

Homelessness & Housing Alliance

Coordinated Entry System Procedure & Workflow

Revised 04/2026

Purpose

- The purpose of this document is to guide local Stakeholders serving persons experiencing homelessness or at-risk of homelessness through the Coordinated Entry System implemented by the Okaloosa Walton Homeless Continuum of Care and operated by Homelessness & Housing Alliance. This document contains an overview of the system workflow. Homelessness & Housing Alliance (HHA) established a centralized intake system for Okaloosa and Walton Counties, named One Way Home.
- HUD requires each Continuum of Care to establish and operate a “centralized or coordinated assessment system” (referred to as coordinated entry or coordinated entry process) with the goal of increasing the efficiency of local crisis response systems and improving fairness and ease of access to resources, including mainstream resources. A CoC’s coordinated entry processes are intended to help communities prioritize people who are in the most need of assistance. This system also helps provide information to the CoC and other stakeholders about service needs and gaps in services to help strategically allocate their current resources and identify the need for additional resources. In January 2017 HUD released Notice: CPD-17-01 titled *Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System*. This Notice establishes additional requirements for coordinated entry, as authorized under 24 CFR 578.7 (a)(8). Each CoC must establish or update its coordinated entry process in accordance with the requirements of 24 CFR 578.7 (a)(8) and this Notice by January 23, 2018. As required under 24 CFR 576.400 (d) and 578.7(a)(8), each CoC and each ESG recipient operating within the CoC’s geographic area must also work together to ensure the CoC’s coordinated entry process allows for coordinated screening, assessment and referrals for ESG projects consistent with the written standards for administering ESG assistance.
- The CES System is intended to increase and streamline access to housing and services for households experiencing homelessness or at-risk of becoming homeless, match appropriate levels of housing and services based on their needs, and prioritize persons with severe service needs for the most intensive interventions. It helps communities prioritize assistance based upon vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. The CES also provides information about service needs and gaps to help communities plan their assistance and identify needed resources
- Homelessness & Housing Alliance identified the following common goals for One Way Home:
 - Reduce the length of time people experience homelessness;
 - Reduce new entries into homelessness through coordinated system wide diversion and prevention efforts;
 - Prevent people experiencing homelessness from entering and exiting multiple programs before getting their needs met;
 - Foster increased collaboration between homelessness assistance providers; and
 - Improve the community’s ability to perform well on Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act outcomes and make progress on ending homelessness
- HEARTH Act information and updates can be found at <https://www.hudexchange.info/homelessness-assistance/hearth-act/>

HHA designed One Way Home to:

- Cover the entire geographic area of Okaloosa and Walton Counties and be easily accessed by anyone seeking housing or services;
- Be well advertised in order to allow anyone who needs assistance to know where to go to get that assistance, to be assessed in a standard and consistent way, and to connect with housing services that best meet their needs;
- Be easy on the client, and ensure that clients gain access as effectively and efficiently as possible to the type of intervention most appropriate to their immediate and long-term housing needs;
- Ensure clarity, transparency, consistency, and accountability for homeless clients, referral sources and homeless service providers throughout the assessment and referral process;
- Facilitate exits from homelessness to stable housing in the most rapid manner possible given the available resources;

- Ensure that people who have been homeless the longest and/or are the most vulnerable have priority access to scarce permanent supportive housing.
- The goal of the coordinated entry process is to provide each consumer with adequate services and support to meet their housing needs, with a focus on returning them to housing as quickly as possible. The following are the guiding principles for this system:

Full Coverage: One Way Home covers the entire geographic area of Okaloosa and Walton Counties and contains access points and opportunities for persons in need of housing or services to access the system regardless of where they reside in the CoC. Persons in need will be notified through various marketing tools and media sources of how to access the system in their area. HHA will make efforts to increase the number of access points and locations available to clients in more rural areas and provide transportation assistance for those with transportation barriers. HHA also promotes mobile outreach access through street outreach teams and initiatives so that persons that live solitary lives and do not seek out services on their own are able to be informed of the services available and how to access those services. All points of access, whether physical, virtual, or mobile must offer the same assessment approach and be usable by all people who may be experiencing homelessness or at risk of homelessness.

Consumer Choice: Consumers will be given information about the programs available to them and have some degree of choice about which programs they want to participate in. They will also be engaged as key and valued partners in the implementation and evaluation of coordinated assessment through forums, surveys, and other methods designed to obtain their thoughts on the effectiveness of the coordinated assessment process.

Barrier Free Access: One Way Home is intended to connect ALL eligible households with available housing as quickly as possible without any preconditions or barriers to entry such as sobriety, service participation, or treatment.

Transparency: Program eligibility, assessment, prioritization, selection and denials are required to be in writing, per policy and transparent. Make thoughtful decisions and communicate directives openly and clearly.

Promote client-centered practices: Every homeless person should be treated with dignity, offered at least minimal assistance, and participate in their own housing plan. Provide ongoing opportunities for consumers' participation in the development, oversight, and evaluation of coordinated assessment. Consumers should be offered a choice whenever possible.

Priority: Prioritizing the most vulnerable as the primary factor among many considerations- Limited resources should be directed first to persons and families who are most vulnerable*. Less vulnerable persons and families will be assisted as resources allow.
*Vulnerability will be defined locally.

Collaboration: Because coordinated assessment is being implemented system wide, it requires a great deal of collaboration between the CoC, providers, mainstream assistance agencies (e.g., Department of Health and Human Services, hospitals, and jails), funders, and other key partners. This spirit of collaboration will be fostered through open communication, transparent work, consistently scheduled meetings between partners, and consistent reporting on the performance of the coordinated assessment/entry process.

Accurate Data: Data collection on people experiencing homelessness is a key component of the coordinated assessment process. Data from the assessment process that reveals what resources consumers need the most will be used to assist with reallocation of funds and other funding decisions. To capture this data accurately, all assessment staff and providers must enter data into HMIS (with the exception of some special populations) in a timely fashion, within 48 hours. Consumers' rights around data will always be made explicit to them, and no consumer will be denied services for refusing to share their data.

Performance-Driven Decision Making: Decisions about and modifications to the CES process will be driven primarily by the need to improve the performance of the homelessness assistance system on key outcomes. These outcomes include reducing new entries into homelessness, reducing the length of episodes of homelessness, and reducing repeat entries into homelessness. Changes may also be driven by a desire to improve process-oriented outcomes, including reducing the amount of waiting time for an assessment.

Housing First: The most successful model for housing people who experience chronic homelessness is permanent supportive housing using a "Housing First" approach, which is a client-driven strategy that provides immediate access to housing without requiring participation in psychiatric treatment, treatment for sobriety, or other service participation requirements. After

settling into housing, consumers are offered a wide range of supportive services that focus primarily on helping them maintain their housing. Coordinated assessment will support a housing first approach and will thus work to connect households with the appropriate permanent housing opportunity, as well as any necessary supportive services, as quickly as possible.

Prioritizing the Hardest to House: Coordinated assessment referrals will prioritize those households that appear to be the hardest to house or serve for program beds and services. This approach will ensure an appropriate match between the most intensive services and the people least likely to succeed with a less intensive intervention, while giving people with fewer housing barriers more time to work out a housing solution on their own. This approach is most likely to reduce the average length of episodes of homelessness and result in better housing outcomes for all.

Staffing Roles and Expectations

Continuum of Care - Recognizing the need to stimulate community-wide planning and coordination of programs for individuals and families who are homeless, the U.S. Department of Housing and Urban Development (HUD) in 1999 instituted a requirement for communities to come together to submit a single, comprehensive application for HUD funds for housing and support services for people who have experienced homelessness. The organizational concept to embody this effort is the Continuum of Care (CoC), which is governed by a Board of Directors composed of representatives from across the community. As a result of its strong leadership, access to resources and high level of visibility in the community, Homelessness & Housing Alliance is the area's lead agency for the CoC. The CoC encompasses Okaloosa and Walton counties, and its purpose is to:

- Promote a community-wide commitment to the goal of ending homelessness;
- Provide coordination among the numerous regional organizations and initiatives that serve the homeless population, and create the region's single, comprehensive grant application to HUD for McKinney-Vento funding.

Coordinating Entity - Homelessness and Housing Alliance is the designated *Coordinating Entity*. The Coordinating Entity is responsible for the day-to-day administration of One Way Home, including but not limited to the following:

- Creating and widely disseminating materials regarding services available throughout Okaloosa and Walton Counties and how to access those services;
- Designing and delivering training at least annually to all key stakeholder organizations, including but not limited to the required training for Access Points;
- Ensuring that pertinent information is entered into HMIS for monitoring and tracking the process of referrals including vacancy reporting and completion of assessments;
- Managing case conferences to review and resolve rejection decisions by providers and refusals by clients to engage in a housing plan in compliance with receiving program guidelines;
- Managing an eligibility determination appeals process in compliance with the protocols described in this manual;
- Managing manual processes as necessary to enable participation in the *One Way Home* by providers not participating in HMIS;
- Designing and executing ongoing quality control activities to ensure clarity, transparency, and consistency in order to remain accountable to clients, referral sources, and homeless service providers throughout the coordinated access process;
- Periodically evaluating efforts to ensure that One Way Home is functioning as intended;
- Making periodic adjustments to One Way Home as determined necessary;
- Ensuring that evaluation and adjustment processes are informed by a broad and representative group of stakeholders;
- Updating policies and procedures; and
- Selecting a staff member to serve to coordinate the system, provide trainings, and implement changes necessary to system improvements

Providers - Housing providers who wish to or are required to participate in One Way Home by accepting referrals from One Way Home.

Participation Requirement

- All providers receiving funding through HHA are required to participate in One Way Home as a designated Access Point, meaning routinely assessing and referring needs seeking clients to Coordinated Entry, even if provider agency cannot directly assist the client. Failure to participate in all requirements listed in this section and document could result in revocation of agency funding or HMIS licensure.
- Accept referrals from the By Name List for RRH or PSH programs
- Must respond to referrals and participate in regular case conferencing meetings
- All agency case managers (or supervisors if case managers are unavailable) are required to actively participate in BNL case conferencing meetings every month
- Must utilize HMIS and should enter all data within 48 hours of a service or outcome being achieved
- Must maintain data quality standards in HMIS
- Update and maintain information on program vacancies/opening. This must be done on a weekly basis
- Providers must provide written documentation to HHA Staff (CE Specialist/Program Director) within 3 business days on why applicant was denied entry into a program
- Providers must have an appeal process for those that have been denied service or entry into a program
- Update and make available all programs eligibility and contact information so proper referrals can be made
- Oversee provision of housing services for eligible clients
- Notify HHA within 48 hours when a participant becomes housed. Notify HHA CE Specialist and/or Program Director by email within 48 hours when a participant becomes housed, is deemed ineligible for referred program, is unreachable, or declines services.
- Bring all suggestions, problems, and concerns to HHA Program Director as soon as possible.
- Partner agencies/Access Points agree to utilize Coordinated Entry Tools provided on HHA Website, listed under Member Resources, to ensure proper input of data and procedures in HMIS.

Partner Providers

Provider agencies* who wish to or are required to participate in One Way Home by completing assessments and making referrals to One Way Home and other community resources. *See the agency Participation Requirement section above.

Responsibilities

- Enter VI-SDPAT assessments and scores into HMIS within 48 hours of completing an assessment
- Participate in Coordinated Entry Case Conferencing meetings for joint staffing of clients on the BNL
- Notify the Program Director/Coordinated Entry Supervisor of any problems or concerns
- Oversee the provision of homeless diversion and prevention as well as referrals to mainstream resources and basic life needs.
- Must use the VI-SDPAT, board approved data collection forms, and referral/information-sharing systems produced by HHA and used by all other Partner Providers. ***The assessment tool is being reevaluated at this time and will be submitted for board review and approval.***

Target Population

One Way Home is open to all households who meet the HUD definition of homeless, as outlined in the HEARTH Act regulations, and have incomes below 30-50% of the Area Median Income or 200% poverty level. The system uses the CoC Board Approved Assessment Tool/VI-SPDAT and other indicators to rank Applicants in order of vulnerability, with the most vulnerable households ranked at the top. Applicants may be offered housing regardless of vulnerability score, but the most vulnerable persons will be offered housing first.

Incorporating Client-Centered Approach

To meet HUD Guidelines One Way Home reinforces a Client-Centered Approach throughout the Coordinated Entry System by:

1. Using assessments that are based in part on participants' strengths, goals, risks, and protective factors.
2. Using tools and processes that are easily understood by participants being assessed and referred, in addition to using required accessible formats for persons with disabilities. HHA will provide appropriate auxiliary aids and services necessary to

ensure effective communication, which includes ensuring that information is provided in appropriate accessible formats needed such as Braille, audio, large type, assistive listening devices, and sign language interpreters. Assistive technology can be utilized through Florida Relay.- [Florida Relay](#) will provide residents in the State of Florida who are Deaf, Hard of Hearing, Deaf/Blind, or Speech Disabled that connects them to standard (voice) telephone users. Using highly trained Operators, calls can be made 24 hours a day, 7 days a week, 365 days a year.

3. Including sensitivity to participants' lived experiences in every aspect of One Way Home, including the development of assessment tools and delivery protocols that are trauma informed, minimizing risk and harm, and address psychological impacts.

4. Including participants' choices in One Way Home decisions such as location and type of housing, level and type of services, and other program characteristics, as well as assessment processes that provide options and recommendations that guide and inform participant choice as opposed to rigid decisions about what participants need.

5. Including a uniform referral process that ensures that participants easily understand which program they are being referred to, what the program expects of them, what they can expect of the program, and evidence of the program's rate of success.

6. Including a commitment to successfully completing the referral process once a referral decision has been made through One Way Home, including supporting the safe transition of participants from an access point or emergency shelter to housing, and supporting participants in identifying and accessing suitable project in the instance of an eligible participant being rejected by a participating project. Transition and/or transportation is provided solely on a case-by-case scenario, if funding and staff is available, and in certain emergent situations to be assessed by HHA staff as incidents present themselves. When an eligible participant is rejected, the cause will be researched by HHA staff to make sure all rejections are with just cause and in compliance with policies.

Rejections New section added 12/23/23.

In the case of any type of rejection of a client, HHA will document all interaction with any provider and client and investigate the reason the client was rejected from the program.

This includes but is not limited to:

- unavailability of funds
- providers, hotels, or shelters who refuse clients that has previously violated the respective rules or bylaws of said hotels or shelters,
- non-compliance of client,
- any other applicable reason for a client to be rejected for any type of program.

This policy holds harmless any provider or hotel/shelter who provides just reason for rejection.

Housing Navigation new section added 4/25

HHA staff Housing navigator will work with partner agency case managers to find affordable housing units that fit client needs. Housing Navigator will attend BNL case conferencing meetings and follow up with agencies who have accepted referred clients to their respective housing programs to coordinate client housing needs.

Access Points

Places (virtual or physical) where an individual or household in need of assistance can access the coordinated entry system.

By definition, a coordinated entry process must cover the entire CoC geographic area and be easily accessible for all individuals and families seeking housing or services. In order to make the system easily accessible for all those in need One Way Home established Access Points throughout the CoC. Access Points are agencies and locations that have agreed to perform assessments for One Way Home. Access Point agencies are responsible for ensuring that all households experiencing homelessness or at-risk of homelessness have prompt access to intake and assessments. Assessments should be administered in a safe, welcoming, private environment. Assessors have signed agreements with HHA that outline responsibilities and expectations of both parties. These agreements contain the policies regarding client confidentiality, informed consent, and timeline for entry data into HMIS. Assessors should make any non-housing referrals at the time of client contact and record the referral in HMIS or client file.

Access Points must be accessible to individuals who use wheelchairs, as well as people in the CoC who are least likely to access homeless assistance.

HHA encourages Access Points to ensure One Way Home can be accessed by persons with Limited English Proficiency. 7-1-1 may be contacted for LEP participants that need assistance. (HHA staff contacted 7-1-1 Florida Relay services to ensure the availability of these services.

Access Points in Okaloosa and Walton counties are as follows:

Okaloosa & Walton County Access Points & Resources

Caring and Sharing of South Walton 850-267-2866 ext.206 caringandsharingsowal.org

Food pantry, clothing vouchers, financial assistance, and walk-in assistance hours are MWF 9 am - 2 p.m. Appointments for counseling or assessments need to be scheduled ahead of time a case manager. Case managers can also help with food stamp/Medicaid applications by appointment. Walton county residents are eligible for non-grant-specific food, clothing and financial assistance (rent, utilities, and Rx), counseling and case management, all persons regardless of county residence eligible for assessment. 112 Lynn Dr, Santa Rosa Beach, FL 32459

Catholic Charities of Fort Walton Beach 850-244-2825 ccnwfl.org

Fort Walton food pantry Mon-Thurs. from 9-12 and bagged lunch from 12:30-4 or until out. Hot lunch on Wednesday 1pm, Friday at noon. The Caring Coach goes to Freeport on the first Tuesday of the month, Crestview the second Tuesday, DeFuniak Springs the third Tuesday, Miramar Beach the fourth Tuesday, Cantonment the 4th Thursday. Food stamp application assistance Friday 9-12 for walk in or by appointment. Matthew's Nursery baby pantry for pregnant women can be referred to for assistance with baby items. Rental & Utility assistance screening, call ext. 1. Walk in hours 9-11am 2nd & F 4th Monday of month. Immigration & Adoption Services by appointment. 11 First St SE, Fort Walton Beach, FL 32548

C.A.S.H. - Crestview Area Shelter For the Homeless 850-634-6036 crestviewareashelter.org

Walk-in street outreach services M-W-F 9am-4pm for showers (last call @ 3pm), sack lunches & sacks of cookable food, SNAP assistance, & laundry service for anyone in need. Client access to Crestview Clinic & pay copay. Rx assistance & specialist copay (when able) for HMIS clients & assistance with Baptist Health Financial Assistance applications. Clothing on site which is also stocked with personal hygiene items, and a retail store in Downtown Crestview. Cold night shelter below 40 degrees. Housing assistance assessment by appointment only. 120 Duggan Ave, Crestview, FL 32536

One Hopeful Place 850-586-7879 onehopefulplace.org

Day Program Tues & Thurs 10am-4pm. Sat 12-4pm. Park & Sleep @ OHP - must fill out a P&S Form. (no tents or sleeping on the ground). Ministry services on Sat night. Attendees can stay in Comfort Place for that night. Cold night shelter below 40 degrees. Assessments for assistance by appointment only. Call for shelter bed availability. \$100 charge per week, food included. 1564 North Beal Extension, Fort Walton Beach, FL 32547

Opportunity Place, Inc. 850-659-3190 opifwb.org

Anyone needing assistance should call ext. 1 for an appointment for eligibility screening. Mon- Fri 9am-5pm. Emergency shelter for women and families. OPI staff is trained to complete assessments for the residents staying at the shelter. Call for for appointment availability for assessment. 305 Lovejoy Rd NW, Fort Walton Beach, FL 32548

The Matrix Community Outreach Center 850-892-1090 www.matrixcoc.org

The Matrix offers cold night shelter services, food pantry services, homeless prevention services, and needs assessments. Hours vary. Call for appointment. 37 N 9th St, Defuniak Springs, FL 32433

Freedom Life Compass 850-420-8280 <https://www.freedomlifecompass.org/>

Transitional housing, halfway house, and emergency shelter for women.

Salvation Army 850-243-4531 <https://southernusa.salvationarmy.org/fortwaltonbeach/>

Food assistance, case management, rental and utility assistance, and access point for coordinated entry.

211

2-1-1 is an automated information and referral system available 24/7/365

Our Continuum of Care is Growing

Please visit the Homelessness & Housing Alliance website for a more complete list of Community Resources, updates on Access Point Updates and Hours, as well as services provided. www.hhalliance.org

Homelessness & Housing Alliance of Okaloosa & Walton Counties does not offer direct services but serves as the lead agency for all agencies in our Okaloosa- Walton Continuum of Care. Please call Monday thru Friday 850-409-3070 for questions or concerns or fill out our contact form on our website and someone from our agency will contact you within 24 business hours.



**HOMELESSNESS
& HOUSING ALLIANCE**
Okaloosa & Walton Counties

This information provided by the Homelessness & Housing Alliance of Okaloosa & Walton Counties, the lead agency for the Okaloosa Walton Continuum of Care (COC). HHA is not an access point or provide direct services at their physical location. www.hhalliance.org 850-409-3070

Access Points will that are open to all will be well advertised and physical locations should have privacy policies and consumer feedback options posted where participants can see and read them clearly. Consumer feedback services will be available at these locations and posted on HHA's website <https://hhalliance.org/client-feedback/Access Point information> is frequently updated and accessible at <https://hhalliance.org/get-help/>

STAGES	GOAL	WHEN DONE	TOOL
1.Triage (Diversion)	<p>Designed to reduce the number of persons entering the homeless response by diverting to mainstream resources or prevention services. Tool will either direct households to:</p> <ul style="list-style-type: none"> • Mainstream services • Prevention services • Emergency Shelter services 	First point of contact - after person has identified housing crisis or requested homeless services.	Triage Questionnaire
2. Prevention	Aimed at keeping persons who are at risk of homelessness housed (persons who are either doubled up or in their own housing).	ONLY after Triage Tool has determined Prevention Services would be appropriate.	Prevention Screen
3. Assessment	Assess for linkage to most appropriate supportive housing intervention (Transitional Housing (TH), Rapid-Rehousing (RRH), Supportive Housing (SH), Permanent Supportive Housing (PSH))	After entry into shelter or after prevention screen has determined prevention services can not resolve housing crisis and more intensive support is needed.	VI-SPDAT and CoC Board Approved Assessment Tool
4. Assignment	Linkage to appropriate intervention based on score, CoC priorities, program eligibility and openings <i>based on discussion in the By Name List, referred to housing projects to reflect CoC need, contacted to be screened for eligibility, and prioritized internally by the agency for program openings and/or placed on a waitlist. If a client is deemed to be ineligible, HHA should be notified of this and client can be placed back on the By Name List if still literally homeless.</i>	Household placed on list after completing Housing Assessment and scoring for RRH – PSH.	By Name List

Step 1: A client or provider may contact an Access Point to begin the process. Trained staff at the hubs will determine the participant’s current housing status prior to utilizing the CoC Board Approved Assessment Tool/VI-SPDAT (Vulnerability Index- Service Prioritization Decision Assistance Tool). Once the participant is deemed eligible for housing interventions through One Way Home, the assessment hubs will utilize the CoC Board Approved Assessment Tool/VI-SPDAT in addition to other indicators to inform the most appropriate housing intervention. Assessors will provide service referrals based on the information gathered during the assessment. No client should leave without a referral for services.

Step 2: Referrals will be to housing resource openings, based on discussion in the By Name List, referred to housing projects to reflect CoC need, contacted to be screened for eligibility, and prioritized internally by the agency for program openings and/or placed on a waitlist. If a client is deemed to be ineligible, HHA should be notified of this, and client can be placed back on the By Name List if still literally homeless. This may include grant and non-grant funded housing options. All referrals are done in HMIS. The receiving agency will update HHA staff regarding the housing status of the referred participants. HHA staff will follow up with agencies to determine any changes in circumstances.

Step 3: Receiving Agencies will strive to house referred participants within 30 - 60 days of referral depending on housing ability unless the participant does not meet eligibility for a specific program. If the participant does not meet eligibility for the program to which they were referred, the client will return to the list so that HHA staff may seek another housing option.

Applicants/Clients

- Clients who are in need of homeless prevention or housing services can access information and eligibility criteria through one of the Access Points or call 2-1-1. Applicants seeking assistance must be assessed at one of the Access Points by Access Point Staff or through mobile street outreach programs prior to being referred for assistance.
- Once the participant is scored using the CoC Board Approved Assessment Tool/VI-SPDAT, he or she will be placed in order of vulnerability on the By Name List housed in HMIS (Homeless Management Information System). This is the master list for housing interventions to include Rapid Rehousing and Permanent Supportive Housing. Applicants not eligible for assistance will be referred to other community resources.

Applicants can expect:

- Informed consent regarding the CoC Board Approved Assessment Tool/VI-SPDAT and the referral process
- To be assessed in a private, secure, location that allows for open and honest dialogue
- To be treated with respect and dignity throughout the process
- Their initial phone call for assistance to be answered or returned within 48 business hours
- Their information to be kept confidential and secure
- To be added to the By Name List once assessment has been complete
- To be matched to the most appropriate program for them based upon their needs
- To be given a client information sheet upon completion of assessment that outlines the next steps and process for obtaining housing
- To be referred to other resources for assistance other than housing if participant has other unmet needs.
- To be contacted at least once a month until housed to maintain contact and update status

Client Responsibilities

- Answer all questions truthfully and to the best of your ability
- Notify the **Access Point Staff** of any changes in contact information or status

Eligibility

One Way Home is intended to facilitate access to the most appropriate housing intervention for each household's immediate and long-term housing needs and ensure that scarce permanent housing resources are targeted to those who are most vulnerable and/or have been homeless the longest. One Way Home is open to all households who meet the HUD definition of homeless, as outlined in the HEARTH Act regulations, and have incomes 30-50% of the Area Median Income or 200% of the poverty level. The system uses vulnerability indices to rank Applicants in order of vulnerability, with the most vulnerable households ranked at the top. More directly, applicants may be offered housing regardless of vulnerability score, but the more vulnerable persons will likely be offered housing before non-vulnerable people.

One Way Home utilizes the CoC Board Approved Assessment Tool/VI-SPDAT on literally homeless households.

For purposes of eligibility for One Way Home if a household that presents as "imminent risk of homelessness" they must be able to demonstrate and document they will lose their housing in 72 hours or less, and include households that:

- Have received a court notice of eviction or foreclosure
- Can demonstrate they cannot be prevented from homelessness within 72 hours through the use of homeless prevention or diversion
- Are staying with friends or family AND can document they must vacate within 72 hours (documentation must include a third-party verification of violation)

Participation

All households must be assessed prior to program entry; or, in the case of households in emergency shelters that admit the same day, the assessment must occur as soon as possible after entry, and before being referred to another program.

Assessment Tool

In the context of coordinated entry, assessment refers to the use of one or more standardized assessment tool(s) to determine a household's current housing situation, housing and service needs, risk of harm, risk of future or continued homelessness, and other adverse outcomes.

Okaloosa Walton Homeless Continuum of Care has adopted standardized tools for assessment for literally homeless and at-risk of homeless households. These tools collect only the information necessary to determine the severity of need and eligibility for housing and mainstream services, and that can provide meaningful recommendations to persons being assessed. It is important to note that trauma-informed care approaches should always be used when completing any assessment tool in this CoC. HHA makes every effort to limit the frequency with which a participant must repeat a personal story so as to reduce trauma and improve system efficiency. One Way Home Housing Assessors should make every effort to collect information regarding mainstream services until an assessment is adopted for mainstream services in our CoC. One Way Home is designed to support access to mainstream services.

Only persons trained on using the CoC Board Approved Assessment Tool/VI-SPDAT should use this tool in Okaloosa and Walton Counties. HHA can provide training on using the CoC Board Approved Assessment Tool/VI-SPDAT. Providers that use the CoC Board Approved Assessment Tool/VI-SPDAT should also have reviewed training in trauma informed and motivational interviewing videos, provided by HHA. New trainings for all agencies will be set up for staff in 2025 with reviews for existing staff and a focus on new staff members.

All literally homeless households will be assessed using the correct version of the Vulnerability Index Service Prioritization Decision Assistant Tool (CoC Board Approved Assessment Tool/VI-SPDAT) or Family VISPDAT, created by Community Solutions and OrgCode Consulting. The CoC Board Approved Assessment Tool/VI-SPDAT is a pre-screening, or triage tool that is designed to quickly assess the health and social needs of homeless persons and match them with the most appropriate support and housing interventions that are available.

It is a brief survey that service providers, outreach workers, and even volunteers can use to determine an acuity score for each homeless person who participates. The CoC Board Approved Assessment Tool/VI-SPDAT survey relies on self-reporting from the participants.

All persons administering assessments should use culturally and linguistically competent questions for all persons that reduce cultural and linguistic barriers to housing and services for special populations; youth, individuals with disabilities; and lesbian, gay, transgender, and questioning persons.

The scores can then be compared and used to identify and prioritize candidates for different housing interventions based upon their acuity.

The CoC Board Approved Assessment Tool/VI-SPDAT is live in Okaloosa Walton's HMIS and the CoC Board Approved Assessment Tool/VI-SPDAT HMIS workflow is contained in this document. A Release of Information is required prior to the assessment and must be kept on file along with other client information obtained during the assessment.

The CoC Board Approved Assessment Tool/VI-SPDAT should only be performed in a private and comfortable environment for the participant due to the personal nature of the questions. Participants should be notified of the confidentiality and privacy policies in place.

The CoC Board Approved Assessment Tool/VI-SPDAT should only be used on literally homeless households and not for those seeking homeless prevention or diversion. The VISPDAT should not be used to provide any type of diagnosis or replace any other valid and reliable instrument used in clinical care.

When staff encounter individuals who do not provide a response to any of the first questions, they should stop and acknowledge that the assessment will not provide useful information if the individual receiving assessment does not want to participate. Staff should utilize continued progressive engagement and rapport building with these individuals until they are willing to be assessed.

Consent

An individual must provide informed consent to the client prior to the CoC Board Approved Assessment Tool/VI-SPDAT being completed. You cannot complete a CoC Board Approved Assessment Tool/VI-SPDAT with a client without that person's knowledge and explicit agreement. You also cannot complete the CoC Board Approved Assessment Tool/VI-SPDAT solely through observation or using known information within your organization. Informed consent should include that some of the questions are personal, an explanation that it is important to be honest and the process that takes place after the assessment. The following information should be shared with the participant prior to the assessment.

- Name of the assessor and their agency
- Purpose of the CoC Board Approved Assessment Tool/VI-SPDAT being completed
- 10 minute duration of the assessment
- Only "yes," "no" or one-word answers are being sought
- Where the information is stored within the Homeless Management Information System
- Assessment information will be shared with providers conducting assessments in the COC and the housing providers connected to One Way Home so that the individual does not need to complete the assessment multiple times, that housing providers can identify people to target for housing resources as they come available, and for planning purposes.

If an individual agrees to participate in the coordinated entry process described in its messaging, then they are asked to sign the release of information before proceeding with the assessment.

Release of Information:

The same Release of Information is utilized by all providers to input all Vulnerability Index/Service Prioritization Decision Assistance Tool (CoC Board Approved Assessment Tool/VI-SPDAT) pre-screen assessments and assessments within the HMIS. The ROI can be found in this document.

For participants with language or physical impairment barriers to completing the assessment HHA should be contacted so arrangements can be made as quickly as possible for appropriate assistance. Florida Relay service can be utilized to assist with this.

Refusals:

For instances when individuals refuse specific questions throughout the assessment, One Way Home does allow participants autonomy to freely refuse to answer assessment questions and to refuse housing and service options without retribution or limiting their access to assistance.

Completion of the Assessment Process:

Upon completion of the CoC Board Approved Assessment Tool/VI-SPDAT, the Assessor should provide the participant with the Client Information/Agreement form that will contain written information about what to expect next, referrals to mainstream services, and the score of their assessment. Refer to the Coordinated Entry Script. The individual receiving assessment should be encouraged to continue to engage with their existing case management support. If not currently connected to case management support, Assessors should provide a brief description of the resources currently available within the community and ask if the individual is interested in being referred to those resources.

Assessors should emphasize the importance of having reliable and comprehensive information regarding the best time and place to contact the individual. Staff should collect information on whereabouts across a 24 hour period, beginning with where they

wake up until they bed down at night, with notations for days when location patterns changed, and record that information within the CoC Board Approved Assessment Tool/VI-SPDAT. This includes where meals are obtained, transportation methods and times to and from meal and shelter providers, cross streets of services received, outside agency names and staff with whom they engage, etc.

Assessors may emphasize that while completion of the assessment does not make them now the individual's case manager, it remains critically important that the assessor possesses the most reliable methods possible for locating the individual being assessed, because the Provider agencies will be contacting the participant after they receive a referral from One Way Home.

Assessment for at-risk households

Assessments for households at-risk of homelessness are also performed at access points and via the telephone through 2-1-1. The Prevention/Diversion Assessment is located in this document and is utilized by all Housing Assessors. This should be administered as soon as a household enters an assessment center to determine if they will need shelter or if they can be assisted and housed without having to enter the homeless assistance system.

Scoring/Prioritization

In the context of coordinated entry, scoring refers to the process of deriving an indicator of risk, vulnerability, or need based on responses to assessment questions. HUD requires the coordinated entry process to prioritize homeless persons within the CoC's geographic region for referral to services and housing.

Once a VI-SPDAT/CoC Board Approved Assessment Tool has been completed the assessment is scored by simply adding up the points allocated for the responses self-reported by the participant. The totaled points determine the "score" of the assessment. The score represents the participant's acuity. Now that a score has been established this will be the indices that determines a participant's vulnerability and also triages that participant to the most appropriate housing intervention for them.

Priority Ranking

Approved by Coordinated Entry Committee on 11-7-2024

- 1) Chronically homeless/ serious disability - medical issues
- 2) Homeless families w Children
- 3) Fleeing Domestic Violence
- 4) Veterans
- 5) Unaccompanied homeless youth
 - If a client fits more than one category, rank as the highest priority applicable

Factors that influence prioritization are:

- Significant challenges or functional impairments, including any physical, mental, developmental, or behavioral health disabilities regardless of the type of disability, which require a significant level of support.
- High utilization of crisis or emergency services to meet basic needs, including but not limited to emergency rooms, jails, and psychiatric facilities
- The extent to which people especially youth and children are unsheltered
- Vulnerability to death or illness
- Risk of continued homelessness
- Vulnerability to victimization, including physical assault, trafficking, or sex work

The CoC Board Approved Assessment Tool/VI-SPDAT does not always produce the entire body of information necessary to determine a household's prioritization, either because of the nature of self-reporting, withheld information, or circumstances outside the scope of assessment questions. For this reason, One Way Home allows case conferencing input as long as only information relevant to factors listed under Scoring in this document are used for prioritization.

Tie breakers: In the event that two or more homeless households within the CoC are identically prioritized for referral to the next unit, and each household is eligible for referral to that unit, HHA will refer the household with longest time homeless.

CoC's are prohibited from discriminating based on race, religion, color, national origin, sex, age, familial status, disability, type or amount of disability-related services or supports required, sexual orientation, gender identity, or marital status therefore prioritization should not consider any of these factors.

Scoring Levels:

- Scores 10 and above will be prioritized for PSH intervention or long-term supportive housing
- Scores 5-9 will be prioritized for RRH
- Scores 4 and below will be prioritized for prevention/diversion and other community resources.

One Way Home adopted HUD's Prioritization Notice CPD-016-11 on Prioritizing Persons Experiencing Chronic Homelessness and other Vulnerable Homeless Persons in PSH

One Way Home will not screen people out of the coordinated entry process for any reason including but not limited to, poor rental history, no income, or criminal record.

By Name List

The By Name List is the community-wide, by-name, prioritized list generated during the prioritization process. The By Name List is housed in HMIS and all data privacy and security protections prescribed by HUD in the HMIS Data and Technical Standards to "by-name list" are adhered to at all times. **HHA provides the BNL to providers who do not have a Business Objects license in HMIS.** HHA staff maintains and manages the By Name List and is responsible for ensuring the list is up to date, does not contain any errors, and has the most accurate information available at all times.

The By Name List contains the following data elements:

- Participants name
- CoC Board Approved Assessment Tool/VI-SPDAT Score
- Household type
- # of people in Household
- Assessment location
- Assessment date
- Referral date
- Agency referred to
- Date of Housing
- Special Population distinction (unaccompanied youth, veteran)

All Providers with HMIS access can view the By Name List however only HHA staff can edit the list. Instructions on how to access the Registry in HMIS are contained in this document under the HMIS Workflow portion.

All participants assessed are added to the By Name List within 48 hours of assessment and will remain on the list until they are housed or until the participant notifies HHA that they no longer wish to participate in the system. The By Name List has a section for those scoring into RRH and a section for those scoring into PSH. Households that score lower than a 5 will be added to a different section of the registry and will be given referrals to community resources.

Prolonged stays on waiting lists for housing resources can have a negative impact on the well-being of participants and reduce the overall performance of our homeless assistance system. According to HUD CoCs should keep the time spent on their single, prioritized list for housing resources at 60 days or less. If a community cannot offer a housing resource to every prioritized household experiencing homelessness in 60 days or less, then the CoC will tighten prioritization standards in order to more precisely differentiate and identify for resources those households with the most needs and vulnerabilities.

A Participant that an Access Point has not been able to engage, locate, or contact for more than 90 days will be removed from the By Name List. Access Points may search local correctional facilities, HMIS, hospitals, and facility-based care to try and locate the participant after 30 days of no contact or engagement.

Referrals

[Click here for a Step by step referral to CE process](#)

Referrals made from one provider to another for housing projects, RRH and PSH ***must go through HHA through Coordinated Entry HMIS.***

If it is determined that the household is not appropriate for the housing intervention to which they were referred, the provider agency will email HHA staff with an explanation as to why the client was not appropriate for the program and a request to place them back onto the Prioritization List that is most appropriate.

If the individual/family is not prioritized for any interventions, the provider administering the CoC Board Approved Assessment Tool/VI-SPDAT should explain why and what other services will be available to them (e.g., shelter case management, connection to mainstream resources, help connecting with family or friends). The client should be added to the By Name List. The client should be referred to the appropriate emergency shelter or other housing crisis resource, where they will receive case management and other services to help them access housing. The assessment process ends for the client at this point.

Agencies making referrals to the By Name List will be responsible for following up with the individuals and families they refer in order to determine whether the individual or family is still in need of permanent or transitional housing. Follow-up contact should occur every 30 days. If the referring agency determines that the client's circumstances have changed, they will then notify HHA to ensure the By Name List is updated with the new information. If the individual or family is still in need of housing, the agency should update contact information if necessary. If the individual or family is no longer in need of housing, the agency will email the HHA designated staff member to move the individual/family to the housed section of the Prioritization List. Providers that contact a referral to offer services and find out the household is no longer in need, should email the designated HHA staff to close the referral in HMIS.

It is prohibited for any HUD-funded homelessness assistance programs to serve individuals and/or families experiencing homelessness or who are at imminent risk of homelessness, without the household first going through One Way Home and receiving a referral to the By Name List. This step is to ensure that all households served are documented on the appropriate list.

Declined Referrals

One of the guiding principles of One Way Home is client choice. Individuals and families will be given information about the programs available to them and have some degree of choice about in which programs they want to participate. If an individual or family declines a referral to a housing program, their name remains on the Prioritization List until the next housing opportunity is available. The criteria on the next page (p. 14) can be printed and distributed to clients along with using the "What Happens Next" portion at the end of the CE Script at the end of this document.

One Way Home uses the following criteria to accurately match needs to resources:

Program Name	Population	Priority Populations
Rapid Re Housing HUD	<ul style="list-style-type: none"> • Singles • Families • Youth (18-24) 	<ul style="list-style-type: none"> • Chronically homeless Households • Veteran Households who are not eligible for VA housing services. • Households with children residing on streets or in emergency shelters
Rapid Re Housing Challenge Grant	<ul style="list-style-type: none"> • Singles • Families • Youth (18-24) <p>(Must meet State definition of homelessness and be under 50% AMI)</p>	<ul style="list-style-type: none"> • Chronically homeless Households • Veteran Households who are not eligible for VA housing services. • Households with children residing on streets or in emergency shelters

Program Name	Population	Priority Population
Rapid Re-Housing ESG	<ul style="list-style-type: none"> • Singles • Families • Youth (18-24) 	<ul style="list-style-type: none"> • Chronically homeless Households • Veteran households with children residing on streets or in emergency shelters that are not eligible for VA-funded RRH • Homeless households with minor children in the household

Program Name	Population	Priority Population
Rapid Re-Housing Supportive Services for Veteran Families	<ul style="list-style-type: none"> • Veteran Households 	<ul style="list-style-type: none"> • Literally homeless Veteran households

Program Name	Population	Priority Populations
Permanent Supportive Housing	<ul style="list-style-type: none"> • Any high needs individual with multiple barriers to housing that is literally homeless (lease-based program) • Specialized eligibility requirements: must have 	<ul style="list-style-type: none"> • Individuals with long-term and or multiple episodes of homelessness • Veterans who are not eligible for HUDVASH

	a disability/ chronically homeless	
Program Name	Population	Priority Populations
HUD VASH Supportive Housing	<ul style="list-style-type: none"> Literally homeless Veterans that are eligible for VA Medical benefits 	<ul style="list-style-type: none"> Chronically homeless Veterans

Disclaimer *One Way Home* is designed to assess eligibility for housing programs targeted to homeless persons. It is not a guarantee that the individual/ household will meet the final eligibility requirements for - or receive a referral to - a particular housing option. Emergency Shelters will be utilized as an emergency solution to those who present in crisis.

Data Input within HMIS:

Whether the CoC Board Approved Assessment Tool/VI-SPDAT is first conducted on paper or directly input within HMIS or on website (password protected), all CoC Board Approved Assessment Tool/VI-SPDAT assessments must be recorded in HMIS within 48 hours of when the information was first collected. At each case conferencing meeting, HHA staff will publicly run the results from the By Name List contained in HMIS to ensure this expectation has been met. This includes each field of the four page CoC Board Approved Assessment Tool/VI-SPDAT assessment, and the score and upload all documents into HMIS such as ROI, Face Sheet, and Client Information/Agreement.

Data will be collected on everyone that is assessed through One Way Home. This section, in addition to instructions embedded within the assessment tool, will detail when and how data about clients going through the system will be collected.

The staff member will explain what data will be requested, how and with whom it will be shared, and what the client’s rights are regarding the use of their data. The staff member will be responsible for ensuring clients understand the Release of Information and their rights regarding data confidentiality. If they sign the form, the staff members will begin the assessment process either in HMIS or on paper, with relevant data entered into the data fields in HMIS within 48 business hours.

Some clients should never be entered into HMIS. These include:

- Clients who want domestic violence-specific services should never have information entered into HMIS. The CoC Board Approved Assessment Tool/VI-SPDAT should be done on a paper form, the score recorded, and the form shredded. If the client is being served by a Domestic Violence Service Provider (DVSP), that agency may enter their information into a HMIS-comparable database.
- Clients who do not consent to data sharing should also never have their data entered into HMIS.
- Clients who want a One Way Home Assessment entered into HMIS do have the option of being added under a fictitious name.

Access to parts of each client record or assessment form may be restricted for safety reasons or by client request.

The HMIS Lead will work with participating agencies to train One Way Home partner agencies on accessing the Prioritization List, entering assessments, making referrals in HMIS, and other pertinent HMIS aspects of One Way Home. Agencies that use HMIS will be able to make referrals to HMIS Prioritization List using the “Referrals” feature of the software. Anyone with a HMIS user license can make a referral to the HMIS Prioritization List. Individuals and families being referred to the Prioritization Lists do not need to be enrolled in a program at the agency making the referral.

Housing Placement/Move-In:

Housing providers must record move-in to each permanent housing program within 48 hours of housing placement. The Housing Move-In Date field must be completed for all clients who have moved into housing. “Move-in” means a lease arrangement that has been made, the client has a key or entry ability to lease the unit and that the client has physically slept in

the unit. Housing move in timeliness and accuracy will impact project and system performance outcomes for the Point in Time info for the housing inventory chart, CAPER report, APR report, System Performance Measure reports, and any other reports for a federal funder like the SSVF program where this may affect project outcomes.

- Still Homeless: Clients without a housing move in date are still considered and should be counted as literally homeless.
- Interim Update: The Housing Move-In Date should occur AFTER program entry and should be added via Interim Update Assessment.
- Data Check: HMIS Administrator will provide a quarterly Housing Move In DQ report or upon request if needed.
- Failure to successfully execute HMIS responsibilities will require additional "refresher training" prior to re-licensure. Repeated failure of HMIS responsibilities or failure to attend refresher training will result in loss of HMIS licensure.

Domestic Violence Survivors:

Initial Screening of Domestic Violence Survivors

The domestic violence victim service providers in the CoC may elect to administer the CoC Board Approved Assessment Tool/VI-SPDAT for their clients who are seeking services from other housing service providers in the CoC.

If the DVSP(s) elect to do so, they will follow this procedure:

- When an individual or family contacts a DVSP for housing assistance, a Pre-Screen Form is completed as an initial screen to determine basic eligibility (e.g. screening out those who are over income or non-DV from a DVSP). This form can be completed in person or over the phone.
- If the individual or family meet eligibility (homeless and below income guidelines), the CoC Board Approved Assessment Tool/VI-SPDAT is completed either in person or over the phone.
- If the individual or family meets the threshold for acuity, the DVSP provides the VISPDAT score and a unique anonymous identifier, such as "Safe Place Client-12345," to HHA. DVSP destroys the paper copy of the CoC Board Approved Assessment Tool/VI-SPDAT.
- HHA enters the client's score and identifier into the By Name List. If and when the requested service becomes available for the client, the appropriate housing agency contacts the participant and references the client using the anonymous identifier.
- DVSP contacts the client and tells him or her that the service is available and asks the client if he or she would like to receive the service. The DVSP then communicates the client's intentions to the housing provider. The DVSP will need a signed release of information and waiver of non-disclosure in order to share the client's name with the housing provider for cases in which the client intends to use the housing provider's service.

If the DVSP decides not to administer the CoC Board Approved Assessment Tool/VI-SPDAT to their clients, the DVSP will refer these clients to HHA or another agency within the local region that does administer the CoC Board Approved Assessment Tool/VI-SPDAT.

System Advertisement and Outreach

HHA staff will contact private and public agencies including those in the Continuum of Care, 2-1-1, VA, social service agencies, community centers, churches, and state and/or local government agencies to educate and provide information on available programs. Outreach activities are required to be done a minimum of once per year. These activities can be done in conjunction with the Point in Time Count or at another time as determined by the CoC.

HHA staff is required to coordinate with existing street outreach programs as well as private and public agencies, social service organizations, etc. for referrals, so that people sleeping on the streets are prioritized for assistance in the same manner as any other person assessed through One Way Home. HHA is working to establish additional Access Points (including non-HMIS users) to broaden the reach of the CoC.

HHA is responsible for providing resources/information about One Way Home to 24 hour establishments, restaurants, hospitals, hot meal programs, churches, schools, check cashing locations, and other places known to be frequented by the target population. In addition, HHA staff is responsible to explore various outreach activities such as hosting a booth at local community events, resource fairs, festivals and county fairs to provide information and resources.

Advertisement

Advertisement is to include a minimum of flyers posted at those places stated above (as allowed). Other forms of advertising can include social media, QR codes, newspaper ads, radio, websites, etc. to generate referrals and applications. Advertising is to focus on people experiencing literal homelessness and will clearly state eligibility requirements in an effort to reach the target population as opposed to those who do not meet the criteria. Information about the One Way Home will also be available on the HHA's website www.hhalliance.org.

Grievance Policy:

Client Grievances

This policy refers to client grievances regarding the One Way Home System only. If a client has a grievance regarding a particular agency, they should follow that agency's grievance procedure. The agency completing the screening should address any complaints by clients as best as they can in the moment. Complaints that should be addressed directly by the agency staff member or agency staff supervisor include complaints about how they were treated by agency staff, agency conditions, or violation of confidentiality agreements. Any other complaints should be referred to the Program Director to be dealt with in a similar process to the one described below for providers. Any complaints filed by a client should note their name and contact information so the Program Director can contact him/her to discuss the issues.

Provider Grievances

It is the responsibility of all boards, staff, and volunteers of CoC-funded programs and ESG funded programs to comply with the rules and regulations of the Coordinated Entry System. Anyone filing a complaint concerning a violation or suspected violation of the policies and procedures must be acting in good faith and have reasonable grounds for believing an agency is violating the Coordinated Entry System policies and procedures.

The following procedure applies to Providers, Partner Providers, and the Coordinating Entity:

To file a grievance regarding the actions of an agency, contact the HHA Program Director with a written statement describing the alleged violation of the Coordinated Entry System policies and procedures, and the steps taken to resolve the issue locally. The Program director will contact the agency in question to request a response to the grievance. Once the Program director has received the documentation he/she will decide if the grievance is valid and determine if further action needs to be taken. If the individual or agency filing the grievance, or the agency against whom the grievance is filed, is not satisfied with the determination they may file an appeal with the CoC Board of Directors Chair. This must be done by providing a written statement regarding the reasons for the appeal. The Board Chair will bring the matter to the Board of Directors for discussion and a final decision.

Addressing waiting times through Coordinated Entry

Long wait times make homeless assistance less effective and reduce the overall performance of a community's homeless assistance system. HHA has a scarcity of needed resources, so we should use the coordinated entry process to prioritize which people will receive housing assistance rather than continuing to add people to a long waiting list. For example, if HHA has enough permanent supportive housing to serve 10 new households per month, but 30 households are assessed as needing PSH every month, the coordinated entry process should be adjusted to prioritize approximately 10 households for PSH each month. The other 20 households should be prioritized for other resources available in the community, such as RRH, housing subsidies, or other mainstream resources.

Short waiting times of a few days or weeks might be necessary to properly manage utilization, but waiting times for homeless assistance of several months or years should be eliminated whenever possible.

Although PSH is almost always the most effective resource for people with high levels of vulnerability and high service needs, including those experiencing chronic homelessness, the lack of available PSH should not result in people desponding in shelters or on the streets without further assistance. Most communities face a gap between need and availability based on limited resources. HHA should be proactively taking steps to close these gaps that are identified through the coordinated entry process. For example, if there is insufficient PSH available in the community, HHA should be working with PHAs, other affordable housing providers, and Medicaid-funded agencies to increase the supply of PSH. To the maximum extent possible, existing PSH should be targeted to chronically homeless people based on the severity of their service needs (as described in Notice CPD-16-11). Where there are individuals in PSH who no longer need a high level of services, HHA will pursue “move up” strategies that help those individuals shift to another form of housing assistance, freeing up the PSH assistance for another prioritized household. Implementing effective assessment tools and processes

Expedition of Referral Process for Clients Who Have Obtained Housing/Lease

For clients who have a One Way Home assessment and are working with a case manager at an agency within Okaloosa-Walton CoC who have obtained a lease, these clients should be expedited in the referral process. This entails that upon the instance that a client presents a valid lease that falls within all requirements to be suitable and rent-reasonable, the case manager of said client can message the Coordinated Entry Specialist directly for a referral to a housing program.

Governance

Governing Board: The role of the Governing Board is to make decisions based on input from established committees regarding the implementation of One Way Home and to handle any grievances made about One Way Home. One Way Home is governed by HHA and CoC Board of Directors.

Committees: Committees are comprised of agency representatives from across both Okaloosa and Walton Counties. Each committee provides input to the Governing Board on the development, implementation and evaluation of the One Way Home project.

The role of the Coordinated Entry Committee is to establish shared policies and procedures for data entry sharing and evaluation; to provide input and support to HHA as the Coordinating Entity.

The **Coordinated Entry Committee** made up of CoC Board members will be responsible for evaluating the system annually. The role of the committee is to evaluate the One Way Home, policies and tools; review and present the finding of the evaluation; and make recommendations to the CoC Board for revisions and updates.

Monitoring of Coordinated Entry

The annual monitoring of Coordinated Entry will be conducted by the Coordinated Entry Committee.

Evaluation

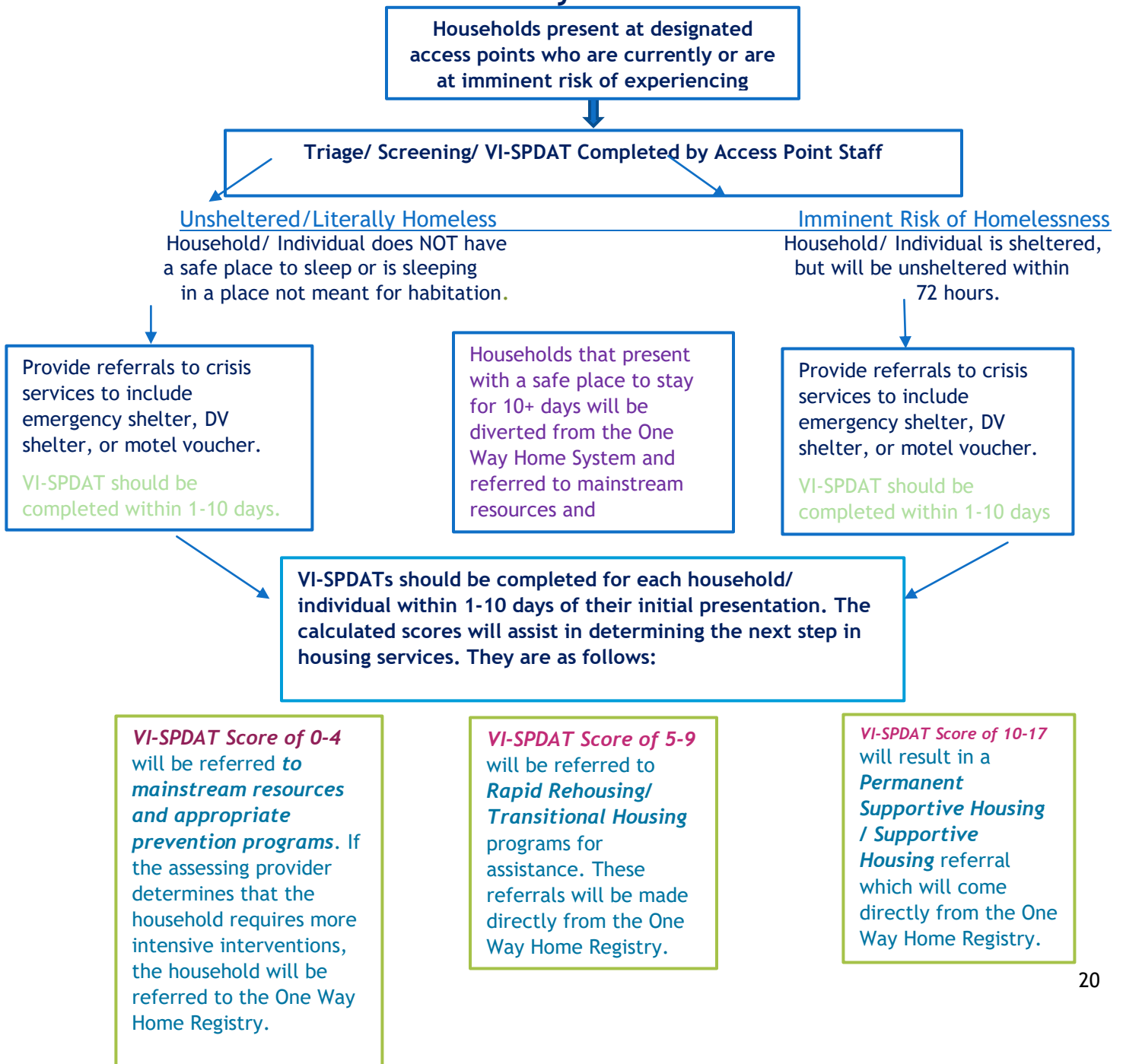
The coordinated entry process will be evaluated on a regular basis to ensure that it is operating at maximum efficiency. Evaluation will be carried out primarily through the CoC Board and any consultants or third parties they engage to help them. Evaluation mechanisms will include the following:

- **A monthly review of metrics from the coordinated entry process.** The data to be reviewed, and the thresholds that should be met, will be developed based on this document.
- **A report issued to the community every six months on coordinated assessment and homelessness assistance system outcomes.** This report will include trends from the month-to-month analysis of coordinated entry data, as well as the

total number of assessments and referrals made, successes to be shared, and a note on the process's progress. Major findings from this report should be presented at the CoC meetings in the quarter it is released.

- **An annual report on the homelessness assistance system with a section devoted to coordinated assessment.** Major findings from this annual report should be presented at the CoC Board meeting the month it is released

One Way Home Workflow



Unaccompanied Youth and Family scores should be compared ONLY with other Youth and Family scores respectively

Client Informed Consent & Release of Information Authorization Homeless Management Information System (HMIS)

_____ is a Partner Agency in the Homeless Management Information System (HMIS). HMIS is a shared homeless and housing database system administered by Homelessness & Housing Alliance (HHA). HMIS can improve the services and programs for homeless and low-income households by allowing authorized staff at Partner Agencies to share client information and to follow trends and service patterns over time. HMIS operates over the internet and uses many security protections to ensure confidentiality.

Participation in the HMIS program is important to our community's ability to provide you with the best services and housing possible. As you receive services, basic information (referred to as Universal Data Elements [UDEs] are listed below) will be collected about you, the services provided to you, and the outcomes these services help you to achieve.

1. Name
2. Social Security Number
3. Date of Birth
4. Race
5. Ethnicity
6. Gender
7. Veteran Status
8. Disabling Condition
9. Residence Prior to Project Entry
10. Project Entry Date
11. Project Exit Date
12. Destination
13. Personal ID
14. Household ID
15. Relationship to Head of Household
16. Client Location Code
17. Length of Time on Street, in an Emergency Shelter or Safe Haven

As stated in our Notice of Privacy Policy, we are required by law to maintain the privacy of this information and explain how, when and why we may use or disclose any of this information.

- Your name and other identifying information will not be shared with any agency not participating in the system (unless required to do so by law).
- Your name, gender, race, social security number and date of birth and other UDEs may be shared with Partner Agencies for Identification purposes even if you elect not to share other sensitive information.
- Sensitive information, such as diagnosis or treatment or mental health disorders, drug or alcohol disorders, HIV/AIDS, or domestic violence concerns, will not be shared between Partner Agencies without specific written consent.*
- A list of Partner Agencies is available upon request.
- Authorizing your information to be entered into the HMIS is voluntary.
- Refusing to do so will not limit your access to shelter or services.

Please initial ONE of the following levels of consent:

(1) I give authorizations for my basic information (UDEs) to be entered into the HMIS and shared between Partner Agencies. I understand that I have the right to receive a copy of all information shared between the Partner Agencies.

(2) I give authorization for my basic and relevant information to be entered into the HMIS, but not shared between Partner Agencies.

I understand that I may cancel this authorization at any time by written request, but the cancellation will not be retroactive. I understand that I have the right to view my HMIS record and will have a report prepared within 72 business hours of my written request. I understand that if I refuse consent to share this information I cannot be denied services. I understand that this release is valid for 5 years from the date of my signature.

<p>Print Name of Head of Household _____</p> <p>_____</p> <p>Signature Date _____</p> <p>_____</p> <p>Print Name of Additional Member _____</p> <p>_____</p> <p>Signature Date _____</p>	<p>Print Name of Spouse _____</p> <p>_____</p> <p>Signature Date _____</p> <p>_____</p> <p>Print Name of Additional Member _____</p> <p>_____</p> <p>Signature Date _____</p>
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This assessment tool will be used to determine if a household needs prevention or diversion assistance. This should be administered as soon as a household enters an access point to determine if they will need shelter or if they can be assisted and housed without having to enter the homeless assistance system. Prevention assistance should be targeted to those households that most closely resemble the households already in shelter.

Instructions for the person administering the tool are in red.

Start by gathering required data to begin HMIS entry and creating an identifier for the household/household members.

Introductory Questions

1. Are you homeless (living on the street, staying in an emergency shelter or transitional housing program, fleeing domestic violence) or at-risk of homelessness?

Yes No

If the household is not homeless or at-risk, refer to other mainstream resources.

2. Where did you stay last night?

With a friend/family member/other doubled up situation

Skip to Diversion Questions.

A hospital

Jail/prison

Juvenile detention facility

In a hotel/motel

In a foster care/group home

In a substance abuse treatment facility

In my own housing - rental

Skip to Prevention Questions.

In my own housing - owned

Refer household to foreclosure prevention resources if necessary.

“ In a car, on the street, or in another place not meant for human habitation

“ In other housing _____

Ask household to define “other housing.”

3. **What brought on your housing crisis?**

“ Problems with landlord

If yes, ask what specific issues are. Interpersonal? Disputes about the unit? Problems being caused by the tenant? Not paying rent? Make a note of the answer. Use this answer to determine what kind of mediation or conflict resolution is necessary.

“ Have rental or utility arrears (circle which)

If yes, list amount owed: \$_____

“ Evicted or in the process of being evicted from a private dwelling or housing provided by family or friends

“ Victim of foreclosure on rental property

If yes, skip to Diversion Questions.

“ Living in housing that has been condemned

If yes, skip to Diversion Questions.

“ Unable to pay rent

“ Experiencing high overcrowding

If yes, determine extent of overcrowding in the unit. If situation seems untenable, skip to Diversion Questions.

“ Violence or abuse occurring in the family’s household

If the household is in immediate danger, refer them to law enforcement and/or the appropriate domestic violence provider.

“ Other _____

Ask household describe “other.”

Diversion Questions

4. **Are you safe in your current living situation?**

Yes “ No

If no, but household is otherwise eligible for diversion, divert them to a location other than where they are currently staying and make sure that it is somewhere where the household feels safe.

5. **Is there anyone else you and your family could stay with for at least the next three (3) to seven (7) days if you were able to receive case management services/transportation assistance/limited financial support?**

“ Yes “ No

Help family think through potential places - with family, friends, co-workers. Have them identify what barriers they think exist to staying in a certain location and how they might be overcome.

If answer to this question is yes, household qualifies for diversion assistance. Skip to Concluding Questions.

If answer to this question is no and shelter diversion has therefore been ruled out, go to Prevention Questions.

Prevention Questions

6. Are you safe in your current living situation?

Yes No

If no, admit or refer to emergency shelter.

7. Do you believe you will become homeless within the next three (3) days?

Yes No

At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

8. Have you ever been to a shelter or another homeless assistance program before?

Yes No

At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

9. If you answered yes to the previous question, what was the name of the program?

When were you last there? ____/____/_____

10. Household income is at or below 30 percent of AMI

Yes No

add one (1) point/tally mark if answer is yes.

11. Has household experienced homelessness in the last 12 months?

Yes No

At the bottom of this sheet, add one (1) point/tally mark if answer is yes.

The total points needed to be eligible for prevention should be adjusted accordingly as additional questions are added to this tool. Some examples of questions to be added:

- Prior living situation matches most common prior living situation of sheltered households (look at response to question two)
- Trigger of housing crisis matches most common housing crisis for sheltered households (look at response to question three)
- Household composition matches that of sheltered households (singles vs. families, age of head of household, number of children, etc.)

Total Prevention Points: _____

Provide prevention assistance if household has at least three points (remember to adjust the number of points necessary if adding additional questions).

Concluding Questions - Case Manager Only

1. Does client qualify for diversion assistance?

Yes No

If no, attempt to make appropriate referrals to other available community/mainstream resources.

2. **If so, what kind of assistance do they need initially to be successfully diverted?**

- Landlord mediation
- Conflict resolution with potential roommate
- Rental assistance (Amount _____)
- Utility assistance (Amount _____)
- Other financial assistance (Amount _____)
- Other assistance (Define: _____)

3. **Does client qualify for prevention assistance?**

- Yes No

If no, attempt to make appropriate referrals to other available community/mainstream resources.

4. **If so, what kind of assistance do they need initially to be successfully diverted?**

- Landlord mediation
- Conflict resolution with potential roommate
- Rental assistance (Amount _____)
- Utility assistance (Amount _____)
- Other financial assistance (Amount _____)
- Other assistance (Define: _____)

This concludes the assessment.

Follow-Up Form (Case Manager/Assessment Staff Only)

1. **Was the household diverted from entering shelter? (If no, skip to question two).**

- Yes No

If yes, to where:

- Friend's house
- Family member's housing
- Previous housing
- Other (please describe): _____

How long were they in this housing? Number of days: _____

2. **Did the household receive prevention assistance?**

Yes No

What type?

Utility assistance in the amount of \$_____

Rental assistance in the amount of \$_____

Security deposit in the amount of \$_____

Moving costs in the amount of \$_____

Other \$_____

After 30 Days...

1. **Did they find permanent housing?**

Yes No

After 90 Days...

1. **Have they come back to shelter/the homeless assistance system since being diverted?**

Yes No

2. **Are there whereabouts known?**

Yes No

3. **If they are known, where do they live currently?**

Remained in initial housing

Relocated to different permanent housing unit

In homeless assistance system

4. **If they “remained in initial housing” or “relocated to different permanent housing unit,” how long have they been there? Number of Days: _____**

Coordinated Entry – Access Point Script

HHA highly recommends that all partner agencies post this near your agency phone where the person answering incoming calls can review.

“Good morning/afternoon, thank you for calling _____.

This is _____, how can I help you today?”

Then, depending on client need, please provide them with one of the following:

- Your shelter openings, food pantry info, or outreach service information
- An appointment date and time for a One Way Home Assessment.
- A promise that someone will call them back within a certain amount of time to make an appointment for a One Way Home Assessment
- A phone number to another agency in our CoC that is physically closer to them to contact for assistance or a One Way Home Assessment
- If the client is residing outside of our service area of Okaloosa and Walton Counties, please give them the number to HHA so we can refer them to a CoC in their area. 850-409-3070

In addition to the above, you should always give them the link to our website hhaliance.org/get-help/

(If you google “Homelessness & Housing Alliance” the site comes up and the link for “Get Help” is at the top of the HHA homepage.) Also, clients can call 211.

Remember, our CoC has a No Wrong Door policy. Agencies should never turn clients away. Even if your agency does not have funding for the specific need of the client, we should never answer them with “We don’t have funding” and a hang up or “We don’t do that.”

A "No Wrong Door" policy in the context of homelessness means that anyone experiencing homelessness can access services and support at any point of entry, regardless of which agency or shelter they initially contact, ensuring they are assessed and directed to the most appropriate assistance based on their needs, without having to navigate a complex system of multiple entry points.

If you have questions or do not understand why it is of utmost importance that as the first line of contact, answering the phone a CoC agency.

More on understanding and exercising the No Wrong Door policy:

“No Wrong Door” as a foundation of care provides an often-essential element to service provision, above and beyond the strict commitments of a community service agreement, grant or contract. In so doing, we aim to provide a timely, flexible and streamlined response to better assist people towards recovery, housing and wellbeing.

The essential ingredients for a No Wrong Door approach are:

1. **A more client-centered approach to service provision;**
2. **Service user involvement in program design and development;**

3. **Respectful engagement with clients by all homelessness staff;**
4. **Greater visibility of homelessness services in the community;**
5. **Better integration and coordination with mainstream services;**
6. **Easy to understand eligibility criteria, particularly for those with complex needs;**
7. **Use of system-wide and simplified intake, assessment and referral documents and processes;**
8. **More flexible and responsive service models that meet client needs;**
9. **Annual reviews of client satisfaction with service provision;**
10. **Provision of basic amenities to clients such as access to bathroom, kitchen, tea and coffee.**

Resources and capacity: There are three key elements to managing the demand for social housing and support:

1. **Worker capacity;**
2. **Client demand; and**
3. **Managing the expectations.**

As client demand increases, worker capacity decreases. The result is often a change in the service response:

- **The worker provides reduced support and assistance;**
- **The worker provides inconsistent or generic telephone support;**
- **The work is more time-limited, but the client needs may be ongoing;**
- **There is a reduced capacity to achieve service obligations and client outcomes;**
- **The increased workload can also quickly turn into a workplace health and safety risk.**

To manage expectations, a No Wrong Door approach aims to ensure:

- **Support and assistance are delivered within the capacity of the workers;**
- **There is clarity for clients about the role of support and tenancy workers;**
- **There is clarity in terms of what services they can really provide;**
- **A reliable and consistent standard of service delivery is achieved;**
- **The service operates within the resources available and is sustainable.**

Accessibility:

Housing and homeless services should be accessible to the people who use them, and those services should be tailored to fit individuals to the degree they are required and requested. Organizations need to creatively and flexibly work with people accessing our services to overcome barriers to effectively support people, whether these be physical, emotional, health-related or time-limited.

We can do this by:

- **Establishing an open, transparent and honest relationship with those we serve, setting realistic expectations, establishing roles and responsibilities, and seeking an informed consent when working with others to respond to presenting needs;**
- **Screening for vulnerability and prioritization of services, allowing for rapid response to acute, chronic or high-risk issues with One Way Home Assessments and SPDATS;**
- **Applying assessment practices that are consistent and comprehensive, and identifying an appropriate service response to the situation**

- Responding with respectful adjustment to any presenting impairment, whether related to physical, mobility, emotional, cognitive or other health state;
- Providing an environment that is culturally respectful, family-friendly, child-safe;
- Designing services that meet people where they are, including assertive outreach responses in the community, as well as a suite of engagement and other services to support people in residential settings;
- Building in step-up/step-down service capacity as the intensity of support to people changes over time and circumstances;
- Providing clear communication in a variety of styles, languages and delivery modes;
- Engaging in strategies to promote services with clear information on eligibility, aims and methods, and with an emphasis on providing information to minority and key vulnerable groups who are over-represented in experiencing homelessness;
- Living the principles of dignity, independence, and equal opportunity.

What is One Way Home/a One Way Home Assessment?

One Way Home is the Coordinated Entry System for Okaloosa and Walton Counties. One Way Home was designed to increase and streamline access to housing and services for households experiencing homelessness or at-risk of becoming homeless.

This program provides referrals to community resources/housing programs.

You must go through an access point for an initial assessment of your housing needs before placement.

One Way Home matches participants with the appropriate level of housing support and services based on their needs and prioritizes persons with severe service needs for the most intensive interventions.

What happens next?

After receiving a One Way Home Assessment, individuals and families will be added to the prioritization list. This is NOT a waiting list but a list that prioritizes serving our most vulnerable clients first in monthly staffing meetings. Each person who receives an OWH assessment will receive a phone call within a month with an update of whether or not there is an opening for them. Explain this to clients after assessing.