## Key Introduction Points to Share w/the Participant

* Purpose of the Assessment: We’ll explore ways you could move out of homelessness using existing supports. Since there is not enough affordable housing for everyone who needs it and the waits can be years long, finding options with natural supports may be the faster way out of homelessness on Long Island.
* How the assessment works: Instead of having to go to every agency to find out what you may qualify for, we collect your information and preferences and provide it to rapid re-housing programs, and other flexible housing programs so they can contact you with availability.
* Programs May/May not be accepting referrals right now: Openings depend on if programs are currently full or taking openings, which changes all the time- this is why we don’t know exact timeframes. Even if they are full and you are interested, it’s worth signing up in case they have openings in the future.
* Right to Refuse Responses: You may refuse to respond to questions on this assessment.
* Start/Stop: You may stop this assessment at any time and pick it back up at a later meeting.
* No Right/Wrong Responses: Your responses will not harm any other services you receive from our agency. The questions are only designed to help explore housing options you may want to pursue.
* Filing a Non-Discrimination Complaint: If at any time you would like information on filing a complaint because you believe you are being discriminated against, let me know and I can give you information on how to pursue this. (Fill in how assessors can access the non-discrimination policy here)
* ***Directions to Assessor: HMIS or comparable database consent:*** *Use your internal agency’s protocols regarding client permissions/consent into your database information. Please note that victim-service providers are prohibited from entering any information into HMIS.*

## Rapid Resolution Problem Solving Guide

*Below is a problem-solving guide for staff conducting Coordinated Entry assessments on Long Island to use to give participants the space to brainstorm ways they can avoid entering or quickly leave emergency shelter or unsheltered homeless situations. The questions on the first page are not required, but are a toolbox of prompts that can be used to explore alternative solutions to a housing crisis. Staff are encouraged to use the order and questions that make sense, given the nature of the relationship with the participant.*

Introduce purpose of a problem-solving conversation to the participant. Suggested key points include:

* Continued homelessness can take a toll on people's health and well-being. Since there are not enough housing resources on Long Island to give everyone affordable, subsidized housing who needs it, we also want to problem solve and explore other options you may have to leave this housing crisis and move to a more stable safe alternative even if for tonight.
* Shelters in New York are mostly managed by the state’s Dept. of Social Services. These shelters require a significant percentage of your income be paid as a shelter fee; there is also no guarantee of what town or location you may be sent to for shelter.
* If you become homeless, there is no guarantee you will be able to access long-term housing assistance. For example, right now on Long Island, it is estimated there is only enough subsidized housing for 1 out of 4 people who need it.
* Do you have any questions before we start?

Assess for Immediate Safety

*Discuss with the participant if they are actively fleeing violence or harm or are experiencing a serious health or mental health crisis. If so, stop the conversation and connect the participant with crisis intervention services such as shelter or safety planning for domestic violence, or urgent medical or psychiatric care if applicable.*

* Is there anyone making you feel unsafe or that you are fleeing from?
	+ *Participant may receive assistance from the Safe Center, Brighter Tomorrows, The Retreat, LIADV, VIBS)*
* Do you have any pressing medical, health or other safety concerns that we should address before discussing your housing situation?

Explore the Situation & Appropriateness of the Shelter Environment

*Gain an understanding of the participant’s living situation. Share realities of the shelter environment so the participant has information to make informed choices about where to stay.*

* What brings you here today? Why are you seeking shelter? Where did you stay last night?
* Do you currently have a housing voucher, even if it expired recently, or your own apartment or home?
* Where have you been staying? What was your most recent indoor living situation? How long had you stayed?
* Where would you stay if shelter was unavailable? If you came to shelter, do you know how you would get around and take care of your personal needs (hygiene, transportation, storage of things, etc)?
* In the past 1-6 months, have you stayed at an institution like detox, treatment, hospitals, jail?

Brainstorm Possible Solutions

*Engage in active listening and think about/reflect back strengths they may share. Brainstorm possibilities and use motivational interviewing skills. Explore potential options with the participant.*

* Is there anyone that may want to know you are seeking shelter tonight, or may want to know you need help?
* Do you have family, friends or anywhere to stay other than shelter, even for the night?
* Tell me about past places you’ve stayed that have been positive.
* Tell me about any strengths you have to navigate difficult situations.
* What support would you need to stay somewhere else or make a housing option work?

## Brainstorming Relocations and/or Roommate or Shared Housing Solutions

*Discuss Housing Affordability as a common barrier for people living on Long Island. Explain that those that have re-located to areas where housing is cheaper have very high success rates from becoming homeless and remaining housed. People often relocate successfully to upstate New York, or other states. The Dept. of Social Services can help with moving costs if a sustainable housing plan is in place.*

*Explore if the participant is interested in relocating to less expensive areas or sharing housing with roommates to lower the cost. Share with the participant that individual units often cost around $1,400 at a minimum.*

* Have you lived in other areas before where you still have family or friends?
* Are there any other areas you would be interested in living that are cheaper, so you would not need to be at-risk of homeless, or become homeless?
* Before you became homeless, how were you managing your rent - how were you paying the bills and what were your income sources that allowed you to remain housed at that time?
* Are you interested in increasing your income to exit homelessness?
* Have you had someone sit down and review your budget with you to come up with a plan to pay rent each month?
* Are you able to be flexible with the different areas you are willing to live, if we can find a different unit that is more affordable?
* If you were to attempt to move out of shelter into a rental unit, is there someone that has an income that could join your household to help have more money for rent moving forward?

*If the participant currently lives in a unit and could relocate to a more sustainable unit, use these prompts instead.*

* You’ve been managing rent up until this point- how were you paying the bills and what are your income sources?
* Have you had someone sit down and review your budget with you to come up with a plan to pay rent each month?
* Are you able to be flexible with the different areas you are willing to live, if we can find a different unit that is more affordable?
* Is there someone that has an income that could join your household to help have more money for rent?
* Do you need assistance to repair credit or do you keep getting turned down by landlords? (offer classes Edna offers- TOB only)

## Referrals to Housing + Income Maximization Outside of Coordinated Entry

**Increasing Household Income through Employment** *and/or Benefits (SOAR and resource referral)*

***Refer households to community employment services.*** *Determine whether household could exit homelessness with additional SSI/SSDI for the household. Stress to the participant if they have a low income and insist on living alone, they will need to increase their income. Provide information and referrals to benefits and job search agencies.*

*Complete SOAR with households when staff time and resources permit for households homeless for greater than one year. \*Please note that we will not be able to pursue SOAR for any new clients at this time, unless more staff/interns are added to the team)*

**Explore Rental Subsidy through the County to assist with rent (SSP):**

Assist households in applying for SSP to exit homelessness.

**Resource Linkages**

All households should be connected to Care Coordination services whenever possible/applicable. All households should be made aware of SPA Housing options. All veteran households should be immediately referred to SSVF- SUS (Nassau) or EOC (Suffolk).

**ALL PERSONS SHOULD BE MADE AWARE OF CARE COORDINATION AND HOW TO ENROLL.**

**Care Coordination Eligibility: HEALTH HOME ELIGIBILITY CRITERIA**

All individuals served in the New York State Department of Health (NYSDOH) Health Home Supportive Housing Pilot (HHSHP) must be enrolled in the Health Home program. To qualify for the Health Home Program (care management services), Medicaid participants must have two chronic conditions, or one single qualifying condition (HIV/AIDS or one serious, persistent mental health conditions (SMI)).

Chronic conditions include, but are not limited to the following:

• Mental health conditions

• Substance abuse disorder

• Asthma

• Diabetes,

• Heart disease

• Being overweight (BMI over 25)

• Hypertension

For more information about Health Home eligibility criteria, including chronic conditions, please

see New York State Health Home State Plan Amendments at:

<http://www.health.ny.gov/health_care/medicaid/program/medicaid_health_homes/nys_implementation.htm>

**Connect Households to Community Drop-in Centers:**

Do you currently go to any food pantries, day programs, or drop-in centers for support?

* Drop-in centers: INN, Pax, HALI, Maureen’s Haven, Federation
* SC Community Centers: Wyandanch, Bellport, Huntington, Brentwood

Next Steps: Data Collection, Services and Assistance to Resolve the Housing Crisis

If a resolution is possible, reflect back potential option(s) to participant and agree on next steps (i.e. confirm with family/friend their return with verbal consent, arrange for transportation, resources, etc. Inform the participant that to provide services like mediation (i.e. talking with a family member) and/or financial assistance, you will ask to collect key data points to both create a client record and inform service delivery.

If resolution is not possible, collect the below data and move forward with any triage or shelter intake work you would do to connect the participant to immediate shelter options.

 *(Required data elements for the universal HMIS diversion form)*

* Participant name
* Participant date of birth and/or social security number
* Race/ethnicity
* Gender
* Housing situation prior to seeking services
* Outcome of conversation
* Referrals or resources provided during conversation
* Amount of funds used if applicable
* Participant Contact and Emergency Contact Info
* Check box (yes, no, participant refused) for staff to confirm they secured releases of information to speak to outside parties (friends, family, other agencies).
* Free text notes to record pieces of the conversation that would be helpful in the future

**RRH opportunities (ESG or CoC):**

Only after discussing housing barriers and seeking to resolve homelessness to no resolve (first encounter), the full Coordinated Entry assessment should be completed for the household (second encounter or when all options above have been explored).

When to proceed in the assessment for people fleeing **Domestic Violence**: Proceed with the assessment. Those unsheltered or in shelter may be prioritized for a housing resource. Those not in shelter or unsheltered may be referred to other housing programs, like ESG homelessness prevention.

When to proceed in the assessment for **everyone else**: Establish if the participant has been unsheltered, in emergency shelters or transitional housing programs for at least one year. If they have, proceed. If they have not, revisit any of the above solutions, information or referrals.

### COVID-19 Awareness Screening

3. COVID-19 Awareness Screening

The purpose of this screening is to ensure that participants in your program have awareness of COVID-19 (Coronavirus). This is not intended to be a medical screening or diagnostic tool. This screening tool is intended to help programs manage activities related to client awareness, potential personal contact, and general symptom monitoring.

**CDC information available here: https://www.cdc.gov/coronavirus/2019-ncov/about/index.html**

Name

Social Security Number

Date of Birth

Gender

**3A. Does anyone in the household meet any of the following CDC high-risk criteria? (select all that apply)** *Note to assessor: At this time, self report will suffice for CDC high risk criteria.*

[ ]  65+ years old

[ ]  Cancer

[ ]  Chronic kidney disease

[ ]  COPD (chronic obstructive pulmonary disease)

[ ]  Heart conditions such as heart failure, coronary artery disease or cardiomyopathies

[ ]  Immunocompromised state (weakened immune system) from solid organ transplant

[ ]  Obesity or severe obesity- body mass index of 30+

[ ]  Sickle cell disease

[ ]  Smoking

[ ]  Type 2 diabetes

Number of adults in the household that meet a CDC high-risk criteria? \_\_\_\_

Number of children (under 18) in the household that meet a CDC high-risk criteria? \_\_\_

Total household members that meet a CDC high-risk criteria? \_\_\_

**Date Completed**

 Click & select a date

Completed By

Awareness Information on COVID-19 provided?

yes no

Additional Details

Education on Personal Hygiene provided?

yes no

Additional Details

Steps to avoid contracting COVID-19 discussed?

yes no

Additional Details

**Potential Contact**

Has the individual traveled outside of the United States, in the past 14 days? If yes, list locations in the Additional Details field.

yes no

Additional Details

Has the individual been in contact with anyone who has traveled outside of the United States in the past 14 days?

yes no

Additional Details

Has the individual been in contact with anyone who has been exposed to COVID-19?

yes no

Additional Details

Does the individual live in a group home setting?

yes no

Additional Details

**Potential Symptom Check**

Is the individual age 65 or older?

yes no

Additional Details

Does the individual have a history of respiratory issues?

yes no

Additional Details

Is the individual presenting with a fever, cough, or shortness of breath?

yes no

Additional Details

**COVID-19 Status**

Date Symptoms Started

 Click & select a date

Referred or Sent for testing?

yes no

Referred/Sent to testing on:

 Click & select a date

Testing conducted?

yes no

Testing conducted on:

 Click & select a date

Test Results

Quarantine Date

 Click & select a date

Hospitalization Date

 Click & select a date

Recovery Date

 Click & select a date

Client Health Notes

## Key Points to Share w/the Participant re: Household History Questions

The next section will ask you questions about your current situation and housing history. Please know that the responses to these questions in no way jeopardize the services you currently use, or any future housing opportunities you choose to pursue; programs do not use these criteria to screen anyone out. These questions are only asked for the purposes of appropriately matching people to the housing resources available.

# 8a. Have you ever been diagnosed by a licensed professional as having a disabling condition? You do not need to disclose the condition.

*Note to assessor on generating an accurate response: if participant receives any type of disability benefits, you can automatically select “yes”; if you or the participant are unsure, ask them if a medical professional has ever written a letter on their behalf for disabled housing, emergency assistance, or other benefits, even if they do not currently receive them*

[ ]  **No**

**[ ]  Unknown**

[ ]  **Yes**

# 8B. We are asking people what factors may be in their backgrounds so we can shape our services to overcome these barriers. Have you experienced any of the following (check all that apply)?

[ ]  A housing authority or housing program terminated your subsidy (i.e. a housing voucher, a public housing unit, etc.)

[ ]  You have been evicted from a legal tenancy where you were the lease holder at least 2 times in the last five years.

[ ]  Prior to entering shelter or sleeping outside during this episode of homelessness, you came directly from jail, prison or a pre-release program.

[ ]  You have been convicted (found guilty of) a violent crime

[ ]  You have been convicted (found guilty of) a drug crime

## Key Points to Share w/the Participant re: Three Year Histories

1. Three Year History: When our programs have limited openings, they use a few factors such as length of homeless history to match people to openings. We’ll check your history in our database, or do a three-year history with you so we can record the time in case it needs to be used.
2. Documentation is required at the time of the assessment. Nights already recorded in the HMIS record are considered documented.

#

# 8c. What is your current living situation?

[ ]  Congregate shelter (emergency shelter without own rooms)

[ ]  Motel/Hotel setting with congregate spaces such as kitchen, cafeteria, recreation areas

[ ]  Unsheltered (outside, place not meant for human habitation)

[ ]  Actively or attempting to flee domestic violence in my own home or doubled up with someone else

[ ]  Hotel or other setting with own room with no shared spaces

[ ]  Other, please specify

# 8d. How many total months of Long Island homelessness in the last three years does the participant’s HMIS record show?

Show the participant their record to confirm this is an accurate history of homelessness they have experienced.

     # of homeless months in HMIS

**8e. Ask the participant if the months of total homelessness in HMIS reflects their three year homeless history in shelters, unsheltered or in institutions on Long Island.**

**[ ]  Accuracy Confirmed** You may skip conducting a three year history.

**[ ]  Accuracy Unsure** If the participant believes there are more homeless months to reflect that are not in HMIS (examples may be unsheltered or outside stays, in domestic violence or other shelters who do not input into HMIS, etc), proceed to collecting a three year history.

#

**List the places the participant stayed in the last three years that include 1.) emergency shelter and 2.) sleeping unsheltered on Long Island only.** *You may also list stays in institutions (behavioral health treatment programs, hospitals, jail, prison) if the participant was in a homeless situation (shelter /unsheltered situation) immediately prior to entry and after the stay, and the stay was fewer than 120 days*.

Order stays by starting with the most recent stay. *All stays must be on Long Island, NY and documented by the shelter, overnight outreach agency or institution* at the time of this assessment*.*

|  |  |
| --- | --- |
| Name of Shelter, Unsheltered Location or Institution: |       |
| Dates:       | # of Homeless months (calculated from date estimates above):       |
| *\*If participant was sleeping unsheltered (outside, place not meant for habitation) one night in a given month counts for that full month of days- ex. 1 night in November would count for 30 days in November when you add up the total nights.* |
| Name of Shelter, Unsheltered Location or Institution: |       |
| Dates:       | # of Homeless months (calculated from date estimates above):       |
| *\*If participant was sleeping unsheltered (outside, place not meant for habitation) one night in a given month counts for that full month of days- ex. 1 night in November would count for 30 days in November when you add up the total nights.* |
| Name of Shelter, Unsheltered Location or Institution: |       |
| Dates:       | # of Homeless months (calculated from date estimates above):       |
| *\*If participant was sleeping unsheltered (outside, place not meant for habitation) one night in a given month counts for that full month of days- ex. 1 night in November would count for 30 days in November when you add up the total nights.* |
| Name of Shelter, Unsheltered Location or Institution: |       |
| Dates:       | # of Homeless months (calculated from date estimates above):       |
| *\*If participant was sleeping unsheltered (outside, place not meant for habitation) one night in a given month counts for that full month of days- ex. 1 night in November would count for 30 days in November when you add up the total nights.* |
| Name of Shelter, Unsheltered Location or Institution: |       |
| Dates:       | # of Homeless months (calculated from date estimates above):       |
| *\*If participant was sleeping unsheltered (outside, place not meant for habitation) one night in a given month counts for that full month of days- ex. 1 night in November would count for 30 days in November when you add up the total nights.* |

8f. Total # of Homeless months:

      (months from 3 yr. hx + months in HMIS if applicable)

Instructions for Staff to Process Assessment Score

**Scoring Sheet:** Do not share scoring mechanism or actual score with participants. The score is one factor to figure out who should be matched next to an open resource, it is not a static place on a “waitlist”.

|  |  |  |
| --- | --- | --- |
| Criteria | Points Value | Participant Score |
| Current living situationSource: Q. 8c | If participant responded yes to any of the below:* Unsheltered= 20 points
* Congregate shelter= 20 points
* Motel/hotel setting with shared spaces\* (available in Suffolk only) such as kitchen, cafeteria, recreation areas (i.e., converted motel/hotel shelter programs) = 15
* Temp hotel or other setting paid by a government/nonprofit with own room- 13 points
* Fleeing domestic violence in own home or doubled up with others = 7 points
 |  |
| Barriers to obtaining housingSource: Q. 8b (at least one item has to be checked off to receive the point) | If participant responded yes to any of the below, 3 points total |  |
| High risk to contract or die from COVIDSource: Q. 3A | * Yes, more than 1 household member=2 points
* Yes, 1 household member=1
* No= 0 points
 |  |
| Length of time literally homeless (unsheltered, emergency shelter and/or transitional housing) in the last three yearsSource: Q. 8f | * 12+ homeless months in the last three years= 1 points
* Less than 12 homeless months in the last three years= 0 points
 |  |
| **Total:** | **26 points total max** |  |

*Criteria used for tie breakers:* Interim solution- for people who are unsheltered or in shelter, use length of time homeless in the event you need a tie breaker (Q 8f). For people who are actively or attempting to flee domestic violence in their own homes or doubled up, use data of referral to the Safe Center as the tie breaker.

**For Assessors Who Do Not Enter Assessments into HMIS:** Please proceed to [xxx](https://cas.boston.gov) website/spreadsheet/etc to input the results of your assessment so that the participant can be added to the pool of people waiting for a housing match.