Title: 1.3.1 Post-Assessment Follow-Up

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Approved By:	Date Approved:

After an assessment is completed with a client, the assessment is entered into the HMIS system where it is calculated for a numeric score. HMIS end-users or CE Lead Agency staff will enter the assessments in HMIS and should follow the guidance provided by HMIS staff (found in the Appendix) to correctly complete this process. Scores are not to be provided to the client under any circumstances and are only used for internal CE purposes. The score of the assessment is used in conjunction with prioritization policies outlined in Section 1.4 to determine which housing referrals and services a client may be eligible for. Below is the breakdown of what scores determine what housing intervention is most appropriate:

- 8 or Higher - Appropriate for Permanent Supportive Housing (Described in Section 1.4)
- 4-7 - Appropriate for Rapid Re-housing (Described in Section 1.4)
- 0-3 - Not appropriate for HUD-funded housing due to the probability of self-resolution. The possibility of independent housing searches, employment assistance, etc. will be discussed in this instance.

POST-ASSESSMENT PROCESS FOR INDIVIDUALS

After an assessment is completed, the CE Lead Agency will add all clients who score a 4 and up to the By-Name List for prioritization for housing program openings. Regardless of the access point, everyone is assessed for vulnerability, prioritized for housing placement, and discussed at the By-Name List meetings prior to a referral match. Outreach and/or providers working with a client are also responsible for helping to gather the proper supportive documentation needed to officially qualify a client for housing. Supportive documentation standards and types required for housing programs are outlined in Section 4.2.

Outreach Follow-Up Post Assessment

After the assessment process is complete, clients who are not already linked with an agency will have an outreach worker assigned to them through the By-Name list meetings by the CE Lead Agency. During the follow-up evaluation, outreach workers and CE partners will confirm and document all self-reported information provided by the client. Outreach workers and providers working with clients are expected to attend all By-Name List meetings and provide timely and accurate updates on clients,

including changes in need, status of documentation, and any additional relevant information.

The outreach worker will also identify any non-self-reported factors that may impact the client's prioritization. Any issues identified will not affect placement and will be solely used to assess the client's need. The outreach worker or local partner will begin the process of linking the client to community services while housing referral is pending.

POST-ASSESSMENT PROCESS FOR FAMILIES

Literally homeless families that present for emergency shelter placement as outlined in Section 1.4.1. are eligible for the Families (F)-VI-SPDAT. When a family accepts a referral to emergency shelter, the next step is to administer the F-VI-SPDAT and determine permanent housing eligibility, prioritization, and placement solutions.

After MIFA staff have assessed a household for vulnerability with the F-VI-SPDAT, assessments are scored to see which housing programs a family qualifies for. Similar to the individuals' side, households can qualify for Rapid-Rehousing (RRH) programs or Permanent Supportive Housing Programs (PSH) depending on the score they receive. Families who qualify for PSH programming are referred to an applicable housing program with a housing opening. MIFA staff will help facilitate the referral through a warm hand-off with email confirmation to ensure that the referral process operates smoothly.

Family RRH programming is offered directly through MIFA. MIFA has Family Housing Specialists (FHSs) who will work with families referred to RRH, which is outlined in Section 1.5.

POST-ASSESSMENT PROCESS FOR CLIENTS FLEEING DV/SA

After receipt of the risk assessment, Victim Service Providers will assist the client in identifying the client's self-identified needs. DV service providers should always allow the client to decide the pace and timeliness of the identified needs.

Service providers will not complete any follow-up that could potentially cause the client any harm. It is vital for the service provider to rely on their information gathering skills, motivational interviewing and case conferencing to best assess how to safely follow up with a client following their assessment. If possible, it is best practice to reach out to the DV service provider the client was referred to, in order to inquire if the client continues to engage through referred services. DV client's active engagement with supportive services is verification of follow up post risk assessment.