Cambridge CAN Policies and Procedures

Version 2.0 (December 3, 2019)
First version released January 23, 2018

Contents

A. Introduction

1. The Cambridge Continuum of Care (CoC) is responsible for coordinating and implementing a system to address the needs of both people experiencing homelessness and those who are at risk of homelessness within the City of Cambridge. The Continuum of Care interim rule at 24 CFR 578, the Emergency Solutions Grant Interim rule at 24 CFR 576, and HUD notice CPD-17-01, Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System ("Coordinated Entry Notice") require dictate that the CoC must establish a system of Coordinated Entry and consistently follow written policies and procedures for operating that system.

   In addition to the System Requirements and Procedures contained herein, Cambridge CAN operates in full concordance with the Cambridge Continuum of Care's CoC and ESG Written Standards (respectively, as pertains), HMIS Policies and Procedures, Antidiscrimination Policy, and other local governing documents.

2. The purpose of this document is to establish requirements and procedures on the system level, ensuring that the CoC is in compliance with HUD regulations concerning Coordinated Entry. This document is primarily responsive to the CoC's regulatory responsibilities; while it dictates some key operational requirements and processes, it is not intended as a comprehensive programmatic guide.

B. Definitions

1. ***Coordinated Entry***: Coordinated Entry is as defined in the CoC Program interim rule at 24 CFR 578.3, and as further described by HUD Notice CPD-17-01. This term is synonymous with Coordinated Intake, Coordinated Access, and Coordinated Assessment.

2. ***Cambridge CAN***: The Cambridge Coordinated Access Network (Cambridge CAN or C-CAN) is a local system, supported in part by a dedicated HUD Continuum of Care grant, fulfilling HUD's requirements for a Coordinated Entry system serving the Cambridge Continuum of Care.

3. ***Cambridge CAN Staff****:* Cambridge CAN staff are staff whose positions are funded in part or in whole by the CoC's Coordinated Entry grant, and/or who provide integral services supporting Cambridge CAN.

4. ***Cambridge CAN Partner Agency***: A Cambridge CAN partner agency is an agency that employs Cambridge CAN staff. Current Cambridge CAN partner agencies are CASPAR, Inc. (Bay Cove Human Services); the Cambridge Multi-Service Center for the Homeless (City of Cambridge); Eliot Community Human Services; and HomeStart.

5. ***Housing Partner Agency***: A housing partner agency is an agency which operates one or more Cambridge CAN participating housing projects.

6. ***Participating Housing Program***: A participating housing program is a grouping of housing beds that are generally administered under common operational criteria, and whose operating agency agrees, either on an opt-in basis or due to CoC program requirements, to take referrals solely from Cambridge CAN and to abide by the Cambridge CAN System Requirements and

Procedures. In this context, the terms project (for CoC-funded housing) and program are used synonymously.

7. ***Household***: A household is any configuration of people applying for assistance, including one individual alone.

8. ***Assessment***: Assessment is the use of one or more standardized assessment tool(s) to determine a household's current housing situation, housing and service needs, risk of harm, risk of future or continued homelessness, and other adverse outcomes.

9. ***Assessment Score***: The output of an assessment tools, which provides a standardized analysis of risk and other objective assessment factors.

10. ***Prioritization***: The coordinated entry-specific process by which all persons in need of assistance who use coordinated entry are ranked in order of priority.

11. ***Determining Eligibility***: Determining eligibility is a project-level process governed by written standards as established in 24 CFR 576.400(e) and 24 CFR 578.7(a)(9).

12. ***Homelessness***: Shall have the meaning defined in HUD's ESG Interim rule at 24 CFR 576.2.

13. ***Chronic Homelessness***: Shall have the meaning defined in HUD's Final Rule Defining Chronic Homelessness at 24 CFR 578.3.

14. ***At Risk of Homelessness***: Shall have the meaning defined in HUD's ESG Interim rule at 24 CFR 576.2.

15. ***Homeless Management Information System, or HMIS*****:** Shall have the meaning defined by The McKinney-Vento Homeless Assistance Act at 42 USC 11360a.

16. ***Cambridge HMIS (CHMIS), or Clarity*****:** The Cambridge CoC's HMIS, which is run on the software Clarity Human Services by Bitfocus, Inc.

C. System Overview

1. Cambridge CAN is supported by a HUD Continuum of Care grant and operated through a partnership between the City of Cambridge, Bay Cove Human Services / CASPAR, Inc., Eliot Community Human Services, and HomeStart, Inc. C-CAN is operated in conjunction with housing partner agencies and a broad array of other stakeholders represented in the CoC.

2. Cambridge CAN has the following primary programmatic functions:

    a) **Assess** people who are homeless in Cambridge, allowing our community's limited housing resources to be allocated to those who most need it, and in turn connecting prioritized clients to housing interventions that are most appropriate for their needs.

    b) **Refer** clients to services appropriate to their needs and interests—not only the limited "hard referrals" to services that are operationally connected to Cambridge CAN, but also "soft referrals" to any number of available resources. C-CAN staff maintain knowledge on a wide range of resources in order to facilitate referrals.

c) **Support** people experiencing homelessness throughout Cambridge with direct services in the form of street outreach, mental health assistance, housing navigation, and landlord engagement.

d) **House** clients in available vacancies at participating housing projects, as well as by helping housing navigation clients connect to other programs and/or market housing opportunities.

e) **Improve** the alignment of services and housing within the Cambridge Continuum of Care, making the system more accessible and equitable, identifying gaps and opportunities, and operationalizing Housing First principles.

3. Cambridge CAN offers separate access points and variations in assessment processes for three of the populations permissible per section I.B.2(a) of the Coordinated Entry Notice:

    a) Adults without children;

    b) Adults accompanied by children;

    c) Persons at risk of homelessness.

D. Access

1. **Access Points**

    a) Separate access points exist for three different populations (see C.3). However, clients fitting any of these three categories who present at any access point will be directed to an access point where they may receive assessment.

    b) **Access Points for Homeless Individuals**

        (i) **Centralized Access Point**: Cambridge CAN staff are available to administer assessments to individuals at the Cambridge Multi-Service Center for the Homeless during regular, fixed walk-in hours as well as on an appointment basis. The walk-in schedule is made publicly available at www.cambridgecoc.org/cambridgeCAN as well as through distributed publicity materials.

        (ii) **Field-Based Access Points**: Cambridge CAN staff are available to administer assessments in the community, including on the street, to households who are not willing or able to visit the Multi-Service Center.

            (a) *Scheduled*: C-CAN staff maintain a regular schedule of community-based access points at specific times and locations based on community need. The field-based access point schedule is made publicly available at www.cambridgecoc.org/cambridgeCAN.

            (b) *Mobile/On-Demand*: C-CAN staff are available to travel within the Cambridge CoC in order to provide assessments as needed. Mobile assessment staff may be requested by any stakeholder or community member, including any household who wishes to be assessed. Requests are dealt with as promptly as logistics

permit. For mobile assessment requests, households should call FirstStep Street Outreach at 617-592-6895 or contact the C-CAN Specialist.

c) Access Point for Homeless Families

Cambridge CAN staff are available to administer assessments to families at the Cambridge Multi-Service Center for the Homeless during regular, fixed walk-in hours as well as on an appointment basis. The walk-in schedule is made publicly available at www.cambridgecoc.org/cambridgeCAN as well as through distributed publicity materials.

d) Access Point for Persons at Risk of Homelessness

Cambridge CAN staff are available to administer assessments to individuals and families at risk of homelessness on a walk-in basis at the Cambridge Multi-Service Center for the Homeless during the MSC's business hours.

2. **Access to Emergency Services**

Cambridge CAN does not use assessments or prioritization processes to make referrals or placements for emergency services, including emergency shelter. Referrals are made based on the household's wants, needs, and goals. Each emergency services provider maintains its own intake procedures and access protocols; Cambridge CAN does not introduce any barriers to entry to these services.

Emergency service providers funded by Cambridge's Emergency Solutions Grant (ESG) are required to refer households for a C-CAN assessment (utilizing any of the access point options detailed above). To facilitate referral, emergency service providers participating in Cambridge HMIS are able to see in the HMIS database whether a household has already received a Cambridge CAN assessment.

3. **Marketing**

Cambridge CAN is well-advertised and marketed proactively through a range of avenues available to the CoC, including web communications, CoC meetings, and relationships with staff at provider agencies and community resources both HUD-funded and not. As part of the CoC's commitment to affirmatively furthering fair housing, Cambridge CAN with its attendant housing and supportive services are marketed to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or handicap who are least likely to apply in the absence of special outreach.

E. Assessment

1. **Eligibility for Assessment**

A household is eligible to begin a C-CAN assessment if the household is (1) either homeless or at risk of becoming homeless and (2) self-reports having, or is known through observation to have, one of the following connections to Cambridge: having lived in Cambridge while housed in the past; a current or previous episode of homelessness while sleeping in

Cambridge; or a relationship with a Cambridge-based homeless-specific or mainstream service provider.

2. **Pre-Screening**

   Before assessing a household, staff ask the household to self-report an eligible connection to Cambridge, and assist with diversion to the appropriate Continuum of Care's Coordinated Entry system if none is reported. Staff also determine which eligible population the household falls under, in order to follow the appropriate assessment process. Staff also seek information to determine whether the client's needs would be better served by an ESG Rapid Rehousing Case Manager. The prescreening phase is not currently built into CHMIS but is expected of staff for all clients.

3. **Assessment Tools**

   Following the pre-screening steps described above, a household is administered one of the following assessment tools, respective to the population under which the household falls:

   a) *For homeless individuals:*

      Individuals who are homeless are administered an assessment tool called the Cambridge Streamlined Assessment. This tool was developed by our CoC informed by feedback from stakeholders, and reflects local priorities as well as nearly three years of collective experience administering an earlier assessment tool. The Cambridge Streamlined Assessment is designed to be as simple and brief as possible and its purpose is to identify those individuals in our community who are most vulnerable and have the greatest barriers to housing.

   b) *For homeless families*:

      Families who are homeless are administered OrgCode Consulting's VI-SPDAT (Vulnerability Index – Service Prioritization Decision Assistance Tool) for Families. This tool is a screening designed to determine whether a household has high, moderate, or low acuity via an outputted score.

   c) *Persons at risk of homelessness*:

      Cambridge CAN assesses housed people who are at risk of becoming homeless using the Prevention Eligibility Screening Tool, which captures basic information on the client's situation in order to gauge their eligibility and type of need.

   Following assessment, a household is added to the Community Queue, which is the pool within Clarity of clients who are active and have not yet been referred to housing.

4. **Standardization of Assessment and Determinations**

   A given household is assessed using the standardized assessment methodology employed for that household's specific population. That methodology is the same for a given population regardless of the access point used.

Determinations related to prioritization for resources that accept prioritized referrals from C-CAN are centralized and standardized, not made at the point of assessment.

5. **Training of Assessors**

   All C-CAN assessors are trained to administer assessments upon hire and at least annually thereafter. The training curriculum reviews the System Requirements and Procedures, outlines requirements for the use of assessment information in determining prioritization, and outlines criteria for uniform decision-making and referrals. The resulting training materials, which clearly describe the assessment method in a way that ensures fidelity with the System Requirements and Procedures, are updated and distributed annually in coordination with the provided training opportunity.

6. **Reassessment**

   If a household's information has changed, they may request and receive C-CAN reassessment as needed, subject to staff availability.

F. Prioritization

1. Prioritization for a given resource is determined on the basis of households' assessment scores for that type of resource.

   a) In addition to the above, prioritization for Housing Navigation services also takes into consideration further situational factors.

2. Clients are not screened out of the coordinated entry process, or out of a referral for any given participating program, due to perceived barriers to housing or services.

3. **Resources Allocated Through Cambridge CAN**

   The following resources within the Cambridge CoC allocate assistance by receiving referrals solely from Cambridge CAN based on client prioritization:

   a) All housing projects funded under HUD's Continuum of Care program, including:

      (i) Permanent Supportive Housing;

      (ii) Rapid Re-Housing;

      (iii) and CoC project types of which at the time of writing there are currently none funded in Cambridge, including Transitional Housing and Joint Transitional Housing / Rapid Re-Housing;

      (iv) with exception made for projects operated by a VAWA provider, which accept prioritized referrals using a separate system of Coordinated Entry operated through the state network for DV providers.

   b) C-CAN Housing Navigation services.

   c) ESG-funded Homelessness Prevention and Rapid Rehousing.

d) Any additional programs, services, or resources that elect to opt in to Cambridge CAN by receiving prioritized referrals and otherwise abiding by its System Requirements and Procedures.

The following resources within the Cambridge CoC do not allocate assistance via referrals from Cambridge CAN:

e) Emergency shelter beds;

f) outreach services;

g) drop-in program services;

h) domestic violence services;

i) and any other program, service, or resource not listed as such in this section, per above.

4. **Prioritization Criteria for Resources Allocated Through Cambridge CAN**

a) *Permanent Housing: Permanent Supportive Housing*

Households are prioritized for PSH vacancies based on the following, progressive factors. Note that a household may be selected for a referral without each factor being considered; a factor is only applied in so far as there are still households with equal priority following the previous factor.

PSH Prioritization Factors (in order)
➢ Special Considerations under VAWA ➢ Chronic Homeless Status ➢ Assessment Scores ➢ Duration of Homelessness ➢ Date of C-CAN Enrollment

(i) *Special Considerations under VAWA*: Households fleeing domestic violence who qualify for an emergency transfer from a CoC funded PSH project shall have priority over all other applicants for PSH provided that the household meets all eligibility criteria required by Federal law or regulation or HUD Notice of Funding Availability; and the household meets any additional criteria established in accordance with 24 CFR 578.93(b)(1),(4),(6), or (7). The household shall retain their original homeless status for purposes of the transfer.

(ii) *Chronic Homeless Status*: Households are ordered by presumptive Chronic Homeless status, as based on a desk review by staff of the household's information in CHMIS, with those indicated as presumptively Chronically Homeless prioritized first.

(iii) *Assessment Scores*

(a) If the vacancy is for an individual, households are ordered by their Cambridge Streamlined Assessment score, with those receiving the highest score (those with the highest severity of service needs) prioritized first.

(b) If the vacancy is for a family, households are ordered by their score on the Family VI-SPDAT, with those receiving the highest score prioritized first.

(iv) *Duration of Homelessness*: Households are ordered by their total duration of homelessness, as recorded within CHMIS, with those having the longest duration prioritized first.

(v) *Date of C-CAN enrollment*: Finally, as per CPD-17-01 II.B.3, if multiple eligible households still maintain equal priority after the above factors have been considered, those households will be ordered based on their date of enrollment in the C-CAN CHMIS project, with the earliest date corresponding to the highest priority.

b) *Permanent Housing: Rapid Rehousing*

Households are prioritized for Permanent Housing RRH vacancies based on the following, progressive factors. Note that a household may be selected for a referral without each factor being considered; a factor is only applied in so far as there are still households with equal priority following the previous factor.

PH: RRH Prioritization Factors (in order)
➢ Special Considerations under VAWA ➢ Assessment Scores ➢ Date of C-CAN Enrollment

(i) *Special Considerations under VAWA*: Households fleeing domestic violence who qualify for an emergency transfer from a CoC funded RRH project shall have priority over all other applicants for RRH provided that the household meets all eligibility criteria required by Federal law or regulation or HUD Notice of Funding Availability; and the household meets any additional criteria established in accordance with 24 CFR 578.93(b)(1),(4),(6), or (7). The household shall retain their original homeless status for purposes of the transfer.

(ii) *Assessment Scores*

(a) If the vacancy is for an individual, households are ordered by their Cambridge Streamlined Assessment score, with those receiving the highest score (those with the highest severity of service needs) prioritized first.

(b) If the vacancy is for a family, households are ordered by their score on the Family VI-SPDAT, with those who have the highest score among those receiving a recommendation of Rapid Rehousing assessment prioritized first.

(iii) *Date of C-CAN enrollment*: Finally, as per CPD-17-01 II.B.3, if multiple eligible households still maintain equal priority after the above factors have been considered, those households will be ordered based on their date of enrollment in the C-CAN CHMIS project, with the earliest date corresponding to the highest priority.

c) *Transitional Housing*

At the time of the present version's (2.0) writing, no Transitional Housing projects participate in C-CAN.

d) *Housing Navigation Services*

The C-CAN Specialist assigns clients to Housing Navigation caseloads, in consultation with other C-CAN staff as appropriate, in a way that supports system goals of housing the most vulnerable clients and efficiently filling vacancies of C-CAN participating housing programs; the agency conducting Housing Navigation retains ultimate discretion in assignation of clients to caseloads.

The majority of the available caseload is to be filled with households having the highest Combined Vulnerability Index or Family VI-SPDAT score at the time of assignation. Other bases upon which a client might be added to a caseload may include:

(i) clients who have been offered referrals to CoC housing projects and need rapid assistance with document readiness;

(ii) clients presenting within the CoC who hold vouchers that are imminently expiring;

(iii) and clients who are not high-prioritized according to their combined score as mentioned above, but are among the highest prioritized for a given lower-acuity intervention, such as Transitional Housing or Rapid Rehousing.

These decisions are made solely on the basis of the client's situational factors, and never on the basis of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status.

e) *ESG Rapid Rehousing*

Households are prioritized for ESG RRH vacancies based on the following circumstances. Within each of the following prioritization groups, households are prioritized by move-in date, with those closer to a move-in date prioritized over those further away from a move-in date.

(i) Highest-prioritized are households needing first month's rent, last month's rent, and or a security deposit in order to move into a housing unit;

(ii) Next prioritized are households needing utility payment assistance when the payment(s) are necessary to move into a housing unit;

(iii) Next prioritized are households needing only moving assistance when that assistance is necessary to gaining and/or maintaining stability in a housing unit.

f) *Homelessness Prevention Services*

Households determined eligible for Homelessness Prevention services will be prioritized to receive services within each available Homelessness Prevention service by the date on which housing will be lost. Eligible participants referred by STAR partners shall be prioritized for STAR services.

G. Referral

1. The Cambridge CAN Specialist, located at the Multiservice Center, is the lead staff person responsible for coordinating and tracking housing referrals from C-CAN. The C-CAN Specialist works with participating housing providers to help them remain consistent with the referral process described here.

2. **Designations Required of Housing Partners**

    a) Each participating housing project must designate a contact staff person who is knowledgeable about that project and available to correspond with C-CAN staff during the referral process.

    b) Each participating housing project must confirm with CoC staff the eligibility criteria by which C-CAN will filter when selecting a referral. For CoC-funded projects, eligibility criteria are determined by the HUD-approved project application.

3. **Referral Process for Participating Housing Programs**

    a) *Reporting a Vacancy*

    When a project has a vacancy to be filled through referral from C-CAN, the agency must create a vacancy within Clarity. Each participating project has a staff person who is trained in generating vacancies.

    b) *Selecting a Client*

    Filtering out any clients known to be ineligible for the vacancy per the eligibility criteria attached to the project or to the bed/unit, The C-CAN Specialist identifies the highest-prioritized household for the available vacancy, per the CoC's Written Standards. Households are never screened out due to actual or perceived barriers to housing.

    c) *Offering the Referral*

    Within Clarity, the C-CAN Specialist refers the client from the Community Queue to the given vacancy. The C-CAN Specialist, either directly or through other staff who may have more direct contact with the identified client, attempts to contact the client to offer the referral and explain the available housing opportunity. If the client is already working with a Housing Navigator, the Housing Navigator will facilitate this process.

    (i) *Non-Responsive Households*

If staff attempt to reach a client without valid contact information for 4 business days after client has been selected for referral, the client's referral offer for that vacancy is withdrawn and the C-CAN Specialist moves to the next highest-prioritized household eligible for the available vacancy. The client will be rendered inactive (removed from the Community Queue in Clarity).

If no response appears forthcoming from the client 4 business days after client has been successfully contacted (including C-CAN staff or partnering staff speaking to the client directly; emailing an address provided by the client that does not bounce; or successfully leaving a voicemail at a phone number provided by the client), the client's referral offer for that vacancy is withdrawn and the C-CAN Specialist moves to the next highest-prioritized household eligible for the available vacancy. The client will be rendered inactive (removed from the Community Queue in Clarity).

(ii) *Client Declination of Referral*

If a household declines an offered referral, the C-CAN Specialist moves to the next highest-prioritized household eligible for the available vacancy. Declining a referral does not affect a household's ability to be offered another unit. The C-CAN Specialist may ask the household whether they would prefer not to be offered housing with certain characteristics in the future, and if affirmative this can be noted in CHMIS case notes to avoid offering unwanted opportunities in the future.

d) *Proceeding with the Referral*

When a selected household accepts the offer of referral, the receiving housing program should promptly begin working with the household to enroll and house them. This should preferably entail a "warm handoff" from Housing Navigators or outreach staff as well as communication with C-CAN staff to understand the level of documentation already established for the client.

e) *Rejecting a Referred Client*

A Housing Program may reject a client referral that it has received on one of the following bases:

(i) *Ineligibility*: The household is determined categorically ineligible for the available vacancy.

(ii) *Inability to document eligibility within 30 days*: 30 days after the client has been referred, eligibility remains unverified despite the program staff's best efforts. Contact with a non-responsive client must have been attempted, at a minimum, once per week. Rejecting a client in this circumstance is not required; however, if the program does not reject the client at this point they commit to working with the client for at least 30 more days.

(iii) *Safety concerns*: Serving the client under the given program would pose a clear danger to the client themselves, to program staff, or to other program participants.

(iv) *Landlord rejection*: The landlord refuses to accept the client as a tenant. This provision is only permissible for site-based beds or units where the landlord is not a CoC subrecipient, i.e. there is no possibility to find another landlord for the given housing opportunity.

All referral rejections must be completed within Clarity, using the HMIS protocol upon which they have been trained. Clients whose referrals are rejected return to the Community Queue, unless they were rejected for inability to establish contact. Rejection does not in and of itself affect a client's priority level in any way, except that a client who has been rejected from a program will not be referred again to the same program or type of program unless their rejection was based on client information that has changed in the intervening time period.

f) Arranging a housing transition (HT) meeting for a client referred to permanent housing by C-CAN is the default expectation. The HT meeting is a "warm handoff" entailing a transfer of care from a client's trusted supports during their time of homelessness (who may or may not continue to be available to them, depending on that provider's/person's scope of services or relationship to the client) to their new case managers in permanent housing. The meeting should be organized shortly after a client accepts a housing referral, although it may take place later up to the point of move-in if that would be beneficial to the individual client's outcome or if that is the client's strong preference. The meeting should not take place until there is someone associated with the housing program who has clear responsibility for the client's service provision, in order for that individual can be present.

The lead staff person in charge of organizing the HT meeting is a client's Housing Navigator, or if the client is not working with a Housing Navigator, their staff contact at the receiving housing program. The C-CAN Coordinator may also lead the process as appropriate, as long as there is clear communication from/with Housing Navigators and housing program staff. The staff person organizing the HT meeting should use what they know about the client, particularly whether they have any trusted supports persons in the community, as a starting point for asking the client about a meeting and whom they would like to be present. While staff should encourage clients to take advantage of the opportunity for an HT meeting, it is the client's ultimate decision whether to have one and who should be there. The meeting is not something that happens "about" the client but rather engages their full participation and autonomy. As the Omaha Metro Area CoC notes about warm handoffs, "transparent handoff of services allows the participant to hear what is said and engages them in communication, giving them the opportunity to clarify or correct information or ask questions about their service options." Staff should be open-minded about who to invite to a meeting if the client identifies them as a trusted support—while this may be a well-known supportive services provider in our community such as FirstStep, it may also be a provider from another CoC, a medical provider, a trusted friend or family member, etc.

Ideally an HT meeting should happen in person, but a phone meeting is preferable to none when logistics or client preference dictate. Relevant staff should record progress towards, and completion of, the HT meeting in the Referral Notes section of CHMIS.

4. **Referral Process for Housing Navigation**

   a) Housing Navigators remain in communication with the C-CAN Specialist on an ongoing basis regarding availability to take on new clients.

   b) The C-CAN Specialist works with Housing Navigators to assign clients to Housing Navigation caseloads, as availability arises, per the criteria outlined in Section F.4.d).

5. **Referral Processes for ESG Rapid Rehousing and Prevention Services**

   Referrals for these resources are not made following a standard C-CAN assessment for homeless households; rather, presumptively eligible households are diverted towards intake and assessment processes for these resources as described in Section E.2.

6. **Client Inactivity**

   A household that is not offered a referral to a participating Housing Program or to Housing Navigation services due to lack of response (as described in Section G.3.c)(i)) is marked inactive by the C-CAN Specialist. A client may also be marked inactive if providers can collectively confirm that the client appears to no longer be in the area. The client is informed of their inactive status if there is any known avenue (i.e. voice mailbox, email address) by which to do so.

   Clients are marked inactive by exiting them in Clarity from the Community Queue, but not from the C-CAN project; they are thus not included within the pool of potential households when prioritization decisions are being generated for referrals. Upon the one-year date of an inactive client's original assessment, the C-CAN Specialist will attempt to establish contact with the client again. If the client is still unable to be contacted, they will be exited from the C-CAN project within CHMIS.

   An inactive household may become active at any point by indicating to the C-CAN Specialist verbally or in writing that they would like to be made active, or if they are observed in the area by providers after previously being believed to have left.

7. **Voluntary Withdrawal by Client**

   A household may voluntarily be exited from C-CAN by indicating such to the C-CAN Specialist in writing or verbally.

H. Accessibility and Non-Discrimination

1. Cambridge CAN operates in full accordance with the Cambridge CoC's Antidiscrimination Policy. Cambridge CAN is available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status and data collected from the assessment process is not used to discriminate or prioritize households on these bases. This includes conducting

operations in accordance with HUD's final rule on Equal Access in Accordance with an Individual's Gender Identity in Community Planning and Development Programs. Clients are not "steered" toward any particular housing facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children, through referrals to participating housing projects, while working with Housing Navigators, or as part of any other interaction with Cambridge CAN. All persons belonging to various populations and subpopulations in Cambridge, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, have fair and equal access to the coordinated entry process; belonging to a subpopulation that may have special eligibility for other dedicated resources does not affect a client's prioritization nor ability to receive services within Cambridge CAN.

These System Requirements and Procedures are designed to permit participating recipients of Federal and State funds to comply with applicable civil rights and fair housing laws and requirements. In particular, projects funded by the CoC and ESG Programs must comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws including the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Titles II and III of the Americans with Disabilities Act.

2. **Nondiscrimination Complaints**

At the point of assessment, clients are informed of their ability to file a nondiscrimination complaint. A client may file a nondiscrimination complaint by completing and submitting the web form located at http://www.cambridgecoc.org/ccan-discrimination-complaint or by submitting a completed paper copy of the form in Appendix C and mailing to Planning and Development, 51 Inman Street, Cambridge MA 02138. The complaint will be assigned to a City of Cambridge staff person who will issue a response, indicating any corrections that will be made in response to the complaint if appropriate, within 10 business days of receipt. A client has the right to lodge an appeal using the same blank form to the address above, at which point a panel consisting of the original respondent's supervisor and two representatives of CoC agencies without direct involvement in the case will review the appeal and issue a final decision within 15 business days.

Cambridge CAN nondiscrimination complaints must pertain to discrimination perceived in the processes of assessment, prioritization, or referral to participating programs. Complaints related to a client's experience receiving direct supportive services, for example outreach Housing Navigation, must be addressed through the due process of the agency against which the client has a complaint, even if otherwise under the auspices of Cambridge CAN.

3. **Accessibility for People with Disabilities**

The sites of all access points are selected to be broadly accessible to persons with physical disabilities. If one of these sites still presents as inaccessible to a given client, Cambridge CAN's multiple access points and ability to dispatch outreach workers to a client on the street allows the flexibility to ensure the client is able to access intake.

Cambridge CAN staff make available, as needed, appropriate and effective communication services accessible to persons with disabilities.

4. **Language Access**

   The CoC takes reasonable steps to ensure that Cambridge CAN is accessible to persons of Limited English Proficiency (LEP), per HUD's LEP guidance (72 FR 2732). All Cambridge CAN staff have access to a dedicated telephonic interpretation service to serve clients who speak a language for which the system otherwise does not have existing capacity. Data collected at intake includes the language that the client is most comfortable in, and these data are reviewed periodically to assess the prevalence of different languages in order to inform evolving language access needs. Key documents, including the Cambridge CAN marketing flyer and the Cambridge CAN Release of Information, are translated into languages with the highest level of community need.

I. Data Privacy and Consent

1. Cambridge CAN operates in full concordance with the Cambridge CoC's HMIS Policies and Procedures, which ensure adequate privacy protections for all participant information per the HMIS Data and Technical Standards. As such, all C-CAN-related data kept in CHMIS is dealt with by users of HMIS who are informed and understand the privacy rules associated with collection, management, and reporting of client data.
2. Before soliciting or collecting any data as part of the Cambridge Streamlined Assessment or the F-VI-SPDAT, clients are given and explained a Release of Information specific to Cambridge CAN. Only clients with a valid Cambridge CAN Release of Information may be given a C-CAN assessment.
3. Upon engaging Cambridge CAN staff for an assessment, clients are explained the C-CAN Release of Information and the implications of consenting to release their information to Cambridge CAN and for it to be stored within Cambridge HMIS.
4. Per the above, once a household has given consent to be assessed, they may still decline to answer any given question.
5. No client is ever required to disclose a specific disability or diagnosis. Specific disability or diagnosis information is only obtained for purposes of determining program eligibility to make appropriate referrals.
6. The list of assessed households that is prioritized and then filtered by eligibility criteria to determine referrals is maintained within a software product called Looker, which is subject to the same HMIS data privacy and security protections prescribed by HUD for HMIS practices in the HMIS Data and Technical Standards.

J. Miscellaneous

1. **Participant Autonomy**

a) No household is required to complete a Cambridge CAN assessment. Declining to engage the Cambridge CAN system does not limit a household's general ability to receive assistance, although they will be unable to access those resources that receive referrals from Cambridge CAN.

b) A household completing a Cambridge CAN assessment reserves autonomy to decline to answer, without fear of retribution, any question that is part of the assessment. This does not limit the household's ability to receive assistance, except that their assessment score will not include points they may have otherwise received from answering that given question, and that declining to answer a question may prevent the household from receiving a referral to a given program if the program has an eligibility criterion directly tied to that question. Neither assessment nor services themselves are denied to a participant due to the participant refusing to provide certain pieces of information, except for information necessary to establish or document program eligibility per the applicable program regulation.

2. **Safety Planning**

a) Cambridge CAN is equipped to address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim specific providers.

b) Per Cambridge HMIS protocol, identifying data of persons fitting the above category are entered anonymously into HMIS.

c) Assessors assist clients in connecting to the state network of victim service providers, if the client wishes to access referral to resources specific to victim services. After completing intake, assessors provide clients with a number of community resources tailored to their apparent needs; among these are services and hotlines for people experiencing domestic violence, dating violence, sexual assault, or stalking, including culturally and/or linguistically targeted services focused on Latino/a/x, Asian-American, and LGBTQ+ populations.

d) No person is ever denied access to the coordinated entry process on the basis that she or he is or has been a victim of domestic violence, dating violence, sexual assault or stalking.

3. **Evaluation**

a) Ongoing informal program and system feedback is encouraged as a key operating principle on the part of all stakeholders with involvement in C-CAN. Avenues for this feedback include the open, monthly meetings of the CoC's Coordinated Entry Working Group, and direct communication with the Coordinated Entry Project Manager and other City of Cambridge staff.

b) Further, Planning and Development is responsible for formal evaluation of the intake, assessment, and referral processes that make up part of C-CAN:

(i) This evaluative effort takes place at least once per calendar year.

(ii) Feedback from this yearly evaluative process will be synthesized by Planning and Development staff in a summary report and presented to the CoC's Coordinated Entry Working Group. The Working Group will use this information to determine whether changes to System Requirements and Procedures should follow.

(iii) Solicitations for feedback address the quality and effectiveness of the entire C-CAN experience for both participating projects and households:

(a) *Feedback Solicitation from Clients*

Representative selections will be made from two groups of clients: those who have been assessed and still remain homeless; and those who have participated in C-CAN in the past and are now housed. Client selections will be made without consideration for anticipating the client's level of satisfaction. However, the process of selecting clients may include measures to minimize the likelihood of feedback solicitation unduly confusing or burdening a client. All feedback provided by clients is collected anonymously using a written survey; any comments offered that may be inadvertently identifying are redacted when feedback is synthesized.

(b) *Feedback Solicitation from Participating Housing Programs*

Feedback will be solicited from all housing partner agencies using a written survey.

(c) *Other Feedback Solicitation*

Feedback from other stakeholders within the system may optionally be sought in support of the evaluative process.

4. This document is made publicly available in the Resources section of the Cambridge CoC's website at www.cambridgecoc.org. The document bears a version number reflecting the presence of any changes from prior versions, and is dated. Major updates to this document are communicated to relevant stakeholders and announced at Coordinated Entry Working Group meetings.

C-CAN Participating Programs and Services

Programs and services listed below now receive referrals solely from Cambridge CAN. Following a Cambridge CAN intake, clients are entered into the pool to potentially be offered a referral to any program below for which they are eligible, if they have received highest priority for a given program based on their acuity/type of need.

Permanent Supportive Housing

AIDS Action Committee: Supportive Housing Ending Homelessness

Cambridge Housing Authority: Tenant-Based Rental Assistance (service providers: AIDS Action Committee, Heading Home)

Cambridge Housing Authority: YMCA SRO (service providers: AIDS Action Committee, Heading Home, Vinfen)

Cambridge Multi-Service Center for the Homeless: Carey PSH

Heading Home: Cambridge Homeless to Housing PSH

Heading Home: Cambridge Stepping Stone PSH

Heading Home: Duley House

Heading Home: Solid Ground PSH

HomeStart: Going Home PSH

HomeStart: Key PSH

Vinfen: Community Based Flexible Supports PSH

Rapid Re-Housing

AIDS Action Committee: Youth Rapid Re-Housing (CoC Program)

Cambridge Multi-Service Center for the Homeless: Rapid Re-Housing (ESG Program)

Just-A-Start: Rapid Re-Housing (CoC Program)

Supportive Services

HomeStart: Housing Navigation

Eliot Community Human Services: Clinical Case Management

Prevention Services for People at Risk of Homelessness

Cambridge Multi-Service Center for the Homeless: Support for Tenants at Risk (STAR)

Authorization for Release of Information
Client Information Sheet

Important: Personally identifying information should never be entered into HMIS for clients who are currently fleeing or in danger from a domestic violence, sexual assault or stalking situation. If this applies to you, do not agree to release your information in HMIS. Your provider will enter an anonymous record in HMIS to protect your identity.

The Cambridge Coordinated Access Network (C-CAN) is a partner in the Cambridge Homeless Management Information System (HMIS), a project of the Cambridge Continuum of Care, which collects information about the characteristics and service needs of individuals and households experiencing or at risk of experiencing homelessness. This information helps continue funding and improve the services and programs for you and other homeless and low-income households.

- This information is necessary for determining your eligibility for housing and services.
- Your HMIS information may be shared to coordinate referral and placement for housing and services.
- Your HMIS information may be further shared by the Partner Agencies to other agencies for care coordination, counseling, food, utility assistance, and other services.

You will never be denied help because you didn't answer a question, unless we need that answer to know if you are eligible for a service.

This authorization is voluntary and allows sharing information needed for entering and moving through the Coordinated Access System. You will not be denied help if you do not want to sign this form or if you do not want to allow C-CAN to share your personal information.

This consent will expire 3 years from the date on the signature form. You have the right to revoke this consent at any time by giving written notice in writing to:

Cambridge HMIS/Office of Planning and Development
ATTN: Marianne Colangelo
51 Inman Street
Cambridge, MA 02139

Revoking this consent will take effect upon receipt, but will not affect any action taken or information shared prior to notice of revocation.

You may have a copy of this authorization.
Your name and other identifying information will never be included in any reports or

publications. We will guard this information with strict security policies to protect your privacy. The CHMIS in an electronic database that is protected by passwords and encryption technology. Every person and agency that is authorized to read or enter information in the database has signed an agreement to maintain the security and confidentiality of the information. Any person or agency that is found to violate the agreement may have their access right terminated and may be subject to further appropriate corrective measures.

A list of the partner agencies within the Cambridge Homeless Management Information System are listed on the back of this page and may change from time to time. The most updated list may be viewed online at http://cambridgecoc.org/hmis-participating-agencies/.

HMIS Participating Agencies

Bridge Over Troubled Waters
Cambridge MultiService Center
CASCAP, Inc.
CASPAR, Inc.
Eliot Community Human Services
Heading Home, Inc.
HomeStart, Inc.
Just-A-Start Corporation
New Communities
Phillips Brooks House Association
Salvation Army of Cambridge
Vinfen

Client Informed Consent/Release of Information

By signing this form, I agree to share the following level of information with other HMIS partner agencies who use the Cambridge Homeless Management Information System (HMIS):

- ❑ I agree to share my primary identifying information and general client information with other HMIS partner agencies. Primary identifying information is: Name, Date of Birth, Social Security Number, and Gender. General client information is: Race, Ethnicity and Veteran Status.
- ❑ I do not agree to share any of my information with other HMIS partner agencies.

I UNDERSTAND THAT:

- My personal information will not be made public and will only be used with strict confidentiality.
- I can take away my consent at any time completing another form and indicating that I do not agree to share this information. However, the revocation will not be retroactive to any information that has already been released.
- Unless revoked, this consent form expires in three (3) years.
- This agency has posted a Privacy Notice and I may request a paper copy from this agency.
- I have read the information sheet, or someone read it to me. I had the chance to ask questions.

Dependent children under 18 in household, if any (first and last names):

_____ _____ _____

_____ _____ _____

_____

Client Name (Printed)

_____ _____

Signature of Client (or Parent/Guardian) Date

Cambridge Coordinated Access System
Client Notice and Consent for Release of Information

I, _____(print client's name), understand that the Cambridge Coordinated Access System (C-CAN) is a partnership of agencies sharing information to provide a more coordinated homeless response system. I authorize that my information can be shared by C-CAN partners to improve services for me. I also authorize that my information can be viewed by the Cambridge Homeless Management Information System (HMIS) designated System Administrators for the purpose of system evaluation, which will help improve services offered to me and others in the Cambridge community.

PURPOSE OF SHARING

Information from the Cambridge CAN screening and assessments will be shared for the purpose of:

- Assessing my program eligibility
- Prioritizing my need for services
- Linking me to the most appropriate services
- Evaluating Cambridge CoC program and system performance
- Evaluating for service gaps, needs and duplication in the Cambridge HMIS

DESCRIPTION OF INFORMATION THAT CAN BE SHARED

This form authorizes identifying assessment information, incuding but not limited to the items listed below, to be routinely shared in the Cambridge HMIS to better help me and/or my family.

- Family/Household Information (Names, Date of Birth, Race, Gender)
- Employment, Income and Benefits Information
- Housing History and Barriers
- Homeless Status and History
- Veteran Status
- Program and Service Involvement and Contacts
- Basic medical, mental health, substance use, and daily living information

INFORMATION FROM CAMBRIDGE CAN ASSESSMENTS MAY BE SHARED WITH:

- Housing Providers
- Veterans Services Offices
- Service Providers
- Shelter Programs

(Continued on back page)

By initialing "yes" below and affixing my signature, I agree that my information may be shared with other Cambridge CAN partners and System Administrators. I also understand that agencies participating in Cambridge HMIS may change from time to time and that a copy of the current list of agencies is available online at http://cambridgecoc.org/hmis-participating-agencies/ and in hard copy by request.

Yes:___ No:___Date:_____ Client Signature: _____

Verbal Consent Only (complete only when participant consents but is unable to sign):

I certify under penalty of perjury that I verbally read this consent form to the participant and the participant consents to all of the statements therein.

Yes: ___ Date:_____ Staff Signature on Client's Behalf:_____

Agency Name: _____

CLARITY HMIS: HUD-CoC PROJECT INTAKE FORM

Use block letters for text and bubble in the appropriate circles.
Please complete a separate form for each household member.

PROJECT START DATE *[All Clients]*

		-			-				

Month **Day** **Year**

SOCIAL SECURITY NUMBER *[All Clients]*

			-			-				

QUALITY OF SOCIAL SECURITY			
○	Full SSN reported	○	Client doesn't know
		○	Client refused
○	Approximate or partial SSN reported	○	Data not collected

CURRENT NAME *[All Clients]*																			**N/A**
Last																			○
First																			
Middle																			○
Suffix																			○

QUALITY OF CURRENT NAME			
○	Full name reported	○	Client doesn't know
○	Partial, street name, or code name reported	○	Client refused
		○	Data not collected

DATE OF BIRTH *[All Clients]*

		-			-					Age:

Month **Day** **Year**

QUALITY OF DATE OF BIRTH			
○	Full DOB reported	○	Client doesn't know
○	Approximate or partial DOB reported	○	Client refused
		○	Data not collected

GENDER *[All Clients]*

○	Female	○	Client doesn't know
○	Male	○	Client refused
○	Trans Female (MTF or Male to Female)	○	Data not collected

○	Trans Male (FTM or Female to Male)
○	Gender Non-Conforming (i.e. not exclusively male or female)

RACE (Select all applicable) *[All Clients]*

○	American Indian or Alaskan Native	○	Client does not know
○	Asian	○	Client refused
○	Black/African American	○	Data Not Collected
○	Hawaiian or Other Pacific Islander		
○	White/Caucasian		

ETHNICITY *[All Clients]*

○	Non-Hispanic/ Non-Latino	○	Client does not know
		○	Client refused
○	Hispanic/Latino	○	Data Not Collected
		○	Other

VETERAN STATUS *[All Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected
IF "YES" TO VETERAN STATUS			
Year entered military service (year)			
Year separated from military service (year)			
Theater of Operations: World War II			
○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected
Theater of Operations: Korean War			
○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected
Theater of Operations: Vietnam War			
○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected
Theater of Operations: Persian Gulf War (Desert Storm)			
○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected
Theater of Operations: Afghanistan (Operation Enduring Freedom)			

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected
Theater of Operations: Iraq (Operation Iraqi Freedom)			
○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected
Theater of Operations: Iraq (Operation New Dawn)			
○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected
Theater of Operations: Other peace-keeping operations or military interventions (such as Lebanon, Panama, Somalia, Bosnia, Kosovo)			
○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

Branch of the Military			
○	Army	○	Coast Guard
○	Air Force	○	Client doesn't know
○	Navy	○	Client refused
○	Marines	○	Data not collected
Discharge Status			
○	Honorable	○	Dishonorable
○	General under honorable conditions	○	Uncharacterized
○	Other than honorable conditions (OTH)	○	Client doesn't know
		○	Client refused
○	Bad Conduct	○	Data not collected

RELATIONSHIP TO HEAD OF HOUSEHOLD *[All Client Households]*

○	Self	○	Head of household - other relation to member
○	Head of household's child		
○	Head of household's spouse or partner	○	Other: non--relation member

WHEN CLIENT WAS ENGAGED *[Street Outreach Only or Night by Night Emergency Shelter]*

Date of Engagement:	____/____/_____

IN PERMANENT HOUSING *[Permanent Housing Projects, for Heads of Households]*

PRIOR LIVING SITUATION

TYPE OF RESIDENCE *[Head of Household and Adults]*

○	Place not meant for habitation (e.g., a vehicle, an abandoned building, bus/train/subway station/airport or anywhere outside)	○	Staying or living in a family member's room, apartment or house
○	Emergency shelter, including hotel or motel paid for with emergency shelter voucher, or RHY-funded Host Home shelter	○	Rental by client, with GPD TIP housing subsidy
○	Safe Haven	○	Rental by client, with VASH housing subsidy
○	Foster care home or foster care group home	○	Permanent housing (other than RRH) for formerly homeless persons
○	Hospital or other residential non--psychiatric medical facility	○	Rental by client, with RRH or equivalent subsidy
○	Jail, prison or juvenile detention facility	○	Rental by client, with HCV voucher (tenant or project based)
○	Long-term care facility or nursing home	○	Rental by client in a public housing unit
○	Psychiatric hospital or other psychiatric facility	○	Rental by client, no ongoing housing subsidy
○	Substance abuse treatment facility or detox center	○	Rental by client, with other ongoing housing subsidy
○	Residential project or halfway house with no homeless criteria	○	Owned by client, with ongoing housing subsidy
○	Hotel or motel paid for without emergency shelter voucher	○	Owned by client, no on-going housing subsidy
○	Transitional housing for homeless persons (including homeless youth)	○	Client doesn't know
○	Host Home (non-crisis)	○	Client refused
○	Staying or living in a friend's room, apartment or house	○	Data not collected

LENGTH OF STAY IN PRIOR LIVING SITUATION

○	One night or less	○	One month or more, but less than 90 days	○	Client doesn't know
○	Two to six nights	○	90 days or more, but less than one year	○	Client refused
○	One week or more, but less than one month	○	One year or longer	○	Data not collected

LENGTH OF STAY LESS THAN 7 NIGHTS *[TH, PH]*

○	No	○	Yes

LENGTH OF STAY LESS THAN 90 DAYS

[*Institutional Housing Situations.]*

○	No	○	Yes

ON THE NIGHT BEFORE - DID YOU STAY - STREETS, IN EMERGENCY SHELTER, SAFE HAVEN

[Head of Household and Adults]

○	Yes	○	No
Approximate Date Homelessness Started		____/____/_____	
Number of *times* the client has been on the streets, ES, or Safe Haven in the last 3 years			
○	One Time	○	Client doesn't know
○	Two Times	○	Client refused
○	Three Times	○	Data not collected
○	Four or More Times		
Total Number of *Months* homeless on the streets, ES, or Safe Haven in the last 3 years			
○	One month (this time is the first month)	○	Client doesn't know
○	2--12 months (specify number of months): _____	○	Client refused
○	More than 12 months	○	Data not collected

DISABLING CONDITION *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

PHYSICAL DISABILITY *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO PHYSICAL DISABILITY – SPECIFY				
Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

DEVELOPMENTAL DISABILITY *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

CHRONIC HEALTH CONDITION *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO CHRONIC HEALTH CONDITION – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

HIV-AIDS *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

MENTAL HEALTH PROBLEM *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO MENTAL HEALTH CONDITION – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

SUBSTANCE ABUSE PROBLEM *[All Clients]*

○	No	○	Both alcohol and drug abuse
○	Alcohol abuse	○	Client doesn't know
		○	Client refused
○	Drug abuse	○	Data not collected

IF "ALCOHOL ABUSE" "DRUG ABUSE" OR "BOTH ALCOHOL AND DRUG ABUSE" – SPECIFY

Expected to be of long-continued and indefinite duration and substantially impairs ability to live independently?	○	No	○	Client doesn't know
	○	Yes	○	Client refused
			○	Data not collected

DOMESTIC VIOLENCE VICTIM/SURVIVOR *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO DOMESTIC VIOLENCE

WHEN EXPERIENCE OCCURRED

○	Within the past three months	○	One year ago or more
○	Three to six months ago (excluding six months exactly)	○	Client doesn't know
		○	Client refused

○	Six months to one year ago (excluding one year exactly)	○	Data not collected		
Are you currently fleeing?		○	No	○	Client doesn't know
		○	Yes	○	Client refused
				○	Data not collected

INCOME FROM ANY SOURCE *[Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO INCOME FROM ANY SOURCE – INDICATE ALL SOURCES THAT APPLY					
Income Source		**Amount**	**Income Source**		**Amount**
○	Earned Income		○	Temporary Assistance for Needy Families (TANF)	
○	Unemployment Insurance		○	General Assistance (GA)	
○	Supplemental Security Income (SSI)		○	Retirement Income from Social Security	
○	Social Security Disability Insurance (SSDI)		○	Pension or Retirement Income from a Former Job	
○	VA Service-Connected Disability Compensation		○	Child Support	
○	VA Non-Service-Connected Disability Pension		○	Alimony and Other Spousal Support	
○	Private Disability Insurance		○	Other source	
○	Worker's Compensation				
Total Monthly Income for Individual:					

RECEIVING NON-CASH BENEFITS [*Head of Household and Adults]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO NON-CASH BENEFITS – INDICATE ALL SOURCES THAT APPLY			
○	Supplemental Nutrition Assistance Program (SNAP)	○	TANF Childcare Services
○	Special Supplemental Nutrition Program for Women, Infants, and Children (WIC)	○	TANF Transportation Services
○	Other (**Specify):**	○	Other TANF-funded services

COVERED BY HEALTH INSURANCE *[All Clients]*

○	No	○	Client doesn't know
○	Yes	○	Client refused
		○	Data not collected

IF "YES" TO HEALTH INSURANCE - HEALTH INSURANCE COVERAGE DETAILS			
○	MEDICAID	○	Employer Provided Health Insurance

○	MEDICARE	○	Health Insurance Obtained Through COBRA
○	State Children's Health Insurance (SCHIP)	○	Private Pay Health Insurance
○	Veteran's Administration (VA) Medical Services	○	State Health Insurance for Adults
○	Other (specify):	○	Indian Health Services Program

SEXUAL ORIENTATION *[For CoC: YHDP funded programs-Adults and Head of Households]*

○	Heterosexual	○	Other
○	Gay	*If Other please specify:*	
○	Lesbian	○	Client doesn't know
○	Bisexual	○	Client refused
○	Questioning/Unsure	○	Data not collected

➢ Cambridge Streamlined Assessment

Date of this assessment: [ ] Assessor: [ ]

Assessment Location: [ ]

What is your monthly income right now?

You do not need to ask the client about "AMI" specifically; referencing the table on the following page, select the corresponding option yourself based on the client's income. In general, you do not even need to ask this question verbally at this point in the assessment, because the client would have provided their income earlier as part of the HUD intake form.

Monthly income: $_____

☐ Above 30% AMI
☐ Between 16% and 30% AMI
☐ 15% AMI or less
☐ Don't know or ☐ refuse

FY 2019 HUD income limits reference for Cambridge – 1 person

income bracket	
Above 30% AMI	$24,901 or more
Between 16% and 30% AMI	$12,451-$24,900
15% AMI or less	$12,450 or less

Do you have any evictions, have you ever been asked to leave your rental apartment, or has a landlord used legal papers to ask you to leave? If so, how many?

As appropriate, it may be useful to explain that a history of eviction(s) will not reduce the person's likelihood of Cambridge CAN prioritizing them for a housing program.

☐ None
☐ One or two
☐ Three or more
☐ Don't know or ☐ refuse

ASSESSOR OBSERVATION ONLY, do not ask: Do you observe signs or symptoms of serious physical health conditions?

Note regarding this and other observation questions: assessors are not expected to have or use a clinical level of judgement for observation questions. The assessment's scoring does not privilege assessor observation over clients' self-reported disability; observation questions are simply a mechanism to screen *in* clients who have an observable barrier to housing but may not identify that way.

☐ Yes
☐ No

Do you have a physical disability that limits your mobility? (i.e. wheelchair, amputation, inability to climb stairs)

☐ Yes
☐ No
☐ Don't know or ☐ refuse

ASSESSOR OBSERVATION ONLY, do not ask: Do you have any reason to suspect the client may have a mental health condition? (either through personal knowledge or observation)

☐ Yes
☐ No

Have you ever been taken to the hospital against your will for mental health reasons?

☐ Yes
☐ No
☐ Don't know or ☐ refuse

ASSESSOR OBSERVATION ONLY, do not ask: Do you observe signs or symptoms of alcohol or drug abuse?

☐ Yes
☐ No

If you consume alcohol, did you consume alcohol every day during the past month?

☐ Yes
☐ No
☐ Don't know or ☐ refuse

Have you ever used injection drugs or shots?

☐ Yes
☐ No
☐ Don't know or ☐ refuse

Have you ever been in jail, arrested, or accused of a crime or criminal activity (even if it wasn't true)?

As appropriate, it may be useful to explain that a criminal history will not reduce the person's likelihood of Cambridge CAN prioritizing them for a housing program.

☐ Yes
☐ No
☐ Don't know or ☐ refuse

Which of these categories (if any) does your criminal history include?

If multiple responses apply, only record the answer for the highest severity of crime. For example, if the client reports both arson and a DUI, record only "Offenses that make it extremely difficult to find housing[…]"

☐ Offenses that make it extremely difficult to find housing, such as arson, crime resulting in placement on the sex offender registry, production of crystal meth, etc.
☐ Drug offenses or crimes against person or property
☐ Just a few minor offenses, such as a moving violation, a DUI, a misdemeanor, etc.
☐ Don't know or ☐ refuse

How many times have you been to an emergency room in the past three months?

☐ 0 times
☐ 1 time
☐ 2 times
☐ 3 or more times
☐ Don't know or ☐ refuse

Are you currently receiving services from the Massachusetts Department of Mental Health (DMH)?

DMH services are not the same as simply having a therapist, counselor or psychiatrist. To be considered a client of DMH, one must have applied and have been approved to receive services from DMH, i.e. having a DMH Case Worker.

☐ Yes
☐ No
☐ Don't know or ☐ refuse

Please record as many ways that the client can be contacted as she/he is willing to provide. (For example, cell phone, email address, location client frequently spends time at, name of a provider they work closely with, etc.) This makes it easier for us to get in touch with them if they receive an offer of services or housing.

Client's Cambridge Streamlined Assessment is now complete.

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Families

AMERICAN VERSION 2.0

1 (800) 355-0420 info@orgcode.com www.orgcode.com

COMMUNITY SOLUTIONS

ORG CODE

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or types of users. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 2.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front-line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 4.0 for Families
- SPDAT V 4.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

1 (800) 355-0420 info@orgcode.com www.orgcode.com

SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

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Administration

Interviewer's Name	Agency	
_____	_____	☐ Team ☐ Staff ☐ Volunteer
Survey Date	**Survey Time**	**Survey Location**
DD/MM/YYYY ____/____/_____	__ __ : __ __	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

PARENT 1

First Name	Nickname	Last Name
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	Age	Social Security Number	Consent to participate
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes ☐ No

PARENT 2

☐ No second parent currently part of the household

First Name	Nickname	Last Name
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	Age	Social Security Number	Consent to participate
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes ☐ No

IF EITHER HEAD OF HOUSEHOLD IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE:

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Children

1. How many children under the age of 18 are currently with you? _____ ☐ Refused
2. How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed? _____ ☐ Refused
3. *IF HOUSEHOLD INCLUDES A FEMALE:* Is any member of the family currently pregnant? ☐ **Y** ☐ N ☐ Refused
4. Please provide a list of children's names and ages:

First Name	Last Name	Age	Date of Birth

IF THERE IS A SINGLE PARENT WITH 2+ CHILDREN, AND/OR A CHILD AGED 11 OR YOUNGER, AND/OR A CURRENT PREGNANCY, THEN SCORE 1 FOR **FAMILY SIZE**.

IF THERE ARE TWO PARENTS WITH 3+ CHILDREN, AND/OR A CHILD AGED 6 OR YOUNGER, AND/OR A CURRENT PREGNANCY, THEN SCORE 1 FOR **FAMILY SIZE**.

SCORE: 0

A. History of Housing and Homelessness

5. Where do you and your family sleep most frequently? (check one)
   - ◉ Shelters
   - ○ Transitional Housing
   - ○ Safe Haven
   - ○ **Outdoors**
   - ○ **Other (specify):** _____
   - ○ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.

SCORE: 0

6. How long has it been since you and your family lived in permanent stable housing? ___ Years ☐ Refused
7. In the last three years, how many times have you and your family been homeless? _____ ☐ Refused

IF THE FAMILY HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.

SCORE: 0

B. Risks

8. In the past six months, how many times have you or anyone in your family...

   a) Received health care at an emergency department/room? ____ ☐ Refused

   b) Taken an ambulance to the hospital? ____ ☐ Refused

   c) Been hospitalized as an inpatient? ____ ☐ Refused

   d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? ____ ☐ Refused

   e) Talked to police because they witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told them that they must move along? ____ ☐ Refused

   f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR **EMERGENCY SERVICE USE.**	**SCORE:** 0

9. Have you or anyone in your family been attacked or beaten up since they've become homeless? ☐ **Y** ☐ N ☐ Refused

10. Have you or anyone in your family threatened to or tried to harm themself or anyone else in the last year? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF HARM.**	**SCORE:** 0

11. Do you or anyone in your family have any legal stuff going on right now that may result in them being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **LEGAL ISSUES.**	**SCORE:** 0

12. Does anybody force or trick you or anyone in your family to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused

13. Do you or anyone in your family ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone they don't know, share a needle, or anything like that? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION.**	**SCORE:** 0

C. Socialization & Daily Functioning

14. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you or anyone in your family owe them money? ☐ **Y** ☐ N ☐ Refused

15. Do you or anyone in your family get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? ☐ Y ☐ **N** ☐ Refused

IF "YES" TO QUESTION 14 OR "NO" TO QUESTION 15, THEN SCORE 1 FOR **MONEY MANAGEMENT.** **SCORE:** 0

16. Does everyone in your family have planned activities, other than just surviving, that make them feel happy and fulfilled? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.** **SCORE:** 0

17. Is everyone in your family currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **SELF-CARE.** **SCORE:** 0

18. Is your family's current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because other family or friends caused your family to become evicted? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS.** **SCORE:** 0

D. Wellness

19. Has your family ever had to leave an apartment, shelter program, or other place you were staying because of the physical health of you or anyone in your family? ☐ **Y** ☐ N ☐ Refused

20. Do you or anyone in your family have any chronic health issues with your liver, kidneys, stomach, lungs or heart? ☐ **Y** ☐ N ☐ Refused

21. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you or anyone in your family? ☐ **Y** ☐ N ☐ Refused

22. Does anyone in your family have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help? ☐ **Y** ☐ N ☐ Refused

23. When someone in your family is sick or not feeling well, does your family avoid getting medical help? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH.** **SCORE:** 0

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24. Has drinking or drug use by you or anyone in your family led your family to being kicked out of an apartment or program where you were staying in the past? ☐ **Y** ☐ N ☐ Refused

25. Will drinking or drug use make it difficult for your family to stay housed or afford your housing? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.**	**SCORE:** 0

26. Has your family ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:

a) A mental health issue or concern? ☐ **Y** ☐ N ☐ Refused

b) A past head injury? ☐ **Y** ☐ N ☐ Refused

c) A learning disability, developmental disability, or other impairment? ☐ **Y** ☐ N ☐ Refused

27. Do you or anyone in your family have any mental health or brain issues that would make it hard for your family to live independently because help would be needed? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.**	**SCORE:** 0

28. *IF THE FAMILY SCORED 1 EACH FOR PHYSICAL HEALTH, SUBSTANCE USE, AND MENTAL HEALTH:* Does any single member of your household have a medical condition, mental health concerns, **and** experience with problematic substance use? ☐ **Y** ☐ N ☐ N/A or Refused

IF "YES", SCORE 1 FOR **TRI-MORBIDITY**.	**SCORE:** 0

29. Are there any medications that a doctor said you or anyone in your family should be taking that, for whatever reason, they are not taking? ☐ **Y** ☐ N ☐ Refused

30. Are there any medications like painkillers that you or anyone in your family don't take the way the doctor prescribed or where they sell the medication? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.**	**SCORE:** 0

31. *YES OR NO:* Has your family's current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you or anyone in your family have experienced? ☐ **Y** ☐ N ☐ Refused

IF "YES", SCORE 1 FOR **ABUSE AND TRAUMA.**	**SCORE:** 0

E. Family Unit

32. Are there any children that have been removed from the family by a child protection service within the last 180 days?	☐ **Y**	☐ N	☐ Refused	
33. Do you have any family legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY LEGAL ISSUES.**				**SCORE:** 0
34. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation?	☐ **Y**	☐ N	☐ Refused	
35. Has any child in the family experienced abuse or trauma in the last 180 days?	☐ **Y**	☐ N	☐ Refused	
36. *IF THERE ARE SCHOOL-AGED CHILDREN:* Do your children attend school more often than not each week?	☐ Y	☐ **N**	☐ N/A or Refused	
IF "YES" TO ANY OF QUESTIONS 34 OR 35, OR "NO" TO QUESTION 36, SCORE 1 FOR **NEEDS OF CHILDREN.**				**SCORE:** 0
37. Have the members of your family changed in the last 180 days, due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that?	☐ **Y**	☐ N	☐ Refused	
38. Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY STABILITY.**				**SCORE:** 0
39. Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a family movie, or anything like that?	☐ Y	☐ **N**	☐ Refused	
40. After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult...				
a) 3 or more hours per day for children aged 13 or older?	☐ **Y**	☐ N	☐ Refused	
b) 2 or more hours per day for children aged 12 or younger?	☐ **Y**	☐ N	☐ Refused	
41. *IF THERE ARE CHILDREN BOTH 12 AND UNDER & 13 AND OVER:* Do your older kids spend 2 or more hours on a typical day helping their younger sibling(s) with things like getting ready for school, helping with homework, making them dinner, bathing them, or anything like that?	☐ **Y**	☐ N	☐ N/A or Refused	
IF "NO" TO QUESTION 39, OR "YES" TO ANY OF QUESTIONS 40 OR 41, SCORE 1 FOR **PARENTAL ENGAGEMENT.**				**SCORE:** 0

Scoring Summary

DOMAIN	SUBTOTAL	RESULTS
PRE-SURVEY	0 /2	
A. HISTORY OF HOUSING & HOMELESSNESS	0 /2	**Score:** **Recommendation:**
B. RISKS	0 /4	0-3 no housing intervention
C. SOCIALIZATION & DAILY FUNCTIONS	0 /4	4-8 an assessment for Rapid Re-Housing
D. WELLNESS	0 /6	9+ an assessment for Permanent Supportive Housing/Housing First
E. FAMILY UNIT	0 /4	
GRAND TOTAL:	0 /22	

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : ____ or Night
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (_____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the adult at some point in the future
- safety planning

Appendix A: About the VI-SPDAT

The HEARTH Act and federal regulations require communities to have an assessment tool for coordinated entry - and the VI-SPDAT and SPDAT meet these requirements. Many communities have struggled to comply with this requirement, which demands an investment of considerable time, resources and expertise. Others are making it up as they go along, using "gut instincts" in lieu of solid evidence. Communities need a practical, evidence-informed way to satisfy federal regulations while quickly implementing an effective approach to access and assessment. The VI-SPDAT is a first-of-its-kind tool designed to fill this need, helping communities end homelessness in a quick, strategic fashion.

The VI-SPDAT

The VI-SPDAT was initially created by combining the elements of the Vulnerability Index which was created and implemented by Community Solutions broadly in the 100,000 Homes Campaign, and the SPDAT Prescreen Instrument that was part of the Service Prioritization Decision Assistance Tool. The combination of these two instruments was performed through extensive research and development, and testing. The development process included the direct voice of hundreds of persons with lived experience.

The VI-SPDAT examines factors of current vulnerability and future housing stability. It follows the structure of the SPDAT assessment tool, and is informed by the same research backbone that supports the SPDAT - almost 300 peer reviewed published journal articles, government reports, clinical and quasi-clinical assessment tools, and large data sets. The SPDAT has been independently tested, as well as internally reviewed. The data overwhelmingly shows that when the SPDAT is used properly, housing outcomes are better than when no assessment tool is used.

The VI-SPDAT is a triage tool. It highlights areas of higher acuity, thereby helping to inform the type of support and housing intervention that may be most beneficial to improve long term housing outcomes. It also helps inform the order - or priority - in which people should be served. The VI-SPDAT does not make decisions; it informs decisions. The VI-SPDAT provides data that communities, service providers, and people experiencing homelessness can use to help determine the best course of action next.

Version 2

Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

You will notice some differences in Version 2 compared to Version 1. Namely:

- it is shorter, usually taking less than 7 minutes to complete;
- subjective elements through observation are now gone, which means the exact same instrument can be used over the phone or in-person;
- medical, substance use, and mental health questions are all refined;
- you can now explicitly see which component of the full SPDAT each VI-SPDAT question links to; and,
- the scoring range is slightly different (Don't worry, we can provide instructions on how these relate to results from Version 1).

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Prevention Eligibility Screening Tool

Date

Household Information

Have you been here before

Total Household Members

Are all members of household US Citizens or Legal Permanent Residents?

Select

STAR Program Only (for tracking purposes) Initial STAR Screening form completed by:

Select

Current Housing Information

Current Monthly Rent

What type of housing do you currently live in?

Select

Do you have a lease?	Select
Who is your landlord?	

What type of assistance are you looking for? (check all that apply)

Back rent assistance (arrears)	☐
Tenant support/clinical services (disability impacting tenancy) STAR ONLY	☐
Legal Services	☐
Utility Arrearage Assistance	☐
Security Deposit	☐
1st and last months rent	☐
Assistance with ongoing rent	☐
Moving Expenses	☐
Storage Expenses	☐
Furniture	☐
Other	☐

What amount are you seeking?

Eviction Status Information

Do you have a 14/30 day notice to quit?

Does the household have a Writ of Summary Process (Summons and Complaint)?

Is there a motion for execution?

Do you have a Judgment with a move-out date?

Income Eligibility

What is the total of your gross income in the last 30 days (include income from all members in your household)?

Percent of AMI	Select

[Income Limit*] [30% AMI] [15% AMI] *Issued on 4/14/17. In effect until superseded.

[1 person].....[$21,700] [$10,850]

[2 people].....[$24,800] [$12,400]

[3 people].....[$27,900] [$13,950]

[4 people].....[$31,000] [$15,500]

[5 people].....[$33,500] [$16,750]

[6 people].....[$36,000] [$18,000]

[7 people].....[$38,450] [$19,225] (If STAR HH of 7 or more, use HOME limits.)

[8 people].....[$41,390] [$20,695]

Brief Summary of client's situation	

MSC Program Referral based on eligibility (to be completed by Maria Melo)

Program Assignment	Select
Case Manager assigned	Select

Save or Cancel

APPENDIX C: Version Tracker with Major Changes Noted

Version 1.0	January 23, 2018	-
Version 1.1	February 7, 2018	Section G.3.e updated to reflect new policy on referral rejections.
Version 1.2	December 26, 2018	Section E.4.a.iii updated for clearer and more straightforward use of scoring outputs in PSH prioritization.
Version 1.3	April 29, 2019	Updates (primarily within Section G) to reflect changes to the referral process resulting from moving the workflow into Clarity HMIS itself. Policy of Specialist-initiated reassessment removed in Section E.6. Some copyedits made throughout for improved clarity.
Version 2.0	December 3, 2019	Updates to reflect switch from obsoleted Housing Prioritization Tool and Vulnerability Index to the Cambridge Streamlined Assessment. Section G.3.f on Housing Transition meetings added. Prioritization factor in Section F.4 Date of First Assessment changed to Date of C-CAN Enrollment. Document title changed from System Requirements and Procedures to Policies and Procedures.