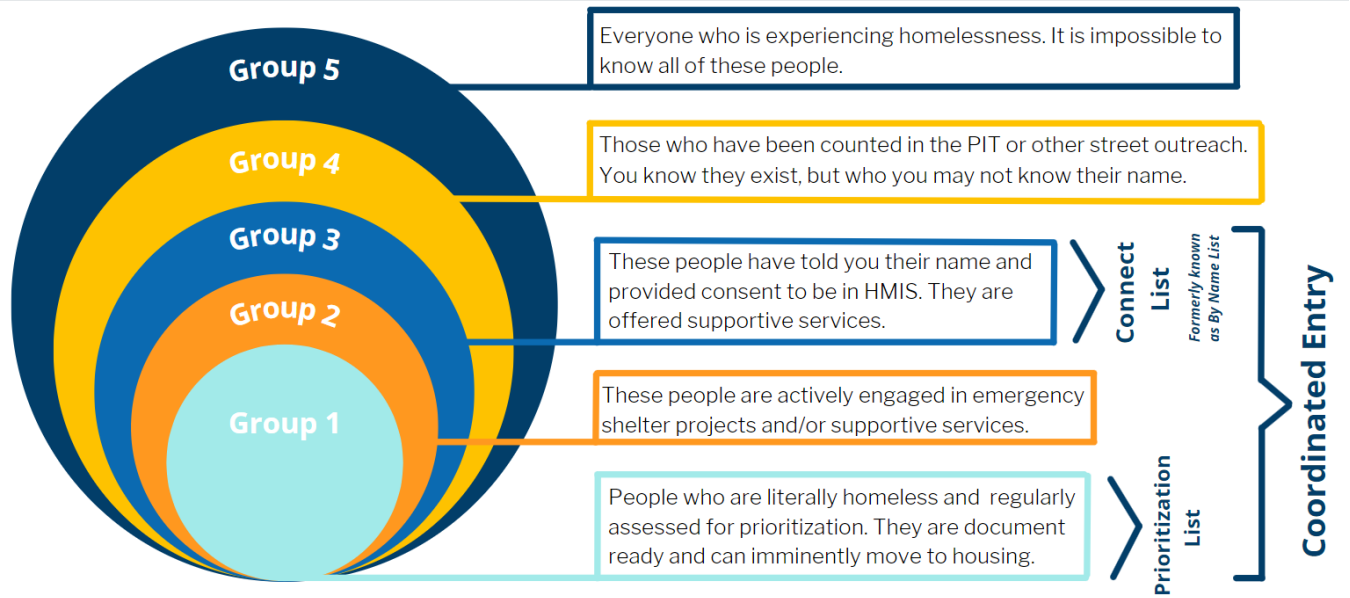
The CoC is committed to aligning and coordinating CE policies and procedures regarding access, assessment, and prioritization with its written standards for administering CoC and ESG program funds. The CoC, in consultation with recipients of ESG Program funds within the geographic area, have established and consistently follow written standards for providing Continuum of Care assistance that can guide the development of formalized policies and procedures for the coordinated entry process. These written standards provide guidance for evaluating individuals' and families' eligibility for assistance and determining and prioritizing who will receive transitional housing, rapid re-housing, and permanent supportive housing assistance. A copy of these standards is included in Attachment B of this document.

Representatives from the CoC and ESG recipient agencies will identify any changes to their written standards and share those with the CoC's CE Specialist (contact below) at least annually. Any updates to the written standards will be reflected in this document.

Sezen Boylan
Coordinated Entry Specialist
727-641-2475
SBoylan@HLApinellas.org

CoC Prioritization Groups

The Pinellas CoC utilizes five prioritization groups to determine the most appropriate intervention at the current point in time. These groups should not be seen as a hierarchy, as clients are not required to go through each group to receive housing assistance.



Group 5 acknowledges the CoC's incomplete knowledge of the total number and characteristics of the people

experiencing homelessness in the community. Group 4 is the most complete count we have and is created through data from the Point in Time County or through Street Outreach. We know these people exist, but we may not know their names or anything about them.

Group 3 consists of clients who are on the "Connect List," formerly known as the By Name List. They have provided their name and consent to be in HMIS. These clients are offered supportive services while they wait for permanent housing. This group also includes clients who may have only accessed the system once. For example, someone that visited a food bank years ago will still show up as a known client in HMIS. Clients in Group 2 are similar to those in Group 3 in that they have provided consent to be in HMIS, but they are currently and/or frequently accessing services. Group 1 consists of clients who are on the "Prioritization List," and are literally homeless, document ready, and regularly assessed for prioritization. Clients in Groups 1, 2, and 3 are all considered to be in actively participating in "Coordinated Entry."

Affirmative Marketing

The CoC will affirmatively market housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, handicap, or likeliness to apply for assistance. CE will be marketed primarily through the Homeless Leadership Alliance of Pinellas' (HLA). An agency can request a CE presentation for their staff or service population by contacting the CE Specialist at SBoylan@HLApinellas.org. CE will have a link on the HLA's website and will encourage participating agencies to provide a link to the CE web page on their homepage. All access points will provide a uniform message, providing an overview of CE.

Each project participating in CE and CE access points are to provide an electronic or printed copy of a CE one pager provided by the CoC. Other homeless service agencies are encouraged to provide the one pager in the agency waiting areas and other areas where participants congregate or receive services. A staff member at each access point should be knowledgeable of CE so they can be utilized as a resource for clients and other staff.

Nondiscrimination

The CoC will ensure the CE process is available to all eligible persons and does not discriminate or prioritize households for housing and services based on race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. Additionally, the age and gender of a child under age 18 may not be used for denying any family's admission. The CE referral process is informed by federal, state, and local laws and regulations and ensures participants are not "steered" toward any housing facility or neighborhood. This nondiscrimination policy is extended to all agencies that participate in CE.

The HLA Rapid Resolution team and Homeless Housing providers are responsible for providing individuals and households with information, in writing, on their rights and remedies under applicable federal, state, and local fair housing and civil rights laws. Applicable laws and regulations include, but are not limited to:

- Fair Housing Act – prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status.
- Section 504 of the Rehabilitation Act – prohibits discrimination on the basis of disability under any program or activity receiving federal financial assistance.
- Title VI of the Civil Rights Act – prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving federal financial assistance.

- Title II of the Americans with Disabilities Act – prohibits public entities, which include state and local governments and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing and housing-related services such as housing search and referral assistance.
- Title III of the Americans with Disabilities Act – prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.
- Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity – A 2012 HUD final rule guaranteeing equal access to all HUD program participants.
- Pinellas Continuum of Care Diversity, Equity, and Inclusion Statement – Declared Pinellas County a diverse, inclusive, and equitable Continuum of Care (CoC) where all clients, providers, stakeholders, members, employees, and volunteers--whatever their gender, race, ethnicity, national origin, age, sexual orientation or identity, education or disability--feel valued and respected.

Rights and remedies must be provided immediately upon working with any household. To ensure effective communication, CE staff must provide reasonable accommodations and modifications of this information as necessary.

All participants have the right to file a nondiscrimination complaint with the HLA's Coordinated Entry Specialist, Sezen Boylan. The complaint can be emailed to SBoylan@HLApinellas.org or mailed to the HLA at 740 4th Street North, Suite 206, St. Petersburg, Florida 33701. The complaint will be reviewed by the CE Specialist, Sr. Strategy and Innovations Manager, Chief of Evaluation and Strategy, and the HLA Chief Executive Officer (CEO). If the issue is unable to be resolved by HLA staff, the issue will be elevated to the CoC Grievance Committee.

The CoC has designated the CoC Board of Directors as the entity responsible for monitoring agencies on compliance with all CE requirements, including adherence to civil rights and fair housing laws and regulations. Failure to comply with these laws and regulations will result in a monitoring finding on the project, which may affect its position in the local CoC rating and ranking process. If the CoC encounters a condition or action that impedes fair housing choice, the CoC shall work with the provider to address and remedy the violation(s).

Reasonable Accommodations and Modifications

The HLA Rapid Resolution team and Homeless Housing providers should provide or connect to organizations that can provide reasonable accommodations and modifications to persons with disabilities to ensure equal access to the CE system and/or housing. Examples of accommodations include but are not limited to:

- Braille, audio, assistive listening devices, and sign language interpreters
- Changes to rules, policies, and procedures to allow a person with a disability to enjoy housing
    - For example, a person with a mobility impairment may request a reasonable accommodation to complete an assessment at a different location accessible to him/her
- Translation services for individuals/households with Limited English Proficiency and/or providing information in accessible formats, such large fonts or type

Cultural and Linguistic Competence

Cultural competence involves understanding and appropriately responding to unique cultural variables, including age, ability, beliefs, ethnicity, experiences, gender identity, gender, linguistic background, national origin, religion, sexual

orientation, and socioeconomic status. CE assessments must include trauma- informed culturally and linguistically competent questions for special subpopulations, including immigrants, refugees, and other subpopulations including but not limited to youth, persons fleeing or attempting to flee DV, and LGBTQIA+ persons.

Organizations and their personnel should do what is reasonably necessary to communicate effectively and convey information in a manner that is easily understood by diverse groups. This linguistic competence includes the ability to effectively communication with persons of limited English proficiency, those who have low literacy skills or are not literate, individuals with disabilities, and those who are deaf or hard of hearing.

The HLA must be culturally and linguistically competent and are provided regular training opportunities to build these skills. HLA must provide or must connect to organizations that can provide information about services and supports in the preferred language, mode of delivery, and/or in the alternative format needed by any population. HLA is expected to develop partnerships with culturally and linguistically competent partners such as the Hispanic Outreach Center and the Lealman and Asian Neighborhood Family Center (LANFC).

Safety Planning and Risk Assessment for Survivors of Domestic Violence

Individuals and households who are fleeing, or attempting to flee, domestic violence (DV), dating violence, sexual assault, or stalking may access the full range of housing and service intervention options available in the CoC.

If a client or household is a victim of domestic violence and presents for intake at a non-victim service provider, they will be connected to homeless shelters and housing options that are best equipped to serve survivors of DV and their children based on their location, program model, and linkages to other supportive services. The CE system includes two domestic violence hotlines; one of which is staffed by CASA (727-895-4912) and the other by the Haven (727-442-4128), both operated 24 hours a day, seven days a week. All persons will have access to these hotlines regardless of which access point they initially contact for services and assistance.

The CoC partners with the local victim service provider agencies to ensure that training for relevant staff is provided by informed experts on domestic violence, dating violence, sexual assault, stalking, and human trafficking. All CE staff are trained on the complex dynamics of domestic violence, privacy and confidentiality, and safety planning, including handling emergency situations at an access point(s), whether a physical or virtual location. Victim service providers within the CoC utilize the same CE Assessment to ensure the coordinated entry process addresses the participants' physical and emotional safety and confidentiality needs.

See Attachment C for the CE DV Emergency Transfer Plan.

Grievance Policy

See Attachment D for the full CE Grievance Policy and Procedure

Clients who feel they did not receive fair treatment, were denied resources, or given an inappropriate referral may file a formal grievance orally or in writing. CE system partners must provide all individuals and households with the CE Grievance Policy upon intake. See table below for explanation of grievance type and receiving authority.

	Agency Grievances	Fair Housing Grievances	Coordinated Entry Grievances
Description	Grievances related to the individual's or family's experience with a CE partner agency.	Grievances related to discrimination.	Grievances related to the Coordinated Entry Policies and Procedures and/or CE decisions.
Submit To	Offending Agency	Pinellas County Office of Human Rights 400 S. Ft. Harrison Ave., 5th Floor Clearwater, FL 33756 727-464-4880 pinellascounty.org/humanrights/	Sezen Boylan Coordinated Entry Specialist Homeless Leadership Alliance of Pinellas 740 4th Street North, Suite 206, St. Petersburg, Florida 33701727.582.7921 SBoylan@HLApinellas.org Grievances related to the Coordinated Entry Manager should be submitted to the CEO at info@hlapinellas.org

Racial Equity Monitoring

The CoC's Diversity, Equity, and Inclusion Committee will quarterly review disaggregated inflow data from Pinellas HMIS to determine if Black, Indigenous, and people of color (BIPOC) are housed at a rate that is proportionate to their make-up of homeless households within the CoC to assist in the development of strategies to ensure continuum-wide equitable access for BIPOC. Inflow data includes clients that have been active in CE, homeless, and housing services within the past 90-days. The HLA will review data for households with minor children separately from adult-only households.

The information will be presented to the CoC Board of Directors annually and at minimum will include:

- A review of HMIS inflow data to determine the rate at which BIPOC are being prioritized for housing and compare it to the proportional ratio of the CoC's racial demographics.
- Recommendations for policy changes to help achieve racial equity within CE's prioritization process.

Access

The CoC utilizes the same assessment at all access points throughout Pinellas County. Every household type including youth only, single adult individuals, adult only households including non-married couples or friends, LGBTQIA+ households, and households with minor children including adopted children and other children under their care may present to any access point. All emergency services may be accessed regardless of the operating hours of the CE system's intake and assessment processes. Access points include emergency shelters, street outreach teams, 211 Tampa Bay Cares and Community and Veteran Navigators.

All access points must be easily accessed by individuals and families seeking shelter or homelessness prevention services. If an access point is not able to meet a persons' needs, an initial screening will be conducted to link them to the appropriate special population (youth, domestic violence, and veteran) services. The next section details specific access points available for special populations.

Housing First and Low Barrier Access

Housing First is a philosophy that homelessness can be most efficiently ended by providing households with access to safe, decent, and affordable housing, regardless of if an individual experiencing homelessness may benefit from supportive services, such as mental health or substance abuse counseling. The participation in these services is not a prerequisite to access housing or a condition of maintaining it.

The CoC believes Housing First programs are effective in engaging and assisting all subpopulations of homeless persons to a path to permanent, stable housing. The CoC requires adoption of the Housing First philosophy and full participation in CE by all CoC and ESG-funded entities.

Designated Access Points

The CoC has designated the following access points for the Coordinated Entry System:

- 2-1-1 Tampa Bay Cares for Families with Minor Children Only
- Street Outreach
- HLA Rapid Resolution for Families with Minor Children Only
- Community Action Stops Abuse (CASA) and Hope Villages of Americans' Haven (DV Survivors Only)
- HLA Veteran Navigators for Veterans Only

All designated access points shall execute a CE Participation Agreement with the Homeless Leadership Alliance of Pinellas (HLA) agreeing to all CE functions and responsibilities.

Specialized Access Points

The CoC has identified a specialized access points at CASA and Hope Villages of American's Haven to ensure survivors of DV receive appropriate housing and supportive services to resolve their housing crisis. These DV shelter providers will conduct the initial CE Assessment to determine acuity. If a participant needs the confidential nature of DV services, they will continue to work with the agency. If they do not require DV specific services, they will be referred

to another service provider.

To ensure there is sufficient coordination and specialized attention given to literally homeless veterans, the CoC has identified a specialized access point at the Homeless Leadership Alliance, Veteran Navigation, to screen Veterans for eligible Veteran related programs such as the Homeless Veteran Grant Per Diem Program, VA benefits such as HUD-Veterans Affairs Supportive Housing (VASH), and Supportive Services for Veteran Families (SSVF).

Emergency Services

Mainstream Services

Depending on the access point, Coordinated Entry assessment services may only be available during regular business hours. If in need of information and referrals during non-business hours, call 2-1-1. If experiencing a life-threatening medical emergency or other life-threatening situation, call 9-1-1.

Domestic Violence (DV)

For individuals and families imminently fleeing a DV situation, the local CASA Domestic Violence Hotline (727) 895-4912 and the Haven Domestic Violence Hotline (727) 442-4128 can provide connections to resources, assistance, and emergency shelter 24 hours a day, 7 days a week.

Homeless Prevention

A strong CE system allows for service interventions before a loss of housing has occurred. Homeless Prevention targets people at imminent risk of homelessness and offers time-limited assistance to families and individuals. Homeless Prevention projects can be reached through contacting 2-1-1 Tampa Bay Cares. The assistance may not be enough to cover all needs but can often leverage other income and support which allows people to remain housed. Agencies providing Homeless Prevention services will screen clients for eligibility and enroll them. The Pinellas CoC has agreed to use the following prevention strategies at system access points:

- Provide housing negotiation, mediation, and counseling services
- Help clients negotiate the terms by which they can stay in or return to housing
- Provide relocation assistance
- Provide financial assistance to pay for rent or utility arrearages, transportation for housing search, first and last month's rent, security deposit, application fees, and help with moving costs and utility connections through:
    - Emergency Solutions Grant (ESG)
    - Temporary Assistance for Needy Families (TANF)
    - Emergency Food and Shelter Program (EFSP)
    - Family Services Initiative (FSI)
    - Social Action Funding (SAF)
    - Adult Emergency Financial Assistance Program (AEFAP)
    - Community Housing Assistance Program (CHAP)

Veterans who meet eligibility requirements may be eligible for Supportive Services for Veteran Families (SSVF) Homeless Prevention through St. Vincent de Paul. For assistance in determining eligibility, email HLA's Veteran Navigation team at VetNav@hlapinellas.org.

Diversion

Diversion programs can reduce the number of individuals/households becoming homeless, the demand for shelter beds, and the size of program wait lists. By offering diversion services at every of point of the system, households who would otherwise enter shelter maintain their current housing situation or quickly relocate to an alternate housing option. To determine which households are appropriate for diversion, the following screening questions may be asked:

1. What are the circumstances surrounding the assistance you are seeking?
2. Are you currently homeless for 72 hours or less? Or do you believe you will become homeless in the next 72 hours?
3. Where did you sleep last night? (at-risk and literal)
4. Was it a safe location? ___Yes ___No
    a. If no, ask "Are you currently residing with, or trying to leave, an intimate partner, family member, caregiver, or other person in your home who threatens you or makes you fearful?" ___Yes ___No and "Is there another place you can think of where you feel safe and could stay for a couple of nights?"
    b. If yes, ask "Could you stay at the same location tonight?"
5. Is there anyone else you could stay with more permanently? (Network: friends, family, co-workers)
6. Do you think there is anything that may help you stay at that location such as: ___Landlord Mediation ___Conflict Resolution ___Rental Assistance ($____) ___Utility Assistance ($_____) ___Other Financial Assistance ($_____)
7. Have you been in shelter within the past 365 days? ___Yes __No

Depending on the clients' answers, the Pinellas CoC has agreed to use the following diversion strategies:

- A provision of financial, utility, and/or rental assistance.
- Short-term case management.
- Traveler's aid/relocation assistance, including limited transportation to bus stations, airport, etc.
- Conflict mediation.
- Connection to mainstream services (services that come from agencies outside of the homeless assistance system, such as welfare agencies) and/or benefits

Street Outreach

It is the policy of the CoC for Street Outreach to serve as an access point for the Pinellas CoC's coordinated entry system. Outreach workers will provide standard assessments to all unsheltered households in the CoC program to facilitate referral to emergency shelter, as space allows and with client consent. Outreach workers will complete the CE Assessment for all Category 1 Homeless as described in the 'Assessment' protocols below to facilitate placement on the CoC's Coordinated Entry Prioritization List. Outreach workers are also able to conduct the family shelter assessment to all unsheltered households with minor children to facilitate referral to emergency shelter as space allows.

The Street Outreach program provides three types of outreach: (1) jurisdictional street outreach, sometimes pairing a Street Outreach worker with a Law Enforcement officer who both canvas areas within their jurisdiction looking for and engaging with individuals and families who are living street homeless, (2) dispatchable street outreach (see Dispatchable Street Outreach below) and (3) targeted street outreach which are aimed at assisting the most high-risk populations.

Special Populations

Dispatchable Street Outreach: Directions for Living Dispatchable Street Outreach for Seniors (62+) works with 211 Tampa Bay Cares to engage seniors who are experiencing homelessness and may be living on the street, in a car, or in another location not meant for human habitation. Contact 2-1-1 for services.

Youth Services: Family Resources Safe Connections Outreach team seeks out runaway and homeless youth 24 years of age and younger on the streets of Pinellas County to assess their immediate needs and provide services, while reviewing options for a more sustainable, safe lifestyle. Street Outreach services include survival aid, crisis intervention, access to emergency shelter, and referrals to supportive services. Contact the Street Outreach Team at (727) 256-7035 or (727) 220-9246. If an unaccompanied youth presents to an adult only or family access point, they will be immediately connected to youth services.

Community Outreach Partners: Service only organizations and local municipalities' Emergency Management departments could also be CE access points. If interested, the agency should contact Avery Slyker at aslyker@hlapinellas.org.

HLA Rapid Resolution

Rapid Resolution Specialists work with the Pinellas CoC, partner agencies, and homeless outreach teams to build relationships with those experiencing homelessness, provide advocacy for clients in their housing search, and assist with connection to benefits and other resources. Community Navigator duties and responsibilities include:

- Providing light case management for Category 1 homeless families with minor children to access resources until shelter or permanent housing is obtained
- Providing advocacy for homeless families when they encounter barriers
- Assistance in obtaining housing readiness documentation such as ID's, social security card, birth certificates, background verification, and income verification for all households experiencing Category 1 homelessness.
- Completing chronicity verification paperwork for individuals pending referral or referred to PSH programs
- Conducting the Family Shelter Assessment (FSA) and the CE Assessment on Category 1 homeless families
- Providing information on public transportation and discounted/free transportation opportunities
- Assisting in case conferencing for Category 1 homeless individuals

HLA Veteran Navigation

Veteran Navigators work with partner agencies, homeless outreach teams, and the local Veterans Affairs team to build relationships with those experiencing homelessness, provide advocacy for clients in their housing search, and assist with connection to benefits and other resources. Veteran Navigator responsibilities also include:

- Providing light case management for Category 1 homeless participants to access resources until shelter or permanent housing is obtained
- Providing advocacy for homeless participants when they encounter barriers
- Assistance in obtaining housing readiness documentation such as ID's, social security card, birth certificates, background verification, and income verification
- Facilitating and assisting with bi-monthly case conferencing for Category 1 homeless individuals

Assessment

The use of shared assessment tools ensures the CE process is consistently applied to achieve fair, equitable, and equal access to services throughout the community. A person-centered focus grounds the assessment to connect people to community resources and support. The assessment process uses a trauma-informed approach to collect only enough participant information to prioritize and refer participants to housing and supportive services. All projects participating in CE must follow the assessment protocols of the CE system described herein. The assessment process varies by participant and access point, but will include one or more of the following tools:

- Family Shelter Assessment (Attachment E)
- Coordinated Entry Assessment (Attachment F)
- Service Prioritization Decision Assistance Tool (SPDAT) (Attachment G)

Qualified Assessors and Assessment Timelines

Family Shelter Assessment (FSA)

The Family Shelter Assessment is used to determine risk and prioritization of Category 1 homeless families with minor children in need of emergency shelter. Once the assessment is completed, the family is immediately placed on the Family Shelter Prioritization List and assigned to a Rapid Resolution Specialist. This assessment allows families access to the CE System without presenting at emergency shelter and expedites the time before they are connected to a housing program. The following providers are qualified to conduct the FSA:

1. 211 Tampa Bay Cares
    a. Category 1 homeless families who call 211's Homeless Helpline will be given the FSA immediately
2. HLA Rapid Resolution
    a. Category 1 homeless families who are referred to the HLA Rapid Resolution team, or who utilize the online Get Help form (https://hlapinellas.wufoo.com/forms/homeless-leadership-alliance-contact-form/) will be assessed within three business days
3. Saint Vincent de Paul (SVdP) Center of Hope
    a. Category 1 homeless families who call SVdP's Center of Hope will be given the FSA when there is staff availability and capacity or if a family shows up with an urgent need, otherwise they will refer to 211's Homeless Helpline
4. Street Outreach

CE Assessment

CE assessments may only be conducted by:

1. Street Outreach
    a. Individuals encountered by street outreach and/or service centers are given the option to be brought to an emergency shelter when there is capacity
        i. If they agree, the shelter is responsible for the CE Assessment
        ii. If they do not agree, street outreach is responsible for conducting the CE Assessment
            - If an individual *has* been entered into HMIS in the past 6 months, they will be given a CE Assessment immediately
            - If an individual has not been entered in HMIS for 7 months or longer, they will be

given a CE Assessment on their third interaction with the client to allow for self-resolution or connection with diversion services

- Street Outreach has the discretion to conduct the CE assessment prior to the third interaction with the client if the client is a part of the CoC priority populations or shows evidence of high service needs

b. Families with children under 18 should be given the CE Assessment immediately
c. Unaccompanied youth encountered by street outreach are assessed for and provided with services to meet their immediate needs. Youth ages 10-17 will be given the option to be brought to SafePlace2B Youth Emergency Shelter. Youth 18-24 will be given the option to go to an emergency shelter.
    i. If they agree, the shelter is responsible for the CE Assessment (18-24)
    ii. If they do not agree, street outreach is responsible for the CE Assessment (18-24)

2. Emergency Shelter Case Managers
    a. Once an individual or family has been admitted to a shelter, the shelter staff will review their Homeless Management Information System (HMIS) record and determine the need for assessment.
        i. If an individual *has* been entered into HMIS in the past 6 months, they will be given a CE Assessment within 3 business days
        ii. If an individual *has not* been entered in HMIS for 7 months or longer, they will be given a CE Assessment after the client has been in shelter for 10 business days to allow for self-resolution or connection with diversion services
            - Emergency Shelter Staff have the discretion to conduct the CE assessment prior to the 14-day mark if the client is a part of the CoC priority populations or shows evidence of high service needs
    b. Families will be given the CE Assessment within 3 business days regardless of HMIS history if they do not already have one completed within the last 90 days.
    c. Once an unaccompanied youth has been admitted to a shelter, the shelter staff will review their Homeless Management Information System (HMIS) record and determine the need for assessment.
    d. Diversion services should be continuous.
3. HLA Rapid Resolution
    a. Literally homeless households with minor children that call 211 and cannot access emergency shelter due to the lack of capacity will be scheduled for a CE Assessment with an HLA Community Navigator.
        i. 211 is responsible for scheduling the assessment appointment between the HLA and the household via Calendly
4. HLA Veteran Navigation
    a. Veterans who are referred to the HLA Veteran Navigation team, or who contact the HLA directly via VetNav@hlapinellas.org, will be contacted by the Veteran Navigation team within 3 business days to conduct a CE Assessment
5. Supportive Services for Veteran Families (SSVF)
    a. When a veteran presents to St. Vincent de Paul Emergency Shelter, SSVF case managers or Peer Mentors will review their Homeless Management Information System (HMIS) record and determine the need for assessment.

i. If an individual *has* been entered into HMIS in the past 6 months, they will be given a CE Assessment within 3 business days
ii. If an individual *has not* been entered in HMIS for 7 months or longer, they will be given a CE Assessment within 10 business days

6. Transitional Housing
    a. A client should have a CE Assessment completed if the client is going to exit to literal homelessness within 30 days as documented in their housing stability plan

Service Prioritization Decision Assistance Tool (SPDAT)

The SPDAT provides a fulsome assessment of housing and support needs to guide service prioritization, individualized service planning to identify the areas in the household's life where support is most likely necessary to avoid housing stability, homelessness proofing and tracking progress in the journey to housing stability.

1. Family Emergency Shelters providers should complete the FSPDAT Assessment after a family has been in emergency shelter for 90 days without connection to a Rapid Re-housing or Permanent Supportive Housing Program.
2. Rapid Re-Housing providers should complete the SPDAT assessment within the first 30 days of a household's project enrollment, 30 days after being housed, annually to the program entry date and then 30 days before program exit. If an RRH project is short term (not longer than 6 months), the SPDAT is required to be completed within the first 30 days of project enrollment, 30 days after being housed and 30 days prior to project exit.
3. Permanent Supportive Housing should complete the SPDAT assessment 30 days after enrollment, then 90 days, and then annually.

Participant Autonomy

CE participants may freely decide what information they provide during the assessment process. Participants may choose to refuse to answer assessment questions, but participants are advised that if they do, it may adversely affect their position on the prioritization list. The CE process may collect and document participant's membership in civil rights protected classes but will not consider membership in a protected class as justification for restricting, limiting, or steering participants to referral options.

Assessors should engage participants in an appropriate and respectful manner to collect only necessary assessment information. The assessment process may attempt to collect specific information about a person's diagnoses or disabilities, but only in so far as is necessary to determine program eligibility to make appropriate referrals, or in so far as is necessary to provide a reasonable accommodation for the household being served. Should a participate choose not to provide a piece of requested information, assessors need to openly communicate that it may make them ineligible for some programs. Assessors shall make every effort to assess and resolve the person's housing needs based on a participant's responses, no matter how limited they may be.

If participants refuse to answer some or all assessment questions, providers should:

- Attempt to understand whether the individual understands the questions being asked and/or whether the barrier is language, comprehension, lack of trust, or discomfort with the person asking the questions.
- Explain the impact of incomplete responses and continue to perform outreach and engagement activities

to build the relationship.

- Offer a different assessor or environment in which to complete the assessment.
- Consider participants that cannot be placed in housing because of a lack of information during Case Conferencing.
- Track how often participants are unable to be housed due to lack of information and evaluate further staff training needs to reduce occurrences.

Privacy Protections

CE participating agencies are required to notify and obtain participant consent for the collection, use, and disclosure of participants' personally identifiable information (PII). Unless in a local, state, or national state of emergency, CE participating agencies shall obtain written client consent from the participant during an in- person assessment. Verbal consent is allowed under a state of emergency, but it is valid for no longer than one year.

All participant information collected, stored, or shared in the operation of CE functions, regardless of whether data is stored in HMIS, shall be considered personal and sensitive information worthy of the full force of protection and security associated with data collected, stored, or shared in HMIS. All CE participating projects will ensure participants' PII will only be collected, managed, reported, and shared if secured in compliance with the HUD established HMIS privacy and security requirements.

Assessor Training

The CoC is committed to ensuring that all staff who assist with CE operations receive sufficient training to implement the CE system in accordance with these policies and procedures. Anyone who administers CE Assessment must complete a new user training, an annual refresher training and an annual Pinellas HMIS training. The purpose of CE Assessment training is to provide all staff administering assessments with access to materials that clearly describe the methods by which assessments are to be conducted with fidelity to the CoC's Coordinated Entry Policies and Procedures. Training will be offered at no cost to the agency or staff and will be delivered by an experienced professional trainer who is identified by the CoC. The assessment training will include but is not limited to:

- A review of CoC's written CE policies and procedures, including any adopted variations for specific subpopulations
- Requirements for the use of assessment information to determine prioritization
- Criteria for uniform decision-making and referrals
- Process for informing participants to file a nondiscrimination complaint
- Conditions for participants to maintain their place in coordinated entry prioritization lists when the participant rejects options
- Ensuring participants know they are allowed to decide what information they provide during the assessment process, to refuse to answer assessment without retribution or limiting their access to assistance
- Assessment engagement, including skills necessary to build trust and rapport with households during the assessment process, empathy, and empathetic responses, focusing on the feelings and thoughts of the individual completing the assessment, and active listening.

End users starting at an agency who were CE Assessment trained at their previous agency of employment are not required to have new user training if employment at the previous agency is within 6 months. The user must complete annual refresher training only.

A CE 101 informational video will be assigned to all new PHMIS users in Talent as an optional course. The HLA encourages service providers to include this video in onboarding for PHMIS users.

Updating the Assessment

Participant data in HMIS can be updated after an initial CE data collection period and throughout project enrollment to reflect emergence of new information, corrections to previously collected information, or additions of previously unanswered questions. Updates to all CE Assessments must be done through an interim update in HMIS. A full CE Assessment should be conducted again after 90 days to ensure the score is reflective of the client's current situation to connect the household to the proper resources.

Prioritization

Non-Veteran Households

The prioritization policies described herein ensure that households with the greatest needs receive priority for any housing and homeless assistance available in the CoC. Prioritization is based on specific and definable criteria collected via the CE Assessment. Prioritization criteria are separate and distinct from eligibility criteria for housing programs. It is ultimately the provider's responsibility to determine and document individual's/ household's eligibility for programs. Prioritization decisions are based on the following identified urgency and vulnerability factors based on assessment information:

- Household's length of time homeless
    - Determined by length of time reported during the CE Assessment in combination with a review of their Pinellas HMIS record.
- Service needs
    - Determined by the acuity captured in the CE Assessment. When applicable, portions of the assessment targeting the use of crisis services are administered to the head of the household if the CE Assessment does not accurately capture the household's needs.

*Prioritization decisions may change with the new Coordinated Entry Assessment utilized in 2023.

Housing units are defined as separate living quarters, such as a house, apartment, or mobile home. If the project allows for roommate rentals in one unit, the Housing Provider should be mindful of client choice and having a roommate may not be safe or conducive to the client. Refusal of participating in shared housing with a roommate should not be grounds for denying a referral.

Per HUD Notice CDP-17-01, CoC's should include participants' choices in coordinated entry process decisions such as location and type of housing, level and type of services, and other program characteristics. Therefore, clients scoring in the PSH range may select the lower intervention of RRH.

<u>Emergency Shelter for Individuals</u>

Entry to emergency shelter for individuals is not prioritized through CE, allowing for immediate crisis response for individuals seeking emergency services. Individuals are ensured access to emergency services through referrals obtained by contacting 2-1-1 Tampa Bay Cares. Individuals will be referred to emergency shelter and CE assessment will take place based on the assessment policies described above.

<u>Emergency Shelter for Families</u>

Entry to emergency shelter for families is prioritized through CE, utilizing the Family Shelter Assessment (FSA) score on the Shelter Prioritization List (SPL). The SPL prioritizes household vulnerabilities based on the households score on the FSA and advocacy at the weekly SPL case conferencing. Families with minor children will be referred to available shelter space as determined by the Family Crisis Flow Chart. See Attachment H for more information.

Veteran Households

Upon entering the homeless system through HLA Veteran Navigation, the Veteran will be screened for Veteran and

homeless status. If determined to be a Veteran other than dishonorable discharge and will be homeless within 30 days, the Veteran will be referred to Saint Vincent de Paul for SSVF eligibility determination. If the Veteran was originally not eligible for SSVF RRH, but circumstances changed that would make the Veteran eligible, they should contact HLA Veteran Navigation at VetNav@hlapinellas.org. Veterans who do not qualify for SSVF and Veterans whose status is dishonorable discharge are prioritized as under the Non-Veteran Households section above. See the Veteran Flow in Attachment I.

Individual and Family Scores for Prioritization

In response to the COVID-19 pandemic, the CoC voted to temporarily increase the VI/F/TAY-SPDAT assessment score required to refer individuals and households as show in the chart below. Before the pandemic, coordinated entry prioritized individuals scoring 4-7 and households with minor children scoring 4- 8 on the VI/F/TAY-SPDAT for rapid re-housing.

Individuals	
VI-SPDAT Score	Recommendation
10+	Permanent Supportive Housing - Participants must be chronically homeless and have a disability
4-9	Rapid Re-Housing
0-3	Diversion/One Time Financial Assistance Programs

Families	
VI-SPDAT Score	Recommendation
11+	Permanent Supportive Housing - Participants must be chronically homeless and have a disability
4-10	Rapid Re-Housing
0-3	Diversion/ One Time Financial Assistance Programs

Tie Breakers

The following criteria (only going to the next level as needed) will be used to break a tie between two or more individuals or families:

1. Pinellas County Resident for 1 or more years
2. HUD definition documented chronic homelessness
3. Documented veteran status
4. Score on Section D (Wellness) of the VI-SPDAT/F-VI-SPDAT
5. Score on Section B (Risks) of the VI-SPDAT/F-VI-SPDAT
6. Score on Section C (Socialization) of the VI-SPDAT/F-VI-SPDAT
7. Date of VI-SPDAT/F-VI-SPDAT Assessment

*Tiebreaker decisions may change with the new Coordinated Entry Assessment utilized in 2023.

Prioritization List Management

The Prioritization List is a list of all the households, which includes individuals, and families with minor children, , who have completed the CE assessment and are awaiting referral for housing assistance. It is used to manage prioritization or housing assistance and is maintained through HMIS. The Prioritization List is managed by HLA's Coordinated Entry Manager.

Every Monday, the CE Specialist generates the Prioritization List from Pinellas HMIS which is separated by individuals, families with minor children, and veterans.

Prioritization List meetings are a form of case conferencing that work on ensure the outcomes from the CE assessment closely align with the CE prioritization process by accounting for population-based vulnerabilities and risk factors. Prioritization List meetings provide an opportunity for providers that have direct contact with households experiencing homelessness to discuss critical updates to reduce barriers to accessing housing services. Any provider assisting the household should be in attendance, including potential housing providers such as RRH and PSH. Prioritization List meetings for families with minor children are held the third Thursday of the month; Veteran Prioritization List meetings are held every other Friday; Prioritization List meetings for individuals are to be held the first Thursday of each month.

Following the generation of the weekly Prioritization List, the CE Specialist reviews the list for proper enrollment in both shelter and RRH/PSH projects and makes efforts to ensure the data in HMIS is up to date. Providers are responsible for maintaining accurate and confidential case records and electronic files in HMIS to provide efficient CE assessment and referrals.

Prioritization List is set up to reflect that unreferred individuals and families are placed on the list in the order of the highest CE assessment scores and CoC determined tiebreakers. This creates the order for the CE Specialist to make referrals to housing providers.

Following unreferred clients is a household list, in alphabetical order of project enrollment that have been referred to housing providers. Following the referred household list are the households that were housed the prior week as part of the preparation for CE closures in HMIS, which is completed by the CE Specialist. The referred household portion of the Prioritization List is shared with providers, the unreferred list is maintained by the CE Specialist and will not be published.

Effective November 1, 2021, providers are required to make the following updates in HMIS, under CE notes section:

- Household progress
- Household cooperation with housing project
- Household location
- Households that have self-resolved their homeless episode
- Critical information that relates to ongoing eligibility of the household

There should NOT be any Protective Health Information (PHI) or Personally Identifiable Information (PII) entered in the CE notes section as they are not confidential. These notes will be generated on each Prioritization List to assist in prioritization and referral efforts. Providers must update HMIS when the client has been housed, so the next run of the Prioritization List is accurate, and the CE Specialist can close the household out of Coordinated Entry in HMIS.

Households Scoring 0-3

Families with minor children and individuals that score a 0-3 fall into the no housing intervention recommendation on the CE Assessment. The goal for these households is to assist with self-resolution for housing through referrals and links to mainstream services to meet immediate needs, Diversion assistance, or Rapid Resolution. For Veteran households that

score 0-3 on the CE assessment, a referral to St. Vincent de Paul's Rapid Resolution should be made within 24 business hours.

Households with CE assessment scores of 0-3 will remain on the Prioritization List for 30 days. If the homeless episode is resolved through Prevention service referral, Diversion, or Rapid Resolution, the case manager should notify the CE Specialist via email of the client's resolution so the client can be successfully exited from CE. If an individual enters back into the Homeless Prevention and Crisis Response System for shelter placement or referred to HLA Navigation for assistance during that 30 day period, the provider should update the CE Assessment to determine if the household's circumstances have changed. If a Veteran enters back into the system for shelter placement, was referred to the HLA Veteran Navigation Team, or is not eligible for Rapid Resolution, the provider should update the CE Assessment to determine if the household's circumstances have changed. If the CE assessment score is above a score of 3, the household and Veteran will remain on the By-Name List and wait for referral to a housing intervention.

If the assessment score does not change the household will be removed and the entry into CE will be closed. The Veteran should be referred to the Veteran's Association for additional resources.

If the CE assessor believes that the CE assessment score do not accurately capture the household's urgent need for housing, the assessor is to request a case conferencing from Coordinated Entry by contacting the CE Specialist These case conferences will take place during By-Name List meetings.

Documentation

RRH

HLA Rapid Resolution and Veteran Navigation staff work together to assist households to gather documentation of eligibility for rapid re-housing programs. Preparing clients to become "document ready" for RRH can include assisting them in obtaining proof of identity (ID, Birth Certificate, SS Card), relationship status (marriage license), proof of custody for households with minor age children, Veteran documents (Veteran status, DD214) and current benefits (VA, SSI/SSDI, TANF, EBT).

While Rapid Resolution and Veteran Navigators make great efforts to get households document ready prior to referral, the responsibility ultimately rests with project staff to collect only the documentation necessary to verify household eligibility and complete enrollment.

PSH

Rapid Resolution, Veteran Navigators, and emergency shelter staff work together to assist households with completion of the Chronic Condition Verification Form. Chronic homelessness is defined by HUD as an individual with a disability who has been living in a place not meant for human habitation, a Safe Haven, or emergency shelter continuously for at least 12 months, or has had four distinct occasions in the last three years where the cumulative length of time for those occasions totals at least 12 months.

Rapid Resolution, Veteran Navigators, street outreach and emergency shelter providers must make reasonable efforts to assist PSH eligible clients in getting a Verification of Disability Form by identifying a licensed provider, creating referrals to provider agencies, and providing resources for transportation to appointments. Verifications of

Disability must be filled out by a licensed professional, therefore Navigators cannot guarantee verification is completed prior to referral and responsibility ultimately rests on the project staff.

Interim Contact Protocols

The following guidelines for contacting individuals and heads of households should be followed:

Initial Contact

Housing providers must contact the household within 2 business days of receiving the referral. If contact is not made during this first attempt, the housing providers should attempt to contact the referred individual/ household for a period of 7 business days from the date of the referral. During this period, providers should attempt to contact the individual and/or head of household on a minimum of three occasions using various means during different days and times of the day, including non-traditional business hours if possible. At a minimum, the first attempt should include a direct phone call using the numbers listed in Pinellas HMIS and contact the most recent/current provider. The following two attempts should also include the use of email (if provided), text messaging, and alternate contacts (e.g., emergency contacts, shelters, case managers, family/friends).

If the individual/household is currently staying in an Emergency Shelter, the shelter staff should be notified of the request to contact and meet with the individual or head of household within 2 business days of the referral. Emergency shelter staff should support the household and help them contact the housing provider to discuss their referral. If the household agrees with the referral, HMIS will need to be updated to "accepted."

Action after the Household Cannot be Located:

If the housing provider has been unable to contact the referral for 5 business days, they must notify the HLA via Pinellas HMIS to indicate the referral has been "declined" and that a new referral is needed because the client cannot be located.

If the individual/household reaches out within a 15 calendar day period from the original referral, has not been referred to another provider, and the housing provider has referral capacity, the housing provider can contact the CE Specialist at SBoylan@HLApinellas.org and request the household be re-referred to the housing provider.

Individuals/households who cannot be located after two consecutive referrals to different projects will not be referred again until they have an updated CE Assessment within Pinellas HMIS.

Action after the Household Declines Housing

Individuals/households being referred through Coordinated Entry can deny up to two (2) housing provider referrals. After the second offer and denial, the housing provider will respond via Pinellas HMIS to indicate the referral has been "declined", and the household will not be considered for any further housing opportunities and will be removed from the CoC Prioritization List.

Housing units are defined as separate living quarters, such as a house, apartment, or mobile home. If the project allows for roommate rentals in one unit, the Housing Provider should be mindful of client choice and having a roommate may not be safe or conducive to the client. Refusal of participating in shared housing with a roommate should not be grounds for denying a referral.

Case Conferencing

Many successful CE systems are supported by case conferencing, a care management technique that brings together all members of the household's care team. Case conferencing allows for coordination, problem-solving, and service prioritization decisions to be made collectively by all community partners.

Goals of Case Conferencing

- To ensure holistic, coordinated, and integrated assistance across providers
- To clarify roles and responsibilities and reduce duplication of services
- To review and work to reduce barriers related to each household's housing goal
- To help housing providers monitor and advance the progress of clients toward housing
- To identify and track system-wide barriers and strategize solutions across multiple providers
- To ensure outcomes of the Coordinated Assessment Tool align with the CoC's prioritization process

Case conferencing will be used by all service providers who participate in CE and receive CoC funding as outlined in the procedures below. All conference participants must demonstrate professional judgment and remain objective in the reviews of cases. All participants must follow the HMIS Release of Information Guidelines, or their organization's policies regarding client confidentiality, whichever is stricter. All written communications regarding household/individuals will use the HMIS Client ID instead of the first and last names for privacy and security.

Tier 1 - Prioritization List Meetings

Meeting attendees may include Community Navigators, housing providers, Street Outreach, participant advocates, and any other direct service providers. The meeting objective is to prepare clients for RRH and PSH referrals, ensuring their prioritized housing pathway is appropriate and the client is prepared for housing placement when a referral is made. CE staff should prepare for each case conferencing meeting by organizing and updating the Prioritization List, which is organized by CoC prioritization. Provider updates for non- veterans should be completed by 5 P.M. each Tuesday. Provider updates for veterans should be completed by 5 P.M. each Wednesday. CE staff preparation occurs on Wednesdays. During the meeting, the following topics should be discussed:

- Current client location
- Barriers to service and potential solutions
- Household safety if unsheltered
- Next steps, including but not limited to critical action items with roles, timelines, and any participant updates that need to be documented

Prioritization Meetings may focus on specific issues impacting the CoC. Examples may include case conferencing for clients on the Prioritization List *for over 90-days or the Chronically Homeless with high CE assessment scores.*

Tier 2 - Provider Coordination Meetings

This meeting is specific to the housing program and providers with clients referred to that respective program. The objective of the meeting is to decrease the time between CE referral and housing placement through swift provider communication. During the meeting, the following topics should be discussed:

- Client barriers to housing placement
- Client communication barriers (Ex: Inability to reach household or household misunderstanding

housing provider directives.)

- Client housing concerns (Ex: Household refuses housing options or is not document ready)
- The possible return of a household/individual to Prioritization List and negative CE closure
- Next steps including target housing dates

When a household/individual is dually enrolled within Emergency Shelter and a Housing Project (Ex: ES/RRH), it is the housing provider's responsibility to organize case coordination to ensure there is accurate and effective communication regarding the household/individual's progress to housing.

Tier 3 - Mediation Meetings

A mediation case conference meeting should be called if a RRH household/individual is found to be unsuccessful and is at-risk of returning to homelessness, regardless of the interventions and goals established by CE Assessment. Meeting attendees may include housing providers, ES staff, Community and Veteran Navigators, participant advocates, and any other direct service providers.

If a housing provider and shelter cannot agree on a resolution to address a household/individual's housing barriers, a Case Presentation Form should be submitted via the form located at: https://hlapinellas.wufoo.com/forms/case-conferencing-presentation-form/ A meeting will be set-up within 3 business days of the receipt of the request. If resolution cannot be attained, CE staff will:

- Elevate the case to Tier 4 if the household/individual is risking an exit to literal homelessness; or
- Elevate the case to a meeting involving a member of the CoC executive leadership team, local funder (if applicable) and executive leadership and management for the housing provider, ES, and any other service providers that may be able to assist.

Tier 4 - Emergency Meetings

Emergency meetings will be scheduled when there is an urgent need for case consultation. Meeting attendees will include volunteers from the Provider's Council who will be alerted of the need to meet via an email from Coordinated Entry Manager at SBoylan@HLApinellas.org. Emergency case consultations will be called not be called later than 6 PM for:

- Families with minor children found to be staying in place not meant for habitation that is considered high risk if there are no family shelter units available
- A household/individual is going to be exited from a project within 24-hours or less to a place not meant for habitation
- A Tier 3 case that cannot be mediated, individuals over the age of 62 in a high-risk situation, and the household/individual is at-risk of exiting to a place not meant for habitation

Required Meeting Follow Up

After each case conference, regardless of tier, there should be action-oriented follow-up that includes:

- Members will complete steps provided by the housing plan established during the Case Conference.
- Tiers One, Three, and Four follow-ups should be tracked and documented by Coordinated Entry staff.
- Tier Two follow-up should be tracked and documented by the Housing Provider.

Required Monthly Data Review

Each month during the HLA Internal Data Review, the effectiveness of the case conferences will be reviewed. The results of these reviews will be shared with the Pinellas Continuum of Care's Data and System Performance Committee quarterly. The discussion should include, but is not limited to, the following questions:

- How many clients on the list have a clear next step documented?
- How many clients have a housing plan that includes a target move-in date?
- What percentage of the list has a target move-in date within the next month?
- How many clients moved in by their target move-in date within the past month?

Referral

Coordinated Entry identifies the next eligible household for a program vacancy in the CoC based on the prioritization policy and tiebreakers, then a referral is made to a housing project based on:

- Appropriate/Best Referral – Unit eligibility and available services are the right fit for household needs.
- Household Choice – Households have the right to reject housing and service options without retribution or limiting their access to additional housing options.
- Funding requirements, which would include city boundaries, family demographics, program eligibility, and income guidelines.
- Project specific requirements, which would include certain disabilities such as a mental health diagnosis

Persons experiencing homelessness who are not eligible or who do not score in a housing intervention category are referred to mainstream resources based on the Households Scoring 0-3 policy.

Referral Process for Rapid Re-housing and Permanent Supportive Housing

Referrals will be made to a Rapid Re-housing or Permanent Supportive Housing Program by the CE Specialist when a vacancy becomes available based on program & staff capacity.

RRH

On the first business day of the week, the CE Specialist will run a capacity report via HMIS. This report will check for case manager capacity based on open project enrollments. Should there be enrollment availability, the CE Specialist will make a referral from the Prioritization List via HMIS to the RRH program based on the prioritization policy and program specific criteria. It is the responsibility of the RRH project to notify the CE Specialist if there has been a change in their staff capacity. This information will be updated annually via the RRH matrix.

PSH

On the first business day of the week, the CE Specialist will utilize the HMIS ShelterPoint module to check for available units in a PSH program. Should there be an available unit that is ready for occupancy, the CE Specialist will make a referral from the Prioritization List via HMIS to the PSH program based on the prioritization policy and program specific criteria.

At the time of CE referral, if no PSH resources are available, those scoring in the PSH range will be given the opportunity to enter RRH, if there are appropriate openings.

RRH and PSH Provider Responsibilities

- Contact the referred client using the contact information in HMIS
    - If unsuccessful, follow the CE Interim Contact Policy and Procedures
- Commit to timely HMIS data entry
    - When a referral leads to successful program entry, project entry in HMIS must be completed within 72

hours
    - Coordinated Entry Case Notes when there is a change in household status, progress or barriers to permanent housing
    - When a referral leads to successful housing, the move-in date in must be added to HMIS within 72 hours as an interim update
- Decline or accept the referral in HMIS so the CE Specialist knows if the referral was successful
- Complete the SPDAT following the Assessment protocols

Referral Process for Family Emergency Shelter

Referrals are made from the Shelter Prioritization List (SPL) via CE for all emergency shelter and non-congregate shelter in the CoC. When there is an opening in a shelter project, the shelter should email the Client Care Manager at obarclay@hlapinellas.org as soon as possible, describing the occupational capacity of the room and any program requirements. At the first opportunity, the Client Care Manager will review the SPL, and will choose the next prioritized household that is eligible and fits the occupational capacity. Referrals also consider client preference, such as location, or needs, such as proximity to work, school, etc. Referrals are made in HMIS, and the shelter provider is required to handle the referral appropriately in a timely manner.

The shelter provider is required to contact the referred family within 48 hours through phone call, email and text message. Clients have 24 hours to return a phone call, text or email from the shelter provider, or they may request a new referral.

Placement on the SPL does not guarantee a household placement due to factors such as high inflow of homeless families or not being program eligible. All shelter programs have different eligibility requirements such as criminal background checks, area medium income and last permanent address that may make a household ineligible for a particular program.

Mobility Transfer Policy

CE recognizes that circumstances arise which may require a change in a current housing placement. The Mobility Policy should be used to transfer a client to a different program when it is in the best interest of the client. To be eligible, households must have a completed CE assessment entered in Pinellas HMIS with a score of more than 3. Households may be eligible for a transfer if they experience any of the following:

- Imminent Safety Issue – An imminent safety issue that cannot be resolved through safety planning within the current placement. A household should contact 911 if they feel they are unsafe. CE will not approve a mobility request for safety if there is a severe safety risk that could endanger those in the new program. Safety issues related to domestic violence should be referred to domestic violence resources.
- Geographic Change – Travel burden that results from a household's resource location (employment, education, childcare) such that it leads to housing instability.
- Change in Service Need– As demonstrated by change in SPDAT score and vulnerabilities that did not present during the CE assessment. A change in service request may be referred for Tier Three Mediation Case Conferencing prior to approval of mobility request.
- Exiting Program Due to Age Limits Without a Safe Place to Go – Aging out of a CE participating program OR aging out of a youth shelter program without a safe housing option available.
- Change in Family Size - A change in the number of household members that impacts the eligibility of current housing placement.

The following process must be followed for all mobility transfers:

1. The housing provider must send a completed Mobility Request form to the CE Supervisor.
    a. The form can be found at: https://hlapinellas.wufoo.com/forms/pinellas-coordinated-entry-mobility-request/
2. CE staff will facilitate conversations with the household and housing provider to understand both perspectives of the mobility request, and ensure the household wants to transfer programs. This follow-up will be completed within:
    a. One business day when there is a safety issue
    b. Three business days when there is not a safety issue
3. If the request is approved, the eligible household will be returned the Prioritization List by the provider declining the referral in HMIS and will be prioritized for the next referral. The eligible household will be referred to an appropriate program as soon as possible.
    a. Households who have been approved for safety reasons will be prioritized
    b. CE staff will update necessary information in Pinellas HMIS
4. If the household has been approved but there is currently no housing available, CE Navigators will work with the household and housing provider to develop a housing plan and refer households to needed services.
5. If denied for mobility through CE, the housing situation will be determined between the housing provider and the household.

Household Relationship Deterioration

Relationship deterioration occurs when a household dynamic changes or a household member is no longer eligible to continue participation in the program, causing one or more household members to exit the household. This may occur in households that have been referred to a Rapid Rehousing or Permanent Supportive Housing program.

The referred housing provider will need to call a case conference with the household. The conference is to ensure that the household member(s) exiting the existing household had been properly assessed, then coordinate with the CE Specialist to ensure the individual(s) are referred to the appropriate housing project or reprioritized within Coordinated Entry.

If the household breakdown is a family with minor children, the adult staying with the children becomes the head of the household, and the household continues within the referred project. The provider should notify the CE Specialist about the household member(s) leaving the household if they still need housing assistance to ensure they are referred to the appropriate housing project or reprioritized within Coordinated Entry.

End of Funding Program Transfers

When planning to transfer a household due to lack of sufficient funding for their current program, providers should consider:

- What other programs are available
- What other programs the household eligible for
- If other programs have sufficient funding to handle new clients
- Which program is best suited to address the needs of the household
- What community services can be paired with the new program to meet the client's needs

If a provider is serving two or more clients in a program in which the funding source in ending and the clients need to be transferred to a different program or funding source, the provider should contact the Strategy and Innovation Manager at SBoylan@HLApinellas.org 1 month prior to the end of funding. The provider should not utilize a Mobility Request for end of funding source transfers. The provider must include the following information:

- Identification and explanation of program is ending
- List of clients enrolled in the program and their program status towards permanent housing
- Identification of program the clients should be transferred to
- End date of the current program and the start date of the new program

The Innovation and Strategy Manager will review the above submitted information and respond within 3 business days. A meeting with the provider will be set at least 2 weeks prior to the end of funding to review the transition plan, or assist in creating one if necessary.

Vouchers

Mainstream Vouchers

All Rapid Re-Housing and Individual Emergency Shelters may refer eligible clients to the CE Specialist for placement in the Mainstream Voucher program. The referral should be completed via Wufoo (https://hlapinellas.wufoo.com/forms/vip-referral-form/). If local housing authorities have vouchers available, the CE Specialist will make a direct referral. To be eligible for the Mainstream Voucher program, clients must:

- Be Category 1-4 Homeless
- Be between 18 and 62 years of age
- Have a documented disability

Emergency Housing Vouchers

All Rapid Re-Housing and Permanent Supportive Housing may refer eligible clients to the CE Specialist for placement in the EHV program. The referral should be completed via Wufoo (https://hlapinellas.wufoo.com/forms/ehv-referral/). If local housing authorities have vouchers available, the CE Specialist will make a direct referral. To be eligible for the EHV program, clients must:

- Be Category 1 Homeless, at-risk of homelessness, or fleeing, or attempting to flee, domestic violence

Shelter Plus Care Vouchers

Individual Emergency Shelters may refer eligible clients to the CE Specialist for placement in a Shelter Plus Care Voucher Program. To be eligible for a Shelter Plus Care voucher, clients must:

- Be Chronically Homeless
- Have a CE Assessment Score of 10+
- Have a Chronic Mental Illness
- Have a Low Income – 0-50% AMI
- Be able to live independently
- Be currently engaged in supportive services

VASH Vouchers

The VASH (Veterans Affairs Supportive Housing) program combines HUD's Housing Choice Voucher rental assistance with case management and clinical services provided by the Department of Veterans Affairs (VA).

Clients enrolled in St. Vincent de Paul's SSVF RRH program that may be eligible for a VASH voucher are referred directly to the VA Medical Center for evaluation. To be eligible for VASH, clients must:

- Be homeless as determined by the VAMC
- Be a VA healthcare eligible Veteran (anything other than dishonorable)
- Have Low to Moderate Income - 0-80% AMI
- Require case management (substance abuse disorder, physical disability, serious mental illness, etc.)
- Be able to live independently
- Have a CE Assessment Score of 8+

Additional HUD Vouchers for Crisis Response

If HUD releases additional vouchers related to a crisis response, the CoC lead agency will convene necessary partners to develop a process to identify and refer appropriate clients. Select providers will be identified by the CoC to refer clients for these special vouchers using a Wufoo referral form. The form will be reviewed by the CE Specialist, and if deemed eligible, the client will be referred to the Housing Authority to complete an application packet.

A Memorandum of Understanding will be instated to outline this process and state the shared goals of the CoC and the housing authorities. Providers should contact the CE Specialist at SBoylan@HLApinellas.org with any questions or concerns.

Domestic Violence Program Referrals

CASA is currently the only local domestic violence provider with Rapid-Rehousing, Transitional Housing and Permanent Supportive Housing programs. If CASA's RRH or PSH is at capacity or the client has received RRH or PSH services from CASA in the last two years, the client will be asked if they consent to receiving mainstream services. If consent is provided, CASA will make a referral to Coordinated Entry via Wufoo and the CE Specialist will place the household on the Prioritization List.

Data Management

The CoC uses HMIS to manage CE data and ensure adequate privacy protections of all participant information. Participating agencies must collect all data required for CE as defined by the CoC, including the "universal data elements" listed in HUD's HMIS Data Standards Data Manual, Pinellas HMIS Policies and Procedures, and Pinellas CoC Data Quality Policies and Procedures. The CoC ensures adequate privacy protections of all participant information per the HMIS Data and Technical Standards and Pinellas HMIS Policies and Procedures.

Data Collection

CE is a process that is supported by multiple agencies for an extended period. CE is a system-level "project," which means that as households are triaged and identified as experiencing homelessness, they are enrolled in the CE project with a "start date." Then data can be collected by different agencies, at different points in time, to populate a single record.

HMIS training is crucial to accurate data collection. All HMIS End Users are required to participant in new user, annual, and refresher trainings. If an End User makes 3 mistakes documented by the CE Specialist, the CE Specialist will submit the information to the HMIS Trainer. The HMIS Trainer will determine the appropriate training session for the End User to complete.

Participant Consent

All households have the right to refuse to share their information among providers within the CoC. The CE process prohibits denying services to participants if they refuse to allow their data to be shared, unless federal statute requires collection, use, storage, and reporting of their PII as a condition of program participation.

The HMIS Release of Information (ROI) is used to obtain participant consent to share and store participant information for purposes of assessing and referring participants through the coordinated entry process. The CE process ensures all users of HMIS are informed of and understand the privacy rules associated with collection, management, and reporting of client data.

As part of the assessment process, participants will be provided with a written copy of the CoC's "Participant Consent" form, which identifies what data will be collected, what data will be shared, which agencies data will be shared with, and what the purpose of the data sharing is. Participants do have the option to decline sharing data.

Inactivity

The Inactive Policy is a critical component of maintaining a real-time Prioritization List ensuring the CoC maintains a robust Coordinated Entry (CE) system. To ensure an efficient assessment and referral process, it is important that the CE system Navigators and Street Outreach teams can rapidly contact and connect households to housing opportunities. This policy minimizes delays in the housing referral process due to spending time searching for households in the community, because of the loss contact.

If a household has had no contact with any Coordinated Entry (CE) access points, System Navigators and/or Street Outreach for 30 days, AND they have had no services or shelter stays in the Homeless Management Information System (HMIS) for the past month, the household will be removed from the Active Prioritization List and moved to the Inactive List. After 60 days without contact with any CE access points, the CE Specialist will close the CE entry. If the client has re-entered the system within the 60-day period, the client will return to the Active Prioritization List.

For the veteran population, we coordinate with our Veteran Affairs (VA) team members to access their HOMES and Remote Data Systems to see if the veteran has relocated or has accessed any other VA services in Pinellas County. The CE Specialist will aid in this process by sending Veteran providers a list of inactive Veterans on Monday's and the household will be closed out on Friday of that week if there has been no contact with the Veteran in their systems in the last 30 days.

Household Loses Stable Housing While Enrolled

If a client vacates a housing opportunity and the project is no longer paying rent on the unit, the client should be exited from the project with an accurate Project Exit Date AND accurate exit destination and a new project enrollment started on the same or following day. The project would continue to work with the client until a new unit is found, at which point a new housing move-in date would be recorded on the second project enrollment. This will ensure that all housing history for the client is preserved for accurate reporting purposes.

HMIS Data Inquiries

The Help Desk

All HMIS questions should be directed to the HMIS Help Desk via email or online request form:
Website: https://pinellashmis.zendesk.com
Email: support@pinellashmis.zendesk.com

Report Requests

Any agency in need of a report generated from HMIS data must submit a report request via Wufoo (https://hlapinellas.wufoo.com/forms/pinellas-hmis-report-request-form/). This includes reports for grants, funders, program tracking, or other data your agency needs to review.

All report requests must be submitted **at least 10 business days prior to the date they are needed**. HMIS staff will review your request and respond within 2 business days.

New Project Requests

Pinellas HMIS participating agencies are required to have at least one project in HMIS to store their client information. Agencies may have additional projects as desired or required by your funding and reporting needs. Any agency that needs a new project built in HMIS must request via Wufoo (https://hlapinellas.wufoo.com/forms/pinellas-hmis-new-project-request/).

Evaluation

Regular and ongoing evaluation of the CE system will be conducted to ensure that improvement opportunities are identified that results are shared and understood, and that the CE system is held accountable. CE system data is reviewed monthly and reported to the CoC's Data and System Performance Committee on a quarterly basis. The CoC's Diversity, Equity, and Inclusion Committee evaluations CE data quarterly to monitor race equity. The HLA will conduct annual monitoring of the CE system and report findings with recommendations for enhancement to the CoC.

HLA CE staff consults with each participating project and project participants at least annually to evaluate the intake, assessment, and referral processes associated with Coordinated Entry. Solicitations for feedback address the quality and effectiveness of the entire Coordinated Entry experience for both participating projects and households. Through an electronic survey, 20 CE participants will be selected at random. The CE Specialist will use participant's phone and/or email addresses from HMIS to record their survey responses. All responses will remain anonymous. The results are grouped into themes by CE staff and reviewed by the HLA's Quality and Performance Improvement department. HLA's Quality and Performance Improvement department will then make recommendations to the Providers Council and CoC Board of Directors for approval and inclusion in updated policies.

Attachments

Attachment A – Key Definitions
Attachment B – CoC Written Standards
Attachment C – DV CE Emergency Transfer Plan
Attachment D – CE Grievance Policy and Procedure
Attachment E – Family Shelter Assessment (FSA)
Attachment F – Coordinated Entry Assessment
Attachment G – Service Prioritization Decision Assistance Tool (SPDAT)
Attachment H – Family Flow
Attachment I – Veteran Flow

ATTACHMENT A – KEY DEFINITIONS

Homeless Leadership Alliance of Pinellas

Working to prevent, divert, and end homelessness

2021	Frequently Used Acronyms and Definitions

211	211 Tampa Bay Cares (TBC) is an information and referral hotline for social services in Pinellas County.
Adult Emergency Financial Assistance Program (AEFAP)	The Adult Emergency Financial Assistance Program (AEFAP) helps qualifying adults (**18 years of age or older, or legally emancipated youth without minor children in household)** by providing financial assistance to help prevent evictions, foreclosures, and unhealthy living conditions as well as things to keep people employed. Assistance is provided only once every twelve months.
Advocacy Committee	This committee develops an annual HLA advocacy agenda to be approved by the Board, advocates on behalf of the Pinellas CoC, and addresses any advocacy issues that may arise throughout the year.
Annual Homeless Assessment Report (AHAR)	The U.S. Department of Housing and Urban Development's Annual Homeless Assessment Report to Congress.
Area Median Income (AMI)	HUD calculations of the median income in an area that are presented by household size and adjusted each year. Many housing programs use percentages of AMI as the guidelines for income eligibility.
Annual Performance Report (APR)	HUD requires an annual progress report for all homeless projects.
Bay Area Legal Services (BALS)	Bay Area Legal Services
Built for Zero	Built for Zero is a program of more than 80 communities working to achieve an end to homelessness that lasts and leaves no one behind. The goal is to achieve a milestone known as functional zero — an ongoing state where homelessness is continuously rare and brief. The Pinellas County CoC began working with Built for Zero in 2021.
Annual Renewal Demand (ARD)	Total dollar amount of all the CoC's projects that will be eligible for annual renewal funding.
CASA	Community Action Stops Abuse
Case Conferencing	A meeting at which all the parties involved in a case come together to discuss it and identify appropriate solutions.

CDBG	Community Development Block Grant - A federal program that allocates money to local governments for low/moderate income community-based projects. These funds can then be spent on a wide variety of housing, infrastructure, human services, and economic development activities.
CDBG-CV	Community Development Block Grant – Coronavirus. Additional CDBG funding authorized by the CARES Act in March 2020.
Chronically Homeless	An individual is defined by HUD as "Chronically Homeless" if they have a disability and have lived in a shelter, safe haven, or place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last three years (must total 12 months).
Code of Federal Regulations (CFR)	The U.S. Department of Housing and Urban Development's Code of Federal Regulations.
Cold Night Shelter (CNS)	Emergency shelters active on nights that the temperature is expected to fall to 40 degrees or lower. Overnight guests are provided with a safe place to sleep, sleeping supplies, and food at 8 locations across Pinellas County. Cold Night Shelters are a volunteer-lead initiative that operate between November and March.
Collaborative Applicant	An entity that applies for HUD funding. The HLA serves as the collaborative applicant for the CoC. The Collaborative Applicant is responsible for collecting and combining the required application information from all Continuum of Care Program funded projects within the geographic area. The Collaborative Applicant is also responsible for submitting the annual application to HUD for Continuum of Care Program funding and to apply for Continuum of Care Planning dollars.
Community Law Program (CLP)	Community Law Program
Connect List	A comprehensive list of every household in a community experiencing homelessness, updated in real time. Using information collected and shared with their consent, each person on the list has a file that includes their name, homeless history, health, and housing needs.
Consolidated Plan	A locally developed plan that must be submitted to HUD as part of the eligibility process for certain HUD programs, including Community Development Block Grant and HOME Investment Partnership Program.
Continuum of Care (CoC)	The Pinellas Continuum of Care has 27 members. The Board includes nine elected officials and sixteen community leaders; (four service experts, two faith-based organizations representatives, two business representatives, a representative of the Juvenile Welfare Board, three Housing Authority representatives, one healthcare representative, one at-large representative and two homeless or formerly homeless representatives).
Coordinated Entry (CE)	A standardized access, assessment, and referral process for housing and other services across agencies in a community. Coordinated entry processes are intended to help communities prioritize assistance to ensure that persons who are most in need of

	assistance receive it in a timely manner. The HLA administers the Coordinated Entry Process on behalf of the CoC. All CoC funded projects must receive their referrals via CE
CoPP	City of Pinellas Park
CoSP	City of St. Petersburg
Data and System Performance Committee (DSP)	The Data and System Performance Committee (DSP) coordinates HMIS data collection, reviews systems performance measures and reviews all PIT/HIC/AHAR data. They also scan the environment for best practices and innovations and evaluate outcomes of the CoC overall and projects funded under HUD.
Department of Children and Families (DCF)	A state agency that provides social services to children, adults, refugees, domestic violence victims, human trafficking victims, the homeless community, childcare providers, disabled people, elderly. DCF funds some HLA programs.
DCF Statewide Homeless Report	The Florida Council on Homelessness submits an annual report to the Florida Governor and Legislature summarizing recommended actions to reduce homelessness, as well as data concerning those persons currently experiencing homelessness in Florida.
Directions for Living (DFL)	Directions for Living
Diversion	An intervention for households who have lost their housing and are about to enter shelter or sleep outside. Services offered may include but are not limited to conflict mediation and financial assistance.
Diversity, Equity, and Inclusion Committee (DEI)	The Diversity, Equity, and Inclusion Committee (DEI) provides insight and advice on promoting diversity, equity, and inclusion in the CoC. The committee will consider and develop strategies for board consideration that foster greater participation and make the CoC more accommodating and reflective of members from diverse backgrounds, perspectives, and abilities. The committee will be aware of and ensure coordination and collaboration of diversity, equity, and inclusion efforts throughout the CoC.
Domestic Violence (DV)	Domestic violence and emotional abuse are behaviors used by one person in a relationship to control the other. Partners may be married or not married; heterosexual, gay, or lesbian; living together, separated, or dating.
Emergency Shelter (ES)	Emergency Shelter
Emergency Housing Voucher (EHV)	Additional housing choice vouchers authorized by the American Rescue Plan in March 2021. Vouchers were given to public housing authorities to assist individuals and families who are homeless, at risk of homelessness, fleeing, or attempting to flee, domestic violence, or were recently homeless or have a high risk of housing instability.
Emergency Rental Assistance (ERA)	Emergency Rental Assistance

Emergency Solutions Grant (ESG)	A federal program which provides funding for a variety of homeless services including homeless prevention and rapid re-housing. ESG was formerly known as Emergency Shelter Grants, with the name change occurring in 2009.
ESG-CV	Emergency Solutions Grant – Coronavirus. Additional CDBG funding authorized by the CARES Act in March 2020.
Eviction Diversion (ED)	Eviction Diversion is an intervention that involves legal aid and mediation to landlords and tenants involved in an eviction-related dispute. It can include payment of past-due rent to keep a tenant in a unit, and/or housing navigation services and financial provisions for relocation to a new unit.
Fair Market Rent (FMR)	HUD calculation of a mid-market rent for localities that are established by unit size and updated each year. FMR is sometimes used as a ceiling for allowable rent in Section 8 or other Tenant-Based Rental Assistance programs.
Federal Poverty Level (FPL)	A measure of income issued every year by the Department of Health and Human Services (HHS). Federal poverty levels are used to determine eligibility for certain programs and benefits.
Fiscal Year (FY)	The HLA's fiscal year is October 1 – September 30
Front Door	A centralized location(s) where individuals and families can access housing and supportive services.
FSI	Family Services Initiative - This project helps families with minor children prevent child protection investigations, homelessness, and further social service engagement by providing families with wrap-around services to meet families' basic needs.
F-SPDAT	Family- Service Prioritization Decision Assistance Tool
F-VI-SPADAT	Family Vulnerability Index - Service Prioritization Decision Assistance Tool
Funders Council	Makes recommendations to the full CoC Board on funding of homeless/at-risk programs and services, either in response to CoC Board requests or on issues raised by Funders Council members. Makes Recommendations on strategically aligning funding resources available for homeless/at-risk programs and services based on CoC Board approved priorities, to make the most effective use of scarce resources.
Grant Inventory Worksheet (GIW)	Document annually submitted to HUD confirming the amount of renewal funding to be requested by the CoC (lists the past CoC grants eligible for renewal in the upcoming competition year).
H2H	Hospital to Hotel Project (Recuperation Hotel)

HEARTH Act	Homeless Emergency Assistance and Rapid Transition to Housing - A federal act which amended and reauthorized the McKinney-Vento Homeless Assistance Act. The legislation increased priority on homeless families with children and significantly increased resources to prevent homelessness.
HEP	Homeless Empowerment Program
HIPAA	Health Insurance Portability and Accountability Act of 1996
HMIS	Homeless Management Information System - A federally and state mandated computerized database system for programs serving homeless persons, especially programs receiving certain federal homeless program funds. The HMIS system is intended to provide the data foundation for program outcome and evaluation monitoring.
HMIS Lead Agency	Entity designated by the CoC in accordance with HUD's CoC Program interim rule to operate the HMIS on the CoC's behalf. The HMIS Lead designated by the CoC may apply for CoC Program funds to establish and operate its HMIS
HOME Investment Partnerships Program (HOME)	A HUD grant program that provides housing subsidies to local and state governments who are recognized as participating jurisdictions. The money can be used to purchase, rehabilitate, or construct housing; it can be used to subsidize rents of tenants as well.
Homeless	HUD defines four categories of homelessness: 1. Literally Homeless - Individual or family who lacks a fixed, regular, and adequate nighttime residence 2. Imminent Risk of Homelessness - Individual or family who will imminently lose their primary nighttime residence within 14 days 3. Homeless Under Other Federal Statutes 4. Fleeing or Attempting to Flee Domestic Violence
Homeless Prevention	An intervention for households who currently have housing but are at high risk of homelessness. Services may include but are not limited to case management and financial assistance.
Household	All the people who occupy a housing unit. A household includes the related family members and all the unrelated people, if any, such as lodgers, foster children, wards, or employees who share the housing unit. A person living alone in a housing unit, or a group of unrelated people sharing a housing unit such as partners or roomers, is also counted as a household.
Housing Quality Standards (HQS) Inspection	An inspection which all units must pass before assistance can be paid on behalf of a family and at least annually throughout the term of the assisted tenancy. HQS define "standard housing" and establish the minimum criteria for the health and safety of program participants.
Housing Choice Voucher (HCV)	Rental subsidy program (also known as Section 8).

Housing First	Housing First is an approach to ending homelessness that centers on the concept that a homeless individual or household's first and primary need is to obtain stable housing, and that other issues that may affect the household can and should be addressed once housing is obtained.
Housing Inventory Count (HIC)	Continuum of Care (CoC) Homeless Assistance Programs Housing Inventory Count Reports provide a snapshot of a CoC's HIC, an inventory of housing conducted annually during the last ten days in January. The reports tally the number of beds and units available on the night designated for the count by program type.
Housing Navigation	Housing navigation is the practice of pairing a homeless individual, households with minor children, or an individual referred from Eviction Diversion, with a trained housing navigator. Together, they work to find, obtain, and make a plan to maintain housing. At the Homeless Leadership Alliance of Pinellas (HLA), housing navigation activities may include searching for housing, developing a housing plan, completing inspections, starting utility services, and moving into housing.
Housing Opportunities for Persons with AIDS (HOPWA)	A HUD housing subsidy program for persons living with AIDS.
HUD	U.S. Department of Housing and Urban Development - The federal department which allocates most funding pertaining to housing and homelessness.
Intake	The series of steps taken when a household or individual enters a new program. This often includes information gathering, HMIS data entry, and may include assessment.
Interdisciplinary Team (IDT) Staffing	A meeting between everyone involved with a case – including the client – to coordinate care, improve communication, encourage teamwork, and promote optimal care
JWB	Juvenile Welfare Board – A countywide special taxing district responsible for helping children lead healthy, successful, and satisfying lives.
Lead Agency	The Pinellas Continuum of Care appoints the CoC Lead Agency that will complete designated work tasks assigned by the Pinellas Continuum of Care and will provide meeting support for the Pinellas Continuum of Care Board and committees. All responsibilities are documented in the Pinellas Continuum of Care Lead Agency Memorandum of Understanding.
Literally Homeless	Has a primary nighttime residence that is a public or private place not meant for human habitation or is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs) or is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.
Low Income Housing Tax Credit (LIHTC)	A federal program which grants tax credits to investors in low-income housing projects.

Mainstream Provider	Agency or entity that can provide necessary services or assistance to persons served by coordinated entry. Examples of mainstream system providers include hospitals, mental health agencies, and schools.
McKinney-Vento Homeless Assistance Act	The McKinney-Vento Homeless Assistance Act authorizes the federal Education for Homeless Children and Youth Program and is the primary piece of federal legislation related to the education of children and youth experiencing homelessness.
NCS	Non-Congregate Shelter
Notice of Funding Opportunity (NOFO)	Notice of Funding Opportunity
Notice of Funding Availability (NOFA)	A NOFA is issued by a governmental body, foundation, etc. which is looking for organizations or individuals to submit proposals in response to a funding opportunity, generally a grant.
Neighborhood Stabilization Program (NSP)	HUD's Neighborhood Stabilization Program provides emergency assistance to state and local governments to acquire and redevelop foreclosed properties that might otherwise become sources of abandonment and blight within their communities.
Projects for Assistance in Transition from Homelessness (PATH)	Program to provide outreach and services to people with serious mental illness who are homeless, in shelter or on the street, or at imminent risk of homelessness.
Pinellas County Human Services (PCHS)	With a network of over 105 partner agencies and managing 190 plus contracts and grants, Human Services helps Pinellas County residents obtain access to medical care, emergency financial assistance, help connect to county judicial resources, optimize benefits for Veterans and Dependents, investigate consumer complaints, and help those who are experiencing homelessness.
Personal Enrichment Through Mental Health Services (PEMHS)	Personal Enrichment Through Mental Health Services **provides behavioral health service.**
Permanent Housing (PH)	A general name for a variety of housing projects which are ongoing and unending. Also see PSH.
Permanent Supportive Housing (PSH)	PSH is permanent housing, with indefinite leasing or rental assistance, paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability achieve housing stability.
Personally Identifiable Information (PII)	Any representation of information that permits the identity of an individual to whom the information applies to be reasonably inferred by either direct or indirect means. Examples include a full name, Social Security number, driver's license number, bank account number, and email address.
Pinellas Board of County Commissioners (PCBCC)	Pinellas County Board of County Commissioners

Pinellas Community Foundation (PCF)	Pinellas Community Foundation
Pinellas County Property Appraiser's Office (PCPAO)	Pinellas County Property Appraiser's Office
Point In Time (PIT)	A HUD-mandated biennial count of persons experiencing homelessness on a specified day of the year intended to provide a snapshot report on the extent of homelessness.
Prioritization List	A comprehensive list of every household currently enrolled in Coordinated Entry. These people are literally homeless and regularly assessed for prioritization. They are document ready and can imminently move to housing.
Providers Council	Makes recommendations to the full CoC Board on homeless/at-risk services system issues, concerns and needed actions, either in response to CoC Board requests or on issues raised by Providers Council members. The membership of the Providers Council shall include representatives from homeless/at-risk service providers and other organizations that are actively involved in services that affect homeless/at-risk target groups in Pinellas County.
Public Housing Authority (PHA)	A local quasi-governmental agency that typically owns and manages public housing units and may administer a Section 8 program.
Quarterly Performance Report (QPR)	QPRs contain project names, activity descriptions, project locations, national objectives, funds budgeted and expended, funding sources, numbers of properties and housing units, beginning, and ending dates of activities, and numbers of low- and moderate-income persons or households benefiting from the use of Neighborhood Stabilization Program funds.
Rapid Re-Housing (RRH)	Rapid re-housing is an intervention designed to help individuals and families to quickly exit homelessness and return to permanent housing. Rapid re-housing assistance is offered without preconditions and the resources and services provided are typically tailored to the unique needs of the household. The core components of a rapid rehousing program are housing identification; rent and move-in assistance (financial); and case management and services.
Request for Information (RFI)	A request for information is a common business process whose purpose is to collect written information about the capabilities of various suppliers. Normally it follows a format that can be used for comparative purposes. An RFI is primarily used to gather information to help make a decision on what steps to take next.
Request for Proposal (RFP)	An RFP is a request for organizations or individuals to submit proposals/bids to provide services or a product outlined in the RFP.
Request for Qualifications (RFQ)	A request for proposals to select a consultant or partner that focuses less on cost and more on experience. It may generate a list of bidders who are then used for an RFP process, or it may lead to a collaborative process to determine projects costs.
Safe Haven (SH)	A safe haven is a form of supportive housing that serves hard-to-reach homeless

	persons with severe mental illness who are on the street and have been unable or unwilling to participate in supportive services.
Section 8	A federally funded rent-subsidy program for low-income households recently renamed the Housing Choice Voucher (HCV) program. Under Section 8, a tenant pays 30-40% of their monthly income for rent and the government pays the remainder, up to a set maximum Fair Market Rent. Section 8 subsidies can be tenant-based (awarded to a tenant household that can take them to any private landlord) or site-based/project-based (awarded to an owner who uses it on the same unit over time).
Shelter Plus Care (S+C or SPC)	SPC provided rent subsidies to households that are homeless and in which at least one adult has a disability that prevents the person/household from being able to live independently.
Social Action Funding (SAF)	Social Action Funding
SSI/SSDI Outreach, Access, and Recovery (SOAR)	SSI/SSDI Outreach, Access, and Recovery: A technical assistance initiative that assists people who are homeless to successfully apply for Social Security Income (SSI) and Social Security Disability Incomes (SSDI). The initiative helps people who are eligible for such benefits to receive them sooner.
Social Security Disability Income (SSDI)	Social Security Disability Insurance is a payroll tax-funded federal insurance program of the United States government. It is managed by the Social Security Administration and designed to provide monthly benefits to people who have a medically determinable disability that restricts their ability to be employed.
SPDAT or "Full SPDAT"	Service Prioritization Decision Assistance Tool
Strategic Planning Committee	This committee shall make recommendations to the full CoC Board for the implementation of a Housing First approach for the homeless system of care in Pinellas County, with a goal of homelessness being rare, brief and non-recurring. This committee focuses on the development of strategic goals and planning for the CoC to provide a sense of direction and outlines measurable goals that will be the guide for driving day-to-day decisions of the CoC Board. Also responsible for developing a means for evaluating progress and changing approaches when moving forward.
Subsidy	A direct or indirect payment to an individual or family to assist with housing and basic needs.
Sunshine Law	The Pinellas Continuum of Care operates in accordance with Chapter 119, Florida Statutes – the "Sunshine Law" – and thus any materials given to Board Members or staff are considered public records and are retained and, upon request, made available to the public and media.
Supplemental Nutrition Assistance Program (SNAP)	SNAP provides nutrition benefits to supplement the food budget of needy families so they can purchase healthy food and move towards self-sufficiency.
Supplemental Security Income (SSI)	The Supplemental Security Income (SSI) program provides monthly payments to adults and children with a disability or blindness have income and resources below

	specific financial limits. SSI payments are also made to people aged 65 and older without disabilities who meet the financial qualifications.
Supportive Services Only (SSO)	HUD Homeless Assistance Program term for projects which provide support services only (no housing provided).
Supportive Services for Veteran Families (SSVF)	Supportive Services for Veteran Families was established by the United States Department of Veterans Affairs in 2011 to create public-private partnerships to rapidly re-house homeless Veteran families and prevent homelessness for very low-income Veterans at imminent risk due to a housing crisis.
SVdP	St. Vincent de Paul
Technical Assistance (TA)	Refers to the provision of support training to organizations that is intended to help the organization strengthen its ability to perform key tasks in the future.
Temporary Assistance to Needy Families (TANF)	The major welfare program that provides income support to poor families. Replaced AFDC (Aid to Families with Dependent Children).
Transitional Housing (TH)	A general name for a variety of time-limited housing programs that are intended to help households ready themselves to move to permanent housing. HUD TH programs are limited to homeless households and are intended to serve households for no more than 2 years and usually have specific supportive services as a part of the program.
Trauma Informed Care	A trauma-informed approach to care acknowledges that health care organizations and care teams need to have a complete picture of a patient's life situation — past and present — to provide effective health care services with a healing orientation. Adopting trauma-informed practices can potentially improve patient engagement, treatment adherence, and health outcomes, as well as provider and staff wellness.
U.S. Department of Housing and Urban Development (HUD)	Federal agency responsible for administering housing and homelessness programs including the CoC and ESG Programs.
USICH	U.S. Interagency Council on Homelessness
VASH	HUD-VA Supportive Housing Program
Violence Against Women Act (VAWA)	U.S. federal legislation, initially passed in 1994, that expanded the juridical tools to combat violence against women and provide protection to women who had suffered violent abuses.
VI-SPDAT	Vulnerability Index - Service Prioritization Decision Assistance Tool
Warm Hand Off	A transfer of care between housing and/or supportive service providers.

Written Standards	A document synthesizing key elements of HUD regulations with the processes and priorities of the CoC to ensure that all projects that receive HUD and ESG funding are administered fairly and methodically.