Cincinnati/Hamilton County Homeless Services System for Veterans

Policy and Procedure Manual

Updated September 2021

Updated November 2022

Updated July 2024

Contents

Introduction

In 2010, the U.S. Interagency Council on Homelessness (USICH) introduced *Opening Doors*, the first comprehensive federal strategy to prevent and end homelessness. This comprehensive strategy outlined several goals related to ending homelessness in the U.S. – the first of these committed to ending Veteran homelessness by 2016. In 2015, the USICH, along with the Department of Housing and Urban Development (HUD) and the Department of Veteran Affairs (VA), adopted a vision to end homelessness and shared specific criteria and benchmarks to help guide communities to take action to achieve the goal, with a focus on long-term, lasting solutions.[1]

In line with the federal goals the Cincinnati/Hamilton County Continuum of Care (CoC) has focused efforts creating policies and procedures to improve our coordinated system response. This document is to be reviewed at minimum annually and more often if priorities or policies in the CoC or at the VA change. The Cincinnati/Hamilton County Continuum of Care (CoC) has determined that ending Veteran homelessness in our CoC means the following:

> *Where Veteran homelessness does occur, it is rare, brief, and non-recurring. More specifically, every identified homeless Veteran who is unsheltered, in emergency shelter, or in Transitional Housing (TH) in the Cincinnati/Hamilton County Continuum of Care (CoC) is provided permanent housing, if they want it, within an average of 90 days or less. To achieve this, the Cincinnati/Hamilton County Continuum of Care (CoC) is committed to the principles of Housing First, primarily focusing on quick placement into permanent housing, respecting Veteran choice, and utilizing Coordinated Entry to target our resources to those with the greatest needs.*

All homeless programs serving Veterans in the Cincinnati/Hamilton County Continuum of Care (CoC), regardless of funding source, must abide by the policies and procedures outlined in this document.

[1]Achieving the Goal of Ending Veteran Homelessness: Criteria and Benchmarks - https://www.usich.gov/tools-foraction/criteria-for-ending-veteran-homelessness/

Compliance and Governance

The Hamilton County Homeless System for Veterans is administered through a partnership of the VA, the CoC Lead Agency and other partners serving Veterans experiencing homelessness, with standards and governance established by the CoC Veteran Workgroup and approved by the Homeless Clearinghouse (CoC Board). Governance and development of the Homeless System for Veterans is ongoing and feedback on the system is solicited from workgroup members each month.

The Cincinnati/Hamilton County Continuum of Care (CoC) Homeless Veterans Workgroup, with support from the COC Lead Agency, is responsible for managing the By Name List, ensuring that the policies and procedures outlined in this document are implemented appropriately at the local community level, and regularly monitoring progress towards ending Veteran homelessness.

In 2018, a Cincinnati/Hamilton County Veteran Leadership group was formed as a sub-committee of the CoC Veteran Workgroup to quickly address systemic issues for veterans experiencing homelessness and to provide guidance and leadership to the larger body of the workgroup. This is a seated group, with seats for all relevant Veteran-serving entities within the continuum. Veteran Leadership Group seats include:

1) Veteran Benefits Administration (VBA)
2) Homeless Shelter
3) Grant and Per Diem (GPD)
4) Supportive Services for Veteran Families (SSVF)
5) HUD-VASH
6) Street Outreach
7) CoC/HMIS Lead Agency
8) VA Outreach Director
9) Veteran Work Group Chairs (Facilitator of Veteran Leadership Team)

Cincinnati/Hamilton County Continuum of Care (CoC) Homeless Veterans Workgroup membership includes:

1) Supportive Services for Veteran Families (SSVF) grantees
2) All VA-funded Health Care for the Homeless Contract Emergency Residential Shelter (HCHV CERS) providers
3) All VA-funded Grant and Per Diem (GPD) grantees
4) Cincinnati VA representatives
5) Emergency Shelters, Transitional Housing (TH), Permanent Supportive Housing (PSH), and Rapid Re-housing (RRH) providers who regularly serve homeless Veterans in their programs.
    a) Other Cincinnati/Hamilton County providers and stakeholders working with veterans who volunteer to participate.
    b) Formerly homeless Veterans who wish to participate

Common Terminology and Definitions

By Name List: A By-Name List is a real-time list of people experiencing homelessness in the community. It includes a set of data points that support coordinated access and prioritization at a household level and an understanding of homeless inflow and outflow. A By-Name List is a critical component to ending homelessness and understanding who in your community is experiencing homelessness at any given time.

CAP Line: Central Access Point (CAP) a centralized intake system for families and individuals who are currently experiencing homelessness or who are at risk of becoming homeless.

Chronically Homeless: A ‘‘homeless individual with a disability,’’ as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), and by this document who:

1) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

2) Has been homeless and living as described in bullet 1 of this listed definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in bullet 1 of this definition. Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, if the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;
3) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all the criteria in bullet 1 of this listed definition, before entering that facility; or
4) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all the criteria in bullet 1 or 2 of this listed definition, including a family whose composition has fluctuated while the head of household has been homeless.

Continuum of Care (CoC): A collaborative funding and planning approach that helps communities develop a unified plan to organize and deliver housing and services to meet the specific needs of people who are homeless, as they move to stable housing and maximize self-sufficiency.

Coordinated Entry: A Coordinated Entry System (CES) is defined as a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. CES streamlines the process of finding housing for those who are homeless with the goal of housing the most vulnerable people first.

Discharges:

1) **Entry-level separation (ELS) uncharacterized:** Entry-level separations, or uncharacterized discharge are given to individuals who separate prior to completing 180 days of military service, or when discharge action was initiated prior to 180 days of service.
2) **Honorable:** To receive an honorable discharge, a service member must have received a rating from good to excellent for his or her service. Service members who meet or exceed the required standards of duty performance and personal conduct and who complete their tours of duty normally receive honorable discharges. However, one need not complete a term of service to receive an honorable discharge, provided the reason for involuntary discharge is not due to misconduct. For instance, a person rendered physically or psychologically incapable of performing assigned duties will normally have his or her service characterized as honorable, regardless of whether the condition or disability was incurred in the line of duty, provided he or she otherwise met or exceeded standards. Similarly, a service member selected for involuntary discharge due to a Reduction in Force (RIF) will typically receive an honorable discharge, assuming his or her conduct while on active duty met or exceeded standards.
3) **General:** General discharges are given to a service member whose performance is satisfactory but is marked by a considerable departure in duty performance and conduct expected of military members.
4) **Other Than Honorable (OTH):** An OTH is the most severe form of administrative discharge. This type of discharge represents a departure from the conduct and performance expected of all military members. **Bad Conduct (BCD):** A Bad Conduct Discharge (BCD) can only be given by a

court-martial (either Special or General) as punishment to an enlisted service-member. Bad conduct discharges are often preceded by a period of confinement in a military prison. The discharge itself is not executed until completion of both confinement and the appellate review process. Virtually all Veterans' benefits are forfeited by a Bad Conduct Discharge; BCD recipients are not eligible for VA disability compensation in accordance with 38 CFR 3.12. Special Court Martial are eligible for GPD and SSVF. Other and General Court Martial are not eligible and are equivalent to dishonorable.

5) **Dishonorable:** A dishonorable discharge (DD) can only be handed down to an enlisted member by a general court-martial. Dishonorable discharges are handed down for what the military considers the most reprehensible conduct. This type of discharge may be rendered only by conviction at a general court-martial for serious offenses that call for dishonorable discharge as part of the sentence.

Emergency Shelter: A facility where the primary purpose is to provide a temporary shelter for the homeless in general or for specific populations of the homeless and which does not require occupants to sign leases or occupancy agreements.

Hamilton County Resident: For the Veterans Workgroup Policies and Procedures, the county of residence for Veterans is based on the current physical location of the living situation or residential address.

Healthcare Navigator – SSVF Healthcare Navigators work with Veterans on a variety of issues to assist them in identifying and overcoming challenges to accessing the VA and other community-based healthcare systems or adhering to recommended health care plans.

Homeless Management Information System (HMIS): A local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals, families, and persons at risk of homelessness. Each Continuum of Care is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

HOMES: The Homeless Operations, Management and Evaluation System (HOMES) is VA's primary platform for collecting intake, progress, and outcome information for homeless Veterans as they move through VA's system of care. This reference guide provides detailed definitions and guidance for every time collected in HOMES.

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

Literally Homeless: An individual/family who lacks a fixed, regular, and adequate nighttime residence, meaning: a) An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a park, abandoned building, bus or train station, airport, or camping ground; or b) An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, State, or local government programs for low-income individuals);

or c) An individual who is exiting an institution where s/he resided for 90 days or less and resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Low-Barrier Shelter: According to the National Alliance to End Homelessness, shelters that are most effective in serving the homeless population operate in a Housing First, low barrier model. A low barrier shelter is a shelter where no unnecessary expectations or requirements are placed on persons who wish to enter or remain in the shelter. With low-barrier access, shelters are able to serve the most vulnerable by removing barriers to entry that require individuals to be sober, compliant with mental health or addiction treatment plans, or to engage in services.

National Guard and Reserves: Veteran Status for members of the National Guard and Reserves can be confusing to those who have primarily worked with Veterans who served on regular active-duty service in the US Armed Forces. National Guard members are eligible for Veteran services if they were mobilized because of a Federal Executive order for deployment to a designated combat zone. If they were mobilized because of an order of the State (i.e., support of a disaster area) they are not activated for the purposes of the federal government, and this period will not count for Veteran eligibility. Reserve members must be activated on a full-time basis and must be serving in an operational or support role, as opposed to a training role.

Permanent Supportive Housing (PSH): A nationally recognized, community-based, effective solution to the needs of vulnerable people with disabilities who are homeless. PSH integrates permanent, affordable rental housing with supportive services needed to help people who are homeless, have serious and long-term disabilities access, and maintain stable housing in the community.

Progressive Engagement - is an approach to helping households end their homelessness as rapidly as possible, despite barriers, with minimal financial and support resources. More supports are offered to those households who struggle to stabilize and cannot maintain their housing without assistance.

Rapid Re-Housing (RRH): An intervention housing model by which households experiencing homelessness move to permanent housing quickly with a focus on connections to long-term community supports.

Rapid Resolution – Rapid Resolution is a housing intervention that seeks to assist households to maintain their current housing situation or identify an immediate and safe housing alternative to emergency shelter or the streets within their own network of family, friends, and social supports. Working alongside people facing a housing crisis in an empowering manner, Rapid Resolution assists them at the very beginning of that crisis or shortly after, they have entered the homeless system. Rapid Resolution also ensures that those households who do not have alternative housing options are quickly connected to existing emergency or crisis-housing services at the VA or in their community to ensure their immediate health and safety needs are met.

Safe Haven: a form of supportive housing that serves hard-to-reach homeless persons with severe mental illness who come primarily from the streets and have been unable or unwilling to participate in housing or supportive services.

1) *Low-Demand GPD* is the only GPD model that is a Safe Haven and not considered Transitional Housing. Low Demand uses a high engagement/harm reduction model to better accommodate chronically homeless Veterans and Veterans who were unsuccessful in traditional treatment settings. Programming does not require sobriety or compliance with mental health treatment as

a condition of admission or continued stay. Overall, demands are kept to a minimum; however, services are made widely available and are actively promoted by program staff as needed. The goal is to establish permanent housing in the community, while providing for the safety of staff and residents.

Shallow Subsidy: The SSVF Shallow Subsidy service provides rental assistance to low-income Veteran households who are enrolled in SSVF's Rapid Rehousing or Homeless Prevention projects. It is likely that most participants will have already received rental assistance via traditional SSVF projects (Rapid Rehousing or Homeless Prevention) but remain rent burdened. Under the Shallow Subsidy service, SSVF grantees provide rental assistance payments to landlords on behalf of the Veteran household. The rental assistance is at a fixed rate every month, regardless of changes in the Veteran household's income or monthly rent amount. SSVF grantees are also expected to offer light case management services but may adjust as needed. For SSVF's Shallow Subsidy service, the maximum amount of rental subsidy that can be provided on behalf of the Veteran household is up to 50% of rent on a unit that is deemed rent reasonable for up to two years.

Street Outreach: Street Outreach goals are to engage, assess, and combat homelessness for individuals living in a place not meant for human habitation, and shelters. Outreach staff works to build trust with those experiencing homelessness first by helping to meet some of their basic needs including food, clothing, showers, laundry, transportation, and identification. Then, they collaborate with each individual to access housing, employment, medical care, mental health care, substance abuse treatment, and other services.

Transitional Housing (TH): A site-based supportive housing model for homeless individuals. Programs provide extended shelter and supportive services for homeless individuals and/or families with the goal of helping them live independently and transition into permanent housing. Grant and Per Diem is a type of Transitional Housing offered to homeless veterans and funded by the Veterans Administration. There are five models of GPD, four of which are considered Transitional Housing:

1) *Bridge Housing*—Designed for Veterans experiencing homelessness who have been offered and have accepted a permanent housing intervention but are not able to immediately enter the permanent housing (e.g., HUD-VASH, SSVF) (e.g., HUD-VASH, SSVF)

   OR

   for whom a HUD-VASH referral and VI-SPDAT must completed and sent within 7 calendar days of admission to shelter/GPD. Bridge beds will be prioritized first for SSVF and HUD-VASH in our community. These are typically short-term stays in transitional housing (approx. 90 days) and services should be focused on the needs of the Veteran to support their move to permanent housing. Length of Stay (LOS) will be individually determined based on need, but in general, is expected to average 90 days.
2) *Hospital-to-Housing*—Homeless Veterans who are identified and evaluated at inpatient care settings and emergency departments for suitability for direct transfer to a designated GPD program for transitional housing and supportive care. Veterans served under this model must be able to receive healthcare services from VA as a Homeless Patient Aligned Care Team (H–PACT), or other appropriate care team, will facilitate the ongoing care needs while in transitional

housing. Hospital-to-Housing is a model to address the housing and recuperative care needs of homeless Veterans who have been hospitalized.

3) *Clinical Treatment* -Homeless Veterans with a specific diagnosis related to a substance-use disorder and or mental-health diagnosis. Veterans actively choose to engage in clinical services. Clinically focused treatment is provided in conjunction with services effective in helping homeless Veterans secure permanent housing and increase income through benefits and/or employment. Although the programming and services have a strong clinical focus, permanent housing and increased income are a required outcome of the program. Treatment programs must incorporate strategies to increase income and housing attainment.
4) *Service-Intensive* -Homeless Veterans who choose a supportive transitional housing environment providing services prior to entering permanent housing. Provides transitional housing and robust services that facilitate individual stabilization, increased income, and movement to permanent housing as rapidly as clinically appropriate. Scope of services should incorporate tactics to increase the Veteran's income through employment and/or benefits and obtaining permanent housing. Services provided, and strategies used by the applicant will vary based on the individualized needs of the Veteran and resources available in the community.

United States Department of Veterans Affairs (VA): VA is a federal Cabinet-level agency that provides comprehensive healthcare services to eligible military Veterans at VA medical centers and outpatient clinics located throughout the country. The VA coordinates the distribution of benefits for Veterans and their dependents. Benefits include compensation for disabilities, the management of Veteran's hospitals, and various insurance programs. In order to bring an end to Veteran homelessness, the VA provides funding for housing and related services for homeless Veterans and their families.

U.S. Interagency Council on Homelessness: USICH was originally authorized by Congress through Title II of the landmark Stewart B. McKinney Homeless Assistance Act of 1987 (PL 100-77) to serve as an "independent establishment" within the executive branch. We were charged with coordinating the federal response to homelessness and creating a national partnership at every level of government and with the private sector to reduce and end homelessness in the nation while maximizing the effectiveness of the federal government in contributing to the end of homelessness.

Veteran: A person who served in the active military service and who was discharged or released under conditions other than dishonorable

Criteria and Benchmarks for Ending Veteran Homelessness

The United States Interagency Council on Homelessness (USICH) and its member agencies have adopted a vision through the federal strategic plan of what it means to end all homelessness, ensuring that it is a rare, brief, and one-time experience. USICH, the Department of Housing and Urban Development (HUD), and the Department of Veterans Affairs (VA) have also developed specific criteria and benchmarks for ending Veteran homelessness in order to help guide communities as they take action to achieve the goal.

Purpose of the Criteria and Benchmarks

Criteria and benchmarks work together to provide an ongoing assessment of a community's response to homelessness. While the criteria focus on describing essential elements and accomplishments of the community's response, benchmarks serve as important indicators of whether and how effectively that system is working on an ongoing basis. Together, these criteria and benchmarks are intended to help communities drive down the number of Veterans experiencing homelessness to as close to zero as possible, while building systems that support long term, lasting solutions that can effectively and efficiently respond to future needs. As we work to apply these criteria and benchmarks, we consider the data and information holistically. For example, it may be possible for a community's data to indicate it achieved all of the benchmarks, while other information indicates that the expectations of the criteria have not been met. Or the benchmarks may indicate that a community's system is working efficiently, but that system has not been working long enough to have fully achieved the goal. USICH will continue to review and evaluate the effectiveness of these criteria and benchmarks as more communities seek federal confirmation and go on to do the challenging work of sustaining an end to Veteran homelessness. Cincinnati/Hamilton County supports these strategies to create sustained success as we pursue the goal of ending Veteran homelessness.

Criteria 1: Identifying All Homeless Veterans

Policy – All literally homeless Veterans in the Greater Cincinnati/Hamilton County CoC are identified.

1) Veterans engaged by street outreach teams, living in emergency shelters, or in transitional housing are entered into HMIS and documented by community standards.
2) If a Veteran or Veteran family meets the criteria of literally homeless, they may be eligible for SSVF, HUD-VASH and other housing programs.
    a) For enrollment in SSVF, CoC, or ESG housing programs, documentation must be obtained to verify homeless status as described in Homeless Documentation Requirements for Enrollment in CoC and ESG Housing Programs Policy.
    b) For enrollment in HUD-VASH, third-party documentation is preferred; however, self-report will be accepted.

Policy - All identified Veterans must be added to the Veteran By-Name-List. Documentation of chronic homelessness will be maintained on that list.

1) The Veteran By Name List (VBNL) is a list of Veterans in our community that was created using profiles in HMIS and the Coordinated Entry VI-SPDAT triage tool. The VBNL Program was developed to be used for veteran specific housing and resource matching within Coordinated Entry and to track specific outcomes for all Veterans experiencing homelessness in our community. Every veteran enrolled in Emergency Shelters, Safe Haven, Transitional Housing

(including GPD), SSVF Emergency Housing Assistance, or Street Outreach programs should be included in the VBNL. The VBNL is independent from the Coordinated Entry Prioritization List, therefore placement on the VBNL does not impact their status on the Coordinated Entry Prioritization List.

2) Transitional Housing, Safe Haven, Emergency Shelter, Street Outreach, and SSVF providers add veterans experiencing literal homeless to the Veteran By-Name-List in Clarity's Coordinated Access Project at time of enrollment.
   a) SSVF should only add Veterans active in Emergency Housing Assistance in Hamilton County. For the purpose of this manual, Veterans active in Emergency Housing Assistance will be considered enrolled in Emergency Shelter.
   b) If a veteran moves from one homeless service project to another, agencies do not exit/re-enroll in the By-Name-List; this is to ensure tracking time homeless.
   c) The Emergency Shelter, Street Outreach, Safe Haven or Transitional Housing (including GPD) provider should update the Veteran's information on the VBNL anytime there is a new Housing Offers or change to the Housing Plan.
   d) The workflow process to enroll, update, and exit a Veteran on the VBNL in HMIS can be found in the following HMIS Article and in Addendum D: https://steh.freshdesk.com/support/solutions/articles/43000630935-veterans-by-name-list-vbnl-
3) Veterans should not be removed from the By-Name-List due to location of unsheltered status.
4) Veterans should not be removed from the By-Name-List due to negative discharge from programs for 90 days. A negative discharge is defined as an exit to non-permanent housing or whereabouts unknown. These discharges will be reviewed during the Veteran Workgroup By-Name List Review. VA and STEH will review records to see if the Veteran resurfaced in another Homeless Program prior to list removal. SSVF will review KY, OH, IN BOS HMIS.
5) In the event a Veteran exits literal homelessness while active in a permanent housing program and has moved into a non-permanent housing situation while they are seeking permanent housing, they will remain on the By-Name-List as "Active – ES/TH" under *List Status* for as long as they remain eligible for that permanent housing program. The *Last Known Provider* will be changed to the Permanent Housing Provider Agency name and the Previous Provider, Exit Date and Destination will be placed in the *Notes* Section of the By-Name List.
   a) It is then the permanent housing provider's responsibility to update the Housing Move-In Date in HMIS or exit the Veteran to a non-permanent housing destination in a timely manner.
6) If a client is flagged as chronic in HMIS but does not have at least 9 months of homelessness actually documented in HMIS and documentation of an additional 3 months of homelessness, they will not be considered chronically homeless for the purposes of prioritizing them for a chronically homeless PSH bed.
   a) If a case manager can provide additional 3rd party documentation (at least up to the required 9 months with evidence of an additional 3 months) in an acceptable format, the client will then be flagged as Chronically Homeless on the Veteran BNL.

b) Self-certification beyond the acceptable 3 months will be reviewed on a case-by-case basis by the BNL administrator.

7) Generally, this is the priority order for establishing a person's chronic homelessness status:

a) 3rd-party documentation
    i. HMIS/comparable database record, or
    ii. Individual record of stay at emergency shelter, safe haven or from a street outreach contact, oral
    iii. Written observation by an outreach or intake worker of encounters with the individual or head of household that includes a description of the conditions where the individual or head of household was living or is currently living.
    iv. Written observation by community member that has physically observed where the person or household was or is currently living (a written referral by another housing/service provider must also be included)

b) Intake worker observation
    i. Written observation by outreach and/or intake worker of encounters with person/household (must include description of living conditions)
    ii. Self-certification* (written) by individual/head of household seeking assistance
    iii. Does not need to be notarized
    iv. Must be signed by individual/head of household, and
    v. Intake worker must still document living situation of individual/head of household seeking assistance, and
    vi. Intake worker must document all steps taken to higher order of priority evidence

c) Attempts to obtain third-party documentation and if necessary, reasons for why third-party documentation was not obtained must be thoroughly documented in each client record.
    i. If third-party documentation cannot be obtained, a written record of intake worker's due diligence to obtain, the intake worker's documentation of the living situation, AND the individual's self-certification of the living situation is required in client file.
        a. <u>Institutional Stays</u> – acceptable documentation:
            1. Discharge paperwork or written/oral referral from a social worker, case manager, or other appropriate official stating the beginning and end dates of the time residing in the institutional care facility.
            2. Where the above is not attainable, a written record of intake workers due diligence to obtain AND the individual's self-certification that he or she is exiting an institutional care facility where resided less than 90 days.

d) Veteran Workgroup Case Conferencing - During the monthly CoC Veteran Workgroup, Homeless Veteran Service Providers meet to review the VBNL pulled from Clarity in Excel format and conduct Case Conferencing.
    i. STEH staff will save a copy of the most current VBNL in the Private VBNL Teams Channel so appropriate Veteran Workgroup members can access prior to the meeting.

ii. Any Veteran Workgroup attendees that are not directly providing services to Veterans on the VBNL are asked to leave during VBNL Review and Case Conferencing and the Workgroup moves into closed session.
iii. A representative from all VA-funded homeless projects (SSVF, VA Outreach, HCHV, and GPD) are required to attend and participate in Monthly Case Conferencing and all non-VA other homeless/housing projects that serve Veterans are invited and encouraged to attend and participate.
iv. The Veteran Workgroup Chairs, with assistance from STEH staff, assist in facilitating the VBNL Case Conferencing. Veterans experiencing Chronic, long lengths of stay, and unsheltered homelessness are reviewed and discussed. The Veteran Workgroup also discusses Veterans without a Housing Plan and allows for open discussion on any other Veterans that are facing barriers and do not fit into these categories.
v. Any updates made to the VBNL Excel Document during or prior to Case Conferencing must be updated in HMIS. It is the homeless or housing service providers responsibility to ensure the VBNL in HMIS is accurate and current.

Criteria 2: Providing Immediate Shelter to Unsheltered Homeless Veterans

Policy – The Cincinnati CoC provides low-barrier shelter immediately to any Veteran experiencing unsheltered homelessness who wants it. Access to shelter is not contingent on sobriety, minimum income requirements, criminal record, or other unnecessary conditions.

All unsheltered Veterans are offered low-barrier shelter using a Housing First, low barrier approach and work to remove barriers to entry. Veterans experiencing homelessness will not be screened out of or discouraged from participating in programs because of such factors as: lack of income or employment, poor credit or financial history, active or history of substance abuse or completion of treatment, having a criminal record with the exception of legally mandated restrictions, history of domestic violence, behaviors that are interpreted as indicating a lack of “housing readiness, ” or any other necessary requirements.

Policy – The Strategies to End Homelessness (STEH) CAP Hotline serves as the coordinated entry provider for all homeless Veterans within Cincinnati/Hamilton County that seek shelter. CAP is responsible for referring all Veterans to the most appropriate shelter, targeted homeless prevention, or other program within the Greater Cincinnati/Hamilton County CoC.

1) Veterans seeking immediate shelter should call the CAP line at 381-SAFE to be connected to an available/appropriate emergency placement. When the Veteran calls the CAP hotline, they will either:
   a) be diverted to SSVF Homeless Prevention if at risk of homelessness but not in immediate need of shelter.
   b) be referred to GPD Facility, and Rapid Resolution.
   c) be referred to emergency shelter and Rapid Resolution immediately; or
2) If a veteran reports experiencing unsheltered homelessness and does not have access to a phone, the VA's Community Outreach staff member will call CAP with the Veteran. If they are unable to reach CAP for more than 30 minutes, the Veterans GPD/CERS basic eligibility approval will be forwarded to CAP. CAP will respond within 30 minutes:

   a) If the client is already enrolled in Clarity, CAP will send the referral (dependent upon eligibility and availability) and respond to the email (i.e., referral sent, eligible but no opening, etc.)

   b) If the client is not enrolled in Clarity, CAP will respond to the email with that information (i.e., caller not in Clarity, CAP is contacting now) and the next available CAP Intake Specialist will contact the veteran directly using the contact number provided by the veteran provider in the eligibility referral. CAP will then conduct the normal call process if able to speak with the veteran

   c) If CAP does not respond within 30 minutes, the VA will send the referral information directly to the GPD/CERS site for screening while the Veteran is present at the VA's Community Outreach Office. If the GPD/CERS site screens the veteran as eligible, the VA liaison or GPD/CERS site will send an email to CAP informing them of the eligibility and request that CAP send the referral to the site via HMIS.

3) If an unsheltered homeless Veteran declines a shelter offer for reasons other than excessive barriers to entry, SSVF grantees and, where applicable, local dedicated street outreach teams will make offers of shelter to the unsheltered homeless Veteran on a bi-weekly basis, at minimum.
   a) In extreme weather situations, shelter offers must be made on every three-day basis, at minimum.
4) Literally homeless Veterans in immediate need of shelter may receive same day shelter services through the community's low barrier shelter option. Every Veteran who presents at any Access Point for emergency services will be offered or referred to appropriate shelter options.
   a) If a Veteran contacts the CAP Hotline, staff will screen for Veteran status through client self-report (CAP does not determine eligibility for VA services including SSVF and GPD). CAP will

verify presumptive eligibility to the best of their abilities using SQUARES. If SQUARES provides a "no" or CAP cannot identify availability in VA programs CAP staff will notify GPD liaisons for review prior to denial.

b) The VA GPD Liaison must approve all veterans prior to veteran placement in a GPD bed and HCHV CERS within 2 operating hours of referral. The VA will review the veteran's medical record and HOMES record prior to approval. During this assessment, the VA GPD Liaison may determine that the bed type is not appropriate and place the veteran in an alternative model. GPD Liaison will document approval or denial in the Clarity Referrals tab and will email GPD site of approval.

c) Upon notification of preliminary approval, the GPD or HCHV CERS site must complete a screening within 4 operating hours.

d) Program intake must occur within 72 hours of screening, if approved therefore GPD sites should not hold beds for approved Veterans for more than 72 hours.

e) If the GPD or HCHV CERS provider denies the Veteran for their program during phone screening, they will inform the Veteran of denial and inform the GPD Liaison and CAP via email of denial and reason for denial.

f) If the GPD or HCHV CERS provider denies the Veteran prior to phone contact, the provider will notify CAP and the GPD liaison via email of denial and reason for denial. CAP will then follow up with the Veteran to identify alternative placement.

g) The GPD site will update the Clarity referrals tab with all approvals and denials. If a GPD site cannot reach the Veteran, this will also be noted in the Clarity Referral tab. If a Veteran does not present to the site for an intake within 72 hours, the GPD site should deny the referral and reply to the original email thread with CAP and the GPD Liaison to inform them of denial and to re-open the bed in Bed Finder.

5) When referring an incarcerated Veteran to a GPD bed, CAP will follow the attached procedure. (See Addendum A)

6) A person is residing in a county when they establish or maintain a physical living arrangement, which they or someone responsible for them, consider to be home. A visit to another county does not make a person a resident of that county, nor does a planned temporary living arrangement prior to admission in a program. Except in unusual situations related to an extended visit, it makes no difference how long a person has been physically located in the county if they maintain a primary residence in another county and intend to return to that county. In all instances the person's intent to reside in a county is the determining factor, regardless of the length of time involved.

a) When a Veteran has been admitted to a program directly from a place of residence outside of Hamilton County, so that no residency has been established, the certified county of residency will be considered as that county in which the program is located. No program may have a residency requirement unless another funder requires it.

Criteria 3: The community provides service-intensive transitional housing (SITH) only in limited instances.

Policy – CAP screens for all other GPD Models prior to assessing for SITH.

CAP will only refer to SITH when all other options have been exhausted and it is determined to be the most appropriate placement. The VA will review the veteran's medical record and HOMES record prior to approval. During this assessment, the VA GPD Liaison may determine that SITH is not appropriate and place the veteran in an alternative model.

Criteria 4: The community will assist Veterans to swiftly move into permanent housing

Policy - All Literally Homeless Veterans in need of permanent housing interventions must go through the Coordinated Entry System.

1) All GPD, Shelter and Street Outreach providers are trained on the VI-SPDAT. The provider completes the VI-SPDAT with the veteran within one week of their enrollment in the homeless program, but may be updated, when necessary, per CoC-wide Coordinated Entry policies. The VI-SPDAT is completed in the Community's Homeless Management Information System, and the scores are accessed by Strategies to End Homelessness (STEH).
2) **Accessing SSVF RRH Shallow Subsidy** – Based on availability, if a Veteran scores between 0-3 on the VI-SPDAT and has income less than 80% of the AMI and could support 50% of their rent, they can be referred to SSVF for RRH Shallow Subsidy Services through the Coordinated Entry System.
3) **Accessing SSVF Rapid Re-housing** - Based on availability, and based on the community RRH Prioritization Policy, Coordinated Entry will refer Veterans to SSVF following the CoC Coordinated Entry Rapid Re-Housing Prioritization of Referrals Policy. If a Veteran is in needs of a more intensive housing intervention, SSVF will coordinate directly with HUD-VASH Care Coordination Team to make the referral.
    a) Veterans enrolled in Phase 1 of Clinical GPD who score within Rapid Re-Housing range will not be referred to Rapid Rehousing for the first 90 days of their Clinic GPD stay unless GPD staff alert Coordinated Entry of a client who is ready for housing before their 90 days.
    b) The following order of priority applies for SSVF openings:
        i) Street Outreach, Emergency Shelter, and Safe Haven/Low Demand GPD
        ii) Bridge
        iii) Clinical, Service Intensive Transitional Housing, and Hospital to Home GPD
4) **Accessing HUD-VASH** – Once a week, Coordinated Entry will refer all veterans to HUD VASH that score 8+ on the community assessment tool (VI-SPDAT). This also includes Veterans enrolled in

Phase 1 of Clinical GPD. If the veteran is appropriate but is in Phase 1 of Clinical GPD, based on Veteran's feedback and recommendations of the HUD-VASH clinical assessment, staff will determine when to engage services. When a match is received, community providers should complete a HUD VASH referral form with the veteran and submit this form to the HUD VASH Supervisor via email, fax, or delivery to the VA Community Outreach Office. HUD-VASH follows national guidance on prioritizing homeless veterans for HUD-VASH services. Veterans can self-refer by contacting the Cincinnati VA Community Outreach Division.

a) If the veteran is not appropriate and is denied HUD-VASH after referral, HUD-VASH will alert Coordinated Entry by responding to the match email, and the veteran will return to the prioritization list to be considered for SSVF RRH. Veterans that are denied from HUD-VASH will not automatically receive an SSVF RRH referral, they will be prioritized based on the CoC Coordinated Entry Prioritization Policies.

5) **Accessing CoC Housing Programs** – In the event that a Veteran in an Emergency Shelter, Safe Haven, or Street Outreach program that cannot be served in a VA funded housing programs, Coordinated Entry may consider the Veteran for consideration of other CoC housing programs based on to the CoC Coordinated Entry Prioritization policies. Veterans in a Transitional Housing are not currently prioritized for CoC housing programs per HUD regulations.
6) **Accessing Coordinated Exit** - Coordinated Exit assists in coordinating exits from housing programs, the bulk of which is through a partnership between STEH and CMHA. Using guidance from HUD's "Moving Up" initiative, the partnership allows clients in all CoC, ESG, VA Housing programs and Transitional Housing programs for the homeless, though PSH is prioritized, who are stabilized in services but are not able to successfully exit due to continued need of financial subsidy to remain stably housed while causing turn-over in housing programs. STEH manages the CMHA partnership; develops and oversees the referral process, reviews, and submits applications, provides communication between CMHA and housing providers/clients and maintains and analyzes data to identify community trends. Providers can refer Veterans who are ready to exit a housing program but for the need of a continued subsidy and who's needs cannot be met by HUD-VASH to Coordinated Exit.

Policy- The Cincinnati CoC prioritizes the use of Transitional Housing (TH), including VA-funded Grant and Per Diem (GPD) or Healthcare for Homeless Veterans (HCHV), as a short-term bridge to PH.

1) Homeless Veterans are only assisted with transitional housing in any of the following situations:
   a) The Veteran is eligible and appropriate for GPD;
   b) the Veteran chooses GPD/HCHV services over other shelter options while being assisted with securing permanent housing with the responsible provider;
   c) The Veteran had declined SSVF RRH assistance via the emergency shelter and is referred to GPD by the responsible provider.
   d) There are two criteria to be eligible for GPD a person must be;
      i) Homeless according to the McKinney-Vento Homeless Assistance Act definition of Homeless

ii) A Veteran- a person who served in the active military, naval, or air service, and who was discharged or released there from under conditions other than dishonorable. The key word here is active military.

e) Regarding GPD, there is no requirement to be eligible for VA Medical Care. The individual must be a Veteran with one day of "active duty" for other than training purposes.

i) If a service member sustains an injury during basic training and has a service connection due to that injury, he would be eligible for GPD.

f) To be eligible for HCHV Contracted Residential Services, a Veteran must meet the requirements of 38 U.S.C. 2031(a) and 38 CFR 63.3.

i) **Eligibility**. In order to serve as the basis for a per diem payment through the HCHV program, a Veteran served by the non-VA community-based provider must be:

(1) Enrolled in the VA health care system, or eligible for VA health care under 38 CFR 17.36 or 17.37; and

(2) Literally Homeless.

ii) **Priority Veterans**. In allocating HCHV program resources, VA will give priority to Veterans, in the following order, who:

(1) Are new to the VA health care system because of VA outreach efforts, and to those referred to VA by community agencies that primarily serve the homeless population, such as shelters, homeless day centers, and soup kitchens.

(2) Have service-connected disabilities.

(3) All other Veterans.

iii) VA will refer a Veteran to a non-VA community-based provider after VA determines the Veteran's eligibility and priority.

g) In situations when a Veteran has enrolled in RRH or has been approved for PSH, but the housing unit is not immediately available, the Veteran may be moved into any GPD Bridge or Low Demand location while waiting for the housing unit to become available, rather than remaining in an emergency shelter, or an unsheltered location.

h) Where a homeless Veteran has chosen to move into a TH project because of a desire for intensive services prior to obtaining PH, a referral to Service Intensive Transitional Housing will be made.

i) Where a homeless Veteran has chosen to move into a TH project because of a desire for clinical treatment and services prior to obtaining PH, a referral to Clinical GPD will be made.

j) All TH providers must make new offers of PH to the Veteran on a bi-weekly basis. The dates of the PH offer and the Veteran's acceptance or decline of the offer must be documented in the Veteran's record in the HMIS BNL Project

k) When a Veteran refuses or is ineligible for SSVF or RRH, GPD will assume responsibility as the reasonable provider, assuring each Veteran has: 1) a housing plan; 2) assistance locating securing housing; 3) access to move in expenses and/or initial rental assistance (HUD-VASH or otherwise).

l) GPD providers must establish an ISP within 5 days of admission that suits the needs of the Veteran.

m) GPD makes clear to all admitted Veterans that the program aims to assist all Veterans obtain permanent housing as soon as possible.

Policy – The Cincinnati CoC is committed to immediately providing permanent housing (PH) to all homeless Veterans who desire it, regardless of perceived barriers or issues

The community is committed to the Housing First Philosophy that permanent housing should be accessible to all Veterans who are in need and desire it. A Veteran is offered PH immediately upon requesting shelter or accessing shelter through Rapid Resolution. When a Veteran applies for shelter, enters shelter, or is engaged with Street Outreach, the SSVF Rapid Resolution Specialist is contacted to discuss other permanent housing options utilizing the Veteran's support system. If the Rapid Resolution Specialist is unsuccessful and the Veteran is unsheltered, the Rapid Resolution Specialist works with the Street Outreach Worker to assist the Veteran in accessing shelter, if the Veteran chooses to.
All veterans are offered housing within 7 days of enrollment into GPD, Emergency Shelter, or Street Outreach. The staff of these programs complete a VI-SPDAT to assist with the determination of the appropriate housing intervention. Once a permanent housing program is available for the Veteran to access, they are immediately referred to those CoC or VA funded housing projects through the Coordinated Entry System.

Criteria 5: The community has resources, plans, partnerships, and system capacity in place should any Veteran become homeless or be at risk of homelessness in the future

Policy – If a Veteran can be diverted from homelessness and remain in current temporary or permanent housing, they will not be entered into Emergency Shelter or GPD Transitional Housing but will instead be connected to resources during their initial screening.

1) Rapid Resolution assists veterans at the very beginning of their housing crisis or shortly after they have entered the homeless system. Through Rapid Resolution, households are engaged in an immediate, deep conversation about safe, alternative housing options so that shelter or other situations of literal homelessness might be avoided. The housing option could be returning to a previous place with family or friends or finding another temporary housing location. That temporary housing location might turn into a permanent location, or it may not. The household might stay in the temporary housing location for one night, several nights, a month, or longer. Rapid Resolution also ensures that those households who do not have alternative housing options are quickly connected to existing emergency or crisis-housing

services at the VA or in their community to ensure their immediate health and safety needs are met. Rapid Resolution is a community process meaning all homeless providers are engaging in diversion conversations with the veterans; however, SSVF has been leading this process and has a designated Rapid Resolution Staff Person.

a) All Veterans seeking shelter or GPD Placement will be screened to determine if they can be diverted from homelessness. The screenings assess whether the Veteran can remain in their current living situation with intervention assistance or must enter shelter immediately. Veterans in Hamilton County can access Emergency Shelter or GPD through the Central Access Point (CAP) Line.
b) Veterans who contact the CAP Line for Emergency Shelter or GPD Placement will be immediately referred to SSVF for a Rapid Resolution Conversation. Rapid Resolution's goal is to divert a veteran from homelessness and assisting the veteran with navigating existing social and familial supports to access alternative temporary or permanent housing placement. The Rapid Resolution Specialist contacts the veteran immediately, no later than 1 business day, to have the initial conversation to either divert the veteran or rapidly resolve their current homeless situation. SSVF will provide annual training to community partners on Rapid Resolution as this is a community initiative and if a veteran cannot be diverted at time of applying for shelter/GPD then the homeless veteran providers will continue to have Rapid Resolution conversations with veterans even after the SSVF initial conversation.
c) Veterans that contact the CAP Line for Emergency Shelter or GPD Placement will be screened for Prevention Services utilizing the attached CAP Screening. During the CAP Screening, if it is determined that the Veteran can be diverted from homelessness but may need further intervention assistance, they will be referred to SSVF Prevention for an assessment. If it is determined that they cannot be diverted from homelessness, they will be referred to the appropriate Emergency Shelter or GPD Site based on availability.
    i. If the Veteran is referred to SSVF, the SSVF Provider will contact the Veteran within one business day of referral to complete the VA-mandated Prevention Screening Tool that determines likelihood of homelessness utilizing a data driven point system. The Veteran receives additional points if they are referred through CAP. If the SSVF Provider determines the Veteran as eligible, they will be entered into the project. If the Veteran is determined ineligible, they will be provided with community resources and will be offered assistance in connecting to those resources. SSVF will inform CAP of eligibility determination.

Monitoring System, Provider Performance, and Capacity to End Veteran Homelessness

Policy-Adherence to Federal Benchmark Tool

1) Cincinnati/Hamilton County CoC's By-Name List (BNL) identifies all homeless Veterans, including those who are in unsheltered and sheltered locations (i.e., transitional housing, emergency shelter, and Safe Haven), regardless of funding source. Veterans who have entered any permanent housing destination will have that outcome noted on the active list. The BNL has input from or is informed by all significant partners in the effort to serve Veterans experiencing homelessness, including the CoC, local VA Medical Center, VA funded providers, shelters, outreach workers, and additional community partners, such as food programs and law enforcement. The BNL is populated by HMIS. HOMES is also used to assist in the maintenance of the BNL. We use the Benchmark Generation Tool, developed by HUD and its partners, to manage our active list and calculate the benchmarks. Updates are conducted at least monthly to ensure information is current. If a Veteran on the active list can no longer be located after repeated attempts for 90 days or more, the status of that Veteran can be changed from "active" to "missing" for purposes of calculating the benchmarks. If the Veteran is located later and is still experiencing homelessness, the date of the most recent contact would become the new date of identification. When it is determined that an individual on the active list is not a Veteran, that individual will be removed from the active list and not included in data and calculations for these criteria and benchmarks.
2) During the monthly review of the BNL, the community also engages in Case Conferencing of veterans that are active to monitor service delivery to those enrolled in homeless programs. During the case conferencing, cases are also referred to community housing programs and those cases are tracked until the veteran has a housing move-in date. The following veterans are reviewed:
    a) Chronically Homeless Veterans
    b) Veterans with Long Lengths of Stay
    c) Unsheltered Veterans
    d) Veterans with no housing plan
    e) Other Veterans Providers would like to discuss due to high barriers/needs
3) Information and data needed to calculate benchmarks:
    a) **[Number of Veterans on active list]**
    b) **[Number of Veterans experiencing chronic homelessness on active list]**
    c) **[Number of Veterans experiencing long-term homelessness on active list]**
    d) **[Date of identification]** of each homeless Veteran. That is, the date of initial contact with a homeless Veteran in any program, including street outreach, emergency shelter, transitional housing, Safe Haven, VA Medical Center, or at any other point of entry in the homelessness system. This date includes Veterans who are experiencing homelessness for the first time and those who may be re-entering homelessness after having exited for at least 90 days.

e) **[Date of documented offer of a permanent housing intervention]** The information regarding the documented offer includes the type of permanent housing intervention offered (e.g., HUD-VASH, RRH, PSH, other subsidy).
f) **[Date of acceptance]** or **[date of decline]** of offer of a permanent housing intervention. In the specific case of Veterans who have previously declined an offer of a permanent housing intervention but who subsequently accept such an offer, the **[date of acceptance]** of the offer will serve as the **[date of identification]** for these Veterans.
g) **[Date of move-in to permanent housing destination]**
h) **[Date of move-in to TH, by type of TH]**
i) **[Yes or No, entering TH to appropriately address a clinical need]**
j) **[Date of removal from Active List for other reasons]** The date that an individual was removed from the active list for reasons other than moving into permanent housing.

Benchmark A: Specification to measure whether long-term and chronic homelessness among Veterans has been ended.

1) **Unit of Measurement:** Number of Veterans experiencing long-term and chronic homelessness in the CoC's geographic area
2) **Contributing Programs:** All projects administering emergency shelter, transitional housing, supportive housing, SSVF, HUD-VASH, street outreach, and permanent housing funded by CoC, local, state, or federal programs in the CoC's geographic area
3) **Data Source:** All Veterans on the BNL with Active status
4) **Target:** Zero Veterans experiencing long-term and chronic homelessness
5) **Measurement Period:** Continuous 90-day period preceding benchmark measurement
6) **Calculation:**
   a) **[Number of Veterans experiencing chronic homelessness on active list]**
   b) PLUS + **[Number of Veterans experiencing long-term homelessness on active list]**
   c) MINUS - **[Exempted Group 1]**
   d) MINUS - **[Exempted Group 2]**
   e) MINUS - **[Exempted Group 3]**
   f) **E**QUALS = Zero (0)
      i) Exempted Group 1: Veterans experiencing either chronic or long-term homelessness who have been identified and offered a permanent housing intervention within the last two weeks but who have not yet accepted. Veterans will be continually engaged and receive a documented offer of permanent housing at least every 14 days.
      ii) Exempted Group 2: Veterans experiencing either chronic or long-term homelessness who have been offered an available permanent housing intervention but have declined and instead chosen to enter a transitional housing program to appropriately address a clinical need. Veterans who have chosen to enter transitional housing programs to access generalized case management or job training are not included within this exempted group.

iii) Exempted Group 3: Veterans who have accepted a permanent housing intervention but who are still actively in the process of identifying, securing, or moving into a unit. Veterans who have been actively in the process of identifying, securing, or moving into a unit for more than 90 days are not included within this exempted group.

Benchmark B: Specification to measure whether Veterans have quick access to permanent housing.

1) **Unit of Measurement:** Community-wide average time from date of identification of homeless Veterans in the CoC's geographic area to date of move-in to a permanent housing destination
2) **Contributing Programs:** All projects administering emergency shelter, transitional housing, supportive housing, SSVF, HUD-VASH, street outreach, and permanent housing funded by CoC, local, state, or federal programs
3) **Data Source**: Active List
4) **Target:** Community-wide average time from the date Veterans are identified as experiencing homelessness in the CoC's geographic area to the date they move-in to a permanent housing destination is 90 days or less.
5) **Measurement Period:** Continuous 90-day period preceding benchmark measurement
6) **Calculation**:
    a) **[Total number of days for all non-exempted Veterans from identification to move-in to permanent housing]**
    b) DIVIDED BY / **[Total # of non-exempted Veterans]**
    c) IS LESS THAN OR EQUAL TO 90 days
        i) Exempted Group 1: Veterans who were identified and offered a permanent housing intervention over the 90-day measurement period but did not initially accept the offer. For these Veterans, the calculation of the average will only include the number of days from when they accepted the intervention until they moved into housing. Veterans will be continually engaged and receive a documented offer of permanent housing at least every 14 days.
        ii) Exempted Group 2: Veterans who have been offered an available permanent housing intervention but declined and have instead chosen to enter service-intensive transitional housing, whether to address a clinical need or not. Veterans who choose to enter service-intensive transitional housing will be provided with ongoing opportunities to express a preference for, to request, and to access a permanent housing intervention instead, through an at-least-monthly review of their individualized service and housing plans and their desired outcomes for services and housing.
    d) NOTE: A Veteran who is already in service-intensive transitional housing but is then offered a permanent housing intervention does not fall within Exempted Group 2. Veterans who are in a transitional housing bed/unit operating as bridge housing are also not included within this exempted group.

Benchmark C: Specification to measure whether the community has sufficient permanent housing capacity.

1) **Unit of Measurement:** Ratio of move-ins to permanent housing destinations to number of Veterans becoming homeless
2) **Contributing Programs:** All projects administering emergency shelter, transitional housing, supportive housing, SSVF, HUD-VASH, street outreach, and permanent housing funded by CoC, local, state, or federal programs.
3) **Data Source:** Active List
4) **Target:** Total number of Veterans moving into permanent housing destinations is greater than the total number of newly identified homeless Veterans
5) **Measurement Period:** Continuous 90-day period preceding benchmark measurement
6) **Calculation:** Total number of Veterans moving into permanent housing destinations over 90-day measurement period is greater than or equal to the total number of newly identified homeless Veterans within the 90-day measurement period.

Benchmark D: Specification to measure whether the community is committed to Housing First and provides service-intensive transitional housing to Veterans experiencing homelessness only in limited instances.

1) **Unit of Measurement:** Ratio of Veterans entering service-intensive transitional housing to Veterans becoming homeless
2) **Contributing Program**s: All projects administering emergency shelter, transitional housing, supportive housing, SSVF, HUD-VASH, street outreach, and permanent housing funded by CoC, local, state, or federal programs.
3) **Data Source:** Active List
4) **Target:** Total number of Veterans entering service-intensive transitional housing is less than the total number of newly identified homeless Veterans within the measurement period
5) **Measurement Period**: Continuous 90-day period preceding benchmark measurement
6) **Calculation**: Total number of Veterans entering service-intensive transitional housing within the 90-day measurement period is significantly less than the total number of newly identified homeless Veterans within the 90-day measurement period.

Addendum A

CAP Process for Screening Incarcerated Veterans Barriers were identified for veterans currently incarcerated and seeking housing upon release. The below process is used to help eliminate these barriers for veterans to ensure a stable placement once they are released back into the community. This process meets both the CAP and GPD requirements while ensuring quality care for our community's homeless veterans and allows access to the services the CAP line offers, despite the significant barrier of little to no phone access. Veterans who are incarcerated will be given the option of an in-person screening completed by a VA Veteran Justice Outreach (VJO) or other court official to start the CAP line referral process. A VJO or other court involved treatment provider will first assess for homelessness utilizing the CAP decision tree (Addendum B). Once homeless status is verified, the provider will complete the referral form with the incarcerated veteran including the CAP release of information. All information will then be sent to the CAP line to be entered into HMIS as a new referral. This process streamlines the referral process for incarcerated veterans.

Addendum B: Incarcerated Veteran Referral Document

CAP/GPD Placement Screening Form		
Veteran Name:	DOB:	
SS #:	Gender:	Ethnicity:
Contact Phone Number:	Email:	
Where did you sleep prior to incarceration?	Zip of last residence:	
VJO Name: Phone Number: Email:	GPD Placement site: GPD model: Intake date/time OR anticipated discharge date:	
What date did you enter incarceration?	Income:	
Are you working with SSVF/HUD/VASH worker? Yes or No; If so, which?	Previous GPD Placements	
Branch of Military:	Discharge Status:	
Year entered military service:	Separated (year):	
Have you served as a Reservist?: Yes or No	Have you served in the Guard?: Yes or No	

HMIS Privacy Notice and Client Consent Form

Please read carefully

This organization enters data into the Homeless Management Information System (HMIS). HMIS is a computer system that collects information about the experiences and needs of people experiencing homelessness or having trouble with housing. Strategies to End Homelessness (STEH) manages the HMIS. Clarity Human Services is the HMIS software.

How is your information protected? All information entered into HMIS is secured to protect your privacy.

- Only trained and approved staff with a reason to use HMIS have access.
- All staff must commit in writing to keep information private and only access information for a specific business reason (like working with a specific person/family or supervising a specific program).
- The HMIS is hosted on a secure server and data is unable to be read when not being used.

Sharing Data with Other Service Providers: You have the right to share your information in HMIS to help:

- Improve access and provide quality services to you.
- Coordinate referrals for housing or services such as food, utility help, counseling, etc.
- Reduce the need for you to repeat your story to every service provider.
- Provide information needed to match you to a housing provider (if available).

What information is shared in the HMIS?

- Only information needed to provide you with help will be collected.
- Personal information like your name, address, date of birth, social security number, and contact information.
- Intake, assessment, and enrollment data including notes, services, and referrals.
- Details to understand your situation.
- History of homelessness and other services provided by organizations who share information in HMIS.
- You may agree to share your data and still ask our staff to set specific information to private.

Your rights: You have the right to:

- Request all or specific HMIS data not be shared with other service providers.
- Ask for a copy of your personal information in HMIS and ask for changes.
- Access services whether you agree or do not agree to share information in HMIS.
- Request a copy of the HMIS Policies and Procedures Manual.

We take your privacy very seriously. It would be impossible to locate every person when this form is changed. For that reason, this form may be changed at any time and affects all information collected.

Your name and social security number will be removed after 7 years. You will be asked to sign a new form if you are still receiving services after 7 years. You can cancel this permission by returning a completed Revocation of Consent form. This will affect sharing future information. Information shared earlier cannot be unshared.

Questions? Just ask. If you have questions or if you think your information was mishandled contact this agency's HMIS grievance contact. You can contact Strategies to End Homelessness if you need additional assistance:

email HMISupport@end-homelessness.org, call 513-263-2790, or mail 2368 Victory Parkway, Suite 600, Cincinnati, Ohio 45206.

Signature: By signing I agree to share my information with other service providers.

I understand my data may still be used:

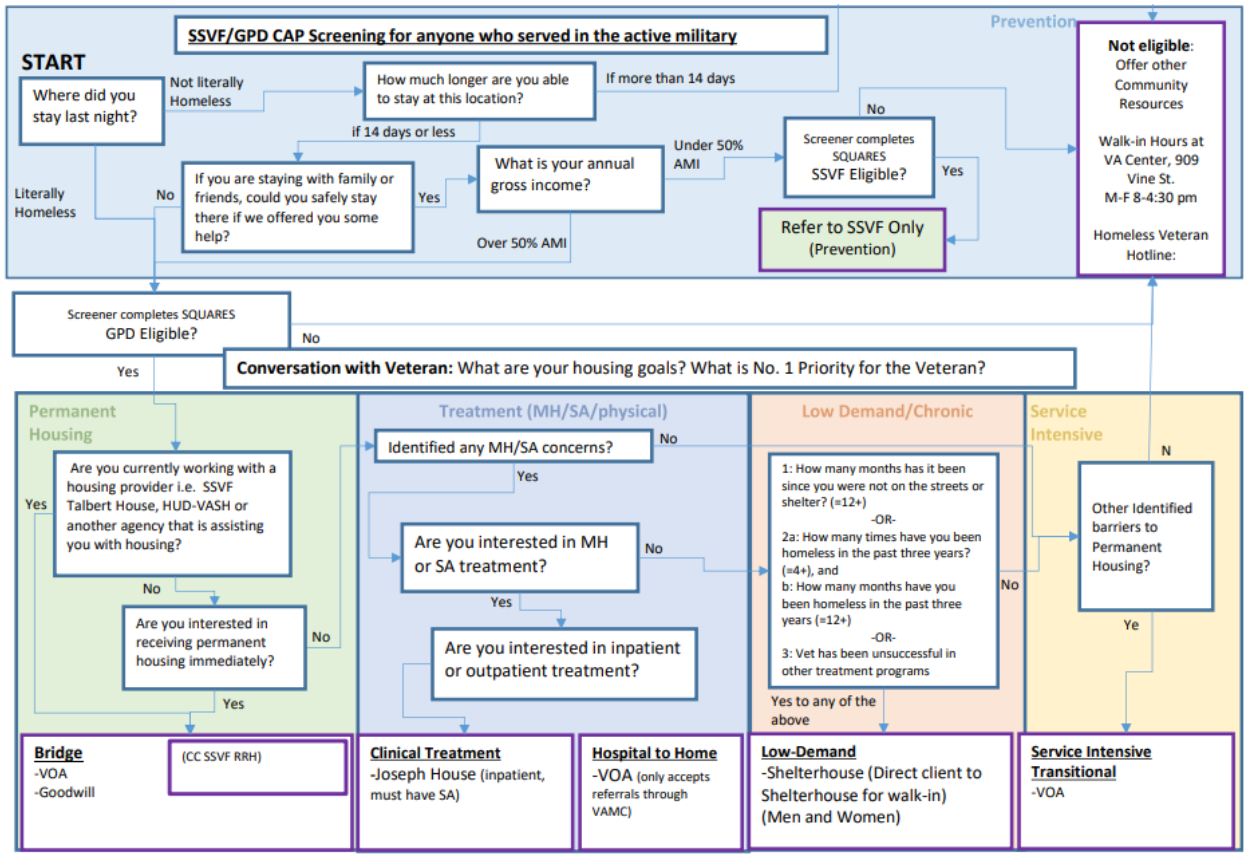
1. To coordinate services within this organization.
2. To report the services I received to funders.
3. Complete reports, supervision, auditing, or oversight needed to get funding for homeless services.
4. When demanded by law through a court order or in a public health emergency.
5. For research to better understand homelessness and housing problems in our community.
6. By HMIS managers to troubleshoot problems or help HMIS users who work with you.

Client Signature Date

Printed Name

Addendum C

CAP GPD Decision Tree

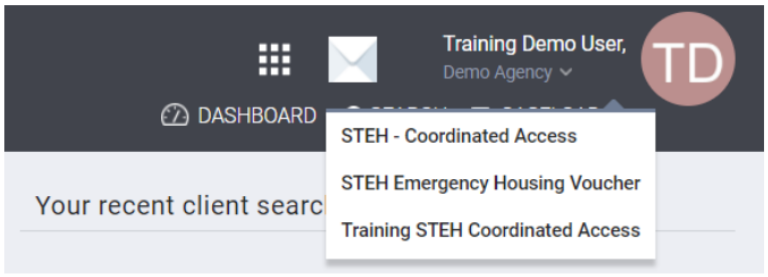


Addendum D:

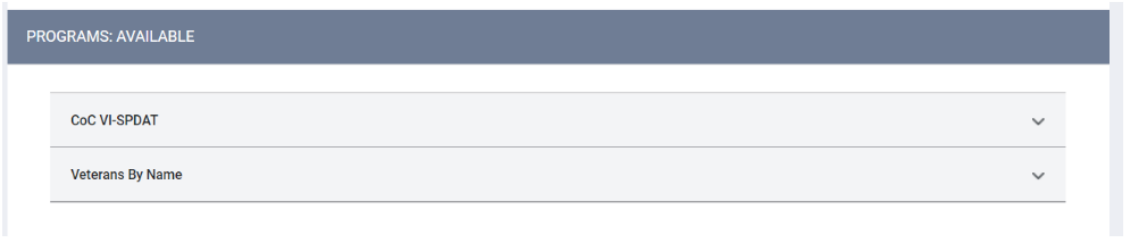
HMIS VBNL

The Veteran By Name List is a list of Veterans in our community that was created using profiles in HMIS and the Coordinated Entry VI-SPDAT triage tool. The VBNL Program was developed to be used for veteran specific housing and resource matching within Coordinated Entry and to track specific outcomes for Veterans experiencing homelessness in our community. Every veteran enrolled in Emergency Shelters, GPD, or Outreach programs should be included in the VBNL.

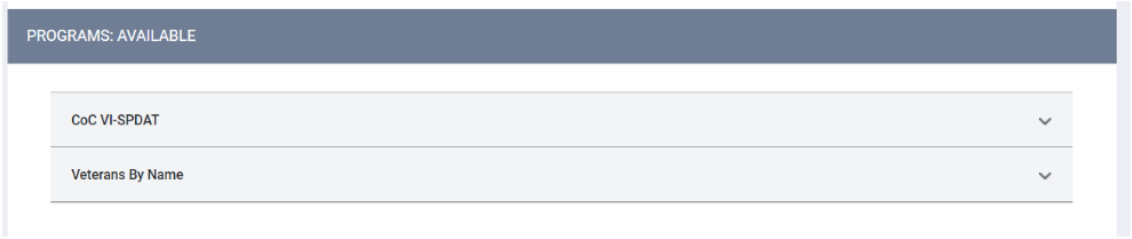
To access the VBNL, switch to "STEH Coordinate Access" agency in Clarity.



Search for the Individual or Head of Household you would like to enroll. Go to "Programs." Scroll down to "Programs: Available and select "Veterans By Name."



Toggle on any household members, if applicable and select "Enroll." Clarity will then walk users through program enrollment.

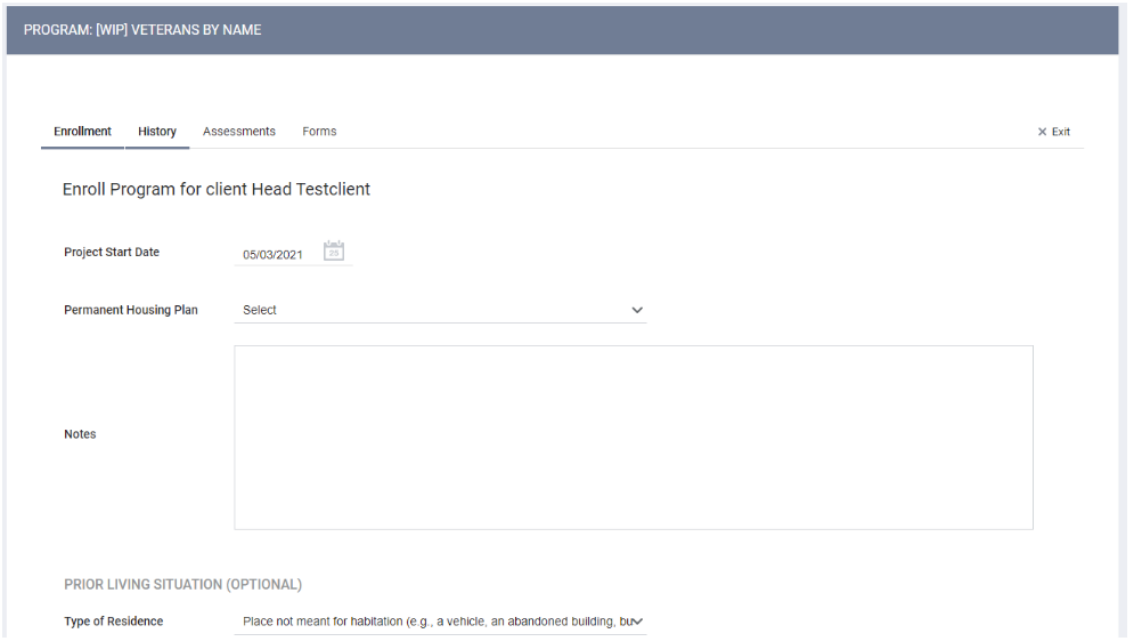


Toggle on any household members, if applicable and select "Enroll." Clarity will then walk users through program enrollment.

Program Information

The program consists of an Enrollment Screen, an Exit Screen, and an Assessment. Each enrollment corresponds to a single entry in the master list of the Benchmark Generation Tool.

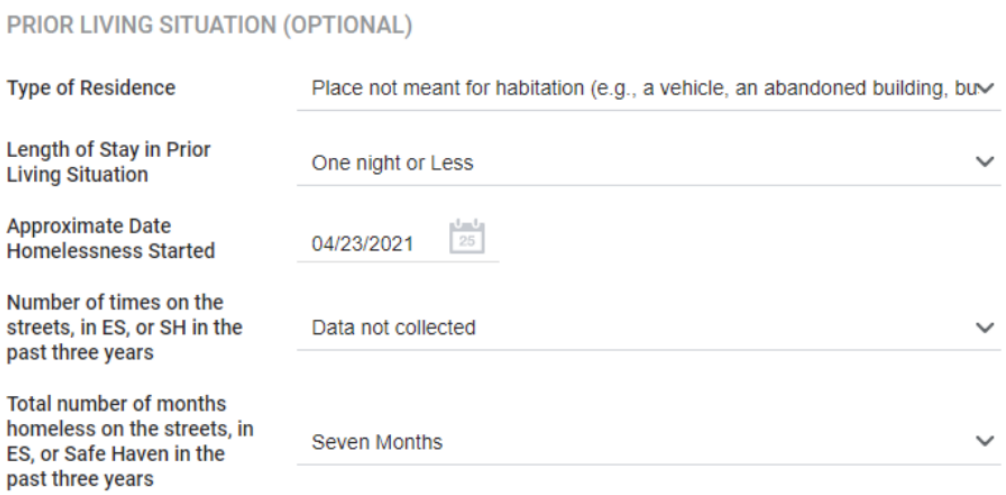
All information in the enrollment screen is optional. Enrollments may be modified at any time after they have been created to add additional information, such as notes, or correct existing information.

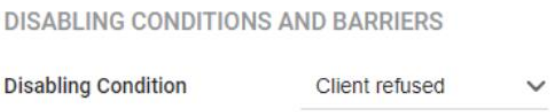


A number of fields are provided only for context and are not used in the Benchmark calculations. This includes a "Notes" field, which may be used to record a per-enrollment note that will show up on the Benchmarks Worksheet.

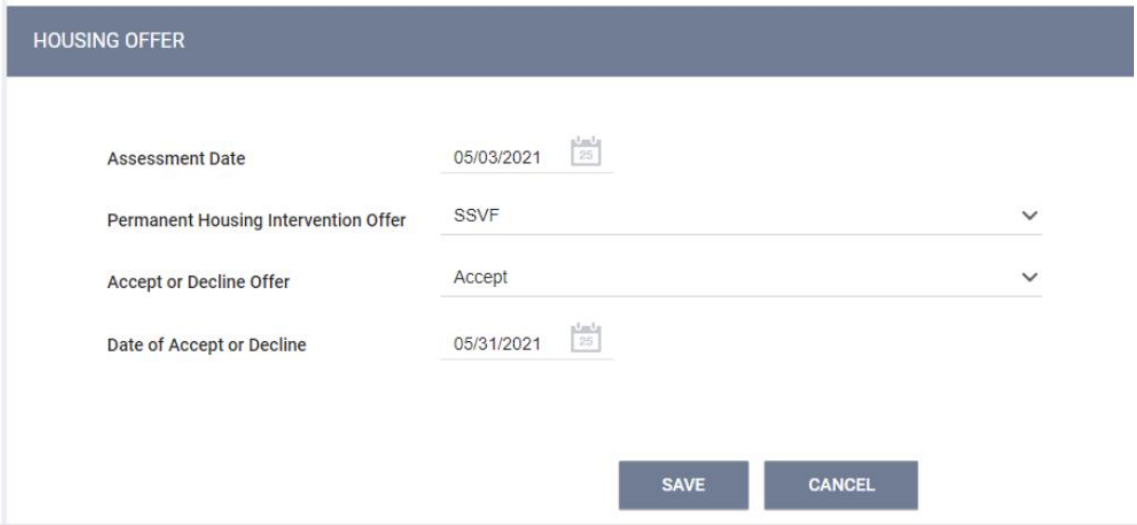
Notes

The enrollment screen also contains prior living situation and Disability information, this is used in the Benchmark calculations, this is optional as it should cascade from other enrollments, and can be acquired if missing.



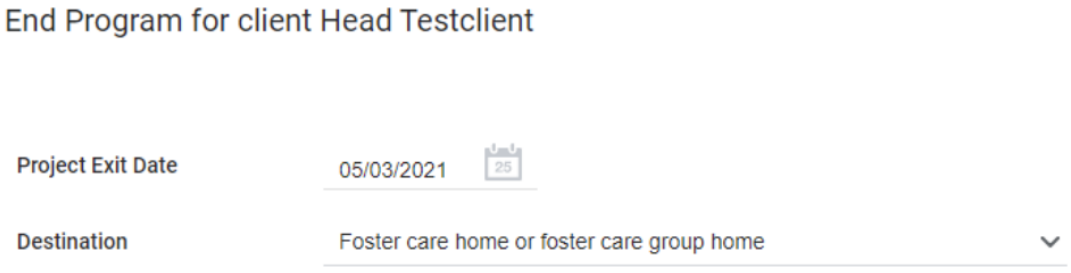


The "Housing Offer" assessment is used to record offers of permanent housing and to populate the Permanent Housing Offers section of the in the Benchmark Generation Tool. Housing offers should typically be made and entered every two weeks. The "Assessment Date" indicates the date the offer was made, and "Date of Accept or Decline" indicates the date of the response to the offer. If the assessment is being completed at a date later than the offer was made and accepted, the assessment date should be modified to indicate the date the offer was made, not the date the assessment is being entered into clarity.

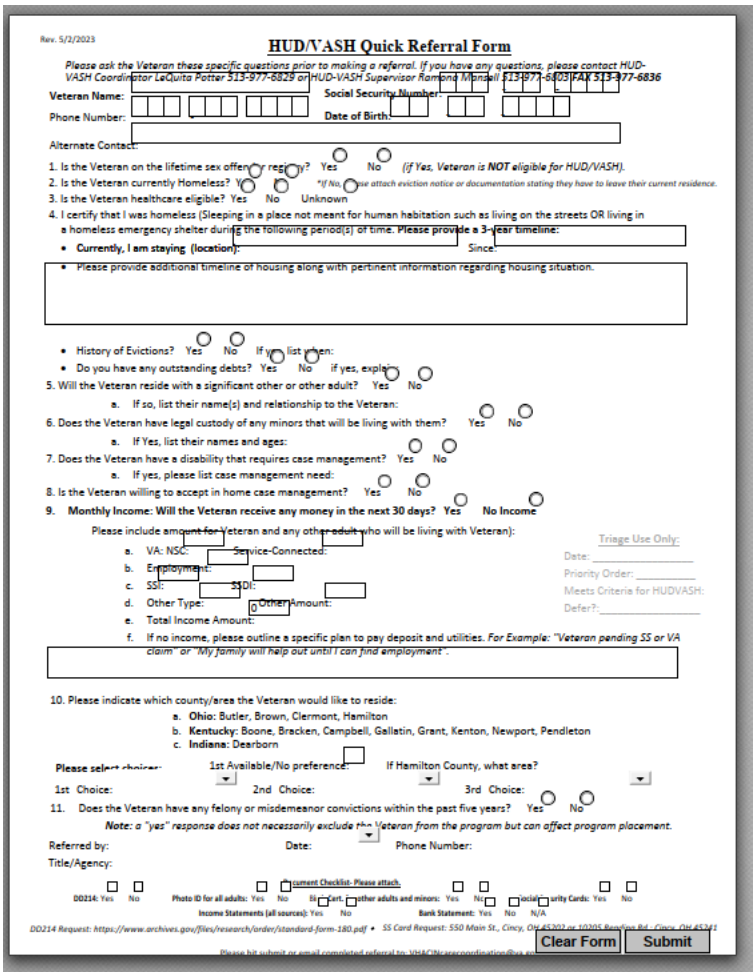


Program Exits

Exits will be automatically generated when a Veteran enters permanent housing, and due to inactivity. Exits may also be entered manually if necessary. The only information collected on the exit screen is the exit destination. This is required.



Addendum F: HUD VASH Referral



Rev. 5/2/2023

HUD/VASH Quick Referral Form

Please ask the Veteran these specific questions prior to making a referral. If you have any questions, please contact HUD-VASH Coordinator LaQuita Potter 513-977-6829 or HUD-VASH Supervisor Raymond Mundell 513-977-6803 FAX 513-977-6836

Veteran Name: **Social Security Number:**

Phone Number: **Date of Birth:**

Alternate Contact:

1. Is the Veteran on the lifetime sex offender registry? Yes No *(If Yes, Veteran is **NOT** eligible for HUD/VASH).*
2. Is the Veteran currently Homeless? Yes No **If No, please attach eviction notice or documentation stating they have to leave their current residence.*
3. Is the Veteran healthcare eligible? Yes No Unknown
4. I certify that I was homeless (Sleeping in a place not meant for human habitation such as living on the streets OR living in a homeless emergency shelter during the following period(s) of time. **Please provide a 3-year timeline:**
   - **Currently, I am staying (location):** Since:
   - Please provide additional timeline of housing along with pertinent information regarding housing situation.
   - History of Evictions? Yes No If yes, list when:
   - Do you have any outstanding debts? Yes No if yes, explain:
5. Will the Veteran reside with a significant other or other adult? Yes No
   a. If so, list their name(s) and relationship to the Veteran:
6. Does the Veteran have legal custody of any minors that will be living with them? Yes No
   a. If Yes, list their names and ages:
7. Does the Veteran have a disability that requires case management? Yes No
   a. If yes, please list case management need:
8. Is the Veteran willing to accept in home case management? Yes No
9. **Monthly Income: Will the Veteran receive any money in the next 30 days? Yes No Income**

   Please include amount for Veteran and any other adult who will be living with Veteran):
   a. VA: NSC: Service-Connected:
   b. Employment:
   c. SSI: SSDI:
   d. Other Type: Other Amount:
   e. Total Income Amount:
   f. If no income, please outline a specific plan to pay deposit and utilities. *For Example: "Veteran pending SS or VA claim" or "My family will help out until I can find employment".*

Triage Use Only:
Date: _____
Priority Order: _____
Meets Criteria for HUDVASH:
Defer?: _____

10. Please indicate which county/area the Veteran would like to reside:
    a. **Ohio:** Butler, Brown, Clermont, Hamilton
    b. **Kentucky:** Boone, Bracken, Campbell, Gallatin, Grant, Kenton, Newport, Pendleton
    c. **Indiana:** Dearborn

Please select choices: 1st Available/No preference: If Hamilton County, what area?

1st Choice: 2nd Choice: 3rd Choice:

11. Does the Veteran have any felony or misdemeanor convictions within the past five years? Yes No

Note: a "yes" response does not necessarily exclude the Veteran from the program but can affect program placement.

Referred by: Date: Phone Number:

Title/Agency:

Document Checklist- Please attach.

DD214: Yes No Photo ID for all adults: Yes No Birth Cert. other adults and minors: Yes No Social Security Cards: Yes No

Income Statements (all sources): Yes No Bank Statement: Yes No N/A

DD214 Request: https://www.archives.gov/files/research/order/standard-form-180.pdf • SS Card Request: SSO Main St., Cincy, OH 45202 or 10205 Reading Rd., Cincy, OH 45241

Clear Form Submit

Please hit submit or email completed referral to: VHACINcareercoordination@va.gov