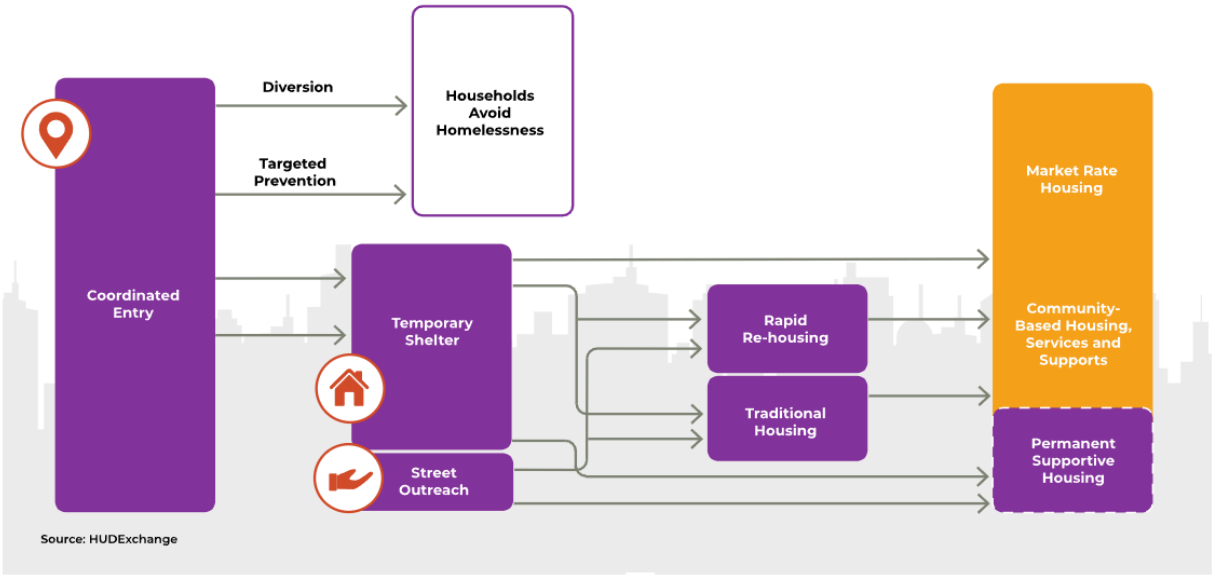
TX-625 Lubbock County & City CoC
Coordinated Entry Data Entry Manual



There are four distinct components to an effective referral process:

Referrals to Coordinated Entry from any agency using the ECHO Database

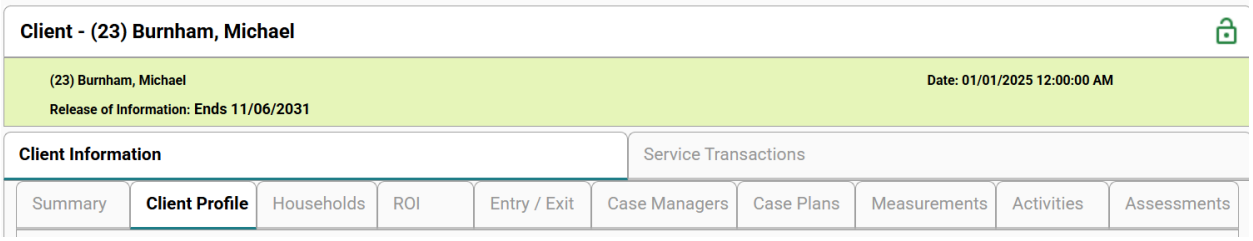
All referrals for housing should be made to the **West TX CoC - Coordinated Entry** project in the ECHO Database/HMIS. To send a referral within the system, a valid ROI must be on file within the database and/or the ROI must be validated in the database by the entering agency. If a client declines an ROI, please contact the ECHO West Texas Coordinated Entry Team. A referral made through the Database cannot be made for any service, including Coordinated Entry, without a valid ROI uploaded to the database and validated by the referring agency. Refer to the Database Manual for more ROI & Client Privacy/Rights guidance.

Prior to referral or enrollment in Coordinated entry, **Diversion** attempts should be made to avoid a person entering homelessness or to provide assistance in allowing someone to quickly obtain shelter. Questions such as, “Do you have any family or friends you can stay with?” are critical at the first stages of engagement. Diversion also includes rapid assistance such as rental assistance and other creative solutions to get an individual or family to a housed state. **Prevention** measures should be taken in the event someone is currently housed but is still facing a housing crisis. This includes more creative solutions to keep an individual or family in stable housing such as rental arrear assistance, utility assistance, job services, etc.

In the event such rapid response measures fail to help someone achieve or retain stable housing, they should be referred to, and enrolled in, the Coordinated Entry project within the ECHO Database. This is a shared project which allows CE Access Points to operate with the same

IMPORTANT: Referrals to emergency shelter and any other emergency needs, such as domestic violence shelter, food, water, etc., should be made directly to those providers and should be made before, or in addition to, a referral to the Coordinated Entry Project

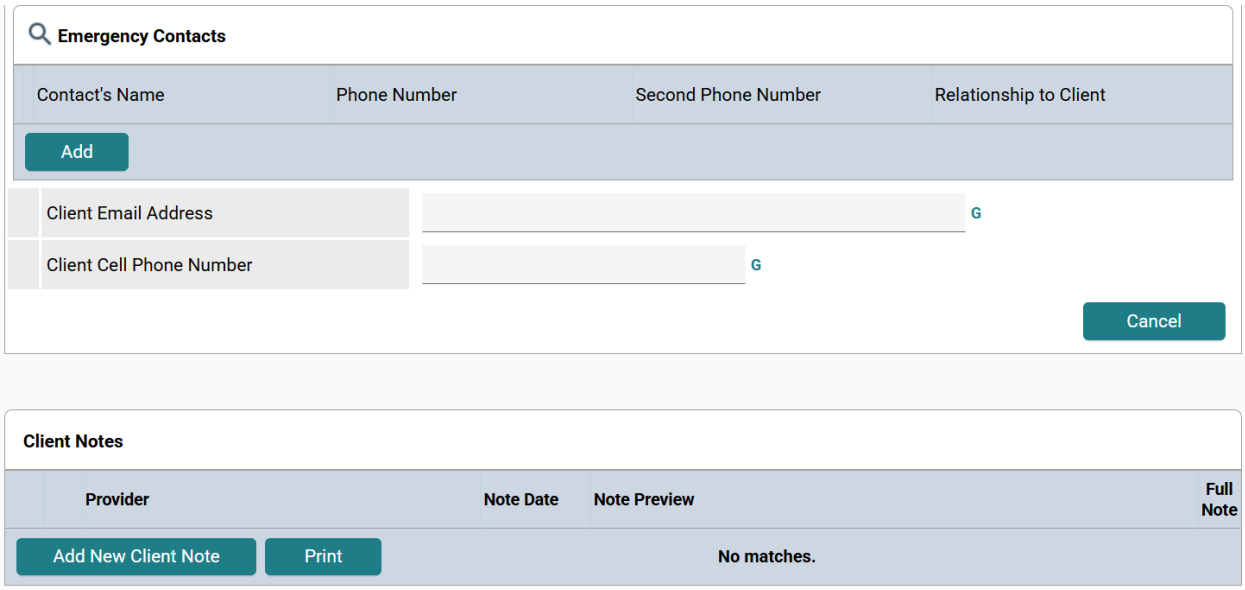
1. Access the client record
    a. If client does not exist, create a new client



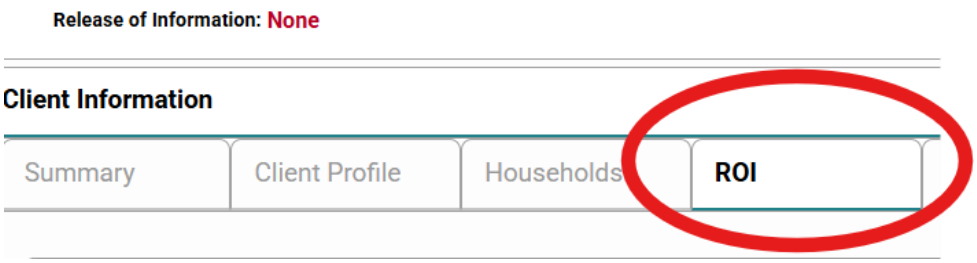
2. Fill out as much information as possible on the client profile tab
    a. Ensure there is contact information
        i. **If client does no t have phone or emai**l, please make note (in the “*client notes*” section of the client profile tab, **not case notes** as case notes are

not shared) of where outreach can find client when housing or other assistance is available to them

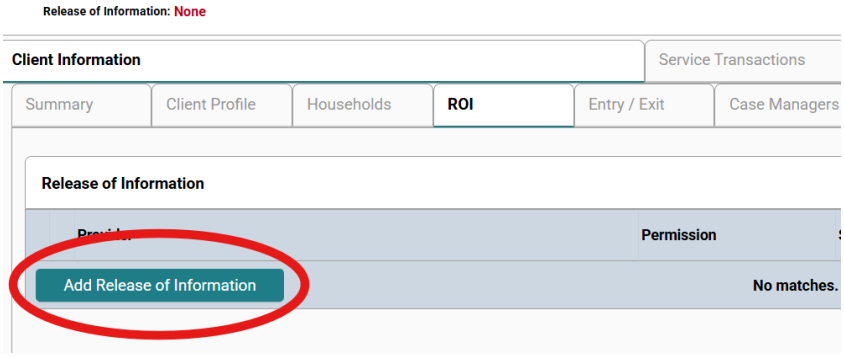
ii. **Note:** case notes and incidents are not shared across the platform regardless of the ROI status



3. Click the ROI tab



   a. **Note:** an ROI is required to make referrals within the system. If a client does **not want to fill out an ROI**, they should be instructed to call or go to a physical Coordinated Entry access point. A refusal to sign an ROI cannot bar anyone from receiving services. It is only needed to share information with other agencies through the database.
   b. If there is no ROI in the record
      i. Offer the client the option to sign an ROI (provided by ECHO on the ECHO website). Explain the reasons for the ROI and that the ROI enables referrals to be made through the database
      ii. Click the “add release of information” button

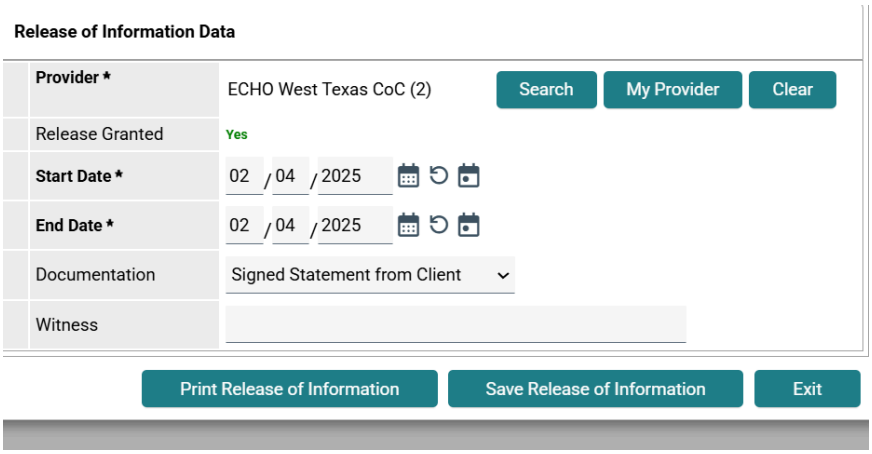


iii. Select the members of the household the release covers

iv. Fill out the rest of the form

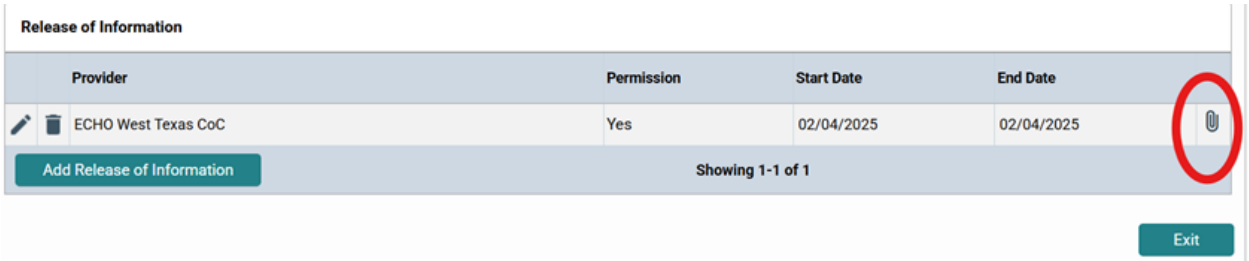
1. Release of Information is good for 7 years, calculate the end date with this in mind
2. No need to fill out the 'witness' portion as this should be documented on the physical ROI

v. Click "save release of information"



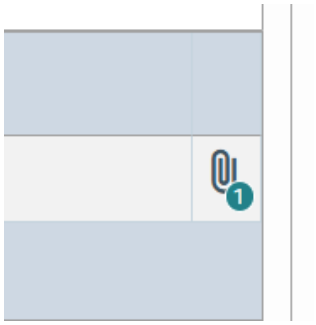
vi. **Required:** Add a scan of the physical ROI to the client's ROI record

1. Scan the physical, signed ROI and save on computer
2. Click the paper clip icon next to the release of information record just created

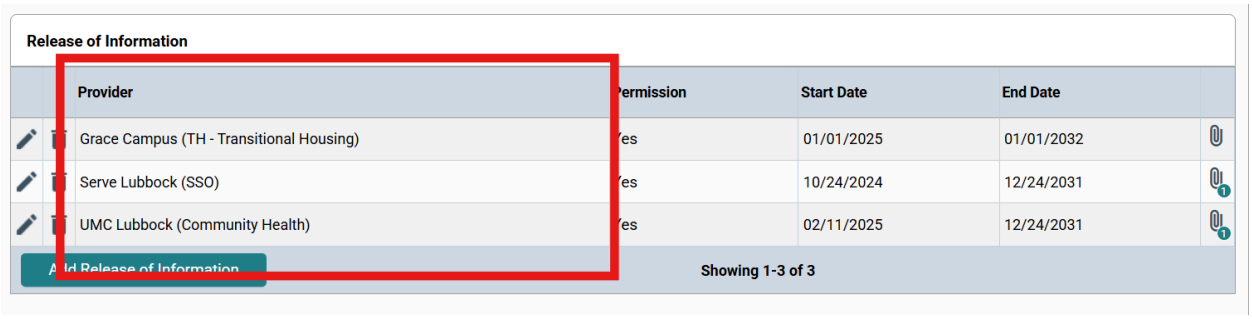


3. In the pop-up, click the "add new file attachment" button
4. Upload the scanned document
    a. Click the "choose file" button
    b. Find the scanned file, double click the file name

5. In the description, type whether the release was granted and the end date of the ROI
6. Click the “upload” button
7. Click the “exit” button in the pop-up
8. If done properly, there should be a 1 under the paper clip

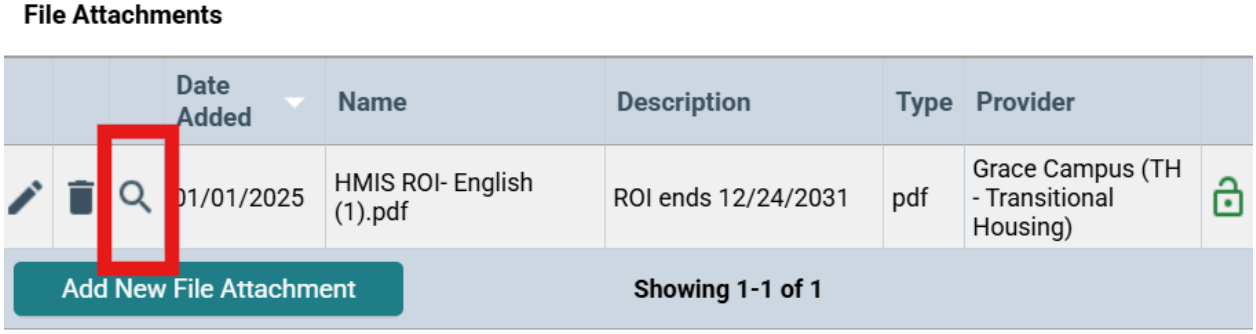


c. If there is an existing ROI record
   i. Check to see if your Provider is listed under the Provider section of the ROI record set



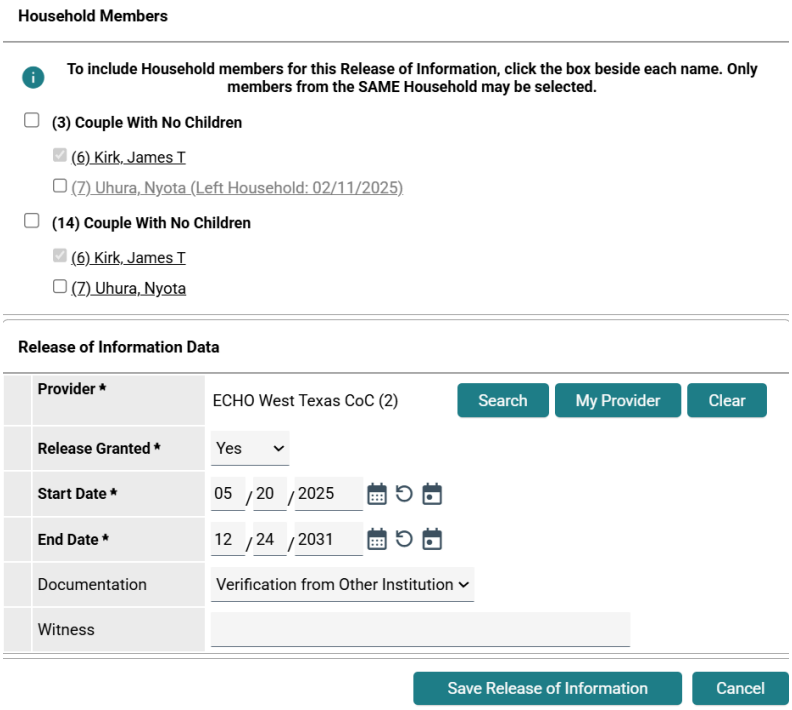
1. If your provider is listed and the ROI is still valid, no further action is needed, continue to the next item
2. If your provider is not listed, click the paperclip that has a 1 under it

   ii. Verify the ROI on file
      1. Click the magnifying glass

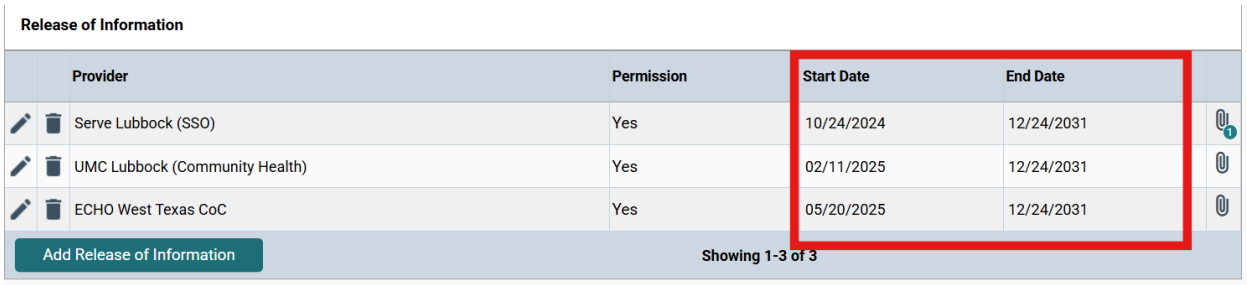


2. Download and verify the existing ROI by checking that it was signed by the client and checking the date signed

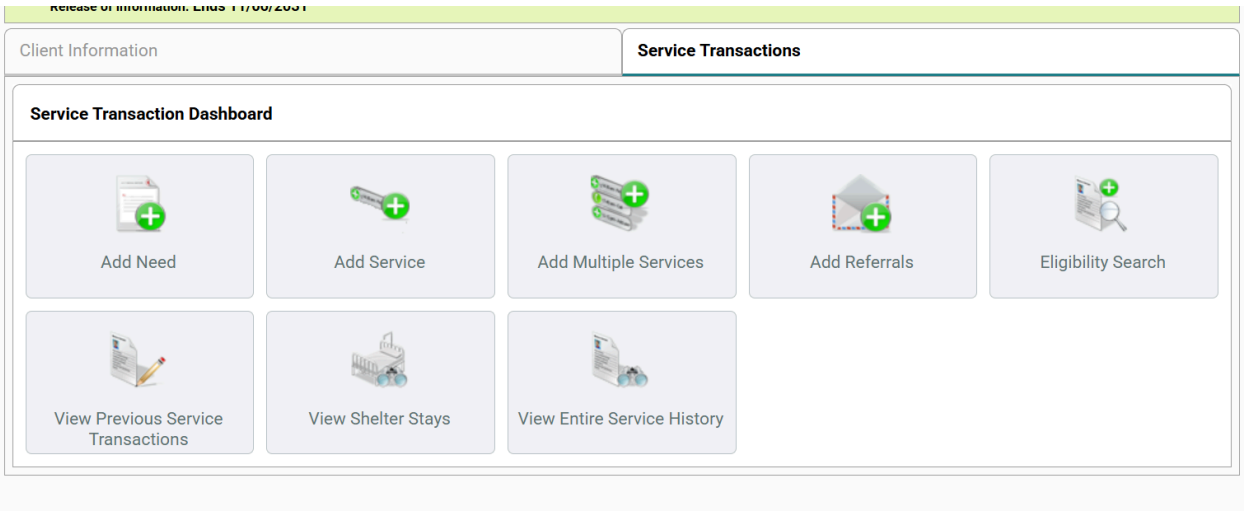
3. Make note of the date signed & the family members covered, then exit the pop up
4. Click the “add release of information” button
5. Fill out the pop-up
    a. making sure to select the members of the household the ROI covers
    b. Enter the date the physical ROI expires, 7 years from the date signed
    c. Select ‘verification from another institution’ from the documentation drop down
    d. Click ‘save release of information’ button



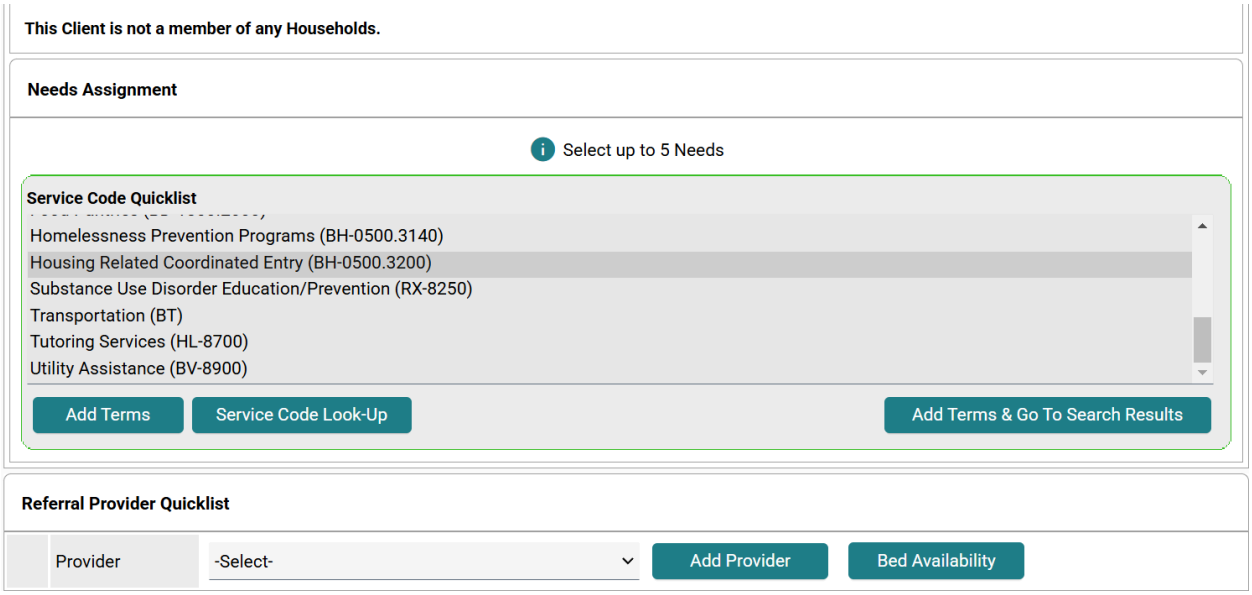
iii. The record set should share the same end date and look similarly to the below snippet



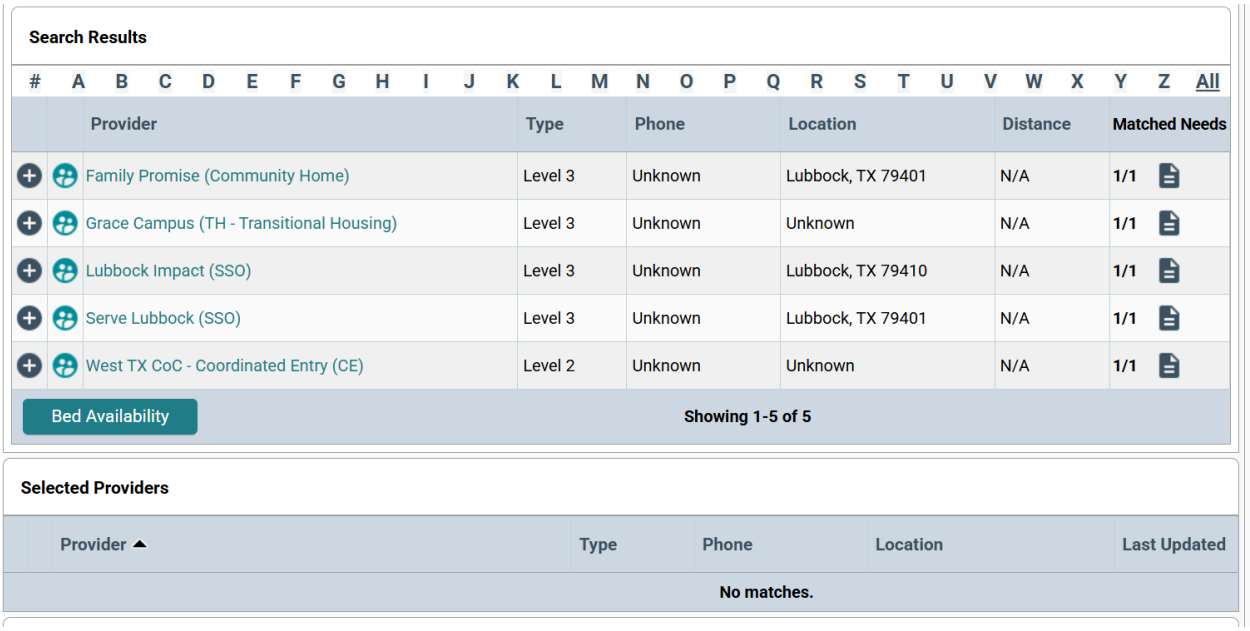
4. Click the “service transactions” tab next to the “client information tab”



5. Click the “Add Referral” or “Eligibility Search”
    a. **If using “add referral”**
        i. Select “Housing related coordinated entry” service code
        ii. Click add terms



        iii. Click the plus sign to the left of the “west TX CoC - Coordinated Entry (CE)” provider
            1. To remove a provider after clicking the plus sign, scroll down and click the red minus sign to remove them from your selected providers

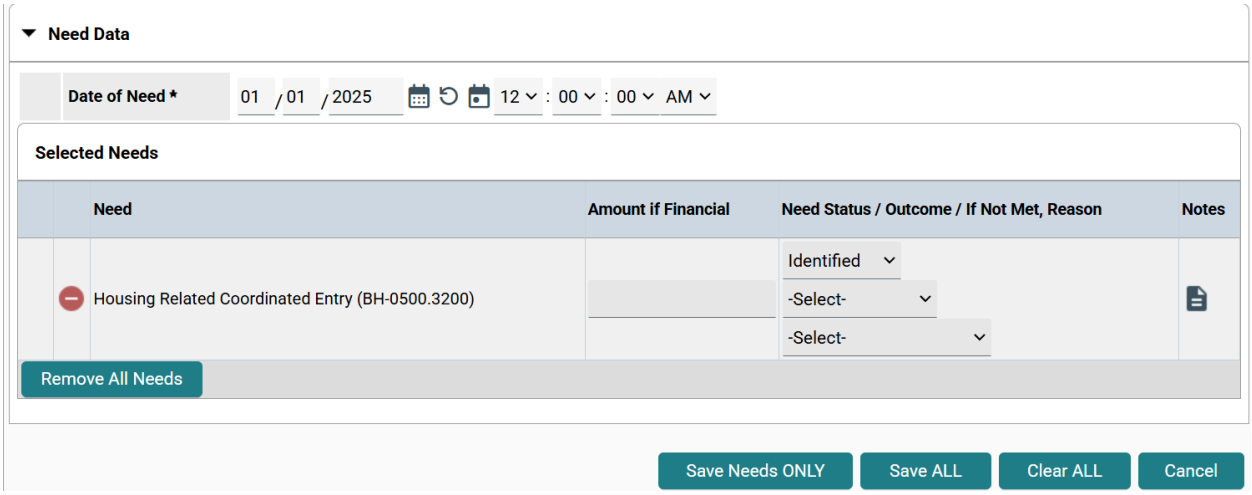


iv. Set Follow Up date as needed for your reference

v. Check the box for “check to notify community services providers by email”

1. This will send an email to those involved in Coordinated Entry that they have a new referral

vi. After verifying accurate information for the referral, click the “save all” button on the bottom right of the page (scroll all the way down the page)

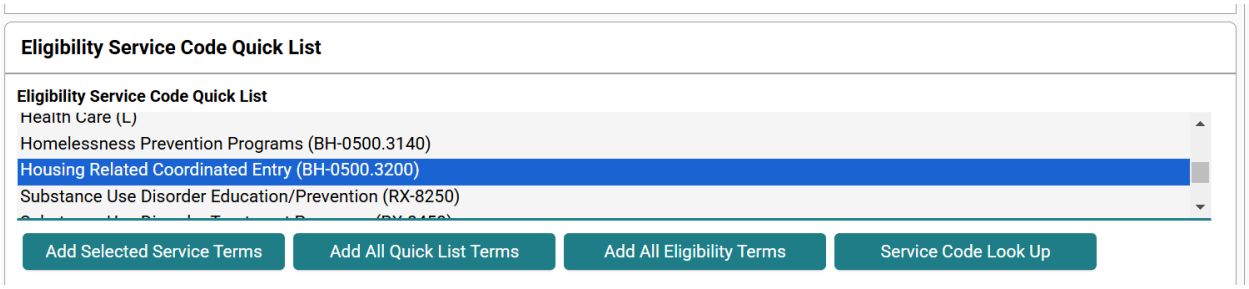


b. If using "eligibility search"

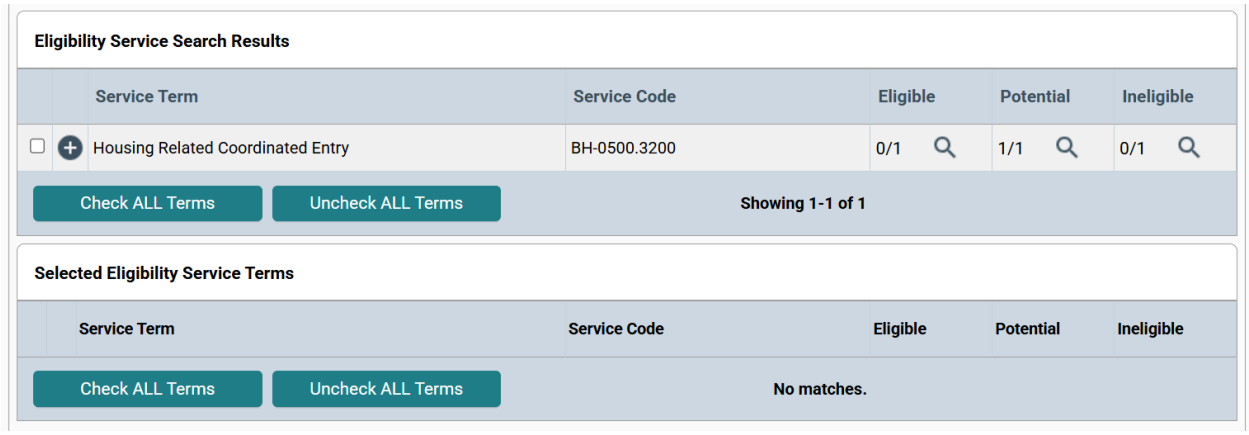
i. Select the "housing related coordinated entry" service code

1. Select any other service codes to match client with other services
2. **Note:** selecting any housing code other than emergency shelter or domestic violence shelter should result in only the West TX CoC CE project result for housing

ii. Click add selected service terms

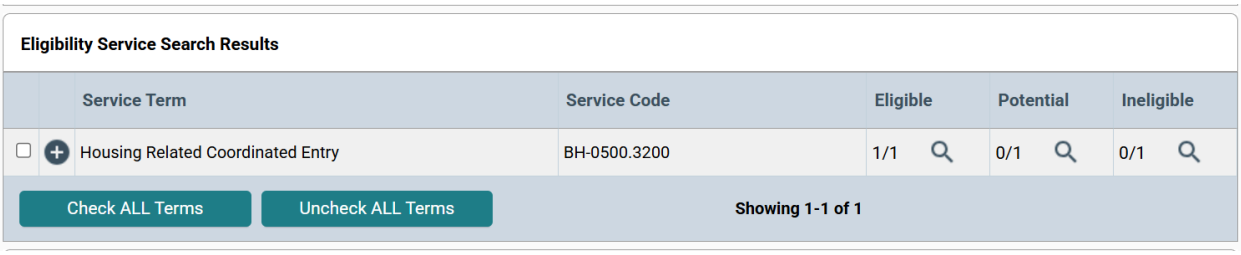


iii. Under the "eligibility service search results" find the "housing related coordinated entry" result



iv. To the right of the result, check the eligible, potential, and ineligible columns

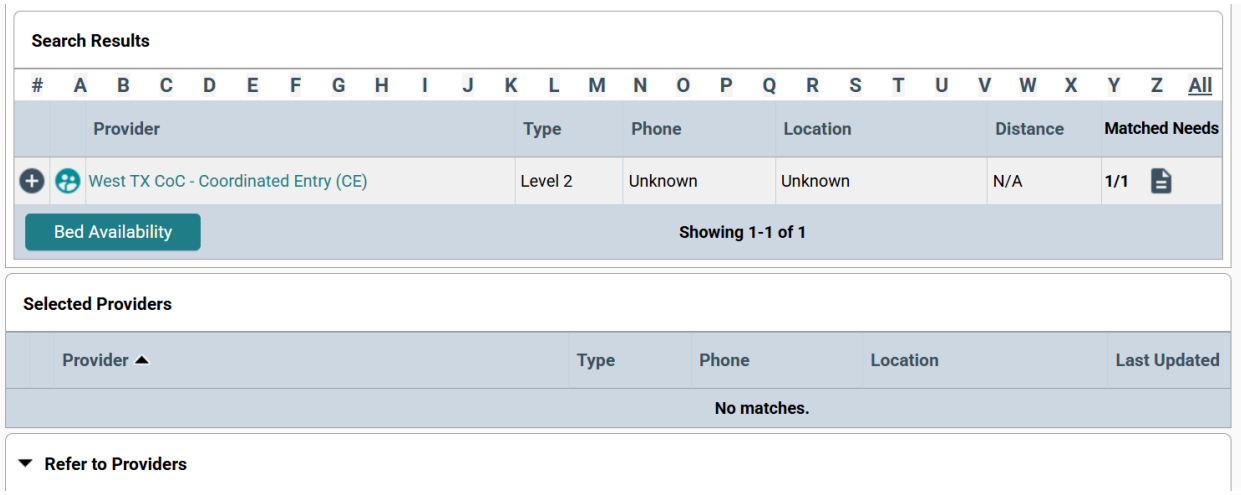
1. If eligible says 1/1, click the plus next to “Housing related coordinated entry”
2. If potential says 1/1, click the magnifying glass next to the potential 1/1
    a. In the new window, click “answer additional questions for checked providers”
    b. Have the client answer the questions to the best of their ability, they do not have to answer all of them if they do not wish to
    c. Click “save and exit”
    d. The 1/1 should move to the eligible column



    e. Click the plus next to the “Housing Related Coordinated Entry” service
3. **Note:** if the ineligible column says 1/1 for the “housing related coordinated entry” program, use the “add referral” workflow above or contact the ECHO Coordinated Entry Team

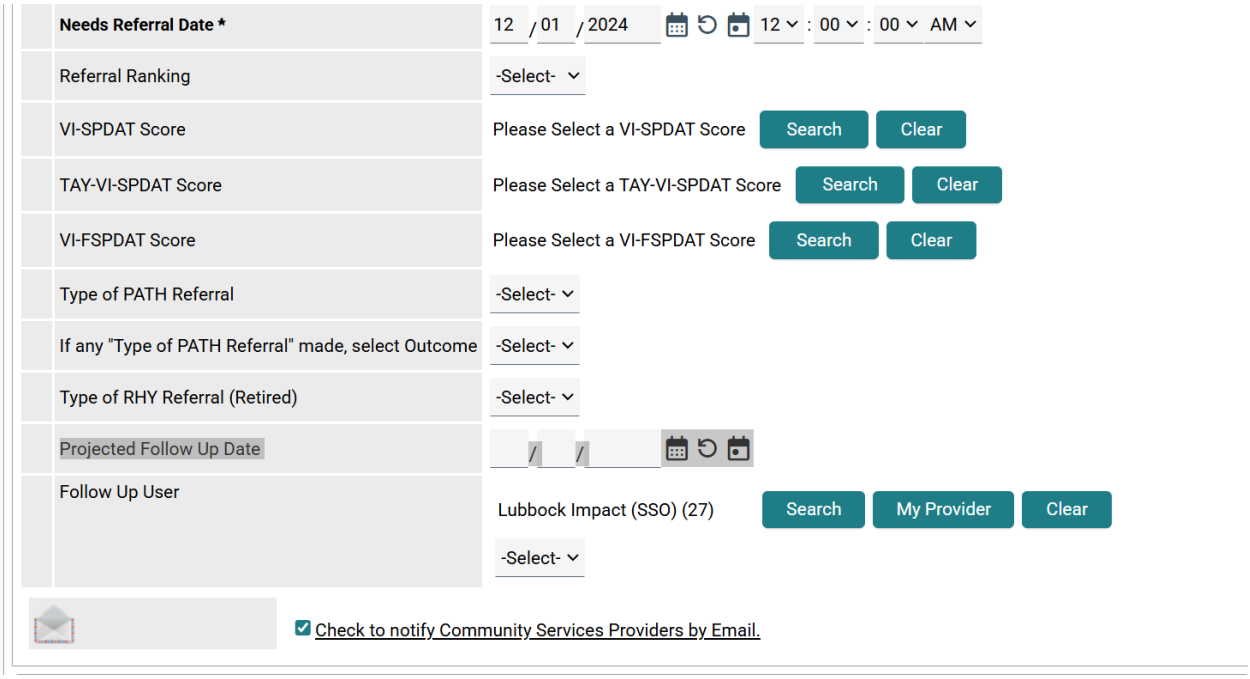
v. Click “continue” at the bottom of the page

vi. Scroll to the “search results” section and click the plus next to the “west TX CoC - Coordinated Entry (CE)” provider



vii. Scroll down and enter a follow up date as desired for the referring agency, not required

viii. Check the “check to notify community service providers by email” box

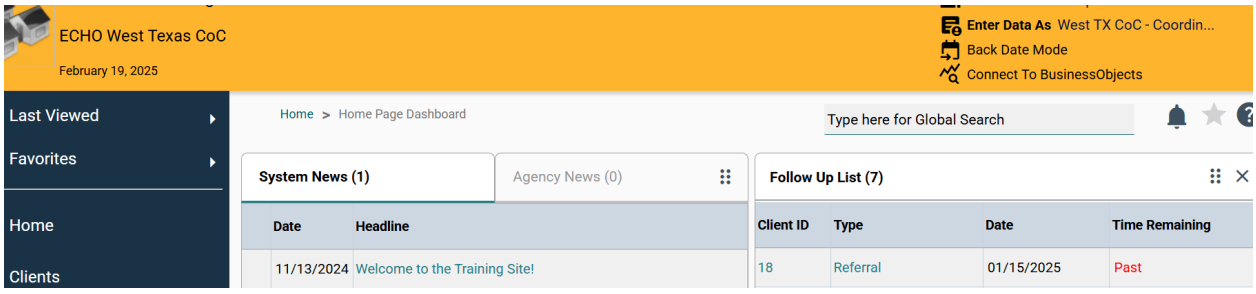


ix. Verify all the information for the referral, then click “save all” at the bottom of the page

Receiving Referrals to Coordinated Entry From Other Agencies

Only those with approved access to the Coordinated Entry Project within HMIS will have the ability to resolve referrals made to CE from other agencies.

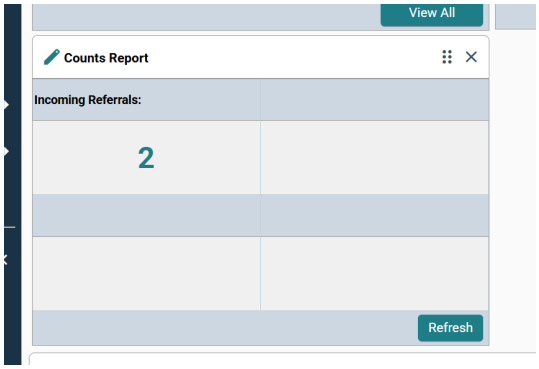
1. Change your “enter data as” to the “West TX CoC - Coordinated Entry” Project (top right of the page)



2. Access the Incoming Referrals (using reports or homepage counts report)
    a. **Using the homepage counts report**
        i. On your ECHO Database Homepage, find the counts report
            1. If you do not have the count report on your Homepage dashboard or do not have incoming referrals on the counts report, refer to the

ECHO Database User Guide(s) to add the count report/referrals to your dashboard

ii. Click the number representing the incoming referrals



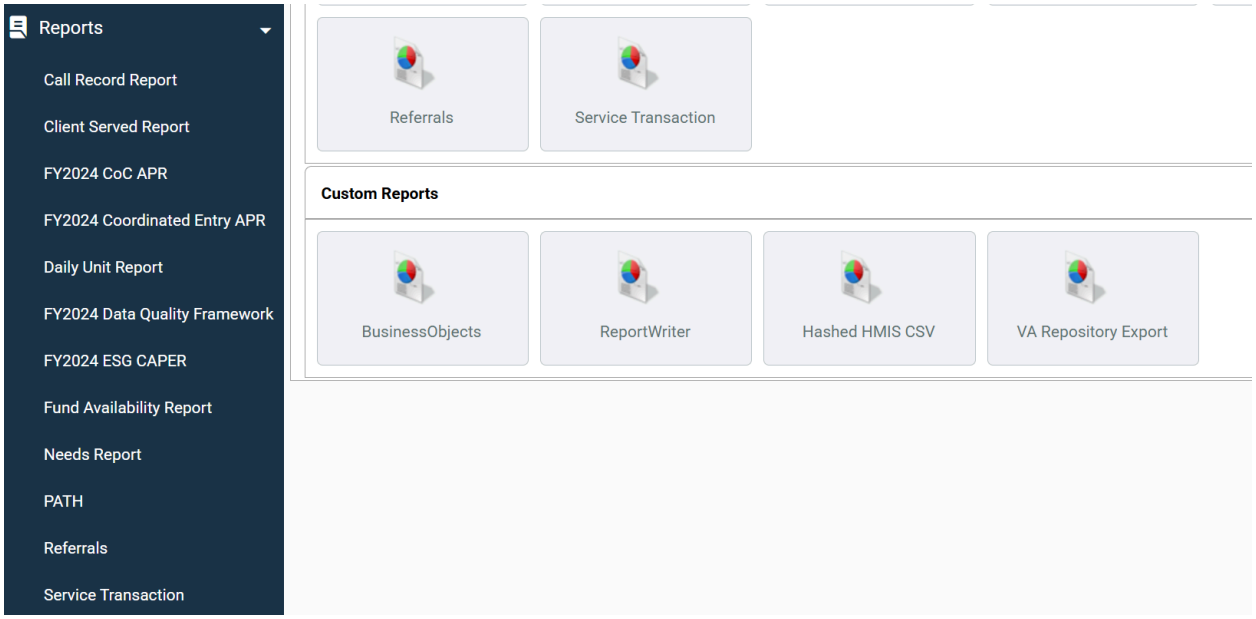
iii. Click the Client ID Number to open the client file

iv. Navigate to the open referral

1. Click the “service transaction tab”; or
2. Click “view entire service history”; or
3. Click the “referrals” tab
4. Here you will see the open referrals for the client
5. Click the pencil icon next the the coordinated entry referral to open the referral

b. Using the reports section

i. Navigate to the reports page and click the “referrals” report



ii. Ensure the provider is “West TX CoC - Coordinated Entry”

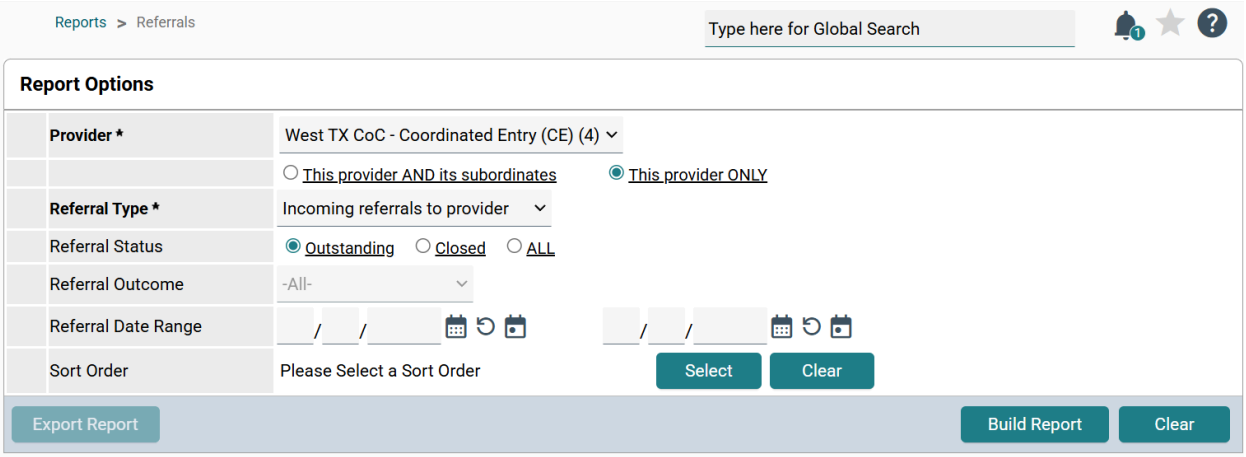
iii. Select “this provider only”

iv. Referral Type, select “Incoming referrals to provider”

v. Referral Status, select “Outstanding”

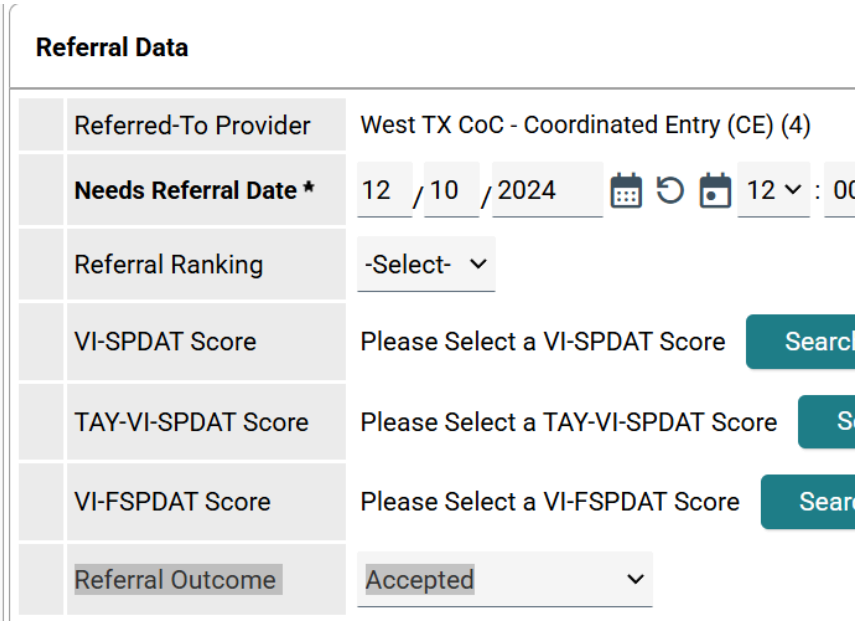
vi. Select Date Range as needed, not required

vii. Click Build Report



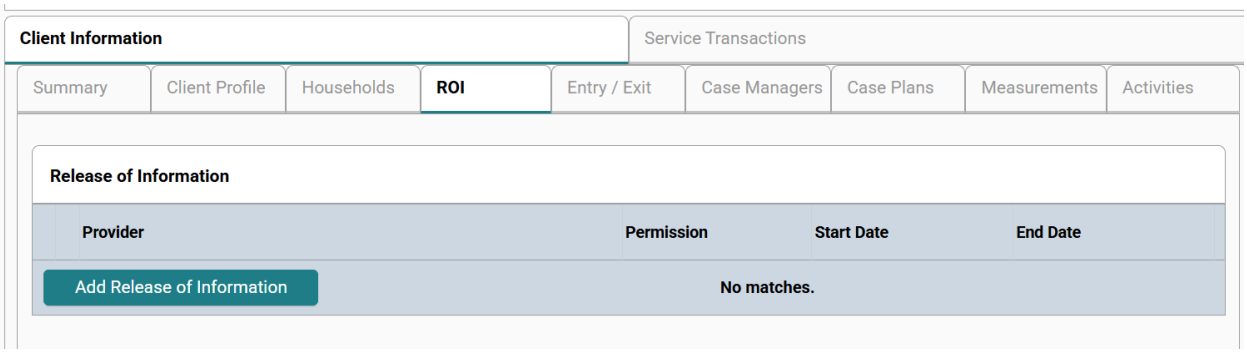
viii. Click the “Need Type” for the client you will begin working with to pull up the referral

3. Set the referral outcome and close the referral
    a. In the “referral data” section, select “accepted” for the referral outcome

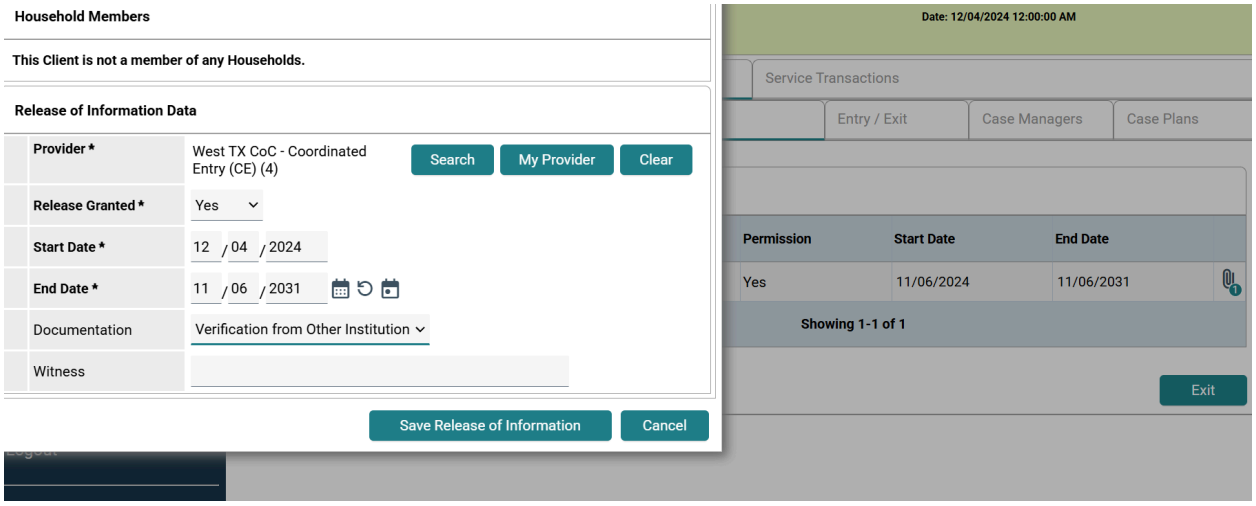


    b. Scroll down to the need status & Outcome section
    c. Need status = closed
    d. Outcome of need = fully met
        i. **Note:** this is to alert the referring agency that the referral has been seen and client has/will be entered into the housing response system, not to indicate the client has been placed in housing.
    e. Click Save & Exit at bottom of page
4. Verify existing ROI

a. **Note:** In order for there to be a referral there would be an existing ROI that needs to be verified by any project, including Coordinated Entry, that accesses the client file
b. Navigate to the “ROI” tab in the “client information section



c. Verify that there is a valid existing ROI on file by downloading the ROI attachment (click the magnifying glass with the 1 under it) and verifying the signatures, dates, and covered family members
d. Click the “add release of information” button
e. In the pop-up:
    i. Release granted = Yes
    ii. End Date = (end date of existing ROI)
        1. ROIs are valid for 7 years after date of signing unless client revokes consent
    iii. Documentation = verification from another institution
f. Click Save Release of Information button

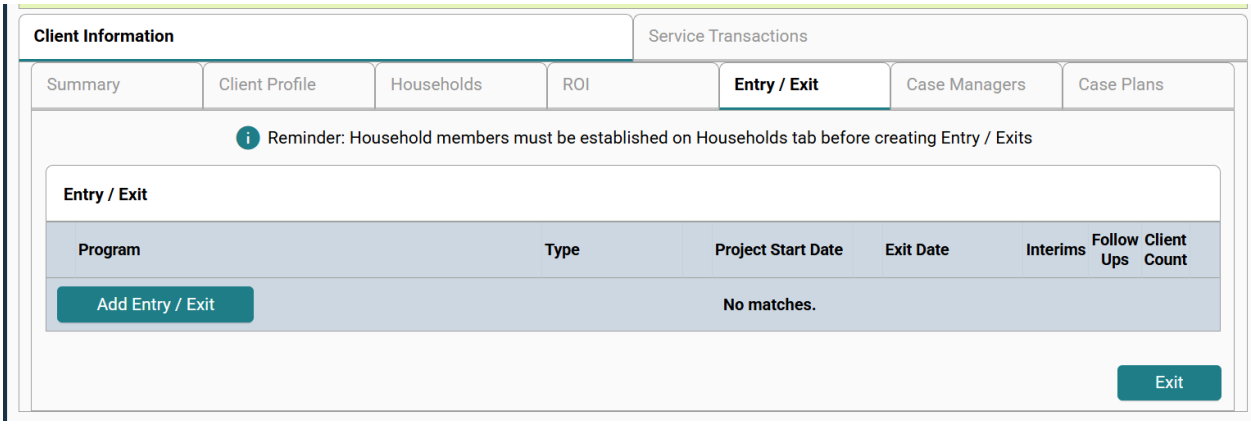


5. Contact client and set up Coordinated Entry Intake
    a. Find the client’s contact information on the client’s profile page
    b. Contact client to set up in person, virtual, or over the phone intake to Coordinated Entry

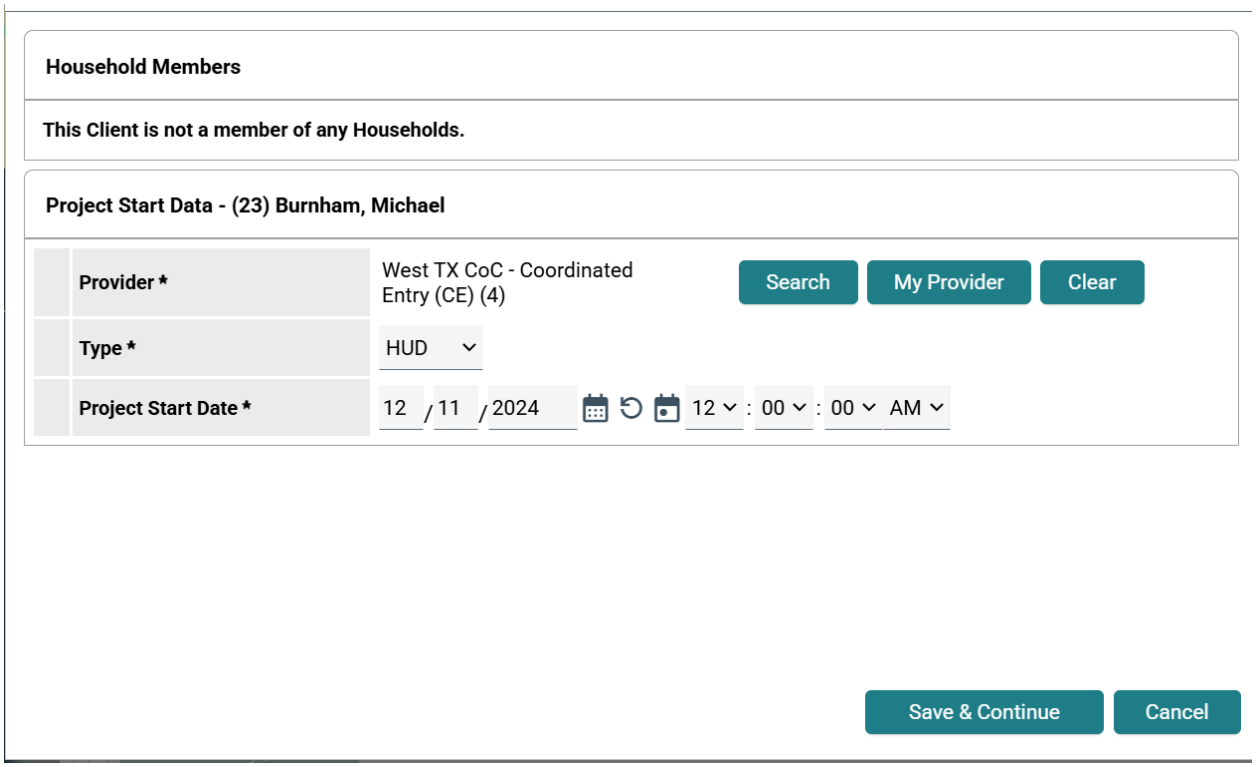
Initial CE Enrollment

After receiving a referral from within the database **or** for walk-in clients:

1. Ensure you are working under the West TX CoC - Coordinated Entry project in “enter data as”
2. Change backdate to reflect the actual date of intake as necessary
3. Access client record
    a. Refer to user guides on accessing existing client or inputting new client
4. Verify Client’s existing ROI or offer client opportunity to sign an ROI for quicker matching to services with internal system referrals (as necessary)
    a. Refer to user guides & policies and procedures for more guidance & requirements on privacy notices and ROIs
    b. Note: if client declines signing an ROI, a review of the privacy notice with the client does allow for their data to be entered and their case to be discussed within Coordinated Entry and the housing response system. An ROI is only required for referrals made within the system and for answers to HUD questions to migrate from initial entry to another provider. **In addition,** if a client declines to have their information input into the database altogether, contact the Coordinated Entry Lead
5. Click the “Entry/Exit” tab in the client file
6. Click Add Entry/Exit button

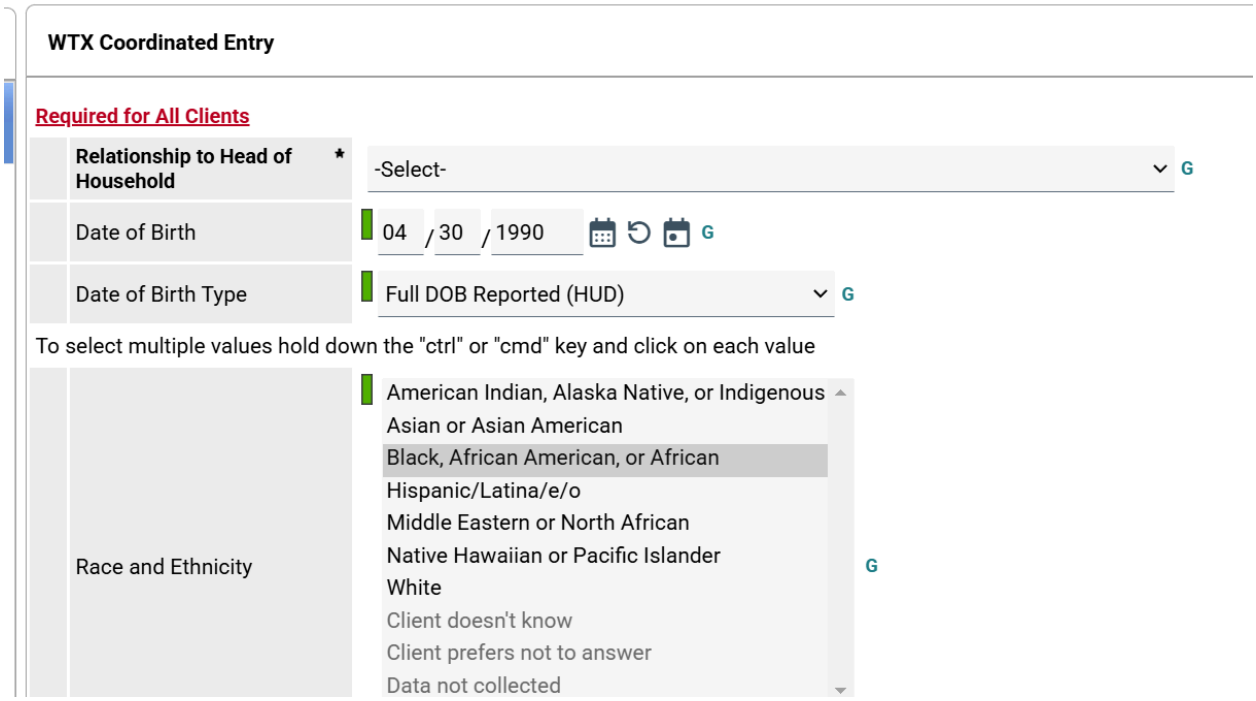


7. In the pop-up window
    a. Select all members of household to be housed through CE as needed for families
    b. Provider = West TX CoC - Coordinated Entry
    c. Type = Hud
    d. Date = [initial date of intake into CE]

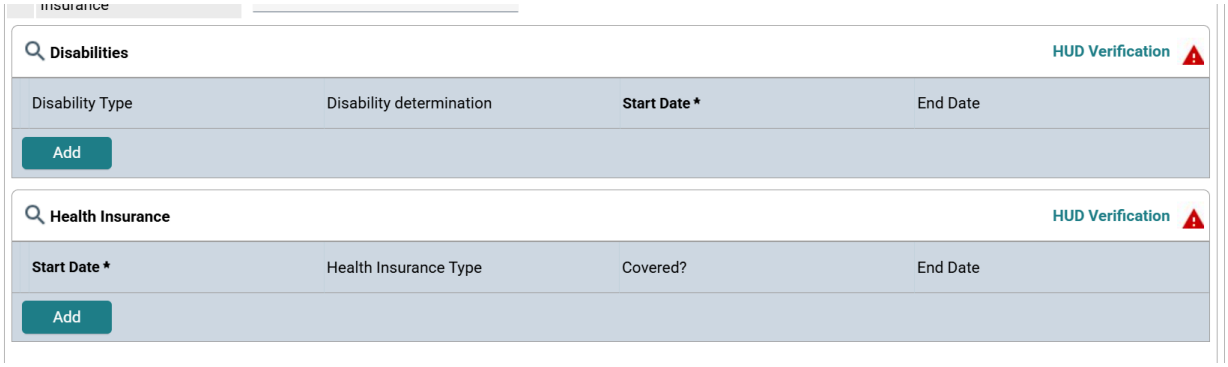


e. Click Save & Continue

8. Ask the various questions to the client(s) to gather/enter required information (**note:** refer to the CoC data quality plan and CE Policies and Procedures for required data capture elements, timeframes, and thresholds)
    a. Section “required for all clients” should be answered for all persons, including minors, entering the CE system



i. To answer sections with a magnifying glass next to the section title, such as Disabilities, click the “Hud Verification” link on the right side of the section banner (may need to scroll to the right)



ii. Select “No (HUD)” radio button to move all answers to No
    1. If the answer is No to all, click the Save & Exit button to save and close responses for that section

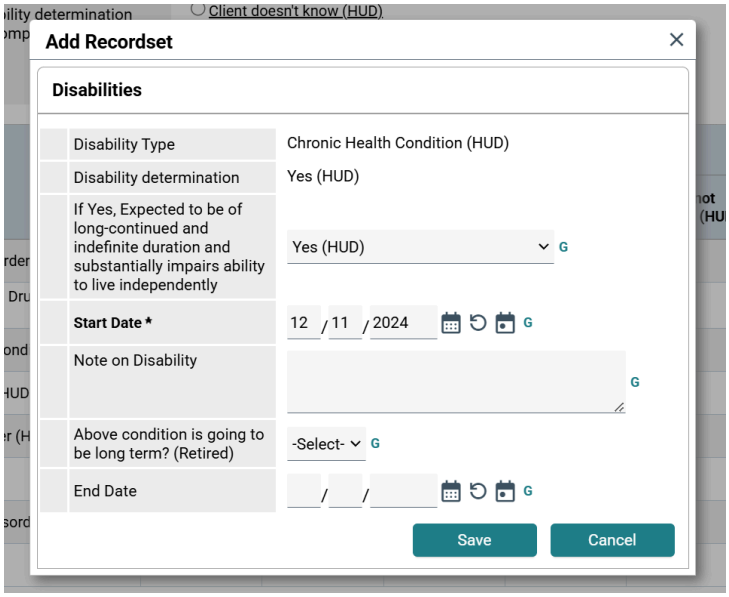
Select the Disability determination value for all incomplete Disability Type records	◉ No (HUD) ○ Client doesn't know (HUD) ○ Client prefers not to answer (HUD) ○ Data not collected (HUD) ○ Incomplete

Disability Type	Disability determination					
	Yes (HUD)	No (HUD)	Client doesn't know (HUD)	Client prefers not to answer (HUD)	Data not collected (HUD)	Incomplete
Alcohol Use Disorder (HUD)	○	◉	○	○	○	○
Both Alcohol and Drug Use Disorder (HUD)	○	◉	○	○	○	○
Chronic Health Condition (HUD)	○	◉	○	○	○	○
Developmental (HUD)	○	◉	○	○	○	○
Drug Use Disorder (HUD)	○	◉	○	○	○	○
HIV/AIDS (HUD)	○	◉	○	○	○	○
Mental Health Disorder (HUD)	○	◉	○	○	○	○
Physical (HUD)	○	◉	○	○	○	○

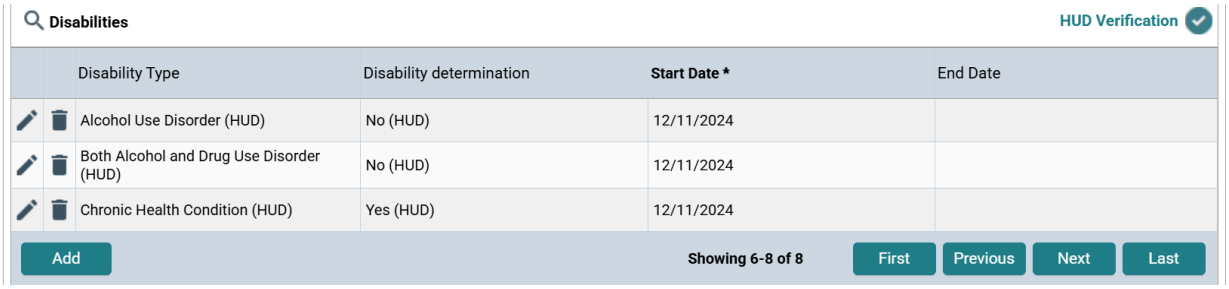
iii. Select the “Yes (HUD)” radio button for any options as appropriate

iv. Fill out the information required in the pop-up window

v. Click Save

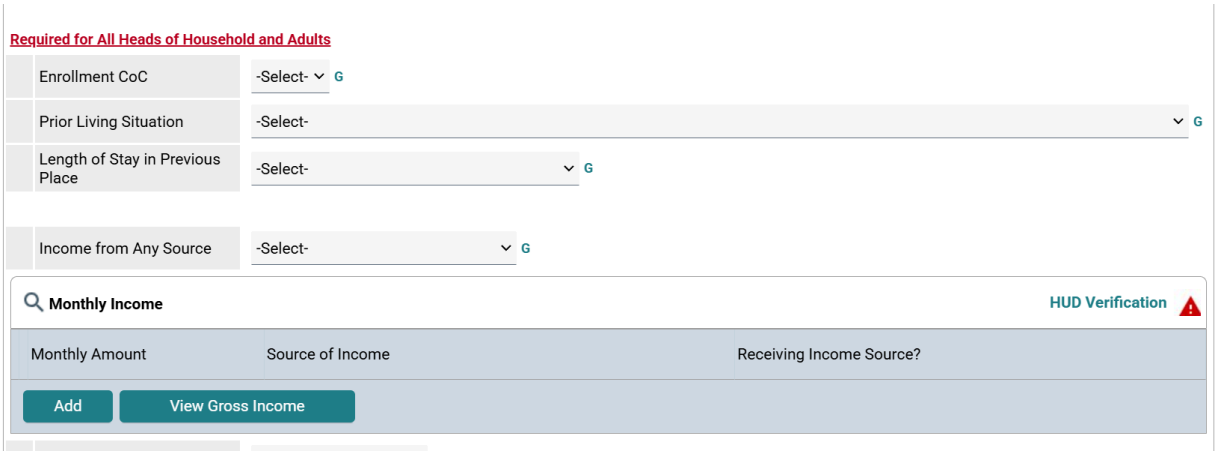


vi. **Note:** answers to these subsections can be accessed by clicking the magnifying glass icon or by using the navigation buttons at the bottom of the section after saving & exiting the verification windows



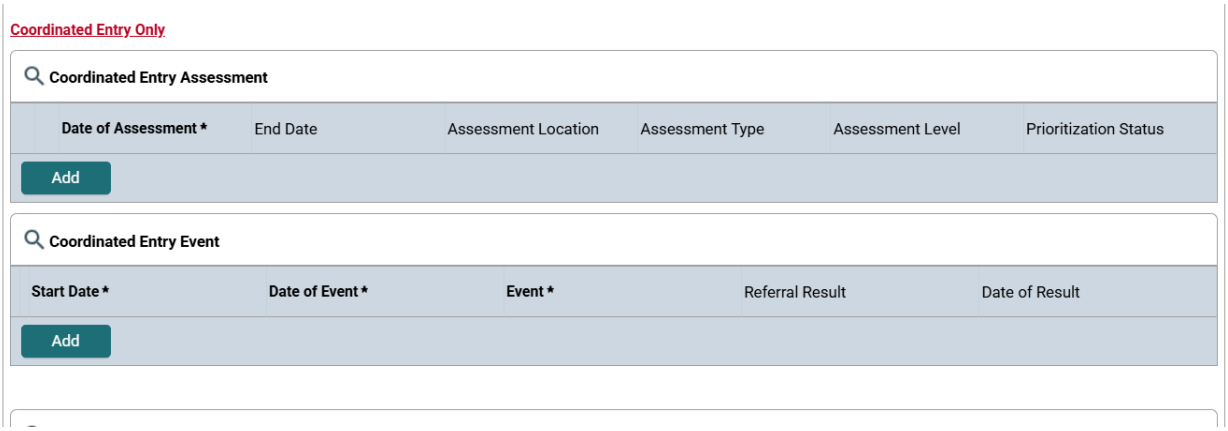
vii. **Note: to update responses, refer to the *Follow Ups section of this document***

b. Section "required for all heads of household and adults" should be answered for **all** adults (18+) in the household, not just head of household



c. **Only for heads of households: Add a coordinated entry event for intake**

i. in the Coordinated Entry Only Section, find the Coordinated Entry Event and click the Add button for that section



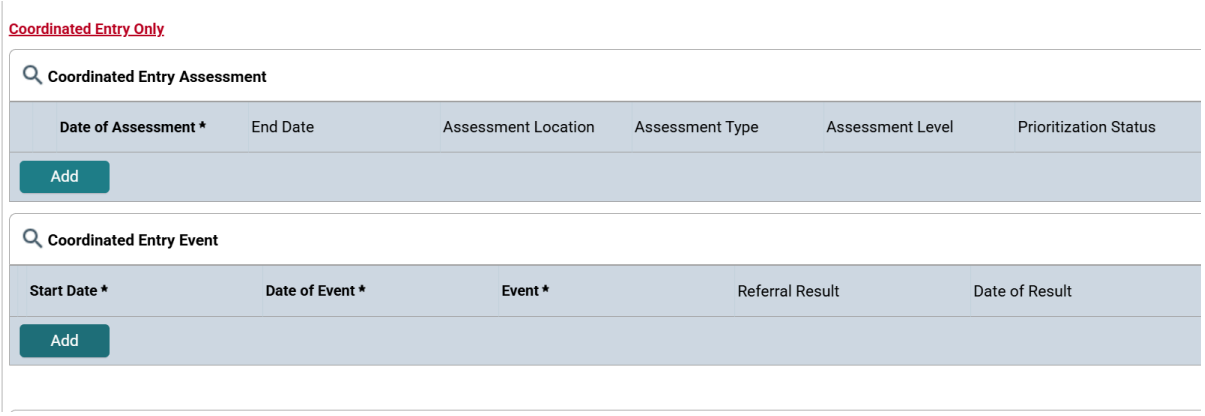
ii. Fill out the information in the pop-up

1. For the Event, select one of the Access Events as appropriate (refer to the CE Lead or applicable policies & procedures for more guidance)

a. **Referral to prevention assistance** for any person who is currently housed who is referred to prevent their homelessness
b. **Problem Solving/Diversion/Rapid Resolution intervention or service** for any person whose housing crisis can be resolved quickly with services outside of the CE Housing system

d. IMPORTANT: if multiple "Events" occur, a separate entry must be made for each to reflect the event(s) that took place during any given contact event with client.

e. ***Note:*** *Refer to the Housing/Crisis Needs Assessment & Update section of this document for information on how to fill out the Coordinated Entry Assessment and SPDAT sections of the Intake form*



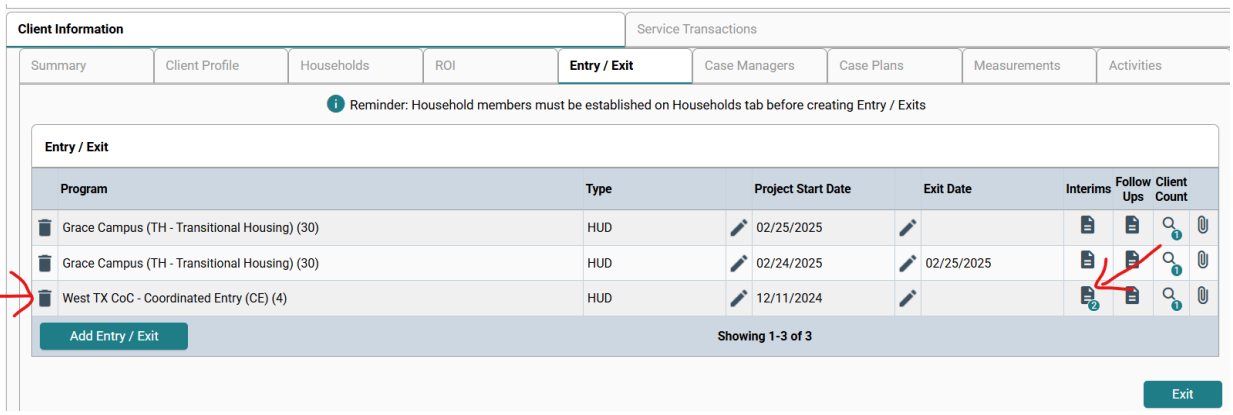
9. To answer questions for multiple members of a household

a. Fill out information for the first client (highlighted in blue to the left of the screen)
b. Scroll to the bottom of the page and click Save (**do not click Save and Exit,** this will exit you from the entry process)
c. Scroll back to the top and select the next client on the left of the page
d. Fill out information as appropriate for adults and minor children/dependants, clicking 'save' at the bottom of each client's information page
e. Remember: click the save button at the bottom of the page for each person before moving on to the next member of the household

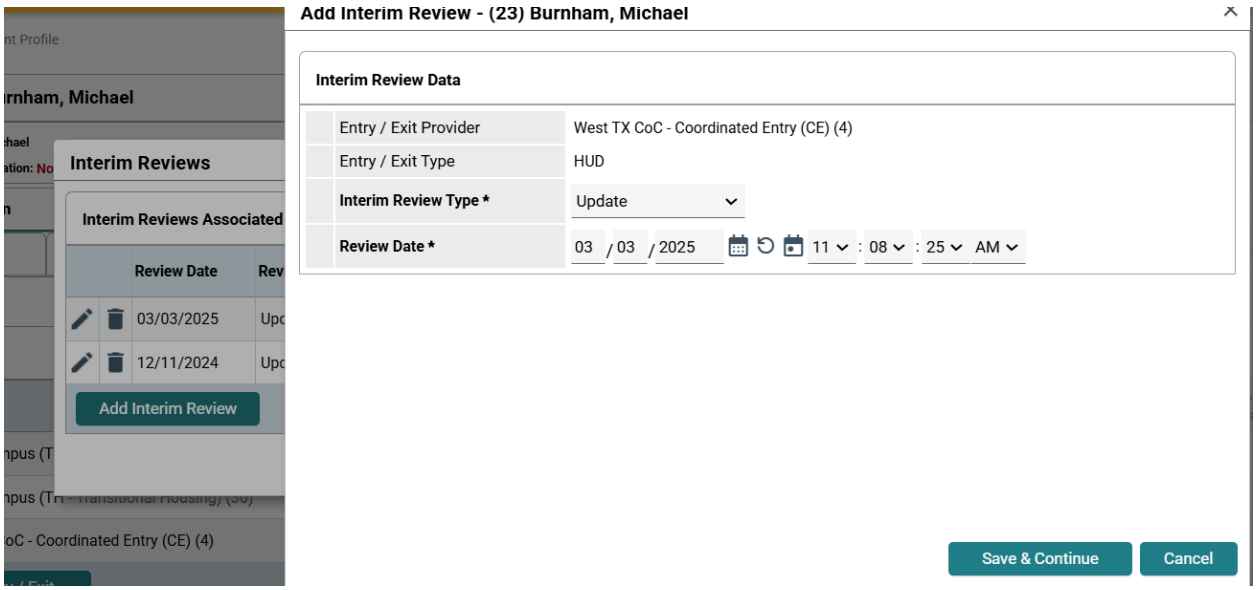
Housing Needs Assessment

This section applies only to those persons who have been trained and verified to assess client(s) for housing and other crisis needs. **Note:** only complete an assessment after CE Enrollment is completed. An assessment cannot be completed without a CE enrollment.

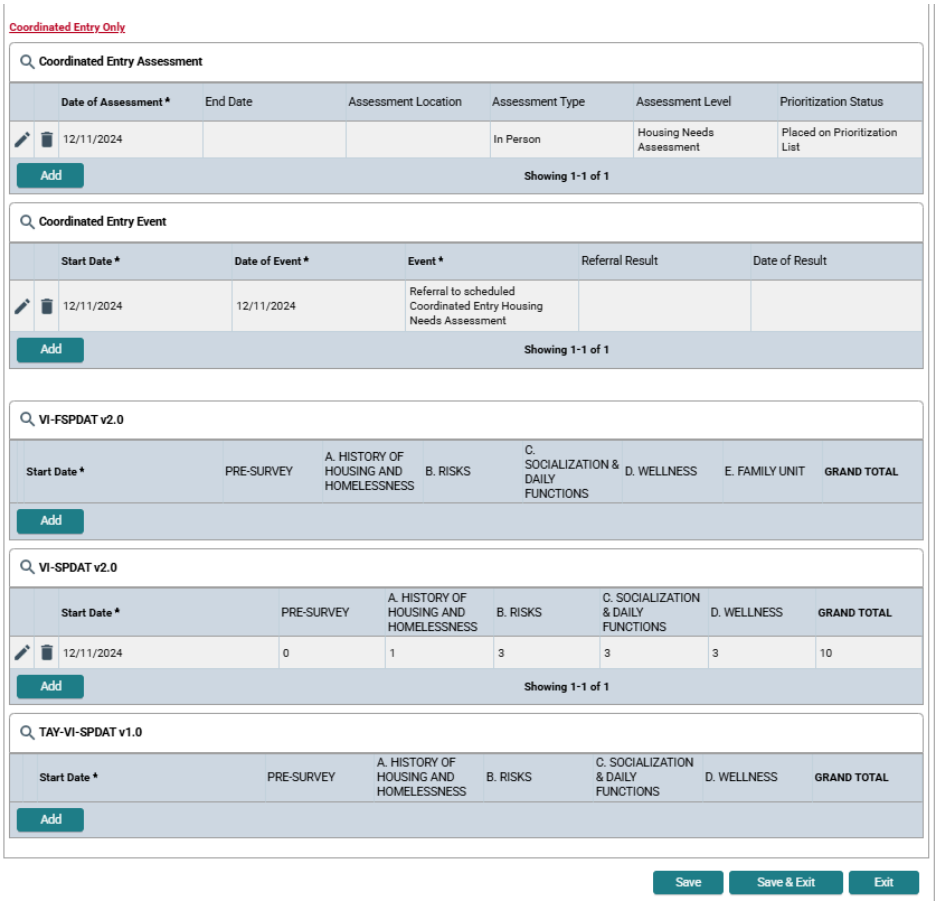
1. Access the client record
2. Navigate to the “Entry/Exit” tab on the client record
3. Locate the client’s “West TX CoC - Coordinated Entry (CE)” project entry
4. Click on the “Interim” review paper icon **or**



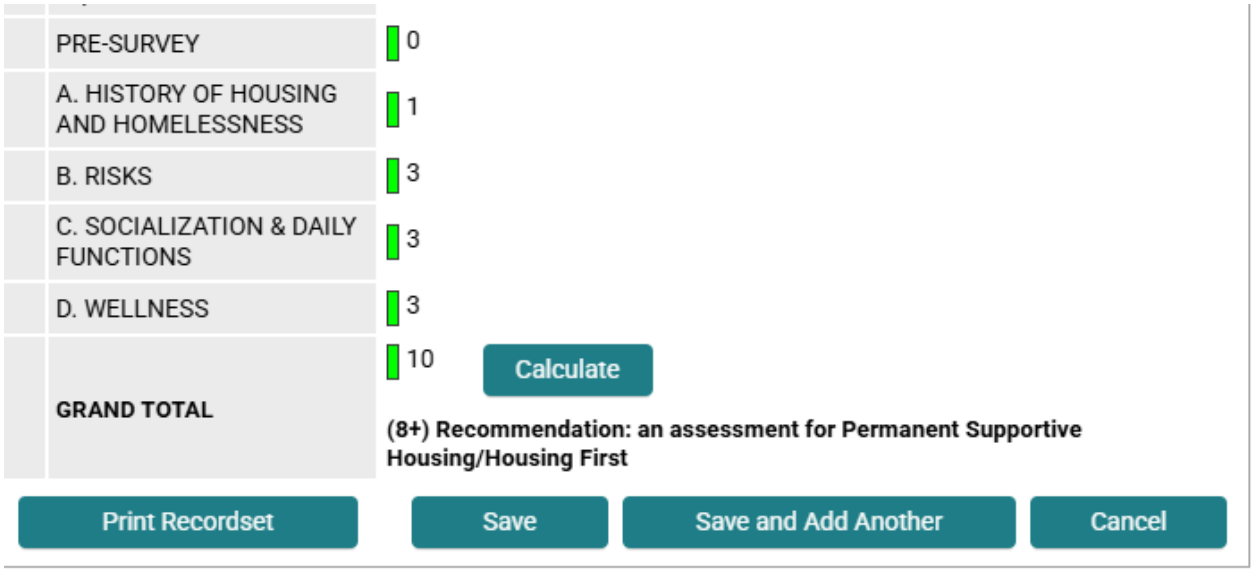
   a. **Note:** do not create a new “Entry/Exit”; you are updating the existing entry/exit with an assessment. If there is not existing open entry/exit, refer to the CE intake portion of this document.
   b. **Note: For you to enter an assessment, the CE entry must not have an exit date. If the enrollment has an exit date, a new entry must be created.**
5. Click “add interim review”
6. Select “update” from the interim review type drop down
7. Change date as necessary



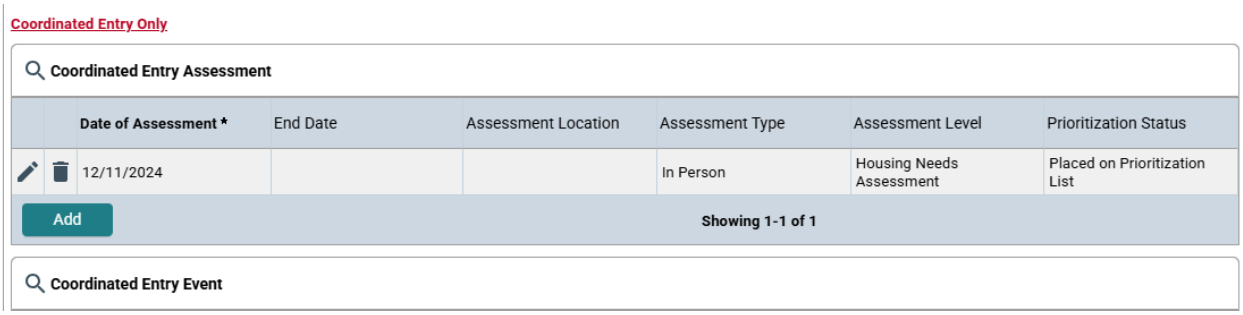
8. Click save & continue
9. Scroll to the bottom of the pop-up and find the appropriate assessment
    a. VI-FSPDAT - **Only** for Households with minor children
    b. VI-SPDAT - For Individuals (including couples without children)
    c. TAY-VI-SPDAT - **Only** for unaccompanied youth under 18 years of age



10. Click Add
11. Answer the questions with the client in accordance with the assessor training you've received
12. When completed, click the "calculate" button to receive the score



13. Click Save
14. Navigate to the Coordinated Entry Assessment section of the entry
15. Click add



16. Fill out the pop-up
    a. Date of assessment = date of assessment
    b. End date = blank
    c. Assessment Location = location you completed the assessment
    d. Assessment Type = Phone / virtual / or in person
    e. Assessment Level = Housing Needs Assessment
    f. Prioritization Status =
        i. Placed on Prioritization List - use if there is a waitlist or if there is no available housing at the time of assessment
        ii. Not Placed on Prioritization List - use if there is available housing, must still notify CE Lead of assessment
17. Click Save
18. Notify the CE Lead of the assessment completion, include:
    a. Client ID number
    b. Assessment score
    c. Date of assessment
    d. Recommendations made to client

e. Any other information you think the CE lead may find important

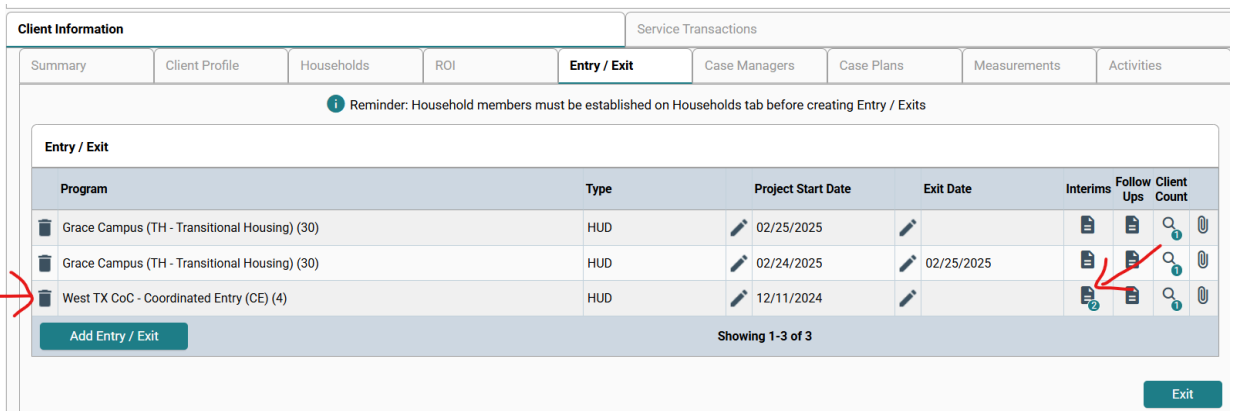
Interim Reviews / Client CE Updates

For any updates to the client's CE information, such as income or disability status, **or** to complete interim reviews while the client is waiting for housing. Interim reviews are completed every 30/60/90/120/365 days. Another Housing Needs Assessment is not needed except for annual reviews or unless instructed to conduct another assessment by the CoC Lead Agency.

Reasons for Update include but are not limited to:

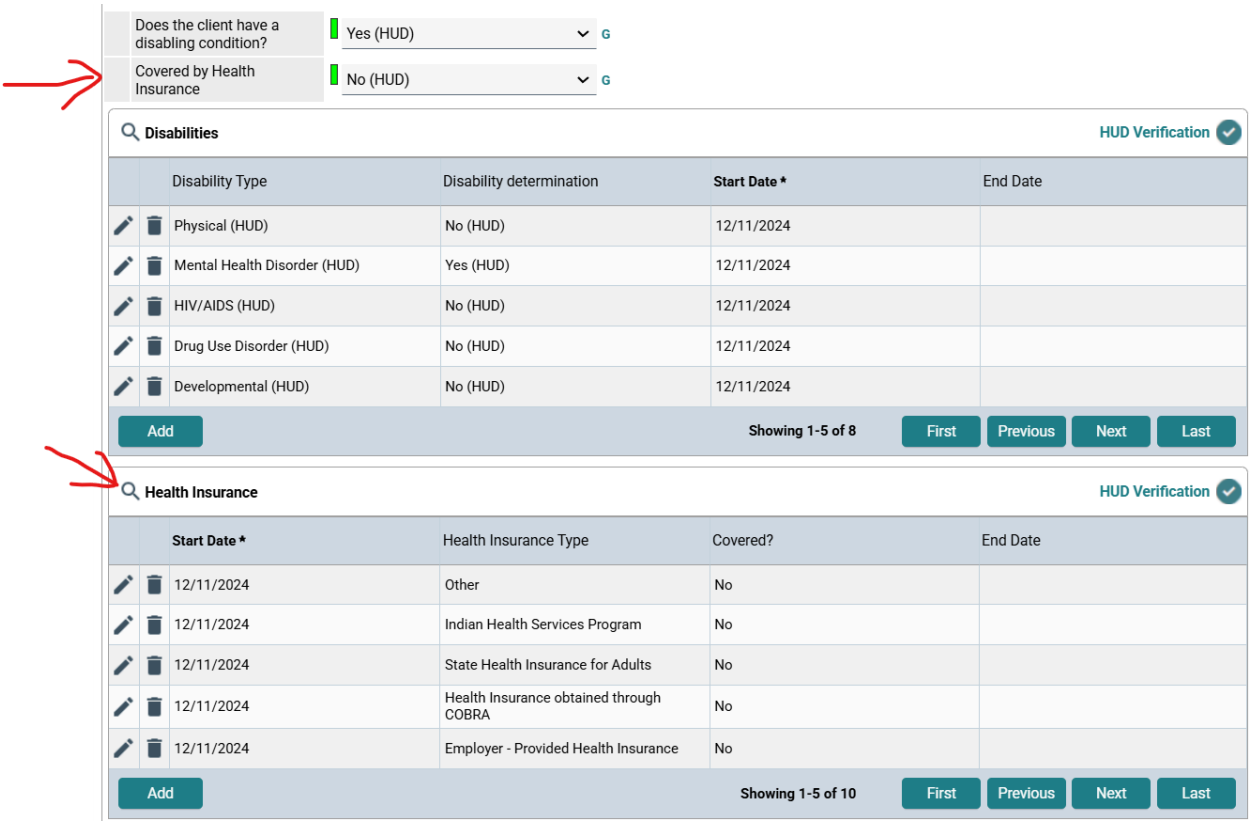
- Change in income
- Change in household
- Change in disability status
- Referral to housing project with acceptance result from said project (accepted/rejected)
- Referral to case management
- etc.

1. Access the client record
2. Navigate to the "Entry/Exit" tab
3. Click the "interim review" paper icon next to the West TX CoC - Coordinated Entry project entry

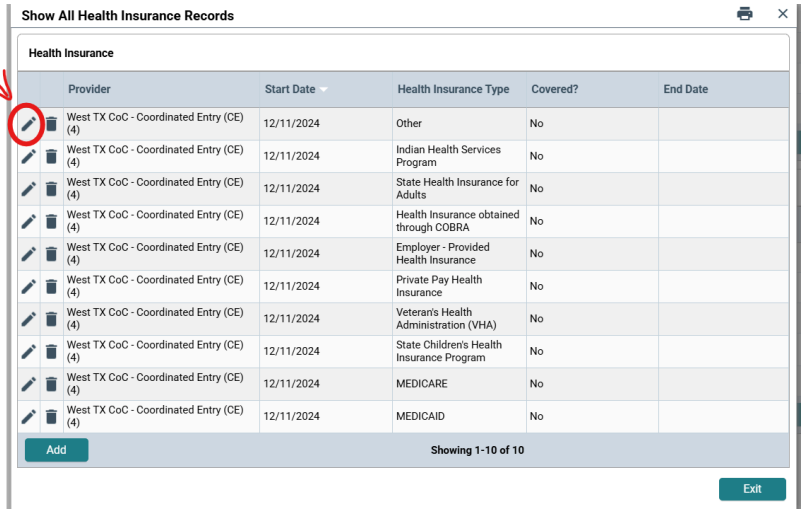


4. Click "Add Interim Review" button in the pop up
5. Fill out the information in the pop-up
    a. Extry/Exit provider = West TX CoC - Coordinated Entry (CE)
    b. Entry/Exit type = HUD
    c. Interim Review Type = Select as appropriate (30/60/90/120/annual/update)
    d. Review Date = Date of interim review, change as needed
6. Click Save & Continue
7. Update information as needed:

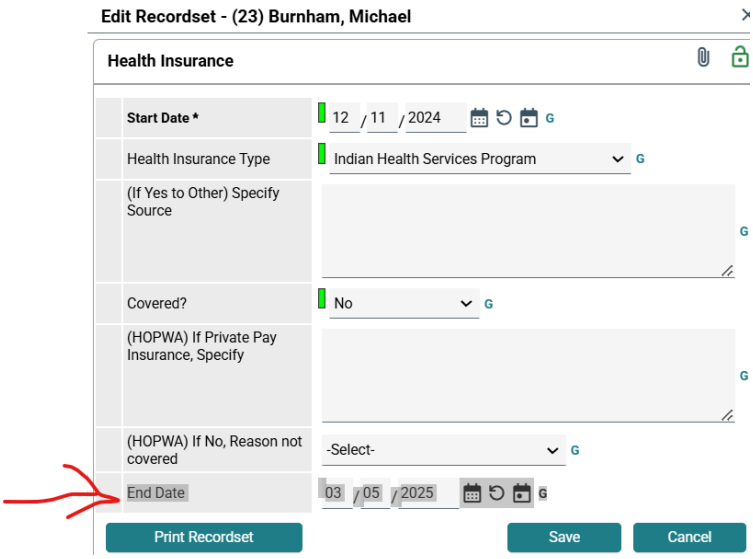
a. To update disabilities, health insurance, income, or non-cash benefits sections (aka subassessments):
    i. **Important:** do not delete any entry in the subassessment sections. This process shows progress over time. If done correctly, the record should show end date statuses for the applicable record, and a new record with the updated information should show having started the day after the end date of the previous records
    ii. **Note:** Be sure to answer/update any supplemental questions in addition to the subassessment
        1. For example, if client started receiving health insurance, change the answer to the "covered by health insurance" question, then update the sub assessment
    iii. Access the subassessment answers by clicking the magnifying glass next to the appropriate section



    iv. In the pop up, find the record to be updated
    v. Click the pencil icon next to the record to be updated



vi. Set the end date to yesterday's date

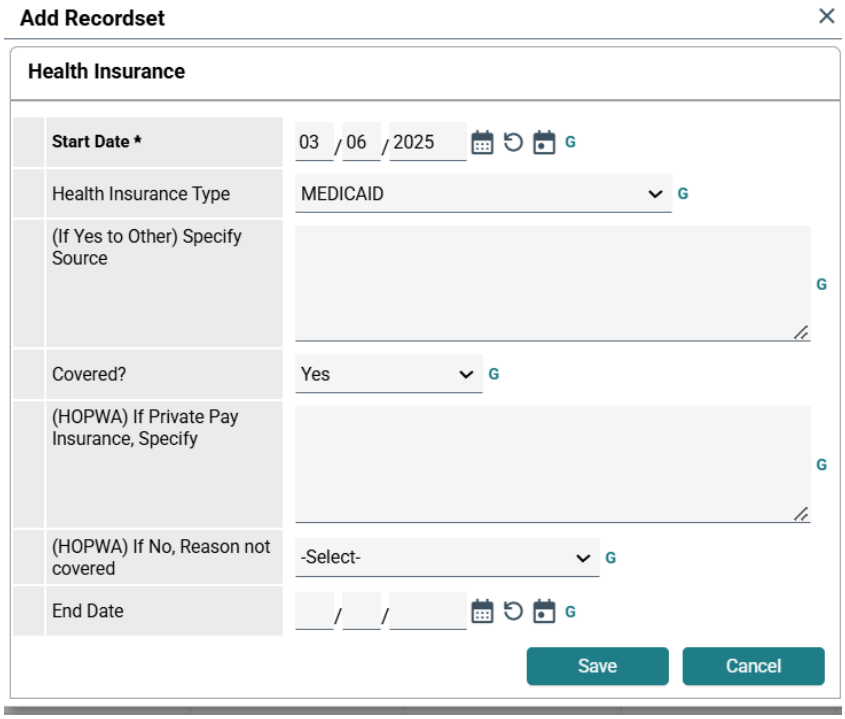


vii. Click Save

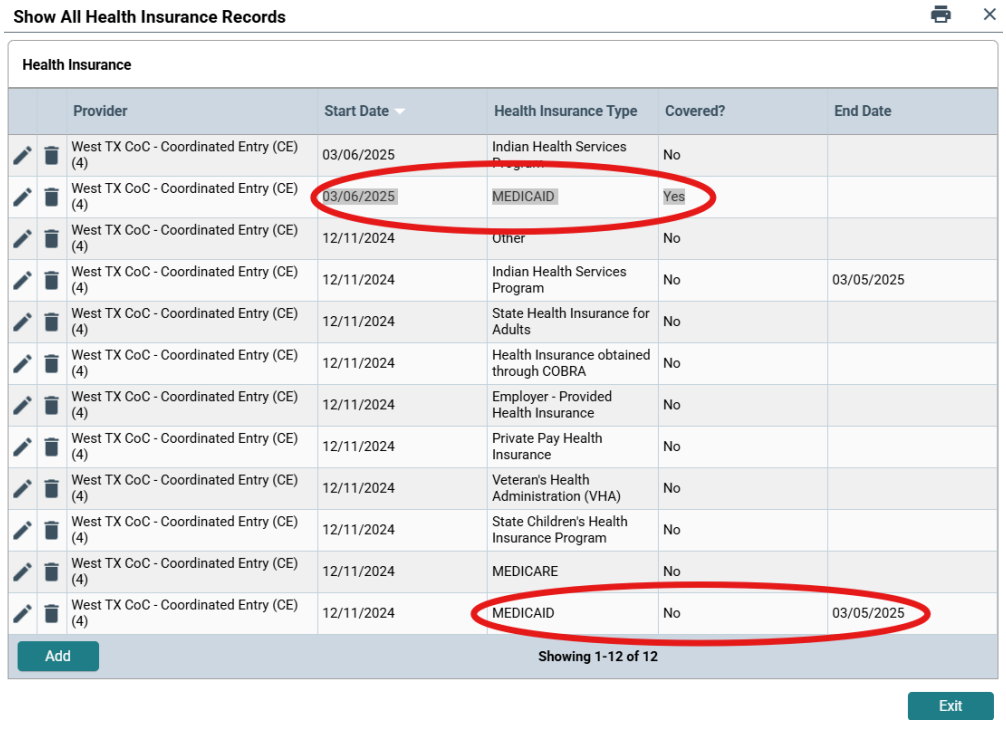
viii. Click Add

ix. Fill out the new pop-up as appropriate

1. Do not fill out an end date



x. Click save

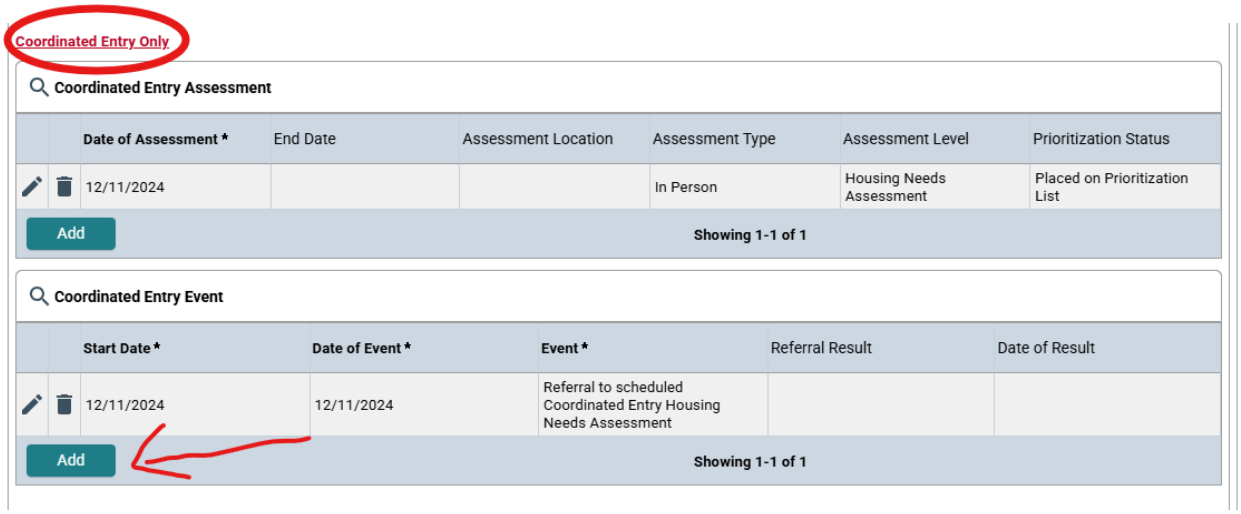


b. For the following client event updates (generally when referrals are made); ***note:*** *every client event update must have a result date & outcome before client is exited from the CE project:*
   i. Events
      1. Referral to Prevention Assistance project

2. Problem Solving/Diversion/Rapid Resolution intervention or service
3. Referral to scheduled Coordinated Entry Crisis Needs Assessment
4. Referral to scheduled Coordinated Entry Housing Needs Assessment
5. Referral to post-placement/follow-up case management
6. Referral to Street Outreach project or services
7. Referral to Housing Navigation project or services
8. Referral to Non-continuum services: Ineligible for continuum services
9. Referral to Non-continuum services: No availability in continuum services
10. Referral to Emergency Shelter bed opening
11. Referral to Transitional Housing bed/unit opening
12. Referral to Joint TH-RRH project/unit/resource opening
13. Referral to RRH project resource opening
14. Referral to PSH project resource opening
15. Referral to Other PH project/unit/resource opening
16. Referral to emergency assistance/flex fund/furniture assistance
17. Referral to a Housing Stability Voucher

ii. Scroll to the Coordinated entry only section

iii. In the Coordinated Entry Even Section, select add

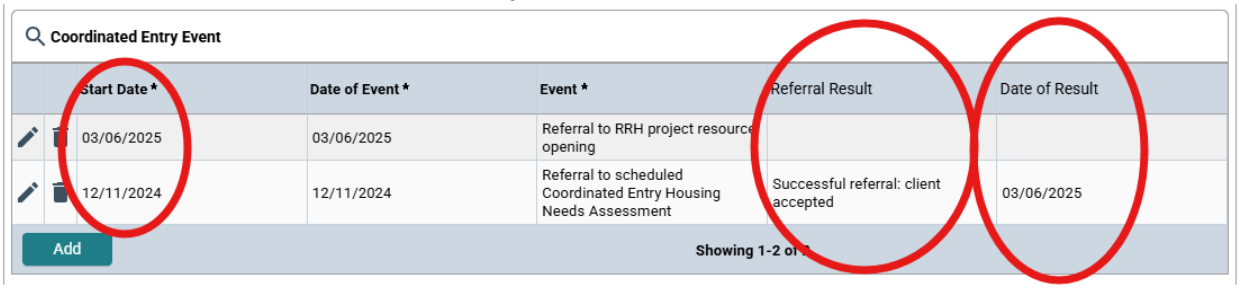


iv. Fill out the pop-up form with the information as needed.

1. If a referral is made but no result, fill out:
    a. Date of event
    b. Event type
    c. Supplemental question(s)
    d. Note leave referral result and date of result section empty until you have a result of the referral
2. If a referral is made and you have a result of that referral
    a. Date of event
    b. Event type
    c. Supplemental questions
    d. Referral result

e. Date of result

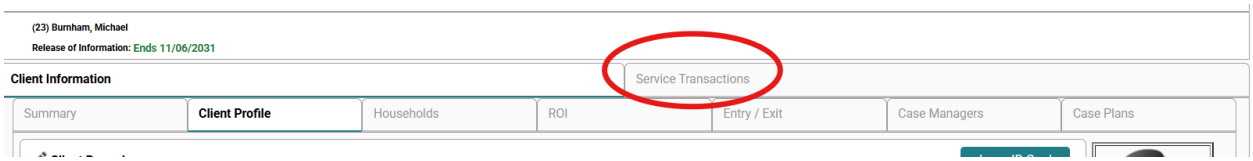
v. **If you receive a result of a previous referral:**
   1. Click the pencil next to the coordinated entry event you want to update
   2. Verify the pop-up is filled out correctly
   3. Select the referral result from the drop down
   4. Enter the result date
   5. Click save
   6. The coordinated entry even section should show the referral result and date of result of every entry prior to client being exited from the CE project



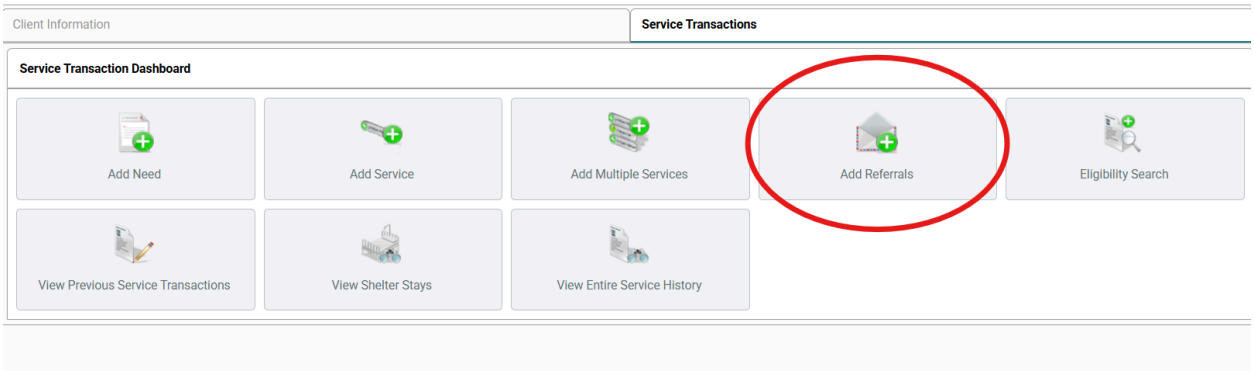
Housing Matching/Placement/Project Exit

Note: The eligibility search function sends all referrals for housing, other than emergency shelter, to coordinated entry. In order to search/refer to housing in the system from the Coordinated Entry Project, use the standard referral functionality, not the eligibility search. The process for housing placement/navigation is in the Coordinated Entry Policies & Procedures (CE P&P).

1. **Match Housing**
   a. Using the criteria in the CE P&P, match client with appropriate housing
   b. Refer client to the housing project (only available to those with a valid ROI on file)
      i. Navigate to the client file
      ii. Click the service transactions tab

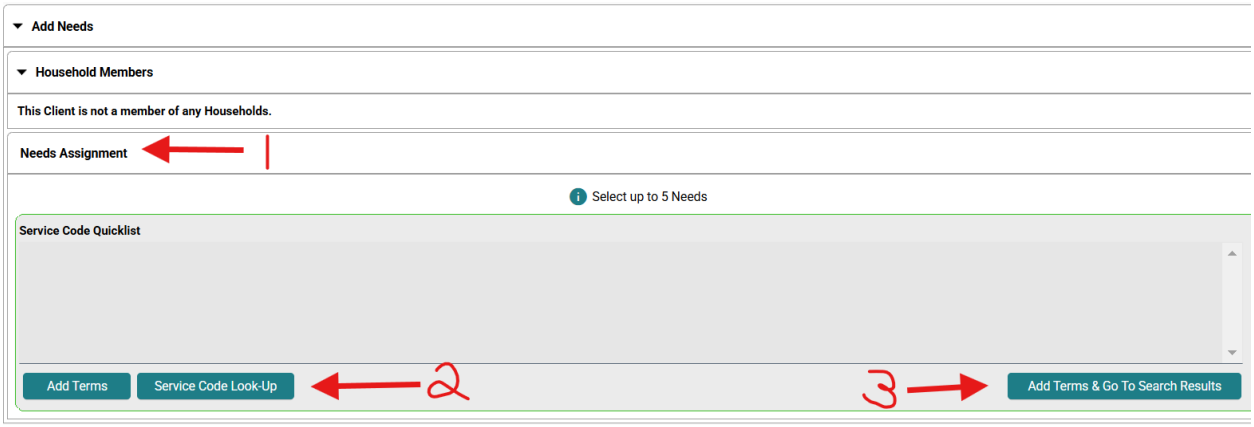


iii. Click “add referrals” button



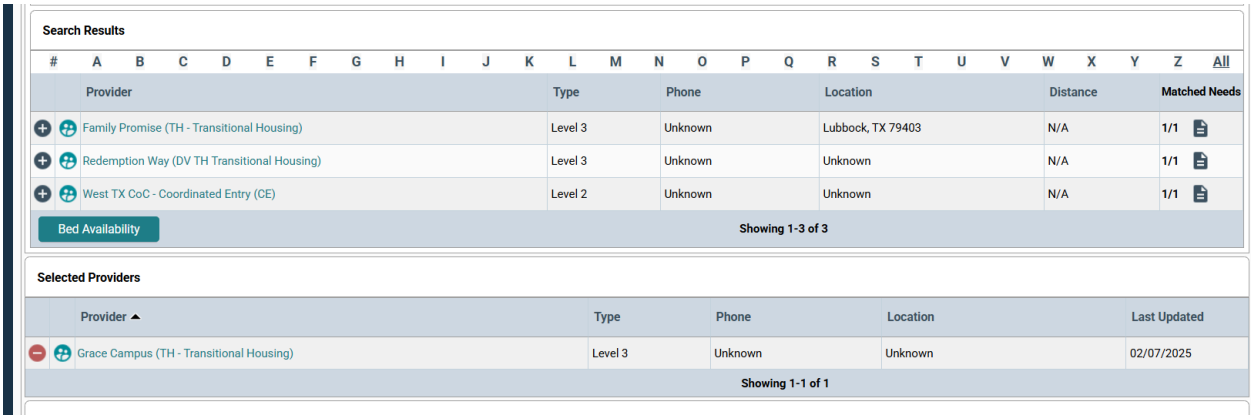
iv. In the needs assignment section, select the housing service code or lookup the housing service code (i.e. transitional housing)

v. Click “add Terms & Go to Search Results” button



vi. Scroll down to the search results

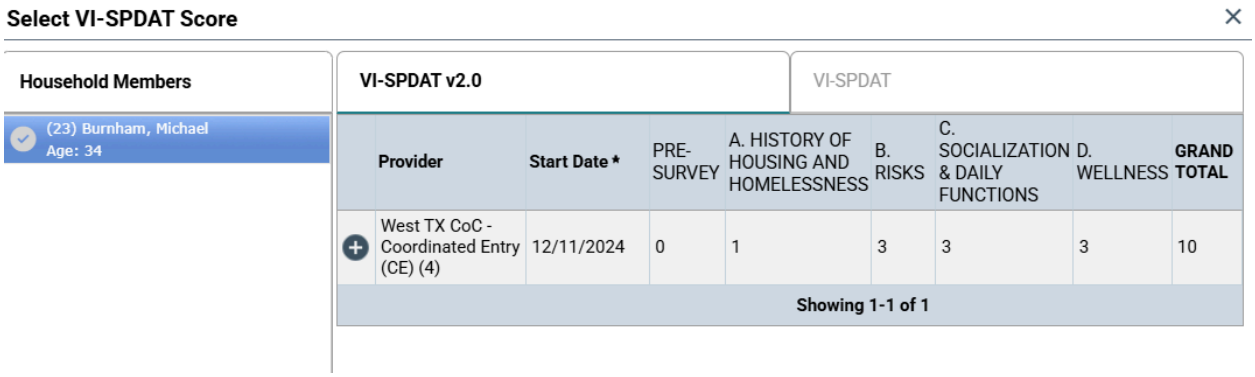
vii. Click the plus sign next to the housing agency you are referring to



viii. Scroll down to the referral data section

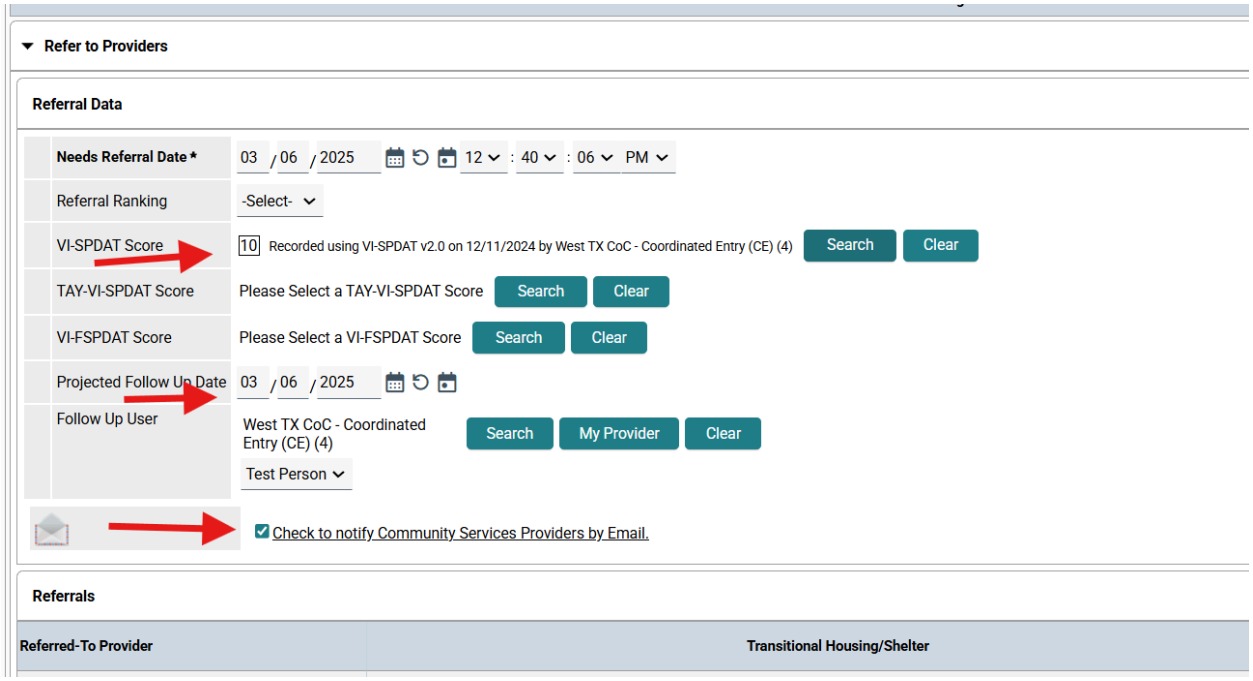
ix. Add the appropriate SPDAT score (TAY, FSPDAT, OR SPDAT)

1. Click search next to the appropriate assessment
2. Find the most recent assessment
3. Click the plus sign next to the assessment to add it to the referral



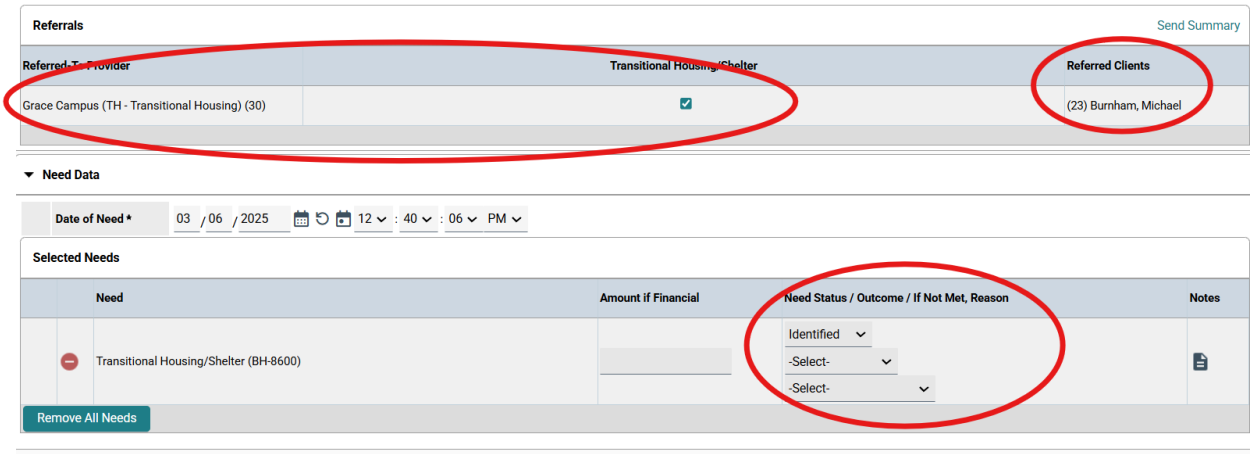
x. Set a follow up date as needed

xi. Check the box for “check to notify community services providers by email”



xii. Verify the information in the next sections

1. Referred to provider matches need and client(s)
2. Need status is “identified” with no additional information selected



xiii. Click “Save All” Button

c. The referral has been sent
   i. **Note:** The housing agency receiving the referral should do their due diligence and gather all information and paperwork required for their program if this has not already been done during the CE process
   ii. **Note:** Once the client(s) has/have been accepted or denied, the housing agency should update the referral accordingly

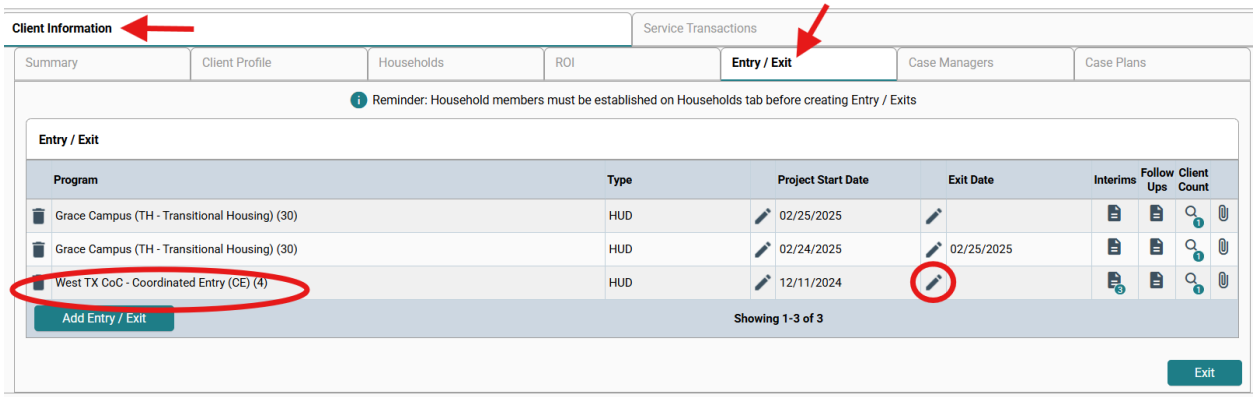
d. Update the client coordinated entry event subassessment in their coordinated entry enrollment
   i. Refer to the above section on Interim Reviews/CE Client Updates to update CE enrollment
   ii. **Note:** Do not exit the client from the CE project until the client is successfully housed. Doing so can remove them from the prioritization list and result in longer times until they are housed

e. Once the referral is updated by the housing provider, record the result of the referral in the client(s) CE project record
   i. Refer to the interim review/CE client updates section of this document

2. Coordinated Entry Project Exit

a. **Note:** Only exit client from CE project once the client has been successfully housed

b. Navigate to the client’s CE project entry



c. Click the pencil icon for exit date
d. Fill out the pop-up:
    i. Exit Date = Date client was housed
    ii. Reason for Leaving = Leave blank
    iii. Destination = select the appropriate placement destination
        1. **Note:** Exits from CE should only happen if client has been successfully housed, has passed away, or has been unreachable for the period of time set in the CE P&P
        2. **Note:** if the client has passed or has been unreachable:
            a. Select the appropriate “reason for leaving” in the drop down
                i. Passed, select deceased for reason for leaving & destination
                ii. Unreachable, select unknown/disappeared in reason for leaving & no exit interview completed in destination
    iv. Make any notes as appropriate for future CE reference
    v. Click save & continue
    vi. Make any updates to the client’s CE record as needed
        1. Refer to the above section on Interim Reviews/CE Client Updates on how to update record
    vii. Click “save & exit” button at bottom of page

Follow ups

No follow ups from the CE Project are required to be documented in HMIS

CE ReEntry

If a client was successfully placed into housing other than emergency shelter and has become homeless again, a new CE project entry must be created. Refer to the Initial CE Intake portion of this document for details on the entry process.

Prevention/Diversion Process

Prior to entry into the coordinated entry project in HMIS, all reasonable measures must be attempted to help the presenting person or family achieve or maintain stable housing prior to enrollment in the CE Project. This could include creative solutions such as rental assistance, one time assistance, utility assistance, vouchers, staying with friends or family to get back on their feet, etc.

The ECHO Database can assist in attempting prevention or diversion by offering a directory of participating providers and their services as well as offering an eligibility engine that can help match people to services they qualify for. Please refer to the ECHO Database user guides for more information on database workflows and processes.

Refer to the CE Policies and Procedures for more information on Prevention/Diversion.