COORDINATED ASSESSMENT AND HOUSING PLACEMENT
POLICY AND PROCEDURES
SAN DIEGO, CA
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Disclaimer: Policies and procedures are subject to change as the system grows and evolves. See Appendix 8 for a list of substantive revisions.
Section 1: Introduction to San Diego’s CAHP System

1.1 Background

The federal Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 requires that communities develop a coordinated entry system to more efficiently and effectively match the appropriate housing resources to the needs of each homeless individual or family.

Led by the U.S. Department of Veterans Affairs (VA), in partnership with the U.S. Department of Housing and Urban Development (HUD) and the U.S. Interagency Council on Homelessness (USICH), the 25 Cities Initiative mobilized local planning efforts and partnerships to create an effective system for aligning housing and service interventions to end homelessness. The aim of this effort was to assist the top 25 communities with the largest homeless populations in the country to accelerate and align their existing efforts toward the creation of Coordinated Assessment and Housing Placement (CAHP) systems, laying the foundation for ending homelessness in their respective communities.

The San Diego 25 Cities Initiative, launched in June 2014, established the use of a common tool for assessing homeless individuals’ and families’ housing needs, and developed a single database identified as the CAHP System for data sharing, which was used to match homeless individuals/families to available and appropriate local housing resources. The Initiative targeted chronic and Veteran homelessness and was initially implemented in a defined area of Downtown San Diego. The common assessment tool utilized is the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT), which examines and scores an individual’s or family’s vulnerability level and prioritized need for housing opportunities. In January 2015, the Initiative expanded to North County communities.

In February 2016, the 25 Cities Initiative was realigned under the San Diego Regional Continuum of Care Council’s (RCCC). The work continues with the CAHP Advisory Committee which was working alongside 25 Cities to meet the federal goals of having a functioning CAHP system and creating the Opening Doors Advisory Committee to focus on structural systems issues. The new structure streamlined goals and priorities, assigned responsibilities, and regionalized the CAHP system within the community’s Homeless Management Information System (HMIS).

The CAHP system allows for the most efficient targeting of resources, increases coordination across community providers and ensures that consumers have equal access to available housing resources.

While homeless service providers who receive funding from HUD and the VA are required to utilize the CAHP system, an ideal system has participation from all homeless services providers in the region, not just those whose funding requires it. The implementation of the CAHP system region-wide will include outreach and engagement efforts to agencies that serve people who are homeless but who are not already involved in the CAHP system.
1.2 Overview

The CAHP system is made up of four key components:

1. Use of the CAT (currently the Vulnerability Index-Service Prioritization and Decision Assistance Tool (VI-SPDAT) with approved supplemental questions)
2. Housing Navigation and Case Conferencing
3. Housing Referral with Consumer Choice
4. Data Sharing and Communication

Within the CAHP system, consumers are prioritized for the appropriate housing resource based on a score from the CAT and local priorities approved by the RCCC Governance Board (see Section 4.3). The score and prioritization criteria are entered into the HMIS, ServicePoint. The Community Coordinator then assigns the most vulnerable, highest scoring consumer(s) to a Housing Navigator to assist in preparing for housing placement. Once a participant has all documents in place needed for a housing referral, a referral is sent to a staff member who identifies an appropriate and available housing resource, known as the Matcher. The Matcher then facilitates the referral of the participant to the provider of the housing resource, who moves forward with housing placement.

CAHP is a complex system that requires changes at the macro community level and at the micro agency/provider level. The first phase of implementation includes integrating all five of the Key Components of CAHP highlighted in Figure 1, however during the first phase only Permanent Supportive Housing and Rapid Rehousing resources will be included in the Housing Placement components. The second phase of implementation will bring in Transitional Housing and Interim Housing resources.

Figure 1: CAHP System Housing Flowchart
CAHP Program in HMIS
The effective functioning of the CAHP system requires a robust system that supports all aspects of the CAHP process. The region utilizes ServicePoint as its HMIS. The CAHP system utilizes several staff user modules in ServicePoint that function interdependently. Data quality is extremely important. The CAHP data entered in ServicePoint is monitored both by the individual agencies accessing ServicePoint and by CAHP staff in coordination with the Regional Task Force on the Homeless, the HMIS operator.

Housing First
In alignment with HUD and federal guidance, CAHP participating agencies should adhere to Housing First principles. For more information, CAHP participating agencies can utilize tools from United Stated Interagency Council on Homelessness, https://www.usich.gov/tools-for-action/housing-first-checklist:

- Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety (for non AOD programs), treatment or service participation requirements.
- Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

Functional Zero
The goal of Opening Doors San Diego is to end veteran homelessness by December 31, 2016 and to end chronic homelessness by December 31, 2017.

To address these goals, the CAHP System will utilize the definition of functional zero, which states that at any point in time, the number of homeless people experiencing sheltered and unsheltered homelessness in a community will be no greater than the average monthly housing placement rate for homeless people experiencing homelessness in that community.

Section 2: Consumer Assessment
2.1 Overview
Housing a consumer through San Diego's CAHP system begins with the administration of the CAT in the field or at assessment sites by trained staff and volunteers of organizations participating in CAHP. The use of a CAT where all consumers are asked the same set of questions ensures that each consumer is evaluated based on the same information and criteria making is possible to prioritize people for placement into housing placed according to priorities established by the community. Consumer assessment is part of the intake process, during which a consumer is interviewed and entered into the CAHP system. The details of intake, and the process of conducting the assessment, are critical to an appropriate and expedient housing placement for each consumer.
2.2 CAHP Program Eligibility Requirements for Consumers
A) Meet HUD definition of homelessness (See Glossary)
B) Homeless within the San Diego Region
C) Complete the Common Assessment Tool (CAT)
   Note: Completing the CAT is not a requirement for a consumer to engage with a CAHP outreach worker/team. However, for a consumer to benefit from the CAHP system’s housing resources a CAT and a signed HMIS release must be completed and entered into the system.

2.3 Outreach
Participants are able to access the CAHP system through completing the Common Assessment Tool with a member of the coordinated street outreach team. Dedicated staff from various CAHP participating agencies help to ensure that all those experiencing homelessness are being engaged and assessed in a coordinated manner. Outreach staff administer the CAT and enter data into the CAHP Program in ServicePoint. If the CAT is not able to be completed in the field, the outreach worker must ensure that the participant is informed of where they can go to complete the CAT and given a flyer with all assessment site locations. If possible, Outreach Workers should also attend case conferencing meetings. Outreach Workers will add to the By-Name List. See section 3.8 for more information about the By-Name List.

Outreach Process/Case Management
Mobile street outreach is arguably one of the most important aspect of the CAHP system. Without qualified, knowledgeable, enthusiastic, and compassionate Outreach Workers it will be difficult to obtain consumer engagement into the CAHP system.

The main goal of street outreach is to develop trust and meet an individual or family where they are at to create accessibility and reduce potential barriers. Street outreach provides linkages to services and resources in the community.

Outreach agencies develop their own outreach schedule. This schedule is coordinated with other agencies doing outreach to help ensure maximum outreach coverage, but ultimately agencies can choose to work any hours that best fit the agency’s needs.

Once trust and rapport are developed with the consumer the Outreach Worker determines if the consumer is eligible for the CAHP system.

Outreach Workers administer the CAT and has the consumer sign it. Outreach Workers are encouraged to complete the CAT with the consumer. However, at times the Outreach Worker might decide it is more beneficial for the consumer to complete the CAT at a local assessment site. It is acceptable to direct the consumer to the assessment site. If this is done the Outreach Worker should attempt to maintain a liaison with the consumer making sure the CAT was completed. Outreach Workers must ensure that any CATs completed in the field are entered into HMIS, ideally on the same day it was administered but no later than three business days.
The Outreach Worker monitors the consumer in HMIS CAHP program and provides a warm handoff to the Housing Navigator once one is assigned.

All person-to-person exchanges where information is discussed about a consumer will be done in a private manner where other consumers are not present.

2.4 Assessment Sites
If a consumer is unable to complete an assessment in the field with an outreach worker, the consumer is encouraged and supported to visit an assessment site. For a full list of active, current assessment sites throughout the County please see Appendix 3: CAHP Brochure (Assessment Sites and Consumer FAQs).

Open Assessments Sites
An Open Assessment Site is managed by a CAHP participating agency and must have dedicated days and times that homeless individuals and/or families are able to complete the CAT with a trained staff member. Agencies are able to provide certain population restrictions (e.g., adults only, women only, etc.) depending on the consumers they serve. Staff at the assessment site are responsible for completing and entering CATs into the CAHP Program in ServicePoint.

Closed Assessment
A Closed Assessment Site is similar to an open assessment site in that a CAHP participating agency must have the ability for a trained staff member to complete the CAT with those experiencing homelessness, however, the assessments only take place with in-house consumers and/or by appointment not on a drop-in basis. Agencies are able to provide certain population restrictions (e.g., adults only, women only, etc.) depending on the consumers they serve. Staff of the agency administering the assessment is responsible for completing and entering CAT into the CAHP Program in ServicePoint.

2.5 Common Assessment Tool (CAT)
Using a common assessment tool is vital for the CAHP system because it establishes the same baseline for prioritization of all consumers in the system. The approved common assessment tool currently in use for the CAHP system is version two of the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT) for individuals and families. This tool examines and scores an individual’s or family’s vulnerability level and prioritized need for housing opportunities. The CAT also includes approved supplemental questions that address specific local needs for matching consumers with available housing programs and resources.

The CAT is designed to provide a preliminary understanding of a participant’s needs but is not designed to provide the same depth of information as a clinical assessment. The tool has the advantage of being simple to use in the field. Non-clinically trained staff or volunteers should be able to administer the CAT in about 7-10 minutes. The tool is integrated into CAHP Program in ServicePoint so that it can be administered and scored electronically. It can be completed in paper format and entered into ServicePoint after administration. The CAT is found on the CAHP website.
VI-SPDAT Version 2 Scoring Recommendations
The following scoring is the official scoring of the VI-SPDAT provided by the developers of the tool, OrgCode Consulting and Community Solutions.

Individual VI-SPDAT (Grand Total: 17):
0-3: no housing intervention
4-7: an assessment for Rapid Re-Housing
8+: an assessment for Permanent Supportive Housing/Housing First

Family VI-SPDAT (Grand Total: 22):
0-3: no housing intervention
4-8: an assessment for Rapid Re-Housing
9+: an assessment for Permanent Supportive Housing/Housing First

Consumer Confidentiality
Consumer confidentiality must be carefully protected. All of a consumer's personal information is carefully protected and kept in a secure location. Information about consumers is shared only after a consumer has signed a Release of Information form. Because the CAT and the entire CAHP process occurs in the HMIS system, CAHP follows all approved HMIS policies and procedures including using the HMIS release of information form. Consumers who wish to participate in CAHP also sign a coordinated assessment release form described in Section 2.5.

Consumer Boundaries
The CAHP System strongly advises against providing any monetary or other types of financial assistance directly to consumers during all phases of the CAHP system process. All assistance must be provided directly through a social service or housing program.

Common Assessment Tool Release of Information (ROI)
The CAT ROI is comprehensive in that it allows for case conferencing among participating agencies and their staff. The CAHP Community Coordinator keeps an updated list of participating organizations. Consumers can request to view a copy of the list.

A signed ROI must be added to the consumer’s CAHP entry in ServicePoint within three business days of original assessment. Staff must not move forward with entering any consumer data in the CAHP program in ServicePoint without uploading the signed ROI first.

It is not necessary to renew the ROI after it has been signed by the consumer or head of household, unless after a full year the consumer has still not been housed, the consumer must sign a new ROI. If working with a family, or two parent household, the head of household is the signatory of the ROI.
Individuals or families who do not sign the ROI are considered as having refused to complete the assessment and cannot be entered into the CAHP Program in ServicePoint nor access CAHP matching resources. Anyone refusing to sign an ROI or complete the Common Assessment Tool are informed that the goal of CAHP is to make it easier for people to access housing resources, that the housing resources are only accessible by participating in the system and that completing the CAT is a necessary first step in that process. Staff remind consumers that all information is kept confidential and only shared on a need to know basis to ensure that the consumer gets the services and supports they need. The consumer is also be informed that failure to complete the assessment may affect their ability to qualify for priorities or preferences for housing opportunities. An Outreach Worker or other staff member familiar with the consumer will be assigned to actively engage any consumers who refuse to sign an ROI or complete the CAT.

**Outreach CAT Script**

It is important for anyone administering the CAT including outreach workers and staff or volunteers at Assessment sites to communicate the purpose and intent of administering the CAT. All consumers must be informed that completing the CAT is not a guarantee for housing and is not an emergency solution, but a way to ensure that people who are homeless get access to a housing resource that will help them resolve their homelessness once and for all.

Anyone administering the CAT and/or Match Initiation Form (MIF) must communicate the following message or something similar when meeting with consumers to complete the CAT:

“We are here today to talk to you about your housing and service needs. If you give us permission, we will ask you questions about your health and housing. It should take about 7-10 minutes. Participation in the coordinated assessment and housing placement system and completing this screening is completely voluntary, however if you choose not to participate it will limit your ability to access some housing resources. All of your information is kept confidential and only shared on a need to know basis to ensure that you get the services and supports you need. If you feel uncomfortable or upset during the interview, you may ask the interviewer to take a break, skip any of the questions, or stop the interview. At any time you can request that your information be removed from the database by contacting the CAHP Community Coordinator listed on your paperwork. Lastly, please know that completing the common assessment tool and working with a Housing Navigator is not a guarantee of housing and is not an emergency solution.”

**2.6 Assessing a Consumer**

The first step in entering a consumer into the CAHP system is referencing or generating a Unique Client Identifier (UCI) in ServicePoint. This allows the consumer to be entered without exposing personally identifiable information (PII). It is important for the person administering the CAT to confirm that the consumer does not already have a UCI in order to avoid duplication. If the consumer does not have a UCI, the consumer is asked to sign the HMIS ROI and staff will enter his/her name, date of birth and social security number in ServicePoint and generate the consumer’s UCI.
Once a UCI is generated, the consumer is entered in CAHP Program in ServicePoint. Further specific details and instructions on utilizing the CAHP program in ServicePoint are found by completing the CAHP ServicePoint training provided by the RCCC’s HMIS lead agency, the Regional Task Force on the Homeless. More details on training can be found in Section 6: Training.

Reassessing a Consumer
A consumer should be reassessed with the CAT when a major life change occurs that may affect a consumer's score occurs, but not more than every six months. Examples of a major life change include a medical emergency, a major health related diagnosis, increased interactions with law enforcement or institutions, a drug or alcohol relapse, etc.

If a consumer has not accessed the system within 12 months, a reassessment should occur. Other reassessments should only occur at the discretion of the Community Coordinator. Reassessing the consumer from their original assessment may change the consumer's score and prioritization, and in some cases their eligibility for certain types of housing.

Releasing a Score to a Consumer
It is not recommend that the consumer’s score be shared with the consumer after an assessment occurs.

2.7 Document Management
CATs that are completed in hard copy format must be entered into the CAHP program in ServicePoint. Copies of documents and forms (ROIs, CATs and Match Initiation Forms) are available for print through the CAHP San Diego webpage (housingsd.org). Paper forms containing consumer information must be stored in a locking storage container.

Document Retention and Storage
All digital entry and processing of consumer information is protected by the HMIS database and is Health Information and Privacy and Portability Act (HIPAA) compliant, however, it is critical that hard copies of the assessment be appropriately stored and/or disposed of. Per HIPAA guidelines, all paper copies of assessment forms should be stored in a locked container during transportation and for long-term storage. Each agency is required to have their own policy on storing hard copies of the CAT and any other CAHP forms that contain consumer data. Agencies are requested to submit a copy of their document storage policy to their CAHP Community Coordinator.

Individual agency policies must include language that is consistent with CAHP policies, specifically: Any documents containing consumer information must be stored behind two locked doors, one of which should include a locked filing cabinet. If transporting consumer information, the document should be transported in locked boxes. Hard copies of documents must be stored in accordance with laws governing California clinical records in which storage of Protected Health Information (PHI) must be maintained for seven years from the date the consumer signed the ROI.
Anyone wishing to have more details about document retention and storage should refer to their agency’s most recent HIPAA training, privacy compliance policy, or Privacy Compliance Officer.

Section 3: Housing Navigation

3.1 Overview
All individuals and families who score as needing Rapid Rehousing or Permanent Supportive Housing as their housing resource are assigned a Housing Navigator to assist consumers in preparing for housing placement.

It is important to know the difference between an outreach worker and a housing navigator. Typically, the Outreach Worker makes the initial contact with the consumer and administers the CAT, while the Housing Navigator is the consumer’s main point of contact and assists them.

The Housing Navigator is responsible for preparing the consumer in any way possible for housing. The Navigator serves as a liaison between the consumer and the agency that is offering services and housing with the assistance of the Matcher.

The Housing Navigator’s tasks may include talking with the consumer about housing goals, collecting documents, filling out a Match Initiation Form, making referrals and linking the consumer to other helpful resources that may be beneficial for success in housing, and assisting consumers through the matching process. The consumer will almost always need to prepare documentation of some sort, whether proof of homelessness or obtaining an ID. This type of documentation is necessary for most federally funded HUD programs and is required by landlords and housing providers. The Navigator facilitates this through technical assistance, providing transportation services when appropriate, and generally guiding the consumer through obstacles they might not overcome without support.

As the most in-depth advocate a consumer will work with prior to case management, it is important for Housing Navigators to understand and effectively communicate their role. Initial messaging can help to prepare consumers for housing, as well as manage expectations. It is important to explain what the Housing Navigators can and cannot do for the consumer (e.g. can assist with transportation, paperwork, etc.; cannot accelerate the housing placement process once the consumer is ready to be matched).

3.2 Housing Navigation Roles and Responsibilities
For an agency to participate in CAHP by providing Housing Navigators, the agency must have dedicated staff (either full or part-time equivalent) who perform Housing Navigator duties for homeless people enrolled in the CAHP system. Housing Navigators serve as the main point of contact, help collect all documents needed for the individual/family to be placed in housing, prepare that person/family for matching including the completion of the Match Initiation Form, and coordinate the entry of information about the individual’s/family’s status into the CAHP Program in ServicePoint. Housing Navigators also attend case conferencing meetings and add
to the By-Name List. After the housing match is made, the Housing Navigator may provide additional support necessary to finalize the housing placement and assist with the individual’s/family’s entry into the housing program including completing the Housing Placement Form. The Navigator is also expected to assist the consumer in locating a front door or friendly landlord who can accept the subsidy or voucher, if the housing resource the consumer is matched to does not include housing location services. See the CAHP Housing Navigator Job Description for more information, found in Appendix 4: Outreach Worker (OW)/ Housing Navigator (HN) Alignment Packet.

### 3.3 Volunteer Housing Navigator Assistants
Any volunteer working within the CAHP system must work on behalf of a CAHP participating agency, must receive training in CAHP and consumer confidentiality as well as adhere to the standards of each agency’s policies. Per Regional Task Force on the Homeless standards, volunteers may not have access to CAHP in ServicePoint. The ability to directly access the CAHP program in ServicePoint is critical to the role of Housing Navigator; therefore volunteers cannot act in the role of Housing Navigator. Volunteers can, however, be Housing Navigator Assistants. Any volunteer serving as a Navigator Assistant must adhere to the standards of each agency’s policies regarding consumer confidentiality or attending case conferencing meetings where identifying consumer information is discussed. Navigator Assistants can perform such helpful tasks such as aiding in completing CAT hard copies in the field, documentation collection, landlord searching, making referrals to supportive services, or transporting consumers.

Any volunteers who administer the CAT must turn over all blank and completed forms to their volunteer supervisor at the end of their volunteer shift. The volunteer supervisor will ensure it is entered into the CAHP program in ServicePoint, a copy is filed and will provide a copy to a Community Coordinator. At no time should a volunteer take completed forms home with them.

### 3.4 Housing Navigator Assignment
Once a consumer is entered into the CAHP system via completing the CAT and being entered in the CAHP program in ServicePoint, the Community Coordinator assigns consumers, based on their CAT score and local priorities to Housing Navigators. The Community Coordinator takes into account the geographic location of the consumer and the Navigator, caseload, subpopulation expertise and any other reasonable considerations, such as grant requirements that are requested by the agency supplying the Housing Navigator. This is subject to a staff or individual agency’s ability to take on consumers outside of their jurisdiction, grant requirements, or subpopulation expertise. The Community Coordinator notifies the Navigator that an assignment has been made and the assignment is noted in the CAHP program. Housing Navigators can also self-assign available consumers. The Navigator runs a referrals report in ServicePoint to see which consumers are not yet assigned to a Navigator. Navigators must follow all local priorities when assigning themselves a consumer. Picking up assignments may occur at case conferencing meetings. A full caseload for a 1.0 Full Time Equivalent (FTE) Navigator is 20 active consumers.
3.5 Self-Assignments
A Housing Navigator can self-assign a consumer with whom they have rapport or whom they feel might be difficult to locate at a later date, assuming the participant falls into the priority range.

Housing Navigators may not take on more than 25% of self-assignments on their caseload at any given time. This is subject to a staff or individual agency’s ability to take on consumers outside of their jurisdiction, grant requirements, or subpopulation expertise.

3.6 Locating the Participant
Locating a newly assigned consumer should include developing an action plan for finding the consumer based on the information provided during the CAT, input from the person who conducted the CAT, other practitioners who may know the consumer, and the consumer’s history or HMIS profile. This can be done at case conferencing or by contacting providers identified in the consumer’s HMIS profile (contact can only be made with other agencies if the CAT ROI covers this provider). Navigators are also encouraged to check the online inmate database particularly if consumer has a criminal justice history indicated on the CAT or in HMIS and check any emergency shelters.

If a Housing Navigator is having difficulty locating a consumer, they can confer with the Community Coordinator. The Community Coordinator will add this to the agenda of the next case conferencing meeting and send a “Missing Consumer” email blast to all Housing Navigators.

If a Navigator is unable to locate the consumer after 90 days, the consumer will be moved to an inactive status on the Housing Navigator’s caseload. Once moved to inactive status, it is appropriate to begin working with a new consumer. However, if the consumer is located, the Navigator is expected to resume working with them.

3.7 Preparing the Consumer for Referral
Once the consumer has been located, the Navigator should contact them and explain the CAHP system, the stages of housing placement, and the role of the Navigator in this process. The Navigator must confirm the consumer’s identity by asking for a full name and date of birth and providing a photo ID, if available.

The Navigator should review the Housing Documents Checklist (see Appendix 4: Outreach Worker (OW)/Housing Navigator (HN) Alignment Packet) with the consumer, giving them a copy, and work with the consumer to determine an action plan for locating required documents. In the case that a consumer has all their documents on hand, the Navigator moves on to completing a Match Initiation Form (MIF). If possible, it is a good idea to start the MIF during the same encounter. Housing Navigators should not submit a MIF until all mandatory documents are collected and uploaded into the consumer’s profile in ServicePoint.
If no match is available after the Navigator has submitted the MIF, the consumer must wait for a housing unit to open up. During this time, the consumer should remain on the Navigator’s caseload as pending a match. The Navigator must maintain communication with the consumer regularly until the consumer is matched with a housing resource and a warm hand off to a Housing Provider is completed.

A consumer who is newly considering housing may benefit from an early introduction to the process of paying rent, communicating with landlords and neighbors, responsibilities of holding a lease, and long-term housing goals therefore the Navigator should speak with the consumer about these issues.

3.8 Case Conferencing
Case conferencing allows outreach workers, housing navigators and other front line staff to locate missing clients and discuss current clients’ progress and barriers to permanent housing.

All CAHP participating agency Program Managers should ensure that new staff are connected to their Community Coordinator in order to provide proper CAHP 101 training and individual role training. This training is what new staff need to go through before attending case conferencing. In order to have productive case conferencing meetings, all staff who attend case conferencing should have updates on consumer progress for the agency.

All staff in attendance should be ready and willing to take on new assignments. If staff are in regular attendance at case conferencing, it is expected that they take on new assignments from their Community Coordinator and can be counted to that sub-region’s total FTE number of Housing Navigators.

Housing Navigators who attend case conferencing should always be prepared to report on consumer updates, consumer whereabouts, barriers, related housing progress for all consumers on the caseload of their entire agency and add to the By-Name List.

The By-Name List informs the community of the progress in meeting the Federal benchmarks and criteria for ending homelessness among veterans, and serves to inform us of where the homeless Veterans are, and will contain information as to the housing status of each homeless Veteran. For all Veteran By-Name List Policies and Procedures please see Appendix 7.

There should always be one staff member from each CAHP participating agency at each appropriate case conferencing meeting. If a Housing Navigator is not able to attend case conferencing, they must attempt to send an alternate staff in their place. Alternate staff should be prepared to report on consumer updates and whereabouts.

Due to the nature of sensitive consumer information and Protected Health Information (PHI) discussed at case conferencing, only CAHP participating agencies can attend case conferencing. There are currently three case conferencing meetings that occur throughout the County: a downtown non-Veteran case conferencing, a North County non-Veteran case conferencing.
conferencing, and a regional Veteran case conferencing. Additional case conferencing meetings will be added or eliminated as needed.

3.9 Emailing Consumer Information
When emailing about consumers between Outreach Workers, Housing Navigators, Matchers, Providers, or Community Coordinators, one must make every effort to protect consumer confidentiality and de-identify any consumer information. When referring to a specific consumer, only use their UCI number which can be found in Service Point. Consumer first and last initials can also be used alongside the UCI number. This will respect a consumer’s electronic Protected Health Information (PHI) and ensure HIPAA compliance.

For more details about emailing consumer information staff should refer to their agency’s most recent HIPAA training, privacy compliance policy, or Privacy Compliance Officer. For example, do not discuss specific consumer behavioral health diagnoses via email or discuss a consumer who is diagnosed with HIV or AIDS. Always make sure to use the language of “life threatening illness” instead of the specific health diagnosis.

3.10 Common Assessment Tool Scores
If a consumer has two or more CAT scores, the Housing Navigator consults the Community Coordinator and case conferencing attendees in the case that attendees are familiar with the consumer history and can provide more helpful information to determine which score to use. It is critical to use case conferencing to consult the experts. After this consultation, the Housing Navigator will either use the highest score, most recent CAT score or complete a reassessment.

3.11 Completing Housing Applications
Once a formal match is completed to a housing resource through the CAHP system, the Housing Navigator has 5-10 business days to complete a housing application with the consumer and submit it to the housing provider or housing authority, if applicable. The Housing Navigator should complete the application with the consumer as soon as possible to avoid delays to housing and prolonged homelessness.

3.12 Housing Placement Form
The Housing Navigator has 48 hours to fill out a Housing Placement Form (HPF) in ServicePoint after the consumer has physically moved into permanent housing. The Navigator may need to gather information from the housing provider to complete the form. Once the participant is placed in housing s/he is removed from the Housing Navigator’s caseload. It is expected that the Navigator maintain contact with the consumer throughout the placement process. Also, it is a good idea for the Housing Provider to maintain a copy of the HPF for their records.
Section 4: Matching

4.1 Overview
Matching in the CAHP system connects a consumer to the most appropriate housing resource based on consumer score, community priorities and housing program eligibility and criteria. The Matcher is a paid staff position of the CAHP system. Though CAHP participating agencies will not be completing matching themselves, it is critical to understand the process for matching to housing resources.

4.2 Matcher Key Responsibilities
The Matcher performs the following functions:
1. Manages information in the CAHP program in ServicePoint through data entry
2. Matches individuals and families who have completed MIF to appropriate housing using CAHP program in ServicePoint
3. Notifies identified Housing Navigator and Housing Provider that a match has been made
4. Tracks acceptance of matches made and documents acceptance in CAHP program in ServicePoint
5. Confirms housing placement in CAHP database
6. Provides on-going matching support to CAHP participating agencies
7. May run data quality reports to ensure agencies are entering data correctly
8. Participate in regional CAHP Matcher trainings as needed

4.3 Priorities/Referral Rankings
The Matcher utilizes the following priorities for matching consumers to available housing resources. Note: these priorities are subject to change.

Veteran Priorities, highest score first for each category:
1. Chronically homeless Veteran families with longest history of experiencing homelessness
2. Chronically homeless single Veterans with longest history of experiencing homelessness
3. Non-chronic Veteran families with longest history of experiencing homelessness
4. Non-chronic single Veterans with longest history of experiencing homelessness

Non-Veteran Priorities, highest score first for each category:
1. Chronically homeless individuals with longest history of experiencing homelessness
2. Chronically homeless youth with longest history of experiencing homelessness
3. Chronically homeless families with longest history of experiencing homelessness
4. Non-chronic homeless individuals with longest history of experiencing homelessness
5. Non-chronic homeless youth with longest history of experiencing homelessness
6. Non-chronic homeless families with longest history of experiencing homelessness
4.4 Matching Steps
The Matcher prioritizes outstanding matches with available vacancies first. Once a MIF and the referral to the Matcher has been submitted in ServicePoint the Matcher identifies a housing provider with an available resource to work with the consumer. This is done according to the consumer’s referral ranking and the provider’s eligibility criteria. The Matcher sends a referral to the housing provider using the CAHP system in ServicePoint. The Matchers also sends an email connecting the Housing Provider, Housing Navigator and any other involved parties as a courtesy. The Matcher works directly with Community Coordinators to create efficient processes for prioritizing eligible consumers to open vacancies. Matches should happen within 48 hours of the Matcher receiving a MIF referral in ServicePoint if there are available resources.

After the matcher sends a consumer referral to the Housing Provider in ServicePoint, the consumer and provider interview each other to make sure that both are compatible. The consumer is supported through this process by the Navigator. If both parties accept the housing placement, the Housing Provider immediately accept the referral in ServicePoint and advises the Matcher and Housing Navigator that the consumer will be moving forward to housing placement. The Housing Provider begins the intake process to bring the consumer into their program/housing.

Alternatively, if either party is unwilling or unable to move forward with the match, the Housing Provider alerts the Navigator and Matcher via email or phone so that the consumer can be matched to another provider. This information should also be reflected in the CAHP Program in ServicePoint as a referral rejection. A Housing Provider will reject the match referral in ServicePoint and enter a case note in the consumer’s profile including a reason why there was a referral rejection. If the match is rejected, the consumer remains on the Navigator’s caseload.

4.5 Consumer Centric System
It is important to note that the CAHP system is consumer-centric and all consumers have the ability to turn down a housing resource. This will not penalize consumers or change their priority level. However, consumers must understand that if they turn down an available housing resource another resource that they are eligible for may not be readily available.

If consumer score is borderline for RRH or PSH score (score of an 7 for example), the Matcher will first check RRH vacancies. If none available, Matcher will then look at PSH to see if there are any vacancy options for consumer. This will only be done if there are no other consumers with MIFs submitted to the Matcher in that jurisdiction scoring into this range first.

5: Housing Providers

5.1 Overview
This section explains the roles of programs that supply funding for housing (here referred to as Housing Providers). Housing Provider does not refer to organizations or individuals who supply the physical units in which participants are housed in apartments or rentals by landlords or property managers, unless a voucher is connected to a specific structure. Housing Providers
have access to CAHP training specific to their role and a CAHP Alignment Checklist and Packet (see Appendix 5: Housing Provider (HP) Alignment Packet).

5.2 Rapid ReHousing and Permanent Supportive Housing Providers

Participation by an agency with housing resources includes the dedication of specified units or slots in a Rapid Rehousing or Permanent Supportive Housing program to be filled by matches made to homeless people enrolled in the CAHP system. Housing Providers complete an eligibility matrix to ensure referred consumers meet the criteria for their program. Housing Providers open available units in ShelterPoint and hold units that are no longer available for matching to a CAHP consumer. It is mandatory that RRH and PSH beds/units that are funded by HUD Continuum of Care and Emergency Solutions Grant funding dedicate their funded units to be filled by CAHP referrals.

5.3 Eligibility Matrix

In order to enter housing resources into the CAHP system so that they can be matched to consumers, Housing Providers must fill out an initial eligibility matrix, which defines the population the provider serves and defines specific criteria of the housing resource. Every criteria the Housing Provider considers in selecting a consumer should be included in the matrix. The Housing Provider completes the CAHP Housing Provider training and completes the CAHP Alignment Checklist and Packet obtained from their Community Coordinator to start the process for finalizing the eligibility matrix (see Appendix 5: Housing Provider (HP) Alignment Packet). Once the packet is completed, the Community Coordinator works with RTFH to program the Housing Providers’ information into the CAHP program in ServicePoint. The RTFH may need to work with the Housing Provider directly if there are additional questions.

5.4 Indicating Vacancies

The Housing Provider indicates when they have a vacancy in ShelterPoint which is a program in ServicePoint. Through ShelterPoint, the Housing Provider has the ability to indicate PSH and RRH bed/unit vacancies with real time availability.

5.5 Program Housing Providers

Once matched to a Housing program provider, a consumer receives the housing subsidy or voucher the Housing Provider administers, as well as any supportive services connected to the housing program. It is the Housing Provider’s responsibility to complete whatever intake or enrollment paperwork is needed to secure the housing subsidy, voucher, or services. A Housing Provider is expected to keep beds/units open or on hold for five business days. If a Housing Provider has not received a match within this time period please contact your Community Coordinator.

5.6 Rejecting Referrals

The Housing Provider has five business days to accept or reject the match that is made their open bed/unit in ServicePoint if they have a vacancy open indicated in ShelterPoint. More time can be given, within reason, if the Housing Provider is waiting to hear from the Housing Provider’s housing authority.
If a Housing Provider rejects a match, the reason for the rejection must be documented in ServicePoint and an email must be submitted to the Community Coordinator stating the reason for the rejection in writing. The Community Coordinator monitors rejected matches. Rejections are subject to review by the RCCC Governance Board Evaluations Committee.

The Housing Provider is responsible for confirming consumer eligibility and completing background checks. Housing matches are based on self-reported data from the consumer. If a housing provider receives a referral for a consumer that does not meet the provider’s program eligibility criteria due to the consumer providing inaccurate information, then a housing program is able to reject the referral at no penalty.

Housing Providers have the discretion to refuse up to 5% (rounded up) of matched consumers (e.g. for a 10-turnover unit program, this would be one per year; for 30-turnover unit program, two per year). It is recognized that Housing Providers may require right of refusal for specific consumers for a number of reasons (e.g. staff safety, program expertise). If a Housing Provider needs to refuse more than 5% of referrals, the Housing Provider can discuss this with their Community Coordinator. All decisions are documented in ServicePoint. The Community Coordinator monitors rejected matches. Rejections are subject to review by the CAHP Advisory Subcommittee, RCCC Governance Board Evaluations Committee.

5.7 Case Management for PSH and Housing Choice Vouchers
Housing Choice Vouchers (HCV) may be provided to the CAHP system without being paired to a specific housing or services provider. HCV has been provided to CAHP in certain areas of the region that may have their own housing authorities that do not offer traditional PSH resources under HUD COC funding.

When these vouchers are available to CAHP to match consumers to, the CAHP system must ensure that high quality, intensive or the most appropriate case management and supportive services are in place so that a consumer is given every opportunity to succeed in housing.

5.8 Landlords
In San Diego, a large number of Housing Providers utilize for-profit affordable and market rate housing funded through vouchers or similar HUD-sponsored programs (such as Shelter Plus Care) and master leased, or leased individually by sponsored consumers. In practice, this requires locating a landlord willing to work with the Housing Provider and the consumer. Since the participant cannot be housed without finding a physical unit of housing like an apartment or studio, the responsibility for finding the actual housing unit may be shared between the Housing Navigator, Housing Provider, and the consumer. Housing Navigators and Housing Providers are encouraged to facilitate consumers’ efforts in finding housing when appropriate so that the consumer may do their part in searching for a front door who will accept a subsidy or voucher. In all cases this is a shared responsibility and will depend on agency resources and their relationships with the participant. When a participant is at least partially involved in their own housing search, there will be more pride and empowerment to maintain the housing and the subsidy or voucher.
In order to build the available housing stock needed for consumers with subsidies or vouchers, it is critical to build and maintain relationships with landlords. The consumer, provider and landlord should have a mutual understanding before the lease is signed about each party’s roles and responsibilities.

In general, the Housing Provider helps establish and maintain long term stability by addressing consumer needs related to mental health, substance use and activities of daily living. Both the consumer and landlord/property manager must commit to upholding the terms of the lease.

5.9 Lease Signing

It is recommended that either the Housing Navigator or Housing Provider review the lease prior to the consumer signing to ensure that the terms are standard and fair. Assuming that this is the case, it is generally a good idea for the Housing Provider to review the terms of the lease with the participant, either one-on-one, with the Housing Navigator, or even with the landlord. The lease is a contract, and the Housing Provider should encourage the participant to recognize their responsibility to uphold its terms.

5.10 Fair Housing

For fair housing information please refer to:

The Regional Steering Committee on Homelessness and Housing. (2013). *Fair Housing Compliance in a Coordinated Housing System.*


Section 6: Training

6.1: CAHP 101 and Specific Role Training

New agencies who want to or are required to participate in CAHP must communicate with the appropriate Community Coordinator regarding agency alignment processes and are responsible for ensuring appropriate staff is trained. CAHP Alignment Packets are provided to agencies that outline the step by step process to participate in CAHP. Currently, CAHP Alignment Packets exist for Outreach Workers, Housing Navigators and Housing Providers. For more information on the CAHP Alignment Packets please see Appendices 4 and 5.

Any new participant regardless of their specific role is required to complete a CAHP 101 video training or training in person if available. After completing the training and passing the practical exam, the trainee can gain access to individual trainings in their specific role (Outreach Worker, Housing Navigation, or Housing Provider). There may be additional trainings for Housing Providers from their individual Housing Authority. New agencies must also be granted access to the CAHP program in ServicePoint from the RTFH. RTFH requires technical training videos that will need to be passed as well. The Community Coordinators help facilitate this process.
The process is as follows:

1. User contacts Community Coordinator with request for training
2. Trainee completes CAHP 101 training video or in person training and completes practical exam
3. Practical exam answers are emailed to the Community Coordinator
4. The Community Coordinator sends the user the individual training for the user’s specific role (Outreach Worker, Housing Navigation, or Housing Provider).
5. Community Coordinator communicates with RTFH to facilitate the user gaining access to CAHP in Service Point.
6. Any questions about accessing ServicePoint in general, fees or updated licenses must be directed to RTFH.

6.2: CAHP Program in HMIS Training

As mentioned above, additional training on entering data in the CAHP Program in ServicePoint is required. All ServicePoint trainings are handled by the RTFH.

In order to understand how the CAHP Program is set up in ServicePoint, it is critical to be familiar with the tree structure (A tree structure is a hierarchical relationship between the various entities in the database. The tree structure guides who has access to information in the database and who can add and/or modify records). The current tree structure in ServicePoint is made up of four main providers with one overarching provider. The overarching provider is the CAHP Regional Match Provider, which specific CAHP staff such as the Community Coordinators and Matcher use for matching and administrative tasks. The four main providers are the CAHP Regional Match Provider for: a) Veterans; b) North County; c) Central; d) East and South. This regional structure allows for each region to report on CAHP data individually as well as for the CAHP to report as a whole.
Coordinated Assessment and Housing Placement System
Acronyms and Glossary

**Assessment Center**- Fixed locations throughout the County where clients can complete the Coordinated Assessment Tool and enroll in CAHP and/or meet with Housing Navigators.

**Bridge Housing**- Housing intervention designed to provide temporary shelter, pending a more permanent housing placement, for people experiencing homelessness.

**By Name List (BNL)**- Commonly used data tracking method used to monitor and keep track of all people experiencing homelessness in the community. The BNL contains critical information on each person who is known to be homeless including their name and whereabouts.

**Chronic Homeless (as defined by HUD)**-
As of January 2016, HUD’s Chronic Homeless Definition is a homeless individual with a disability who:

1. Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and has been homeless continuously for at least 12 months or at least 4 separate occasions in the last 3 years where the combined occasions must total at least 12 months (occasions separated by at least 7 nights).
2. Stays in institution of fewer than 90 days do not constitute a break.
3. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraphs 1 or 2 of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

For the most up to date information please visit: [https://www.hudexchange.info/resource/4847/hearth-defining-chronically-homeless-final-rule/](https://www.hudexchange.info/resource/4847/hearth-defining-chronically-homeless-final-rule/)

**Community Coordinator**- Individual responsible for maintaining the day-to-day operations of the CAHP system, monitoring the work of CAHP in the ServicePoint, and assigning clients (persons experiencing homelessness) to Housing Navigators.

**Continuum of Care (CoC/RCCC)**- The Regional Continuum of Care Council oversees approximately $16 million in annual HUD funding and sets priorities for addressing homelessness across the region. The RCCC and all the projects serving homeless people are often referred to as the Continuum of Care. CoC also refers to the specific type of HUD funding for homeless projects in CAHP.
Coordinated Assessment and Housing Placement System (CAHP)- A client centered process which streamlines access to the most appropriate housing interventions for each homeless individual or family. CAHP is a data driven and real time system for prioritizing and tracking housing referrals and placements for homeless people that uses common assessment tool.

Common Assessment Tool (CAT)- A combination of the VI-SPDAT version 2 and locally generated questions. All homeless people who wish to access housing resources complete the tool. People are asked the same set of questions to ensure that everyone is evaluated based on the same information and criteria making is possible to prioritize people for placement into housing based on priorities established by the community.

Coordinated Entry System (CES)- Another term for CAHP that HUD and other communities use interchangeably with the term CAHP.

Emergency Solutions Grant (ESG)- HUD funding used primarily to pay for rapid re-housing programs.

Housing and Community Development (HCD)- California Department of Housing and Community Development managing public housing resources for the County of San Diego.

Housing Inventory Count (HIC)- An annual count of the homeless housing resources in the region managed by RTFH.

Homeless Individual/Family- HUD defines four categories of homelessness.
   1. Literally homeless;
      a. Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning: (i) Has a primary nighttime residence that is a public or private place not meant for human habitation; (ii) Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or (iii) Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution
   2. Imminent risk of homelessness;
      a. Individual or family who will imminently lose their primary nighttime residence, provided that: (i) Residence will be lost within 14 days of the date of application for homeless assistance; (ii) No subsequent residence has been identified; and (iii) The individual or family lacks the resources or support networks needed to obtain other permanent housing
   3. Homeless under other Federal statutes;
a. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who: (i) Are defined as homeless under the other listed federal statutes; (ii) Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application; (iii) Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and (iv) Can be expected to continue in such status for an extended period of time due to special needs or barriers.

4. Fleeing/attempting to flee domestic violence.
   a. Any individual or family who: (i) Is fleeing, or is attempting to flee, domestic violence; (ii) Has no other residence; and (iii) Lacks the resources or support networks to obtain other permanent housing

For the most up to date information please visit: https://www.hudexchange.info/resources/documents/HomelessDefEligibility%20_SHP_SPC_ESG.pdf

**Homeless Management Information System (HMIS)**- Electronic record keeping system for homeless information. The regional HMIS software that is used is called ServicePoint.

**Homeless Outreach Team (HOT)**- Law enforcement police and community partners, with objective of identifying and providing support for individuals and families experiencing homelessness.

**Housing Navigator (HN)**- Individual responsible for engaging and preparing a client for housing placement once assigned through the CAHP system. The Housing Navigator serves as the primary point of contact for the homeless individual or family after they have been assessed. After being assessed means once the Coordinated Assessment Tool is completed and scored. The success of a housing navigator is measured by permanent housing placements. This is often the key difference between housing navigation and outreach.

**Housing Provider (HP)**- Agency or program that manages programs meant to house homeless clients.

**Housing and Urban Development (HUD)**- United States Department of Housing and Urban Development

**Matcher**- Individual responsible for maintaining list of housing resources and pairing them to match-ready clients.
**Match Initiation Form (MIF)**- Form filled out in HMIS by Housing Navigator working with a client in the CAHP system in order to match a housing-ready client to an appropriate provider based on eligibility criteria.

**Permanent Supportive Housing (PSH)**- Permanent supportive housing is community-based housing with indefinite leasing or rental assistance paired with wrap-around supportive services to help people with disabilities who are experiencing homelessness, especially chronic homelessness, achieve housing stability, live independently, decrease public costs, and improve their overall quality of life.

**Protected Health Information (PHI)**- Data to an individual’s medical record that is considered confidential under HIPAA.

**Personal Identifying Information (PII)**- Information that can be used to distinguish or trace an individual's identity, either along with or when combined with other personal or identifying information that is linked or linkable to a specific individual.

**Point In Time Count (PIT)**- An annual snapshot count of all sheltered and unsheltered homeless people in a community. PIT counts are performed nationwide.

**Rapid Re-housing (RRH)**- Rapid re-housing is a Housing First intervention designed to help individuals and families quickly exit homelessness, return to housing in the community, and not become homeless again in the near future. The core components of rapid re-housing include housing identification, move-in and rental assistance, and housing stabilization case management and services designed to increase the household’s income so that the household can fully take on the cost of rent at program termination.

**Regional Task Force on the Homeless (RTFH)**- A local non-profit charged with tracking regional data on homelessness. They are also the administrator of the central HMIS for the region, organize the PIT count, and manage the annual HIC.

**Release of Information (ROI)**- A consent form signed by clients which authorizing the sharing of client information.

**San Diego Housing Commission (SDHC)**- Public housing authority facilitating HUD programs for the City of San Diego.

**ServicePoint (SP)**- HMIS used by San Diego County, maintained by Regional Task Force on the Homeless, as appointed by the Regional Continuum of Care Council.
Street Outreach Teams- This includes teams from any agency or individuals willing to be mobile in order to meet “one on one” with clients on the streets.

Street Outreach- A set of strategies of outreach and engagement, in the geographical location where individuals and families experiencing homeless reside, including streets, parks, campsites, abandoned buildings, cars, and other places not meant for human habitation with the intention to establish relationships, build trust and rapport, provide basic necessities, and begin the process to link households to housing and support services. Outreach is a process rather than an outcome.

Transitional Housing (TH)- Temporary housing intervention, usually between six and 24 months, targeted toward clients who will eventually be capable of living independently.

Unique Client Identifier (UCI)- Number assigned to client in ServicePoint; used to identify clients in HMIS and the CAHP system.

Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT)- An evidence based common assessment tool containing a set of questions designed for initial screening to quickly assess the health and social needs of homeless people and match them with the most appropriate support and housing interventions that are available. The VI-SPDAT makes up a bulk of the questions asked in the region’s Coordinated Assessment Tool.
Coordinated Assessment and Housing Placement (CAHP) Participation Definition

I. General Participation in CAHP

We as a community of agencies believe that a coordinated service approach is the most effective way to end homelessness. We are working as a unified team to develop and implement a regional Coordinated Assessment and Housing Placement (CAHP) system. This includes a process of outreach, assessment, housing navigation, matching to appropriate housing resources and placement, which prioritizes the most acute chronically homeless and Veterans in San Diego County.

The intent of this participation language is to further define each agency’s dedication to this collaborative, community driven effort; increase the efficacy and scope of CAHP through additional housing resources, navigation, retention support and leadership; and reach our goal of ending homelessness by serving the homeless community of San Diego County.

The language found in this Participation Definition covers CAHP Phase 1: Rapid Re-Housing and Permanent Supportive Housing programs, to be implemented July 1, 2016, or in alignment with program’s funding contract(s).

Other types of program alignment, including emergency shelter and transitional housing, will be covered in CAHP Phase 2 to be implemented at a later date.

a. Requirements for General Participation include:
   i. Attendance at required trainings and CAHP alignment meetings
   ii. Usage of the common assessment tool, the VI-SPDAT and approved supplemental questions prior to program entry
   iii. Usage of CAHP Program in ServicePoint
   iv. Sufficient data entry and quality (< 5% error)
   v. ServicePoint data sharing as outlined in the Data Sharing Policy through HMIS lead (once approved by CoC Governance Board)
   vi. RRH and PSH Housing Providers only: 100% CoC and ESG HUD funded beds dedicated to the CAHP system
   vii. Housing First Oriented
   viii. Follow all CAHP policies and procedures

b. Additional but not required ways to participate include but are not limited to:
   i. Coordinated street outreach under CAHP (including completing VI-SPDATs)
   ii. Certified Assessment Site (open drop in center to complete VI-SPDATs)
   iii. Complete VI-SPDATs in house with clients (closed site)
   iv. Usage of approved priorities for enrollments defined by CAHP (emergency shelter and transition housing)
   v. Dedicate housing navigators (quantified by # FTE depending on staffing capacity)
vi. Attend case conferencing meetings and add to the By Name List

II. Detailed Definitions

a. Coordinated Street Outreach: Outreach dedicated staff help to ensure that all those experiencing homelessness are being engaged and assessed in a coordinated manner. Agencies participating in coordinated street outreach will follow all policies are procedures provided by the CAHP Outreach and Coordination Committee. This dedicated staff will administer the VI-SPDAT and approved supplemental questions and enter data into the CAHP Program in ServicePoint. If applicable, dedicated staff should also attend case conferencing meetings and add to the By Name List.

b. Assessment Sites
   i. Open Assessments Sites: To be considered a Certified Open Assessment Site, the participating agency must have dedicated days and times that homeless individuals and/families are able to complete a VI-SPDATs and supplemental questions with a trained staff member. Agencies are able to provide certain population restrictions (e.g., adults only, women only, etc.) depending on the clients they serve. This dedicated staff will be responsible for completing and entering VI-SPDATs into the CAHP Program in ServicePoint.
   ii. Closed Assessment Sites: To be considered a Closed Assessment Site, the participating agency must have the ability for a trained staff member to complete VI-SPDAT and supplemental questions with homeless people in house and/or by appointment, but not on a drop-in basis. Agencies are able to provide certain population restrictions (e.g., adults only, women only, etc.) depending on the clients they serve. This dedicated staff will be responsible for completing and entering VI-SPDATs into the CAHP Program in ServicePoint.

c. Housing First: In alignment with HUD, all homeless programming will adhere to Housing First principles as noted below:
   i. Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety (for non AOD programs), treatment or service participation requirements.
   ii. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry.

d. **Housing Navigation**: For an agency to participate by providing Housing Navigators, the agency must have dedicated staff (either full or part-time FTE) who perform Housing Navigator duties, described in this paragraph for homeless people enrolled in the CAHP system. Housing Navigators serve as the main point of contact for each high-priority individual targeted for immediate housing placement. The Housing Navigators help collect all documents needed for the individual/family to be placed in housing, prepare that person/family for matching including the completion of the Match Initiation Form, and coordinate the entry of information about the person’s/family’s status into the CAHP Program in ServicePoint. Housing Navigators should also attend case conferencing meetings and add to the By Name List. After the housing match is made, the Housing Navigator may provide additional support necessary to finalize the housing placement and assist the individual’s/family’s entry into the housing program.

e. **RRH and PSH Housing Providers**: Participation by an agency with housing resources includes the dedication of specified units to be filled by matches made to homeless people enrolled in the CAHP system. Housing providers will complete an eligibility matrix to ensure referred clients meet the criteria for their program and they will have the ability to hold and remove vacancies as they become available. It is mandatory that RRH and PSH beds/units that are funded by HUD Continuum of Care and Emergency Solutions Grant funding dedicate their funded units to be filled by clients in CAHP.

### III. Accountability and Monitoring

For accountability and external monitoring in regards to this participation language, agencies must provide a lead point person and corresponding contact information. This lead point person will be contacted periodically to ensure the agency’s required tasks are implemented according to CAHP Policies and Procedures.

**CAHP Participation Grid**

This grid summarizes the required and optional ways that homeless service providers who have beds/units participate in CAHP.
### CAHP Participation Task (*Required for Phase 1*)

<table>
<thead>
<tr>
<th>Task Description</th>
<th>PSH</th>
<th>RRH</th>
<th>TH</th>
<th>SO</th>
</tr>
</thead>
<tbody>
<tr>
<td>100% of CoC and ESG HUD funded beds dedicated to CAHP*</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use Service Point*</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>ServicePoint Data Sharing* (once privacy policies are approved by CoC Governance Board)</td>
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<td>X</td>
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<tr>
<td>Data Entry and Quality (less than 5% errors)*</td>
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<td>X</td>
<td>X</td>
<td>X</td>
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<tr>
<td>Housing First Oriented*</td>
<td>X</td>
<td>X</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Use Common Assessment Tool (VI-SPDAT)*</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
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<td>Attend ALL required CAHP Trainings*</td>
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<tr>
<td>Follow Policies and CAHP Alignment Procedures*</td>
<td>X</td>
<td>X</td>
<td>X</td>
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</tr>
</tbody>
</table>

### Optional Participation Methods

<table>
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<tr>
<th>Task Description</th>
<th>PSH</th>
<th>RRH</th>
<th>TH</th>
<th>SO</th>
</tr>
</thead>
<tbody>
<tr>
<td>Coordinated street outreach under CAHP (including completing VI-SPDATs)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Certified Assessment Site (open drop in center to complete VI-SPDATs)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Complete VI-SPDATs in house with clients (closed site)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Usage of priorities for enrollments defined by CAHP (transitional housing)</td>
<td></td>
<td></td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>Dedicate housing navigators (quantified by # FTE depending on staffing capacity)</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
<tr>
<td>Attend case conferencing meetings and add to the By Name List</td>
<td>X</td>
<td>X</td>
<td>X</td>
<td>X</td>
</tr>
</tbody>
</table>

**Key**

PSH: Permanent Supportive Housing  
RRH: Rapid Rehousing  
TH: Transitional Housing  
SO: Service Only
What is the VI-SPDAT?
The Vulnerability Index and Service Prioritization Decision Assistance Tool enables providers to fairly and uniformly provide resources to those in need based on:

1. Level of need
2. Score on the assessment
3. Available housing resources

What happens after the assessment?
After completing a VI-SPDAT, you may be assigned to a Housing Navigator based on scores, priorities, and room on staff caseload.

More Information
Opening Doors Coordinated Assessment and Housing Placement (CAHP) system is not an emergency solution.

Completing an assessment is not a guarantee of housing.

Make sure you give the staff completing your assessment any helpful contact information so that we may be in touch with you.

You can start collecting your necessary documentation (CA ID, SS card, Birth Certificate if applicable, DD214 if applicable) needed for federally funded housing resources. This will expedite the housing referral process after assigned to a Housing Navigator.

OpeningDoorsSD@gmail.com
(619) 232-4785
www.housingsd.org

Regional Continuum of Care Council
RCCC

Are you homeless and looking for a permanent place to call home?

What can I do while I wait to be assigned to a Housing Navigator?

If you need immediate shelter, please call 2-1-1 for a list of open emergency shelters or safe havens in your area.
# Opening Doors

**VI-SPDAT Assessment Sites**

## Central and Downtown San Diego

**Father Joe’s - Day Center**  
299 17th St, San Diego 92101  
(619) 230-7390  
Monday-Friday, 8:00am-2:00pm,  
sign up starting at 6:00am  
Age 18 and above only

**Father Joe’s - Village**  
1501 Imperial Ave, San Diego 92101  
corner of 15th and Imperial  
(619) 233-8500  
Monday-Friday, 8:00am-2:00pm,  
sign up starting at 8:00am  
Open to all families

**Friend to Friend Clubhouse**  
2144 El Cajon Blvd, San Diego 92104  
(619) 955-8217  
Thursdays 9:00am-3:00pm  
Age 18 and above only

**Rachel’s Women’s Center**  
759 8th Ave, San Diego 92101  
Sundays 10:00am-3:00pm  
Mondays 1:00pm-3:00pm  
Single women only

## North County San Diego

**Alpha Project- Casa Raphael**  
993 Postal Way, Vista 92083  
Monday-Wednesday 12:00pm-3:00pm  
Friday 12:00pm-3:00pm  
For an appointment, contact Clifford Morris at 619-929-6253

**Community Resource Center**  
650 Second St, Encinitas 92024  
(760) 753-8300  
Monday-Friday 9:00am-5:00pm  
Veterans and civilians

**Interfaith Community Services**  
550 W. Washington Ave, Escondido 92025  
(760) 489-6380  
Veterans only: Monday-Friday 1:00pm-3:00pm  
Open to all: Tuesdays and Thursdays 8:00am-10:00am

**Oceanside Police Homeless Outreach Team**  
307 N. Nevada St, Oceanside 92054  
Thursdays 1:30pm-3:00pm

**TAY Academy**  
215 Barnes St, Oceanside 92054  
(760) 908-9647  
Monday and Friday 9am-1pm  
Wednesday 10am-5pm  
ages 18-25 only

**Veterans**

**VA Medical Center- Homeless Outreach Clinic**  
3350 La Jolla Village Dr, San Diego 92161  
Monday-Friday 7:30am-2:00pm

**VA Oceanside Clinic-Homeless Outreach Clinic**  
1300 Rancho del Oro, Ste 1-F 109, Oceanside 92056  
(760) 643-4698  
Thursdays 8:00am-12:00pm

**Veterans Assistance of North County- Interfaith**  
1617 Mission Ave, Oceanside 92058, north entrance  
(760) 529-9979  
Monday-Friday 1:00pm-3:00pm

## Veterans continued

**Veterans Community Services**  
5605 El Cajon Blvd, San Diego 92115  
(800) 974-9909  
Mondays 12:00pm-4:00pm  
Tuesday- Friday 9:00am-4:00pm

1405 Sixth Ave, San Diego 92101  
(800) 974-9909  
Monday 12:00pm-4:00pm  
Tuesday-Friday 9:00am-4:00pm

330 W. Felicita Ave, Ste E-4, Escondido 92025  
(800) 974-9909  
Monday 12:00pm-4:00pm  
Tuesday-Friday 9:00am-4:00pm

765 Third Ave, Ste 305, Chula Vista 91910  
(800) 974-9909  
Monday 12:00pm-4:00pm  
Tuesday-Friday 9:00am-4:00pm

327 Van Houten Ave, El Cajon 92020  
(800) 974-9909  
Monday 12:00pm-4:00pm  
Tuesday-Friday 9:00am-4:00pm

**Veterans Village of San Diego-Supportive Services for Veteran Families**  
3320 Kemper St, Ste 104, San Diego 92110  
(619) 961-2165  
Monday-Friday 9:00am-5:00pm  
Veteran singles and families

**Veteran assessment line and to check if you have a Housing Navigator:**  
855-813-1131  
Monday-Friday  
7:00am-7:00pm
San Diego Coordinated Assessment Housing Placement (CAHP) Alignment Checklist for Outreach Workers and Housing Navigators

**Alignment Task**

**Completion Date**

<table>
<thead>
<tr>
<th>Task</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>TASK 1:</td>
<td>Define your internal alignment strategy and workflow.</td>
</tr>
<tr>
<td>TASK 2:</td>
<td>Review CAHP process work flow with CAHP Alignment Team.</td>
</tr>
<tr>
<td>TASK 3:</td>
<td>Determine which staff members will function as outreach workers and/or housing navigators.</td>
</tr>
<tr>
<td>TASK 4:</td>
<td>Identified staff utilizing the CAHP system will need to complete a CAHP 101 training and corresponding specialized trainings for outreach and housing navigation.</td>
</tr>
<tr>
<td>TASK 5:</td>
<td>If program staff are new ServicePoint users they will need to contact RTFH to receive new user trainings and discuss setting up licenses.</td>
</tr>
<tr>
<td>TASK 6:</td>
<td>Once new user training is complete, program staff will complete the appropriate CAHP training videos for data entry into ServicePoint. Note: These are different from CAHP 101 trainings.</td>
</tr>
<tr>
<td>TASK 7:</td>
<td>Begin to use CAHP Program in ServicePoint.</td>
</tr>
</tbody>
</table>

**Detailed Task Key**

<table>
<thead>
<tr>
<th>Task</th>
<th>Point of Contact</th>
<th>Expected Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td>TASK 1: Discuss program internally to identify funding streams and an alignment strategy prior to meeting with CAHP staff. Your organization should consider whether they will dedicate street outreach staff, outreach worker staff in house to complete assessments (closed assessment site), outreach worker staff to complete assessments for participants who drop in (open assessment site) and/or housing navigation. Once complete, connect with the appropriate Community Coordinator for your regional service area (i.e. City and County).</td>
<td>Agency and CC</td>
<td>60-120 minutes</td>
</tr>
<tr>
<td>TASK 2: Program manager and other staff will meet with the Community Coordinator to review CAHP process work flow.</td>
<td>Agency and CC</td>
<td>60-120 minutes</td>
</tr>
<tr>
<td>TASK 3: Outreach workers are responsible for completing the VI-SPDAT with participants and entering data in the CAHP Program in ServicePoint. Housing navigators are responsible for assisting participants assigned to them by collecting critical documentation, submitting a Match Initiation Form and a referral to the Regional Matcher in the CAHP Program in ServicePoint.</td>
<td>Agency and CC</td>
<td>60-90 minutes</td>
</tr>
<tr>
<td>TASK 4: All staff utilizing the CAHP system will need to complete a CAHP 101 training and corresponding specialized trainings for outreach and housing navigator. Staff will need to complete a quiz in order for their information to be sent to RTFH for the next step in training.</td>
<td>To complete/CC To submit: RTFH</td>
<td>5 business days</td>
</tr>
<tr>
<td>TASKS: If program staff are new ServicePoint users they will need to contact RTFH to receive new user trainings and discuss setting up licenses. Please note that there is a fee per year per user associated with the use of ServicePoint.</td>
<td>RTF1SD</td>
<td>15-60 minutes</td>
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</tbody>
</table>

**Ways to Participate in CAHP**

1. Coordinated street outreach under CAHP (including completing VI-SPDATs)
2. Certified Assessment Site (open drop in center to complete VI-SPDATs)
3. Complete VI-SPDATs in house with clients (closed site)
4. Usage of priorities for enrollments defined by CAHP (emergency shelter and transition housing)
5. Housing navigators (quantified by FTE depending on staffing capacity)
6. Attend case conferencing meetings and add to the By Name List
7. Maintain housing referrals to and from the CAHP system

**Agency/Property**

**Sign/Date**

**CAHP Representative**

**Sign/Date**
Project Overview:

The Coordinated Assessment and Housing Placement (CAHP) System designed and implemented by the former 25 Cities San Diego in 2014 plays a key role in laying the groundwork to meet the national campaign goals. The CAHP system creates coordinated entry points for homeless individuals to be assessed and access services and housing - while prioritizing resources on an individual basis. It focuses on a person's specific needs versus fitting a client into a one-size-fits-all program, and replaces previously used methods that were disconnected, confusing and inefficient.

Job Description:

As part of CAHP, the Outreach staff will be assess individuals or families either in the field during street outreach or at a CAHP designated assessment site. The Outreach staff will need to have some experience working with individuals and families that are chronically homeless and/or homeless Veterans. Some knowledge of HIPAA, consumer privacy, sensitivity to health and social issues effecting homeless people, and basic safety during street outreach is necessary. The Outreach staff provides sensitivity to consumers, respect and dignity to their privacy and situation, as well as thorough documentation and record keeping practices. Outreach staff will provide individualized consumer support by applying CAHP’s Common Assessment Tool, the VI-SPDAT and entering this information collected into the community's Homeless Management Information System, HMIS called ServicePoint. Staff will respect consumer responses to assessment and provide follow up if necessary. Outreach staff will provide follow up information to CAHP staff and Housing Navigators as needed. Outreach staff will attend biweekly or monthly case conferencing meetings as needed.

Responsibilities:

Outreach and Rapport Building

- Conduct screening interviews through a Common Assessment Tool, the VI-SPDAT
- Effectively communicate the purpose of the assessment and follow uniform messaging to consumers that will help manage their expectations from the program and answer frequently asked questions
- Work outdoors or standing for long periods of time depending on individual program’s grant requirements.
- Encourage and promote an environment that is strength based to assist clients in assessing their situation and factors that may have contributed to their homeless situation
- Maintaining professionalism while meeting a consumer where they’re at
- Continuing to engage and build rapport as often as necessary in order to build trust and open dialogue
- Maintain privacy, respect, and dignity when actively listening to a client and recording their responses to the VI-SPDAT

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Regional Continuum of Care Council
RCCC

CAHP Opening Doors
Outreach Staff Job Description

Safety, Use of Technology, and Record Keeping
- Outreach to consumers in the field or at designated assessment sites.
- Respond to community requests for street outreach intervention.
- Attend collaborative meeting as necessary.
- Network with other agencies, coalitions, and local community meetings as needed.
- Actively participate in all meetings and trainings as needed.
- Enter all collected data into HMIS ServicePoint.
- Knowledge of and understanding basic HIPAA and privacy requirements for collecting sensitive information from a consumer.
- Always encouraging and following safety first above all other duties.

Qualifications:
- High school degree or Associate’s degree in Sociology, Psychology, Social Work or related field preferred but not required.
- Two years in related experience with homeless populations preferred but not required.
- Computer skills with proficiency in Microsoft Office.
- HMIS Service Point training a plus.
- Project a professional demeanor.
- Demonstrated ability to work independently and as part of a team.
- Strong written and verbal communication skills.
- Must maintain and execute confidential information while maintaining HIPAA and PHI compliance.
- Ability to work with diverse communities and exercise mature judgment.
- Problem solving and conflict resolution skills.

Rev. 5/2016
Regional Continuum of Care Council
RCCC

CAHP Opening Doors
Housing Navigator Job Description

Project Overview:
The Coordinated Assessment and Housing Placement (CAHP) System designed and implemented by the former 25 Cities San Diego in 2014 plays a key role in laying the groundwork to meet the national campaign goals. The CAHP system creates coordinated entry points for homeless individuals to be assessed and access services and housing - while prioritizing resources on an individual basis. It focuses on a person's specific needs versus fitting a client into a one-size-fits-all program, and replaces previously used methods that were disconnected, confusing and inefficient.

Job Description:
As part of CAHP, the Housing Navigator will be assigned individuals or families from the Community Coordinator and will attend all case conferencing meetings and other meetings as required. The Housing Navigator will need to have some experience working with individuals that are chronically homeless and/or homeless Veterans. Some knowledge of public housing authorities and housings subsidies or vouchers is ideal (i.e., Section 8, Shelter Plus Care, VASH, SSVF). The Housing Navigator provides client advocacy, linkage to stable housing, and all other supportive services as needed.

Housing Navigators will provide individualized client support by helping each client develop a plan to address their barriers such as gathering required documentation, referrals to agencies that provide financial assistance for identification and other fees, completing housing applications, assisting the client in identifying housing preferences, can assist in identifying potential units, and advocating with landlords.

Responsibilities:

Supportive Services
- Conduct screening interviews, complete intake documentation and coordinate move in and exit of all program participants.
- Provide navigation services designed to assist clients and their families obtain stability.
- Perform initial VI-SPDAT assessment if needed and work with client to determine what housing related documents are needed.
- Respond to referrals and begin working with client within required response time.
- Encourage and promote an environment that is strength based to assist clients in meeting their housing goals.
- Identify appropriate permanent housing options for clients. Assist clients with housing applications, complete supportive and subsidized housing paperwork, survey rental market for affordable housing, and advocate for clients with prospective landlords.

Rev. 5/2016
CAHP Opening Doors
Housing Navigator Job Description

Outreach and Relationship Management
- Outreach to community, realtors, landlords, housing developers and other service providers to identify new and existing opportunities and build strong relationships to ensure housing opportunities.
- Respond to community requests for street outreach intervention.
- Attend collaborative meetings.
- Network with other agencies, coalitions, and local community meetings.
- Actively participate in all meetings and trainings.

Qualifications:
- Bachelor’s degree in Sociology, Psychology, Social Work or related field preferred but not required.
- Two years in related experience with homeless populations preferred but not required.
- Computer skills with proficiency in Microsoft Office.
- HMIS Service Point training a plus.
- Project a professional demeanor.
- Demonstrated ability to work independently and as part of a team.
- Strong written and verbal communication skills.
- Must maintain and execute confidential information while maintaining HIPAA and PHI compliance.
- Ability to work with diverse communities and exercise mature judgment.
- Problem solving and conflict resolution skills.
Housing Navigator Process Flow

1. **Contact your client.** Upon receiving your assigned client you should be sure to contact the client **within 48 hours.** Inform the client that you are their Housing Navigator, and that you will be assisting them in taking the necessary steps to match them to housing resources they may be eligible for.

   Note- if your agency completed the VI-SPDAT with the client please also give a copy of the hard copy VI-SPDAT to your Community Coordinator for central filing. Keep a copy for your program’s records.

2. **Assess for Safety.** Remember that your safety and that of your client is important. If after speaking to your new client, you feel that there should be another person present to support you, make sure you take the necessary steps to ensure safety. You can take a co-worker or peer Housing Navigator to meet a client in a public space or in your office. Utilize the Housing Navigator Roster to ask for help from your fellow Housing Navigators if needed. Check Megan’s Law, Service Point, Anasazi, or other secure databases you have access for safety before meeting with a client.

3. **Supportive Services.** As a Housing Navigator, it is your duty to ensure your client has all the resources they will need to be successful in housing. This may include budgeting help, referrals to Financial Education classes, referrals to SSI/SSDI/the HOPE program, referrals to employment support programs/EDD/Americas One Stop Job Centers, applying for free or low income credit reports, and the like. We also suggest that if your client does not have a personal cell phone that you help them in applying for an Assurance Wireless free phone for low income persons.

4. **Gather required documentation.** Make sure that your client has all of the necessary forms to expedite the housing process. It is suggested that you make copies of all forms for your clients to store in their hardcopy file at your program. You will have the ability to scan these documents into ServicePoint.

   Use this checklist as a guide:
   
   ___ State ID card or Driver’s License (or receipt of application)
   ___ Birth certificate (required for match initiation)
   ___ Social Security card (or receipt of application)
   ___ Current proof of income within last 60 days (bank statements/Section 8, GR/SSI/EDD benefits letter)
   ___ Zero Income Certification (if applicable, Section 8 only)
   ___ Proof of TANF (Section 8 only)
   ___ Proof of food stamps (Section 8 only)
   ___ Certification of Disability (if eligible for PSH)
   ___ Homeless verification
   ___ Proof of residency (if applicable)
   ___ Reference letter (if necessary for landlord)
5. **Match Initiation Form (MIF).** Once your client has all of the required documentation on file it is time to fill out the MIF. On version 2 of the VI-SPDAT, if the client (individual) scores between 4 and 7, fill out a MIF for Rapid Rehousing (RRH). If 8 or above fill out the MIF for Permanent Supportive Housing (PSH) form. Please note scoring recommendations are different for version 2 of the family VI-SPDAT. If you believe your client's score is inaccurate, please discuss this with your Community Coordinator. A new assessment may be required of you.

Note-if self-assigning or “manually matching” a client to your program a note will need to be made in the Action Steps in ServicePoint. This is the place to write in that you are assigning the client to yourself or another program the client already meets eligibility criteria for.

6. **Wait for contact from the Matcher.** Once the matcher finds a vacancy match for your client you will receive an email that will put you in touch with a housing resource your client meets eligibility for. At this point it is assumed that the client has accepted the match unless otherwise noted. This is a client choice project, so the client has every right to refuse the match. If this is the case, contact the matcher immediately so that the vacancy can be made available to other clients and the client can go back in the queue.

7. **Housing Placement Form (HPF).** Once a client signs a lease and moves into permanent housing, the housing navigator should complete the HPF within 3-5 days.
Checklist of Documents for Housing:

- State ID card or Driver's License (or receipt of application)
- Birth certificate (required for match initiation)
- Social Security card (or receipt of application)
- Current proof of income within last 60 days (bank statements/Section 8, GR/SSI/EDD benefits letter)
- Zero Income Certification (if applicable, Section 8 only)
- Proof of TANF (Section 8 only)
- Proof of food stamps (Section 8 only)
- Certification of Disability (if applicable)
- Homeless verification, third party certified
- Proof of residency (if applicable)
- Reference letter (if necessary for landlord)
- DD214 (Veterans)
San Diego Coordinated Assessment Housing Placement (CAHP) Alignment Checklist for Housing Providers

**Alignment Task** | **Completion Date**
--- | ---
**TASK 1**: Define your internal alignment strategy and workflow. |  |
**TASK 2**: Review CAHP process workflow with CAHP Alignment Team. All staff utilizing the CAHP system will need to complete a CAHP 101 training and corresponding specialized trainings for housing providers. |  |
**TASK 3**: Complete an eligibility matrix and decide how many units will be dedicated to CAHP and submit to Community Coordinator. |  |
**TASK 4**: Your eligibility criteria and units will be programmed into ServicePoint by the Regional Task Force on the Homeless (RTFH). |  |
**TASK 5**: If program staff are new ServicePoint users they will need to contact RTFH to receive new user trainings and discuss setting up licenses. |  |
**TASK 6**: Once new user training is complete, program staff will complete the appropriate CAHP training videos for data entry into ServicePoint. Note: These are different from CAHP 101 trainings. |  |
**TASK 7**: Begin to use system for filing vacancies. |  |

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### Detailed Task Key

<table>
<thead>
<tr>
<th>Task</th>
<th>Point of Contact</th>
<th>Expected Duration</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>TASK 1</strong>: Discuss program internally with your Housing Authority to identify funding streams and an alignment strategy prior to meeting with CAHP staff. Once complete, connect with the appropriate Community Coordinator for your regional service area. (i.e. City and County)</td>
<td>Agency/ Property, Housing Authority and CC</td>
<td>10-60 minutes</td>
</tr>
<tr>
<td><strong>TASK 2</strong>: Program manager and Housing Authority representative will meet with the Community Coordinator to review CAHP process workflow. Community Coordinators will provide staff with CAHP 101 training and corresponding specialized trainings for housing providers. Staff will need to complete a quiz in order for their information to be sent to RTFH for the next step in training.</td>
<td>Agency/ Property, Housing Authority and CC</td>
<td>90-120 minutes</td>
</tr>
<tr>
<td><strong>TASK 3</strong>: Program manager will complete an eligibility matrix for the program/s. Community Coordinator will provide program manager with the eligibility matrix template and other supporting documents. Please note that a program may need to complete multiple eligibility matrices depending on different program criteria, grant benchmarks, etc. Programs will also need to inform the Community Coordinator of how many units/beds the program is dedicating to the CAHP system. All completed documents and other information requested will be sent to the Community Coordinator for review, the Community Coordinator will send this to RTFH.</td>
<td>Agency/ Property and CC</td>
<td>15-35 minutes</td>
</tr>
<tr>
<td><strong>TASK 4</strong>: Once complete, the eligibility criteria will be programmed into ServicePoint by the Regional Task Force on the Homeless (RTFH).</td>
<td>To complete CC To submit, RTFH</td>
<td>5-10 business days to process</td>
</tr>
<tr>
<td><strong>TASK 5</strong>: If program staff are new ServicePoint users they will need to contact RTFH to receive new user trainings and discuss setting up licenses. Please note that there is a fee per year per user associated with the use of ServicePoint. Once set up, program staff will complete the CAHP training videos for PSH providers on how to run referrals in ServicePoint and how to hold/hold beds in ShelterPoint.</td>
<td>RTFHSD</td>
<td>15-65 minutes</td>
</tr>
</tbody>
</table>

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### Ways to Participate in CAHP

I. Coordinated street outreach under CAHP (including completing VI-SPDATs)
II. Certified Assessment Site (open door to center to complete VI-SPDATs)
III. Complete VI-SPDATs in house with clients (closed site)
IV. Usage of priorities for encampments defined by CAHP (emergency shelter and transition housing)
V. Dedicate housing navigators (quantified by # FTE depending on staffing capacity)
VI. Attend case conferencing meetings and add to the By Name List
VII. Make and accept housing referrals to and from the CAHP system

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**Agency/Property**

**Sign/Date**

---

**CAHP Representative**

**Sign/Date**

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*Updated: 6/28/2021 6:01 PM*
**Instructions:** Complete one row per project that will be participating in CAHP. For each criteria, identify whether or not the client "must be/have," "can't be/have," "can be/have", or "can't be/have." Highlight each must be/have and can't be/have in yellow, as these specific must/can't items will be used to configure client eligibility for your project. In the example listed, in order to quality for this project, the client must be homeless, can't be on parole, can't have at least 1 arrest for misdemeanor or felony within the past year and/or is currently in detention or has been in detention within the previous year, can't be in a family, must be an individual client by themselves and must be in the City of San Diego. If your program requires that clients must be from another location within the County, please edit the "Location of Client" column to reflect that criteria. Please contact your Community Coordinator if you have any questions.

<table>
<thead>
<tr>
<th>Project Information</th>
</tr>
</thead>
<tbody>
<tr>
<td>Provider Name</td>
</tr>
<tr>
<td>EXAMPLE: Alpha Project</td>
</tr>
</tbody>
</table>
## HMIS CAHP Eligibility Criteria Matrix

<table>
<thead>
<tr>
<th>Homelessness</th>
<th>Income</th>
<th>Citizenship</th>
</tr>
</thead>
<tbody>
<tr>
<td>Homeless</td>
<td>Extremely Low Income (30% of Area Median Income)</td>
<td>Very Low Income (50% of Area Median Income)</td>
</tr>
</tbody>
</table>

| Must Be | Can Be | Can Be | Can Be | Can Be | Can Be | Can Be |


<table>
<thead>
<tr>
<th>Ineligible Immigrant (Including Undocumented)</th>
<th>Disability</th>
<th>Serious Mental Illness</th>
<th>Chronic Substance Use Issues</th>
<th>Co-Morbid (MI and SA)</th>
<th>MI, SA or Co-Morbid</th>
<th>AIDS or Related Diseases</th>
</tr>
</thead>
<tbody>
<tr>
<td>Can Be</td>
<td>Can Be</td>
<td>Can Have</td>
<td>Can Have</td>
<td>Can Have</td>
<td>Can Be</td>
<td>Can Be</td>
</tr>
<tr>
<td>Veteran Status</td>
<td>Eligible for VA Health Care Services</td>
<td>Life-Time Sex Offender Status</td>
<td>On Parole (currently or within last 5 years)</td>
<td>On Probation (currently or within last 5 years)</td>
<td>Meth Production Conviction</td>
<td>Conviction for Violent Crime Last Three Years (including Arson)</td>
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<td>-------------------------------------------------------------</td>
</tr>
<tr>
<td>Veteran Status</td>
<td>Can Have</td>
<td>Can Have</td>
<td>Can't Be</td>
<td>Can Be</td>
<td>Can Be</td>
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<tr>
<td>Can Have</td>
<td>Can Have</td>
<td>Can Be</td>
<td>Can't Be</td>
<td>Can Be</td>
<td>Can Be</td>
<td>Can Have</td>
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<tr>
<td>Conviction for Violent Crime Last Two Years (including Arson)</td>
<td>Conviction for Arson</td>
<td>Client has at least 1 arrest for misdemeanor or felony within the past year, and/or is currently in detention or has been in detention within the previous year</td>
<td>Section 8 Status</td>
<td>Rental History within Past 2 Years</td>
<td>Eviction within Past 2 Years from Federally Subsidized Housing</td>
<td>Termination of Unit due to Fraud In Last 10 Years</td>
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<td>-------------------------------------------------------------</td>
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<tr>
<td>Can Have</td>
<td>Can Have</td>
<td>Can't Have</td>
<td>Can Have</td>
<td>Can Have</td>
<td>Can Have</td>
<td>Can Have</td>
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<tr>
<td>Termination of Unit with Damages to Unit in Last 10 Years</td>
<td>If Money Owed on Previous Federally Subsidized Unit Payment Plan In Place</td>
<td>Client is clinically capable of managing an apartment that would not constitute a danger to self or others.</td>
<td>Client uses an accompaniment (service) animal.</td>
<td>Client meets eligibility requirements for ACT or Strengths Based Case Management.</td>
<td>Families only?</td>
<td>Individuals only?</td>
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<tr>
<td>Can Have</td>
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<td>Can Have</td>
<td>Can Have</td>
<td>Can't Be</td>
<td>Must Be</td>
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<tr>
<td>Location of Client</td>
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<tr>
<td>City of San Diego</td>
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</tbody>
</table>

*Must Be*
Sydney Roberts

ABSTRACT

This document is a ServicePoint tutorial for programs participating in CAHP, or Coordinated Assessment and Housing Placement. This workflow tutorial is divided into the four roles that are involved in the CAHP process- Outreach Worker, Housing Navigator, Matcher, and Housing Provider.
Overview

Outreach Worker
The role of the Outreach Worker in ServicePoint will be to engage with the client and collect information via the VI-SPDAT assessment, then create a ServicePoint entry into the appropriate Match Provider.

1) Log into ServicePoint
   a) Logon with your username and password
   b) Check the provider you are logged on to (top left)

      ![ServicePoint Login](image)

      i) Click the *EDA* link on the top right to change to the correct CAHP provider.
      ii) Determine which CAHP provider you need to Enter Data As. If the client is a veteran, choose Veteran #6629. Otherwise, choose your EDA based on where the client is located—choose Central #6626, North #6627, or South and East #6628. Do not Enter Data As CAHP Regional Match Provider #6622.
      iii) Click the *green plus* next to the correct provider.

    ![EDA Selection](image)

   c) Right below EDA is *Back Date*. If you are doing same day data entry, then you do not need to back date. If you are doing data entry at a later date, click back date to the program entry/intake date.

    ![Back Date](image)

2) Find or add the Client
   a) Click on *ClientPoint*
   b) Enter the client’s First Name, Last Name and SSN to search for him/her.
c) -OR- Search by Client ID (ServicePoint #)

d) Review the list of possible matches that ServicePoint displays by checking both Name, Social, and DOB for a match.

e) If you see your client, select him/her by clicking on the pencil on the left of the name or the name itself.

f) If No Matches, click Add New Client with this Information. Make sure you input the name, SSN and SSN data quality before clicking “Add New Client With This Information”.

3) If the client is in a Family, create a Household that includes all members of the household living together. See the “Adding and Updating Households in ServicePoint” workflow documentation for instructions or contact the RTFH.

4) Create a Release of Information (ROI)

   a) Click on the ROI tab

   b) Click Add Release of Information

   c) If for a Family, select all members of the Household
If not defaulted based on your EDA, select the correct CAHP provider from the Provider dropdown.

Select Yes for Release Granted.

Start Date should be the date the client authorized the ROI.

End Date should be the date the ROI expires, usually one year from the start date.

Select the appropriate Documentation type, usually Signed Statement from Client.

Click Save Release of Information.

Scan and save the physical Release of Information document by clicking on the binder clip image on the far right of the saved Release of Information, or by going back into the saved Release of Information and clicking the binder clip image.

Click Add New File Attachment.

Browse for the file on your computer.

Click Upload.

Add a Case Manager.

Click the Case Managers tab.

Click Add Case Manager.

Assign the case manager to the individual.

If for a family, select all Household members.

Select Me as the Type if you are the Housing Navigator.

Your contact information will auto-populate.

Provider will default based on your EDA.

Enter the start date, which will auto-populate to today’s date or the backdate.

Click Add Case Manager.

Create an Entry into the appropriate CAHP provider (Veterans, Central, North County, or South and East).

Click on the Entry/Exit tab.

If there is already an entry into CAHP, check the dates. If entry is approximately one year or older, continue. If entry is more recent than that, the client may be currently working with CAHP; contact the CAHP Community Coordinators.

If a Family, select all members of the Household.

Select type: HUD.
i) **Complete the CAHP assessments for all Household members**

1. **HUD UDE's (default assessment on entry screen)**
2. **CAHP Outreach – San Diego VI-SPDAT (Family) if in a Family –OR— CAHP Outreach – San Diego VI-SPDAT (Individual) if for an Individual**
   a) **Complete any HUD Verification sub-assessments**
      i) Click *HUD Verification*
      ii) Verify each source with either a Yes or No
      iii) Click *Save and Exit*
   b) **Complete the VI-SPDAT sub-assessment Tool within the VI-SPDAT assessment**
      i) Click *Add*
      ii) Answer all questions
      iii) Calculate pre-screen total
   c) **If the client is a Veteran, complete the Veteran Information sub-assessment within the VI-SPDAT assessment**
(i) Click Add
(ii) Answer all questions
(iii) Click Save

5) Refer client to CAHP Regional Match Provider in Service Transactions tab
   a) Click on the Services Transactions tab
   b) Click Add Referrals
   c) If for a Family, select all members of the Household
   d) Highlight/Click Housing Search Assistance in Service Code Quicklist
   e) Click “Add Terms”
      i. This adds the service to Selected Needs at the bottom of the page

   f) Select the appropriate (same) CAHP Provider from the dropdown in Referral Provider Quicklist
   g) Click Add Provider
      i. This adds the provider to the Selected Providers
   h) Refer to Providers
      i. Enter the Needs Referral Date, if different than the default date
      ii. Enter Referral Ranking, if appropriate
      iii. Select the VI-SPDAT score
           1. Click Search next to the VISPDAT Score
           2. Click the green plus sign next to the VISPDAT score
              (a) If for a Family, select the Head of Household’s VI-SPDAT score
      iv. Select the appropriate (same) CAHP Regional Match Provider
           1. If you are unsure which provider to choose, speak with the Community Coordinators.

   i) Check the Housing Search Assistance box in Referrals
Housing Navigator

The role of the Housing Navigator in ServicePoint will be to continue to engage with the client.

1) Log into ServicePoint
   a) Logon with your username and password.
   b) Check the default provider you are logged on as on the top left of your dashboard.

   i. Click the EDA link on the top right to change to the correct CAHP provider.
   ii. Determine which CAHP provider you need to Enter Data As. Choose your EDA based on which region you normally work in - Central #6626, North #6627, or South and East #6628. If you work with Veterans, choose the Veteran provider #6629. Do not choose CAHP Regional Match Provider #6622.
   iii. Click the green plus next to the correct program.

2) Create the Referrals Report
   a) Click on the Reports tab on the left-hand Dashboard panel
   b) Click on the Referrals Report
   c) Your Provider will auto-populate based on your EDA provider
      i. If necessary, select a different provider from the drop down
   d) Choose Incoming Referrals to Provider in Referral Type
   e) Keep Outstanding Referrals in Referral Status
   f) Select your desired Date Range
   g) Click Build Report

j) Click Save All
h) The referrals report will generate in the same window. You can sort the report by Referral Ranking or VI-SPDAT score by clicking on any of the blue hyperlinks on the top row of the report.

3) Accept the referral for each client
   a) Click on the Need Type (e.g. Housing Search Assistance). This opens the Referrals for the client
   b) In Referral Data, select the appropriate Referral Outcome from the drop down
   c) In Need Status and Outcome, select the appropriate Need Status from the drop down
      i. Select the appropriate Outcome of Need
         1. If you are denying the referral, choose Reason why Need is Not Met
   d) Click Save and Exit
4) Verify Client Information
   a) Click back to the Client Information tab
   b) Click the ROI tab
   c) Verify the ROI is in place
   d) If for a family, verify the Household Composition
      i. Click the Households tab
      ii. Verify the Household composition
5) Add a Case Manager
   a) Click the Case Managers tab
   b) Click Add Case Manager
   c) Assign the case manager to the individual
      i. If for a family, select all Household members
   d) Select Me as the Type if you are the Housing Navigator
   e) Your contact information will auto-populate
   f) Provider will default based on your EDA
   g) Enter the start date, which will auto-populate to today’s date or the backdate
   h) Click Add Case Manager

![Image of Case Manager details]

6) Create a Case Plan
   a) Click on the Case Plans tab
   b) Click Add Goal
   c) Provider will default based on your EDA
   d) Select the appropriate Case Manager from the drop down
      i. If you are unsure who to choose, contact the CAHP Community Coordinators
   e) Select Coordinated Entry as the Classification from the drop down
   f) Select Coordinated Entry Case Plan as the Type from the drop down
   g) Enter helpful Case Notes as you meet with the client
   h) Change Overall Status to Identified from the drop down

![Image of Case Plan details]

7) Click Add Goal
8) Click *Save and Exit*
9) When all documentation is in place and the client is ready for matching, complete the Match Initiation
   a) Click *Entry/Exit* tab
   b) Find the appropriate CAHP entry
   c) Start an interim review by clicking the *Interim Review symbol (pad of paper)*
      
      ![Interim Review symbol](image)
   d) Click *Add Interim Review*
      i. Select *Interim Review* as Type
   e) Click the appropriate CAHP assessment- CAHP Housing Navigator RRH Match Initiation Form –OR- CAHP Housing Navigator PSH Match Initiation Form (based on the client’s VISPDAT score)
      
      ![Select an Assessment](image)
      i. Be sure to answer **all** questions and sub-assessments. This information will be used by the Matchers to match the client to programs based on eligibility criteria.
      ii. Click *Save and Exit*
      iii. Click *Exit*
10) Create a Follow-Up
   a) Click on the *Case Plans* tab
   b) Open the existing client’s Case Plan by clicking the *pencil* to the left of the Goal
   c) Click *Add Action Step*
   d) Add any notes or instructions for the Matcher- “client is ready for RRH –or- PSH match”
   e) Select *Identified* as Overall Status
   f) Select today’s date or another date as the Projected Follow Up Date
   g) Select CAHP Regional/Match Provider #6622 in *Follow-Up User*
   h) Select your assigned Matcher in *Follow-Up User – select any person*
      i. Contact the CAHP Community Coordinators if you have questions about who to choose
11) Click *Save Action Step*
12) Click *Save and Exit*

13) Once the client has been permanently housed or is no longer working with CAHP, exit the client from CAHP:
   
   a) Click on the *Entry/Exit* tab
   b) Click on the *pencil* next to the blank Exit Date for the appropriate entry into CAHP
   c) Answer all Questions
   d) Complete the CAHP Housing Navigator – SD Housing Placement Form
      i. Answer all Questions
      ii. Click *Save and Exit*
Matcher

The role of the Matcher is to find potential housing options for the client based on their VISPDAT score. The matcher is also a second set of eyes for the data entered by the housing navigator and must communicate closely with the housing navigator to ensure all data has been collected so that the client is eligible for programs and can be housed.

1) Log into ServicePoint
   a) Logon with your username and password.
   b) Check the provider you are logged on to (top left). Your default provider should be CAHP Regional/Match Provider.
      i) If your default provider is not CAHP Regional/Match Provider, please contact the RTFH.

2) Check your outstanding referrals on your Follow-Up List
   a) On your Home screen, click on a Client ID #
      b) Click on the Summary tab to find the VISPDAT score, located at the bottom

3) Verify information
   a) Click on the Entry/Exit tab and verify there is an appropriate entry into CAHP.
   b) Click the Interim Review symbol next to the appropriate entry into CAHP. Verify the VISPDAT score is appropriate on either the CAHP – Housing Navigator PSH Match Initiation Form – OR – CAHP – Housing Navigator – RRH Match Initiation Form assessment
   c) Click Save & Exit when done

4) Add yourself as Case Manager.
   i) Click the Case Managers tab
   j) click Add Case Manager
   k) Assign the case manager to the individual
      i. If for a family, select all Household members
   l) Select Me as the Type if you are the Housing Navigator
   m) Your contact information will auto-populate
   n) Provider will default based on your EDA
   o) Enter the start date, which will auto-populate to today’s date or the backdate
   p) Click Add Case Manager
5) View Case Plans
   a) Click the pencil next to the Coordinated Entry goal to view Notes and Action Steps
   b) If necessary because information is missing or if extra information is required and the client is not yet ready to be matched, create a follow-up Action Step and refer back to the Housing Navigator/Case Manager
      i) Click Add Action Step
      ii) Write a note for the Housing Navigator
      iii) Select Identified as the Overall Status
      iv) Select the CAHP Regional Match Provider (Central, South and East, or Veterans) and User you are referring back to
      v) Click Save Action Step
   c) Open the existing client’s Case Plan by clicking the pencil
   d) Change Overall Status to Closed
   e) Click Save and Exit

6) Eligibility Search
   a) Click on the Services Transactions tab
   b) Click Eligibility Search
c) Select either Homeless Permanent Supportive Housing –OR- Rapid Re-Housing Programs in the Eligibility Services Code Quick List based on the VISPDAT score

![Eligibility Service Code Quick List]

d) Click **Add Selected Service Terms**
   i) This adds the service into Eligibility Service Search Results, and shows how many programs the client is eligible, potentially eligible, or ineligible for based on the eligibility criteria and questions answered by client. 1/9 for example, means, out of 9 possible openings, the client is eligible for 1 of them.
   (1) Click the magnifying glass next to each type to see the list of programs in each category
   (a) Click on each provider name to see more information about each program, and to determine which program may be most appropriate to refer client to
   (b) If potentially eligible or ineligible, click *Reason* to see why
   (i) If necessary, refer back (via Action Step) to Housing Navigator go back and answer unanswered questions
   ii) In Eligibility Service Search Results, click the green plus sign next to the selected Service (either Homeless Permanent Supportive Housing –OR- Rapid Re-Housing Programs)
   (1) This adds the selected serve into Selected Eligibility Service Terms
   (2) Click the checkbox next to the selected Service (either Homeless Permanent Supportive Housing –OR- Rapid Re-Housing Programs)
   (3) Click *Continue*

e) In Search Results, click *Bed Availability* to check the availability of the programs

![Bed Availability]

i) If wanted, select the type *Unit List Type* (ie family or individual housing)

f) Click the green plus sign next to one of the programs client is eligible for to refer to that program
   i) This adds the selected program into Selected Providers

g) Refer to Provider
   i) Choose Needs Referral Date, typically same date as the day you are entering information
   ii) Choose a Referral Ranking, if appropriate
   iii) Select a VISPDAT score
(1) Click Search
(2) Click the green plus sign next to the client’s VISPDAT tool
   (a) If for a family, add the VISPDAT score for the Head of Household
   iv) Click the checkbox to notify ServicePoint Providers by Email

<table>
<thead>
<tr>
<th>Referral Data</th>
</tr>
</thead>
<tbody>
<tr>
<td>Needs Referral Date: 12/29/2013</td>
</tr>
<tr>
<td>Referral Ranking: High</td>
</tr>
<tr>
<td>VISPDAT Score: 10</td>
</tr>
<tr>
<td>Type of PATH Referral: -Select-</td>
</tr>
<tr>
<td>If any Type of PATH Referral made, select Outcome: -Select-</td>
</tr>
<tr>
<td>Type of RHY Referral: -Select-</td>
</tr>
<tr>
<td>Projected Follow Up Date:</td>
</tr>
<tr>
<td>Follow Up User: CAMP Regional/Match Provider - North County (0527)</td>
</tr>
</tbody>
</table>

h) When done, click Save All
   i) This will open All Service Transactions, and you should see the CAHP Need marked as Identified, and a Referral to the selected Provider

7) Contact the Housing Provider to provide hand-off
8) Check Outgoing Referrals
   a) Click on the Reports tab on the left-hand Dashboard panel
   b) Click on the Referrals Report
   c) Select Outgoing Referrals From Provider in Referral Type
   d) Select All as Referral Status
   e) Select your desired date range
   f) Select Build Report
   g) See all outgoing referrals
Provider
The role of the RRH and PSH Providers is to receive and close out referrals sent to their provider from the CAHP Match Project.

1) Log into ServicePoint
   a) Logon with your username and password.
   b) Check the provider you are logged on to (top left).
   i) Determine which housing Provider you need to Enter Data As. Select the green plus next to the correct program.

2) Create the Referrals Report
   a) Click on the Reports tab on the left-hand Dashboard panel
   b) Click on the Referrals Report
   c) Your Provider will auto-populate based on your EDA provider
      i. If necessary, select a different provider from the drop down
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3) Accept the referral for each client
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   b) In Referral Data, select the appropriate Referral Outcome from the drop down
c) In Need Status and Outcome, select the appropriate Need Status from the drop down
   i. Select the appropriate Outcome
      1. If you are denying the referral, choose Reason why Need is Not Met

   ![Need Status and Outcome]

   d) Click **Save and Exit**

4) Add an entry into your program on the Entry/Exit tab
   a) Answer all assessment questions assigned to your program.

   ![2014 HUD - PSDE - Income / Disability]
   ![HUD UDEs (2015)]

   i. See the appropriate workflow documentation for further instructions or contact the RTFH.

5) Use ShelterPoint to add new clients into open beds/units, hold beds so they are not available for
   incoming referrals, or to reserve beds/units for a particular client.
   a) From the dashboard, click **Shelterpoint** on the left module.
   b) Your provider should auto-populate based on your default provider.
      i. If you do not see provider listed, click **Search** and select the correct provider.
   c) Click **Submit**.
   d) To add a new client into an open bed/unit
      i. From the ShelterPoint dashboard menu, click **Check Client In**.

      ![ShelterPoint Dashboard]

      ii. Select an open bed, which is one with the green plus to the left of it. Click the **green plus** to
          place a client or household into the bed/unit.

      ![Bed Status]

      iii. Enter the head of household’s client ID number or search for his/her name on the client
          search screen.
iv. At the top, enter the date that the client began sleeping in the bed / unit. Be sure to edit the time so it correctly reflects when the client checked in.

1. For RRH providers, use project entry date as the “Date In;” the date your client moves into housing will be tracked in the PSDE assessment.
2. For PSH providers, use date the client moved into housing as the “Date In”

v. Under “Household Members” click the checkboxes to select all household members who are staying there.

vi. Click *Save and Exit*. You can see on the main screen that the bed is now occupied by the Head of Household. The other household members have dropped down to the bottom under “Overflow.”

6) When necessary, exit the client from your program.
   a) Click the *pencil* next to the exit date.
   b) Answer all assessment questions assigned to your program.
      i. See the appropriate workflow documentation for further instructions or contact the RTFH.
   c) Exit the client from ShelterPoint
      i. From the dashboard, click *Shelterpoint* on the left module.
      ii. Your provider should auto-populate based on your default provider.
          1. If you do not see provider listed, click *Search* and select the correct provider.
      iii. Click *Submit*.
   iv. Click *View All*.

v. Find your client in the assigned bed, and click the *Red Minus Sign*

   ii) At the top, enter the date that the client stopped sleeping in the bed / unit. Be sure to edit the time so it correctly reflects when the client checked out.
   iii) If for a Family, select all members of the Household

   iv) Click *Save and Exit*. 
7) ShelterPoint on-going maintenance
   a) To hold a bed/unit so that it is not available for a referral
      i) Click *Hold* to the right of the bed number.
      ii) To unhold it, click *HELD*.

   b) To reserve a bed/unit for a particular client so that the bed/unit is not available for referral, click *Add Reservation* on the bottom.
      i) Search for your client. The client will then display at the bottom.
      ii) To place a reserved client into a bed/unit, click the *green plus* next to the client name and select the bed/unit you want to place him in.
      iii) Click save.
      iv) To cancel a reservation, click *Cancel Reservation*
   c) To print a daily roster to help manage beds, click *Print Unit List* on the bottom left corner of the bed list.
Veteran By-Name List
Policies and Procedures

San Diego County
Regional Continuum of Care Council
Opening Doors Task Force
San Diego County Regional Continuum of Care Council Opening Doors Task Force
Policies and Procedures for the Veteran By-Name List

Background

Led by the U.S. Department of Veterans Affairs (VA), in partnership with the U.S. Department of Housing and Urban Development (HUD) and the U.S. Interagency Council on Homelessness (USICH), the 25 Cities effort, mobilized local planning efforts and partnerships to create an effective system for aligning housing and service interventions to end homelessness. The aim of this effort was to assist the top 25 communities with the largest homeless populations in the country to accelerate and align their existing efforts toward the creation of coordinated assessment and housing placement (CAHP) systems, laying the foundation for ending homelessness in their respective communities.

The San Diego 25 Cities Initiative, launched in June 2014, established the use of a common tool for assessing homeless individuals’ and families’ housing needs, and developed a single database/CAHP system for data sharing, which was used to match individuals/families experiencing homelessness to available and appropriate local housing resources. The Initiative targeted Chronic and Veteran homelessness and was initially implemented in a defined area of San Diego, downtown. The common assessment tool utilized is the Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT), which examines and scores an individual’s or family’s vulnerability level and prioritized need for housing opportunities, in concert with other criteria from the assessment. In January 2015, the Initiative expanded to Escondido and surrounding North County communities.

In February 2016, the 25 Cities Initiative was realigned under the San Diego Regional Continuum of Care Council (RCCC). The new structure streamlined goals and priorities, assigned responsibilities, and regionalized the CAHP system within the community’s Homeless Management Information System (HMIS). The RCCC charged the Opening Doors Committee Task Force (ODC) with the responsibility to lead the community’s plan to end homelessness. The ODC oversees the Veteran’s Consortium Committee, which manages the Veteran-specific community plan for ending homelessness among Veterans in San Diego.

Vision

Concurrently with the realignment, the ODC and the Veterans Consortium have set a goal to satisfy the Benchmarks and Criteria for Ending Homelessness among Veterans, which were collaboratively developed by the VA, HUD, and the USICH. In keeping with the Benchmarks, San Diego will utilize an active, functional By-Name List (BNL) of Veterans and their families experiencing homelessness, managed by members of the Veteran Sub-Population Committee in collaboration with the HMIS Lead Agency, The Regional Task Force on the Homeless (RTFH). The BNL will inform our community of our progress in meeting the Federal Benchmarks and Criteria for Ending Homelessness among Veterans, will serve to
inform us of who our homeless Veterans are, and will contain information as to the housing status of each homeless Veteran. Until the RTFH can fully encapsulate the BNL into HMIS and provide progress reports towards meeting the Benchmarks, the Veteran Sub-Population Committee will be using a temporary Excel spreadsheet, developed by the Federal partners (Federal Master List and Benchmarks Generation Tool), that will contain data derived from HMIS, data entered by community providers who are participating in the RTFH’s HMIS Multiparty Agreement, and data obtained during Case Conferencing meetings, where the most current information about each Veteran will be discussed. In order to ensure the highest level of data integrity, to avoid duplications, and to prevent the loss of Veterans in the process, the BNL will be reconciled with HMIS data (and vice versa) on a monthly basis.

Until HMIS has capacity to encapsulate the BNL data, the following Policies and Procedures are intended to ensure consistent and clear guidelines for use of the interim BNL. The interim BNL will be under the responsibility of the Veteran Sup-Population Committee until it is absorbed into HMIS.

Note: Additional policies and procedures will be developed to address the non-Veteran populations, including Chronic and youth, and are separate from this document.

Eligibility for the Veteran BNL

1. Individuals must be a Veteran. For these purposes, a Veteran is defined as an individual who has served his or her country by enlisting in the Armed Services or Reserves (not limited to Veterans with Honorable or General under Honorable conditions or Veterans with access to VA health care).
   a. Recommended documents used to verify Veteran status:
      i. DD-214 (preferred)
      ii. Statement of Service
      iii. HINQ Report
      iv. VA ID Card
      v. VA Disability Award

2. Veterans must be in San Diego County

3. Veterans must be Homeless, as defined by the US Department of Housing and Urban Development (HUD) in the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (HEARTH Act (P.L. 111-22, Section 1003)):
   a. Any Veteran who lacks a fixed, regular and adequate nighttime residence;
   b. Any Veteran who has a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
c. Any Veteran living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including hotels/motels paid for by Federal, State or local government programs for low-income individuals or by charitable organizations, congregate shelters, Save Haven and transitional housing including both Grant and Per Diem or other COC Transitional Housing;

d. And other situations as spelled out in the HEARTH Act:  
https://www.hudexchange.info/resources/documents/HEARTH_HomelessDefinition_FinalRule.pdf;

e. If a Veteran is residing at a friend’s/family member’s home (i.e., “couch surfing”) he/she is not considered to be homeless under this definition.

Data Entry, Data Sharing Processes and Responsibilities, HMIS Reconciliation

1. Initial data for the BNL will be drawn from an HMIS report that includes all Veterans experiencing homelessness from all HMIS programs in San Diego County.

2. Weekly BNL updates, additional data elements specific to the BNL, and Veterans who are not yet entered into HMIS, will be added to the BNL by staff from community agencies that are participating in the RTFH’s HMIS Multiparty Agreement.
   a. Data may also be entered into the BNL by participating agencies that collaborate with other community agencies and/or staff that are not participating in data entry for the BNL and/or are not enrolled into HMIS. ROIs will need to be shared with participating agencies, in order to enter information obtained from non-participating agencies. - see section, Privacy 3 a. and b., below.

3. Agencies that desire to participate in data entry for the BNL should enroll, as follows:
   a. Complete and submit to the RTFH the “San Diego County Homeless Management Information System (HMIS) Agency Participation Agreement.”
   b. Ensure that participating agency staff have completed the required RTFH HMIS trainings regarding proper handling of the data.
   c. Ensure that participating agency staff have signed the “San Diego County Homeless Management Information System (HMIS) User Agreement.”
   d. Ensure that participating agency staff have participated in the BNL training, as provided by the List Manager, or a designated representative of the Veteran Sub-Population Committee.
   e. Ensure that designated agency staff attend Case Conference meetings, as scheduled by the List Manager.
4. Agencies that have completed the enrollment process, above, and are actively participating in the BNL and the HMIS data entry are expected to do the following:
   a. Develop and implement an internal agency policy/procedure that ensures all internal updates are entered into the agency’s internal copy of the BNL within 3 days.
   b. Follow the San Diego County Regional Continuum of Care Council’s Homeless Management Information System (HMIS) Policies and Procedures regarding HMIS data entry timelines, which dictates that entries should be within 3 business days from the interaction with the Veteran.
   c. Ensure that all Veterans sign the required Releases of Information (ROIs) - see section, Privacy 3 a. and b., below- at the earliest possible time, in order to allow for sharing of information.
      i. In accordance with HMIS policies and procedures, ROIs must be uploaded into HMIS within three (3) business days of being signed.
   d. Designate a staff person responsible for managing his/her organization’s data for the BNL updates. This individual is responsible in ensuring that all data elements within the BNL from his/her agency are accurate and as complete as possible.
   e. At least once a week, each participating agency’s designated representative will upload his/her agency’s BNL updates into HMIS by the designated time period (as determined by the List Manager), in order to ensure that the updates can be reconciled with the Master BNL, managed by the List Manager.
   f. Ensures that their internal copy of the BNL is stored and maintained in accordance with their agency’s policies and procedures, meets privacy and confidentiality laws, including all local, State, and Federal laws, and follows HMIS Privacy and Security Policies and Procedures, as outlined in the “San Diego County Regional Continuum of Care Council’s Homeless Management Information System Policies and Procedures,” Section 5, “Security and Privacy.”
   g. Conducts monthly internal data quality checks to ensure that all data elements on the internal BNL are completed and are up-to-date. Errors noted on the BNL are to be corrected immediately upon notice by the responsible participating agency. Weekly updates uploaded into HMIS should include all corrections made. Errors within HMIS should be changed by the responsible participating agency immediately upon notice of the error. All corrections made should be communicated to the List Manager in order to ensure high data quality.

5. The List Manager(s):
   a. Is a member of the Veteran Sub-Population Committee
b. Is the primary person responsible for managing the BNL under the leadership of the Veteran Population Sub-Committee Chair, in partnership with the HMIS Lead Agency, RTFH.

c. Will ensure that each participating agency contributing to the BNL has been certified and trained by the RTFH prior to granting access to the BNL.

d. Will ensure that each participating agency staff member has been trained on use of the BNL prior to access.

e. Will be responsible for responding to concerns about privacy breaches and will communicate immediately to the VA’s HCHV Coordinator, the Veteran Sub-Population Committee Chair or Co-Chair, and the RTFH’s designated representative regarding any such breaches.

f. Manages and communicates weekly BNL updates
   i. A minimum of once a week, the List Manager is responsible for ensuring that BNL data updates (spreadsheet) have been uploaded into HMIS by participating agencies and that any changes are reconciled with the Master BNL that s/he manages.
   ii. Attends Case Conference meetings and ensures that the BNL (spreadsheet) is updated during these regularly scheduled meetings (see Case Conferencing 2. a., b., and c., below).
   iii. A minimum of once a week the List Manager is responsible to ensure that an updated Master BNL spreadsheet (after all updates above have been added) is uploaded into HMIS by the designated time period (as determined by the List Manager), so that each participating agency can then download the most current list for their ongoing internal use. This will help to ensure that the list functions as “real-time” as possible. The RTFH and the List Manager will determine the placement of the BNL updates within HMIS. Agencies using HMIS must comply with San Diego County Regional Continuum of Care Council’s Homeless Management Information System (HMIS) Policies and Procedures in regards to privacy and access to information on the BNL, as not all Veterans on the updated Master List will be their direct clientele.

g. Is the primary point of contact for information sharing and/or data input into the BNL on behalf of the VA, as needed.

h. Ensures that Veterans on the BNL who have not signed a Release of Information (ROI) have been sorted and separated from the BNL prior to weekly uploads into HMIS for sharing, and prior to monthly reconciliation with HMIS.
   i. Will ensure that Veterans without ROI’s are indicated in the BNL’s “ROI” column as “No” and will sort the list each week to prevent those Veterans from being entered into HMIS.
ii. Ensures data sharing and updates of Veterans without ROI’s to the Case Conference group via encrypted thumb drives, verbal communication, and/or confidential fax, until ROIs are obtained.

i. Works closely with RTFH during the reconciliation of the BNL data with HMIS and ensure ROIs are uploaded on at least a monthly basis.

j. Works with the RTFH to establish a set schedule and process for reconciliation.

k. Reminds agency participants to perform monthly data quality checks. The List Manager will update the original BNL with any reported errors.

6. Reconciliation between the most updated original BNL spreadsheet and HMIS will be conducted monthly by the RTFH and the List Manager, in order to ensure quality of data without duplication.

Training

1. All agency staff that will be participating in data entry for the BNL are required to complete the RTFH’s HMIS training (see San Diego County Regional Continuum of Care Council’s Homeless Management Information System (HMIS) Policies and Procedures).

2. All agency staff that will be participating in data entry for the BNL and in Case Conferencing will be required to complete a BNL training, as provided by the List Manager or a designated representative of the Veteran Population Sub-Committee. Access to Case Conferencing and BNL updates will be made available after the training has occurred.

3. Trainings will be offered on a schedule, as determined by the List Manager.

Privacy

1. Each participating agency will ensure that all participating staff within that agency have completed the Privacy and Confidentiality training and are certified by the RTFH in regards to utilization and data handling within the HMIS.

2. Each agency ensures that their internal BNL is stored and maintained in accordance with their agency’s policies and procedures and meets privacy and confidentiality laws, including all local, State, and Federal laws, and follows HMIS’ Privacy and Security Policies and Procedures, as outlined in the “San Diego County Regional Continuum of Care Council’s Homeless Management Information System Policies and Procedures,” Section 5, “Security and Privacy.”

   a. Under no circumstances will any participating agency or staff person store the BNL on any personally owned media or store this data in removable data devices for personal use.
b. It is preferred that agencies do not print paper copies of the list, however, if they do, agencies agree to ensure compliance with all above mentioned privacy and confidentiality laws and policies, will store any printed copies in locked cabinets, and will shred those printed copies immediately upon completion of the task that required printing.

3. Each participating staff member will ensure that Veterans sign the following ROIs for the BNL:
   a. San Diego County HMIS Multiparty Authorization to Use and/or Disclose Information
   b. VA Release of Information

4. Agencies that meet with Veterans and perform the VI-SPDAT assessment tool during that meeting should ensure that the Veteran signs the ROI attached to the VI-SPDAT and then upload that ROI into HMIS within 3 business days of contact with the Veteran.

5. Participating staff members must upload both of the Veteran’s signed ROIs into HMIS within 3 days of the Veteran signing it.

6. Guidance released on 04/15/2016 by Stephania H. Griffin, JD, RHIA, Director of Information Access and Privacy Office, VHA Privacy Officer entitled, “VA Privacy Guidance on Authority to Make Disclosures to Community Partners,” (see attachment) will be followed, allowing communication to occur between the VA and community organizations regarding Veteran housing status without an ROI on file.
   a. Without an ROI on file, shared information should be limited to the minimum amount needed for the community partner to immediately assist the Veteran.
   b. Agencies do not have the authority to share health information protected under 38 U.S.C 7332 (any information related to the diagnosis of infection with HIV or sickle cell anemia, or the diagnosis of and treatment for drug abuse, alcohol abuse, or alcoholism) unless a signed written authorization is obtained from the Veteran.
      i. The staff member will NOT list the name of any treatment facilities for which the Veteran is residing on the BNL, but will instead, list only the address of the facility.
   c. Veterans without an ROI can be added to the BNL, but cannot be reconciled into HMIS until an ROI is on file, in accordance with San Diego County Regional Continuum of Care Council’s Homeless Management Information System Policies and Procedures.
      i. Participating staff members will make their best effort to follow-up with Veterans to ensure that ROI’s are signed and uploaded into HIMS as soon as possible.
      ii. Once the ROI’s have been signed, the participating staff member will ensure that the Veteran’s ROI column reads, “Yes” on the BNL.
d. Verbal ROIs will be accepted for data entry into the BNL; however, written ROIs must be collected prior to including the Veteran’s information into HMIS. For those with only verbal ROIs, procedures for not having an ROI will be followed.

7. Any violations or potential violations of privacy will be reported immediately to the VA’s HCHV Coordinator and to List Manager.

8. If a participating agency or staff member is found to be utilizing the list with disregard to the privacy policies and procedures section of this BNL or that of RTFH related to HMIS, s/he may be barred from further access and participation in the BNL process, at the discretion of the VA, the List Manager, the Chair/ Co-Chair of the Veteran Sub-Population Committee, or the Designated Representative of RTFH.

By-Name List Spreadsheet Data Elements

1. Veteran Last Name
2. Veteran First Name
3. Veteran HMIS Client identifier
   a. All Veterans should be entered into HMIS within 3 business days of initial contact and should have a unique identifier derived from HMIS to enter into the BNL
4. Veterans HOMES Client Identifier
   a. VA staff are responsible for entering Veterans into HOMES within 3 business days of initial contact with the Veteran and should have a unique HOMES identifier derived from HOMES to enter into the BNL
5. List Status
   a. Status Classifications on the list are selected from a drop-down menu including:
      a. Active-unsheltered
      b. Active-ES/TH
      c. Inactive-unknown/missing
      d. Inactive--permanently housed.
      e. Inactive-non-permanently housed
      f. Housing Search
      g. Moved
   b. Definitions:
      i. **Active-unsheltered**: currently literally homeless and residing in a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human being, including a car, park, abandoned building, bus or train station, airport, camping ground, or make-shift structure.
ii. **Active-Emergency Shelter/Transitional Housing**: currently literally homeless and residing in an emergency shelter, Safe Haven, or transitional housing (including VA-funded Grant and per Diem (GPD) programs). This will also include Veterans in an institutional care facility (including jail, substance abuse or mental health treatment facility, hospital, domiciliary, or other similar facility) for fewer than 90 days and who were in and an emergency shelter just prior to entering the institutional care facility.

iii. **Inactive-Unknown/Missing Status**: current whereabouts are unknown and cannot be located by Outreach staff or other agency staff after repeated attempts for 90 days or more.

   1. Agencies that entered the Veteran into the BNL will hold the primary responsibility for maintaining data and monitoring engagement and progress of the Veteran.
   2. Agencies are expected to make significant weekly attempts to locate or contact the missing Veteran including alerting outreach teams to the fact that he/she is being sought; checking in HMIS to see if they he/she been entered into another program in the community; checking with law enforcement as to the possibility that he/she has been jailed. Contact attempts must include in-person, telephone, e-mail, and attempts to find them through their friends, close contacts, or other service providers.
   3. The agency will document attempts to locate the Veteran in the “Notes and Additional Information” column of the BNL with dates of attempts to contact.
   4. At the point that the Veteran is located and is identified as still literally homeless, a new entry should be started for the Veteran with a new date of identification reflecting the most recent contact.

iv. **Inactive—permanently housed**: currently no longer literally homeless: residing in permanent housing.

   1. This status is used to ensure that Veterans who have moved into any permanent housing are tracked as to their stability in housing. Once they are found to be in permanent housing, they will no longer be discussed during case conferencing.

v. **Inactive-non-permanently housed**: currently no longer literally homeless; residing in a non-permanent housing situation (i.e., friends/family-temporary tenure, residential treatment) This will also include Veterans in an institutional care facility (including jail, substance abuse or mental health treatment facility, hospital, domiciliary, or other similar facility, etc.) that have resided there for more than 90 days.
c. Changes of the status of a Veteran will be made by the agency assigned to that Veteran or by other participating staff, as applicable, as soon as a change in status has occurred.

d. Changes to status can be made during weekly BNL updates into HMIS, during Case Conferencing meetings, or via phone calls and/or discussions with the List Manager.

6. **Date Veteran Identified**: date of initial contact with a Veteran experiencing homelessness in any program including Street Outreach, ES, TH, Safe Haven, at a VA Medical Center or at any other point of the homeless system entry, including Veterans who are first time homeless and those who may have been homeless previously but exited homelessness at least 90 days prior to the date of identification.

7. **Last Review/Update on Master List**
   a. This is the date that any of the Veteran’s information on the BNL was updated.

8. **Last Known Location/Provider**
   a. If unsheltered, this is the estimated location of where the Veteran is known to reside (i.e., green tent under 24th street overpass in downtown)
   b. If Veteran is sheltered, this is the name (or address in the case of a treatment facility) of the agency who last entered their information into the BNL.

9. **Confirmed Veteran status** – using drop down menu:
   a. Yes
   b. No
   c. If unknown, please indicate “No” until you have further information and describe in the “Notes and Additional information” column

10. **VHA Eligible** - indicates whether or not the Veteran is eligible for healthcare at the VA - using drop down menu:
    a. Yes
    b. No
    c. Not Confirmed – If you do not have specific information that their VHA eligibility has been confirmed by the VA, do not choose yes or no. Indicate status/actions pending in the “Notes and Additional information” column

11. **SSVF Eligible** - using drop down menu:
    a. Yes
    b. No
c. Not Confirmed – please indicate status/actions pending in the “Notes and Additional information” column

12. **Permanent Housing Plan/Track** – This is the intervention that the Veteran has indicated s/he is interested in working towards or is already enrolled - using drop down menu, including:
   a. SSVF- RRH
   b. Other – RRH
   c. HUD VASH
   d. Other – PHA
   e. Other PH
   f. Self-Resolve/No Assist
   g. None currently

13. **Family Size** – Include the number of individuals the Veteran reports to you – even if s/he is not residing with the family members at current. Include spouse, children, parents, other adults that the Veteran plans to reside with, once permanently housed.

14. **Client Phone or e-mail**

15. **Veteran DOB** – list the Veteran’s date of birth

16. **Assessment Score** – This is the column where the VI-SPDAT score is recorded

17. **Chronic Status** – using a drop down menu
   b. Non-chronic
   c. Unknown

18. **Provider Name and Contact** -List the name of the organization that the Veteran is residing and list contact information
   a. If the Veteran is residing in a Drug or Alcohol treatment facility or HIV/AIDS treatment program, **DO NOT include the name of the treatment program** – only list the address of the facility.
b. The contact number may be the direct telephone number or e-mail address of the Veteran’s Case Manager or the facility’s main telephone number.

19. **Current Project Enrollment Type** – Indicate the type of program that the Veteran is enrolled or engaged - using a drop down menu including:
   i. Emergency Shelter (including Safe Haven and hotel/motel voucher, paid by an agency)
   ii. Transitional Housing (including GPD)
   iii. RRH – SSVF (Rapid Rehousing – Supportive Services for Veteran Families)
   iv. RRH- Other (Other type of Rapid Rehousing Program, i.e., 1,000 Veterans)
   v. VASH
   vi. Street Outreach
   vii. Not yet enrolled in a project
   viii. Other (this may include substance abuse treatment facilities or HIV/AIDS programs)

20. **Date Permanent Housing Plan Created** – Once the Veteran has been enrolled in a program and staff have created a housing plan for that Veteran, the date of the creation of the plan should be noted here.

21. **Physical Description** – Indicate anything that will assist Outreach staff in identifying the Veteran in the community, especially for Veterans who are “street-sleeping” (i.e., Veteran always has a purple hat on)

22. **Date of Move to TH, including GPD**

23. **Exit Destination - Permanent Housing**
   a. Owned by Client, no ongoing housing subsidy
   b. Owned by Client with on-going subsidy
   c. Permanent Housing for formerly homeless (such as COC Project, HUD housing program, Permanent HOPWA, Churchill, etc.)
   d. Rental by client, no ongoing housing subsidy
   e. Rental by client with VASH
   f. Rental by client with GPD Transition in Place (TIP) subsidy
   g. Rental by client with SSVF RRH
   h. Rental by client with other ongoing housing subsidy
   i. Staying or living with family permanently
   j. Staying or living with friends permanently
24. Date of Permanent Housing Placement /Exit from Literal Homelessness
   a. This is the date of move into permanent housing

25. Exit Destination – Other (non-Permanent Housing, non-literal homeless exits)
   a. Deceased
   b. Foster Care or group home
   c. Hospital or other residential non-psychiatric medical facility
   d. Hotel/motel not paid for by agency
   e. Jail, prison, or juvenile detention facility
   f. Long-term care or nursing home facility
   g. Psychiatric Hospital or other psychiatric facility
   h. Residential program or half-way house with no homeless criteria
   i. Stay/living with family temporarily
   j. Stay/live with friends temporarily
   k. Other
   l. No Exit interview conducted
   m. Client does not know
   n. Client refused
   o. Domiciliary (after 90 days of stay)

26. Date of Other Exit (from non-Literal Homelessness)
   a. This is the date the Veteran moved into non-Permanent Housing or into a facility that is classified as a non-literal homeless facility, as listed above.

27. Notes and Additional Information
   a. Do not include any Protected Health Information (PHI) in this section (i.e., diagnoses).

28. Permanent Housing Intervention – Subsidy or other forms of rental assistance, with appropriate services and supports. Interventions can include HUD-VASH, SSVF and COC program-funded rapid rehousing (where rental assistance is included), COC program-funded permanent supportive housing, Housing Choice Voucher (HCV), or other form of permanent housing subsidy or rental assistance.

29. Offers of Permanent Housing – Permanent Housing Intervention where the subsidy or rental assistance is immediately available at the time the offer is made, i.e. a Veteran can immediately be issued a voucher or subsidy and begin the housing search process (if the subsidy is not attached to a hard unit).
This section is to be used to demonstrate that an offer of a PH intervention has been made to any Veteran that has declined a PH intervention in the past. Veterans should be offered a PH intervention every 2 weeks, if possible, and documented in this section. The list repeats 4 columns 7 times to demonstrate a 90-day period of time, in accordance with the 90-day look back process that is required by the Federal Benchmarks and criteria. If after 90 days, write over the oldest intervention offered date and continue.

b. Date of Permanent Housing Intervention Offer
c. Type of PH Intervention Offered
   i. HUD VASH
   ii. SSVF
   iii. COC Program with Rental Assistance
   iv. COC Program with PSH
   v. Housing Choice Voucher
   vi. Other Permanent Housing Subsidy
   vii. Other Rental Assistance
d. Accept or Decline Offer – using drop down menu
   i. Accept
   ii. Decline
e. Date of Accept or Decline – if a Veteran accepts, the staff person updating the BNL will need to edit other previous columns of the BNL such as
   i. Permanent Housing Plan/Track
   ii. Date Permanent Housing Plan Created

30. Self-Calculating Client-Level Measures - do not write in this section, as it auto-populates data from entered data elements

31. Optional – Local Data Elements
   a. ROI Signed – as per Privacy Section, above, the Veteran must sign the following ROI’s:
      i. San Diego County HMIS Multiparty Authorization to Use and /or Disclose Information
      ii. VA Release of Information
   b. Date ROI Signed
Case Conferencing

1. Case Conferencing discussions will occur bi-weekly, or on such schedule as agreed upon by the Veteran Sub-Population Committee.

2. The List Manager:
   a. Schedules the Case Conference and communicates to interested parties relevant information about the Case Conference (location, time, cancellations, etc.).
   b. Sorts the BNL to ensure efficiency of Case Conference meetings and manages data to ensure that there are no duplications on the list.
   c. Manages and communicates weekly BNL updates
      i. Ensures that the BNL is updated to reflect discussion during Case Consultation meetings.
      ii. Ensures that the updates to the BNL from the Case Conferencing meetings are shared with participating agencies after the meeting within the designated time period (as set by the List Manager).

3. All providers included on the BNL, HMIS and/or VI-SPDAT Multiparty Authorization/ROIs can participate in the case conferencing meetings and can add/update information about Veterans experiencing homelessness. If an agency serves Veterans and wishes to participate in these discussions and in tracking the data on the BNL they will work with the List Manager and RTFH to receive training and permission to participate (see Data Entry, Data Sharing Processes and Responsibilities, HMIS Reconciliation 3. a. – e., above).
   a. It is preferred that even agencies who are not currently entering data into HMIS participate in Case Conferencing meetings, as it is important that all Veterans be represented on the list (see Data Entry, Data Sharing Processes and Responsibilities, HMIS Reconciliation 2. a., above).

4. During the course of a Case Conference meeting, when a Veteran is “assigned” to a new agency, that agency will agree to contact the Veteran within 2 business days.

5. Discussions of Veterans during Case Conferencing will be determined by List Manager and will cover the following:
   a. Newly identified and unassigned Veterans
   b. Most vulnerable, as determined by VI-SPDAT score
   c. Still on the street, unengaged
   d. Involved in a housing search for more than 90 days
   e. Veterans who are inactive-missing
f. Veterans whom the participating agency/staff member would like to have consultation/assistance

Attachments

1. San Diego County Regional Continuum of Care Council’s Homeless Management Information System (HMIS) Policies and Procedures
2. VA Release of Information
3. Blank BNL Spreadsheet
4. Email- “VA Privacy Guidance on Authority to Make Disclosures to Community Partners,”
Appendix 8: Record of Changes

CAHP policies and procedures will be updated as needed to ensure that they accurately reflect current operations and decisions about the system. The table below will be used to provide a record of substantive changes to policies and procedures. The Section and Subsection where the change was made, the date of the revision, and a brief description of the change will be recorded in the table below.

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