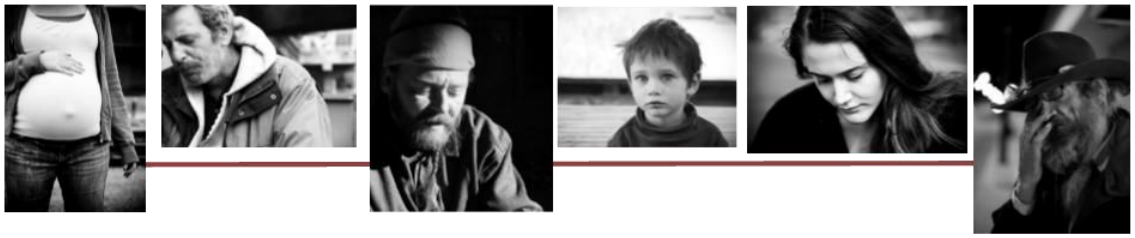
COMMUNITY PARTNERSHIP

Working Together to Build Strong Communities

Ozarks Alliance to *End* Homelessness

Coordinated Entry System: Policies and Procedures Manual



Springfield/Greene, Christian and Webster Counties
Continuum of Care

Revised December 2025

Coordinated Entry System Policies and Procedures Manual

Revised April 2023

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OVERVIEW

Overview of Coordinated Entry System

Coordinated Entry System (CES) refers to the process used to assess and assist in meeting the housing needs of individuals and families at risk of or experiencing homelessness. Key elements of coordinated entry include:

- A designated set of coordinated assessment locations or "front doors";
- The use of standardized assessment and vulnerability-determining tools to assess client needs and risks;
- Referrals—based on the results of the assessment and vulnerability-determining tools—to homelessness assistance programs and other related programs as appropriate;
- Capturing and managing data related to assessment and referrals in a Homeless Management Information System (HMIS); and
- Prioritization of clients to ensure those with the highest barriers to housing are matched with the most cost- and service-intensive interventions.

The implementation of a CES is now a requirement of receiving certain funding (namely Emergency Solutions Grant and Continuum of Care funds) from the Department of Housing and Urban Development (HUD) and is also considered national best practice. When implemented effectively, coordinated entry can:

- Reduce the amount of research and the number of phone calls/in-person visits people experiencing homelessness must make before finding crisis housing or services;
- Reduce new entries into homelessness through coordinated system-wide diversion and prevention efforts;
- Prevent people experiencing homelessness from entering and exiting multiple programs before getting their needs met;
- Reduce or erase entirely the need for individual provider waitlists for services;
- Foster increased collaboration between homelessness assistance providers; and
- Improve a community's ability to perform well on Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act outcomes and make progress on ending homelessness.

This Document

These policies and procedures will govern the implementation, governance, and evaluation of the HUD-designated Coordinated Entry System of the Ozarks Alliance to End Homelessness (OAEH) service area of Springfield/Greene, Christian, and Webster counties. These policies may only be changed by the approval of the OAEH Executive Board based on recommendations from the CES Policy Development Workgroup, a committee described in greater detail beginning on Page 20.

Basic Definitions

- **Provider –** Organization that provides services or housing to people experiencing or at-risk of homelessness (e.g. The Kitchen, Inc.)
- **Assessment Staff –** Program staff who are working with clients to complete assessment and vulnerability-determining tools to identify needs and risks
- **Program –** A specific set of services or shelter offered by a provider (e.g. emergency shelter or substance abuse treatment)
- **Client –** Individual or family at-risk of or experiencing homelessness or being served by the Coordinated Entry System
- **Housing Interventions –** Housing programs and subsidies; these include transitional housing, rapid re-housing and permanent supportive housing programs, as well as permanent housing subsidy programs (e.g. Shelter Plus Care)

Target Population

This process is intended to serve people experiencing homelessness and those who believe they are at imminent risk of homelessness. Homelessness will be defined in accordance with the official HUD definitions of homelessness.[1] People at imminent risk of homelessness are people who believe they will become homeless based on the criteria set by HUD, which can be found in Appendix A along with definitions of Categories 1-4 of homelessness. People who think they have a longer period of time before they will become homeless should be referred to other prevention-oriented resources available in the community.

This CES was developed primarily for residents within the OAEH service area of Christian, Greene and Webster counties. In cases where it is forbidden by their funders or local, state, or federal law, providers may not be able to serve individuals who do not have adequate proof of residence within these counties. Assessment staff will attempt to link clients that fall into this category with resources that may be available in their area of origin or wherever they are currently staying.

Specialized Service Pathways for Subpopulations

Literally or at-risk homeless pregnant women, unaccompanied youth, and persons fleeing domestic violence are referred to specific sites for CES navigation and customized services, understanding that providers tasked with serving specialized populations possess unique experience and expertise in serving those specific populations. In addition to administering the uniform assessment and vulnerability-determining tools as well as implementing diversion and prevention when possible, these sites also use customized assessments that are geared toward determining services and referrals that best meet the specific needs of that population.

[1] The definition is available here:
https://www.onecpd.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf

Goals and Guiding Principles

The goal of the CES is to provide each client with equal and fair access to services and supports to meet their housing needs, with a focus on returning them to housing as quickly as possible. Below are the guiding principles that will help the OAEH meet these goals.

- **Client Choice**: Clients will be given information about the programs available to them and have some degree of choice about which programs they want to participate in. They will also be engaged as key and valued partners in the implementation and evaluation of CES through forums, surveys, and other methods designed to obtain their thoughts on the effectiveness of the CES.
- **Collaboration**: Because coordinated entry is being implemented system wide, it requires a great deal of collaboration between the OAEH, providers, mainstream assistance agencies, funders and other key partners. This spirit of collaboration will be fostered through open communication, transparent work by a strong governing committee (the OAEH Executive Board), consistently scheduled meetings between partners, and consistent reporting on the performance of the system.
- **Accurate Data:** Data collection on people experiencing homelessness is a key component of the CES. Data from the assessment process that reveals what resources clients need the most will be used to assist with funding decisions and to identify gaps in service. To capture this data accurately, all assessment staff and providers must enter data into ServicePoint or Apricot in a timely fashion (within 72 hours). Client's rights around data will always be made explicit to them, and no client will be denied services for refusing to share their data.
- **Performance-Driven Decision Making**: Decisions about and modifications to the CES process will be driven primarily by the need to improve the performance of the homelessness assistance system on key outcomes. These outcomes include reducing new entries into homelessness, reducing lengths of episodes of homelessness, and reducing repeat entries into homelessness. Changes may also be driven by a desire to improve process-oriented outcomes, including reducing the amount of time spent waiting for an assessment.
- **Housing First:** Our Coordinated Entry System will support a Housing First approach and will thus work to connect households with the appropriate permanent housing opportunity, as well as any necessary supportive services, as quickly as possible.
- **Prioritizing the Most Vulnerable:** Coordinated Entry System referrals for permanent housing will prioritize those individuals and families who are the most vulnerable as determined using a vulnerability assessment. This will ensure an appropriate match between the most intensive services and the clients that are least likely to succeed with a less intensive intervention, while giving people with fewer housing barriers access to diversion and prevention resources. This approach is most likely to reduce the average length of episodes of homelessness and result in better housing outcomes for all.
- **Agency Compliance with Applicable Laws:** Coordinated Entry System permits recipients of federal and state funds to comply with applicable civil rights and fair housing laws and requirements, including nondiscrimination and equal opportunity provisions of federal civil rights laws. Each participating agency will maintain documentation indicating compliance.

KEY COMPONENTS OF THE COORDINATED ENTRY SYSTEM

This section outlines and defines the key components of the Coordinated Entry System (CES) and how the CES process will work.

Designated CES "Front Doors"
The designated CES "front door" programs will be the only locations (outside of any place where outreach workers engage with people) where people experiencing homelessness will be assessed and referred to homelessness assistance services. All people experiencing homelessness or at imminent risk of homelessness should be directed to these locations to be assessed for housing services**.** Clients accessing emergency or transitional housing services at agencies not designated as front doors will be referred to One Door or a population-appropriate front door the next business day to complete an assessment for referral to the Prioritization List for Rapid Re-Housing and Permanent Supportive Housing Services.

Front door programs have been specifically designated within the OAEH and have signed a Memorandum of Understanding (MOU) agreeing to the operational guidelines of CES. A copy of this MOU is available in Appendix B of this document. A detailed model of the OAEH CES with a description is available in Appendix C. The designated front doors for the OAEH are:

- One Door (main CES hub)
- Harmony House (DV survivors)
- The Rare Breed – The Kitchen (youth)
- Home at Last – The Kitchen (Veterans)
- Burrell's PATH program (chronically homeless)
- Springfield Public Schools Office of Students in Transition (youth/families in SPS)
- Foster Adopt Connect Youth Connect Center (youth and families)
- MSU Care/Greene Co. Family Justice Center (chronically homeless/DV survivors)

This list will be updated if additional designated front doors are added or removed. All front doors must be handicap accessible.

Front Door Responsibilities
Staff at Front Door agencies will be responsible for all homelessness assistance system assessments, including the initial triage assessment and the vulnerability-determining tool (OAEH has adopted the VI-SPDAT II as the chosen tool for determining vulnerability). Staff at front door agencies, including case managers and assessment staff, are responsible for:

- Participating in initial HMIS/front door training and subsequent refresher trainings, facilitated by HMIS lead and CES lead personnel and provided quarterly – the expectation is that every agency with a program functioning as a front door will allow staff as appropriate to participate in these refresher trainings;
- Providing or referring to prevention and diversion-related assistance whenever possible to prevent households at imminent risk of homelessness or low-barrier clients from entering the shelter system;

- Providing reasonable steps to offer CES process materials and instruction in multiple languages to meet the needs of minority, ethnic, and groups with limited English proficiency;
- Working with the OAEH to ensure appropriate auxiliary aids and services necessary to ensure effective communication are available (e.g. Braille, audio, large type, assistive listening devices, and sign language interpreters);
- Connecting clients to other mainstream resources outside of the homelessness assistance system. For example, Family Support for Medicaid and SNAP (Food Stamps);
- Ensuring that the client, upon completing all assessments and the VI-SPDAT II tool, is referred to the Prioritization List for permanent housing; and
- Any other service provision related to their agency's program model.

Throughout this manual, program staff will find instructions and other guidance on how to conduct assessments, make referrals, and prioritize clients for services. However, not every conceivable situation is covered in this manual. Assessment staff will need to rely on their judgment, their training, and their supervisor in these situations.

System Entry
Access to the Coordinated Entry System is available to all eligible persons.

Clients seeking homelessness assistance services who present at agencies other than the designated front doors will be referred to a front door program for assessment. If the client is unable to reach the agency due to a disability or lack of transportation, an effort should be made by the agency where they present to assist the client with transportation needs. If the designated front door program is closed or cannot provide an after-hours assessment but provides beds or other crisis housing, they may admit the client if appropriate and complete an assessment the next business day. If a client accesses beds or crisis housing through a program that does not act as a front door, that client should be referred to One Door the next business day to complete an assessment. **All clients who are literally homeless or homeless due to fleeing domestic violence (Categories 1 and 4) seeking to receive housing assistance services should complete a front door assessment and VI-SPDAT II. See HUD definitions of homelessness in Appendix A. Note: Some Category 2 clients may be eligible (see Policy Title: Transitional Housing Eligibility for Households at Imminent Risk of Homelessness on page 12).**

Phone Calls
Staff at the designated front doors and other pre-identified locations may receive phone calls from people experiencing or at imminent risk of homelessness who are interested in being assessed or receiving homelessness assistance services. These callers should be asked a few pre-screening questions:

- Are you homeless (living on the street, staying in an emergency shelter, fleeing domestic violence) or at risk of homelessness?
- Where did you stay last night?
- Are you safe in your current living situation?
- What brought on your current housing crisis?

If the client is currently homeless or staying in an unsafe living situation, program staff answering the phones should do one of the following:

- Complete required ROIs and the front door intake assessment w/VI-SPDAT II over the phone with the caller (if category 1, 2 (in certain instances) or 4) and provide any appropriate service referrals, including those to emergency shelter; OR
- Let the caller know about the designated front door locations and the hours they are open and encourage them to come in to be assessed.

If a client IS NOT currently homeless/living in an unsafe situation, program staff answering the phone can either redirect the caller to a more appropriate agency or encourage the caller to dial 2-1-1 for assistance.

If the phone system for a program functioning as a front door is set up such that callers are initially greeted by agency-level (i.e. not front door program) personnel, the agency's staff should follow their internal procedure for directing applicable calls to the front door program; the front door program staff will be the ones to complete the pre-screening steps described above.

The Assessment Process

Assessment refers to the process of asking the client a set of questions to determine which programs or services are most appropriate to meet their needs and prioritize them for permanent housing. A standardized set of assessment tools, including a vulnerability-determining tool, will be used to make these determinations. Staff at front door programs will be trained on administering and scoring these tools, as well as the order in which they should be administered and the average amount of time each should take. Assessments can be administered at any of the front door programs.

The assessment process will unfold in several stages.

During normal business hours:

1. Each person walking or calling into an identified front door program will be asked the pre-screening questions to determine if they should go through the coordinated entry intake process. If the client is not literally homeless or homeless due to fleeing domestic violence (categories 1, 2 (in certain instances) and 4), staff will discuss prevention or diversion resources and/or direct to other more appropriate resources.
2. If they are literally homeless or homeless due to fleeing domestic violence (categories 1, 2 (in certain instances) and 4), they will be directed to an available coordinated assessment staff member. The assessment staff will then explain the assessment process, share and discuss data confidentiality documents with the client, and complete all signed documentation needed to begin the assessment. If the client is an unaccompanied youth 17 or under, they will be referred to either The Rare Breed or YouthConnect Center.
3. The assessment staff member will determine if the client has alternative housing options within the community and attempt to divert the client from shelter if at all possible.
4. Those who are literally homeless or homeless due to fleeing domestic violence (categories 1, 2 (in certain instances) and 4) and unable to be diverted will continue with the assessment process, including completing the VI-SPDAT II (See Appendix I for ServicePoint Front Door Project workflow).

5. Once the assessment process is completed, assessment staff will refer the client to the Prioritization List, which will prioritize them for housing interventions including rapid re-housing and permanent supportive housing.
6. If immediate placement in a housing program is not available, including through emergency or transitional housing, program staff should work with the client to identify alternative housing options as much as possible.

Individuals and families fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking can present at any of the established front doors for intake and assessment; utilizing best practices for engaging with victims, staff will work with those clients to make connections to DV service providers and non-victim specific providers as appropriate and desired.

Survivors presenting at Harmony House will be assessed and added to the Prioritization List via the confidential process adopted by Harmony House and One Door.

After business hours:

1. People presenting with a need for emergency shelter will be offered a bed in the emergency shelter where they arrived (if they are population-appropriate and space is available). If they are not population-appropriate, they will be referred to an appropriate shelter. If no shelter has available space, they will be sent to any available crisis housing (churches, hotels or motels, etc.). If they do not initially present at an emergency shelter, they will be referred to a population-appropriate one.
2. Shelter staff will refer the client to an appropriate CES front door the next business day for screening and assessment.
3. 24-hour hotlines are available for subpopulations: Single women over the age of 18 can access emergency overnight shelter through Safe to Sleep via the Burrell hotline (417.761.5555 or toll free 1.800.494.7355). Women utilizing Safe to Sleep will be referred by Safe to Sleep staff to One Door for assessment the following business day.

   Young adults (17-24) should call the Rare Breed on-call number (417.865.6400). Families with children should contact Isabel's House (417.865.CARE) or KVC's Empowering Youth program (417.861.4244).

   Survivors fleeing domestic violence should contact Harmony House's 24-hour hotline (417.864.7233).

Data Collection

Data will be collected on everyone assessed through the Coordinated Entry System. The data sharing policy for the OAEH can be found in Appendix D.

Once a client has been asked the pre-screening questions and deemed eligible to be assessed, the assessment staff will go over the HMIS Release of Information and Referral/Case Conferencing Release with the client, including what data will be requested, who will have access to that data and what the client's right are in regards to that data. Assessment staff will be responsible for ensuring clients

understand their rights as far as release of information and data confidentiality. Once the HMIS and Referral/Case Conferencing ROIs are complete, the assessment staff member will begin the assessment process in ServicePoint. During or immediately following the assessment process, signed ROIs should be scanned and uploaded to the client's record in HMIS.

Some clients should never be entered into ServicePoint for the purposes of coordinated entry. These include:

- Clients who do not sign an HMIS Release of Information
- Unaccompanied youth under the age of 17
- Clients who are not homeless or at imminent risk of homelessness unless they fall under the eligibility outlined in Policy Title: Transitional Housing Eligibility for Households at Imminent Risk of Homelessness (see page 12)

Once the assessment process has been completed, the assessment staff member will refer the client through ServicePoint to One Door for addition to the Prioritization List (see workflow in Appendix I). Access to parts of each client record or assessment form may be restricted by client request. The Client Release of Information and Release for Case Conferencing/Referral can be found in Appendix E.

Homelessness Prevention

Households and individuals seeking homelessness prevention services will be directed to the appropriate prevention service providers. ESG-funded prevention programs will work with the CES to determine and implement a prioritized referral process.

While non-ESG-funded agencies offering prevention services are invited to participate in CES and case conferencing, prioritization for assistance through these providers is currently determined at the agency/program level.

Basis of Referrals

Referrals to additional services will be made based on the following factors:

- Results of the assessment process;
- Bed availability and current Prioritization List;
- Established system-wide priority populations; and
- Program eligibility admission criteria, including populations served and services offered.

Each of these elements is discussed in more detail below.

Assessment Process:
One of the assessment tools, the Vulnerability Index-Service Prioritization Decision Assistance Tool II (VI-SPDAT II), has a built-in scoring mechanism that will determine the vulnerability and risk of individuals and families who are homeless and prioritize them for access to Rapid Re-Housing and Permanent Supportive Housing Services. The VI-SPDAT II will serve as a guiding point for discussion between the assessment staff and the client about how referrals are made through the CES and what services outside of housing might be beneficial.

Priority Populations:
The OAEH Executive Board has identified specific populations for priority for housing services. Those populations are:

- Veterans
- Youth
- Families with Children
- Single adults

In addition, the CES will be geared toward prioritizing those households identified as the most vulnerable, or those with the most intensive service needs and housing barriers (e.g. chronically homeless households and households with multiple episodes of homelessness). A client's risk and vulnerability will be determined based on the results of the VI-SPDAT II tool and the assessment process. The OAEH will have a renewed discussion annually about the priority populations for the CES process.

Update: December 2025
Transitional Housing Eligibility for Households at Imminent Risk of Homelessness

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Policy Statement
Households who meet the criteria for being at Imminent Risk of Homelessness (per HUD definition) will be eligible to receive assistance through CoC funded Transitional Housing projects *if* their risk of homelessness was caused, in whole or in part, by a reallocation of CoC funding from a Permanent Housing project.

Purpose
To ensure clients who are not prepared or able to maintain permanent housing on their own will be able to receive continued assistance through CoC programing.

Scope
This policy applies to all staff and subrecipients administering CoC-funded housing programs and the clients they are serving.

Procedures

1. When an agency reallocates funding – either voluntarily or involuntarily – from a Permanent Housing project (Permanent Supportive Housing or Rapid Rehousing) to a Transitional Housing project, the agency shall meet with currently housed clients to: 1) inform them of the reallocation and 2) create an action plan for immediately after the current Permanent Housing project ends.

2. During planning, the agency should determine whether the client will be at Imminent Risk of Homelessness after the current project closes.
3. If the client meets the criteria for Imminent Risk of Homelessness, the client will be directed to complete a housing assessment at one of the Coordinated Entry System Front Doors.
4. Once the assessment is completed and the Imminent Risk determination has been reflected by the assessor, a referral to an appropriate Transitional Housing program can then be made.

Documentation Requirements

- All documentation should be maintained in accordance with HUD retention requirements.

UPDATE: March 2017

Coordinated Entry Prioritization in regards to Violence Against Women Reauthorization Act of 2013: Implementation in HUD Housing Programs Final Rule

In the event that domestic violence occurs within a household enrolled in a HUD-funded housing program and the agency administering the program is unable to re-house the victim within any of their existing programs (per their internal policies compliant with HUD's final rule), the victim will be moved to the top of the prioritization list for whatever programs he/she may be eligible for (regardless of VI-SPDAT score or other prioritization criteria).

The agency housing the victim when the domestic violence occurs is responsible for communicating the need for this prioritization policy exception to go into effect. Notice should be provided in writing to the Coordinated Entry Prioritization List administrator (One Door) once they have determined that they are unable to re-house the domestic violence victim.

Eligibility Criteria:

Agencies will submit eligibility criteria for each of their housing programs to the designated OAEH representative annually; this will occur in September in conjunction with end-user annual HMIS recertifications. Referrals to any program will be based on that program's admissions eligibility criteria, including populations served. For example, programs that serve only single adult men will only receive single adult men as referrals. If a program's eligibility criteria changes at any time, notice must be given to the CES Administrator and/or OAEH Executive Board to ensure referral protocol is updated accordingly.

Agencies are asked to consider Housing First and limit project eligibility requirements to only those required by funders or by program designation - such as gender or family - in an effort to reduce barriers to clients per the CES MOU.

Written standards regarding program-specific eligibility and prioritization for federally funded transitional housing, rapid rehousing, and permanent supportive housing programs will be established and maintained at the program level. This information will be provided to the OAEH annually.

Making Referrals and Prioritizing Clients

The referral process will be standard across all front doors.

1. A client will be asked pre-screening questions to determine what services are appropriate. If the initial screening indicates the client is literally homeless or homeless due to fleeing domestic violence (categories 1, 2 (in certain instances) and 4), he or she will then be assessed using the Universal Intake Assessment and the VI-SPDAT II.
2. Once the full assessment process is complete, the assessment staff should refer the client's information through ServicePoint to the CPO-OAEH Coordinated Entry project for addition to the Prioritization List. The assessment staff should then describe how the referral process will work based on prioritization of population, risk and vulnerability.
3. In addition to being prioritized for services, a client will also be referred to the appropriate emergency shelter or other housing crisis service.
4. If a client is low-barrier and/or at imminent risk of homelessness or homeless under other federal statutes (categories 2 and 3), assessment staff may initiate diversion or prevention techniques instead of referring to shelter services. If an agency does not have diversion services, assessment staff may refer the client to One Door to screen for eligibility for One Door's Diversion Program.
5. Clients fleeing domestic violence, veterans, pregnant women and youth clients can be referred to agencies that specialize in services for those populations. These services will not be limited to the prioritization process. For example: All veterans who meet basic eligibility (as communicated to front doors by the program) should be referred to Home at Last. All households with school-aged children must be provided information about McKinney–Vento rights and given contact information for the applicable school district's homeless liaison.
6. If a program has an opening, they must notify One Door. One Door will provide a referral using the Prioritization List through ServicePoint for the client that is at the top of the list and meets that program's eligibility criteria. The referral may also be discussed during regular case conferencing prior to being sent through ServicePoint.
7. Once the referral is complete in ServicePoint, agency staff may contact the client to follow up and complete any program-based assessments. Once all program-based requirements are completed, the agency will enroll that client into their program in ServicePoint.
8. Referrals must be acknowledged within Servicepoint within 72 hours of being received. This process can be found in Appendix I.
9. To remove a client from the Prioritization List upon receiving housing, program staff must communicate the following back to the CES via email or during case conferencing: Program accepting the client, program enrollment date, and move-in date.
10. If agency staff are not able to accept a referral or are not able to contact a referred client, the agency must refer to the procedures outlined in the *Decline Referrals and Grievance Procedures* section of this manual.

Data collected from the assessment process is not used to discriminate or prioritize households for housing and services.

Prioritization via Observational Assessment

Persons with severe and persistent mental health conditions may occasionally be presumed to be highly vulnerable but not self-report accurately, resulting in scoring too low on the VI-SPDAT to be prioritized for intensive housing services. To provide a safety net for these individuals and households unable to

complete a standard assessment and to support accurate prioritization, on those occasions the OAEH Case Conferencing group may determine that an observational assessment can be completed and submitted for coordinated entry prioritization consideration.

Please note: The purpose of this policy inclusion is to provide a safety net when it is believed the assessment process does not accurately reveal the full depth and urgency of a household or individual's situation; it is NOT a side door and requires the utmost professional judgment and objectivity on the part of agency personnel.

When to Complete an Observational Assessment
Observational assessments can only be completed on behalf of individuals who (1) display signs of severe and persistent mental illness or impairment (e.g. traumatic brain injury), (2) meet the HUD definition of literal homelessness or are fleeing domestic violence (categories 1 and 4), and (3) are not able to accurately complete a standard front door assessment and VISPDAT due to their mental health condition.

Three attempts must first be made by front door staff to complete the standard assessment; these can be completed by different front door programs and staff. These attempts demonstrate that completing an observational assessment on the person's behalf is a last resort.

How to Request an Observational Assessment
Members of the OAEH Case Conferencing group can make an official request by contacting the One Door Coordinator, who will provide a copy of the Observational Assessment Request Form (Appendix H). The form should be completed and brought to Case Conferencing. During Case Conferencing, the group will discuss the particular situation and determine if an observational assessment is appropriate and if prerequisites have been satisfied. If the person in question meets the requirements outlined above and at least three attempts have been made to conduct a standard assessment, the case conferencing group will review any supporting documentation and an in-person observational assessment will be scheduled.

How to Complete an Observational Assessment
Observational assessments will be conducted by a designated One Door Assessment Specialist, who will consult with the person who originally submitted the observational assessment request prior to conducting the assessment.
Observational assessments will be completed within HMIS and noted within HMIS as observational.

Observational Assessment Process - Scoring
Scoring will be identical to the standard assessment process (i.e. VI-SPDAT score). Points will be assigned based on observation and information provided by agency personnel who have extensive experience with and knowledge of the person. Documentation of the following VI-SPDAT areas should be included in the process as much as possible:

- Mental health
- Alcohol and/or substance use disorder
- Physical health
- Risk of harm to self and/or others

- Frequent hospital and/or jail utilization

Observational Assessment Process - Prioritization

Those who are unable to complete a standard assessment due to the severity of their mental health conditions and require an observational assessment will be prioritized above applicants with the same VI-SPDAT score. All other prioritization criteria will be the same as with the standard assessment.

Prioritization List Management and Notification of Referral

One Door will act as the administrative entity for the Coordinated Entry System and the Prioritization List for housing services. As such, management of the Prioritization List and program referrals will be the responsibility of One Door staff. All mandated programs agree to notify One Door when referrals are needed and to participate in at least twice-monthly case conferencing.

Whenever possible, referrals will occur through ServicePoint. If a referral agency does not use ServicePoint, One Door will work with that agency to set up a separate referral system using a secure process to be developed during the initial pilot of coordinated entry. However, the referral process as well as the decline and grievance procedures will remain the same as much as possible.

Case Conferencing

Referrals may also occur during case conferencing. Per HUD's requirement, case conferencing will occur regularly as part of the CES and will include all agencies participating in coordinated entry as well as others that may advocate on behalf of homeless or at-risk clients.

Referrals:

- Participating agencies will attend regularly-scheduled case conferencing sessions.
- Receiving agencies will communicate openings as they become available to One Door. Referrals will be provided based on program eligibility criteria and information collected on the Prioritization List and will occur within ServicePoint for agencies using that platform (See Appendix I for ServicePoint workflow to accept/decline/cancel referrals).
- For agencies not using ServicePoint, referrals will be made via phone and email, or through another secure referral process yet to be determined. Receiving agencies will communicate openings to One Door prior to case conferencing and will work with One Door to ensure a mutually agreeable referral process is in place.

Case Conferencing:

- The purpose of case conferencing will be to advocate for individual referrals, to identify potential gaps in service, to communicate and discuss program options, to request and make referrals, and to share resources.
- Meetings will occur at least monthly. As the CES administrative entity, One Door will be responsible for setting up these recurring meetings.
    - Meetings will be held in-person, at a central and consistent location.
    - Invited attendees will include representatives from any agencies that accept clients from the Prioritization List or refer people to the Prioritization List (e.g. The Kitchen, Inc., Catholic Charities of Southern Missouri, One Door, Harmony House, KVC, Burrell, VA, MDMH, FosterAdopt Connect, others TBD).
- Prioritization during case conferencing will be based on the priority populations adopted by OAEH Executive Board and information collected on the Prioritization List.
- Programs participating in CES will provide appropriate representative(s) for each meeting. Appropriate representatives can include case managers, program coordinators, etc.

- All participating agencies should send program-level representatives as often as possible. However, it is also appropriate and acceptable for agencies to send a single representative, provided that representative is an appropriate representative and is able to speak on behalf of all CES-participating programs within an agency.
- In the event that no representatives from an agency will be attending, advance notice to One Door via phone or email is requested. Programs mandated by HUD must attend 75% of case conferencing meetings quarterly.
- If significant travel would be required for agency staff to attend case conferencing, the ability to call in via telephone will be made available.

Disclosure Forms:

Upon entering a "Front Door" agency, Heads of Household will be given, explained, and asked to sign two separate Releases of Information (ROI):

1. HMIS Data Sharing ROI – will allow for sharing of data within ServicePoint between agencies participating in the OAEH Sharing Group and other Missouri HMIS partner agencies (Appendix E).
2. Case Conferencing and Referral ROI – will allow for written and verbal sharing of data for the purpose of case conferencing and making referrals (Appendix E).

DECLINED REFERRALS AND GRIEVANCE PROCEDURES

Program Declines Referral

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

- The person does not meet the clearly stated program's eligibility criteria, which is submitted annually;
- The person would be a danger to others or themselves if allowed to stay at this particular program;
- The person has previously caused serious conflicts within the program (e.g. was violent with another consumer or program staff) or is on the program's internal Do Not House list;
- The client declines housing services through the referral program; and
- The client is unable to be contacted within 3-7 business days; (exact deadline within 3-7 business days' timeframe to be determined by individual programs. Expectation is that at least one attempt at contact will be made each business day).

If the program determines a client is not eligible for their program after they have received the referral through coordinated assessment, the referral agency will follow up with One Door and provide a reason for declination; One Door will then work with the client to determine if there is a more appropriate referral or if other supportive services are needed. One Door may also follow up with referral program staff as necessary to determine if another program or service might better serve the client. This follow up could occur during regular case conferencing as well.

If a client fails to show up to a program assessment or a program is unable to get in contact with that client within 3-7 business days (exact deadline within 3-7 business days' timeframe to be determined by individual agencies or programs) after making at least one attempt per day, the program can refuse the referral. In those cases, the program should contact One Door, who will attempt to make contact with the client within 1 business day. However, if the client is still unable to be contacted, One Door can refer the next client on the Prioritization List for services.

If it becomes readily apparent early on in the process that a client is unlikely to be contactable, the program receiving the referral should contact One Door to discuss possible solutions.

Declining and Cancelling Referrals

Referrals not accepted must be either Cancelled or Declined in ServicePoint. See process in Appendix I.

As the referring agency, it is One Door's job to ensure all referrals are quality and meet eligibility criteria for the program receiving the referral; however, due to gaps in time between when a household presents and when an opening becomes available, circumstances may change and referrals that may appear valid based on HMIS data might no longer be appropriate. If a program is consistently refusing referrals, One Door may request a meeting with the program agency to determine possible solutions or identify any areas of concern within the referral process.

Consumer Declines Referral

Assessment staff, through the administration of the assessment tools and the coordinated entry process (which includes consumer input), will attempt to do what they can to meet each consumer's needs while also respecting communitywide prioritization standards. The OAEH has the right to limit the number of program refusals any consumer can make per episode of homelessness if necessary. However, if a client tells agency staff during or following the intake process that he or she does not want the housing services offered, that consumer should be asked to sign the Acknowledgment of Consumer Decline form (Appendix G) and may be moved to the inactive portion of the prioritization list. A client can be moved back to the active list at any time once he or she is ready to receive services and updated CES assessments are completed.

Provider Grievances

Providers should address any concerns about the process to the OAEH Executive Board. A provider should submit a summary of concerns via email to the OAEH Executive Board chair; the chair should then schedule for that provider's representative to meet with the oversight group so the issue can be resolved. If the issue needs more immediate resolution, the chair will be in charge of determining the best course of action to resolve the issue. However, if a provider believes a consumer is being put in immediate or life-threatening danger, they should deal with the situation immediately without waiting for the grievance process.

Consumer Grievances

Program staff or supervisors should address any complaints by consumers as best they can in the moment per their internal program guidelines. Complaints that should be addressed directly by the program staff member or program supervisor include complaints about how they were treated by staff, program center conditions, or violation of confidentiality agreements. Any other complaints specific to the CES should be referred to the chair of the OAEH Executive Board to be dealt with in a similar process to the one described above for providers. All program-specific complaints should be addressed by individual programs prior to involving the OAEH. Any complaints filed by a consumer should note their name and contact information so the chair can contact them and ask them to appear to discuss the complaint.

CES POLICY DEVELOPMENT & SYSTEM OVERSIGHT

OAEH CES Oversight: Roles and Responsibilities

The Coordinated Entry System will be governed by the Ozarks Alliance to End Homelessness Executive Board and/or its designee (e.g. Funded Agency Subcommittee). This group will be responsible for:

- Investigating and resolving client and provider complaints or concerns about the process, other than declined referrals (which will be dealt with using the process described on page 13);
- Providing information and feedback to the general Continuum and the community at-large about coordinated entry;
- Evaluating the efficiency and effectiveness of the coordinated entry process;
- Reviewing performance data from CES; and
- Recommending changes or improvements to the process, based on performance data.

Meeting Schedule

The OAEH Executive Board meets monthly on the 2nd Wednesday of the month at 11:00 a.m. The Executive Board will review system data, address client and agency grievances, and discuss any system changes on a quarterly basis

Conflicts of Interest

If at any point a provider or client wishes to address a complaint or grievance with a provider or agency that has a representative on the body tasked with CES oversight, that particular member must recuse themselves from participating in those proceedings or voting on the outcome of that particular issue.

Funded Agency Committee:

Roles and Responsibilities

This group is a standing committee of the OAEH. This group will:

- Act as the voice for all agencies within the CoC, and specifically those participating in coordinated entry;
- Assist in identifying areas of new policy development;
- Review all CES policy changes and provide feedback to the Policy Development Group and the OAEH Executive Board on behalf of the Policy Development Workgroup.

Committee Composition

This committee will include, but is not limited to, agencies that receive federal dollars and are participating in coordinated entry. Other representatives may be appointed by the OAEH Executive Board.

Meeting Schedule

The Funded Agency Subcommittee meets monthly on the 2nd Wednesday of the month at 9:30 a.m.

CES Policy Development Workgroup:

Roles and Responsibilities

This group will consist of agencies that provide services within CES. This group will:

- Assist in drafting new policy and procedures around CES;

- Provide input into CES, including identifying barriers that prevent clients from accessing services;
- Provide recommendations to the Funded Agency Subcommittee regarding CES; and
- Provide recommendations to the OAEH Executive Board.

Committee Composition
This committee will include, but is not limited to, agencies that are participating in coordinated entry and/or serving special populations, including veterans, youth, and victims of Domestic Violence.

Meeting Schedule
The Policy Development Workgroup will meet annually and on an as-needed basis throughout the year.

EVALUATION

The coordinated assessment process will be evaluated on a regular basis to ensure it is operating at maximum efficiency.

For information on the data and outcomes collected, please see Appendix F

Evaluation mechanisms may include the following:

- **A monthly review of metrics from the coordinated entry process.** The data to be reviewed, and the thresholds that should be met, will be developed based on the document in Appendix F.
- **A quarterly forum with people experiencing homelessness who have been through the coordinated entry process.**
- **A report issued to the community every six months on coordinated entry and homelessness assistance system outcomes.** This report will include trends from the month-to-month analysis of coordinated entry data, as well as the total number of assessments and referrals made, successes to be shared, and a note from the OAEH CES Oversight Committee Chair on the process's progress. Major findings from this report should be presented at CoC meetings by a member of the OAEH CES Oversight Committee. Committee members may ask for staff assistance in writing and producing this report.
- **An annual report on the homelessness assistance system with a section devoted to coordinated entry.** Major findings from this annual report should be presented at a meeting of the OAEH by a member of the OAEH CES Oversight Committee or their designated representative.

Additionally, participation in CES and adherence to applicable rules and regulations will be factored into the OAEH Rank and Review process for HUD CoC funded programs. This will include, but is not limited to assessment of:

- **Case Conferencing attendance**
- **Acknowledging/Accepting referrals within HMIS**
- **Accepting referrals solely from CES (if mandated to do so)**

CONTACT INFORMATION

Questions about these policies and procedures should be directed to:

Adam Bodendieck
Director of Homeless Services
Community Partnership of the Ozarks
ph 417-225-7499 ext. 171
fax 417-631-4489
abodendieck@cpozarks.org

APPENDIX A

Criteria for Defining At Risk Homelessness

Category 1: Individuals and Families
An individual or family who:

(i) Has an annual income below 30% of median family income for the area; AND

(ii) Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the "homeless" definition; AND

(iii) Meets one of the following conditions:

a. Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR
b. Is living in the home of another because of economic hardship; OR
c. Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR
d. Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR
e. Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR
f. Is exiting a publicly funded institution or system of care; OR
g. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved Con Plan

Category 2: Unaccompanied Children & Youth
A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute

Category 3: Families with Children & Youth
An unaccompanied youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under section 725(2) of the McKinney-Vento Homeless Assistance Act, and the parent(s) or guardian(s) or that child or youth if living with him or her.

Comprehensive definitions of homelessness can be found at
https://www.onecpd.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf

Homeless Definitions

CATEGORY 1	LITERALLY HOMELESS	(1) Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: i. Has a primary nighttime residence that is a public or private place not meant for human habitation; ii. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or iii. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
CATEGORY 2	IMMINENT RISK OF HOMELESSNESS	(2) Individual or family who will imminently lose their primary nighttime residence, provided that: i. Residence will be lost within 14 days of the date of application for homeless assistance; ii. No subsequent residence has been identified; and iii. The individual or family lacks the resources or support networks needed to obtain other permanent housing
CATEGORY 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 the other listed federal statutes; ii. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application; iii. Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and iv. Can be expected to continue in such status for an extended period of time due to special needs or barriers
CATEGORY 4	FLEEING/ ATTEMPTING TO FLEE DV	(4) Any individual or family who: i. Is fleeing, or is attempting to flee, domestic violence; ii. Has no other residence; and iii. Lacks the resources or support networks to obtain other permanent housing

APPENDIX B

Homeless Management Information System Client (HMIS)

& Coordinated Entry System Front Door Memorandum of Understanding

for the Ozarks Alliance to End Homelessness

I. Introduction

The purpose of this Memorandum of Understanding (MOU) is to confirm agreements between the Greene, Christian and Webster County Continuum of Care, otherwise known as the Ozarks Alliance to End Homelessness (OAEH), and its partner agencies related to management of the Homeless Missourians Information System (HMIS) database and the implementation of a Coordinated Entry System (CES). This MOU establishes the Continuum's Executive Board as the oversight group for the CES and the HMIS database, defines general understandings, and defines the roles and specific responsibilities of each party related to functioning as a Front Door partner within the CES.

HMIS is mandated by the U.S. Department of Housing and Urban Development (HUD) for all communities and agencies receiving HUD Continuum of Care (CoC) and Emergency Solutions Grant program (ESG) funding. HMIS is essential to coordinate client services and inform community planning and public policy. The entry and analysis of client information in HMIS is critical to the preparation of a periodic accounting of homelessness in our Continuum, including all HUD-required reporting.

The CES represents a Continuum-wide process for facilitating access to all homeless designated resources, identifying and assessing the needs of persons experiencing a housing crisis, and referring clients to the most appropriate service strategy or housing intervention. CES enables our CoC to more consistently and accurately document needs, and ensures limited resources are allocated to achieve the most effective results.

Through HMIS and the CES, individuals and families experiencing homelessness benefit from improved coordination in and between agencies, informed advocacy efforts, and policies that result in targeted services. The parties to this MOU recognize that thorough and accurate capture and analysis of data about homeless services and individuals is necessary to service and systems planning, effective resource allocation, and advocacy, and thus, share a mutual interest in successfully implementing and operating coordinated entry and HMIS.

Designated CES Front Doors

Designated CES Front Door agencies will be the only locations (outside of any place where outreach workers engage with people) where people experiencing homelessness will be assessed and referred to the Prioritization List for homelessness assistance services. All people experiencing homelessness or at imminent risk of homelessness should be directed to these locations to be assessed for housing services**.** Clients accessing emergency or transitional housing services at agencies not designated as Front Doors will be referred to Community Partnership's One Door program or a population-appropriate Front Door the next business day to complete an assessment for referral to the Prioritization List for Rapid Re-Housing and Permanent Supportive Housing Services.

II. Duration

Except as provided in Section VIII (Termination), the duration of this MOU shall be as follows:

- *HUD Funded Agencies:* MOU valid for 3 years from date of signature
- *Front Door Partners under MHDC MOHIP grant:* MOU valid for one year, from April 1, 2018 through March 31, 2019

While it is anticipated that this MOU will be renewed annually for equal periods thereafter, the parties will review and affirmatively agree to the terms of this relationship prior to renewal. This review is intended to ensure the continued relevance of the terms to the parties and to ensure continued consistency and compliance with HUD regulation.

III. Guiding Principles of the OAEH

The following principles have been adopted by the Executive Board of the OAEH. This MOU ensures that all partner agencies within the Continuum also agree to adopt these guiding principles:

- Comply with HUD regulations and standards as required while allowing flexibility for local customization.
- Promote client-centered practices by ensuring every person experiencing homelessness is treated with dignity, offered at least minimal assistance, and is able to participate in their own housing plan. The Continuum will provide ongoing opportunities for client participation in the development, oversight and evaluation of the CES. Participants should be offered choice whenever possible.
- Prioritization of the most vulnerable persons and families will determine the allocation of limited resources. The OAEH has adopted the Vulnerability Index Service Prioritization Decision Assistance Tool II (VI-SPDAT II) as the prioritization tool with which to determine an individual's or family's vulnerability risk. The OAEH has also adopted the use of a Prioritization List for use by agencies providing Rapid Re-Housing and Permanent Supportive Housing to determine who should receive services first.
- Attend case conferencing twice monthly to ensure clients are referred to the appropriate resources and that prioritization is observed in the referral process for housing services.
- Reduce barriers to housing placement by identifying system practices or program requirements that may contribute to the exclusion of participants from services and eliminating those barriers. Barriers could include conditions such as income or sobriety as eligibility requirements for program enrollment. They can also include difficulty accessing services for rural families or those without transportation. A homeless outreach team has been determined to be a priority for our Continuum.
- Promote system-wide transparency ensuring open communication between agencies, the governing board and administrative entities.
- Promote collaborative planning and decision-making practices.
- Acknowledge and honor cultural, regional, programmatic, linguistic and philosophical differences.
- The OAEH will use CES and HMIS data to analyze housing needs throughout the Continuum and create a variety of housing options.
- Adopt the concepts of prevention and diversion when applicable for families that are low barrier and low risk for homelessness.

IV. Responsibilities of the governing board

The OAEH Executive Board will:

1. Coordinate with local HUD and ESG recipients in the OAEH on coordinated entry, performance measurement, written standards, and other related topics.
2. Coordinate, integrate and leverage resources to maximize impact of services for individuals who are experiencing homelessness.
3. Identify the group and/or persons charged with managing daily activities associated with CES planning, implementation, operations and evaluation, and communicate those roles to participating agencies.
4. Identify local access points ("front doors") for the CES that cover the Continuum's geography and can be accessed by all households in need of assistance.
5. Ensure that participating agencies have access to and are using the same eligibility and assessment tools.
6. Develop an affirmative marketing plan for CES that communicates to local stakeholders, advocates and the general public where and how to access housing services.
7. Provide oversight and accountability for all participating CES and HMIS participating agencies, including timeliness of data entry, prioritization of services, the elimination of barriers to services, and the rate of service denial.
8. Oversee client grievance and any local case conferencing process as necessary.
9. Set the overall standards for prioritization and referral, and ensure that all participating providers are following these expectations.
10. Evaluate at least annually the Continuum's CES performance and progress of the CES. Implement quality improvement adjustments to the CES as necessary.
11. Provide regular performance reports to agencies participating in CES.

V. Responsibilities of CES administrative entity

Community Partnership's One Door program will:

1. Act as the front door for all homeless services and housing referrals for the Continuum.
2. Provide oversight for the system's Prioritization List, including ensuring client prioritization by subpopulation and completion of the vulnerability-determining tool.
3. Work with clients and partner agencies to ensure clients are document-ready. One Door will assist with state IDs, social security cards, birth certificates, veterans' documents, and income verification. All documents will be scanned and saved in the client's file electronically.
4. Coordinate at least twice-monthly case conferencing between agencies.
5. Provide referrals for services to all agencies that serve the homeless and at risk in the Continuum, including emergency shelter, transitional housing, Rapid Re-Housing, permanent supportive housing, mental health services, physical health services, and veterans' services.
6. Track program openings and ensure referrals made for these openings best fit the needs of the client while also observing prioritization based on vulnerability and subpopulation.
7. Communicate with agencies when a denial of service occurs to determine the reason for denial. Assist in the identification of alternative housing options when a referral is not accepted.
8. Employ the concepts of prevention and diversion when applicable for families that are low barrier and low risk for homelessness.
9. Coordinate data tracking and assessments with the street outreach team, and act as a central entry point into the system for those clients that may be high-barrier and high-need.

VI. Responsibilities of Participating Front Door programs

[Front Door Program] will:

1. Participate in the required training necessary to access the HMIS system and effectively function as a Front Door;
2. Collect defined Unique Data Elements within the Front Door HMIS project and administer the Front Door intake assessment, including the vulnerability-determining tool (OAEH has adopted the VI-SPDAT II as the chosen tool for determining vulnerability);
3. Provide or refer to prevention and diversion-related assistance whenever possible to prevent low-barrier clients from entering the shelter system;
4. Provide reasonable steps to offer CES process materials and instruction in multiple languages to meet the needs of minority, ethnic, and groups with limited English proficiency;
5. Work with the OAEH to ensure appropriate auxiliary aids and services necessary to ensure effective communication are available (e.g. Braille, audio, large type, assistive listening devices, and sign language interpreters);
6. Connect clients to other mainstream resources outside of the homelessness assistance system. For example, Family Support for Medicaid and SNAP (Food Stamps);
7. Ensure the client, upon completing all assessments and the VI-SPDAT II tool, is referred to the Prioritization List for permanent housing; and
8. Any other service provision related to their agency's program model.

VII. Confidentiality

All parties agree that they shall be bound by and shall abide by all applicable Federal and/or State statutes or regulations pertaining to the confidentiality of client records or information. This agreement pertains to both agency employees as well as volunteers. The parties shall not use or disclose any information about a recipient of the services provided under this agreement except with the written consent of such recipient, recipient's attorney or recipient's parent or guardian.

VIII. Terms of Agreement

This MOU shall be effective upon adoption by each signatory agency and entity. Annually, this MOU will be reviewed and updated to incorporate changes and clarification of roles and responsibilities. Any party must provide written notice of change ninety (90) days to the OAEH Executive Board before the annual termination date or it will be automatically renewed. Otherwise, this Agreement may be terminated in accordance with the section on Termination below.

Termination. Any party may terminate this MOU by giving sixty (60) days written notice to the other parties. If the funding relied upon to undertake activities described in this MOU is withdrawn or reduced, or if additional conditions are placed on such funding, any party may terminate this MOU within thirty (30) days by providing written notice to the other parties. The termination shall be effective on the date specified in the notice of termination.

Amendment/Notices. This MOU may be amended in writing by either party. Notices shall be mailed or delivered to:

Ozarks Alliance to End Homelessness
Attn: Adam Bodendieck
330 N. Jefferson Ave.
Springfield, MO 65806

Signature and Acknowledgment

_____	_____
Print name of partner organization	Print name of partner organization staff
_____	_____
Signature of partner organization staff	Date
Community Partnership of the Ozarks – One Door	_____
Print name of administrative entity	Print name of administrative entity staff
_____	_____
Signature of administrative entity staff	Date
Ozarks Alliance to End Homelessness	_____
Print name of oversight organization	Print name of oversight organization staff
_____	_____
Signature of oversight organization staff	Date

APPENDIX C

Ozarks Alliance to End Homelessness (OAEH)
Coordinated Entry System Access & Referral Process

- Client accesses services via one of the established Front Doors, which are currently One Door, Rare Breed (The Kitchen, Inc.), Home at Last (The Kitchen, Inc.), Harmony House, YouthConnect Center (FosterAdopt Connect), SPS Office of Students in Transition, MSU Care, and PATH (Burrell).
    - Assessment staff at the Front Door administers pre-screen triage to determine what services are appropriate (Prevention, Diversion, or Shelter); Front Door provides whatever prevention/diversion interventions they are able to provide and/or works to connect client with mainstream prevention resources (e.g. Salvation Army, Catholic Charities of Southern Missouri, OACAC) or One Door's diversion program.
    - Assessment staff at the Front Door EITHER administers the universal intake assessment and VI-SPDAT II OR works to connect client with One Door (via phone or in person) to administer the universal intake assessment and VI-SPDAT II.

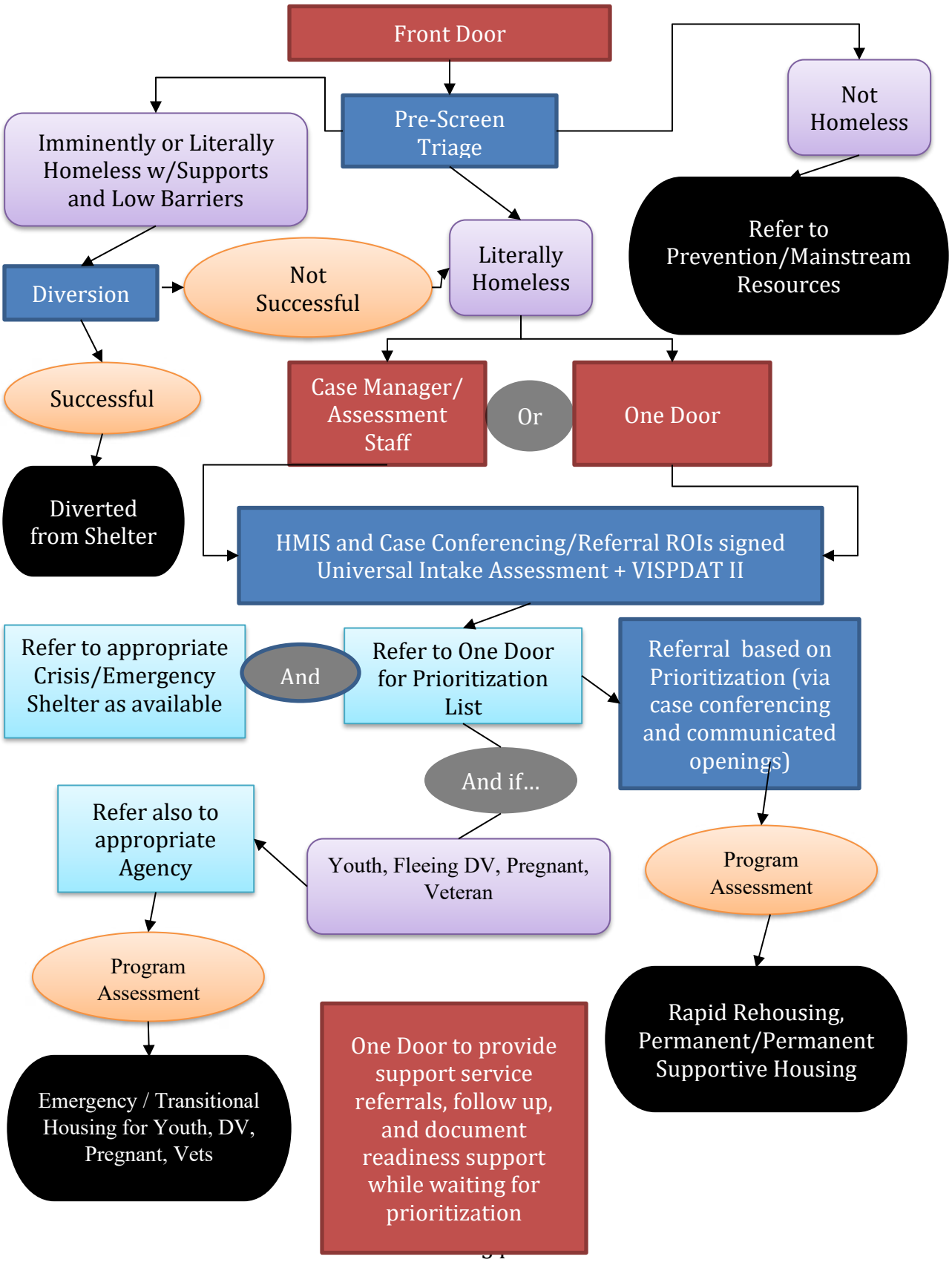
- If emergency shelter is needed, Front Door staff will EITHER work to connect client with One Door OR direct client to appropriate emergency shelter (provided space is available).

- Front Door assessment staff will refer client to the OAEH Prioritization List (kept by One Door) for Rapid Re-Housing and Permanent Supportive Housing services.
    - For agencies agreeing to accept Rapid Re-Housing and Permanent Supportive Housing referrals via prioritization, all referrals will be made by One Door in ServicePoint and be based on the Prioritization List.
    - Clients fleeing domestic violence, pregnant women, youth, and veterans will be referred to agencies specializing in services for those populations; these services are not governed by the prioritization process and may not occur in ServicePoint.

- Agencies will communicate program availability as soon as openings are available and during case conferencing, which will occur at least twice monthly. Program eligibility guidelines must be clearly communicated and up-to-date to ensure good referrals are being made.

- When a referral is made, the receiving agency will have the opportunity to accept or reject the referral; this process will occur via email and within ServicePoint.

- While clients are waiting to receive Rapid Re-Housing and Permanent Supportive Housing services, One Door will continue to provide support service referrals, follow-up, and document readiness support as available and appropriate.


Front Door
Pre-Screen Triage
Not Homeless
Imminently or Literally Homeless w/Supports and Low Barriers
Refer to Prevention/Mainstream Resources
Diversion
Not Successful
Literally Homeless
Successful
Case Manager/ Assessment Staff
Or
One Door
Diverted from Shelter
HMIS and Case Conferencing/Referral ROIs signed Universal Intake Assessment + VISPDAT II
Refer to appropriate Crisis/Emergency Shelter as available
And
Refer to One Door for Prioritization List
Referral based on Prioritization (via case conferencing and communicated openings)
And if...
Refer also to appropriate Agency
Youth, Fleeing DV, Pregnant, Veteran
Program Assessment
Program Assessment
Rapid Rehousing, Permanent/Permanent Supportive Housing
Emergency / Transitional Housing for Youth, DV, Pregnant, Vets
One Door to provide support service referrals, follow up, and document readiness support while waiting for prioritization

APPENDIX D

Ozarks Alliance to End Homelessness
(Springfield-Greene, Christian, and Webster Counties CoC) Data Sharing Policy

Background Information:

The Homeless Management Information System (HMIS) is used to facilitate and protect data sharing among homeless service providers participating in coordinated entry. The Ozarks Alliance to End Homelessness (OAEH) operates an "open" system to ensure efficient and coordinated referrals and case conferencing. Upon signing the OAEH HMIS release of information (ROI), all records, including health questions and special needs, are visible/open within HMIS to the designated OAEH HMIS Sharing Group.

Additionally, the household's record is visible to the entire Missouri Implementation (STL City CoC, STL County CoC, Missouri Balance of State CoC, Jasper/Newton Counties CoC) with the exception of health questions and special needs, which remain visible only to the agency collecting that information and the OAEH Sharing Group.

Policy:

CoC agencies participating in the OAEH HMIS Sharing Group will request that households sign an HMIS specific ROI that reflects this policy; this will enable agencies to collect and share a household's information. The level of sharing will be determined at the household level and consist of one of the following:

- Consent to share ALL information with the OAEH Sharing Group and all information EXCEPT health and special needs information with the entire Missouri HMIS implementation.
- Consent to share all information EXCEPT health and special needs information with both the OAEH Sharing Group and the entire Missouri HMIS implementation.
- Information entered into HMIS but NOT shared with anyone other than the agency collecting the information.

If a household had provided consent to share in the past but wants to revoke that consent, the historical data will remain open but any data collected following the revocation of sharing consent will be visible only to the agency collecting the data.

Case conferencing and referrals requires the household to sign a separate Coordinated Entry ROI that enables referring agencies and all agencies represented at case conferencing meetings to participate in open discussions, both written and verbal, about the household's access to housing and placement into participating housing projects. This ROI is not dependent on the household signing the HMIS ROI. The household could choose to sign the case conferencing ROI and not the HMIS ROI, or vice versa.

However, if a household chooses not to sign a consent to share for HMIS and/or case conferencing purposes, this does not restrict access to services within the CoC. Participating agencies will still work together, while protecting the household's data, to assist the household in obtaining housing.

APPENDIX E

Ozarks Alliance to End Homelessness
HMIS Client Release of Information

This agency participates in the Ozarks Alliance to End Homelessness (OAEH) Homeless Management Information System (HMIS) Sharing Group and the Missouri HMIS Network, collecting information about individuals and families that seek housing services in the OAEH tri-county service area. The information collected will be shared through HMIS, a computerized database, in order to coordinate and improve programs and services.

To provide the most effective services in moving people from homelessness to permanent housing, we need to collect some personal information. You may be asked to provide the following information:

- Name
- Race and Ethnicity
- Social Security Number
- Income Sources
- Veteran Status
- Birth Date
- Household Composition
- Housing History
- Education
- Legal History

** This information will be visible to the OAEH Sharing Group and the entire Missouri HMIS Network.*

In addition, you may be asked questions regarding:

- Physical and Mental Disabilities / Health Conditions
- Domestic Violence History

** This information will be visible only to the OAEH Sharing Group and not the rest of the Missouri HMIS Network.*

Information you provide will be used to better identify appropriate resources for you and your household.

- You have the right to not answer any questions asked. If you do not consent to share your information, the data entered into the system by this agency will not be shared with any other HMIS partner agency. Services will not be refused if you decide to not share your data in HMIS.
- If you agree to share your information, you have the right to revoke your consent at any time in writing or by completing the Client Revocation of Consent to Release Information form. Upon completion of your revocation, any information entered into HMIS after that date will not be shared outside this agency.
- Regardless of consent to share with other agencies within the OAEH Sharing Group and the Missouri HMIS Network, your data is accessible to limited staff at the HMIS lead agency, the Institute for Community Alliances, and the software provider for the purposes of technical support. Additionally, non-identifying information is pulled into various reports and publications required for billing and analysis of performance measures; your name and identifying information will NEVER be included in ANY reports or publications.

How is your information protected?
Your information in HMIS is secured by limiting access to the database and with whom that information may be shared per federal HMIS Privacy Standards. Every person or agency that is authorized access to the information in the database has signed an agreement to maintain the security and confidentiality of the information. Aggregate or statistical data that is released from HMIS will not disclose any of your Protected Personal Information. Your data in HMIS will be archived after seven years.

Please Check Only One of the Following:

☐ Regarding personal information pertaining to me and my household, I authorize the sharing of collected information with other service agencies within the OAEH Sharing Group and Missouri HMIS Network. I understand that my personal information will not be made public and will only be used with strict confidentiality. I understand that I am not waiving any rights protected under Federal or Missouri law. I also understand that I may withdraw my consent at any time.

☐ I understand that some personal information about me and my household will be collected and shared in HMIS but DO NOT authorize information about health, disabilities, or domestic violence for myself or others in my household to be shared with other service agencies within the OAEH Sharing Group or the Missouri HMIS Network.

☐ I understand that my information will be entered into the HMIS system. However, I DO NOT consent to share any personal information in HMIS about me or my household with the OAEH Sharing Group or the Missouri HMIS Network.

_____

Head of Household Name (Printed) Date Head of Household Signature

Other Adults in Household (first and last names):

_____ _____

_____

Staff Name (Printed) Date Staff Signature

_____

Name of Agency

Upon request, we will provide you with a copy of the Client Revocation of Consent to Release Information form; a copy of the HMIS Notice of Client Rights and Confidentiality Policies; and a current list of participating agencies in the OAEH Sharing Group and the Missouri HMIS Network.

For Staff Use Only

☐ Telephonic Consent: Staff obtained telephonic consent from client over the age of 18 listed above. Written consent must be obtained the first time the client is physically present at an organization with access to the HMIS system.

Ozarks Alliance to End Homelessness
Case Conferencing/Referral Client Release of Information
Authorization to Disclose Information per Client

This document allows the following agencies to share information between themselves via referrals and case conferencing for the purpose of determining available housing-related resources for you and your household:

- Catholic Charities of Southern Missouri
- The Kitchen, Inc.
- Safe to Sleep
- Burrell Behavioral Health
- The Salvation Army
- OACAC
- Veterans Administration and Veterans Healthcare System of the Ozarks
- HUD
- MSU Care
- The Missouri Dept. of Mental Health
- Springfield Public Schools – Office of Students in Transition
- Harmony House
- Victory Mission
- One Door
- KVC (Empowering Youth)
- Isabel's House
- Other: _____

Personally identifying information may be shared during case conferencing and the referral process. Information shared will be relevant to program criteria and may include: income sources, household composition, veteran status, health and disability status, and domestic violence history.

Your decision not to share your information for the purposes of case conferencing and referral will not affect the services you are able to receive from this agency, nor will it be used to deny outreach, shelter, or housing. If you agree to share your information, you have the right to revoke your consent at any time. Regardless of consent, demographic information provided may be subject to random audit by funding sources as part of program monitoring.

➔ ☐ I consent to the sharing of my information with the above agencies as it applies to the referral and case conferencing process. I understand that I can revoke this release at any time.

➔ First and Last Name of **Head of Household (Print)**: _____

➔ Date of Birth (**Head of Household)** ___ / ___ / ___ SSN **(Head of Household)** _____

➔ _____
Signature Date (MM/DD/YYYY)

_____
Staff Signature Date (MM/DD/YYYY)

_____
Staff Name Printed Agency Name

*The authorization (unless expressly revoked earlier) expires on: ___ / ____ / ____
(**If the date is not identified, it will expire 120 days from the date signed.**)

REVOCATION
****I (The client) hereby revoke my consent for the release of the previously stated information****

_____
Signature Date (MM/DD/YYYY)

APPENDIX F

Coordinated Entry System Metrics

Process Metrics

- Number of assessments completed
- Number of assessments completed weekly at each site/by each assessment staff member
- Percent of households receiving diversion assistance (currently tracking One Door Program)
- Number of households receiving diversion assistance (currently tracking One Door Program)
- Percent of declined/cancelled referrals (provider)
- Number of declined/cancelled referrals (provider)
- Percent of declined/cancelled referrals (client)
- Number of declined/cancelled referrals (client)
- Average amount of time spent per assessment
- Number of complaints filed with Coordinated Assessment Committee (provider)
- Number of complaints filed with Coordinated Assessment Committee (consumer)
- Average wait time for an assessment

Outcome Measures

- Percent of households exiting from homelessness to permanent housing (RRH, PSH, other subsidized or non-subsidized housing)
- Number of households exiting from homelessness to permanent housing (RRH, PSH, other subsidized or non-subsidized housing)
- Percent of households diverted but requesting shelter placement within 12 months
- Number of households diverted but requesting shelter placement within 12 months
- Average length of episodes of homelessness
- Number of repeat entries into homelessness
- Number of new entries into homelessness

APPENDIX G

Acknowledgment of Consumer Decline

Ozarks Alliance to End Homelessness
Springfield-Greene, Christian, and Webster Counties CoC

Consumer Refusal Acknowledgment

By signing my name below, I am acknowledging that I was given the opportunity to participate

in the _____ program run by _____.
(program name) (agency name)

At this time, I am choosing to not participate in the program.

_____

Applicant Name

_____ _____

Applicant Signature Date

_____

Agency Staff Name

_____ _____

Agency Staff Signature Date

APPENDIX H

OAEH Observational Assessment Request Form

Client Name: _____ SP ID: _____

Agency Personnel Requesting

Name: _____ Agency/Program: _____

Signature: _____

Observational Assessment Requirements

___ Client meets the HUD definition of literal homelessness

___ Client displays signs of a severe and persistent mental health condition or impairment

__ At least three (3) attempts have been made to conduct a standard front door assessment / VISPDAT

Assessment Dates: _____

_____

Supporting Evidence

Please attach documentation to this form as possible and allowable

Agency personnel has reason to believe the following are applicable:

___ Mental health issues or impairments *(Documentation exists to support ___ Yes ___ No)*

___ Alcohol and/or substance use disorder *(Documentation exists to support ___ Yes ___ No)*

___ Physical health disability *(Documentation exists to support ___ Yes ___ No)*

___ Risk of harm to self and/or others *(Documentation exists to support ___ Yes ___ No)*

___ Frequent hospital and/or jail utilization *(Documentation exists to support ___ Yes ___ No)*

___ Other: _____

_____

_____

The following to be completed by administrative entity ONLY

Date discussed during case conferencing: _____

Observational Assessment Request Accepted? ___ Yes ___ No

If no, describe reason:

_____

_____

_____

Name:

_____

Signature:

_____

APPENDIX I

Front Door Project Workflow

Pre-assessment

- First Step: Determine Homeless Status
  - If Category 1 or 4—Use Front Door Project
  - If Category 2—Do not use Front Door Project; provide diversion assistance or refer to One Door
  - Anything else—Determine need prior to entering anything in HMIS; connect guest with appropriate resource
- For all guests being entered into HMIS: Complete HMIS ROI and Case Conferencing/Referral ROI

Initial Assessment

Home Page Dashboard	
Home Page	Select appropriate **Enter Data As** provider (OAEH Front Door)
ClientPoint	1. Enter Client's **Name** 2. **Search**. a. If a correct match is found, ensure that this is the same client by checking SSN, if listed; click on the **green plus** to the left of the client name b. If no matches are found, click **Add New Client With This Info** 3. Back Date Prompt: change the date to the Initial Assessment date and click **Set New Back Date**
Client Information	
Client Profile tab	1. Enter or verify accuracy of **Client Record** information. 2. Enter or verify accuracy of **Client Demographic** information. *3. Optional: Add or update **Residence History, Contact Information, Emergency Contacts, Client Notes, File Attachments** or **Incidents.***
Summary tab	1. Add **Release of Information** a. **Provider:** Verify this is correct b. **Release Granted:** Yes (If "No", contact your System Administrator) c. **Start Date:** Date signed by client d. **End Date:** 1 year from Start Date e. **Documentation:** Signed Statement from Client f. **Witness:** Enter name of witness, if needed g. Click **Save Release of Information** 2. If it isn't a household, continue with the OAEH Front Door Assessment. If it is a household, complete the household information. 3. Complete the **OAEH Front Door Assessment** information, including the correct **VI-SPDAT** **a. VI-SPDAT 2.0 – Singles** **b. VI-FSPDAT 2.0 – Families** 4. Complete the **Client Contact Information** 5. Click **Save**
Assessments tab	1. Complete **Special Needs** information, including the **Domestic Violence** question 2. Click **Save**

Case Manager tab	1. Add Case Manager a. **Type**: select **Me** b. Click **Add Case Manager**
Service Transactions	
Add Referral	*Follow instructions in Service Transactions section*

Update

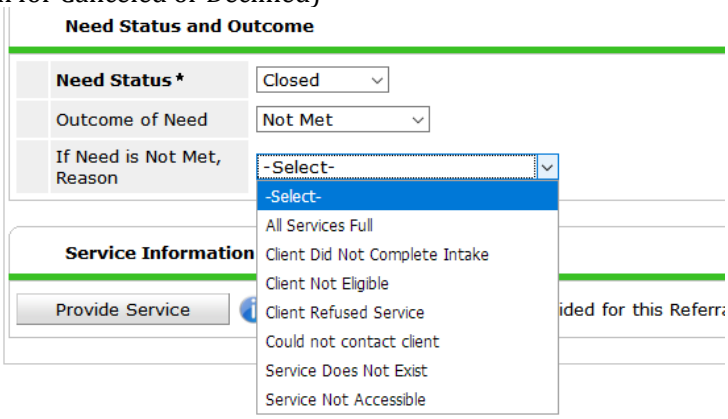
Home Page Dashboard	
Home Page	Select appropriate **Enter Data As** provider
ClientPoint	1. **Search** for client's name or enter ID Number 2. Back Date Prompt: change the date to the update date and click **Set New Back Date**
Client Information	
Client Profile tab	1. Review the **Client Record** and **Client Demographics** to ensure the data is correct. Correct/update any needed changes.
Summary tab	1. Review to ensure the **Release of Information** is current. If it isn't follow the steps for the initial assessment from the first page. 2. Review the **OAEH Front Door Assessment** to ensure it has the current/correct data. 3. If adding a new **VI-SPDAT** score, please make sure to complete a **NEW VI-SPDAT** assessment. Do **not** edit the original. 4. Review/update the **Client Contact Information**. 5. Click **Save**
Assessments tab	1. Review/update the **Special Needs Assessment**. 2. Click **Save**
Service Transactions	
Add Referral	*Follow instructions below*

Service Transactions – Add Referral

Service Transactions	
Add Referral	1. Click on **Add Referral** a. Remember to check the boxes for the correct household members (the system automatically only selects the Head of Household). b. Select **Supportive Housing Placement/Referral** in the Service Code Quicklist; click **Add Terms** c. Select **OAEH Coordinated Entry** from the Referral Provider Quicklist dropdown; click **Add Provider** d. In the **Referrals** section, check the box under Supportive Housing Placement/Referral e. In the **Selected Needs** section, set Need Status to **Identified** and **Service Pending** f. Click **Save All** 2. Click **Exit**

OAEH Accepting/Declining/Canceling Housing Referrals

Home Page Dashboard	
Home Page	Click on the most recent **Outstanding Incoming Referral** from the correct Counts Report quadrant
ClientPoint	You will be prompted to set a **Back Date**, which should be the date you're accepting the referral
Accepting/Declining/Canceling the Referral	
Client Profile	4. Click the **Service Transactions** tab
Within 72 hours of Receiving the Housing Referral	6. Click the **View Entire Service History** button 7. Select the appropriate referral by clicking the *pencil icon*, which should be **Supportive Housing Placement/Referral** type 8. Scroll down to the **Referral Data** section and select **Accepted** for the **Referral Outcome**. 9. Scroll down to **Need Status and Outcome** 10. Select **Identified** from the dropdown list for the **Need Status** 11. For **Outcome of Need**, select the appropriate answer: If you are accepting the referral, then select **Service Pending.** 12. Click **Save & Exit** 13. Begin the process of contacting the household and completing the intake.
If Client Successfully Enrolls in Agency's Project	1. Click the **View Entire Service History** button 2. Select the appropriate referral by clicking the *pencil icon*, which should be **Supportive Housing Placement/Referral** type 3. Scroll down to the **Referral Data** section and select **Accepted** for the **Referral Outcome**. 4. Scroll down to **Need Status and Outcome** 5. Select **Closed** from the dropdown list for the **Need Status** 6. For **Outcome of Need**, select the appropriate answer: If you are accepting the referral, then select **Fully Met.** 7. Click **Save & Exit**

If Client ***Doesn't*** Successfully Enroll in Agency's Project	1. Click the **View Entire Service History** button 2. Select the appropriate referral by clicking the *pencil icon*, which should be **Supportive Housing Placement/Referral** type 3. Scroll down to the **Referral Data** section and select **Declined/Canceled** for the **Referral Outcome**. **a. If Canceled or Declined, Reason** i. Reasons for Canceled **1. Cannot Contact Client** **2. Client Did Not Show for Intake** **3. Client Died** **4. Client Disappeared (Unable to Contact Client)** **5. Client Refused Service** **6. Client Requested Cancellation of Referral** **7. Client Resolved Housing Crisis Independently** **8. Duplicate Referral** ii. Reasons for Declined **1. All Services Full** **2. Client Not Eligible Due to Program Guidelines** **3. Needs Could Not Be Met** iii. Reason that shouldn't be used *1. Client VISPDAT is between 0 and 3* *2. No Contact Information* *a. Reach out to the referring agency, if this is an issue* *3. Service Not Accessible* 4. *Service Does not Exist* 4. Scroll down to **Need Status and Outcome** 5. Select **Closed** from the dropdown list for the **Need Status** 6. For **Outcome of Need**, select **Not Met.** a. **If Need is Not Met, Reason** (select the appropriate choice that would match the reason for Canceled or Declined)  7. Click **Save & Exit**