Oklahoma City CoC

Coordinated Intake & By Name List Policies and Procedures

Background

What is Coordinated Intake?

Coordinated intake (also known as coordinated entry) is a consistent, community wide process to match people experiencing homelessness to community resources that will most adequately address their situations. In a community using coordinated intake, homeless individuals and families complete a standard assessment survey that helps identify the services that are most well-suited to the needs of that household. Participating programs accept referrals from the system, reducing the need for people to traverse the city seeking assistance at every provider separately. When participating programs do not have enough space to accept all referrals, people are prioritized for services based on vulnerability.

HUD Requirement

A Continuum of Care (CoC) is a group of organizations that provide services to citizens who are homeless or impoverished within a defined geographic area. Through the Continuum of Care Program, the Department of Housing and Urban Development (HUD) allocates funds to several of these organizations for the provision of permanent supportive housing to disabled individuals who are homeless or families that are homeless and have a disabled family member. Under the interim rule for the Continuum of Care Program, each CoC must establish and operate a centralized or coordinated assessment system (24 CFR 587.7 (a)(8)). HUD defines a centralized or coordinated assessment system as "a centralized or coordinated process designed to coordinate program participants' intake assessment and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool" (24 CFR 578.3)

Participation in the coordinated intake system is required for HUD CoC and ESG grantees.

The Coordinated intake system described in this manual is designed to meet the requirements of the HEARTH Act, under which, at a minimum, Continuums of Care must adopt written standards that include:

i. Policies and procedures for providing an initial housing assessment to determine the best housing and services intervention for individuals and families;
ii. A specific policy to guide the operating of the centralized or coordinated assessment system on how its system will address the needs of individuals and families fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter services from non-victim service providers;
iii. Policies and procedures for evaluating individuals' and families' eligibility for assistance;

iv. Policies and procedures for determining and prioritizing which eligible individuals and families will received transitional housing assistance;
v. Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid rehousing assistance;
vi. Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance.

Systems Change

The implementation of the Coordinated Intake System necessitates significant, community-wide change. To help ensure that the system will be effective and manageable for homeless persons and persons at-risk of homelessness and for the housing and service providers tasked with meeting their needs, a group of stakeholders was involved in its design. In addition, particularly during the early stages of implementation, The City of Oklahoma City Continuum of Care anticipates adjustments to the processes described in this manual. An evaluation of the Coordinated Intake System will occur at least annually or as needed and will provide ongoing opportunities for stakeholder feedback. This process will be initiated by the Coordinating Entity and will involve partner agencies. The Coordinating Entity will be responsible for monitoring the Coordinated Intake System.

Benefits of Coordinated Intake

Coordinated intake will benefit our community by:

- Providing a clearer and more streamlined path to accessing assistance for people who are currently or at imminent risk of experiencing homelessness;
- Reducing the need for people to contact multiple housing programs and fill out multiple applications to join waitlists. Coordinated intake will assess people for all participating permanent housing programs at the same time;
- Prioritizing scarce housing resources for the most vulnerable; and
- Improved data collection and quality that supports data-driven decision making based on client-level and system-wide needs.

Overview

Journey Home OKC is an initiative that consists of more than 40 nonprofits, private businesses and government agencies that work together to provide housing and case management supports for chronically homeless individuals and veterans. This initiative helped get more than 290 chronically homeless people off the streets and into housing in Oklahoma City in 2013 and 2014. Since January 2015, the group has been focused on ending chronic and veteran homelessness, though they also work with youth and families that meet HUD definitions of literal and chronic homelessness.

The group uses a housing first philosophy, which places the most vulnerable people in the community in housing first, and then applies case management to address their needs and the problems that are keeping them on the street. Clients will not be screened out for services based on perceived barriers to housing or services including but not limited to, too little or no income, active or history of substance abuse,

domestic violence history, resistance to receiving services, the type or extent of a disability-related services or supports that are needed, history of eviction or poor credit, lease violations or history of not being a leaseholder, or criminal record.

For definitions of many terms used throughout these policies and procedures, refer to Appendix A.

Disclaimer

The Coordinated Intake System for Journey Home OKC uses an assessment process which triages for the best housing intervention (Permanent Supportive Housing or Rapid Rehousing) and determines prioritization for housing and case management based on vulnerability. This is not a guarantee that the individual will meet the final eligibility requirements for, or receive a referral for, a particular housing option. The tool used by the Coordinated Intake System for assessment is the evidence-based VI-SPDAT (Vulnerability Index Service Prioritization Decision Assistance Tool).

Release of Information

All clients must sign a HIPPA-compliant release of information prior to the assessment process. This release of information allows client data to be shared between Journey Home OKC participant organizations in HMIS and allows the CoC to securely store client information in HMIS. Clients are also asked to sign a Coordinated Case Management release form, which allows for case conferencing during Coordinated Case Management meetings. Clients may opt of the release entirely, or may chose to leave specific agencies and partners off of the release.

> ***Clients Fleeing Domestic Violence***: No agency will enter any information for any client fleeing domestic violence into HMIS so long as that client is considered to be in danger from an abuser.
>
> ***Client Photos:*** Photos should be taken at the time of the assessment, but are not required. Photos are encouraged for by-name and by-face identification for outreach. If a photo is taken and uploaded into HMIS, a photo release must be signed by the client prior to the photo being taken.

Roles and Expectations

> ***Coordinating Entity***: The City of Oklahoma City Continuum of Care is the designated Coordinating Entity. The Coordinating Entity is responsible for the day-to-day administration of the Coordinated Intake System, including but not limited to the following:
>
> - Designing and delivering training at least annually to all key stakeholder organizations but not limited to the required training for sub recipients. This may include cultural and linguistic competency training;
> - Ensuring pertinent information is entered into HMIS for monitoring and tracking the process of referrals including vacancy reporting and completion of assessments;
> - Managing manual processes as necessary to enable participation in the Coordinated Intake System by providers not participating in HMIS;
> - Designing and executing ongoing quality control activities to ensure clarity, transparency, and consistency in order to remain accountable to clients, referral

source, and homeless service providers throughout the coordinated intake process. This will mean that controls are in place to ensure that data is a valid and up-to-date source to which the aforementioned parties can refer throughout the process;

- Updating the Coordinated Intake & By Name List Policies and Procedures;
- Leading periodic evaluation efforts to ensure that the Coordinated Intake System is functioning as intended; such evaluation efforts shall happen at least annually;
- Leading efforts to make periodic adjustments to the Coordinated Intake System as determined as necessary; such adjustments shall be made at least annually based on findings from evaluation efforts;
- Ensuring that the Coordinated Intake System process is informed by a broad and representative group of stakeholders;
- Ensuring that the coordinated Intake System is updated as necessary to maintain compliance with all federal statutory and regulatory requirements;
- Conducting annual monitoring of CoC and ESG agencies. This will ensure that the CES process 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. They also monitor that steps are taken to ensure effective communication with individuals with disabilities and limited English proficiency. Finally, they monitor CoC agencies to ensure that all access points to the CES are providing connections to other main-stream and community-based assistance services.

Journey Home OKC Program Director: The Journey Home OKC Program Director is a Homeless Alliance employee who works in coordination with Journey Home OKC partner agencies to address the broad array of client needs through referral to providers of necessary services.

- Serves as the contact for partner agency staff and case managers and for clients when case managers are not available;
- Convenes and manages coordinated case management meetings for the purpose of staffing cases and prioritizing housing and case management resources;
- Maintains quality assurance of the program;
- Coordinates the housing placement and case management of vulnerable chronically homeless persons via the by-name list;
- Works with the HMIS Administrator to maintain and update the by-name list and run any necessary reports.
- Conducts trainings at least annually or as needed to ensure that staff persons at organizations that serve as CES access points are up to date on current common assessment tools. All staff administering the assessment should have access to materials that clearly describe the methods by which the assessments are conducted.

Partner Agencies: All recipients of ESG and CoC funding are considered partner agencies and are responsible for the following:

- Ensuring that all households experiencing homelessness or at-risk of homelessness have prompt access to the Centralized Intake System and that all assessments are administered in a safe, welcoming environment.
- All Permanent Supportive Housing and Rapid Re-housing programs are responsible for reporting vacancies to the Journey Home OKC Program Director in compliance with the protocols described in this document.
- All programs that receive a referral from the Coordinated Intake System are responsible for responding to that referral and participating in case conferences, in compliance with the protocols described in this document.

HMIS Administrator: The HMIS Administrator is responsible for the administration of the HMIS software and providing technical assistance to participating agencies.

- Responsible for making sure and agencies are entering data regularly and keeping data up-to-date.
- Responsible for making sure that all HMIS users have signed the HMIS memorandum of agreement.

Target Population

The Coordinated Entry System is open to all households who are homeless and seeking services. The system uses a 'no wrong door' approach, which means that clients can enter through any partner agency including 211. The system uses vulnerability to rank applicants with the most vulnerable households being ranked at the top of the list.

System Overview & Workflow: Permanent Supported Housing and Rapid Rehousing

Ideally, everyone who touches the CIS would have completed a VI-SPDAT**.** Partner agencies can look up a client in HMIS to see if they have a VI-SPDAT on file. Participating agencies do not keep their own priority lists or wait lists and CoC funded agencies are prohibited from doing so. All prioritization is done through the communitywide by-name list and is staffed during coordinated case management meetings. No one is banned from accessing the CIS, and the CIS may not reject any referral. Some individual projects may not be appropriate for all clients, which is why the coordinated case management meetings are used to help match clients to appropriate, available resources. If a client is not an appropriate referral for an available housing resource, a different housing referral will be made for that client.

Connecting to the Coordinated Entry System-Step 1: Client is administered a VI-SPDAT and gives Release of Information; this can happen either at a partner agency, during outreach, or by calling 211. Organizations without the staff capacity to perform intakes should refer prospective clients to 211 for screening.

Client is added to By-Name List-Step 2: The client is added to the by-name list as soon as possible. Clients are added based upon data entered into HMIS including VI-SPDAT, length of time homeless, episodes of homelessness, etc. ALL VI-SPDATs must be entered.

Clients are prioritized for housing-Step 3: Clients are prioritized on By-Name Lists based on the following criteria:

1. VI-SPDAT scores: VI-SPDAT scores are ranked from highest to lowest, with higher scores being prioritized first for PSH and case management openings. If someone is not willing to complete a VI-SPDAT, they may still be added to the by-name list; they will only show a null-entry for VI-SPDAT, and other criteria will be taken into consideration for their prioritization. For RRH programs, clients will still be prioritized by VI-SPDAT score with higher scores in the RRH range of the VI-SPDAT being prioritized over lower scores. There are different VI-SPDATs for sub-populations (youth and families); the correct VI-SPDAT assessment will be used at time of entry to the CES. For more information about the different VI-SPDAT assessments, see Appendix A.
2. Length of Time Homeless: When VI-SPDAT scores are tied, the first tie-breaker will be the length of time homeless as defined by self-report data that is entered into HMIS. People who have been homeless longer will be prioritized.
3. Date of VI-SPDAT: When VI-SPDAT scores are tied, and the length of time homeless is equal, a second tie-breaker will be the date that the VI-SPDAT was completed. Older VI-SPDATs will be prioritized.

As case management and housing resources become available, clients are referred from the list based on the aforementioned prioritization criteria to the available resources. As clients move to the top of the list, they are staffed and chronicity is verified. The burden of documentation of chronic status, disability status and/or literal homelessness is placed on the case manager to whom the client is referred. During the early stages of case management, case managers may have to do some work to prepare the client for housing such as getting IDs, proof of income, homeless verification, transporting the client, etc.

Referral-Step 4: Once the client has been matched to resources, the case manager takes over the case and reports updates during the appropriate case conferencing meetings (CCM-SA or VCCM). If the client is being housed through Journey Home OKC, then the Journey Home OKC housing referral must be sent to the Journey Home OKC Program Director as well as the Contract Administrator/FSS Coordinator for OCHA. OCHA delivers regular reports to the Journey Home OKC Program Director showing which referrals have been recently processed. Clients may not be referred for Journey Home OKC Housing if they have not been staffed for eligibility during a coordinated case management meeting.

Housing Navigation and Placement-Step 5: Case managers assist the client in navigating the housing market. This may include locating housing units, helping the client apply for housing subsidies, etc. Once a placement is found, the case manager assists the client during move-in and makes appropriate referrals for furniture, deposit assistance, utility assistance, etc. The case manager is expected to follow-up with the client regularly after housing has been secured and after move-in, in order to make sure that client's needs are being met. This includes visits to the client's home at least monthly.

Discharging-Step 6: When a case manager and client agree that the services are no longer needed and that the client is able to maintain the housing on his/her own, then the case manager may recommend the client for program discharge during regular case conferencing. The

recommendation should be accompanied by justification of self-sufficiency. The preferred measure of client acuity is the Full SPDAT assessment.

System Overview and Workflow: Emergency Services and Prevention

Access points for emergency services and prevention are the same as those for RRH and PSH. Persons may access CES for these services through 211 outside of normal operational hours as 211 takes calls 24/7.

Communications

As needed, the Coordinating Entity and/or the Journey Home OKC partners will send and/or report on information and updates regarding the Coordinated Entry System to stakeholders and the general public.

By-name List

The by-name list is driven by VI-SPDAT scores and is the main way by which clients are prioritized for housing and case management in the community. The following sub-populations are filtered from the main by-name list in HMIS:

Chronic: Clients are added to the list as their HMIS data suggests that they meet HUD's definition of chronic homelessness and that they have been active in the community in the last 90 days. Chronic status is not verified at the time of entry into the system but on a case by case basis as clients come up next on the list. Partner agencies determine an eligibility threshold for VI-SPDAT scores. Any client with a score that exceeds this threshold is prioritized for Permanent Supportive Housing/Housing First. Once partners house all individuals on the list with scores that exceed the threshold, then the threshold can be modified to prioritize lower scores. The threshold can be modified for other reasons if partners find it necessary. Clients on the list are staffed for housing and case management services during CCM-SA meetings and remain on the by-name list until they are housed or become inactive. Inactive status is defined as no known contact with any service provider in the community for 90 days. Activity may be contact with service-providers that is documented through HMIS, or via manual updates given during coordinated case management meetings. When a client is moved to inactive, he/she is not deleted from the list and their position on the list is not affected. A client's status will change from inactive to active once they contact services again. If clients remain active on the list for an entire year, the Coordinated Intake System will make an effort to update the VI-SPDAT score in order to note any changes in vulnerability, and therefore update the client's position on the list.

Veteran: Clients are added to the list as their HMIS data suggests that they are a veteran and that they have been active in the community in the last 90 days. Veterans may also come into the HMIS system via outreach contacts, partner agencies, and 211. New VI-SPDATs are brought to the weekly VCCM meeting as potential referrals. Each referral is staffed during VCCM, and each referral is assigned to a representative from partner agencies for follow-up. Clients remain on the By-Name List until they are housed or become Inactive. Inactive status is defined as no known contact with any service provider in the community for 90 days. Activity may be contact with service-providers that is documented through HMIS, or via manual updates given during coordinated case management meetings. When a client is moved to inactive, he/she is not deleted from the list and their position on the list is not affected. A client's status will change from inactive to active once they contact services again. If clients remain active on the list for an entire

year, the Coordinated Entry System will make an effort to update the VI-SPDAT score in order to note any changes in vulnerability, and therefore update the client's position on the list.

Youth: Clients are added to the list as their HMIS data suggests that they are a homeless youth and that they have been active in the community in the last 90 days. Youth who qualify as chronically homeless as defined by HUD are staffed for eligibility for housing through Journey Home OKC. Youth who do not qualify as chronically homeless may still be staffed and prioritized for housing and case management placements that suit their needs.

Family: The family by-name list is not currently required by the CoC; however, partner agencies are encouraged to prioritize families for rapid rehousing and permanent supported housing by using the VI-F-SPDAT and maintaining a priority list.

Coordinated Case Management (CCM)

CCM is the model of case conferencing used within the Oklahoma City CoC to staff clients. All participating agencies attend regularly and are engaged in the case conferencing.

Chronic: CCM-SA**:** *(Coordinated Case Management-Single Adults)* This meeting occurs every weekly unless otherwise scheduled. It is held at the WestTown Resource Center, and is convened by the Journey Home OKC Program Director. All partner agencies are required to attend this meeting at least twice a month. During this meeting, agency representatives staff client cases, and new clients get assigned to case management and housing resources.

Veteran: VCCM: (Veteran's Coordinated Case Management) This meeting occurs weekly unless otherwise scheduled. It is held at the WestTown Resource Center, and it is convened by the Journey Home OKC Program Director and the VA. The Journey Home OKC Program Director attends this meeting, and makes necessary updates to the by-name list. All partner agencies that serve veterans are required to attend at least twice a month. During this meeting, agency representatives staff client cases, and new clients get assigned to case management and housing resources.

Youth: YCCM: (Youth Coordinated Case Management) This meeting occurs twice a month unless otherwise scheduled. It is convened by the Journey Home OKC Program Director and Be the Change. All partner agencies that serve youth are required to attend. There are housing and case management resources unique to youth and children that are taken into consideration when going through the youth by-name list. Youth that qualify as chronically homeless under the HUD definition are given consideration for Journey Home OKC placements. During this meeting, agency representatives staff client cases, and new clients get assigned to case management and housing resources.

Family: Families are staffed using a coordinated case management model. At intake, families are screened for eligibility using the VI-F-SPDAT and are then recommended for either rapid re-housing or PSH. Cases are prioritized using a by-name list. Families are assigned to available housing and case management resources based on the aforementioned prioritization criteria.

Special Cases

While the VI-SPDAT is the chosen tool for coordinated intake in the Oklahoma City CoC, it is to be used as a guide for prioritization, and may be overridden if necessary.

Inaccurate VI-SPDAT: Occasionally a case will arise where the case manager or referring agent does not believe that the VI-SPDAT score is consistent with the actual vulnerability of the client. In these cases the case manager or referring agent may advocate for the client to receive a higher score during the regular case conferencing. All present at the case conferencing must reach a consensus in granting the priority to the client in lieu of the VI-SPDAT score. These cases are then worked into available housing and case management spots and follow the steps detailed in the System Overview and Workflow section of these policies and procedures.

No VI-SPDAT: Sometimes clients do not want to do the VI-SPDAT; this does not disqualify them from the by-name list or potential housing opportunities. In the event that a client does not have a VI-SPDAT, he/she can be added to the by-name list as long as we have a release of information. These people will also be prioritized for coordinated outreach in the hope that over time, continual contacts will lead to increased openness to engaging in services and completing the VI-SPDAT.

Domestic Violence: This includes individuals who are fleeing, or attempting to flee domestic violence, dating violence, sexual assault, but who are seeking shelter or services from non-victim service providers. These individuals must have safe and confidential access to the CES as well as victim-services. They must also have immediate access to emergency shelters such as domestic violence hotlines and shelter.

Street Outreach

Street outreach workers are CES entry points. Persons encountered by street outreach are offered the same standardized process as persons who access CES through 211 or physical locations. CoC agencies who conduct outreach efforts meet together monthly for Coordinated Outreach to ensure that outreach efforts are comprehensive and not duplicated, and that persons needing outreach are being appropriately targeted for services.

Client Rights

Client Rights may be based on partner agency client rights and grievance policies, which may vary from agency to agency. Appeals regarding eligibility decisions also occur at the agency level. If clients feel that they have been discriminated against, then a non-discrimination complaint may be filed through Legal Aid Services of Oklahoma, Inc.

Client Choice: Clients may decline a referral because of program requirements that are inconsistent with their needs or preferences. In the event that a client declines a referral, the Coordinated Intake System will try to come up with alternative options for the client. This may involve additional wait time for the client.

Fair Housing Act: Clients are protected by the Fair Housing Act, which protects from discrimination when people are renting, buying, or securing financing for any housing. Specifically, these policies and procedures are informed by Federal, State, and local Fair Housing

laws and regulations to ensure that participants are not steered towards any particular facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children. For more information regarding Fair Housing Act or to address complaints or violations, clients and/or case managers can reach out to Legal Aid Services of Oklahoma, Inc. The CoC and all participating agencies in the coordinated intake process must comply with the equal access and nondiscrimination provisions of Federal civil rights laws.

Disability Accommodations: CoC access points, if physical locations, must be accessible to individuals with disabilities, including accessible physical locations for individuals who use wheel chairs, as well as people in the CoC who are least likely to access homeless assistance. This is monitored by the coordinating entity.

Section 504 of the Rehabilitation Act: Clients are protected by Section 504 of the Rehabilitation Act, which prohibits discrimination on the basis of disability under any program or activity receiving federal assistance.

Title VI of the Civil Rights Act: Clients are protected by Title VI of the Civil Rights Act, which prohibits discrimination on the basis of race, color, or national origin under any program or activity receiving federal funding.

Title II of the Americans with Disabilities Act: Clients are protected under Title II of the Americans with Disabilities Act, which prohibits public entities, including state and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housie-related services such as housing search and referral assistance.

Title III of the Americans with Disabilities Act: Clients are protected under Title III of the Americans with Disabilities Act, which prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

Evaluating and Updating Policies and Procedures

As the implementation of the Coordinated Intake System will require significant changes to the CoC homeless services system, The Oklahoma City Continuum of Care anticipates that adjustments to the process will need to occur. To make this determination, The Coordinated Intake System will be evaluated by the CoC annually or more frequently if necessary. During this time, partner agencies may give feedback as to how the system may be improved. This feedback will be solicited through the Coalition to End Poverty to ensure that no CoC participating agencies are excluded. Partners may also give feedback at any time outside of an evaluation by contacting the CoC lead.

Appendix A: Definitions

Definitions

Terms used throughout this manual are defined below:

Area Median Income: Refer to the following link for the most current AMI limits: https://www.huduser.gov/portal/datasets/il.html

***At imminent risk of becoming homeless (HUD Definition Category 2)*:** 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

By-Name List: The Oklahoma City CoC has four separate by -name lists that are updated and maintained by partner agencies; these are literally names that identify people experiencing homelessness in the community by name and prioritize housing placements and case management resources based on VI-SPDAT scores. The subpopulations included in those by-name lists are as follows: Chronic, Veteran, Youth, and Family. These by-name Lists are the mechanism by which clients are moved from prescreen for vulnerability to case management and housing placement. The list is updated based on VI-SPDATs that have been inputted at any agency in the community and entered into HMIS. The list is managed based on vulnerability rather than the entry date to the coordinated entry system. VI-SPDAT scores are ranked such that clients are served in order of vulnerability. It is important to note that the family by-name list is not currently being maintained community-wide; agency participation in the family by-name list is preferred but not required. It is also important to note that apart from the family list, there is only one list per population for the entire community; individual agencies do not maintain their own priority lists or waiting lists. Prioritization for all placements through partner agencies should come from the appropriate by-name list. Since all prioritization occurs via this list it is also referred to as the 'Master List'.

***Chronically Homeless (HUD Definition)*:** To be considered chronically homeless, a person must have a disability and have been living in a place not meant for human habitation, in an emergency shelter (including hotels and motels paid for by charitable organizations or by federal, state and local government programs), or transitional housing for the last 12 months continuously or on at least four occasions in the last three years where those occasions cumulatively total at least 12 months

CoC: The Oklahoma City Continuum of Care Committee (OKC CoC) is a committee comprised of citizens and non-profit service providers interested in working on community homeless and poverty issues. The OKC CoC Committee provides oversight in coordinating competitive and formula programs specific to serving the City's homeless population. This group also makes funding recommendations for the City's Social Services grant. The HUD Continuum of Care Grant is an annual competitive grant that builds on the previous year's performance in developing specialized housing with supports for those who are homeless, chronically homeless and have significant disabilities.

Community Solutions: Community Solutions is a national organization that works with communities across the country to help them become better, more adaptive problem solvers so they can tackle complex challenges as they emerge. Their main goals are to help communities end homeless and ensure that poverty never follows families beyond a single generation.

Coordinated Outreach: This is a monthly meeting during which community partners meet to discuss outreach strategies as well as clients who need to be outreached.

***Disability (HUD Definition)*:** A physical, mental, or emotional impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury that is expected to be long-continuing or of indefinite duration, substantially impedes the individual's ability to live independently, and could be improved by the provision of more suitable housing conditions.

***Fleeing domestic abuse or violence (HUD Definition Category 4)*:** 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

Functional Zero: At any point in time, the number of people experiencing sheltered and unsheltered homelessness in a community will be no greater than the current monthly housing placement rate for people experiencing homelessness.

HMIS: (Homeless Management Information System) This is the database used to record and track client-level information. HMIS ties together homeless service providers within a community to help create a more coordinated and effective housing and service delivery system. The City of Oklahoma City's HMIS is staffed by a contracted administrator. The software provider is Bowman Systems, Service Point.

***Homeless Under other Federal statuses (HUD Definition Category 3)*:** Unaccompanied youth under 25 years of age, or families with Category 3 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

Housing First: This model provides housing first, and then combines that housing with supportive treatment services in the areas of mental and physical health, substance abuse, education, and employment. Housing is provided in apartments scattered throughout a community.

Journey Home OKC: This is the name of Oklahoma City's program that houses homeless veterans and people experiencing chronic homelessness and provides them with wraparound case management services. Journey Home OKC is comprised of over 40 government, non-profit, and faith-based organizations that work together to end veteran and chronic homelessness.

Journey Home OKC Housing Referral: The Oklahoma City Housing Authority (OCHA) reserves their turnover vouchers for chronically homeless individuals. These are Journey Home OKC Vouchers; they may be accessed only through CCM-SA, and a Journey Home OKC Referral must be completed. Similarly applications for public housing that are seeking Journey Home OKC prioritization must be accessed through CCM-SA and appropriate referral.

Literally Homeless (HUD Definition Category 1)**:** 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

OCHA: The Oklahoma City Housing Authority is a partner to Journey Home OKC. Their mission is to provide affordable, decent, safe, and sanitary housing or housing assistance, with quality environments and opportunities to low income people of Oklahoma City. OCHA prioritizes Journey Home OKC clients for housing choice vouchers and public housing placements.

OHFA: The Oklahoma Housing Finance Agency operates in all 77 Oklahoma counties, providing assistance that helps families pay rent or purchase their first home. OHFA also works with nonprofit organizations, developers and municipalities to bring quality housing opportunities to communities across the state. OHFA has priorities for people with disabilities and people experiencing homelessness.

Permanent Supportive Housing: (PSH) is a program that helps eligible people find a permanent home and also connects them to case management and other supportive services in the community. Permanent Supportive Housing is prioritized for the most vulnerable people in the community.

Rapid Re-housing: *Rapid re-housing* is designed to help individuals and families quickly exit homelessness and return to permanent *housing. Rapid re-housing is prioritized by medium acuity levels as determined by the VI-SPDAT. This assistance is generally shorter and less intensive than PSH.*

SPDAT: (Service Prioritization Decision Assistance Tool) The full assessment tool that is the preferred method of measurement for baseline acuity as well as other acuity measures overtime. There is also a family version which is called the FSPDAT.

TAY-VI-SPDAT: (*Transition Age Youth Vulnerability Index Service Prioritization Decision Assistance Tool)* The prescreen triage tool our community uses to assess vulnerability in homeless youth age 24 and under. The assessment is scored, and scores are sorted into three ranges; those that are not recommended for housing intervention, those recommended for

assessment for time-limited supports with moderate intensity, and those recommended for assessment for long-term housing with high service intensity.

Unaccompanied Youth: These are people under the age of 24 who present for services without an adult. This definition applies to local program planning and reporting to other funders; HUD defines youth as 18-24 and classifies 17 and below as children.

VI-FSPDAT: *(Vulnerability Index Family Service Prioritization Decision Assistance Tool)* The prescreen triage tool our community uses to asses vulnerability in families with minor children in the household. The assessment is scored, and scores are sorted into three ranges; those that are not recommended for housing intervention, those recommended for rapid rehousing intervention, and those recommended for permanent supported housing/Housing First. This tool differs from the VI-SPDAT in that it assesses vulnerability of the entire family, and has extra sections that focus on children.

VI-SPDAT: *(Vulnerability Index Service Prioritization Decision Assistance Tool)* The prescreen triage tool our community uses to asses vulnerability in single adults. The assessment is scored, and scores are sorted into three ranges; those that are not recommended for housing intervention, those recommended for rapid rehousing intervention, and those recommended for permanent supported housing/Housing First. VI-SPDAT is used as a general term, and may be used to include the VI-FSPDAT and TAY-VI-SPDAT when talking about the assessment in general.

WestTown Resource Center: The WestTown campus brings together service providers to prevent and address homelessness through effective collaboration. All activity is based on best business practices, with the ultimate goal of helping people achieve and maintain safe, secure and affordable housing. The resource center houses Homeless Alliance staff in addition to community partners; provides clients with convenient access to several community resources in one location.