Oakland County Centralized Housing Registry
Policies and Procedures

Revised 10.31.22

BACKGROUND

The Alliance for Housing (Oakland County's Continuum of Care) established a centralized housing registry to provide equitable and consistent access to all potential program participants seeking permanent supportive housing in our local community. A workgroup was established through the Alliance's Systems and Integration Committee, under the CIST (Community Interagency Service Team) to develop both a centralized intake process with prioritization standards, and to provide continued implementation and oversight of the disposition process. Over time, this group has expanded to include representation of youth programs, rapid rehousing and transitional housing.

Referrals that are populated on the registry contain information that is compiled from a basic screening which can include self-reporting from the individual/household related to their demographics, including history of homelessness and disability. These factors must be verified in order to determine eligibility for programs, including determination of homelessness. As HUD and the community are emphasizing the goal to end chronic homelessness, this will include certification of chronic homelessness as applicable. In addition, all potential program participants must meet a minimum of Category I Homelessness for permanent supportive housing and rapid rehousing programs, HUD rapid rehousing can also assist Category 4 homelessness. Other programs may have different requirements related to contractual and funder requirements. The Alliance also adheres to HUD's recommended order of priority and the certification will include where the person is experiencing homelessness (streets, shelter, transitional housing, etc.). Upon referral, the participating partner begins the process of contacting the program participant and verifying all information. The partner is also responsible for updating the HMIS record to reflect up to date and accurate information throughout this process as well as providing input and updates to the coordinated entry system in weekly calls and monthly face to face meetings.

Membership

The workgroup consists of members beyond Permanent Supportive Housing (PSH), Rapid Rehousing (RRH), and Transitional Housing (TH) providers to make sure that decisions made are transparent. This measure also safeguards that all prioritizations would be with the community and potential program participant's benefit in mind, rather than to serve any organizations' needs. This also allows for coordination between different entities and program participants often participate in multiple programs over the course of resolving their homeless situation.

Currently the Oakland County's Centralized Prioritized Housing Partners include representation from the following groups/entities:

- Alliance for Housing
- CHN - Housing Assessment and Resource Agency (HARA)

- PSH/RRH/SHU Provider - Community Housing Network
- PSH/RRH/TH Provider – Lighthouse/SOS
- PSH Provider - Training and Treatment Innovations
- TH Provider - Common Ground (Youth Transitional Housing) and Victim Advocate Crisis Line
- Oakland County Homeless Management Information System (HMIS)
- HAVEN – local shelter for Domestic Violence
- HOPE Shelters. - Local Low Barrier Shelter and Recuperative Care Center
- Oakland County Health Network – local CMH provider and their network of providers
- Oakland County Schools Homeless Liaison
- Oakland County Health Division
- Honor Health – local FHQC
- OLHSA HOPWA
- MSHDA
- Veteran's Administration
- Oakland County Veterans' Administration
- MSHDA Voucher Agents, as needed

PROCEDURE

Screening

A QSOBAA (Qualified Service Organization Business Associate Agreement) was put in place to allow for sharing of information for those that share data in HMIS. Registry Partners are able to utilize a community wide assessment that allows a Partner utilizing HMIS to assess and refer those presenting as homeless. This assessment was tailored to include the essentials (including HUD standard questions related to chronicity and other factors, as well as the VI SPDAT[1]) to determine potential eligibility for permanent supportive housing, rapid rehousing and transitional housing and to streamline the system without duplication of HARA duties. Each partner agency, has the ability to make a referral or to choose to have the potential program participant call the HARA. If a potential program participant qualifies for an available program based on the assessment, a referral is made in HMIS to the Alliance Centralized Housing Registry. Additionally, it should be noted that anyone that is reported to be chronically homeless[2], or is experiencing 12+ months of homelessness continuously OR 4 episodes of homelessness in the past three years equaling 12+ months & qualifying disability, are added to the registry regardless of VI SPDAT score as those who are chronically homeless are prioritized in the community. Please refer to page 7 of this document – Order of Priority – for further detailed information.

Because of the need to share information beyond the partners covered in the QSOBBA, a Community MOU was put in place that allows for the partners to share program participant information to coordinate services.

[1] SPDAT stands for Service Prioritization Decision Assistance Tool (SPDAT) and is a full assessment. The VI – SPDAT is the Vulnerability Index which provides a screening to determine need. Both assessments are used to assess need and risk factors for persons that present as homeless.

[2] Department of Housing and Urban Development: 24 CFR Parts 91 and 578

Based on HUD's guidance for prioritization and the emphasis on assisting those who meet the definition of chronic homelessness[3], those who report as "chronically homeless" during initial screening will be placed on the Registry regardless of VI SPDAT score. To ensure the ability to also manage and monitor other subpopulations who report as homeless but who do not meet the chronic definition, the community has established thresholds that are agreed upon by the community partners based on capacity and need. These are routinely updated through the coordinated entry system and communicate to the partners beyond the group. Those who meet threshold are referred to the Centralized Housing Registry[4]. At times this score may be expanded to include lower VI scores if the vacancies are increased and the community has more capacity to assist more potential program participants that meet other eligibility requirements.

While those who are reported to be chronic are prioritized for PSH, there may be times that a slot of PSH may not be immediately available due to capacity. For this reason, and for other potential program participants that are on the registry, the team coordinates with Rapid Rehousing Programs and other housing resources in the CoC to explore all other potential housing assistance for presenting households. This may include using "bridging" to provide a potential program participant with a shorter-term program, while maintaining the name on the registry for when a vacancy may become available to transition into a longer-term housing option. Then the short-term program (RRH) would end and the long-term (PSH) program takes over.

While the Registry considers the vulnerability of a potential program participant as part of the prioritization process, there may be instances where a potential program participant refuses to participate in this screening process or is unable to complete the interview. Community members will continue to attempt to engage the potential program participant in this process, but this will not hinder the person from being placed on the registry. In these situations, the referral will be made, and length of time homelessness will be utilized for placement on the list. For instance, if a person is reported to be "chronic" and has been homeless for 12+ months, the person will be placed on the registry in that appropriate spot based on this information. In situations where the person is not chronic, the potential program participant will be placed in the appropriate category with a note and reviewed by the team to place in the appropriate section of the registry during scheduled meetings. The community partner referring the potential program participant will have opportunity to discuss mitigating factors and the situation to ensure that any vulnerability factors can be considered in this discussion for appropriate prioritization.

External Reporting Details

1. Using Community Services, the HMIS software, from the vendor, WellSky, a local custom referrals report is run and exported to Excel by the Oakland County HMIS System

[3] Federal Register/Vol. 80, No. 233 Friday December 4, 2015: Department of Housing and Urban Development 24 CFR Parts 91 and 578: Homeless Emergency Assistance and Rapid Transition to Housing: "Defining Chronic Homelessness"

[4] There are situations where a person may have a lower VI score than threshold but not have access to other long-term community resources such as vouchers or publicly funded housing due to the "one strike rule". In these instances, the community may agree upon a referral to the Registry as long as the potential program participant meets all other eligibility criteria. In these situations, documentation will reflect the lack of access to other programs without specifics of the nature of why the individual cannot access these other community resources.

Administrator. The HMIS System Administrator was assigned this task to ensure transparency, as this position is neutral when it comes to housing vacancies and disposition. This document serves as the Registry for the community.

2. The HMIS System Administrator contacts the provider/source of referral to get additional information or clarification for the record of a particular individual. This could include a missing VI score, clarification of Category of homelessness, more information about a disability, length of time homeless, etc.

3. The Alliance for Housing then prepares the registry for weekly disposition and facilitates a meeting of the Centralized Housing Partners. This occurs generally on a weekly basis. Typically, the group meets weekly on a virtual basis (GoToMeeting and phone call meeting) with an in-person meeting scheduled once per month.

SAMPLE OF ALLIANCE CENTRALIZED HOUSING REGISTRY

	Name/ID	VI SPDAT Score	Housing Status	Client entering from the streets/ES/SH	If, entering from streets, ES or SH Approx start Date	Number of times the client has been on the streets/ES/SH in past 3 yrs	Total number of months homeless on the street/ES/SH in past 3 yrs	Homeless at least 1 year	Chron	HH	Vet	DV	AGE	HIV/AIDS	Dis	Disposition
12/21/2015 0:00	Mann, Stan	7	Cat1	Y	10/1/2015	1	14 months	Y	Y	1	N	N	37	N	Y	Alc/chronic health/drug/mental health/phy
12/15/2015 0:00	Holly, Buddy	VIFSPDAT Score of 12 for family.	Cat1	Y	9/15/2015	1	2	N	N	2 Adults, 2 Children	N	Y	40	N	Y	Mental Health/Phy
PREVIOUS DISPOSTIONS																
12/17/2015 0:00	Presley, Elvis	VIFSPDAT Score of 14 for family.	Cat1	Y	8/17/2015	3	15	Y	Y	1 Adult, 1 child	Y	N	55	N	Y	12/22/2015 Agency #4 assigned Mental Health/Alc
12/4/2015 0:00	Joplin, Janis	10	Cat1	Y	11/15/2015	1	2	N	N	1	N	Y	39	N	Y	12/22/2015 Agency #3 Assigned Physical/Mental Health
INELIGIBLE OR "CLOSED OUT" PROGRAM PARTICIPANTS																
10/15/2015 0:00	Guthrie, Arlo	12	Cat1	Y	7/15/2014	4	18	Y	Y	1	Y	N	62	N	Y	12/1/2015 Program participant is no longer homeless, reports living with family, will deactivate from list and update HMIS 10/31/2015 Agency #1 assigned Mental Health/Alc
PULLED FOR HCV-HP OR HOUSED WITH OTHER PROGRAM																
11/18/2015 0:00	Hart, Nancy	15	Cat1	Y	8/16/2015	4	13	Y	Y	1	Y	N	62	N	Y	11/25/2015 Pulled for voucher, will continue to monitor to make sure housed with other program. Mental Health/Drug/Physical
HOUSED WITH PSH																
12/1/2015 0:00	Starr, Ringo	12	Cat1	Y	6/14/2014	2	19	Y	Y	1	Y	N	43	N	Y	12/22/2015 Housed, lease up 12/20/15 12/18/2015 Housing identifed, inspection schedule 12/20/2015 12/5/2015 Collecting p/w, homeless verification requested from state to determine chronicty 12/2/2015 Agency #1 Assigned Mental Health/Drug/Physical

Prioritization and Disposition

The registry is an Excel spreadsheet and is sorted by prioritization thresholds. Referrals that need additional information are placed at the top of the registry list to fill in any gaps prior to placement on the registry for a period of one week.

At the beginning of each meeting, all participating providers report on any available vacancies in their programs. The group then reviews the potential program participants on the list that have not yet been referred to a Provider.

The prioritization process is as follows:

1. The available referrals are first sorted to distinguish between those who reported as "chronically homeless" vs. those who did not. For ease of organization and review, several subcategories will be grouped within the registry to include chronic, potential program

participants that have experienced 12+ months of homelessness but do not meet chronic definition, those who are homeless less than 12 months but have severe service needs, and youth (under 25)[5] who have aged or will age out of foster care. Additionally, those who are in imminent risk due to DV will be added based on Danger Assessment (DA)[6] scores to determine risk of lethality. Once the registry is sorted into these groups, each group is again sorted by VI-SPDAT/DA score, ranked from highest score (highest need) to lowest score (less need)[7].

In accordance with guidance from HUD[8], for permanent supportive housing programs, the community will prioritize at least all available beds to chronically homeless individuals and households available from turnover. The chronic definition is in accordance with the "final rule" published on December 4, 2015[9]

1. An individual who:

- *Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter, and*
- *Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least 1 year or on at least four separate occasions in the last 3 years, where the cumulative total of the four occasions is at least one year. Stays in institutions of 90 days or less will not constitute as a break in homelessness, but rather such stays are included in the cumulative total; and*
- *Can be diagnosed with more or more of the following conditions: Substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C.15002), post-traumatic stress disorder, cognitive impairments result from brain injury, or chronic physical illness or disability;*

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 the criteria in paragraph (1), before entering the facility; or

[5] The community is committed to addressing youth homelessness. While the Youth Provider does not currently have PSH programming there is a capacity to serve youth through TH funding. The community partners address capacity and additional resources for this population in addition to PSH at all meetings.
[6] Danger Assessment is a tool utilized to determine lethality and to develop safety planning for individual attempting to flee Domestic Violence situations. For more information please visit https://www.dangerassessment.org/.
[7] Consistent with Iain De Jong's training, VI V2 assessment will be provided one time and the score shared by the PSH Partners over the course of the service provision. Based on De Jong's recommendations and guidance, the VI score holds true for a *minimum* of 6 months unless a life altering event occurs.
[8] U.S. Department of Housing and Urban Development, Community Planning and Development, Notice of Funding Availability for the 2015 Continuum of Care Program Competition FR-5900-N-25 (Page 18 3. C.) and Notice CPD-14-012: Prioritizing Persons Experiencing Chronic Homelessness in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homelessness (Page 5, II. B.)
[9] Department of Housing and Urban Development: 24 CFR Parts 91 and 578

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 the criteria in paragraph (1), including a family whose composition has fluctuated while the head of household has been homeless.

- For other programs such as RRH, SHU and TH, prioritization is used in combination with the coordinated entry system disposition process. Some programs provide less assistance and the group meets to determine the best fit for a slot based on appropriate referrals, matching of the eligible household to the vacancy, and additional criteria set forth by specific funders.

- It will be the responsibility of each organization, and subsequent participating program, to track their individual turnover rate and numbers regarding vacancies filled by households and individuals experiencing chronic homelessness.

- There may be situations where a housing unit is not the appropriate fit for a particular program participant with their specific needs. For instance, some programs have minimal supportive services provided in the program (i.e. one housing case management face to face contact every six months). In these situations, the group will discuss the appropriateness of the available slot of housing and ensure that an alternate slot of housing is identified.

- In situations where housing can be made available to a potential program participant that is not chronically homeless, the group will consider the person with the most need who meets the eligibility for the available slot of PSH, as evidenced by the highest VI score, on the registry as well as length of homelessness. A form will be filled out and signed by the Alliance, to note that the vacancy went to someone who was not chronic due to vacancies and potential program participants.

- In situations where there is a person who was in a RRH program, and is about to lapse, that may be still designated as chronic, or would have been chronic without this intervention, the group will meet to discuss the specific case to provide recommendations for prioritization to transition into PSH. This would be in situations where the program participant will "lapse" their RRH assistance and be at risk for subsequent homelessness. Then the short term (RRH) program would end and the long-term program takes over (PSH).

- In situations where the resources are limited for a specific program participant due to extenuating circumstances that prevent them from accessing other programs, the group may make a recommendation to prioritize for a more intensive program such as PSH. Examples of this include an individual with a lifetime ban from subsidized housing due to lifetime registration on the sexual offender list. In these situations the group will meet to provide alternate options.

2. In accordance with guidance from HUD[10], the following system to prioritize households will be used, for PSH slots, prioritizing those who meet chronic homelessness first, and then other potential program participants as outlined below. Based on guidance from HUD , additional considerations have been provided to include those who do not meet the HUD definition of chronic homelessness, but have experienced 12+ months of homelessness in the past three years, and households where it is not the head of household who has the qualifying disability, but an immediate family member presenting in the household, as in accordance with specific grant requirements and funding:

ORDER OF PRIORITY – Permanent Supportive Housing
Leasing Assistance Programs and Supportive Housing Units

Order of Priority	Meet's HUD's Chronic Homeless Definition	Has Severe Service Needs	Other Requirements	Snapshot
Potential Program Participant Meets HUD's Chronic Definition				
1	Yes	Yes	Placed in Chronic section of registry Meets HUD's Final Rule for Chronic Homelessness: At least 12 months of continuous or at least 12 months cumulative across 4 occasions in three years. High server services needs, regardless of VI Score. HOH must have a qualifying disability. .	Chronic –HUD Definition
2	Yes	No	Placed in Chronic section of registry Meets HUD's Final Rule for Chronic Homelessness: At least 12 months of continuous or at least 12 months cumulative across 4 occasions in three years. Low severe service needs, regardless of VI. HOH must have a qualifying disability. *Those that would have been considered chronic but are not due to a "break in homelessness" due to a PH placement (RRH or PSH that ended and returned them to homelessness) are considered in this category.*	Chronic – HUD Definition
Potential Program Participant Does Not Meet HUD's Chronic Definition				

[10] HUD CPD-16-11: Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing July 25, 2016

3A	No	Yes	Placed on 12+ months section of registry Does not meet the new HUD Final Rule for Chronic Homelessness: Individual/Household has 12+ months cumulative homelessness with *less than 4 occasions* in three years. High services need as evidenced by a VI-SPDAT V2 Score. HOH must have a qualifying disability. The homeless status must include coming from streets, shelter, or uninhabitable.	Not Chronic – HUD Definition *but* 12+ months homeless but not 4 occasions and a VI 10+ with a qualifying disability
3B	No	No	Placed on 12+ months section of registry Does not meet the new HUD Final Rule for Chronic Homelessness: Individual/Household has 12+ months cumulative homelessness with *less than 4 occasions* in three years. Low services need as evidenced by a VI-SPDAT V2 Score HOH must have a qualifying disability. Does not meet the new HUD Final Rule for Chronic Homelessness: Individual/Household has 12+ months cumulative homelessness with *less than 4 occasions* in three years. Low services need as evidenced by a VI-SPDAT V2 Score HOH must have a qualifying disability.	Not Chronic – HUD Definition *but* 12+ months homeless but not 4 occasions Does not meet thresholds for PSH but is served because 12+ months of homelessness in past three years and a VI 10+ with a qualifying disability
4	No	Yes	Placed in Not Chronic – Any definition section of registry Does not meet the HUD Final Rule for Chronic Homelessness: Less than 12 months cumulative homelessness. High services need as evidenced by a VI-SPDAT V2 Score. HOH (or member of immediate household*) must have a qualifying disability, or a member of the household has the disability and will be served with specific PLUS Grants. The homeless status must include coming from streets, shelter, or uninhabitable. TH is not included in this category.	Not Chronic – HUD Definition *"Regular Homeless" coming from street, shelter, uninhabitable* Meets thresholds for PSH and a VI 10+ with a qualifying disability
N/A RRH	CAT 1 OR CAT 4	Yes and No	Placed in Not Chronic – Any definition section of registry Additional potential program participants will be added to the	Not Chronic – HUD Definition (no QD) *but* 12+ months homeless any VI Score Meets thresholds for RRH (VI of 9 or DA of 14)

			community registry for consideration for Rapid Rehousing programs in accordance to community established thresholds. These may be individuals and households who have been homeless over 12 months but do not have a disability and therefore cannot be designated as "chronic" or have lower thresholds than those established for PSH. **As the community has various funding streams and grants to provide rapid rehousing, program funding, length of assistance, and capacity will be evaluated in order to place eligible program participants into specific programs. For instance, some programs are dedicated to women with children. Other programs provide a maximum of six months of assistance. The group will meet to review vacancies, capacity and available potential program participants that have been referred.* *Programs that provide up to twelve months of assistance will be geared toward those with higher needs and vulnerability when PSH is not immediately available while programs that provide six months or less of assistance will be used to work with those who have lower vulnerabilities but have met threshold for the registry*	
N/A YOUTH TH	SEE NOTES	Yes and No	Placed in Youth – foster care section of registry Youth – Individuals, age 18 – under 25, who are aging/or aged out of foster care are placed on the list regardless of VI score with any definition of homelessness (Cat 1, 2, 3 or 4). All others will be placed on the registry when they meet criteria established for RRH and/or PSH regardless of county. Please note that while the youth programs can serve any county, all other programs will be OC specific	Prioritized: Youth 24 and under: • Any VI if Aging Out/Aged Out Foster Care • Any VI if Aging out of CG TLP Youth programs can take any county. *This group is also considered for RRH and PSH when eligible.*

			based on HUD and other grant requirements. **Common Ground will have additional prioritization measures in place based on funder contractual requirements including providing 25% of transitional housing slots to those aging out of foster care and prioritizing those who are aging out of RHY TLP programming that is designed for youth 16-20, who do not have subsequent housing identified and would become homeless. With this priority in mind, Lighthouse will also prioritize those who have are "aging out" or "aged out" of foster care.*	

As noted earlier in this document, there may be situations where a potential program participant refuses to complete, or is unable to complete, the VI SPDAT which provides a score for vulnerability. Community members will continue to attempt to engage the potential program participant in this process, but this will not hinder the person from being placed on the registry. In these situations, the referral will be made, and length of time homelessness will be utilized for placement on the list. For instance, if a person is reported to be "chronic" and has been homeless for 12+ months, the person will be placed on the registry in that appropriate spot based on this information. In situations where the person is not chronic, the potential program participant will be placed in the appropriate category with a note and reviewed by the team to place in the appropriate section of the registry. The community partner referring the potential program participant will have opportunity to discuss mitigating factors and the situation to ensure that any vulnerability factors can be considered in this discussion.

3. While there is an emphasis and commitment to serve those, who are experiencing chronic homelessness first, through both dedicated and prioritized beds, there are times when there are not enough potential program participants on the registry who meet the criteria for chronic homelessness who can be "matched" to available open slots of permanent supportive housing in the community. In these situations, as advised by HUD[11], the group will move to house non-chronically homeless individuals or families who are eligible for permanent supportive housing to prevent ongoing vacancies in programs, following the above prioritization. The next group that is considered would be individuals and households experiencing 12+ months of homelessness in the past three years but do not meet the specific "Final Rule". Documentation will be placed in each PSH program participant's file when this occurs, using the Non-Chronic Placement Form. Additionally, the placement will be noted on the registry in the comments section.

[11] HUD Notice CPD-16-11 July 26, 2016 and Federal Register Vol. 80, No. 233 December 4, 2015

4. For PSH in accordance with guidance from HUD[12], certain groups or subpopulations should be prioritized in situations when there is not a chronically homeless household available (for dedicated/prioritized beds within the 85% turnover rate) or in situation where a bed may be used to serve a non-chronically homeless household (not dedicated or within the 85% prioritized at turnover). Additional consideration will be provided for those who have been living on the street the longest (homeless start date), homeless households with children living in unsheltered situations, referred date and those who are medically vulnerable. These additional factors will be included in consideration when the group meets for disposition and are also utilized when determining placement for limited vacancies in other programs such as SHU, TH, and RRH.

   For additional clarification the group will consider the following information to determine the individual or household meets these considerations as follows:

   - Homeless households living in unsheltered situations will include those households staying in a car, on the streets or another place not meant for human habitation, versus those utilizing shelter, transitional housing, or a program that provides short term temporary financial assistance.

   - For medically vulnerable the definition will include those that have been recently discharged from a hospital or have a chronic or acute health condition. Referrals to the registry that are initiated by the HOPE Recuperative Care Center will automatically be considered “medically vulnerable.” The partners will also identify program participants that they are aware of during disposition that have serious medical issues as the partners will often have knowledge from their referrals.

5. In accordance with guidance from HUD[13], veterans who are unable to be served effectively with VA housing and services should receive priority over non-veterans with the same level of need when using a standardized tool for assessment when veteran specific resources are not available to meet their need.

   If the potential program participant is unable to access veteran-specific programs, the veteran will then be considered for PSH disposition as well as other eligible programs. In situations where the veteran has the same level of need as another potential program participant, and matches eligibility criteria, the veteran will be prioritized for the available slot of housing. If a veteran provider is assisting a veteran with SSVF or HUD VASH then they should not be pulled for RRH or PSH.

[12] U.S. Department of Housing and Urban Development, Community Planning and Development, Notice of Funding Availability for the 2015 Continuum of Care Program Competition FR-5900-N-25 (Page 10 5. B.)
[13] U.S. Department of Housing and Urban Development, Community Planning and Development, Notice of Funding Availability for the 2015 Continuum of Care Program Competition FR-5900-N-25 (Page 12 6.)

6. The individuals referred to the Registry are then compared to the available vacancies/slots of PSH per provider. The potential program participant with the highest score that "matches" specific eligibility for the grant and vacancy characteristics is referred to the PSH provider. To illustrate this point, a few examples follow:

   - In situations where there are two program participants with similar circumstance (i.e. both chronic, unsheltered and same VI Score) the programs will provide preference to the veteran.

   - All PSH programs are targeted to serve individuals/households who are experiencing chronic homelessness. The potential program participant that has the highest VI score that is chronically homeless will be the referred household. This may mean a potential program participant with a higher VI score, who is not chronically homeless, is not served. As noted in earlier portions of this document, the community will prioritize at least 85% of available beds to chronically homeless individuals and households available from turnover.

   - Some grants have additional criteria that are associated with the specific targeted population. For instance, some grants that service those who are experiencing chronic homelessness may have additional eligibility requirements for co-occurring disorders. In these situations, the particular service provider will receive a referral for the person who meets first the definition of chronic homelessness, and then the highest VI score, that matches the particular grant requirements.

   - An available vacancy may be a family unit, meaning the vacancy has the ability to serve multiple potential program participants within a household unit (more than a one-bedroom unit). In these situations, the family with first chronicity, and then the highest VI score, that meets additional grant specific eligibility program will be served.

   - A provider's grant may have more limited eligibility requirements related to disability. For instance, a provider may only be able to serve a potential program participant with a diagnosis of SPMI (severe and persistent mental illness) but cannot serve those that have a primary diagnosis of a developmental disability or substance use. In these situations, the provider will be assigned the potential program participant with the chronicity, and then the highest VI score, that meet the grant's specific eligibility criteria.

If two potential program participants have been determined to be chronically homeless, the group will look at homeless start date, where the person is experiencing homelessness – "unsheltered" versus "sheltered". Those that are unsheltered will be

considered more vulnerable due to environmental circumstances and will be prioritized for the available placement.

- Chronic
- Homeless Start date
- Unsheltered/Sheltered
- VI
- Referral Date

When a slot of housing is available for potential program participants that are not chronically homeless, the group will look at Homeless start date, Unsheltered/sheltered, VI, referral date.

7. The Centralized Registry Partner group will discuss as a team and come to a general consensus regarding any dispositions. To illustrate this point, a few examples follow:

   - Additional consideration will be provided to potential program participants that are unable to access other programs to resolve their homelessness that would provide long term resources to assist with the housing crisis. This includes those who are unable to access vouchers or other subsidized housing due to the "one strike rule" that prohibits those that are lifetime registered sex offenders or have been convicted of manufacturing methamphetamine in public housing. Because there are no other options available and there is a need for supportive housing, the group will examine these situations on a case by case basis. In these situations, the potential program participant may be prioritized for immediate disposition if a suitable vacancy is presented in the community.

   - When homeless start date, sheltered/ unsheltered are the same, the VI-SPDAT will then be looked at for prioritization. The VI-SPDAT provides an extra point when the household composition includes more children than adults in the household. The one point is provided for one extra child in proportion to adults. However, the assessment does not provide extra points for each additional child. In the event two families with similar VI scores and other eligibility characteristics are presented, the team will look at how many household members are present in the familial unit.

     For instance, two potential program participants may score 12 points on the VI and have similar characteristics, but one family includes 1 adult and 3 children, and the other household consists of one adult and five children.

     If all other characteristics are the same, the team may elect to provide the one slot to the family of six (1 adult plus five children).

- There have been instances where new or updated information has been provided to a community partner that has led to discussion that the VI should be reassessed. When this occurs, the provider brings the information to the group prior to a new assessment being conducted and the team makes a recommendation based on consensus.

  Examples of this occurring include but are not limited to 1. Potential program participant was diagnosed with a chronic health condition while in the shelter, after initial VI occurred, 2. Potential program participant reported no use of substances at initial intake but later revealed, after trust was established, that they had a history of substance use and was actively using. Documentation was provided regarding involvement with rehabilitation and supportive services by the individual.

  In both these situations the group met and discussed, making a recommendation for a new VI to be conducted. In these cases, the VI is conducted again and placed in HMIS with notes explaining why the assessment was repeated. The original VI stays in the record as well, as we do not overwrite initial results.

- A specific PSH partner may be able to serve a population that cannot be served by other partners in the group. In these situations, the group may elect to use this spot to serve someone that would not typically have access to the PSH programs despite documented need.

  For instance, a person with a developmental disability may have a need for housing but will often not meet the criteria set forth by individual grants that may limit access to those who have a primary diagnosis of SPMI. There are some HUD grants in the community that are limited, by the grant, to a specific identified target population.[14]

  In these situations, the PSH team may elect to reserve this spot for a potential program participant that would typically not be able to access PSH without these more flexible guidelines. In these situations, the group may decide to provide PSH to a person on the list that does not have the very highest VI but has a demonstrated need.

8. The above methodology for prioritization will be utilized during all disposition meetings. As potential program participants are "matched" to available slots of PSH, the registry will be updated to reflect which agency has received the referral. As noted earlier in this document the registry also includes consideration of eligible households and individuals for TH, RRH and SHU. These programs will also utilize prioritization while also considering specific grant requirements as well as the maximum length of time the program can provide assistance. For instance, programs that will provide six months of assistance would not necessarily be the best "match" for a person who is chronically homeless and is prioritized for PSH consideration. Those who are unable to be referred, due to lack of available slots, will remain on the registry for further review at subsequent meetings. Notes will be updated as needed on these potential program participants.

---

[14] HUD CPD-16-11: Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing, Section III A 3

9. At subsequent meetings the team will review progress towards successfully securing housing for those individuals referred through each program. Centralized Housing partners will provide updates, and these will be recorded during the disposition meetings on the registry.

10. Once a potential program participant has successfully completed the process and is housed, the record will be highlighted in green and placed in the "housed" section of the registry. For those that transition to other programs such as a subsidized unit or HCV burnt orange coding will be utilized, housed as self-resolved is orange and housed but may be bridged is teal.

11. If a potential program participant is unable to successfully access an assigned program the team will review the reason why. If a program was unable to provide the housing because of specific grant requirements the potential program participant will be placed back on the registry in their appropriate spot.

    For instance, a potential program participant may have been reported initially to be "chronically homeless" but does not have the necessary documentation to be placed in a grant that specifically serves chronically homeless individuals despite concerted and intensive efforts to verify status.

12. If a potential program participant is unable to successfully access a program because they are ineligible not literally homeless, over income or has not maintained contact with the provider, the group will update notes in the record and deactivate the record, by graying out the line on the spreadsheet. All providers will use a consistent approach to attempt to contact potential program participants to engage and link the individual, using all avenues provided in HMIS for contact, as well as alternate email addresses, as noted in the in this document under the section 'Communication Attempts'. In these situations, the record will be sorted and placed in the "deactivated". It should be noted that if the potential program participant reengages with a provider, a new updated referral will be made. If the potential program participant's situation changes and they do become eligible, an updated referral will also be made.

13. There have been situations that while working with a potential program participant through the Disposition process they have also received notice about being pulled for a Housing Choice Voucher (sometimes referred to as "Section 8"). This is predominantly through the MSHDA program that provides a preference to those who are homeless. In these situations, if the potential program participant has met all of the eligibility criteria for the available PSH,TH or RRH slot, they are provided a choice between the two housing programs with the potential program participant receiving education about the differences between the two programs. While both the PSH programs and the voucher provide continued subsidy to make the housing affordable, the voucher does not come with built in supportive services. In these situations, the community partners that are working closest with the individual or household will be asked to work through this process with the potential program participant, explaining the risks and benefits of each option. In all situations the partners will honor the potential program participant's choice.

When a potential program participant chooses the voucher over PSH the record will be shaded burnt orange and the record moved to the voucher section of the registry.

There may be situations where a potential program participant initially chooses the voucher over an available PSH slot but then is denied access to the voucher through the administrative process. The potential program participant may also change their mind and decide to access PSH instead. The potential program participant will remain on the registry until fully housed with a voucher. If the voucher does not work out the program participant will remain on the registry for other programs. If a program participant is working with a case manager and pulled for a voucher at the same time, the program would keep them and then release them once the program participant has been briefed, if they were pulled for a housing program via our registry and not yet connected to a case manager, but have been pulled for a voucher, the slot will be released.

14. Only participants who voluntarily exit or graduate from the program can re-enter within 90 days

Prioritization for Rapid Rehousing

1. Rapid Rehousing (RRH) pulls will start from the 12+ months definition (without disability unless grant requires) and alternate from the top to the bottom of the list. For example, if there are multiple RRH pulls within one meeting the pulls will go from the top of the non chronic definition (without disability) and then the next pull will be from the bottom. The reason for this is to ensure everyone has a chance at getting pulled for services, as new additions to the list are consistently being added.
    - Advocating for a RRH slot: In each meeting the facilitator will ask the group if anyone has a person they would like to advocate for a Rapid Rehousing slot. Reasons for advocation could be that the person has found housing and is ready to be housed or that their shelter stay time is about to end. Prioritization will be as follows:
        - Homeless start date
        - Unsheltered/Sheltered
        - VI/DA
        - Referral Date
    - For individuals/ families that are referred to the registry that are Category 4 (feeing or attempting to flee) that do not have a homeless start date, the following prioritization will be used:
        - Chronic, 12+, any definition
        - Referral Date
        - Sheltered/Unsheltered
        - DA

2. To expedite the process and maximize resources participants are to be pulled for one program. There are always exceptions to the rule, such as a RRH program participant needing to be bridged to PSH as talked about on page 3, paragraph 2.

Communication attempts for RRH/PSH/TH:

When a potential program participant is referred to a provider for services, the provider is supplied with information through the Homeless Management Information System (HMIS) which will include contact information. The provider will reach out to the potential program participant directly to begin the assessment and verification process. It is recognized that in some situations the provider may have challenges contacting the referred individual or household as these potential program participants are literally homeless. Carriers often arise when a potential program participant has left the shelter that they were staying in at the time of referral, or due to a contact number no longer being in service or out of minutes or a variety of other factors and will be taken into consideration

The group is committed to making contact and serving those with the most need while balancing with the need of the programs and communities. Providers will make attempts to contact the referred potential program participants through all avenues provided in HMIS and the registry, including contact numbers as well as alternate email addresses, and document all efforts within HMIS.

Providers will attempt contact at least 3 times with the primary contact number and all additional supplied potential contacts (both phone and email) over the span of 30 days.

In situations where these efforts are unsuccessful, the provider will bring updates to the Centralized Registry meetings and the group will discuss the barriers to reach the potential program participant. At that time the group will make a decision to 'deactivate' the referral. The potential program participant may make contact at a later date with a partner or the HARA. In those cases, the potential program participant will be screen, and if their circumstances meet the eligibility criteria, they will be referred again to the registry.