Wisconsin Balance of State CoC Coordinated Entry and Referral Process

Institute for Community Alliances – Updated July 2016

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**INTRODUCTION**

The Wisconsin Balance of State Continuum of Care (WI BoS CoC) has implemented a streamlined process for referring and enrolling individuals and households into permanent supportive housing (PSH) programs, transitional housing (TH) and rapid re-housing (RRH) programs. This process is now part of the CoC coordinated entry system. The WI BoS CoC will maintain community-wide priority lists for each program type for single adults and another for families. Individuals and households in need of housing, will be placed on this priority list and ranked in order of greatest need. All PSH, TH and RRH programs that are funded through the HUD Continuum of Care Program or the State of Wisconsin ETH Grant are required to enroll clients using the priority lists, and other community programs are encouraged to use the priority lists as well. Additional information about the WI BoS CoC Coordinated Entry process can be found here, http://www.wiboscoc.org/coordinated-entry.html.

1. **REQUIREMENTS FOR ADDING CLIENTS TO THE PRIORITY LISTS**

Anyone with a ServicePoint user license can add an individual or household to the priority lists. It is not necessary for the individual or household to be enrolled in a program at your agency in order for you to add the person to the priority list. In order to make a referral to a priority list, you will need to know the person’s VI-SPDAT 2.0 score from a VI-SPDAT 2.0 survey screening and you will need some additional information about the client that will be used to contact the individual or household after the referral is accepted.

2. **HOW TO ADD AN INDIVIDUAL OR HOUSEHOLD TO THE PRIORITY LISTS**

**A. ADD THE CLIENT TO SERVICEPOINT**

- If the client or household you’re referring is not enrolled in any program at your agency, it will be easiest to enter the client into ServicePoint and make the referral from your main agency provider (not a program-specific provider). This is not a requirement if you do not have access to your main agency (Level 2) provider, or if you would rather enter the referral under a program provider.

- Use the Client Search to look for an existing client file or add a new client to ServicePoint. If you’re referring a household, use the Client Search to look for the head of household, and enter this household member first.

- The minimum data needed in order to add someone to ServicePoint is a name, the client’s gender and date of birth. In order to make a good referral, you will need some additional information including a VI-SPDAT score, the length of time the client has been homeless and some information about the best way to contact the client.

**B. COMPLETE THE CLIENT RECORD AND THE COORDINATED ENTRY ASSESSMENT – WI BoS CoC**

The client record is found at the top of the Client Profile tab.
The Coordinated Entry (CE) Assessment – WI BoS CoC can be found in two places. If you are entering the client under your main agency provider, you will see the CE Assessment on the Client Profile tab. If you are using one of your agency’s program providers, you will need to go to the Assessments tab and choose the CE Assessment. Either way you use to access the assessment is fine. Fill in as much of the information as you have for the client. Questions in bold with stars are required. These fields will need to be completed before you can save the assessment.

COORDINATED ENTRY ASSESSMENT ON THE CLIENT PROFILE

- Scroll down until you see the Coordinated Entry Assessment.

![Client Record]

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Name</td>
<td>Test, Test</td>
</tr>
<tr>
<td>Name Data Quality</td>
<td>Full Name Reported</td>
</tr>
<tr>
<td>Alias</td>
<td></td>
</tr>
<tr>
<td>Social Security</td>
<td>222-22-1114</td>
</tr>
<tr>
<td>SSN Data Quality</td>
<td></td>
</tr>
<tr>
<td>U.S. Military Veteran?</td>
<td>Yes (HUD)</td>
</tr>
<tr>
<td>Age</td>
<td>43</td>
</tr>
</tbody>
</table>

![Client Demographics]

<table>
<thead>
<tr>
<th>Field</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>Date of Birth</td>
<td>01/17/1972</td>
</tr>
<tr>
<td>Date of Birth Type</td>
<td>Full DOB Reported (HUD)</td>
</tr>
<tr>
<td>Gender</td>
<td>Female</td>
</tr>
<tr>
<td>If Other Gender, specify</td>
<td></td>
</tr>
<tr>
<td>Race</td>
<td>White (HUD)</td>
</tr>
<tr>
<td>Secondary Race</td>
<td>Asian (HUD)</td>
</tr>
<tr>
<td>(leave blank if none</td>
<td></td>
</tr>
<tr>
<td>indicated)</td>
<td></td>
</tr>
<tr>
<td>Ethnicity</td>
<td>Non-Hispanic/Non-Latino (HUD)</td>
</tr>
</tbody>
</table>

![Coordinated Entry Assessment]

COORDINATED ENTRY ASSESSMENT ON THE ASSESSMENTS TAB

- Go to the Assessments Tab. Choose the Coordinated Entry Assessment. Click Submit.

![Assessments Tab]
When completing the assessment, make sure that the questions used to determine chronic homeless status have been completed accurately. The questions are shown below:

**To determine Chronic Homeless Status - HUD uses the following questions & the disability-related questions**

**For this Section - Only includes time on Street, in an Emergency Shelter, or Safe Haven**

<table>
<thead>
<tr>
<th>Question</th>
<th>Answer</th>
</tr>
</thead>
<tbody>
<tr>
<td>Client entering from the Streets, Emergency Shelter or Safe Haven</td>
<td>Yes</td>
</tr>
<tr>
<td>If Yes for “Client entering from Streets, Emergency Shelter or Safe Haven,” Approximate date started</td>
<td>05/01/2016</td>
</tr>
<tr>
<td>Housing Status</td>
<td>Category 1 - Homeless</td>
</tr>
<tr>
<td>Regardless of where they stayed last night - Number of times the client has been on the Streets, in Emergency Shelter, or Safe Haven in the past three years including today</td>
<td>Four or more times</td>
</tr>
<tr>
<td>Total number of months homeless on the Street, in Emergency Shelter or Safe Haven in the past three years</td>
<td>More than 12 months</td>
</tr>
<tr>
<td>If more than 12 Months homeless on the street, in emergency shelter, or safe haven, Enter Total Number of Months</td>
<td>15</td>
</tr>
<tr>
<td>Does the client have a disabling condition?</td>
<td>No</td>
</tr>
</tbody>
</table>

3. REFERRAL PROCESS FOR SINGLES

**A. ENTER THE VI-SPDAT 2.0**

The VI-SPDAT 2.0 is entered directly on the Coordinated Entry Assessment. Click Add to open the VI-SPDAT pop-up box. Complete all the questions, and click Save at the bottom. The VI-SPDAT will be automatically scored.

**VI-SPDAT v2.0**

<table>
<thead>
<tr>
<th>Start Date</th>
<th>PRE-SURVEY</th>
<th>A. HISTORY OF HOUSING AND HOMELESSNESS</th>
<th>B. RISKS</th>
<th>C. SOCIALIZATION &amp; DAILY FUNCTIONS</th>
<th>D. WELLNESS</th>
<th>GRAND TOTAL</th>
</tr>
</thead>
<tbody>
<tr>
<td>01/19/2016</td>
<td>0</td>
<td>1</td>
<td>3</td>
<td>3</td>
<td>3</td>
<td>10</td>
</tr>
</tbody>
</table>

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After completing the VI-SDPAT, answer the remaining questions on the Coordinated Entry Assessment.

**B. ADD A REFERRAL TO THE SINGLES PRIORITY LIST**

Once you’ve completed the Coordinated Entry Assessment, you are ready to make a referral to the priority list for singles. To add a referral, go into the Service Transactions tab of HMIS:

![Add Referral to the Singles Priority List](image)

To create a referral, you need to identify a service transaction type, a provider of that service and the date on which the referral was made.

- Your service transaction type will be Rent Payment Assistance (BH-3800.7000). Select the service transaction type, and then click Add Terms. It will look like nothing has happened, but if you scroll to the bottom of the screen, you will see the service transaction type listed.
Next, select the provider. To make a referral to the priority list for singles, you need to choose your local CoC Priority List – Singles provider. For example, BoS Brown County Priority List – Singles. Select the correct list and click Add Provider.

Finally, you will need to enter the date of the referral. This is also where you attach the client’s VI-SPDAT score. You do not need to complete the referral ranking when making a referral for singles.

To attach the VI-SPDAT score, click the Search button. Then click the green plus sign next to the VI-SPDAT score.
Make sure to check the box by the service transaction type in the Referrals section.

Set a Projected Follow Up Date and enter your user information for the Follow Up User.

Set the Need Status/Outcome to “Identified/Service Pending.” Once you have selected the appropriate items, your referral will look like the example below. Click Save ALL.
4. REFERRAL PROCESS FOR FAMILIES

A. ENTER THE VI-F-SPDAT 2.0

The VI-F-SPDAT 2.0 is entered directly on the Coordinated Entry Assessment. Click Add to open the VI-F-SPDAT pop-up box. Complete all the questions, and click Save at the bottom. The VI-F-SPDAT will be automatically scored.
After completing the VI-F-SDPAT, answer the remaining questions on the Coordinated Entry Assessment.

**B. ADD A REFERRAL TO THE FAMILY PRIORITY LIST**

Once you’ve completed the Coordinated Entry Assessment, you are ready to make a referral to the priority list. To add a referral, go to the Service Transactions tab of HMIS:

When making a referral for a family, you do not need to include the entire family. Make the referral for the head of household, or if you are referring a chronically homeless family, make the referral for the adult household member with the disability (if not the head of household). Make sure only the box by the head of household’s name is checked.

- Reminder: the prioritization report pulls the family size from the “number in household” question on the Coordinated Entry Assessment. Please make sure this question is accurately completed.
To create a referral, you will need to identify a service transaction type, a provider of that service, and the date on which the referral was made.

- Your service transaction type will be Rent Payment Assistance (BH-3800.7000). Select the service transaction type, and then click Add Terms. It will look like nothing has happened, but if you scroll to the bottom of the screen, you will see the service transaction type listed.

- Next, select the provider. To make a referral to the priority list for singles, you need to choose your local CoC Priority List – Families provider. For example, BoS Brown County Priority List – Families.

- Enter the date of the referral, and attach the household’s VI-F-SPDAT score. Enter a Projected Follow Up Date and a Follow Up User.
• Make sure to check the box by the service transaction type in the Referrals section.

Once you have selected the appropriate items, your referral will look like the example below. Click Save All.
5. Updating a Referral with a New VI-SPDAT Score

If the client’s assessment score has changed, their existing priority list referral should be updated.

A. Updating a Referral for Singles

Return to the Coordinated Entry Assessment, and go to the VI-SPDAT 2.0 Sub-assessment. Click Add to enter a new VI-SPDAT.
After entering the new VI-SPDAT, click Save to update the coordinated entry assessment. Then return to the original referral to the priority list. Go to the Service Transaction tab, then click the tile for Entire Service History. Find the correct referral, and click on the pencil on the referral line.

Under the Referral Data section, find the VI-SPDAT score. Click Search, then click the green plus sign to add the new score. Then click Save and Exit to update the referral.

**B. UPDATING A REFERRAL FOR FAMILIES**

Return to the original referral to the priority list. Go to the Service Transaction tab, then click the tile for Entire Service History. Find the correct referral, and click on the pencil on the referral line.

Select the new score from the Referral Ranking field. Click Save and Exit to update the referral.
6. VIEWING THE PRIORITY LISTS

Agencies in the CoC that provide permanent supportive housing and/or rapid re-housing services, will need to use the Advanced Reporting Tool (ART) to view the priority lists.

- Click the black arrow to display the Public Folder

- Navigate to the Coordinated Entry folder, and open the folder for the Balance of State CoC. This folder contains two reports – one for the family report, and another for the singles priority list. Use the most recent version available.

- Click on the magnifying glass. Then select View Report. All users with an ART license can run this report in “View” mode.

- Complete the required report prompts. Set the effective date to the current date. Choose the correct prioritization list provider. Once both prompts are complete, click Run Query.
A. SINGLES REPORT

Summary – confidentiality statement and summary statistics
PSH Prioritization
TH Prioritization
RRH Prioritization
Accepted Referrals
Declined Referrals
Raw Data – displays data used to determine client chronic homeless status

B. FAMILY REPORT

Summary – confidentiality statement and summary statistics
PSH Prioritization
TH Prioritization
RRH Prioritization
Accepted Referrals
Declined Referrals
Raw Data – displays data used to determine client chronic homeless status
7. HOW TO ACCEPT AN INDIVIDUAL OR HOUSEHOLD OFF THE PRIORITY LIST FOR PROGRAM ENROLLMENT

FOR CLIENTS ENROLLING IN A PROGRAM AT YOUR AGENCY

If you are accepting a referral because you’re enrolling a client in a program at your agency, then you will need to add a Service Transaction for your agency’s program. Your agency’s program may be PSH, TH, RRH or TBRA. Make sure to use the correct program provider in HMIS.

Update 9/16 – Only “accept” the referral for clients entering a program at your agency. See the “Canceled/Declined” Section for more information about removing clients no longer in need of housing from the priority list, including clients who secured housing on their own or clients who obtained housing from a provider that does not use HMIS.

- Go to the client file for the client you are going to accept off the priority list, and click on the Service Transactions tab.

- Click on “View Entire Service History”

- Click on the Referrals tab

- Click on the pencil for the referral that you want to accept.
• Change the referral outcome to “Accepted”

![Referral Data](image1)

<table>
<thead>
<tr>
<th>Referral Data</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Referred-To Provider</td>
<td>BoS Dairyland Priority List - Singles (9782)</td>
</tr>
<tr>
<td>Needs Referral Date</td>
<td>01/15/2016</td>
</tr>
<tr>
<td>Referral Outcome</td>
<td>Accepted</td>
</tr>
<tr>
<td>VT-SPDAT Score</td>
<td>11 Recorded using VT-SPDAT on 01/15/2016 by Western</td>
</tr>
</tbody>
</table>

• Select Need Status as “Closed” and select Outcome as “Fully Met”

![Need Status / Outcome / If Not Met, Reason](image2)

<table>
<thead>
<tr>
<th>Need Status / Outcome / If Not Met, Reason</th>
<th>Details</th>
</tr>
</thead>
<tbody>
<tr>
<td>Need Status</td>
<td>Closed</td>
</tr>
<tr>
<td>Outcome</td>
<td>Fully Met</td>
</tr>
<tr>
<td>-Select-</td>
<td>-Select-</td>
</tr>
</tbody>
</table>

• For all accepted referrals, click on Provide Service. **Important** - Make sure the Service Transaction is created for the specific program in which the client is enrolling.

![Service Information](image3)

![Provide Service](image4)

A Service has not yet been provided for this Referral.

8. RETURNING A CLIENT TO THE PRIORITY LIST

Individuals or households accepted off the Priority List that DO NOT Enroll in your program (were not permanently housed) must be returned to the priority list.

• Return to the “Entire Service History” page for the client and find the referral to the priority list, and subsequent service transaction for housing

• Click on the garbage can on the Service line to delete the service transaction (If you cannot delete, contact your ICA System Administrator)
• When the Service is deleted, the original Referral will also be deleted. You will have to re-enter the referral from the original need. **NOTE** – do not re-enter the referral until the original is deleted, and do not create both a new need and a new referral. This part can be confusing. If you have questions, contact your ICA System Administrator.

This is what the Entire Service History looks like *before* the Service is deleted.

This is what the Entire Service History looks like *after* the Service is deleted.

• To add a referral from the existing Need, click on the envelope with the green plus sign. The Need will be from the original referral date.

• When you re-create the referral, make sure to set the referral date back to the date of the original referral. This should be the same date as the Need date, which is listed at the bottom of the referral page.
• Leave the Referral Outcome at “Select.” This will return the client to the priority list.

• The Need Status is “Identified”

**Update 9/16**

• Complete the CE Follow Up sub-assessment to document the client was returned to the priority list. Scroll down and find the CE Follow Up sub-assessment box. Click Add to enter a new follow-up.

• Complete the follow-up information. For “Outcome of Follow Up” select:
  - Previously removed from list and then returned to list
  
  Use the notes field to document the reason housing was not secured from your agency program. Leave the end date field blank.
9. CANCELED REFERRAL

**Update 9/16** – Referrals should be “canceled” or “declined” for one of the following reasons:

1. Client living with family/friends – permanent tenure
2. Client secured housing on their own
3. Client obtained Section 8 or site-based housing
4. Client asked to be removed from list
5. Unable to contact client
6. Client declined housing offer
7. Death

**NOTE** – You no longer need to create a service transaction to document when a client secures housing with a non-HMIS agency or secures housing on their own. You should cancel the referral and select one of the above reasons.

- Go to the client file for the client you are going to remove from the priority list, and click on the Service Transactions tab.

- Click on “View Entire Service History” and click on the Referrals tab

- Click on the pencil for the referral that you want to accept.
Then set the Referral Outcome to Declined, and enter the reason why the referral was declined. Click Save and Exit.

**Follow Up Information**

- **Referral Outcome:** Declined
- **If Canceled or Declined, Reason:** Client secured housing on their own

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### 10. DOCUMENTING A 90-DAY CLIENT FOLLOW-UP

#### Update 9/16

- Go to the client file and click on the Assessments tab.

![Assessments tab](image)

- Use the drop down to find the Coordinated Entry Assessment and click submit.

![Select an Assessment](image)

- Make sure to update the client information on the CE Assessment, if necessary, paying particular attention to the following questions:

  **For this Section - Only includes time on Street, in an Emergency Shelter, or Safe Haven**

  - **Client entering from the Streets, Emergency Shelter or Safe Haven:** Yes (HUD)
  - **If Yes for "Client entering from Streets, Emergency Shelter or Safe Haven," Approximate date started:** 05/01/2016
  - **Housing Status:** Category 1 - Homeless (HUD)
  - **Regardless of where they stayed last night - Number of times the client has been on the Streets, in Emergency Shelter, or Safe Haven in the past three years including today:** Four or more times (HUD)
  - **Total number of months homeless on the Street, in Emergency Shelter or Safe Haven in the past three years:** More than 12 months (HUD)
  - **If more than 12 Months homeless on the street, in emergency shelter, or safe haven, Enter Total Number of Months:** 15

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• Scroll down and find the CE Follow Up sub-assessment box. Click Add to enter a new follow-up.

• Complete the follow-up information. Choose one of the following options for the “Outcome of Follow Up”:
  o 90 Day required follow up (completed), (client) still needs housing, remains on list
  o Client asked to be removed from list, secured housing on their own
  o Unable to contact client

Enter additional notes if needed. Leave the end date field blank.

• Then click on the pencil next to the Need Information.

• Use the Need Notes field to document client information such as the client’s preferred county or location for permanent housing and the number of bedrooms needed.