Before Starting the CoC Application

The CoC Consolidated Application consists of three parts, the CoC Application, the CoC Priority Listing, and all the CoC's project applications that were either approved and ranked, or rejected. All three must be submitted for the CoC Consolidated Application to be considered complete.

The Collaborative Applicant is responsible for reviewing the following:

1. The FY 2018 CoC Program Competition Notice of Funding Available (NOFA) for specific application and program requirements.
2. The FY 2018 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.
6. Questions marked with an asterisk (*), which are mandatory and require a response.

1A. Continuum of Care (CoC) Identification

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

1A-1. CoC Name and Number: NY-505 - Syracuse, Auburn/Onondaga, Oswego, Cayuga Counties CoC

1A-2. Collaborative Applicant Name: United Way of Central New York

1A-3. CoC Designation: CA

1A-4. HMIS Lead: United Way of Central New York

1B. Continuum of Care (CoC) Engagement

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

1B-1. CoC Meeting Participants. For the period from May 1, 2017 to April 30, 2018, using the list below, applicant must: (1) select organizations and persons that participate in CoC meetings; and (2) indicate whether the organizations and persons vote, including selecting CoC Board members.

Organization/Person Categories	Participates in CoC Meetings	Votes, including selecting CoC Board Members
Local Government Staff/Officials	Yes	Yes
CDBG/HOME/ESG Entitlement Jurisdiction	Yes	Yes
Law Enforcement	Yes	Yes
Local Jail(s)	Yes	No
Hospital(s)	Yes	Yes
EMS/Crisis Response Team(s)	Yes	No
Mental Health Service Organizations	Yes	Yes
Substance Abuse Service Organizations	Yes	Yes
Affordable Housing Developer(s)	Yes	Yes
Disability Service Organizations	Yes	Yes
Disability Advocates	Yes	Yes
Public Housing Authorities	Yes	Yes
CoC Funded Youth Homeless Organizations	Yes	Yes
Non-CoC Funded Youth Homeless Organizations	Yes	Yes
Youth Advocates	Yes	Yes
School Administrators/Homeless Liaisons	Yes	No
CoC Funded Victim Service Providers	Yes	Yes
Non-CoC Funded Victim Service Providers	Yes	Yes
Domestic Violence Advocates	Yes	Yes
Street Outreach Team(s)	Yes	Yes
Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates	Yes	Yes
LGBT Service Organizations	Yes	Yes
Agencies that serve survivors of human trafficking	Yes	Yes
Other homeless subpopulation advocates	Yes	Yes
Homeless or Formerly Homeless Persons	Yes	Yes
Mental Illness Advocates	Yes	Yes
Substance Abuse Advocates	Yes	Yes

Other:(limit 50 characters)		
Central New York Fair Housing	Yes	Yes
Legal Service Agencies	Yes	Yes
United Way of Central New York	Yes	Yes

1B-1a. Applicants must describe the specific strategy the CoC uses to solicit and consider opinions from organizations and/or persons that have an interest in preventing or ending homelessness.
(limit 2,000 characters)

In order to solicit opinions from organizations and/or persons that have an interest in preventing or ending homelessness, the Collaborative Applicant and CoC Advisory Board build partnerships through local advocacy, meeting representation and trainings, and networking. The CoC provides opportunities to receive feedback on all policies and procedures created within its committees and workgroups. A majority of these committees and workgroups are open to any person or organization interested in ending homelessness. Most of these committees and workgroups are open to anyone who has interest in preventing or ending homelessness. Policies are created and reviewed by various committees of the CoC. Final drafts are voted upon and approved or amended by the CoC Advisory Board.
The CoC conducts annual gaps & needs analyses which surveys people who are or have experienced homelessness to determine gaps in the system and how the CoC can strengthen partnerships with key stakeholders to fill these gaps. The outcomes of these surveys are presented to the community and the CoC uses this information to build partnerships with new stakeholders, i.e. the healthcare community, legal services, re-entry channels, among other services. For example, the CoC was able to strengthen relationships with transportation providers after a previous year's gaps & needs survey identified transportation as one of the biggest barriers in homelessness.
The CoC has two board positions on the Advisory Board for people who are formerly homeless.
The CoC is also developing a Client Advisory Board to directly receive feedback from those who are or have experienced homelessness within the CoC's system. It will be directly targeted to those who have received services from CoC funded agencies, as well as those who have moved through the shelter system.

1B-2.Open Invitation for New Members. Applicants must describe:
(1) the invitation process;
(2) how the CoC communicates the invitation process to solicit new members;
(3) how often the CoC solicits new members; and
(4) any special outreach the CoC conducted to ensure persons experiencing homelessness or formerly homeless persons are encouraged to join the CoC.
(limit 2,000 characters)

1) The CoC maintains an open invitation for CoC membership. The CoC has coalition meetings every other month that are open to the public and are highly

attended with over 60 participants from various organizations. The CoC uses its website (hhccny.org) and social media sites (Facebook & Twitter) to inform the public about coalition meetings, committee meetings, and events.

2) The CoC staff and CoC Advisory board meet with new members and potential new members to encourage partnerships and strengthen community services. The CoC staff also provides presentations about the coalition and extends training opportunities to new or potential members. New partners are also invited to give presentations of their services in CoC meetings.

3)The CoC solicits new members on an ongoing basis throughout the year. The CoC has hired a Community Engagement Coordinator to have concentrated effort to solicit new members for the CoC. The responsibilities of this position include meeting with potential new members and stakeholders, developing and facilitating a client advisory board, and conducting informational session and presentations about the work of the CoC and the benefits of membership.

4)The CoC has approach all CoC and ESG funded agencies to identify project participants that would be interested in joining the CoC. During monitoring, the CoC also assesses an agency's ability to gain feedback from project participants and encourages participation in the CoC. In this year's Gaps & Needs analysis, CoC project participants will be asked to join the CoC in the survey process.

1B-3.Public Notification for Proposals from Organizations Not Previously Funded. Applicants must describe how the CoC notified the public that it will accept and consider proposals from organizations that have not previously received CoC Program funding, even if the CoC is not applying for new projects in FY 2018, and the response must include the date(s) the CoC publicly announced it was open to proposals.
(limit 2,000 characters)

On July 20, 2018, the Collaborative Applicant released notice in several ways that it was accepting and considering proposals for new and renewal applications. The notice was posted on the CoC's website and announced on social media. The notice emphasized that both funded and unfunded agencies are encouraged to apply. The notice was also sent to the CoC listserv containing over 300 members, including local government officials, all CoC member organizations both funded and non-funded, and stakeholders. A press release also went out to local media to inform the public about this funding opportunity explaining that the CoC was accepting new applications and the amount available for both renewal and new applications. The notice also included the local applications, instructions for completing the application, and the Ranking and Rating protocol, all attached. Leading up to the notice, the CoC held meetings regarding the NOFA process for any agency interested in applying for funding. These meetings were attended by both funded and unfunded agencies. The application process was also presented in all committees and sub-committees of the CoC, as well as all community meetings attended by CoC staff. The Collaborative Applicant also met with interested parties in the months leading up to the application process to facilitate membership and provide guidance in applying for funding.

1C. Continuum of Care (CoC) Coordination

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

1C-1. CoCs Coordination, Planning, and Operation of Projects. Applicants must use the chart below to identify the federal, state, local, private, and other organizations that serve individuals, families, unaccompanied youth, persons who are fleeing domestic violence who are experiencing homelessness, or those at risk of homelessness that are included in the CoCs coordination, planning, and operation of projects.

Entities or Organizations the CoC coordinates planning and operation of projects	Coordinates with Planning and Operation of Projects
Housing Opportunities for Persons with AIDS (HOPWA)	Yes
Temporary Assistance for Needy Families (TANF)	Yes
Runaway and Homeless Youth (RHY)	Yes
Head Start Program	Yes
Funding Collaboratives	Yes
Private Foundations	Yes
Housing and services programs funded through U.S. Department of Justice (DOJ) Funded Housing and Service Programs	Yes
Housing and services programs funded through U.S. Health and Human Services (HHS) Funded Housing and Service Programs	Yes
Housing and service programs funded through other Federal resources	Yes
Housing and services programs funded through State Government	Yes
Housing and services programs funded through Local Government	Yes
Housing and service programs funded through private entities, including foundations	Yes
Other:(limit 50 characters)	

1C-2. CoC Consultation with ESG Program Recipients. Applicants must describe how the CoC:
(1) consulted with ESG Program recipients in planning and allocating ESG funds; and
(2) participated in the evaluating and reporting performance of ESG Program recipients and subrecipients.
(limit 2,000 characters)

1) The City of Syracuse and Onondaga County are ESG recipients and both sit on the CoC Advisory Board and the CoC's Performance Evaluation and Selection Committee, which operates the CoC's program rating and ranking process. The CoC Director sits on both ESG recipients' committees to make

funding decisions and to help write the Consolidated Plan and any updates.
2) The CoC HMIS Administrator assists the ESG recipients in evaluating performance of subrecipients using data from the HMIS system, including tracking returns to shelter and other system performance measures. The CoC provides ESG recipients with up to date data analysis about community needs in order to inform funding decisions based on local data.
The CoC, in collaboration with City ESG determined 3 performance measures for ESG Year 43. They were:
(1)Increase the leadership, governance, collaboration and civic engagement among agencies and mainstream resources and other support services in assessing the needs of homeless or housing vulnerable individuals and families.
(2)Increase access to stable and affordable housing by creating and utilizing a centralized housing database that identifies safe, decent affordable housing to rapidly re-house individuals and families.
(3)Retool the homeless crisis response system to prevent and rapidly return individuals who experience homelessness to stable housing.

1C-2a. Providing PIT and HIC Data to Consolidated Plan Jurisdictions. Did the CoC provide Point-in-Time (PIT) and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area?	Yes to both
1C-2b. Providing Other Data to Consolidated Plan Jurisdictions. Did the CoC provide local homelessness information other than PIT and HIC data to the jurisdiction(s) Consolidated Plan(s)?	Yes

1C-3. Addressing the Safety Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors. Applicants must describe:
(1) the CoC's protocols, including the existence of the CoC's emergency transfer plan, that prioritizes safety and trauma-informed, victim-centered services to prioritize safety; and
(2) how the CoC maximizes client choice for housing and services while ensuring safety and confidentiality.
(limit 2,000 characters)

1) The CoC ensures all survivors of violence are provided confidential services. The CoC monitors each funded agency for Emergency Transfer Plans to ensure that agencies are prepared if there is an occurrence of domestic violence while a person is enrolled in a housing project.
The local victim service providers, Cayuga/Seneca Community Action Agency, Oswego County Opportunities, and Vera House, are all voting members of the CoC. A victim service provider has a representative on the Advisory Board of the CoC.
The shelters provide specialized, trauma informed, and confidential services to

all residents, including survivors of violence. Shelter staff ensure residents are connected to appropriate services, such as counseling services and advocacy, if required. Housing accommodations are confidentially maintained and CoC-funded projects are monitored on the non-disclosure of client location.
2) Residents of DV shelters have full access to the Coordinated Entry system and are provided with choices regarding housing opportunities, equal to all other people experiencing homelessness. The CoC works with these providers to ensure survivors have pathways to housing and are de-identified on the Coordinated Entry list. The CoC's Coordinated Entry system operates within its HMIS system. DV providers are able to operate outside of that system, working with CoC staff to provide de-identified referrals through a CoC staff person to Coordinated Entry. CoC staff and agencies using Coordinated Entry are not given any identifying information to ensure survivor safety and privacy.

1C-3a. Applicants must describe how the CoC coordinates with victim services providers to provide annual training to CoC area projects and Coordinated Entry staff that addresses best practices in serving survivors of domestic violence, dating violence, sexual assault, and stalking. (limit 2,000 characters)

The local victim service providers are CoC members. The CoC has DV providers conduct training at the Housing Service Provider workgroup. This workgroup is open to all staff at member organizations of the CoC. It provides training to primarily front line staff and direct service providers on a monthly basis. Through this training, DV service providers are able to offer training to direct service staff from a variety of agencies providing services to people experiencing homelessness, including survivors of domestic violence. In addition, the CoC meetings have been a vehicle for connecting DV service providers to housing providers to have front line staff trained in best practices. CoC housing programs and shelters held a combined Trauma Informed Care training with a focus on DV in 2016. Projects then updated practices to be more trauma informed. There will be another Trauma Informed Care training offered this fiscal year to train new staff.

1C-3b. Applicants must describe the data the CoC uses to assess the scope of community needs related to domestic violence, dating violence, sexual assault, and stalking, including data from a comparable database. (limit 2,000 characters)

The CoC collects data from all domestic violence service providers across the three counties it covers. This data is added aggregately in the PIT count. This data is used to assess community need relating to domestic violence, dating violence, sexual assault and stalking. The CoC also collects data regarding history with domestic violence and reason for entering emergency shelter for all clients entering the shelter system. This data, in addition to data provided directly from DV providers, allows the CoC to evaluate trends and better target resources to community need.
Data is gathered from HMIS and is also collected from the comparable databases from the victim service providers. Victim service providers work with the HMIS Administrator to identify needs and trends.

1C-4. DV Bonus Projects. Is your CoC applying for DV Bonus Projects? Yes

1C-4a. From the list, applicants must indicate the type(s) of DV Bonus project(s) that project applicants are applying for which the CoC is including in its Priority Listing.

SSO Coordinated Entry	
RRH	X
Joint TH/RRH	X

1C-4b. Applicants must describe:
(1) how many domestic violence survivors the CoC is currently serving in the CoC's geographic area;
(2) the data source the CoC used for the calculations; and
(3) how the CoC collected the data.
(limit 2,000 characters)

1) The CoC has served 1383 victim/ survivors of domestic violence in emergency and DV shelters between 7/1/17 to 6/30/18. This accounts for 26% of the total homeless population within the HMIS and DV Provider systems. Out of these 1383 people who identified as being victim/ survivors of domestic violence, 60% were currently fleeing an unsafe, domestic violence situation. Of 336 youth (18 to 24) experiencing homelessness, 80 (24%) identified as being survivors of domestic violence.
2) The DV data was compiled from multiple sources. Data was pulled directly from HMIS from emergency shelters and collected from the victim service providers within the 3 counties (Vera House, Oswego County Opportunities and Cayuga Seneca Community Action Agency). This data was compiled to give a total number of people (individuals and families) who identified as being a victim/ survivor of domestic violence, and who were currently fleeing.
3) The CoC collects data in HMIS from DV survivors with two data elements- history of domestic violence and if the person is actively fleeing. These data points are collected at project intake for every project that enters data into HMIS. DV service providers use comparable databases to track services provided and bed nights.

1C-4c. Applicants must describe:
(1) how many domestic violence survivors need housing or services in the CoC's geographic area;
(2) data source the CoC used for the calculations; and
(3) how the CoC collected the data.
(limit 2,000 characters)

1) All DV Services providers reported that over 75% of clients were in need of housing intervention in order to transition successfully into the community. From 7/1/17 to 6/30/18, there were 210 referrals for clients who identified as being a victim/ survivor of domestic violence sent through the Coordinated Entry System from non-DV shelters for RRH Services. This accounted for 15% of all RRH referrals made through Coordinated Entry. During that year over 185

victims/ survivors of DV were served in the CoC's RRH Projects. This number accounts for 16% of all clients served in RRH projects in the CoC.
2) All DV Providers within the CoC were surveyed and asked to quantify the percentage of clients in need of housing and services. Data was also compiled from Coordinated Entry referrals made during the reporting year of 7/1/17 to 6/30/18. This date range was chosen in order to give the most recent information from Coordinated Entry referrals in HMIS. The data was pulled from a report generated to create a list of all people referred through Coordinated Entry with demographic information, such as DV status. These totals were compiled and compared to the total number of RRH referrals made for that year. Data was also pulled directly from our RRH projects to determine the DV victim/ survivor population within RRH projects.
3) The data used to determine need was pulled directly from HMIS from all of the Emergency Shelters and Rapid Rehousing Projects via an APR. Data from HMIS determined if there was a referral made for housing intervention/ services via the Coordinated Entry system, and that information was calculated into a percentage against the overall homeless population served within ES and RRH. The data from the DV providers was requested and submitted as a percentage of clients needing housing services as collected in surveys from DV providers from comparable databases.

1C-4d. Based on questions 1C-4b. and 1C-4c., applicant must:
(1) describe the unmet need for housing and services for DV survivors, or if the CoC is applying for an SSO-CE project, describe how the current Coordinated Entry is inadequate to address the needs of DV survivors;
(2) quantify the unmet need for housing and services for DV survivors;
(3) describe the data source the CoC used to quantify the unmet need for housing and services for DV survivors; and
(4) describe how the CoC determined the unmet need for housing and services for DV survivors.
(limit 3,000 characters)

1) There is a gap between the number of DV survivors in the system who need a housing intervention and the number of DV survivors who have received RRH services. The services that the DV providers identified as the biggest need for the clients were housing interventions.
2) During the past year, the CoC served 1,383 people who identified as victim/ survivors of domestic violence, 586 who were coming specifically from DV Shelters. Based upon the reporting of need by the DV Providers in our CoC the number of people who need assistance with housing is between 440-586 survivors of domestic violence this past year. It was reported that the number of people we served in RRH projects (CoC and non-CoC funded) was 185 people. That means that there are 255-401 victims of domestic violence who needed assistance with housing, specifically services provided by RRH, and were not provided that service.
The CoC used HMIS data from the Emergency Shelters and aggregate data collected from the DV Providers in the community to establish what the need was for the community.
3) There were survey questions asked of all DV providers about specific needs with client referrals/ services, specifically around percentages of people who would need or had been referred to housing interventions. Data was pulled from the Coordinated Entry system to determine the level of need established within the HMIS. An RRH APR was pulled from the HMIS to see what the

overall DV Victim/ survivor population looked like currently in our RRH projects. All of this data was used to determine a deficit in the amount of RRH and Th-RRH services for DV survivors needed in the community.
4) This was a collaborative effort that involved all of the DV Providers within the CoC and the CoC staff. Data was pulled from a variety of sources and analyzed to get an overall view of what the DV population within the community. The DV providers were surveyed about client needs for housing and services. That data was then used to determine what the overall need was for housing and services for individuals and families who are DV victims/ survivors. The CoC then did an overall assessment of what we are currently serving in our CoC and non-CoC funded RRH projects. This data was pulled directly from HMIS. Then the CoC assessed the difference in identified need verses who the RRH projects are currently serving. After that assessment it was determined that there are several hundred people per year who are in need of the service and are not getting that need met.

1C-4e. Applicants must describe how the DV Bonus project(s) being applied for will address the unmet needs of domestic violence survivors. (limit 2,000 characters)

One of the DV bonus projects is a RRH project designed to serve both families and individuals. The project will serve families and individuals from DV and emergency shelters in the whole CoC. The project will assist in filling the need for RRH services for survivors of domestic violence. It will serve 106 people. The second DV bonus project is a TH-RRH project designed to serve parenting youth, ages 18 to 24.

1C-4f. Applicants must address the capacity of each project applicant applying for DV bonus projects to implement a DV Bonus project by describing:
(1) rate of housing placement of DV survivors;
(2) rate of housing retention of DV survivors;
(3) improvements in safety of DV survivors; and
(4) how the project applicant addresses multiple barriers faced by DV survivors.
(limit 4,000 characters)

There are two projects applying for DV bonus projects- The Salvation Army Transitional Apartment and Parenting Center for Th-RRH (TSA TAPC and Catholic Charities with Oswego County Opportunities as a sub-recipient for RRH (CCOC/OCO).
1)TSA TAPC: TSA TAPC provides housing and case management services for approximately 40 homeless pregnant and parenting youth per year. Of these 40 youth, 40% are identified as being domestic violence survivors. The TAPC seeks to create 12 beds which adhere to the HUD TH/RRH model. Of the DV survivors participating in the TH/RRH model, 90% will achieve a housing placement of permanent housing, either located directly at the TAPC campus or in a community of their own choice.
CCOC/OCO: CCOC and OCO homeless programs provide housing and case management services for over 500 families and individuals per year. Of the clients served 20% have experienced or are actively fleeing DV. Catholic Charities of Onondaga County Rapid Re-Housing for DV survivors is proposing

to serve 106 individuals and families over 12 months. Of the DV survivors participating in the Rapid Re-Housing for DV Survivors project, 100% will achieve a housing placement into safe and stable housing of their choice.
2)TSA TAPC: Ongoing TH/RRH program services will provide TAPC clients with the type of support and intervention necessary to assist DV survivors with retaining permanent housing. Of those clients placed in permanent housing, 90% will maintain such housing for six months or more.
CCOC/OCO: Through ongoing case management and rental assistance services up to 12 months the DV survivors will be provided with the necessary supports and interventions to retain permanent housing. Of those clients placed in permanent housing 80% will maintain their housing for six months or more.
3) TSA TAPC: One of the strongest features of the TAPC TH/RRH is the ability for program participants to elect to live on campus at the TAPC, particularly valuable for DV survivors who require increased measures of safety and security.The TAPC employs 24-hour on-site staffing, has visitor check-ins, surveillance cameras, transportation assistance, recreation facilities and case management services.
CCOC/OCO: Each participant in the project will be paired with a DV advocate at Vera House or OCO in order to assess safety needs and concerns. Participants will decide on location and type of housing to ensure their needs are being met. Case management and check-ins will be provided on an as needed basis, determined by the participant. The case manager, DV advocate and resident will work together to determine safety plans, referrals to community services and will have access to an after-hours call number.
4) TSA TAPC: The TAPC provides programming and services such as survivor synergy, financial assistance, DV support groups, independent living skills, goal and service planning, assistance navigating resources, and aftercare when participants are housed, and discharge planning.
CCOC/OCO: Project staff, working closely with DV advocates will work with participants to assess immediate needs, determine barriers to independent housing, and develop an independent living plan. This will include a determination of the size and location of housing needed, a budget for a sustainable level of housing affordability, and search for housing, including but not limited to, transportation, landlord negotiations, and inspection of potential housing units. Other factors impacting housing stability will also be addressed such as employment, public benefits, health and health insurance needs, legal issues, child care, and general life skills training. The amount and duration of assistance will be determined in each case, with the goal of participants' independence in 12 months. Follow-up case management services will be available as needed for up to 24 months to ensure the successful outcome of housing stability.

1C-5. PHAs within CoC. Applicants must use the chart to provide information about each Public Housing Agency (PHA) in the CoC's geographic areas:
(1) Identify the percentage of new admissions to the Public Housing or Housing Choice Voucher (HCV) Programs in the PHA who were experiencing homelessness at the time of admission;
(2) Indicate whether the PHA has a homeless admission preference in its Public Housing and/or HCV Program; and
(3) Indicate whether the CoC has a move on strategy. The information

should be for Federal Fiscal Year 2017.

Public Housing Agency Name	% New Admissions into Public Housing and Housing Choice Voucher Program during FY 2017 who were experiencing homelessness at entry	PHA has General or Limited Homeless Preference	PHA has a Preference for current PSH program participants no longer needing intensive supportive services, e.g. move on?
Syracuse Housing Authority	0.00%	No	No
Auburn Housing Authority	21.00%	No	No
North Syracuse Housing Authority	0.00%	No	No
Christopher Community	16.00%	Yes-HCV	No
City of Oswego, Office of Community Development	0.00%	No	No

If you select "Yes--Public Housing," "Yes--HCV," or "Yes--Both" for "PHA has general or limited homeless preference," you must attach documentation of the preference from the PHA in order to receive credit.

**1C-5a. For each PHA where there is not a homeless admission preference in their written policy, applicants must identify the steps the CoC has taken to encourage the PHA to adopt such a policy.
(limit 2,000 characters)**

Syracuse Housing Authority- The CoC, including Collaborative Applicant staff and Advisory Board members, meet annually with SHA regarding homeless preference and partnership in the CoC. This includes conversations regarding new funding opportunities and HCV set asides for those moving on from PSH.

Auburn Housing Authority- The deputy director of the AHA sits on the CoC Advisory Board. The AHA contacts all local homeless providers when the HCV waitlist opens. Through the advisory board and committee work, the CoC continues to encourage adoption of a homeless preference.

North Syracuse Housing Authority- The CoC staff has encouraged the North Syracuse Housing Authority with verbal and written communication on at least an annual basis to adopt a homeless preference.

City of Oswego, Office of Community Development- The CoC continues to engage the City of Oswego. A representative of the Office of Community Development has started attending committee meetings of the CoC. In this meeting, the CoC is able to engage and encourage homeless preference.

1C-5b. Move On Strategy with Affordable Housing Providers. Does the CoC have a Move On strategy with affordable housing providers in its jurisdiction (e.g., multifamily assisted housing owners, PHAs, Low Income Tax Credit (LIHTC) developments, or local low-income housing programs)? No

1C-6. Addressing the Needs of Lesbian, Gay, Bisexual, Transgender (LGBT). Applicants must describe the actions the CoC has taken to address the needs of Lesbian, Gay, Bisexual, and Transgender individuals and their families experiencing homelessness. (limit 2,000 characters)

The CoC has provided Equal Access Training through the Volunteer Lawyer's Project for all funded and non-funded member agencies. These trainings are offered annually or as requested as new projects begin or projects have turnover. The Human Service Provider workgroup, a workgroup of the CoC, offers ongoing monthly trainings throughout the year.
All local shelters have received Equal Access training. Safety and choice for LGBT individuals is taken into account when determining shelter offerings. A person experiencing homelessness is able to identify where they would feel safe. If someone does not feel safe during a stay in shelter, they are able to be moved to another shelter option.
The CoC currently has a CoC-funded RRH project targeting LGBT youth to address the unique needs of the LGBT youth population.
During monitoring, all CoC funded agencies are assessed for policies addressing needs for LGBT participants.
The Collaborative Applicant staff also serves as a mediator if issues arise in emergency or housing projects.

1C-6a. Anti-Discrimination Policy and Training. Applicants must indicate if the CoC implemented a CoC-wide anti-discrimination policy and conducted CoC-wide anti-discrimination training on the Equal Access Final Rule and the Gender Identity Final Rule.

1. Did the CoC implement a CoC-wide anti-discrimination policy that applies to all projects regardless of funding source?	Yes
2. Did the CoC conduct annual CoC-wide training with providers on how to effectively implement the Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity (Equal Access Final Rule)?	Yes
3. Did the CoC conduct annual CoC-wide training with providers on how to effectively implement Equal Access to Housing in HUD Programs in Accordance with an Individual's Gender Identity (Gender Identity Final Rule)?	Yes

1C-7. Criminalization of Homelessness. Applicants must select the specific strategies the CoC implemented to prevent the criminalization of homelessness in the CoC's geographic area. Select all that apply.

Engaged/educated local policymakers:	X
Engaged/educated law enforcement:	X
Engaged/educated local business leaders:	X
Implemented communitywide plans:	X
No strategies have been implemented:	
Other:(limit 50 characters)	

	☐
	☐
	☐

1C-8. Centralized or Coordinated Assessment System. Applicants must:
(1) demonstrate the coordinated entry system covers the entire CoC geographic area;
(2) demonstrate the coordinated entry system reaches people who are least likely to apply homelessness assistance in the absence of special outreach;
(3) demonstrate the assessment process prioritizes people most in need of assistance and ensures they receive assistance in a timely manner; and
(4) attach CoC's standard assessment tool.
(limit 2,000 characters)

1) The Coordinated Entry system covers the entire CoC geographic area. The CE system is used by street outreach and shelter providers in the three counties of the CoC to ensure that all people experiencing homelessness are referred into the Coordinated Entry system.
2) People entering homelessness for the first time are assessed using the appropriate SPDAT within two weeks of entering homelessness. Street outreach and shelter providers engage in ongoing outreach to those least likely to apply for housing to offer services on a weekly basis, even to those refusing housing options. Street outreach providers conduct outreach on a daily basis, providing personal items, food, clothing, and sometimes medical care in order to initiate a relationship to those refusing services outside. All CoC and ESG funded providers use the Coordinated Entry system to fill beds. SSVF, VA's HCHV, and HOPWA providers also use the Coordinated Entry system.
3) The Coordinated Entry system prioritizes the chronically homeless with the longest length of time homeless and the highest service needs as evidenced by SPDAT assessment score. Housing providers target the highest priority individuals and families to fill beds, ensuring that those most vulnerable are matched with appropriate housing opportunities.
4) The Collaborative Applicant staff monitors the Coordinated Entry system to ensure that people experiencing homelessness are entering housing in a timely manner. The CoC also has a monthly workgroup to case conference difficult to serve cases, persons refusing housing, persons who have been on the list for longer than 90 days, possible evictions from PH programs, and potential permanent supportive housing transfers.

1D. Continuum of Care (CoC) Discharge Planning

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

1D-1. Discharge Planning–State and Local. Applicants must indicate whether the CoC has a discharge policy to ensure persons discharged from the systems of care listed are not discharged directly to the streets, emergency shelters, or other homeless assistance programs. Check all that apply (note that when "None:" is selected no other system of care should be selected).

Foster Care:	X
Health Care:	X
Mental Health Care:	X
Correctional Facilities:	X
None:	

1D-2. Discharge Planning Coordination. Applicants must indicate whether the CoC actively coordinates with the systems of care listed to ensure persons who have resided in them longer than 90 days are not discharged directly to the streets, emergency shelters, or other homeless assistance programs. Check all that apply (note that when "None:" is selected no other system of care should be selected).

Foster Care:	X
Health Care:	X
Mental Health Care:	X
Correctional Facilities:	X
None:	

1E. Continuum of Care (CoC) Project Review, Ranking, and Selection

Instructions

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

1E-1. Project Ranking and Selection. Applicants must indicate whether the CoC used the following to rank and select project applications for the FY 2018 CoC Program Competition:
(1) objective criteria;
(2) at least one factor related to achieving positive housing outcomes;
(3) a specific method for evaluating projects submitted by victim services providers; and
(4) attach evidence that supports the process selected.

Used Objective Criteria for Review, Rating, Ranking and Section	Yes
Included at least one factor related to achieving positive housing outcomes	Yes
Included a specific method for evaluating projects submitted by victim service providers	Yes

1E-2. Severity of Needs and Vulnerabilities. Applicants must describe:
(1) the specific severity of needs and vulnerabilities the CoC considered when reviewing, ranking, and rating projects; and
(2) how the CoC takes severity of needs and vulnerabilities into account during the review, rating, and ranking process.
(limit 2,000 characters)

The CoC uses a scored ranking process to determine severity of needs and vulnerabilities. The scores reflect community need and severity of need. Full points are awarded to projects serving chronically homeless, followed by youth and re-entry populations, then families and veterans. The CoC recognizes the special needs of the chronically homeless and is actively working to end chronic homelessness.

The CoC has seen a great need in the youth population (ages 18 to 24), DV survivors, and a rise in the number of re-entry, previously incarcerated population in shelter. In the CoC, Onondaga County ended veteran homelessness in 2015 and has maintained adherence to the criteria and benchmarks put forth in the declaration. The CoC has also seen a decrease in family homelessness. Projects were scored on a scale based on the need level of these specialized populations in the community.

The CoC takes into account the commitment of projects to Housing First as it has been proven to lead to reductions in homelessness. All renewal projects are

scored on Housing First policies, as assessed by HUD's Housing First Assessment; including but not limited to serving those with little or no income, current or past substance abuse, a history of victimization, criminal histories and chronic homelessness. These scores are factored into the review of projects. The CoC asks new applicants to provide Housing First policies which are also scored and reviewed in the ranking and rating process. Renewal applicants are also scored based on the project's use of the Coordinated Entry system to fill beds with the highest vulnerable people.

1E-3. Public Postings. Applicants must indicate how the CoC made public:
(1) objective ranking and selection process the CoC used for all projects (new and renewal);
(2) CoC Consolidated Application–including the CoC Application, Priority Listings, and all projects accepted and ranked or rejected, which HUD required CoCs to post to their websites, or partners websites, at least 2 days before the CoC Program Competition application submission deadline; and
(3) attach documentation demonstrating the objective ranking, rating, and selections process and the final version of the completed CoC Consolidated Application, including the CoC Application with attachments, Priority Listing with reallocation forms and all project applications that were accepted and ranked, or rejected (new and renewal) was made publicly available, that legibly displays the date the CoC publicly posted the documents.

Public Posting of Objective Ranking and Selection Process		Public Posting of CoC Consolidated Application including: CoC Application, Priority Listings, Project Listings	
CoC or other Website	☐	CoC or other Website	☐
Email	☐	Email	☐
Mail	☐	Mail	☐
Advertising in Local Newspaper(s)	☐	Advertising in Local Newspaper(s)	☐
Advertising on Radio or Television	☐	Advertising on Radio or Television	☐
Social Media (Twitter, Facebook, etc.)	☐	Social Media (Twitter, Facebook, etc.)	☐

1E-4. Reallocation. Applicants must indicate whether the CoC has cumulatively reallocated at least 20 percent of the CoC's ARD between the FY 2014 and FY 2018 CoC Program Competitions.

Reallocation: Yes

1E-5. Local CoC Competition. Applicants must indicate whether the CoC:
(1) established a deadline for project applications that was no later than 30 days before the FY 2018 CoC Program Competition Application deadline–attachment required;
(2) rejected or reduced project application(s)–attachment required; and

(3) notify applicants that their project application(s) were being rejected or reduced, in writing, outside of e-snaps, at least 15 days before FY 2018 CoC Program Competition Application deadline–attachment required. :

(1) Did the CoC establish a deadline for project applications that was no later than 30 days before the FY 2018 CoC Program Competition Application deadline? Attachment required.	Yes
(2) If the CoC rejected or reduced project application(s), did the CoC notify applicants that their project application(s) were being rejected or reduced, in writing, outside of e-snaps, at least 15 days before FY 2018 CoC Program Competition Application deadline? Attachment required.	Yes
(3) Did the CoC notify applicants that their applications were accepted and ranked on the Priority Listing in writing outside of e-snaps, at least 15 before days of the FY 2018 CoC Program Competition Application deadline?	Yes

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

2A-1. Roles and Responsibilities of the CoC and HMIS Lead. Does your CoC have in place a Governance Charter or other written documentation (e.g., MOU/MOA) that outlines the roles and responsibilities of the CoC and HMIS Lead? Attachment Required.	Yes
2A-1a. Applicants must: (1) provide the page number(s) where the roles and responsibilities of the CoC and HMIS Lead can be found in the attached document(s) referenced in 2A-1, and (2) indicate the document type attached for question 2A-1 that includes roles and responsibilities of the CoC and HMIS Lead (e.g., Governance Charter, MOU/MOA).	Pages 5, 6, & 13 in the NY-505 Governance Charter, NY-505 Operational Guidelines
2A-2. HMIS Policy and Procedures Manual. Does your CoC have a HMIS Policy and Procedures Manual? Attachment Required.	Yes
2A-3. HMIS Vender. What is the name of the HMIS software vendor?	Mediware
2A-4. HMIS Implementation Coverage Area. Using the drop-down boxes, applicants must select the HMIS implementation Coverage area.	Single CoC

2A-5. Bed Coverage Rate. Using 2018 HIC and HMIS data, applicants must report by project type:
(1) total number of beds in 2018 HIC;
(2) total beds dedicated for DV in the 2018 HIC; and

(3) total number of beds in HMIS.

Project Type	Total Beds in 2018 HIC	Total Beds in HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
Emergency Shelter (ES) beds	568	55	497	96.88%
Safe Haven (SH) beds	0	0	0	
Transitional Housing (TH) beds	210	14	196	100.00%
Rapid Re-Housing (RRH) beds	623	0	623	100.00%
Permanent Supportive Housing (PSH) beds	1,181	0	1,181	100.00%
Other Permanent Housing (OPH) beds	139	0	139	100.00%

2A-5a. To receive partial credit, if the bed coverage rate is 84.99 percent or lower for any of the project types in question 2A-5., applicants must provide clear steps on how the CoC intends to increase this percentage for each project type over the next 12 months. (limit 2,000 characters)

N/A

2A-6. AHAR Shells Submission: How many 2017 Annual Housing Assessment Report (AHAR) tables shells did HUD accept? 12

2A-7. CoC Data Submission in HDX. Applicants must enter the date the CoC submitted the 2018 Housing Inventory Count (HIC) data into the Homelessness Data Exchange (HDX). (mm/dd/yyyy) 04/20/2018

2B. Continuum of Care (CoC) Point-in-Time Count

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

2B-1. PIT Count Date. Applicants must enter the date the CoC conducted its 2018 PIT count (mm/dd/yyyy).	01/24/2018
2B-2. HDX Submission Date. Applicants must enter the date the CoC submitted its PIT count data in HDX (mm/dd/yyyy).	04/20/2018

2C. Continuum of Care (CoC) Point-in-Time (PIT) Count: Methodologies

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

2C-1. Change in Sheltered PIT Count Implementation. Applicants must describe any change in the CoC's sheltered PIT count implementation, including methodology and data quality changes from 2017 to 2018. Specifically, how those changes impacted the CoC's sheltered PIT count results.
(limit 2,000 characters)

The CoC reallocated or lost several Transitional Housing Programs in the community, which accounted for more than a 50 bed decrease in TH beds. The temperature outside for this year's PIT was approximately 20 degrees colder than the previous year at about 15ºF, which could account for the increase in shelter numbers. The colder weather, increased street outreach, and cold weather policies in shelters resulted in a decrease in the unsheltered count. This year Hutchings Psychiatric and Victory Transformations emergency shelter beds were added to the PIT Count, which accounted for 15 out of the 21 person increase in emergency shelter numbers for individuals. Family homelessness saw a decrease in this year's PIT count. There were over 100 volunteers in the PIT count across the three counties of the CoC, including the Mayor of the City of Syracuse which brought attention to the PIT count and the efforts in ending homelessness.

2C-2. Did your CoC change its provider coverage in the 2018 sheltered count? Yes

2C-2a. If "Yes" was selected in 2C-2, applicants must enter the number of beds that were added or removed in the 2018 sheltered PIT count.

Beds Added:	16
Beds Removed:	50
Total:	-34

2C-3. Presidentially Declared Disaster Changes to Sheltered PIT Count. Did your CoC add or remove emergency shelter, transitional housing, or Safe Haven inventory because of funding specific to a Presidentially declared disaster, resulting in a change to the CoC's 2018 sheltered PIT No

count?

2C-3a. If "Yes" was selected for question 2C-3, applicants must enter the number of beds that were added or removed in 2018 because of a Presidentially declared disaster.

Beds Added:	0
Beds Removed:	0
Total:	0

2C-4. Changes in Unsheltered PIT Count Implementation. Did your CoC change its unsheltered PIT count implementation, including methodology and data quality changes from 2017 to 2018? If your CoC did not conduct and unsheltered PIT count in 2018, select Not Applicable. No

2C-5. Identifying Youth Experiencing Homelessness in 2018 PIT Count. Did your CoC implement specific measures to identify youth experiencing homelessness in its 2018 PIT count? Yes

2C-5a. If "Yes" was selected for question 2C-5., applicants must describe:
(1) how stakeholders serving youth experiencing homelessness were engaged during the planning process;
(2) how the CoC worked with stakeholders to select locations where youth experiencing homelessness are most likely to be identified; and
(3) how the CoC involved youth experiencing homelessness in counting during the 2018 PIT count.
(limit 2,000 characters)

1) The CoC has a Runaway and Homeless Youth Advisory Committee that focuses on ending youth homelessness. The CoC engaged stakeholders to participate in the PIT count in this meeting. This meeting is attended by representatives from shelters, housing programs, school districts, McKinney-Vento liaisons, law enforcement, juvenile justice, youth shelters/housing facilities, youth employment services, Office of Children and Family Services, child advocacy representatives, human trafficking services, LGBT services, mental health services, Department of Social Services, pregnant/parenting services, youth recreation centers and HUD-funded programming. The CoC is meeting quarterly with school McKinney Vento liaisons to develop strategies to better capture data from in-school surveys.
2) The CoC targeted youth drop-in centers in the CoC for conducting the next day surveys, including a day care targeting service to parenting youth. CoC staff also engaged with the McKinney Vento liaisons in the CoC to participate in the next day surveys.
3) The CoC received surveys from schools and aggregates data with data pulled directly from HMIS. The CoC also had staff from youth programs

participating in the PIT Count targeting known locations of youth.

2C-6. 2018 PIT Implementation. Applicants must describe actions the CoC implemented in its 2018 PIT count to better count:
(1) individuals and families experiencing chronic homelessness;
(2) families with children experiencing homelessness; and
(3) Veterans experiencing homelessness.
(limit 2,000 characters)

1) Over 97% of the CoC's homeless data is in HMIS. This year, the CoC focused on the data quality surrounding those individuals actively served in shelters and street outreach projects to ensure the chronic homeless questions were answered correctly. The result was being able to accurately identify who was chronically homeless under the HUD definition and pull that data from HMIS. This was accomplished through the development of the Chronic Workgroup, which consists of Emergency shelter, street outreach, and housing providers in the community. The CoC staff continues to provide training to frontline staff across the geographic area regarding accurate identification of chronically homeless individuals and families. The CoC also conducts next day surveys at local soup kitchens and day centers to capture anone who had slept outside the night before accessing these services. This method has been successful in identifying individuals and families experiencing chronic homelessness.
2) All family shelters input data into HMIS apart from DV shelters. DV shelters provide aggregate, de-identified count on the night of the PIT.
3) The Veteran Workgroup actively identifies homeless veterans to maintain the end to veteran homelessness in Onondaga County and tracks progress towards ending veteran homelessness in the entirety of the CoC. Every person who enters shelter, is met outdoors, or calls 211 is asked if he or she has served in the military. The CoC's VA HUD VASH providers are all in the HMIS system.

3A. Continuum of Care (CoC) System Performance

Instructions

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

3A-1. First Time Homeless as Reported in HDX. In the box below, applicants must report the number of first-time homeless as reported in HDX.

Number of First Time Homeless as Reported in HDX.	161

3A-1a. Applicants must:
(1) describe how the CoC determined which risk factors the CoC uses to identify persons becoming homeless for the first time;
(2) describe the CoC's strategy to address individuals and families at risk of becoming homeless; and
(3) provide the name of the organization or position title that is responsible for overseeing the CoC's strategy to reduce the number of individuals and families experiencing homelessness for the first time. (limit 2,000 characters)

1)The CoC determines which risk factors contribute to homelessness by tracking the reason for entering homelessness at shelter entry as a data element in the HMIS system. At entry for shelter or first contact during street outreach, people experiencing homelessness for the first time are asked to identify the primary and secondary reason for entering homelessness. Clients are able to identify reasons such as eviction, substandard housing, conflict in the household, lack of affordable housing, unemployment, loss of benefits, mental health or substance abuse, among others.

2)Data from these questions are able to be compiled and used to identify where community resources should be directed in preventing and diverting homelessness, including building partnerships and identifying key stakeholders to intervene and divert from homelessness. For example, eviction has been historically one of the highest reasons for entering homelessness. Multiple prevention services are now dedicated to aiding in the eviction court process through legal services. Using targeted interventions, the CoC saw an 8% decrease in family homelessness from the 2017 PIT to 2018 PIT.There are a number of programs throughout the community dedicated to providing homeless prevention services, including ESG funded projects that have seen housing stability rates of over 90%.

3)The local Departments of Social Services (LDSS) and 211 are responsible for diverting homelessness. All three counties in the CoC use a single point of access for shelter. The HMIS system administrator is responsible for monitoring shelter entry data and presenting it to the community. The Program/Advocacy Planning Committee, a committee of the CoC, is responsible for establishing

CoC priorities and implementing those plans. This committee is responsible for using data to develop strategies to reduce the number of individuals and families experiencing homelessness for the first time.

3A-2. Length-of-Time Homeless as Reported in HDX. Applicants must:
(1) provide the average length of time individuals and persons in families remained homeless (i.e., the number);
(2) describe the CoC's strategy to reduce the length-of-time individuals and persons in families remain homeless;
(3) describe how the CoC identifies and houses individuals and persons in families with the longest lengths of time homeless; and
(4) provide the name of the organization or position title that is responsible for overseeing the CoC's strategy to reduce the length of time individuals and families remain homeless.
(limit 2,000 characters)

1)The average length of time families and individuals remain homeless is 36 days, a decrease of one day from last year.

2) The CoC uses the Coordinated Entry system to target chronically homeless individuals and families with the longest histories of homelessness which has helped reduced the average length of time homeless. The Coordinated Entry workgroup case conferences individuals and families with lengths of stay over 90 days in the monthly workgroup meeting to address barriers and to ensure prioritization for housing. The CoC monitors for rapid entry into permanent housing programs in both annual monitoring and the local application process for funding.

3) The CoC uses HMIS data and client self-report to determine the individuals and families with the longest lengths of time homeless. This data is attached to all Coordinated Entry referrals. The Coordinated Entry list is organized based on length of time homeless. Individuals and families who are chronic with the longest length of time homeless and highest service needs are prioritized for housing.

4)The Collaborative Applicant, including the HMIS Administrator, is responsible for overseeing the strategy the Coordinated Entry system and the strategy to reduce the length of time individuals and families remain homeless. System performance measures reports are run quarterly by the HMIS Administrator. These reports are sent to agency leads and reported out in the Data Administrators meeting. This has decreased issues with data quality and provides the opportunity for technical assistance for projects or agencies. LDSS is also responsible for providing oversight of emergency shelters and hotel stays to monitor for long lengths of stay.

3A-3. Successful Permanent Housing Placement and Retention as Reported in HDX. Applicants must:
(1) provide the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid rehousing that exit to permanent housing destinations; and
(2) provide the percentage of individuals and persons in families in permanent housing projects, other than rapid rehousing, that retain their

permanent housing or exit to permanent housing destinations.

	Percentage
Report the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid re-housing that exit to permanent housing destinations as reported in HDX.	47%
Report the percentage of individuals and persons in families in permanent housing projects, other than rapid re-housing, that retain their permanent housing or exit to permanent housing destinations as reported in HDX.	94%

3A-3a. Applicants must:
(1) describe the CoC's strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations; and
(2) describe the CoC's strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations.
(limit 2,000 characters)

1) The CoC saw a 4% increase in exits to permanent housing from emergency shelters and a 5% increase in exits to permanent housing from street outreach from 2016 to 2017's system performance measures. Housing projects other than ES/TH/RRH saw a 94% retention rate.

2) The CoC's strategy to increase the rate of persons in emergency shelter, transitional housing, and rapid rehousing exit to permanent housing is a multi-tiered approach. All persons entering shelter are assessed using the appropriate VI-SPDAT and referred to Coordinated Entry to be placed into permanent housing.
The CoC promotes a Housing First approach for all funded permanent housing projects allowing for ease of access into permanent housing from shelters and street outreach. All CoC funded projects are scored during monitoring using HUD's Housing First Assessment Tool and all CoC-funded projects monitored met the threshold of being Housing First. The CoC also ensures that all ESG projects are also Housing First in partnership with the ESG administrators. Using a Housing First strategy allows for those experiencing homelessness to have better and quicker access to permanent housing.
The CoC also uses its CE system to ensure that persons experiencing homelessness are connected with the appropriate housing intervention to ensure exits to permanent housing. The CoC's strategy for retention in permanent housing or exit to permanent housing also uses housing first strategies to ensure retention in PH. Persons in permanent housing are connected to supportive services to help in maintaining housing. The CoC's Coordinated Entry workgroup also case conferences potential evictions from permanent housing monthly to develop strategies for permanent housing retention. This case conferencing includes projects both funded and not funded by CoC or ESG.

3A-4. Returns to Homelessness as Reported in HDX. Applicants must report the percentage of individuals and persons in families returning to homelessness over a 6- and 12-month period as reported in HDX.

	Percentage

Report the percentage of individuals and persons in families returning to homelessness over a 6- and 12-month period as reported in HDX	21%

3A-4a. Applicants must:
(1) describe how the CoC identifies common factors of individuals and persons in families who return to homelessness;
(2) describe the CoC's strategy to reduce the rate of additional returns to homelessness; and
(3) provide the name of the organization or position title that is responsible for overseeing the CoC's strategy to reduce the rate individuals and persons in families returns to homelessness.
(limit 2,000 characters)

1) The CoC uses data collected in HMIS at shelter entry to assist in identifying common factors of persons who return to homelessness. The CoC conducts an in depth analysis of this data to determine reasons for returning to homelessness, including trends in project types most likely to result in returns to homelessness. The CoC uses this data to address projects with high returns to homelessness to provide technical assistance. This performance measures is also assessed during annual monitoring visits and informs ranking in the CoC local application process.
2) The CoC's strategy for reducing the rate in which persons return to homelessness is to provide and refer to ongoing support services, case conference on an ongoing basis, and monitoring data of returns to homelessness.The CoC develops partnerships to assist housing projects in providing supportive services that help maintain housing stability. This past year, the CoC has had panel discussion with employment service providers, judges and legal services within eviction court, and increased communication with healthcare providers.
The Coordinated Entry workgroup also case conferences potential evictions and potential permanent supportive housing transfers in order to reduce chances for discharges into homelessness.
The CoC staff monitors project returns to homelessness and facilitates community conversations regarding the reduction in returns to homelessness.
3)The Coordinated Entry workgroup and the Collaborative Applicant staff are responsible for overseeing the strategy to reduce the rate of individuals and families returning to homelessness.

3A-5. Job and Income Growth. Applicants must:
(1) describe the CoC's strategy to increase access to employment and non-employment cash sources;
(2) describe how the CoC works with mainstream employment organizations to help individuals and families increase their cash income; and
(3) provide the organization name or position title that is responsible for overseeing the CoC's strategy to increase job and income growth from employment.
(limit 2,000 characters)

1) The CoC saw a 2% increase in job and income growth for stayers in projects and 3% increase for project leavers. The CoC facilitates partnerships with employment and non-employment cash source providers. Projects are monitored for performance in increasing income for participants. The CoC also

tracks system-wide performance of this measure and reports to community.
2) LDSS in the three counties are actively involved in the CoC and are present for case conferencing. This allows for case managers and LDSS staff to ensure a continuation of benefits and planning for future income. LDSS staff in Onondaga County are SOAR trained for those unable to work needing connection to SSI/SSDI.
The CoC has developed partnerships with workforce development programs, including holding an informational panel on available workforce opportunities throughout the CoC.
The CoC also monitors for job and income growth performance measures during the local application process to identify projects that are low performing in order to identify strategies for improvement in this measure.
3) The Collaborative Applicant staff are responsible for overseeing the CoC's strategy to increase job and income growth from employment.

3A-6. System Performance Measures Data Submission in HDX. Applicants must enter the date the CoC submitted the System Performance Measures data in HDX, which included the data quality section for FY 2017 (mm/dd/yyyy)	05/31/2018

3B. Continuum of Care (CoC) Performance and Strategic Planning Objectives

Instructions

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

3B-1. DedicatedPLUS and Chronically Homeless Beds. In the boxes below, applicants must enter: (1) total number of beds in the Project Application(s) that are designated as DedicatedPLUS beds; and (2) total number of beds in the Project Application(s) that are designated for the chronically homeless, which does not include those that were identified in (1) above as DedicatedPLUS Beds.

Total number of beds dedicated as DedicatedPLUS	12
Total number of beds dedicated to individuals and families experiencing chronic homelessness	234
Total	246

3B-2. Orders of Priority. Did the CoC adopt the Orders of Priority into their written standards for all CoC Program-funded PSH projects as described in Notice CPD-16-11: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing? Attachment Required. Yes

3B-2.1. Prioritizing Households with Children. Using the following chart, applicants must check all that apply to indicate the factor(s) the CoC currently uses to prioritize households with children during FY 2018.

History of or Vulnerability to Victimization (e.g. domestic violence, sexual assault, childhood abuse)	X
Number of previous homeless episodes	X
Unsheltered homelessness	X
Criminal History	
Bad credit or rental history	
Head of Household with Mental/Physical Disability	X

3B-2.2. Applicants must:
(1) describe the CoC's current strategy to rapidly rehouse every household of families with children within 30 days of becoming homeless;
(2) describe how the CoC addresses both housing and service needs to ensure families successfully maintain their housing once assistance ends; and
(3) provide the organization name or position title responsible for overseeing the CoCs strategy to rapidly rehouse families with children within 30 days of becoming homeless.
(limit 2,000 characters)

1)The average length of stay in shelter for families with children is 20 days. Within a week of entering shelter, families are assessed using the F-SPDAT and placed on the Coordinated Entry list. Priority is given to families with the longest histories of homelessness paired with the highest service needs, as evidenced by the SPDAT. The CoC has seen an 8% reduction in family homelessness. Families are prioritized for ESG Supplemental Rapid Rehousing projects allowing for families to move quickly into housing. All CoC and ESG projects use a Housing First model.
The CoC has two CoC-funded RRH projects and three PSH projects that target families and address housing and service needs of families needing housing interventions.
The CoC also has a non-CoC funded transitional housing program serving parenting youth that can address the unique needs of parenting youth experiencing homelessness.
2) Once families are placed in housing, projects provide referrals to supportive services and focus on job and income growth. This allows families to become self sufficient and able to maintain housing once assistance has ended. The CoC holds training and panels for all service providers so projects without ongoing case management services are able to network and refer to services before project exit.
3) The Collaborative Applicant oversees the Coordinated Entry process for entry into these projects.

3B-2.3. Antidiscrimination Policies. Applicants must check all that apply that describe actions the CoC is taking to ensure providers (including emergency shelter, transitional housing, and permanent supportive housing (PSH and RRH) within the CoC adhere to antidiscrimination policies by not denying admission to or separating any family members from other members of their family or caregivers based on age, sex, gender, LGBT status, marital status, or disability when entering a shelter or housing.

CoC conducts mandatory training for all CoC and ESG funded service providers on these topics.	☐
CoC conducts optional training for all CoC and ESG funded service providers on these topics.	☐
CoC has worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients.	☐
CoC has worked with ESG recipient(s) to identify both CoC and ESG funded facilities within the CoC geographic area that may be out of compliance, and taken steps to work directly with those facilities to come into compliance.	☐
CoC has sought assistance from HUD through submitting AAQs or requesting TA to resolve non-compliance of service providers.	☐

3B-2.4. Strategy for Addressing Needs of Unaccompanied Youth Experiencing Homelessness. Applicants must indicate whether the CoC's

strategy to address the unique needs of unaccompanied homeless youth includes the following:

Human trafficking and other forms of exploitation	Yes
LGBT youth homelessness	Yes
Exits from foster care into homelessness	Yes
Family reunification and community engagement	Yes
Positive Youth Development, Trauma Informed Care, and the use of Risk and Protective Factors in assessing youth housing and service needs	Yes

3B-2.5. Prioritizing Unaccompanied Youth Experiencing Homelessness Based on Needs. Applicants must check all that apply from the list below that describes the CoC's current strategy to prioritize unaccompanied youth based on their needs.

History or Vulnerability to Victimization (e.g., domestic violence, sexual assault, childhood abuse)	X
Number of Previous Homeless Episodes	X
Unsheltered Homelessness	X
Criminal History	
Bad Credit or Rental History	

3B-2.6. Applicants must describe the CoC's strategy to increase:
(1) housing and services for all youth experiencing homelessness by providing new resources or more effectively using existing resources, including securing additional funding; and
(2) availability of housing and services for youth experiencing unsheltered homelessness by providing new resources or more effectively using existing resources.
(limit 3,000 characters)

1) Each year the CoC works to expand its services to end youth homelessness. Efforts are aided by a variety of funding resources including CoC/ESG funding, Health and Human Services, Supportive Housing Initiative, United Way, OTDA, Office of Child and Family Services, OMH and LDSS. These continuing resources are utilized to provide programming for all youth experiencing homelessness.
The CoC also has a Runaway and Homeless Youth Committee which meets bi-monthly with representatives from shelters, housing programs, school districts, McKinney-Vento liaisons, law enforcement, juvenile justice, youth shelters/housing facilities, youth employment services, Office of Children and Family Services, child advocacy representatives, human trafficking services, LGBT services, mental health services, Department of Social Services, pregnant/parenting services, youth recreation centers and HUD-funded programming. The RHY Committee also ensures that community remains on schedule with the current plan proposed by the United States Interagency Council on Homeless (USICH) to end youth homelessness by 2020.The CoC

RHY Committee collaborates on the special needs of youth including identifying homeless youth, identifying resources, and creating system wide strategies for preventing youth homelessness. Committee efforts also include the role of representing the CoC at statewide advisory levels such as the New York State Runaway and Homeless Youth Advisory Board and the New York State Association of Youth Bureaus.
2) Throughout the past year, the CoC has conducted street outreach services on a nightly basis, identifying 14% of persons served as being under the age of 25. These youth are immediately referred to youth shelters within the jurisdiction of the CoC, where they receive services, referrals and become connected to our Coordinated Entry System. Even those unwilling to accept shelter services are still provided with basic needs and assisted with Coordinated Entry by the guidance of the on scene Street Outreach Worker.
New Street Outreach funding is also being sought through the Department of Health and Human Services. The CoC has formally endorsed The Salvation Army's efforts at submitting an HHS Street Outreach grant application, with the hopes of receiving funding as early as 10/01/18. These street outreach services will provide prevention and intervention services to youth throughout the CoC regardless of which definition of homelessness is employed.
The CoC is also developing a Youth Advisory Board consisting of youth who currently or formerly have experienced homelessness. The function of this group will be to lead discussions regarding strategies to reduce youth homelessness and gather feedback on local community policies.

3B-2.6a. Applicants must:
(1) provide evidence the CoC uses to measure both strategies in question 3B-2.6. to increase the availability of housing and services for youth experiencing homelessness;
(2) describe the measure(s) the CoC uses to calculate the effectiveness of the strategies; and
(3) describe why the CoC believes the measure it uses is an appropriate way to determine the effectiveness of the CoC's strategies.
(limit 3,000 characters)

1) The CoC uses HMIS data to assess trends in youth experiencing homelessness from year to year, noting increases or decreases in youth under the age of 18, aged 18 to 24, and parenting youth to better allocate resources. The CoC also receives data from the school districts in order to identify all youth experiencing homelessness. The CoC is developing a by-name list of all youth experiencing homelessness in the Runaway and Homeless Youth Committee of the CoC.
2) The CoC monitors project performance for all CoC and ESG funded programs serving youth, including length of time in shelter, rapid access to housing, and permanent housing retention. The Collaborative Applicant also assesses Coordinated Entry to ensure that youth move through the Coordinated Entry system quickly.
3) The CoC tracks progress towards meeting the criteria and benchmarks for ending youth homelessness as provided by USICH.
The CoC uses all of these measures to determine the effectiveness of the CoC's strategies. Using multiple measures allows the CoC to track effectiveness of both the Coordinated Entry system for youth and its progress as a whole in ending youth homelessness.

3B-2.7. Collaboration–Education Services. Applicants must describe how the CoC collaborates with:
(1) youth education providers;
(2) McKinney-Vento State Education Agency (SEA) and Local Education Agency (LEA);
(3) school districts; and
(4) the formal partnerships with (1) through (3) above.
(limit 2,000 characters)

1)The CoC collaborates to end youth homelessness through the CoC's Runaway and Homeless Youth Committee which meets bi-monthly with representatives from shelters, housing programs, school districts, McKinney-Vento liaisons, law enforcement, juvenile justice, youth shelters/housing facilities, youth employment services, Office of Children and Family Services, child advocacy representatives, human trafficking services, LGBT services, mental health services, DSS, pregnant/parenting services, youth recreation centers and HUD-funded programming. The CoC RHY Committee is one of the leading advocates to ensure that Committee members are fully knowledgeable in regards to McKinney-Vento laws and regulations regarding the educational rights of homeless students. The CoC RHY Committee also assists with distributing posters, brochures and electronic media to provide the public with additional information regarding McKinney-Vento legislation and its relationship to homeless youth.
2) The McKinney-Vento Liaison Meeting takes place on a quarterly basis and is attended by school districts from multiple counties. This meeting is also attended by members of the CoC, including a member of the CoC Advisory Board. The McKinney Vento Liaison Meeting discusses rules and regulations regarding the services and privileges afforded to homeless youth.
3) These same meetings have resulted in collaborative training sessions where CoC members have conducted trainings for school liaisons, teachers, guidance counselors, social workers and administrators. When homeless youth require services associated with McKinney-Vento legislation, CoC members utilize these ongoing relationships with McKinney-Vento Liaison, advocating for the rights of homeless students, guaranteeing immediate enrollment into classes and accessing transportation to and from their school of choice.

3B-2.7a. Applicants must describe the policies and procedures the CoC adopted to inform individuals and families who become homeless of their eligibility for education services.
(limit 2,000 characters)

To ensure that all clients remain informed about the rights and privileges afforded to homeless youth and families through the provision of the McKinney-Vento Homeless Assistance Act, the CoC has initiated several dissemination strategies.
First, the CoC monitors emergency shelter and housing programs associated with CoC funding to determine that they possess adequate knowledge regarding the rules and regulations associated with the McKinney-Vento Act. On an annual basis, CoC programs must provide the CoC with policies and procedures in writing which describe in detail how clients are provided with McKinney-Vento information. Each CoC program must provide the CoC with annual up to date names and contact information regarding specific program

staff assigned the responsibility of making certain that all clients are provided with clear and understandable McKinney-Vento information and assistance. Second, monthly CoC Coalition Meetings provide opportunity for homeless providers and educational services to coordinate and problem solve any McKinney-Vento provisions requiring attention, including enrollment and busing. The CoC Coalition Meetings have also been utilized during the past year to provide McKinney-Vento trainings as well as McKinney-Vento legislation summaries and updates.
Third, the CoC utilizes 211 for all after hours requests for emergency shelter or street outreach interventions. The CoC ensures that 211 operators are knowledgeable in regards to McKinney-Vento legislation, providing callers with information regarding student enrollment and transportation, despite being in the very beginning stages of requiring immediate emergency housing.

3B-2.8. Does the CoC have written formal agreements, MOU/MOAs or partnerships with one or more providers of early childhood services and supports? Select "Yes" or "No". Applicants must select "Yes" or "No", from the list below, if the CoC has written formal agreements, MOU/MOA's or partnerships with providers of early childhood services and support.

	MOU/MOA	Other Formal Agreement
Early Childhood Providers	No	No
Head Start	No	No
Early Head Start	No	No
Child Care and Development Fund	No	No
Federal Home Visiting Program	No	No
Healthy Start	No	No
Public Pre-K	No	No
Birth to 3 years	No	No
Tribal Home Visting Program	No	No
Other: (limit 50 characters)		

**3B-3.1. Veterans Experiencing Homelessness. Applicants must describe the actions the CoC has taken to identify, assess, and refer Veterans experiencing homelessness, who are eligible for U.S. Department of Veterans Affairs (VA) housing and services, to appropriate resources such as HUD-VASH, Supportive Services for Veterans Families (SSVF) program and Grant and Per Diem (GPD).
(limit 2,000 characters)**

Every person who enters shelter, is met outdoors, or calls 211 is asked if he or she has served in the military and are asked to sign a release of information to facilitate communication with the VA. The CoC is able to track all homeless veterans through HMIS. VA and SSVF providers conduct weekly outreach to shelters across all three counties to identify veterans and offer services. Veterans are referred to Coordinated Entry and are prioritized for both RRH and PSH projects in conjunction with length of time homeless and service needs. HUD VASH is also using the Coordinated Entry system to fill vacancies. The

VA's Healthcare for Homeless Veterans Outreach program is now documenting data for homeless veterans served by the VA. All veterans experiencing homelessness are case conferenced weekly between shelters, VA, GPD providers, and SSVF providers to connect veterans experiencing homelessness with the appropriate resources. SSVF providers also meet with the local HVRP providers in order to increase employment opportunities for veterans experiencing homelessness.
In November 2015, Onondaga County ended veteran homelessness as designated by USICH. The Veteran Workgroup meets monthly to discuss any systematic challenges and confirm the community's adherence to the criteria and benchmarks for ending veteran homelessness. The workgroup is also pursuing strategies to end veteran homelessness in the entirety of the CoC.

3B-3.2. Does the CoC use an active list or by name list to identify all Veterans experiencing homelessness in the CoC?	Yes
3B-3.3. Is the CoC actively working with the VA and VA-funded programs to achieve the benchmarks and criteria for ending Veteran homelessness?	Yes
3B-3.4. Does the CoC have sufficient resources to ensure each Veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach?	Yes
3B-5. Racial Disparity. Applicants must: (1) indicate whether the CoC assessed whether there are racial disparities in the provision or outcome of homeless assistance; (2) if the CoC conducted an assessment, attach a copy of the summary.	Yes

3B-5a. Applicants must select from the options below the results of the CoC's assessment.

People of different races or ethnicities are more or less likely to receive homeless assistance.	
People of different races or ethnicities are more or less likely to receive a positive outcome from homeless assistance.	
There are no racial disparities in the provision or outcome of homeless assistance.	X
The results are inconclusive for racial disparities in the provision or outcome of homeless assistance.	

3B-5b. Applicants must select from the options below the strategies the CoC is using to address any racial disparities.

The CoC's board and decisionmaking bodies are representative of the population served in the CoC.	☐
The CoC has identified steps it will take to help the CoC board and decisionmaking bodies better reflect the population served in the CoC.	☐
The CoC is expanding outreach in geographic areas with higher concentrations of underrepresented groups.	☐
The CoC has communication, such as flyers, websites, or other materials, inclusive of underrepresented groups	☐
The CoC is training staff working in the homeless services sector to better understand racism and the intersection of racism and homelessness.	☐
The CoC is establishing professional development opportunities to identify and invest in emerging leaders of different races and ethnicities in the homelessness sector.	☐
The CoC has staff, committees or other resources charged with analyzing and addressing racial disparities related to homelessness.	☐
The CoC is educating organizations, stakeholders, boards of directors for local and national non-profit organizations working on homelessness on the topic of creating greater racial and ethnic diversity.	☐
The CoC reviewed coordinated entry processes to understand their impact on people of different races and ethnicities experiencing homelessness.	☐
The CoC is collecting data to better understand the pattern of program use for people of different races and ethnicities in its homeless services system.	☐
The CoC is conducting additional research to understand the scope and needs of different races or ethnicities experiencing homelessness.	☐
Other:	☐

4A. Continuum of Care (CoC) Accessing Mainstream Benefits and Additional Policies

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

4A-1. Healthcare. Applicants must indicate, for each type of healthcare listed below, whether the CoC:
(1) assists persons experiencing homelessness with enrolling in health insurance; and
(2) assists persons experiencing homelessness with effectively utilizing Medicaid and other benefits.

Type of Health Care	Assist with Enrollment	Assist with Utilization of Benefits?
Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)	Yes	Yes
Private Insurers:	Yes	Yes
Non-Profit, Philanthropic:	Yes	Yes
Other: (limit 50 characters)		

4A-1a. Mainstream Benefits. Applicants must:
(1) describe how the CoC works with mainstream programs that assist persons experiencing homelessness to apply for and receive mainstream benefits;
(2) describe how the CoC systematically keeps program staff up-to-date regarding mainstream resources available for persons experiencing homelessness (e.g., Food Stamps, SSI, TANF, substance abuse programs); and
(3) provide the name of the organization or position title that is responsible for overseeing the CoC's strategy for mainstream benefits. (limit 2,000 characters)

1) The CoC maintains strong relationships with LDSS in the three counties, responsible for providing TANF, SNAP, and Medicaid. All incoming shelter residents/unsheltered populations are provided with information and assistance on how to apply for benefits. All shelter residents without income are required to apply for temporary assistance. All shelter residents are provided with 4002s from LDSS outlining for what services a person experiencing homelessness is eligible. Many agencies provide health insurance enrollment, health home services, and/or substance abuse referral. LDSS promotes a SOAR model for assisting people obtain SSI/SSDI.
People with communication barriers are provided interpreter services, access to phones, transportation, and specialized care.

2) The CoC provides ongoing training and presentations regarding access to mainstream benefits to program staff in the Human Service Providers workgroup on a monthly basis and in the CoC bimonthly meetings.
3) The Program/Advocacy and Planning Committee of the CoC oversees the strategy for mainstream benefits.

4A-2.Housing First: Applicants must report: (1) total number of new and renewal CoC Program Funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC is applying for in FY 2018 CoC Program Competition; and (2) total number of new and renewal CoC Program Funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC is applying for in FY 2018 CoC Program Competition that have adopted the Housing First approach–meaning that the project quickly houses clients without preconditions or service participation requirements.

Total number of new and renewal CoC Program Funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC is applying for in FY 2018 CoC Program Competition.	36
Total number of new and renewal CoC Program Funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC is applying for in FY 2018 CoC Program Competition that have adopted the Housing First approach–meaning that the project quickly houses clients without preconditions or service participation requirements.	36
Percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects in the FY 2018 CoC Program Competition that will be designated as Housing First.	100%

4A-3. Street Outreach. Applicants must: (1) describe the CoC's outreach; (2) state whether the CoC's Street Outreach covers 100 percent of the CoC's geographic area; (3) describe how often the CoC conducts street outreach; and (4) describe how the CoC tailored its street outreach to persons experiencing homelessness who are least likely to request assistance. (limit 2,000 characters)

1) The CoC has five street outreach providers, two that target youth. Street outreach providers are able to provide food, water, hygiene items, medical care and clothing to attempt engagement with people, even those least likely to request assistance. Outreach is conducted on a continuous basis, even to those refusing service. This year, a new project providing acute medical care and connection to primary care has joined the CoC and is conducting outreach on a weekly basis. This outreach project has been able to connect with hard to serve individuals. Psychiatric care is also available to those sleeping outdoors.
2) 100% of the geographic area is covered by street outreach providers with a strong presence in urban areas and with increased efforts in the two rural counties.
3) Outreach is conducted 7 days/week. 211 also fields calls from citizens regarding concerns for people outside. 211 directly connect with street outreach providers to engage with these people. There is a monthly street outreach committee that includes representatives from the psychiatric center, substance abuse counselors, the Syracuse Downtown Committee, police, shelters and local soup kitchen.
4) Anyone engaged with street outreach is also connected to Coordinated

Entry. Street outreach providers conduct assessments with those who are experiencing homelessness and referring to services. The CoC has tailored street outreach to those least likely to request assistance by offering a number of services and engaging on a daily basis. The CoC has seen an 8% decrease of people sleeping outside this past year.

4A-4. Affirmative Outreach. Applicants must describe:
(1) the specific strategy the CoC implemented that furthers fair housing as detailed in 24 CFR 578.93(c) used to market housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, gender identify, sexual orientation, age, familial status or disability; and
(2) how the CoC communicated effectively with persons with disabilities and limited English proficiency fair housing strategy in (1) above.
(limit 2,000 characters)

1) Per monitoring requirements for CoC and ESG, each CoC/ESG agency is required to have policies in place that provide nondiscrimination and equal opportunity policies that apply to housing and employment, reasonable accommodations/modifications for person with disabilities, meaningful access for Spanish-speaking/other Limited English proficiency persons to access program and supportive services to eligible person. The agency is also required to maintain and provide copies of marketing, outreach, and other materials used to inform eligible persons of the program, information on rights and remedies available under applicable federal, state and local fair housing and civil rights laws, and HUD's Equal Access Rule and programs have received the HUD training on the Rule. Compliance with these requirements is monitored on an annual basis.

2) CNY Fair Housing sits on the CoC's Advisory Board and does annual presentations at bi-monthly CoC meetings to give updates on local, state, and national legislation and to ensure "top of mind awareness' regarding this issue. Information regarding fair housing is made accessible to anyone entering a CoC or ESG funded project.

4A-5. RRH Beds as Reported in the HIC. Applicants must report the total number of rapid rehousing beds available to serve all household types as reported in the Housing Inventory Count (HIC) for 2017 and 2018.

	2017	2018	Difference
RRH beds available to serve all populations in the HIC	372	623	251

4A-6. Rehabilitation or New Construction Costs. Are new proposed project applications requesting $200,000 or more in funding for housing rehabilitation or new construction? No

4A-7. Homeless under Other Federal Statutes. Is the CoC requesting to designate one or No

more of its SSO or TH projects to serve families with children or youth defined as homeless under other Federal statutes?

4B. Attachments

Instructions:

Multiple files may be attached as a single .zip file. For instructions on how to use .zip files, a reference document is available on the e-snaps training site: https://www.hudexchange.info/resource/3118/creating-a-zip-file-and-capturing-a-screenshot-resource

Document Type	Required?	Document Description	Date Attached
1C-5. PHA Administration Plan–Homeless Preference	No	Christopher Commu...	09/14/2018
1C-5. PHA Administration Plan–Move-on Multifamily Assisted Housing Owners' Preference	No		
1C-8. Centralized or Coordinated Assessment Tool	Yes	NY-505 FY18 Coord...	09/14/2018
1E-1. Objective Critiera–Rate, Rank, Review, and Selection Criteria (e.g., scoring tool, matrix)	Yes	NY-505 Project Ra...	09/14/2018
1E-3. Public Posting CoC-Approved Consolidated Application	Yes		
1E-3. Public Posting–Local Competition Rate, Rank, Review, and Selection Criteria (e.g., RFP)	Yes	NY-505 Public Pos...	09/13/2018
1E-4. CoC's Reallocation Process	Yes	NY-505 FY18 Reall...	09/11/2018
1E-5. Notifications Outside e-snaps–Projects Accepted	Yes	NY-505 Notice Out...	09/13/2018
1E-5. Notifications Outside e-snaps–Projects Rejected or Reduced	Yes	NY-505 Notice Out...	09/13/2018
1E-5. Public Posting–Local Competition Deadline	Yes	NY-505 Public Pos...	09/13/2018
2A-1. CoC and HMIS Lead Governance (e.g., section of Governance Charter, MOU, MOA)	Yes	NY-505 Operationa...	09/13/2018
2A-2. HMIS–Policies and Procedures Manual	Yes	NY-505 HMIS Polic...	09/13/2018
3A-6. HDX–2018 Competition Report	Yes	NY-505 HUD HDX Co...	09/13/2018
3B-2. Order of Priority–Written Standards	No	NY-505 Coordinate...	09/14/2018

3B-5. Racial Disparities Summary	No	NY-505 Racial Dis...	09/13/2018
4A-7.a. Project List–Persons Defined as Homeless under Other Federal Statutes (if applicable)	No		
Other	No		
Other	No		
Other	No		

Attachment Details

Document Description: Christopher Community Homeless Preference

Attachment Details

Document Description:

Attachment Details

Document Description: NY-505 FY18 Coordinated Assessment Tool (VISPDAT)

Attachment Details

Document Description: NY-505 Project Ranking and Rating

Attachment Details

Document Description:

Attachment Details

Document Description: NY-505 Public Posting- Rate, Rank, Review and Selection

Attachment Details

Document Description: NY-505 FY18 Reallocation Protocol

Attachment Details

Document Description: NY-505 Notice Outside e-snaps of Projects Accepted

Attachment Details

Document Description: NY-505 Notice Outside e-snaps of Projects Rejected

Attachment Details

Document Description: NY-505 Public Posting- Local Competition Deadline

Attachment Details

Document Description: NY-505 Operational Guidelines

Attachment Details

Document Description: NY-505 HMIS Policies and Procedures Manual

Attachment Details

Document Description: NY-505 HUD HDX Competition Report

Attachment Details

Document Description: NY-505 Coordinated Entry Standards with Order of Priority

Attachment Details

Document Description: NY-505 Racial Disparities Summary

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Submission Summary

Ensure that the Project Priority List is complete prior to submitting.

Page	Last Updated
1A. Identification	09/11/2018
1B. Engagement	09/13/2018
1C. Coordination	09/14/2018
1D. Discharge Planning	09/11/2018
1E. Project Review	09/12/2018
2A. HMIS Implementation	09/13/2018
2B. PIT Count	09/13/2018
2C. Sheltered Data - Methods	09/12/2018
3A. System Performance	09/13/2018
3B. Performance and Strategic Planning	09/12/2018
4A. Mainstream Benefits and Additional Policies	09/12/2018
4B. Attachments	Please Complete

Submission Summary	No Input Required

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Families

AMERICAN VERSION 2.0

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COMMUNITY SOLUTIONS

ORG CODE

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or types of users. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front-line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

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SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

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Administration

Interviewer's Name	Agency	
_____	_____	☐ Team ☐ Staff ☐ Volunteer
Survey Date	**Survey Time**	**Survey Location**
DD/MM/YYYY ____/____/_____	__ __ : __ __ AM/PM	_____

Opening Script

Every assessor in your community regardless of organization completing the VI-SPDAT should use the same introductory script. In that script you should highlight the following information:

- the name of the assessor and their affiliation (organization that employs them, volunteer as part of a Point in Time Count, etc.)
- the purpose of the VI-SPDAT being completed
- that it usually takes less than 7 minutes to complete
- that only "Yes," "No," or one-word answers are being sought
- that any question can be skipped or refused
- where the information is going to be stored
- that if the participant does not understand a question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

PARENT 1

First Name	Nickname	Last Name
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	Age	Social Security Number	Consent to participate
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes ☐ No

PARENT 2

☐ No second parent currently part of the household

First Name	Nickname	Last Name
_____	_____	_____

In what language do you feel best able to express yourself? _____

Date of Birth	Age	Social Security Number	Consent to participate
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes ☐ No

IF EITHER HEAD OF HOUSEHOLD IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE:

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Children

1. How many children under the age of 18 are currently with you? _____ ☐ Refused
2. How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed? _____ ☐ Refused
3. *IF HOUSEHOLD INCLUDES A FEMALE:* Is any member of the family currently pregnant? ☐ **Y** ☐ N ☐ Refused
4. Please provide a list of children's names and ages:

First Name	Last Name	Age	Date of Birth

IF THERE IS A SINGLE PARENT WITH 2+ CHILDREN, AND/OR A CHILD AGED 11 OR YOUNGER, AND/OR A CURRENT PREGNANCY, THEN SCORE 1 FOR **FAMILY SIZE**.

IF THERE ARE TWO PARENTS WITH 3+ CHILDREN, AND/OR A CHILD AGED 6 OR YOUNGER, AND/OR A CURRENT PREGNANCY, THEN SCORE 1 FOR **FAMILY SIZE**.

SCORE:

A. History of Housing and Homelessness

5. Where do you and your family sleep most frequently? (check one)

☐ Shelters
☐ Transitional Housing
☐ Safe Haven
☐ **Outdoors**
☐ **Other (specify):** _____
☐ **Refused**

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", "TRANSITIONAL HOUSING", OR "SAFE HAVEN", THEN SCORE 1.

SCORE:

6. How long has it been since you and your family lived in permanent stable housing? _____ ☐ Refused
7. In the last three years, how many times have you and your family been homeless? _____ ☐ Refused

IF THE FAMILY HAS EXPERIENCED 1 OR MORE CONSECUTIVE YEARS OF HOMELESSNESS, AND/OR 4+ EPISODES OF HOMELESSNESS, THEN SCORE 1.

SCORE:

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B. Risks

8. In the past six months, how many times have you or anyone in your family...

   a) Received health care at an emergency department/room? ____ ☐ Refused

   b) Taken an ambulance to the hospital? ____ ☐ Refused

   c) Been hospitalized as an inpatient? ____ ☐ Refused

   d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? ____ ☐ Refused

   e) Talked to police because they witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told them that they must move along? ____ ☐ Refused

   f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? ____ ☐ Refused

IF THE TOTAL NUMBER OF INTERACTIONS EQUALS 4 OR MORE, THEN SCORE 1 FOR **EMERGENCY SERVICE USE.**	**SCORE:**

9. Have you or anyone in your family been attacked or beaten up since they've become homeless? ☐ **Y** ☐ N ☐ Refused

10. Have you or anyone in your family threatened to or tried to harm themself or anyone else in the last year? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF HARM.**	**SCORE:**

11. Do you or anyone in your family have any legal stuff going on right now that may result in them being locked up, having to pay fines, or that make it more difficult to rent a place to live? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **LEGAL ISSUES.**	**SCORE:**

12. Does anybody force or trick you or anyone in your family to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused

13. Do you or anyone in your family ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone they don't know, share a needle, or anything like that? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **RISK OF EXPLOITATION.**	**SCORE:**

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C. Socialization & Daily Functioning

14. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you or anyone in your family owe them money? ☐ **Y** ☐ N ☐ Refused

15. Do you or anyone in your family get any money from the government, a pension, an inheritance, working under the table, a regular job, or anything like that? ☐ Y ☐ **N** ☐ Refused

IF "YES" TO QUESTION 14 OR "NO" TO QUESTION 15, THEN SCORE 1 FOR **MONEY MANAGEMENT.** **SCORE:**

16. Does everyone in your family have planned activities, other than just surviving, that make them feel happy and fulfilled? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.** **SCORE:**

17. Is everyone in your family currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ **N** ☐ Refused

IF "NO," THEN SCORE 1 FOR **SELF-CARE.** **SCORE:**

18. Is your family's current homelessness in any way caused by a relationship that broke down, an unhealthy or abusive relationship, or because other family or friends caused your family to become evicted? ☐ **Y** ☐ N ☐ Refused

IF "YES," THEN SCORE 1 FOR **SOCIAL RELATIONSHIPS.** **SCORE:**

D. Wellness

19. Has your family ever had to leave an apartment, shelter program, or other place you were staying because of the physical health of you or anyone in your family? ☐ **Y** ☐ N ☐ Refused

20. Do you or anyone in your family have any chronic health issues with your liver, kidneys, stomach, lungs or heart? ☐ **Y** ☐ N ☐ Refused

21. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you or anyone in your family? ☐ **Y** ☐ N ☐ Refused

22. Does anyone in your family have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help? ☐ **Y** ☐ N ☐ Refused

23. When someone in your family is sick or not feeling well, does your family avoid getting medical help? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **PHYSICAL HEALTH.** **SCORE:**

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24. Has drinking or drug use by you or anyone in your family led your family to being kicked out of an apartment or program where you were staying in the past? ☐ **Y** ☐ N ☐ Refused

25. Will drinking or drug use make it difficult for your family to stay housed or afford your housing? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **SUBSTANCE USE.** **SCORE:**

26. Has your family ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:

a) A mental health issue or concern? ☐ **Y** ☐ N ☐ Refused

b) A past head injury? ☐ **Y** ☐ N ☐ Refused

c) A learning disability, developmental disability, or other impairment? ☐ **Y** ☐ N ☐ Refused

27. Do you or anyone in your family have any mental health or brain issues that would make it hard for your family to live independently because help would be needed? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **MENTAL HEALTH.** **SCORE:**

28. *IF THE FAMILY SCORED 1 EACH FOR PHYSICAL HEALTH, SUBSTANCE USE, AND MENTAL HEALTH:* Does any single member of your household have a medical condition, mental health concerns, **and** experience with substance use? ☐ **Y** ☐ N ☐ N/A or Refused

IF "YES", SCORE 1 FOR **TRI-MORBIDITY**. **SCORE:**

29. Are there any medications that a doctor said you or anyone in your family should be taking that, for whatever reason, they are not taking? ☐ **Y** ☐ N ☐ Refused

30. Are there any medications like painkillers that you or anyone in your family don't take the way the doctor prescribed or where they sell the medication? ☐ **Y** ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **MEDICATIONS.** **SCORE:**

31. *YES OR NO:* Has your family's current period of homelessness been caused by an experience of emotional, physical, psychological, sexual, or other type of abuse, or by any other trauma you or anyone in your family have experienced? ☐ **Y** ☐ N ☐ Refused

IF "YES", SCORE 1 FOR **ABUSE AND TRAUMA.** **SCORE:**

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E. Family Unit

32. Are there any children that have been removed from the family by a child protection service within the last 180 days?	☐ **Y**	☐ N	☐ Refused	
33. Do you have any family legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY LEGAL ISSUES.**				**SCORE:**
34. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation?	☐ **Y**	☐ N	☐ Refused	
35. Has any child in the family experienced abuse or trauma in the last 180 days?	☐ **Y**	☐ N	☐ Refused	
36. *IF THERE ARE SCHOOL-AGED CHILDREN:* Do your children attend school more often than not each week?	☐ Y	☐ **N**	☐ N/A or Refused	
IF "YES" TO ANY OF QUESTIONS 34 OR 35, OR "NO" TO QUESTION 36, SCORE 1 FOR **NEEDS OF CHILDREN.**				**SCORE:**
37. Have the members of your family changed in the last 180 days, due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that?	☐ **Y**	☐ N	☐ Refused	
38. Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR **FAMILY STABILITY.**				**SCORE:**
39. Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a family movie, or anything like that?	☐ Y	☐ **N**	☐ Refused	
40. After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult...				
a) 3 or more hours per day for children aged 13 or older?	☐ **Y**	☐ N	☐ Refused	
b) 2 or more hours per day for children aged 12 or younger?	☐ **Y**	☐ N	☐ Refused	
41. *IF THERE ARE CHILDREN BOTH 12 AND UNDER & 13 AND OVER:* Do your older kids spend 2 or more hours on a typical day helping their younger sibling(s) with things like getting ready for school, helping with homework, making them dinner, bathing them, or anything like that?	☐ **Y**	☐ N	☐ N/A or Refused	
IF "NO" TO QUESTION 39, OR "YES" TO ANY OF QUESTIONS 40 OR 41, SCORE 1 FOR **PARENTAL ENGAGEMENT.**				**SCORE:**

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Scoring Summary

DOMAIN	SUBTOTAL	RESULTS
PRE-SURVEY	/2	
A. HISTORY OF HOUSING & HOMELESSNESS	/2	**Score:** **Recommendation:**
B. RISKS	/4	0-3 no housing intervention
C. SOCIALIZATION & DAILY FUNCTIONS	/4	4-8 an assessment for Rapid Re-Housing
D. WELLNESS	/6	9+ an assessment for Permanent Supportive Housing/Housing First
E. FAMILY UNIT	/4	
GRAND TOTAL:	/22	

Follow-Up Questions

On a regular day, where is it easiest to find you and what time of day is easiest to do so?	place: _____ time: ___ : _____ or Morning/Afternoon/Evening/Night
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (_____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

Communities are encouraged to think of additional questions that may be relevant to the programs being operated or your specific local context. This may include questions related to:

- military service and nature of discharge
- ageing out of care
- mobility issues
- legal status in country
- income and source of it
- current restrictions on where a person can legally reside
- children that may reside with the adult at some point in the future
- safety planning

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Appendix A: About the VI-SPDAT

The HEARTH Act and federal regulations require communities to have an assessment tool for coordinated entry - and the VI-SPDAT and SPDAT meet these requirements. Many communities have struggled to comply with this requirement, which demands an investment of considerable time, resources and expertise. Others are making it up as they go along, using "gut instincts" in lieu of solid evidence. Communities need a practical, evidence-informed way to satisfy federal regulations while quickly implementing an effective approach to access and assessment. The VI-SPDAT is a first-of-its-kind tool designed to fill this need, helping communities end homelessness in a quick, strategic fashion.

The VI-SPDAT

The VI-SPDAT was initially created by combining the elements of the Vulnerability Index which was created and implemented by Community Solutions broadly in the 100,000 Homes Campaign, and the SPDAT Prescreen Instrument that was part of the Service Prioritization Decision Assistance Tool. The combination of these two instruments was performed through extensive research and development, and testing. The development process included the direct voice of hundreds of persons with lived experience.

The VI-SPDAT examines factors of current vulnerability and future housing stability. It follows the structure of the SPDAT assessment tool, and is informed by the same research backbone that supports the SPDAT - almost 300 peer reviewed published journal articles, government reports, clinical and quasi-clinical assessment tools, and large data sets. The SPDAT has been independently tested, as well as internally reviewed. The data overwhelmingly shows that when the SPDAT is used properly, housing outcomes are better than when no assessment tool is used.

The VI-SPDAT is a triage tool. It highlights areas of higher acuity, thereby helping to inform the type of support and housing intervention that may be most beneficial to improve long term housing outcomes. It also helps inform the order - or priority - in which people should be served. The VI-SPDAT does not make decisions; it informs decisions. The VI-SPDAT provides data that communities, service providers, and people experiencing homelessness can use to help determine the best course of action next.

Version 2

Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

You will notice some differences in Version 2 compared to Version 1. Namely:

- it is shorter, usually taking less than 7 minutes to complete;
- subjective elements through observation are now gone, which means the exact same instrument can be used over the phone or in-person;
- medical, substance use, and mental health questions are all refined;
- you can now explicitly see which component of the full SPDAT each VI-SPDAT question links to; and,
- the scoring range is slightly different (Don't worry, we can provide instructions on how these relate to results from Version 1).

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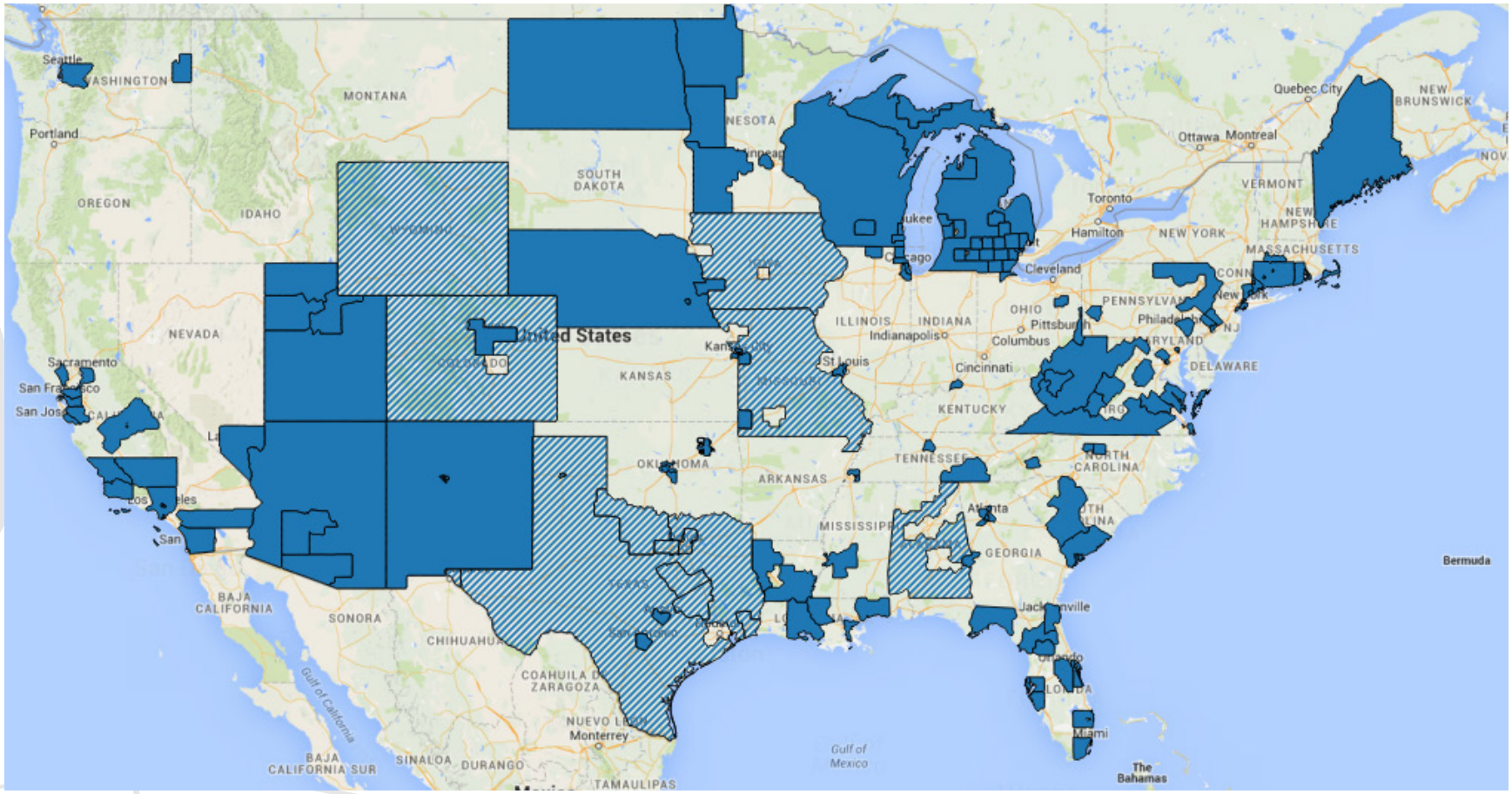
Appendix B: Where the VI-SPDAT is being used in the United States

Since the VI-SPDAT is provided completely free of charge, and no training is required, any community is able to use the VI-SPDAT without the explicit permission of Community Solutions or OrgCode Consulting, Inc. As a result, the VI-SPDAT is being used in more communities than we know of. It is also being used in Canada and Australia.



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A partial list of continua of care (CoCs) in the US where we know the VI-SPDAT is being used includes:

Alabama
- Parts of Alabama Balance of State

Arizona
- Statewide

California
- San Jose/Santa Clara City & County
- San Francisco
- Oakland/Alameda County
- Sacramento City & County
- Richmond/Contra Costa County
- Watsonville/Santa Cruz City & County
- Fresno/Madera County
- Napa City & County
- Los Angeles City & County
- San Diego
- Santa Maria/Santa Barbara County
- Bakersfield/Kern County
- Pasadena
- Riverside City & County
- Glendale
- San Luis Obispo County

Colorado
- Metropolitan Denver Homeless Initiative
- Parts of Colorado Balance of State

Connecticut
- Hartford
- Bridgeport/Stratford/Fairfield
- Connecticut Balance of State
- Norwalk/Fairfield County
- Stamford/Greenwich
- City of Waterbury

District of Columbia
- District of Columbia

Florida
- Sarasota/Bradenton/Manatee, Sarasota Counties
- Tampa/Hillsborough County
- St. Petersburg/Clearwater/Largo/Pinellas County
- Tallahassee/Leon County
- Orlando/Orange, Osceola, Seminole Counties
- Gainesville/Alachua, Putnam Counties
- Jacksonville-Duval, Clay Counties
- Palm Bay/Melbourne/Brevard County
- Ocala/Marion County
- Miami/Dade County
- West Palm Beach/Palm Beach County

Georgia
- Atlanta County
- Fulton County
- Columbus-Muscogee/Russell County
- Marietta/Cobb County
- DeKalb County

Hawaii
- Honolulu

Illinois
- Rockford/Winnebago, Boone Counties
- Waukegan/North Chicago/Lake County
- Chicago
- Cook County

Iowa
- Parts of Iowa Balance of State

Kansas
- Kansas City/Wyandotte County

Kentucky
- Louisville/Jefferson County

Louisiana
- Lafayette/Acadiana
- Shreveport/Bossier/Northwest
- New Orleans/Jefferson Parish
- Baton Rouge
- Alexandria/Central Louisiana CoC

Massachusetts
- Cape Cod Islands
- Springfield/Holyoke/Chicopee/Westfield/Hampden County

Maryland
- Baltimore City
- Montgomery County

Maine
- Statewide

Michigan
- Statewide

Minnesota
- Minneapolis/Hennepin County
- Northwest Minnesota
- Moorhead/West Central Minnesota
- Southwest Minnesota

Missouri
- St. Louis County
- St. Louis City
- Joplin/Jasper, Newton Counties
- Kansas City/Independence/Lee's Summit/Jackson County
- Parts of Missouri Balance of State

Mississippi
- Jackson/Rankin, Madison Counties
- Gulf Port/Gulf Coast Regional

North Carolina
- Winston Salem/Forsyth County
- Asheville/Buncombe County
- Greensboro/High Point

North Dakota
- Statewide

Nebraska
- Statewide

New Mexico
- Statewide

Nevada
- Las Vegas/Clark County

New York
- New York City
- Yonkers/Mount Vernon/New Rochelle/Westchester County

Ohio
- Toledo/Lucas County
- Canton/Massillon/Alliance/Stark County

Oklahoma
- Tulsa City & County/Broken Arrow
- Oklahoma City
- Norman/Cleveland County

Pennsylvania
- Philadelphia
- Lower Marion/Norristown/Abington/Montgomery County
- Allentown/Northeast Pennsylvania
- Lancaster City & County
- Bristol/Bensalem/Bucks County
- Pittsburgh/McKeesport/Penn Hills/Allegheny County

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country
- Columbia/Midlands

Tennessee
- Chattanooga/Southeast Tennessee
- Memphis/Shelby County
- Nashville/Davidson County

Texas
- San Antonio/Bexar County
- Austin/Travis County
- Dallas City & County/Irving
- Fort Worth/Arlington/Tarrant County
- El Paso City and County
- Waco/McLennan County
- Texas Balance of State
- Amarillo
- Wichita Falls/Wise, Palo Pinto, Wichita, Archer Counties
- Bryan/College Station/Brazos Valley
- Beaumont/Port Arthur/South East Texas

Utah
- Statewide

Virginia
- Richmond/Henrico, Chesterfield, Hanover Counties
- Roanoke City & County/Salem
- Virginia Beach
- Portsmouth
- Virginia Balance of State
- Arlington County

Washington
- Seattle/King County
- Spokane City & County

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming Statewide is in the process of implementing

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Family Service Prioritization Decision Assistance Tool

(F-SPDAT)

Assessment Tool for Families

VERSION 2.01

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Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or service delivery contexts. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The **Vulnerability Index – Service Prioritization Decision Assistance Tool** (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and may not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The **Service Prioritization Decision Assistance Tool** (SPDAT) was developed as an assessment tool for frontline workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. It is an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

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SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

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Terms and Conditions Governing the Use of the SPDAT

SPDAT products have been developed by OrgCode Consulting, Inc. with extensive feedback from key community partners including people with lived experience. The tools are provided free of charge to communities to improve the client centered services dedicated to increasing housing stability and wellness. Training is indeed required for the administration and interpretation of these assessment tools. Use of the SPDAT products without authorized training is strictly prohibited.

By using this tool, you accept and agree to be bound by the terms of this expectation.

No sharing, reproduction, use or duplication of the information herein is permitted without the express written consent of OrgCode Consulting, Inc.

Ownership

The Service Prioritization Decision Assistance Tool ("SPDAT") and accompanying documentation is owned by OrgCode Consulting, Inc.

Training

Although the SPDAT Series is provided free of charge to communities, training by OrgCode Consulting, Inc. or a third party trainer, authorized by OrgCode, must be successfully completed. After meeting the training requirements required to administer and interpret the SPDAT Series, practitioners are permitted to implement the SPDAT in their work with clients.

Restrictions on Use

You may not use or copy the SPDAT prior to successfully completing training on its use, provided by OrgCode Consulting, Inc. or a third-party trainer authorized by OrgCode. You may not share the SPDAT with other individuals not trained on its use. You may not train others on the use of the SPDAT, unless specifically authorized by OrgCode Consulting, Inc.

Restrictions on Alteration

You may not modify the SPDAT or create any derivative work of the SPDAT or its accompanying documentation, without the express written consent of OrgCode Consulting, Inc. Derivative works include but are not limited to translations.

Disclaimer

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

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A. Mental Health & Wellness & Cognitive Functioning

PROMPTS	CLIENT SCORE:
• *Has anyone in your family ever received any help with their mental wellness?* • *Do you feel that every member in your family is getting all the help they need for their mental health or stress?* • *Has a doctor ever prescribed anyone in your family pills for nerves, anxiety, depression or anything like that?* • *Has anyone in your family ever gone to an emergency room or stayed in a hospital because they weren't feeling 100% emotionally?* • *Does anyone in your family have trouble learning or paying attention, or been tested for learning disabilities?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby? What about when you were pregnant?* • *Has anyone in your family ever hurt their brain or head?* • *Do you have any documents or papers about your family's mental health or brain functioning?* • *Are there other professionals we could speak with that have knowledge of your family's mental health?*	**NOTES**

SCORING	
4	**Any** of the following among any family member: ☐ Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
3	**Any** of the following among any family member: ☐ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about the family's safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason for any member of the family to be screened by an expert in mental health or cognitive functioning prior to housing to fully understand capacity
1	☐ All members of the family are in a heightened state of recovery, have a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** are engaged with mental health supports as necessary.
0	☐ No mental health or cognitive functioning issues disclosed, suspected or observed.

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B. Physical Health & Wellness

PROMPTS	CLIENT SCORE:
• *How is your family's health?* • *Are you getting any help with your health? How often?* • *Do you feel you are getting all the care you need for your family's health?* • *Any illnesses like diabetes, HIV, Hep C or anything like that going on in any member of your family?* • *Ever had a doctor tell anyone in your family that they have problems with blood pressure or heart or lungs or anything like that?* • *When was the last time anyone in your family saw a doctor? What was that for?* • *Do you have a clinic or doctor that you usually go to?* • *Anything going on right now with your family's health that you think would prevent them from living a full, healthy, happy life?* • *Are there other professionals we could speak with that have knowledge of your family's health?* • *Do you have any documents or papers about your family's health or past stays in hospital because of your health?*	**NOTES**

SCORING	
4	**Any** of the following for any member of the family: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Pallative health condition
3	Presence of a health issue among any family member with **any** of the following: ☐ Not connected with professional resources to assist with a real or perceived serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) ☐ Unable to follow the treatment plan as a direct result of homeless status
2	☐ Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition in a family member, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements.
0	☐ No serious or chronic health condition ☐ If any minor health condition, they are managed appropriately

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C. Medication

PROMPTS	CLIENT SCORE:
• *Has anyone in your family recently been prescribed any medications by a health care professional?* • *Does anyone in your family take any medication, prescribed to them by a doctor?* • *Has anyone in your family ever had a doctor prescribe them a medication that wasn't filled or they didn't take?* • *Were any of your family's medications changed in the last month? Whose? How did that make them feel?* • *Do other people ever steal your family's medications?* • *Does anyone in your family ever sell or share their medications with other people it wasn't prescribed to?* • *How does your family store their medication and make sure they take the right medication at the right time each day?* • *What do you do if you realize someone has forgotten to take their medications?* • *Do you have any papers or documents about the medications your family takes?*	**NOTES**

SCORING	
4	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason.
3	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following for any family member: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following is true for **every** family member: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

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D. Substance Use

PROMPTS	CLIENT SCORE:
• *When was the last time you had a drink or used drugs? What about the other members of your family?* • *Anything we should keep in mind related to drugs/alcohol?* • *How often would you say you use [substance] in a week?* • *Ever have a doctor tell you that your health may be at risk because you drink or use drugs?* • *Have you engaged with anyone professionally related to your substance use that we could speak with?* • *Ever get into fights, fall down and bang your head, do things you regret later, or pass out when drinking or using other drugs?* • *Have you ever used alcohol or other drugs in a way that may be considered less than safe?* • *Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?*	**NOTES**

Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

SCORING	
4	☐ An adult is in a life-threatening health situation as a direct result of substance use, **or**, ☐ Any family member is under the legal age but over 15 and would score a 3+, **or**, ☐ Any family member is under 15 and would score a 2+, **or** who first used drugs prior to age 12, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times ☐ Substance use resulting in passing out 2+ times
3	☐ An adult is experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or**, ☐ Any family member is under the legal age but over 15 and would score a 2, **or**, ☐ Any family member is under 15 and would score a 1, **or** who first used drugs at age 13-15, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Drug use reached the point of complete inebriation 12+ times ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times
2	☐ Any family member is under the legal age but over 15 and would otherwise score 1, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Drug use reached the point of complete inebriation fewer than 12 times ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times
1	☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or**, ☐ If making claims to sobriety, no substance use in the past 30 days
0	☐ In the past 365 days, no substance use

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E. Experience of Abuse & Trauma of Parents

PROMPTS	CLIENT SCORE:
To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported. ***Because this section is self-reported, if there are more than one parent present, they should each be asked individually.*** • *"I don't need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?"* • *"Are you currently or have you ever received professional assistance to address that abuse?"* • *"Does the experience of abuse or trauma impact your day to day living in any way?"* • *"Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?"* • *"Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?"* • *"Have you ever become homeless as a direct result of experiencing abuse or trauma?"*	**NOTES**

SCORING	
4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☐ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

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F. Risk of Harm to Self or Others

PROMPTS	CLIENT SCORE:
• *Does anyone in your family have thoughts about hurting themselves or anyone else? Have they ever acted on these thoughts? When was the last time? What was occurring when that happened?* • *Has anyone in your family ever received professional help – including maybe a stay at hospital – as a result of thinking about or attempting to hurt themself or others? How long ago was that? Does that happen often?* • *Has anyone in your family recently left a situation you felt was abusive or unsafe? How long ago was that?* • *Has anyone in your family been in any fights recently – whether they started it or someone else did? How long ago was that? How often do they get into fights?*	**NOTES**

	SCORING
4	**Any** of the following for any family member: ☐ In the past 90 days, left an abusive situation ☐ In the past 30 days, attempted, threatened, or actually harmed self or others ☐ In the past 30 days, involved in a physical altercation (instigator or participant)
3	**Any** of the following for any family member: ☐ In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 180 days, but not in the past 30 days ☐ In the past 365 days, involved in a physical altercation (instigator or participant), but not in the past 30 days
2	**Any** of the following for any family member: ☐ In the past 365 days, left an abusive situation, but no exposure to abuse in the past 180 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 365 days, but not in the past 180 days ☐ 366+ days ago, 4+ involvements in physical alterations
1	☐ 366+ days ago, a family member had 1-3 involvements in physical alterations
0	☐ Whole family reports no instance of harming self, being harmed, or harming others

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G. Involvement in Higher Risk and/or Exploitive Situations

PROMPTS	CLIENT SCORE:
• *[Observe, don't ask] Any abcesses or track marks from injection substance use?* • *Does anybody force or trick people in your family to do things that they don't want to do?* • *Do you or anyone in your family ever do stuff that could be considered dangerous like drinking until they pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* • *Does anyone in your family ever find themselves in situations that may be considered at a high risk for violence?* • *Does your family ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 10+ higher risk and/or exploitive events ☐ In the past 90 days, any member of the family left an abusive situation
3	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 4-9 higher risk and/or exploitive events ☐ In the past 180 days, any member of the family left an abusive situation, but not in the past 90 days
2	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 1-3 higher risk and/or exploitive events ☐ 181+ days ago, any member of the family left an abusive situation
1	☐ Any involvement in higher risk and/or exploitive situations by any member of the family occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no involvement by any family member in higher risk and/or exploitive events

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H. Interaction with Emergency Services

PROMPTS	CLIENT SCORE:
• *How often does your family go to emergency rooms?* • *How many times have you had the police speak to members of your family over the past 180 days?* • *Has anyone in your family used an ambulance or needed the fire department at any time in the past 180 days?* • *How many times have members of your family called or visited a crisis team or a crisis counselor in the last 180 days?* • *How many times have you or anyone in your family been admitted to hospital in the last 180 days? How long did they stay?*	**NOTES**

Note: Emergency service use includes: admittance to emergency room/department; hospitalizations; trips to a hospital in an ambulance; crisis service, distress centers, suicide prevention service, sexual assault crisis service, sex worker crisis service, or similar service; interactions with police for the purpose of law enforcement; interactions with fire service in emergency situations.

SCORING	
4	☐ In the past 180 days, cumulative family total of 10+ interactions with emergency services
3	☐ In the past 180 days, cumulative family total of 4-9 interactions with emergency services
2	☐ In the past 180 days, cumulative family total of 1-3 interactions with emergency services
1	☐ Any interaction with emergency services by family members occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no interaction with emergency services

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I. Legal

PROMPTS	CLIENT SCORE:
• *Does your family have any "legal stuff" going on?* • *Has anyone in your family had a lawyer assigned to them by a court?* • *Does anyone in your family have any upcoming court dates? Do you think there's a chance someone in your family will do time?* • *Any outstanding fines?* • *Has anyone in your family paid any fines in the last 12 months for anything?* • *Has anyone in your family done any community service in the last 12 months?* • *Is anybody expecting someone in your family to do community service for anything right now?* • *Did your family have any legal stuff in the last year that got dismissed?* • *Is your family's housing at risk in any way right now because of legal issues?*	**NOTES**

SCORING	
4	**Any** of the following among any family member: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand
3	**Any** of the following among any family member: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand
2	**Any** of the following among any family member: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)
1	☐ There are no current legal issues among family members, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration
0	☐ No family member has had any legal issues within the past 365 days, **and** currently no conditions of release

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J. Managing Tenancy

PROMPTS	CLIENT SCORE:
• *Is your family currently homeless?* • *[If the family is housed] Does your family have an eviction notice?* • *[If the family is housed] Do you think that your family's housing is at risk?* • *How is your family's relationship with your neighbors?* • *How does your family normally get along with landlords?* • *How has your family been doing with taking care of your place?*	**NOTES**

Note: Housing matters include: conflict with landlord and/or neighbors, damages to the unit, payment of rent on time and in full. Payment of rent through a third party is <u>not</u> considered to be a short-coming or deficiency in the ability to pay rent.

SCORING	
4	**Any** of the following: ☐ Currently homeless ☐ In the next 30 days, will be re-housed or return to homelessness ☐ In the past 365 days, was re-housed 6+ times ☐ In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters
3	**Any** of the following: ☐ In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days ☐ In the past 365 days, was re-housed 3-5 times ☐ In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters
2	**Any** of the following: ☐ In the past 365 days, was re-housed 2 times ☐ In the past 180 days, was re-housed 1+ times, but not in the past 60 days ☐ Continuously housed for at least 90 days but not more than 180 days ☐ In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters
1	**Any** of the following: ☐ In the past 365 days, was re-housed 1 time ☐ Continuously housed, with no assistance on housing matters, for at least 180 days but not more than 365 days
0	☐ Continuously housed, with no assistance on housing matters, for at least 365 days

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K. Personal Administration & Money Management

PROMPTS	CLIENT SCORE:
• *How are you and your family with taking care of money?* • *How are you and your family with paying bills on time and taking care of other financial stuff?* • *Does anyone in your family have any street debts or drug or gambling debts?* • *Is there anybody that thinks anyone in your family owes them money?* • *Do you budget every single month for every single thing your family needs? Including cigarettes? Booze? Drugs?* • *Does your family try to pay your rent before paying for anything else?* • *Is anyone in your family behind in any payments like child support or student loans or anything like that?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ No family income (including formal and informal sources) ☐ Substantial real or perceived debts of $1,000+, past due or requiring monthly payments **Or**, for the person who normally handles the household's finances, **any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Not aware of the full amount spent on substances, if the household includes a substance user
3	☐ Real or perceived debts of $999 or less, past due or requiring monthly payments, **or** For the person who normally handles the household's finances, **any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use, if the household includes a substance user
2	☐ In the past 365 days, source of family income has changed 2+ times, **or** For the person who normally handles the household's finances, **any** of the following: ☐ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) ☐ Self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ The person who normally handles the household's finances has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ The person who normally handles the household's finances has been self-managing financial resources and taking care of associated administrative tasks for at least 180 days

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L. Social Relationships & Networks

PROMPTS	CLIENT SCORE:
• *Tell me about your family's friends, extended family or other people in your life.* • *How often do you get together or chat with family friends?* • *When your family goes to doctor's appointments or meet with other professionals like that, what is that like?* • *Are there any people in your life that you feel are just using you, or someone else in your family?* • *Are there any of your family's closer friends that you feel are always asking you for money, smokes, drugs, food or anything like that?* • *Have you ever had people crash at your place that you did not want staying there?* • *Have you ever been threatened with an eviction or lost a place because of something that friends or extended family did in your apartment?* • *Have you ever been concerned about not following your lease agreement because of friends or extended family?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Currently homeless and would classify most of friends and family as homeless ☐ Friends, family or other people are placing security of housing at imminent risk, **or** impacting life, wellness, or safety ☐ In the past 90 days, left an exploitive, abusive or dependent relationship ☐ No friends or family and any family member demonstrates an inability to follow social norms
3	**Any** of the following: ☐ Currently homeless, and would classify some of friends as housed, while some are homeless ☐ In the past 90-180 days, left an exploitive, abusive or dependent relationship ☐ Friends, family or other people are having some negative consequences on wellness or housing stability ☐ No friends or family but all family members demonstrate ability to follow social norms ☐ Any family member is meeting new people with an intention of forming friendships ☐ Any family member is reconnecting with previous friends or family members, but experiencing difficulty advancing the relationship
2	**Any** of the following: ☐ Currently homeless, and would classify friends and family as being housed ☐ More than 180 days ago, left an exploitive, abusive or dependent relationship ☐ Any family member is developing relationships with new people but not yet fully trusting them
1	☐ Has been housed for less than 180 days, **and** family is engaged with friends or family, who are having no negative consequences on the individual's housing stability
0	☐ Has been housed for at least 180 days, **and** family is engaged with friends or family, who are having no negative consequences on the individual's housing stability

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M. Self Care & Daily Living Skills of Family Head

PROMPTS	CLIENT SCORE:
• *Do you have any worries about taking care of yourself or your family?* • *Do you have any concerns about cooking, cleaning, laundry or anything like that?* • *Does anyone in your family ever need reminders to do things like shower or clean up?* • *Describe your family's last apartment.* • *Do you know how to shop for nutritious food on a budget?* • *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* • *Do you tend to keep all of your family's clothes clean?* • *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* • *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?*	**NOTES**

SCORING	
4	**Any** of the following for head(s) of household: ☐ No insight into how to care for themselves, their apartment or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life
3	**Any** of the following for head(s) of household: ☐ Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life
2	**Any** of the following for head(s) of household: ☐ Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, family accessed community resources 4 or fewer times, **and** head of household is fully taking care of all the family's daily needs
0	☐ For the past 365+ days, fully taking care of all the family's daily needs independently

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N. Meaningful Daily Activity

PROMPTS	CLIENT SCORE:
• *How does your family spend their days?* • *How does your family spend their free time?* • *Do these things make your family feel happy/fulfilled?* • *How many days a week would you say members of your family have things to do that make them feel happy/fulfilled?* • *How much time in a week would you or members of your family say they are totally bored?* • *When people in your family wake up in the morning, do they tend to have an idea of what they plan to do that day?* • *How much time in a week would you say members of your family spend doing stuff to fill up the time rather than doing things that they love?* • *Are there any things that get in the way of your family doing the sorts of activities they would like to be doing?*	**NOTES**

SCORING	
4	☐ Any member of the family has no planned, legal activities described as providing fulfillment or happiness
3	☐ Any member of the family is discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness
2	☐ Some members of the family are attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment or happiness, **or** they are not fully committed to continuing the activities.
1	☐ Each family member has planned, legal activities described as providing fulfillment or happiness 1-3 days per week
0	☐ Each family member has planned, legal activities described as providing fulfillment or happiness 4+ days per week

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O. History of Homelessness & Housing

PROMPTS	CLIENT SCORE:
• *How long has your family been homeless?* • *How many times has your family experienced homelessness other than this most recent time?* • *Has your family spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your family's permanent address?* • *Has your family ever spent time sleeping in a car, alleyway , garage, barn, bus shelter, or anything like that?* • *Has your family ever spent time sleeping in an abandoned building?* • *Was anyone in your family ever been in hospital or jail for a period of time when they didn't have a permanent address to go to when they got out?*	**NOTES**

SCORING	
4	☐ Over the past 10 years, cumulative total of 5+ years of family homelessness
3	☐ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of family homelessness
2	☐ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of family homelessness
1	☐ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of family homelessness
0	☐ Over the past 4 years, cumulative total of 7 or fewer days of family homelessness

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P. Parental Engagement

PROMPTS	CLIENT SCORE:
• *Walk me through a typical evening after school in your family.* • *Tell me about what role, if any, the older kids have with the younger kids. Do they babysit? Walk them to school? Bathe or put the younger kids to bed?* • *Does your family have play time together? What kinds of things do you do and how often do you do it?* • *Let's pick a day like a Saturday...do you know where your kids are the entire day and whom they are out with all day?*	**NOTES**

Note: In this section, a child is considered "supervised" when the parent has knowledge of the child's whereabouts, the child is in an age-appropriate environment, and the child is engaged with the parent or another responsible adult. "Caretaking tasks" are tasks that may be expected by a parent/caregiver such as getting children to/from school, preparing meals, bathing children, putting children to bed, etc.

	SCORING
4	☐ No sense of parental attachment and responsibility ☐ No meaningful family time together ☐ Children 12 and younger are unsupervised 3+ hours each day ☐ Children 13 and older are unsupervised 4+ hours each day ☐ In families with 2+ children, the older child performs caretaking tasks 5+ days/week
3	☐ Weak sense of parental attachment and responsibility ☐ Meaningful family activities occur 1-4 times in a month ☐ Children 12 and younger are unsupervised 1-3 hours each day ☐ Children 13 and older are unsupervised 2-4 hours each day ☐ In families with 2+ children, the older child performs caretaking tasks 3-4 days/week
2	☐ Sense of parental attachment and responsibility, but not consistently applied ☐ Meaningful family activities occur 1-2 days per week ☐ Children 12 and younger are unsupervised fewer than 1 hour each day ☐ Children 13 and older are unsupervised 1-2 hours each day ☐ In families with 2+ children, the older child performs caretaking tasks fewer than 2 days/week
1	☐ Strong sense of parental attachment and responsibility towards their children ☐ Meaningful family activities occur 3-6 days of the week ☐ Children 12 and younger are never unsupervised ☐ Children 13 and older are unsupervised no more than an hour each day
0	☐ Strong sense of attachment and responsibility towards their children ☐ Meaningful family activities occur daily ☐ Children are never unsupervised

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Q. Stability/Resiliency of the Family Unit

PROMPTS	CLIENT SCORE:
• *Over the past year have there been any different adults staying with the family like a family friend, grandparent, aunt or that sort of thing? If so, can you tell me when and for how long and the changes that have occurred?* • *Other than kids being taken into care, have there been any instances where any child has gone to stay with another family member or family friend for any length of time? Can you tell me how many times, when and for how long that happened?*	**NOTES**

SCORING	
4	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relative within the family have changed 4+ times ☐ Children have left or returned to the family 4+ times
3	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 3 times ☐ Children have left or returned to the family 3 times
2	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 2 times ☐ Children have left or returned to the family 2 times
1	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 1 time ☐ Children have left or returned to the family 1 time
0	In the past 365 days, **any** of the following have occurred: ☐ No change in parental arrangements and/or other adult relatives within the family ☐ Children have not left or returned to the family

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R. Needs of Children

PROMPTS	CLIENT SCORE:
• *Please tell me about the attendance at school of your school-aged children.* • *Any health issues with your children?* • *Any times of separation between your children and parents?* • *Without going into detail, have any of your children experienced or witnessed emotional, physical, sexual or psychological abuse?* • *Have your children ever accessed professional assistance to address that abuse?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 15+ days in any month ☐ School-aged children are not currently enrolled in school ☐ Any member of the family, including children, is currently escaping an abusive situation ☐ The family is homeless
3	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 7-14 days in any month ☐ School-aged children typically miss 3+ days of school per week for reasons other than illness ☐ In the last 180 days, any child(ren) in the family has experienced an abusive situation that has since ended
2	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 1-6 days in any month ☐ School-aged children typically miss 2 days of school per week for reasons other than illness ☐ In the past 365 days, any child(ren) in the family has experienced an abusive situation that has ended more than 180 days ago
1	**Any** of the following: ☐ In the last 365 days, children needed to live with friends or family for 7+ days in any month, but not in the last 90 days ☐ School-aged children typically miss 1 day of school per week for reasons other than illness
0	**All** of the following: ☐ In the last 365 days, children needed to live with friends or family for fewer than 7 days in every month ☐ School-aged children maintain consistent attendance at school ☐ There is no evidence of children in the home having experienced or witnessed abuse ☐ The family is housed

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S. Size of Family Unit

PROMPTS	CLIENT SCORE:
• *I just want to make sure I understand how many kids there are, the gender of each and their age. Can you take me through that again?* • *Is anyone in the family currently pregnant?*	NOTES

SCORING	FOR ONE-PARENT FAMILIES:	FOR TWO-PARENT FAMILIES:
4	**Any** of the following: ☐ A pregnancy in the family ☐ At least one child aged 0-6 ☐ Three or more children of any age	**Any** of the following: ☐ A pregnancy in the family ☐ Four or more children of any age
3	**Any** of the following: ☐ At least one child aged 7-11 ☐ Two children of any age	**Any** of the following: ☐ At least one child aged 0-6 ☐ Three children of any age
2	☐ At least one child aged 12–15.	**Any** of the following: ☐ At least one child aged 7-11 ☐ Two children of any age
1	☐ At least one child aged 16 or older.	☐ At least one child aged 12 or older
0	☐ Children have been permanently removed from the family and the household is transitioning to services for singles or couples without children	

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T. Interaction with Child Protective Services and/or Family Court

PROMPTS	CLIENT SCORE:
• *Any matters being considered by a judge right now as it pertains to any member of your family?* • *Have any of your children spent time in care? When was that? For how long were they in care? When did you get them back?* • *Has there ever been an investigation by someone in child welfare into the matters of your family?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 90 days, interactions with child protective services have occurred ☐ In the past 365 days, one or more children have been removed from parent's custody that have **not** been reunited with the family at least four days per week ☐ There are issues still be decided or considered within family court
3	In the past 180 days, **any** of the following have occurred: ☐ Interactions with child protective services have occurred, but not within the past 90 days ☐ One or more children have been removed from parent's custody through child protective services (non-voluntary) **and** the child(ren) has been reunited with the family four or more days per week; ☐ Issues have been resolved in family court
2	☐ In the past 365 days, interactions with child protective services have occurred, but not within the past 180 days, and there are no active issues, concerns or investigations
1	☐ No interactions with child protective services have occurred, within the past 365 days, and there are no active issues, concerns or investigations.
0	☐ There have been no serious interactions with child protective services because of parenting concerns

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Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
MENTAL HEALTH & WELLNESS AND COGNITIVE FUNCTIONING		
PHYSICAL HEALTH & WELLNESS		
MEDICATION		
SUBSTANCE USE		
EXPERIENCE OF ABUSE AND/ OR TRAUMA		
RISK OF HARM TO SELF OR OTHERS		
INVOLVEMENT IN HIGHER RISK AND/OR EXPLOITIVE SITUATIONS		
INTERACTION WITH EMERGENCY SERVICES		

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Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
LEGAL INVOLVEMENT		
MANAGING TENANCY		
PERSONAL ADMINISTRATION & MONEY MANAGEMENT		
SOCIAL RELATIONSHIPS & NETWORKS		
SELF-CARE & DAILY LIVING SKILLS		
MEANINGFUL DAILY ACTIVITIES		
HISTORY OF HOUSING & HOMELESSNESS		

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Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
PARENTAL ENGAGEMENT		
STABILITY/RESILIENCY OF THE FAMILY UNIT		
NEEDS OF CHILDREN		
SIZE OF FAMILY		
INTERACTION WITH CHILD PROTECTIVE SERVICES AND/ OR FAMILY COURT		
TOTAL		**Score: Recommendation:** 0-26: No housing intervention 27-53: Rapid Re-Housing 54-80: Permanent Supportive Housing/Housing First

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Appendix A: About the SPDAT

OrgCode Consulting, Inc. is pleased to announce the release of Version 4 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

SPDAT Design

The SPDAT is designed to:

- Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
- Prioritize the sequence of clients receiving those services
- Help prioritize the time and resources of Frontline Workers
- Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
- Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team
- Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan
- Track the depth of need and service responses to clients over time

The SPDAT is NOT designed to:

- Provide a diagnosis
- Assess current risk or be a predictive index for future risk
- Take the place of other valid and reliable instruments used in clinical research and care

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, we have also created the VI-SPDAT as an initial screening tool.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client's acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services.

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Family SPDAT

Upon the release of SPDAT Version 3, a special version was released - the Family SPDAT Version 1. This tool introduced five new components that specifically address the unique challenges to housing stability faced by homeless families. In addition, the tool has a focus on households throughout.

SPDAT Version 4/Family SPDAT Version 2

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale, Camberwell Assessment of Needs, Vulnerability Index, and Transition Aged Youth Triage Tool.

In preparing SPDAT v4 and F-SPDAT v2, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff have observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics review enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

The new versions build upon the success of previous versions of the SPDAT products with some refinements. Starting in August 2014, a survey was launched of existing SPDAT and F-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

The major differences from F-SPDAT Version 1 to Version 2 include:

- The structure of the tools is the same: four domains (five for families) with components aligned to specific domains. The names of the domains and the components remain unchanged.
- The scoring of the tools is the same: 60 points for singles, and 80 points for families.
- The scoring tables used to run from 0 through to 4. They are now reversed with each table starting at 4 and working their way down to 0. This increases the speed of assessment.
- The order of the tools has changed, grouped together by domain.
- Language has been simplified.
- Days are used rather than months to provide greater clarification and alignment to how most databases capture periods of time in service.
- Greater specificity has been provided in some components such as amount of debts.

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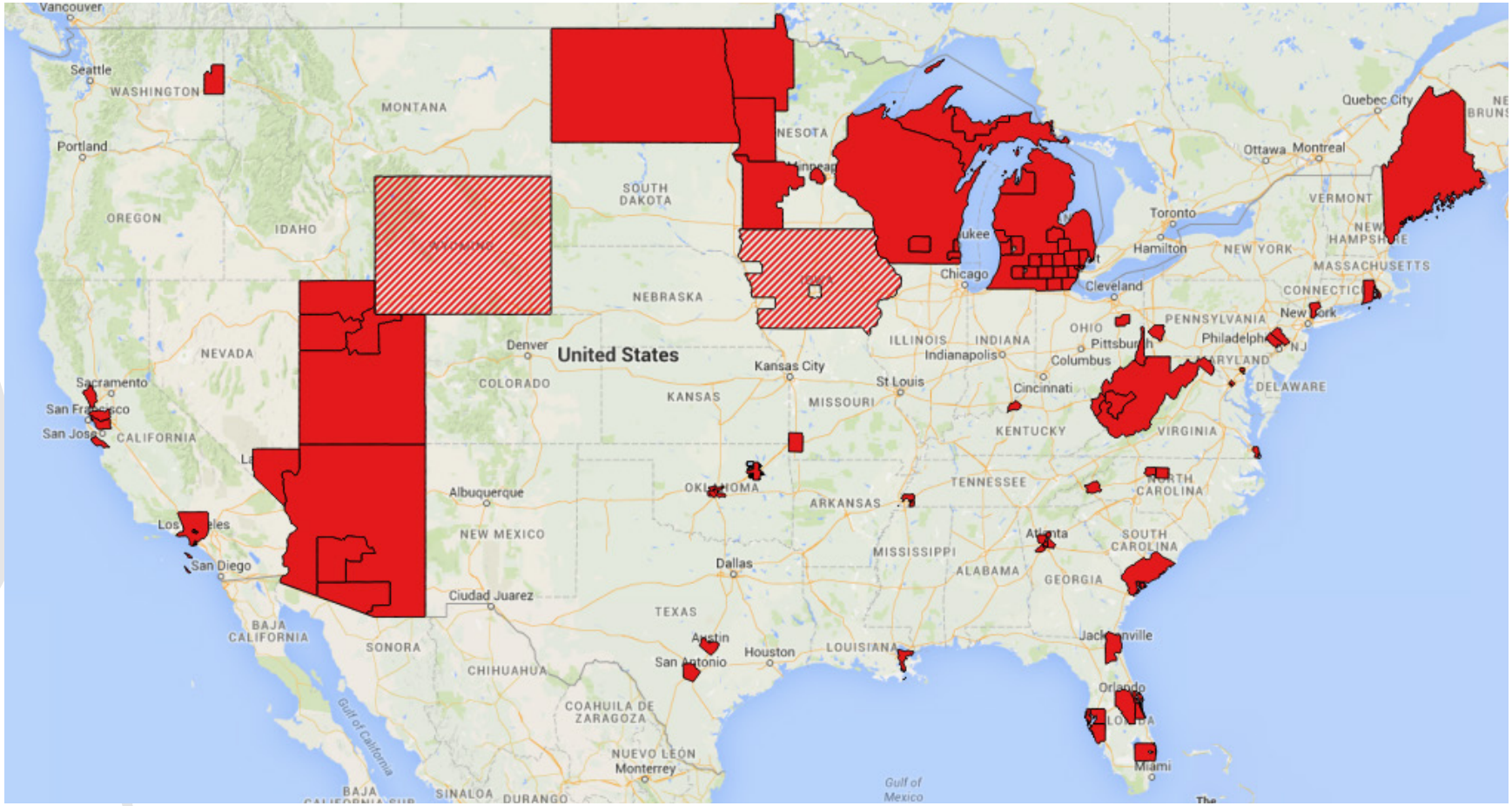
Appendix B: Where the SPDAT is being used (as of May 2015)

United States of America



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Arizona
- Statewide

California
- Oakland/Alameda County CoC
- Richmond/Contra Costa County CoC
- Watsonville/Santa Cruz City & County CoC
- Napa City & County CoC
- Los Angeles City & County CoC
- Pasadena CoC
- Glendale CoC

District of Columbia
- District of Columbia CoC

Florida
- Sarasota/Bradenton/Manatee, Sarasota Counties CoC
- Tampa/Hillsborough County CoC
- St. Petersburg/Clearwater/Largo/Pinellas County CoC
- Orlando/Orange, Osceola, Seminole Counties CoC
- Jacksonville-Duval, Clay Counties CoC
- Palm Bay/Melbourne/Brevard County CoC
- West Palm Beach/Palm Beach County CoC

Georgia
- Atlanta County CoC
- Fulton County CoC
- Marietta/Cobb County CoC
- DeKalb County CoC

Iowa
- Parts of Iowa Balance of State CoC

Kentucky
- Louisville/Jefferson County CoC

Louisiana
- New Orleans/Jefferson Parish CoC

Maryland
- Baltimore City CoC

Maine
- Statewide

Michigan
- Statewide

Minnesota
- Minneapolis/Hennepin County CoC
- Northwest Minnesota CoC
- Moorhead/West Central Minnesota CoC
- Southwest Minnesota CoC

Missouri
- Joplin/Jasper, Newton Counties CoC

North Carolina
- Winston Salem/Forsyth County CoC
- Asheville/Buncombe County CoC
- Greensboro/High Point CoC

North Dakota
- Statewide

Nevada
- Las Vegas/Clark County CoC

New York
- Yonkers/Mount Vernon/New Rochelle/Westchester County CoC

Ohio
- Canton/Massillon/Alliance/Stark County CoC
- Toledo/Lucas County CoC

Oklahoma
- Tulsa City & County/Broken Arrow CoC
- Oklahoma City CoC

Pennsylvania
- Lower Marion/Norristown/Abington/Montgomery County CoC
- Bristol/Bensalem/Bucks County CoC
- Pittsburgh/McKeesport/Penn Hills/Allegheny County CoC

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country CoC

Tennessee
- Memphis/Shelby County CoC

Texas
- San Antonio/Bexar County CoC
- Austin/Travis County CoC

Utah
- Salt Lake City & County CoC
- Utah Balance of State CoC
- Provo/Mountainland CoC

Virginia
- Virginia Beach CoC
- Arlington County CoC

Washington
- Spokane City & County CoC

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming is in the process of implementing statewide

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Canada

Alberta
- Province-wide

Manitoba
- City of Winnipeg

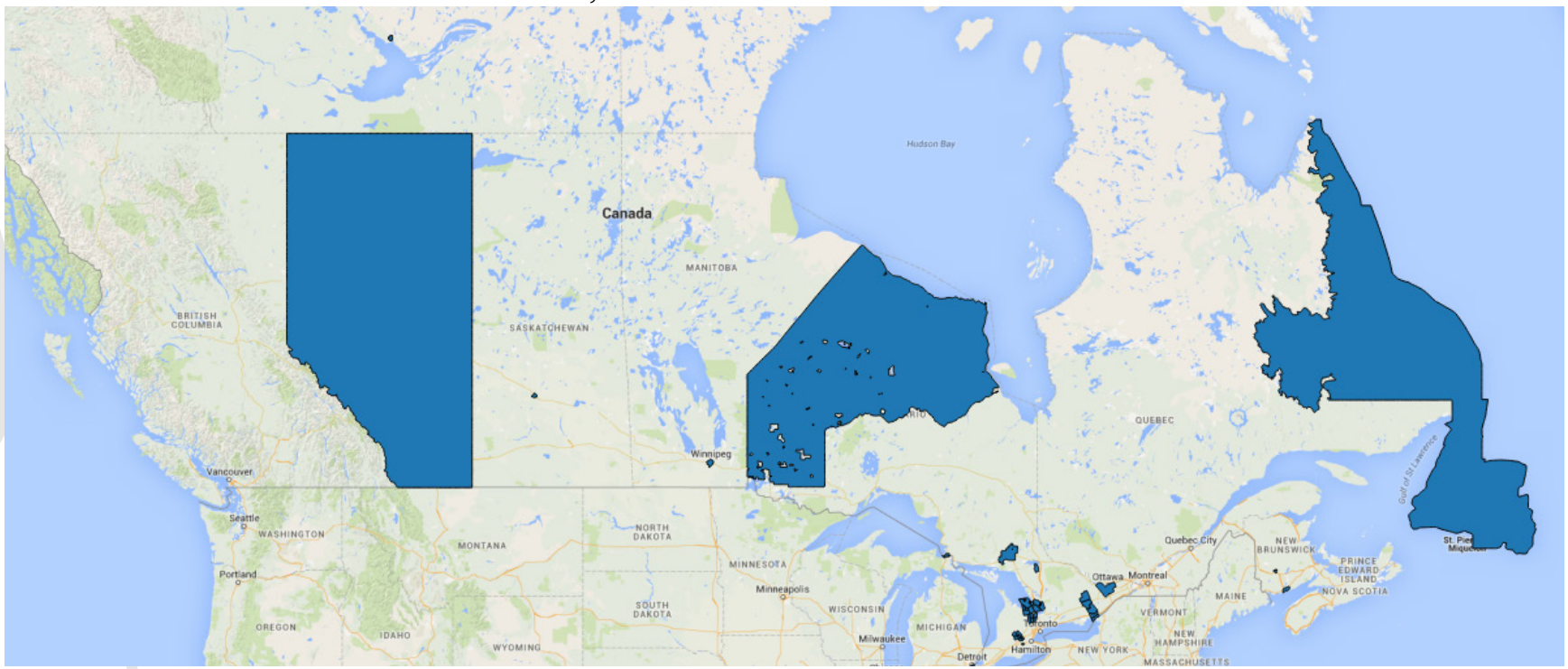
New Brunswick
- City of Fredericton
- City of Saint John

Newfoundland and Labrador
- Province-wide

Northwest Territories
- City of Yellowknife

Ontario
- City of Barrie/Simcoe County
- City of Brantford/Brant County
- City of Greater Sudbury
- City of Kingston/Frontenac County
- City of Ottawa
- City of Windsor
- District of Kenora
- District of Parry Sound
- District of Sault Ste Marie
- Regional Municipality of Waterloo
- Regional Municipality of York

Saskatchewan
- Saskatoon



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Australia

Queensland
- Brisbane

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Youth

Service Prioritization Decision Assistance Tool

(Y-SPDAT)

Assessment Tool for Single Youth

VERSION 1.0

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Disclaimer
The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or types of users. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and do not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0
- Family VI-SPDAT V 2.0
- Next Step Tool for Homeless Youth V 1.0

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for front-line workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. The SPDAT tools are also designed to help guide case management and improve housing stability outcomes. They provide an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- F-SPDAT V 2.0 for Families
- Y-SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

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SPDAT Training Series

To use the SPDAT assessment product, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

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Terms and Conditions Governing the Use of the SPDAT

SPDAT products have been developed by OrgCode Consulting, Inc. with extensive feedback from key community partners including people with lived experience. The tools are provided free of charge to communities to improve the client centered services dedicated to increasing housing stability and wellness. Training is indeed required for the administration and interpretation of these assessment tools. Use of the SPDAT products without authorized training is strictly prohibited.

By using this tool, you accept and agree to be bound by the terms of this expectation.

No sharing, reproduction, use or duplication of the information herein is permitted without the express written consent of OrgCode Consulting, Inc.

Ownership

The Service Prioritization Decision Assistance Tool ("SPDAT") and accompanying documentation is owned by OrgCode Consulting, Inc.

Training

Although the SPDAT Series is provided free of charge to communities, training by OrgCode Consulting, Inc. or a third party trainer, authorized by OrgCode, must be successfully completed. After meeting the training requirements required to administer and interpret the SPDAT Series, practitioners are permitted to implement the SPDAT in their work with clients.

Restrictions on Use

You may not use or copy the SPDAT prior to successfully completing training on its use, provided by OrgCode Consulting, Inc. or a third-party trainer authorized by OrgCode. You may not share the SPDAT with other individuals not trained on its use. You may not train others on the use of the SPDAT, unless specifically authorized by OrgCode Consulting, Inc.

Restrictions on Alteration

You may not modify the SPDAT or create any derivative work of the SPDAT or its accompanying documentation, without the express written consent of OrgCode Consulting, Inc. Derivative works include but are not limited to translations.

Disclaimer

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

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A. Mental Health & Wellness & Cognitive Functioning

PROMPTS	CLIENT SCORE:
• *Have you ever had a conversation with a psychiatrist, psychologist, or school counsellor? When was that?* • *Do you feel you are getting all the help you might need with whatever mental health stress you might have?* • *Have you ever hurt your brain or head?* • *Do you have trouble learning or paying attention?* • *Has anyone ever told you you might have ADD or ADHD?* • *Was there ever any special testing done to identify learning disabilities?* • *Has any doctor ever prescribed you pills for anxiety, depression, or anything like that?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby?* • *Are there any professionals we could speak with that have knowledge of your mental health?*	**NOTES**

SCORING		
4	**Any** of the following: ☐ Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability	
3	**Any** of the following: ☐ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability	
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason for screening by an expert in mental health or cognitive functioning prior to housing to fully understand capacity	**FOR YOUTH** ☐ Age 16 or under and would not otherwise score higher
1	☐ In a heightened state of recovery, has a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** is engaged with mental health supports as necessary.	☐ Age 17-23 and would not otherwise score higher
0	☐ Age 24+ **and** no mental health or cognitive functioning issues disclosed, suspected or observed	

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B. Physical Health & Wellness

PROMPTS	CLIENT SCORE:
• *How is your health?* • *Do you feel you are getting all the care you need for your health? When was the last time you saw a doctor? What was that for?* • *Do you have a clinic or doctor that you usually go to?* • *Any illness like diabetes, HIV, Hep C or anything like that going on?* • *Do you have any reason to suspect you might be pregnant? Is that impacting your health in any way? Have you talked with a doctor about your pregnancy? Are you following the doctor's advice?* • *Anything going on right now with your health that you think would prevent you from living a full, healthy, happy life?* • *Are there other professionals we could speak with that have knowledge of your health?*	**NOTES**

Note: In this section, a current pregnancy can be considered a health issue.

SCORING	
4	**Any** of the following: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Pallative health condition
3	Presence of a health issue with **any** of the following: ☐ Not connected with professional resources to assist with a real or perceived serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) ☐ Unable to follow the treatment plan as a direct result of homeless status
2	☐ Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements.
0	☐ No serious or chronic health condition ☐ If any minor health condition, they are managed appropriately

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C. Medication

PROMPTS	CLIENT SCORE:
• *Have you recently been prescribed any medications by a health care professional?* • *Do you take any medications prescribed to you by a doctor?* • *Have you ever sold some or all of your prescription?* • *Have you ever had a doctor prescribe you medication that you didn't have filled at a pharmacy or didn't take?* • *Were any of your medications changed in the last month? If yes: How did that make you feel?* • *Do other people ever steal your medications?* • *Do you ever share your medications with other people?* • *How do you store your medications and make sure you take the right medication at the right time each day?* • *What do you do if you realize you've forgotten to take your medications?* • *Do you have any papers or documents about the medications you take?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason
3	**Any** of the following: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping night-time medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

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D. Substance Use

PROMPTS	CLIENT SCORE:
• *When was the last time you had a drink or used drugs?* • *Is there anything we should keep in mind related to drugs or alcohol?* • *[If they disclose use of drugs and/or alcohol] How frequently would you say you use [specific substance] in a week?* • *Ever get into fights, fall down and bang your head, or pass out when drinking or using other drugs?* • *Have you ever used alcohol or other drugs in a way that may be considered less than safe?* • *Do you ever end up doing things you later regret after you have gotten really hammered?* • *Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?* • *Have you engaged with anyone professionally related to your substance use that we could speak with?*	**NOTES**

Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women. "Under legal age" refers to under the age at which it is legal to purchase and consume the substance in question.

SCORING		FOR YOUTH
4	☐ In a life-threatening health situation as a direct result of substance use, **or**, In the past 30 days, **any** of the following are true... ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times ☐ Substance use resulting in passing out 2+ times	☐ First used drugs before age 12 ☐ Scores a 2-3 and is under age 15 ☐ Scores a 3 and is under legal age
3	☐ Experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or**, In the past 30 days, **any** of the following are true... ☐ Drug use reached the point of complete inebriation 12+ times ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times	☐ First used drugs aged 12-15 ☐ Scores a 1 and is under age 15 ☐ Scores a 2 and is under legal age
2	In the past 30 days, **any** of the following are true... ☐ Drug use reached the point of complete inebriation fewer than 12 times ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times	☐ Scores a 1 and is under legal age
1	☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or**, ☐ If making claims to sobriety, no substance use in the past 30 days	
0	☐ In the past 365 days, no substance use	

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E. Experience of Abuse & Trauma

PROMPTS	CLIENT SCORE:
To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported. • *"I don't need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?"* • *"Are you currently or have you ever received professional assistance to address that abuse?"* • *"Does the experience of abuse or trauma impact your day to day living in any way?"* • *"Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?"* • *"Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?"* • *"Have you ever become homeless as a direct result of experiencing abuse or trauma?"*	**NOTES**

SCORING	
4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☐ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

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F. Risk of Harm to Self or Others

PROMPTS	CLIENT SCORE:
• *Do you have thoughts about hurting yourself or anyone else? Have you ever acted on these thoughts? When was the last time?* • *What was occurring when you had these feelings or took these actions?* • *Have you ever received professional help – including maybe a stay at hospital – as a result of thinking about or attempting to hurt yourself or others? How long ago was that? Does that happen often?* • *Have you recently left a situation you felt was abusive or unsafe? How long ago was that?* • *Have you been in any fights recently - whether you started it or someone else did? How long ago was that? How often do you get into fights?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 90 days, left an abusive situation ☐ In the past 30 days, attempted, threatened, or actually harmed self or others ☐ In the past 30 days, involved in a physical altercation (instigator or participant)
3	**Any** of the following: ☐ In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 180 days, but not in the past 30 days ☐ In the past 365 days, involved in a physical altercation (instigator or participant), but not in the past 30 days
2	**Any** of the following: ☐ In the past 365 days, left an abusive situation, but no exposure to abuse in the past 180 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 365 days, but not in the past 180 days ☐ 366+ days ago, 4+ involvements in physical alterations
1	☐ 366+ days ago, 1-3 involvements in physical alterations
0	☐ Reports no instance of harming self, being harmed, or harming others

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G. Involvement in High Risk and/or Exploitive Situations

PROMPTS	CLIENT SCORE:
• *[Observe, don't ask] Any abcesses or track marks from injection substance use?* • *Does anybody force or trick you to do something that you don't want to do?* • *Do you ever do stuff that could be considered dangerous like drinking until you pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* • *Do you ever find yourself in situations that may be considered at a high risk for violence?* • *Do you ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?*	**NOTES**

SCORING		
		YOUTH PREGNANCY
4	**Any** of the following: ☐ In the past 180 days, engaged in 10+ higher risk and/or exploitive events ☐ In the past 90 days, left an abusive situation	☐ Under the age of 24, and has ever become pregnant
3	**Any** of the following: ☐ In the past 180 days, engaged in 4-9 higher risk and/or exploitive events ☐ In the past 180 days, left an abusive situation, but not in the past 90 days	☐ Under the age of 24, and has ever gotten someone else pregnant, and wouldn't otherwise score a 4
2	**Any** of the following: ☐ In the past 180 days, engaged in 1-3 higher risk and/or exploitive events ☐ 181+ days ago, left an abusive situation	
1	☐ In the past 365 days, any involvement in higher risk and/or exploitive events, but not in the past 180 days	
0	☐ In the past 365 days, no involvement in higher risk and/or exploitive events	

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H. Interaction with Emergency Services

PROMPTS	CLIENT SCORE:
• *How often do you go to emergency rooms?* • *How many times have you had the police speak to you over the past 180 days?* • *Have you used an ambulance or needed the fire department at any time in the past 180 days?* • *How many times have you called or visited a crisis team or a crisis counselor in the last 180 days?* • *How many times have you been admitted to hospital in the last 180 days? How long did you stay?*	**NOTES**

Note: Emergency service use includes: admittance to emergency room/department; hospitalizations; trips to a hospital in an ambulance; crisis service, distress centers, suicide prevention service, sexual assault crisis service, sex worker crisis service, or similar service; interactions with police for the purpose of law enforcement; interactions with fire service in emergency situations.

SCORING	
4	☐ In the past 180 days, cumulative total of 10+ interactions with emergency services
3	☐ In the past 180 days, cumulative total of 4-9 interactions with emergency services
2	☐ In the past 180 days, cumulative total of 1-3 interactions with emergency services
1	☐ Any interaction with emergency services occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no interaction with emergency services

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I. Legal

PROMPTS	CLIENT SCORE:
• *Do you have any "legal stuff" going on?* • *Have you had a lawyer assigned to you by a court?* • *Do you have any upcoming court dates? Do you think there's a chance you will do time?* • *Any involvement with family court or child custody matters?* • *Any outstanding fines?* • *Have you paid any fines in the last 12 months for anything?* • *Have you done any community service in the last 12 months?* • *Is anybody expecting you to do community service for anything right now?* • *Did you have any legal stuff in the last year that got dismissed?* • *Is your housing at risk in any way right now because of legal issues?*	**NOTES**

SCORING		
		JUVENILE DELINQUENCY
4	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand	☐ The youth is under the age of 18 and has current outstanding legal issue(s) that are likely to result in incarceration
3	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand	☐ The youth is under the age of 24 and was ever incarcerated while still a minor, and would not otherwise score a 4
2	**Any** of the following: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)	
1	☐ There are no current legal issues, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration	
0	☐ Has not had any legal issues within the past 365 days, **and** currently no conditions of release	

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J. Managing Tenancy

PROMPTS	CLIENT SCORE:
• *Are you currently homeless?* • *Have you ever signed a lease? How did that go?* • *[If the person is housed] Do you have an eviction notice?* • *[If the person is housed] Do you think that your housing is at risk?* • *How is your relationship with your neighbors?* • *How do you normally get along with landlords (or your parents/guardian(s))?* • *How have you been doing with taking care of your place?*	**NOTES**

Note: Housing matters include: conflict with landlord and/or neighbors, damages to the unit, payment of rent on time and in full. Payment of rent through a third party is <u>not</u> considered to be a short-coming or deficiency in the ability to pay rent.

SCORING		
		RUNAWAYS
4	**Any** of the following: ☐ Currently homeless ☐ In the next 30 days, will be re-housed or return to homelessness ☐ In the past 365 days, was re-housed 6+ times ☐ In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters	☐ In the past 90 days, ran away from foster home, group home, or parent's home
3	**Any** of the following: ☐ In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days ☐ In the past 365 days, was re-housed 3-5 times ☐ In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters	☐ In the past 365 days, ran away from foster home, group home, or parent's home, but not in the past 90 days
2	**Any** of the following: ☐ In the past 365 days, was re-housed 2 times ☐ In the past 180 days, was re-housed 1+ times, but not in the past 60 days ☐ For the past 90 days, was continuously housed, but not for more than 180 days ☐ In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters	☐ Ran away from foster home, group home, or parent's home, but not in the past 365 days
1	**Any** of the following: ☐ In the past 365 days, was re-housed 1 time ☐ For the past 180 days, was continuously housed, with no assistance with housing matters, but not for more than 365 days	
0	☐ For the past 365+ days, was continuously housed in same unit, with no assistance with housing matters	

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K. Personal Administration & Money Management

PROMPTS	CLIENT SCORE:
• *How are you with taking care of money?* • *How are you with paying bills on time and taking care of other financial stuff?* • *Do you have any street debts?* • *Do you have any drug or gambling debts?* • *Is there anybody that thinks you owe them money?* • *Do you budget every single month for every single thing you need? Including cigarettes? Booze? Drugs?* • *Do you try to pay your rent before paying for anything else?* • *Are you behind in any payments like child support or student loans or anything like that?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Does not have an income (including formal and informal sources) ☐ Not aware of the full amount spent on substances, if they use substances ☐ Substantial real or perceived debts of $1,000+, past due or requiring monthly payments
3	**Any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use, if they are a substance user ☐ Real or perceived debts of $999 or less, past due or requiring monthly payments
2	**Any** of the following: ☐ In the past 365 days, source of income has changed 2+ times ☐ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) ☐ Has been self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ Has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ Has been self-managing financial resources and taking care of associated administrative tasks for at least 180 days

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L. Social Relationships & Networks

PROMPTS	CLIENT SCORE:
• *Tell me about your friends, family and other people in your life. How often do you get together or chat?* • *How do you get along with teachers, doctors, police officers, case workers, and other professionals?* • *Are there any people in your life that you feel are just using you?* • *Are there any of your closer friends that you feel are always asking you for money, smokes, drugs, food or anything like that?* • *Have you ever had people crash at your place that you did not want staying there?* • *Have you ever been kicked out of where you were living because of something that friends or family did at your place?* • *Have you ever been concerned about not following your lease agreement because of your friends or family?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 90 days, left an exploitive, abusive or dependent relationship, **or** left home due to family violence or conflict over religious or moral differences, including sexual orientation ☐ Friends, family or other people are placing security of housing at imminent risk, **or** impacting life, wellness, or safety ☐ No friends or family and demonstrates no ability to follow social norms ☐ Currently homeless and would classify most of friends and family as homeless
3	**Any** of the following: ☐ In the past 90-180 days, left an exploitive, abusive or dependent relationship, **or** left home due to family violence or conflict over religious or moral differences ☐ Friends, family or other people are having some negative consequences on wellness or housing stability ☐ No friends or family but demonstrating ability to follow social norms ☐ Meeting new people with an intention of forming friendships, **or** reconnecting with previous friends or family members, but experiencing difficulty advancing the relationship ☐ Currently homeless, and would classify some of friends and family as being housed, while others are homeless
2	**Any** of the following: ☐ More than 180 days ago, left an exploitive, abusive or dependent relationship, **or** left home due to family violence or conflict over religious or moral differences ☐ Developing relationships with new people but not yet fully trusting them ☐ Currently homeless, and would classify friends and family as being housed
1	☐ Has been housed for less than 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability
0	☐ Has been housed for at least 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability

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M. Self Care & Daily Living Skills

PROMPTS	CLIENT SCORE:
• *Do you have any worries about taking care of yourself?* • *Do you have any concerns about cooking, cleaning, laundry or anything like that?* • *Do you ever need reminders to do things like shower or clean up?* • *Describe your last apartment.* • *Do you know how to shop for nutritious food on a budget?* • *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* • *Do you tend to keep all of your clothes clean?* • *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* • *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ No insight into how to care for themselves, their apartment or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life
3	**Any** of the following: ☐ Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life
2	**Any** of the following: ☐ Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, accessed community resources 4 or fewer times, **and** is fully taking care of all their daily needs
0	☐ For the past 365+ days, fully taking care of all their daily needs independently

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N. Meaningful Daily Activity

PROMPTS	CLIENT SCORE:
• *How do you spend your day?* • *How do you spend your free time?* • *Does that make you feel happy/fulfilled?* • *How many days a week would you say you have things to do that make you feel happy/fulfilled?* • *How much time in a week would you say you are totally bored?* • *When you wake up in the morning, do you tend to have an idea of what you plan to do that day?* • *How much time in a week would you say you spend doing stuff to fill up the time rather than doing things that you love?* • *Are there any things that get in the way of you doing the sorts of activities you would like to be doing?*	**NOTES**

SCORING		
		SCHOOL-AGED YOUTH
4	☐ No planned, legal activities described as providing fulfillment or happiness	☐ Not enrolled in school **and** with no planned, legal activities described as providing fulfillment or happiness
3	☐ Discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness	☐ Enrolled in school, but attending class fewer than 3 days per week
2	☐ Attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment or happiness, **or** the individual is not fully committed to continuing the activities.	☐ Enrolled in school, and attending class 3 days per week
1	☐ 1-3 days per week, has planned, legal activities described as providing fulfillment or happiness	☐ Enrolled in school and attending class 4 days per week
0	☐ 4+ days per week, has planned, legal activities described as providing fulfillment or happiness	☐ Enrolled in school and maintaining regular attendance

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O. History of Homelessness & Housing

PROMPTS	CLIENT SCORE:
• *How long have they been homeless?* • *How many times have they been homeless in their life other than this most recent time?* • *Have they spent any time sleeping on a friend's couch or floor? And if so, during those times did they consider that to be their permanent address?* • *Have they ever spent time sleeping in a car or alleyway or garage or barn or bus shelter or anything like that?* • *Have they ever spent time sleeping in an abandoned building?* • *Were they ever in hospital or jail for a period of time when they didn't have a permanent address to go to when they got out?*	**NOTES**

SCORING	
4	☐ Over the past 10 years, cumulative total of 5+ years of homelessness
3	☐ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of homelessness
2	☐ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of homelessness
1	☐ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of homelessness
0	☐ Over the past 4 years, cumulative total of 7 or fewer days of homelessness

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Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
MENTAL HEALTH & WELLNESS AND COGNITIVE FUNCTIONING		
PHYSICAL HEALTH & WELLNESS		
MEDICATION		
SUBSTANCE USE		
EXPERIENCE OF ABUSE AND/ OR TRAUMA		
RISK OF HARM TO SELF OR OTHERS		
INVOLVEMENT IN HIGH RISK AND/OR EXPLOITIVE SITUATIONS		
INTERACTION WITH EMERGENCY SERVICES		

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Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
LEGAL INVOLVEMENT		
MANAGING TENANCY		
PERSONAL ADMINISTRATION & MONEY MANAGEMENT		
SOCIAL RELATIONSHIPS & NETWORKS		
SELF-CARE & DAILY LIVING SKILLS		
MEANINGFUL DAILY ACTIVITIES		
HISTORY OF HOUSING & HOMELESSNESS		
TOTAL		**Score: Recommendation:** 0-19: No housing intervention 20-34: Rapid Re-Housing 35-60: Permanent Supportive Housing/Housing First

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Appendix A: About the SPDAT

OrgCode Consulting, Inc. is pleased to announce the release of Version 4 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

SPDAT Design

The SPDAT is designed to:

- Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
- Prioritize the sequence of clients receiving those services
- Help prioritize the time and resources of Frontline Workers
- Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
- Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team
- Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan
- Track the depth of need and service responses to clients over time

The SPDAT is NOT designed to:

- Provide a diagnosis
- Assess current risk or be a predictive index for future risk
- Take the place of other valid and reliable instruments used in clinical research and care

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, we have also created the VI-SPDAT as an initial screening tool.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client's acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services.

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Version 4

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale, Camberwell Assessment of Needs, Vulnerability Index, and Transition Aged Youth Triage Tool.

In preparing SPDAT v4, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff have observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics review enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

Version 4 builds upon the success of Version 3 of the SPDAT with some refinements. Starting in August 2014, a survey was launched of existing SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

The major differences from Version 3 to Version 4 include:

- The structure of the tools is the same: four domains (five for families) with components aligned to specific domains. The names of the domains and the components remain unchanged.
- The scoring of the tools is the same: 60 points for singles, and 80 points for families.
- The scoring tables used to run from 0 through to 4. They are now reversed with each table starting at 4 and working their way down to 0. This increases the speed of assessment.
- The order of the tools has changed, grouped together by domain.
- Language has been simplified.
- Days are used rather than months to provide greater clarification and alignment to how most databases capture periods of time in service.
- Greater specificity has been provided in some components such as amount of debts.

Youth SPDAT

To complement the launch of the Next Step Tool, OrgCode has also created a modified version of the Service Prioritization Decision Assistance Tool (SPDAT) for use specifically with youth.

The Youth SPDAT was developed based on feedback from many communities using the SPDAT who identified the need for a complete assessment tool that emphasized the unique issues faced by homeless youth.

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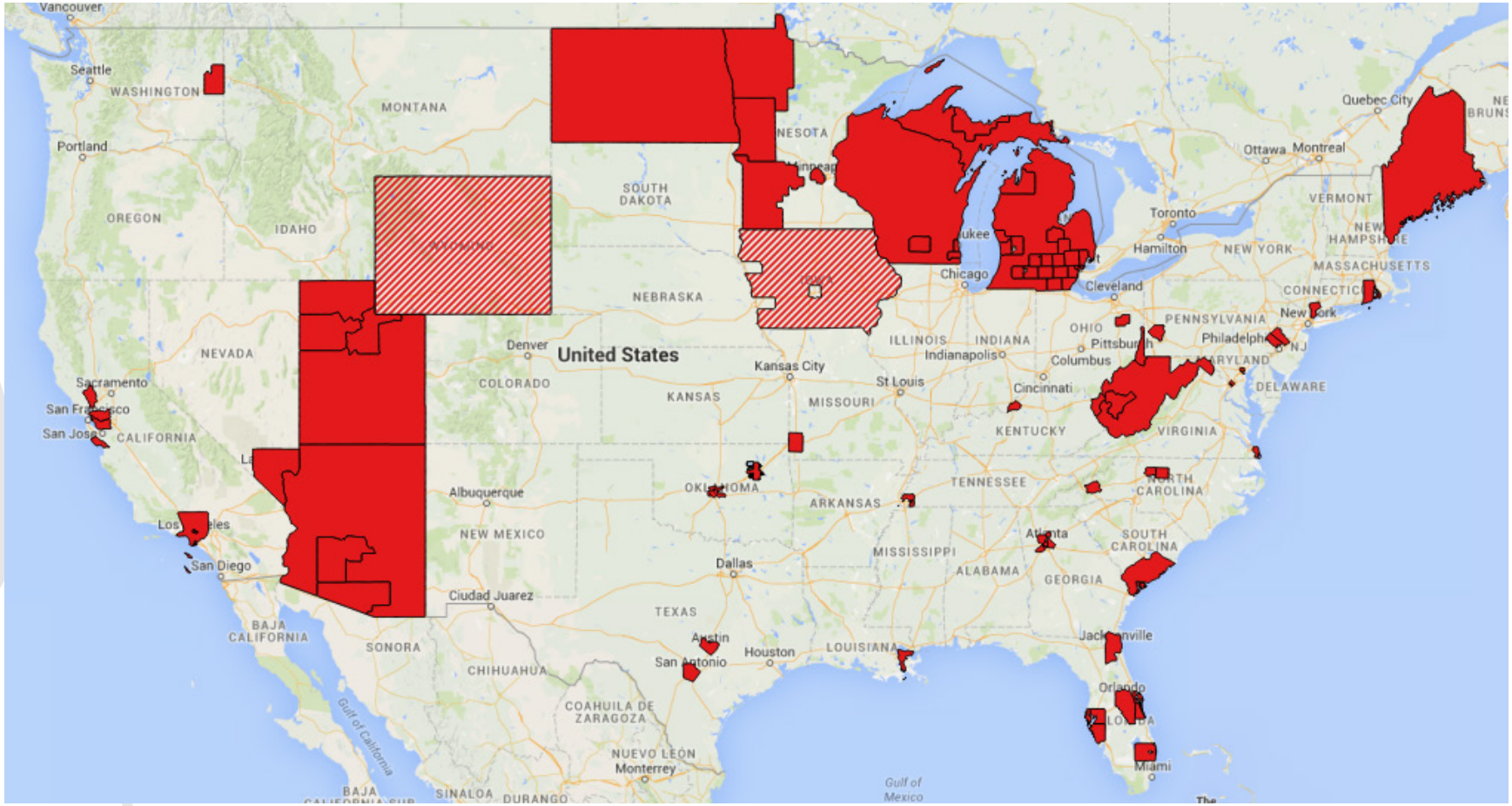
Appendix B: Where the SPDAT is being used (as of May 2015)

United States of America



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Arizona
- Statewide

California
- Oakland/Alameda County CoC
- Richmond/Contra Costa County CoC
- Watsonville/Santa Cruz City & County CoC
- Napa City & County CoC
- Los Angeles City & County CoC
- Pasadena CoC
- Glendale CoC

District of Columbia
- District of Columbia CoC

Florida
- Sarasota/Bradenton/Manatee, Sarasota Counties CoC
- Tampa/Hillsborough County CoC
- St. Petersburg/Clearwater/Largo/Pinellas County CoC
- Orlando/Orange, Osceola, Seminole Counties CoC
- Jacksonville-Duval, Clay Counties CoC
- Palm Bay/Melbourne/Brevard County CoC
- West Palm Beach/Palm Beach County CoC

Georgia
- Atlanta County CoC
- Fulton County CoC
- Marietta/Cobb County CoC
- DeKalb County CoC

Iowa
- Parts of Iowa Balance of State CoC

Kentucky
- Louisville/Jefferson County CoC

Louisiana
- New Orleans/Jefferson Parish CoC

Maryland
- Baltimore City CoC

Maine
- Statewide

Michigan
- Statewide

Minnesota
- Minneapolis/Hennepin County CoC
- Northwest Minnesota CoC
- Moorhead/West Central Minnesota CoC
- Southwest Minnesota CoC

Missouri
- Joplin/Jasper, Newton Counties CoC

North Carolina
- Winston Salem/Forsyth County CoC
- Asheville/Buncombe County CoC
- Greensboro/High Point CoC

North Dakota
- Statewide

Nevada
- Las Vegas/Clark County CoC

New York
- Yonkers/Mount Vernon/New Rochelle/Westchester County CoC

Ohio
- Canton/Massillon/Alliance/Stark County CoC
- Toledo/Lucas County CoC

Oklahoma
- Tulsa City & County/Broken Arrow CoC
- Oklahoma City CoC

Pennsylvania
- Lower Marion/Norristown/Abington/Montgomery County CoC
- Bristol/Bensalem/Bucks County CoC
- Pittsburgh/McKeesport/Penn Hills/Allegheny County CoC

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country CoC

Tennessee
- Memphis/Shelby County CoC

Texas
- San Antonio/Bexar County CoC
- Austin/Travis County CoC

Utah
- Salt Lake City & County CoC
- Utah Balance of State CoC
- Provo/Mountainland CoC

Virginia
- Virginia Beach CoC
- Arlington County CoC

Washington
- Spokane City & County CoC

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming is in the process of implementing statewide

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Canada

Alberta
- Province-wide

Manitoba
- City of Winnipeg

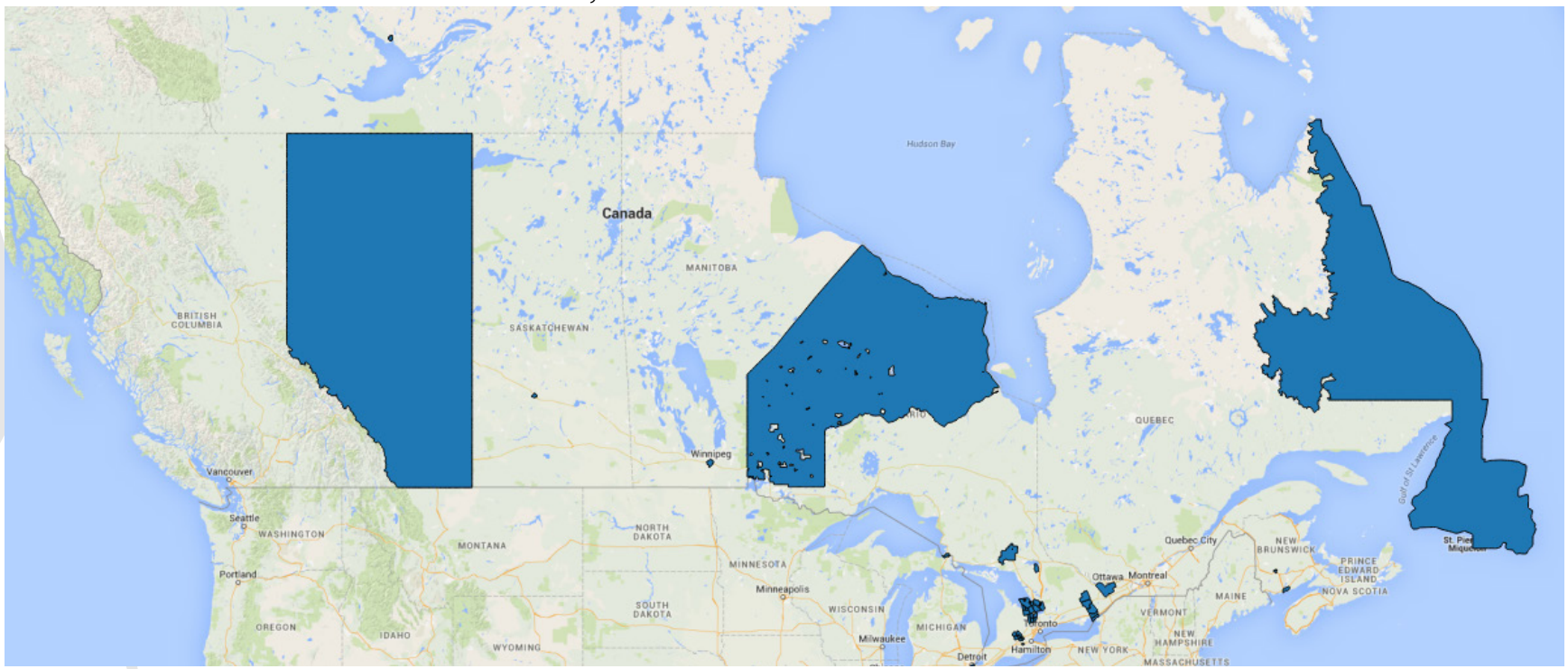
New Brunswick
- City of Fredericton
- City of Saint John

Newfoundland and Labrador
- Province-wide

Northwest Territories
- City of Yellowknife

Ontario
- City of Barrie/Simcoe County
- City of Brantford/Brant County
- City of Greater Sudbury
- City of Kingston/Frontenac County
- City of Ottawa
- City of Windsor
- District of Kenora
- District of Parry Sound
- District of Sault Ste Marie
- Regional Municipality of Waterloo
- Regional Municipality of York

Saskatchewan
- Saskatoon



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Australia

Queensland
- Brisbane

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Housing & Homeless Coalition
Of Central New York

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Continuum of Care Written Standard for Rankings and Ratings Protocol

NY-505 Syracuse/Auburn, Onondaga, Oswego and Cayuga Counties

I. Purpose

The Housing and Homeless Coalition of Central New York (HHC) NOFA protocols for the Continuum of Care (CoC) establishes a transparent framework for the annual CoC NOFA scoring, ranking and approval process. In order to best serve our community members through provision of effective projects and capturing the maximum funds available, projects which most closely align with the HUD and CoC priorities will be prioritized for funding.

The HUD Selection and Performance Evaluation Committee ("the Committee") consists only of non-CoC or ESG funded Advisory Board Members and also non-voting members of the Housing and Housing Coalition staff. Please see Appendix A for a list of the current members of the Performance Evaluation Committee. The duties are to oversee all monitoring of funding agencies (which is performed by the HHC staff), develop and revise the monitoring tool, perform ratings and rankings for all applications to the NOFA, and conduct HMIS user evaluations including evaluating completeness and determining whether a new applicant should receive an HMIS license. Agencies are able to submit new and renewal applications. The Committee will score these applications, based on criteria explained below, and place projects into Tier 1 and Tier 2 levels of funding.

II. FY2018 HUD Funding Availability

Total Annual Renewal Demand (ARD): $8,475,964
Bonus: $508,558
Amount available for new projects (Bonus amount): $508,558
DV Bonus: $599,313
Planning Funds: $254,279 (planning funds are not ranked)
Tier 1 (94% ARD): $7,967,406
Tier 2 (ARD-Tier 1+ bonus amounts): $1,616,429

III. Evaluation Process (Scoring and Ranking Overview)

On behalf of the CoC, the HHC issues new and renewal applications for agencies seeking CoC funding. Applications can be found in the appendices of this document and on the HHC's website at hhccny.org. Agencies are able to submit both renewal and new project applications. The criteria for the scoring of both types of projects can be found below.

Both New and Renewal Applications are due Friday, August 3, 2018

A. New Projects (140 points)

Each agency considering applying for a new project will be required to submit an application to the HHC Director, including an operating budget. Please see Appendix B for a copy of the current new project application. The Committee then reviews and scores applications for adherence to the following HUD and local threshold criteria:

- Appropriateness of project (5 points)
- Demonstrated need for project (10 points)
- Supportive services provided to increase income (10 points)
- Project implementation plan (10 points)
- Ability to adhere to Housing First principles (20 points)
- Client-centered practices (10 points)
- Access to HMIS (5 points)
- Plan for housing retention (10 points)
- Local Priorities' match with project's primary target population (one possible answer)
    - Chronically Homeless (15 points)
    - Youth (10 points)
    - Re-entry (10 points)
    - Families (5 points)
    - Veterans (5 points)
- Budget review (10 points)
- Match Documentation (5 points)
- Cost Effectiveness (5 points)
- Management letter from agency's most recent financial audit (5 points)
- Drawdown Efficiency : Experience utilizing federal or other governmental funds (10 points)
- Coordinated Entry participation (5 points)
- NOFA Workgroup (5 points)

B. Renewal Projects

All projects requesting renewal funding will be evaluated via a local application sent to the HHC Director and reviewed by the Committee to determine their effectiveness in achieving the stated goals of the project and in

addressing local and federal priorities; including meeting the HUD System Performance Measurements. Projects can receive up to 250 points. The following items will be evaluated upon application review:

1. Local Application (75 points) Please see Appendix C for the Local Renewal Application

- Client-centered practices (5 points)
- HMIS participation and data quality (10 points)
- Match with local priorities (one possible answer)
    - Chronically Homeless (15 points)
    - Youth (10 points)
    - Re-entry (10 points)
    - Families (5 points)
    - Veterans (5 points)
- Cost Effectiveness (20 points)
- Drawdown Efficiency (20 points)
- NOFA workgroup attendance (5 points)

2. Performance Measures (40 points)

- Percentage of newly enrolled clients that came from the Coordinated Entry list (10 points)
- RRH: Average time from project entry to housing move-in date is 15 days or less (10 points)
- PSH: Average length of stay is 180 days or greater (10 points)
- RRH: 90% of participants exit to Permanent Housing (10 points)
- PSH: 90% of participants exit to Permanent Housing (10 points)
- Less than 15% of participants returned to homelessness after 12 months in permanent housing (10 points)

3. Project Monitoring and Scoring (135 points)

The Committee also reviews and updates the monitoring/scoring tool used to score renewal projects on effectiveness and compliance annually. Please see Appendix D for the most recent scoring tool. Once the tool is completed, it is reviewed by CoC-funded agencies and then voted on by members of the Committee. From there, the tool is then sent to the HHC Advisory Board For final approval.

HHC staff conducts annual monitoring visits to CoC-funded programs five client files (four open and one closed) are reviewed on-site and HHC Staff monitors for HMIS data are heavily weighted measures used by HUD in determining the overall CoC Application scores of Continuums.

The Scoring Tool assesses projects in the following categories:

- Housing Stability, including program average length of stay
- Assistance obtaining and maintaining non-cash benefits, income, and employment

- Housing First, assessed using HUD's Housing First Assessment Tool
- For PSH projects: percentage of chronic homelessness and bed utilization
- For RRH projects: ability to serve proposed number in previous year's application
- HMIS data quality
- CoC participation
- Coordinated Entry participation
- Ability to spend program funds
- Timely submission of APR to HUD

HHC staff scores the projects accordingly from the monitoring/scoring tool with oversight by the HHC Director and the Committee Chair. Total scores for each project are determined by adding up points in each section. The completed tools are provided to the programs and a score listing is generated by the Director and sent to the Advisory Board along with any issues presented. Additionally, a letter from the HHC Director is sent to the Executive Directors of each CoC-funded agency to inform them of the scoring and any issues. All project types (i.e., PSH and RRH) are judged together in the Committee meetings, both new and renewals.

C. Ranking protocol

A project ranking list is then generated using scores described above, in alignment with HUD and local CoC priorities. Ranking for renewal applications is determined by the project's monitoring score, system performance measures, and local application. Projects that have not been operational for an entire program year will be evaluated on the local application and local priorities. These projects will automatically be placed in Tier 1.

Projects will be recommended based upon the project application and monitoring scores that fall within the final pro rata share for the CoC, split between Tiers 1 and 2, according to HUD's NOFA. Projects will be ranked, based on score and local priority, and placed into Tier 1 until all Tier 1 funds are allocated.

The remaining projects selected for funding will be ranked and placed into Tier 2 until all Tier 2 funds are allocated.

In this project year, special attention will be given to projects that serve survivors of domestic violence when applying for set aside bonus funding.

New projects will be ranked in conjunction with Renewal Projects to ensure that the best applications are forwarded to the federal competition.

The CoC HMIS grant will be placed into Tier 1. The Planning Grant is not ranked in the NOFA process.

For the FY2018 NOFA Competition, the Committee determined to rank and prioritize all projects in the following order, based on Point In Time, System Performance Measures, Annual Performance Report and the Coordinated Entry list to determine severity/level of need to rank projects in our CoC,: chronically homeless (CH) individuals, CH families, Veterans), RRH Individuals, PSH youth, RRH youth, PSH families, RRH families HMIS, PSH individuals only.

The HHC uses the project rating tool provided by HUD. The tool uses the community's weights for rating criteria and calculates an overall score for each project out of 100. An example of this would be, the total unweighted score for a new project is 120/140 for information on the local application, although the weighted score will be 86/ 100. An example of a renewal, the total unweighted score for a renewal project is 70/75 for information on the local application, 30/40 for performance measures collected from HMIS, and 120/135 for information collected from the monitoring tool, resulting in an 88/100 in a weighted score. Project Performance is weighted the least since this is the first year Project Performance will be scored separately.

Any renewal projects that received a significant finding during FY15 monitoring must submit a Project Improvement Plan with the renewal application. This plan must contain detailed action steps to resolve the significant finding.

There may be new projects which fail to meet the requirements that will be held out of the competition. These projects will have the lowest scores on the new application. These projects may request that the CoC provide them with technical assistance to assist them in improving their interest in submitting an application for future competitions. This process ensures that organizations that may lack the current capacity to receive a federal grant and can build their capacity for a future year.

IV. Appeals Process

Once the HHC Director, in conjunction with the Committee, have ranked applicants' renewal applications, the preliminary ranking will be emailed to all member agencies with specific scoring forwarded to the related applicant.

The Committee's recommendation will be presented to the HHC Advisory Board for approval and then presented to the full HHC (CoC general membership) for approval. An applicant may challenge the Committee's recommendation to the Board by emailing the HHC Director a Notice of Appeal. The appellant must attend the HHC Advisory Board meeting where they will be allowed to make a 10 minute presentation to the Board. The Board's decision on the slate is final. No Board Member with a conflict of interest may participate in the discussion or vote on the slate.

NOTE: Appeals will only be considered in cases where applicants have concerns specific to the review process and scoring of their application. Appeals specific to the ranking or funding recommendation will not be considered. All notices of appeal must be based on the information submitted by the application due date. No new or additional information will be considered. Omissions to the application cannot be appealed.

Should the project decide to pursue a formal appeal to HUD, the applicant will be referred to page 58 of the FY2018 NOFA Section X to follow HUD's appeals process for submitting a solo application outside of the CoC.

Tier 1 and Tier 2 structures will be reviewed with the Committee and HHC Advisory Board and, at the next general membership or a special meeting called to ensure voting is accomplished 15 days prior to the submission deadline for the CoC Application, approved by the HHC membership.

The recommendation of the HHC Director with General Membership approval will be final.

V. Reallocation protocol

The CoC will use the reallocation process to shift funds in whole or part from existing renewal projects to new project applications, as needed. Agencies with the lowest performing projects or consistent inability to expend grant funds may be subject to reallocation.

Agencies with the lowest performing projects will be notified of the recommendation for either reallocation or development of a Project Improvement Plan, as decided by the Committee and HHC Director. In the event that an agency has failed to make progress on a previous Project Improvement Plan, the agency will be notified of the recommendation for funding reduction, or non-renewal and reallocation. Projects may also be reallocated if they no longer meet HUD and/or local priority. Any project with the same significant finding for two years in a row will be brought to the committee's attention for possible reallocation.

Agencies that choose to self-reallocate are encouraged to apply for the reallocated funds to be made available and will receive an additional 5 points on their local application for self-reallocation; however the funds will be competitive and subject to the local application process.
Any funds reallocated will return to the county of origin per merger agreements with Oswego and Cayuga Counties. For instance, if a Cayuga County Permanent Supportive Housing project is reallocated, only a Cayuga County provider could apply for those funds.

Funds may be reallocated to develop new permanent supportive housing projects, new rapid re-housing projects, or HMIS funds. The CoC has decided not to apply for the SSO for Coordinated Assessment in this fiscal year.

When the NOFA is released, the Committee will convene to adjust the local application and review the score listing from the scoring tools. The Committee will also discuss and set HUD priorities for the current NOFA application and conduct reallocation deliberations. Once the Committee decides to reallocate the funding from the CoC-funded agency, the Advisory Board is immediately notified by the HHC Director along with the agency whose funding will be reallocated. The appeals process previously mentioned in this document will be applicable to the reallocation process.

Should any agency have questions regarding this document please contact the HHC Director.

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Appendix A

Performance, Evaluation and Selection Committee Participating Agencies

United Way of Central NY (Collaborative Applicant)
City of Syracuse – Neighborhood and Business Development (ESG Coordinator)
Onondaga County Community Development (ESG Director)
Cayuga County Department of Social Services
Auburn Housing Authority
Onondaga County Department of Children and Family Services (RHY Coordinator)
Oswego County Department of Social Services
HHC Staff (Non-voting)

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Appendix B

Onondaga/Oswego/Cayuga County Continuum of Care
2018 Local Application
Rubric FOR RE-ALLOCATION, BONUS and DV BONUS Applications (NEW)

Project Name:	

Applicant Name **Address** **Phone Number** **& Email**	
Funding Choice	**Please indicate the funding stream for this project:** **1. Bonus/ Reallocation** **2. Domestic Violence (DV) Bonus**

Category	Key	Question	Point Value
Narrative	A	Please provide a general description of the program including the total amount requested and a rationale for why the program should be funded. Explain type, scale and location of housing, and supportive services. If applying for DV Bonus, please describe the projects ability to serve survivors of domestic violence, dating violence and stalking. (500 word limit) If all requirements present, full points.	5 points
Demonstrated Need	B	Please provide local data used to determine need for project type and target population. If sources of data are specified, data is current and demonstrate **local** need: 10 points No partial points will be awarded.	10 points
Supportive Services	C	Describe how clients will be assisted in obtaining employment, income and mainstream resources to maximize their ability to live independently. (250 word limit) Demonstration of case management services, strategies to increase income using local resources, and supportive services description: 10 points No partial points.	10 points
Project Implementation	D	Describe your detailed plan for rapid implementation of the program, documenting how the program will be ready to begin housing the first program participant. (250 word limit) If project has a timeline for full implementation within 90 days of startup, including unit leasing, staffing, participation enrollment using Coordinated Entry: 10 points No partial points.	10 points

HUD Priority			**Yes**	**No**	
Housing First	E	Do you have a policy of zero barriers to entry besides homeless and disability verification, and minimum federal safety requirements? (Policy must be attached, as "Policy A, Housing First Policy") Full points if attached.			5 points
	F	Do you have a policy that prioritizes highest-needs clients (chronic homeless)? (Policy must be attached, as "Policy B, Chronic Homeless Prioritization Policy") Full points if attached.			5 points
	G	Do you have a discharge policy? (Policy must be attached, as "Policy C, Discharge/ Termination Policy") Full points if attached.			5 points
	H	Do you have an Equal Access policy? (Policy must be attached, as "Policy D, Equal Access Policy") Full points if attached.			5 points
Client-centered Practice	I	Does the program have policies in place to support client-centered practice? (Policy must be attached, as "Policy E, Client-Centered Policy") Full points if attached.			5 points
	J	Describe the plan to assist clients to rapidly secure and maintain permanent housing that is safe, affordable, accessible and acceptable to their needs. (Policy must be attached, as Policy F, "Access to Permanent Housing Policy") Full points if attached.			5 points
	K	Is your agency currently in HMIS? If not, do you have a plan to obtain access to HMIS? Please describe your plan. (150 word limit) If agency is currently in HMIS or has started the application process for entry into HMIS: 5 points			5 points
Retention	L	Describe your plan to ensure 90% of participants will exit to Permanent Housing or remain in Permanent Housing. Description of supportive services provided and specific strategies for maintaining housing, including but not limited to: daily living skills, discharge planning, connections to community resources, landlord/tenant relationships, building of natural supports, etc. = 10 points No partial points.			10 points
Category	**Key**	**Question**	**Yes**	**No**	**Point Value**
LOCAL PRIORITIES	M	What is your Primary Target Population to be served? (choose ONLY one)			
		• Chronic Homeless			15 points
		• Youth			10 points
		• Re-entry			10 points
		• Families			5 points
		• Veterans			5 points
Financial Feasibility	N	Please attach project budget to prove that expenses are reasonable, allocable and allowable.			10 points

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		Budget does not include ineligible expenses and is reasonable: 10 points			
	O	Provide 25% match documentation. Match documentation is eligible and attached.			5 points
	P	Cost effectiveness: Annual Budget divided by number of beds. PSH: Under $13,654/bed= 5 points RRH: Under $4,601/bed= 5 points			5 points
	Q	Please attach management letter from your agency's recent financial audit. If attached and agency is in good standing= 5 points			5 points
Category	**Key**	**Question**	**Yes**	**No**	**Point Value**
Strategically Allocating Resources	S	Drawdown efficiency: Does the agency have a plan to efficiently utilize and timely expend HUD funds? Describe experience in effectively utilizing federal, state, or other grant funds. If agency has previous experience with drawdowns and grant administration = 10 points			10 points
Coordinated Entry	T	Will the program participate in Coordinated Entry and follow the community's prioritization policy? Minimum requirement is 95% of referrals from Coordinated Entry (Attend meetings, accept referrals from CE List) No partial points			5 points
Additional Information/ Requirements	U	Did a program representative attend the NOFA Workgroup session? No partial points			5 points
	V	Please use this space to resolve or explain any answer you think did not accurately portray your program. Be specific.			
		TOTAL POINTS	**_____out of 140**		

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Appendix C

Onondaga/Oswego/Cayuga County Continuum of Care
2018 Local Application
Rubric FOR Renewal Applications (NEW)

Category	Key	Question			Point Value
Narrative	A	Not Scored			
			Yes	**No**	
Client Centered Policy	D	Does the program have policies in place to support client-centered practice? (Policy must be attached, as "Policy A, Client-Centered Policy.") If attached, full points.			5 points
HMIS Data Quality	E	Does the project fully and accurately participate in HMIS? Attach HUD Data Quality Report Framework (report should be for 7/1/17 to 7/1/18) 10 points: Less than 5% error rate in all categories 5 points: Between 5% to 10% error rate in all categories 0 points: Over 10% error rate			10 points
Local Priorities	I	What is your Primary Target Population to be served? (choose ONLY one)			
		• Chronic Homeless			15 points
		• Youth			10 points
		• Re-entry			10 points
		• Families			5 points
		• Veterans			5 points
Cost Effectiveness	J	Annual Budget divided by number of beds (people)*? **Median Cost PSH: $11,378** Under the Median Cost per bed: 20 points 10% Above Median ($12,515): 15 points 20% Above Median ($13,654): 10 points 30% Above Median ($14,791): 5 points Above 30%: no points Median Cost RRH: **$3,681** Under Median Cost per bed: 20 points 25% Above Median ($4,601): 15 points 50% Above Median ($5,521): 10 points 75% Above Median ($6,441): 5 points Above 75%: no points *Youth projects are exempt from this measure and should be awarded full points			20 Points
Strategically		Drawdown efficiency: how efficiently is the	FY2014:		20 points

Allocating Resources	M	project using its grant funds? How much is left over and returned to HUD in FY2014 and FY2015? Produce current draws for FY2016 grants. Does the agency have a plan in place to more fully utilize and expend timely HUD funds? Plan must be attached, as "Plan B, Efficiency Plan." (if below 90%) 100% funds drawn: 20 points 90-99%: 10 points Below 90%: no points	FY2015: FY2016: Average %:_____	
	N	Did you attend the NOFA Workgroup		5 points
	P	Please use this space to resolve or explain any answer you think did not accurately portray your program. Be specific.		
		TOTAL POINTS	**_____out of 75**	

This portion of the Renewal Application will completed by HHC Staff in regards to your Project Performance.

Category	Key	Question			Point Value
Coordinated Entry	A	What percentage of clients enrolled between July 1, 2017 and June 30, 2018 came from the Coordinated Entry List? 100% gets 10 points, 85-99% gets 5 points and less than 85% gets 0 points.	_____%		10 points
HUD Priority			**Yes**	**No**	
Measuring Project Performance	B1	RRH: On Average participants spend 15 days from project entry to Housing Move In Date. 15 days or less gets full points 30 days or less is 5 points More than 30 days is zero points			10 points
	B2	PSH: On Average participants spend 180 days in project. 180 days or more gets full points; anything less gets no points			10 points
	C1	RRH: 90% of residents exit to Permanent Housing. 90% or more gets full points; less than 90% gets no points			10 points
	C2	PSH: 90% of residents exit to or remain in Permanent Housing. 90% or more gets full points; less than 90% gets no points			10 points
	D	Less than 15% of participants returned to homelessness after 12 months in permanent housing Less than 15% gets full points; more than 51% gets no points			10 points

		Total Points	**_____ out of 40**

Renewal Application Ranking Summary

Renewal Application Score	**_____out of 75**
Project Performance Score	**_____out of 40**
Monitoring Score (Attach Project Improvement Plan if needed. See Application instructions for more information)	**_____out of 135**
TOTAL Score	**_____out of 250**

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Appendix D

CoC Scoring Tool

Name of Grantee:		Date:	
Name(s) of Reviewer(s):			
A. Housing Stability	**Point Range:**	**Score:**	**Comments:**
PSH Only: Program participants exiting to shelter after 12 months in housing	20 pts. = 10% or less* 15 pts. = 11% to 20% 10 pts. = 21% to 40% 5 pts. = 41% to 50% 0 pts. = 51% or more		
RRH Only: Program participants exited to permanent housing	20 pts. = 80% or more 15 pts. = 70% to 79% 10 pts. = 60% to 69% 5 pts. = 50% to 59% 0 pts. = 49% or less		
Program Average Length of Stay	5 points = 6 months (RRH)/12 months (PSH)* 0 points = 6 months (RRH) or less/12 months (PSH) or less		
B. Access to Income and Benefits	**Point Range:**	**Score:**	**Comments:**
Participants with one or more source(s) of non-cash benefits (including medical insurance) by program exit	10 pts. = 80% or more 7 pts. = 65 to 79% 5 pts. = 50 to 64% 0 pts. = 49% or less		
Program participants experiencing increased income	5 pts. = 30% or more 3 pts. = 15 to 29% 0 pts. = 14% or less		
Program participants who gain employment	5 pts. = 17% or more 3 pts. = 12% to 16% 0 pts. = 11% or less		

C. Meeting Community Need	Point Range:	Score:	Comments:
Program participants coming from the street (or other locations not meant for human habitation) or emergency shelters	10 pts. = 80% or more 7 pts. = 60 to 79% 5 pts. = 30 to 59% 0 pts. = 29% or below		
Project uses Housing First practices, as assessed by the Housing First Assessment Tool	10 pts. = 80% or more 7 pts. = 60 to 79% 5 pts. = 30 to 59% 0 pts. = 29% or below		
D. PSH (leasing)	**Point Range:**	**Score:**	**Comments:**
What percentage of entries were chronically homeless?	10 pts. = 85% or more/ N/A 7 pts. = 65 to 84% 5 pts. = 50 to 64% 0 pts. = 49% or less		
Bed utilization rate	10 pts. = 90% or more 7 pts. = 75 to 89% 5 pts. = 65 to 74% 0 pts. = 64% or below		
E. Rental Assistance only	**Point Range:**	**Score:**	**Comments:**
Did the project serve the number proposed in the application?	20 pts. = 100% 15 pts. = 95% to 99% 10 pts. = 90% to 94% 5 pts. = 85% to 89% 0 pts. = 84% or less		
F. HMIS Data Quality	**Point Range:**	**Score:**	**Comments:**
HMIS HUD Data Quality Framework Error Rate	10 pts. ≤ 5% 5 pts. = 5-10% 0 pts. = 11% or above		
G. CoC Participation	**Point Range:**	**Score:**	**Comments:**
Is the agency an eligible voting member and does it participate as defined by CoC standards?	10 pts. = Yes 0 pts. = No		
Does the agency participate on minimum of one committee/workgroup with regular attendance?	5 pts. = Yes 0 pts. = No		

What percentage of entries came from the Coordinated Entry list?	10 pts. = 90% or more/ N/A 7 pts. = 75 to 89% 5 pts. = 60 to 74% 0 pts. = 59% or less		
What percentage of entries from Coordinated Entry were in the top 20% of the priority list?			
H. Project Performance	**Point Range:**	**Score:**	**Comments:**
Did the project have any significant findings during monitoring? *Significant Findings are:* *-Participants Served not meeting HUD homeless definition* *-Chronic Definition* *-Missing disability documentation* *-Rents exceeding FMR* *-Units not meeting HQS* *-Violation of termination policy* *-Ineligible spending*	Deduct 20 pts. = Yes 0 pts. = No		
What percentage of CoC funds did the program spend in their last full operating year? (Compare APR to funding amount)	10 pts = 91-100% 7pts. = 81-90% 5 pts. = 71-80% 0 pts. = 70% or less		
Was the APR submitted on time? (within 90 days of program end)	5 pts. = Yes 0 pts. = No		
TOTAL:	135		

*** Programs funded for the first time in FY16 will receive full points for these questions due to not having been operational for enough time to satisfy the questions**

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Onondaga/Oswego/Cayuga Counties Continuum of Care 2018 Local Application
APPLICATION INSTRUCTIONS
Introduction

The Onondaga/Oswego/Cayuga Continuum of Care (CoC), representing the City of Syracuse, County of Onondaga, City of Auburn, County of Cayuga and the County of Oswego (NY-505), will submit a CoC Program Consolidated Application for funding from the U.S. Department of Housing and Urban Development (HUD) in the upcoming FY 2018 Continuum of Care Homeless Assistance Program Competition. These instructions describe the local application submission and review process.

The CoC will accept Renewal grants for Permanent Supportive Housing (PSH), Rapid Rehousing (RRH) and Homeless Management Information System (HMIS).

The CoC will also accept new applications for projects created through reallocation dollars for PSH for Chronically Homeless Individuals and Families, and RRH for Individuals and Families, Joint Transitional Housing and Rapid Rehousing (TH-RRH), HMIS, Support Services Only to develop or operate a new centralized or coordinated assessment system, and Expansion projects for existing eligible renewal projects that will increase the number of units in the project, or allow the recipient to serve additional persons.

The CoC will accept new projects created through bonus funding for PSH that meet the requirements of DedicatedPLUS as defined in Section III.A.3.d. of the NOFA or PSH projects where 100% of the beds are dedicated to chronic homelessness, RRH to serve individuals, families and unaccompanied youth, Joint TH-RRH), and Expansion projects as mentioned in the previous paragraph. The CoC will also accept new applications for projects created through the DV Bonus funding for RRH for individuals and families, and joint TH-RRH for individuals and families, specifically for projects serving victims and survivors of domestic violence, dating violence and stalking.

A CoC Planning Grant and HMIS grant will be accepted as non-competitive. All applications will be scored together according to CoC Local Priorities, HUD Goals, Policies and Performance Measures.

CoC Local Priorities:

Priority 1	**Chronically Homeless**
Priority 2	**Youth**
Priority 3	**Re-entry**
Priority 4	**Families**
Priority 5	**Veterans – Declared Functional Zero per United States Interagency Council on Homelessness in November 2015**

HUD Goals as articulated in its Strategic Plan and *Opening Doors: Federal Strategic Plan to Prevent and End Homelessness,* are as follows:

1. Meet the Need for Quality Affordable Rental Homes: End homelessness and substantially reduce the number of families and individuals with severe housing needs
2. End chronic homelessness
3. End veteran homelessness
4. End family and youth homelessness
5. End all homelessness

HUD Policy Priorities

1. Ending homelessness for all persons
2. Create a systemic response to homelessness

3. Strategically allocate resources
4. Using a housing first approach

HUD Performance Measures

1. Average length of time homeless
2. Rates of returns to homelessness
3. Number of homeless persons
4. Employment and income growth
5. First time homeless
6. Stabilizing people in homelessness (category 3)
7. Successful placement and retention of housing

Wednesday, June 20, 2018	HUD CoC NOFA Application Available
Thursday, July 12, 2018, 2pm	NOFA Workgroup meeting (United Way) Purpose: Introduction to NOFA changes and process, *mandatory* for one representative of any agency planning to submit a local application
Thursday, July 19, 2018, 2pm	Performance Evaluation and Selection Committee Meeting to review Local Application (New and Renewal) and Instructions as well as preliminary renewal rankings. (United Way)
Friday, July 20, 2018, 5pm	Local applications sent to all interested parties. (via email)
Friday, August 3, 2018, 5pm	Local Applications Due (Renewals and New) to HHC Director for Ranking and Rating Committee to Review
Thursday, August 9, 2018, 2pm	Performance Evaluation and Selection Committee Meeting (United Way) 'Renewal/Re-Allocation/Bonus Funding *Amount* Locally Approved to Apply For in ESNAPS' Notification
Thursday, August 16, 2018, 2pm	NOFA Workgroup Meeting (United Way) Purpose: To review Consolidated Application as well as assign reviewers for New Applications
Friday August 17, 2018	All Projects Submitted in E-SNAPS (to allow time to review and amend for any changes)
Wednesday, August 22, 2018	Performance Evaluation and Selection Committee Meeting (United Way) All projects ranked and notification from Committee to projects
Thursday, August 30, 2018	NOFA Workgroup Meeting (United Way) – To review Consolidated Application and any last final edits Deadline to Appeal – See page 58 of NOFA for instructions. https://www.hudexchange.info/resources/documents/F

	Y-2017-CoC-Program-Competition-NOFA.pdf
September 18, 2018	NOFA Application due to HUD – submitted on E-SNAPS

Application Review

The Performance Evaluation and Selection Committee is the entity that will review, score, recommend and rank applications. It consists of individuals without conflicts of interest who sit on the Advisory Board. Members of the Performance Evaluation and Selection Committee are not employees, owners, stakeholders, directors, officers, or board members of, or independent contractors to, any organization that submits or will benefit from a local application that is being reviewed, scored, and ranked.

The Performance Evaluation and Selection Committee will evaluate the application based on the attached Scoring Rubric, with the following considerations in mind:

1. The process shall be transparent and fair.
2. The process will include the right to appeal.
3. The Renewal and New applications will be scored using the Scoring Rubric (attached).
4. The reallocation amount should be based on efficiency of programs.

The Committee reserves the right to make decisions that are aligned with the HUD principles, guidelines, and funding limitations outlined in the NOFA subsequent to the local application process.

Application Checklist

The following checklist identifies the components that constitute a complete application for local ranking and allowable funding amount for the HUD CoC Program. **Incomplete applications will not be reviewed and will not be considered for funding.**

1. Renewal/New Local Application (All)
2. Match Documentation (All)
3. Budget Workbook (All)
4. Policies as outlined in Application (All)
    a. Policies A,B,C,D,E, F (New)
        A: Housing First Policy
        B: Chronic Homeless Prioritization Policy
        C: Discharge Policy
        D: Equal Access Policy
        E: Client Centered Policy
        F: Access to Permanent Housing Policy
    b. Policies A, B (Renewals)
        A: Client-Centered Policy
        B: Efficiency Corrective Plan

Applications should be submitted in **Word**. Budget Workbooks should be submitted in **Excel**. Match documentation, and Polices should be submitted in **Adobe PDF**. Policies can be submitted together as a single PDF with each Policy in the PDF labeled correctly.

- **Application Scoring**

The Scoring Rubric used by the Rating and Ranking Committee will score all applications by specific criteria and a point allocation system guided by the following HUD Policy Priorities.

New Applications

Narrative, Project Implementation, Supportive Services	35 points
Housing First	20 points
Client Centered Practices & HMIS	15 points
Retention	10 points
Local Priorities	15 points
Financial Feasibility & Strategically Allocating Resources	35 points
Coordinated Entry & CoC participation	10 points
Total Application Score	**140**

Renewal Applications*

Client Centered Policy	5 points
HMIS Data Quality	10 points
Local Priorities	15 points
Cost Effectiveness & Strategically Allocating Resources	40 points
CoC Involvement	5
Total Application Score	**75**
System Performance Measures	40
Monitoring Score**	135
Total Renewal Score	250

*Renewal applications are scored and ranked using three documents: Renewal Applications, Monitoring Score, & System Performance Measures. Renewal and New project scores are weighted to 100.

**Any renewal projects that received a significant finding during FY15 monitoring must submit a Project Improvement Plan with the renewal application. This plan must contain detailed action steps to resolve the significant finding.

Application Submission

To be reviewed and considered for funding, completed applications, including all required documentation, must be submitted electronically by ***5:00pm on Friday, August 3, 2018.***
All components of an application must be transmitted at the same time via email at mstuart@unitedway-cny.org. For all renewal applications, projects may only be considered if a Grant Inventory Worksheet form was completed for the project. *Questions about the local application should be directed to Megan Stuart at mstuart@unitedway-cny.org, or 315-428-2224.*

HUD References

- All applicants must complete or renew their registration in the Central Contractor Registration (CCR)/System for Award Management (SAM) registration. Those project applicants who have not yet registered with Dun and Bradstreet (DUNS) must do so. In addition, each project applicant should begin verifying and updating the information in its *e-snaps* Project Applicant File. Taking these steps now will ensure that organizations are ready to apply for funding via *e-snaps* once the HUD application becomes available.

- *CoC Program Interim Rule (24 CFR part 578)*
  https://www.hudexchange.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf

- *FY 2018 CoC Program Registration*
  https://www.hudexchange.info/resources/documents/FY-2018-CoC-Program-Registration-Notice.pdf

- ***The 2018 CoC Program Notice of Funding Availability***:
  https://www.hudexchange.info/resources/documents/FY-2018-CoC-Program-Competition-NOFA.pdf

- FY2018 NOFA Resource Landing Page:
  https://www.hudexchange.info/programs/e-snaps/fy-2018-coc-program-nofa-coc-program-competition/#nofa-and-notices

- https://www.hudexchange.info/resources/documents/Housing-First-Permanent-Supportive-Housing-Brief.pdf

- https://www.hudexchange.info/resources/documents/Rapid-Re-Housing-Brief.pdf

- https://www.hudexchange.info/resource/2889/rapid-rehousing-esg-vs-coc/

- https://www.hudexchange.info/resources/documents/Notice-CPD-17-01-Establishing-Additional-Requirements-or-a-Continuum-of-Care-Centralized-or-Coordinated-Assessment-System.pdf

- Chronic homelessness resources: https://www.hudexchange.info/homelessness-assistance/resources-for-chronic-homelessness/

- System Performance Measures Resources:
  https://www.hudexchange.info/programs/coc/system-performance-measures/

- United States Interagency Council on Homelessness Resources:
  https://www.usich.gov/opening-doors

Housing & Homeless Coalition
Of Central New York

www.hhccny.org
housingandhomelesscoalition@gmail.com
@hhcofcny facebook.com/hhccny
315-428-2216

Reallocation Protocol

The CoC will use the reallocation process to shift funds in whole or part from existing renewal projects to new project applications, as needed. Agencies with the lowest performing projects or consistent inability to expend grant funds may be subject to reallocation.

Agencies with the lowest performing projects will be notified of the recommendation for either reallocation or development of a Project Improvement Plan, as decided by the Committee and HHC Director. In the event that an agency has failed to make progress on a previous Project Improvement Plan, the agency will be notified of the recommendation for funding reduction, or non-renewal and reallocation. Projects may also be reallocated if they no longer meet HUD and/or local priority. Any project with the same significant finding for two years in a row will be brought to the committee's attention for possible reallocation.

Agencies that choose to self-reallocate are encouraged to apply for the reallocated funds to be made available and will receive an additional 5 points on their local application for self-reallocation; however the funds will be competitive and subject to the local application process.
Any funds reallocated will return to the county of origin per merger agreements with Oswego and Cayuga Counties. For instance, if a Cayuga County Permanent Supportive Housing project is reallocated, only a Cayuga County provider could apply for those funds.

Funds may be reallocated to develop new permanent supportive housing projects, new rapid re-housing projects, or HMIS funds. The CoC has decided not to apply for the SSO for Coordinated Assessment in this fiscal year.

When the NOFA is released, the Committee will convene to adjust the local application and review the score listing from the scoring tools. The Committee will also discuss and set HUD priorities for the current NOFA application and conduct reallocation deliberations. Once the Committee decides to reallocate the funding from the CoC-funded agency, the Advisory Board is immediately notified by the HHC Director along with the agency whose funding will be reallocated. The appeals process previously mentioned in this document will be applicable to the reallocation process.

Should any agency have questions regarding this document please contact the HHC Director.

Housing & Homeless Coalition
Of Central New York

www.hhccny.org
housingandhomelesscoalition@gmail.com
@hhcofcny facebook.com/hhccny
315-428-2216

Housing & Homeless Coalition Corrective Action Plan

Project	HHC Finding	Agency's Plan to Correct

From: Megan Stuart
Sent: Friday, August 10, 2018 10:29 AM
To: Marissa Rice
Subject: HHC Application

Good morning Marissa,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for ACR Health's Rapid Rehousing for LGBT Youth.

Please begin working on your application in E-SNAPS. Applications need to be in E-SNAPS by August
17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm where
your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking.
Please let me know if you have any questions.

Megan Stuart
Director; Housing & Homeless Coalition of Central New York
HUD Continuum of Care (CoC) NY-505 Collaborative Applicant Onondaga, Oswego and Cayuga Counties
United Way of Central NY
518 James Street
PO Box 2129
Syracuse, NY 13220

P: (315) 428-2224
F: (315) 428-2227

From: Megan Stuart
Sent: Friday, August 10, 2018 10:12 AM
To: 'dcondliffe@communityalternatives.org'
Cc: Kelly Gonzalez
Subject: HHC Application

Good morning,

I am writing to inform you that the Performance Evaluation and Selection Committee of the Housing and Homeless Coalition met yesterday and has decided to award Center for Community Alternatives' CCA Rapid Rehousing Program at the funding level requested, $94,533.

You may now enter the project's information into E-SNAPS. Please be aware that the budget submitted with the application is $306.25 short of meeting the 25% match requirement. This would need to be corrected before submission in E-SNAPS. Please let me know if there is any issue with this correction.

On August 16th, there is a NOFA Workgroup meeting at 2pm. This meeting is mandatory for a representative from your agency. At this meeting, someone will be assigned to review your E-SNAPS application. Final ranking of projects will take place on August 22nd and you will be notified after that meeting as to your project's ranking.

Congratulations and I look forward to working with you.

Megan Stuart
Director; Housing & Homeless Coalition of Central New York
HUD Continuum of Care (CoC) NY-505 Collaborative Applicant Onondaga, Oswego and Cayuga Counties
United Way of Central NY
518 James Street
PO Box 2129
Syracuse, NY 13220

P: (315) 428-2224
F: (315) 428-2227

From: Megan Stuart
Sent: Friday, August 10, 2018 10:38 AM
To: Laurie Piccolo
Subject: HHC Application

Good morning Laurie,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday and has decided to approve your renewal application for CSCAA's Rapid Re-Housing Program. The Committee has also decided to approve the request expansion but could only approve the expansion in the amount of $261,548.

Please begin working on both of these applications in E-SNAPS, with the updated expansion amount. Applications need to be in E-SNAPS by August 17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm where your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking. Please let me know if you have any questions.

Megan Stuart
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Syracuse, NY 13220

P: (315) 428-2224
F: (315) 428-2227

From: Megan Stuart
Sent: Friday, August 10, 2018 10:32 AM
To: Monica Brown
Subject: HHC Application

Good morning Monica,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for DSS-ES's HUD Rental Assistance Program.

Please begin working on your application in E-SNAPS. Applications need to be in E-SNAPS by August
17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm where
your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking.
Please let me know if you have any questions.

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P: (315) 428-2224
F: (315) 428-2227

From: Megan Stuart
Sent: Friday, August 10, 2018 10:39 AM
To: Allison Brooks
Subject: HHC Application

Good morning Allison,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for The Salvation Army's HALE RRH project.

Please begin working on your application in E-SNAPS. Applications need to be in E-SNAPS by August
17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm where
your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking.
Please let me know if you have any questions.

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Syracuse, NY 13220

P: (315) 428-2224
F: (315) 428-2227

From: Megan Stuart
Sent: Friday, August 10, 2018 12:21 PM
To: Sonja Gottbrecht
Subject: HHC Applications

Good afternoon Sonja,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for CCOC's PSH for the Chronically Homeless 1,
PSH for the Chronically Homeless 2, Home at Last, PSH for the Homeless 2, Housing First for Homeless
Individuals and Families, and PSH for Homeless Vets.

The Committee has also decided to award CCOC's Expansion 2- Permanent Housing for the Chronically
Homeless II application but could only approve the expansion in the amount of $152,477.

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by
August 17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm
where your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking.
Please let me know if you have any questions.

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P: (315) 428-2224
F: (315) 428-2227

From: Megan Stuart
Sent: Friday, August 10, 2018 12:15 PM
To: Kristian Allen (kpeterson@ccoc.us)
Subject: HHC Applications

Good afternoon Kristian,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for CCOC's Rapid Rehousing and Rapid Rehousing
2 Renewal Applications.

The Committee has decided not to award CCOC's Rapid Rehousing 3 Bonus Funding Application. We
would like to further discuss your DV Bonus Application and the potential for a partnership with another
provider.

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by
August 17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm
where your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking.
Please let me know if you have any questions.

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Syracuse, NY 13220

P: (315) 428-2224
F: (315) 428-2227

From: Megan Stuart
Sent: Friday, August 10, 2018 1:49 PM
To: Jenni Gratien
Subject: HHC Applications

Good afternoon Jenni,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for Chadwick's PSH project.

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by
August 17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm
where your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking.
Please let me know if you have any questions.

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F: (315) 428-2227

From: Megan Stuart
Sent: Friday, August 10, 2018 10:55 AM
To: Katrina Webb
Cc: Donna Cruz
Subject: HHC Applications

Good morning Katrina,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal applications for CNY Services RPSHP, RPSHP II, and Susan's
Place.

Please begin working on your application in E-SNAPS. Applications need to be in E-SNAPS by August
17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm where
your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking.
Please let me know if you have any questions.

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Syracuse, NY 13220

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From: Megan Stuart
Sent: Friday, August 10, 2018 12:12 PM
To: Renee Clark (RClark@Helio.health)
Subject: HHC Applications

Good afternoon Renee,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for Helio Health's renewal projects- KEES II, KEES
III, KEES IV, Grove Point, and FAST Housing.

The Committee has decided not to award Helio Health's Housing Innovation project due to the project's
cost effectiveness and high cost per bed.

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by
August 17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm
where your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking.
Please let me know if you have any questions.

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Syracuse, NY 13220

P: (315) 428-2224
F: (315) 428-2227

From: Megan Stuart
Sent: Tuesday, August 14, 2018 11:13 AM
To: Marta Durkin
Subject: HHC Applications

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for Liberty Resource's Permanent Supportive
Housing renewal application.

The Committee has decided not to award Liberty Resource's PSH bonus project due it being outscored
by other projects.

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by
August 17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm
where your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking.
Please let me know if you have any questions.

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Syracuse, NY 13220

P: (315) 428-2224
F: (315) 428-2227

From: Megan Stuart
Sent: Friday, August 10, 2018 11:59 AM
To: Diane Cooper-Currier
Subject: HHC Applications

Good morning Diane,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for OCO's Rapid Re-Housing and Permanent
Supportive Housing projects. As we discussed on the phone this morning, we will be looking further into
your DV Bonus application.

The Committee has decided not to award Oswego County Opportunities funding request for the Youth
TH-RRH project due to community data not supporting the need.

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by
August 17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm
where your E-SNAPS application will be assigned a reviewer.

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Syracuse, NY 13220

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From: Megan Stuart
Sent: Friday, August 10, 2018 10:47 AM
To: Tom Roshau
Subject: HHC Applications

Good morning Tom,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal applications for The Salvation Army's State Street Apartments
and Barnabas Rapid Re-Housing projects. The Committee has also decided to fund your new application
for TAPC's TH-RRH Domestic Violence Bonus Application at the amount requested, $136,922.

Please begin working on your applications in E-SNAPS. Applications need to be in E-SNAPS by August
17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm where
your E-SNAPS application will be assigned a reviewer.

Final ranking of projects will take place on August 22nd and you will be notified after of your ranking.
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From: Megan Stuart
Sent: Friday, August 10, 2018 12:15 PM
To: Kristian Allen (kpeterson@ccoc.us)
Subject: HHC Applications

Good afternoon Kristian,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for CCOC's Rapid Rehousing and Rapid Rehousing
2 Renewal Applications.

The Committee has decided not to award CCOC's Rapid Rehousing 3 Bonus Funding Application. We
would like to further discuss your DV Bonus Application and the potential for a partnership with another
provider.

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by
August 17th. Also a reminder, there is a NOFA Workgroup meeting next Thursday, August 16th at 2pm
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From: Megan Stuart
Sent: Friday, August 10, 2018 12:12 PM
To: Renee Clark (RClark@Helio.health)
Subject: HHC Applications

Good afternoon Renee,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for Helio Health's renewal projects- KEES II, KEES
III, KEES IV, Grove Point, and FAST Housing.

The Committee has decided not to award Helio Health's Housing Innovation project due to the project's
cost effectiveness and high cost per bed.

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From: Megan Stuart
Sent: Friday, August 10, 2018 11:59 AM
To: Diane Cooper-Currier
Subject: HHC Applications

Good morning Diane,

I am writing to let you know that the Performance Evaluation and Selection Committee met yesterday
and has decided to approve your renewal application for OCO's Rapid Re-Housing and Permanent
Supportive Housing projects. As we discussed on the phone this morning, we will be looking further into
your DV Bonus application.

The Committee has decided not to award Oswego County Opportunities funding request for the Youth
TH-RRH project due to community data not supporting the need.

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by
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where your E-SNAPS application will be assigned a reviewer.

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Please let me know if you have any questions.

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GOVERNANCE CHARTER

HUD Continuum of Care: NY-505

REVISED: June 20, 2018

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1. Organization

The Housing and Homeless Coalition of Central New York ("HHC") serves as the Continuum of Care ("CoC") designated by the United States Department of Housing and Urban Development ("HUD") as NY-505, bringing together Onondaga, Oswego and Cayuga Counties.

The United Way of Central New York has been designated the Collaborative Applicant and HMIS Lead and has been designated by the CoC to certify and submit the annual CoC Program funding application and annual homeless reports required by HUD.

2. Geographical Area

The HHC includes the City of Syracuse and the City of Auburn, the County of Onondaga, the County of Oswego and the County of Cayuga including the HUD Geo-codes: 366376, 369067, 361256, 369075, 360300, and 369011. HHC is the Continuum of Care (CoC) identified by HUD as NY-505. This region was previously includes Oswego County CoC (NY-509) (which merged in March 2015) and Cayuga/Auburn CoC (NY-502) (which merged in May 2016).

3. Purpose and Mission

The mission of the HHC is to assess community needs and to develop a comprehensive community strategy to reduce, prevent and ultimately end homelessness and housing vulnerability in our community.

The vision of the HHC is a community with a comprehensive, effective and coordinated network of services to reduce, prevent and ultimately end homelessness.

The purpose of the HHC is to serve as the community coalition to address homelessness and housing vulnerability. The HHC promotes inclusion and facilitates both informal networking and formal linkages between service providers and individuals who currently or previously experienced homelessness. The HHC provides a regular forum for ongoing dialogue, which enables participants to enhance understanding, coordination and cooperation regarding the multi-faceted problems of homelessness and housing vulnerability. The HHC engages the participants in planning for future services through an outcome-oriented process that eliminates overlapping planning processes and unnecessary duplication of effort.

The HHC will work to alleviate homelessness by:

- Assessing community needs as they relate to homelessness and housing vulnerability;
- Developing an easily accessible continuum of services for individuals and families experiencing homelessness;
- Coordinating local resources to avoid duplication of services and unnecessary gaps in the service system;
- Collaborating to access funding opportunities;
- Providing a forum for communication between service recipients and service providers;
- Educating the general community on the needs of persons experiencing homelessness and the services available;
- Contributing information and participating in the community Consolidated Planning Process with the City of Syracuse and Onondaga County and the City of Auburn (ESG; CDBG; HOME);
- Developing and bringing together stakeholders to form and implement plans to end homelessness (i.e. 10 year plans, etc.).

4. Organizational Chart

The structure of the HHC is defined in the HHC Organizational Chart. The Rights and Responsibilities of each of these entities is defined Section 5 below.

5. Rights and Responsibilities

The Rights and Responsibilities of the entities within the HHC are as follows

5.1. HHC Body

- Review and approve any changes to governance charter/operational guidelines annually.
- Establish an Advisory Board to act on behalf of the CoC.
- Review, update and approve a written process to select a board to act on behalf of the CoC at least once every 5 years.
- Approve fundamental changes in the structure of the coalition, such as mergers or consolidations.
- Designate HUD Collaborative Applicant, an HMIS Lead, and an HMIS Vendor/Software.
- Hold meetings of full membership at least semi-annually.
- Make an invitation for new members to join publicly available within the geographic region at least annually.
- Approve and follow written standards for providing CoC assistance.

5.2. HHC Advisory Board

- Ensure HHC obeys applicable HUD regulations and statutes.
- In consultation with the Collaborative Applicant and HMIS Lead, develop, follow and update annually a governance charter that will include all procedures and policies needed to comply with HUD and HMIS requirements, a code of conduct and recusal process for the board, its chair(s), and any person acting on behalf of the board (Final governance charter must be approved by full HHC if changes are made).
- Appoint additional committees, subcommittees or workgroups.
- In consultation with HUD Emergency Solutions Grants ("ESG") Programs, establish/update written standards for providing CoC assistance.
- In consultation with ESG programs, design, oversee and approve changes to a coordinated assessment system that provides a comprehensive assessment of the needs of individuals and families for housing and services.
- Develop a CoC plan that includes coordinating the implementation of a housing and service system that encompasses:
    - Outreach, engagement and assessment;
    - Shelter, housing and supportive services; and
    - Prevention strategies.
- In consultation with HMIS Lead, review, revise and approve HMIS privacy plan, security plan, and data quality plan for HMIS.

- Consult with recipients and subrecipients to establish performance targets appropriate for population and program type, monitor recipient and subrecipient performance, evaluate outcomes, and address concerns regarding poor performers.
- Evaluate outcomes of projects funded under the ESG and CoC programs, and report to HUD.
- Engage in HUD Funding Process – NOFA related activities, including establish funding priorities and perform ratings and rankings to determine who will be included in the response to the NOFA.
- In conjunction with Collaborative Applicant/HMIS Lead, evaluate HHC Director performance

5.3. Collaborative Applicant and HMIS Lead

- Collect, combine and submit the required NOFA application.
- Apply for and manage CoC Planning Grant and HMIS Grants.
- Employ HHC Staff; directly supervise HHC Director and Staff; and provide space, equipment, and needed supplies to staff.
- Provide insurance for HHC-related activities.
- Maintain finances for HHC planning and HMIS programs.
- House and manage HMIS. Enter HMIS use agreements with all HMIS users, and ensure HMIS users are complying with HMIS privacy and security policies

5.4. HHC Director & Staff

- Operate as the public face of CoC.
- Carry out planning activities and all other CoC activities.
- Carry out monitoring of recipients and subrecipients.
- Ensure consistent participation of recipients and subrecipients in HMIS.
- Ensure HMIS is administered in compliance with requirements prescribed by HUD.
- Planning for and conducting a point-in-time count of homeless persons in accordance with HUD requirements.
- Conduct annual gaps analysis of the homeless needs and services available within the geographic area.
- Gather information required to complete Consolidated Plan.
- Consult with ESG program recipients on plan for allocating and reporting on ESG program recipients and subrecipients.

6. HHC Body Operations

6.1. General Membership in the HHC Body

HHC Body meetings are open to all individuals, especially those who are currently experiencing or formerly experienced homelessness, and representatives from all sectors interested in learning about or addressing homelessness, housing vulnerability or other issues relevant to the mission, vision and purpose of the HHC. Membership in the HHC Body is also open to all stakeholders in Central New York, including nonprofit homeless assistance providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, and organizations that serve veterans and homeless and formerly homeless individuals.

All HHC Body members are encouraged to participate in HHC Committees and Workgroups. The HHC Body will consist of voting and non-voting members. Voting members are defined below in section 6.2. All other members are encouraged to participate but do not vote.

Membership and participation is required for all agencies actively receiving funds through the HUD CoC and ESG programs. At a minimum, participation shall be defined as attending and participating in regular meetings.

New members may enroll at any time during the year by providing to the HHC Director their names, contact information, and any relevant affiliations. Contact information, meeting agendas and minutes are listed on the HHC's website: http://www.hhccny.org/

6.2. Voting Membership in the HHC Body

An agency or organization gets one vote. An individual not associated with an agency or organization gets one vote. In order to be in good standing to vote, the individual or organization must have attended at least 4 of the last 6 scheduled HHC General Meetings. The agency or organization can determine the representative who will vote at each meeting. Attendance may be in person, telephonically, or through web-based program.

Items or decisions requiring a vote must be made known to Members in good standing at least 5 business days prior to the vote. Members must be notified utilizing the current listing of Membership Contact Information which is via email through the HHC listserv. Members who do not have email access may request any correspondence via USPS Mail. Notification must include the date, time, location and voting item.

Quorum for a vote is defined as 1/2 of members in good standing for voting purposes. Any action by this quorum shall be considered an act of the full membership. A vote may only take place if a quorum of voting members is present.

Voting is to be conducted in a manner that protects the anonymity of the vote being cast by those participating in the vote. Ballots are distributed to eligible members at the HHC meeting at the end of the presentation of the voting topic. Ballots are then collected when voting is completed and tallied. The outcome of the vote will be shared in a group session with the present members of the HHC. Actions must be approved by a majority of voting members present.

6.3. HHC Body Meetings

Frequency: The HHC holds General Meetings year-round on the 3rd Wednesday of even months, unless otherwise determined and communicated. The meetings are scheduled for a time during the regular business day at a place that offers a central location with access to public transportation.

Annual Meeting: The HHC will hold its Annual Meeting each year in June, during which time Advisory Board members and Advisory Board officers for the following year (defined as July through June) shall be elected and HHC Operational Guidelines will be approved. This annual meeting will take place instead of the regular general meeting that month.

Agenda: The HHC Director and Advisory Board Chair, with input from the coalition members, will determine the HHC General Meeting agenda and the order of the meeting. Agenda items include committee reports, agency updates, ending homelessness reports, legislative updates, and various presentations/trainings related to better serving those experiencing homelessness and identifying housing for vulnerable populations. The Agenda is distributed via the HHC email listserv.

Minutes: Minutes of the proceedings of the HHC General Meeting and any special meeting of the HHC are kept (by a notetaker appointed by the HHC Director) and shall include at a minimum the date, time, place of the meeting, agency updates, announcements, reports, and any issues or topics raised for discussion and any action taken. Minutes are distributed via the HHC email listserv.

Attendance: Meeting attendees are required to sign the meeting attendance sheets which serve as the formal document confirming participation and to maintain "good standing" status. Members participating telephonically or via web-based program must announce their participation, and the HHC Director (or their designee) will record their official attendance. The HHC Director takes attendance and maintains attendance records.

7. HHC Advisory Board

7.1. Advisory Board Structure

The HHC Advisory Board shall be composed of up to twenty-five (25) voting members and two (2) non-voting members:

- 6 Service Providers (At least 1 from each county)
- 3 Key Stakeholders, such as non-HUD funded providers, faith-based community providers, housing developers, landlords, major employers or others
- ESG Recipient (City of Syracuse, Onondaga County for 2 total slots) – No term limit
- 2 Main Public Housing Authorities
- 3 representatives from state or county agencies or others addressing physical or mental healthcare, jail/corrections, substance abuse treatment, child welfare or other systems essential for addressing homelessness (one from each county)
- 3 Private Foundation Funders
- 3 at Large Members
- 2 Members who are Homeless or Formerly Homeless
- Collaborative Applicant/HMIS Lead (United Way) – no term limit
- HHC Director (Non-voting member) – no term limit
- HMIS Administrator (Non-voting member) – no term limit

7.2. Terms

All Advisory Board Members shall serve staggered terms of three years so that approximately one-third of Board Members will transition off the Board or go through the nomination process each year. A Board Member may serve for up to three consecutive years with one additional successive term and then must wait one year before accepting nomination to the Board again.

In the first year, newly appointed Advisory Board members will draw lots to determine the length of their terms- one, two, or three years.

7.3. Nomination and Approval of Advisory Board Members

Each January, the Nominating Workgroup will solicit nominations for open Homeless or Formerly Homeless Members, At-Large, Service Provider and Key Stakeholder Board positions from CoC membership. State and County agencies/Major System and Private Funder seats will be assigned or appointed and given to the Nominating Workgroup.

The Nominating Committee will prepare for Membership approval a slate of candidates for the Board to be presented before the Annual Meeting. The Nominating Committee will prepare brief bios that outline employment, board affiliations, and qualifications for the HHC Advisory Board for

the presentation to the HHC Membership. Finally, the Nominating Committee's primary goal is ensuring a balanced and representative Advisory Board.

7.4. Balanced and Representative Board

To ensure a Board of balanced stakeholder groups, no more than one member of the board or staff of a particular organization, plus no more than one volunteer or consumer affiliated with that organization may serve on the Advisory Board at the same time. If the Governance Committee nominates two candidates with a common organizational affiliation (e.g., CEO and consumer), the materials presented to the HHC membership should note their shared affiliation, and should include a rationale for that decision. If the Governance Committee determines that a candidate put forth does not meet eligibility criteria or decides not to include a candidate on the slate for any reason, the Governance Committee will notify the entity making the nomination and allow a new nomination to be put forth. The Governance Committee will strive to have balanced representation between the different counties.

7.5. Officers

The Officers of the HHC Advisory Board shall consist of the following members, who shall be elected by the HHC Body at its annual meeting.

Chair: The HHC Chair is elected to a one-year term and the option to renew for one additional term. Duties of the Chair include facilitating HHC Advisory Board meetings; acting as a liaison between the HHC and the Collaborative Applicant and HMIS Lead; working closely with the HHC Director to ensure that the mission and purposes of the HHC are being met; and such further duties as assigned by the HHC body and Advisory Body.

Chair Elect: The HHC Chair Elect is elected to succeed the HHC Chair at the termination of their term and, in the absence or at the request of the Chair, to perform the duties and exercise the powers of the Chair.

Treasurer: The HHC Treasurer is elected to oversee the care and custody of all of the funds of the HHC. The Treasurer will work together with the HHC Director and the Collaborative Applicant to prepare at least quarterly financial reports to the HHC Advisory Board. The Treasurer will assist the HHC Director to prepare annual and grant-based budgets.

Secretary: The Secretary is elected to attend all meetings of the Advisory Board and keep minutes thereof, as well as maintain the primary repository of all official policies and procedures of the HHC Advisory Board.

7.6. Quorum

Quorum HHC Advisory Board meetings shall be one half of all HHC Advisory Board Members.

7.7. Resignation and Removal

Any HHC Advisory Board Member may resign at any time by giving written notice to

the Chair. In addition, Advisory Board Members may be removed from their position by a majority vote of Advisory Board Members for repeated absence, misconduct, failure to participate, or violation of conflict of interest policies. Advisory Board Members are expected to attend two-thirds of all board meetings, except in extraordinary circumstances.

7.8. Vacancies

When an Advisory Board Member resigns or is removed from their position, or cannot serve their full term for any reason, the HHC Body may elect a new person to fill the remaining unexpired term at the next general meeting of the HHC Body.

7.9. Conflict of Interests and Recusal Process

If at any time there is a conflict of interest whereby an organization or individual will have a direct interest in the funding, scoring, ranking, or policy decision making, then that organization, representative of the organization or individual will recuse themselves for the process in order to mitigate any perceived conflict of interest. The recusal may be oral or in writing. In addition, the HHC Advisory Board may request an organization, representative of organization or individual to recuse themselves from any activities.

8. Committees of the HHC Advisory Board

Except as specified otherwise below, membership in the Committees of the HHC Advisory Board shall be limited to HHC Advisory Board members. All HHC Advisory Board members are expected to participate actively in at least one HHC Advisory Board Committee.

8.1. Executive Committee

There shall be an Executive Committee, consisting of the officers of the HHC and the Chairs of each Committee of the Advisory Board, which shall have all of the authority of the Advisory Board, and shall be authorized to act, between meetings of the Advisory Board, on those matters on which action must be taken before the next regularly scheduled meetings of the Advisory Board, provided that the Executive Committee shall not have authority to remove any member of the Advisory Board. Additional duties of the Executive Committee include: approving HHC letters of support, assisting with the annual review of the HHC Director, liaise with the Collaborative Applicant, and oversee community relations and communications (e.g. press releases, website, year-end reports, etc.)

8.2. HUD Selection/Performance Evaluation Committee

There shall be a HUD Selection/Performance Evaluation Committee, consisting only of non-CoC or ESG funded Advisory board member. The duties are to oversee all monitoring of funding agencies (which is performed by the HHC Director), develop and revise the monitoring tool, perform ratings and rankings for all applications to the NOFA, and conduct HMIS user

evaluations including evaluating completeness and determining whether a new applicant should receive an HMIS license.

8.3. Governance/Policies Committee

There shall be a Governance/Policies Committee whose duties are to update all HHC and HMIS policies on an annual basis, including HHC Operational Guidelines and HHC Guidelines, and to engage in Advisory Board Nomination and Leadership. The Governance/Policies Committee will engage in board recruitment, accept board nominations, and prepare the slate of Advisory Board nominations and officers for the HHC Body. The Governance/Policies Committee will also engage in board training and leadership development for new Advisory Board members.

8.4. Program/Advocacy Planning Committee

The Program/Advocacy Planning Committee shall consist of all Officers, and is open to all Advisory Board Members, HHC Body Members, and Community Stakeholders. The Program/Advocacy Planning Committee is responsible for establishing HHC-wide priorities and plans for implementation, including updating 10 year plan and goals, identifying Gaps & Needs, and evaluating HMIS data outcomes to determine goals for the community. The Committee will explore other collaborative funding opportunities for the HHC. The Committee will update program policies for Coordinated Entry. The Committee will liaise with other housing-related committees and coalitions in the community to create a unified plan for advancing the mission and purposes of the HHC.

9. HHC Body Committees and Working Groups

In general, HHC committees are made up largely of HHC members and focus on policies, plans, operations, etc. of the different service providers within the HHC. HHC Workgroups are made up primarily of Direct Service Provider Staff and generally focus on addressing individual client needs through collaboration and coordination. The following are a list of Committees and Workgroups.

9.1. Data Administration Committee

Required for all funded agencies, open to all HHC members, and responsible for:

- Organizing, overseeing, and compiling counts of the population and subpopulations of people experiencing homelessness
- Helping to plan, organize, promote and carry out the Point-In-Time (PIT) Count
- Working with the HHC Director and HMIS Administrator to provide education, feedback, and support to the membership on improving data quality
- Working with the HHC Director to review Homeless Management Information System (HMIS), Annual Homeless Assessment Report (AHAR), Housing Inventory Count (HIC) and System Performance Measures

(SysPM).

9.2. Funded Agency Committee

Required for all funded agencies funded through the CoC or ESG. Advises funded agencies on HUD compliance and new HUD policies. Meets on an as-need basis at least once per year.

9.3. Oswego County Committee

Consists of all Oswego County HHC members, and is open to other Oswego County Stakeholders, and meets to address concerns particular to the Oswego County region. The county will address local gaps and needs issues such as Runaway and Homeless Youth. The Committee will regularly meet in odd-numbered months at a place and time determined by the Committee, and may meet more regularly if it so chooses.

9.4. Cayuga County Committee

Consists of all Cayuga County HHC members, and is open to other Cayuga County Stakeholders, and meets to address concerns particular to the Cayuga County region. The county will address local gaps and needs issues such as Runaway and Homeless Youth. The Committee will regularly meet in odd-numbered months at a place and time determined by the Committee, and may meet more regularly if it so chooses.

9.5. Onondaga County Committee

Consists of all Onondaga County HHC members, and is open to other Onondaga County Stakeholders, and meets to address concerns particular to the Onondaga County region. The county will address local gaps and needs issues such as Runaway and Homeless Youth. The Committee will regularly meet in odd-numbered months at a place and time determined by the Committee, and may meet more regularly if it so chooses.

9.6. Coordinated Entry Workgroup

Ensures that the HHC is prioritizing those experiencing chronical homelessness and other vulnerable individuals for housing. Works with Program/Advocacy Committee to update Coordinated Entry Policies. See Coordinated Entry Policy and Procedures Manual on our website for more information: http://www.hhccny.org/coc/coordinated-entry/

9.7. Street Outreach Workgroup

Meets regularly to address the needs of all individuals that are unsheltered as well as discussing any community concerns regarding street homelessness and outreach/engagement activities. The Street Outreach Workgroup also assists with the annual Point in Time (PIT) count and training for the count as it applies to unsheltered individuals.

9.8. Veterans Workgroup

Meets regularly to address the needs of all veterans experiencing homelessness as well as following any new guidance regarding sustaining an end to Veteran homelessness as Syracuse/Onondaga was granted an official declaration in 2015 from the United States Interagency Council on Homelessness. The Workgroup also reviews any practices or policies for programs that serve Veterans and updates the CoC's Functional Zero plan as needed.

9.9. Housing Service Providers Workgroup

Meets regularly to address to share information regarding programs and services available to individuals and families, and provide opportunities for networking and professional development for housing service providers.

10. Appointment of Agents and Designation of HMIS

10.1. Collaborative Applicant

The United Way of Central New York serves as the HHC's Collaborative Applicant.

10.2. HMIS Lead

The United Way of Central New York serves as the HHC's HMIS Lead.

11. HHC Director

The HHC, through its Collaborative Applicant, shall employ an HHC Director, who, subject to the control and discretion of the Board, shall have general charge, oversight and direction of the day-to-day affairs and business of the HHC. The HHC Director shall ensure that the activities of the HHC are operated in accordance with the mission, purposes, and policies of the HHC. The HHC Director shall perform such other duties and have such other power as may be assigned from time to time by the Board. The selection of the HHC Director shall be made by a Selection Committee made up of members of the Advisory Board and the Collaborative Applicant, who shall identify a final candidate that shall be submitted to the Advisory Board for approval by a majority vote of the Board present at the meeting. The final candidate shall be submitted to the Collaborative Applicant for their approval and final decision-making in hiring. The HHC Director shall be an employee of the Collaborative Applicant and must conform to the policies and procedures of the Collaborative Applicant.

12. Operational Guidelines Amendments

The Operational Guidelines may be amended at any time by the HHC body through the

procedures outlined above regarding Voting and Voting Membership, and will be reviewed and updated at least annually.

2018 HDX Competition Report

PIT Count Data for NY-505 - Syracuse, Auburn/Onondaga, Oswego, Cayuga Counties CoC

Total Population PIT Count Data

	2016 PIT	2017 PIT	2018 PIT
Total Sheltered and Unsheltered Count	**867**	**798**	**722**
Emergency Shelter Total	563	532	547
Safe Haven Total	0	0	0
Transitional Housing Total	277	238	163
Total Sheltered Count	**840**	**770**	**710**
Total Unsheltered Count	**27**	**28**	**12**

Chronically Homeless PIT Counts

	2016 PIT	2017 PIT	2018 PIT
Total Sheltered and Unsheltered Count of Chronically Homeless Persons	**62**	**43**	**36**
Sheltered Count of Chronically Homeless Persons	60	42	34
Unsheltered Count of Chronically Homeless Persons	2	1	2

2018 HDX Competition Report

PIT Count Data for NY-505 - Syracuse, Auburn/Onondaga, Oswego, Cayuga Counties CoC

Homeless Households with Children PIT Counts

	2016 PIT	2017 PIT	2018 PIT
Total Sheltered and Unsheltered Count of the Number of Homeless Households with Children	**95**	**77**	**60**
Sheltered Count of Homeless Households with Children	93	76	60
Unsheltered Count of Homeless Households with Children	2	1	0

Homeless Veteran PIT Counts

	2011	2016	2017	2018
Total Sheltered and Unsheltered Count of the Number of Homeless Veterans	**65**	**56**	**49**	**41**
Sheltered Count of Homeless Veterans	64	56	48	41
Unsheltered Count of Homeless Veterans	1	0	1	0

2018 HDX Competition Report

HIC Data for NY-505 - Syracuse, Auburn/Onondaga, Oswego, Cayuga Counties CoC

HMIS Bed Coverage Rate

Project Type	Total Beds in 2018 HIC	Total Beds in 2018 HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
Emergency Shelter (ES) Beds	**557**	**55**	**486**	**96.81%**
Safe Haven (SH) Beds	**0**	**0**	**0**	**NA**
Transitional Housing (TH) Beds	**202**	**14**	**188**	**100.00%**
Rapid Re-Housing (RRH) Beds	**623**	**0**	**623**	**100.00%**
Permanent Supportive Housing (PSH) Beds	**1161**	**0**	**1161**	**100.00%**
Other Permanent Housing (OPH) Beds	**123**	**0**	**123**	**100.00%**
Total Beds	2,666	69	2581	99.38%

2018 HDX Competition Report

HIC Data for NY-505 - Syracuse, Auburn/Onondaga, Oswego, Cayuga Counties CoC

PSH Beds Dedicated to Persons Experiencing Chronic Homelessness

Chronically Homeless Bed Counts	2016 HIC	2017 HIC	2018 HIC
Number of CoC Program and non-CoC Program funded PSH beds dedicated for use by chronically homeless persons identified on the HIC	127	261	280

Rapid Rehousing (RRH) Units Dedicated to Persons in Household with Children

Households with Children	2016 HIC	2017 HIC	2018 HIC
RRH units available to serve families on the HIC	60	84	138

Rapid Rehousing Beds Dedicated to All Persons

All Household Types	2016 HIC	2017 HIC	2018 HIC
RRH beds available to serve all populations on the HIC	170	313	623

2018 HDX Competition Report

FY2017 - Performance Measurement Module (Sys PM)

Summary Report for NY-505 - Syracuse, Auburn/Onondaga, Oswego, Cayuga Counties CoC

For each measure enter results in each table from the System Performance Measures report generated out of your CoCs HMIS System. There are seven performance measures. Each measure may have one or more "metrics" used to measure the system performance. Click through each tab above to enter FY2017 data for each measure and associated metrics.

RESUBMITTING FY2017 DATA: If you provided revised FY2017 data, the original FY2017 submissions will be displayed for reference on each of the following screens, but will not be retained for analysis or review by HUD.

ERRORS AND WARNINGS: If data are uploaded that creates selected fatal errors, the HDX will prevent the CoC from submitting the System Performance Measures report. The CoC will need to review and correct the original HMIS data and generate a new HMIS report for submission.

Some validation checks will result in warnings that require explanation, but will not prevent submission. Users should enter a note of explanation for each validation warning received. To enter a note of explanation, move the cursor over the data entry field and click on the note box. Enter a note of explanation and "save" before closing.

Measure 1: Length of Time Persons Remain Homeless

This measures the number of clients active in the report date range across ES, SH (Metric 1.1) and then ES, SH and TH (Metric 1.2) along with their average and median length of time homeless. This includes time homeless during the report date range as well as prior to the report start date, going back no further than October, 1, 2012.

Metric 1.1: Change in the average and median length of time persons are homeless in ES and SH projects.
Metric 1.2: Change in the average and median length of time persons are homeless in ES, SH, and TH projects.

a. This measure is of the client's entry, exit, and bed night dates strictly as entered in the HMIS system.

2018 HDX Competition Report
FY2017 - Performance Measurement Module (Sys PM)

	Universe (Persons)			Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Submitted FY 2016	Revised FY 2016	FY 2017	Submitted FY 2016	Revised FY 2016	FY 2017	Difference	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
1.1 Persons in ES and SH	4489	4678	4928	38	37	36	-1	22	21	22	1
1.2 Persons in ES, SH, and TH	4850	5058	5217	60	58	54	-4	26	26	25	-1

b. This measure is based on data element 3.17.

This measure includes data from each client's Living Situation (Data Standards element 3.917) response as well as time spent in permanent housing projects between Project Start and Housing Move-In. This information is added to the client's entry date, effectively extending the client's entry date backward in time. This "adjusted entry date" is then used in the calculations just as if it were the client's actual entry date.

The construction of this measure changed, per HUD's specifications, between FY 2016 and FY 2017. HUD is aware that this may impact the change between these two years.

	Universe (Persons)			Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Submitted FY 2016	Revised FY 2016	FY 2017	Submitted FY 2016	Revised FY 2016	FY 2017	Difference	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
1.1 Persons in ES, SH, and PH (prior to "housing move in")	4298	4687	4942	89	91	69	-22	26	26	27	1
1.2 Persons in ES, SH, TH, and PH (prior to "housing move in")	4653	5131	5330	110	116	90	-26	32	32	31	-1

2018 HDX Competition Report

FY2017 - Performance Measurement Module (Sys PM)

Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness

This measures clients who exited SO, ES, TH, SH or PH to a permanent housing destination in the date range two years prior to the report date range.Of those clients, the measure reports on how many of them returned to homelessness as indicated in the HMIS for up to two years after their initial exit.

After entering data, please review and confirm your entries and totals. Some HMIS reports may not list the project types in exactly the same order as they are displayed below.

	Total # of Persons who Exited to a Permanent Housing Destination (2 Years Prior)		Returns to Homelessness in Less than 6 Months			Returns to Homelessness from 6 to 12 Months			Returns to Homelessness from 13 to 24 Months			Number of Returns in 2 Years	
	Revised FY 2016	FY 2017	Revised FY 2016	FY 2017	% of Returns	Revised FY 2016	FY 2017	% of Returns	Revised FY 2016	FY 2017	% of Returns	FY 2017	% of Returns
Exit was from SO	17	58	6	14	24%	0	2	3%	0	4	7%	20	34%
Exit was from ES	1497	1778	235	279	16%	124	142	8%	79	122	7%	543	31%
Exit was from TH	305	315	33	29	9%	16	20	6%	17	11	3%	60	19%
Exit was from SH	0	0	0	0		0	0		0	0		0	
Exit was from PH	422	490	49	37	8%	25	43	9%	11	17	3%	97	20%
TOTAL Returns to Homelessness	2241	2641	323	359	14%	165	207	8%	107	154	6%	720	27%

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

2018 HDX Competition Report
FY2017 - Performance Measurement Module (Sys PM)

This measures the change in PIT counts of sheltered and unsheltered homeless person as reported on the PIT (not from HMIS).

	January 2016 PIT Count	January 2017 PIT Count	Difference
Universe: Total PIT Count of sheltered and unsheltered persons	867	798	-69
Emergency Shelter Total	563	532	-31
Safe Haven Total	0	0	0
Transitional Housing Total	277	238	-39
Total Sheltered Count	840	770	-70
Unsheltered Count	27	28	1

Metric 3.2 – Change in Annual Counts

This measures the change in annual counts of sheltered homeless persons in HMIS.

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Unduplicated Total sheltered homeless persons	5023	5247	5481	234
Emergency Shelter Total	4619	4810	5099	289
Safe Haven Total	0	0	0	0
Transitional Housing Total	642	710	630	-80

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

Metric 4.1 – Change in earned income for adult system stayers during the reporting period

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults (system stayers)	529	596	474	-122
Number of adults with increased earned income	23	26	34	8
Percentage of adults who increased earned income	4%	4%	7%	3%

Metric 4.2 – Change in non-employment cash income for adult system stayers during the reporting period

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults (system stayers)	529	596	474	-122
Number of adults with increased non-employment cash income	60	93	78	-15
Percentage of adults who increased non-employment cash income	11%	16%	16%	0%

Metric 4.3 – Change in total income for adult system stayers during the reporting period

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults (system stayers)	529	596	474	-122
Number of adults with increased total income	80	113	105	-8
Percentage of adults who increased total income	15%	19%	22%	3%

2018 HDX Competition Report
FY2017 - Performance Measurement Module (Sys PM)

Metric 4.4 – Change in earned income for adult system leavers

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults who exited (system leavers)	336	366	423	57
Number of adults who exited with increased earned income	38	42	61	19
Percentage of adults who increased earned income	11%	11%	14%	3%

Metric 4.5 – Change in non-employment cash income for adult system leavers

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults who exited (system leavers)	336	366	423	57
Number of adults who exited with increased non-employment cash income	155	162	182	20
Percentage of adults who increased non-employment cash income	46%	44%	43%	-1%

Metric 4.6 – Change in total income for adult system leavers

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults who exited (system leavers)	336	366	423	57
Number of adults who exited with increased total income	155	188	226	38
Percentage of adults who increased total income	46%	51%	53%	2%

2018 HDX Competition Report

FY2017 - Performance Measurement Module (Sys PM)

Measure 5: Number of persons who become homeless for the 1st time

Metric 5.1 – Change in the number of persons entering ES, SH, and TH projects with no prior enrollments in HMIS

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Person with entries into ES, SH or TH during the reporting period.	4679	4894	5139	245
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	1646	1707	1695	-12
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time)	3033	3187	3444	257

Metric 5.2 – Change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollments in HMIS

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	4990	5208	5376	168
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	1730	1793	1800	7
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)	3260	3415	3576	161

FY2017 - Performance Measurement Module (Sys PM)

Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD's Homeless Definition in CoC Program-funded Projects

This Measure is not applicable to CoCs in FY2017 (Oct 1, 2016 - Sept 30, 2017) reporting period.

Measure 7: Successful Placement from Street Outreach and Successful Placement in or Retention of Permanent Housing

Metric 7a.1 – Change in exits to permanent housing destinations

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Persons who exit Street Outreach	468	469	245	-224
Of persons above, those who exited to temporary & some institutional destinations	34	37	29	-8
Of the persons above, those who exited to permanent housing destinations	63	63	35	-28
% Successful exits	21%	21%	26%	5%

Metric 7b.1 – Change in exits to permanent housing destinations

2018 HDX Competition Report
FY2017 - Performance Measurement Module (Sys PM)

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	4218	4488	4635	147
Of the persons above, those who exited to permanent housing destinations	1776	1914	2171	257
% Successful exits	42%	43%	47%	4%

Metric 7b.2 – Change in exit to or retention of permanent housing

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Persons in all PH projects except PH-RRH	1549	1395	1421	26
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	1456	1311	1340	29
% Successful exits/retention	94%	94%	94%	0%

2018 HDX Competition Report

FY2017 - SysPM Data Quality

NY-505 - Syracuse, Auburn/Onondaga, Oswego, Cayuga Counties CoC

This is a new tab for FY 2016 submissions only. Submission must be performed manually (data cannot be uploaded). Data coverage and quality will allow HUD to better interpret your Sys PM submissions.

Your bed coverage data has been imported from the HIC module. The remainder of the data quality points should be pulled from data quality reports made available by your vendor according to the specifications provided in the HMIS Standard Reporting Terminology Glossary. You may need to run multiple reports into order to get data for each combination of year and project type.

You may enter a note about any field if you wish to provide an explanation about your data quality results. This is not required.

2018 HDX Competition Report

FY2017 - SysPM Data Quality

	All ES, SH				All TH				All PSH, OPH				All RRH				All Street Outreach			
	2013-2014	2014-2015	2015-2016	2016-2017	2013-2014	2014-2015	2015-2016	2016-2017	2013-2014	2014-2015	2015-2016	2016-2017	2013-2014	2014-2015	2015-2016	2016-2017	2013-2014	2014-2015	2015-2016	2016-2017
1. Number of non-DV Beds on HIC	487	444	421	452	415	276	293	275	1243	1270	1382	1493			170	313				
2. Number of HMIS Beds	439	438	417	441	415	276	293	232	1221	1248	1382	1493			170	313				
3. HMIS Participation Rate from HIC (%)	90.14	98.65	99.05	97.57	100.00	100.00	100.00	84.36	98.23	98.27	100.00	100.00			100.00	100.00				
4. Unduplicated Persons Served (HMIS)	4997	4878	4808	5099	532	598	598	553	1573	1460	1509	1437	0	0	528	1075	1	8	24	17
5. Total Leavers (HMIS)	4469	4418	4340	4612	312	392	412	411	378	252	359	411	0	0	328	538	1	1	18	13
6. Destination of Don't Know, Refused, or Missing (HMIS)	2792	2364	1403	1246	40	27	20	23	4	7	16	19	0	0	1	3	0	0	2	1
7. Destination Error Rate (%)	62.47	53.51	32.33	27.02	12.82	6.89	4.85	5.60	1.06	2.78	4.46	4.62			0.30	0.56	0.00	0.00	11.11	7.69

2018 HDX Competition Report

Submission and Count Dates for NY-505 - Syracuse, Auburn/Onondaga, Oswego, Cayuga Counties CoC

Date of PIT Count

	Date	Received HUD Waiver
Date CoC Conducted 2018 PIT Count	1/24/2018	

Report Submission Date in HDX

	Submitted On	Met Deadline
2018 PIT Count Submittal Date	4/20/2018	Yes
2018 HIC Count Submittal Date	4/20/2018	Yes
2017 System PM Submittal Date	5/31/2018	Yes

Housing & Homeless Coalition
Of Central New York

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Continuum of Care Written Standard for NY-505

Syracuse/Auburn, Onondaga, Oswego and Cayuga Counties

Revised January 21, 2018

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Introduction

The Continuum of Care (CoC) is responsible for coordinating and implementing a system to meet the needs of the population and subpopulations experiencing homelessness within the geographic area of Onondaga, Oswego and Cayuga Counties. Both the Emergency Solution Grant Rules and Regulations (ESG) and the Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Continuum of Care Program Interim Rules state that the Continuum of Care (CoC), in consultation with recipients of Emergency Solutions Grants program funds within the geographic area, (1) establish and consistently follow written standards for providing Continuum of Care assistance, (2) establish performance targets appropriate for population and program type, and (3) monitor recipient and sub-recipient performance.

All programs that receive ESG or CoC funding are required to abide by these written standards. Agency program procedures should reflect the policy and procedures described in this document. The CoC strongly encourages programs that do not receive either of these sources of funds to accept and utilize these written standards.

The written standards have been established to ensure that persons experiencing homelessness who enter programs throughout the CoC will be given similar information and support to access and maintain permanent housing.

The written standards have been created in conjunction with HUD Notice CPD-16-11 issued on July 25, 2016 titled Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing that can be found online here: https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf

The Continuum of Care Written Standards will:

- Assist with the coordination of service delivery across the geographic area and will be the foundation of the coordinated entry system;
- Assist in assessing individuals and families consistently to determine program eligibility;
- Assist in administering programs fairly and methodically;
- Establish common performance measurements for all CoC components; and
- Provide the basis for the monitoring of all CoC and ESG funded projects.

These written standards have been developed in conjunction with ESG recipients (City of Syracuse, Onondaga County) and with service providers to allow for input on the procedure of Coordinated Entry/Assessment System, standards, performance measures and the process for full implementation of the standards throughout the CoC from the perspective of those organizations that are directly providing homeless housing and services, Street Outreach (SO), Emergency Shelter (ES), Transitional Housing (TH), Permanent Supportive Housing (PSH) and Rapid Rehousing (RRH).

The CoC Written Standards have been approved by the CoC, the County and City ESG recipients and providers. The Written Standards will be reviewed and revised as needed at a minimum of once per year by the Governance/Policies Committee and the Coordinated Entry Workgroup.

Program Requirement for All Programs

- Programs must coordinate with other homeless services within the CoC
- Programs must coordinate with, refer to, and ensure client access to mainstream resources in the CoC including housing, social services, employment, education and youth programs for which participants may be eligible
- Programs must have written policies and procedures and must consistently apply them to all participants. Policies and procedures will be reviewed during an annual monitoring visit by HHC staff.
- Programs that serve households with children:
    - A staff person must be designated as the educational liaison that will ensure that children are enrolled in school, connected to appropriate services in the community, including early childhood program such as Head Start, Part C of the Individuals with Disabilities Education Act, and the McKinney Vento education services.
    - The age and gender of a child under age 18 must not be used as a basis for denying any family's admission to a project that provides shelter for families with children
- Programs receiving ESG and CoC funding must participate in HMIS (Homeless Management Information System), unless otherwise stated by federal regulations. Homeless programs that are not federally funded are strongly encouraged to participate in HMIS. The CoC has established an HMIS Policies and Procedures Manual. This manual can be found here.
- Programs must meet minimum HMIS data quality standards (maintaining under a 5% error rate on the Data Quality Framework Report in HMIS).
- Programs providing Domestic Violence services may opt out of HMIS participation but must utilize a comparable database to collect HUD required data elements.
- Programs must participate in Coordinated Entry System and use the prioritization criteria established in this document.
- Programs must conduct an initial evaluation to determine the amount and type of assistance needed to regain stability in permanent housing.
- Program rules and regulations should be designed in the spirit of inclusion rather than as grounds for denial or termination.
- Programs must have a formal procedure for terminating assistance to a participant that recognizes the rights of the participant(s) involved.
    - Programs must use judgment and examine all extenuating circumstances in determining that a violation should result in termination
    - Every effort should be made to allow the participant to remain in the program; termination should only be exercised in the most severe cases.
    - Termination should not necessarily preclude assistance at a future date
- Programs must make known that use of the facilities and services are available to all on a nondiscriminatory basis.
- Programs may not engage in inherently religious activities such as worship, religious instruction or proselytization as part of the programs or services funded under the CoC or ESG. These activities can be conducted (but not supported with federal funds) but must be separate and voluntary for program participants.
- Participants must be free to decide what information they provide during any assessment process. This includes, but is not limited to the Entry assessments by shelter or housing providers that are done upon entry, and the assessment to determine program eligibility.

Providers are prohibited from denying assessment or services to a participant if the participant refuses to provide certain pieces of information, unless the information is necessary to establish or document program eligibility. Providers are also prohibited from denying services to participants if the participant refuses their data to be shared via HMIS.

- The assessment and prioritization process cannot require disclosure of specific disabilities or diagnoses. Specific diagnosis or disability information may only be obtained for purposes of determining program eligibility to make appropriate referrals.
- All housing and supportive services including, but not limited to, entry points into the homeless services system will be affirmatively marketed throughout the CoC to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to apply in the absence of special outreach, and maintain records of those marketing activities. (24 CFR 5.105 (a)(2).
- All participating agencies must connect all individuals and families who require access to interpretation services.
- All participating agencies must adhere to their agency's requirements, along with the CoC's requirements for incorporating cultural and linguistic competencies surrounding all special populations; including immigrants, refugees, and other generation populations; youth; individuals with disabilities; and lesbian, gay, bisexual, transgender, queer, or questioning (LGBTQ) persons.
- Emergency Shelter and Street Outreach staff are required to thoroughly explain the program that has accepted them from the prioritization list in order for that client to make an informed decision/choice to accept that housing provider's referral. This includes, but is not limited to which program they are being referred, what the program expects of them what they can expect of the program, and evidence of the program's rate of success.
- Emergency Shelter and Street Outreach staff should have an understanding of possible restrictions, trauma related issues, and obstacles in regards to particular housing providers or housing types. They should educate themselves in this via the assessment process. Programs working with an individual/ family that has experienced significant trauma and is triggered during the administering of the VI-SPDAT tool, that staff person can stop the assessment to allow that client a break. When the client feels comfortable and able to continue the staff can come back to finish the assessment on a later date.

Recordkeeping Requirements for All Projects

Participant Recordkeeping Requirements include:

- All records containing personally identifying information must be kept secure and confidential
- Programs must have written confidentiality/privacy notice a copy of which should be made available to participants if requested
- Documentation of homelessness must be kept (following HUD's guidelines)
- A record of services and assistance provided to each participant
- Documentation of any applicable requirements for providing services/assistance
- Documentation of use of coordinated assessment system
- Documentation of use of HMIS
- Records must be retained for a minimum of 5 years as prescribed by HUD

Financial Recordkeeping Requirements include:

- Documentation for all costs charged to the grant
- Documentation that funds were spent on allowable costs
- Documentation of the receipt and use of program income
- Documentation of compliance with expenditure limits and deadlines
- Retain copies of all procurement actions as applicable
- Documentation of amount, source and use of resources for each match contribution
- Documentation of audits, financial statements, bank statements, general ledgers, and financial policies/procedures

Occupancy Standards for All Programs

All housing units, including scattered site programs owned and managed by private landlords, must meet HUD Housing Quality Standards (for CoC-funded projects) or Housing Habitability Standards (for ESG-funded projects).

The Program, Record Keeping and Occupancy Standards as represented above apply to all programs regardless of the type of services/housing that they provide.

Other Federal Requirements

The CoC and recipients of CoC and ESG program funded projects must comply with the nondiscrimination provisions of Federal civil rights laws, including, but not limited to, the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Titles II and III of the Americans with Disabilities Act, as applicable. See 24 C.F.R. § 5.105(a). In addition, HUD Equal Access Rule at 24 CFR 5.105(a)(2) prohibits eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC program, ESG program, and HOPWA program.

Community Values

All CoC and ESG projects are committed to the following community values.

Housing First

Housing providers are required to adhere to a Housing First philosophy and implement this philosophy into their intake process as well as their program process. A Housing First philosophy and intervention must be adopted by all CoC and ESG programs, which lowers barriers to housing by ensuring applicants are not screened out due to:

- Having too little or no income
- Active or history of substance abuse
- Having a criminal history (with exceptions for state-mandated restrictions)
- History of domestic violence (lack of order of protection, period of separation from abuser, law enforcement involvement)
- Resistance to receiving services

- The type or extent of disability related services or supports that are needed
- History of evictions of poor credit
- Lease violations or history of not being an lease holder

A Housing First philosophy and intervention also ensures that residents are not terminated due to:

- Failure to participate in support services
- Failure to make progress on a service plan
- Loss of income or failure to improve income
- Domestic violence
- Any other activity not covered in a lease agreement typically found in the community

To be able to better serve persons entering housing programs, it should not be a requirement that persons are subjected to a drug test or breathalyzer upon the intake process or at any point in their housing stay. It should also not be a requirement that persons are forbidden to have alcohol in their apartment (i.e. refrigerator checks for alcohol) if the program participant is over the legal drinking age of 21 in New York State, and especially if the resident's alcohol and drug use is not affecting their housing stability. It is important to have a strength-based approach when working with clients. Please note that while these items are not considered Housing First to national experts that this CoC has received guidance from when developing this Coordinated Entry Plan, the CoC does understand that there are some programs that do not receive CoC and ESG funding and operate in a group home environment where Housing First may be challenging. We urge these programs to think creatively about ways that they can implement Housing First in this environment (i.e. different floors or sections for residents who require a sober living environment for their recovery, engaging with residents to seek substance abuse services if their drug/alcohol intake is affecting their housing stability).

Requiring an in-person interview prior to being admitted to screen for housing to the program in an effort to determine eligibility is not Housing First (i.e. to determine if they are a challenging client, etc.).

Requiring participants to go through a non-Housing First Transitional Housing prior to entering a "Housing First" Permanent Housing program is not Housing First and is not prioritizing those beds for the chronically homeless.

Recognizing that Housing First and prioritizing those who may be harder to serve may be challenging on front line staff, staff should be receiving motivational interviewing, trauma-informed care, and any other training to support the client and themselves in doing this work. Opportunities for these types of training are regularly sent out from the HHC list serve. Please contact the CoC Director to be added to this list serve to receive this communication and for any questions, comments or concerns regarding this process.

A current, "real-time" vacancy list can be found on HMIS. Please contact the CoC's HMIS Administrator to receive an HMIS license and for any needed training regarding this process and any additional HMIS trainings.

Client Centered Approach:

Emergency Shelters and Outreach Providers should assess the strengths, goals, risk, and protective factors of all individuals and families prior to referring them to the coordinated entry prioritization list.

This will allow the programs to not only identify areas of risk/concern, but also identify areas of strength that will assist the client with maintaining housing stability and increasing overall well-being. Emergency Shelters and Outreach Providers should fully explain the difference in housing options available through the Coordinated Entry system. Clients are able to be referred to both Rapid Re-Housing and Permanent Supportive Housing options.

Serving Victims of Violence:

Participants may not be denied access to the coordinated entry process on the basis that the participant is or has been a victim of domestic violence, dating violence, sexual assault or stalking.

Should an individual or family seeking shelter or services that is currently fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, and are unable to access a licensed victim service provider, a non-victim service provider should take the following steps to ensure the safety and confidentiality of the individual or family:

- Thoroughly informing the individual or Head of Household regarding the CNY HMIS Release of Information, and what information will be shared across the CoC, specifically addressing who has access to that knowledge.
- (discussion with group) HMIS ROI for non-DV Providers.
- All records containing their PII are kept secure and confidential and the address of any family violence project not be made public.

Assessor Training

The Housing and Homeless Coalition of Central New York (HHC) will provide training on the Coordinated Entry Process and Procedures at least annually and if there are any updates/changes to the policy or procedure. This is typically done via the HMIS New User and Agency Administrator Training, along with the Coordinated Entry and Data Administrators Committees.

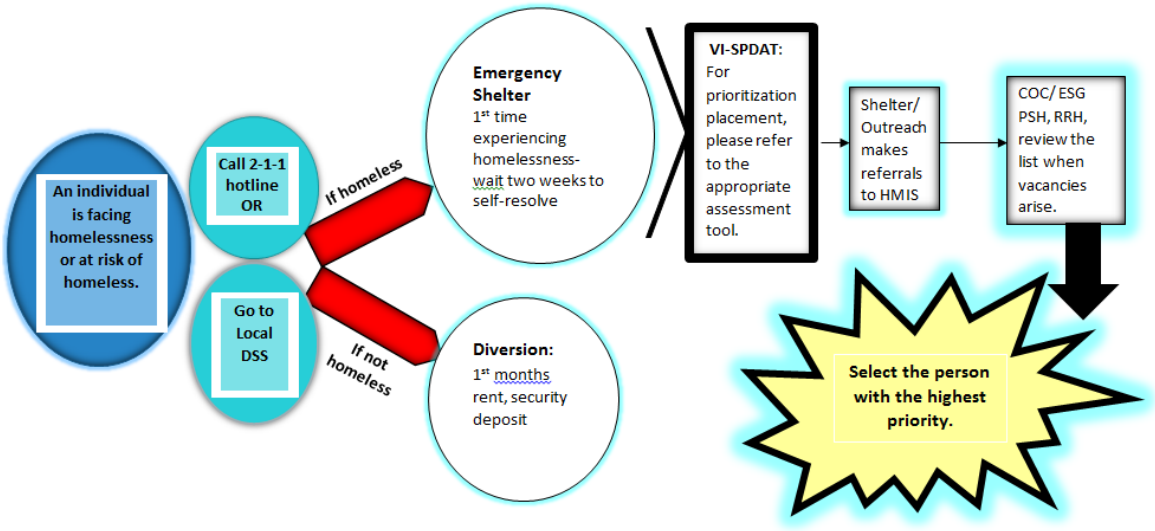
Coordinated Entry Evaluation and Stakeholder Consultation

The CoC Collaborative Applicant will evaluate the Coordinated Entry process annually as part of the CoC's Gaps & Needs Annual Survey. This is conducted every Spring and surveys will be distributed to current individuals and families that have been housed through the Coordinated Entry system within the last year. This will be a representative sample of participating providers and households. The participants will be randomly selected via HMIS by the Collaborative Applicant and 5 individuals or families per program will be selected to be surveyed. If an individual or family is not willing to participate, a new individual or family will be selected via HMIS. The Collaborative Applicant will facilitate their participation via the Performance Specialist. The feedback that is received will be anonymously presented to the Coordinated Entry Workgroup, the HHC Advisory Board and the HHC General Body to ensure changes are made to the process if possible.

Components of the Coordinated Entry System

Access Points – The coordinated entry system serves the entire geographic area of Onondaga, Oswego and Cayuga Counties through multiple access points for families and individuals seeking housing and services.

County	Entry Point	Hours of Operation
Onondaga County	**Onondaga County Department of Social Services** **Contact 2-1-1** **Vera House Crisis line** **Outreach**	**M-F 8am to 4pm** **24/ 7 Access; Shelter placement after hours and referrals.** **24/ 7 Access** **5 to 6 days a week and via Contact 2-1-1**
Oswego County	**Oswego County Department of Social Services** **Contact 2-1-1**	**M-F 8am to 4pm** **24/ 7 Access; Shelter placement after hours (M-F after 4:30pm and weekends)**
Cayuga County	**Cayuga County Department of Social Services** **Finger Lakes 2-1-1**	**24/7 and has an after hours line for shelter referrals** **24/ 7 Access to provide referrals and DSS After hours line for shelter**



The Local Department of Social Services is the primary contact during business hours to receive shelter services and to be assessed to determine whether shelter services are necessary for individuals and families (shelter diversion). In Onondaga and Oswego County, Contact Community Services is responsible for the 2-1-1 system whereby individuals contact this line for after-hours shelter services and shelter diversion – www.211cny.com. In Cayuga County, the after-hours line is through DSS. Fingerlakes 211 will refer callers back to Cayuga DSS.

All CoC and ESG programs have their intake paperwork on the HHC website (www.hhccny.org) to help shelters provide quicker referrals and easier access to these forms. Program directors will provide updated intake paperwork when it becomes available.

Street Outreach providers will offer shelter options to all individuals and families experiencing homelessness in places not meant for human habitation. If an individual or family refuses shelter, all street outreach providers are required to assess persons found in places not meant for human habitation using the assessment tool per the local ESG funding requirements. Outreach providers will use hard copy forms of the VI-SPDAT and work with the individuals to complete the assessment using a client centered approach to meet them where they are at, meaning literally on the streets. Once assessed, the VI-SPDAT assessment will be entered into HMIS and the person will be referred to housing on the HMIS referral list. The street outreach worker will continue to work with their client to make other referrals for additional services as needed and to follow up on any documentation or other requirements the housing providers need to accept their client into their project.

All emergency shelter providers are required to assess persons in shelter using the assessment tools, per the Local Department of Social Services Per Diem Shelter Contracts, if they have been in shelter for two weeks or more and this is their first experience of homelessness. If this shelter stay is a return to homelessness, the shelter provider must assess the resident(s) and work with the resident to make other referrals for additional services as needed and to follow up on any documentation or other requirements the housing providers need to accept their client into the project. The coordinated entry

system is publically advertised through community websites (2-1-1, HHC, Local DSSs, local Agencies), community outreach, local press via interviews, and social media (Facebook and Twitter). The broad advertisement of the system ensures that all people within the CoC in need of homeless services will have fair and equal access to the system regardless of where or how the household presents at any entry point. Street outreach ensures that people who are sleeping on the streets are equally prioritized for assistance as anyone else presenting with service needs.

Assessment Tool

All coordinated entry locations offer the same assessment approach and referrals using transparent and uniform decision-making processes. The Vulnerability Index Service Prioritization Decision Assistance Tool (VI-SPDAT) developed by OrgCode Consulting has been approved by the CoC and will be the coordinated entry tool for single individuals, including the chronically homeless and will be used by all projects that are dedicated or prioritized for the chronically homeless. The Family SPDAT (F-SPDAT) developed by OrgCode Consulting has been approved by the CoC and will be the coordinated entry tool for families who are experiencing homelessness. The Transition Aged Youth SPDAT (TAY-SPDAT) developed by OrgCode Consulting has been approved by the CoC and will be the coordinated entry tool for unaccompanied youth (24 and under) who are experiencing homelessness. For purposes of this document, the written standards will use the term “assess” or “assessment” which will refer to these tools and will specify the types of tools as needed. All shelter and street outreach providers are responsible for conducting these assessments and entering them in to HMIS.

Referrals

The CoC has developed one streamlined waitlist that can be found in the CoC’s HMIS: https://sp5.servicept.com/cnyhmis/com.bowmansystems.sp5.core.ServicePoint/index.html

Housing providers are required to review the HMIS referral list when there is an anticipated vacancy to immediately fill the bed with a new program participant. Housing providers are required to do this within one week of the anticipated vacancy. The housing provider must select the person with the longest length of homelessness with the highest service needs and the individual/family that fits the housing project’s eligibility requirements (i.e. an adult cannot be accepted for a project that only accepts unaccompanied youth).

HHC staff emails the de-identified by name list out weekly to the Coordinated Entry Workgroup. This group consists of HMIS providers of Outreach, Emergency Shelters, Transitional Housing, Rapid Rehousing, Permanent Supportive Housing, Department of Social Services (DSS), Contact 2-1-1, and the local correctional facilities, along with non-HMIS Providers, such as the Veterans Administration and Domestic Violence/ Victim Service Providers, and meets to discuss how to move shelter residents and unsheltered people into our PSH/TH/RRH programs and updating Coordinated Entry Policies and Procedures.

Projects will no longer carry their own independent waitlist as this has the potential to create “cherry-picking” and “side doors” to housing that more vulnerable individuals and families could have benefitted from. (Page 10 of CPD-17-01 – By-Name List).

Acceptance/Rejection Policy- Housing Provider

Housing Providers can only reject a referral that matches their program eligibility requirements for the following reasons: the client is a danger to themselves or others or client has previously been unsuccessful in the agency's housing project. These decisions will be documented in HMIS and securely communicated to the HHC Performance Specialist via email with the reasons as to why the housing provider is not accepting the client. If a client is rejected due to safety concerns, the client will be added to the case conferencing discussion during the Coordinated Entry Workgroup meeting.

Acceptance/Rejection Policy- Client

Should a housing provider select an individual or family off of the prioritization list that family can then choose to accept or reject that housing option. Should the individual or family decide to reject the housing provider, the original provider will then select the next individual or family from the list by following the prioritization process listed in this policy. If an individual or family rejects multiple housing provider placements the Coordinated Entry Workgroup will review the case and discuss reasons for rejections in order to come up with alternative housing solutions. If an individual or family consistently rejects housing placements, they will be re-engaged by street outreach and shelter caseworkers on a bi-weekly basis to offer housing. These attempts will be documented in HMIS.

The two policies above will be monitored by the Performance Specialist of the HHC and they will communicate any issues or concerns to the agency in question. These matters will be reviewed and reported annually to the Program/ Advocacy Committee and to the Coordinated Entry Workgroup.

In an effort to ensure that Individuals/households are not on the waitlist for longer than 90 days, these individuals and families will be prioritized for case conferencing during the Coordinated Entry Workgroup meetings. If an individual or household is on the list for more than 90 days, the HHC will communicate with the shelter/street outreach provider to get the individual or family connected with another resource outside of CoC or ESG funded providers.

After an individual or family has been accepted into a program but before an appropriate unit has been identified, a household may stay with a friend or family, hotel or motel, or transitional housing bed without losing their eligibility for the permanent supportive housing program in which they have already been accepted. The permanent supportive housing program should continue working to decrease the length of time it takes to locate and house a program participant in a permanent supportive housing unit. Programs should follow a Housing First approach and establish policies and procedures that reduce barriers to obtaining a unit and reduce the amount of time households wait for units. This could include strategies such as identifying landlords who are willing to work with the recipient, inspecting units for Housing Quality Standards in advance of a household being shown the unit, and identifying landlords who are willing to rent units already in compliance with HUD's standards of Fair Market Rent and rent reasonableness.

Should an individual/household be housed via a non-ESG/CoC funded project or subsidized housing provider they should be taken off of the list by the Emergency Shelter/ Street Outreach provider who made the referral. An individual/household should be taken off of the list if there is no contact or shelter stay for a period of more than 90 days. Street outreach and shelter providers should continue to make attempts to engage those persons that have been resistant to accepting an offer of housing (PSH,

RRH & TH) and these individuals and families must continue to be prioritized until they are housed. If a client disappears that is next on the list and is no longer in shelter, the housing provider will hold that bed while the shelter or street outreach staff attempt to make contact with that client for up to two weeks. If there has been no contact made, the housing provider can then move on to the next eligible person on the list. If the person re-appears then they will be eligible for the next housing placement that opens up.

Participants who have already been enrolled in a program and moved into their apartment will retain their apartment unless it has been vacated without notice for more than 30 days.

Grievance Policy

The HHC will respond to grievances regarding Coordinated Entry in the following manner, depending on the nature of the concern or grievance.

A. Housing Program Grievance- Grievances about rejections from homeless housing programs will be redirected back to the program to follow grievance policies and procedures of that organization. Agencies should maintain internal documentation of all complaints received. If a client is not satisfied with the housing program's response to the grievance, they can contact the HHC staff to request that the HHC review the grievance, and if needed, enter into discussion with the housing provider. Requests may be made by telephone or in writing.
B. Fair Housing Grievance- Grievance about a participating program's screening or program participation practices which appear to have a discriminatory impact: Contact CNY Fair Housing. More information at: http://cnyfairhousing.org/
C. Program Grievance- Grievances about HHC Coordinated Entry policies and procedures should be sent to the HHC staff. A grievance is an expression of dissatisfaction about any aspect of the Coordinated Entry service delivery. It is an informal process that can be initiated by telephone or in writing. Upon receipt of the complaint, if possible, HHC staff will address the grievance. If the grievance cannot be resolved by HHC staff, the grievance will brought to the attention of the Governance Committee.

Coordinated Entry Workgroup

The Coordinated Entry Workgroup covers the entire CoC geographic region (Onondaga, Oswego and Cayuga Counties) and is primarily comprised of shelter discharge planners, permanent housing intake workers, street outreach providers and LDSS/211 staff. Agency staff determines participation based upon a list of clients that are sent out monthly by the CoC. The group meets monthly and works to case conference clients who:

a. Return to the list (i.e. return to homelessness)
b. Refuse to do VI-SPDAT
c. Are on the list for longer than 90 days
d. Are in permanent housing programs and are close to being evicted
e. Potential PSH project transfers
f. Clients refusing multiple housing placement options

Coordinated Entry Eligibility and Prioritization

Permanent Supportive Housing Eligibility

For permanent supportive housing programs, households must meet the HUD definition of homelessness under Category I or IV, and have a disability. Households are then prioritized by the CoC's written standards. Programs may not establish additional eligibility requirements beyond those specified in Category I or IV and those required by funders.

Rapid Re-Housing Eligibility

For CoC rapid re-housing programs, households must meet the HUD definition of homelessness under Category I or IV. Programs may not establish additional eligibility requirements beyond those specified in Categories I and IV and those required by funders.

For ESG rapid re-housing programs, households must meet the HUD definition of homelessness under Category I. Programs may not establish additional eligibility requirements beyond those specified in Category I and those required by funders.

Prioritization Criteria

The CoC will follow the following order of prioritization for filling vacancies in **PSH and RRH projects:**

1. Chronically homeless individuals and families with the longest histories of homelessness and any SPDAT score of 8 or above. Longest history of homelessness is measured by total cumulative months homeless.
2. All other chronically homeless individuals and families with a SPDAT score of 8 or below.
3. Homeless individuals and families with a disability with the most severe service needs, evidenced by their assessment score on their respective SPDAT
4. Homeless individuals and families with the longest periods of continuous or episodic homelessness
5. Homeless individuals and families coming from places not meant for human habitation

Tie Breakers:

1. An individual or family who is living in an unsheltered location during Code Blue
2. Veteran status

Prioritization example:

An individual or family with cumulatively 20 months of homelessness with a SPDAT score of 10 will be prioritized over a family with cumulatively 12 months of homelessness with a SPDAT score of 14.

The CoC will follow the following order of prioritization for filling vacancies in the **Supplemental ESG Year 43 projects:**

1. Literally homeless individuals and families with a VI-SPDAT score for individuals or F-SPDAT score for families of 7 or less with the longest length of stay in shelter.

2. Families with a F-SPDAT score of 7 or less.
3. Individuals with a VI-SPDAT score of 7 or less.

Tie Breakers:

1. An individual or family who is living in an unsheltered location during Code Blue
2. Veteran Status
3. Households with a housing option identified
4. Individuals or families fleeing domestic violence

Supplemental ESG for Year 43 provides a very limited amount of rental assistance and is a temporary program running from July 2018 to April 2019. Because of its temporary nature, the funds will be used to target individuals and families on the Coordinated Entry list who will be successfully stable with a very limited amount of rental assistance.

Veteran Services

Every person who enters shelter, is met outdoors from street outreach, enters DSS, calls 211CNY is asked if they have ever served in the military and if so, they are asked to sign a release of information for these entities to communicate with the VA. The shelter or outreach worker refers to the SSVF Outreach Case Worker or Healthcare for Homeless Veterans (HCHV) Outreach Social Worker, who then determines veteran status by requesting a DD-214, using the SQUARES system, or using the VA's database. The shelter/outreach staff does an assessment of that veteran's vulnerability by completing the Vi-SPDAT and makes a referral to the Coordinated Entry list. SSVF will accept the referral off of the Coordinated Entry list if the individual qualifies for their RRH program. HCHV staff, SSVF staff, and shelter case workers meet on a weekly basis to discuss the by-name list of veterans currently residing in emergency shelter. Veterans who are on Coordinated Entry are able to access VA programs through this case conferencing meeting.

The VA also receives referrals through the National Hotline for Homeless Veterans. They also assess need for shelter services or housing. They do provide referrals outside of the Coordinated Entry system, but also send clients to our Shelter Services or via SSVF providers, who will enter the data into HMIS, will assess clients for level of vulnerability using the VI-SPDAT and also send referrals to the Coordinated Entry list.

Homeless Prevention

Financial Assistance and Case Management

At the time that a person who is experiencing homelessness or at risk of homelessness apply for assistance, s/he is also screened for eligibility into other welfare and assistance programs, such as the Supplemental Nutrition Assistance Program, Temporary Assistance and other financial assistance programs.

The CoC's Local Departments of Social Services (LDSS) provide many aid programs that assist county residents in staying in their own home and thus serves as the first point of access for homelessness

prevention services. Other best practices, such as attempting diversion from the homeless shelters, have been standard practice at LDSS for many years.

County ESG funds prevention programs in Onondaga County focusing on those facing issues such as eviction, including back rent and security deposits. Onondaga County Department of Social Service – Economic Security is required to conduct face-to-face interviews before, or within 24 hours, clients are placed into shelters which have proven effective in diverting people from shelters.

The following programs are dedicated to homeless prevention in the CoC:

1. Catholic Charities Homeless Prevention Programs (ESG & Homeward Connection) - Provides case management and homeless prevention services to individuals and families in Onondaga County
2. Catholic Charities SSVF Homeless Prevention Services- Provides case management and homeless prevention services to Veterans and their families in Onondaga County
3. Soldier On SSVF Homeless Prevention – provides case management and homeless prevention services to Veterans and their families in Onondaga, Oswego and Cayuga Counties.
4. The Salvation Army STEHP Homeless Prevention Program – Provides case management and homeless prevention services to individuals and families in Onondaga County
5. AmeriCorps - Provides case management services to people in Oswego County. Volunteers are located at each one of the agencies listed above to provide direct services to homeless consumers. Clients must be TANF eligible and services provided include security deposits, back rent payments, and mattresses funded by FFFS wrap-around funding.
6. Oswego County Opportunities STEHP
7. Oswego County DSS
8. Catholic Charities
9. Oswego County Probation
10. Cayuga County Homsite Development Corporation –renter counseling to prevent eviction
11. Options for Independence – provides a self-sufficiency program for individuals and families with disabilities in Cayuga County who are experiencing homelessness upon intake to the program in addition to case management and housing subsidies.
12. Unity House – provides rental assistance, security deposits, utility stipends, case management, budgeting and assistance with landlord relationships to individuals with mental illnesses in Cayuga County
13. Cayuga Seneca Community Action Agency

Homeless Prevention Legal Services

1. Volunteer Lawyers Project - This agency provides homeless prevention services through our Eviction Court in Syracuse, NY, and these are same day services. They are identified, served, and exited on most occasions within the same day. This agency also provides legal services to our clients while in our Emergency Shelters who need legal advice on a variety of issues surrounding criminal, family, and other areas of law.
2. Legal Aid Society of Mid New York and Legal Services of CNY - Provides Civil Legal services to eligible residents of Onondaga, Oswego, and Cayuga County who are unable to afford private

counsel. Services include: legal advice and representation on landlord/tenant problems such as evictions, housing discrimination, and foreclosures.

3. Frank H. Hiscock Legal Aid Society - Provides Civil Legal services to eligible residents of Onondaga County who are unable to afford private counsel. Services include: legal advice and representation on landlord/tenant problems such as evictions, housing discrimination, and foreclosures. Legal Services of Central New York

Emergency Shelters

The Emergency Shelter System in the CoC is currently composed of **11 providers; a total of 505 year round beds.** Placements can also be made at LDSS contracted hotels/motels if there is no appropriate shelter available. The level of support services available to participants varies greatly from program to program. The length of stay is generally expected to be less than 30 days; extensions may be granted at some shelters in some circumstances.

Access to Emergency Shelter: Information on how to access Emergency Shelter is available 24 hours a day/7 days a week:

Onondaga County Emergency Shelter Access

People experiencing homelessness access shelter programs by:

- Going directly to Onondaga Department of Social Services (DSS) during regular business hours (8AM – 4PM)
- Calling 2-1-1
- Vera House Crisis and Support line – 315-468-3260 (primarily for domestic and sexual violence, but can assist in other matters)
- Syracuse Booth House (Youth) – 1-800-660-6999

Currently, there is "no wrong door" (multiple entry points) into the emergency shelter system. The largest single point of entry is the Onondaga County Department of Social Services – Economic Security (DSS-ES). People experiencing homelessness or at risk of homelessness must be approved for placement by DSS before entering the program. To be obtained in the following ways:

- Person(s) experiencing homelessness must go to the 2nd floor of the Civic Center, located at 421 Montgomery Street between 8AM and 4PM and be screened for eligibility by the Emergency Housing unit.
- You may call the DSS Call Center at 315-435-2700 for information during business hours.
- After hours, weekend and holiday placements can be made by calling 211. For all callers seeking shelter 2-1-1 completes a Homeless Assessment form to determine eligibility. If person/household is eligible for and determined to be in need of shelter services the staff refer them to the appropriate shelter that has space available (M, F, SFHC, HC). If The Salvation Army Emergency Family shelter does not have space available the staff at the shelter will arrange for the family to be placed in a motel. All clients who have been referred to a shelter or motel after house need to report to DSS the following day.

- If determined to be eligible, a placement will be made at one of the emergency shelters or a hotel/motel placement can be made if an appropriate shelter bed(s) is not available.
- While in shelter the participant must fulfill all DSS requirements provided to them in writing; i.e. – housing search, getting additional documentation for public benefits eligibility determination, etc.
- If transportation is an issue, 2-1-1 can provide transportation to the shelter/motel.
- If denied an emergency shelter placement or placement is terminated before permanent housing is accessed, a fair hearing may be requested by calling the Fair Hearing Unit at 315-435-2585 or toll-free 1800-342-3334.

Emergency shelters include: Catholic Charities Men's Shelter, Catholic Charities Dorothy Day House, The Salvation Army Emergency Family Shelter, The Salvation Army Women's Shelter, The Salvation Army Barnabas Shelter, The Salvation Army Booth House, Rescue Mission Transformations and Vera House Emergency Shelter (DV only).

Oswego County Emergency Shelter Access

There is currently no emergency shelter located in Oswego County with the exception of a domestic violence shelter for women and children and the Youth Shelter (16-20 years old). Oswego County DSS is located at 100 Spring Street in Mexico, NY. People who go to Oswego DSS and are eligible for emergency shelter will be placed into hotel/motels, rooming houses, SAF shelter for victims of domestic or sexual violence, or host homes for youth under age 21. Homeless persons access these programs by:

- Going directly to DSS during business hours (M-F, 8am to 4pm)
- Calling 2-1-1

After hours, weekend and holiday placements are determined through an eligibility assessment and may be made by calling 2-1-1 CNY. For all callers seeking shelter 2-1-1 completes a Homeless Assessment form to determine eligibility. If person/household is eligible for shelter and is a female in a domestic violence situation 2-1-1 staff call Oswego County Opportunities SAF shelter to refer them to shelter. If there is a youth age 16 to 20 staff call Oswego County Opportunities Draper Street Shelter and make a referral. If there are no vacancies or if the person/household calling does not fit those two population types the 2-1-1 staff complete a Motel Assessment form and refer the individual/ household to the motel closest to their location. 2-1-1 does not provide transportation to the motel or shelter.

Cayuga County Emergency Shelter Access

The only emergency shelter located in Cayuga County is Chapel House for single men with the exception of Cayuga Seneca Community Action Agency, which is a domestic violence shelter for women and children. Cayuga County DSS is located at 160 Genesee St, Auburn, NY 13021. People who go to Cayuga DSS and are eligible for emergency shelter will be placed into hotels/motels. People experiencing homelessness may access these programs by:

- Going directly to DSS

- Calling DSS after-hours: 315-255-6272
- Cayuga Seneca Community Action Agency – 315-255-6221 (primarily for domestic and sexual violence)
- Calling Finger Lakes 211

Permanent Supportive Housing

There are 1,411 Permanent Supportive Housing (PSH) beds funded by the CoC, in which 127 are dedicated to chronically homeless which is 9% of the total PSH units. All non-dedicated chronically homeless PSH projects have committed to prioritize 100% of their turnover beds to serve chronically homeless clients.

There are several non-CoC funded PSH programs. These include ACR Health HOPWA, Rescue Mission Gifford Place Independent Living Program, YMCA, CNY Services The Hawthorne & Susan's Place TH, HUD VASH for veterans, Oswego County Opportunities Backstreet Apartments, and Oswego County OMH Division of Mental Hygiene Supported Housing. Many of these programs have separate eligibility requirements.

Rapid Rehousing

There are currently a total 215 Rapid Rehousing beds funded in this CoC through Catholic Charities (ESG & CoC funded), The Salvation Army HALE program (CoC and ESG Funded) and Barnabas RRH for youth, ACR Health RRH for LGBT Youth (can accept non-LGBT youth if there are no LGBT youth currently experiencing homelessness), Syracuse Behavioral Healthcare RRH for individuals, Oswego County Opportunities, and Cayuga Seneca Community Action Agency.

Prior to rental assistance, the apartment must pass the necessary inspections (habitability, and visual lead for families & pregnant individuals) and a one year lease must be provided. The rent for the apartment must also be within Rent Reasonableness Guidelines and not exceed the Short to Medium Term financial/rental assistance may be provided. Amounts may vary depending on household need. The following percentage is based on the client responsible rent, which is the actual rent minus rental allowance that the Department of Social Service provides, if there is any. The length of rental assistance should be determined by the client's need and should not be longer than 24 months with an additional 6 months of case management supportive services. The percentage of rent will be scaled if client and caseworkers determine that a briefer stay is more appropriate. The client portion does not exceed 30% of their income. A household's eligibility for this program cannot exceed 24 months.

Transitional Housing (non-youth)

There is no longer any transitional housing funded by the CoC. There are several non-CoC Transitional Housing Programs in Onondaga County: Chadwick Residence, Rescue Mission Willing to Work, The Salvation Army Women's Shelter Apartment, YMCA Residence and the YWCA Transitional Residence.

The Veterans Administration has the Veterans Grant Per Diem (GPD) program for transitional housing for Veterans.

Oswego County Opportunities has Mental Health Transitional Living (MHTL), Arbor House Community Residence and the Supportive Living Program for people with substance use disorders and SAF program for people fleeing domestic violence.

The Auburn Rescue Mission has transitional housing for families. Cayuga-Seneca Community Action Agency has transitional housing for people fleeing domestic violence.

Individuals or families must meet the HUD homeless definition to be eligible for many of these programs.

Transitional Housing for Youth

Program Summary and Eligibility:

As previously mentioned, there are no longer any transitional housing funded by the CoC. The Salvation Army Syracuse Area Services has two transitional housing programs for youth, one of which is a pregnant and parenting program, which are all ESG funded and Oswego County Opportunities PATH program for homeless youth. Cayuga Seneca Community Action Agency has one transitional housing program for youth.

Mainstream Resources

The HHC has a vast membership list and has many dedicated community partners who are engaged in the process to end homelessness in the Continuum of Care. The HHC works daily on building and preserving these partnerships in an effort to ensure people are getting housed and maintaining their housing and overall well-being. For instance, the HHC connected to the local Workforce Investment Opportunity Act (WIOA) program, CNY Works, to ensure rapid rehousing providers are connecting their participants to job training programs and other services that this program offers.

The local justice system is in HMIS and is having conversations with shelters and the HHC regarding which clients will be released from prison and what are the next steps to getting them housed.

The HHC is also working with the local Public Housing Authority (PHAs) on moving out of PSH to get PSH participants connected to a housing voucher if they no longer require supportive housing as to fill that PSH opening for someone residing in shelter or on the streets.

There are many other initiatives that the HHC is actively working on in order to incorporate mainstream services into the coordinated entry process as well as the overall process to ending homelessness in the community. The HHC will communicate these initiatives at the monthly general meeting as well as in committee meetings and update this policy and procedure manual should any of these initiatives be relevant to Coordinated Entry.

Onondaga County Single Point of Access (SPOA)

The Onondaga County Department of Adult and Long Term Care Services (DALTC), has a New York State Office of Mental Health (OMH) funded SPOA process to determine eligibility and prioritize access to specific OMH high end services reserved for OMH priority high need individuals. Services accessed through SPOA are: OMH licensed congregate residential and apartment treatment, OMH certified supportive housing, Assertive Community Treatment (ACT Team), Forensic Enhanced Services/Case Management, and non-Medicaid care management.

SPOA has provided a brief "Optional SPOA Eligibility Screening Form" for use by shelter and non-clinical staff, to clarify when a SPOA application is needed.

Onondaga County SPOA for adults participates with the Coordinated Entry Committee, and the Outreach Committee. The SPOA Coordinator does in reach at HPC when a patient is exercising their civil rights and is insisting on being discharged to homelessness. The SPOA coordinator attempts to engage hospitalized clients to prevent them from discharging to homelessness.

Applicants not eligible for OMH SPOA programs are redirected to alternate providers. For housing programs which are jointly funded by both OMH and HUD, SPOA assures that the applicant meets the OMH priority criteria, and the housing provider is responsible for determining HUD/CoC priority level via the Coordinated Entry process and assessment score.

Definitions

HUD Chronic Homeless Definition:

For all dedicated/prioritized chronically homeless units, participants must meet the chronically homeless definition as stated in Definition of Chronically Homeless final rule which is:

(a) A "homeless individual with a disability," as defined in section 401(9) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who:

i. lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

ii. Has been homeless and living as described in paragraph (a)(i) continuously for at least 12 months or on at least four separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (a)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering an institutional care facility;

(b) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (a) of this definition, before entering the facility;

i. A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (a) or (b) of this definition (as described in Section I.D.2. (a) of this Notice), including a family whose composition has fluctuated while the head of household has been homeless.

If an individual or family refuses to participate in the Coordinated Entry process (answer the VI-SPDAT assessment question, engage with housing providers, etc.) they can still be prioritized in the Coordinated Entry List. They would be prioritized based upon the orders of priority list; length of time homeless, veteran status, etc. This decision for prioritization will be the responsibility of the Coordinated Entry Committee.

The HUD Chronic Homelessness Final Rule can be found online:
https://www.hudexchange.info/resources/documents/Defining-Chronically-Homeless-Final-Rule.pdf

HUD Homeless Definition:

(1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or a place not meant for human habitation immediately before entering that institution;

(2) Individuals and families who will imminently lose their primary nighttime residence;

(3) Unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; or

(4) Individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

The HUD Homeless Definition with recordkeeping requirements can be found here:
https://www.hudexchange.info/resources/documents/HomelessDefEligibility%20_SHP_SPC_ESG.pdf

For all non-dedicated/prioritized CH PSH/TH units that are CoC and ESG funded, participants must meet the homeless definition and have a disability.

Severity of Needs:

Units will be prioritized for people meeting the chronic homeless definition or participants with the highest severity of service needs which means an individual for whom at least one of the following is true:

i. History of high utilization of crisis services, which include but are not limited to, emergency rooms, jails, and psychiatric facilities; and/or

ii. Significant health or behavioral health challenges, substance use disorders, or functional impairments which require a significant level of support in order to maintain permanent housing.

iii. For youth and victims of domestic violence, high risk of continued trauma or high risk of harm or exposure to very dangerous living situations.

This Severity of Needs criteria is a directive by HUD Notice CPD 16-11 titled Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing dated July 25, 2016 can be found online: https://www.hudexchange.info/resources/documents/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh.pdf

Continuum of Care Written Standard for NY-505

Authorization Memorandum – CoC Membership

I have carefully assessed the Continuum of Care Written Standard for NY-505 for the Syracuse/Onondaga, Auburn/Cayuga, and Oswego Continuum of Care (CoC).

I accept the Standards as reasonable expectations for Coordinated Entry Process regarding the Syracuse/Onondaga, Auburn/Cayuga, and Oswego CoC's designated Coordinated Entry Policies and Procedures and support the adoption of this Standard.

_____

NY-505 Participating Agency

_____	_____
Agency Representative (Print Name)	Representative's Title
_____	_____
Signature	Date

SPARC
an initiative of
Center for Social Innovation

SUPPORTING PARTNERSHIPS FOR ANTI-RACIST COMMUNITIES

SYRACUSE NEW YORK

WHY SPARC?

The Center for Social Innovation launched Supporting Partnerships for Anti-Racist Communities (SPARC) in 2016 in response to the overwhelming evidence that people of color were dramatically overrepresented in the nation's homeless population—across the country and regardless of jurisdiction.

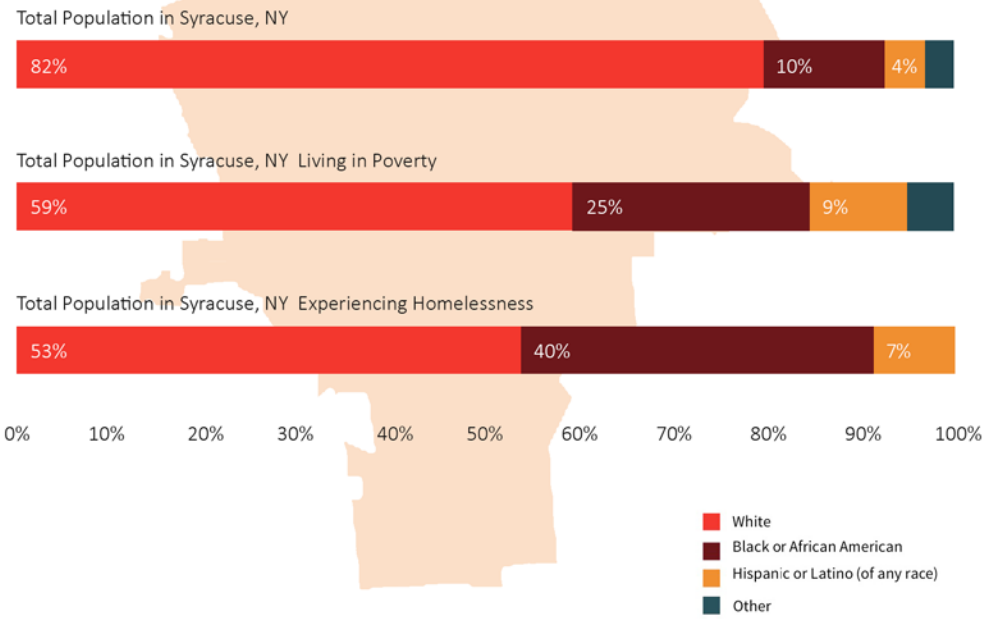
In March 2017, The Center for Social Innovation partnered with The Housing and Homeless Coalition of Central New York (HHC) and other service providers in Syracuse to collect qualitative and quantitative data to examine the racial dimensions of homelessness in the area. This document is a distilled report presenting preliminary findings and initial recommendations.

3 STRUCTURAL CHANGE OBJECTIVES

for our work to address racial inequity in the homelessness response system in Syracuse, New York

- **Implementation of trauma-informed care and anti-racism** at the policy and practice levels.
- **Staff diversity and inclusion,** with careful attention to increasing the number of senior managers of color.
- **Promoting housing quality,** including improving the current stock of affordable housing.

EXAMINING HOMELESSNESS BY COLOR IN SYRACUSE



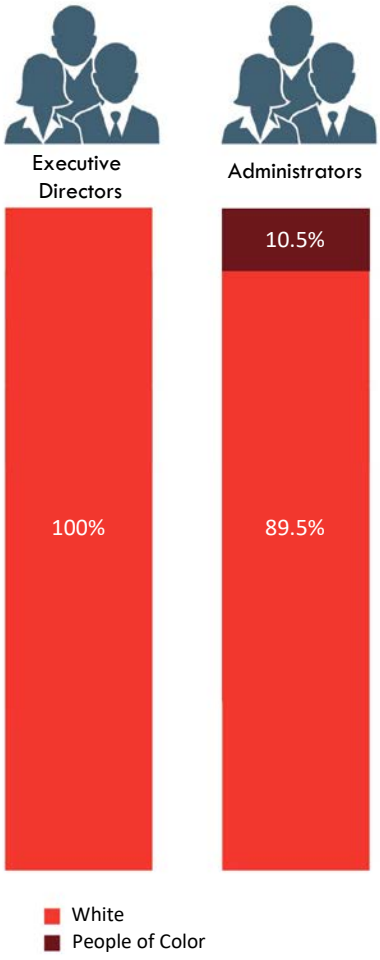
DATA COLLECTION INCLUDED:

- HMIS data from fiscal years 2011 to 2016.
- Qualitative research, including 26 individual interviews with people of color experiencing homelessness and 3 focus groups of providers, stakeholders, and consumers.
- An online demographic survey of homeless service providers.

HOMELESSNESS SERVICE PROVISION

Through an online survey, data was collected on the background of providers working in homelessness response programs and their self-reported desires for professional development. The findings were:

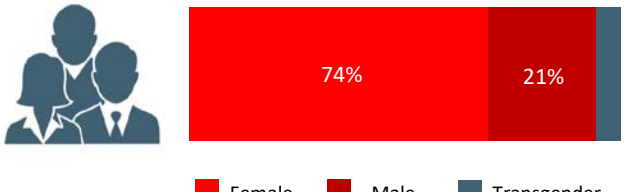
- The vast majority of surveyed service providers identified as White and Non-Hispanic or Latinx. 100% of Executive Directors and nearly 90% of Administrators identified as White.
- About three fourths (74.2%) identified as female, 21.0% as male; 3.2% identified as other, transgender or genderqueer.
- Among all respondents, Black and White individuals reported similar educational background; with 33.3% and 39.2%, respectively, holding Master's degrees.

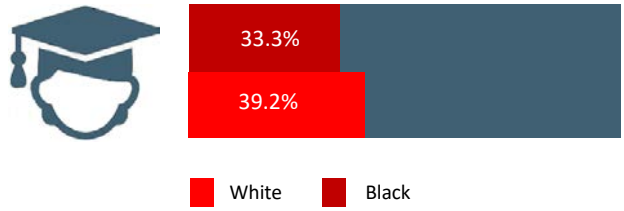


STAFF EXPERIENCE WITH OWN HOMELESSNESS

Over twenty percent (22.6%) of respondents reported their own experience with homelessness.

In order to protect anonymity on this sensitive question, results are not presented by race.





THE SURVEY SUGGESTS THERE IS A SIGNIFICANT UNDERREPRESENTATION OF PEOPLE OF COLOR IN SENIOR-LEVEL POSITIONS, AND PEOPLE OF COLOR MAY NOT BE PROMOTED OR HIRED TO SENIOR MANAGEMENT AT THE SAME RATE AS THEY ARE HIRED TO WORK THE FRONTLINE.

SYRACUSE NEW YORK

SUMMARY OF QUALITATIVE FINDINGS

SPARC
an initiative of
Center for Social Innovation

PATHWAYS INTO HOMELESSNESS

- NETWORK IMPOVERISHMENT - There is no extra money anywhere in a respondent's social network.
- ECONOMIC MOBILITY - Respondents do not have difficulty finding jobs, but cannot secure jobs with adequate wages.
- FAMILY DESTABILIZATION - Families faced significant psychosocial stressors associated with poverty, substance use and mental illness, child welfare involvement, criminal justice involvement, and trauma.
- BEHAVIORAL HEALTH ISSUES - Instability and trauma correlate with substance use issues.
- VIOLENCE - Women frequently had histories of intimate partner violence (IPV) connected to their pathways into homelessness.

> "It's like you look at your parents' faces and it's like you see the hurt. It's like she doesn't know what else to do. She can't really feed her kids like she needs to, properly. So, me being the oldest, um, I'm watching the streets. I took to the streets like fish take to water."

> "What kind of place can I get with that kind of rent ($300) but somewhere in the projects, somewhere in a drug infested area, you know, crime all around. I'm on parole. Why would I want to be somewhere where the chances of me having police contact is greater? So, you putting– you're not even giving me a chance or an opportunity to succeed."

BARRIERS TO EXITING HOMELESSNESS

- CRIMINAL JUSTICE SYSTEM INVOLVEMENT - Criminal records limit housing and employment options.
- QUALITY AFFORDABLE HOUSING - Frustration at high rents for low quality housing was very common among participants.
- TRANSPORTATION - Respondents lacked extra money for transportation costs and cited a disconnect between affordable neighborhoods and job location.
- NAVIGATING THE SYSTEM - Many respondents felt the system was strapped for resources and designed to be difficult, and as result felt they had to strategize where they sought services and how they presented themselves to providers.

RECOMMENDATIONS

SPARC
an initiative of
Center for Social Innovation

There are numerous actions that Syracuse, led by HHC, can take now and plan to take in the future. SPARC's recommendations include:

1. **Design an equitable Coordinated Entry System.**
2. **Include racial equity data analysis and benchmarks in strategic planning.**
3. **Support organizational development**
   - Encourage anti-racist program delivery
   - Promote ongoing anti-racism training
   - Incorporate racial equity into grantmaking and contracting
4. **Collaborate to increase affordable housing availability**
5. **Investigate flexible subsidies**
6. **Innovative upstream interventions**

GLOSSARY OF TERMS:

As established by the: Center for Social Innovation

- **EQUITY** — A state in which belonging to a particular social group does not determine success, and where all groups have access to the resources and opportunities necessary to eliminate gaps and improve the quality of their lives

- **STRUCTURAL RACISM** — A system by which public polices, institutional practices, cultural representations, and other norms work in various, and often reinforcing ways, to perpetuate power disparities based on race. It involves the cumulative effects of history, culture and ideology, and it systematically privileges White people and disadvantages people of color, in ways that allows it to persist and adapt over time.

- **RACIAL EQUITY LENS** — A way of viewing the world through an understanding of systemic racism, and a recognition that equity for all cannot be achieved without simultaneous work to dismantle racism.