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VA, HUD, AND USICH  
COMMUNITY PLANNING  
SURVEY

COMPANION GUIDE

April 2019

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## Overview and Instructions

### Background

This is the third year that the Department of Veterans Affairs (VA), The Department of Housing and Urban Development (HUD), and the United States Interagency Council on Homelessness (USICH) are releasing a national community planning survey to gauge the development of sustainable Coordinated Entry Systems (CES) to meet the goal of ending Veteran homelessness. The following *Companion Guide* provides an overview of how to complete the survey and a more in-depth description of survey questions.

### Overview

The purpose of the survey is to help us to better understand community progress related to ending Veteran homelessness. The information gathered through this survey will help the VA, HUD, and USICH—tailor training and technical assistance provision so that it more effectively addresses local needs.

- Responses should be inclusive of the perspectives of the Continuum of Care (CoC) or the CoC's official representative in cases where the Veteran Work Group/Subcommittee has been designated by the CoC to respond, Veteran Work Groups/Subcommittees, the VA Medical Center(s) homeless leadership covering the CoC, SSVF grantees, GPD grantees, and other community partners/relevant stakeholders.
- SSVF grantees will help to facilitate submissions (data entry into survey tool). However, responses must depict a collective review, analysis, and discussion to accurately identify community progress and needs.
- SSVF grantees should **not** submit responses in isolation. Instead, this would ideally be an agenda item in your Veteran Workgroup where all relevant stakeholders may contribute.
- Sections of this survey should be filled out with your HMIS Lead Agency for data accuracy.
- If a community is unable to engage a partner, they should email Tamara Wright at Tamara.Wright2@va.gov by **May 17<sup>th</sup>** for assistance.
- This survey is **not** an evaluation; it has no impact on funding, awards, or compliance. Open and honest responses are required.
- Balance of States (BOS) should prepare a collective response as one (1) submission, using averages where applicable.
- **One (1)** submission per CoC is due on or before Monday, **June 3<sup>rd</sup>**.

### Submission

SSVF grantees will facilitate the data entry into the survey tool to assist communities. However, they should not do this until the community has prepared their collective responses which are inclusive of the stakeholders listed above. It is the responsibility of all community and VA stakeholders to ensure that the information accurately reflects the community's progress and needs.

### Accessing the Survey

SSVF grantees will receive the survey link via email. SSVF grantees with shared geography should coordinate together to determine who will assist with data entry for the CoC.

The survey link should **not** be accessed until responses are ready to be submitted to avoid duplicate and incomplete responses. For the small number of communities that do not have an assigned SSVF grantee, a separate email will be sent to the CoC leads with additional instructions and data entry assistance.

### Past Survey Responses

Past survey responses can be located at: [VA, HUD, and USICH Community Planning Survey](#) (formerly Community Plans).

### Tools

This Companion Guide, a copy of the pdf questions of the survey (preparation only), and an instructional webinar are available for communities.

## Survey Deadline

All Survey responses must be submitted on or before **Monday, June 3<sup>rd</sup>**.

## Part 1: Demographics

### 1. Contact Information

- a. **Name of Person Completing This Survey:** Open

*Please enter the name of the person completing the data entry for the survey including first name and last name.*

- b. **Title of Person Completing This Survey:** Open

*Please enter the job title of the person completing the data entry of the survey.*

- c. **Agency of Person Completing This Survey:** Open

*Please enter the name of the agency the person completing survey is affiliated with.*

- d. **Email of Person Completing This Survey:** Open

*Please enter the email address of the person completing the data entry for the survey. This is the email address that we will use if there are any questions related to the survey submission.*

### 2. Contact Information for Continuum of Care Point of Contact

- a. **Name:** Open

*Please enter the name of the person who works for the CoC who is the main point of contact for the Veteran Workgroup (if no one from the CoC is on the Veteran Workgroup, please enter who your community regularly works with from the CoC); please include first name and last name.*

- b. **Title:** Open

*Please enter the title of the person who works for the CoC and who is the main point of contact for the Veteran Workgroup (if no one from the CoC is on the Veteran Workgroup, please enter the title of who your community regularly works with from the CoC).*

- c. **Email Address:** Open

*Please enter the email address of the person who works for the CoC and who is the main point of contact for the Veteran Workgroup (if no one from the CoC is on the Veteran Workgroup, please enter the title of who your community regularly works with from the CoC).*

### 3. Contact Information for the VA Medical Center Point of Contact

- a. **Title of VA Medical Center Point of Contact:** Open

*Please enter the title of the person who works with VA Medical Center in your CoC who is helping to inform this survey. We are hopeful this is also the person who participates in the Veteran Workgroup/Leadership Team. If not, please include the most accurate point of contact from the VA who actively participates in the planning process.*

- b. **Title:** Open

*Please enter the job title of the person who works with VA Medical Center in your CoC who is helping to inform this survey.*

- c. **Email:** Open

Please enter the email address of the person completing the data entry for the survey. This is the email address that we will use if there are any questions related to the survey submission.

**4. Continuum of Care Number and Name:** Dropdown (CoC Number and Name)

Please select the Continuum of Care Number and Name that this survey response represents. This information can be gathered through your Point of Contact at the CoC.

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## PART 2: SURVEY COMPLETION

**5. Does the community have a Veteran Workgroup/Committee or other group charged with community planning and implementation efforts related to ending homelessness among Veterans?** Yes, No, Not applicable

Please indicate if the community has a Veteran leadership team, committee, or other group that is responsible for planning and implementation efforts related to ending homelessness among Veterans. It is understood that this group may have another title such as Veteran Task Force, Veteran Leadership Team, subcommittee, work group, etc.

**6. Was this survey completed with support from the CoC Governing body or Collaborative Applicant?** Yes/No

Please indicate if the community has completed this survey with the support of the CoC; this could include reviewing and completing together, a review of the workgroup proposed submission (using the available PDF of questions for planning purposes) prior to submission for feedback and accuracy, and/or support of designated CoC support staff member.

**7. Was the survey filled out with support from the VA Medical Center(s) (VAMC) who cover this CoC?** Yes/No

Was the survey completed with support from all the VA Medical Center(s) (VAMC) that cover this CoC? It is understood that multiple VAMCs may cover a CoC. In some cases, one VAMC may cover the majority of a CoC with another VAMC covering smaller areas within the CoC. The expectation is that the VAMC that covers the majority or larger portion of the CoC (where applicable) provides input into the survey responses. The other VAMCs can and should help with responses. However, it is understood that their level involvement may vary depending on catchment area. For example, one VAMC may cover 1 county in a Balance of State whereas another VAMC covers 20 counties within the Balance of State. The VAMC covering 20 counties in the Balance of State may be more actively involved in the CoC due to their catchment area. While both VAMCs should assist with providing input into the survey responses, the one VAMC may have additional day to day experience based on the number of areas that they cover.

**8. If no, please explain.** An example of a “No” response might include: No response, multiple VAMC’s cover area but not all participated, VAMC capacity challenges (staffing) and/or staff transition. Other (Please note that if a community needs assistance engaging with partners, they should reach out Tamara Wright [Tamara.wright2@va.gov](mailto:Tamara.wright2@va.gov) by May 17<sup>th</sup>).

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## PART 3: MAYOR OR PUBLIC OFFICIAL INVOLVEMENT AND MILESTONES

**9. Does your community have a commitment from the Mayor’s Office or other local Public Officials in support of your efforts to end homelessness among Veterans?** Please rate from 0 to 4.

This question uses a scale from 0 to 4.

**0=No commitment or involvement**

**1=Limited commitment or involvement** (Might include awareness of efforts or officially signed on to work but limited involvement since then)

**2=Some commitment or involvement** (Might include asking for updates, hosting an annual meeting, or participating when specifically invited)

**3=Engaged** (Might include regular attendance at meetings or quarterly or more updates)

**4=Actively engaged** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, committing resources such as funding for a Landlord Mitigation/Contingency/Risk Mitigation Fund, or Barrier Busting from a System-Level)

Please note that in places where a Mayor is not involved but perhaps a County Commissioner or State Governor is, responses could include their level of commitment.

**10. How would you describe the Mayor's Office or other local Public Official's role in ending Veteran homelessness?**

Checkbox: Actively participates in leadership meetings, serves as chair or co-chair, Assists with system barrier busting and/or leveraging of resources, Awareness of efforts but not an active participant

Whereas the previous question asked for level of commitment on a scale, this question asks for a description of the type of involvement.

Please note that in places where a Mayor is not involved but perhaps a County Commissioner or State Governor is, responses could include their level of commitment.

**11. Is your community participating in the Mayors Challenge, Built for Zero (Community Solutions), and/or pursuing the Federal Criteria and Benchmarks?** Mayors Challenge, Built for Zero (Community Solutions), Federal Criteria and Benchmarks, none related to Veterans, Other (specify) (please select all that apply ---checkbox)

Please help us to understand any initiatives (and goals) that this CoC is participating in or pursuing. Please check all that apply.

**12. If applicable, when would your community be able to submit a claim to your USICH Regional Coordinator on achieving the Federal Criteria and Benchmarks?** Submitted – Approved, Submitted – Approved – Difficulty Sustaining, Submitted-Pending, Next Month, Next 3 Months, Next Six Months, Next Year, Longer than a year, Never-pursuing but will not submit, Never –pursuing but not attainable, N/A – not pursuing

If your committee has pursued or is pursuing submitting a claim of Effectively Ending Veteran Homelessness to USICH based on the [Federal Criteria and Benchmarks for Achieving the Goal of Ending Veteran Homelessness](#), please note your progress. If you have submitted a claim and have been approved or if that claim is pending, please let us know. Additionally, we are gathering feedback from communities who have been approved but have had difficulty sustaining. This could include an increased Point in Time count of homeless Veterans or if the community routinely reviews the Federal Criteria and Benchmarks against current data/conditions. If you plan to submit a claim in the future, please indicate the approximate timeframe of when you might submit the claim. If the community pursuing but will not submit, is pursuing but will not attain, or is not pursuing, they should select the appropriate response.

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## PART 4: PLANNING AND IMPLEMENTATION EFFORTS

### GENERAL COORDINATED ENTRY QUESTIONS

- 13. What type of Coordinated Entry access model or models is your community using?** (Checkbox) Single Point of Access, Multi-Site Centralized Access, No Wrong Door, and Assessment Hotline *Select all that apply.*

*Please help us to understand the Coordinated Entry access model or models that your community is using. It is understood that a community may be using a combination of models. Please check all that apply.*

- 14. What coordinated entry common assessment tool has the CoC chosen or developed?** (Dropdown) VI-SPDAT, Sufficiency Matrix or Variation with Life Domains, Developed Own Tool, Acuity Assessment, Other, please specify.

*Please select the coordinated entry assessment tool that the CoC has chosen or developed. If a tool was selected or developed that is not listed and does not fall into one of the drop-down options, please select "Other" and specify.*

- 15. Are the assessment results recorded in HMIS?** Yes/No

*Are your common assessments recorded in your HMIS system: this could mean scores and other criteria are entered into your HMIS system for purposes of CES.*

- 16. If you answered "no" to the previous question, how do you document the results of the assessments?**

*Please indicate the alternate procedures your community uses to record results gathered from the common assessment tool for purposes of coordinated entry and referral.*

- 17. Does the CoC have a working By Name List/Master List/Active List of all Veterans experiencing homelessness?** Yes/No

*Has your community identified all Veterans by name who are experiencing homelessness, including: sheltered (GPD, Transitional Housing, Shelter, etc.) and unsheltered (street, place not meant for human habitation, etc) for purposes of addressing needs and facilitating the efficient coordination of housing and services.*

- 18. What are the strengths of your Coordinated Entry System?** Check all that apply

*Please check all strengths that apply: 1) **Provider access to By Name List (BNL) through HMIS:** providers have direct access to HMIS and can directly view the BNL; 2) **Continuum of Care prioritization of resources for Veterans (such as housing for Veterans ineligible for VA programs):** This refers to other permanent supportive housing options, Section 8 preferences, HUD Multifamily Unit preferences, Medicaid healthcare or Healthcare for Homeless access, etc; 3) **Common assessment tool: tool used to prioritize resources based on initial information regarding acuity** 4) **Real time referrals from BNL:** referrals happen as soon as a Veteran experiencing homelessness is identified, this could be through HMIS or other database; 5) **Effective case conferencing that prioritizes most vulnerable:** this refers to a case conferencing model that discusses highest acuity Veterans first and prioritizes them for housing options and case management; 6) **VA resources are integrated into Coordinated Entry:** VA resources, such as HUDVASH vouchers and GPD beds, are part of the coordinated entry system; 7) **Coordinated outreach across Continuum of Care:** This refers to geographical coverage of outreach, ensuring entire continuum is covered; 8) **VAMC enters into HMIS:** refers to VAMC staff entering data into HMIS for purposes of coordinated entry; 9) **VAMC has HMIS Read-Only access:** refers to VAMC staff having access in HMIS to read data but they cannot enter into system 10) **Other:** if there is another strength you would like to highlight, please let us know*

- 19. How often does Veteran case conferencing currently take place?**

Please let us know how often your community is reviewing the BNL and discussing housing options for Veterans based on their acuity/prioritization.

**20. Does your Community Have Homeless Prevention resources available to Veterans through Coordinated Entry? Yes/No**

Please indicate if Homeless Prevention resources are available through Coordinated Entry. Selecting "In Progress" might include that there have been preliminary discussions around prevention and diversion/rapid resolution. There may be linkages to Coordinated Entry. However, processes may not be fully implemented yet.

**21. Is Diversion a component of your Coordinated Entry System or is your system currently implementing SSVF's Rapid Resolution?**

Does your community seek to resolve homelessness by helping people experiencing a housing crisis and/or seeking shelter identify alternate housing that is safe and appropriate through crisis intervention problem-solving conversations to avert shelter entry and the trauma of homelessness immediately?

**22. If the answer to the previous question is yes, is Diversion/Rapid Resolution happening prior to entry into your homeless system?**

Does your community have a way to divert households from emergency shelter and immediately aid to get reconnected to family, friends, or other resources? A response of "In Progress" would mean that discussion has occurred but that a process has not been fully implemented.

#### VA INTEGRATION INTO COORDINATED ENTRY SYSTEMS

**23. Do your Coordinated Entry Policies and Procedures include clear protocol for identifying and connecting Veterans to permanent housing? Yes, No, In Progress**

Please respond based on your current Coordinated Entry Policies and Procedures.

**24. Does your Coordinated Entry System have a process for connecting Veterans with employment services? Please note that employment is never a prerequisite to obtain permanent housing. Yes, No, In Progress**

Please respond based on your current processes. Please note that employment is never a prerequisite to housing. This specific question is just trying to learn more about if employment services are available and are part of Coordinated Entry planning in cases where a Veteran may benefit from these services. Employment is **not** required to access permanent housing.

**25. Does the Coordinated Entry System have a process for connecting Veterans to benefits, both mainstream and VA? Examples of mainstream benefits are TANF, SNAP, Medicaid, Child Care Subsidy Programs, etc. Yes, No, In Progress**

Please respond based on your current processes. Please note that benefits are never a prerequisite to housing. This specific question is just trying to learn more about if benefit services are available and are part of Coordinated Entry planning in cases where a Veteran may need these services. Benefits are **not** required to access permanent housing.

**26. Does the Coordinated Entry System use the SSI/SSDI Outreach, Access, and Recovery (SOAR) model to help Veterans with disabling conditions access SSI/SSDI? Yes, No, In progress**

Does the CoC use SOAR to assist Veterans and Veteran households with accessing SSI/SSDI?



**27. Does the Coordinated Entry System have a process for connecting Veterans with legal services to or access to a Veteran's Court? Yes, No, In Progress**

*Please help us to understand if the CoC has a process for connecting Veterans and Veteran households with legal services. The goal of Veterans Court is to ensure veterans entering the criminal justice system contact specific programs to address the root causes of behavior that resulted in the Veteran becoming a defendant in the criminal justice system. This is usually implemented through local partnerships of: Municipal Court, Prosecutors Office, Public Defender's Office, and the local VAMC.*

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## **PART 5: PARTNERSHIPS**

**28. Is there a designated individual from the VAMC(s) assigned to the CoC Board or Veteran Workgroup/Leadership Team to participate in developing local strategies to effectively end Veteran homelessness?**

**a. If no, please explain.**

*This question is asking if there is a formal point of contact from the VAMC or VAMCs (in the cases where multiple VAMCs cover the CoC) who is involved in policy work and strategic leadership related to ending Veteran homelessness. This could include an SSVF Regional Coordinator, HUDVASH staff member, VA Medical Center Director, etc. If no, please explain. In instances where multiple VAMCs cover the CoC and one or several VAMCs are involved but perhaps not all, please indicate who is involved and note where continued relationship building and integration is occurring or needed.*

**29. Is there a designated individual from the VAMC or VAMCs assigned to Case Conferencing and the Master List/By-Name List/Active List?**

**a. If no, please explain.**

*This question is asking if there is a formal point of contact from the VAMC or VAMCs who is involved in case conferencing and the active list/master list/by name list/one list related to ending Veteran homelessness.*

**30. How would you describe the level of coordination between the Continuum of Care Coordinated Entry System with VA Health Care for Homeless Veterans (HCHV) outreach and contract residential services?**

**a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level)**

*This question uses a scale from 0 to 4.*

**0= Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3= Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4= Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and

case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources)

**31. How would you describe the level of coordination between the Continuum of Care Coordinated Entry System with HUD and VA Supportive Housing (HUD-VASH)?**

- a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level)

This question uses a scale from 0 to 4.

**0= Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3=Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4=Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources)

**32. How would you describe the level of coordination between the Continuum of Care Coordinated Entry System with the Grant and Per Diem Providers (GPD) that serve your community?**

- a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level)

This question uses a scale from 0 to 4.

**0= Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3= Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4= Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and

case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources)

Use the most common number. For example, if you have one GPD grantee/provider where your coordination level is a 4 but 2 others at a 2, please use 2 for your response.

There will be an opportunity to provide clarifying narrative under Part 10: Open-Ended questions at the end of the survey if needed.

**33. How would you describe the level of coordination between the Continuum of Care Coordinated Entry System with the Supportive Services for Veteran Families (SSVF) grantees that serve your community?**

- a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level), N/A

This question uses a scale from 0 to 4.

**0= Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3=Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4=Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources)

Use the most common number. For example, if you have one SSVF grantee/provider where your coordination level is a 4 but 2 others at a 2, please use 2 for your response.

**34. How would you describe the level of coordination between the Continuum of Care Coordinated Entry System with Veterans Justice Outreach (VJO)?**

- a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level)

**0= Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3=Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4=Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources)

There will be an opportunity to provide clarifying narrative under Part 10: Open-Ended questions at the end of the survey if needed.

**35. How would you describe the level of coordination between the Continuum of Care Coordinated Entry System with the Community Resource and Referrals Center (CRRC)?**

- a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level)

**0= Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3=Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4=Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources)

There will be an opportunity to provide clarifying narrative under Part 10: Open-Ended questions at the end of the survey if needed.

**36. How would you describe the level of coordination between the Continuum of Care Coordinated Entry System with VA Homeless Veterans Community Employment Services (HVCES)?**

- a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level)

**0= Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For

example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3=Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4=Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources) .

**37. What is your level of coordination with the Continuum of Care Governing Board as a Veteran Work Group/Committee?**

a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level)

**0=Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3=Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4=Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources)

**38. How would you describe the level of coordination between the Continuum of Care Coordinated Entry System between HUD funded homeless service providers and Medicaid funded care and case management programs? Examples: Shelter Plus Care & Case Management, Hospital Diversion Programs, etc.**

a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level)

**0=Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3=Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4=Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources)

**39. How would you describe the level of coordination between the Continuum of Care Coordinated Entry System and the Department of Labor's Homeless Veteran Reintegration Program?**

- a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level)

**0=Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3=Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4=Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources)

**40. How would you describe the level of coordination between the Continuum of Care Coordinated Entry System and Low-Income Housing Tax Credit (LIHTC) properties or other affordable housing providers? Example: LIHTC units are part of coordinated entry and prioritized based on need.**

- a. Likert Scale: 0, 1, 2, 3, 4 (with 4 as highest level)

**0=Resource Does not Exist in Community**

**1= Awareness** (Might include little or no knowledge of resource, awareness, or communication, staffing changes causing limited communication, and/or infrequent knowledge sharing and referrals)

**2= Basic Communication** (Might include awareness of efforts and general communication including an understanding of eligibility requirements, how to make referrals, and clear referral partners amongst partners; however, deeper level collaboration is absent. For example, a partner might attend a meeting or call but have limited input during the meeting or limited to no feedback during discussions.)

**3=Coordination** (Might include specific points of contact for referrals, warm hand-offs, regular active participation in meetings and strategy including providing input, taking on action items, sharing information with team and other programs, and helping to identify barriers.)

**4=Enhanced Coordination/Collaboration** (Might include possibly co-chairing a committee, providing staff support to the Veteran Work Group/Leadership Team/Committee, full participation in Coordinated Entry, having specific staff assigned to functions like policy and case conferencing/master list, staff fully embracing plan and helping to develop shared goals and expectations, shared decision-making and evaluation of needs, and full integration of resources)

There will be an opportunity to provide clarifying narrative under Part 10: Open-Ended questions at the end of the survey if needed.

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## PART 6: DATA AND DATA SHARING

**It is required that this section be filled out in conjunction with local VA Medical Center staff and your HMIS Lead Agency or HMIS administrator for accuracy.**

**41. Are your HMIS Administrator/HMIS Lead Agency and a VAMC point of contact helping to fill this survey out? (Required)**

*To ensure we are receiving the most accurate data possible, we require that the data sections be filled out with the appropriate staff members. If you are having trouble connecting with staff members, please reach out to Tamara Wright at [Tamara.Wright2@va.gov](mailto:Tamara.Wright2@va.gov)*

**42. Does your HMIS Policies and Procedures include data sharing with VAMC(s) for the purposes of coordinating care for Veterans experiencing homelessness?**

*To support comprehensive master lists/by name lists/active lists, do data sharing policies include VAMC(s) and other VA programs*

**43. If yes, please indicate how the data sharing primarily occurs between VAMC(s) and the CoC. Select all that apply.**

*How does your community share information in accordance with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) and protecting Veteran personal identifying information while still coordinating care? Select all that apply 1) Email, 2) Encrypted email 3) VA staff direct entry into HMIS 4) VA data imports into HMIS 5) List is manually updated outside of HMIS and VA Databases 6) Fax 7) other means of sharing data and coordinating care*

**44. Is your community aware of VA form Routine Use #30? Yes, No**

Routine Use #30 states that VA may disclose relevant healthcare and demographic information to health and welfare agencies, housing resources, and community providers, consistent with good medical-ethical practices, for Veterans assessed by or engaged in VA Homeless Programs for purposes of:

1. Coordinating care;
2. Expediting access to housing;
3. Providing medical and related services;
4. Participating in coordinated entry processes;
5. Reducing Veteran homelessness;
6. Identifying homeless individuals in need of immediate assistance; and
7. Ensuring program accountability by assigning and tracking responsibility for urgently-required care.

This routine use provides legal authority for VHA Homeless Program staff to disclose pertinent Veteran information, excluding 38 U.S.C. 7332-protected information **without a formal data sharing agreement or prior signed, written authorization** from the Veteran **if** the requirements of the legal authority are followed.

All disclosures must be recorded locally in accordance with privacy guidelines.

VHA does NOT have legal authority to share health information protected under 38 U.S.C 7332 (any information related to the diagnosis of infection with HIV or sickle cell anemia, or the diagnosis of and treatment for drug abuse, alcohol abuse or alcoholism) with community partners UNLESS a signed, written authorization is obtained from the Veteran. If a Veteran is being treated for, or has any of these diagnoses, this information or any information that would imply these diagnoses cannot be shared without the Veteran's signed authorization, including information such as, the name of a residential treatment facility that would infer the Veteran is being treated for substance abuse.

This legal authority supports effective and efficient collaboration between VA and outside agencies by allowing disclosure of information documented in the Homeless Operations Management and Evaluation System (HOMES) for improving timeliness and access to necessary services for Veterans in the homeless continuum.

**45. Are there any programs in your community that are not accounted for in your data? Select all that apply: SSVF, GPD, HCHV, HUDVASH, Faith-Based organizations serving persons experiencing homelessness, Domestic Violence, Shelter(s), Other, N/A;**

*It is understood that some programs may not be accounted for in your data. Please help us to understand what information might not currently be included.*

**46. How many Veterans are currently experiencing homelessness in your community? Please make sure that the number of literally homeless veterans matches the total number of sheltered and unsheltered Veterans.**

*The following questions appear as a chart in the survey. The total number of Veterans on the current by-name list/master list/active list is asked. Then, this number is broken down into sheltered and unsheltered and further broken down into sub-categories.*

- **Please note that the total number of Veterans who are Unsheltered and Sheltered should add up to the Number of Veterans Total.**
- **Please note that the Number of Veterans who are Sheltered should equal the Sheltered subcategories.**

**a. Number of Veterans Total**

*The total number of Veterans who are currently experiencing homelessness and are on your by name list/master list/active list. For example, if your master list is comprehensive and includes all Veterans experiencing homelessness (sheltered and unsheltered), this would be the number that you would use. This number should equal the number of unsheltered Veterans plus the number of sheltered Veterans entered below.*

**b. Number of Veterans who are Unsheltered**

*The total number of unsheltered Veterans currently experiencing homelessness and are on your by name list/master list/active list. **Do not count the same Veteran in more than 1 location below.***

- i. **Unsheltered-** Veterans who are experiencing unsheltered homelessness Including street, car, tent/camp, places not meant for habitation (abandoned building, subway station, sewer) etc.

**c. Sheltered-**

*The total number of sheltered Veterans who are currently experiencing homelessness and are on your by name list/master list/active list. Please break this number down further by shelter type (Emergency Shelter, Transitional Housing (GPD and Non-VA), and Safe Haven). **Do not count the same Veteran in more than 1 shelter type below.** This number should equal the sum of all of the numbers below: emergency shelter plus (+) transitional housing plus (+) VA Grant and Per Diem plus (+) Non-VA Transitional Housing plus (+) Safe Haven.*

**d. Sheltered-Emergency Shelter**

**e. Sheltered-Non-VA Transitional Housing**

**f. Sheltered-VA Grant and Per Diem Service Intensive Transitional Housing**

**g. Sheltered- VA Grant and Per Diem Bridge Housing**

**h. Sheltered- VA Grant and Per Diem Hospital to Housing**

**i. Sheltered- VA Grant and Per Diem Clinical**

**j. Sheltered- VA Grant and Per Diem Low Demand**

**k. Sheltered-Safe Haven**

**47. Of all the Veterans who are sheltered and unsheltered, how many are chronically homeless? (number)**

*Based on the total number of Veterans experiencing homelessness entered above (both sheltered and unsheltered), how many of these Veterans are chronically homeless. For example, if there are 20 unsheltered Veterans and 40 sheltered Veterans, there are a total of 60 Veterans experiencing homelessness. Of the 60 Veterans experiencing homelessness, how many are chronic? In this example, perhaps 10 Veterans currently meet HUD's definition of chronic homelessness. So the response would be 10. **Response should be a number.***

**48. What percentage of all Veterans who are sheltered and unsheltered are eligible for VA Healthcare Administration Medical Care? (percentage)**

*Using the example above, we have 60 Veterans experiencing homelessness total. Based on our master list, we know that 20 of the Veterans are eligible for VHA (eligible for VA health care). Therefore, 20/60 equals 33% (rounded down 33.33%), so 33% of the Veterans who are sheltered and unsheltered are eligible for VA Healthcare.*

*If you have questions on who would be eligible for VHA, and the information is not clear on your master list, please feel we have 60 Veterans experiencing homelessness; 10 meet VA Medical eligibility. Therefore, the percentage is 10/60 which equals approximately 17% (rounded up 16.6%). **Response should be a percentage.***



- 49. What is the average monthly inflow of Veterans experiencing homelessness into your homeless system? To calculate the monthly average, please use the time period of the last 90 days.**

*Inflow is the number of Veterans entering your homeless system per month. It includes Veterans who are new to the homeless system as well as Veterans who were involved in the homeless system and are perhaps returning to the system/re-entering the system. This information can be calculated using your master list and/or HMIS. Please provide us with an average based on the same 90 day time frame that is used below. **Response should be a number.***

- 50. What is the average monthly outflow of Veterans experiencing homelessness into your system? Outflow is how many Veterans exit your system each month. To calculate, please use last 90 days.**

*Please indicate the average number of Veterans who are exiting your system each month. This could be housed, self-resolved, moved to inactive on your BNL, etc. This information can be calculated using your master list and/or HMIS. Please provide us with an average based on the same 90 day time frame that is used below. **Response should be a number.***

- 51. What percentage of your HUD-VASH vouchers are in “lease-up status?” Example: A Veteran has a HUD-VASH voucher and has signed a lease to move into a unit or has already moved in.**

*This question will need to involve your Public Housing Authority(s) and/or HUD-VASH team. In looking at all allocated vouchers for the continuum, what percentage are attached to a lease? Our goal is to see the HUD-VASH voucher utilization rate.*

- 52. What is the average length of time in days from identification of a Veteran experiencing homelessness to housing placement in each of the VA Homeless Programs listed below?**

*How long does it take from entry into the homeless system to housing placement for Veterans. Use the same 90 day timeframe as above to calculate the average. For GPD, we are looking at the average across all models if the resource exists. If a resource does not exist, please put N/A. **Response is a number (number of days).***

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## PART 7: PERMANENT HOUSING

- 53. Do you have enough permanent housing available housing to place every Veteran experiencing homelessness in 90 days or less after being identified? Yes, No**

*We are interested in better understanding local housing stock within your community*

- 54. If yes, is the existing permanent housing currently available to Veterans experiencing homelessness affordable? The Department of Housing and Urban Development defines “affordable housing” as one that a household can obtain for 30% or less of their income. Yes, No**

*Please tell us about permanent housing availability. This follow up question is focused on understanding if affordable housing is generally available within the community’s context. It is understood that many households may be spending more than 30% of their income on housing.*

- 55. If you answered no, what is the average rent burden for extremely low-income households in your state? Please use data from the National Low Income Housing Coalition (link in Companion Guide)?**

*We are interested in better understanding the rental burden of the majority clients without permanent subsidies within your community. Please give us a percentage based on the most recent [Housing Affordability and Cost Burden study from the National Low Income Housing Coalition](#).*

**56. Do you have a municipal or regional housing strategy to sustain and increase affordable housing options? Of note: A municipal/regional housing strategy is not the Consolidated Plan or the Comprehensive Plan; A housing strategy describes the approach a jurisdiction plans to take to meet its housing needs using all available data and resources.**

*More information regarding the importance and scope of an effective local housing strategy can be found [here](#).*

**57. Please provide a link to your housing strategy:**

*Most housing strategies are posted online by the local or regional planning department, municipality, or CoC*

**58. Are you working with your local apartment association? Yes, No, In Progress, Not Sure**

*Please indicate if your community is working with a local apartment association to engage in conversations and strategy related to permanent housing.*

**59. Do you have a community landlord incentive fund/contingency/risk mitigation fund? Yes, No, In Progress, N/A**

*Does the community have a landlord incentive fund, contingency fund, and/or risk mitigation fund? It is understood that communities may have one fund that encompasses these functions where other communities might not have a fund or may have separate funds depending on specific landlord needs.*

**60. If yes, does the fund cover the following? Check all that apply.**

- i. Damages
- ii. Utility arrears
- iii. Vacancy Payments
- iv. Support for Landlords to Meet Code Requirements
- v. Application Fees
- vi. Other

*If your community does have a fund or funds, please check all that apply.*

**61. If you answered “Yes,” How is the landlord incentive fund funded? Check all that apply.**

- i. Municipal General Revenue
- ii. Dedicated Funding Source
- iii. Philanthropic Resources
- iv. Corporate Funded
- v. Faith Community Funded

*Please tell us what funding is used to fund the fund. If there are multiple funding sources, please check all that apply.*

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## PART 8: ADOPTION OF BEST PRACTICES

**62. Has the Continuum of Care implemented a CoC-wide prioritization strategy for ensuring the most intensive resources (HUD-VASH, PSH) are targeted to the Veterans that need it most? Yes, No, In Progress**

*Targeting and prioritizing resources for Veterans and Veteran households most in need is important. For example, not every household will need permanent supportive housing (highest level of intervention). Progressive engagement/assistance should be employed where possible. For those Veterans and Veteran households that need the most intensive resources, does the CoC have a clear policy/procedure that is consistent across the CoC for prioritizing and targeting resources?*

- 63. Has the Continuum of Care paired Housing Choice vouchers and Medicaid services for Veterans and household members who are not eligible for VA Medical Care? Note: By law, Medicaid cannot cover rent. Under certain waiver authorities, states can choose to cover housing-related services using Medicaid.** Yes/No/Resource Does Not Exist

*What level of integration does your community have with Medicaid providers and accessing care for highly vulnerable veterans and their family members?*

- 64. If your community has GPD, are the models that are currently in place aligning with community needs? Example: Do you have enough Bridge Beds to provide temporary shelter for Veterans searching for housing?**

*We are interested in understanding how GPD grantees/providers are meeting your current community needs.*

- 65. Has the Continuum of Care worked to integrate GPD programs and the new models into coordinated entry system with the support of the VA Medical Center? Yes, No, In Progress, Resource**

*We are interested in understanding how GPD grantees/providers and GPD liaisons are working together to integrate into Coordinated Entry. It is understood that the new GPD models went live October 1 and that this is a significant change for providers. We want to work together to support each other in the process of full integration.*

- 66. Has the Continuum of Care developed standards regarding the Progressive Engagement of housing resources? For example, if a household needs more on-going support than Rapid Rehousing can provide, is there a protocol to transfer them to a Permanent Supportive Housing subsidy?**

*Does your community have something in the policies and procedures regarding the progressive engagement of households to more appropriate housing interventions?*

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## PART 9: FEDERAL CRITERIA AND BENCHMARKS

Please indicate to what extent the Continuum of Care or the community for which you are responding has reached the following federal criteria.

- 67. Criteria 1: Has your community identified all Veterans experiencing homelessness?** Yes, No, In Progress

*Please refer to the [Federal Criteria and Benchmarks for Achieving the Goal of Ending Veteran Homelessness](#) for additional information.*

- 68. Criteria 2: Does your community provide shelter immediately to any Veteran experiencing unsheltered homelessness who wants it?** Yes, No, In Progress, Not pursuing

*Please refer to the [Federal Criteria and Benchmarks for Achieving the Goal of Ending Veteran Homelessness](#) for additional information.*

- 69. Criteria 3: Does your community only provide service-intensive transitional housing in limited instances?** Yes, No, In Progress, Not pursuing

*Please refer to the [Federal Criteria and Benchmarks for Achieving the Goal of Ending Veteran Homelessness](#) for additional information.*

- 70. Criteria 4: Does your community have the capacity to assist Veterans to swiftly move into permanent housing?** Yes, No, In Progress, Not pursuing

*Please refer to the [Federal Criteria and Benchmarks for Achieving the Goal of Ending Veteran Homelessness](#) for additional information.*

**71. Criteria 5: Does your community have the resources, plans, and system capacity in place should any Veteran become homeless or be at risk of homelessness in the future?** Yes, No, In Progress, Not pursuing

*Please refer to the [Federal Criteria and Benchmarks for Achieving the Goal of Ending Veteran Homelessness](#) for additional information.*

**72. Does your CoC assess community level data at least every 90 days against the federal benchmarks or other community performance goals and continue to make that performance data publicly available??** Yes, No, Not pursuing, Other

*Please refer to the [Federal Criteria and Benchmarks for Achieving the Goal of Ending Veteran Homelessness](#) for additional information*

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## PART 10: TECHNICAL ASSISTANCE

**73. If interested in receiving technical assistance to end Veteran homelessness, what areas would be the most helpful to your community??** Yes, No

*Technical assistance is meant in the broadest sense of the term which could include connection to existing tools and resources and hands-on support based on availability. The provision of technical assistance is also broad and could be conducted by connecting peer communities, working with Regional Coordinators/other Subject Matter Experts, or a TA provider. Please note that this is an exploratory list. It may not be all-inclusive.*

**74. Additional feedback**

*Any additional feedback regarding the community plan to end veteran homelessness that would be helpful for the Federal Partners to be aware of, please let us know.*