Northlake Homeless Coalition
Coordinated Entry Policies and Procedures Addendum

Effective Date: 10/7/2020

Purpose: To ensure that the current Coordinated Entry Policy is responsive to the COVID-19 Pandemic and that our policies and procedures protect those most vulnerable to the virus' severe effects by speeding up connections to permanent housing for people at high risk of COVID-19 complications. This addendum is adopted in conjunction with the COVID-19 Equity Vision Statement to ensure that historic and current racial biases and discrimination embedded in our systems, processes, and practices are eliminated and those most at risk are prioritized for housing.

Scope: This policy addendum applies to all current and future recipients and subrecipients of CoC and ESG program funds for region LA-506 and the CoC Collaborative Applicant, the Northlake Homeless Coalition and is in effect through December 31, 2020. *Please note: This is an ongoing and evolving public health crisis; effective dates and policy addendums may change as the response evolves.*

Background: The spread of COVID-19 has created new, urgent needs and has shifted priorities in communities throughout the country. With new and expanded resources available through the CARES Act, communities should make sure their prioritization criteria efficiently and accurately targets resources to families and individuals impacted by or at high risk of being impacted by COVID-19. This is a crucial moment to make these changes as systems like justice and healthcare are rapidly updating their operations in response to the outbreak; both of which could dramatically impact the flow of families and individuals into homelessness.

Responsible Party: The NHC Executive Director, in conjunction with the CAAS Committee Chair, is responsible for administering and enforcing this policy. This policy will be reviewed and updated monthly by the CAAS Committee.

I. Policy Statement

During this public health crisis, people at high risk of developing severe COVID-19 symptoms (those 65+ and people of all ages with underlying medical conditions, per the CDC) are at higher risk of death than most others living in congregate settings or unsheltered. Rehousing this high-risk population will limit the spread and impact of COVID-19, so prioritization policies will support swift assessment and rehousing for anyone meeting ANY of the risk factors indicated by the CDC. The NHC will continue working with local health partners, including public health authorities, and monitoring CDC guidance to maintain an updated understanding of who is most vulnerable to severe illness or death from COVID-19 and adjust prioritization criteria as appropriate. The science is changing as we learn more about COVID-19 and the CE assessment and prioritization process needs to adapt accordingly.

Black people and people of color also experience disproportionate impacts of COVID-19. These health and housing disparities represent high vulnerabilities that CE assessment and prioritization processes should be actively addressing. Although the NHC cannot set prioritization based solely on protected classes, the CE process can and should prioritize the vulnerabilities created by the compounding effect of other systems' inequities that contribute to people of color experiencing homelessness and impacts of COVID-19 at higher rates. This policy addendum will incorporate housing barriers such as criminal records, poor credit histories, and histories of evictions—all of which disproportionately impact people of color—as prioritization factors, as these factors often contribute to difficulties accessing and maintaining housing.

II. Coordinated Entry Policy Change Process:

A. HUD has identified 10 steps to assist CoCs assessing, updating and implementing changes to Coordinated Entry Polices and Procedures:

1. Create values to specifically address your community's immediate needs and guide decisions.

   a. The NHC Board has adopted a COVID-19 Equity Statement to transform our homeless response systems so that **all** those we serve have a safe, stable home from which to thrive. Equity must be the foundation of these refined systems, embedding it in the design, implementation, performance measures, and monitoring of our work.

   b. The Coordinated Entry System will use a data-driven approach to prioritize those most vulnerable to severe illness or death from COVID-19.

   c. The Coordinated Entry System has adopted the National Innovation Service' Equity Based Decision Making Framework to ensure that as we respond to the COVID-19 pandemic, system processes and policies proactively eliminate racial inequalities and advance equity.[1]

2. Merge leadership teams and staffing to review, approve, and evaluate ongoing implementation.

   a. On August 5, 2020 The NHC Board authorized the CAAS Committee as the decision-making body to make changes to the Coordinated Entry System in response to COVID-19. The CAAS Committee is comprised of the CoC Lead, CE Management Entity, HMIS Lead, CoC-funded providers and ESG-funded providers. The CAAS Oversight Committee Chair (and NHC Board Member) has joined the CAAS Committee to provide continuity to the policy-making process. This authorization will remain in effect through December 31, 2020.

   b. Previously, the CAAS Oversight Committee was responsible for making CE policy recommendations and the NHC Board was responsible for the adoption of policies and procedures after the solicitation of feedback from the Providers and Stakeholders Association. The merging of the CAAS Oversight Committee and the CAAS Committee ensures participation from providers and board

[1] https://www.nis.us/equity-based-decision-making-framework

members while simplifying and reducing the timeline of the decision-making and implementation process.

c. The CAAS Committee meets on a bi-weekly basis and will review, approve and evaluate ongoing changes to the CE system in real time so that the CE COVID-19 response can be flexible and adaptive to community needs.

3. Identify processes that can or must be simplified to reduce time and increase staff capacity. This should include identifying recipients who are utilizing available CoC, ESG, and HOPWA waivers.

   a. In order to streamline the referral process and utilize CAAS Committee capacity to review, approve and evaluate ongoing changes to the CE system, the CAAS Committee will no longer approve referrals for available openings. As the CAAS Management Entity, The Northlake Homeless Coalition will make referrals for available openings based on the prioritization standards agreed upon by the CAAS Committee in Section II.A.4 of this document. The prioritization list and referrals will be made available to the CAAS Committee on a monthly basis to ensure transparency and adherence to the agreed upon prioritization standards.

   b. The Northlake Homeless Coalition will work with CoC and ESG providers to identify applicable CoC and ESG waivers that can reduce barriers to housing clients.

4. Document how current prioritization standards will change, which projects will be impacted (e.g. Diversion, Emergency Shelter, Permanent Supportive Housing, Rapid Rehousing, etc.), eligibility criteria, priority populations, and the applicable time period of changes.

   a. For all project types, clients residing in non-congregate shelters will be prioritized for housing based on program eligibility criteria and the Place Value Assessment score. Clients who were most vulnerable to COVID-19 were placed into non-congregate shelter and therefore must be prioritized into new and existing housing resources. This prioritization standard goes into effect October 1, 2020 and remains in effect until the non-congregate shelters are depopulated or while this addendum remains in effect, whichever is first.

   b. Once clients from the non-congregate shelters have been placed into housing, the CoC will utilize the Place Value Assessment to prioritize clients into available housing resources.

5. Update your assessment process and tools to allow for collecting the minimum required information for prioritization and ensure diversion, housing-focused problem solving, flexible fund resources, and other resources are available and accessible for participants and staff during assessments.

   a. The updated assessment process has implemented the following tools to allow for collecting the minimum required information for prioritization and ensure diversion and problem solving:

i. The first step of the assessment process is the Triage Tool which is limited to three questions to immediately assess crisis needs.

ii. For persons who are at imminent risk of homelessness, the assessment process will include a problem solving conversation facilitated by the Initial Assessment Worksheet and the Targeted Prevention Eligibility Screening for homeless prevention services. The targeted prevention screening is one page versus the VI-SPDAT which was previously utilized for homeless prevention assessments.

iii. For persons who are currently experiencing sheltered or unsheltered homelessness, the assessment process will include a problem solving conversation facilitated by the Initial Assessment Worksheet and the Place Value Assessment Tool. The Place Value Assessment Tool replaces the VI-SPDAT Assessment Tool and reflects a reduction of required information collected.

iv. All clients will receive two problem solving conversations prior to being placed on the prioritization list. For unsheltered clients in need of a Rapid Rehousing (RRH) Intervention, a Self-Certification of Homelessness Statement will suffice for homeless verification. Third Party homeless verifications will still be required for Permanent Supportive Housing (PSH) referrals.

v. Coordinated Entry staff will complete the Cleveland Mediation Center Diversion Training by October 31, 2020. Diversion experts from the Cleveland Mediation Center have trained over 30 communities across the country in homeless system diversion since 2014. 95% of participants gave the training an Excellent or Very Good Overall Rating.

6. Implement accompanying changes to expedite the matching and referral process.

   a. As the Coordinated Entry Management Entity, all Northlake Homeless Coalition staff have been trained by the Homeless Management Information System (HMIS) Provider to implement the accompanying changes to the assessment process to expedite the matching and referral process. This training was completed on 9/29/2020 with changes going into effect on 10/1/2020.

   b. The implementation of the new assessment, prioritization, matching and referral process is an iterative process. The CAAS Committee will review assessment and prioritization data from the first month of implementation (October 2020) in November and assess what changes need to be made to improve the process moving forward.

7. Ensure housing programs receiving CE referrals have the guidance, tools, and logistics to facilitate move-ins while also following local public health orders.

   a. The NHC will ensure that programs receiving CE referrals have the guidance tools and logistics necessary to facilitate move-ins while also following public health orders. Clients, housing providers and landlords will be required to wear

masks during all phases of the housing identification, housing inspection and move-in process in accordance with CDC and LDH public health recommendations.

8. Communicate changes widely and in writing with remote/recorded training for new/updated tools or data entry processes.
    a. Changes to the Coordinated Entry process are documented in this policies and procedures addendum and will be posted to the NHC website, distributed to the NHC mailing list and discussed at the NHC Providers and Stakeholders Association Meeting.
    b. As the CE Management Entity, the NHC is responsible implementation of the new assessment tools, matching and referral process, prioritization list and CE data entry process. The NHC will hold a formal training on the updated process in November once any issues have been identified in the pilot phase of the new CE Process (October 1 – 31).
9. Meet frequently with leadership to monitor for further changes and evaluation of impact.
    a. The CAAS Committee will meet on a twice monthly basis to monitor for further changes and evaluation of impact to the Coordinated Entry System.
10. Support efforts to reduce system-wide barriers to housing such as ID and documentation requirements.
    a. The NHC will no longer require IDs as a requirement to be placed on the NHC prioritization list, but will continue to work with clients to obtain needed identification.
    b. For clients needing a Rapid Rehousing Intervention, a Self-Certification of Homelessness Statement will suffice for homeless verification. For clients entering a PSH program, Third Party Verification will still be required.

III. Policies and Procedures Attachments

1. Triage Tool
2. Triage Tool Telephone Script
3. Initial Assessment Worksheet
4. Targeted Prevention Screening
5. Place Value Assessment Tool

NORTHLAKE HOMELESS COALITION

CAAS TRIAGE TOOL

Date		Caller Name		DOB:
Phone Number		Alt Phone Number		Parish:
Gender	☐Male ☐Female ☐Transgender			
Persons 18 or older	☐0 ☐1 ☐2 ☐3 ☐4 ☐5+			
Persons 17 or younger	☐0 ☐1 ☐2 ☐3 ☐4 ☐5+			

1. Can you tell me where you stayed last night and the night before?

☐ Street/Woods/Outdoors ☐ Emergency Shelter ☐ Abandoned Bldg ☐ Motel paid by church ☐ Vehicle ☐ Transitional Housing	⇨	This household is determined to be Literally Homeless. Administer VI-SPDAT if not in HMIS.
☐ House or apartment ☐ Jail, hospital, treatment ☐ Other, Specify:	⇨	The housing status of this household has yet to be determined. **Proceed to #2.**

2. Why do you have to leave the place you stayed last night?

☐ Eviction ☐ Fleeing Violence/Abuse ☐ Discharged from institution	⇨	This household is determined to be Homeless or at Imminent Risk. Complete Targeted Prevention Worksheet. If DV, complete VI-SPDAT.
☐ Staying with family/friends	⇨	The housing status of this household has yet to be determined. **Proceed to #3.**
☐ Foreclosure ☐ Rent Increase ☐ Loss of Income ☐ Other, Specify	⇨	Complete Targeted Prevention Worksheet and Problem Solving Conversation.

3. Why are you currently staying with family or friends?

☐ Eviction (court ordered within 30 days) ☐ Lease Violation with landlord letter	⇨	Complete Initial Assessment Worksheet and Problem Solving Conversation.
☐ Told to leave by family/friends	⇨	Complete Initial Assessment Worksheet and Problem Solving Conversation.

4. If Literally Homeless (Q.1) or Fleeing Domestic Violence, administer Place Value Assessment and Verify Phone Number

Northlake Homeless Coalition
Coordinated Entry Telephone Triage

Good Afternoon! Thank you for calling the Northlake Homeless Coalition

1

Can you please tell me where you slept last night and the night before?

If experiencing literal homelessness (they stayed outside, in an emergency shelter, vehicle, or a place not meant for human habitation),

Say "*I'm sorry to hear that, can I ask you a few more questions so that I can help connect you with the assistance you may need to resolve your housing crisis*?"

and go to Question #2.

If NOT currently literally homeless

Go to Question #3

2

Do you have a place you may be able to sleep tonight? Do you have any other safe housing options for the next few days or weeks?

If yes, encourage rapid resolution of their housing crisis through accessing their other housing options if it is safe and appropriate.

Say, "*Please go ahead and arrange those options, as there is not always immediate emergency shelter availability and we want to ensure you have somewhere safe to stay tonight."*

If no, ask

"How many people are in your household and are there any children under 18?"

Then ask

Are you interested in emergency shelter?"

If yes,

Provide them with contact information for the appropriate emergency shelter based on household composition.

If they say "I have been sleeping on the street. I won't go to shelter.", ask:

"*Where have you been staying? Can I have an outreach worker get in touch with you?*' and record as many details as possible about where they are staying, and for how long in that location. Are there other locations where they stay. [Record on the outreach street homeless verification list]

Then go on to Question #3.

3

Are you currently in danger or experiencing any safety concerns?

If yes,

Connect to the appropriate intervention (i.e. 9-1-1, EMS, Child Protective Services, etc.).

If they are **actively fleeing domestic violence,**

Say "*Would you like me to connect you with a domestic violence provider who may be able to help?"* If they say yes, provide them with the phone numbers for:

- LA Domestic Violence Hotline at **1-888-411-1333**
- St. Tammany Parish: Safe Harbor at **985-626-5740**
- Livingston, St. Helena, Tangipahoa and Washington Parishes: SAFE at **985-542-8384**

For other safety issues, encourage them to reach out to the below as appropriate:

- **Mental Health Crisis:**
  - Florida Parishes Human Services Authority at 985-543-4333
  - Suicide Prevention Lifeline **(800) 273-TALK or (800) SUICIDE**
- **Abuse or Neglect (Adult):** Adult Protective Services **(800) 898-4910**
- **Abuse, Neglect, or Exploitation (Age 60+):** Elderly Protective Services **1-833-577-6532**
- **Abuse or Neglect (Children):** Child Protective Services **855-4LA-KIDS /855-452-5437**
- **Human Trafficking: (888) 373-7888**

If no safety concerns,

Currently Homeless (yes to Q1)
say *"May I ask you one more question?"*
and proceed on to Question #4.

Not currently homeless (no to Q1)
Say *"Can I get your name and phone number to have someone call you back?"*

4

Have you ever been assessed for the Coordinated Access and Assessment System or completed an Assessment? If so, with who?

If they answer yes,

ask them *"Have you been assigned an Outreach Navigator? Do they know how to reach you? Do you know how to reach them?'*

If they answer no or don't know,

Tell them "Okay, let me check on that for you. Can I also get your number now in case I need to call back?" Record the telephone number and check HMIS to see if the individual/family is already on the Prioritization List. If not, facilitate a Place Value Assessment via phone or in person.

Commonly Asked Questions:

Q: "Do you have rental assistance available?"
I'm not sure. Often there are no openings in these programs.

Q: "I already went there/called there and they sent me to you."
That doesn't seem right. Who did you talk to?

Q: "I was told that you would help me get a house."
We work with clients to find housing solutions, but often there are no openings.

Q: "Do you know how long the waiting list is?"
It's not really a waiting list.

Things NOT to Say:

Do NOT promise housing.
Do NOT say "You must be homeless for a year to get housing."
Do NOT say "You need to be in a shelter to get any help."

Do NOT say how long someone may get assistance.
Do NOT say "RRH is only for 3 months."

Do NOT give opinions about particular agencies or programs that clients may get referred to.
Do NOT say "You don't want that program."
Do NOT say "I think you would qualify for PSH."

Do NOT judge or express criticism about someone's housing crisis.
Do NOT say "Why are you with him?"
Do NOT say "Why do you keep having babies?"

Northlake Homeless Coalition
Initial Assessment Worksheet

Client Name: _____ Date: _____

Navigator: _____ Location: _____

This is a worksheet to help guide your conversation. Space is provided to take notes. This is not an official form.

Step 1: Introduce yourself and the purpose of the appointment

" Hi, my name is _____ and I work for the Northlake Homeless Coalition Coordinated Entry System. The purpose of this meeting is to help you and your family find a safe place to stay. Typically shelters in this area are very full and the goal is that we brainstorm alternatives to staying in shelter. The hope is we can find another safe place for you to stay, other than a shelter OR help you return to where you were staying previously."

Step 2: Active Listening

Allow the person to tell their story about their housing crisis

Step 3: Strengths Exploration

Over the past 6 months, what have you been able to do to avoid seeking emergency shelter?	Identify when you have been a support to others?	What were things like for you when things were going better?	Who are your friends, allies, and family members?

Step 4: Moving Forward

It's their choice!

Help pick the best option:

Going back to live with friends and family	Returning to their own residence	Temporarily diverted as they seek new housing	Relocating to a safe, permanent place out of town	Shelter Waitlist

Consider?

- Is this option:
  - Safe?
  - Appropriate for the client?
- If not, use reality testing

Reality Testing

- "How would this look?"
- "What is the timeline?"
- "Have you done something like this before?"
- "What other options have you considered?"
- "What resources do you have to carry this out?"
- "In case this does not work out as well as you would like, would you like to explore a back-up plan?"

Step 5: Getting Help

- Help the client call family and friends
- Make referrals to other resources
- If they cannot be diverted, place household on shelter waitlist

Step 6: Complete the paperwork

Fill out what you can; you may have already obtained much of the required information by active listening.

- ☐ LSNDC Release of Information
- ☐ Coordinated Entry Assessment (Preferably directly into HMIS)
- ☐ Place Value Assessment – ONLY if the client is literally homeless (outdoors, in a car, uninhabitable location)
  - have been staying outside/uninhabitable location and will return to staying outside
  - Check HMIS to see if they have an existing Assessment. Only do a new one if major life changes have occurred.

Northlake Homeless Coalition
Targeted Prevention Eligibility Screening

Head of Household Name:		**Date:**	

Homelessness Prevention Minimum Eligibility

Household must meet both of the following criteria:

- ☐ At imminent risk of homelessness:
  - ✓ Losing primary nighttime residence within 14 days
  - ✓ No subsequent residence identified
  - ✓ Lacks resources /support networks need to obtain other housing
- ☐ At or below 30% AMI

A. Household Income (Check ONE that applies to the household.)

☐ No Income……10 points ☐ Income at or below 15% AMI……5 points	SCORE (0-10):

B. Re-Housing Challenge Factors (Check all that apply to any adult household member.)

☐ Eviction history……3 points ☐ Felony likely to impact housing (drug, sex crime, arson, etc.)……3 points ☐ Two or more residences in past twelve months……3 points ☐ Five or more people in family……3 points ☐ Lack of available childcare for children……3 points ☐ Limited English proficiency……3 points	SCORE (0-18):

C. High Risk of Homelessness Factors (Check all that apply to any adult household member.)

☐ Experienced homelessness[1] in past 3 years……15 points ☐ Severe or life-threatening health condition……10 points ☐ Housing crisis caused by race, gender identity or sexual orientation discrimination……10 points ☐ Disabling[2] condition or conditions……5 points ☐ Experienced domestic violence[3] ……5 points ☐ Temporarily staying with friends or family……5 points ☐ Exited a system of care or institution within past 90 days……5 points	SCORE (0-55):

D. Eligibility Determination

☐ Level I: 40 + points (up to 6 months assistance) ☐ Level II: 20 – 39 points (up to 3 months assistance)	**TOTAL SCORE** (0-83):

Staff Signature		Date	

Override Approval I approve override for this household. **Attach justification.**

Supervisor Signature		Date	

[1] Unsheltered or resided in emergency shelter

[2] Disability includes: a physical, developmental, mental, or emotional impairment, including impairment caused by alcohol or drug abuse, post-traumatic stress disorder, or brain injury. A person with HIV or AIDS is considered disabled.

[3] People fleeing or attempting to flee domestic violence are unsheltered homeless and are not required to complete the Targeted Prevention Screening.

PLACE VALUE SCORE GROUP		PLACE SCORE CRITERIA	PLACE SCORE	
TEN THOUSANDS *HOUSEHOLD TYPE* *Use open-ended questions to identify the Place Score Criteria that most closely represents the applicant's family situation, and enter one Household Type Place Score.* *Data protocols for applicants fleeing unsafe situations differ by community.*	Adults only	Single adult head of household	10000	
		Household with more than one adult	20000	
	Adults with children	Household with adults and children	30000	
		Household with pregnant adult or children under age 5	40000	
	Youth individuals and families	Individual age 18-24	50000	
		Unaccompanied minor individual age 17 or younger	60000	
		Family with youth parent **or** pregnant youth age 24 or younger	70000	
	Unsafe situations	Single fleeing partner violence, trafficking or unsafe situation	80000	
		Family fleeing partner violence, trafficking or unsafe situation	90000	
THOUSANDS *LIVING SITUATION* *Ask the applicant about their typical nighttime residence, or where they will spend the night if they do not connect with shelter or housing. Select the most appropriate Living Situation, and enter one Living Situation Place Score.*	Immanent risk of homelessness	Own home, including rental and family housing	1000	
		Hotel or temporary rental requiring ongoing payment	2000	
		Doubled up / couch surfing	3000	
	Engaged with multiple systems	Medical or behavioral health inpatient care	4000	
		Prison / jail	5000	
	Experiencing literal homelessness	Transitional housing	6000	
		Emergency shelter	7000	
		Voucher hotel room / non congregate shelter	8000	
		Outdoors, car, vacant building, or other unsheltered location	9000	
HUNDRENDS *HEALTH SCALE* *Say, "Please rate your household's overall physical and mental health on a scale of 1-9, 1 meaning 'no health problems' and 9 meaning 'emergency situation.' You can also use this scale to rank the severity of your household's substance use, if you think it's impacting health." Read back the description for the client's number, adjust health rating as needed, and enter one Health Scale Place Score.*		In good health	000	
		Has a temporary, minor health issue	100	
		Has an ongoing health issue that is well managed	200	
		Has an untreated condition, but not in pain / having symptoms	300	
		Experiencing minor pain or symptoms	400	
		Experiencing moderate pain or symptoms	500	
		Experiencing pain or symptoms from 2 or more health conditions	600	
		Experiencing severe pain or symptoms from one or more health conditions	700	
		In a mental or physical health emergency, or recovering from acute episode	800	
		High risk for COVID-19 Complications (Age > 50 & Underlying Conditions)	900	
TENS *LENGTH OF TIME HOMELESS* *Ask the applicant for the total length of time they have experienced homelessness. Enter one Length of Time Place Score.*		No history of homelessness	10	
		Up to 12 months of homelessness	20	
		More than 1 year but under 2 years	30	
		More than 2 years but under 3 years	40	
		More than 3 years but under 4 years	50	
		More than 4 years but under 5 years	60	
		More than 5 years but under 6 years	70	
		More than 6 years but under 7 years	80	
		7 or more years of homelessness	90	
ONES *RISK AND BARRIERS* *Say, "Our providers recognize known risk factors for homelessness and barriers to housing. Do any of the following situations apply to your household?" Read risk and barrier list.* *Score 1 per affirmed Risk and Barrier, and enter the sum as Place Score, i.e 3 barriers = 0.3.*		No household income		
		History with evictions		
		English as a second language		
		History with housing discrimination based on race or ethnicity		
		History with foster care		
		Bad credit / excessive debt		
		History with incarceration / criminal record		
		2 or more emergency room visits or inpatient stays within last 12 months		
		Household size of 6 or more people		
		Unwilling to work with Coordinated Entry System		
		Add all 5 Place Scores to calculate PLACE VALUE SUM *Do not add **TEN Thousands Place Score** for applicants at Imminent Risk for Homelessness.*		

Easy Place Value Assessment Method With Case Note

1. Print several copies of Place Value scoring tool. A paper copy for each client is not necessary, but might help at first. As case managers become familiar with the process, the paper document is only necessary to support scoring, but does not need to be filled out.

2. Using the scoring tool or any piece of scrap paper, record the Ten Thousands Place Score as a single digit.

Example: "2" for a household with more than one adult.

3. Next, record the Thousands Place Score to the right of the Ten Thousands Place Score, as a single digit.

Example continued: "27"for a household with more than one adult staying in Emergency Shelter

4. Continue to build the score by recording single digits for each Place Value Score Group.

5. For the Ones Score Group, Barriers, read the list of barriers to the client and keep count. Nine is the upper limit for total number of barriers. It is unlikely that a client will affirm all ten barriers.

6. Record the final, 5 digit Place Value Sum in ServicePoint.

7. Record a case note that summarizes the score, with the date.

Example:
Place Value Sum: 27943
Case Note: 9/21/20 Two adults, staying in shelter, considered to be at high risk for COVID19 due to age and heart conditions, homeless for just over two years, with 3 barriers (no income, history with incarceration and bad credit)

8. If a client or household's situation changes, change the score and add a new case note, with a date, explaining the change. Leave the previous case note for reference

Example:
New Place Value Sum: 17943

Updated Case Note:

9/28/2020 One member of the household found housing, therefore only one adult needs housing and the Place Value Sum has been updated.

Two adults, staying in shelter, considered to be at high risk for COVID19 due to age and heart conditions, homeless for just over two years, with 3 barriers (no income, history with incarceration and bad credit)