



Bridging The Gap Coordinated Entry System Policies & Procedures

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I. PURPOSE

In July 2012, HUD published the Continuum of Care (CoC) Program interim rule. The CoC Program interim rule requires that Bridging the Gap (BTG) establish and consistently follow written standards for providing CoC assistance, in consultation with recipients of the Emergency Solutions Grant Program (ESG).

At a minimum, these written standards must include:

- Policies and procedures for evaluating eligibility for assistance through the CoC Program.
- Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent and transitional housing assistance.

The goals of the written standards are to:

- Establish community-wide expectations on the operations of projects within each community.
- Ensure that the system is transparent to users and operators.
- Establish a minimum set of standards and expectations in terms of the quality expected of projects.
- Make local priorities transparent to recipients and sub-recipients of funds.
- Foster consistency and coordination between access points and housing projects that operate within BTG's jurisdiction.
- Support CoC Program standards in accordance with Violence Against Women Act (VAWA) regulations.

The Coordinated Entry System (CES) is BTG's method for organizing and providing services and assistance to families and individuals experiencing a housing crisis within the CoC. Families and individuals, including youth, who are seeking homeless services or homelessness prevention assistance are directed to defined entry/access points, assessed in a uniform and consistent manner, prioritized for housing and services, and then linked to available interventions in accordance with the intentional service strategy defined by BTG BOD leadership. Each service participant's acuity level and housing needs are aligned with a set of services and program strategies that represent the appropriate intensity and scope of services needed to resolve their housing crisis.

II. ROLES AND RESPONSIBILITIES

A. Convener Responsibilities

1. Case Conferencing: Management and Facilitation

CES conveners operate within each rural county, oversee the CES process, and conduct case conferencing meetings. Case conference meetings are convened to discuss issues surrounding CES including the By-Name-List (BNL), referral status of those on the BNL, warm handoffs between access points and housing providers, etc. The goal is to achieve and sustain a well-coordinated and efficient community system that assures homelessness is rare, brief and non-recurring.

CES conveners will have access to CES-related dashboards to:

- Generate solution-based discussions.
- Make targeted inquiries to promote efficient coordination among service providers, shelter and emergency services, and housing resources.
- Foster a group dynamic by asking for feedback during meetings, by email or through alternative sharing methods. If there is a need to change policies or procedures, these topics will be added to agenda for discussion.
- Ensure that successes are celebrated and partner efforts are affirmed by striving to include positive anecdotes from providers in the meeting. Rotate who gets to share if possible. No success is too small to celebrate.

2. Meeting Attendees and Format

CES conveners will ensure key services and housing partners are actively involved and dialogue is focused on case coordination and problem-solving.

- Organizations Represented: Access point and housing resource providers that are on the current BTG Authorized Agencies list.
- Attendees: Determine which specific staff should be present at case conference meetings. Ideally, attendees are those who have in-depth knowledge of the status, needs and preferences of each client being reviewed and who are also able to make decisions regarding provision of shelter, services or housing assistance. Attendees should be streamlined to keep the group's size manageable.
- Medium of Meeting: Convene in-person when possible. Utilize electronic meetings to accommodate attendees/conveners separated by distance.
- Agenda: Simple and to the point. The primary focus of case conferencing meetings are the clients who are being discussed. A simple agenda may include the following items:
 - Welcome and introductions.
 - Key System Updates. Be sure to keep this brief and include any critical system indicators, such as average length of time for all individuals to access housing.
 - Case Conferencing: Client specific updates and discussion.
 - Follow Up Items: General, client specific follow-up or action items identified during the meeting.

3. Meeting Frequency

Once per month minimally or more frequently when necessary.

4. Vacancies and Referrals

- a. Provide updates at each BTG BOD meeting regarding the following:
 - i. PSH and RRH vacancies.
 - ii. Does the BNL have enough available referrals to fill all vacancies.
 - iii. BNL summary analysis that includes the number of individuals and families in each priority category and movement from month to month.
 - iv. Concerns or issues that the BTG BOD should be aware of.
- b. The convener is responsible for understanding vacancies and available referrals within their county.
- c. If the convener does not respond to a request for targeted referrals or is unable to provide enough referrals to housing providers:
 - i. First occurrence, the BTG Oversight Committee will work with the convener to understand responsibilities outlined in #1 and 2 above. The BTG Oversight Committee can require additional technical assistance and/or training for the convener.
 - ii. Second occurrence, the BTG Oversight Committee to discuss if convener should continue serving as convener or if they should be replaced.
 - iii. Third occurrence, the BTG Oversight Committee will replace the convener.

B. CES Oversight Committee

The BTG CES Oversight Committee is responsible for updating and maintaining CES policies and procedures. This Committee also receives and responds to any CES grievances.

Process for providing additional referrals:

<i>If convener responds:</i>	<i>If convener doesn't respond or provide adequate referrals:</i>
Convener has 10 business days to find enough referrals to fill vacancies.	Housing resource shall submit an HMIS help desk ticket if they do not receive referrals that enable them to fill all vacancies. Tickets will be forwarded to the CES Oversight Chair.
If vacancies are not filled, convener must immediately notify CES Oversight Chair.	
CES Oversight Chair to convene a CES Oversight Committee meeting to strategize filling vacancies. • Convener and housing resource provider must attend. • Determine why vacancies are not being filled. • Determine steps that need to be accomplished to fill vacancies. • Create timeline and next steps to fill vacancies. • Convener will be responsible for implementation of plan and follow up requirements as determined by the CES Oversight Committee.	
CES Oversight Chair to inform BTG BOD of actions taken.	

C. BTG Board of Directors

The BTG BOD oversees all CES processes including CES conveners and the CES Oversight Committee. The BTG BOD ensures that HMIS Policies & Procedures, CES Policies & Procedures and the HMIS Participation Agreement are followed.

D. Access Point Responsibilities

Access points include projects that fall under the Supportive Services Only, Street Outreach, Emergency Shelter, and Transitional Housing project types. Access point responsibilities include:

- Completing the State Homeless Verification for all adults in the household and uploading this form to the HMIS under the appropriate document type. This form can be found in **Appendix F**.
 - State Homeless Emergency Shelters are access points into the CES. Homeless Verifications shall only be accepted on the approved form from HPO state-funded outreach providers and subcontracted agencies, and homeless shelters.
 - The provider shall verify homelessness utilizing the following procedures:
 - The provider shall check and confirm whether the individual or family is identified as currently enrolled in the HMIS.
 - For unsheltered homeless, the provider shall contact the Street Outreach program provider(s) AND/OR shall verify and maintain adequate documentation of the participant's homeless eligibility.
 - For sheltered homeless, the provider shall contact the shelter program provider(s) and shall obtain and maintain adequate documentation of the participant's homeless eligibility.
- Completing the VI-SPDAT assessment based on household configuration in HMIS.
- Street Outreach and Supportive Services Only (SSO) projects must complete at least one encounter per month in the HMIS. Encounters must be entered under the head of household enrollment.
- Household document readiness: photo ID, social security card or letter, and completion of the chronic homeless verification packet as applicable; with all documents uploaded to the HMIS. Staff must quantify which essential documents the client currently possesses and begin working with them to begin collecting missing documents.
- Preparing clients for housing:
 - Verifying and documenting sources of current income
 - Identifying potential future income sources
 - Applying for eligible non-earned income sources
 - Life skills
 - Tenancy skills
 - Detailed housing history
 - Geographic location needed
 - Size of unit
 - Transportation
 - Service animals/pets
 - Smoking/nonsmoking
 - Rental references
 - Is ADA required or preferred

- Completing the Rental Readiness Ruler in [Appendix H](#)
- Access Point agencies must document discussions with clients about what it means to be housed. Basic points of understanding for clients and providers include:
 - Clients may not understand that they must pay rent under the program
 - Consideration of how rent will be paid by the client (not provider)
 - Access Point needs to have discussion with the client about the rent payment plan for how they will pay rent (could be a HUD Voucher)
 - Clients need a self-sufficient and stable income plan
- For Permanent Supportive Housing (PSH), the Access Point agency is responsible for completing the Chronic Homeless Verification's length of homelessness and disability documentation.
 - See Chronic Homelessness Definition & Documentation Checklist in [Appendix D](#)
 - See Verification of Disability in [Appendix E](#)
 - See Homeless Verification in [Appendix F](#)
- Management level Access Point staff should check the following HMIS dashboards on a routine basis:
 - Unassigned referrals
 - Unassignments requiring follow-up
 - Social Security Card or Letter
 - Photo ID
 - Chronic Homeless Status and Verification.
- Points of verification for Access Point discussions with the client include:
 - Uploading the HPO Housing Plan to the HMIS under the relevant document type. This will help document how much the client can afford to pay in terms of rent and confirm that the client is aware that they will need to pay rent.
 - Chronic Homeless Verification documentation
- Locating households that the organization added to the BNL when the household becomes referred to the housing resource.
- Serving as CES point of contact for the household until they are permanently housed.
- Responding within 72 hours to requests for warm handoff from the housing provider.

“Warm handoff” is a person-to-person transfer of responsibility to an alternate service provider who is better equipped to address the relevant, specific needs of the participant. If access points do not respond within 72 hours, the housing provider may unassign the CES referral. (See Warm Handoff Intake in [Appendix G](#))

Some documents are required by housing providers before referrals can be generated through the automated HMIS referral process. These documents are listed below for reference.

Permanent Supportive Housing (PSH) referrals require the following documents:

- CH Verification Documentation for the Head of Household ([Appendix D](#))
 - The Verification of Disability ([Appendix E](#)) must be signed by a certified medical doctor, APRN or certified psychologist who diagnoses and treats the patient. The letter must be on the clinic's letterhead and include Length of Homelessness and Housing History documentation.
- Valid government issued Photo ID (Driver's License, State ID, Military ID or Passport); and
- Social Security Card or Letter

Rapid Re-Housing (RRH) referrals require the following documents:

- Homeless Verification ([Appendix F](#))
- Valid government issued Photo ID (Driver's License, State ID, Military ID or Passport)
- Social Security Card or Letter

Transitional Housing (TH) referrals require the following documents:

- Homeless Verification ([Appendix F](#))

Some programs may require additional eligibility documents. For households with minor children, programs must minimally require the following documents.

- Social Security Card or Letter
- Birth Certificate

E. Domestic Violence (DV) Specific CES Referral Process

1. DV Access Point Agencies

- Responsible for entering DV households into the HMIS using the anonymous DV client referral form.
- Completes all steps required of an access point agency.

2. Anonymous DV Referrals to Housing Providers

- CES referrals are generated from the HMIS based on the Prioritization Scheme outlined in Section III.
- Housing providers will request a warm handoff from the access point agency within 72 hours of pulling the CES referral.
- Responsible for ensuring that all households served through their housing program meet all funder requirements.
- Housing providers will assist clients in locating suitable housing. Clients are not solely responsible for finding their own housing units.

III. PRIORITIZATION SCHEME

Clients will be triaged utilizing the VI-SPDAT and F-VI-SPDAT and prioritized for housing resources per the below. Current VI-SPDAT forms can be found [here](#).

A. Transitional Housing

Single and Adult Only Households

- Verified as experiencing homelessness
- VI-SPDAT Score Range 4-7

Families with Minor Children & Pregnant Women

- Verified as experiencing homelessness
- F-VI-SPDAT Score Range 4-8

B. Rapid Re-housing

Single and Adult Only Households

- Verified as experiencing homelessness
- VI-SPDAT Score Range 8-17 and not verified as chronically homeless
- Document Ready (all documents must be uploaded to HMIS):
 - Valid Government Issued Photo ID
 - Social Security Card/Letter

Families with Minor Children & Pregnant Women

- Verified as experiencing homelessness
- F-VI-SPDAT Score Range 9-22 and not verified as chronically homeless
- Document Ready (all documents must be uploaded to HMIS):
 - Valid Government Issued Photo ID
 - Social Security Card/Letter

C. Permanent Supportive Housing

Single and Adult Only Households

- Verified as chronically homeless
- VI-SPDAT Score Range 8-17
- Document Ready (all documents must be uploaded to HMIS):
 - Valid Government Issued Photo ID
 - Social Security Card/Letter
 - Chronically Homeless Verification Packet including supporting documents

Families with Minor Children & Pregnant Women

- Verified as chronically homeless
- F-VI-SPDAT Score Range 9-22
- Document Ready (all documents must be uploaded to HMIS):
 - Valid Government Issued Photo ID
 - Social Security Card/Letter
 - Chronically Homeless Verification Packet including supporting documents

D. Domestic Violence Funded Projects

Clients that are currently fleeing are prioritized as defined above.

E. Special Populations

Veteran Programs

Referrals shall be based on current subsidy requirements.

Steadfast Group Home Projects *PSH criteria as defined above

1. PSH and AMHD verified
2. PSH and CCS verified
3. PSH

IV. CONSENT TO SHARE DOCUMENTS

Upon completion of the VI-SPDAT, access point organizations shall review and explain the purpose and intention of the HMIS/CES Consent Form with the client. With the client's consent, HMIS participating organizations will share client documents within the HMIS. Organizations **MUST** ensure that the document that is uploaded to the HMIS matches the selected document type. Clients **MUST** have a signed consent form for their information to be shared in the HMIS.

V. CES REFERRALS

A. Referrals

CES referrals are based on the Prioritization Scheme detailed in Section III.

- BTG's CES referral system is automated within the HMIS.
- Housing Providers shall request referrals based on program vacancies and staff capacity.
- If housing programs do not receive an adequate number of CES referrals to fill their vacancies, they **MUST** immediately email the convener for assistance. The convener can make targeted efforts to find potential clients to fill housing vacancies. Access Points will identify, locate and document ready eligible clients. Once a client meets the minimum referral eligibility criteria, the client can then be referred to fill the housing vacancy.
- If adequate referrals are not received, please refer to Section II.A.4.: Vacancies and Referrals.

B. Case Notes

Case notes **MUST** be completed weekly for all active CES referrals and **MUST** be marked as shared in the HMIS. Weekly case notes should include the following, as applicable:

- Last meeting date and next meeting date
- Where the meeting took place
- Housing/resource applications and status
- Any updates to the client's situation, which may include contact info, location, vouchers, and/or family configuration changes
- Assignments, unassignments or CES status changes
- Changes in income or benefits

C. Unassignments

Unassignments will be made in accordance with the information below.

Category 1: NO FURTHER REFERRALS WILL BE GENERATED FOR THIS VI-SPDAT (Active VI-SPDATS MUST be exited)
1. Client has obtained housing
2. Client is no longer on island
3. Client is no longer interested in housing at this time
4. Client is already matched to other housing resources
5. Client has been confirmed as deceased
Category 2: CLIENT CAN BE REFERRED AGAIN BUT NOT TO THIS PROGRAM
1. Client expressed safety concerns with this program
2. Program denial
3. Client declined housing through this program
4. Client does not meet program eligibility criteria and does not qualify for this program.
Category 3: ACTION IS REQUIRED BEFORE CLIENT CAN BE REFERRED TO ANY PROGRAM AGAIN (see note below)
1. Client is not document ready
2. Client unable to be located after multiple communication attempts
3. Client is confirmed as hospitalized or in treatment facility for unspecified length of time

Note: Category 3 Unassignments: Action is required before the client can be referred to any program again: The Access Point/Referring agency is responsible for regular review of the ***CES Referral Unassignments Requiring Follow-up Report***. Regular review of this report will help to ensure that clients who are still interested in housing resources can be referred again and are not “stuck” on the Unassigned list.

VI. GRIEVANCE POLICY

The BTG BOD oversees the CES process through its CES Oversight Committee. All CES concerns or grievances should be brought to the CES convener and the BTG CES Oversight Committee in writing via the BTG HMIS help desk:

<https://helpdesk.hawaiihomelessprogramshmis.org/>. The ticket will be forwarded to the CES convener and the BTG Oversight Committee Chair. A response will be provided within 5-7 business days.

All grievances must be received in writing.

VII. COORDINATED ENTRY SYSTEM TERMS

A. Chronically Homeless (HUD Definition)

HUD defines a chronically homeless single individual and family as follows:

An individual, including youth, who:

1. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
2. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last three 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 a break in homelessness, but rather such stays are included in the cumulative total; and
3. Can be diagnosed with one 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 resulting from brain injury, or chronic physical illness or disability;
4. A person 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) of this definition, before entering that facility; or
5. Who meets all of the criteria in paragraph (1) of this definition.

A family that:

1. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
2. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last three 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 a break in homelessness, but rather such stays are included in the cumulative total; and
3. Can be diagnosed with one 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 resulting from brain injury, or chronic physical illness or disability;
4. A family 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) of this definition, before entering that facility; or
5. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

B. Youth

For purposes of the BTG Coordinated Entry System, the term “youth” includes individuals ages 12 to 17 and parenting young adults ages 18 to 24. In general, young adults and parenting young adults, ages 18-24, will follow the same triage/assessment/intake process outlined for other adults, except a different triage tool

may be used and assistance may be sought from youth-focused agencies. (See “Additional Subpopulation Considerations” for details about triage/assessment tools.)

Unaccompanied youth ages 12 through 17 who are experiencing homelessness while not in the physical custody of a parent or legal guardian, will be connected with a local youth provider agency for services, including access to shelter.

Note: Although the CES serves youth and young adults, for purposes of Rapid Rehousing (RRH) programs, youth must be at least 18 years old to sign a lease. Therefore, for purposes of RRH, youth are defined as ages 18 to 24.

C. Disability (HUD Definition)

HUD defines a person with disabilities as a person who:

1. Has a disability as defined in Section 223 of the Social Security Act (42 U.S.C.423), or
2. Is determined by HUD regulations to have a physical, mental, or emotional impairment that:
 - a. is expected to be of long, continued, and indefinite duration;
 - b. substantially impedes his or her ability to live independently; and
 - c. is of such a nature that more suitable housing conditions could improve such ability,or
3. Has a developmental disability as defined in the Developmental Disabilities Assistance and Bill of Rights Act (42 U.S.C. 15002(8)), or
4. Has the disease acquired immunodeficiency syndrome (AIDS) or any conditions arising from the etiologic agent for acquired immunodeficiency syndrome (HIV).

For qualifying for low-income housing under HUD public housing and Section 8 programs, the definition does not include a person whose disability is based solely on any drug or alcohol dependence.

D. Literally Homeless (HUD Homeless Definition Category 1)

A person or family lacking a fixed, regular, and adequate night-time residence.

- a. An individual or family with a primary night-time residence that is a public or private place not designed for or ordinarily used as regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, camping ground; or
- b. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government program for low-income individuals); or
- c. A family or an individual who is exiting an institution where they 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.

- E. **At Imminent Risk of Homelessness (HUD Homeless Definition Category 2)**
A person or family who will imminently lose their housing (within 14 days) and become literally homeless
- F. **Homeless under Other Federal Statutes (HUD Homeless Definition Category 3)**
A person or family defined as “homeless” by other federal statute (e.g., Dept. of HHS, Dept. of Ed.)
- G. **Fleeing Domestic Abuse or Violence (HUD Homeless Definition Category 4)**
A person or family fleeing or attempting to flee domestic violence, stalking, dating violence, or sexual assault.
- H. **At Risk of Homelessness**
1. Category 1- A family or person who:
 - a. has an annual income below 30% of median income for the area; AND
 - b. 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 Meets one of the following conditions:
 - i. Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR
 - ii. Is living in the home of another because of economic hardship; OR
 - iii. 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
 - iv. 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 households; OR
 - v. 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
 - vi. Is exiting a publicly funded institution or system of care; OR
 - vii. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient’s approved consolidated plan.
 2. Category 2: A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute
 3. Category 3: 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) of that child or youth if living with him or her.
- I. **Homeless Management Information System (HMIS)**
A Homeless Management Information System is an electronic web-based data collection and reporting tool designed to record and store person-level information on the characteristics and service needs of homeless individuals and families throughout a Continuum of Care (CoC) jurisdiction. Usage of the HMIS is mandated by the U.S. Department of Housing and Urban Development (HUD) for any person experiencing homelessness.

J. **Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT)**

The Vulnerability Index and Service Prioritization Decision Assistance Tool (VI-SPDAT) developed and owned by OrgCode and Community Solutions is a triage tool that assists in informing an appropriate ‘match’ to a particular housing intervention to people based on their acuity in several core areas. Within those recommended housing interventions, the VI-SPDAT allows for prioritization based on presence of vulnerability across five components: (A) history of housing and homelessness (B) risks (C) socialization and daily functioning (D) wellness - including chronic health conditions, substance usage, mental illness and trauma and (E) the family unit. BTG’s Coordinated Entry System has agreed to use the VI-SPDAT version appropriate for each population (for example, the VI-SPDAT for individuals and F-VI-SPDAT for families) as the universal assessment tool across the Continuum of Care for screening and matching individuals experiencing homelessness in Hawai’i. Staff administering any of the SPDAT tools must be trained by an authorized trainer.

Appendix A: CES Component Definitions

Component definitions provide detailed descriptions of each CoC program type available through CES.

Street Outreach

Component Type	Essential Elements	Target Population
Emergency services and engagement intended to link unsheltered households (individuals and families) who are homeless and in need of shelter, housing, and support services.	Low-demand, street and community-based services that address basic needs (e.g., food, clothing, blankets) and seek to build relationships with the goal of moving people into housing and engaging them in services over time. In addition, outreach staff should provide or link individuals and families with: case manager assistance to develop a person-centered case management plan, housing placement and housing location support, psychiatric and addictions assessment, medication, other immediate and short-term treatment, and assessment to other programs and services.	Homeless individuals and families on the streets, frequently targeting those living with mental illness(es), severe addiction(s), or dual-diagnoses As providers funded to end people's experience of homelessness match individuals and families to their available housing resources, street outreach will target people connected to a housing resource through these providers in order to demonstrate Coordinated Entry participation

Homelessness Prevention

Component Type	Essential Elements	Target Population
Prevention from homelessness includes financial assistance and services to prevent individuals and families from becoming homeless and help those who are experiencing homelessness to be quickly re-housed and stabilized. The funds under this program are intended to target individuals and families who would be homeless but for this assistance.	Programs can provide a variety of assistance, including: short-term or medium-term rental assistance and housing relocation and stabilization services, including such activities as mediation, credit counseling, security or utility deposits, utility payments, moving cost assistance, and case management.	Individuals and families who are "at risk of homelessness."

Emergency Shelter

Component Type	Essential Elements	Target Population
Emergency Shelter programs providing stabilization and assessment; focusing on quickly moving all individuals (singles as well as families) to housing, regardless of disability or background. Short-term shelter that provides a safe, temporary place to stay (for those who cannot be diverted from shelter) with focus on initial housing assessment, immediate housing placement and linkage to other services.	Entry point shelter with: • showers, • laundry, • meals, • other basic services, • and linkage to case manager and housing counselor (co-located on-site), with the goal of helping households move into stable housing as quickly as possible. Shelters include an array of stabilization options that allow for varying degrees of participation and levels of support based on family needs and engagement at the time they enter the system (i.e., for those with chronic addictions, mental illness, and co-occurring disorders). On-site supportive service staff should conduct the appropriate VI-SPDAT of repeat families and individuals, or families and individuals requesting such assessment following 7+ shelter nights to determine housing needs (e.g., unit size, rent levels, location), subsidy needs, and identify housing barriers, provide ongoing case management, and manage ongoing housing support and services that the family or individual will need to remain stably housed	Homeless individuals or families. As providers funded to end homelessness match families and individuals to their available housing resources, emergency shelters will target individuals or families connected to a housing resource through these providers in order to demonstrate Coordinated Entry participation

Permanent Housing - Rapid Re-Housing

Component Type	Essential Elements	Target Population
Rapid re-housing is an intervention designed to help individuals and families exit homelessness quickly and return to permanent housing. Rapid re-housing assistance is offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of the household. While a rapid re-housing program must have all three core	Housing Identification • Recruit landlords to provide housing opportunities for individuals and families experiencing homelessness. • Address potential barriers to landlord participation such as concern about short term nature of rental assistance and tenant qualifications. Rent and Move-In Assistance (Financial) • Provide assistance to cover move-in costs, deposits, and the rental and/or	Homeless households with temporary barriers to self-sufficiency

components available, it is not required that a single entity provide all three services nor that a household utilize them all.	utility assistance (typically six months or less) necessary to allow individuals and families to move immediately out of homelessness and to stabilize in permanent housing. Rapid Re-Housing Case Management and Services • Help individuals and families experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources. • Help individuals and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues). • Help individuals and families negotiate manageable and appropriate lease agreements with landlords. • Make appropriate and time-limited services and supports available to families and individuals to allow them to stabilize quickly in permanent housing. • Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing financial assistance is provided. • Provide or assist households with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the household has access to resources related to benefits, employment and community-based services (if needed/appropriate) so that they can sustain rent payments independently when rental assistance ends. • Ensure that services provided are self-directed, respectful of individuals' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance. • Assist households to find and secure appropriate rental housing.	
--	--	--

Transitional Housing

Component Type	Essential Elements	Target Population
	Safe units located in site-based or scattered site housing that focuses on housing planning, addictions treatment, stabilization, and recovery for individuals and families with temporary barriers to self-sufficiency. Recognizing that a zero tolerance approach does not work for all participants, transitional housing programs employ a harm reduction, or tolerant, approach to engage residents and help them maintain housing stability. Housing assistance may be provided for up to two years, including rental assistance, housing stabilization services, landlord mediation, case management, budgeting, life skills, parenting support, and child welfare preventive services. Housing plan within two weeks. Average stay is six months. Could stay up to two years. All programs provide follow up case management post exit. Expectation of six months of post placement tracking to assess success	• Homeless families and individuals contemplating recovery or newly in recovery, • youth, • ex-offenders, • single-parent females younger than 25 with children under six years old, • veterans (utilizing GPD) • Families and individuals who are actively fleeing domestic violence

Permanent Housing - Permanent Supportive Housing

Component Type	Essential Elements	Target Population
Project-based, clustered and scattered site permanent housing linked with supportive services that help residents maintain housing.	Permanent housing with supports that help families and individuals maintain housing and address barriers to self-sufficiency. PSH programs should provide subsidized housing or rental assistance; tenant support services; and recognize that relapse is part of the recovery process, PSH programs should hold units open for 30 days while families are in treatment or in other institutions. If a family of individual returns to a program after 30 days and their unit was given to someone else, staff should work with that family or individual to keep them engaged and place them in a unit when one is available. Some PSH programs should have a tolerant, or harm reduction, approach to engage families with	Families and individuals experiencing long-term homelessness, living with disabilities, and significant barriers to self-sufficiency.

	serious substance abuse issues. While in PSH, families should receive supportive services appropriate to their needs from their case manager and/or the ACT or other multidisciplinary team.	
--	--	--

Permanent Housing – Market Rentals

Component Type	Essential Elements	Target Population
Housing where people may stay indefinitely with temporary or long-term rental assistance and/or supportive services.	Broad range of clustered or scattered-site permanent housing options for individuals and families with temporary barriers to self-sufficiency, including group living arrangements, shared apartments, or scattered-site apartments. Families and individuals can receive rental subsidies (transitional or permanent, deep, or shallow) and supportive services. Both length and intensity of housing subsidy and services are defined on a case-by-case basis depending on individual's and family's needs. Once families or individuals are placed in housing, a multi-disciplinary case management team (lead by the primary case manager of an assigned PH provider) should conduct a comprehensive assessment and develop a long-term case management plan based on their needs. Families and individuals should maintain the same primary case manager for as long as they are in the homeless system, but members of the multi-disciplinary team may change as the participants' needs change.	Families and individuals who were formerly homeless

Appendix B: Conducting the VI-SPDAT

Sample Messaging for Conducting the VI-SPDAT:

"My name is [] and I work for a group called []. I have a 10-minute survey I would like to complete with you. The answers will help us determine how we can go about providing supports. Most questions only require a "yes" or "no." Some questions require a one-word answer. All that I need from you is to be honest in responding, so that there isn't a "correct" or preferred answer that you need to provide, or information you need to conceal. We can come back to or skip any question you don't feel comfortable answering, and I can explain what I mean for any question that's unclear.

The information collected goes into the Homeless Management Information System, which will ensure that instead of going to agencies all over town to get on waiting lists, you will only have to fill out this paperwork one time. If you have a case manager who is helping you apply for housing, you should still work with them once you have finished this survey.

After the survey, I can give you some basic information about resources that could be a good fit for you. I want to make sure you know, though, that there are very few housing resources that are connected to the survey, so it's possible but unlikely that you would be housed through this process. The primary benefit to doing the survey is that it will help give you and me a better sense of your needs and what resources I can refer you to.

Would you like to take the survey with me?"

Appendix C: VI-SPDAT Forms

Refer to the BTG website via the link below for the most current versions of the Adult, Youth, and Family VI-SPDAT forms.

[Forms | Bridging The Gap Hawaii](#)

Appendix D: Chronic Homelessness Definition & Documentation Checklist



Chronic Homelessness Definition

This tool provides sample recordkeeping tools for the Chronic Homelessness Definition. To review the exact language, please refer to 24 CFR Parts 91 & 578 and the [HUD Exchange](#).

Recordkeeping Documentation Options Explained			
3 rd Party Documentation			
	Documentation from HMIS/Comparable Database <i>Records must show entries/exits at Shelters.</i> <i>An answer of "Yes" to the question as to whether the individual is chronically homeless (Universal Data Element 3.917) is not sufficient.</i>	Written observation by an outreach worker or Written referral by another housing or service provider	Documentation from Institutions like Hospitals, Correctional Facilities, etc. <i>Must include records about stay the length of stay, signed by Clinician or other appropriate staff.</i>
Self Certification		Signed certification by the individual seeking assistance describing how they meet the definition, which must be accompanied by the intake worker's documentation of the living situation and the steps taken to obtain evidence to support it. Remember that for each Project: • 100% of households served can use self-certification for 3 months of their 12 months, • 75% of households served need to use 3rd Party documentation for 9 months of their 12 months, and • 25% of households served can use self-certification as documentation for any and all months.	
When do you need third party documentation?  Preferred to record all occasions of homelessness to document Chronic Homelessness.  Not necessary to record breaks in homelessness, these can be based on self reports.			

An individual is defined by HUD as "Chronically Homeless" if they have a disability and have lived in a shelter, safe haven, or place not meant for human habitation for 12 continuous months or for 4 separate occasions in the last three years (must total 12 months). Breaks in homelessness, while the individual is residing in an institutional care facility will not count as a break in homelessness. Additionally, an individual who is currently residing in an institutional care facility for less than 90 days and meets the above criteria for chronic homelessness may also be considered chronically homeless. Lastly, a family with an adult/minor head of household who meets the above mentioned criteria may also be considered chronically homeless, despite changes in family composition (unless the chronically homeless head of household leaves the family).

Client Name:	Date of Birth:
Number in Household:	Client Head of Household: ☐ Yes ☐ No

Part 1: Current Housing Status <i>Client must currently be in one of these locations to be considered chronically homeless.</i> Client is currently residing: ☐ In Emergency Shelter ☐ On the Streets/Place not Meant for Human Habitation ☐ In the Safe Haven ☐ In an Institutional Care Facility (Where they have been for fewer than 90 days)
--

Start Date: _____	End Date: _____
--------------------------	------------------------

Location Name/Address:
Current Housing Status Notes:
Chronic Homelessness Documentation Checklist - Page 1 of 4

Part 2: Housing History

	Month # 1	Month # 2	Month # 3	Month # 4	Month # 5	Month # 6	Month # 7	Month # 8	Month # 9	Month # 10	Month # 11	Month # 12
Mo./Yr.												
Location	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter	☐ Streets ☐ Shelter
Check all that Apply	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)	☐ Safe Haven ☐ Inst. (<90 days)
Doc. Type	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork (Except Self-Cert. select both) ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☒ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence	☐ HMIS ☐ Obsv. By Outreach ☐ Comp. Database ☐ Discharge Paperwork ☐ Referral ☐ Self-Cert. ☐ Staff Doc. of Situation ☐ Doc. of steps to obtain evidence
Doc. Att.	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No	☐ Yes ☐ No
Break Mo./Yr. & Descr. or N/A	Break 1: Break 2: Break 3: If there are additional, breaks please detail and attach.											
Notes												
Self-Cert. Check	Does the documentation include more than 3 Months of Self-Certifications? * ☐ Yes ☐ No <i>*Please be advised that if you answered YES, that for at least 75% of the households assisted by a recipient in a project during an operating year, no more than 3 months can be self-certified. Please check with you project administrator to ensure your project has not exceeded its self-certification cap.</i>											
Key	Mo. = Month, Yr. = Year, Inst. = Institution, Doc. = Documentation, Obsv. = Observation, Comp. = Comparable, Cert. = Certification, Descr. = Description											

Chronic Homelessness Documentation Checklist - Page 2 of 4

Part 3: Disability Status

The term homeless individual with a disability' means an individual who is homeless, as defined in section 103, and has a disability that

- *Is expected to be long-continuing or of indefinite duration;*
 - *Substantially impedes the individual's ability to live independently;*
 - *Could be improved by the provision of more suitable housing conditions; and*
 - *Is a physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury;*
- *Is a developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002); or*
- *Is the disease of acquired immunodeficiency syndrome or any condition arising from the etiologic agency for acquired immunodeficiency syndrome.*

The head of household has been diagnosed with one or more of the following (check all that apply):

- ☐ Substance use disorder
- ☐ Serious mental illness
- ☐ Developmental disability
- ☐ Post-traumatic stress disorder
- ☐ Cognitive impairments resulting from brain injury
- ☐ Chronic physical illness or disability
- ☐ Other:

Documentation Attached:

- ☐ Written verification of the disability from a licensed professional;
- ☐ Written verification from the Social Security Administration;
- ☐ The receipt of a disability check; or
- ☐ Intake staff-recorded observation of disability that, no later than 45 days from the application for assistance, accompanied by supporting evidence.

Disability Notes:

Part 4: Staff and Client Certifications

Client Certification:

To the best of my knowledge and ability, all the information provided in this document is true and complete. I also understand that any misrepresentation or false information may result in my participation being cancelled or denied, or in termination of assistance. It is my responsibility to notify _____ of any changes in my housing status or address in writing during program participation and I understand that my application may be cancelled if I fail to do so.

Client Name: (Printed)	Client Signature:	Date:
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Staff Certification:

To the best of my knowledge and ability, all of the information and documentation used in making this eligibility determination is true and complete.

Staff Name: (Printed)	Staff Signature:	Date:
Staff Role:	Agency:	

1. HOUSEHOLD DOES NOT MEET THE THRESHOLD FOR “CHRONICALLY HOMELESS” BECAUSE:

2. REASONS TO CONSIDER THIS HOUSEHOLD FOR PLACEMENT IN PERMANENT HOUSING:

AGENCY: _____

REVIEWED BY: _____ TITLE _____ DATE _____

(HPO) REVIEWED BY: _____ TITLE _____ DATE _____

APPROVED BY: _____ TITLE _____ DATE _____

☐ APPROVED

☐ NOT APPROVED

☐ NEED MORE INFORMATION

Appendix E: Verification of Disability

PART 1: INSTRUCTIONS			
- To be eligible for all CoC funded PSH, evidence that one or more members of the household is diagnosed with a disability must be documented in the participant file. - To be eligible for a PSH unit that is dedicated to serve chronically homeless people, the disability must be documented for an adult head of household, or, if there is no adult in the family, a minor head of household. - Complete all fields in Part 2. - Complete all fields under the relevant option in Part 3 - Attach all supporting documents to this form. - Maintain this form and all supporting documents in the participant's file.			
PART 2: GENERAL INFORMATION			
Admitting CoC Agency Name:		CoC Project Name:	
Participant Name:	HMIS #	Date of Birth	CoC Project Entry Date
Part 3: DISABILITY CERTIFICATION			
Option #1: Social Security (SSI/DI) or Veteran's Disability			
Evidence must include one of the following (Check One):			
☐ A) Written verification from the Social Security Administration; OR ☐ B) Copies of a disability check (e.g., SSI, SSDI or Veterans Disability Compensation)			
ATTACH EVIDENCE OF EITHER A OR B TO THIS FORM ☐ Check here to indicate that evidence has been attached.			

Option #2: Verification by a Qualified Licensed Professional

(Certifying professional must be licensed by the State to diagnose and treat the qualifying condition.
(Must be a medical doctor, psychologist or APRN)

The term homeless individual with a disability means an individual who is homeless, as defined in section 103, and has a disability that is :

1. A physical, mental, or emotional impairment, including an impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that:
 - Is expected to be long-continuing or of indefinite duration; and
 - substantially impedes the individual's ability to live independently; and
 - could be improved by the provision of more suitable housing conditions; OR
2. A developmental disability, as defined in section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000 (42 U.S.C. 15002) – means a severe, chronic disability that:
 - Is attributable to a mental or physical impairment or combination and
 - Is manifested before age 22 and
 - Is likely to continue indefinitely and
 - Results in substantial limitations in three or more major life activities – self-care; receptive and expressive language, learning, mobility, self-direction, capacity for independent living, economic self-sufficiency and
 - Reflects need for
 - A combination and sequence of special, interdisciplinary or generic services; OR
 - Individualized supports; OR
 - Other forms of assistance that are of lifelong or extended duration and are individually planned and coordinated
3. The disease of acquired immunodeficiency syndrome (AIDS) or any condition arising from the etiologic agency for acquired immunodeficiency syndrome (HIV).

I, hereby, certify that _____ (Insert Participant Name) has been diagnosed with the following:

□□□□ Attach written diagnosis on professional letterhead or under the letterhead of health affiliation

-Information About the Certifying Licensed Professional

Signature of Licensed Professional:	Credentials:	Date:
Printed Name:	Organization:	
License #:	Phone #:	

Appendix F: Hawaii State Homeless Verification Form (DHS HPO)

HAWAII STATE HOMELESS VERIFICATION

Department of Human Services Homeless Programs Office

This is to certify that _____
Participant's Name – Head of Household

Including Household Member(s)

Check all boxes that apply

☒ record of entries/exits at shelters found on Homeless Management Information System (HMIS)/comparable database.

☒ is currently living in a place not meant for human habitation (e.g. cars, parks, abandoned buildings, streets/sidewalks).

☒ is currently living in an emergency shelter for homeless persons.

Emergency Shelter and Agency Name: _____

☐ is currently living in a transitional shelter for homeless persons.

Transitional Shelter and Agency Name: _____

☐ is currently living in a hotel/motel through sponsorship by a social service / government agency.

Social Service Agency Name: _____ ☒ Documentation Attached

☐ is being evicted or forced out from a private dwelling unit, no subsequent residence has been identified and the person lacks the resources and support needed to obtain housing.

☐ At-Risk (within 45 days)

☐ Imminent At-Risk (within 14 days)

☐ Eviction Notice Attached

☐ is being discharged from an institution, such as hospital, mental health facility, substance abuse treatment facility or jail/prison in which the person has been a resident for fewer than 90 days and no subsequent residence has been identified and the person lacks the resources and support networks necessary to obtain housing.

Institution Name: _____

☐ is fleeing a domestic violence housing situation and no subsequent residence has been identified and the person lacks the resources and support necessary to obtain housing.

☐ has been diagnosed with the following disability:

☐ Documentation Attached:

- ☐ Written verification of the disability from a licensed professional;
- ☐ Written verification from the Social Security Administration;
- ☐ The receipt of a disability check; or
- ☐ Intake staff-recorded observation of disability
- ☐ Other: _____

Additional information (e.g. current living situation, homeless/housing history, disability status):

State Homeless Programs on Oahu and the rural counties require compliance with HUD's definition of "Chronically Homeless" as an individual or family that:

1. is homeless and lives or resides in a place not meant for human habitation, a safe haven, or in an emergency shelter; and
2. has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one (1) year or on at least four (4) separate occasions in the last three (3) years where those occasions cumulatively total at least 12 months; and
3. has an adult head of Household (or a minor head of Household if no adult is present in the Household) with a diagnosable substance abuse disorder, serious mental illness, developmental disability (as defined by HUD regulations), post-traumatic stress disorder, cognitive impairments resulting from a brain injury, or chronic physical illness or disability, including the co-occurrence of two (2) or more of those conditions; the disability is expected to be long-continuing or of indefinite duration and substantially impedes the individual's ability to live independently.

Does this person meet the definition of Chronically Homeless?

- ☐ Yes, this person is chronically homeless.
- ☐ No. He/she is currently homeless but not chronically homeless.

Signature of Person Completing Form: _____

Date: _____

Name & Title of Person Completing Form: _____

Organization of Person Completing Form: _____

Participant's Signature: _____

Date: _____

Appendix G: Warm Handoff Intake

WARM HANDOFF INTAKE

Client Name:					Client ID:			
Phone Contact:					Family ID:			
Email Contact:								

CES Referral Date:		VISPDAT	CES Batch #		Program Referred:	HPO-RRH-RR		
Current Program Enrollment:					Case Mgr:			
1-Auto email sent								
2-F/Up email sent					Warm Hand-off Date:		Time:	

FLC Housing	CM Name:		Date:		Time:	
Resch FLC Housing	CM Name:		Date:		Time:	
Resch FLC Housing	CM Name:		Date:		Time:	

These are the names listed in your family. Are these all the individuals that will be housed with you?									
Client Name HOH	1	Last Name	First Name	SSN	DOB	Age	M	F	Citizen
Hshold members	2								
	3								
	4								
	5								
	6								
	7								
	8								
	9								
	10								

Are you willing to do whatever it takes to be housed?		Desired Area / Unit Size	
What is your plan to pay rent?			
Monthly Income	Employment		
	Monthly salary		
SSI/Other: \$	SSI/Other: \$		
Did you apply for HUD / EHV?			
Does your household have an animal?			
Are you or someone in your household a smoker?			

Case Note Entered		Un-Assigned Date:	
Workbook Entered		Reason:	

Appendix H: Rental Readiness Ruler

RENTAL READINESS RULER



Are you willing to do whatever it takes to be housed?

1. Are you willing to pay rent? How much: \$ _____
Y / N
2. Are you willing to look for housing? How: _____
Y / N
3. Can you complete rental applications on your own? Online applications?
Y / N
4. Are you flexible to living anywhere on the island? Y / N
If not, then where: _____
5. Are you willing to increase income/find employment to stay housed? Y / N
When will you start? _____
6. Are you willing to comply with a lease agreement and house rules?
Y / N
7. Are you willing to comply with monthly case management follow-up?
Y / N
8. Do you believe that you have any criminal history that would prevent you from being housed? Is there anything that would prevent you from being housed at government-funded housing projects?
Y / N
9. Have you applied for low-income housing? Y / N Where: _____
Are you wait-listed for HUD? Y / N What year: _____
10. Are you willing to live in shared housing? Would you consider group homes?
Y / N

Additional: If needed, could you re-home your pets? Y / N