Before Starting the CoC Application

You must submit all three of the following parts in order for us to consider your Consolidated Application complete:

1. the CoC Application,
2. the CoC Priority Listing, and
3. all the CoC's project applications that were either approved and ranked, or rejected.

As the Collaborative Applicant, you are responsible for reviewing the following:

1. The FY 2021 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2021 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.

Your CoC Must Approve the Consolidated Application before You Submit It

- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2021 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

Answering Multi-Part Narrative Questions

Many questions require you to address multiple elements in a single text box. Number your responses to correspond with multi-element questions using the same numbers in the question. This will help you organize your responses to ensure they are complete and help us to review and score your responses.

Attachments

Questions requiring attachments to receive points state, "You Must Upload an Attachment to the 4B. Attachments Screen." Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process. Include a cover page with the attachment name.

- Attachments must match the questions they are associated with–if we do not award points for evidence you upload and associate with the wrong question, this is not a valid reason for you to appeal HUD's funding determination.
- We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

1A. Continuum of Care (CoC) Identification

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

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. Coordination and Engagement–Inclusive Structure and Participation

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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1B-1.	**Inclusive Structure and Participation–Participation in Coordinated Entry.**	
	NOFO Sections VII.B.1.a.(1), VII.B.1.e., VII.B.1.n., and VII.B.1.p.	

	In the chart below for the period from May 1, 2020 to April 30, 2021:
1.	**select yes or no in the chart below if the entity listed participates in CoC meetings, voted–including selecting CoC Board members, and participated in your CoC's coordinated entry system; or**
2.	**select Nonexistent if the organization does not exist in your CoC's geographic area:**

	Organization/Person	Participated in CoC Meetings	Voted, Including Electing of CoC Board Members	Participated in CoC's Coordinated Entry System
1.	**Affordable Housing Developer(s)**	Yes	Yes	Yes
2.	**Agencies serving survivors of human trafficking**	Yes	Yes	Yes
3.	**CDBG/HOME/ESG Entitlement Jurisdiction**	Yes	Yes	Yes
4.	**CoC-Funded Victim Service Providers**	Yes	Yes	Yes
5.	**CoC-Funded Youth Homeless Organizations**	Yes	Yes	Yes
6.	**Disability Advocates**	Yes	Yes	No
7.	**Disability Service Organizations**	Yes	Yes	No
8.	**Domestic Violence Advocates**	Yes	Yes	Yes
9.	**EMS/Crisis Response Team(s)**	Yes	Yes	No
10.	**Homeless or Formerly Homeless Persons**	Yes	Yes	Yes
11.	**Hospital(s)**	Yes	No	Yes
12.	**Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)**	No	No	No
13.	**Law Enforcement**	Yes	No	Yes
14.	**Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates**	Yes	Yes	Yes
15.	**LGBT Service Organizations**	Yes	Yes	Yes
16.	**Local Government Staff/Officials**	Yes	Yes	No
17.	**Local Jail(s)**	Yes	No	No
18.	**Mental Health Service Organizations**	Yes	Yes	Yes

19.	**Mental Illness Advocates**	Yes	No	No
20.	**Non-CoC Funded Youth Homeless Organizations**	Yes	Yes	Yes
21.	**Non-CoC-Funded Victim Service Providers**	Nonexistent	No	No
22.	**Organizations led by and serving Black, Brown, Indigenous and other People of Color**	Yes	Yes	Yes
23.	**Organizations led by and serving LGBT persons**	Yes	No	No
24.	**Organizations led by and serving people with disabilities**	Nonexistent	No	No
25.	**Other homeless subpopulation advocates**	Nonexistent	No	No
26.	**Public Housing Authorities**	Yes	Yes	Yes
27.	**School Administrators/Homeless Liaisons**	Yes	No	Yes
28.	**Street Outreach Team(s)**	Yes	Yes	Yes
29.	**Substance Abuse Advocates**	Yes	Yes	No
30.	**Substance Abuse Service Organizations**	Yes	Yes	Yes
31.	**Youth Advocates**	Yes	Yes	No
32.	**Youth Service Providers**	Yes	Yes	Yes
	Other:(limit 50 characters)			
33.	Fair Housing Organizations	Yes	Yes	No
34.				

1B-2.	**Open Invitation for New Members.**	
	NOFO Section VII.B.1.a.(2)	

	Describe in the field below how your CoC:
1.	**communicated the invitation process annually to solicit new members to join the CoC;**
2.	**ensured effective communication with individuals with disabilities, including the availability of accessible electronic formats;**
3.	**conducted outreach to ensure persons experiencing homelessness or formerly homeless persons are encouraged to join your CoC; and**
4.	**invited organizations serving culturally specific communities experiencing homelessness in the geographic area to address equity (e.g., Black, Latino, Indigenous, persons with disabilities).**

(limit 2,000 characters)

1. The CoC holds its Annual Membership Meeting in June of each year. Leading up to that meeting, potential new members are solicited through a variety of methods including in the CoC's Weekly newsletter, communication via listserv, the CoC's website, and social media. The CoC also solicits and accepts new members year-round. The CoC staff also provide 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. An agency or individual wishing to obtain voting membership status would meet with the CoC staff or board members to encourage partnership.
2.CoC announcements are posted in PDF or DOCX format that include searchable and machine-readable text. In addition, the CoC's data dashboard was designed with a color scheme visible to people with color blindness. The CoC also has partnerships to translate documents to Braille if requested.
3. The CoC has approached all CoC and ESG funded agencies to identify project participants that would be interested in joining the CoC. The CoC also maintains a youth and an adult advisory board of people with lived experience. Both boards operate as official committees of the CoC and have active MOUs.

Current members of the lived experience boards have been successful in recruiting peers for both board and CoC membership. All members of the lived experience boards are compensated for meetings attended.
4. The CoC has many member organizations that serve culturally specific communities including Black, Latino, and persons with disabilities. The CoC continues to reach out to organizations to extend membership. These efforts have recently included facilitating meetings with organizations serving refugees, New Americans, and tenant organizers to work on equity goals and improve the homelessness system for these communities.

1B-3.	CoC's Strategy to Solicit/Consider Opinions on Preventing and Ending Homelessness.	
	NOFO Section VII.B.1.a.(3)	

	Describe in the field below how your CoC:
1.	solicited and considered opinions from a broad array of organizations and individuals that have knowledge of homelessness, or an interest in preventing and ending homelessness;
2.	communicated information during public meetings or other forums your CoC uses to solicit public information; and
3.	took into consideration information gathered in public meetings or forums to address improvements or new approaches to preventing and ending homelessness.

(limit 2,000 characters)

1.The CoC solicits and considers opinions from a broad array of organizations by targeting board recruitment to sectors both directly and indirectly involved in ending and preventing homelessness. This includes but is not limited to board representation from local government, the health sector, private foundations, lived experience boards, fair housing, legal services, public housing authorities and other affordable housing providers. Voting members of the general CoC include housing service providers, victim service providers, and youth service providers. The CoC holds various committees, most of which are open to the public to discuss strategies for ending and preventing homelessness. The CoC also has two client advisory boards, one comprised of youth, and one comprised of adults with lived expertise to guide community strategies to end homelessness.

2.The CoC's general membership meetings are open to the public and accessible to all who are interested. The CoC has an open listserv to communicate these meetings. The CoC also uses social media to announce meetings and activities. The CoC also sends out a weekly newsletter with meeting times, dates, and updates on efforts to end and prevent homelessness. The CoC opens all policies annually for edits and feedback from the community. This includes HMIS, Coordinated Entry, and Written Standards.
In the past year, the CoC held multiple public forums and feedback sessions to create its new strategic plan. This included open, public facilitated meetings and anonymous surveying to ensure participation and honest feedback.

3.The CoC debriefs from all meetings and public forums in the advisory board and general membership meetings. Decisions regarding policies created by the CoC are discussed openly and require vote and approval from CoC member organizations, lived experience boards, and CoC advisory board when changing policies or processes in the homelessness system.

1B-4.	**Public Notification for Proposals from Organizations Not Previously Funded.**	
	NOFO Section VII.B.1.a.(4)	

	Describe in the field below how your CoC notified the public:
1.	**that your CoC's local competition was open and accepting project applications;**
2.	**that your CoC will consider project applications from organizations that have not previously received CoC Program funding;**
3.	**about how project applicants must submit their project applications;**
4.	**about how your CoC would determine which project applications it would submit to HUD for funding; and**
5.	**how your CoC effectively communicated with individuals with disabilities, including making information accessible in electronic formats.**

(limit 2,000 characters)

1.On September 3, 2021 the Collaborative Applicant released the notice 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 CoC staff also hosted a meeting, open to the public, reviewing the applications for funding, funding priorities, and review of the ranking and reallocation protocols.

2. 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. This year, the CoC had two non-CoC funded organizations submit applications.

3. Instructions for completion, including ranking protocol and submission explanation were posted alongside the applications for funding. Agencies were able to schedule one on one technical assistance meetings with CoC staff to discuss funding opportunity and program design.

4. The determination for funding decisions is posted publicly and sent alongside the application in the Ranking Protocol.

5. The CoC posted all funding materials on its website in accessible formats, including written and video/audio.

1C. Coordination and Engagement–Coordination with Federal, State, Local, Private, and Other Organiza

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1C-1.	**Coordination with Federal, State, Local, Private, and Other Organizations.**	
	NOFO Section VII.B.1.b.	

	In the chart below:
1.	**select yes or no for entities listed that are included in your CoC's coordination, planning, and operations of projects that serve individuals, families, unaccompanied youth, persons who are fleeing domestic violence who are experiencing homelessness, or those at risk of homelessness; or**
2.	**select Nonexistent if the organization does not exist within your CoC's geographic area.**

	Entities or Organizations Your CoC Coordinates with for Planning or Operations of Projects	Coordinates with Planning or Operations of Projects
1.	**Funding Collaboratives**	Yes
2.	**Head Start Program**	No
3.	**Housing and services programs funded through Local Government**	Yes
4.	**Housing and services programs funded through other Federal Resources (non-CoC)**	Yes
5.	**Housing and services programs funded through private entities, including Foundations**	Yes
6.	**Housing and services programs funded through State Government**	Yes
7.	**Housing and services programs funded through U.S. Department of Health and Human Services (HHS)**	Yes
8.	**Housing and services programs funded through U.S. Department of Justice (DOJ)**	Yes
9.	**Housing Opportunities for Persons with AIDS (HOPWA)**	Yes
10.	**Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)**	No
11.	**Organizations led by and serving Black, Brown, Indigenous and other People of Color**	Yes
12.	**Organizations led by and serving LGBT persons**	Yes
13.	**Organizations led by and serving people with disabilities**	Yes
14.	**Private Foundations**	Yes
15.	**Public Housing Authorities**	Yes
16.	**Runaway and Homeless Youth (RHY)**	Yes
17.	**Temporary Assistance for Needy Families (TANF)**	Yes
	Other:(limit 50 characters)	

18.		

1C-2.	**CoC Consultation with ESG Program Recipients.**	
	NOFO Section VII.B.1.b.	

	Describe in the field below how your CoC:
1.	**consulted with ESG Program recipients in planning and allocating ESG and ESG-CV funds;**
2.	**participated in evaluating and reporting performance of ESG Program recipients and subrecipients;**
3.	**provided Point-in-Time (PIT) count and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area; and**
4.	**provided information to Consolidated Plan Jurisdictions within your CoC's geographic area so it could be addressed in Consolidated Plan update.**

(limit 2,000 characters)

1.The CoC and ESG Administrators collaborate on both ESG and ESG-CV funding. The CoC Director and Deputy Director review funding applications in the ESG process. The CoC and ESG Administrators collaborated to design and implement ESG-CV funding including reviewing data, creating a committee to discuss funding priorities, and collaborating on the plan submitted to HUD. CoC Staff and ESG Administrators meeting at minimum bi-weekly to review ESG-CV implementation.
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 also monitors ESG projects during HMIS monitoring and adherence to Coordinated Entry policies and procedures.
3. The CoC provides reports of localized PIT and HIC data to the Consolidated Planning jurisdictions, including analysis of need with the raw data.
4. The CoC Director also assists in developing and updating the Consolidated Plans for both the City of Syracuse and Onondaga County. The CoC uses meetings and its listserv to assist both districts in gathering information to inform the Consolidated Plan. The CoC also provides written priorities for use in the Consolidated Plans.

1C-3.	**Ensuring Families are not Separated.**	
	NOFO Section VII.B.1.c.	

	Select yes or no in the chart below to indicate how your CoC ensures emergency shelter, transitional housing, and permanent housing (PSH and RRH) do not deny admission or separate family members regardless of each family member's self-reported gender:

1.	**Conducted mandatory training for all CoC- and ESG-funded service providers to ensure families are not separated.**	No
2.	**Conducted optional training for all CoC- and ESG-funded service providers to ensure families are not separated.**	Yes
3.	**Worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients.**	Yes

4.	**Worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within your CoC's geographic area that might be out of compliance and took steps to work directly with those facilities to bring them into compliance.**	No
5.	**Sought assistance from HUD by submitting AAQs or requesting technical assistance to resolve noncompliance of service providers.**	No
6.	**Other. (limit 150 characters)**	

1C-4.	**CoC Collaboration Related to Children and Youth–SEAs, LEAs, Local Liaisons & State Coordinators.**	
	NOFO Section VII.B.1.d.	

	Describe in the field below:
1.	**how your CoC collaborates with youth education providers;**
2.	**your CoC's formal partnerships with youth education providers;**
3.	**how your CoC collaborates with State Education Agency (SEA) and Local Education Agency (LEA);**
4.	**your CoC's formal partnerships with SEAs and LEAs;**
5.	**how your CoC collaborates with school districts; and**
6.	**your CoC's formal partnerships with school districts.**

(limit 2,000 characters)

1.The CoC has Runaway and Homeless Youth (RHY) Advisory Committees in each of its three counties, designed to provide collaboration and coordination related to ending youth homelessness. These RHY Advisory Committees are attended by school district McKinney-Vento liaisons, educational and workforce development providers, juvenile justice personnel, and homeless services providers. During each RHY Advisory Committee meeting, McKinney-Vento liaisons give updates regarding overall federal and state policies and procedures or provide information regarding changes and events taking place within their own specific school district. Often times, problem solving occurs during Committee meeting as issues such as eligibility and transportation are discussed among the McKinney-Vento liaisons and RHY service providers.

2.The CoC has formal partnerships through its county-specific RHY Committees, as well as representation for the community RHY Coordinator on the CoC Advisory Board.

3.The CoC works with school district McKinney Vento liaisons in school districts to share data during the Point in Time and Youth Needs Assessment. The RHY Coordinator and members of the various RHY programs also attend annual training events conducted by NYS TEACHS, the McKinney-Vento Advocacy Program contracted by the NYS Department of Education. NYS TEACHS also provides CoC staff and RHY staff with in-depth individual assistance when dealing with families seeking to maintain their educational status despite being homeless. RHY staff also provide clients and family members with direct NYS TEACHS contact information so they themselves can also understand and advocate as they so choose.

4.The CoC partners with SEA or LEAs in both its RHY committee membership and with CoC members and staff attending training and advocacy meetings.

5.CoC Staff regularly attends quarterly McKinney-Vento Liaison meetings

comprised of liaisons from across the CoC region.

1C-4a.	CoC Collaboration Related to Children and Youth–Educational Services–Informing Individuals and Families Experiencing Homelessness about Eligibility.	
	NOFO Section VII.B.1.d.	

Describe in the field below written policies and procedures your CoC adopted to inform individuals and families who become homeless of their eligibility for educational services.

(limit 2,000 characters)

All emergency shelters have policies and systems in place to ensure children receive educational services via the McKinney-Vento Act. Family shelters work closely with the school districts to coordinate bussing and enrollment so that students miss the fewest possible days of school while experiencing homelessness. Shelter staff transport students as early as day one to their home school until bussing has been arranged. For families who are placed in emergency hotels, case managers facilitate buses. School districts have three business days to ensure children can attend school while experiencing homelessness. Every CoC funded agency also has a designated staff person to educate families and children about their rights regarding accessing school. The CoC also uses NYS TEACHS to provide advocacy if needed.

1C-4b.	CoC Collaboration Related to Children and Youth–Educational Services–Written/Formal Agreements or Partnerships with Early Childhood Services Providers.	
	NOFO Section VII.B.1.d.	

Select yes or no in the chart below to indicate whether your CoC has written formal agreements or partnerships with the listed providers of early childhood services:

		MOU/MOA	Other Formal Agreement
1.	Birth to 3 years	No	Yes
2.	Child Care and Development Fund	No	Yes
3.	Early Childhood Providers	No	Yes
4.	Early Head Start	No	No
5.	Federal Home Visiting Program–(including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)	No	Yes
6.	Head Start	No	No
7.	Healthy Start	No	No
8.	Public Pre-K	No	No
9.	Tribal Home Visiting Program	No	No
	Other (limit 150 characters)		
10.			

1C-5.	Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Annual Training–Best Practices.	
	NOFO Section VII.B.1.e.	

	Describe in the field below how your CoC coordinates to provide training for:
1.	Project staff that addresses safety and best practices (e.g., trauma-informed, victim-centered) on safety and planning protocols in serving survivors of domestic violence and indicate the frequency of the training in your response (e.g., monthly, semi-annually); and
2.	Coordinated Entry staff that addresses safety and best practices (e.g., trauma informed care) on safety and planning protocols in serving survivors of domestic violence and indicate the frequency of the training in your response (e.g., monthly, semi-annually).

(limit 2,000 characters)

1.The CoC provides free annual trainings to community on trauma informed care and best practices in serving survivors of domestic violence. These CoC trainings are open to both member and non-member organizations, especially those working directly with people experiencing homelessness.
2.The Coordinated Entry system has been developed to ensure anonymity of survivors whereas victim service providers are providing access to coordinated entry. The CoC does not have dedicated CE staff, and staff from community agencies serve as assessors for the coordinated entry system. Assessors are trained annually on administering assessments and coordinated entry policies and procedures, including serving survivors of domestic violence. These assessors are also highly encouraged to attend freely provided semi-annual training on trauma informed care and best practices for serving survivors.

1C-5a.	Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Using De-identified Aggregate Data.	
	NOFO Section VII.B.1.e.	

Describe in the field below how your CoC uses de-identified aggregate data from a comparable database to assess the special needs related to domestic violence, dating violence, sexual assault, and stalking survivors.

(limit 2,000 characters)

The CoC collects Point in Time and annual aggregate data from comparable databases to assess the needs related to domestic violence, dating violence, sexual assault, and stalking. The CoC uses data about housing, referrals, advocacy, and specialized services used by survivors of domestic violence to assess need. The CoC is able to assess trends in populations and services needed in order to ensure that specialized needs are addressed.

1C-5b.	Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Coordinated Assessment–Safety, Planning, and Confidentiality Protocols.	
	NOFO Section VII.B.1.e.	

	Describe in the field below how your CoC's coordinated entry system protocols incorporate trauma-informed, victim-centered approaches while maximizing client choice for housing and services that:
1.	prioritize safety;
2.	use emergency transfer plan; and
3.	ensure confidentiality.

(limit 2,000 characters)

1. 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. Local shelters provide specialized, trauma informed, and confidential services to all residents, especially survivors of violence. Shelter staff ensure residents are connected to appropriate services, including counseling services and DV advocates.
2. The CoC monitors each funded agency for Emergency Transfer Plans to ensure that agencies are prepared for an occurrence of domestic violence. All CoC funded PSH projects have emergency transfer policies in their leases with tenants. RRH providers are working to establish emergency transfer plans in leases with local landlords.
3. . The CoC works with these providers to ensure survivors have pathways to housing and are confidentially on the Coordinated Entry list. These providers can refer de-identified households to the Coordinated Entry system to ensure safety and privacy of survivors of domestic violence. The CoC's Coordinated Entry system uses the HMIS for non-DV clients. DV providers can operate outside of that system through CoC staff. CoC staff and agencies using Coordinated Entry are not given any identifying information to ensure survivor safety and privacy.
The CoC ensures all survivors of violence are provided confidential services. Housing accommodations are confidentially maintained, and CoC funded projects are monitored on the non-disclosure of client location. The CoC uses a de-identified process for emergency transfer plan allowing projects to use a de-identified transfer form to refer to another project. The CoC allows survivors of domestic violence to have choice in selecting projects and housing location. Victim service providers can work directly with housing projects to ensure anonymity until the survivor has agreed to move forward with a project or location.

1C-6.	**Addressing the Needs of Lesbian, Gay, Bisexual, Transgender–Anti-Discrimination Policy and Training.**	
	NOFO Section VII.B.1.f.	

1.	**Did your CoC implement a written CoC-wide anti-discrimination policy ensuring that LGBT individuals and families receive supportive services, shelter, and housing free from discrimination?**	Yes
2.	**Did your 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 your 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.	**Public Housing Agencies within Your CoC's Geographic Area–New Admissions–General/Limited Preference–Moving On Strategy. You Must Upload an Attachment(s) to the 4B. Attachments Screen.**	
	NOFO Section VII.B.1.g.	

Enter information in the chart below for the two largest PHAs highlighted in gray on the CoC-PHA Crosswalk Report at https://files.hudexchange.info/resources/documents/FY-2020-CoC-PHA-Crosswalk-Report.pdf or the two PHAs your CoC has a working relationship with–if there is only one PHA in your CoC's geographic area, provide information on the one:

Public Housing Agency Name	Enter the Percent of New Admissions into Public Housing and Housing Choice Voucher Program During FY 2020 who were experiencing homelessness at entry	Does the PHA have a General or Limited Homeless Preference?	Does the PHA have a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On?
Syracuse Housing Authority	26%	Yes-HCV	Yes
Auburn Housing Authority	30%	No	No

1C-7a.	Written Policies on Homeless Admission Preferences with PHAs.	
	NOFO Section VII.B.1.g.	

	Describe in the field below:
1.	steps your CoC has taken, with the two largest PHAs within your CoC's geographic area or the two PHAs your CoC has working relationships with, to adopt a homeless admission preference–if your CoC only has one PHA within its geographic area, you may respond for the one; or
2.	state that your CoC has not worked with the PHAs in its geographic area to adopt a homeless admission preference.

(limit 2,000 characters)

1. The CoC maintains two advisory board seats for the two largest PHAs to facilitate better partnerships and strategic planning. The CoC has a partnership with one of its largest PHAs for the mainstream voucher program to facilitate moving on from PSH. The CoC continues to encourage PHAs to adopt homeless preference. Currently, there are limited homeless preferences in the largest PHA for veterans receiving HUD VASH vouchers and people who are currently fleeing domestic violence. This includes moving on strategies for veterans. There are PHAs in the area with homelessness preferences that work with the CoC.

1C-7b.	Moving On Strategy with Affordable Housing Providers.	
	Not Scored–For Information Only	

Select yes or no in the chart below to indicate affordable housing providers in your CoC's jurisdiction that your recipients use to move program participants to other subsidized housing:

1.	Multifamily assisted housing owners	No
2.	PHA	Yes
3.	Low Income Tax Credit (LIHTC) developments	Yes
4.	Local low-income housing programs	Yes
	Other (limit 150 characters)	
5.		

1C-7c.	Including PHA-Funded Units in Your CoC's Coordinated Entry System.	
	NOFO Section VII.B.1.g.	

Does your CoC include PHA-funded units in the CoC's coordinated entry process?	Yes

1C-7c.1.	**Method for Including PHA-Funded Units in Your CoC's Coordinated Entry System.**	
	NOFO Section VII.B.1.g.	

	If you selected yes in question 1C-7c., describe in the field below:
1.	**how your CoC includes the units in its Coordinated Entry process; and**
2.	**whether your CoC's practices are formalized in written agreements with the PHA, e.g., MOUs.**

(limit 2,000 characters)

1. Coordinated Entry is used to fill Emergency Housing Vouchers and Mainstream Vouchers. Participants both currently homeless and in projects who are looking to move on from PSH and RRH are assessed and referred in the Coordinated Entry process to voucher programs. Specific locally created moving on assessments are used for referrals coming from Rapid Rehousing and Permanent Supportive Housing programs. The CoC staff refer families and individuals to PHAs for vouchers in order of priority as evidenced through the assessments.
2. CoC Coordinated Entry practices are formalized in MOUs with PHAs for EHV.

1C-7d.	**Submitting CoC and PHA Joint Applications for Funding for People Experiencing Homelessness.**	
	NOFO Section VII.B.1.g.	

Did your CoC coordinate with a PHA(s) to submit a joint application(s) for funding of projects serving families experiencing homelessness (e.g., applications for mainstream vouchers, Family Unification Program (FUP), other non-federal programs)?	Yes

1C-7d.1.	**CoC and PHA Joint Application–Experience–Benefits.**	
	NOFO Section VII.B.1.g.	

	If you selected yes to question 1C-7d, describe in the field below:
1.	**the type of joint project applied for;**
2.	**whether the application was approved; and**
3.	**how your CoC and families experiencing homelessness benefited from the coordination.**

(limit 2,000 characters)

1. The CoC and Syracuse Housing Authority, one of the largest PHAs in the CoC applied for a joint Mainstream Housing Voucher program to support moving on efforts from CoC PSH.
2. The application was approved for this project.
3. This coordination has allowed people to have an option to move on from PSH when intensive case management is no longer needed but subsidy is still necessary to maintain permanent housing. This has allowed the CoC to place high need people into the PSH slots that have been made available by moving on.

1C-7e.	Coordinating with PHA(s) to Apply for or Implement HCV Dedicated to Homelessness Including American Rescue Plan Vouchers.	
	NOFO Section VII.B.1.g.	

Did your CoC coordinate with any PHA to apply for or implement funding provided for Housing Choice Vouchers dedicated to homelessness, including vouchers provided through the American Rescue Plan?	Yes

1C-7e.1.	Coordinating with PHA(s) to Administer Emergency Housing Voucher (EHV) Program–List of PHAs with MOUs.	
	Not Scored–For Information Only	

Did your CoC enter into a Memorandum of Understanding (MOU) with any PHA to administer the EHV Program?	Yes

If you select yes, you must use the list feature below to enter the name of every PHA your CoC has entered into a MOU with to administer the Emergency Housing Voucher Program.

PHA
Syracuse Housing ...
NYS Housing Trust...
City of Fulton

1C-7e.1. List of PHAs with MOUs

Name of PHA: Syracuse Housing Authority

1C-7e.1. List of PHAs with MOUs

Name of PHA: NYS Housing Trust Fund Corporation

1C-7e.1. List of PHAs with MOUs

Name of PHA: City of Fulton

1C. Coordination and Engagement–Coordination with Federal, State, Local, Private, and Other Organiza

1C-8.	Discharge Planning Coordination.	
	NOFO Section VII.B.1.h.	

Select yes or no in the chart below to indicate whether your 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.

1. Foster Care	Yes
2. Health Care	Yes
3. Mental Health Care	Yes
4. Correctional Facilities	Yes

1C-9.	Housing First–Lowering Barriers to Entry.	
	NOFO Section VII.B.1.i.	

1.	Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects your CoC is applying for in FY 2021 CoC Program Competition.	25
2.	Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects your CoC is applying for in FY 2021 CoC Program Competition that have adopted the Housing First approach.	25
3.	This number is a calculation of the percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects the CoC has ranked in its CoC Priority Listing in the FY 2021 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.	100%

1C-9a.	Housing First–Project Evaluation.	
	NOFO Section VII.B.1.i.	

Describe in the field below how your CoC regularly evaluates projects to ensure those that commit to using a Housing First approach are prioritizing rapid placement and stabilization in permanent housing and are not requiring service participation or preconditions of program participants.

(limit 2,000 characters)

The CoC monitors existing CoC funded projects for compliance annually to ensure that projects are using the Housing First approach to prioritize rapid placement and stabilization in permanent housing. Housing projects are required to have housing first policies, including nondiscrimination and equal

opportunity policies in place. Policies are reviewed during monitoring.
The CoC requires that 100% of projects that are CoC and ESG funded operate under the Housing First model to prioritize rapid placement and stabilization in permanent housing in its written standards. The CoC includes the Housing First requirements in the local application to ensure that projects do not have precondition requirements at intake and will not discharge participants due to lack of project or treatment participation.
All families and individuals who enter the homeless system are placed on the Coordinated Entry list regardless of any preconditions or classifying status such as mental health, sobriety, income, ethnicity, gender, or victim status.
Participants are then matched with a housing program that best fits their needs.
The CoC requires all housing providers to document attempts to contact and reasons for rejection in HMIS. Housing providers have the option to reject a participant if the participant is a danger to themselves or others. 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 to discuss other housing opportunities.
Participants terminated from CoC funded programs that are selected for monitoring are reviewed for their adherence to a housing first discharge plan.
Case conferencing is also used to limit discharges from CoC programming, including the option for transfer to a project that better suits the needs of the participant.

1C-9b.	**Housing First–Veterans.**	
	Not Scored–For Information Only	

Does your CoC have sufficient resources to ensure each Veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach?	Yes

1C-10.	**Street Outreach–Scope.**	
	NOFO Section VII.B.1.j.	

	Describe in the field below:
1.	**your CoC's street outreach efforts, including the methods it uses to ensure all persons experiencing unsheltered homelessness are identified and engaged;**
2.	**whether your CoC's Street Outreach covers 100 percent of the CoC's geographic area;**
3.	**how often your CoC conducts street outreach; and**
4.	**how your CoC tailored its street outreach to persons experiencing homelessness who are least likely to request assistance.**

(limit 2,000 characters)

1) The CoC conducts street outreach through mobile vans, food give away, mental health crisis response teams, and acute medical care. Street outreach teams respond to calls received through 211 reporting people sleeping outside and visiting frequented sites to engage new people sleeping outside. The CoC does not have large encampments and continues to see low numbers of people sleeping outside during its annual PIT count.. Anyone engaged with street outreach is connected to Coordinated Entry. Outreach is provided even to those refusing housing or services. There is a monthly street outreach committee that includes substance abuse counselors, the Downtown Committee, local police,

shelters and street outreach. The CoC is successful in housing people directly from the street into permanent housing. In 2021, People in street outreach projects exited to permanent housing destinations (33% of all exits) as often as they exit to positive temporary destinations (31%).

2) 100% of the geographic area is covered with a strong presence in urban areas.

3) Outreach is conducted 7 days/week and street outreach teams share on call duties during code blue months.

4) Outreach is conducted on a continuous basis even to those who are least likely to receive assistance or who refuse assistance. Street outreach teams provide food, water, hygiene items, medical care and clothing to attempt engagement with people least likely to request assistance. The CoC uses street outreach to build relationships with those experiencing unsheltered homelessness to ultimately move street to shelter or street directly to housing. By forming the relationships while outdoors, the CoC has increased the ability to move directly from the street into housing for the shelter resistant. Street outreach distributes housing information materials and have used interpreters when needed.

1C-11.	**Criminalization of Homelessness.**	
	NOFO Section VII.B.1.k.	

Select yes or no in the chart below to indicate strategies your CoC implemented to prevent the criminalization of homelessness in your CoC's geographic area:

1.	**Engaged/educated local policymakers**	Yes
2.	**Engaged/educated law enforcement**	Yes
3.	**Engaged/educated local business leaders**	Yes
4.	**Implemented communitywide plans**	Yes
5.	**Other:(limit 500 characters)**	

1C-12.	**Rapid Rehousing–RRH Beds as Reported in the Housing Inventory Count (HIC).**	
	NOFO Section VII.B.1.l.	

	2020	**2021**
Enter the total number of RRH beds available to serve all populations as reported in the HIC–only enter bed data for projects that have an inventory type of "Current."	700	486

1C-13.	**Mainstream Benefits and Other Assistance–Healthcare–Enrollment/Effective Utilization.**	

	NOFO Section VII.B.1.m.

Indicate in the chart below whether your CoC assists persons experiencing homelessness with enrolling in health insurance and effectively using Medicaid and other benefits.

	Type of Health Care	Assist with Enrollment?	Assist with Utilization of Benefits?
1.	**Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)**	Yes	Yes
2.	**Private Insurers**	Yes	Yes
3.	**Nonprofit, Philanthropic**	Yes	Yes
4.	**Other (limit 150 characters)**		

1C-13a.	**Mainstream Benefits and Other Assistance–Information and Training.**	
	NOFO Section VII.B.1.m	

	Describe in the field below how your CoC provides information and training to CoC Program-funded projects by:
1.	**systemically providing up to date information on mainstream resources available for program participants (e.g., Food Stamps, SSI, TANF, substance abuse programs) within your CoC's geographic area;**
2.	**communicating information about available mainstream resources and other assistance and how often your CoC communicates this information;**
3.	**working with projects to collaborate with healthcare organizations to assist program participants with enrolling in health insurance; and**
4.	**providing assistance with the effective use of Medicaid and other benefits.**

(limit 2,000 characters)

1.Quarterly CoC membership meetings have standing agenda items for updates to available mainstream resources, including updates from all local departments of social services and local governments. Providers, agencies, or other coalitions are welcome to present any new information at programs at these meetings. These meetings have included updates on new substance use resources, changes to eviction moratoria during the pandemic, and how participants can access assistance like TANF and food stamps remotely during the pandemic.
2.The CoC has informational membership meetings quarterly. The CoC also maintains a weekly newsletter to push out information about changing and new resources.
3.Projects work with healthcare navigators to enroll in health insurance plans. If someone enters shelter with no health insurance, shelter staff assistance in public assistance applications, including SNAP and Medicaid. CoC funded projects 94% of people enrolled in at least one form of insurance by project exit.
4.Navigators also work with project participants to use Medicaid effectively. The CoC also partners with Medicaid expansion programs like Health Homes. Health Homes Care Managers use HMIS and work closely with CoC funded projects to ensure that participants are able to access and use Medicaid effectively.

1C-14.	**Centralized or Coordinated Entry System–Assessment Tool. You Must Upload an Attachment to the 4B. Attachments Screen.**	

	NOFO Section VII.B.1.n.

	Describe in the field below how your CoC's coordinated entry system:
1.	**covers 100 percent of your CoC's geographic area;**
2.	**reaches people who are least likely to apply for homeless assistance in the absence of special outreach;**
3.	**prioritizes people most in need of assistance; and**
4.	**ensures people most in need of assistance receive assistance in a timely manner.**

(limit 2,000 characters)

1. The Coordinated Entry System covers the entire CoC geographic area. Access to shelter is obtained through the LDSS in the three counties of the CoC, as well as the 211 system for after-hours access. The CES is used by street outreach and shelter providers to ensure that all people experiencing homelessness are assessed for services the same way. People entering homelessness for the first time are assessed using the assessment tool within two weeks of entering homelessness giving time for self-resolution. All CoC and ESG funded providers use the CES to fill beds. SSVF, VA's HCHV, and HOPWA providers also use the CES.
2. 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. The CoC has been successful at building relationships with the hardest to serve and has housed several people experiencing chronic homelessness that previously refused housing assistance.
3. The Coordinated Entry system prioritizes the chronically homeless with the longest length of time homeless and the highest service needs as evidenced by VI-SPDAT score. Housing providers target the highest priority individuals and families to fill beds, ensuring that those most vulnerable are matched with appropriate housing opportunities. Housing providers communicate with CoC staff the number of openings available in their project on a weekly basis. CoC staff then matches participants to open beds on the basis of prioritization to ensure those most in need receive assistance.
4. The Collaborative Applicant staff monitors the CES 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.

1C-15.	**Promoting Racial Equity in Homelessness–Assessing Racial Disparities.**	
	NOFO Section VII.B.1.o.	

Did your CoC conduct an assessment of whether disparities in the provision or outcome of homeless assistance exists within the last 3 years?	Yes

1C-15a.	**Racial Disparities Assessment Results.**	
	NOFO Section VII.B.1.o.	

Select yes or no in the chart below to indicate the findings from your CoC's most recent racial disparities assessment.

1.	**People of different races or ethnicities are more likely to receive homeless assistance.**	Yes
2.	**People of different races or ethnicities are less likely to receive homeless assistance.**	No
3.	**People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.**	Yes
4.	**People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.**	No
5.	**There are no racial or ethnic disparities in the provision or outcome of homeless assistance.**	No
6.	**The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.**	No

1C-15b.	**Strategies to Address Racial Disparities.**	
	NOFO Section VII.B.1.o.	

Select yes or no in the chart below to indicate the strategies your CoC is using to address any racial disparities.

1.	**The CoC's board and decisionmaking bodies are representative of the population served in the CoC.**	No
2.	**The CoC has identified steps it will take to help the CoC board and decisionmaking bodies better reflect the population served in the CoC.**	Yes
3.	**The CoC is expanding outreach in geographic areas with higher concentrations of underrepresented groups.**	Yes
4.	**The CoC has communication, such as flyers, websites, or other materials, inclusive of underrepresented groups.**	No
5.	**The CoC is training staff working in the homeless services sector to better understand racism and the intersection of racism and homelessness.**	Yes
6.	**The CoC is establishing professional development opportunities to identify and invest in emerging leaders of different races and ethnicities in the homelessness sector.**	Yes
7.	**The CoC has staff, committees, or other resources charged with analyzing and addressing racial disparities related to homelessness.**	Yes
8.	**The CoC is educating organizations, stakeholders, boards of directors for local and national nonprofit organizations working on homelessness on the topic of creating greater racial and ethnic diversity.**	Yes
9.	**The CoC reviewed coordinated entry processes to understand their impact on people of different races and ethnicities experiencing homelessness.**	Yes
10.	**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.**	Yes
11.	**The CoC is conducting additional research to understand the scope and needs of different races or ethnicities experiencing homelessness.**	Yes
	Other:(limit 500 characters)	
12.		

1C-15c.	**Promoting Racial Equity in Homelessness Beyond Areas Identified in Racial Disparity Assessment.**	
	NOFO Section VII.B.1.o.	

Describe in the field below the steps your CoC and homeless providers have taken to improve racial equity in the provision and outcomes of assistance beyond just those areas identified in the racial disparity assessment.

(limit 2,000 characters)

The CoC and homeless providers have committed to improving racial equity in the provision and outcomes of assistance by analyzing system data, identifying disparities, and creating goals to eliminate the findings.
The CoC is a SPARC/Racial Equity Design and Implementation community. SPARC assessed the CoC for disparities in 2017. Since then, the CoC has created a racial equity committee that consists of stakeholders within the CoC including members of the fair housing organization, legal services, county and city government officials, and emergency shelter representatives. This committee is tasked to identify systemic issues and barriers that lead to disparities within the homelessness system.
The CoC has analyzed homelessness data using the LSA and PIT count to identify existing disparities within our system. People of color make up for 19% of our community population, but account for 50% of our homeless population. The CoC has created cross sector collaboration partnerships in attempt to eliminate this disparity. Homeless providers have created racial equity policies to commit to moving towards an antiracist community.
The CoC has imbued racial equity work throughout its new strategic plan. The CoC is in the process of moving away from the VI-SPDAT and incorporating a more equitable assessment to have better outcomes and ensure that individuals and families are getting connected to services and permanent housing equitably.
The CoC created an assessment for the use of dispersing ESG-CV homelessness prevention funds designed to improve geographic and racial equity in enrollments. The CoC prioritized applications for ESG-CV and CDBG-CV homelessness prevention funds from high-need census tracts, which were identified through US Census Data. To further homeless prevention work for people of color, the CoC is working with the Volunteer Lawyers Project of Central New York on a project to analyze disparities within the eviction process and outcomes of eviction.

1C-16.	**Persons with Lived Experience–Active CoC Participation.**	
	NOFO Section VII.B.1.p.	

Enter in the chart below the number of people with lived experience who currently participate in your CoC under the five categories listed:

	Level of Active Participation	Number of People with Lived Experience Within the Last 7 Years or Current Program Participant	Number of People with Lived Experience Coming from Unsheltered Situations
1.	**Included and provide input that is incorporated in the local planning process.**	9	2
2.	**Review and recommend revisions to local policies addressing homelessness related to coordinated entry, services, and housing.**	9	2
3.	**Participate on CoC committees, subcommittees, or workgroups.**	9	2
4.	**Included in the decisionmaking processes related to addressing homelessness.**	9	2

5.	**Included in the development or revision of your CoC's local competition rating factors.**	9	2

1C-17.	**Promoting Volunteerism and Community Service.**	
	NOFO Section VII.B.1.r.	

Select yes or no in the chart below to indicate steps your CoC has taken to promote and support community engagement among people experiencing homelessness in the CoC's geographic area:

1.	**The CoC trains provider organization staff on connecting program participants and people experiencing homelessness with education and job training opportunities.**	Yes
2.	**The CoC trains provider organization staff on facilitating informal employment opportunities for program participants and people experiencing homelessness (e.g., babysitting, housekeeping, food delivery, data entry).**	No
3.	**The CoC works with organizations to create volunteer opportunities for program participants.**	Yes
4.	**The CoC works with community organizations to create opportunities for civic participation for people experiencing homelessness (e.g., townhall forums, meeting with public officials).**	Yes
5.	**Provider organizations within the CoC have incentives for employment and/or volunteerism.**	Yes
6.	**Other:(limit 500 characters)**	

1D. Addressing COVID-19 in the CoC's Geographic Area

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1D-1.	**Safety Protocols Implemented to Address Immediate Needs of People Experiencing Unsheltered, Congregate Emergency Shelter, Transitional Housing Homelessness.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below protocols your CoC implemented during the COVID-19 pandemic to address immediate safety needs for individuals and families living in:
1.	**unsheltered situations;**
2.	**congregate emergency shelters; and**
3.	**transitional housing.**

(limit 2,000 characters)

The CoC worked with its local county and city governments to establish protocols for ensuring safety for people experiencing homelessness. The CoC, county officials, shelter, transitional, and street outreach providers followed all CDC guidance throughout the pandemic.

All people experiencing homelessness, including those on the street, in congregate emergency shelters, and transitional housing who were symptomatic, awaiting test results, COVID positive, or otherwise quarantined were sent to non-congregate shelters for the duration of their quarantine. Services were provided to people placed in non-congregate shelters including transportation, food, and PPE supplies. People who were unsheltered were tested right on the street and/or transported to testing sites.

Personal protective equipment was distributed to all shelters, transitional housing, and to street outreach providers for distribution to staff and residents. Masks were required in all congregate setting and distributed and cleansed regularly.

Congregate shelters and transitional housing providers developed plans for sanitization, as well as implementing strategies to distance beds, reduce the amount of people in one room, and put up protective barriers to keep people safe and distanced. Signage was provided to shelters to post regarding hand washing, social distancing, and general information about COVID-19. COVID screening and temperature checks were administered at the entry of each congregate setting and results were tracked in HMIS.

Staff in large congregate shelters were also given hazard pay to ensure staff retention and recognition for support people experiencing homelessness during the pandemic.

1D-2.	Improving Readiness for Future Public Health Emergencies.	
	NOFO Section VII.B.1.q.	

Describe in the field below how your CoC improved readiness for future public health emergencies.

(limit 2,000 characters)

Plans are now in place for public health emergencies, including a worsening of COVID, including non-congregate sheltering options and how to quickly adapt the homelessness response system to respond safely. This included communication strategies, transportation services, as well as protocols for operating congregate shelters as safely as possible. Many public benefits can now be accessed remotely, and the framework now exists for continuing case management services during a public health emergency. Investment has been made to congregate shelters to assist in the preparedness for future health emergencies, like sanitization machines and upgrades to HVAC systems.
The CoC has also set forth policies adapting to CoC program staff working from home, including HMIS and Coordinated Entry policies. CoC agencies, including shelters and permanent housing programs, have developed agency policies regarding staff safety, hazard pay, and adapting technology for clients and staff to provide services.
The CoC has created invaluable partnerships with health departments and county governments to improve readiness for future public health emergencies. Each county in the CoC has created plans to respond locally that has included input from CoC staff, stakeholders, and community service providers that follow national guidelines but also respect the unique needs of each community in the CoC. These plans have created a framework to be used for a coordinated response in future public health emergencies.

1D-3.	CoC Coordination to Distribute ESG Cares Act (ESG-CV) Funds.	
	NOFO Section VII.B.1.q	

	Describe in the field below how your CoC coordinated with ESG-CV recipients to distribute funds to address:
1.	safety measures;
2.	housing assistance;
3.	eviction prevention;
4.	healthcare supplies; and
5.	sanitary supplies.

(limit 2,000 characters)

1. ESG-CV funds were used to fund street outreach, including increased testing and medical assistance on the street and increased outreach efforts and supplies for people experiencing unsheltered homelessness.
2. ESG-CV funds funded rapid rehousing programs to quickly move people out

of congregate shelters and into permanent housing. These projects prioritized people most at risk of having serious complications from COVID-19, including those above age 65 and/or immuno-compromised.
3. ESG-CV funds were used to set up homelessness prevention programs to keep people out of congregate shelter during the pandemic. These programs were designed for people who were not protected by NYS or federal eviction moratoria and/or federal emergency rental assistance.
4. ESG-CV funds were utilized to distribute PPE and other healthcare supplies to people in congregate, non-congregate, transitional, and unsheltered situations. Congregate shelters also purchased thermometers for temperature and other healthcare supplies.
5. Sanitization machines and cleaning supplies were purchased for congregate shelters.

1D-4.	**CoC Coordination with Mainstream Health.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below how your CoC coordinated with mainstream health (e.g., local and state health agencies, hospitals) during the COVID-19 pandemic to:
1.	**decrease the spread of COVID-19; and**
2.	**ensure safety measures were implemented (e.g., social distancing, hand washing/sanitizing, masks).**

(limit 2,000 characters)

1.Local shelters partnered with health department to facilitate testing and receive guidance on best practices, especially in congregate settings. The local federally qualified health department had staff on site at local shelters to assist in the mitigation of COVID-19 spread. Congregate shelters also partnered with physicians from both the federally qualified health center and the hospital chosen as the regional vaccine hub, to come directly into congregate shelters to help screen and test for COVID.

2.The CoC saw that masks, including N-95 masks, were distributed to shelters and street outreach providers regularly for both staff and residents. Shelters also adjusted bed placement and number to ensure social distancing.

1D-5.	**Communicating Information to Homeless Service Providers.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below how your CoC communicated information to homeless service providers during the COVID-19 pandemic on:
1.	**safety measures;**
2.	**changing local restrictions; and**
3.	**vaccine implementation.**

(limit 2,000 characters)

The CoC used its listserv, weekly newsletter, and various committees to communicate changing safety measures, changing local restrictions, and vaccine implementation. State and local guidance was communicated regularly throughout the pandemic as well as communication of waivers for CoC and ESG programs to continue operations as needed.

The CoC worked with local county departments of social services and health departments to keep updated information on local restrictions.

The CoC held numerous vaccine implementation meetings with congregate shelter providers and county officials, including the planning of pop-up clinics.

The CoC also dedicated all its quarterly membership meetings during the pandemic to COVID response and planning.

1D-6.	Identifying Eligible Persons Experiencing Homelessness for COVID-19 Vaccination.	
	NOFO Section VII.B.1.q.	

Describe in the field below how your CoC identified eligible individuals and families experiencing homelessness for COVID-19 vaccination based on local protocol.

(limit 2,000 characters)

The CoC advocated for people experiencing homelessness to be early priority groups in vaccine distribution, including providing written strategies to reduce barriers to the communitywide vaccine equity committee. The CoC set up a vaccine tracking system in HMIS to track vaccinations and identify people experiencing homelessness that have not been vaccinated.

Pop up vaccine clinics were held in its largest congregate emergency shelters. CoC staff and shelter providers used HMIS and nightly bed check ins to verify homelessness status for people at vaccine clinics. Street outreach providers also assisted in transporting people experiencing unsheltered homelessness to vaccine clinics.

Doctors and nurses who worked in emergency shelters or in the medical street outreach team were present at most pop-up vaccine clinics to ensure that people experiencing homelessness had medical professionals they recognized and trusted administering vaccines whenever possible.

Shelter providers in congregate emergency shelters offered vaccine to all shelter residents and became trusted messengers in promoting vaccines and dispelling concerns related to efficacy and safety. Marketing materials were distributed to emergency shelters regarding vaccine efficacy and safety.

Shelters were also on call lists for priority for unused vaccines at off-site clinics, allowing shelters to transport people to receive vaccines regularly.

1D-7.	Addressing Possible Increases in Domestic Violence.	
	NOFO Section VII.B.1.e.	

Describe in the field below how your CoC addressed possible increases in domestic violence calls for assistance due to requirements to stay at home, increased unemployment, etc. during the COVID-19 pandemic.

(limit 2,000 characters)

The CoC's emergency shelters serving people fleeing domestic violence did not close during the pandemic. Systems were in place to utilize other non-DV specific sheltering options and/or other DV shelters in other parts of the CoC to assist in the increased need.

The CoC has used its current CoC-funded DV bonus RRH project to quickly move survivors of domestic violence out of shelter and into permanent housing. This has helped mitigate increases in sheltering needs by turning over beds.

The CoC also used Emergency Housing Vouchers to help respond to the increases in people experiencing domestic violence. Survivors of Domestic Violence were in the first or second priority groups for vouchers in the three EHV implementations in the CoC region.

1D-8.	**Adjusting Centralized or Coordinated Entry System.**	
	NOFO Section VII.B.1.n.	

Describe in the field below how your CoC adjusted its coordinated entry system to account for rapid changes related to the onset and continuation of the COVID-19 pandemic.

(limit 2,000 characters)

The CoC made multiple changes to the coordinated entry system to account for COVID- 19. The CoC met with and gathered input from all stakeholders that would be affected by the changes including the Coordinated Entry workgroup, lived expertise boards, CoC and ESG housing providers, county DSS, and emergency shelter staff. Access to shelter was adjusted to allow for eligibility paperwork to be faxed or mailed to the LDSS rather than require a face to face meeting which had previously been a state mandate.

The CoC updated and changed the Coordinated Entry prioritization policies and procedures in response to COVID-19. Those who stated they were at increased risk of having severe complications from COVID-19 were prioritized for permanent housing placements. Individuals or head of households who are 65 and up were also prioritized for all housing projects.

Individuals and families with housing identified were matched to a rapid rehousing provider immediately, to limit the number of people residing in congregate shelter.

Coordinated Entry was also adjusted to accommodate the increase in rapid rehousing projects funded through ESG-CV funding.

1E. Project Capacity, Review, and Ranking–Local Competition

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1E-1.	**Announcement of 30-Day Local Competition Deadline–Advance Public Notice of How Your CoC Would Review, Rank, and Select Projects. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.a. and 2.g.	

1.	**Enter the date your CoC published the 30-day submission deadline for project applications for your CoC's local competition.**	09/03/2021
2.	**Enter the date your CoC publicly posted its local scoring and rating criteria, including point values, in advance of the local review and ranking process.**	09/03/2021

1E-2.	**Project Review and Ranking Process Your CoC Used in Its Local Competition. You Must Upload an Attachment to the 4B. Attachments Screen. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria listed below.**	
	NOFO Section VII.B.2.a., 2.b., 2.c., and 2.d.	

Select yes or no in the chart below to indicate how your CoC ranked and selected project applications during your local competition:

1.	**Established total points available for each project application type.**	Yes
2.	**At least 33 percent of the total points were based on objective criteria for the project application (e.g., cost effectiveness, timely draws, utilization rate, match, leverage), performance data, type of population served (e.g., DV, youth, Veterans, chronic homelessness), or type of housing proposed (e.g., PSH, RRH).**	Yes
3.	**At least 20 percent of the total points were based on system performance criteria for the project application (e.g., exits to permanent housing destinations, retention of permanent housing, length of time homeless, returns to homelessness).**	Yes
4.	**Used data from a comparable database to score projects submitted by victim service providers.**	Yes
5.	**Used objective criteria to evaluate how projects submitted by victim service providers improved safety for the population they serve.**	Yes
6.	**Used a specific method for evaluating projects based on the CoC's analysis of rapid returns to permanent housing.**	Yes

1E-2a.	**Project Review and Ranking Process–Addressing Severity of Needs and Vulnerabilities.**	

	NOFO Section VII.B.2.d.

	Describe in the field below how your CoC reviewed, scored, and selected projects based on:
1.	**the specific severity of needs and vulnerabilities your CoC considered when ranking and selecting projects; and**
2.	**considerations your CoC gave to projects that provide housing and services to the hardest to serve populations that could result in lower performance levels but are projects your CoC needs in its geographic area.**

(limit 2,000 characters)

1. The populations having more severe service needs identified by the CoC were youth, people experiencing chronic homelessness, survivors of domestic violence, and people entering projects with no income. Project data on outcomes, duration of services, and intensity of services were considered to identify these populations that could contribute to lower performance.
2. Our local rank and review scoring metrics included 5 points out of 100 if 75% or more of the households served in the program year were in one of the following categories: Chronically Homeless, Youth Ages 18-24, Fleeing Domestic Violence, or No Income. Our rating tool gave one point out of 100 to projects that accepted 90% or more of their entries through referrals made by the coordinated entry system. Projects that received these points served clients with the highest lengths of time homeless in their geographic region.

1E-3.	**Promoting Racial Equity in the Local Review and Ranking Process.**	
	NOFO Section VII.B.2.e.	

	Describe in the field below how your CoC:
1.	**obtained input and included persons of different races, particularly those over-represented in the local homelessness population, when determining the rating factors used to review project applications;**
2.	**included persons of different races, particularly those over-represented in the local homelessness population, in the review, selection, and ranking process;**
3.	**rated and ranked projects based on the degree to which their program participants mirror the homeless population demographics (e.g., considers how a project promotes racial equity where individuals and families of different races are over-represented).**

(limit 2,000 characters)

1.The CoC obtained input including those of different races by including those with lived experience, the NOFO workgroup, and the performance and evaluation committee in the rating and review process. All boards include BIPOC members.
2.People of color are disproportionately represented in the local homelessness population. The CoC has included people of color who have lived experience of homelessness in the review, selection, and ranking process.
3.The CoC did not directly use the demographic makeup of program participants to rate and rank projects. However, all projects receiving CoC Funding are required to use the CES for 100% of their referrals, which relies on objective criteria to make decisions about project referrals rather than administrator or case manager discretion. This process is assessed for disparities and projects' participation in CES was a factor in determining their rating and ranking.

1E-4.	**Reallocation–Reviewing Performance of Existing Projects. We use the response to this question as a**	

	factor when determining your CoC's eligibility for bonus funds and for other NOFO criterion below.	
	NOFO Section VII.B.2.f.	

	Describe in the field below:
1.	**your CoC's reallocation process, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed;**
2.	**whether your CoC identified any projects through this process during your local competition this year;**
3.	**whether your CoC reallocated any low performing or less needed projects during its local competition this year;**
4.	**why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable; and**
5.	**how your CoC communicated the reallocation process to project applicants.**

(limit 2,000 characters)

1.Projects that demonstrate consistently low performance or no longer meet local needs are, subject to transfer or reallocation. Low performance is defined as consistent findings during annual monitoring, ineligible spending, lack of participation in Coordinated Entry, low utilization rates, lack of , higher cost per successfully housed client, and/or inability to meet community threshold for system performance measures. The five lowest performing projects are brought to the Committee for possible reallocation as well as any projects that have consistent ineligible spending. Reallocation decisions are voted upon by the Committee and the Advisory Board is immediately notified by the HHC Director along with the agency whose funding will be reallocated.

2.The CoC did not have any projects that were no longer meeting a community need. The committee discussed the lowest performing projects.

3. Projects that were lower performing were not reallocated.

4.Projects reported that COVID had affected performance. Projects had no significant concerns such as ineligible spending or serving ineligible participants. Projects that were low performing were given performance improvement plans that need to be completed prior to the next monitoring process. All projects are serving populations that the CoC has identified as needing housing and services. All projects are utilizing best practice program designs to serve their clients.

5.The reallocation protocol was published alongside the NOFO local application and ranking protocol. All projects received the protocol via email, and it was posted on the CoC's website. The CoC holds meetings to vote to approve the reallocation protocol for both the CoC Advisory Board and CoC funded agencies. The protocol was passed by both committees. Video and audio recordings of the information meeting regarding funding were also published on the CoC's website.

1E-4a.	**Reallocation Between FY 2016 and FY 2021. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criterion below.**	
	NOFO Section VII.B.2.f.	

Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2016 and FY 2021?	No

1E-5.	**Projects Rejected/Reduced–Public Posting. You Must Upload an Attachment to the 4B. Attachments Screen if You Select Yes.**	
	NOFO Section VII.B.2.g.	

1.	**Did your CoC reject or reduce any project application(s)?**	Yes
2.	**If you selected yes, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.**	10/12/2021

1E-5a.	**Projects Accepted–Public Posting. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.g.	

Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	10/12/2021

1E-6.	**Web Posting of CoC-Approved Consolidated Application. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.g.	

Enter the date your CoC's Consolidated Application was posted on the CoC's website or affiliate's website–which included: 1. the CoC Application; 2. Priority Listings; and 3. all projects accepted, ranked where required, or rejected.	11/05/2021

2A. Homeless Management Information System (HMIS) Implementation

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

2A-1.	**HMIS Vendor.**	
	Not Scored–For Information Only	

Enter the name of the HMIS Vendor your CoC is currently using.	Wellsky

2A-2.	**HMIS Implementation Coverage Area.**	
	Not Scored–For Information Only	

Select from dropdown menu your CoC's HMIS coverage area.	Multiple CoCs

2A-3.	**HIC Data Submission in HDX.**	
	NOFO Section VII.B.3.a.	

Enter the date your CoC submitted its 2021 HIC data into HDX.	05/12/2021

2A-4.	**HMIS Implementation–Comparable Database for DV.**	
	NOFO Section VII.B.3.b.	

	Describe in the field below actions your CoC and HMIS Lead have taken to ensure DV housing and service providers in your CoC:
1.	**have a comparable database that collects the same data elements required in the HUD-published 2020 HMIS Data Standards; and**
2.	**submit de-identified aggregated system performance measures data for each project in the comparable database to your CoC and HMIS lead.**

(limit 2,000 characters)

1.The CoC has met with VSPs across the geographic area to ensure that they use HMIS-comparable databases. Two VSPs in the CoC use EmpowerDB as their comparable database, which allows them to collect all data elements required in the 2020 HMIS CoC and ESG manuals for Emergency Shelter and Rapid Re-housing project types.
2.Their database solution also allows the VSP organizations to compile and submit an Annual Performance Report (APR) to the CoC and HMIS team that contains de-identified performance measures for each of the CoC-funded projects. The VSPs are also able to report demographic information for the Point in Time count and information on the following applicable HUD system performance measures: Measures 1 and 1b related to the length of time a client remains homeless, Measure 4 related to Employment and Income growth for clients in rapid rehousing, and Measure 7 related to positive destinations. System performance measures that are not applicable include Measure 2: Returns to Homelessness after Permanent Housing Placement, Measure 3: Number of Homeless Persons, and Measure 5: Number of persons who become homeless for the first time. These three measures require de-duplication of individuals using personally identifiable information and cannot be assessed with de-identified aggregate data.

2A-5.	**Bed Coverage Rate–Using HIC, HMIS Data–CoC Merger Bonus Points.**	
	NOFO Section VII.B.3.c. and VII.B.7.	

Enter 2021 HIC and HMIS data in the chart below by project type:

Project Type	Total Beds 2021 HIC	Total Beds in HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
1. Emergency Shelter (ES) beds	594	65	514	97.16%
2. Safe Haven (SH) beds	0	0	0	
3. Transitional Housing (TH) beds	176	14	162	100.00%
4. Rapid Re-Housing (RRH) beds	486	0	486	100.00%
5. Permanent Supportive Housing	968	0	946	97.73%
6. Other Permanent Housing (OPH)	201	7	194	100.00%

2A-5a.	**Partial Credit for Bed Coverage Rates at or Below 84.99 for Any Project Type in Question 2A-5.**	
	NOFO Section VII.B.3.c.	

	For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-5, describe:
1.	**steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and**
2.	**how your CoC will implement the steps described to increase bed coverage to at least 85 percent.**

(limit 2,000 characters)

N/A- The CoC has over 84.99% coverage for all project types.

2A-5b.	**Bed Coverage Rate in Comparable Databases.**	

	NOFO Section VII.B.3.c.

Enter the percentage of beds covered in comparable databases in your CoC's geographic area.	100.00%

2A-5b.1.	**Partial Credit for Bed Coverage Rates at or Below 84.99 for Question 2A-5b.**	
	NOFO Section VII.B.3.c.	

	If the bed coverage rate entered in question 2A-5b. is 84.99 percent or less, describe in the field below:
1.	**steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent; and**
2.	**how your CoC will implement the steps described to increase bed coverage to at least 85 percent.**

(limit 2,000 characters)

N/A- The CoC has over 84.99% coverage for all project types.

2A-6.	**Longitudinal System Analysis (LSA) Submission in HDX 2.0.**	
	NOFO Section VII.B.3.d.	

Did your CoC submit LSA data to HUD in HDX 2.0 by January 15, 2021, 8 p.m. EST?	Yes

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

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

2B-1.	**Sheltered and Unsheltered PIT Count–Commitment for Calendar Year 2022**	
	NOFO Section VII.B.4.b.	

Does your CoC commit to conducting a sheltered and unsheltered PIT count in Calendar Year 2022?	Yes

2B-2.	**Unsheltered Youth PIT Count–Commitment for Calendar Year 2022.**	
	NOFO Section VII.B.4.b.	

Does your CoC commit to implementing an unsheltered youth PIT count in Calendar Year 2022 that includes consultation and participation from youth serving organizations and youth with lived experience?	Yes

2C. System Performance

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

2C-1.	**Reduction in the Number of First Time Homeless–Risk Factors.**	
	NOFO Section VII.B.5.b.	

	Describe in the field below:
1.	**how your CoC determined which risk factors your CoC uses to identify persons becoming homeless for the first time;**
2.	**how your CoC addresses individuals and families at risk of becoming homeless; and**
3.	**provide the name of the organization or position title that is responsible for overseeing your CoC's strategy to reduce the number of individuals and families experiencing homelessness for the first time or to end homelessness for individuals and families.**

(limit 2,000 characters)

1.The CoC's Program Planning and Advocacy committee, along with the lived experienced boards were consulted to create questions for the CoC's Annual Gaps and Needs Survey, which collects information about antecedents to homelessness. The Data Administrators Committee approves locally collected data elements to examine upstream causes of homelessness.
2.The CoC has three primary strategies for preventing first-time homelessness: 1. Early intervention and prevention for people at imminent risk of homelessness. Using ESG Homelessness Prevention funds, legal services are provided to low-income households at eviction court. Local data shows that 9% of people experiencing homelessness for the first time cited eviction as their primary reason for homelessness. Input from our Lived Experience Boards has suggested that eviction leads to doubling up with friends or family, which then leads to homelessness if conflict occurs between family members. 2. Diversion from shelter. Intake workers at local departments of social services and staff at the 2-1-1 human services referral hotline are trained to connect clients requesting emergency shelter with family and community resources and refer to emergency shelter only when appropriate. 3. Advocacy for increased affordable housing resources as primary prevention. The CoC continues to advocate for prevention funding and services at all levels of government. The CoC also takes an active role in creating local governments' Consolidated Plans to increase affordable housing. Even prior to the COVID-19 pandemic, the CoC saw steady decreases in the number of people experiencing homelessness for the first time (4% decrease in FY2018, and a 10% decrease in FY2019).
3.The CoC's Program Planning and Advocacy Committee is responsible for overseeing strategies to reduce first-time homelessness.

2C-2.	**Length of Time Homeless–Strategy to Reduce.**	
	NOFO Section VII.B.5.c.	

	Describe in the field below:
1.	**your CoC's strategy to reduce the length of time individuals and persons in families remain homeless;**
2.	**how your CoC identifies and houses individuals and persons in families with the longest lengths of time homeless; and**
3.	**provide the name of the organization or position title that is responsible for overseeing your CoC's strategy to reduce the length of time individuals and families remain homeless.**

(limit 2,000 characters)

1.The CoC's primary strategy for reducing the length of time individuals and persons in families remain homeless is to ensure that all emergency shelter residents are rapidly assessed and referred to housing resources. Clients with the longest lengths of time homeless are prioritized for PSH and RRH programs, but housing case managers with emergency shelters and street outreach programs are encouraged to help clients seek housing resources from a variety of mainstream sources. A second strategy is to reduce barriers to housing programs by providing case management at emergency shelters who provide warm handoffs to housing programs and assist with housing search and placement. Local shelters and LDSS review any cases of individuals and families residing in emergency shelters for over 30 days. Though lengths of stay in shelter increased in FY2020 due to the COVID-19 pandemic, they have reduced in FY2021, suggesting that the strategies put in place by the CoC are effective and resilient to disruptions from events like COVID-19. Lastly, the CoC advocates for increased housing resources that are targeted to literally homeless individuals and families and have low barriers to housing.
2.The CoC uses a combination of HMIS data and client self-report to identify individuals and families with the longest lengths of time homeless. CES assessors are trained at least once a year on the standards of evidence for self-report of homelessness. Once a month, inconsistencies between HMIS records and self-reported lengths of time homeless are examined and rectified during case conferencing in the Chronic Homelessness Task Force meeting and through follow-ups with shelter and outreach staff. The Coordinated Entry workgroup and Chronic Homelessness Taskforce case-conference individuals and families with lengths of stay over 90 days to ensure prioritization for housing.

3.The Coordinated Entry Workgroup is responsible for the CoC's strategy to reduce length of time homeless.

2C-3.	**Exits to Permanent Housing Destinations/Retention of Permanent Housing.**	
	NOFO Section VII.B.5.d.	

	Describe in the field below how your CoC will increase the rate that individuals and persons in families residing in:
1.	**emergency shelter, safe havens, transitional housing, and rapid rehousing exit to permanent housing destinations; and**
2.	**permanent housing projects retain their permanent housing or exit to permanent housing destinations.**

(limit 2,000 characters)

1.All shelter and street outreach projects use a housing first strategy to reduce

barriers to housing. All PSH and RRH projects operate from a housing first philosophy meaning that they do not have any service participation requirements and offer individualized services to help clients to stabilize in their units and increase their income. The CoC also promotes a housing first approach for all projects that primarily serve homeless individuals and families that are not CoC and ESG-funded. The CoC encourages non-CoC and ESG funded housing projects to utilize CES. For all individuals and families experiencing homelessness, assistance is provided to access mainstream housing subsidies and medical assistance. For housing subsidies, eligible applicants receive assistance applying to mainstream housing resources. For clients who need long-term medical care, the CoC advocates with hospitals and medical facilities not to discharge clients into homelessness and to coordinate access to appropriate long-term care facilities. All families and individuals are connected to community support services and benefits like state temporary assistance, SNAP, Medicaid, child care subsidies, primary medical care, mental health and substance use services, and more to help them stabilize their housing situation after leaving transitional housing and rapid rehousing.
2.Clients who are disabled are connected with SOAR-trained staff members to help begin the process of applying for disability benefits. Household in RRH who were chronically homeless upon entry are able to access PSH through CES. The CoC also provides PSH and RRH projects with low-cost or free training opportunities for frontline staff. CES assists with PSH transfers for clients who need different housing resources.
3.The Coordinated Entry Workgroup oversees strategy to increase positive ES, TH, and RRH exits.
4.The CoC Planning Staff oversee strategy for PSH placement and retention.

2C-4.	**Returns to Homelessness–CoC's Strategy to Reduce Rate.**	
	NOFO Section VII.B.5.e.	

	Describe in the field below:
1.	**how your CoC identifies individuals and families who return to homelessness;**
2.	**your 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 your CoC's strategy to reduce the rate individuals and persons in families return to homelessness.**

(limit 2,000 characters)

1. The CoC uses system performance measure reports in HMIS to identify returns to homelessness. These reports are reviewed on a quarterly basis to identify data quality issues. One strategy is to advocate for increased affordable housing resources across the CoC's geographic area. Given the limited quantity of rental assistance, the majority of clients exit who shelter services to permanent destinations do so with very little or no ongoing assistance. The CoC therefore focuses the bulk of data analysis on returns to homelessness after clients received assistance from RRH and PSH projects. The CoC also tracks returns at the project level to provide technical assistance to projects needing to improve placements into stable housing situations. The CoC reviews both quantitative and qualitative data and reports on the trends in returns to homelessness across time to the CoC's Program Planning and Advocacy committee.
2. The Chronic Homelessness Task Force and Coordinated Entry Workgroups facilitate case conferencing and identify people who have returned to

homelessness after being permanently housed in CoC projects. These discussions include common barriers to remaining housed and are an opportunity for providers to share best practices and strategies to address those barriers. The Coordinated Entry Workgroup also facilitates permanent supportive housing transfers for clients needing services.
CoC projects link clients to resources that help them to maintain safe stable housing, including employment resources, health resources, and mainstream cash and non-cash benefits. The CoC provides regular trainings on how to access these resources for caseworkers.
Lastly, Homelessness prevention projects funded through ESG-CV prioritize clients who have previously experienced homelessness.
3. The Program planning and advocacy committee is responsible for overseeing the CoC's strategy to reduce the rate individuals and persons in families return to homelessness.

2C-5.	**Increasing Employment Cash Income-Strategy.**	
	NOFO Section VII.B.5.f.	

	Describe in the field below:
1.	**your CoC's strategy to increase employment income;**
2.	**how your 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 your CoC's strategy to increase income from employment.**

(limit 2,000 characters)

1.The CoC attempts to connect all able persons to employment services to increase employment income. The CoC uses partnerships and trainings to keep CoC member organizations connected with employment services. The CoC projects are monitored and scored on the ability to increase cash income for projects.

2.The CoC has a partnership agreement with the local workforce development board to connect individuals and families to mainstream employment.
CoC projects make direct referrals to CNY WORKS, New York State's ACCES-VR program for supported employment, and agencies that work with LDSSes to provide job search assistance or vocational training. The CoC provides information to project directors and frontline staff about available employment resources through monthly trainings and through announcements in a weekly newsletter transmitted to the entire CoC Membership.

3. The Program Planning and Advocacy committee is responsible for overseeing the CoC's strategy to increase jobs and income from employment.

2C-5a.	**Increasing Employment Cash Income–Workforce Development–Education–Training.**	
	NOFO Section VII.B.5.f.	

	Describe in the field below how your CoC:
1.	**promoted partnerships and access to employment opportunities with private employers and private employment organizations, such as holding job fairs, outreach to employers, and partnering with staffing agencies; and**

2.	**is working with public and private organizations to provide meaningful education and training, on-the-job training, internships, and employment opportunities for program participants.**

(limit 2,000 characters)

1.The CoC has a partnership with the local workforce development board in order to connect clients of permanent housing programs with employers. The CoC encourages projects to employ employment specialists to connect with private employers and staffing agencies. One promising strategy that has emerged in our community is the development of training programs that are open to the community, but target recruitment from residents in PSH and RRH programs. One such program, Project Joseph, run by Catholic Charities of Onondaga County, trains participants in property maintenance skills and has seen a high success rate in job placement. In Oswego County, the agency that administers the CoC Rapid Re-housing Program in that geographic area maintains a mobile employment hub that connects people with employers and employment resources across the county. Moving forward, the CoC plans to track agencies' employment partnership activity, including job fairs and staffing agency partnerships, to assess activity in this area and identify practices that are working well with the intention of encouraging best practices across all providers.
2. There are numerous training opportunities for residents of permanent housing including, connection with vocational rehab, job training programs, and employment specialists designed to connect those able to work to employment to further their recovery and well-being.

2C-5b.	**Increasing Non-employment Cash Income.**	
	NOFO Section VII.B.5.f.	

	Describe in the field below:
1.	**your CoC's strategy to increase non-employment cash income;**
2.	**your CoC's strategy to increase access to non-employment cash sources; and**
3.	**provide the organization name or position title that is responsible for overseeing your CoC's strategy to increase non-employment cash income.**

(limit 2,000 characters)

1.Local Departments of Social Services (LDSS) in the three counties are actively involved in the CoC, participating in the CoC Advisory Board, General Membership Meetings, Coordinated Entry Workgroup meetings, and Planning and Advocacy Committee meetings. LDSS administer federal and state non-employment cash benefits This allows for case managers and LDSS staff to ensure a continuation of benefits and planning for future income. Emergency shelters connect residents with no income to state and federal non-employment cash benefits. L-DSSes have designated staff members that clients, shelter or CoC housing program case managers can contact if special accommodations are needed in the application process. LDSS staff also communicate with CoC partners about changes to state, federal, and local regulations and changes in their organizational structure through CoC Membership and Committee meetings. One strategy that has increased access to public benefits is that this year, eligibility documents for state and federal assistance can now be submitted to Local DSSes using a phone app. The CoC hosts trainings on best practices to connect clients to non-employment cash income, like the SOAR method. The CoC encourages agencies during Membership meetings to access

trainings hosted by the regional SOAR TA provider and provides meeting space and access to SOAR TA trainers.
2.The Program Planning and Advocacy Committee is responsible for overseeing the CoC's strategy to increase non-employment cash income.

3A. Coordination with Housing and Healthcare Bonus Points

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3A-1.	**New PH-PSH/PH-RRH Project–Leveraging Housing Resources.**	
	NOFO Section VII.B.6.a.	

Is your CoC applying for a new PSH or RRH project(s) that uses housing subsidies or subsidized housing units which are not funded through the CoC or ESG Programs to help individuals and families experiencing homelessness?	No

3A-1a.	**New PH-PSH/PH-RRH Project–Leveraging Housing Commitment. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.6.a.	

Select yes or no in the chart below to indicate the organization(s) that provided the subsidies or subsidized housing units for the proposed new PH-PSH or PH-RRH project(s).

1.	**Private organizations**	No
2.	**State or local government**	No
3.	**Public Housing Agencies, including use of a set aside or limited preference**	No
4.	**Faith-based organizations**	No
5.	**Federal programs other than the CoC or ESG Programs**	No

3A-2.	**New PSH/RRH Project–Leveraging Healthcare Resources.**	
	NOFO Section VII.B.6.b.	

Is your CoC applying for a new PSH or RRH project that uses healthcare resources to help individuals and families experiencing homelessness?	No

3A-2a.	**Formal Written Agreements–Value of Commitment–Project Restrictions. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.6.b.	

1.	**Did your CoC obtain a formal written agreement that includes: (a) the project name; (b) value of the commitment; and (c) specific dates that healthcare resources will be provided (e.g., 1-year, term of grant, etc.)?**	No
2.	**Is project eligibility for program participants in the new PH-PSH or PH-RRH project based on CoC Program fair housing requirements and not restricted by the health care service provider?**	No

3A-3.	**Leveraging Housing Resources–Leveraging Healthcare Resources–List of Projects.**	
	NOFO Sections VII.B.6.a. and VII.B.6.b.	

If you selected yes to question 3A-1. or 3A-2., use the list feature icon to enter information on each project you intend for HUD to evaluate to determine if they meet the bonus points criteria.

Project Name	Project Type	Rank Number	Leverage Type
This list contains no items			

3B. New Projects With Rehabilitation/New Construction Costs

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3B-1.	**Rehabilitation/New Construction Costs–New Projects.**	
	NOFO Section VII.B.1.r.	

Is your CoC requesting funding for any new project application requesting $200,000 or more in funding for housing rehabilitation or new construction?	No

3B-2.	**Rehabilitation/New Construction Costs–New Projects.**	
	NOFO Section VII.B.1.s.	

	If you answered yes to question 3B-1, describe in the field below actions CoC Program-funded project applicants will take to comply with:
1.	**Section 3 of the Housing and Urban Development Act of 1968 (12 U.S.C. 1701u); and**
2.	**HUD's implementing rules at 24 CFR part 75 to provide employment and training opportunities for low- and very-low-income persons, as well as contracting and other economic opportunities for businesses that provide economic opportunities to low- and very-low-income persons.**

(limit 2,000 characters)

3C. Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3C-1.	**Designating SSO/TH/Joint TH and PH-RRH Component Projects to Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.**	
	NOFO Section VII.C.	

Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes?	No

3C-2.	**Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.C.	

	If you answered yes to question 3C-1, describe in the field below:
1.	**how serving this population is of equal or greater priority, which means that it is equally or more cost effective in meeting the overall goals and objectives of the plan submitted under Section 427(b)(1)(B) of the Act, especially with respect to children and unaccompanied youth than serving the homeless as defined in paragraphs (1), (2), and (4) of the definition of homeless in 24 CFR 578.3; and**
2.	**how your CoC will meet requirements described in Section 427(b)(1)(F) of the Act.**

(limit 2,000 characters)

4A. DV Bonus Application

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

4A-1.	**New DV Bonus Project Applications.**	
	NOFO Section II.B.11.e.	

Did your CoC submit one or more new project applications for DV Bonus Funding?	Yes

4A-1a.	**DV Bonus Project Types.**	
	NOFO Section II.B.11.	

Select yes or no in the chart below to indicate the type(s) of new DV Bonus project(s) your CoC included in its FY 2021 Priority Listing.

	Project Type	
1.	**SSO Coordinated Entry**	No
2.	**PH-RRH or Joint TH/RRH Component**	Yes

You must click "Save" after selecting Yes for element 1 SSO Coordinated Entry to view questions 4A-3 and 4A-3a.

4A-2.	**Number of Domestic Violence Survivors in Your CoC's Geographic Area.**	
	NOFO Section II.B.11.	

1.	**Enter the number of survivors that need housing or services:**	578
2.	**Enter the number of survivors your CoC is currently serving:**	115
3.	**Unmet Need:**	463

4A-2a.	**Calculating Local Need for New DV Projects.**	
	NOFO Section II.B.11.	

Describe in the field below:

1.	**how your CoC calculated the number of DV survivors needing housing or services in question 4A-2 element 1 and element 2; and**
2.	**the data source (e.g. comparable database, other administrative data, external data source, HMIS for non-DV projects); or**
3.	**if your CoC is unable to meet the needs of all survivors please explain in your response all barriers to meeting those needs.**

(limit 2,000 characters)

To calculate the number of DV survivors needing housing or services, we subtracted the number of survivors who were served in PH projects during FY2021 from the total number of survivors that applied for crisis housing assistance in FY2021, assuming that 75% of survivors will require some form of PH assistance (rapid rehousing or permanent supportive housing).
We used data from HMIS, comparable databases, and from other records kept by local victim service providers. We summed the number of clients in emergency shelter that reported they were currently fleeing from domestic violence during FY2021 (10/1/2020 – 9/30/2021), the number of clients served in emergency shelters by victim services providers, as recorded in their comparable database, and the number of people waitlisted for DV shelters or diverted to non-DV-specific emergency shelters. While there may be some overlap between clients who were waitlisted for DV shelters and those who were served by non-DV emergency shelter, we included both groups because there is a chance that the survivors moved to a different geographic area, did not utilize emergency shelter, or had some other reason that they did not utilize non-DV emergency shelter.

Barriers to meeting the needs of all survivors include a low number of DV-specific beds in each of the geographic areas, a low number of DV targeted permanent housing resources, and a lack of trained personnel able to provide services directed to victims of domestic violence. In addition, relatively few organizations exist in our geographic area whose primary mission is to provide direct services to victims of domestic violence, so the CoC depends heavily on these three organizations to provide services to victims of domestic violence.

4A-4.	**New PH-RRH and Joint TH and PH-RRH Component DV Bonus Projects–Project Applicant Information.**	
	NOFO Section II.B.11.	

Use the list feature icon to enter information on each unique project applicant applying for New PH-RRH and Joint TH and PH-RRH Component DV Bonus projects–only enter project applicant information once, regardless of how many DV Bonus projects that applicant is applying for.

Applicant Name
Oswego County Opp...

Project Applicants Applying for New PH-RRH and Joint TH and PH-RRH DV Bonus Projects

4A-4.	**New PH-RRH and Joint TH and PH-RRH Component DV Bonus Projects–Project Applicant Information–Rate of Housing Placement and Rate of Housing Retention–Project Applicant Experience.**	
	NOFO Section II.B.11.	

Enter information in the chart below on the project applicant applying for one or more New PH-RRH and Joint TH and PH-RRH Component DV Bonus Projects included on your CoC's FY 2021 Priority Listing:

1.	**Applicant Name**	Oswego County Opportunities
2.	**Rate of Housing Placement of DV Survivors–Percentage**	100.00%
3.	**Rate of Housing Retention of DV Survivors–Percentage**	100.00%

4A-4a.	**Calculating the Rate of Housing Placement and the Rate of Housing Retention–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below:
1.	**how the project applicant calculated the rate of housing placement and rate of housing retention reported in question 4A-4; and**
2.	**the data source (e.g. comparable database, other administrative data, external data source, HMIS for non-DV projects).**

(limit 1,000 characters)

1. The rate of housing placement and rate of housing retention is calculated based on all families in shelter who were enrolled in DV-RRH program. All the families enrolled in DV-RRH received housing placement services and also have maintained that housing placement.
2. This data was tracked in the agency's comparable database.

4A-4b.	**Providing Housing to DV Survivor–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below how the project applicant:
1.	**ensured DV survivors experiencing homelessness were assisted to quickly move into safe affordable housing;**
2.	**prioritized survivors–you must address the process the project applicant used, e.g., Coordinated Entry, prioritization list, CoC's emergency transfer plan, etc.;**
3.	**connected survivors to supportive services; and**
4.	**moved clients from assisted housing to housing they could sustain–address housing stability after the housing subsidy ends.**

(limit 2,000 characters)

1. Currently, SAF is the only provider in Oswego County whose primary purpose is to serve victims of DV, SA, dating violence, and stalking. SAF

ensures that victims of DV/SA ensures survivors have immediate access to low barrier services that offer immediate safety, confidentiality, and necessary supports to achieving long term housing stability. Oswego County Opportunities, Inc. (OCO)' s Domestic Violence program; Services to Aid Families (SAF) embraces Housing First in its RRH program. Applicants to OCO's DV RRH program will not be turned away or evicted for chronic substance use, poor credit of financial history, lack of participation or compliance in offered services or criminal offenses.
2. The shelter operated by OCO assesses survivors and refers to Coordinated Entry for housing placement. The current CoC DV Bonus project operated by Oswego County Opportunities uses Coordinated Entry to fill its beds.
3. During the intake process the staff collect information about skills, financial supports and community connections the survivor may or may not have in place and to assist them with identifying barriers that could affect their economic independence so a comprehensive plan can be developed for success. SAF has adapted a model approach to working with victims of Domestic Violence, Sexual Assault, Dating Violence and Stalking that was created by the National Network to End Domestic Violence (NNEDV). The guiding principles require that participation in services is voluntary and not mandated, and that staff work as allies and not as providers. These relationships are then used as the foundation to assist survivors in reaching their goals. Input from survivors is actively solicited and incorporated when designing services and policies to ensure services are driven by survivors.
4. OCO ensures that survivors are given services needed to maintain housing stability. The SAF program has also used Emergency Housing Vouchers to ensure long term stability of survivors.

4A-4c.	**Ensuring DV Survivor Safety–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below examples of how the project applicant ensured the safety of DV survivors experiencing homelessness by:
1.	**training staff on safety planning;**
2.	**adjusting intake space to better ensure a private conversation;**
3.	**conducting separate interviews/intake with each member of a couple;**
4.	**working with survivors to have them identify what is safe for them as it relates to scattered site units and/or rental assistance;**
5.	**maintaining bars on windows, fixing lights in the hallways, etc. for congregate living spaces operated by the applicant; and**
6.	**keeping the location confidential for dedicated units and/or congregate living spaces set-aside solely for use by survivors.**

(limit 5,000 characters)

1.
OCO Services to Aid Families (SAF) is a licensed victim services provider. SAF has 43 years of experience providing trauma-informed, victim-centered direct services to survivors, regardless of age, sex, race, ethnicity, gender, and/or religious affiliation.
SAF continues to be the county's sole provider of domestic violence and rape crisis services, including an 18-bed licensed shelter, a 24-hour crisis hotline, supportive individual and group counseling, advocacy, therapy, legal assistance, case management, housing and relocation services, emergency

financial assistance, outreach, accompaniment, training and OVS application assistance. All SAF staff are required to complete initial training (40 hours) including: DV Basics, Marginalized Groups, Children and Victimization, Victim Sensitivity and Counseling, Court Systems, Advocacy, Shelter/Residential Services, Safety Planning, Community Resources, & Documentation. In addition, all OCO-SAF staff complete 2 weeks of training answering the hotline to ensure information is disseminated accurately to victims accessing services. All staff are required to complete a comprehensive written exam to test their knowledge of victim services. Ongoing Staff Development includes 10 hours annually of additional training related to DV/SA. SAF Staff are also provided opportunities to attend local, regional, and out of state trainings that focus on providing services to victims of DV/SA.

2.Direct victim services provided at various locations throughout Oswego County align with best practices and confidentiality mandates. At each location, Advocates have designated space where they can meet with clients in private to ensure that the confidentiality of the client and the information being shared is maintained. Partnerships with community agencies and criminal justice organizations allow for increased opportunities to meet with and access victims of domestic violence and other crimes. In addition, Advocates are frequently accessed by staff within those agencies for information and consultation in regards to specific cases and services that can be offered. Information sharing among staff about clients is only to be done when several staff people are working with a single client and their household, when soliciting advice on applying SAF's policies and procedures, or when case management is discussed. Whenever discussing a client's issues care should be taken to insure that others cannot overhear the conversation.
3.An Advocate would never meet with or interview a couple in the same space/location.
4.The HUD Advocate will work with landlord and complete necessary documentation that the housing unit has been inspected and meets habitability standards prior to signing a lease or receiving of rental assistance. The Advocate will also assist the client with reviewing the lease to ensure that repairs and safety issues will be the responsibility of the landlord/leasing company and will be addressed promptly. Clients will be encouraged to secure housing in areas of the county where police response time is faster and to ensure they have a printed copy of any Orders issues by local courts available for law enforcement. Staff recognizes that some survivors choose to limit the amount of information they provide to landlords and will support the decision to not inform the landlord that an Order of Protection exists, but will discuss how it can be beneficial to provide the landlord with some detail so they can assist in helping keep themselves and their children safe. This may include, but is not required by program participants; providing a copy of the Order of Protection, a physical description of their abusive partner, or any vehicle being used by the abusive party to the landlord/leasing agency. If the unit is located in an area where there is an active neighborhood watch committee, the option for the victim to participate will be explored and will depend on the victim's specific circumstances and decision.
5.Not Applicable- not a congregate setting
6.Not Applicable - not a congregate setting

NOFO Section II.B.11.

Describe in the field below how the project evaluated its ability to ensure the safety of DV survivors the project served.

(limit 2,000 characters)

SAF Program Evaluates the safety of each client and the success of ensuring the safety of the client based on the information the program receives from the survivor. Each survivor is asked to complete a comprehensive survey that provides details of how the program has assisted them in increasing their knowledge of available services, safety, accessibility to a violence free environment and housing stability. In addition, staff conduct face to face home visits with HUD participants and ask for their feedback on how we can improve service delivery. The evaluation process which is structured to evaluate the program specific objectives and goals which will determine if the performance measures are being achieved. Total Performance will be measured for the following goals and specific objectives as outlined:
•Make comprehensive non–residential services available victims of domestic, sexual violence, dating violence, trafficking and other crimes in Oswego County.
•Increase the safety and well-being of victims of domestic, sexual violence and other crimes, who access support services through the OCO SAF Program.
•Provide trauma-informed support services for victims of domestic, sexual violence and other crimes, to assist them with understanding the dynamics of abuse and to assist with stabilizing their lives after victimization.
•Increase domestic, sexual violence, dating violence, trafficking and other crime victim's satisfaction with agency services received.

4A-4d.	**Trauma-Informed, Victim-Centered Approaches–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below examples of the project applicant's experience in using trauma-informed, victim-centered approaches to meet needs of DV survivors in each of the following areas:
1.	**prioritizing program participant choice and rapid placement and stabilization in permanent housing consistent with participants' preferences;**
2.	**establishing and maintaining an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures program participant staff interactions are based on equality and minimize power differentials;**
3.	**providing program participants access to information on trauma, e.g., training staff on providing program participants with information on trauma;**
4.	**emphasizing program participants' strengths, e.g., strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans include assessments of program participants strengths and works towards goals and aspirations;**
5.	**centering on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;**
6.	**providing opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and**
7.	**offering support for parenting, e.g., parenting classes, childcare.**

(limit 5,000 characters)

1.Upon program entry, staff will work with clients, obtaining their input, to create a realistic, detailed and time-oriented stability plan which includes strategies and resources for maintaining and increasing income and maintaining stable housing. Stability plans are reviewed throughout service provision to assess

progress and to develop additional strategies to overcome new barriers and/or changing priorities. Staff meet with a client weekly to provide direct 1:1 assistance and provide direct linkage and referrals to external community providers that align with the client's goals for self sufficiency and individual need. Program services are self-guided by each individual client. The amount of time a client remains in program is based on their determination of need.
2.SAF staff use strength-based, voluntary, and trauma-informed care approaches with survivors of DV through each step of assisting them in securing housing and working towards self-sufficiency. The Voluntary Services approach is based on the notion that participation in services should be voluntary and not a condition of housing or receiving other services.
3.Trauma-informed advocacy takes "good advocacy" a step further, by incorporating an understanding of the effects of trauma on staff, survivors, organizations, and communities. Staff emphasize that trauma can stem from experiences that occur over a lifetime, including childhood, intergenerational, community, system-induced, historical, political, and immigration-related trauma. In understanding that trusting relationships are central to healing from trauma, SAF staff provide a range of services that strive to validate survivors' diverse experiences; enhance their feelings of connection, empowerment and engagement; and reduce their social isolation. Staff work to provide a physically and emotionally safe environment for both survivors and staff, ensuring that programs are warm, secure, inviting, and culturally respectful and resonant. Providing an emotionally safe, non-judgmental environment is to avoid any further traumatization of survivors, including not mirroring abusive behaviors in any way; being careful to avoid replicating power and control dynamics; and refraining from punishing, "policing," or subjecting survivors to excessive and rigid rules. SAF Advocates provide clear information to survivors about what they can expect from staff and the agency is part of creating an emotionally safe, predictable, and stable environment.
4.Client-centered programming is critical to ensure DV survivors engage in services and work toward housing permanency. Advocates individualize the way services are delivered in recognition that people are experts in their own lives. Goals are developed, but each participant defines success. Procedures are developed to be non-intrusive into people's lives, invite participants to have input about services in which they'll participate and information they will share, provide clear, consistent information about program expectations, rely on natural consequences as the best teacher and acknowledge that even though we are considered experts in the field, we don't know what's best for everyone.
5. OCO maintains and promotes an environment where consumers' and employees' similarities and differences are respected/valued. OCO is committed to achieving racial equity, focusing on the power and influence of the program and working in partnership with other community organizations to develop better policy and practices that address the racial disparities in all social services systems. C&DS continues to review and implement best practices within the program that are firmly grounded in inclusion and equity.
Working to counteract ongoing oppression, including racism, heterosexism, discrimination, classism, and the effects of colonialism and eurocentrism, plus how forms of oppression intersect with domestic and sexual violence and other kinds of trauma; how forms of oppression can impede access to resources; and ultimately, incorporating this understanding into the services provided, through the ways that survivors and staff work together, and through systems, policy, and social change work.
6. SAF provides 24/7 Crisis support to survivors of domestic violence, sexual assault, stalking, and dating violence through the Crisis Hotline. SAF also

provides a full continuum of services to ensure survivors are provided with the needed supports to achieve safety. Counseling and therapy services are free of charge and are available without any time limits, SAF offers both short and long-term therapy options. SAF has established satellite offices throughout Oswego County due to the rural nature of our community and limited transportation options available.
7. Referrals to childcare and parenting classes are provided to all survivors.

4A-4e.	**Meeting Service Needs of DV Survivors–Project Applicant Experience.**	
	NOFO Section II.B.11.	

	Describe in the field below:
1.	**supportive services the project applicant provided to domestic violence survivors experiencing homelessness while quickly moving them into permanent housing and addressing their safety needs; and**
2.	**provide examples of how the project applicant provided the supportive services to domestic violence survivors.**

(limit 5,000 characters)

1.SAF Advocates provide DV survivors who are homeless with supports and linkages that assist them with maintaining permanent housing. Consumers can receive case management for up to 2 years before exiting the program.
Upon entry to the program staff will work with clients, obtaining their input, to create a realistic, detailed and time-oriented stability plan which includes strategies and resources for maintaining and increasing income and maintaining stable housing. Stability plans are reviewed throughout service provision to assess and identify where progress has been made and to develop additional strategies to overcome new barriers and/or changing priorities. Staff meet with clients weekly to provide direct 1:1 assistance and provide direct linkage and referrals to external community providers that align with the client's goals for self-sufficiency and individual need. amount of time a client remains in program is based on their determination of need. Clients have the ability to self-determine that they no longer want to participate in services and program staff then work with the individual/family to develop an exit plan tailored to the needs of the family. The exit plan will be developed with the client's input to ensure that proper supports are in place to reduce the likelihood of a return to homelessness if/when challenges arise. Once a client has successfully discharged from the program, at a minimum, staff will attempt to conduct 3 follow-up phone interviews to assess the client's progress/stability and, if applicable, discuss any issues or concerns that they may need assistance with to resolve. If the client is struggling, or in need of additional supports, staff will continue to provide information and referrals, or directly connect them to the appropriate agencies that are able to assist in maintaining permanent housing.
2.Advocacy
The HUD Housing staff provide advocacy to assist in securing financial assistance, victim's compensation, counseling services, securing safe and affordable housing, assisting a victim with obtaining any needed supports, resources, or services including; employment, healthcare, food, clothing, or personal care items.
Crisis Intervention
Staff will respond in person or via telephone to clients experiencing a crisis to aid in the development of a safety plan and next steps for service.
Counseling

The staff provide confidential, private, non-judgmental, and supportive individual counseling which empowers victims to make their own decisions.
Goal Planning
Participants work with the Advocate to prioritize their goals and determine the steps necessary to accomplish those goals. The HUD funded staff will work with participants to develop detailed and time oriented stability plans which include strategies and resources for maintaining and increasing income and maintaining stable housing.
Transportation
Transportation is provided to assist participants in attending appointments when no other options are available. Transportation will be provided to victims and their children to services such as; medical, legal, interviews for employment, job training, and financial assistance compliance with Local DSS.
Connection to Financial Resources- Each survivor lacking financial resources/income is given the opportunity to meet with Local DSS to apply for TANF services. Survivors that are in need of applying for SSDI, unemployment insurance, child support, spousal maintenance, or any other form of financial assistance are provided with direct assistance from staff or connected to the appropriate agency for assistance.
Financial Counseling Sessions - “Moving Ahead through Financial Management”, a curriculum created by the Allstate Foundation and the National Network to End Domestic Violence, will be used for financial planning..
Connect to OCO Workforce Development programs – The Advocate provide information on all options available through OCO Workforce Development programming. Services are offered through a “Community Hub” to increase access and address multiple needs in one location. RRH participants who are interested will be connected to the program and, if needed, provided with transportation to sessions
Follow-up
Support services will be available after exiting the program. Clients will be encouraged to contact the SAF Program to ensure their continued goal of stable housing.
Case Management
The HUD funded staff will use a comprehensive strength based service approach that promotes partnering with consumers to work on mutually developed goals. It empowers consumers to take charge of their lives and become self-reliant and developing their natural supports.
Skill Assessment
The Housing Advocate will assess individual aptitudes, interests, education background, work history and acquired job skills. Information gathered will direct participants towards educational and employment tracks that they would be most likely to succeed in.

4A-4f.	**Trauma-Informed, Victim-Centered Approaches–New Project Implementation.**	
	NOFO Section II.B.11.	

	Provide examples in the field below of how the new project will:
1.	**prioritize program participant choice and rapid placement and stabilization in permanent housing consistent with participants’ preferences;**
2.	**establish and maintain an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures program participant staff interactions are based on equality and minimize power differentials;**

3.	**provide program participants access to information on trauma, e.g., training staff on providing program participants with information on trauma;**
4.	**place emphasis on program participants' strengths, e.g., strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans include assessments of program participants strengths and works towards goals and aspirations;**
5.	**center on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;**
6.	**provide opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and**
7.	**offer support for parenting, e.g., parenting classes, childcare.**

(limit 5,000 characters)

1.Upon program entry, staff will work with clients, obtaining their input, to create a realistic, detailed and time-oriented stability plan which includes strategies and resources for maintaining and increasing income and maintaining stable housing. Stability plans are reviewed throughout service provision to assess progress and to develop additional strategies to overcome new barriers and/or changing priorities. Staff meet with a client weekly to provide direct 1:1 assistance and provide direct linkage and referrals to external community providers that align with the client's goals for self sufficiency and individual need. Program services are self-guided by each individual client. The amount of time a client remains in program is based on their determination of need.
2.SAF staff use strength-based, voluntary, and trauma-informed care approaches with survivors of DV through each step of assisting them in securing housing and working towards self-sufficiency. The Voluntary Services approach is based on the notion that participation in services should be voluntary and not a condition of housing or receiving other services.
3.Trauma-informed advocacy takes "good advocacy" a step further, by incorporating an understanding of the effects of trauma on staff, survivors, organizations, and communities. Staff emphasize that trauma can stem from experiences that occur over a lifetime, including childhood, intergenerational, community, system-induced, historical, political, and immigration-related trauma. In understanding that trusting relationships are central to healing from trauma, SAF staff provide a range of services that strive to validate survivors' diverse experiences; enhance their feelings of connection, empowerment and engagement; and reduce their social isolation. Staff work to provide a physically and emotionally safe environment for both survivors and staff, ensuring that programs are warm, secure, inviting, and culturally respectful and resonant. Providing an emotionally safe, non-judgmental environment is to avoid any further traumatization of survivors, including not mirroring abusive behaviors in any way; being careful to avoid replicating power and control dynamics; and refraining from punishing, "policing," or subjecting survivors to excessive and rigid rules. SAF Advocates provide clear information to survivors about what they can expect from staff and the agency is part of creating an emotionally safe, predictable, and stable environment.
4.Client-centered programming is critical to ensure DV survivors engage in services and work toward housing permanency. Advocates individualize the way services are delivered in recognition that people are experts in their own lives. Goals are developed, but each participant defines success. Procedures are developed to be non-intrusive into people's lives, invite participants to have input about services in which they'll participate and information they will share, provide clear, consistent information about program expectations, rely on natural consequences as the best teacher and acknowledge that even though we are considered experts in the field, we don't know what's best for everyone.
5. OCO will continue to maintain and promote an environment where

consumers' and employees' similarities and differences are respected/valued. OCO is committed to achieving racial equity, focusing on the power and influence of the program and working in partnership with other community organizations to develop better policy and practices that address the racial disparities in all social services systems. Working to counteract ongoing oppression, including racism, heterosexism, discrimination, classism, and the effects of colonialism and eurocentrism, plus how forms of oppression intersect with domestic and sexual violence and other kinds of trauma; how forms of oppression can impede access to resources; and ultimately, incorporating this understanding into the services provided, through the ways that survivors and staff work together, and through systems, policy, and social change work.
6. Counseling and therapy services are free of charge and are available without any time limits, SAF offers both short and long-term therapy options. SAF has established satellite offices throughout Oswego County due to the rural nature of our community and limited transportation options available.
7 The new project will cover childcare costs from licensed community providers, as needed.

4B. Attachments Screen For All Application Questions

We prefer that you use PDF files, though other file types are supported. Please only use zip files if necessary.

Attachments must match the questions they are associated with.

Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process.

We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

Document Type	Required?	Document Description	Date Attached
1C-14. CE Assessment Tool	Yes	CE Assessment Tool	11/05/2021
1C-7. PHA Homeless Preference	No	PHA Homeless Pref...	11/05/2021
1C-7. PHA Moving On Preference	No	PHA Moving On Pre...	11/05/2021
1E-1. Local Competition Announcement	Yes	Local Competition...	11/05/2021
1E-2. Project Review and Selection Process	Yes	Project Review an...	11/05/2021
1E-5. Public Posting–Projects Rejected-Reduced	Yes	Public Posting- P...	11/05/2021
1E-5a. Public Posting–Projects Accepted	Yes	Public Posting- P...	11/05/2021
1E-6. Web Posting–CoC-Approved Consolidated Application	Yes		
3A-1a. Housing Leveraging Commitments	No		
3A-2a. Healthcare Formal Agreements	No		
3C-2. Project List for Other Federal Statutes	No		

Attachment Details

Document Description: CE Assessment Tool

Attachment Details

Document Description: PHA Homeless Preference

Attachment Details

Document Description: PHA Moving On Preference

Attachment Details

Document Description: Local Competition Announcement

Attachment Details

Document Description: Project Review and Selection Process

Attachment Details

Document Description: Public Posting- Projects Rejected-Reduced

Attachment Details

Document Description: Public Posting- Projects Accepted

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. CoC Identification	09/21/2021
1B. Inclusive Structure	11/04/2021
1C. Coordination	11/04/2021
1C. Coordination continued	11/05/2021
1D. Addressing COVID-19	11/05/2021
1E. Project Review/Ranking	11/05/2021
2A. HMIS Implementation	11/05/2021
2B. Point-in-Time (PIT) Count	10/25/2021
2C. System Performance	11/05/2021
3A. Housing/Healthcare Bonus Points	11/05/2021
3B. Rehabilitation/New Construction Costs	10/25/2021

3C. Serving Homeless Under Other Federal Statutes	09/21/2021
4A. DV Bonus Application	11/05/2021
4B. Attachments Screen	Please Complete
Submission Summary	No Input Required

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.0

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1 (800) 355-0420 info@orgcode.com www.orgcode.com

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:

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- 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.

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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 or the assessor does not understand the 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

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 THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE:

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A. History of Housing and Homelessness

1. Where do you 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:**

2. How long has it been since you lived in permanent stable housing? _____ ☐ Refused

3. In the last three years, how many times have you been homeless? _____ ☐ Refused

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

B. Risks

4. In the past six months, how many times have you...

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 you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you 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:**

5. Have you been attacked or beaten up since you've become homeless? ☐ **Y** ☐ N ☐ Refused

6. Have you threatened to or tried to harm yourself 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:**

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7. Do you have any legal stuff going on right now that may result in you 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:**

8. Does anybody force or trick you to do things that you do not want to do? ☐ **Y** ☐ N ☐ Refused

9. Do you ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you 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:**

C. Socialization & Daily Functioning

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

11. Do you 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 10 OR "NO" TO QUESTION 11, THEN SCORE 1 FOR **MONEY MANAGEMENT.** **SCORE:**

12. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled? ☐ Y ☐ **N** ☐ Refused

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

13. Are you 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:**

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

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

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D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?	☐ **Y**	☐ N	☐ Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ **Y**	☐ N	☐ Refused
17. 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?	☐ **Y**	☐ N	☐ Refused
18. Do you 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
19. When you are sick or not feeling well, do you avoid getting help?	☐ **Y**	☐ N	☐ Refused
20. *FOR FEMALE RESPONDENTS ONLY:* Are you currently pregnant?	☐ **Y**	☐ N	☐ N/A or Refused

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

21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?	☐ **Y**	☐ N	☐ Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing?	☐ **Y**	☐ N	☐ Refused

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

23. Have you 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
24. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused

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

IF THE RESPONENT SCORED 1 FOR **PHYSICAL HEALTH** AND 1 FOR **SUBSTANCE USE** AND 1 FOR **MENTAL HEALTH**, SCORE 1 FOR **TRI-MORBIDITY**. **SCORE:**

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25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? ☐ **Y** ☐ N ☐ Refused

26. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? ☐ **Y** ☐ N ☐ Refused

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

27. *YES OR NO:* Has your 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 have experienced? ☐ **Y** ☐ N ☐ Refused

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

Scoring Summary

DOMAIN	SUBTOTAL	RESULTS
PRE-SURVEY	/1	**Score: Recommendation:**
A. HISTORY OF HOUSING & HOMELESSNESS	/2	0-3: no housing intervention
B. RISKS	/4	4-7: an assessment for Rapid Re-Housing
C. SOCIALIZATION & DAILY FUNCTIONS	/4	8+: an assessment for Permanent Supportive Housing/Housing First
D. WELLNESS	/6	
GRAND TOTAL:	/17	

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 practical, evidence-informed tools that enhance their ability to to satisfy federal regulations and quickly implement 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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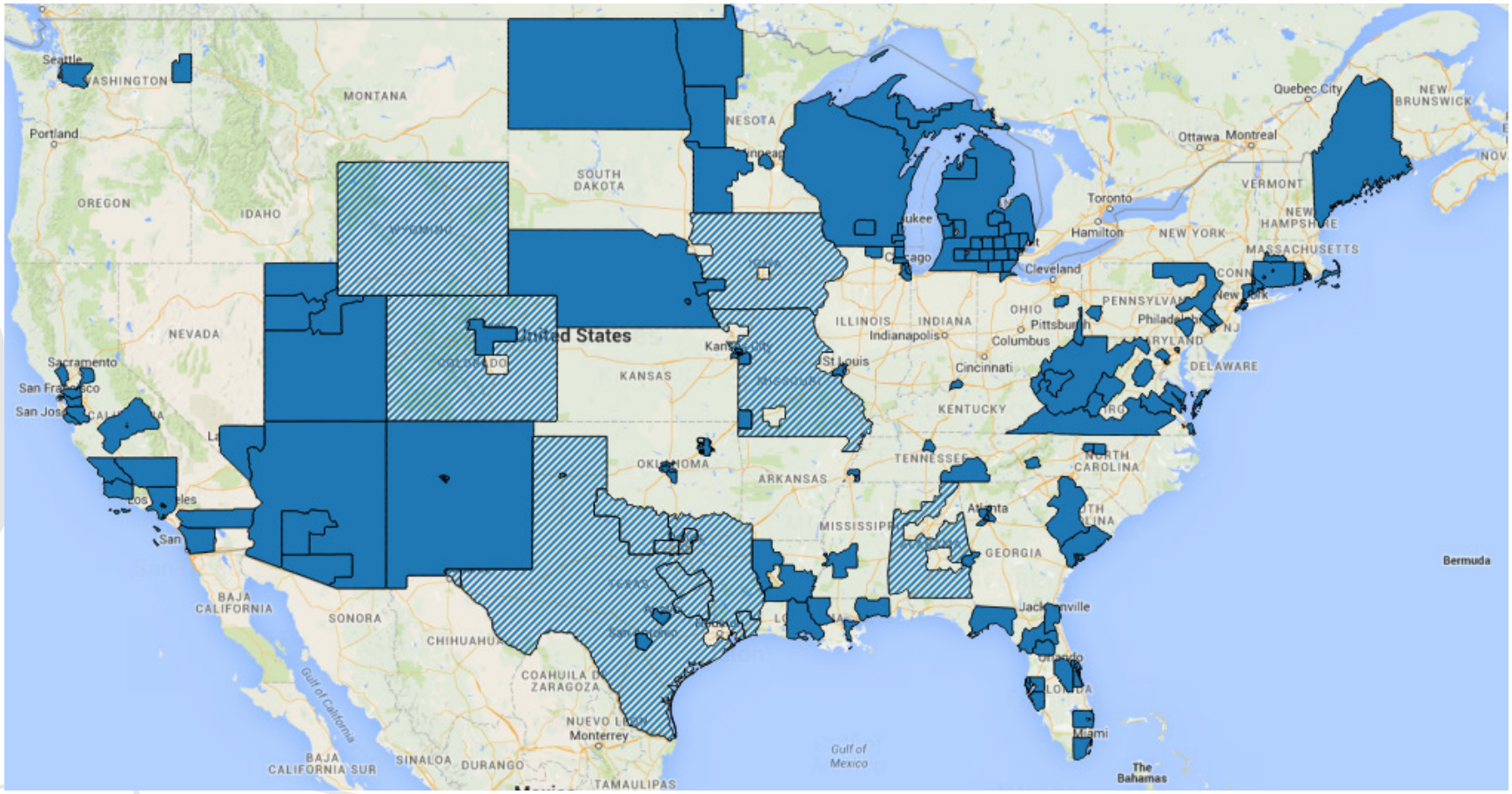
Appendix B: Where the VI-SPDAT is being used in the United States

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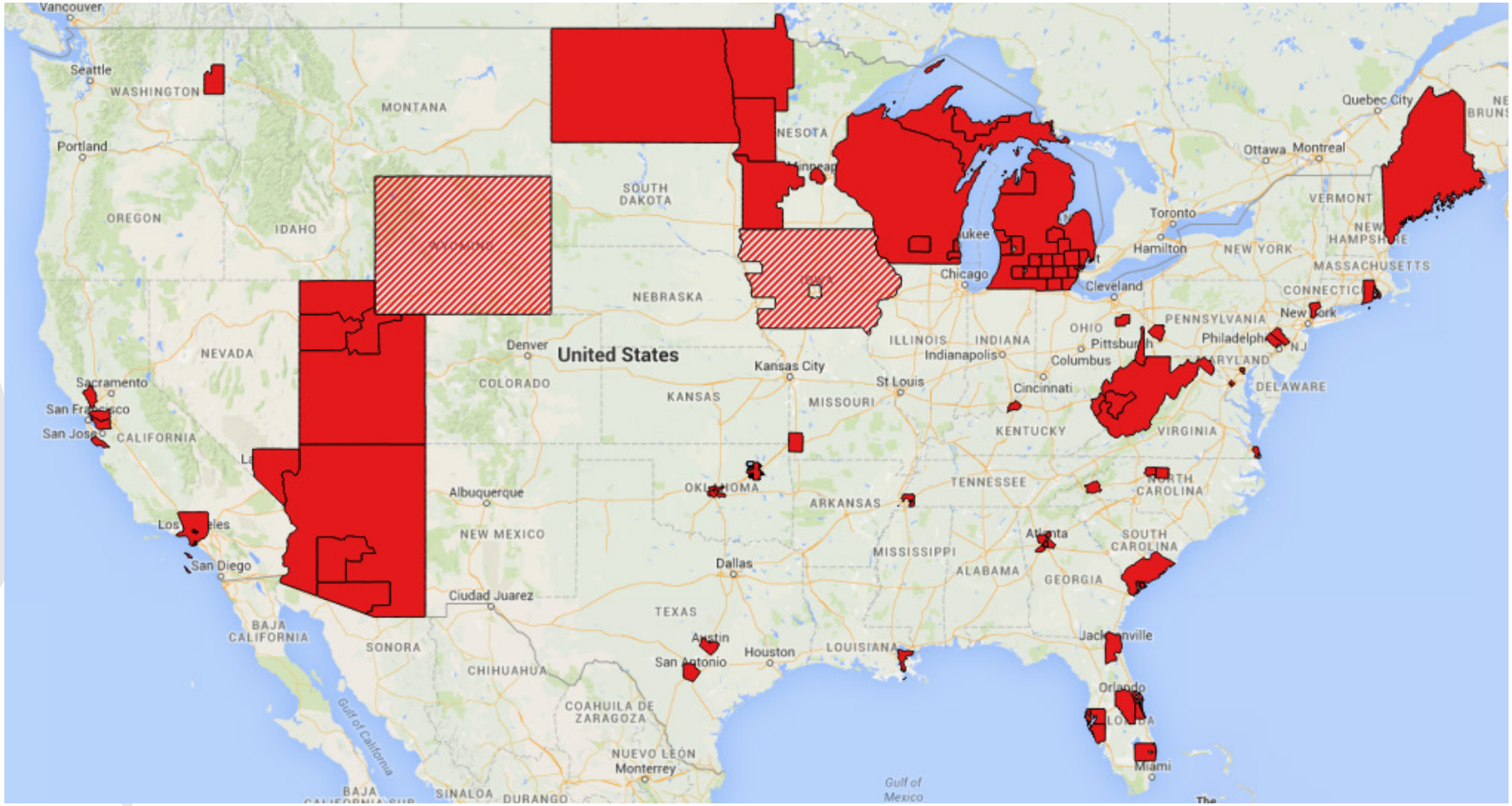
Appendix B: Where the SPDAT is being used (as of May 2015)

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

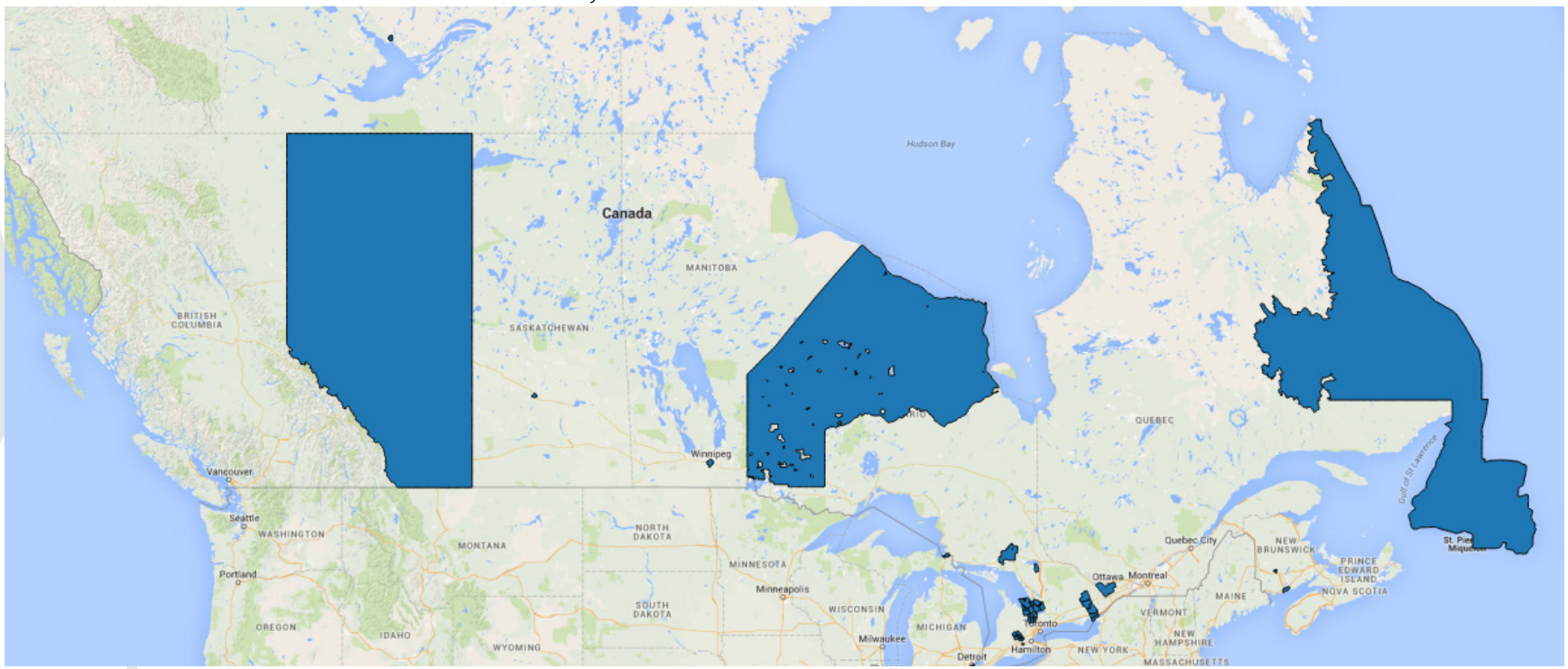
New Brunswick
- City of Fredericton
- City of Saint John

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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Transition Age Youth -

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(TAY-VI-SPDAT)

"Next Step Tool for Homeless Youth"

AMERICAN VERSION 1.0

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Eric Rice, PhD

COMMUNITY SOLUTIONS

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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
- 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/

The TAY-VI-SPDAT – The Next Step Tool for Homeless Youth

OrgCode Consulting, Inc. and Community Solutions joined forces with the Corporation for Supportive Housing (CSH) to combine the best parts of products and expertise to create one streamlined triage tool designed specifically for youth aged 24 or younger.

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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

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 THE PERSON IS 17 YEARS OF AGE OR LESS, THEN SCORE 1.

SCORE:

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A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)

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

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

2. How long has it been since you lived in permanent stable housing? _____ ☐ Refused

3. In the last three years, how many times have you been homeless? _____ ☐ Refused

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

B. Risks

4. In the past six months, how many times have you...

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 you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? ____ ☐ Refused

f) Stayed one or more nights in a holding cell, jail, prison or juvenile detention, whether it 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:**

5. Have you been attacked or beaten up since you've become homeless? ☐ **Y** ☐ N ☐ Refused

6. Have you threatened to or tried to harm yourself 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:**

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7. Do you have any legal stuff going on right now that may result in you being locked up, having to pay fines, or that make it more difficult to rent a place to live?	☐ **Y**	☐ N	☐ Refused	
8. Were you ever incarcerated when younger than age 18?	☐ **Y**	☐ N	☐ Refused	
IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **LEGAL ISSUES.**				**SCORE:**
9. Does anybody force or trick you to do things that you do not want to do?	☐ **Y**	☐ N	☐ Refused	
10. Do you ever do things that may be considered to be risky like exchange sex for money, food, drugs, or a place to stay, run drugs for someone, have unprotected sex with someone you 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:**

C. Socialization & Daily Functioning

11. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money?	☐ **Y**	☐ N	☐ Refused	
12. Do you get any money from the government, an inheritance, an allowance, working under the table, a regular job, or anything like that?	☐ Y	☐ **N**	☐ Refused	
IF "YES" TO QUESTION 11 OR "NO" TO QUESTION 12, THEN SCORE 1 FOR **MONEY MANAGEMENT.**				**SCORE:**
13. Do you have planned activities, other than just surviving, that make you feel happy and fulfilled?	☐ Y	☐ **N**	☐ Refused	
IF "NO," THEN SCORE 1 FOR **MEANINGFUL DAILY ACTIVITY.**				**SCORE:**
14. Are you 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:**

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15. Is your current lack of stable housing...

a) Because you ran away from your family home, a group home or a foster home?	☐ **Y**	☐ N	☐ Refused
b) Because of a difference in religious or cultural beliefs from your parents, guardians or caregivers?	☐ **Y**	☐ N	☐ Refused
c) Because your family or friends caused you to become homeless?	☐ **Y**	☐ N	☐ Refused
d) Because of conflicts around gender identity or sexual orientation?	☐ **Y**	☐ N	☐ Refused

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

e) Because of violence at home between family members?	☐ **Y**	☐ N	☐ Refused
f) Because of an unhealthy or abusive relationship, either at home or elsewhere?	☐ **Y**	☐ N	☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **ABUSE/TRAUMA.** **SCORE:**

D. Wellness

16. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?	☐ **Y**	☐ N	☐ Refused
17. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?	☐ **Y**	☐ N	☐ Refused
18. 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?	☐ **Y**	☐ N	☐ Refused
19. Do you 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
20. When you are sick or not feeling well, do you avoid getting medical help?	☐ **Y**	☐ N	☐ Refused
21. Are you currently pregnant, have you ever been pregnant, or have you ever gotten someone pregnant?	☐ **Y**	☐ N	☐ Refused

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

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

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

24. If you've ever used marijuana, did you ever try it at age 12 or younger? ☐ **Y** ☐ N ☐ Refused

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

25. Have you 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

26. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help? ☐ **Y** ☐ N ☐ Refused

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

IF THE RESPONENT SCORED 1 FOR **PHYSICAL HEALTH** AND 1 FOR **SUBSTANCE USE** AND 1 FOR **MENTAL HEALTH**, SCORE 1 FOR **TRI-MORBIDITY**. **SCORE:**

27. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? ☐ **Y** ☐ N ☐ Refused

28. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? ☐ **Y** ☐ N ☐ Refused

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

Scoring Summary

DOMAIN	SUBTOTAL
PRE-SURVEY	/1
A. HISTORY OF HOUSING & HOMELESSNESS	/2
B. RISKS	/4
C. SOCIALIZATION & DAILY FUNCTIONS	/4
D. WELLNESS	/6
GRAND TOTAL:	/17

RESULTS	
Score:	**Recommendation:**
0-3:	no moderate or high intensity services be provided at this time
4-7:	assessment for time-limited supports with moderate intensity
8+:	assessment for long-term housing with high service intensity

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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 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 youth at some point in the future
- safety planning

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Appendix A: About the TAY-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 practical, evidence-informed tools that enhance their ability to to satisfy federal regulations and quickly implement 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.

The Youth – Transition Age Youth Tool from CSH

Released in May 2013, the Corporation for Supportive Housing (CSH) partnered with Dr. Eric Rice, Assistant Professor at the University of Southern California (USC) School of Social Work, to develop a triage tool that targets homeless Transition Age Youth (TAY) for permanent supportive housing. It consists of six items associated with long-term homelessness (five or more years) among transition-aged youth (age 18-24).

Version 2 of the VI-SPDAT

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.

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The TAY-VI-SPDAT – The Next Step Tool for Homeless Youth

One piece of feedback was the growing concern that youth tended to score lower on the VI-SPDAT, since the Vulnerability Index assesses risk of mortality which is less prevalent among younger populations. So, in version 2 of the VI-SPDAT, OrgCode Consulting, Inc. and Community Solutions joined forces with CSH to combine the best parts of the TAY, the VI, and the SPDAT to create one streamlined triage tool designed specifically for youth aged 24 or younger.

If you are familiar with the VI-SPDAT, you will notice some differences in the TAY-VI-SPDAT compared to VI-SPDAT 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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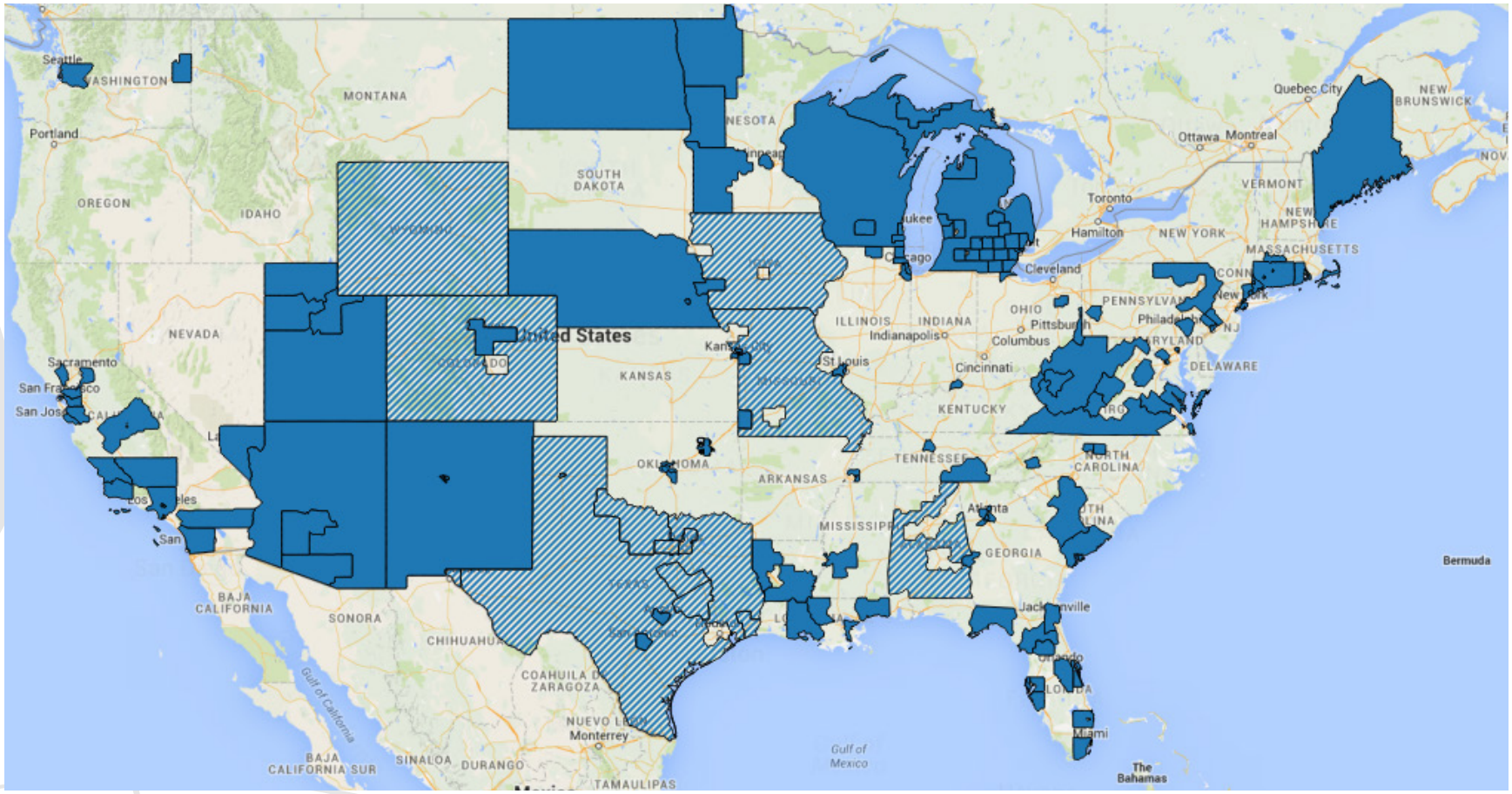
Appendix B: Where the VI-SPDAT is being used in the United States

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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For all applicants who do not have a preference, to the extent that it is necessary to meet income targeting requirements, those who have household incomes above 30% of AMI may be bypassed.

First Preference, Special Programs

Families eligible for the following special programs will be maintained on special Waiting Lists for each program. The lists for each special program shall be organized based upon date and time of application. Persons in this preference category shall be eligible to apply for assistance even when the general Waiting List is closed. The special programs are as follows:

- Homeless Veterans with Severe Psychiatric or Substance Abuse Disorders, certified by the Syracuse Veterans Affairs Medical Center for participation in the HUD-VASH Program. SHA will accept eligible applicants for this program via a written referral form the local Veterans Administration Medical Center Housing unit.
- Eligible applicants for the SRO Mod-Rehab Program. These participants will be referred via a memo from the Syracuse YMCA.
- Household to be admitted to the program via target funding, including, but not limited to, tenant protection vouchers, enhanced vouchers, or any special purchase voucher.

Second Preference:

All of the following shall have equal preference:

- Families with children whose blood lead level is equal or greater than 20 ug/dL (micrograms of lead per deciliter) for a single test or 15-19 ug/dL in two tests taken at least three (3) months apart in children age six and under, as identified by the Onondaga County Health Department, and the lead problem is attributed to the family's present housing.
- Domestic Violence: An applicant who vacated their unit because of domestic violence or lives in a unit with a person who engages in violence. Documented actual or threatened violence directed toward self or member(s) of household by spouse or other member of applicant's household must come from a third party source, i.e. shelter advocate, social worker, law enforcement agency, etc. The domestic violence should have occurred recently or be of a continuing nature.
- Families who are involuntarily displaced via a government or government sponsored action and through no fault of their own. Persons displaced due to a foreclosure shall not be eligible for this preference.

- Eligible families and Youths (18 or older) referred by written memo to SHA from the County Child Welfare Agency for the Family Unification Program (FUP).

All persons in this preference category shall be placed on the Waiting List in order of the date and time of application. Persons in this preference category shall be eligible to apply for assistance even when the general Waiting List is closed.

Third Preference:

- Applicants and Tenants in NON-profit neighborhood based housing programs.

- Families presently under the SHA Shelter Pus Care Program and/ or VASH program who, in the opinion of their sponsoring agency and the Authority, will no longer require involvement in the "care" aspects of the program will be given a first preference. Families that have progressed to a point where they are stable and no longer require the support and aid of the partnering agencies will be given a Housing Choice Voucher. This action will make slots available in the Shelter Plus care Program for *more* homeless families who are in need and require the aid of the other partnering Agencies involved.

8. Notice and Opportunity for a Meeting where Local Preference is Denied

If SHA determines that an applicant does not meet the criteria for receiving a local preference, the applicant has the right to meet with SHA to review the decision. If requested, the Supervisor of Section 8 or their designee will conduct the meeting. The procedures specified in this paragraph will be carried out in accordance with HUD's requirements. The applicant may exercise other rights if the applicant believes that he or she has been discriminated against on the basis of race, color, religion, sex, national origin, age, or handicap.

VI. Leasing a Unit – Occupancy Policies

A. Issuance of a Voucher (24 CFR 982.302) & Information when Family is Selected (24 CFR 982.301)

Vouchers:

The number of unused Vouchers will be evaluated on at least a monthly basis. Once a determination has been made of available Vouchers, the next individuals/families on the waiting list will be contacted. The applicants will be mailed a letter advising them that their name has come to the top of the list for subsidy assistance and will be requested to schedule an interview/briefing for the formal application and verification of their preferences.

Executive Director
William Simmons

SYRACUSE HOUSING AUTHORITY
Building Neighborhoods. Growing Dreams.

Main Office

MEMORANDUM OF UNDERSTANDING

Syracuse Housing Authority Housing Choice Voucher Program
& Mainstream Voucher Grant Service Partner Housing and Homeless Coalition of Central New York

I. Purpose of This MOU

This memorandum of understanding ("MOU") has been created and entered into on September 5, 2019 between the **Syracuse Housing Authority** ("SHA") and **The United Way of Central New York on behalf of the Housing and Homeless Coalition of Central New York ("The Coalition"),** (collectively, "the Parties") in connection with SHA's application ("the Application") in response to the U.S. Department of Housing and Urban Development (HUD) FY 2019Mainstream Voucher Program Notice of Funding Availability ("the NOFA"). This MOU outlines the basic agreement between the Parties during operation of the **Mainstream Housing Choice Voucher Program,** a tenant-based supportive housing program that assists non-elderly persons with disabilities ("the Program").

II. Program Goal and Definitions

The goal of the Program is to pair housing subsidies with supportive services to provide sustained community-based integrated housing for non-elderly persons with disabilities, with a preference for disabled non-elderly persons who are transitioning out of institutional or other segregated settings, at serious risk of institutionalization, homeless, or at risk of becoming homeless ("the Preference"). SHA shall provide the housing subsidies and the Coalition shall provide appropriate referrals from housing programs funded by the Continuum of Care as a "Moving On" strategy from Continuum of Care beds. All relevant terms defined in the NOFA and Application are incorporated herein.

III. Term

This MOU is intended to facilitate the award of Mainstream Voucher Program funding to SHA and utilization of the vouchers by eligible families pursuant to HUD Notice of Funding Availability for FY2019, No. FR-6300-N-43 and shall remain in effect for the duration of such vouchers.

IV. Operational Roles and Responsibilities

A. SHA

1. Establish a preference for households that qualify for Mainstream vouchers, including those referred by the Coalition.

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2. Canvas people on the SHA Housing Choice Voucher wait list to help SHA and the Agency identify any families currently on the wait list who would qualify for the Program and the Preference.
3. Commit a sufficient number of staff and other resources to ensure that the application, certification, and voucher issuance processes are completed in a timely manner.
4. Commit a sufficient number of staff and other resources to ensure that inspections of units are completed in a timely manner.
5. Hold an initial SHA application and work process meeting for all involved Coalition staff.
6. Hold semi-annual evaluation meetings with Agency staff to monitor and correct issues with such benchmarks as number of referrals received, vouchers issued, units leased/families housed, service coordination and tenancy support provided, lease infraction notices, average length of time in unit, and overall utilization.
7. Maintain releases of information for each participant in the Program to ensure open communication between SHA and the Coalition.
8. Designate a staff person to meet with the Coalition's representative in person or by phone on a regular basis to exchange updates about participants' housing stability.
9. Notify the Coalition's contact person when a participant's housing is at risk due to noncompliance with the Program or their landlord.
10. Provide training to applicable staff on an ongoing basis to support operations of the Program and facilitate training and coordination between SHA and Agency.
11. Generate a quarterly report that tracks Program performance metrics, including
    a. Number of referrals received by Coalition
    b. Number of vouchers issued by SHA
    c. Number of vouchers leased-up
    d. Program utilization rate

B. The Coalition

1. Identify and maintain a single point of contact for communication with SHA.
2. Identify households who are eligible for the Program and the preference using existing Coordinated Entry system.
3. Obtain releases of information for potential Program households to ensure open communication between the Coalition and SHA.
4. Assist applicants with application completion, paperwork and verifications, and ensure that the applications are complete prior to the Agency's submission of the application package to SHA.
5. Attend participant briefings when needed.
6. Provide training to applicable Coalition members on an ongoing basis to support operations of the Program and facilitate training and coordination between SHA and Coalition.
7. Commit to attending quarterly evaluation meetings with SHA staff.
8. Add relevant data on Program performance metrics to the monthly report generated by SHA and available to all parties.

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V. Further Cooperation

The Parties hereby commit to cooperating with one another to address issues as they arise and to resolve them based on the agreements stated in this MOU.

VIII. Signatures

SHA

William J. Simmons,
Executive Director

8/26/19
Date

United Way of Central New York

Nancy Kern Eaton
President

8/29/19
Date

516 Burt Street / Syracuse, New York 13202 / PH 315.475.6181 / FAX 315.470.4203 / www.syracusehousing.org

From: Megan Stuart

Bcc: kpeterson@ccoc.us; malobaidi@ifwcny.org; aalvarez@syracuseymca.org; stacy.alvord@oswegocounty.com; heatherrose.austin@gmail.com; fbarwinczak@caphelps.org; cbennett@caphelps.org; Hbenson@ccoc.us; Lindsay.Bentley@excellus.com; kbequer@acrhealth.org; rexfordbeverage@yahoo.com; Jennifer.L.Bordonaro@omh.ny.gov; eric.boye@accesscny.org; allison.brooks@use.salvationarmy.org; jbrooks@wesoldieron.org; monica.brown@dfa.state.ny.us; wbrown@wesoldieron.org; brumfib@gmail.com; jbutts@ccoc.us; david.carr2@va.gov; debbie.carter@rmsyr.org; Sherrain Clark; rclark@helio.health; dcondliffe@communityalternatives.org; dcurrier@oco.org; dcornwell@caphelps.org; CrystalC@homehq.org; dcruz@cnyservices.org; scurran@onvlp.org; ccurry@ccoc.us; ddaby@oco.org; dlockhart@ccoc.us; JDaughton@scsd.us; Adavis@477home.org; AimeeD@sbh.org; gdewan@hlalaw.org; Suzanne.Dianetti@warriorsalute.com; timmy5710@yahoo.com; cdoody@lscny.org; svpcpastor@gmail.com; hdunn@syracuseymca.org; kdunn@chapelhouseshelter.org; pdunn@cnycf.org; mdurkin@liberty-resources.org; jdyke@helio.health; Miranda Eddy; ladyhawk924@gmail.com; meisenstadt@syracuse.com; Nathan.Emmons@OswegoCounty.com; denglish@acrhealth.org; aeversley@cnyfairhousing.org; bfarranto@ccoc.us; Erin.Felix@USE.SalvationArmy.Org; mikefps15@gmail.com; nfink@cir.care; SFitzgerald2@scsd.us; sfrance@oco.org; igalan@wesoldieron.org; Natalie.Gallagher@dfa.state.ny.us; cogibbons@nycourts.gov; casemanagement@samcenter.org; dgill@cnycf.org; cgill@oco.org; Roxanna.Gillen@yahoo.com; karen@shinemanfoundation.org; kgonzalez@communityalternatives.org; sgotttbrecht@ccoc.us; jennig@chadwickresidence.org; cgreen@liberty-resources.org; jgriffey@oco.org; Tim.Griffin@dfa.state.ny.us; sgriffith@lscny.org; rgrobosky@ccoc.us; khaskins@ariseinc.org; Fred Hintz; liddy.hintz@wellsky.com; Jessica.Horning@va.gov; khubel@ccsi.org; Randhughes734@gmail.com; ajandrew@ariseinc.org; rjensen@auburnny.gov; jkarasek@ariseinc.org; bkarpinska@ariseinc.org; MKelley@ccsi.org; cking@oco.org; JoeKing@ongov.net; stephani.klumpp@use.salvationarmy.org; RKreis@scsd.us; kkukula@helio.health; klabarge@oco.org; mlaflair@housingvisions.org; smeidenbauer@cnyservices.org; maxluttinger@gmail.com; omack@chapelhouseshelter.org; WMajda@ACRHealth.org; Gary.Mann@AuburnRescueMission.org; tysha@nehda.org; Amy.Cunningham@dfa.state.ny.us; mcdonaldmaria71@gmail.com; SMcintyre@scsd.us; smcmahon@syrgov.net; MMcRobbieTaru@scsd.us; jemiller@helio.health; nmirra@cir.care; janmoag@ongov.net; Cassandra Montressor; m.murphy@ongov.net; outreach@uumcsyracuse.org; DNevidomsky@caphelps.org; JNicolucci@caphelps.org; spasquale@allynfoundation.org; tpatton@liberty-resources.org; cherese.peck@ariseinc.org; DPerkins@scsd.us; cporter@cnyfairhousing.org; pprehn@ariseinc.org; nputnan@ywca-syracuse.org; pam@ccoc.us; Mary.Rathbun@dfa.state.ny.us; Erin.Reed@OswegoCounty.com; mreed@liberty-resources.org; Heather.Renda@use.salvationarmy.org; rreynolds@oco.org; ARivera@caphelps.org; jacquelyn.robinson@oswegocounty.com; jrodriguez@ywca-syracuse.org; lrolnick@onvlp.org; development@responsivecommunity.org; Tom.Roshau@USE.SalvationArmy.Org; Benjamin.rowe@va.gov; rrubinstein@hlalaw.org; ssantangelo@cnyfairhousing.org; Sarah Schutt; osephuma@ifwcny.org; shordge@ccoc.us; Holley.sharer@use.salvationarmy.org; cshepard@ymcacny.org; Sharon@syracusetenant.org; rshoff@syracusepolice.org; amy.sholes@ariseinc.org; martinskahen@ongov.net; Vadra.Skinkle@use.salvationarmy.org; Gidget.Stevens@OswegoCounty.com; Megan Stuart; psullivan@snccsyr.org; dszemkow@ccoc.us; ntalev@hlalaw.org; Christina.Thornton@use.salvationarmy.org; Shane.Truman@dfa.state.ny.us; KTull3@scsd.us; amber.vanderploeg@rmsyr.org; Raquel.Viel@dfa.state.ny.us; liz@auburnha.org; pwaite@oco.org; andrea@nehda.org; sweiss@cayugahealthnetwork.org; Hilary.Weyant@use.salvationarmy.org; kwhite@contactsyracuse.org; SWilson@ACRHealth.org; hwise@ymcacny.org; ezaremba@hlalaw.org; lzender@onvlp.org; lzolkowski@hslccny.org

Subject: The HHC Weekly

Date: Friday, September 3, 2021 3:08:00 PM

Attachments: image001.png
image002.jpg
CoC Sample Budget.xlsx
FY2021 County Specific Data.xlsx
Ranking Protocol - FY21 Final.pdf
2021 HHC Application for NEW, BONUS, and DV BONUS Funding.docx

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Text Description automatically generated with medium confidence

Friday, September 3, 2021
Central New York's Housing and Homeless Coalition
hhc@unitedway-cny.org
www.hhccny.org

In This Issue:

- NOFO Application Funding Announcement
- Happy Labor Day

Upcoming Events & Meetings

Street Outreach- Wednesday, September 8th @ 2 pm

Data Administrators Committee- Friday, September 10th @ 9 am

Chronic Taskforce & Veteran's Workgroup- Tuesday, September 14th @ 10 am

HHC Advisory Board Meeting- Tuesday, September 14th @ 2:30 pm

HMIS New User Training- Thursday, September 16th @ 1 pm

Coordinated Entry Training- Friday, September 17th @ 9 am

Funding Announcement

The Housing and Homeless Coalition is opening its local competition for CoC funding. Agencies are encouraged to apply for new bonus funding. Please visit our website and attached materials. Applications are due Friday, September 24th by 5pm to mstuart@unitedway-cny.org.

Funding Availability:
Total Annual Renewal Demand (ARD): $9,818,095
Bonus: $490,905
DV Bonus: $1,119,214
Planning Funds: $294,543 (planning funds are not ranked)
Tier 1 (100% ARD): $9,818,095
Tier 2: $1,610,149

Questions? Email hhc@unitedway-cny.org

Happy Labor Day

Each day, every agency staff member in our CoC works towards aiding our community and helping its people.

Your efforts are appreciated and deserve to be recognized, respected and, celebrated.
Thank you for all your hard work.

Happy Labor Day from the HHC Team.

Have something to add?
Send all updates to hhc@unitedway-cny.org

CoC Funding Competition

The Housing and Homeless Coalition of Central New York (HHC), with United Way of Central New York as its Collaborative Applicant, as the CoC Lead Agency, coordinates the process that selects the local projects that will be moved forward to the federal HUD CoC Program Competition. A local application has to be submitted in response to the Request For Proposal (RFP) released by the HHC. Projects will be reviewed and ranked by an independent project selection committee called the Performance Selection Committee. Projects that make the selection list will advance to the federal application process.

2021 Competition

The Housing and Homeless Coalition announces its local opportunity for Continuum of Care funding.

Currently funded and new agencies are encouraged to apply. **Applications are due to mstuart@unitedway-cny.org by 5pm on September 24th.** Application, instructions and protocol can be found below.

Funding Available

Total Annual Renewal Demand (ARD): $9,818,095

Bonus: $490,905

DV Bonus: $1,119,214

Tier 1 (100% ARD): $9,818,095

Tier 2: $1,610,149

Materials to Apply

Ranking Protocol – FY21 Final Download

2021 HHC Application for NEW, BONUS, and DV BONUS Funding Download

HHC CoC Sample Budget Download

FY2021 County Specific Data Download

View the recording of the Funding Competition Informational Meeting Below:

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Housing and Homeless Coalition of Central New York
Published by Megan Stuart · 1m ·

The Housing and Homeless Coalition is opening its local competition for CoC funding. Agencies are encouraged to apply for new bonus funding. Applications are due Friday, September 24th by 5pm to mstuart@unitedway-cny.org.

Visit our website for details on how to apply!
http://www.hhccny.org/coc/coc-funding-competition/

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CoC Funding Competition | The Housing and Homeless Coalition of Central New...
CoC Funding Competition The Housing and Homeless Coalition of Central New York (HHC), with United Way of Central New York as its...

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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. This document will be reviewed and approved by both the NOFA workgroup, made up of representatives of agencies applying for funding, and the Performance Evaluation and Selection Committee, outlined below. Both the NOFA workgroup and the Performance Evaluation and Selection Committee are designated by the CoC's full membership body to oversee the ranking and rating process.

The HUD Performance Evaluation and Selection Committee ("the Committee") consists only of non-CoC or ESG funded Advisory Board Members, members of the CoC's Lived Experience Boards 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 and perform ratings and rankings for all applications to the NOFA.

II. CoC Transparency

The CoC will present this document as well as the funding application and competition report to both the NOFA Workgroup and Performance Evaluation and Selection Committee for comment, edit, and vote prior to the public posting of the competition.

III. FY2019 HUD Funding Availability

Total Annual Renewal Demand (ARD): $9,818,095
Bonus: $490,905
DV Bonus: $1,119,214
Planning Funds: $294,543 (planning funds are not ranked)
Tier 1 (100% ARD): $9,818,095
Tier 2: $1,610,149

IV. Eligible Project Types

For the FY2021 funding competition, the HHC is accepting applications of the following project types for funding priority:

1. Rapid Rehousing
2. Supportive Services Only (SSO)- Coordinated Entry
3. Permanent Supportive Housing
4. HMIS

V. Priority Populations

The CoC has identified the following priority populations for new CoC projects. These populations were determined by analysis of trends in homelessness based on Point in Time Count and LSA data. This data includes DV data from the comparable database.

1. Cayuga County:
    a. Individuals with SMI/SUD, including Chronically Homeless
    b. Individuals coming from institutions (re-entry)
    c. Survivors of Domestic Violence
2. Onondaga County
    a. Individuals with SMI/SUD, including Chronically Homeless
    b. Survivors of Domestic Violence
3. Oswego County
    a. Individuals or families with SMI/SUD
    b. Survivors of Domestic Violence
    c. Youth ages 18 to 24

VI. New Project Application Process

On behalf of the CoC, the HHC issues new applications for agencies seeking CoC funding. Applications are publicly distributed through the RFP process and are advertised on social media, the CoC's full listserv, and the CoC's website.

New funding applications also encompasses expansion applications for existing CoC projects. Only projects that scored in Tier 1in the previous year's competition are eligible to apply for an expansion of the existing project. For FY 2021, Tier 1 of the FY2019 will be used. A list of CoC projects eligible to submit expansion projects can be found in Appendix B.

Applications are split into four sections: threshold requirements, program design narrative, performance measures, and project specific bonus questions. Projects and agencies must meet threshold requirements to be considered in the funding competition. Program design, performance measures, and bonus questions will be used to determine ranking in the funding competition.

VII. Renewal Project Application Process

Renewal projects are scored according to the rubric described in the renewal application. The majority of the information in the renewal application is information that is reported to HUD on the Annual Performance Report, during project monitoring by CoC staff, or is otherwise available through HMIS. Projects serving domestic violence survivors are asked to submit data from their comparable database for the renewal process.

The objective rating criteria is compiled into a Competition Report by CoC staff that is made available to all funded projects at the same time as the application.

The Competition Report will be released to all funded projects at the same time as the new application. Projects will have until the application due date to review and dispute or accept the Competition Report and respond to narrative questions. An acknowledgement of the acceptance or dispute must be submitted by the due date.

If a project seeks to dispute the competition report, project representatives can give written or verbal justification of the dispute to the Performance Evaluation and Selection Committee. The Committee will then vote to accept or reject the dispute.

VIII. Selection Process

The Committee reviews and scores all renewal and new applications. Scores are compiled and reviewed in a committee meeting to ensure accuracy and limit discrepancies between reviewers. New applications are reviewed and scored by all members of the Committee.

Projects which fail to meet threshold requirements will be held out of the competition. These projects may request that the CoC provide them with technical assistance to assist them in improving their interest in applying in 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.

All renewal projects will be selected to move forward in the competition, unless subject to reallocation. The reallocation process can be found in Section VI.

New projects that meet threshold requirements will be selected to move forward based on score for performance measures. Scores will be determined using an average of scores given by each member of the Committee. New projects may be asked to scale funding request based on number of applications approved. Geographic coverage of the CoC will also be taken into consideration when determining funding scale.

All projects will receive written notice on the outcome of the initial review process outside of e-snaps.

IX. 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, ineligible spending, or consistent inability to expend grant funds may be subject to transfer or reallocation. Low performance is defined as consistent findings during annual monitoring, no longer meeting community need and/or inability to meet community threshold for system performance measures. Projects may also be reallocated if they no longer meet HUD and/or local priority.

The five lowest performing projects will be brought to the Committee for possible reallocation as well as any projects that have consistent ineligible spending. Reallocation decisions are voted upon by the Committee and the Advisory Board is immediately notified by the HHC Director along with the agency whose funding will be reallocated. The appeals process in Section XI will be applicable to the reallocation process.

For Fiscal Year 2021, renewal projects will not be subjected to reallocation or transfer. All existing projects are still meeting community need and will be subjected only to the ranking protocol, as follows.

X. Ranking Protocol

A project ranking list is then generated using scores outlined in Section IV, in alignment with HUD and local CoC priorities. Ranking for renewal applications is determined by the project's local application. Projects that have not been operational for an entire program year will receive full points for performance measures in the local application.

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.

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

The HHC uses the project ranking tool provided by HUD.

XI. Appeals Process

Once 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 86 of the FY2021 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 General Membership approval will be final.

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Appendix A

Performance, Evaluation and Selection Committee Participating Agencies

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)
Onondaga County Department of Social Services
Oswego County Department of Social Services
Onondaga County Re-Entry Taskforce
City of Auburn (CDBG)
Lived Experience Board Members
HHC Staff (Non-voting)

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Appendix B

Existing CoC Projects Eligible for Applying for Expansion

Catholic Charities of Onondaga County Permanent Housing for Chronically Homeless 1
Chapel House HUD Permanent Supportive Housing Program
Chadwick Residence Chadwick Apartments 1
Oswego County Opportunities OCO HUD-RRH
The Salvation Army TSA Housing & Life Skills Education Helio Health Susan's Place PSH
Catholic Charities of Onondaga County CC Rapid Rehousing Consolidated
Catholic Charities of Onondaga County PHH: Housing First for Individuals and Families
Catholic Charities of Onondaga County Permanent Housing for Chronically Homeless 2
Helio Health RPSHP Combined
Helio Health Helio Housing First
The Salvation Army TSA Barnabas Youth RRH
The Salvation Army State Street Apartments
Chapel House ARISE PSH
Liberty Resources LR-PSH Families and Individuals
Catholic Charities of Onondaga County HUD RAP
Helio Health KEES 2

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Onondaga/Oswego/Cayuga County Continuum of Care
2021 Local New Application
Applications are due September 24, 2021, at 5pm.
Applications and all attachments must be submitted in a single PDF to Megan Stuart via email: mstuart@unitedway-cny.org

Agency and Project Information

Agency Name:			
Program Name:			
Application Contact Person:			
Amount Requesting:		Projected Number Served:	
Component Type:	☐ RRH ☐ PSH ☐ SSO (Coordinated Entry) ☐ Th-RRH		
County Serving:	☐ Cayuga ☐ Onondaga ☐ Oswego		
Special Population:	☐ Chronically Homeless ☐ Youth ☐ People Fleeing DV ☐ SMI/SUD		

Is this project partnering with a healthcare service?	☐ Yes ☐ No
Is this project a subsidy partnership project?	☐ Yes ☐ No
Is this project serving survivors of domestic violence and applying for DV Bonus funds?	☐ Yes ☐ No
Is this project an expansion of an existing CoC project?	☐ Yes ☐ No

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Threshold Requirements	
Applicant is a Non-Profit organization with active 501(c)3 status, public housing authority, or local government organization	☐ Yes ☐ No
Agree to use HMIS (or comparable database if DV)	☐ Yes ☐ No
HHC Membership- has a current MOU or agrees to enter MOU with HHC	☐ Yes ☐ No
If the answer is no to any of the above questions, please explain below.	
If agency does not meet threshold requirements, stop scoring. Agency is not eligible for CoC funding.	

Narrative Questions	
Program Design: 5 points	Please provide a general description of the program including the population served, bed/unit configuration. (500 words)
4-5 points: project design is clear, population served is one of the priority populations, and bed/unit configuration matched number projected to serve 2-3 points: project design is not clear, bed/unit configuration does not match people served 0-1 points: population served is not one of priority populations, does not address bed/unit configuration	
Community Need: 5 points	Using local data on homelessness, how does this project support the HHC's goals of ending chronic, youth, family or homelessness for all persons? Please include agency's unique ability to serve the population. (250 words)
4-5 points: Narrative uses local HMIS data from CoC data sheet or from HHC-CNY Fact Sheet Dashboard to support project goals. Rationale for project is clearly related to HMIS data. Agency has demonstrated leadership in serving this population 2-3 points: Either narrative does not use HMIS/ HHC dashboard data OR Agency does not demonstrate evidence of leadership in serving population 0-1 points: Narrative does not use HMIS/HHC Dashboard data AND agency does not demonstrate evidence of leadership in sering proposed population	
Capacity: 5 points	Please describe housing programs the agency currently administers and describe success of the programs. If agency currently or has received CoC funding in the past, address, if any, programs fell into Tier 2 or have past of current unresolved significant findings (250 words)
4-5 points: Agency demonstrates experience operating housing programs, addresses any issues with past performance issues with plan to improve in the future 2-3 points: Has some experience operating housing programs 0-1 points: Agency has little or no experience operating housing programs	
Coordinated Entry: 5 points	Will the program participate in Coordinated Entry and follow the community's prioritization policy? What percentage of referrals will be taken from Coordinated Entry? Please describe how the agency will use

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	Coordinated Entry to fill beds if not currently part of the Coordinated Entry System. (250 words)
4-5 points: Agency gives full commitment ot Coordinated Entry and demonstrates knowledge about prioritization policies. Full points must require a 100% referral commitment. 2-3 points: Agency gives commitment but gives any percentage below 100% or does not demonstrate understanding of Coordinated Entry. 0-1 points : Agency does not commit to Coordinated Entry.	
Client-Centered Practice: 5 points	Describe how your program will support client-centered practice and provide appropriate case management and supportive services to meet the needs of each client. (250 words)
4-5 points: Answer demonstrates the program plans to allow participants to develop their own goals and outlines detailed supportive services 2-3 points: Does not fully outline supportive services 0-1 points: Does not outline how participants will be involved in goal planning	
Racial Equity: 5 points	Describe how your agency promotes racial equity practices and how this project will address racial disparities in the homelessness system. (250 words)
4-5 points: Agency has promising goals for promoting racial equity. The answer clearly demonstrates how this project will ensure equity and address racial disparities. 2-3 points: Agency is committed to equity but has no clear actionable practices. 0-1 points: Agency does not have clear commitment to racial equity.	
Housing First: 5 points	Describe how the program will promote housing first within the intake and discharge policies, as well as how the program will prioritize highest-need clients. (250 words)
4-5 points: Answer clearly demonstrates understanding of Housing First practices and how they will be implemented in the project. 2-3 points: Commits to housing first but does not describe prioritizing high-need clients 0-1 points: Answer does not address housing first or prioritizing highest-need clients	
Elevating Lived Experience: 5 points	Describe how your program plans to elevate the voices of and employ people with lived experience of homelessness to create better support for your clients. (250 words)
4-5 points: Agency has actionable practices to employ and elevate people with lived experience, including employment, board representation, and/or intentional feedback. 2-3 points: Agency incorporates feedback from participants in project design or conducts feedback surveys. 0-1 points: Agency does not have a clear strategy for elevating the voices of people with lived experience. Examples of actionable practices: - Policies to ensure that all clients are able to access services at the level of their need - People with lived experience of homelessness, including people from BIPOC communities, are represented on the board of the organization - Client feedback on the project is requested and a process is in place to examine and improve client satisfaction	

- Outcome data is collected, disaggregated for race and ethnicity, and used to inform policy decisions - Training for frontline staff to provide high-quality services - Recruiting staff with lived experience of homelessness - Services include peer support positions - Mentorship and training for frontline staff interested in management positions)	
Serving Intersectional Identities: 5 points	Describe how your program will provide consistent help across intersectional identities. (e.g. LGBTQIA+, youth, BIPOC, etc.) (250 words)
4-5 points: Agency has a strategy to provide consistent services for people with intersectional identities. Strategies could include staff training, hiring people who represent the people served, etc. 2-3 points: Agency commits to providing consistent service but does not address strategies. 0-1 points: Agency does not outline strategies to provide consistent service to people across intersectional identities.	

Performance Measures	
Employment Income Growth: 10 points	Describe how clients will be assisted in obtaining employment, income, and mainstream health resources to maximize their ability to live independently. (250 words)
8-10 points: Agency describes their ability and commitment to helping clients in each of the three areas described. Specific strategies include: Job coaching, Connections with specific named workforce development agencies or programs (e.g., JobCorps, CNYWorks), SOAR training for staff members, Medicaid enrollment, Connections with specific named Health homes agencies, Connections with specific named primary care providers, Connections with specific named substance abuse treatment providers, Motivational Interviewing. 5-7 points: Specific strategies are named, but do not include all three resource areas. 2-4 points: All three resource areas are described, but specific strategies are not described. Strategies are vague. 0-1 points: Answer is not applicable to the question or does not give any detail	
Project Implementation: 10 points	Describe your detailed plan for rapid implementation of the program, documenting how the program will be ready to begin housing the first program participant. Please discuss agency timelines for staffing the project and otherwise complying with CoC Program deadline. (250 words)
8-10 points: Agency provides a specific timeline and describes past experience with program deadlines. Agency has identified strategies for locating housing units, managing funds, hiring staff. 5-7 points: Agency provides a timeline but no action steps or experience in meeting program deadlines. 2-4 points: Agency has some strategies but does not have a timeline or a plan to house participants. 0-1 points: Answer is not applicable to the question or does not give details.	
Retention: 10 points	How will the program ensure that participants will exit to or remain in permanent housing? (250 words)

8-10 points: Describes commitment to moving or transferring clients with complex challenges along with specific strategies to serve these clients. Agency describes experience negotiating with landlords and advocating for clients, and doing appropriate discharge planning. Agency also describes supportive services provided to ensure housing stability.
5-7 points: Agency describes commitment to ensuring participants remain in or exit to permanent housing but strategies are unclear or limited. Agency has limited experience retaining clients in permanent housing
2-4 points: Agency commits to ensuring participants will exit or remain in permanent housing but does not include strategies for achieving the goal.
0-1 points: Answer is not applicable to the question or does not give details.

Budget Questions

Please attach a project budget to prove that expenses are reasonable, allocable, and allowable as well as 25% match documentation. (5 points) ☐ Attached

Budget must include: no line items outside of the categories of: Leasing, Rental Assistance, Supportive Services, Operations, and Administration.
Admin cannot be over 10% unless agency has an approved cost rate.
Match must be 25% of total grant amount*, indicate whether it is cash or kind and have attached match letter.

*If a project has a LEASING budget line, this does not require match. In this case, you would subtract the leasing line amount from the total grant amount to determine the 25% mtch requirement.

Provide management letter from agency's most recent fiscal audit demonstration that agency is in good standing. (5 points) ☐ Attached

Cost Effectiveness: 5 points	Annual budget will be divided by number of beds. Community averages are as follows: Rapid Rehousing: $8869/bed Permanent Supportive Housing: $16,305/bed Transitional-Rapid Rehousing: N/A SSO (Coordinated Entry): N/A

5 points: Under community average
3 points: Within 10% above community average
0 points: More than 10% above community average

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Special Project Questions
Only fill out these questions if you are applying for these specific project types

ONLY For Domestic Violence Bonus Applicants: 10 points

Please answer these two questions in the section below: (250 words)

- Describe agency's experience working with victims/survivors of Domestic Violence.
- Indicate whether your organization is a Victim Service Provider

8-10 points: Agency applying is a Victim Service Provider with demonstrated experience working with survivors of DV, including receiving federal and state funding to operate DV programs.
5-7 points: Agency has experience working with the DV population but is not a Victim Service provider.
2-4 points: Agency has some experience working with the DV population.
0-1 points:Agency has no experience working with the DV population.

ONLY For Coordinated Entry Applicants: 10 points

Please answer the following questions in the section below (250 words)

- Describe how agency will ensure that the coordinated assessment system will be easily available/reachable for all persons within the CoC's geographic area who are seeking homelessness assistance including those with disabilities.
- Describe how advertising strategy will be designed to specifically reach homeless persons with the highest barriers within the CoC's geographic area.
- Describe how standardized assessment process will ensure program participants are directed to appropriate housing and services that fit their needs.

8- 10 points: Agency has a strategy to ensure all points of CE project are met including demonstrating experience working in or with the Coordinated Entry system.
5-7 points: Agency has experience working with Coordianted Entry system but does not address each element of CES implementation.
2-4 points: Agency has little experience working the Coordinated Entry system.
0-1 points: Agency does not address any components of CES.

ONLY For Healthcare Project Applicants: 10 points

Please describe how the project will structure program to provide healthcare services to participants. (250 words)

8-10 points: Agency has created a partnership with a healthcare provider and describes 25% funding commitment or access to SUD services for all participants. Commitment of healthcare provider must be attached. Program design is clear.
5-7 points: Program design is somewhat clear but some questions remain.
2-4 points: Program design is not clear and/or does not have healthcare provider secured.
0-1 points: Agency does not provide explanation of program design, healthcare provider and/or does not have letter attached.

Please attach a commitment letter from a healthcare organization demonstrating commitment of either: ☐ Attached

i. For recovery or substance use treatment, services that are available for all program participants and chose those services; or ii. An amount that is equivalent to 25% of the funding being requested for the project to be covered by the healthcare organization.
ONLY For Subsidized Partnership Project Applicants: 10 points
Please describe how the project will structure the program to ensure at least 25% of project serves unit/participants in PSH or RRH. Please include partners and additional funding source. (250 words)
8-10 points: Agency has created a partnership with an affordable housing funding source and explains how at least 25% of units or persons will be served by the project. Commitment of separate funding source must be attached. Program design is clear. 5-7 points: Program design is somewhat clear but some questions remain. 2-4 points: Program design is not clear and/or does not have additional funding source defined or secured. 0-1 points: Agency does not provide explanation of program design, additional funding source and/or does not have letter attached.
Please attach a funding letter from a housing organization demonstrating commitment of either: ☐ Attached i. 25% of units will be dedicated to PSH participants; or ii. 25% of persons served will be dedicated to RRH participants

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Onondaga/Oswego/Cayuga County Continuum of Care
2021 Local Renewal Application Detailed Rubric
Applications are due September 24, 2021, at 5 pm.
Applications must be submitted in a single PDF to
Megan Stuart via email: mstuart@unitedway-cny.org

Agency and Project Information	
Agency Name:	
Program Name:	
Application Contact Person:	
Component Type:	☐ RRH ☐ PSH ☐ Th-RRH
County Serving:	☐ Cayuga ☐ Onondaga ☐ Oswego

Narrative Response Questions	
Consistent Service Delivery: 5 points	Describe how your program will provide consistent help across intersectional identities. (e.g. LGBTQIA+, youth, BIPOC, etc.) (250 words)
Elevating Lived Experience: 5 points	Describe how your program plans to elevate the voices of and employ people with lived experience of homelessness to create better support for your clients. (250 words)
CE Workgroup Attendance: 5 points	Did a representative of your project attend 75% of quarterly coordinated entry workgroup meetings? ☐ Yes ☐ No
CoC Membership Attendance: 5 points	Did a representative of your project attend 75% of CoC General Membership meetings? ☐ Yes ☐ No
Racial Disparities: 5 points	How does your project work to eliminate racial disparities in housing outcomes?

	(250 words, examples include: - Policies to ensure that all clients are able to access services at the level of their need - People with lived experience of homelessness, including people from BIPOC communities, are represented on the board of the organization - Client feedback on the project is requested and a process is in place to examine and improve client satisfaction - Outcome data is collected, disaggregated for race and ethnicity, and used to inform policy decisions - Training for frontline staff to provide high-quality services - Recruiting staff with lived experience of homelessness - Services include peer support positions - Mentorship and training for frontline staff interested in management positions)

Project Competition Report:	
All performance data is for FY2020 (10/1/2019 to 9/30/2020). Financial data is for the most recent completed Fiscal Year. Monitoring score is for the most recent monitoring visit.	
Utilization: 5 points	Projected households served during average PIT: ___ Actual Number households served during PITs (APR Q8): October 2019 Households: January 2020 Households: April 2020 Households: July 2020 Households: Households Average Actual ___ / Projected ___ = Utilization ____ % Did your project meet its projected number or either households or persons served during the year (100% utilization?)
Utilization Follow-up: 3 points	If the utilization rate of households was less than 100% due to circumstances beyond the project's control (e.g. Covid-19), please explain why in 250 words or less: [For reviewers:] - Lack of available rental housing

	- Staffing shortages - Inability to provide remote case management
Vulnerable Populations: 5 points	What percentage of clients served in FY2020 were in the following categories? Chronically Homeless (Q5a #11 / Q5a # 14): (>75%) Youth [Q27a Youth Ages 18-24 / Q5a #1]: (>75%) Domestic Violence[Q14b Yes / Q5a#1]: (>75%) No Income [Q16 / Q5a#1] : (>75%) Score 5 points if any were above 75%
Data Quality: 1 point	Were all of the following error rates below 5% for Q6 of your FY2020 APR? Personally-Identifying information (6a), Universal Data Elements (6b), Income and Housing Data Quality (6c), Chronic Homelessness (6d)
☐ Yes ☐ No	

Coordinated Entry Participation: 2 points	What percentage of new entries to the project during FY2020 were matched to your project through the coordinated entry system? 90-100%: 2 points Less than 90%: 0 points
Permanent Housing Placement and Retention: 20 points	For PSH, what percentage of clients served in FY2020 either stayed in the project or exited to a permanent housing destination (APR Q5a Stayers, Q23c Exiting to housing destinations)? The CoC-wide percentage of PSH clients retained or exited to permanent housing is 97% (Positive housing destinations + Stayers) / (Total Participants – Persons excluded) <90% : 0 points 90-95% : 10 points 96-100%: 20 points For RRH, of the clients who exited your project, what percentage of clients served in FY2020 exited to a permanent housing destination (APR Q23c)? The CoC-wide percentage of RRH clients exited to a permanent housing destination is 91% <80%: 0 points 80-90%: 10 points 90-100%: 20 points

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Employment growth – Stayers: 5 points	What percentage of clients enrolled in your program at the end of FY2020 had increased their employment income since entering the program (APR Q19a1)? PSH: CoC-wide Average is 7% >10%: 5 points 5-10% : 3 points <5%: 0 points RRH: CoC-Wide Average is 26% >30% : 5 points 20-30% : 3 points <20%: 0 points
Employment Growth – Leavers: 5 points	What percentage of clients who left your program increased their employment income during FY2020 (APR Q19a2)? PSH: CoC-wide average is 7% >10%: 5 points 5-10%: 3 points <5%: 0 points RRH: The CoC-wide Percentage is 13% >15%: 5 points 5-15%: 3 points <10%: 0 points
Income Growth – Stayers: 5 points	What percentage of clients enrolled in your program at the end of FY2020 had increased their non-employment cash income since entering the program (APR Q19a2)? (SSI or state/local public assistance benefits, increases in SSI benefits) PSH: The CoC-wide percentage for PSH programs was 46% >50%: 5 points 40-50%: 3 points <40%: 0 points RRH: The CoC-wide percentage for RRH programs was 27% >30%: 5 points 25-30%: 3 points <25%: 0 points
Income Growth – Leavers: 5 points	What percentage of clients who left your program increased their non-employment cash income during FY2020 (APR Q19a2)?

	PSH: The CoC-wide percentage for PSH programs was 20% >25%: 5 points 15-25%: 3 points <15%: 0 points RRH: The CoC-wide percentage for RRH programs was 25% >30%: 5 points 20-30%: 3 points <20%: 0 points
Health Insurance: 1 point	What percentage of leavers in your project had health insurance upon exit from the project (APR Q21 + APR Q5a)? 1- (Number of Leavers with No Health Insurance / Number of Leavers) The CoC-Wide Percentage was 88% for PSH The CoC-Wide Percentage was 93% for RRH >90%: 1 point <90% 0 points
Non-Cash Benefits: 1 point	What percentage of leavers enrolled in your project had other non-cash benefits upon exit from the project (Q20b, Q5a)? 1- (Number of Leavers with No Noncash Benefits / Number of Leavers) The CoC-Wide Percentage for PSH was 76% [1-(62/254)] The CoC-Wide Percentage for RRH was 85% [1-(102/670)] >80%: 1 point < 80%: 0 points
Time to Move-in: 1 point	For RRH, what was the average time for households to move into housing after enrolling in the project? The CoC-Wide Average Length of time is 26 days <30 days: 1 point
Fund expenditure: 5 points	Were all funds expended in the last completed program year? 100%: 5 points 95-99%: 3 points

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	<94%: 0 points
Fund expenditure: 3 points	If less than 95% of funds were not expended, please provide an explanation of the reason for not expending the funds. (250-word limit)
Monitoring: 15 points	Were there significant findings for your project during CoC monitoring?
☐ Yes ☐ No	

Total	

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Onondaga/Oswego/Cayuga County Continuum of Care
2021 Local New Application
Applications are due September 24, 2021, at 5pm.
Applications and all attachments must be submitted in a single PDF to Megan Stuart via email: mstuart@unitedway-cny.org

Agency and Project Information

Agency Name:			
Program Name:			
Application Contact Person:			
Amount Requesting:		Projected Number Served:	
Component Type:	☐ RRH ☐ PSH ☐ SSO (Coordinated Entry) ☐ Th-RRH		
County Serving:	☐ Cayuga ☐ Onondaga ☐ Oswego		
Special Population:	☐ Chronically Homeless ☐ Youth ☐ People Fleeing DV ☐ SMI/SUD		

Is this project partnering with a healthcare service?	☐ Yes ☐ No
Is this project a subsidy partnership project?	☐ Yes ☐ No
Is this project serving survivors of domestic violence and applying for DV Bonus funds?	☐ Yes ☐ No
Is this project an expansion of an existing CoC project?	☐ Yes ☐ No

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Threshold Requirements	
Applicant is a Non-Profit organization with active 501(c)3 status, public housing authority, or local government organization	☐ Yes ☐ No
Agree to use HMIS (or comparable database if DV)	☐ Yes ☐ No
HHC Membership- has a current MOU or agrees to enter MOU with HHC	☐ Yes ☐ No
If the answer is no to any of the above questions, please explain below.	
If agency does not meet threshold requirements, stop scoring. Agency is not eligible for CoC funding.	

Narrative Questions	
Program Design: 5 points	Please provide a general description of the program including the population served, bed/unit configuration. (500 words)
4-5 points: project design is clear, population served is one of the priority populations, and bed/unit configuration matched number projected to serve 2-3 points: project design is not clear, bed/unit configuration does not match people served 0-1 points: population served is not one of priority populations, does not address bed/unit configuration	
Community Need: 5 points	Using local data on homelessness, how does this project support the HHC's goals of ending chronic, youth, family or homelessness for all persons? Please include agency's unique ability to serve the population. (250 words)
4-5 points: Narrative uses local HMIS data from CoC data sheet or from HHC-CNY Fact Sheet Dashboard to support project goals. Rationale for project is clearly related to HMIS data. Agency has demonstrated leadership in serving this population 2-3 points: Either narrative does not use HMIS/ HHC dashboard data OR Agency does not demonstrate evidence of leadership in serving population 0-1 points: Narrative does not use HMIS/HHC Dashboard data AND agency does not demonstrate evidence of leadership in sering proposed population	
Capacity: 5 points	Please describe housing programs the agency currently administers and describe success of the programs. If agency currently or has received CoC funding in the past, address, if any, programs fell into Tier 2 or have past of current unresolved significant findings (250 words)
4-5 points: Agency demonstrates experience operating housing programs, addresses any issues with past performance issues with plan to improve in the future 2-3 points: Has some experience operating housing programs 0-1 points: Agency has little or no experience operating housing programs	
Coordinated Entry: 5 points	Will the program participate in Coordinated Entry and follow the community's prioritization policy? What percentage of referrals will be taken from Coordinated Entry? Please describe how the agency will use

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	Coordinated Entry to fill beds if not currently part of the Coordinated Entry System. (250 words)
4-5 points: Agency gives full commitment ot Coordinated Entry and demonstrates knowledge about prioritization policies. Full points must require a 100% referral commitment. 2-3 points: Agency gives commitment but gives any percentage below 100% or does not demonstrate understanding of Coordinated Entry. 0-1 points : Agency does not commit to Coordinated Entry.	
Client-Centered Practice: 5 points	Describe how your program will support client-centered practice and provide appropriate case management and supportive services to meet the needs of each client. (250 words)
4-5 points: Answer demonstrates the program plans to allow participants to develop their own goals and outlines detailed supportive services 2-3 points: Does not fully outline supportive services 0-1 points: Does not outline how participants will be involved in goal planning	
Racial Equity: 5 points	Describe how your agency promotes racial equity practices and how this project will address racial disparities in the homelessness system. (250 words)
4-5 points: Agency has promising goals for promoting racial equity. The answer clearly demonstrates how this project will ensure equity and address racial disparities. 2-3 points: Agency is committed to equity but has no clear actionable practices. 0-1 points: Agency does not have clear commitment to racial equity.	
Housing First: 5 points	Describe how the program will promote housing first within the intake and discharge policies, as well as how the program will prioritize highest-need clients. (250 words)
4-5 points: Answer clearly demonstrates understanding of Housing First practices and how they will be implemented in the project. 2-3 points: Commits to housing first but does not describe prioritizing high-need clients 0-1 points: Answer does not address housing first or prioritizing highest-need clients	
Elevating Lived Experience: 5 points	Describe how your program plans to elevate the voices of and employ people with lived experience of homelessness to create better support for your clients. (250 words)
4-5 points: Agency has actionable practices to employ and elevate people with lived experience, including employment, board representation, and/or intentional feedback. 2-3 points: Agency incorporates feedback from participants in project design or conducts feedback surveys. 0-1 points: Agency does not have a clear strategy for elevating the voices of people with lived experience. Examples of actionable practices: - Policies to ensure that all clients are able to access services at the level of their need - People with lived experience of homelessness, including people from BIPOC communities, are represented on the board of the organization - Client feedback on the project is requested and a process is in place to examine and improve client satisfaction	

- Outcome data is collected, disaggregated for race and ethnicity, and used to inform policy decisions - Training for frontline staff to provide high-quality services - Recruiting staff with lived experience of homelessness - Services include peer support positions - Mentorship and training for frontline staff interested in management positions)	
Serving Intersectional Identities: 5 points	Describe how your program will provide consistent help across intersectional identities. (e.g. LGBTQIA+, youth, BIPOC, etc.) (250 words)
4-5 points: Agency has a strategy to provide consistent services for people with intersectional identities. Strategies could include staff training, hiring people who represent the people served, etc. 2-3 points: Agency commits to providing consistent service but does not address strategies. 0-1 points: Agency does not outline strategies to provide consistent service to people across intersectional identities.	

Performance Measures	
Employment Income Growth: 10 points	Describe how clients will be assisted in obtaining employment, income, and mainstream health resources to maximize their ability to live independently. (250 words)
8-10 points: Agency describes their ability and commitment to helping clients in each of the three areas described. Specific strategies include: Job coaching, Connections with specific named workforce development agencies or programs (e.g., JobCorps, CNYWorks), SOAR training for staff members, Medicaid enrollment, Connections with specific named Health homes agencies, Connections with specific named primary care providers, Connections with specific named substance abuse treatment providers, Motivational Interviewing. 5-7 points: Specific strategies are named, but do not include all three resource areas. 2-4 points: All three resource areas are described, but specific strategies are not described. Strategies are vague. 0-1 points: Answer is not applicable to the question or does not give any detail	
Project Implementation: 10 points	Describe your detailed plan for rapid implementation of the program, documenting how the program will be ready to begin housing the first program participant. Please discuss agency timelines for staffing the project and otherwise complying with CoC Program deadline. (250 words)
8-10 points: Agency provides a specific timeline and describes past experience with program deadlines. Agency has identified strategies for locating housing units, managing funds, hiring staff. 5-7 points: Agency provides a timeline but no action steps or experience in meeting program deadlines. 2-4 points: Agency has some strategies but does not have a timeline or a plan to house participants. 0-1 points: Answer is not applicable to the question or does not give details.	
Retention: 10 points	How will the program ensure that participants will exit to or remain in permanent housing? (250 words)

8-10 points: Describes commitment to moving or transferring clients with complex challenges along with specific strategies to serve these clients. Agency describes experience negotiating with landlords and advocating for clients, and doing appropriate discharge planning. Agency also describes supportive services provided to ensure housing stability.
5-7 points: Agency describes commitment to ensuring participants remain in or exit to permanent housing but strategies are unclear or limited. Agency has limited experience retaining clients in permanent housing
2-4 points: Agency commits to ensuring participants will exit or remain in permanent housing but does not include strategies for achieving the goal.
0-1 points: Answer is not applicable to the question or does not give details.

Budget Questions

Please attach a project budget to prove that expenses are reasonable, allocable, and allowable as well as 25% match documentation. (5 points) ☐ Attached

Budget must include: no line items outside of the categories of: Leasing, Rental Assistance, Supportive Services, Operations, and Administration.
Admin cannot be over 10% unless agency has an approved cost rate.
Match must be 25% of total grant amount*, indicate whether it is cash or kind and have attached match letter.

*If a project has a LEASING budget line, this does not require match. In this case, you would subtract the leasing line amount from the total grant amount to determine the 25% mtch requirement.

Provide management letter from agency's most recent fiscal audit demonstration that agency is in good standing. (5 points) ☐ Attached

Cost Effectiveness: 5 points	Annual budget will be divided by number of beds. Community averages are as follows: Rapid Rehousing: $8869/bed Permanent Supportive Housing: $16,305/bed Transitional-Rapid Rehousing: N/A SSO (Coordinated Entry): N/A

5 points: Under community average
3 points: Within 10% above community average
0 points: More than 10% above community average

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Special Project Questions
Only fill out these questions if you are applying for these specific project types

ONLY For Domestic Violence Bonus Applicants: 10 points

Please answer these two questions in the section below: (250 words)

- Describe agency's experience working with victims/survivors of Domestic Violence.
- Indicate whether your organization is a Victim Service Provider

8-10 points: Agency applying is a Victim Service Provider with demonstrated experience working with survivors of DV, including receiving federal and state funding to operate DV programs.
5-7 points: Agency has experience working with the DV population but is not a Victim Service provider.
2-4 points: Agency has some experience working with the DV population.
0-1 points:Agency has no experience working with the DV population.

ONLY For Coordinated Entry Applicants: 10 points

Please answer the following questions in the section below (250 words)

- Describe how agency will ensure that the coordinated assessment system will be easily available/reachable for all persons within the CoC's geographic area who are seeking homelessness assistance including those with disabilities.
- Describe how advertising strategy will be designed to specifically reach homeless persons with the highest barriers within the CoC's geographic area.
- Describe how standardized assessment process will ensure program participants are directed to appropriate housing and services that fit their needs.

8- 10 points: Agency has a strategy to ensure all points of CE project are met including demonstrating experience working in or with the Coordinated Entry system.
5-7 points: Agency has experience working with Coordianted Entry system but does not address each element of CES implementation.
2-4 points: Agency has little experience working the Coordinated Entry system.
0-1 points: Agency does not address any components of CES.

ONLY For Healthcare Project Applicants: 10 points

Please describe how the project will structure program to provide healthcare services to participants. (250 words)

8-10 points: Agency has created a partnership with a healthcare provider and describes 25% funding commitment or access to SUD services for all participants. Commitment of healthcare provider must be attached. Program design is clear.
5-7 points: Program design is somewhat clear but some questions remain.
2-4 points: Program design is not clear and/or does not have healthcare provider secured.
0-1 points: Agency does not provide explanation of program design, healthcare provider and/or does not have letter attached.

Please attach a commitment letter from a healthcare organization demonstrating commitment of either: ☐ Attached

i. For recovery or substance use treatment, services that are available for all program participants and chose those services; or ii. An amount that is equivalent to 25% of the funding being requested for the project to be covered by the healthcare organization.
ONLY For Subsidized Partnership Project Applicants: 10 points
Please describe how the project will structure the program to ensure at least 25% of project serves unit/participants in PSH or RRH. Please include partners and additional funding source. (250 words)
8-10 points: Agency has created a partnership with an affordable housing funding source and explains how at least 25% of units or persons will be served by the project. Commitment of separate funding source must be attached. Program design is clear. 5-7 points: Program design is somewhat clear but some questions remain. 2-4 points: Program design is not clear and/or does not have additional funding source defined or secured. 0-1 points: Agency does not provide explanation of program design, additional funding source and/or does not have letter attached.
Please attach a funding letter from a housing organization demonstrating commitment of either: ☐ Attached i. 25% of units will be dedicated to PSH participants; or ii. 25% of persons served will be dedicated to RRH participants

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Onondaga/Oswego/Cayuga County Continuum of Care
2021 Local Renewal Application Detailed Rubric
Applications are due September 24, 2021, at 5 pm.
Applications must be submitted in a single PDF to
Megan Stuart via email: mstuart@unitedway-cny.org

Agency and Project Information	
Agency Name:	
Program Name:	
Application Contact Person:	
Component Type:	☐ RRH ☐ PSH ☐ Th-RRH
County Serving:	☐ Cayuga ☐ Onondaga ☐ Oswego

Narrative Response Questions	
Consistent Service Delivery: 5 points	Describe how your program will provide consistent help across intersectional identities. (e.g. LGBTQIA+, youth, BIPOC, etc.) (250 words)
Elevating Lived Experience: 5 points	Describe how your program plans to elevate the voices of and employ people with lived experience of homelessness to create better support for your clients. (250 words)
CE Workgroup Attendance: 5 points	Did a representative of your project attend 75% of quarterly coordinated entry workgroup meetings? ☐ Yes ☐ No
CoC Membership Attendance: 5 points	Did a representative of your project attend 75% of CoC General Membership meetings? ☐ Yes ☐ No
Racial Disparities: 5 points	How does your project work to eliminate racial disparities in housing outcomes?

	(250 words, examples include: - Policies to ensure that all clients are able to access services at the level of their need - People with lived experience of homelessness, including people from BIPOC communities, are represented on the board of the organization - Client feedback on the project is requested and a process is in place to examine and improve client satisfaction - Outcome data is collected, disaggregated for race and ethnicity, and used to inform policy decisions - Training for frontline staff to provide high-quality services - Recruiting staff with lived experience of homelessness - Services include peer support positions - Mentorship and training for frontline staff interested in management positions)

Project Competition Report:	
All performance data is for FY2020 (10/1/2019 to 9/30/2020). Financial data is for the most recent completed Fiscal Year. Monitoring score is for the most recent monitoring visit.	
Utilization: 5 points	Projected households served during average PIT: ___ Actual Number households served during PITs (APR Q8): October 2019 Households: January 2020 Households: April 2020 Households: July 2020 Households: Households Average Actual ___ / Projected ___ = Utilization ____ % Did your project meet its projected number or either households or persons served during the year (100% utilization?)
Utilization Follow-up: 3 points	If the utilization rate of households was less than 100% due to circumstances beyond the project's control (e.g. Covid-19), please explain why in 250 words or less: [For reviewers:] - Lack of available rental housing

	- Staffing shortages - Inability to provide remote case management
Vulnerable Populations: 5 points	What percentage of clients served in FY2020 were in the following categories? Chronically Homeless (Q5a #11 / Q5a # 14): (>75%) Youth [Q27a Youth Ages 18-24 / Q5a #1]: (>75%) Domestic Violence[Q14b Yes / Q5a#1]: (>75%) No Income [Q16 / Q5a#1] : (>75%) Score 5 points if any were above 75%
Data Quality: 1 point	Were all of the following error rates below 5% for Q6 of your FY2020 APR? Personally-Identifying information (6a), Universal Data Elements (6b), Income and Housing Data Quality (6c), Chronic Homelessness (6d)
☐ Yes ☐ No	

Coordinated Entry Participation: 2 points	What percentage of new entries to the project during FY2020 were matched to your project through the coordinated entry system? 90-100%: 2 points Less than 90%: 0 points
Permanent Housing Placement and Retention: 20 points	For PSH, what percentage of clients served in FY2020 either stayed in the project or exited to a permanent housing destination (APR Q5a Stayers, Q23c Exiting to housing destinations)? The CoC-wide percentage of PSH clients retained or exited to permanent housing is 97% (Positive housing destinations + Stayers) / (Total Participants – Persons excluded) <90% : 0 points 90-95% : 10 points 96-100%: 20 points For RRH, of the clients who exited your project, what percentage of clients served in FY2020 exited to a permanent housing destination (APR Q23c)? The CoC-wide percentage of RRH clients exited to a permanent housing destination is 91% <80%: 0 points 80-90%: 10 points 90-100%: 20 points

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Employment growth – Stayers: 5 points	What percentage of clients enrolled in your program at the end of FY2020 had increased their employment income since entering the program (APR Q19a1)? PSH: CoC-wide Average is 7% >10%: 5 points 5-10% : 3 points <5%: 0 points RRH: CoC-Wide Average is 26% >30% : 5 points 20-30% : 3 points <20%: 0 points
Employment Growth – Leavers: 5 points	What percentage of clients who left your program increased their employment income during FY2020 (APR Q19a2)? PSH: CoC-wide average is 7% >10%: 5 points 5-10%: 3 points <5%: 0 points RRH: The CoC-wide Percentage is 13% >15%: 5 points 5-15%: 3 points <10%: 0 points
Income Growth – Stayers: 5 points	What percentage of clients enrolled in your program at the end of FY2020 had increased their non-employment cash income since entering the program (APR Q19a2)? (SSI or state/local public assistance benefits, increases in SSI benefits) PSH: The CoC-wide percentage for PSH programs was 46% >50%: 5 points 40-50%: 3 points <40%: 0 points RRH: The CoC-wide percentage for RRH programs was 27% >30%: 5 points 25-30%: 3 points <25%: 0 points
Income Growth – Leavers: 5 points	What percentage of clients who left your program increased their non-employment cash income during FY2020 (APR Q19a2)?

	PSH: The CoC-wide percentage for PSH programs was 20% >25%: 5 points 15-25%: 3 points <15%: 0 points RRH: The CoC-wide percentage for RRH programs was 25% >30%: 5 points 20-30%: 3 points <20%: 0 points
Health Insurance: 1 point	What percentage of leavers in your project had health insurance upon exit from the project (APR Q21 + APR Q5a)? 1- (Number of Leavers with No Health Insurance / Number of Leavers) The CoC-Wide Percentage was 88% for PSH The CoC-Wide Percentage was 93% for RRH >90%: 1 point <90% 0 points
Non-Cash Benefits: 1 point	What percentage of leavers enrolled in your project had other non-cash benefits upon exit from the project (Q20b, Q5a)? 1- (Number of Leavers with No Noncash Benefits / Number of Leavers) The CoC-Wide Percentage for PSH was 76% [1-(62/254)] The CoC-Wide Percentage for RRH was 85% [1-(102/670)] >80%: 1 point < 80%: 0 points
Time to Move-in: 1 point	For RRH, what was the average time for households to move into housing after enrolling in the project? The CoC-Wide Average Length of time is 26 days <30 days: 1 point
Fund expenditure: 5 points	Were all funds expended in the last completed program year? 100%: 5 points 95-99%: 3 points

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	<94%: 0 points
Fund expenditure: 3 points	If less than 95% of funds were not expended, please provide an explanation of the reason for not expending the funds. (250-word limit)
Monitoring: 15 points	Were there significant findings for your project during CoC monitoring?
☐ Yes ☐ No	

Total	

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Onondaga/Oswego/Cayuga County Continuum of Care
2021 Local Renewal Application
Applications are due September 24, 2021, at 5 pm.
Applications must be submitted in a single PDF to
Megan Stuart via email: mstuart@unitedway-cny.org

Agency and Project Information	
Agency Name:	Helio Health, Inc.
Program Name:	KEES II
Application Contact Person:	Donna Cruz DCruz@Helio.Health
Component Type:	☐ RRH ☒ PSH ☐ SSO (Coordinated Entry) ☐ Th-RRH
County Serving:	☐ Cayuga ☒ Onondaga ☐ Oswego

Narrative Response Questions	
Consistent Service Delivery: 5 points	Describe how your program will provide consistent help across intersectional identities. (e.g. LGBTQIA+, youth, BIPOC, etc.) (250 words)
Helio Health is committed to fostering and preserving a culture of diversity, equity, and inclusion. Employees have a responsibility to treat everyone with dignity and respect. Interaction with residents will be consistent and quality based. This will allow the residents to feel valued. Keeping consistent contact with some of the residents is difficult, due to the lack of phones and the inability of residents to be at home when visits and inspections are scheduled. However, staff have left entry notices and send appointment letters in the mail as reminders. A large portion of our residential population has been subject to trauma, in one form or another. Helio staff engages with residents and offers referrals to community options as well as in house referrals, to assist them with working through and overcoming their concerns related to trauma. Helio Health itself provides treatment for Mental Health Disorders, Substance Use Disorders and well as a 24/7 walk-in clinic to determine recommended level of care for those in need. Helio Health also has available a Health Home, which is care coordination that can assist with medical, behavioral, and social needs. Referrals can be made by any residential case manager to other in-house departments should the resident request or feel that	

they need additional supports and services. At the core of the Helio Health mission is the relationship between the resident receiving support and the staff member that is providing the support.

Lived Experience: 5 points	Describe how your program plans to elevate the voices of and employ people with lived experience of homelessness to create better support for your clients. (250 words)

Staff with lived experiences of homelessness do have the best reality to help prevent and end homelessness. Helio Health does employ staff with lived experience as well as having those that sit on the Board of Directors that have that lived experience. There is a general belief that people that are homeless do not have competence to participate in organizations. Helio Health takes pride in its programs and the value of working alongside of those with lived experience. Employing those with experience is empowering. It strengthens the accountability and integrity of the program. Employees offer new direction for residents by cultivating relationships with outside entities to include existing and potential landlords. Staff share community and in-house training and learning opportunities that residents can utilize to become more self-sufficient. One example of how Helio Health as an organization is moving forward with this initiative is by offering a SUPERCARE program. A SUPERCARE program is
Substance **U**se **P**eer/Counselor **E**xperiential **R**eadiness **C**ourse for **A**ddiction **R**ehabilitation **E**mployment. It is designed to expand the behavioral health workforce in an eight-county region, including Broome, Cayuga, Cortland, Madison, Oneida, Onondaga, Oswego, and Tioga counties. This project is supported by the Health Resource and Services Administration (HRSA) of the Dept. Of Health and Human Services.

CE Workgroup Attendance: 5 points	Did a representative of your project attend 75% of quarterly coordinated entry workgroup meetings? ☒ Yes ☐ No
CoC Membership Attendance: 5 points	Did a representative of your project attend 75% of CoC General Membership meetings? ☒ Yes ☐ No
Racial Equity: 5 points	How does your project work to eliminate racial disparities in housing outcomes? (250 words; examples include: - Policies to ensure that all clients are able to access services at the level of their need - People with lived experience of homelessness, including people from BIPOC communities, are represented on the board of the organization - Client feedback on the project is requested and a process is in place to examine and improve client satisfaction - Outcome data is collected, disaggregated for race and ethnicity, and used to inform policy decisions - Training for frontline staff to provide high-quality services - Recruiting staff with lived experience of homelessness - Services include peer support positions - Mentorship and training for frontline staff interested in management positions)

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Helio Health is committed to ensure that the intake of Permanent Supportive Housing individuals does not show bias to any racial or ethnic group. The agency strives to provide multiethnic staff that is reflective of the community and our program participants. Program staff strive for a service delivery in an environment that is culturally sensitive and accessible to all persons likely to be found among the target populations for our programs. Helio Health mandates a 5-Part training in Cultural Competence as well as Person-Centered approach training. Data is collected through our record keeping system and utilized to examine and improve overall client satisfaction, outcomes and without bias, that data is used to form policy and procedures. Individuals cultural, ethnic, lifestyle, values, attitudes, and personal preferences will drive decision making in terms of placement and services requested by the resident. The organization has representation of BIPOC on the Board of Directors that have lived experience. Residents are linked to services which utilize peer support positions within the agency. Helio Health is dedicated to providing equal housing opportunities for the communities in which it serves regardless of sex, race, creed, color, sexual orientation, gender identity, age, marital status, disability, religion, national origin, military services, arrest/conviction record and victims of domestic violence. The organization will comply with all laws and regulations governing fair housing and nondiscrimination. This applies to all terms and conditions of housing, including but not limited to, appropriate program placement, rental agreements, and termination of housing when necessary.

Project Competition Report	**Percentage**	**Points**
Utilization: Did your project meet its projected number or either households or persons served during the year (100% utilization?)	101%	5 / 5 points
If the utilization rate of households was less than 100% due to circumstances beyond the project's control (e.g. Covid-19), please explain why in 250 words or less below:		
N/A		
Vulnerable Populations: What percentage of clients served in FY2020 were in the following categories:		
Chronically Homeless (Entries before 2016 are grandfathered in)	86%	5 /5 points
Youth	5%	
Domestic Violence	0%	
No Income	19%	
Data Quality: Were all of the following error rates below 5% for Q6 for your FY2020 APR? • Personally-Identifying Information • Universal Data Elements • Income and Housing Data Quality • Chronic Homelessness	PII: 0 % UDE: 0 % I & H: 0 % CH: 0 %	1/ 1 point
☒ Yes ☐ No		

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Coordinated Entry Participation: What percentage of new entries to the project during FY2020 were matched to your project through the coordinated entry system?	100%	1 / 1 point
Permanent Housing Placement and Retention: For **PSH**, what percentage of clients served in FY2020 either stayed in the project or exited to a permanent housing destination? For **RRH**, of the clients who exited your project, what percentage of clients served in FY2020 exited to a permanent housing destination?	95%	10 / 20 points
Employment growth – Stayers: What percentage of clients enrolled in your program at the end of FY2020 had increased their employment income since entering the program?	12%	5 / 5 points
Employment Growth – Leavers: What percentage of clients who left your program increased their employment income during FY2020?	11%	5 /5 points
Income Growth – Stayers: What percentage of clients enrolled in your program at the end of FY2020 had increased their non-employment cash income since entering the program?	38%	0 / 5 points
Income Growth – Leavers: What percentage of clients who left your program increased their non-employment cash income during FY2020?	11%	0 / 5 points
Health Insurance: What percentage of leavers in your project had health insurance upon exit from the project?	78%	0 / 1 point
Non-Cash Benefits: What percentage of leavers enrolled in your project had other non-cash benefits upon exit from the project?	78%	0/ 1 point
Time to Move-in: For **RRH**, what was the average time for households to move into housing after enrolling in the project?	N/A	0 / 1 point
Fund expenditure: Were all funds expended in the last completed program year?	97.4%	3 / 5 points
Fund expenditure: If less than 95% of funds were not expended, please provide an explanation of the reason for not expending the funds in the area below. (250 words)		
N/A		
Monitoring: Were there significant findings for your project during CoC monitoring?	☐ Yes ☒ No	15
Total		**50 / 75 points**

Housing & Homeless Coalition
Of Central New York

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Agency Certification

Project Certification of objective criteria:	☒ Accept ☐ Dispute ☐ Dispute and Request Meeting with Committee
If the agency disputes the report, please describe which of the objective criteria are incorrect.	
Signature:	
Printed Name:	Donna Cruz

Reviewer Nan	Agency Name	Project Name	Amount Requested	Consistent Service Delivery	Comments?	Elevating Lived Experience responses	Comments?	CE Workarous Attendance	CoC Membership Attendance	Racial Disparity narrative responses	Comments?	Utilization Narrative Re	Comments?	Fund Expenditure Nari	Comments?	Project Competition Report Base Score	Total Score	Average
Sue McMahon	ACR Health	Rapid Rehousing for LGBT Youth	unknown	5	Good answer.	5	Well thought out answer	5	5	5	Good answer	3	79% but added a good explanation as to whs.	0	97.1% spent.	27	56	54.5
Joe Kine	ACR Health	Rapid Rehousing for LGBTQ Youth	134,427.00	5		5		5	5	5		2		0		27	54	
Marlene Klock	Catholic Charities of Onondaga Cour	CC Housing First for Individuals and Families	$886,755	5		5		5	5	5		0		0		50	75	
Marty Stahen	Catholic Charities of Onondaga Cour	CC Housing First for Individuals and Families	$886,755	5		5		5	5	5		0		0		50	75	74.666667
Renee Jensen	Catholic Charities of Onondaga Cour	CC Housing First for Individuals and Families	$886,755	5		5		5	5	4	Narrative discusses training of staff, provides a harassment free workplace, and how clients can submit grievances. Expansion on lived experience, data collection and recruitment of staff with lived experience in this section is needed	0		0	100% of funds were expended	50	74	
Sue McMahon	Catholic Charities of Onondaga Cour	CC Permanent Housinv for Chronically Homeless 1	unknown	5	Good explanation	5	Good explanation and practice	5	5	5	Good explanation and practice	2	83% with no explanation.	0	10% spent with no explanation	58	85	86
Sue McMahon	Catholic Charities of Onondaga Cour	CC Permanent Housinv for Chronically Homeless 11	unknown	5	Well thought out answer	5	Complete answer/practice	5	5	5	complete answer/practice in place.	2	82% No explanation as to why it is below 100%	0	94.03%	63	70	70
Liz Vuillemot	Catholic Charities of Onondaga Cour	HUD Rental Assistance Program	5775874	4	Lack of specifics for various populations	4	Does not have current representation of those with lived experiences on	5	5	5	Specific strategies are explained	3	Due to Covid and transfer of esir from DSS	0	N/A Fund expenditure at 96.7% - Response not necessary	49	75	75
Marlene Klock	Catholic Charities of Onondaga Cour	Rapid Rehousing Consolidated	$275,542	5		5		5	5	5		3		3		45	76	76
Mary Rathbun	Chadwick	Chadwick Supportive Housing	243,069.00	5		5		5	5	5		0	Not 100%	0	100%	51	76	76
Renee Jensen	Chapel House	Chapel House PSH Consolidation FY2019	$228,519	5		5		5	5	4	Could have expanded on lived experience and client feedback answers. Also data collection	0	Utilization was 110%	0	100% of funds were expended	41	65	65.333333
Liz Vuillemot	Chapel House	Chapel House PSH Consolidation FY2019	$228519	5	Actually mentions recruitment from specific communities	5	Has representation from those with lived experiences	5	5	4	Doesn't describe specific strategies to eliminate racial disparities.	0	N/A Utilization at 100% = No response necessary	0	N/A Fund expenditure at 100% - No response necessary	41	65	
Mary Rathbun	Chapel House	Chapel House PSH Consolidation FY2019	222,427.00	5		5		5	5	5		0	110%	0	N/A	41	66	
Liz Vuillemot	Community Action Programs Cayuga	RRH for Families	$15,682	4	Lacks specifity to intersectional identities	5		5	5	5		0	N/A Utilization was at 100%	3	Due to Covid and eviction moratorium	41	68	67.7
Mary Rathbun	Community Action Programs Cayuga	RRH for Families	$ 168,596.00	5		5		5	5	5		0		0		41	66	
Renee Jensen	Community Action Programs Cayuga	RRH for Families	$155, 867	5		5		5	5	5		3	Utilization 106%	3	Fund expenditure 91% due to COVID 19 eviction moratorium, less affordable housing stock was available in Cayuga County	41	69	
Marlene Klock	Helio Health Inc	Helio Housing First	$875,629	5		5		5	5	5		3		0		51	79	
Liz Vuillemot	Helio Health Inc	Susan's Place	$134500	5	Doesn't address or even mention how the program will help specifically across intersectional identities.	5	Does or strives to employ those with lived experiances or hold seats on the BOD	5	5	5		3	Damaned unit	0	N/A Funds were exxended at 100%	60	86	80.5
Sue McMahon	Helio Health, Inc	Fast Housing	unknown	5	Complete well thought out answer	5	Good answer/out into practice.	5	5	5	Good answer/best practices used.	0	151%	3	94% with good explanation	47	75	
Liz Vuillemot	Helio Health, Inc	Helio Housing First	$975629	5	Does not specifically address or mention how program will provide consistent help across intersectional identities	5	Has representation and strategies to incorporate those with lived experiences with administration of the program	5	5	5		0	N/A Utilization rate at 100% - no response necessary	0	N/A Funds were expended at 96% - no response necessary	51	74	74
Sue McMahon	Helio Health, Inc	HH Recovery Permanent Supportive Housing	unknown	5	Complete answer	5	Great practice.	5	5	5	Solid answer/best practices	0	104%	0	100% spent	74	99	99.0
Marty Stahen	Helio Health, Inc	HH Recovery Permanent Supportive Housing	$480,845	5		5		5	5	5		0		0		74	99	
Ed Hughes	Helio Health, Inc	HH Recovery Permanent Supportive Housing	PSH	5	Dealt with Helios and believe their main concern is what they can eat out of b	5	Yes and no	5	5	5	Are committed to anv racial or ethnic aroup	0	Must say yes	0	Numbers realistic	74	99	
Liz Vuillemot	Helio Health, Inc	KEEL II	$706295	3	Lacks specific strategies to reach and provide consistent help across intersectiion identities. vaaue	5	Has representation of those with lived experiences	5	5	5	Has elements and strotegies to eliminate racial disparities.	0	N/A Utilization at 100% = No response necessary	0	N/A Fund expenditure at 97.4% No response necessary	50	73	
Mary Rathbun	Helio Health, Inc	KEEL II	$23,031.00	5		5		5	5	5		0	101%	0	97.4%	50	75	
Renee Jensen	Helio Health, Inc	KEEL II	$706,295	4	very broad and generic	5		5	5	5		0	106% utilization. No narrative	0	97.4% exxended	50	74	74.0
Marty Stahen	Helio Health, Inc	Susan's Place	$134,500	5		5		5	5	5		0		0		60	85	
Sue McMahon	Liberty Resources Inc.	LRI PSH Family and Individuals	unknown	5		5	Complete explanation/examples out into practice.	5	5	5	Complete detailed answer.					48	73	
Mary Rathbun	Liberty Resources, Inc.	LRI PSH Family and Individuals	$28,866.00	5		5		5	5	5		0	99%	3	99%	48	76	74.5
Marty Stahen	Oswego County Opportunities, Inc	OCO Chronic PSH-HOPE Housing Program	$121,166	5		5		5	5	5		0		0		31	56	56
Sue McMahon	Oswego County Opportunities, Inc	OCO DV - RRH	unknown	5	Well thought out answer	5	Well thought out answer	5	5	5	Aaaears committed towards racial equity. systems in place	0		0		75	100	100
Renee Jensen	Oswego County Opportunities, Inc	OCO RRH	$268,552.00	3	OCO does partner with COACH, involving individuals with lived experience and the OCO Board of director's is 1/3 low mod income. Although OCO is an equal opportunity employer and opportunities were shared with clients, it was not shared that individuals with lived experience have worked for OCO or how the feedback and support they received has been succesful.	5		5	5	5	I used the examples provided in application as a guideline and OCO does train frontline staff. Policies on access to services, feedback from clients, outcome data and more information lived experience of homelessness and BIPOC communities should have been exxanded upon.	5		0	99.7% of funds were expended so no narrative response was given	52	78	
Marty Stahen	Oswego County Opportunities, Inc	OCO RRH	$268,552	5		5		5	5	5		3		0		52	80	79
Marlene Klock	Oswego County Opportunities, Inc	PSH Hope Housing Program	$121,166	5		5		5	5	5		3		0		31	59	
Ed Hughes	Oswego County Opportunities, Inc.	OCO Chronic PSH-Hope Housing Program	PSH	5	Dealt with in other states. Very successful	5	Will receive what you out in	5	5	5	Preventions in place	3	High successful rate	0	Simple	31	59	
Mary Rathbun	The Salvation Army	Barnabas Rapid Rehousing	217,942.00	5		5		5	5	5		0	85%	0	84.2%	38	63	67.0
Renee Jensen	The Salvation Army	Barnabas Rapid Rehousing	$237,888	5		5		5	5	5		3	85% utilization. Response explained this was due to staff turnover and COVID	3	84.2% due to staff vacancy and COVID	38	69	
Joe King	The Salvation Army	Barnabas Rapid Rehousing	229,028	5		5		5	5	5		3		3		38	69	
Marlene Klock	The Salvation Army	State Street Apartments	$255,929	5		5			0	5		3		0		62	82	
Renee Jensen	The Salvation Army	State Street Apartments	$255,929	5		5			0	5	Great statistics and explanations	3		0	Fund Expenditure was 100%	62	82	82.0
Joe Kine	The Salvation Army	State Street Apartments	253,846	5		5			0	5		3		0		62	82	
Joe Kine	The Salvation Army	TSA Housing and Life Skills Education	375,148	5		5		5	5	5		3		3		54	85	85
Ed Hughes	The Salvation Army	TSA Housing and Life Skills Education	RRH	5	Agree totally with what they ensure	5	Myself was able to establish a life through Salvation Army	5	5	5	Never felt less welcome , belittle or like I deserve less	3	In short what time one put in to this is what they receive	3	Not specific in dollars from what I could see	54	85	

Funding Categories and Amounts

CoC Bonus Funding	490905	DV Bonus Funding	1110244	Tier 1 (ARD - YHDP)	9818095	Tier 2 (CoC Bonus)	1610149
Allocated	490905	Allocated	832969	Allocated to DV Bonus	0	Allocated to DV Bonus	832969
% Allocated	1	% Allocated	0.74	Allocated from Tier 1	9818095	Allocated from Tier 2	1323874
Remaining	0	Remaining	286275	Remaining*	0	Remaining	286275

*If DV Bonus not selected this will be subtracted from Tier 1

TIER (ARD - YHDP)	Rankine	Weighted Ratine Score	Renewal, New, Expansion, Reallocate	Grant Number	Project Type	General/DV	Organization Name	Project Name	CoC Funding Requested	CoC Amount Expended Last Closestine Year	CoC Funding Recommendation (manual entry)	All Fam Beds	DV Fam Beds	CH Fam Beds	Vet Fam Beds	Par Youth Beds	All Ind Beds	DV Ind Beds	Total CH Ind Beds	Vet Ind Beds	Single Youth Beds	Is 100% Dedicated + or CH Fam (Yes/No)	Is 100% Dedicated + or CH Ind (Yes/No)	Is 100% DV (Yes/No)	Met All CoC Threshold Requirements
	1	100	Renewal	NY1252I2C051900	RRH	DV	Oswego County Opportunities Inc.	OCO DV Rapid Rehousing	352361	$-	352361	0	0	0	0	0	0	0	0	0	0				Yes
	2	99	Renewal	NY0085L2C051912	PSH	General	Hello Health Inc.	BPSHP	430845	414617	430845	17	0	0	0	0	30	0	0	0	0				Yes
	3	85	Renewal	NY0769L2C051908	PSH	General	Hello Health Inc.	Susans Place PSH	134500	128625	134500	2	0	0	0	0	12	0	0	0	0				Yes
	4	85	Renewal	NY0946L2C051906	RRH	General	The Salvation Army	TSA Housing & Life Skills Education	385732	334184	385732	144	0	0	0	0	6	0	0	0	0				Yes
	5	82	Renewal	NY0089L2C051912	PSH	General	The Salvation Army	State Street Apartments	255929	251846	255929	0	0	0	0	0	6	0	0	0	4				Yes
	6	79	Renewal	NY0077L2C051912	PSH	General	Hello Health Inc.	Hello Housing First	975629	916738	975629	10	0	0	0	0	66	0	2	0	0				Yes
	7	79	Renewal	NY0083L2C051912	PSH	General	Catholic Charities	Perm. Housing for Chronically Homeless 1	734277	706532	734277	25	0	0	0	0	45	0	30	0	0				Yes
	8	79	Renewal	NY0605L2C051908	PSH	General	Catholic Charities	PHH Housing First for Individuals and Families	886755	853003	886755	37	0	0	0	0	59	0	21	0	0				Yes
	9	79	Renewal	NY1000D1C051904	RRH	General	Oswego County Opportunities Inc.	OCO - HUD RRH	268552	265807	268552	78	0	0	0	0	6	0	0	0	0				Yes
	10	79	Renewal	NY0999L2C051904	RRH	General	The Salvation Army	TSA Barnabas Youth RRH	237888	197115	237888	20	0	0	0	0	1	0	0	0	0				Yes
	11	76	Renewal	NY0093L2C051912	PSH	General	Chadwick Residence	Chadwick Permanent Supportive Housing	281895	272566	281895	24	0	0	0	0	8	0	0	0	0				Yes
	12	76	Renewal	NY1003L2C051904	RRH	General	Catholic Charities	CC Rapid Rehousing	275542	274226	275542	4	0	0	0	0	19	0	0	0	0				Yes
	13	75	Renewal	NY1004L2C051904	PSH	General	Liberty Resources	LR- PSH Families and Individuals	400580	383135	400580	6	0	0	0	0	23	0	23	0	0				Yes
	14	75	Renewal	NY0088L2C051912	PSH	General	Catholic Charities	CC HUD RAP	775974	718190	775974	53	0	0	0	0	75	0	0	0	0				Yes
	15	75	Renewal	NY1008L2C051904	RRH	General	Hello Health Inc.	FAST Housing	206893	203919	206893	0	0	0	0	0	22	0	0	0	0				Yes
	16	74	Renewal	NY0662L2C051908	PSH	General	Hello Health Inc.	KEES 2	706205	661458	706205	2	0	0	0	0	47	0	0	0	0				Yes
	17	70	Renewal	NY0527L2C051911	PSH	General	Catholic Charities	Perm. Housing for Chronically Homeless 2	1684179	1606213	1684179	0	0	0	0	0	126	0	126	0	0				Yes
	18	68	Renewal	NY1077L2C051903	RRH	General	Cayuga/Seneca Community Action Agency	HUD Rapid Rehousing Program	155867	144040	155867	13	0	0	0	0	5	0	0	0	0				Yes
	19	65	Renewal	NY0690L2C051910	PSH	General	Chapel House	Chapel House - Permanent Housing	228519	95694	228519	10	0	0	0	0	20	0	0	0	0				Yes
	20	58	Renewal	NY1002L2C051904	PSH	General	Oswego County Opportunities Inc.	OCO - Chronic PSH	121166	113505	121166	12	0	0	12	0	0	0	2	0	0				Yes
	21	55	Renewal	NY1052L2C051904	RRH	General	ACR Health	ACR - LGBT RRH	134427	154566	134427	0	0	0	0	0	8	0	0	0	8				Yes
	22	Not Rated	Renewal	NY0566L2C051911	HMIS	General	United Way of Central New York	HMIS	184380	184380	184380	0	0	0	0	0	0	0	0	0	0				Yes

TIER 2 (COC BONUS)	Ranking	Weighted Ratine Score	Renewal, New, Expansion, Reallocate	Grant Number	Project Type	General/DV	Organization Name	Project Name	CoC Funding Requested	CoC Amount Expended Last Closestine Year	CoC Funding Recommendation (manual entry)	All Fam Beds	DV Fam Beds	CH Fam Beds	Vet Fam Beds	Par Youth Beds	All Ind Beds	DV Ind Beds	Total CH Ind Beds	Vet Ind Beds	Single Youth Beds	Is 100% Dedicated + or CH Fam (Yes/No)	Is 100% Dedicated + or CH Ind (Yes/No)	Is 100% DV (Yes/No)	Met All CoC Threshold Requirements
	23	94	New		SSO - coordinated entry	D	United Way of Central New York	Coordinated Entry	130161	$-	130161	0	0	0	0	0	0	0	0	0	0	No	No	No	Yes
	24	88	New		TH+RRH	General	Center For Community Alternatives	Freedom Commons TH-RRH	105231	$-	105231	0	0	0	0	0	8	0	0	0	0	No	No	No	Yes
	25	86	Expansion		PSH	General	Chapel House	Chapel House PSH Expansion	140081	$-	122840	0	0	0	0	0	10	0	10	0	0	No	Yes	No	Yes
	26	85	New		TH+RRH	General	Oswego County Opportunities	OCO PATH Joint TH-RRH	217523	$-	127523	0	0	0	0	0	6	0	0	0	0	No	No	No	Yes
	27	87	New		TH+RRH	DV	Oswego County Opportunities	OCO Victim Services TH-RRH	572550	$-	832969	15	15	0	0	0	15	15	0	0	0	No	No	Yes	Yes

PROJECTS EXCEEDING ARD	Ranking	Weighted Ratine Score	Renewal, New, Expansion, Reallocate	Grant Number	Project Type	General/DV	Organization Name	Project Name	CoC Funding Requested	CoC Amount Expended Last Closestine Year	CoC Funding Recommendation (manual entry)	All Fam Beds	DV Fam Beds	CH Fam Beds	Vet Fam Beds	Par Youth Beds	All Ind Beds	DV Ind Beds	Total CH Ind Beds	Vet Ind Beds	Single Youth Beds	Is 100% Dedicated + or CH Fam (Yes/No)	Is 100% Dedicated + or CH Ind (Yes/No)	Is 100% DV (Yes/No)	Met All CoC Threshold Requirements
	Exceeds ARD	86	Expansion		RRH	General	The Salvation Army	HALE Expansion	198067	$-	$-	0	0	0	0	0	20	0	0	0	0	No	No	No	Yes
	Exceeds ARD	80	New		PSH	General	A Tiny Home For Good	Two Tiny Homes	122025	$-	$-	0	0	0	0	0	2	0	2	0	0	No	Yes	No	Yes

From: Megan Stuart
To: Andrew Lunetta
Subject: RE: [External Email] - A Tiny Home for Good - 2021 CoC Application
Date: Tuesday, October 12, 2021 9:47:00 AM

Good morning Andrew,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and did not select your application for the Tiny Home for Good Two Tiny project for funding. The Committee did not think construction costs are the best use of CoC dollars.

The Committee and I would encourage future applications from A Tiny Home for Good for CoC funding with a focus on providing subsidies and supportive services for the tenants of the tiny homes.

I would love to discuss this further before the next funding opportunity.

Megan Stuart
(she/her)
Director, Housing & Homeless Coalition of Central New York
Office: 315-428-2224 | Cell: 315-481-6633
Visit our website: www.hhccny.org

From: Andrew Lunetta <alunetta@atinyhomeforgood.org>
Sent: Friday, September 24, 2021 8:04 AM
To: Megan Stuart <mstuart@unitedway-cny.org>
Subject: [External Email] - A Tiny Home for Good - 2021 CoC Application

Morning Megan,

Hope you're well. See attached for our CoC application. Let me know if you need anything further from me. Best of luck as you begin what is sure to be the long process of reviewing!

Take care.

Andrew Lunetta
Executive Director, A Tiny Home for Good
315.640.8205

From: Megan Stuart
To: Deborah Daby
Cc: cking@oco.org; jbrzuszkiewicz@oco.org; Patrick Waite
Subject: RE: [External Email] - CoC applications (2 renewals, 2 new) - OCO C&DS
Date: Tuesday, October 12, 2021 9:40:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following Oswego County Opportunities, Inc. project(s):

OCO-RRH	**$260,548**
OCO-VH-DV-RRH	**$341,705**

The Committee has also decided to award your PATH TH-RRH project but could only approve the expansion in the amount of **$127,523.** The Committee has also decided to award your DV BONUS project at the full requested amount of **$572,550.**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

Final ranking of projects will take place on October 22nd and you will be notified after your ranking.

Please let me know if you have any questions.

Megan Stuart
(she/her)
Director, Housing & Homeless Coalition of Central New York
Office: 315-428-2224 | Cell: 315-481-6633
Visit our website: www.hhccny.org

From: Megan Stuart
To: Christina Thornton
Subject: RE: [External Email] - TSA HALE RRH applications
Date: Tuesday, October 12, 2021 9:44:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following The Salvation Army, a New York Corporation project(s):

HALE RRH	**$385,732**

The Committee did not select your application for the HALE Expansion RRH project as it did not score as highly as other applications.

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

Final ranking of projects will take place on October 22nd and you will be notified after your ranking.

Please let me know if you have any questions or would like to discuss the funding decision.

Megan Stuart
(she/her)
Director, Housing & Homeless Coalition of Central New York
Office: 315-428-2224 | Cell: 315-481-6633
Visit our website: www.hhccny.org

From: Megan Stuart
To: Olan Mack
Cc: Olan Mack
Subject: RE: [External Email] - Renewal and NEW CoC Application 2021 - Chapel House
Date: Tuesday, October 12, 2021 9:36:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following Chapel House Inc. project(s):

Chapel House PSH Consolidation FY2019 **$228,519**

The Committee has also decided to award your PSH Expansion project but could only approve the expansion in the amount of **$122,840.**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

Final ranking of projects will take place on October 22nd and you will be notified after your ranking.

Please let me know if you have any questions.

Megan Stuart
(she/her)
Director, Housing & Homeless Coalition of Central New York
Office: 315-428-2224 | Cell: 315-481-6633
Visit our website: www.hhccny.org

From: Housing & Homeless Coalition
Subject: FY2021 Ranking Now Posted
Date: Tuesday, November 2, 2021 4:26:26 PM

Good afternoon,

The FY2021 Continuum of Care Rankings are now posted on our website at:
https://www.hhccny.org/coc/coc-funding-competition/

The approved Consolidated Plan will be posted later this week.

Thank you and let us know if you have any questions.

Megan Stuart
(she/her)
Director, Housing & Homeless Coalition of Central New York
Office: 315-428-2224 | Cell: 315-481-6633
Visit our website: www.hhccny.org

	Ranking	Weighted	Renewal, New, Expansion, Reallocate	Grant Number	Project Type	General/DV	Organization Name	Project Name	CoC Funding Requested
TIER (ARD - YHDP)	1	100	Renewal	NY1252D2C051900	RRH	DV	Oswego County Opportunities Inc.	OCO DV Rapid Rehousing	**$352,361**
	2	99	Renewal	NY0085L2C051912	PSH	General	Helio Health Inc.	RPSHP	**$430,845**
	3	85	Renewal	NY0769L2C051908	PSH	General	Helio Health Inc.	Susans Place PSH	**$134,500**
	4	85	Renewal	NY0945L2C051906	RRH	General	The Salvation Army	TSA Housing & Life Skills Education	**$385,732**
	5	82	Renewal	NY0089L2C051912	PSH	General	The Salvation Army	State Street Apartments	**$255,929**
	6	79	Renewal	NY0073L2C051912	PSH	General	Helio Health Inc.	Helio Housing First	**$975,629**
	7	79	Renewal	NY0082L2C051912	PSH	General	Catholic Charities	Perm. Housing for Chronically Homeless 1	**$734,277**
	8	79	Renewal	NY0835L2C051908	PSH	General	Catholic Charities	PHH:Housing First for Individuals and Families	**$886,755**
	9	79	Renewal	NY1000l2C051904	RRH	General	Oswego County Opportunities Inc.	OCO - HUD RRH	**$268,552**
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Funding Available

Total Annual Renewal Demand (ARD): $9,818,095

Bonus: $490,905

DV Bonus: $1,119,214

Planning Funds: $294,543 (planning funds are not ranked)

Tier 1 (100% ARD): $9,818,095

Tier 2: $1,610,149

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HHC CoC Sample Budget Download

FY2021 County Specific Data Download

NOFA Schedule 2021 Download

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12:54 PM
11/2/2021

From: Megan Stuart
To: Jenni Gratien
Subject: RE: [External Email] - 2021 Local Renewal Application- Chadwick Supportive Housing
Date: Tuesday, October 12, 2021 9:34:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following Chadwick Residence, Inc. project(s):

Chadwick Supportive Housing	**$281,895**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

Final ranking of projects will take place on October 22nd and you will be notified after your ranking.

Please let me know if you have any questions.

Megan Stuart
(she/her)
Director, Housing & Homeless Coalition of Central New York
Office: 315-428-2224 | Cell: 315-481-6633
Visit our website: www.hhccny.org

From: Megan Stuart
To: Catherine Green
Cc: Marta Durkin
Subject: RE: [External Email] - attached-HHC CoC FY2021 Renewal Application-LRI
Date: Tuesday, October 12, 2021 9:38:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following Liberty Resources Inc. project(s):

Permanent Supportive Housing for Individuals and Families- LRI	**$400,580**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

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Please let me know if you have any questions.

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From:	Megan Stuart
To:	Kristian Allen
Cc:	Chris Curry; cwillson@ccoc.us; dlockhart@ccoc.us; hbenson@ccoc.us
Subject:	RE: [External Email] - Catholic Charities of Onondaga County HUD Local Applications 2021
Date:	Tuesday, October 12, 2021 9:32:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following Catholic Charities of the Roman Catholic Diocese of Syracuse, NY project(s):

CC Permanent Housing for the Chronically Homeless 1	**$743,277**
Catholic Charities HUD Rental Assistance Program	**$755,974**
CC Permanent Housing for the Chronically Homeless 2	**$1,684,179**
CC Housing First for Individuals and Families	**$886,755**
Catholic Charities Rapid Rehousing Consolidated	**$275,542**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

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Please let me know if you have any questions.

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Visit our website: www.hhccny.org

From: Megan Stuart
To: Deborah Daby
Cc: cking@oco.org; jbrzuszkiewicz@oco.org; Patrick Waite
Subject: RE: [External Email] - CoC applications (2 renewals, 2 new) - OCO C&DS
Date: Tuesday, October 12, 2021 9:40:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following Oswego County Opportunities, Inc. project(s):

OCO-RRH	**$260,548**
OCO-VH-DV-RRH	**$341,705**

The Committee has also decided to award your PATH TH-RRH project but could only approve the expansion in the amount of **$127,523.** The Committee has also decided to award your DV BONUS project at the full requested amount of **$572,550.**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

Final ranking of projects will take place on October 22nd and you will be notified after your ranking.

Please let me know if you have any questions.

Megan Stuart
(she/her)
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From:	Megan Stuart
To:	Amy D"Amico
Cc:	kgonzalez@communityalternatives.org
Subject:	RE: [External Email] - Freedom Commons Academy TH-RRH Program by Center for Community Alternatives
Date:	Tuesday, October 12, 2021 9:45:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your new application for the following Center for Community Alternatives at the full amount requested:

Freedom Commons Academy Th-RRH	**$105,231**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

Note that your application budget included a line for food. HUD CoC funding is unable to pay for food. When completing your E-SNAPS application, please move this amount to another line item.

Final ranking of projects will take place on October 22nd and you will be notified after your ranking.

Please let me know if you have any questions or would like to discuss the funding decision.

Megan Stuart
(she/her)
Director, Housing & Homeless Coalition of Central New York
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From: Megan Stuart
To: Tom Roshau
Subject: RE: [External Email] - Renewal Application: Barnabas Rapid Rehousing
Date: Tuesday, October 12, 2021 9:43:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following The Salvation Army, a New York Corporation project(s):

State Street Apartments	**$255,929**
Barnabas Rapid Rehousing	**$237,888**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

Final ranking of projects will take place on October 22nd and you will be notified after your ranking.

Please let me know if you have any questions.

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From: Megan Stuart
To: Reva Reynolds
Cc: ethompson@oco.org
Subject: RE: [External Email] - Renewal Application - OCO HOPE Housing
Date: Tuesday, October 12, 2021 9:41:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following Oswego County Opportunities, Inc. project(s):

OCO-PSH	**$121,166**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

Final ranking of projects will take place on October 22nd and you will be notified after your ranking.

Please let me know if you have any questions.

Megan Stuart
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From: Megan Stuart
To: Olan Mack
Cc: Olan Mack
Subject: RE: [External Email] - Renewal and NEW CoC Application 2021 - Chapel House
Date: Tuesday, October 12, 2021 9:36:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following Chapel House Inc. project(s):

Chapel House PSH Consolidation FY2019 **$228,519**

The Committee has also decided to award your PSH Expansion project but could only approve the expansion in the amount of **$122,840.**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

Final ranking of projects will take place on October 22nd and you will be notified after your ranking.

Please let me know if you have any questions.

Megan Stuart
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From: Megan Stuart
To: Danielle Cornwell
Subject: RE: [External Email] - HUD Renewal Application
Date: Tuesday, October 12, 2021 9:33:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following Cayuga/Seneca Community Action Agency, Inc. project(s):

Rapid Rehousing Program **$155,867**

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

Final ranking of projects will take place on October 22nd and you will be notified after your ranking.

Please let me know if you have any questions.

Megan Stuart
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From:	Megan Stuart
To:	Renee Clark
Cc:	Donna Cruz; Danielle Meyers; jgiordano@cnyservices.org
Subject:	RE: [External Email] - Helio Health 2021 Local Renewal Applications
Date:	Tuesday, October 12, 2021 9:37:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal applications for the following Helio Health, Inc. project(s):

Helio Housing First	**$975,629**
Recovery Permanent Supportive Housing Program Combined	**$430,845**
K.E.E.S. II	**$706,205**
Susan's Place	**$134,500**
FAST Housing	**$206,893**

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Please let me know if you have any questions.

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From: Megan Stuart
To: Marissa Rice
Cc: ssimone@acrhealth.org; Lisa Dunn Alford
Subject: RE: [External Email] - FY2021 Local Application
Date: Tuesday, October 12, 2021 9:31:00 AM

Good morning,

I am writing to let you know that the Performance Evaluation and Selection Committee met Thursday and has decided to approve your renewal application(s) for the following AIDS Community Resources project(s):

Rapid Rehousing for LGBT Youth $134,427

Please begin working on your awarded applications in E-SNAPS. Applications need to be in E-SNAPS by October 21st.

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Please let me know if you have any questions.

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From: Housing & Homeless Coalition
Subject: FY2021 Ranking Now Posted
Date: Tuesday, November 2, 2021 4:26:26 PM

Good afternoon,

The FY2021 Continuum of Care Rankings are now posted on our website at:
https://www.hhccny.org/coc/coc-funding-competition/

The approved Consolidated Plan will be posted later this week.

Thank you and let us know if you have any questions.

Megan Stuart
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The Housing and Homeless Coalition of Central New York (HHC), with United Way of Central New York as its Collaborative Applicant, as the CoC Lead Agency, coordinates the process that selects the local projects that will be moved forward to the federal HUD CoC Program Competition. A local application has to be submitted in response to the Request For Proposal (RFP) released by the HHC. Projects will be reviewed and ranked by an independent project selection committee called the Performance Selection Committee. Projects that make the selection list will advance to the federal application process.

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12:54 PM
11/2/2021

	Ranking	Weighted	Renewal, New, Expansion, Reallocate	Grant Number	Project Type	General/DV	Organization Name	Project Name	CoC Funding Requested
TIER (ARD - YHDP)	1	100	Renewal	NY1252D2C051900	RRH	DV	Oswego County Opportunities Inc.	OCO DV Rapid Rehousing	**$352,361**
	2	99	Renewal	NY0085L2C051912	PSH	General	Helio Health Inc.	RPSHP	**$430,845**
	3	85	Renewal	NY0769L2C051908	PSH	General	Helio Health Inc.	Susans Place PSH	**$134,500**
	4	85	Renewal	NY0945L2C051906	RRH	General	The Salvation Army	TSA Housing & Life Skills Education	**$385,732**
	5	82	Renewal	NY0089L2C051912	PSH	General	The Salvation Army	State Street Apartments	**$255,929**
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