INDIANAPOLIS COORDINATED ENTRY SYSTEM POLICIES & PROCEDURES

INDIANAPOLIS CONTINUUM OF CARE

This Policies and Procedures document provides an overview of the Indianapolis Coordinated Entry system, outlines the responsibility of stakeholders, and discusses program prioritization and eligibility and system administration policy.

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INTRODUCTION

COORDINATED ENTRY SYSTEM OVERVIEW

An effective Coordinated Entry System (CES) is an essential component of Indianapolis' homelessness prevention and intervention system, and critical to ensuring that homelessness is rare, short-lived, and recoverable. The CES prioritizes and refers people experiencing homelessness to all projects receiving Emergency Solutions Grants (ESG) program, and Housing Trust Fund (HTF) program and Continuum of Care (CoC) program funds. In addition, the CES coordinates projects from the Veteran Affairs (VA) programs and designated housing and service providers. The CES provides the CoC with information on service needs and gaps to help the community strategically allocate and identify additional resources.

There are two key components to the CES: the coordination of the crisis response system (Shelter Coordination) and the coordination of permanent housing and services (the Coordinated Entry System into Housing). For the purposes of this document, CES shall refer primarily to the coordination of housing and services. Information specifically related to Shelter Coordination will be designated as such.

The goals of an effective crisis response system are to identify those experiencing homelessness, prevent homelessness when possible, connect people with housing quickly and provide services when needed. The coordination of emergency shelter (Shelter Coordination) is a key component to a high functioning crisis response system. Shelter Coordination is based on a no wrong doors approach, meaning that households can access emergency shelter directly through multiple Shelter Entry Points.

The Indianapolis Coordinated Entry System into Housing provides a structured process for entry, assessment, scoring, prioritization, determining eligibility, and referral for homeless housing and services. The goal is to efficiently and fairly allocate resources by prioritizing severity of service needs and vulnerability using policies established by the Indianapolis (CoC in accordance with the Indianapolis CoC Written Standards.[1] In addition to these methods of assessment, the CES will maintain a forum for case workers to give additional information related to eligibility and prioritization.

Another key aspect of the CES is the development of physical, mobile, and virtual entry points that improve the ease of access to resources. The CES provides multiple Access Points within the Indianapolis CoC's designated service area where individuals and families can visit and present information in order to receive homeless housing and services. All entry points and methods offer the same uniform decision-making process and must be usable by all people who may be experiencing homelessness or are at risk of homelessness.

The CES shall provide client autonomy in selecting service providers and types of services, including the ability to refuse services. The CES shall permit recipients of Federal and State funds to comply with applicable civil rights and fair housing laws and requirements. The CES is not designed to screen individuals with high vulnerability and severe service needs from certain resources. The CES shall

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[1] *Indianapolis CoC Written Standards*. Indianapolis Continuum of Care (2020, October 19). Retrieved August 22, 2022 from https://www.indycoc.org/policies-and-program-models.html

take care to ensure prioritization does not allow the more vulnerable or those who have more service needs to remain in shelters or on the streets because more intensive types of services are not available.

COORDINATED ENTRY SYSTEM IN INDIANAPOLIS

In January 2014, CoC leaders began working to develop a coordinated approach to assess prioritization and refer clients to homeless services and housing that would align with community values and US Department of Housing and Urban Development (HUD) requirements.

In May 2014, experts from the Corporation for Supportive Housing (CSH) conducted a Coordinated Assessment Design Charrette with community stakeholders resulting in the Indianapolis Coordinated Access Flow Chart, which outlined the steps through which people experiencing a housing crises would be engaged in services throughout the continuum.

In February 2016, a Coordinated Entry Workgroup convened to determine the best path forward to develop a CES in Indianapolis. The workgroup engaged a consulting firm (Community Solutions, Inc.) to assist with planning and selected a System Lead (Coalition for Homelessness Intervention and Prevention[CHIP]) to lead the planning and the implementation of the system in concert with the Coordinated Entry Workgroup. In the fall of 2017, the System Lead convened key stakeholders from the homeless crisis response system to develop a system to coordinate shelter. The Shelter Coordination Workgroup convened monthly to create the foundation for shelter coordination.

An important component of the planning process was the collection of information through meetings with individual agencies and the larger workgroup. These meetings provided immediate feedback to the planning process, project level knowledge, and the need of the overall system. In addition, information on coordinated entry best practices established in other communities helped to augment the information collected at a local level.

HUD guidance for the CES Policies & Procedures includes the Coordinated Entry Brief,[2] the Coordinated Entry Notice,[3] and the Coordinated Entry Self-Assessment.[4] HUD also provides additional information on eligibility, prioritization, and defining and documenting chronic homeless status in the Defining Chronically Homeless Final Rule,[5] Flowchart of HUDs Definition of Chronic

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[2] *Coordinated Entry Policy Brief*. The US Department of Housing and Urban Development (2015, February). Retrieved August 22, 2022 from https://www.hudexchange.info/resource/4427/coordinated-entry-policy-brief/

[3] *Notice CPD-17-01: Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System*. The US Department of Housing and Urban Development (2017, January). Retrieved August 22, 2022 from https://www.hudexchange.info/resource/5208/notice-establishing-additional-requirements-for-a-continuum-of-care-centralized-or-coordinated-assessment-system/

[4] *Coordinated Entry Self-Assessment*. The US Department of Housing and Urban Development (2017, March). Retrieved August 22, 2022 from https://www.hudexchange.info/resource/5219/coordinated-entry-self-assessment/

[5] *Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining Chronically Homeless Final Rule*. The US Department of Housing and Urban Development (2015, December). Retrieved August 22, 2022 from https://www.hudexchange.info/resource/4847/hearth-defining-chronically-homeless-final-rule/

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Homelessness,[6] and Four Categories of the Homeless Definition.[7] The CES Policies and Procedures are used to compliment the Indianapolis CoC Written Standards (see Footnote 1) and provide additional direction on project eligibility and prioritization.

POLICIES AND PROCEDURES PURPOSE

The Policies & Procedures detailed in this document focus on intake, assessment, prioritization, and referral to homeless resources and housing for literally homeless individuals and families. The policies and procedures in this document outline the process and guiding principles for the implementation of the Indianapolis CES. Procedures establish a series of steps to complete the coordinated entry process with guidance on eligible individuals and services. Policies develop the specific purpose of the program and the widespread application of specific components of CES.

COORDINATED ENTRY SYSTEM POLICY OVERVIEW

The Indianapolis CES is designed to serve clients within the Indianapolis CoC coverage area that are considered literally homeless or under the imminent risk of homelessness, as defined by HUD (see Footnote 7), and are seeking or would benefit from homeless services and housing. These clients enter the CES through designated Access Points. Access Points are virtual or physical locations where clients interact with a trained Assessor to learn about homeless housing and services and complete the CES Enrollment.

The enrollment is housed in the Homeless Management Information System (HMIS) and is comprised of 8 components: the client record, diversion questions, the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT), veteran assessment (if applicable), barrier assessment, domestic violence assessment, financial assessment, and the collection of eligibility information. When complete, the client's enrollment is submitted into HMIS and will enter in the client pool within HMIS. It is important to note that eligibility documentation must be submitted prior to referral to a housing program. The CES System Lead will manage the matching process for referrals to designated homeless housing and services through project eligibility and prioritization established in the Indianapolis CoC Written Standards. The CES System Lead will communicate match referrals directly to the service provider or assigned case manager after completing case conferencing, unless services are designed for immediate prevention or crisis resolution. The CES will be evaluated annually by multiple stakeholders to ensure the system is efficiently and fairly allocating homeless resources and housing.

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[6] *Flowchart of HUD's Definition of Chronic Homelessness*. The US Department of Housing and Urban Development (2016, November). Retrieved August 22, 2022 from https://www.hudexchange.info/resource/5181/flowchart-of-huds-definition-of-chronic-homelessness/
[7] *Four Categories of the Homeless Definition.* The US Department of Housing and Urban Development (2022). Retrieved August 22, 2022 from https://www.hudexchange.info/homelessness-assistance/coc-esg-virtual-binders/coc-esg-homeless-eligibility/four-categories/

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COORDINATED ENTRY SYSTEM STAKEHOLDERS

INDIVIDUALS EXPERIENCING HOMELESSNESS

CES is designed to serve persons that are experiencing literal homelessness, as defined by HUD, or under imminent risk of homelessness and are seeking or would benefit from homeless resources or services (see Footnote 7).

SYSTEM LEAD

The CES System Lead is responsible for overall management, operation, monitoring, and evaluation of the CES. CHIP serves as the CES System Lead.

ACCESS POINTS

Access Points are the places – either virtual or physical – where an individual or family in need of assistance accesses the CES process. Access Points may include any crisis service provider, such as emergency shelters and social service agencies. Access Points are responsible for identifying staff (Assessors) who will complete the CES enrollment process, entering all data into HMIS, or providing data in a format that can be uploaded or entered into HMIS by the System Lead. Assessors will also address the client's immediate crisis needs and serve as the point-of-contact for the client until they choose to exit services, are housed, or are connected to another service provider. Each Access Point must use the standardized CES assessment and it must be administered by CES trained Assessors. Training for Access Points will be provided at least annually.

Access Points are chosen based on geographic location, proximity to public transportation, connection to special populations, and ability to accommodate all populations including individuals with disabilities, language barriers, and individuals least likely to access homeless assistance. Access Points are virtually and physically offered across the Indianapolis CoC's geographic area to ensure clients within the entire Indianapolis CoC coverage area can access homeless housing and services.

In accordance with HUD guidelines, the CES may provide separate Access Points for specific subpopulations to ensure they receive access to appropriate services and resources. The CES has deemed it necessary to provide separate and optional Access Points for households fleeing domestic violence, dating violence, sexual assault, or other dangerous or life-threatening conditions and for youth and young adults.[8] Subpopulation providers have experience and expertise working with the designated subpopulation. The Access Points that serve these subpopulations will complete the standard CES Enrollment and meet all Access Point requirements while considering the need for client anonymity.

An individual or family may not be denied access to the CES due to being a victim of domestic violence, dating violence, sexual assault, or stalking. In cases where client safety is at risk, subpopulation Access Points may work with the System Lead to make alternative accommodations for access to homeless housing and services, including but not limited to providing anonymized client information to the System Lead.

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[8] *The Indianapolis Coordinated Community Plan to End Youth and Young Adult Homelessness*. The Indianapolis CoC (2020, April). Retrieved August 22, 2022 from https://www.indycoc.org/plan-to-end-youth--young-adult-homelessness.html

HOMELESS HOUSING AND SERVICE PROVIDERS

The CoC and recipients of CoC, ESG, HTF, Grant Per Diem (GPD), HUD-Veterans Affairs Supportive Housing (HUD-VASH) and Supportive Services for Veteran Families (SSVF) program funds must participate in CES to screen, assess, and refer clients to homeless housing and services. These resources include:

- Permanent Supportive Housing (PSH)
- Rapid Re-Housing (RRH)
- Prevention and Diversion Services
- Emergency Shelter/Operations
- Street Outreach

Other non-CoC and ESG funded providers with homeless housing and services may also be included in the CES.

CASE CONFERENCING WORKGROUP

The Case Conferencing Workgroup is an essential component of the CES and supports the community's goal to make homelessness rare, brief, and nonrecurring. The Case Conferencing Workgroup shall include all relevant Homeless Housing and Service Providers including but not limited to Access Points, Street Outreach, Emergency Shelters, CoC and ESG program fund recipients, and the System Lead. The group meets weekly and is responsible for monitoring and conducting the referral process for housing matches. Participants of the workgroup must have a signed confidentiality statement on file, which shall be re-signed annually, and will have the opportunity to discuss transfer requests, barriers to getting and keeping individuals and families stably housed, and other concerns regarding the effectiveness of the CES. Instances that limit the reach and efficiency of the CES, such as difficulties in locating and/or contacting a CES applicant, shall be discussed in Case Conferencing.

KEY STAKEHOLDER REQUIREMENTS

Requirements for System Lead

The System Lead is responsible for overseeing CES including the implementation, coordination, maintenance, and evaluation of the CES. Specifically, the System Lead will:

- Recruit, train, and onboard participating partner agencies into the CES.
- Make ongoing site visits and implement quality assurance strategies for CES process.
- Maintain information about all providers' available housing and service programs, client eligibility, and housing inventory. All information will be updated at least annually.
- Assure data and assessment quality, and when appropriate work with providers to improve submission processes.
- Manage client pools and housing referrals, in accordance with the CoC Written Standards (see Footnote 1) and CES Policies & Procedures.
- Facilitate case conferencing processes with all applicable case conferencing groups (including sub-populations) as needed with the goal of assuring clients are referred to appropriate interventions.
- Create and implement a strong marketing strategy for the CES that targets providers who serve homeless individuals and families and educate the broader community about how to

access the CES and is pursuant to affirmatively furthering fair housing,[9] abide by federal nondiscrimination and equal opportunity requirements[10] and affirmative outreach requirements (see Footnote 10).

- Convene various CoC groups to keep stakeholders updated and aware of changes to the CES.
- Lead efforts for evaluation and continuous quality improvement which include both provider feedback and client input, including outcome reports.
- Provide ongoing updates to the Blueprint Council and relevant committees of the CoC.
- In cases where no Access Point can be identified, connect client to Homeless Initiative Program (HIP) for completion of the CES Enrollment.
- Review and update training protocols on an annual basis.
- Comply with the non-discrimination and equal opportunity provisions of the Federal civil rights laws[11] and ensure clients should not be motivated to choose a certain housing or service location based on race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.

Requirements for Access Points

Access Points must sign the CES partner agency agreement, comply with the Written Standards, and meet the following requirements:

- Use HMIS to enter all required data or provide data to the System Lead using a mutually negotiated process.
- Require staff (Assessors), who will be supporting clients entering housing, to complete required training at least annually and ensure that at least one staff member is up-to-date in training at all times.
- Provide Assessors with training on cultural and linguistic competency, trauma-informed assessment, and safety planning.
- Confirm that the individual or family has not already completed the CES Enrollment prior to assessment, conduct updated assessment if older than six (6) months, and ensure that all contact and eligibility-related information is current.
- Provide shelter diversion services, referral, connection to mainstream benefits, and connection to supports and services to individuals and families who have completed the CES Enrollment, as appropriate.
- Provide client with an in depth explanation of available housing and service choices and ensure the client understands the CES grievance procedure.
- Participate in the case conferencing process through the Case Conferencing Workgroup as requested.
- Allow participants autonomy to freely refuse to answer assessment questions unless the information is necessary to establish or document program eligibility and to refuse housing service options without retribution or limiting their access to assistance.

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[9] 24 C.F.R. 578.93(c). Retrieved August 22, 2022 from https://www.ecfr.gov/current/title-24/subtitle-B/chapter-V/subchapter-C/part-578

[10] 24 C.F.R. 576.407(a, b). Retrieved August 22, 2022 from https://www.ecfr.gov/current/title-24/subtitle-B/chapter-V/subchapter-C/part-576/subpart-E/section-576.407

[11] 24 C.F.R. 5.105(a). Retrieved August 22, 2022 from https://www.ecfr.gov/current/title-24/subtitle-A/part-5/subpart-A/section-5.105

- Ensure appropriate data protections are in place as defined in the Indianapolis CoC HMIS Policies and Procedures.[12]
- Participate in ongoing evaluation and quality improvement processes.
- Identify individuals who face safety risks, especially individuals fleeing domestic violence and interpersonal abuse. If risk of harm is determined, refer individuals or families to appropriate Access Points.
- Identify individuals with a risk of harm to self or others and refer them to crisis mental health services when appropriate.
- Comply with the non-discrimination and equal opportunity provisions of the Federal civil rights laws (see Footnote 11). In addition, clients should not be motivated to choose a certain housing or service location based on race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.

Requirements for Service Provider

In order to serve as a CES Provider, agencies must have a signed CES partner agency agreement, comply with the Written Standards, and meet the following requirements:
- Provide housing and service inventory data or anticipated housing and service inventory data to CES System Lead within three (3) business days of any changes to the number of available units.
- Accept housing referrals in accordance with the Indianapolis CoC Written Standards (see Footnote 1) and CES Policies & Procedures document.
- Agree to use the CES as the only referral source for filling vacancies in designated housing and/or services projects.
- Locate clients when they are referred to their housing program within ten (10) business days in collaboration with Access Points or providers who are serving the client.
- Document instances when a client declines the housing opportunity in HMIS and notify the System Lead.
- Verify documentation of client eligibility provided by Access Points or other case management provider or collect and submit required eligibility documentation if not provided by the Access Point or System Lead.
- Notify System Lead when a client referred is not eligible for the housing opportunity.
- Upon referral, provide the client clear information about the project, what the participant can expect from the project, expectations of the project including transfer policies, and written information on the CES grievance procedure.
- Coordinate with partners and the System Lead to follow the housing referral process, develop a housing stability plan, assist with housing search and placement, assist clients with submitting rental applications and understanding leases, and addressing barriers to project admission.
- Provide ongoing case management to referrals in accordance to project standards.
- Participate in weekly Case Conferencing meetings.
- Ensure appropriate data protections are in place as defined in the Indianapolis Continuum of Care HMIS Policies and Procedures.
- Participate in ongoing evaluation and quality improvement processes.

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[12] *HMIS Policy and Procedures*. The Indianapolis CoC (2019, November 9). Retrieved August 22, 2022 from https://www.indycoc.org/uploads/1/4/0/8/140828032/hmis_policies_and_procedures.pdf

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- Comply with the non-discrimination and equal opportunity provisions of the Federal civil rights laws (see Footnote 11). In addition, clients should not be motivated to choose a certain housing or service location based on race, color, national origin, religion, sex, disability, or the presence of children.

COORDINATED ENTRY SYSTEM ENROLLMENT

The CES Enrollment is a standardized process for collecting information necessary to determine the severity of need and eligibility for homeless housing and related services. It is a standardized process of data collection and assessment of vulnerability. The enrollment creates a vulnerability score, assesses project eligibility, and results in a prioritized pool of households in accordance with the CoC Written Standards (see Footnote 1). It is important to note that client choice is central to the assessment process. It is the responsibility of the Access Points to educate clients on all eligible homeless housing and service options during the enrollment process.

Households that are experiencing homelessness for the first time should be enrolled in the CES on or after the 14th day of homelessness. Household should be enrolled into HMIS immediately, but the CES enrollment should not be completed until the 14th day of homelessness to account for self-resolved homelessness.

Assessors at Access Points complete the CES Enrollment within the HMIS module using a standardized client interview process. The enrollment consists of two portions: the Crisis Needs Assessment and the Housing Needs Assessment. The Crisis Needs Assessment includes the following components and should be completed for households that meet HUD's definition of experiencing literal homelessness, at imminent risk of homelessness, or fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking or human trafficking (see Footnote 7).

The components of the Crisis Needs Assessment include:
- Creating the client record (if applicable)
- Household demographic and contact information
- Universal Data Assessment
- Triage assessment (includes domestic violence assessment, diversion questions)
- Eligibility documentation

For households experiencing literal homelessness per HUD's definition, or fleeing or attempting to flee domestic violence, dating violence sexual assault, stalking or human trafficking (see Footnote 7), the Housing Needs Assessment portion of the CES enrollment should also be completed.

The components of the Housing Needs Assessment include:
- Veteran assessment (if applicable)
- Barriers assessment
- Income assessment
- VI-SPDAT (Vulnerability Index – Service Prioritization Decision Assistance Tool)
- Eligibility status and custom CES questions
- Eligibility documentation

The enrollment can be completed in phases and/or across multiple Access Points depending on the household need. Clients can freely refuse to answer any question that does not directly impact eligibility and prioritization, including disclosure of specific disabilities or diagnosis.

Prior to administering the CES Enrollment, the Assessor must complete the CES confidentiality and release statement with the household in addition to providing written information on the grievance procedure contained within the CES Policy & Procedures.

ANONYMOUS ENROLLMENTS

Any individual or household (including survivors of domestic violence) who do not wish to consent to having their personal identifying information entered into HMIS are still eligible to receive services through CES.

In this case, the CES Assessor will complete and retain a paper version of the CES Enrollment. The Assessor with then complete a Confidential Inclusion Form,[13] following the Confidential Application Instructions,[14] and send it to the CES Lead. Then, the CES Lead will create an anonymous CES Assessment using only the information provided on the Confidential Inclusion Form, which is the minimum information needed to prioritize and match the individual or household to appropriate resources through CES.

Upon referral, the Access Point is responsible for providing a copy of the paper version of the CES Enrollment directly to the housing or service provider to ensure anonymity from the rest of the CES.

VULNERABILITY ASSESSMENT

The VI-SPDAT should be administered as a component of the CES assessment by a trained Assessor of an Access Point in a quiet, safe, and confidential setting. The instrument includes an introductory script, which should be read aloud to the client. Each question should be read aloud to the client as well, and the Assessor should record all answers on the form or directly into HMIS. Clients need only provide yes/no responses to most questions and should be politely discouraged from providing additional details or further information during the assessment in order to ensure a consistent assessment for all clients, in alignment with coordinated entry best practices. Upon completion of the assessment and the additional eligibility-related questions at the end of the assessment, the staff member can and should follow up with the client on relevant service needs, providing direct resources or referrals to other services when appropriate.

The VI-SPDAT for Single Adults is on a 17-point scale, with 0 representing the lowest level of acuity and 17 representing the highest level of acuity. Clients who score 0-3 should not be referred to a housing intervention and should instead be referred to other community resources and supports. Clients scoring 4-7 are recommended to be referred to RRH. Clients scoring 8-17 are recommended to be referred to PSH. The Assessor conducting the intake should NOT provide the VI-SPDAT acuity score to the client, but should discuss the recommendation for next steps, based on the resulting score.

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[13] Confidential CES Application – Prioritization Inclusion Form. Indianapolis Continuum of Care (2017, November 6). Retrieved September 14, 2022 from https://www.indycoc.org/ces-documents.html
[14] Confidential CES Application – Prioritization Inclusion Form Instructions. Indianapolis Continuum of Care (2017, November 6). Retrieved September 14, 2022 from https://www.indycoc.org/ces-documents.html

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Assessors will discuss all eligible housing options with each client and should respect the client's choice of housing preference. Clients scoring one or two points above the recommended RRH range may indicate their preference for RRH over PSH. In these instances, the Assessor will need to submit an RRH Discrepancy Form to the CES Lead for the client to be considered for RRH. The RRH Discrepancy Form should be added to AirTable by a CES Skilled Assessor. Since the discrepancy form only informs eligibility and not prioritization, it will be automatically approved and the CES Lead will complete administrative steps to ensure the household's assessment is updated for inclusion in the RRH housing pool.

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VI-SPDAT Assessment

Score:	Recommendation:
0 – 3	No Housing Intervention (community supports)
4 – 7	May refer for RRH
8 – 17	May refer for PSH

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Other versions of the VI-SPDAT will be utilized by the CES for specific populations (Families, Transition Aged Youth, and Justice Involved individuals). Population specific VI-SPDATs are similar to the VI-SPDAT for Single Adults. The CES shall use the recommended scale and scoring recommendations for each VI-SPDAT version.

The VI-SPDAT does not need to be updated after the initial scoring. However, Assessors may update households VI-SPDAT assessment at any time if the household has experienced a life changing event that would impact the VI-SPDAT score or the current VI-SPDAT score is deemed to be significantly inaccurate. Updates to the VI-SPDAT can be made at the discretion of Assessors in consultation with the household. The VI-SPDAT can be updated by any Access Point and Assessor that the client engages with.

If the client is not in a mental state that would allow them to answer the VI-SPDAT fully and accurately, the Assessor may complete or update the VI-SPDAT at a later time when the client is in an improved mental state.

If the Assessor has additional information or reason to believe the VI-SPDAT score would be higher if the client had fully disclosed or had the insight to do so, the Assessor may complete the VI-SPDAT Discrepancy Form and submit it to the CES Team for review at case conferencing. Additional points approved by the Case Conferencing Workgroup will be added to the final score for prioritization purposes.

Additional Assessments
The additional assessments (Barrier, Financial, Veteran and Domestic Violence) are considered valuable for the purposes of eligibility for housing programs and to better understand the need of the household. They are completed in addition to the common assessment (VI-SPDAT).

Eligibility Status and Custom CES Questions
The collection of eligibility data provides the System Lead with information on what homeless housing and services each household are eligible for and information on client choice for eligible housing and service options. In addition, households provide information that allows the System Lead to ensure that households are connected to the appropriate housing matches. Assessors must provide detailed information about the housing and services options clients are eligible for during

the eligibility status section of the assessment and not screen potential project participants out of assistance based on perceived barriers related to housing or services.

ELIGIBILITY DOCUMENTATION

Access Points should assist in collecting and/or providing documentation of chronic homelessness and disability, when applicable. This information will be necessary to complete the housing placement process so Access Points should make reasonable effort to collect and submit the documentation, and/or discuss with the client how best to obtain the applicable documentation. This may include, but is not limited to, referring clients to, or collaborating with, other service providers. The CES assessment is completed and the client is placed in the housing pool regardless of the availability of documentation at the time of the assessment. However, the following documentation is required prior to referral into a housing program.

- CES Consent Form/Release of Information
- Homeless Documentation
- Chronic Homeless Documentation (if applicable)
- Disability Documentation (if applicable)

If a client does not have all required documentation on file, they will not be referred to a housing program, even if they are the highest prioritized applicant.

The System Lead shall identify households that are highly prioritized and will likely be matched with housing resources soon that still need documentation collected and/or uploaded with the enrollment. The Case Conferencing Workgroup will review these households weekly and create a community plan for assisting the client in obtaining the necessary documentation. The System Lead shall regularly verify documentation for these identified households.

Households with documentation verified by the System Lead within the last six (6) months may be referred into a housing program. After 6 months, additional information will be required to verify that the household is still homeless in order to be referred into a housing program. The household will be required to provide the housing program with updated homeless documentation if there are gaps prior to program enrollment.

CONFIDENTIALITY AND RELEASE OF INFORMATION

The CES, including the prioritization list in HMIS, will comply with the Indianapolis CoC HMIS Policies and Procedures (see Footnote 12) and the HMIS Data and Technical Standards prescribed by HUD.[15] All Access Points will inform clients of the HMIS privacy notice and trained Assessors must have a signed HMIS individual user agreement on file with the lead agency.

The Indianapolis HMIS Policy and Procedures, Agency Agreement, and HMIS User Agreement (see Footnote 12) provide detailed requirements that all HMIS users must meet to ensure data protection.

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[15] *HMIS Data Standards Manual*. The US Department of Housing and Urban Development (2017, July). Retrieved August 22, 2022 from https://www.indycoc.org/uploads/1/4/0/8/140828032/hmis-data-standards-manual-2017.pdf

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PARENTAL CONSENT FOR MINORS SEEKING ASSISTANCE

Consent from a parent or guardian is required in order to serve unaccompanied minors through the CES and adhere to Indiana state law. System navigators understand they are mandated reporters of abuse or neglect of minors and will follow this law.[16] Outlined below are two pathways for obtaining parental or guardian consent, minors with parental involvement and minors not in contact with a parent or legal guardian.

Unaccompanied Minors with Parental/Legal Guardian Contact:

Upon contacting YouthLink, the youth and young adult Access Point, an unaccompanied minor will provide the system navigator with contact information for their parent or legal guardian. The system navigator will contact the parent or legal guardian in order to obtain written consent, via the CES Parental Consent Form,[17] for the unaccompanied minor to participate in CES. Once consent is obtained, the minor can sign their own CES Consent Form.[18] Participation in CES is necessary in order for the unaccompanied minor to access housing interventions within the community. If consent is not received within 72 hours, the system navigator will contact the DCS hotline to report the unaccompanied minor (see Footnote 14). Regardless of parental or guardian consent, a system navigator must make a report with the DCS hotline if there are any signs of abuse and/or neglect, including sleeping outside or unsheltered.[19]

Unaccompanied Minors without Parental Contact

Upon contacting YouthLink, an unaccompanied minor will provide the system navigator with contact information for their parent or legal guardian. If the unaccompanied minor cannot or will not provide contact information for the parent or guardian, the system navigator must call and make a report with the DCS hotline (see Footnote 14). The system navigator should continue to work with the unaccompanied minor to obtain consent from a parent or guardian. If consent is received within 72 hours, utilizing the CES Parental Consent Form, the system navigator should notify DCS. However, DCS may still decide to investigate the report.

Note: Staff from local school districts, particularly social workers and McKinney-Vento liaisons, might refer unaccompanied minors to YouthLink and be present as the unaccompanied minor speaks with a system navigator. However, staff cannot provide any information to the system navigator without a release of information.

HOUSING POOLS

It is anticipated that the demand for housing and services will be greater than the available inventory, and that individuals and families who are not able to resolve their homelessness (with or without other community supports) will need to wait weeks or months for an appropriate housing referral to become available. This will result in a pool of clients waiting for a housing opportunity. Access Points should continue to provide support and/or case management and refer clients to services and/or on-going case management if they are unable to provide it.

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[16] *Child Abuse and Neglect Hotline*. Indiana Department of Child Services (2022). Retrieved August 22, 2022 from https://www.in.gov/dcs/contact-us/child-abuse-and-neglect-hotline/

[17] *Parental Consent for Services for Unaccompanied Minors*. The Indianapolis CoC. Retrieved August 22, 2022 from https://www.indycoc.org/ces-documents.html

[18] *Client Release of Information and Sharing Plan*. The Indianapolis CoC. Retrieved August 22, 2022 from https://www.indycoc.org/ces-documents.html

[19] IC 31-34-1-1 (Juvenile Law: Children in Need of Services). Retrieved August 22, 2022 from http://iga.in.gov/legislative/laws/2020/ic/titles/031#31-35

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The housing pool will fluctuate greatly because of the following factors in the CES: the inventory of available housing opportunities, the eligibility criteria for those available units, and the prioritization of individuals based on the CoC Written Standards. Due to these factors, it will not be possible for the System Lead to identify where a client is "located" in the pool. If inquiries are made about a client's "location," a standard response reflecting this issue will be provided.

COORDINATED ENTRY SYSTEM PRIORITIZATION AND ELIGIBILITY

The process of prioritizing individuals and families for services is done through an automated process within HMIS using the information gathered during assessment and is monitored by the System Lead. Data collected from the enrollment will not be used to discriminate or prioritize households for housing and services on a protected basis, such as race, color, religion, national origin, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. Individuals and families seeking housing assistance are prioritized in accordance with the CoC Written Standards (see Footnote 1), using a Housing First approach. Individuals and families may or may not be eligible for certain programs, which is why it is extremely important that Access Points gather or support the collection of eligibility documentation.

EMERGENCY SHELTERS

Emergency shelter provides safe, basic lodging where individuals and families can stay temporarily while they resolve their housing crisis.

Eligibility Criteria

Providers of emergency shelter will admit individuals and families who meet Categories 1 (Literally Homeless), 2 (At Imminent Risk of Homelessness), 3 (Homeless Under Other Federal Statues), or 4 (Fleeing or Attempting to Flee Domestic Violence) from the HUD definition of homeless (see Appendix A) and agency's eligibility criteria.

Prioritizing/Targeting Eligible Households for Emergency Shelter

Aside from Veteran Contract, the CES does not prioritize emergency services hotlines, drop-in service programs, or emergency services so that they may operate with as few barriers as possible. Although these resources are not prioritized through the CES, HUD requires that all ESG funded shelters follow the Indianapolis CoC Written Standards (see Footnote 1). Individuals and families will have access to emergency services at all hours including hours outside of the standard CES hours.

Veteran Contract

The CES prioritizes Veteran Contract ES as follows:
1. Chronically homeless veterans and families with the longest history of homelessness and with the most severe service needs
2. Non-chronically homeless individuals and families with the longest history of homelessness and with the most severe service needs
3. Veterans and Families at imminent risk of homelessness with the most severe service needs

In instances where two or more households have equal priority, applicants will be further prioritized as follows:
- Victims of domestic violence
- Youth (18 – 24 years of age)
- First presented for assistance

Please see the CoC Written Standards for Assessment, Length of Stay/Discharge, Safety and Shelter Needs of Special Populations Standards, and Performance Metrics (see Footnote 1).

NON-ELDERLY DISABLED (NED) MAINSTREAM VOUCHER

NED Mainstream Housing Choice Vouchers are fulfilled in partnership with the Indianapolis Housing Agency (IHA) and are considered Other Permanent Housing (OPH). NED vouchers are intended to assist persons with disabilities who often face difficulties finding accessible housing on the private market and for non-elderly disabled families to lease their choice of an affordable private housing unit.

Eligibility Criteria
- Household must meet the HUD definition of homelessness (see Footnote 7)
- Head of household must be 18 - 61 years of age
- Head of household, spouse or co-head must have a disabling condition (see Appendix A)
- All adult household members must pass an IHA background check

Note: there is no limit to household size

Prioritization

Eligible participants are referred to the NED program for which they are eligible and prioritized based on the following prioritization:

1. Chronically homeless households with the longest history of homelessness and most severe service needs
2. Non-chronically homeless households with the longest history of homelessness and most severe service needs
   - The most severe service needs are determined by the household's VI-SPDAT score

Households will be prioritized within the VI-SPDAT score range of 7-10. Chronic homeless documentation is not required. The household must receive income from SSI/SSDI.

Please see the CoC Written Standards for OPH Performance Metrics (see Footnote 1).

PERMANENT SUPPORTIVE HOUSING

Permanent Supportive Housing (PSH) is community-based housing, the purpose of which is to provide housing without a designated length of stay for people experiencing homelessness. PSH can only serve individuals with disabilities and families in which at least one adult or child has a disability. HUD defines a disability as one or more of the following: physical, mental, or emotional impairment; developmental disability; HIV or AIDS.[20]

Eligibility Criteria

For detailed eligibility criteria, see the Indianapolis CoC Written Standards (see Footnote 1). Programs may not establish additional eligibility requirements beyond those specified in the Written Standards and those required by funders.

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[20] 24 C.F.R. 578.3 (Definitions). Retrieved August 22, 2022 from https://www.govinfo.gov/content/pkg/CFR-2017-title24-vol3/xml/CFR-2017-title24-vol3-part578.xml

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Prioritizing Eligible Households

The Indianapolis CoC has adopted the orders of priority for PSH as established in Notice CPD-16-11: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing.[21] As such, all PSH eligible households will be prioritized as follows:

Dedicated/Prioritized CoC

For Dedicated PSH beds, the priority population is chronically homeless (see Appendix A)individuals and families with the longest history of homelessness and with the most severe service needs.

In instances where two or more households have equal priority, applicants will be further prioritized as follows:

- Veterans not eligible for housing/health VA services
- Victims of domestic violence
- Youth (18 – 24 years of age)
- First presented for assistance

Non-Dedicated/Prioritized CoC

For non-Dedicated PSH beds, the priority populations are as follows:

- Homeless individuals and families with a disability (see Appendix A) with long periods of episodic homelessness and severe service needs.
- Homeless individuals and families with a disability with severe service needs.
- Homeless individuals and families with a disability coming from places not meant for human habitation, Safe Haven, or Emergency Shelter without severe service needs.
- Homeless individuals and families with a disability coming from Transitional Housing.
  - An individual or family that is eligible for CoC Program-funded PSH who is currently residing in a transitional housing project, where prior to residing in the transitional housing had lived in a place not meant for human habitation, in an emergency shelter, or Safe Haven.

In instances where two or more households have equal priority, applicants will be further prioritized as follows:

- Veterans not eligible for housing/health VA services
- Victims of domestic violence
- Youth (18 – 24 years of age)
- First presented for assistance

Please see the CoC Written Standards for PSH Minimum Standards of Assistance and Performance Metrics (see Footnote 1).

PREVENTION SERVICES

Prevention services are designed to prevent an individual or family from moving into an emergency shelter or living in a public or private place not meant for human habitation through housing stabilization services and short- and/or medium-term rental assistance.

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[21]*Notice CPD-16-11: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in PSH.* The United States Department of Housing and Urban Development (2016, July). Retrieved June 23, 2022 from https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf

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Eligibility Criteria

Households must be at imminent risk of homelessness and meet the eligibility requirements of the program under which the project is funded including any applicable income limits (ESG, SSVF, etc.).

Prioritizing/Targeting Eligible Households

Providers of Prevention Funds can set their own policies regarding prioritization and targeting of households so long as the policies are outlined in a written document(s) and do not conflict with any part of the CoC Written Standards.

Please see the CoC Written Standards for Prevention Minimum Standards and Performance Metrics (see Footnote 1).

RAPID RE-HOUSING

Rapid Re-housing (RRH) is available to help those who are homeless become quickly and permanently housed. RRH Projects provide housing relocation and stabilization services and short (1-3 months) or medium term (4-24 months) rental assistance as needed to help a homeless individual or family move as quickly as possible to permanent housing and achieve stability in that housing. Youth and Young Adult households receiving assistance through a Youth Homelessness Demonstration Program (YHDP) project may receive up to 36 months of assistance.

Eligibility Criteria for RRH

For detailed eligibility criteria, see the Indianapolis CoC Written Standards (see Footnote 1). Programs may not establish additional eligibility requirements beyond those specified in the Written Standards and those required by funders.

Prioritizing for Rapid Re-Housing Programs

CoC & ESG Program RRH

Eligible participants are referred to the RRH program for which they are eligible and prioritized based the following prioritization:
1. Chronically homeless individuals and families with the longest history of homelessness and with the most severe service needs
2. Non-chronically homeless individuals and families with the longest history of homelessness and with the most severe service needs

In instances where two or more households have equal priority, applicants will be further prioritized as follows:
- Veterans not eligible for housing/health VA services
- Victims of domestic violence
- Youth (18 – 24 years of age)
- First presented for assistance

The most severe service needs will be determined by the household's VI-SPDAT score. Households will be prioritized within the recommended VI-SPDAT score of 4 to 7 for households without minor children and 4 to 8 for households with minor children unless there are households higher on the prioritization list that specifically requested RRH and were approved using the RRH Discrepancy Form. For YHDP funded projects, households of all VI-SPDAT scores (for all versions of the VI-SPDAT) may be considered. Case conferencing will examine household needs and vulnerabilities to determine if RRH is the best and most appropriate available resource for the household at the time.

If no eligible and interested literally homeless households are in the housing pool, case conferencing will determine how to prioritize households at-risk of homelessness in the housing pool based on household needs and vulnerability.

Prior to Rapid Re-housing being used as a Bridge to PSH, the System Lead and associated case workers must develop a plan based on the Bridge section of this document to ensure that the projects are resourced to successfully bridge the household into PSH.

CoC and ESG projects that planned to target non-chronic households may request a waiver to the above prioritization, which will be review and granted on a project-by-project basis that may be time-limited. The waiver would allow projects to target non-chronic households within the established prioritization. Waiver requests should be submitted in a letter to the System Lead at CES@chipindy.org. The letter should include the reason for the waiver request, the specific grant term for which the waiver is being requested and be signed by an authorized signee. The System Lead will respond within 30 days of the request. Projects must have an approved waiver prior to spending RRH project funds. Any grievances based on waiver requests should follow the established grievance procedure established with the CES Policy & Procedures, Management and Oversight section.

SSVF RRH
Eligible participants will be prioritized or targeted based on the agreed upon standards set forth in the provider's SSVF grant agreement. For detailed information on Rent limits and guidelines for Rapid Re-housing please refer to the Indianapolis CoC Written Standards (see Footnote 1).

Please see the CoC Written Standards for RRH Rent Limits, Minimum Standards of Assistance, and Performance Metrics (see Footnote 1).

STREET OUTREACH

Street Outreach (SO) is designed to increase access and connection to services for people who are living unsheltered on the streets. Outreach includes the provision of urgent, non-facility-based care to people who are unsheltered and unwilling or unable to access emergency shelter, housing, or an appropriate health facility.

Dedicated, housing focused outreach is a coordinated, targeted and intentional effort to engage individuals experiencing unsheltered homelessness with the primary purpose of moving them into permanent housing.

The CES partners with all providers funded through ESG to support street outreach programs. The System Lead will recruit providers as Access Points and sign agreements with these providers, which will include specific language regarding street outreach programs.

Eligibility/Targeting Criteria
Providers of SO services shall target unsheltered homeless individuals and families, meaning those with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings. Examples of these types of accommodations include a car, public park, abandoned building, bus or train station, airport, or camping ground.

Prioritizing/Targeting Eligible Households for Emergency Shelter

It is important to note that the CES does not prioritize street outreach so that it may operate with as few barriers as possible. Although these resources are not prioritized through the CES, HUD requires that all ESG funded programs must follow the Indianapolis CoC Written Standards.

Please see the CoC Written Standards for SO Minimum Standards and Performance Metrics (see Footnote 1).

TRANSITIONAL HOUSING

Transitional Housing (TH) is designed to provide homeless individuals and families with interim stability and support so that they can successfully move to and maintain permanent housing.

Eligibility Criteria

For detailed eligibility criteria, see the Indianapolis CoC Written Standards (see Footnote 1). Programs may not establish additional eligibility requirements beyond those specified in the Written Standards and those required by funders.

Prioritizing Eligible Households for Transitional Housing Programs

Non-GPD TH

Eligible participants are referred to the TH program for which they are eligible and prioritized based the following prioritization:
1. Households with the most severe service needs not eligible for PSH
2. Households with the longest histories of homelessness

In instances where two or more households have equal priority, applicants will be further prioritized as follows:
- Veterans not eligible for housing/health VA services
- Victims of domestic violence
- Youth (18 – 24 years of age)
- First presented for assistance

Recipients must inform any chronically homeless households being referred to non-GPD TH that by entering the transitional housing project they will not be eligible for PSH projects dedicated to serving chronically homeless.

GPD Transitional Housing

Eligible participants will be prioritized as follows:
1. Chronically homeless veterans and families with the longest history of homelessness and with the most severe service needs
2. Non-chronically homeless individuals and families with the longest history of homelessness and with the most severe service needs
3. Veterans and families at imminent risk of homelessness with the most severe service needs

In instances where two or more households have equal priority, applicants will be further prioritized as follows:
- Victims of domestic violence
- Youth (18 – 24 years of age)
- First presented for assistance

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Eligible participants will be targeted based on the standards set forth in the GPD TH Model being provided as follows:

- Bridge Housing Targeted Population - Homeless Veterans that have been offered and accepted a permanent housing intervention (e.g., SSVF, HUD-VASH, CoC) but are not able to immediately enter the permanent housing. Veterans must have been offered and accepted a permanent housing intervention prior to admission or within the first 14 days of admission.
- Clinical Treatment Targeted Population - Homeless veterans with a specific diagnosis related to a substance use disorder and/or mental health diagnosis; AND veteran actively chooses to engage in clinical services.
- Service- Intensive Transitional Housing (SITH) Targeted Population - Homeless veterans who choose a supportive transitional housing environment providing services prior to entering permanent housing.

TRANSITIONAL HOUSING (TH) AND RAPID REHOUSING (RRH) JOINT PROJECT

A joint transitional housing (TH) and rapid rehousing (RRH) component project is a project type that combines these two existing program components into a single project to serve individuals and families experiencing homelessness.

Eligibility Criteria for TH-RRH

For detailed eligibility criteria, see the Indianapolis CoC Written Standards (see Footnote 1). Programs may not establish additional eligibility requirements beyond those specified in the Written Standards and those required by funders.

Prioritizing for Joint TH-RRH Programs

Eligible participants are referred to the TH-RRH program for which they are eligible and prioritized based the following prioritization:

1. Chronically homeless individuals and families with the longest history of homelessness and with the most severe service needs
2. Non-chronically homeless individuals and families with the longest history of homelessness and with the most severe service needs

In instances where two or more households have equal priority, applicants will be further prioritized as follows:

- First presented for assistance

Households will be prioritized for Joint TH-RRH programs within the VI-SPDAT score range of 4 to 10. The CES Workgroup determined this range to be appropriate for this program type based on community experience with TH and RRH programs individually and anticipated blending of program elements.

For YHDP funded projects, households of all VI-SPDAT scores (for all versions of the VI-SPDAT) may be considered. Case conferencing will examine household needs and vulnerabilities to determine if TH-RRH is the best and most appropriate available resource for the household at the time. If no eligible and interested literally homeless households are in the housing pool, case conferencing will determine how to prioritize household at-risk of homelessness in the housing pool based on household needs and vulnerability.

COORDINATED ENTRY SYSTEM REFERRAL PROCESS

The System Lead will be responsible for identifying housing and service matches by reviewing HMIS data on a weekly basis, at minimum, and matching individuals and families to appropriate housing opportunities, based on availability and in accordance with the CoC Written Standards and CES Policies & Procedures regarding prioritization.

A housing and service match can be made at any time when there is an opening at the Service Provider's request. Each week, the System Lead will bring all appropriate housing matches that have not been made to the Case Conferencing Workgroup. The Case Conferencing Workgroup will include case workers and individuals working with clients to provide additional information, expedite the referral process, or address grievances with housing matches. The Committee will not be able to change prioritization, unless new information is presented at case conferencing that is relevant to CoC Written Standards prioritization and eligibility guidelines. Households highest on the prioritization list that match program eligibility can accept or deny housing and services. In addition, if multiple housing opportunities are available, the highest prioritized client that is eligible must have the opportunity to choose which housing option best fits their needs. It is essential that the CES maintain client choice during the referral process.

Once a referral is issued by the System Lead to the Service Provider, the following steps will occur:
1. The System lead will inform the Access Point and Service Provider of the match.
2. The Service Provider must locate the client, advise them of the housing or service opportunity, and determine interest, within ten (10) business days.
3. The Service Provider must verify eligibility for the housing opportunity.
4. Service Provider must provide services in accordance with Service Provider requirement and the Indianapolis CoC Written Standards.

Grant Per Diem (GPD) & Contract Program Referral Process

In the event that GPD model/Contract program has openings but no Veteran households in the housing pool who qualify for the model, a GPD service provider or Contract provider may self-match an eligible Veteran who engages directly with their agency as long as the Veteran's eligibility is checked with the Veteran's Administration GPD/Contract Liaison team.

The CES System Lead recognizes the need to have a more active response to GPD and Contract openings when there is a pool of eligible applicants waiting for placement. In response, GPD/Contract providers will receive a batch of up to 20 Veteran applications every two weeks from the CES System Lead. This allows the provider to build rapport, ensure the application and GPD model is accurate and the Veteran requests GPD programs or Contract program and can fill openings more quickly while still allowing prioritized Veterans to quickly be matched to GPD and Contract openings. As part of the referral process, the following providers will focus on subsets of the Veteran GPD pool.

- HVAF: Batches will consist of three GPD models provided (Bridge, Service Intensive and Clinical) while focusing on individual adult Veterans.
- Homeless Initiative Program: Batches will consist of two GPD models provided (Bridge and Service Intensive) while focusing on Veteran families. If no Veteran families are in the pool for the models provided, then Individual Adult Veterans will be provided.

- The GPD/Contract providers will also provide the batch received to the Veterans Administration GPD Liaison Team so they may provide eligibility confirmation. The GPD and Contract providers will communicate this eligibility information as well as Veterans matched at the provider level with openings to the system lead who will update the appropriate notes and send the referral through HMIS.

TH-RRH Referral Process

When a referral is made to a TH-RRH program, the participant may choose whether to enter TH or RRH, as long as the program has availability in both components. If they choose to enter TH, they may choose when to move into RRH, as long as it is within the time constraints of the TH component and there is an RRH opening available. Because it is possible for participants to choose to move directly into RRH, there could be a situation where a TH-RRH program has TH beds available and no remaining RRH slots. In this case, the TH-RRH program should continue to utilize TH beds, while considering the impact on participants (specifically that a TH enrollment breaks chronicity, which has implications for households not yet connected to a different permanent housing solution).

If there is no RRH slot available, Case Conferencing should decide whether to:
- Offer the TH bed to an individual who is highly vulnerable and/or unsheltered and is already working with a different RRH or PSH project. This would not impact the pre-existing RRH or PSH referral and would offer temporary housing while they pursue permanent housing
- Offer the TH bed to the next individual normally prioritized who is also eligible for RRH. In this case, the individual or household would be added to an RRH-only transfer list at the time of referral; see Transfer Policies

HOUSING MATCH CHALLENGES

Client cannot be located

The Housing Provider should locate the client within ten (10) business days, make at least three (3) *documented* attempts to find them, and log those attempts in HMIS. The Service Provider should consult members of the Case Conferencing Workgroup when attempting to locate the client. If the Service Provider is unable to locate the client within ten (10) business days, then they should consult with the System Lead, who will identify the next highest priority client who is eligible for the housing opportunity.

Documentation

If not provided at the time of the referral, documentation required by the housing and services provider must be submitted within 10 business days of referral. If documentation is not submitted within 10 business days, it is at the housing and service provider's discretion to decline the referral and request a new referral from CES.

Client is not actually eligible

In the event that the client is determined to be ineligible for the housing opportunity during the referral process, the client is placed back in the housing pool at the appropriate priority level. The Housing Provider should notify the System Lead of the ineligibility within 24 hours. The System Lead will then identify the next eligible client in the pool, and issue a referral to the Service Provider.

The System Lead is responsible for monitoring this process. If a particular Access Point, organization or staff member consistently refers clients who are not eligible for housing, the System Lead will provide additional support and training to improve the quality of the referrals.

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Client declines housing opportunity

The eligible client may decline any housing opportunity and will be placed back in the housing pool at the appropriate priority level. The reason for the decline should be recorded in HMIS by the Service Provider.

Housing Provider declines the referral

Service Providers who participate in CES must abide by the CoC Written Standards and accept all eligible referrals. In the event that the Service Provider does not agree that the referred individual or family meets the eligibility requirements, the Service Provider must provide a written explanation to the System Lead. Service providers may only decline clients based on established project eligibility criteria. The System Lead will be monitoring agencies' decline rates and rationales, and will provide additional information on the expectations of the system and seek clarification on program eligibility and requirements for housing providers who frequently decline referrals. Decline rates from providers and the referral quality of the System Lead will be assessed during annual CES evaluation.

HOUSING PROGRAM INVENTORY

Data on housing and services will be managed by the System Lead. All housing and service providers must provide the CES Lead with updates on available housing and service opportunities and any changes to eligibility criteria within three (3) business days of any change in status by emailing the information to the CES System Manager at CES@chipindy.org.

HOUSING TRANSFERS

Transfers between programs occur when an individual or family needs to move from one program or project to another. Individuals and families may transfer for a variety of reasons, but the priority is to keep them stably housed in order to prevent returns to homelessness and ensure the household is receiving appropriate services.

Some transfers are a "net zero" for the housing system (if a household moves from PSH Project A to PSH Project B, there is now an opening at PSH Project A), but this is not always the case (if a household moves from an RRH project to a PSH project, there may not be a new RRH opening and it does not create a new PSH opening). This policy cannot anticipate every circumstance, but the following guidelines will be used by the System Lead and housing and service providers during case conferencing.

Common reasons a client would transfer are:
1) Client has violated significant provider policies and cannot remain in the program anymore, and needs to move to a different provider or program.
2) Household size changes and the current unit is no longer appropriate.
3) Client requires a transfer due to safety reasons related to domestic violence or interpersonal abuse.
4) Case manager determines that a client who was in an RRH program needs long-term assistance and is eligible for PSH.
5) Client in RRH or PSH no longer needs the program's supportive services but still needs financial support and is ready to "move on" to long-term subsidy only
6) Client was placed in RRH as an intentional bridge to PSH.

Transfer Process

Transfer requests shall first be discussed by the household and Service Provider, who will determine if the transfer request meets the provider's transfer policy requirements.

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If the housing provider determines the transfer request does not meet the provider's transfer policy requirements, the provider has the ability to deny the request and it will not be brought forward to case conferencing. Clients may file a grievance with the provider if they disagree with the decision. If there is future disagreement, a grievance can be filed at the system level.

If the Service Provider determines that the request meets their policy requirements, they will submit it to case conferencing with details such as: how long the household can stay in their current program; what alternative options have been attempted previously; their barriers or if they are a special population; how they engage with their current program; why the household and provider believe another program will be more suitable; and what preferences the household has for next steps. If the case conferencing workgroup agrees, the System Lead will add the household to the transfer list.

The transfer list will be prioritized based on urgency (those who must move immediately will be top priority; those who may remain stably and safely housed for longer will be lower priority). When there is availability in a program for which a household on the transfer list is eligible, case conferencing should review the transfer list and prioritize those with an urgent need in order to prevent returns to homelessness.

The System Lead should maintain the transfer list and review with the case conferencing workgroup monthly for updates.

If the housing provider determines the transfer request does not meet the provider's transfer policy requirements, the provider has the ability to deny the request and it will not be brought forward to case conferencing. Clients may file a grievance with the provider if they disagree with the decision. If there is future disagreement, a grievance can be filed at the system level.

PSH to PSH
CoC-funded PSH projects may serve individuals and families from other CoC-funded PSH projects, as long as program participants originally met the eligibility requirements for the PSH project to which they are transferring at the time they entered their initial PSH project.

To verify eligibility requirements, disability and chronic documentation should be uploaded to HMIS prior to the transfer being initiated. Upon transfer, the original PSH project will keep the original client file, which includes documentation of disability, intake paperwork, CES paperwork, chronic documentation, case notes, etc. The original PSH project will make a copy of the entire folder and provide it to the new PSH project.

RRH to PSH
Program participants that are receiving RRH assistance through ESG, CoC, and SSVF maintain their homeless status and chronically homeless status for the purpose of eligibility for other permanent housing programs, such as HUD-VASH and CoC-funded PSH (so long as they meet any other additional eligibility criteria for these programs).

To verify eligibility requirements, disability and chronic documentation should be uploaded to HMIS prior to the transfer being initiated. Upon transfer, the RRH project will keep the original client file, which includes documentation of disability, intake paperwork, CES paperwork, chronic

documentation, case notes, etc. The RRH project will make a copy of the entire folder and provide it to the new PSH project.

RRH to RRH
Per HUD guidance, transfers between RRH programs are not allowed. Note: In some cases, TH-RRH to RRH transfers are allowed; please see TH-RRH to RRH section below.

RRH or PSH to OPH ("Moving On")
After sufficient time stabilizing in an RRH or PSH program and increasing income or benefits, a household will ideally exit the program. If the household no longer needs supportive services but has limited income, they may be eligible for an Other Permanent Housing (OPH) referral to a "moving on voucher," which offers long-term subsidy to maintain housing stability. When a client expresses readiness to move on, the current provider should complete an assessment with the household to determine next steps. If OPH is the best next step, the provider will submit the household to the System Lead to discuss adding them to the Transfer List in case conferencing. If the next best step is unclear based on the assessment, the household should be staffed in case conferencing. As soon as OPH vouchers are available, CES will refer households from the Transfer List, generally beginning with those who must exit their current program the soonest. Unique or urgent cases should be considered in case conferencing.

Moving on vouchers are commonly important for youth and young adults, survivors of domestic violence, people with unstable employment, and large families or single-parent households.

TH-RRH to RRH
In the event that a joint component TH-RRH project has TH beds available but no remaining RRH slots, they should continue to utilize TH beds as outlined in this policy. In this situation, a TH-RRH to RRH transfer is allowable per HUD.

If Case Conferencing chooses to offer a TH bed to the next individual normally prioritized who is also eligible for RRH, the individual or household would be added to an RRH-only transfer list at the time of referral, and Case Conferencing would agree to prioritize this person for an RRH opening when appropriate in order to prevent their return to emergency shelter or an unsheltered location.

When discussing a transfer to RRH, Case Conferencing should consider that:
- Total length of assistance will include the time already spent in TH component of TH-RRH program
- Transfers from TH-RRH program to an originally YHDP-funded RRH program are subject to a maximum of 36-months of combined assistance (i.e. if a young adult spent 18 months in TH component of a TH-RRH project and was then transferred to a YHDP RRH project, they would have a maximum of 18 remaining months for RRH).
- Transfers from TH-RRH program to a CoC-funded RRH program are subject to a maximum of 24-months of combined assistance (i.e. if a person spent 9 months in TH component of a TH-RRH project and was then transferred to a CoC RRH project, they would have a maximum of 15 remaining months for RRH).

Bridge Housing
The homeless response system recognizes that a need exists to utilize RRH as a Bridge to PSH for chronically homeless individuals and families in the community who prefer and are eligible for PSH but for which no open PSH unit exists.

Bridge Housing may be used in an effort to house the most vulnerable individuals and families in the community when there are insufficient PSH units. If the RRH unit is intended to Bridge the client into a PSH unit, that individual or family will maintain their spot in the housing pool for PSH and will be offered a PSH unit that they are eligible for once it becomes available. The Bridge process is different from a RRH household utilizing the Transfer process to move to a PSH level of care since the expectation was that the household would initially be successful in RRH. The Bridge Housing policy was developed by the CES Refinement ad hoc workgroup as part of the refinement of the Indianapolis Coordinated Entry System.

- Case Conferencing Workgroup is integral in this process and will have flexibility to determine appropriate project matches for RRH as a bridge to PSH.
- Case Conferencing Workgroup will match the most appropriate households to RRH as a bridge to PSH projects, with additional consideration for referral to other community programs for wrap around support if appropriate. When the appropriate match for a PSH transfer is determined, a PSH referral will be generated by Coordinated Entry to begin the process for project intake. If an appropriate PSH match is not made, the household will remain active on the RRH Bridge list until the next eligible unit is matched.
- An RRH Bridge list will be reviewed in Housing Case Conferencing at least monthly to ensure households can complete the Bridge process to eligible PSH projects in the most efficient and effective manner.
- Coordinated Entry will update a spreadsheet with pertinent information including, but not limited to:
  - PSH project needs:
    - Household income
    - Specific supportive services needed or need for subsidy only
    - Household size and number of bedrooms needed
    - PSH eligibility (household would need to be eligible for PSH at time of RRH referral)
    - Documentation of disability (for dedicated PSH Projects)
    - Chronic homeless documentation (Documentation may be verified prior to the referral or can be obtained in a reasonable period of time for dedicated PSH Projects)
  - Date RRH lease ends and duration of RRH project and whether current property manager will accept a Housing Choice Voucher
  - Any other relevant information

Dedicated RRH Bridge projects will help facilitate the handoff to the PSH project and will be responsible for providing applicable documentation and support based on the needs of the household.

HOUSING POOL MAINTENANCE

INACTIVE HOUSEHOLDS

In order to maintain an updated housing pool that accurately reflects the needs in the community and enhances system performance, it is anticipated that some households may be enrolled in the CES that no longer need to be active in the housing pool. The System Lead will monitor the auto-exit

process for inactive households and will monitor the housing pool on a regular basis and exit inactive households from the CES in the following circumstances.

Auto-exits

Households who have been enrolled in the CES but have not had a CES contact for the most recent 90 day period will be auto-exited from the CES program enrollment. CES contacts include services and referrals attached to the coordinated entry enrollment.

Unsuccessful referrals

Households who have been matched and referred to a housing program that were unable to be located within 10 business days and 3 documented attempts will return to the pool and will remain active for an additional 20 business days. If the client cannot be located and/or does not have any system contacts within 20 business days of being returned to the housing pool, the household will be exited from the CES program enrollment.

Temporary holds

Households who have expressed a desire to be temporarily placed on hold in the CES, regardless of reason, will remain open in the CES but will not be referred to housing and services. The System Lead will document and monitor the hold until the household communicates they would like to be active again. This includes but is not limited to households who are exploring other housing options outside of the CES, households in treatment programs who would like to finish before housing, and households who need additional time to gather eligibility documentation. Households on a temporary hold will continue to need a CES contact at least every 90 days or they will be auto-exited due to inactivity.

No longer in need of CES resources

Households that have self-resolved, left town, or, for another reason, are no longer in need of resources within the CES will be exited on as needed basis. Any HMIS user can log the service "CES – Exit" to indicate a household can be exited from the system. The comments box of the services page will be utilized to indicate the exit destination that should be used when the enrollment is exited by the CES Team.

The System Lead shall notify the Case Conferencing Workgroup of households that have been or are going to be exited from the CES program enrollment due to the reasons above. If additional information is provided that suggests the household needs to remain active, the System Lead will not exit the household from the CES and will log a system contact to keep them active. Household that have been exited from the CES within the last 30 days can have their enrollment reactivated by an Assessor if contact is made. After 30 days, households can complete a new CES Enrollment if desired and eligible.

INDIANAPOLIS SHELTER COORDINATION

PURPOSE

The goals of an effective crisis response system are to identify those experiencing homelessness, prevent homelessness when possible, connect people with housing quickly and provide services when needed. An effective crisis response system is an essential component of Indianapolis' homelessness prevention and intervention system and critical to ensuring that homelessness is rare, brief, and non-recurring. The coordination (Shelter Coordination) of emergency shelter beds or similar resources is a key component to a high functioning crisis response system. The goal of

Shelter Coordination is to provide households experiencing homelessness with a clear understanding of eligibility and availability of emergency shelter, ability to quickly connect to available resources and decrease client trauma and anxiety associated with the search for shelter. Through Shelter Coordination, the crisis response system will be able to communicate more effectively to all stakeholders, improve the ability to quickly serve clients, and increase the efficiency of emergency shelter operations.

MODEL

Shelter Coordination includes three key stakeholders: households experiencing homelessness, Shelter Entry Points and Emergency Shelters. The term Households experiencing homelessness refers to clients within the Indianapolis CoC coverage area that are considered literally homeless or at imminent risk of homelessness as defined by the US Department of Housing and Urban Development (HUD). Shelter Entry Points are physical or virtual locations that provide emergency shelter eligibility and availability information to homeless households and then assist in referring those households to emergency shelter. Emergency Shelter providers are the agencies that provide the programs, services and shelter associated with a crisis response system. The Coalition for Homelessness Intervention and Prevention (CHIP) acts as the CES Lead and is responsible for maintaining and evaluating the systemic structure of Shelter Coordination and providing technical assistance in partnership with Emergency Shelters and Shelter Entry Points.

Shelter Coordination is based on a no wrong doors approach, meaning that households can access the crisis response system directly through multiple Shelter Entry Points or by receiving information on how to connect to a Shelter Entry Point from another agency.

PROCESS

Households may access the crisis response system by calling Indiana 2-1-1, calling a homeless provider, or directly contacting a shelter. If a household presents at a homeless provider for shelter, the provider should assist them with locating shelter by calling Indiana 2-1-1 or directly contacting shelter(s) until they find a vacancy.

CES MANAGEMENT AND OVERSIGHT

The primary oversight of the day-to-day operations of CES will be managed by the System Lead. CES Workgroups will continue to convene, as appropriate, to engage in ongoing planning for CES, including engaging partners, supporting communication efforts, addressing systemic issues that may arise in implementation, and assessing feedback from system stakeholders.

The CES System Lead will conduct an annual Policy & Procedure review in partnership with CES Leadership Workgroup, using qualitative and quantitative data from monthly CES Monitoring, the CES Annual Evaluation, and other stakeholder input.

Other changes to the CES Policies & Procedures will be made to increase efficiency, effectiveness, and equity of CES, in accordance with the CoC Written Standards. These changes are developed and recommended by the System Lead in partnership with key stakeholder workgroups, approved for pilot by the CES Leadership Workgroup, and ultimately codified by the CoC Blueprint Council.

There are situations when an agency, project or Assessor can be recommended for removal from the CES by the System Lead. Reasons for removal include refusal to comply with CES Policies and Procedures, HMIS Policies and Procedures, or CoC Written Standards, or instituting any practice that

would be detrimental to client safety or severely impact the System Lead and agencies associated with CES. Parties will be given 30 days to correct the errors, respond to violations, or file a grievance. If the violation is substantiated, then a group of peers will recommend further action with a final decision on further action or removal with the Blueprint Council.

TRAINING AND AUTHORIZATION OF ACCESS POINTS AND ASSESSORS

Training for CES Skilled Assessors is provided by the CES System Lead and provides Assessors with a detailed process and script to administer the CES Enrollment and complete the workflow in HMIS. At a minimum, staff must complete the following training components prior to conducting a CES Enrollment:

1. HMIS User Training (if a new HMIS User).
2. CES Skilled Assessor Training, which includes the following elements: Safety Planning, Diversion Questions, Intake information, VI-SPDAT, Barrier assessment, Financial assessment, Veteran assessment, Domestic Violence Assessment, Eligibility status and custom CES questions.
3. Training on eligibility documentation.
4. Training on administering the VI-SPDAT.
5. Review of CES Policies & Procedures, including assessment and prioritization requirements and criteria for decision making and referrals to CES homeless housing and services.

In addition, Assessors must complete Coordinated Entry refresher trainings at least annually.

The CES System Lead will maintain the list of all approved Access Points and staff members. Access Points can register new Assessors for training at https://www.indycoc.org/training.html, or can contact the CES System Lead at CES@chipindy.org to request ad hoc training.

EVALUATION

CoCs are required to conduct an annual CES Evaluation.[22] The evaluation process should include planning, collecting data, evaluating the CES implementation process, identifying areas for improvement, and creating a feedback loop to the CES Leadership Group. The annual CES Evaluation may be conducted by a board or committee but may not be conducted by the CES System Lead[20]. The System Lead, in collaboration with the CES Leadership Group, will identify the board, committee, and/or agency that will complete the CES Evaluation each year. It should focus on whether the system is efficient, effective, and equitable in moving people out of homelessness and preventing homelessness through peoples' entire CES experience (intake, assessment, and referral) for both service providers and participants.

Participating service providers include housing and service projects that are required to participate in CES, as well as other-funded projects serving people experiencing homelessness in the Indianapolis CoC. Participants include individuals or households experiencing homelessness or who were connected to housing through CES in the last year. Other key stakeholders may include community, political, and CoC leaders.

Evaluation data will be collected by directly surveying CES stakeholders and analyzing aggregate data focused on key system performance measures from HMIS. Survey questions will focus on

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[22] *Coordinated Entry Management and Data Guide*. The U.S. Department of Housing and Urban Development. Retrieved August 15, 2022 from https://files.hudexchange.info/resources/documents/coordinated-entry-management-and-data-guide.pdf

efficiency, effectiveness, and equity of CES. Data will be incorporated annually into the CES Evaluation Report, which will inform CES refinement work and will be given to the CES Leadership Workgroup, Access Points, Service Providers and the CoC Blueprint Council.

Efficiency refers to whether resources are being used logically and people most in need of assistance are being prioritized. Questions about efficiency may include:

- How long are people waiting for housing through CES?
- Are rates of diversion increasing?
- Is the length of time homeless decreasing?
- Is CES well integrated with a collaborative community of service providers?

Effectiveness refers to the CES process connecting people experiencing homelessness to appropriate referrals. Questions about effectiveness may include:

- Are people being appropriately matched to homeless housing and services?
- Do community stakeholders have confidence in the system and report high levels of satisfaction with the system?
- Is the system properly resourced with homeless services and housing?
- Are there clear referral pathways to additional resources for people who are less likely to receive a housing referral or are many people being turned away empty-handed?
- Are rates of first-time homeless individuals decreasing?
- Are rates of exits to, and retention in, permanent housing increasing?

Equity refers to fairness within the system, in accessing the system, and treatment by the system. Questions about equity may include:

- Are people knowledgeable about how to access the system and how it works?
- Does CES reach all populations, regardless of race, ethnicity, gender, sexual orientation, veteran status, disability status, language, and geography?
- Are translation services available when needed?
- Is there accessible language in written materials that indicates that CES is affirming of diverse identities?
- Are people assessed consistently across all sites?
- Is there broad participation among homeless prevention and intervention services, including mainstream services, crisis services, emergency services, emergency shelters, and housing?
- Do people feel safe accessing CES and safe while completing the CES enrollment?
- Were people able to choose a different CES Assessor when needed?
- Is Assessors' data completeness equitable (i.e. they are not routinely skipping certain questions about gender or race, assessments are completed evenly across genders and races)

MONITORING

The Coordinated Entry manager is responsible for conducting CES monitoring at least quarterly (see Footnote 20). Monitoring should gauge how CES performance objectives are being achieved, whether participating providers are in compliance with CES processes, and whether CES is functioning as intended (see Footnote 20).

Metrics

CES Monitoring should attempt to answer the following questions:

- Are programs appropriately taking referrals from CES, efficiently connecting to clients, and complying with CES Policies and Procedures regarding referrals?
- Do referrals lead to permanent housing solutions?
- Is CES serving people who are eligible?
- Are CES Skilled Assessors properly completing the CES enrollment?
- Is the CES Lead appropriately prioritizing for programs?
- Are CES outcomes racially equitable?
- Are Case Conferencing members and Assessors following guidance listed in documents like Case Conferencing Confidentiality Agreement and CES Assessor Agreements?
- Are Access Points advertising as required to connect with hard-to-reach audiences?
- Are providers operating according to principals that lower barriers (ex. Housing First)?

Monitoring Communication Plan

CES Monitoring metrics will be displayed on a dashboard. Dashboard data will be reviewed by the CES Lead, CES Leadership Workgroup, and other relevant stakeholders as appropriate. This data will be used to inform refinement needs, CES site visit agendas, and CES and HMIS training content.

CES COMMUNICATION PLAN

The goal of the CES Communication Plan is to provide accurate and consistent information on the homeless service system to individuals experiencing homelessness per HUD's Category 1 (literal homelessness) Category 2(imminent risk of homelessness), or Category 4 (fleeing or attempting to flee domestic violence) regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. This plan is designed to provide information to nonprofit, private, or government agencies focused on the prevention or intervention of homelessness.

The System lead will ensure that programs and services are affirmatively marketed as pursuant to Interim rule 24 CFR 578 93 (c) and ESG Interim rule 24 CFR 576.407 (a) and (b; see Footnotes 9 and 10). In addition, the System Lead will provide agencies print materials to distribute to clients that fit the CES target population. Upon request of the agency, information will be altered to meet the needs of persons with limited English proficiency or other appropriate accessible formats (e.g., braille, audio, large type, assistive listening devices, and other assistance to the hearing impaired). Requests for alterations and the response of the System Lead will be documented.

POINTS OF CONTACT

Organizations both inside and outside CES should contact the CES System Lead at the dedicated email ces@chipindy.org for questions about coordinated entry, clients, referrals, or services.

Agencies should also reference the Indianapolis "Keys to Housing" Resource Guide,[23] which lists initial points of contact for the following services:
- Emergency shelter or other immediate resources
- Long-term housing solutions (including for veterans)
- Prevention and diversion assistance (including for people with felony convictions)
- Online resource guides for other types of services

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[23] *Are You Experiencing Homelessness?* Indianapolis CoC (2022). Retrieved August 22, 2022 from https://www.indycoc.org/are-you-experiencing-homelessness.html

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CES Access Points should ensure that all eligible individuals and households have equal access to CES. Access Points are chosen based on their affiliation with CES, their alignment with CES's purpose, their geographic location and/or their population served, including people experiencing domestic violence or unsheltered homelessness, veterans, and youth and young adults.

ACCESSING CES FORMS AND NEWS

The Indianapolis CoC website hosts the following:
- CES general information and FAQ[24]
- CES news and policy updates[25]
- CES-related documents and forms[26]
- List of active CES workgroups[27]

News or changes affecting CES are also communicated via case conferencing. News or changes affecting CES Skilled Assessors or the CES enrollment workflow are communicated to all Assessors via email.

ACCESSING CASE CONFERENCING INFORMATION

The Indianapolis CoC holds two weekly case conferencing meetings:
- CoC Case Conferencing – focuses on general CoC programs, including youth and young adult and domestic violence-specific programs
- Veteran Case Conferencing – focuses on veteran-specific programs and people who identify as a veteran

General information about case conferencing can be found on the CoC website (see Footnote 23). For more information or to join case conferencing, email ces@chipindy.org.

Via AirTable, CoC Case Conferencing members have access to digital forms, a list of meeting members with contact information, the Transfer List, and the weekly agenda (including referral requests and staffing) and minutes. Meeting members are able to submit client inquiries or other staffing items to the weekly agenda via AirTable. Agendas and notes for Veteran Case Conferencing are communicated via email and the Veteran By Name List.

TRAINING

Training for CES is administered by the System Lead in the following ways:
- For new CES Skilled Assessors, training is now offered as an online, self-paced training course. The form to request this training is located on the CoC website.[28]

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[24] *Coordinated Entry System*. Indianapolis CoC (2022). Retrieved August 22, 2022 from https://www.indycoc.org/coordinated-entry-system.html

[25] *CES Resources*. Indianapolis CoC (2022). Retrieved August 22, 2022 from https://www.indycoc.org/ces-resources.html

[26] *CES Documents*. Indianapolis CoC (2022). Retrieved August 22, 2022 from https://www.indycoc.org/ces-documents.html

[27] *Current Strategies & Work Groups*. Indianapolis CoC (2022). Retrieved August 22, 2022 from https://www.indycoc.org/current-strategies-and-work-groups.html

[28] *Coordinated Entry and HMIS Request A Training*. Indianapolis CoC (2022). Retrieved August 22, 2022 from https://www.indycoc.org/coordinated-entry-system--hmis-training.html

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- For existing CES Skilled Assessors, ad hoc training is offered as needed following quarterly data quality audits. CES Skilled Assessors are also required to participate in annual refresher trainings, which are communicated via email to all Assessors.
- For organizations accepting referrals from CES, training is offered within the HMIS New User Training. The form to request this training is located on the CoC website (see Footnote 25).
- The CES and HMIS System Leads create and maintain training videos, which are listed in HMIS, and a knowledge base.[29]
- Other introductory or ad hoc trainings can be requested by submitting a Help Desk ticket in HMIS or emailing ces@chipindy.org.

ACCESSING CLIENT AND SERVICE INFORMATION

Listed program vacancies, sent referrals, and the Transfer List are submitted to AirTable by housing and service providers and maintained by the CES System Lead. This information can be accessed by any Case Conferencing member at any time via AirTable.

A real-time housing wait list can be accessed by any verified CES user in HMIS at any time. Someone who is not a CES user may email client-related question to ces@chipindy.org. Please note that the CES System Lead is not able to share any information with someone who is not an HMIS User due to privacy and data sharing agreements. The CES System Lead also cannot say where a client is "located" in the housing wait list due to a number of variables affecting referrals and prioritization.

Additional tools in HMIS serve to communicate client needs and eligibility, including the CES Auto-Exit List, Program Eligibility features, and the Chronic, Youth and Young Adult, Family, ands Veteran By Name List.

REFERRAL AND ENROLLMENT COMMUNICATION

Housing and service providers should communicate anticipated inventory to the CES System Lead within three (3) business days of any changes to the number of available units, as outlined in the Key Stakeholder Requirements in this document.

Referrals are generally discussed in Case Conferencing, and the agreed upon matches should be recorded in Case Conferencing notes. Once a referral is issued by the System Lead to the Service Provider, the System Lead will communicate the referral to the Access Point and Service Provider.

GRIEVANCE PROCEDURE

PROVIDER-LEVEL GRIEVANCES

As defined in the Indianapolis CoC Written Standards, each provider shall have a grievance procedure concerning the coordinated entry system and their agency.

CES-LEVEL GRIEVANCES

All housing and services decisions and decisions associated with the management and oversight of CES, made in accordance with the CoC Written Standards, and CES Policies & Procedures outlined in this document must be followed. In the event that an individual or group feels that decisions were not made within the Policies & Procedures and in accordance with the CoC Written Standards, a

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[29] *Indianapolis HMIS Guidance*. Indianapolis CoC (2022). Retrieved August 22, 2022 from https://chipindy.notion.site/Indianapolis-HMIS-Guidance-48155fc9c9dd4627b628344dc21a5ff6

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grievance may be filed for further review without fear of retaliation. Written grievance shall be filed within 30 days of the event and can be submitted to the Senior Director of Impact at CHIP, 1014 Prospect St., Indianapolis, IN 46203 or danielle@chipindy.org. Written grievances should include the date of the potential policy infraction, the reason for the grievance, the specific policy/written standard that pertains to the grievance and follow up contact information of the person/group that has submitted the grievance.

A formal review of the grievance will then commence. The System Lead shall respond to the grievance within 10 business days using the contact information provided in the written grievance. At this stage, the Senior Director of Impact may determine that no valid grievance exists, the grievance may be resolved, or the grievance may not be resolved to the individual's satisfaction. If the latter occurs, the grievance will be forwarded to the Executive Director at CHIP, where further review and response will occur within the next 10 business days. The Executive Director may determine that no valid grievance exists, the grievance may be resolved, or the grievance may not be resolved to the individual's satisfaction. In a case where the final response of the System Lead's Executive Director is not satisfactory or deemed by the agency to directly impact the ability to fulfill contractual obligations, the grievance can be escalated to the Indianapolis CoC Blueprint Council, where three non-conflicted members will make a final decision.

Clients who feel they have been discriminated against under the Federal Fair Housing Act such as Section 504 of the Rehabilitation Act,[30] Title VI of the Civil Rights Act of 1964,[31] Section 109 of the Housing and Community Development Act,[32] and the Age Discrimination Act of 1975,[33] among others, may file a grievance with the Indiana Office of Fair Housing and Equal Opportunity (FHEO) by calling 317-957-7332.

APPENDIX A: HUD DEFINITIONS

HOMELESS

According to HUD, the definition of homeless is based on four categories[34]:

Category 1: Literally Homeless
1) An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

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[30] *Section 504 of the Rehabilitation Act of 1973*. The US Department of Housing and Urban Development (1973). Retrieved June 23, 2022 from http://portal.hud.gov/hudportal/HUD?src=/programdescription/sec504

[31] *The Civil Rights Act (1964)*. Retrieved August 22, 2022 from https://www.archives.gov/milestone-documents/civil-rights-act

[32] *The Housing and Community Development Act (1974)*. The US Department of Housing and Urban Development. Retrieved August 22, 2022 from https://www.hud.gov/programdescription/sec109#:~:text=Summary%3A,(CDBG)%20programs%20or%20activities.

[33] *Age Discrimination Act (1975)*. The US Department of Labor. Retrieved August 22, 2022 from https://www.dol.gov/agencies/oasam/regulatory/statutes/age-discrimination-act

[34] *Criteria and Recordkeeping Requirements for Definition of Homelessness*. The United States Department of Housing and Urban Development (2012, January). Retrieved June 23, 2022 from https://www.hudexchange.info/resource/1974/criteria-and-recordkeeping-requirements-for-definition-of-homeless/

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i) Has a primary nighttime residence that is a public or private place not meant for human habitation (including a car, garage, park, abandoned building, bus or train station, airport, camping ground, etc.[35])

ii) Is living in a supervised 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, or local government programs for low income individuals); or

iii) is exiting an institution where he or she 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

Category 2: Imminent Risk of Homelessness

2) An individual or family who will imminently lose their primary nighttime residence, provided that

i) The primary nighttime residence will be lost within 14 days of the date of application for homeless assistance. This includes situations where people are in their own housing but being evicted within 14 days, they are in a hotel or motel but cannot stay for more than 14 days (often due to lack of ability to continue paying), or are living with family or friends and being asked to leave within 14 days (see Footnote 32)

ii) No subsequent residence has been identified; and

iii) The individual or family lacks the resources or support networks to obtain other permanent housing (e.g., family, friends, faith-based or other social networks)

Category 3: Homeless under other Federal Statutes

3) Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

i) Are defined as homeless under other federal statutes, including:

a) Section 387 of the Runaway and Homeless Youth (RHY) Act[36]

b) Section 637 of the Head Start Act[37]

c) Section 41403 of The Violence Against Women Act (VAWA) of 1994[38]

d) Section 330(h) of The Public Health Service Act[39]

e) Section 3 of The Food and Nutrition Act of 2008[40]

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[35] *Determining Homeless Status of Youth*. The United States Department of Housing and Urban Development (2015, October). Retrieved June 23, 2022 from https://www.hudexchange.info/resource/4783/determining-homeless-status-of-youth/

[36] *Runaway and Homeless Youth.* Children and Families Administration. 45 C.F.R. 1351 (2016, December 20). Retrieved June 23, 2022 from https://www.federalregister.gov/documents/2016/12/20/2016-30241/runaway-and-homeless-youth

[37] *42 U.S.C. 9832* (2015, December 10). Retrieved June 23, 2022 from https://www.law.cornell.edu/uscode/text/42/9832

[38] *The Violence Against Women Act.* 24 C.F.R. 576.2. The United States Department of Housing and Urban Development (2015, December 7). Retrieved June 23, 2022 from https://www.law.cornell.edu/cfr/text/24/576.2

[39] *The Public Health Service Act.* 42 U.S.C. 254b (2020). Retrieved June 23, 2022 from https://www.law.cornell.edu/uscode/text/42/254b

[40] *The Food and Nutrition Act of 2008.* 7 U.S.C. 2012 (2018). Retrieved June 23, 2022 from https://www.law.cornell.edu/uscode/text/7/2012

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f) Section 17(b) of The Child Nutrition Act of 1966,[41] or

g) Section 725 of The McKinney-Vento Homeless Assistance Act[42]

ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance

iii) Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and

iv) Can be expected to continue in such status for an extended period of time because of special needs or barriers, including chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment

Category 4: Fleeing or Attempting to Flee Domestic Violence

4) Any individual or family who:

i) Is fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence. This includes trading sex for housing, trafficking, physical abuse, violence or perceived threats of violence because of the person's sexual orientation, etc. (see Footnote 32)

ii) Has no other residence; and

iii) Lacks the resources or support networks to obtain other permanent housing (e.g., family, friends, faith-based or other social networks)

CHRONICALLY HOMELESS

Chronically homeless means[43]:

1) A ''homeless individual with a disability,'' as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act,[44] who:

i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

ii) Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating

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[41] *The Child Nutrition Act of 1966.* 42 U.S.C. 1786(b) (2022). Retrieved June 23, 2022 from https://www.law.cornell.edu/uscode/text/42/1786

[42] *The McKinney-Vento Homeless Assistance Act*. 42 U.S.C. 11434a (2015). Retrieved June 23, 2022 from https://www.law.cornell.edu/uscode/text/42/11434a

[43] *Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH): Defining Chronically Homeless Final Rule.* The United States Department of Housing and Urban Development (2015, December). Retrieved June 23, 2022 from https://www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf

[44] *The McKinney-Vento Homeless Assistance Act, as amended by the HEARTH Act*. (2009, May). Retrieved June 23, 2022 from https://www.hudexchange.info/resource/1715/mckinney-vento-homeless-assistance-act-amended-by-hearth-act-of-2009/

the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless

HOMELESS INDIVIDUAL WITH A DISABILITY

HUD's definition of a homeless individual with a disability Is defined in section 401(9) of The McKinney-Vento Assistance Act (see Footnote 41), as a person who has a disability that:

i)
    I) Is expected to be long-continuing or of indefinite duration;
    II) Substantially impedes the individual's ability to live independently;
    III) Could be improved by the provision of more suitable housing conditions; and
    IV) Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;

ii) Is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000[45]; or

iii) Is the disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for AIDS

FAMILY

HUD defines family as including, but not limited to, the following, regardless of actual or perceived sexual orientation, gender identity, or marital status, any group of people presenting for assistance together, with or without children and irrespective of age, relationship, or whether or not a household member has a disability.[46] A child who is temporarily away from the home because of placement in foster care is considered a member of the family.[47]

LONGEST HISTORY OF HOMELESSNESS AND MOST SEVERE SERVICE NEEDS

A household's length of time homeless is determined by the Universal Data Assessment question "approximate date homelessness started." For the purposes of prioritization, longest history of homelessness refers to the household with earliest reported date for this field. This question is self-reported and seeks to capture the entire history of one's homelessness, not just the current episode. If a household has a history of multiple episodes of homelessness, the date reported should be the date the very first episode of homelessness began, unless the household has since had a period of stable housing for two or more years. If the household has had a period of stable housing

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[45] *The Developmental Disabilities Assistance and Bill of Rights Act of 2000*. 42 U.S.C. 15002 (2000). Retrieved June 23, 2022 from https://www.law.cornell.edu/uscode/text/42/15002

[46] *FAQ 1529*. The United States Department of Housing and Urban Development (2014, July). Retrieved June 23, 2022 from https://www.hudexchange.info/faqs/programs/emergency-solutions-grants-esg-program/program-requirements/eligible-participants/how-is-the-definition-of-family-that-was-included/

[47] 24 C.F.R. 5.403. Retrieved June 23, 2022 from https://www.law.cornell.edu/cfr/text/24/5.403

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for two or more years, the date reported should be the date they re-entered homelessness after stable housing for two or more years.

A household's service need is determined by the VI-SPDAT score. For the purposes of prioritization, most severe service needs refers to the household with the highest VI-SPDAT score.

For program in which longest history of homeless and most severe service needs are the basis for prioritization, the CES Workgroup, with approval of the Blue Print Council, has determined the order in which these factors will be examined. For PSH, prioritization will be completed by first looking at chronicity, then highest VI-SPDAT score, and then longest length of time homeless. For RRH and TH-RRH, prioritization will be completed by first looking at chronicity, then longest length of time homeless, then highest VI-SPDAT score.