Ithaca/Tompkins County Continuum of Care

Coordinated Entry Policies and Procedures

NY-510
ITHACA/TOMPKINS
CONTINUUM OF CARE

Ending homelessness together.

Overview

The Coordinated Entry system is designed to identify, engage, assess, and refer individuals and their families who are experiencing homelessness as defined by the Department of Housing and Urban Development (HUD).

HUD requires each CoC to establish and operate a "centralized or coordinated assessment system" (referred to as "coordinated entry" or "coordinated entry process") with the goal of increasing the efficiency of local crisis response systems and improving fairness and ease of access to resources, including mainstream resources. Both the CoC and ESG Program interim rules require use of the CoC's coordinated entry process, provided that it meets HUD requirements.[1] Coordinated entry processes are intended to help communities prioritize people who are most in need of assistance. They also provide information to CoCs and other stakeholders about service needs and gaps to help communities strategically allocate their current resources and identify the need for additional resources.[2]

This Document

These policies and procedures will govern the implementation, governance, and evaluation of the Coordinated Entry system in Tompkins County. These policies may only be changed by the approval of the Continuum of Care (CoC) Governance Committee based on recommendations from the Coordinated Entry (CE) Lead of the CoC.

Basic Definitions

Housing Provider

An organization that provides housing to people experiencing homelessness as defined by HUD. The providers below are members of the Coordinated Entry referral network as of November 2024.

- Catholic Charities Tompkins/Tioga
- The Learning Web
- Opportunities, Alternatives, and Resources (OAR)
- The Salvation Army
- Soldier On
- St. John's Community Services
- Tompkins Community Action
- Tompkins County Department of Social Services

[1] Per HUD 24 CFR 576 400 E2: "if a recipient is a state (NYS OTDA), the recipient must establish and consistently apply written standards for providing ESG assistance" NYS OTDA requirements for coordinated entry are that a recipient "be involved with coordinated entry to the maximum degree practicable."

[2] HUD Notice 17-01CPDN

CE Service Provider
An organization that provides services to people experiencing homelessness as defined by HUD. The providers on the list are trained in the Coordinated Entry system. Organizations can be added at any time after completing training on the assessment tool with the Coordinated Entry (CE) lead.

- 2-1-1 Information/Referral
- The Advocacy Center
- Catholic Charities Tompkins/Tioga
- Cayuga Addiction Recovery Services (CARS) inpatient and outpatient clinic
- Cayuga Medical Center
- Child Development Council
- Family & Children Services Open Doors Program
- Human Services Coalition of Tompkins County
- Law Enforcement Assisted Diversion (LEAD) Program
- The Learning Web
- Opportunities, Alternatives, and Resources (OAR)
- REACH Medical Community Outreach Program
- Second Wind Cottages
- Southern Tier AIDS Program (STAP)
- Soldier On
- Tompkins Community Action
- Tompkins County Whole Health
- Tompkins County Treatment Courts
- Village at Ithaca

Program
A specific set of services or housing intervention offered by a provider.

Participant
A person experiencing homelessness according to HUD; a person who is being assessed through the Coordinated Entry system.

Housing Interventions
Housing programs and subsidies; these include transitional housing, rapid re-housing, and permanent supportive housing programs. There are currently no mainstream housing choice voucher (Section 8) providers using the Coordinated Entry process for referrals.

No Wrong Door Approach to Services
People experiencing homelessness should be able to enter into any participating agency within the Continuum of Care (CoC) and be linked with a staff person trained to identify their needs, assess their situation, and make appropriate referrals.

Standardized Assessment
Coordinated Entry uses a standardized assessment tool to identify vulnerabilities and assist in matching individuals seeking services with the appropriate level of support to meet their needs. The assessment is aligned with the CoC's order of priority.[3] Households with the highest vulnerability score are placed at the top of the waitlist for all housing programs within the CoC for which they are eligible.

The NY-510 CoC will transition from utilizing the VI-SPDAT to utilizing the New York State Balance of State Vulnerability Assessment Tool (BoS-VAT) by the end of calendar year 2025.

For the purposes of the VI-SPDAT:

- **Single adults** of age 25 or older should use the VI-SPDAT
- **Single transition-aged youth** of age 24 or younger should use the TAY-VI-SPDAT
- **Heads of household with more than one household member** regardless of age should use the VI-FSPDAT
- **Veterans** should use the tool appropriate to their age/household size but have immediate follow up to hotline numbers for immediate attention and referral.

The BoS-VAT is designed to score any household type and/or age group. The tool will be used across all Participant demographic groups by the end of 2025. This tool can be found in Appendix B.

Referrals
Based on the results of the Vulnerability Assessment Score, as well as any known severe service needs[4], a Participant will be referred to a homelessness assistance program and other service providers when appropriate. More information on page 14.

[3] See the CoC's Written Standards
[4] a client may have severe service needs when any combination of the following factors apply to them: 1) they require a significant level of support in order to maintain permanent housing because they are facing significant challenges or functional impairments—including any physical, mental, developmental, or behavioral health disabilities regardless of the type of disability; 2) they require high utilization of crisis or emergency services to meet basic needs, including but not limited to emergency rooms, jails, and psychiatric facilities; 3) they currently live in an unsheltered situation or have a history of living in an unsheltered situation; 4) they are experiencing a vulnerability to illness or death; 5) they have a risk of continued or repeated homelessness; and 6) they are experiencing a vulnerability to victimization, including physical assault, trafficking or sex work.

Definition of Homelessness

Category 1: Literally Homeless
Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

- Has a primary nighttime residence that is a public or private place not meant for human habitation; or
- Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or
- Is exiting an institution where they have resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Note: An individual or family only needs to meet one of the three subcategories to qualify as Homeless Category 1: Literally Homeless.

Category 2: Imminent Risk of Homelessness
An individual or family who will imminently lose their primary nighttime residence, provided that:

- Residence will be lost within 14 days of the date of application for homeless assistance;
- No subsequent residence has been identified; and
- The individual or family lacks the resources or support networks needed to obtain other permanent housing.

Note: Includes individuals and families who are within 14 days of losing their housing, including housing they own, rent, are sharing with others, or are living in without paying rent.

Category 3: Homeless under other Federal Statutes
Unaccompanied youth under 25 years of age, or families with Category 3 children and youth, who do not otherwise qualify as homeless under this definition, but who:

- Are defined as homeless under the other listed federal statutes;
- Have not had a lease, ownership interest in permanent housing during the 60 days prior to the homeless assistance application;
- Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and
- Can be expected to continue in such status for an extended period of time due to special needs or barriers

Note: HUD has not authorized any CoC to serve the homeless under Category 3. HUD determines and approves the use of CoC Program funds to serve this population based on each CoC's Consolidated Application. See 24 CFR 578.89. Individuals and families that qualify as homeless under Category 3 may be served by the ESG program if they meet required eligibility criteria for certain ESG components.

Category 4: Fleeing/Attempting to Flee Domestic Violence
Any individual or family who:

- Is fleeing, or is attempting to flee, domestic violence;
- Has no other residence; and
- Lacks the resources or support networks to obtain other permanent housing

Note: "Domestic Violence" includes dating violence, sexual assault, stalking, and other dangerous or life-threatening conditions that relate to violence against the individual or family member that either takes place in, or him or her afraid to return to, their primary nighttime residence (including human trafficking).

Target Population

The Coordinated Entry system is intended to serve individuals and their families experiencing homelessness. Homelessness will be defined in accordance with the official HUD definition of homelessness detailed above. This Coordinated Entry process was developed primarily for residents of Tompkins County.

The Ithaca/Tompkins Coordinated Entry Forms can be found in Appendix A and B of this document. There are currently three parts:

1. Release of Information (Verbal or Written)
2. Pre-Screening Questionnaire
3. Vulnerability Assessment

The Coordinated Entry Process, also referred to as the Centralized or Coordinated Assessment System is a proven national best practice and all housing and service providers in the country are encouraged to participate. When implemented effectively, Coordinated Entry can minimize the time and frustration individuals and families who are in crisis may face when trying to access services. Some other goals of the program include:

1. Reduce new entries into homelessness through a coordinated system of diversion and prevention efforts;
2. Prevent people experiencing homelessness from entering and exiting multiple programs before having their needs met;
3. Reduce or erase entirely the need for individual provider wait lists for services;
4. Foster increased collaboration between homelessness assistance providers; and

5. Improve a community's ability to end homelessness.

Goals and Guiding Principles

The goal of the Coordinated Entry system is to provide each Participant with services and support to meet their housing needs with a focus on a rapid exit to permanent housing. Below are the guiding principles that will help Tompkins County meet these goals:

Participant Choice
Participants will be given information about the programs available to them and have some degree of choice about which programs they want to participate in.

Collaboration
Coordinated Entry is a system-wide process that requires a great deal of collaboration between providers within the CoC, other local service providers, mainstream assistance agencies, funders, and other key partners. Collaboration will be fostered through open communication and transparency, monthly meetings between partners and CE staff, and consistent reporting on the performance of the Coordinated Entry system.

Accurate Data Collection
CE staff are required to track the referrals made after a Participant is assessed and provide that information to the CE lead at the monthly CE meeting. Data collected will reveal what resources Participants need the most and will help in determining how best to allocate, or reallocate, resources. Participants' rights regarding data collection will be made explicit, and no Participant will be denied services for refusing to share their information, however Participants must be made aware that refusing to share some information may reduce their housing options. Per OTDA Participants who refuse to participate in HMIS data collection or Coordinated Entry may still be served through STEHP.

Performance-Driven Decision Making
Decisions about, and modifications to, the Coordinated Entry system will be driven primarily by the need to improve the performance of homelessness assistance and system performance measures. These outcomes include reducing new entries into homelessness, reducing lengths of episodes of homelessness, and reducing repeat entries into homelessness. Changes may also be driven by a desire to improve process-oriented outcomes, including reducing the amount of waiting time for an assessment.

Housing First
Coordinated Entry will support a "Housing First" approach by working to connect Participants with an appropriate permanent housing opportunity, as well as any necessary supportive services, as quickly as possible, with little to no barriers to entry.

Prioritizing the Hardest to House
Coordinated Entry referrals will prioritize Participants that appear to be the hardest to house or serve for program beds and services. This approach will ensure an appropriate match between the most intensive services and the Participants least likely to succeed with a less intensive intervention, while giving Participants with fewer housing barriers more time to work out a housing solution on their own. This approach is most likely to reduce the average length of episodes of homelessness and result in better housing outcomes for all.

Key Components of the Coordinated Entry Process

Screening Overview
This section outlines and defines the key components of Coordinated Entry and how the Coordinated Entry process will work. Ithaca/Tompkins CoC uses a *No Wrong Door* approach to providing screenings and assessments.

With the No Wrong Door approach, there are multiple ways a Participant can access the system:

1. A Participant presents at a *Coordinated Entry Service Provider*[5] and is assessed by a trained CE staff person.
2. A Participant presents at an organization where there are no trained assessors, the staff person will contact 211 to ensure the individual meets the criteria to be screened for Coordinated Entry.
    a. *If the Participant is eligible* for Coordinated Entry, 211 will guide the caller to a CE Service Provider to complete the assessment in-person.
    b. *If the Participant is not eligible* for Coordinated Entry, 211 will provide the caller with referrals to prevention resources or instructions on how to access the emergency shelter.
3. A Participant can call 211 directly to be assessed for eligibility and then referred.

All Participants experiencing homelessness should be directed to one of the above options to be assessed prior to receiving any services or admission to any homelessness assistance program participating in Coordinated Entry.

[5] See pages four and five (4-5)

The Coordinated Entry Service Providers will have the capacity to conduct a full assessment in person, and Participants experiencing homelessness will be assessed and referred to homelessness assistance services. Coordinated Entry Service Providers are approved by the Coordinated Entry Team and have been trained by the CE Lead. The designated CE Service Providers in Tompkins County are noted on pages four and five (4-5) of this document.

A vulnerability assessment will be administered by trained assessment staff at each agency listed above. This list of agencies will be updated if and when additional designated CE organizations are added or removed.

Outreach staff whose agencies have been trained in the Coordinated Entry intake and screening process will assess Participants living on the street or other places not meant for human habitation. Domestic Violence survivors are referred directly to the victim services agency in our continuum listed above, Advocacy Center, who are trained on a confidential, de-identified CE referral process.

The Coordinated Entry Lead, staffed by the Human Services Coalition, will be responsible for inputting Coordinated Entry assessments into the Homeless Management Information System (HMIS), identifying resources and programs available on an individual basis, update the community-wide wait list, and alerting Coordinated Entry Service Providers when the individuals they referred are selected for a project opening. The timeline for selection depends on the availability of housing projects to serve individuals on the community-wide wait list.

Coordinated Entry Screening Process

Staff at the CE Service Providers, 2-1-1, or other provider locations who answer phones may encounter Participants experiencing homelessness who are interested in being assessed for the Coordinated Entry process. All of these callers should be asked the pre-screening questions:

1. Are you currently living outside or sleeping at the emergency shelter?
2. Are you fleeing or attempting to flee domestic violence?
3. Are you currently under the age of 25 **AND** couchsurfing?

If the Participant answers yes to questions 1, 2, or 3, they meet HUD's definition of homelessness and can be referred through Coordinated Entry.

Coordinated Entry Assessment Process

Assessment refers to the process of administering the vulnerability assessment tool and pre-screening questionnaire to determine what level of support is appropriate for the individual's level of vulnerability. Coordinated Entry Service Providers will be trained on administering the assessment, client choice, client privacy, and program eligibility. Assessments will be administered at the trained Coordinated Entry Service Providers listed on pages four and five of this document (4-5).

Assessment Protocol:

1. Each Participant presenting at a CE Service Provider, or other agency that works with Participants, will be asked the screening questions.
2. If the Participant is eligible according to the screening questions, they will be directed to an available CE Service Provider. The CE Service Provider will then explain the assessment process and share and discuss the release of information with the Participant. If the Participant signs the NY-510 CNY HMIS Client Consent Form[6] the CE staff member will begin the vulnerability tool. If the Participant is seeking domestic violence specific services, they will be referred immediately to the local victim services provider or emergency shelter. If a Participant refuses to sign the release forms, the CE staff person should alert the Participant that homelessness assistance would potentially be limited.
3. Participants who are eligible for diversion will be provided with a list of available resources to help them stay in housing, mediate disputes, or other resources for alternative housing as appropriate. The CE staff person will need to utilize judgment and knowledge of resources to assess what alternatives are available to the Participant at the time.
4. If the Participant is successfully diverted, they will end their engagement with the assessment worker, who will make a note in the assessment form and report to the CE lead that the Participant was diverted.
5. Participants who are not eligible for diversion will continue with the assessment process. This process will prioritize the Participant for housing interventions and accompanying services, including transitional housing, rapid re-housing, and permanent supportive housing.

If Assessment Staff are Off Duty:

1. Participants presenting with a need for emergency shelter should be offered a bed at the shelter or another available crisis housing center.
2. Shelter staff will conduct the assessment and provide the information to the CE Lead.

[6] See Appendix A

3. If the Participant has called the 211 call center, the call center will provide the list of CE organizations and earliest available time for a full screening. 211 will also provide information on accessing the shelter after-hours.

Data Collection

Data will be collected on everyone that is assessed through the coordinated entry process. This section, in addition to instructions embedded within the NY-510 CNY HMIS Client Consent Form[7], will detail when and how Participant information will be collected.

After the Participant has completed the pre-screening questions and is eligible to be assessed, the CE staff member will review, with the Participant, the confidentiality form and explain what data will be collected, how it will be shared, with whom it will be shared , and the Participant's rights regarding the use of their data. CE staff will be responsible for ensuring Participants understand their rights. When the forms are complete, the CE staff member will complete the vulnerability assessment tool. The assessment can be completed in hard copy format or on the computer, however agencies are required to provide the client assessment score and information to the CE Lead within 24 hours for input onto the community wait list in HMIS. Agencies are also required to provide the signed ROI, in electronic format via secure upload for the monthly CE meetings, to the CE Lead for safe keeping.

Some Participants should never be entered into HMIS. These include:

- Participants who are fleeing or attempting to flee domestic violence should never have information shared unless it is with DV specific agencies and/or the Participant has agreed. The assessment should be done on a paper form and passed off to the appropriate provider (The Advocacy Center). If they are being served by a domestic violence provider, that agency may enter their information into a comparable database.
- Participants who do not sign a data confidentiality form. Participants who do not consent to their information being shared would reduce their ability to access certain housing programs.

Access to parts of each Participant record or assessment form may be restricted for safety reasons or by Participant request.

Coordinated Entry Referral Process

[7] See Appendix A

Referrals to housing services from the Coordinated Entry list will be made based on the following factors:

- Program eligibility criteria, including populations served and services offered;
- Results of the assessment tool process (vulnerability assessment score);
- Bed availability and size of intervention priority lists; and
- Established system wide priority populations.

Each of these elements is discussed in more detail below.

The Vulnerability Assessment Tool (VAT) has a built-in scoring mechanism that will prioritize households for access to different housing interventions. This will serve as a starting point for discussion between the CE staff member and the Participant about what services will be most effective. most vulnerable being placed highest on the list and connected with appropriate programs based on their score. The assessment process will be geared toward prioritizing Participants with the most intensive service needs and housing barriers (e.g. chronically homeless and households with multiple episodes of homelessness).

Agencies must contact the CoC Coordinator by email regarding the number of available beds or units (specifying which bed or unit the population is for if they serve multiple populations) as units become available or at least monthly.

The community wait list will be maintained by the CoC lead organization, the Human Services Coalition of Tompkins County. Housing providers will contact the CE Lead for the information of the next Participant on the list that meets their program eligibility. Each housing provider will still utilize their program application and report to the CE Lead on the outcome. If enrolled in the program, the HMIS information is to be collected (if a HUD funded program). If determined to be ineligible, the provider must inform the CE Lead of the decision and provide written justification when a Participant is denied entry into a program.

The Coordinated Entry Team will review the waitlist on a monthly basis. The Team will monitor trends and review the reports of eligibility determinations.

The Continuum of Care should revisit the Coordinated Entry System and vulnerability tool annually to ensure the tool is aligned with the CoC and HUD priorities. The vulnerability tool being used at intake will be updated to reflect any changes to the priority groups. The Coordinated Entry Team will be responsible for ensuring changes and updates are distributed to the CE agencies and larger CoC.

Referrals will be based on each program's eligibility criteria, including populations served. For example, programs that serve only single adult men will only receive single adult men as referrals. An outline of program eligibility will be used to assist providers in determining which programs a Participant may be eligible for based on their situation and assessment.

Housing providers must submit program eligibility criteria to the Coordinated Entry Team before they can participate in the coordinated assessment process. Any changes to a program's eligibility criteria or target population must be sent immediately to the CoC Coordinator and the CE Lead to ensure referral protocol is updated accordingly. If the Team has a concern that a program's requirements may be contributing to "screening out" or excluding Participants from needed services, the Team may request to meet with the provider to discuss their criteria. If the Team can clearly show a link between underserved populations and eligibility criteria from a provider, and the provider is unwilling to modify the criteria, the Team may recommend to the CoC Governance Committee that the provider be de-prioritized for CoC or other sources of funding.

Making Referrals and Prioritizing Participants

The referral process will be standard across all assessment sites.

1. After the assessment process is complete, the CE staff will make an immediate referral to appropriate services, and submit the Participant's information to the CE Lead, through HMIS or secure upload, to be included on the waitlist.
2. If the Participant was not prioritized for any interventions, the CE staff should explain why and what other services will be available to them (e.g., shelter case management, connection to mainstream resources, help connecting with family or friends). The Participant, if experiencing homelessness, should be referred to the emergency shelter immediately where they will receive case management and other services to help them connect to housing.
3. If the Participant is first on the list for a particular intervention and there is an opening in a program they are eligible for (and it is during that program's business hours), a referral should be made directly to that program via the CE Lead.
4. The CE lead will be responsible for coordinating the referrals from the assessing agency to the program for which the Participant is eligible. The CE agency that assessed the client will be responsible for submitting the required documents to the CE lead via secure upload.
5. If there is not currently an opening at an appropriate program within the intervention, the Participant should be referred to the appropriate emergency

shelter or other housing resource. The CE staff should explain that once a spot opens up for them, they will be notified.

Priority List Management and Notification of Referral
The Human Services Coalition of Tompkins County, via the CE lead, will be responsible for maintaining the community waitlist and providing service providers with eligible clients as openings become available. CE staff, during the assessment process, are responsible for making and documenting immediate referrals and submitting the referrals to the CE Lead.

Special Populations
Participants with special needs who present to a CE agency may need to be directed to specific resources that are not covered in this manual or through the vulnerability assessment. CE staff are encouraged to confer with their program supervisor and CE member to ensure proper referrals are made and documented.

It is extremely important that veterans are connected to the appropriate hotline phone numbers after hours. 211 should have these numbers on hand for immediate linkage.

Post-Referral Procedure
Once successfully placed in a program, the Participant should be connected to a case manager to assist in other service needs. The housing provider is responsible for notifying the CE Lead in writing of the program placement and completing the appropriate HMIS data entry. The Participant will be removed from the spreadsheet and their placement reported to the CE Team at the monthly meeting.

Declined Referrals and Grievance Procedures

Program Declines Referral
In the instance a program declines a referral from the CE Lead, the program must provide written justification that corresponds to one of the below stated reasons:

- The person does not meet the program's eligibility criteria; OR
- The person would be a danger to others or themselves if allowed to stay at this particular program; OR
- The person has previously caused serious conflicts within the program (e.g. was violent with another Participant or program staff).

If the program determines a Participant is ineligible for their program after the referral from the CE Lead, the Participant will be kept on the waitlist, but will be encouraged to visit DSS special services for emergency placement, if necessary.

Programs that refuse more than three (3) Participants in a 12 month period will have their criteria reviewed by the Coordinated Entry Team.

Participant Declines Referral

CE staff, through the administration of the vulnerability assessment and discussion with the Participant, should attempt to meet each Participant's needs while also respecting community-wide prioritization standards. Every effort should be made to engage the Participant in appropriate programs. However, Participants have the right to refuse interventions they feel do not fit their needs. While Participant choice will be honored, the CoC has the right to limit the number of program refusals any Participant can have per episode of homelessness. If a Participant continuously declines housing options the CE will try to identify and find solutions to the barrier.

Provider Grievances

Providers should address any concerns about the process to the CE Lead unless they believe a Participant is being put in immediate or life-threatening danger, in which case they should deal with the situation immediately. The CE Lead will discuss the issue with the CoC Coordinator. If a solution cannot be determined the CE Lead will arrange for the provider's representative to attend the next CE team meeting to resolve the issue. If a more immediate resolution is needed, the CE Lead will be in charge of determining the best course of action. The CE Lead will provide a written summary of the Team's decision regarding the grievance that will be sent to the provider filing the grievance.

Participant Grievances

The CE staff member or the CE staff supervisor will address any complaints by Participants as best they can when problems arise. Complaints that should be addressed directly by the CE staff member or staff supervisor include complaints about how the Participant was treated by assessment staff, assessment center conditions, or violation of confidentiality agreements. Any other complaints will be referred to the CoC Coordinator and the CE Lead. The CE will be brought in to identify solutions as appropriate. Any complaints filed by a Participant will include the Participant's name and contact information so the CE Lead can contact them and ask them to attend a team meeting to discuss the grievance. The CE Lead will provide a written summary of the Team's decision regarding the grievance that will be sent to the Participant.

Governance

Roles and Responsibilities

The coordinated entry process will be governed by the Coordinated Entry Committee of the CoC. This group will be responsible for:

- Investigating and resolving Participant and provider complaints or concerns about the process, other than declined referrals (which will be dealt with using the process described on page 17);
- Providing information and feedback to the CoC, CoC Governance Council, and the community at-large about coordinated entry;
- Evaluating the efficiency and effectiveness of the coordinated entry process;
- Reviewing performance data from the coordinated entry process; and
- Recommending changes or improvements to the process based on performance data, to the CoC and CoC Governance Committee.
- Review grievances received from providers and/or Participants.

Policies and Procedures
CE Composition
The Coordinated Entry Team will include the following seats:

- CE Lead;
- 211 call center staff;
- emergency shelter staff representative;
- Permanent Supportive Housing Program Staff;
- Street outreach staff;
- veteran services representative;
- youth services representative; and
- mental health representative

Other seats that may be included in future iterations of the committee are faith-based organizations, substance use service providers, school system representatives, and front-line staff in service organizations.

Expectations of Members
To remain in good standing and be allowed to vote and participate as members of the Coordinated Entry Team, all members must attend at least 75 percent of meetings. The CE Lead must attend 90 percent of meetings. Meetings will take place at least once a month, more if determined necessary.

Term Length and Limits
Each organization listed above commits to having a member seated on the committee at all times.

Meeting Schedule and Agenda
The CE committee will meet at least monthly to review actual assessments and referrals made through coordinated entry and monitor the list placements and outcomes. CE will hold a special meeting once quarterly to conduct a review of the overall process.

Voting Procedures
Decisions made at meetings are made based on a majority vote by CE members present at the meeting the decision is required. Any decisions that would lead to a modification of the coordinated entry process, including changes to the vulnerability tool or policies and procedures, must be approved by majority vote by the Team AND approved by the CoC Governance Council.

Conflicts of Interest
If at any point a provider or Participant wishes to address a complaint or grievance with a provider or agency that is a representative on the CE, that particular representative must recuse themselves from participating in those proceedings or voting on the outcome of that particular issue.

Review of Coordinated Entry Committee Policies and Procedures
The policies and procedures governing the CE will be separated into a bylaw document that must be approved by the CoC Governance Committee. The CoC Governance Committee should review these bylaws bi-annually or at the request of the Coordinated Entry Team.

Evaluation

The coordinated entry process will be evaluated on a regular basis to ensure that it is operating at maximum efficiency. Evaluation will be carried out primarily through the Coordinated Entry Team and any consultants or third Parties engaged to assist. Evaluation mechanisms will include the following:

1. A monthly review of the coordinated entry process. The CE team will review individual assessments and referrals monthly. The team will identify any barriers in the system and discuss potential solutions.
2. Quarterly review of coordinated system metrics: The CE team will review system performance and metric quarterly. Data to be reviewed, and the thresholds that should be met, will be developed based on the CoC's written standards.
3. A verbal report will be issued to the community every six months on coordinated entry and homelessness assistance system outcomes. This report will include trends from the month-to-month analysis of coordinated entry data, as well as the total number of assessments and referrals made, successes to be shared, and a note from the CE Lead on the progress of the system.

4. An annual report on the homelessness assistance system with a section devoted to coordinated entry. Major findings from this annual report should be presented at the CoC and Homeless & Housing Task Force meeting the month it is released by a member of the Team.

Contact Information

Questions about these policies and procedures should be directed to:

CoC Coordinator
Liddy Bargar
Continuum of Care Coordinator
Human Services Coalition of Tompkins County
118 N. Tioga St, Suite 304
Ithaca, NY 14850
607-273-8686 phone
lbargar@hsctc.org

Coordinated Entry Lead
Simone Gatson
CoC Housing Specialist and Coordinated Entry Lead
Human Services Coalition of Tompkins County
118 N. Tioga St, Suite 304
Ithaca, NY 14850
607-252-7220 phone
sgatson@hsctc.org

Ithaca/Tompkins NY-510 Continuum of Care
Emergency Transfer Plan for Victims of Domestic Violence, Dating Violence, Sexual Assault, or Stalking

Emergency Transfers

In accordance with the Violence Against Women Act (VAWA),[1] the Ithaca/Tompkins NY-510 Continuum of Care and its housing providers allow tenants who are victims of domestic violence, dating violence, sexual assault, or stalking to request an emergency transfer from the tenant's current unit to another unit. The ability to request a transfer is available regardless of sex, gender identity, or sexual orientation.[2]

The ability of the Ithaca/Tompkins NY-510 Continuum of Care and its housing providers to honor such request for tenants currently receiving assistance, however, may depend upon a preliminary determination that the tenant is or has been a victim of domestic violence, dating violence, sexual assault, or stalking, and on whether the Ithaca/Tompkins NY-510 Continuum of Care and its housing providers has another dwelling unit that is available and is safe to offer the tenant for temporary or more permanent occupancy.

This plan identifies tenants who are eligible for an emergency transfer, the documentation needed to request an emergency transfer, confidentiality protections, how an emergency transfer may occur, and guidance to tenants on safety and security. This plan is based on a model emergency transfer plan published by the U.S. Department of Housing and Urban Development (HUD), the Federal agency that oversees that the Ithaca/Tompkins NY-510 Continuum of Care and its housing providers are in compliance with VAWA.

Eligibility for Emergency Transfers

A tenant who is a victim of domestic violence, dating violence, sexual assault, or stalking, as provided in HUD's regulations at 24 CFR part 5, subpart L is eligible for an emergency transfer, if: the tenant reasonably believes that there is a threat of imminent harm from further violence if the tenant remains within the same unit. If the tenant is a victim of sexual assault, the tenant may also be eligible to transfer if the sexual assault occurred on the premises within the 90-calendar-day period preceding a request for an emergency transfer.

A tenant requesting an emergency transfer must expressly request the transfer in accordance with the procedures described in this plan.

Tenants who are not in good standing may still request an emergency transfer if they meet the eligibility requirements in this section.

Emergency Transfer Request Documentation

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[1] Despite the name of this law, VAWA protection is available to all victims of domestic violence, dating violence, sexual assault, and stalking, regardless of sex, gender identity, or sexual orientation.
[2] Housing providers cannot discriminate on the basis of any protected characteristic, including race, color, national origin, religion, sex, familial status, disability, or age. HUD-assisted and HUD-insured housing must be made available to all otherwise eligible individuals regardless of actual or perceived sexual orientation, gender identity, or marital status.

To request an emergency transfer, the tenant shall notify the housing provider's management office and submit a written request for a transfer to the housing provider. The housing provider will provide reasonable accommodations to this policy for individuals with disabilities. The tenant's written request for an emergency transfer should include either:

1. A statement expressing that the tenant reasonably believes that there is a threat of imminent harm from further violence if the tenant were to remain in the same dwelling unit assisted under HP's program; OR
2. A statement that the tenant was a sexual assault victim and that the sexual assault occurred on the premises during the 90-calendar-day period preceding the tenant's request for an emergency transfer.

Confidentiality

The housing provider will keep confidential any information that the tenant submits in requesting an emergency transfer, and information about the emergency transfer, unless the tenant gives the housing provider written permission to release the information on a time limited basis, or disclosure of the information is required by law or required for use in an eviction proceeding or hearing regarding termination of assistance from the covered program. This includes keeping confidential the new location of the dwelling unit of the tenant, if one is provided, from the person(s) that committed an act(s) of domestic violence, dating violence, sexual assault, or stalking against the tenant. See the Notice of Occupancy Rights under the Violence Against Women Act For All Tenants for more information about the housing provider's responsibility to maintain the confidentiality of information related to incidents of domestic violence, dating violence, sexual assault, or stalking.

Emergency Transfer Timing and Availability

The housing provider cannot guarantee that a transfer request will be approved or how long it will take to process a transfer request. The housing provider will, however, act as quickly as possible to move a tenant who is a victim of domestic violence, dating violence, sexual assault, or stalking to another unit, subject to availability and safety of a unit. If a tenant reasonably believes a proposed transfer would not be safe, the tenant may request a transfer to a different unit. If a unit is available, the transferred tenant must agree to abide by the terms and conditions that govern occupancy in the unit to which the tenant has been transferred. HP may be unable to transfer a tenant to a particular unit if the tenant has not or cannot establish eligibility for that unit.

If the housing provider has no safe and available units for which a tenant who needs an emergency is eligible, the housing provider will assist the tenant in identifying other housing providers who may have safe and available units to which the tenant could move, including completing a referral for Coordinated Entry. At the tenant's request, the housing provider will also assist tenants in contacting the local organizations offering assistance to victims of domestic violence, dating violence, sexual assault, or stalking that are attached to this plan.

Safety and Security of Tenants

The Ithaca/Tompkins NY-510 Continuum of Care's Emergency Transfer Program is not intended to be a witness protection program and cannot guarantee the safety or security of individuals and families who choose to apply and/or who are transferred under this program. Pending

processing of the transfer and the actual transfer, if it is approved and occurs, the tenant is urged to take all reasonable precautions to be safe.

Tenants who are or have been victims of domestic violence are encouraged to contact the National Domestic Violence Hotline at 1-800-799-7233, or our local domestic violence shelter at 607-277-5000, for assistance in creating a safety plan. For persons with hearing impairments, the National Domestic Violence Hotline can be accessed by calling 1-800-787-3224 (TTY).

Tenants who have been victims of sexual assault may call the Rape, Abuse & Incest National Network's National Sexual Assault Hotline at 800-656-HOPE, or visit the online hotline at https://ohl.rainn.org/online/.

Tenants who are or have been victims of stalking seeking help may visit the National Center for Victims of Crime's Stalking Resource Center at https://www.victimsofcrime.org/our-programs/stalking-resource-center.

Disapprovals

Tenants may be found ineligible for the transfer if, at the time of review of the request, they do not meet the documentation requirements for the type of transfer requested, family composition does not meet criteria for unit size, the tenancy has been terminated following administrative proceedings, or a warrant of eviction has been issued.

The housing provider must send a letter to the tenant advising them of the disapproval. The tenant has 14 days to appeal the decision through the housing provider's standard grievance process.

Appendix A

CNYHMIS Client Consent Form

Client Name: _____ Date of Birth: _____

Provider Name: _____ Agency: _____

- I know that this agency is part of the CNY HMIS (Homeless Management Information System). The CNY HMIS is a system that uses computers to collect information about homelessness in order to help plan and pay for services to people who are homeless or requiring services to prevent homelessness. The CNY HMIS is administered by the Housing and Homeless Coalition of Central New York (HHCCNY).
- With this written consent, CNY HMIS agencies that offer me services may enter, see, and update basic information about me and/or my children including name, gender, race, ethnicity, birth date, veteran status, proof of homelessness, income, insurance, disabilities (including HIV/AIDS status) and service transactions related to housing, food, and material goods.
- The Agency shall only release client records to non-partner agencies with proper written consent by the client unless otherwise permitted by relevant laws or regulations. Any research performed with this data is completely de- identified. No personally identifying information will ever be revealed in research or public reporting from HMIS data.
- Decisions to deny outreach, shelter, or housing will not be based solely on information in this system. My decision to sign or not sign this consent document will not be used to deny outreach, shelter, or housing services.
- I have a right to see my CNY HMIS record, ask for changes, and to have a copy of my record from this agency upon written request.

I may withdraw the consent except for information that has already been given out or actions already taken, by informing the agency in writing that I want to withdraw my consent. This consent will **end one year** from the date signed.

Dates of release: _____/_____/ _____ to _____/_____/ _____
(today's date to one year from that date)

Tompkins County Coordinated Entry Network:

The Advocacy Center, Catholic Charities of Tompkins/Tioga, Cayuga Addiction Recovery Services (CARS), Family and Children's Service of Ithaca, Greater Ithaca Activities Center (GIAC), Homes and Community Renewal, Human Services Coalition of Tompkins County, Ithaca Housing Authority, Lakeview Health Services, The Learning Web, Opportunities, Alternatives, and Resources (OAR), Rehabilitation Support Services (RSS), REACH Medical, The Salvation Army, Second Wind Cottages, Southern Tier AIDS Program (STAP), Soldier On, St. John's Community Services, Tompkins Community Action, Tompkins County Department of Social Services, Tompkins County Whole Health, the United States Department of Veterans Affairs, and Village at Ithaca.

Coordinated Entry Releases:

- ☐ I authorize the Coordinated Entry Network listed above to share and record information pertaining to my eligibility for housing programs and homelessness history for the purpose of case conferencing.
- ☐ I authorize HSC to share my homelessness history as it is recorded in HMIS with the Coordinated Entry Network listed above.
- ☐ I authorize HSC to record and share my medical information pertaining to my eligibility for housing programs. This information is only shared with Coordinated Entry Agencies, and the minimum necessary information is collected and shared.

Client Signature: _____ Date: _____

Agency Witness: _____ Date: _____

Appendix B

Updated 2025

NY-510 Coordinated Entry Questionnaire

Client's Name: _____ Date of Birth:_____

Where did you sleep **last night**?	☐ Emergency Shelter ☐Outside ☐Couch-surfing/doubled up ☐ Somewhere else (specify):_____
If your answer is an institution such as a rehab center, hospital, or jail, were you living outside or in emergency shelter before entering that institution?	☐ Yes ☐No ☐Refused How long have you been living in that institution? _____ Anticipated date to exit? _____
If your answer is outside, are you in living the non-enforcement zone?	☐ Yes ☐No ☐Refused If no, have you been asked to relocate? ☐Yes ☐No ☐Refused
What is your gender identity? **(check all that apply)**	☐ Woman ☐Man ☐Transgender ☐Non-Binary ☐ Questioning ☐Culturally Specific Identity (e.g., Two-Spirit) ☐ Different Identity:_____ ☐ Client doesn't know ☐Client prefers not to answer
What is your race? **(check all that apply)**	☐ Black, African American, or African ☐ White ☐ Asian or Asian American ☐ Hispanic/Latina/e/o ☐ American Indian, Alaska Native, or Indigenous ☐ Native Hawaiian or Pacific Islander ☐ Two or more races ☐ Client prefers not to answer
Have you ever **served in the US Military**?	☐ Yes ☐ No ☐ Refused
Are you currently on **parole or probation**?	☐ Yes ☐ No ☐ Refused
Have you ever been in **foster care**?	☐ Yes ☐ No ☐ Refused
Are you currently experiencing a lack of safety related to domestic or family violence, dating violence, sexual assault, stalking, **or other dangerous, traumatic, or life-threatening conditions related to violence against you or a family member?**	☐ Yes ☐ No ☐ Refused
If yes, **are you currently fleeing** that dangerous, traumatic, or life-threatening situation?	☐ Yes ☐ No
Do you currently have any **orders of protection** in place against you or someone else?	☐ Yes- against me ☐ Yes- against someone else ☐ No ☐ Refused
In that city of town was your **last permanent address**? (prior to experiencing homelessness)	City or zip code: What year did you live there? _____
How many people are in your household and will need to be housed?	How many?_____ Family Composition (if applicable):_____ ☐ children listed are currently living with head of household ☐ children listed are NOT living with head of household
Please indicate which of the following housing options you are interested in.	☐ **Refer me for any housing options I am eligible for (PSH, TH, and Short-Term Housing Vouchers)** ☐ Permanent Supportive Housing ☐ Short-Term Housing Vouchers (STEHP, TBRA) ☐ Transitional Housing
Please note any housing opportunities you are NOT interested in here.	

Please provide a **phone number** where a message can be left when a housing opportunity arises.	
Please provide any alternative means of contact (text now, social media, email) where a message can be left when a housing opportunity arises.	
Please provide contact information for an advocate, case worker, friend, or relative who we can reach out to on your behalf when a housing opportunity arises.	

Disabling Condition: Do you have a disability or condition that makes life challenging for you? ___Yes ___ No

If yes, please indicate which disability type below.

__ Alcohol Use Disorder __ Chronic Health Condition __ HIV/AIDS __ Physical Health

__ Drug Use Disorder __ Developmental __ Mental Health Disorder

Has this disability or condition been officially diagnosed by a healthcare provider? ____Yes ____ No

Income: Do you have income? ____Yes ____ No Total Monthly Income $_____

$_____ Alimony/ Spousal Support $_____ Child Support

$_____ Earned Income $_____ General Assistance

$_____ Pension or retirement income from another job $_____ Worker's Compensation

$_____ Private Disability Insurance $_____ Retirement Income from Social Security

$_____ Social Security Disability Income (SSDI) $_____ Social Security Income (SSI)

$_____ Temporary Assist for Needy Families TANF $_____ Unemployment Insurance

$_____ VA Non-Service-Connected Disability Pension $_____ VA Service-Connected Disability Compensation

Non-Cash Benefits: Do you have Non-Cash Benefits? ____Yes ____ No

Source of Non-Cash Benefits:

_____ Supplemental Nutrition Assistance Program (SNAP) (HUD) (Previously known as Food Stamps)

_____ Special supplemental Nutrition Program for (WIC) (HUD)

_____ Housing Choice Voucher (Section 8)

_____ TANF Child Care Services (HUD)

_____ TANF Transportation Services (HUD)

_____ Other TANF-Funded Services (HUD); If "Other" Specify: _____

NY-510
ITHACA/TOMPKINS
CONTINUUM OF CARE

Balance of State Vulnerability Assessment Tool (BoS-VAT)

Interviewer Name:

Agency:

Date of Interview:

Opening Script/Intro

The purpose of this survey is to help us learn more about you in hopes of finding the best type of housing for your needs. We are going to take the information from this survey along with some other details and use it to add you to a community-wide list of people in need of housing. We use that list to prioritize people for available housing slots.

Your answers to these questions are only discussed with service agencies and will not affect any other benefit you have, such as public assistance or food stamps. All agencies have agreed to keep your information confidential.

If you are asked a question that you are not comfortable answering, let me know and we can move on to a different question. If you do not understand a question, please let me know so I can better explain. Try to answer the questions honestly and accurately so we can find services that you may qualify for.

Please provide us with updated contact information so we can locate you when housing is available. If you get a new phone number, you can always reach out to the person or agency that did your survey so we can update our records.

Consent to Participate: ☐ Yes ☐ No

Basic Information

Name: Preferred Name:

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

Date of Birth: ___/___/___ Age: _____

Social Security Number: _____-_____-_____

Housing Status

Location of Homelessness

Where did you sleep last night?

Type of Homelessness **[staff to complete]**

☐ Place not meant for human habitation

☐ Temporary shelter, including hotel/motel paid for by DSS or other organizations

☐ Fleeing, or is attempting to flee, domestic violence

☐ Imminent risk of losing primary nighttime residence (including pending eviction, asked to leave shared residence, couch surfing, self-pay at a hotel)

Where do you usually sleep?

Own Apartment	With Family/Friends	Shelter or Hotel/Motel paid for by DSS	Warming Center	Abandoned/ Condemned Building, Vehicle, Camper	Outdoors (tent, bench, encampment)
0	0.5	1	1.5	2	3

Length of Time Homeless

How long have you been homeless?

Newly Homeless or At-Risk of Homelessness	Moderate History of Homelessness	Chronically Homeless
Has been homeless less than 1 month or new to the area OR At imminent risk of homelessness	Has been homeless for 1 month to 12 months	Has been homeless for 1 year or longer, or has had at least 4 episodes of homelessness within the last 3 years
0.5	1	2

Have you or anyone else in your household ever been permanently housed and lost housing?

No	Yes
0	1

Comments related to housing status:

Basic Needs

How do you and those in your household currently take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that?

[Based on response to questions above and assessment, is participant able to meet basic needs, such as obtain food and maintain hygiene?]

No Vulnerability	Low Vulnerability	Moderate Vulnerability	Severe Vulnerability
Able to use services to get food; takes care of hygiene	Some trouble staying on top of basic needs, but usually can do for self; hygiene/ clothing is usually clean/good	Generally poor hygiene, but able to meet needs with assistance; some openness to discussing needs	Unable to access food on own; very poor hygiene, e.g., clothes soiled, dirty; resistant to offers of help; no insight re: needs
0	1	2	3

Comments related to basic needs:

Independence and Autonomy

Have you or anyone else in your household been a victim of or witnessed a crime that continues to impact your daily life?

Does anybody force or trick you to do things that you do not want to do?

Do your friends typically ask you or anyone in your household for money or to share your benefits (such as Food Stamps or Social Security)?

Do you run out of money by the end of the month? Have you been unable to cover household expenses due to sharing/lending money to other people?

Do you have trouble saying no to people who ask you for favors? Are you able to establish boundaries?

Do you have a Rep Payee?

Have you or anyone else in your household been assaulted or experienced violence since your housing has become unstable?

Do you or anyone else in your household ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that?

[Based on responses to questions above and assessment, is participant vulnerable to being exploited and aware of safe behaviors?]

No Vulnerability	Low Vulnerability	Moderate Vulnerability	Severe Vulnerability
Independent and autonomous; knows how to get around; knows how to stay safe; knows how to advocate for self	Reports some independence and autonomy; is occasionally taken advantage of; needs some help recognizing unsafe behaviors	Is frequently in dangerous situations; communicates fears about people or situations; reports being taken advantage of	Vulnerable to exploitation; is victimized regularly; no insight regarding dangerous behavior or personal safety
0	1	2	3

Comments related to independence and autonomy:

Household Safety

Are you currently residing with, or trying to leave, someone you live with who threatens you or makes you fearful?

[Based on responses to questions above and assessment, is participant in an unsafe and/or unstable housing environment?]

No Vulnerability	Low Vulnerability	Moderate Vulnerability	Severe Vulnerability
Environment is apparently safe and stable	Environment appears safe; however, future is uncertain; safety planning is important	Safety is threatened/temporary protection is available; ongoing safety planning is essential	Home or residence is not safe; immediate level of lethality is extremely high; possible CPS involvement
0	1	2	3

Comments related to household safety:

Social Behaviors

How do you interact with others when you are stressed?

How do you and your household stay organized for appointments?

How do you communicate your needs with others?

[Based on responses to questions above and assessment, is participant able to act appropriately in social situations?]

No Vulnerability	Low Vulnerability	Moderate Vulnerability	Severe Vulnerability
More than adequately advocates for own needs; has strong ability to communicate clearly with others; able to keep track of appointments	Some difficulty in staying organized; can tolerate input and respond with minimal problems; may need repeated approaches about same issue; occasionally reacts inappropriately when stressed	Has some difficulty coping with stress; some disorganized thoughts; poor attention span; withdrawn but will interact with others when approached; sometimes has angry outbursts when in contact with others	Has difficulty engaging and communicating with others; has minimal insight regarding behavior and consequences; often responds in angry or aggressive manner; may come across as intimidating; has impaired ability to deal with stress
0	1	2	3

Comments related to social behaviors:

Physical/Medical Health

When you or a household member is sick or not feeling well, how do you seek medical assistance?

Do you or any members of your household have any chronic health issues, such as with your liver, kidneys, stomach, lungs, or heart?

Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently, such as a first-floor apartment or accessible bathrooms?

Have you and your household ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?

Are you currently taking medications? If so, do you take them as prescribed?

[Based on responses to questions above and assessment, does the participant have physical limitations or medical conditions that impact their ability to function?]

No Vulnerability	Low Vulnerability	Moderate Vulnerability	Severe Vulnerability
Seeks medical help when needed; no major medical or chronic health conditions	Has a medical or physical health issue that is managed (e.g., diabetes, high blood pressure); takes medication as prescribed and attends appointments	Has a medical or physical health issue that is not being managed (e.g., diabetes, high blood pressure); medication not taken as directed; does not seek help from providers	Disabling physical illness; refusal to get treatment
0	1	2	3

Comments related to physical/medical health:

Mental Health

Do you have any mental health concerns that would make it hard for you to live independently?

Have you experienced a traumatic brain injury (TBI) that would make it hard for you to live independently?

Are you on any medication for your mental health? Do you find it hard to take meds as prescribed?

Have you ever been asked to leave an apartment, shelter, or hotel where you were staying in the past?

[Based on responses to questions above and assessment, does the participant appear to have issues related to mental health?]

No Vulnerability	Low Vulnerability	Moderate Vulnerability	Severe Vulnerability
No apparent mental health issues	Reports having mental health issues; reports having service provider in place; taking medications as prescribed	Reports not taking medications as prescribed; not engaged in recommended mental health services	No connection to needed services; reports/exhibits symptoms that impair functioning (e.g., talking to self, depressed); no insight regarding mental illness
0	1	2	3

Comments related to mental health:

Substance Use

Have you ever attended alcohol or drug treatment?

Has your drinking or drug use impacted your daily life? If so, how?

Has your drinking or drug use impacted your ability to reach your goals?

Has your drinking or drug use led you to being asked to leave an apartment, shelter or hotel where you were staying in the past?

[Based on responses to questions above and assessment, does the participant have issues related to substance use?]

No Vulnerability	Low Vulnerability	Moderate Vulnerability	Severe Vulnerability
No substance use or strictly social use; no impact on level of functioning	Occasional use of substances; still able to meet basic needs	Substance use affecting ability to meet basic needs; has some support; has trouble making progress in goals	No engagement with needed services/ support; apparent deterioration in functioning; inability to meet basic needs
0	1	2	3

Comments related to substance use:

Scoring

Housing Status:

Basic Needs:

Independence and Autonomy:

Household Safety:

Social Behaviors:

Physical/Medical Health:

Mental Health:

Substance Use:

Total Score: