Before Starting the CoC Application

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

The Collaborative Applicant is responsible for reviewing the following:

1. The FY 2019 CoC Program Competition Notice of Funding Available (NOFA) for specific application and program requirements.
2. The FY 2019 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.
6. Questions marked with an asterisk (*), which are mandatory and require a response.
1A. Continuum of Care (CoC) Identification

Instructions:
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
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https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources
The FY 2019 CoC Program Competition Notice of Funding Availability at:

1A-1. CoC Name and Number:  PA-605 - Erie City & County CoC

1A-2. Collaborative Applicant Name:  County of Erie

1A-3. CoC Designation:  CA

1A-4. HMIS Lead:  County of Erie
1B. Continuum of Care (CoC) Engagement

Instructions:
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

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Warning! The CoC Application score could be affected if information is incomplete on this formlet.

1B-1. CoC Meeting Participants.
For the period of May 1, 2018 to April 30, 2019, applicants must indicate whether the Organization/Person listed:
1. participated in CoC meetings;
2. voted, including selecting CoC Board members; and
3. participated in the CoC’s coordinated entry system.

<table>
<thead>
<tr>
<th>Organization/Person</th>
<th>Participates in CoC Meetings</th>
<th>Votes, including selecting CoC Board Members</th>
<th>Participates in Coordinated Entry System</th>
</tr>
</thead>
<tbody>
<tr>
<td>Local Government Staff/Officials</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CDBG/HOME/ESG Entitlement Jurisdiction</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Law Enforcement</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Jail(s)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospital(s)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>EMS/Crisis Response Team(s)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Health Service Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Substance Abuse Service Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Affordable Housing Developer(s)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Disability Service Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Disability Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Public Housing Authorities</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CoC Funded Youth Homeless Organizations</td>
<td>Not Applicable</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Non-CoC Funded Youth Homeless Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Applicant: Erie City & County CoC
Project: PA-605 CoC Registration FY2019

COC_REG_2019_170595

FY2019 CoC Application Page 3 09/12/2019
<table>
<thead>
<tr>
<th>Category</th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>School Administrators/Homeless Liaisons</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>CoC Funded Victim Service Providers</td>
<td>Not Applicable</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Non-CoC Funded Victim Service Providers</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Domestic Violence Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Street Outreach Team(s)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>LGBT Service Organizations</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Agencies that serve survivors of human trafficking</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other homeless subpopulation advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Homeless or Formerly Homeless Persons</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Mental Illness Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Substance Abuse Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other:(limit 50 characters)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Local VA</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Community Action Committee</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-CoC Funded Crisis Shelter Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**1B-1a. CoC’s Strategy to Solicit/Consider Opinions on Preventing/Ending Homelessness.**

Applicants must describe how the CoC:
1. solicits and considers opinions from a broad array of organizations and individuals that have knowledge of homelessness, or an interest in preventing and ending homelessness;
2. communicates information during public meetings or other forums the CoC uses to solicit public information;
3. takes into consideration information gathered in public meetings or forums to address improvements or new approaches to preventing and ending homelessness; and
4. ensures effective communication with individuals with disabilities, including the availability of accessible electronic formats, e.g., PDF. (limit 2,000 characters)

1) The CoC, (Home Team) actively recruits new members. The Home Team is open to any community members or agencies. It consists of a continuously expanding network of housing providers, service providers, youth providers, school districts, businesses and community members that are invested in ending homelessness. Our membership increased to 117 members from 93 members the previous year. The Home Team meets regularly to discuss and share information on homelessness, new strategies, improving efforts, sharing data, outreach and sharing ideas to improve efforts in solving homelessness. 2) The Home Team meets bimonthly where the solicitation of new members is a topic of discussion. We have a website that is open to the public. Home team members can contact the Chair if they know any new members that are interested in joining our CoC. The CoC solicits for new members on an ongoing basis. The executive committee meets bimonthly to brainstorm on processes for recruiting new members and developing new strategies. 3) Our CoC receives
input from the geographic area by attending meetings that our collaborators hold to network with other systems that are interested in ending homelessness. Our CoC has developed a strategic plan, and one of our objectives is broadening our membership to include additional non-profit organizations, businesses and community members to create an increasingly diverse membership. 4) Members of the CoC attend the Mayor's Roundtable on disabilities monthly to share current information and receive input on ideas to address solutions to homelessness. The CoC works closely with our local VA hospital and domestic violence providers who attend home team meetings as well as Coordinated Entry (CE) master list meetings. In addition, the Home team solicits and has members that are mental health providers, D&A providers and agencies that work with the physically disabled. All communications are submitted electronically.

1B-2. Open Invitation for New Members.

Applicants must describe:
1. the invitation process;
2. how the CoC communicates the invitation process to solicit new members;
3. how the CoC ensures effective communication with individuals with disabilities, including the availability of accessible electronic formats;
4. how often the CoC solicits new members; and
5. any special outreach the CoC conducted to ensure persons experiencing homelessness or formerly homeless persons are encouraged to join the CoC.

(limit 2,000 characters)

1) Membership of the Erie County CoC is open to any person or agency that demonstrates a concern and/or commitment to ending homelessness in our region. During the past year, CoC leadership has engaged in a process to expand the membership base and recruit new and different persons and approaches. An ad-hoc group of the governing board has developed recruitment tools used to reach out and discuss the CoC with potential new members. In addition to this, the CoC held a 'meet and greet' breakfast for interested parties, which proved to be successful in bringing in new members. The newly introduced recruitment efforts have brought in new members from criminal justice reentry programs, higher education, hospitals, and private business. 2) The CoC communicates the invitation process through various leadership individuals recruiting potential members on a one-on-one basis. Our CoC also has applications for membership available on the website www.hometeamerie.org. 3) All housing information is shared electronically through our Home Team list serve as well as the Mayor's Roundtable monthly meeting which consists of disabled individuals and providers. 4) Membership recruitment is an on-going process, as new members are welcome at any point. Those who are interested are invited to attend any general meeting. 5) CoC currently has a formally homeless member on our board. The CoC and providers are encouraged to invite homeless and formally homeless to ensure that those experiencing homelessness can provide input and bring concerns to the CoC.

1B-3. Public Notification for Proposals from Organizations Not Previously
Funded.

Applicants must describe:
1. how the CoC notifies the public that it is accepting project application proposals, and that it is open to and will consider applications from organizations that have not previously received CoC Program funding, as well as the method in which proposals should be submitted;
2. the process the CoC uses to determine whether the project application will be included in the FY 2019 CoC Program Competition process;
3. the date(s) the CoC publicly announced it was open to proposal;
4. how the CoC ensures effective communication with individuals with disabilities, including the availability of accessible electronic formats; and
5. if the CoC does not accept proposals from organizations that have not previously received CoC Program funding or did not announce it was open to proposals from non-CoC Program funded organizations, the applicant must state this fact in the response and provide the reason the CoC does not accept proposals from organizations that have not previously received CoC Program funding.
(limit 2,000 characters)

1) Our CoC advertises an open application process. The Home Team website and Erie County’s facebook page solicits for both new and renewal project applications on open public forums so organizations that have not received CoC funding may apply. Emails were sent out to the Home Team email list serve soliciting new and renewal applications, including the CoC and DV bonus projects. Such emails included information regarding the 2019 NOFA and application process, including detailed instructions and links to the NOFA, and all required documentation. The Home Team email list serve has 117 individuals from a multitude of disciplines who are interested in ending homelessness in our community. Most Home Team members do not receive any CoC funding. 2) All applications submitted are reviewed, scored, and ranked for inclusion by the Home Team scoring committee. An e-mail to the Home team was sent that all new applications were due on August 23, 2019 so there was enough time for review and scoring (Renewal applications were already sent in to the CoC lead). 3) There was an announcement that the NOFA was released at the July 11, 2019 Home Team meeting. A follow-up e-mail was sent to the Home Team list serve announcing that applications were being accepted into the competition on August 2, 2019. The announcement for applications being accepted was also posted on 8/6/2019 to the Home Team website and on 8/9/2019 to the Erie County DHS facebook website. 4) The Home Team consists of a number of organizations that work with people of various disabilities including Voices for Independence, Northwest Legal Services and Veteran’s Affairs. They are members of the Home Team list serve which also consists of both formerly homeless and disabled individuals. The agencies and disabled individuals on the e-mail list are also aware of the Home Team website which posts any new housing information and public notification of this years’ NOFA competition. 5) N/A
1C. Continuum of Care (CoC) Coordination

Instructions:
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Resources:
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1C-1. CoCs Coordination, Planning, and Operation of Projects.

Applicants must select the appropriate response for each federal, state, local, private, other organizations, or program source the CoC included in the planning and operation of projects that serve individuals experiencing homelessness, families experiencing homelessness, unaccompanied youth experiencing homelessness, persons who are fleeing domestic violence, or persons at risk of homelessness.

<table>
<thead>
<tr>
<th>Entities or Organizations the CoC coordinates planning and operation of projects</th>
<th>Coordinates with Planning and Operation of Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Opportunities for Persons with AIDS (HOPWA)</td>
<td>Not Applicable</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families (TANF)</td>
<td>Yes</td>
</tr>
<tr>
<td>Runaway and Homeless Youth (RHY)</td>
<td>Yes</td>
</tr>
<tr>
<td>Head Start Program</td>
<td>Yes</td>
</tr>
<tr>
<td>Funding Collaboratives</td>
<td>Yes</td>
</tr>
<tr>
<td>Private Foundations</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and services programs funded through U.S. Department of Justice (DOJ) Funded Housing and Service Programs</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and services programs funded through U.S. Health and Human Services (HHS) Funded Housing and Service Programs</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and service programs funded through other Federal resources</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and services programs funded through State Government</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and services programs funded through Local Government</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and service programs funded through private entities, including foundations</td>
<td>Yes</td>
</tr>
<tr>
<td>Other:(limit 50 characters)</td>
<td></td>
</tr>
<tr>
<td>IU5 with local school districts homeless liaisons</td>
<td>Yes</td>
</tr>
</tbody>
</table>
1C-2. CoC Consultation with ESG Program Recipients.

Applicants must describe how the CoC:
1. consulted with ESG Program recipients in planning and allocating ESG funds;
2. participated in the evaluating and reporting performance of ESG Program recipients and subrecipients; and
3. ensured local homelessness information is communicated and addressed in the Consolidated Plan updates.

(limit 2,000 characters)

1) Our ESG program recipient and subrecipients are members of the CoC and attend regularly. The ESG recipients and subrecipients seek approval from the CoC for all program guidance related to the administration of the program. The City of Erie's ESG programs (rapid rehousing and emergency shelter) were developed and approved by the CoC Governance Body. 2) Throughout the year, our CoC HMIS staff work closely with the City of Erie, our ESG Recipient, as well as all subrecipients to ensure program requirements for data collection and reporting are met. HMIS staff ran the ESG reports and worked with each provider to ensure all data was accurate in HMIS. In addition, HMIS staff include the ESG CAPER report in annual HMIS User training to improve understanding of data collection and reporting requirements by subrecipient staff at all levels. HMIS staff also work with subrecipient providers to improve data collection, especially at shelters where turnover is high. Subrecipients are encouraged to enter their data in a timely manner and to run their ESG CAPER monthly to support the monthly monitoring submissions required by the City of Erie. One shelter with high turnover who serves our most vulnerable population is running the CAPER daily to catch errors quickly and improve data quality for her program. Our CoC plans to use this provider as a local ‘best practice’ example to encourage other providers to focus on improving data quality as well. 3) Our CoC ensures local homelessness information is communicated and updated in the Consolidated Plan through our County’s planning department.

1C-2a. Providing PIT and HIC Data to Consolidated Plan Jurisdictions.

Applicants must indicate whether the CoC provided Point-in-Time (PIT) and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area.

Yes to both

1C-2b. Providing Other Data to Consolidated Plan Jurisdictions.

Applicants must indicate whether the CoC ensured local homelessness information is communicated to Consolidated Plan Jurisdictions within its geographic area so it

No
can be addressed in Consolidated Plan updates.

1C-3. Addressing the Safety Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors.

Applicants must describe:
1. the CoC’s protocols, including protocols for coordinated entry and the CoC’s emergency transfer plan, that prioritize safety and incorporate trauma-informed, victim-centered services; and
2. how the CoC, through its coordinated entry, maximizes client choice for housing and services while ensuring safety and confidentiality. (limit 2,000 characters)

1) Our CoC has a single-access point Coordinated Entry (CE) system. CE utilizes a Domestic Violence (DV) Procedure, which entails an initial screening during which individuals are immediately asked if they are fleeing DV and further asked if they fear for their safety. Identified DV individuals are then asked if 911 must be called on their behalf. Persons are asked if they would like to speak to a DV provider. Those that prefer to speak with a certified DV provider will be referred directly. The CE staff will ask the person if they would like to remain on the line while the agency is contacted. If not, the person will be given the number to the DV agency. If a DV identified individual does not choose to speak to the DV provider, they are able to continue screening with CE staff. Any participant has the opportunity to work with a DV provider, and their information is not entered into HMIS. The participant’s personally identifying information is entered into a comparable database. Their information is kept confidential and is assigned a confidential identifying number for reference. Many agencies, including the CoC lead, are Trauma-informed or in the process of becoming trauma-informed. Those who engage with a DV provider in the CoC have access to victim-centered services such as legal assistance, counseling, medical needs, etc. 2) If an individual indicates that they are fleeing from DV during their screening, they are given the option of being warmly handed off to a local DV provider or may continue with the assessment for services through CE. It is the individual’s choice which housing and services they participate in. In addition, if a client is already participating in a program and indicates safety concerns including fleeing DV, the person may request transfer to another program. The person would be referred to another program with availability. Confidentiality is maintained throughout this process.

1C-3a. Training—Best Practices in Serving DV Survivors.

Applicants must describe how the CoC coordinates with victim services providers to provide training, at least on an annual basis, for:
1. CoC area 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
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. (limit 2,000 characters)
1) Erie County Care Management (ECCM), as Lead Local Agency for Coordinated Entry (CE), will coordinate DV safety, best practices, and planning protocol training directly with any provider to serve the unique needs of survivors of DV. The CoC lead will offer, at least annually, trainings pertaining to survivors of domestic violence. The CoC is also engaging the Erie County Trauma Informed Coalition to provide trainings on trauma education and awareness opportunities. 

2. ECCM and CE personnel will engage in and complete the DV safety, best practices, and planning protocol training on a regular basis. Safety Planning will be reviewed frequently. Since the launch of our coordinated entry system on January 23, 2018, all coordinated entry staff as well as homeless service providers, have been trained on the policies and procedures that we have put in place to ensure that best practices are implemented with serving survivors of domestic violence, sexual assault, and stalking. We contracted with a technical assistance group to assist us with our system and they conducted two on-site trainings for all of our local homeless service providers. Our local victim service provider has participated in all trainings and provides input for best practice. As our coordinated entry system is still a new program, we are still in the process of enhancing our training schedule. We plan to have our victim service provider conduct an annual training for all area homeless service providers on best practices. Our victim service providers are voting members of the Home Team and attend meetings on a regular basis.

1C-3b. Domestic Violence—Community Need Data.

Applicants must describe how the 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.

(limit 2,000 characters)

A key feature of our Coordinated Entry process is to collaborate in prioritizing and permanently housing survivors of DV, giving this population the highest priority. Our CoC works closely with our designated Domestic Violence providers in assuring anonymity is kept. This is done by keeping a separate Master List of survivors managed by CE and DV staff. This arrangement provides the data we need to better serve the unique needs of this population and understand their experiences, while ensuring confidentiality. For DV participants, CE separately uses the Homeless Management Information System (HMIS) only if DV clients’ agree to be entered into and referred by CE to housing interventions. One DV provider uses the HUD approved Efforts To Outcomes (ETO) data base. ETO is a comparable HMIS data base developed by Pa Commission on Crime and Delinquency (PCCD) and Pennsylvania Coalition Against Domestic Violence (PCADV). Confidentiality and safety of victim/survivor information is protected by this database. The database produces an annual CAPER report that is used to create the SAGE Reporting Repository.

*1C-4. PHAs within CoC. Attachments Required.

Applicants must submit information for the two largest PHAs or the two PHAs with which the CoC has a working relationship within the CoC’s geographic area.
1C-4a. PHAs’ Written Policies on Homeless Admission Preferences.

Applicants must:
1. provide the steps the CoC has taken, with the two largest PHAs within the CoC’s geographic area or the two PHAs the CoC has working relationships with, to adopt a homeless admission preference—if the CoC only has one PHA within its geographic area, applicants may respond for one; or
2. state that the CoC does not work with the PHAs in its geographic area. (limit 2,000 characters)

1) CoC Lead staff have engaged both agencies to request a homeless preference be established. Though not formally in place at this time, a positive relationship exists and dialog continues. Both PHA agencies attend our CoC meetings and are willing to collaborate with CoC members. 2) N/A

1C-4b. Moving On Strategy with Affordable Housing Providers.

Applicants must indicate whether the CoC has a Moving On Strategy with affordable housing providers in its jurisdiction.

No

1C-5. Protecting Against Discrimination.

Applicants must describe the actions the CoC has taken to address all forms of discrimination, such as discrimination based on any protected classes under the Fair Housing Act and 24 CFR 5.105(a)(2) – Equal Access to HUD-Assisted or -Insured Housing. (limit 2,000 characters)

Annually, our CoC votes and approves a CoC-wide policy on equal access and non-discrimination. As per our policy, recipients and sub-recipients of CoC funds must comply with all Federal Statutes and regulations including the Fair Housing Act, The Americans with Disabilities Act, and Equal Access to Housing Final Rule. The CoC also participated in a HUD webinar series that provided education to participants about the requirements of the Equal Access Rule and Gender Identity Rule and how to ensure that projects operate in compliance with these rules.
**1C-5a. Anti-Discrimination Policy and Training.**

Applicants must indicate whether the CoC implemented an anti-discrimination policy and conduct training:

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the CoC implement a CoC-wide anti-discrimination policy that applies to all projects regardless of funding source?</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Did the CoC conduct annual CoC-wide training with providers on how to effectively address discrimination based on any protected class under the Fair Housing Act?</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Did the CoC conduct annual training on how to effectively address discrimination based on any protected class under 24 CFR 5.105(a)(2) – Equal Access to HUD-Assisted or -Insured Housing?</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**1C-6. Criminalization of Homelessness.**

Applicants must select all that apply that describe the strategies the CoC implemented to prevent the criminalization of homelessness in the CoC’s geographic area.

<table>
<thead>
<tr>
<th>Strategy</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Engaged/educated local policymakers:</td>
<td>X</td>
</tr>
<tr>
<td>2. Engaged/educated law enforcement:</td>
<td>X</td>
</tr>
<tr>
<td>3. Engaged/educated local business leaders:</td>
<td>X</td>
</tr>
<tr>
<td>4. Implemented communitywide plans:</td>
<td></td>
</tr>
<tr>
<td>5. No strategies have been implemented:</td>
<td></td>
</tr>
<tr>
<td>6. Other:(limit 50 characters)</td>
<td></td>
</tr>
</tbody>
</table>

**1C-7. Centralized or Coordinated Assessment System. Attachment Required.**

Applicants must:

1. demonstrate the coordinated entry system covers the entire CoC geographic area;
2. demonstrate the coordinated entry system reaches people who are least likely to apply for homelessness assistance in the absence of special outreach; and
3. demonstrate the assessment process prioritizes people most in need of assistance and ensures they receive assistance in a timely manner.

(limit 2,000 characters)
1) The CoC’s CE system is available to anyone seeking homeless services by phone or walk-in. The phone line is available 24/7 365 days a year. The CE system utilizes a single access point that is located downtown. The access point is walking distance to bus lines, mental health facilities, drug & alcohol centers, food banks, hospitals, shelters, and the county jail. The bus lines can be accessed throughout the county and cover the full geographic area of the CoC. CE specialists also travel into the community to meet with persons seeking homeless services. 2) Our CoC markets our system to those least likely to apply for assistance. Our CoC approved an Affirmative Marketing policy which details the steps that our community will take to ensure that services are offered to everyone. The policies are made available on our CoC website, as well as the County DHS website. In addition, at least once annually, our local multicultural resource centers are contacted to inform of homeless services available for all persons. The centers have everyday contact with refugees and those with limited English proficiency and can enable use of CE to this population. 3) The CE system utilizes the VI-SPDAT. When someone calls on the phone or presents to CE, they are immediately given an initial screening. Once crisis housing concerns are addressed (ex. shelter referral), the person is given the VI-SPDAT to determine eligibility for PH. The VI-SPDAT takes multiple vulnerabilities into account which allows our community to prioritize the most vulnerable persons first. The tool rates higher for factors such as fleeing DV, having mental health concerns, substance abuse issues, length of time homeless, families and youth. In addition, there is a monthly master list meeting with CE, DHS and housing providers. Individuals are discussed to further prioritize housing needs based on chronic homelessness, fleeing DV, client circumstances and how long a person has been on the master list.
1D. Continuum of Care (CoC) Discharge Planning

Instructions:
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

1D-1. Discharge Planning Coordination.

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

<table>
<thead>
<tr>
<th>System</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Care:</td>
<td>X</td>
</tr>
<tr>
<td>Health Care:</td>
<td>X</td>
</tr>
<tr>
<td>Mental Health Care:</td>
<td>X</td>
</tr>
<tr>
<td>Correctional Facilities:</td>
<td>X</td>
</tr>
<tr>
<td>None:</td>
<td></td>
</tr>
</tbody>
</table>
1E. Local CoC Competition

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at:
https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources
The FY 2019 CoC Program Competition Notice of Funding Availability at:

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*1E-1. Local CoC Competition—Announcement, Established Deadline, Applicant Notifications. Attachments Required.

Applicants must indicate whether the CoC:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Yes</th>
<th>Did not reject or reduce any project</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Informed project applicants in its local competition announcement about point values or other ranking criteria the CoC would use to rank projects on the CoC Project Listings for submission to HUD for the FY 2019 CoC Program Competition;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Established a local competition deadline, and posted publicly, for project applications that was no later than 30 days before the FY 2019 CoC Program Competition Application submission deadline;</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Notified applicants that their project application(s) were being rejected or reduced, in writing along with the reason for the decision, outside of e-snaps, at least 15 days before the FY 2019 CoC Program Competition Application submission deadline; and</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Notified applicants that their project applications were accepted and ranked on the CoC Priority Listing in writing, outside of e-snaps, at least 15 days before the FY 2019 CoC Program Competition Application submission deadline.</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Applicants must indicate whether the CoC used the following to rank and select project applications for the FY 2019 CoC Program Competition:

<table>
<thead>
<tr>
<th>Objective</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Used objective criteria to review and rank projects for funding (e.g., cost effectiveness of the project, performance data, type of population served);</td>
<td></td>
</tr>
<tr>
<td>2. Included one factor related to improving system performance (e.g., exits to permanent housing (PH) destinations, retention of PH, length of time homeless, returns to homelessness, job/income growth, etc.); and</td>
<td></td>
</tr>
<tr>
<td>3. Included a specific method for evaluating projects submitted by victim services providers that utilized data generated from a comparable database and evaluated these projects on the degree they improve safety for the population served.</td>
<td></td>
</tr>
</tbody>
</table>

Applicants must describe:
1. the specific severity of needs and vulnerabilities the CoC considered when reviewing and ranking projects; and
2. how the CoC takes severity of needs and vulnerabilities into account when reviewing and ranking projects.

(limit 2,000 characters)

1) Our ranking and review process considered several specific needs/vulnerabilities such as performance measures (length of stay, exits to permanent housing, new or increased income), how applicants follow the housing first approach, fund utilization, monitoring findings, data quality (chronic homelessness and timeliness), how applicants coordinate and integrate with other mainstream resources, how applicants can assist clients to rapidly secure and maintain permanent housing, and did the applicants meet the local need of the community. 2) All project applications were reviewed and ranked based on their written applications as well as their HMIS data quality. The scoring committee is given all renewal and new applications along with a rating and ranking tool. The rating and ranking tool’s questions are based on the specific needs/vulnerabilities listed above. The scoring committee then gives a score based on the applicant’s answers to all the questions.


Applicants must:
1. indicate how the CoC made public the review and ranking process the CoC used for all project applications; or
2. check 6 if the CoC did not make public the review and ranking process; and
3. indicate how the CoC made public the CoC Consolidated Application–including the CoC Application and CoC Priority Listing that includes all project applications accepted and ranked or rejected–which HUD required CoCs to post to their websites, or partners websites, at least 2 days before the FY 2019 CoC Program Competition application submission deadline; or
4. check 6 if the CoC did not make public the CoC Consolidated Application.

<table>
<thead>
<tr>
<th>Public Posting of Objective Review and Ranking Process</th>
<th>Public Posting of CoC Consolidated Application including: CoC Application, CoC Priority Listing, Project Listings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Email</td>
<td>X</td>
</tr>
<tr>
<td>2. Mail</td>
<td></td>
</tr>
<tr>
<td>3. Advertising in Local Newspaper(s)</td>
<td></td>
</tr>
</tbody>
</table>
4. Advertising on Radio or Television

5. Social Media (Twitter, Facebook, etc.)

6. Did Not Publicly Post Review and Ranking Process

1E-5. Reallocation between FY 2015 and FY 2018.

Applicants must report the percentage of the CoC’s ARD that was reallocated between the FY 2015 and FY 2018 CoC Program Competitions.

Reallocation: 20%


Applicants must:
1. describe the CoC written process for reallocation;
2. indicate whether the CoC approved the reallocation process;
3. describe how the CoC communicated to all applicants the reallocation process;
4. describe how the CoC identified projects that were low performing or for which there is less need; and
5. describe how the CoC determined whether projects that were deemed low performing would be reallocated.

(limit 2,000 characters)

1) At this time, our CoC does not have a local written process for reallocation. 2) Since there is no written process for reallocation, our CoC did not approve anything. 3) The CoC was informed about the lack of a reallocation process. 4) No projects were identified. 5) No projects were identified for reallocation. We do however, follow any and all of HUD’s guidelines pertaining to reallocation. This application year, our CoC will not be reallocating any funds. Our CoC will be writing and approving a reallocation process.
DV Bonus

Instructions
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

1F-1   DV Bonus Projects.

Applicants must indicate whether the CoC is requesting DV Bonus projects which are included on the CoC Priority Listing:

Yes

1F-1a. Applicants must indicate the type(s) of project(s) included in the CoC Priority Listing.

<table>
<thead>
<tr>
<th>1. PH-RRH</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Joint TH/RRH</td>
<td></td>
</tr>
<tr>
<td>3. SSO Coordinated Entry</td>
<td>x</td>
</tr>
</tbody>
</table>

*1F-2. Number of Domestic Violence Survivors in CoC’s Geographic Area.

Applicants must report the number of DV survivors in the CoC’s geographic area that:

- Need Housing or Services: 396.00
- the CoC is Currently Serving: 196.00
1F-2a. Local Need for DV Projects.

Applicants must describe:
1. how the CoC calculated the number of DV survivors needing housing or service in question 1F-2; and
2. the data source (e.g., HMIS, comparable database, other administrative data, external data source).
(limit 500 characters)

1) The CoC calculates the number of survivors using HMIS and a comparable database. A DV provider makes aggregate numbers of DV and homeless DV victims based on the monthly reports. These numbers, as well as the entire CoC RRH numbers, indicate a need for increased RRH capacity. 2) The data sources used for the above numbers are Efforts to Outcomes and Runaway and Homeless Youth Homeless Information Management System.

1F-3. SSO-CE Project—CoC including an SSO-CE project for DV Bonus funding in their CoC Priority Listing must provide information in the chart below about the project applicant and respond to Question 1F-3a.

<table>
<thead>
<tr>
<th>DUNS Number</th>
<th>800184355</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant Name</td>
<td>Erie County Care Management</td>
</tr>
</tbody>
</table>

1F-3a. Addressing Coordinated Entry Inadequacy.

Applicants must describe how:
1. the current Coordinated Entry is inadequate to address the needs of survivors of domestic violence, dating violence, or stalking; and
2. the proposed project addresses inadequacies identified in 1. above.
(limit 2,000 characters)

1) Survivors of DV experience delayed referrals to housing projects due to the lack of dedicated staff. Coordinated Entry uses HMIS and Erie County’s Certified DV provider uses ETO (Efforts To Outcome). Having two databases, as well as addressing the unique needs of the DV population requires more staff time to coordinate all of the manual tracking, coordination and follow up with all DV clients, essentially spending twice as long per DV client. Currently a CE supervisor, who has multiple duties within their agency, is also solely managing the DV clients for CE. 2) A full-time staff will better meet the needs of people experiencing homelessness who are survivors of DV, dating violence, or stalking. A dedicated staff person would create a level of trust and cooperation between the CE system and the DV and victim service providers, which is often the largest barrier in dealing with these providers. This staff member would work to design and implement new policies and procedures for the DV subpopulation that are trauma informed and client-centered. The policies and procedures would be designed to better coordinate referrals between the CoC’s CE and the DV and victim service providers in the areas where the needs or concerns are different from the standard CE process. Often the data related to this subpopulation is hard to obtain and building a strong relationship with the providers through a single point of contact may break down some of those barriers. The DV and victim service population is one of the most vulnerable groups in our society and their need for housing and shelter is paramount in
helping them begin to break the cycle and get out of their current situations. Having a unique process catered to the specific needs and issues of the population will allow the CE process to better serve these individuals and address their complicated housing needs.

1F-4. PH-RRH and Joint TH and PH-RRH Project Applicant Capacity.

Applicants must provide information for each unique project applicant applying for PH-RRH and Joint TH and PH-RRH DV Bonus projects which the CoC is including in its CoC Priority Listing—using the list feature below.

<table>
<thead>
<tr>
<th>Applicant Name</th>
<th>DUNS Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>SafeNet Domestic ...</td>
<td>156521445</td>
</tr>
</tbody>
</table>
### 1F-4. PH-RRH and Joint TH and PH-RRH Project

#### Applicant Capacity

<table>
<thead>
<tr>
<th>DUNS Number:</th>
<th>156521445</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant Name:</td>
<td>SafeNet Domestic Violence Safety Network</td>
</tr>
<tr>
<td>Rate of Housing Placement of DV Survivors–Percentage:</td>
<td>66.00%</td>
</tr>
<tr>
<td>Rate of Housing Retention of DV Survivors–Percentage:</td>
<td>80.00%</td>
</tr>
</tbody>
</table>

### 1F-4a. Rate of Housing Placement and Housing Retention.

**Applicants must describe:**

1. how the project applicant calculated the rate of housing placement and rate of housing retention reported in the chart above; and
2. the data source (e.g., HMIS, comparable database, other administrative data, external data source). (limit 500 characters)

1,2) The rate was calculated from our Emergency Shelter using data from the comparable HMIS database. We used the percentage of all shelter adult clients and those clients who left for permanent housing. For housing retention, the percentage was based on the number of returning clients within 12 months’ time. We do not screen out those who left but were not permanently housed. Housing retention is based on all clients who came to emergency shelter who were homeless because of domestic violence.

### 1F-4b. DV Survivor Housing.

**Applicants must describe how project applicant ensured DV survivors experiencing homelessness were assisted to quickly move into permanent housing.**

(limit 2,000 characters)

SafeNet has changed the housing goals for our Transitional Housing project which houses those survivors who were homeless because of domestic violence. The initial Transitional Housing program provided 12 months and up to 24 months of housing for survivors before they relocated to permanent housing. We now limit their housing contract to 3 months, which is flexible based on need. Survivors are often waiting for permanent supportive housing, rapid rehousing or entry into public housing during their stay. Safety is the highest priority for these victims. Survivors are relocating to permanent housing from emergency shelter. If a client’s choice is for immediate housing, we will assist them in resolving any barriers that they have to obtaining and remaining in permanent housing.

### 1F-4c. DV Survivor Safety.

**Applicants must describe how project applicant:**

1. ensured the safety of DV survivors experiencing homelessness by:
   (a) training staff on safety planning;
(b) adjusting intake space to better ensure a private conversation;
(c) conducting separate interviews/intake with each member of a couple;
(d) working with survivors to have them identify what is safe for them as
it relates to scattered site units and/or rental assistance;
(e) maintaining bars on windows, fixing lights in the hallways, etc. for
congregate living spaces operated by the applicant;
(f) keeping the location confidential for dedicated units and/or congregate
living spaces set-aside solely for use by survivors; and

2. measured its ability to ensure the safety of DV survivors the project
served.

(limit 2,000 characters)

1a) All SafeNet staff who work with adults or children – either residential, legal,
non-residential are trained in Safety Planning. This training is refreshed on a
regular basis. 1b) Any SafeNet facility that provides services to adult
survivors/victims would have a private room with a closed door to conduct an
intake interview. 1c) SafeNet always conducts interviews with only one member
of a couple. A 2nd person would be directed to other service providers either
dv or homeless housing service. 1d) We work with survivors to have them
identify what is safe for them as it relates to any assistance. this is an important
part of safety planning for a survivor. 1e) SafeNet facilities serving DV victims
have bullet-proof glass on all 1st floor windows and reception areas. All
residents are survivors of DV. Window locks and other safety devices are
available to clients through our Legal services programs and nonresidential
counseling. 1f) SafeNet has provided Confidentiality for victims since we
incorporated in 1972. All our residential service building are at non-published
addresses. Our SafeNet Center has High security with a singular entrance. 2)
Protecting the safety of our clients and their children is SafeNet's high priority.
For 47 years, we have been keenly aware of the potential danger that
surrounds a victim when they leave their abuser. Our facilities are highly secure
with bullet-proof glass on the windows. Not only residential clients but every
client of SafeNet is asked to develop a safety plan that uses strategies that the
survivor has used in the past to protect themselves and their children. SafeNet
and PFACS have home safety devices that we can pass to clients to protect
their doors and windows. Our DV counseling informs all clients about what the
legal system can do to truly protect their safety.

1F-4d. Trauma-Informed, Victim-Centered Approaches.

Applicants must describe:
1. project applicant’s experience in utilizing trauma-informed, victim-
centered approaches to meet needs of DV survivors; and
2. how, if funded, the project will utilize trauma-informed, victim-centered
approaches to meet needs of DV survivors by:
(a) prioritizing participant choice and rapid placement and stabilization in
permanent housing consistent with participants’ preferences;
(b) 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;
(c) providing program participants access to information on trauma, e.g.,
training staff on providing program participant with information on
trauma;
(d) placing emphasis on the participant’s strengths, 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;
(e) centering on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;
(f) delivering opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and
(g) offering support for parenting, e.g., parenting classes, childcare.

1) SafeNet recognizes the signs of trauma in staff, clients and has incorporated knowledge about trauma into policies, procedures, practices and our physical operations. We prioritize restoration of the survivors’ feeling of safety, choice and control. SafeNet has been providing trauma informed services for over 40 years. Our staff discusses what a victim’s choices and preferences are for their situation and works to remove barriers to obtaining the goals that they set for themselves. This victim centered advocacy places the survivor’s needs and interests at the heart of the work. Services are non-judgmental emphasizing the client’s self-determination and clarifying choices. We work to restore feelings of safety and guard against actions that could re-traumatize. In DV services there is a saying, “Who is driving the bus”? The answer is ‘the client’ - “they are driving their bus.” We, as staff, are simply along for the ride. SafeNet will utilize their typical process of prioritizing participant choices, while working with them to obtain housing. SafeNet staff are considered advocates. Advocates who work to help remove road blocks for victims, any decisions made regarding the victims housing are always based on the service recipients desires/needs. SafeNet staff is seen as the equal participants, without a power differential. SafeNet follows the guiding principles of one of their major funder, the Pennsylvania Coalition Against Domestic Violence (PCADV). It is a requirement of PCADV that SafeNet Staff are trained in J.A.R.S (Justice Autonomy Restoration and Safety). SafeNet provides annual training to staff regarding trauma and trauma informed approaches.

2) Direct service staff participates in trauma informed approaches at bi-weekly at case management meetings. Much of this information is meant to be carried back to victims who participate in SafeNet Services. SafeNet advocates work with each participant to identify what works well for their relationships and where they may need some additional ideas. For example, when safety planning: the advocate would ask the victim what they have been doing so far to stay safe? The advocate would then use those ideas to build on what they are already doing. SafeNet serves all victims of domestic violence. As part of SafeNet’s training program all new staff are trained in cultural awareness/cultural competence. SafeNet regularly participates in local trainings that provide awareness regarding cultural competence, and inclusivity for LGBT +Q individuals. SafeNet maintains a referral list that is used to ensure that victims have a connection to the Erie Community and services/programs that are offered by other providers. SafeNet also works to provide both individual and systems advocacy with local agencies. SafeNet has staff that has been trained in multiple parenting programs, including: Strengthening Families Curriculum, Parents In the Know, and K.I.S.S. (a Kid Is So Special) Curriculum created by the Pennsylvania Coalition Against Domestic Violence. This 12-week child-focused curriculum was developed to assist adult survivors in recognizing the impact that domestic violence has on children, as well as understanding and responding appropriately to children’s reactions to abuser

1F-4e. Meeting Service Needs of DV Survivors.

Applicants must describe how the project applicant met services needs and ensured DV survivors experiencing homelessness were assisted to quickly move into permanent housing while addressing their safety needs, including:

- Child Custody
- Legal Services
- Criminal History
- Bad Credit History
- Education
- Job Training
- Employment
- Physical/Mental Healthcare
- Drug and Alcohol Treatment
- Childcare

(limit 2,000 characters)

SafeNet and our incorporated legal services have offices at our Center. Legal service are staffed by in-house attorney, a para legal, 2 legal counselors and 4 part-time attorneys. Legal does divorce, custody, immigration, Protection from Abuse Orders, advocacy with Landlords, clearing of erroneous credit information or incorrect criminal history are offered to low-income victims without charge. As part of intake, victims are provided with DV education and assistance in developing their personal Safety Plan. As part of intake, victims are provided with screening which identifies history and need for employment income to reduce barriers. Referrals to St. Benedict Education Center will be made if this is the client’s choice. Case management will assist the victim in developing an IESP (Individual Economic Safety Plan). SafeNet can offer the victims a choice of 2 evidenced based economic recovery programs: Allstate’s Moving Ahead through Financial Empowerment and WoW (Wider Opportunities for Women that will help move the victim to Financial Stability. Referrals can be made to GECAC for employment and income programs. As part of intake, victims are provided with screening which identifies history and need for physical and mental healthcare. Referrals will be made if this is client choice. As part of intake, victims are provided with screening which identifies history and need for drug, alcohol and other chemical healthcare. Referrals will be made if this is client choice to D&A services i.e. Gaudenzia. SafeNet will refer to ELR, Early learning Resources, who will provide eligible homeless victims with subsidized daycare. Safenet will assist with referrals to enable victims to comply with informational documentation avoiding jeopardizing safety. SafeNet can provide short-term or situational daycare. SafeNet has a full-time Children’s Program director supervising interns, volunteers and part-time staff. Daycare is also assisted if the victim has an open case with OCY.
2A. Homeless Management Information System (HMIS) Implementation

Instructions:
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

2A-1. HMIS Vendor Identification.
Wellsky Corporation

Applicants must review the HMIS software vendor name brought forward from FY 2018 CoC Application and update the information if there was a change.

2A-2. Bed Coverage Rate Using HIC and HMIS Data.

Using 2019 HIC and HMIS data, applicants must report by project type:

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Total Number of Beds in 2019 HIC</th>
<th>Total Beds Dedicated for DV in 2019 HIC</th>
<th>Total Number of 2019 HIC Beds in HMIS</th>
<th>HMIS Bed Coverage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shelter (ES) beds</td>
<td>267</td>
<td>54</td>
<td>231</td>
<td>108.45%</td>
</tr>
<tr>
<td>Safe Haven (SH) beds</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>100.00%</td>
</tr>
<tr>
<td>Transitional Housing (TH) beds</td>
<td>137</td>
<td>28</td>
<td>109</td>
<td>100.00%</td>
</tr>
<tr>
<td>Rapid Re-Housing (RRH) beds</td>
<td>178</td>
<td>0</td>
<td>178</td>
<td>100.00%</td>
</tr>
<tr>
<td>Permanent Supportive Housing (PSH) beds</td>
<td>397</td>
<td>0</td>
<td>295</td>
<td>74.31%</td>
</tr>
<tr>
<td>Other Permanent Housing (OPH) beds</td>
<td>90</td>
<td>0</td>
<td>90</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

2A-2a. Partial Credit for Bed Coverage Rates at or Below 84.99 for Any Project Type in Question 2A-2.

For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-2, applicants must describe:
1. steps the 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 the CoC will implement the steps described to increase bed coverage to at least 85 percent.
(limit 2,000 characters)

1) Our PSH beds are only missing the HUD-VASH beds. Our CoC works very closely with our Veterans Affairs (VA) Homeless Team. We have discussed entering the HUD-VASH clients as they currently participate in HMIS to enter their Homeless Outreach clients. However, this past year the VA Homeless Team experienced more staffing issues due to turnover and extended illness leave. Although entering these clients is voluntary, we will again work toward including this project in HMIS by training VA HUD-VASH staff to enter them directly into HMIS. 2) HMIS staff will meet with VA Homeless staff to discuss an implementation plan. We will collaborate to determine what tasks and training are needed and schedule these.


Applicants must indicate whether the CoC submitted its LSA data to HUD in HDX 2.0. Yes

*2A-4. HIC HDX Submission Date.

Applicants must enter the date the CoC submitted the 2019 Housing Inventory Count (HIC) data into the Homelessness Data Exchange (HDX). (mm/dd/yyyy) 06/24/2019
2B. Continuum of Care (CoC) Point-in-Time Count

Instructions:
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
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https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources
The FY 2019 CoC Program Competition Notice of Funding Availability at:

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2B-1. PIT Count Date. 02/01/2019
Applicants must enter the date the CoC conducted its 2019 PIT count (mm/dd/yyyy).

2B-2. PIT Count Data–HDX Submission Date. 04/26/2019
Applicants must enter the date the CoC submitted its PIT count data in HDX (mm/dd/yyyy).

Applicants must describe:
1. any changes in the sheltered count implementation, including methodology or data quality methodology changes from 2018 to 2019, if applicable; and
2. how the changes affected the CoC’s sheltered PIT count results; or
3. state “Not Applicable” if there were no changes.
(limit 2,000 characters)

1) This year our HMIS System Administrator and our Planning grant consultant scheduled time to meet in person with each agency and gather the data on site. For each project the agency had, the team verified the clients in HMIS with actual project records. This new approach was preferred by both agency staff as well as CoC staff and stakeholders as it streamlined the process. 2) Although data submitted previously were verified and accurate, this process improvement reduced the time and effort involved tremendously. This is because data quality issues were immediately rectified in HMIS with provider verification. HMIS staff assisted agency personnel in fixing inaccurate data on the spot.
**2B-4. Sheltered PIT Count–Changes Due to Presidentially-declared Disaster.**

Applicants must select whether the CoC added or removed emergency shelter, transitional housing, or Safe-Haven inventory because of funding specific to a Presidentially-declared disaster, resulting in a change to the CoC’s 2019 sheltered PIT count.  

No

**2B-5. Unsheltered PIT Count–Changes in Implementation.**

Applicants must describe:
1. any changes in the unsheltered count implementation, including methodology or data quality methodology changes from 2018 to 2019, if applicable; and
2. how the changes affected the CoC’s unsheltered PIT count results; or  
3. state “Not Applicable” if there were no changes.  
(limit 2,000 characters)

1) The methodology of the unsheltered count remained the same as past years in 2019. Erie County is a relatively small county compared to other CoC geographic areas, and the local process tends to be efficient. What does change from year to year is the volunteer base that participates. This year we enlisted the assistance of a local university Public Health department with faculty and students to help with the count. Over 20 students participated throughout the evening. Their participation not only helped cover the geographic area, but also educated the students on the situations that those experiencing homelessness face on any given night. 2) This group enhanced our geographic reach enabling us to cover more rural areas. Although no unsheltered homeless persons were identified, it was important for the CoC to continue our geographic expansion of the unsheltered count. The additional volunteer base also allowed the lead agency staff to spend time at the local seasonal shelter to gather information that evening.

**2B-6. PIT Count–Identifying Youth Experiencing Homelessness.**

Applicants must:

Indicate whether the CoC implemented specific measures to identify youth experiencing homelessness in their 2019 PIT count.  

Yes

2B-6a. PIT Count–Involving Youth in Implementation.

Applicants must describe how the CoC engaged stakeholders serving youth experiencing homelessness to:
1. plan the 2019 PIT count;
2. select locations where youth experiencing homelessness are most likely to be identified; and
3. involve youth in counting during the 2019 PIT count.
(limit 2,000 characters)

1) The CoC board includes all providers who serve youth experiencing homelessness. All members are encouraged to participate in the PIT count. 2) The CoC included any known locations for youth in our count. 3) The CoC included university students, which enhanced our knowledge beyond what the providers knew. Many of these students volunteered at other local events and gave us ideas of new places to search.

2B-7. PIT Count–Improvements to Implementation.

Applicants must describe the CoC’s actions implemented in its 2019 PIT count to better count:
1. individuals and families experiencing chronic homelessness;
2. families with children experiencing homelessness; and
3. Veterans experiencing homelessness.
(limit 2,000 characters)

1) PIT and HMIS coordinators communicate to providers the data that will identify individuals and families who may be chronically homeless. The questions asked focus on disability status, prior living situation and length of stays. Coordinators work one-on-one with providers to ensure the data is accurate. 2) The Erie County CoC continuously engages providers that serve families with children. This homeless population is sizably sheltered during the PIT count, which makes identification and counting this group a straightforward approach. When working with providers, special attention is given to identification of families with children and accounting for bed spaces. 3) The local PIT count also benefits from a strong relationship with the Erie Veterans Affairs hospital, which ‘co-hosts’ the annual event. Their presence, as well as the high level of involvement, assures that our count of this population is better accounted for.
3A. Continuum of Care (CoC) System Performance

Instructions

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Warning! The CoC Application score could be affected if information is incomplete on this formlet.

*3A-1. First Time Homeless as Reported in HDX.

Applicants must:

Report the Number of First Time Homeless as Reported in HDX.  

<table>
<thead>
<tr>
<th>Applicants must:</th>
<th>1,005</th>
</tr>
</thead>
</table>


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

1) One of the CoC's strategies to identify these risk factors is for the Coordinated Entry (CE) provider to document notes about persons' prior living situations. Also, during the CoC PIT count, a survey is given to persons that have already been housed. The survey is filled out by consumers and staff who are asked to identify what they consider to be the contributing factors that led to participants' homelessness. The CoC also records participants' permanent zip codes to determine if they are relocating here to seek housing services. This data is analyzed to help us in understanding the risk factors for our first-time homeless population and to determine appropriate strategies to reduce this measure.

2) In the new CoC Strategic Plan, Client Services was identified as an
area of focus. This includes the need to utilize more local data to identify the
causes of homelessness and what supportive services are needed to assist
those at risk of becoming homeless. Stronger case management for both
prevention and as a bridge between services has also been identified. The CoC
CE main access point is the Mental Health Lead agency, chosen for their
expertise in assessing and referring clients as quickly as possible. This process
is diverting as many persons as possible from entering our homeless system as
the CE staff interview and assess each participant for the correct intervention. In
addition, the CoC is building reports that will allow us to identify unmet needs.
As the CoC continues to gather, analyze and report our local data, we will
design better prevention and diversion strategies. 3) The CoC governing body is
responsible for overseeing this strategy.

*3A-2. Length of Time Homeless as Reported in HDX.

Applicants must:

| Report Average Length of Time Individuals and Persons in Families Remained Homeless as Reported in HDX. | 75 |


Applicants must:
1. describe the CoC’s strategy to reduce the length of time individuals and persons in families remain homeless;
2. describe how the 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 the CoC’s strategy to reduce the length of time individuals and families remain homeless.
(limit 2,000 characters)

1) The CoC is focused on permanently and stably housing persons as quickly as possible. The CoC Coordinated Entry (CE) process utilizes a prioritized Master List for permanent housing placement. A prioritizing criterion is identifying those with the longest wait time. Providers meet monthly and triage each case to increase the probability that an individual or family will be successful in a permanent housing placement. This year, the CoC added a new Rapid Re-housing program. This increased capacity in permanent housing should reduce our length of time homeless as we move clients more quickly into a permanent home. The CoC also utilizes RRH as a bridge to PSH when the unique needs of the potential participant indicate that short term RRH placement would be successful. 2) Our Master List currently utilizes HMIS records to identify clients’ homeless history, tracking the dates clients initially call our hotline as well as each contact made to our CE system. Projects that serve clients also enter data in HMIS, increasing the historical information gathered pertaining to their lengths of homelessness. This year, the CoC is contracting with our HMIS vendor to build custom reports that will give us a clearer picture of local data. The CoC will utilize the SPMs and Stella to examine the subpopulations we serve and the effectiveness of each intervention. The HMIS vendor has committed to completing a request for a custom report of Client Homeless History by the end of 2019. This report will be
utilized to increase the effectiveness of prioritizing those with the longest 
homelessness history for permanent housing and services. The CoC is focused 
on ensuring the appropriate strategies are in place to improve the process for 
quickly moving persons through the homeless system, identifying persons' 
length of time homeless, and stabilizing those who achieve a permanent home. 

3) The CoC governing body is responsible for overseeing this strategy.

*3A-3. Successful Permanent Housing Placement and Retention as 
Reported in HDX.

Applicants must:

<table>
<thead>
<tr>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Report the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid rehousing that exit to permanent housing destinations as reported in HDX.</td>
</tr>
<tr>
<td>2. Report the percentage of individuals and persons in families in permanent housing projects, other than rapid rehousing, that retain their permanent housing or exit to permanent housing destinations as reported in HDX.</td>
</tr>
</tbody>
</table>

3A-3a. Exits to Permanent Housing Destinations/Retention of Permanent Housing.

Applicants must:
1. describe the CoC’s strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations;
2. provide the organization name or position title responsible for overseeing the CoC’s strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations;
3. describe the CoC’s strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations; and
4. provide the organization name or position title responsible for overseeing the CoC’s strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations.  
(limit 2,000 characters)

1) The CoC is collecting and analyzing data from our SPMs and Stella to gain 
critical insight into our sub-populations and the pathways that are most effective 
in permanently housing them. Insights provided by Stella have identified that 
improving the ES/SH Only pathway will have the highest impact on increasing 
exports to permanent housing across all household types and preventing returns 
to homelessness. Stella has also identified missing Destination and RRH Move-
in Date as major data quality issues. We are addressing these data quality 
issues through improved processes and trainings for provider staff. Utilizing our 
local data in a more effective way will increase the effectiveness of permanently 
housing persons in shelters, safe havens, transitional housing and rapid re-
housing. 2) The CoC governing body will be responsible for overseeing this
3) In our monthly Master List meetings, providers triage persons to identify the best placement for each unique situation. We have identified the need to look outside our local providers to engage more community stakeholders, such as landlord groups, developers and business leaders. Through engagement, both of our PHAs are active members of our CoC team. We will be utilizing local data to clearly identify our needs and build these collaborative relationships through focused community engagement. Also, we have designed our CE system with a focus on continuous improvement and best practices review to ensure we are consistently improving our processes and maintaining the most effective, client-centered process for our community’s needs. By considering each person’s unique experiences and needs, we increase the likeliness that a PH placement will be successful in providing a stable and permanent home. 

4) The CoC governing body is responsible for overseeing this strategy.

**3A-4. Returns to Homelessness as Reported in HDX.**

Applicants must:

<table>
<thead>
<tr>
<th>Step</th>
<th>Description</th>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>Report the percentage of individuals and persons in families returning to homelessness over a 6-month period as reported in HDX.</td>
<td>12%</td>
</tr>
<tr>
<td>2.</td>
<td>Report the percentage of individuals and persons in families returning to homelessness over a 12-month period as reported in HDX.</td>
<td>6%</td>
</tr>
</tbody>
</table>

**3A-4a. Returns to Homelessness—CoC Strategy to Reduce Rate.**

Applicants must:

1. describe the strategy the CoC has implemented to identify individuals and persons in families who return to homelessness;
2. describe the CoC’s strategy to reduce the rate of additional returns to homelessness; and
3. provide the name of the organization or position title that is responsible for overseeing the CoC’s strategy to reduce the rate individuals and persons in families return to homelessness. (limit 2,000 characters)

1) Stella has identified that our CoC can have the highest impact on this measure by focusing on the ES/SH Only pathway, which has an impact score of 75 for all household types. Drilling down further, we see that the impact increases for Adult Only to 86 and even higher for Adult Only Veterans at 100. The greater the number, the higher effect our CoC has on reducing returns to homelessness. With this detailed local insight, we will focus our efforts on the providers who serve this particular pathway. We also know that missing destination data is high for this population and have made process improvements that we will incorporate into our CoC training to improve this. 2) Our local data for this SPM will be used to identify and understand the different causes for persons returning to homelessness. In our monthly Master List meetings, we hear unique stories of participants that help us to identify commonalities that will be targeted for improved services and supports. This transparency allows us to collaborate across providers to ensure each client
receives the best placement for his/her unique needs. We are identifying providers who are most successful at maintaining participants' housing and why. We will use this data to offer local best practices for sharing with providers who may benefit from these strategies. In addition, as part of our Strategic Plan, we have identified the need to review best practices for other similar communities who are successfully stabilizing persons in PH to determine if there are other strategies that may be adopted in our community. 3) The CoC governing body is responsible for overseeing this strategy.

*3A-5. Cash Income Changes as Reported in HDX.

Applicants must:

| Percentage |
|-----------------|-----------------|
| 1. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their employment income from entry to exit as reported in HDX. | 8% |
| 2. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their non-employment cash income from entry to exit as reported in HDX. | 13% |


Applicants must:

1. describe the CoC's strategy to increase employment income;
2. describe the CoC's strategy to increase access to employment;
3. describe how the CoC works with mainstream employment organizations to help individuals and families increase their cash income;
and
4. provide the organization name or position title that is responsible for overseeing the CoC's strategy to increase jobs and income from employment.

(limit 2,000 characters)

1) The CoC Strategic plan has identified poverty as a leading variable of homelessness in our community. Currently, homeless providers work with clients to overcome employment barriers and prepare for job opportunities. Providers assist clients with identifying job interests, completing job searches, preparing for interviews, acquiring appropriate attire, and transportation to and from interviews. Several providers offer vocational rehabilitation assistance, financial literacy, budgeting, etc. These providers are key CoC partners and attend meetings regularly. Housing providers and Coordinated Entry incorporate strategies to gain employment with participants in their service plans. The CoC monitors providers' impact on employment income. 2) The CoC consists of providers that offer access to employment and employment services. The CE provider is centrally located and has access to both bus lines and the LIFT service (a transportation program for local residents unable to utilize traditional bus services). Many housing providers give out bus tokens and passes to individuals for transportation to employment. The CoC providers also work with job placement agencies that often provide transportation to and from places of employment. 3) Key partnerships have been established between job placement agencies and homeless providers. Housing case managers assist
participants in job searching and often refer to these job placement agencies. When new job openings are available, the job agency often reaches out to these providers to contact the participants seeking employment. 4) The CoC Home Team Homeless and Housing Coalition is responsible for overseeing this strategy to increase jobs and income through employment.


Applicants must:
1. describe the CoC’s strategy to increase non-employment cash income;
2. describe the CoC’s strategy to increase access to non-employment cash sources;
3. provide the organization name or position title that is responsible for overseeing the CoC’s strategy to increase non-employment cash income.

1) Housing Providers refer to a local SOAR- certified program to assist with identifying eligibility for non-employment cash sources. These case managers assist participants with disabilities in applying for Social Security and for cash assistance through the Department of Welfare’s assistance programs (Temporary Assistance for Needy Families, General Assistance, Diversion Program, Refugee Cash Assistance Program). Housing Providers and Coordinated Entry incorporate strategies for participants in need of non-employment income in their service plans. The CoC monitors providers’ impact on non-employment income. 2) Many CoC providers assist in helping individuals access services offered by the Social Security office and the Department of Welfare. The CE provider for our COC is centrally located and has access to both bus lines and the LIFT service. Many providers give out bus tokens and passes to individuals to access services. 3) The CoC Home Team Homeless and Housing Coalition is responsible for overseeing the strategy to increase non-employment cash income.


Applicants must describe how the 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, internship, and employment opportunities for residents of permanent supportive housing that further their recovery and well-being.
(limit 2,000 characters)

1) Our homeless providers work with mainstream employment resources to improve their clients’ opportunities for employment. Some local businesses have relationships with homeless providers to hire participants who are referred for work. Housing case managers work with our job placement agencies to assist in their hiring of employees that have difficulty finding work due to lack of work history, a criminal record or disability. These job placement agencies also connect with local businesses willing to hire individuals who have these barriers to employment including the homeless population. 2) Our CoC providers offer
case management services for clients facing any employment barriers. These case managers assist participants with the referral process to several vocational programs offered through the Office of Vocational Rehabilitation, Career Link and the Department of Welfare who partner with local Colleges, GED programs and Tech schools. These agencies assess for workforce testing and preparedness as well as offer financial assistance to the local vocational schools and colleges.


Applicants must select all the steps the CoC has taken to promote employment, volunteerism and community service 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.
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).
3. The CoC trains provider organization staff on connecting program participants with formal employment opportunities.
4. The CoC trains provider organization staff on volunteer opportunities for program participants and people experiencing homelessness.
5. The CoC works with organizations to create volunteer opportunities for program participants.
6. The CoC works with community organizations to create opportunities for civic participation for people experiencing homelessness (e.g., townhall forums, meeting with public officials).
7. Provider organizations within the CoC have incentives for employment.
8. The CoC trains provider organization staff on helping program participants budget and maximize their income to maintain stability in permanent housing.

3A-6. System Performance Measures

Data–HDX Submission Date

Applicants must enter the date the CoCs submitted its FY 2018 System Performance Measures data in HDX. (mm/dd/yyyy)
3B. Continuum of Care (CoC) Performance and Strategic Planning Objectives

Instructions

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3B-1. Prioritizing Households with Children.

Applicants must check each factor the CoC currently uses to prioritize households with children for assistance during FY 2019.

<table>
<thead>
<tr>
<th>Factor</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of or Vulnerability to Victimization (e.g. domestic violence, sexual assault, childhood abuse)</td>
<td></td>
</tr>
<tr>
<td>2. Number of previous homeless episodes</td>
<td></td>
</tr>
<tr>
<td>3. Unsheltered homelessness</td>
<td></td>
</tr>
<tr>
<td>4. Criminal History</td>
<td></td>
</tr>
<tr>
<td>5. Bad credit or rental history</td>
<td></td>
</tr>
<tr>
<td>6. Head of Household with Mental/Physical Disability</td>
<td></td>
</tr>
</tbody>
</table>

3B-1a. Rapid Rehousing of Families with Children.

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

1) Coordinated Entry works closely with Rapid Re-housing programs to accept, prioritize, and house referrals within 30 days. There is a monthly master list meeting with CE, Erie County DHS and housing providers where families with children are reviewed for Rapid Re-housing. This year the CoC added a RRH program, increasing the number of beds for families with children. CoC housing providers continually work on landlord engagement and apartment availability which has aided rapid re-housing efforts. Apartments are typically available when the participant is ready to move in. Additionally, some RRH sub-recipients expedite move in by providing furnished apartments and moving services as part of the program. All program participants are assessed and connected for any service need. 2) The CoC’s Rapid Re-housing programs provide case management services to help maintain participants’ housing. Providers are familiar with education/employment, mental health, D & A and criminal justice systems. Our providers also have understanding serving families with lived experiences. Families are referred to any supports to help maintain their housing. Additionally, our RRH providers have case managers that are ethnically diverse which helps maintain a positive relationship in order to keep families stably housed. 3) The CoC is ultimately responsible for overseeing the CoC’s strategy by coordinating services for faster entries to rapid-rehousing and faster exits to permanent housing. The CoC monitors Rapid Re-housing providers to ensure they are following the core components and practices of this model.

3B-1b. Antidiscrimination Policies.

Applicants must check all that apply that describe actions the CoC is taking to ensure providers (including emergency shelter, transitional housing, and permanent housing (PSH and RRH)) within the CoC adhere to antidiscrimination policies by not denying admission to or separating any family members from other members of their family or caregivers based on any protected classes under the Fair Housing Act, and consistent with 24 CFR 5.105(a)(2) – Equal Access to HUD-Assisted or -Insured Housing.

1. CoC conducts mandatory training for all CoC- and ESG-funded housing and services providers on these topics.

2. CoC conducts optional training for all CoC- and ESG-funded housing and service providers on these topics.

3. CoC has worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients.

4. CoC has worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within the CoC geographic area that might be out of compliance and has taken steps to work directly with those facilities to come into compliance.

3B-1c. Unaccompanied Youth Experiencing Homelessness–Addressing
Needs.

Applicants must indicate whether the CoC’s strategy to address the unique needs of unaccompanied youth experiencing homelessness who are 24 years of age and younger includes the following:

<table>
<thead>
<tr>
<th>Needs</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unsheltered homelessness</td>
<td></td>
</tr>
<tr>
<td>2. Human trafficking and other forms of exploitation</td>
<td></td>
</tr>
<tr>
<td>3. LGBT youth homelessness</td>
<td></td>
</tr>
<tr>
<td>4. Exits from foster care into homelessness</td>
<td></td>
</tr>
<tr>
<td>5. Family reunification and community engagement</td>
<td></td>
</tr>
<tr>
<td>6. Positive Youth Development, Trauma Informed Care, and the use of Risk and Protective Factors in assessing youth housing and service needs</td>
<td></td>
</tr>
</tbody>
</table>

3B-1c.1. Unaccompanied Youth Experiencing Homelessness—Prioritization Based on Needs.

Applicants must check all that apply that describes the CoC’s current strategy to prioritize unaccompanied youth based on their needs.

<table>
<thead>
<tr>
<th>Needs</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of, or Vulnerability to, Victimization (e.g., domestic violence, sexual assault, childhood abuse)</td>
<td></td>
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<td></td>
</tr>
</tbody>
</table>

3B-1d. Youth Experiencing Homelessness–Housing and Services Strategies.

Applicants must describe how the CoC increased availability of housing and services for:

1. all youth experiencing homelessness, including creating new youth-focused projects or modifying current projects to be more youth-specific or youth-inclusive; and
2. youth experiencing unsheltered homelessness including creating new youth-focused projects or modifying current projects to be more youth-specific or youth-inclusive.

(limit 3,000 characters)

1) The CoC has had an active Children and Youth subcommittee that has been engaging stakeholders in several capacities, including outreach and education. It has conducted best-practice research of what other communities have done to incorporate existing or new services to provide leverage in assisting
unsheltered homeless youth. CoC members have attended trainings on ending youth homelessness and identifying better strategies to engage homeless youth, as well as collect better data to identify problem areas. The CoC has also initiated an agreement with the local Intermediate Unit 5, which is a consortia of public school districts in the region. In this agreement, data will be shared to better gauge the extent of underserved homeless youth in the county. The implementation of Coordinated Entry has led to more effective use of existing resources. Erie County Care Management administers not only Coordinated Entry, but intake for the Mental Health, Early Intervention, and Intellectual Disabilities systems. Any of these systems of care can identify and provide assistance to homeless youths. The process for youth with multiple needs is more seamless, and the amount of administrative overhead is reduced. 2) The Children and Youth subcommittee along with the DHS Office of Children and Youth has been looking at the feasibility of a local drop-in center for youth. During the planning process, one key strategic area identified is that of client services and engagement. Part of the discussion is focusing on prevention and outreach strategies aimed at priority populations, including youth. The proposed Funding subcommittee mentioned above would also pursue new funding for unsheltered homeless youth.

3B-1d.1. Youth Experiencing Homelessness–Measuring Effectiveness of Housing and Services Strategies.

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

1) In addition to partnering with the IU3 for data reporting, we have instituted efforts to improve local youth data collection and reporting that will help us to understand the extent and needs of this population. Our CoC has a confidentiality release of information that will allow for better data sharing with our youth providers, including school districts. We have designed better reports that incorporate data elements and review these reports regularly to measure the success of our strategies. We will continue to grow our efforts to identify homeless youth during our PIT count. 2) The CoC will utilize the custom youth reports, CoC APRs of individual projects including the new Coordinated Entry system, as well as other system reports, (such as the PIT and LSA) to measure the effectiveness of our homeless youth strategies. Several of the focus areas identified in our CoC’s strategic plan consider youth homelessness. Client Services, Community Engagement and Data Use/Collection subcommittees will all incorporate aspects of youth homelessness. 3) The CoC believes these measures of collecting and reviewing local project and system data will enable us to define usable objectives to serve this population. Once the extent and needs of this population are more clearly understood, we will be much better positioned to examine and measure the needs of the homeless youth population and our effectiveness in addressing them
3B-1e. Collaboration–Education Services.

Applicants must describe:

1. the formal partnerships with:
   a. youth education providers;
   b. McKinney-Vento LEA or SEA; and
   c. school districts; and

2. how the CoC collaborates with:
   a. youth education providers;
   b. McKinney-Vento Local LEA or SEA; and
   c. school districts.

(limit 2,000 characters)

1) Local and State education leaders are members of the CoC and attend meetings regularly. Homeless liaisons from local school districts are active members and are an integral part of our CoC. The CoC also partners with the Allegheny Intermediate Unit 3 to obtain information on homeless youth in our community. 2) The IU3 data is useful in determining how youth homelessness will be addressed in our community. Our CoC has identified Community Engagement and Client Services as areas of focus in our Strategic plan, which includes education services. The need to expand our partnerships with these education providers is included and addressed with specific action steps to improve and increase these relationships.

3B-1e.1. Informing Individuals and Families Experiencing Homeless about Education Services Eligibility.

Applicants must describe policies and procedures the CoC adopted to inform individuals and families who become homeless of their eligibility for education services.

(limit 2,000 characters)

It is the policy of the CoC that any child of school age residing in a CoC funded program attend school. Service providers within the CoC educate program participants regarding the rights of students who are homeless within the education system. McKinney-Vento school liaisons assist families experiencing homelessness with referrals to available resources and ensure that McKinney-Vento entitlements are relayed to families. Our CoC has a longtime working relationship with Early Intervention for children ages birth to 3 years old. It is a policy of the CoC that all children residing in a CoC funded program birth to 3 years old be referred to Early Intervention Services when needed. Service providers also evaluate adults for needs of education services and make referrals to adult education resources on an as needed basis.

3B-1e.2. Written/Formal Agreements or Partnerships with Early Childhood Services Providers.

Applicant must indicate whether the CoC has an MOU/MOA or other types of agreements with listed providers of early childhood services and

Applicant: Erie City & County CoC
Project: PA-605 CoC Registration FY2019
FY2019 CoC Application  Page 41  09/12/2019
supports and may add other providers not listed.

<table>
<thead>
<tr>
<th>MOU/MOA</th>
<th>Other Formal Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Early Childhood Providers</td>
<td>Yes</td>
</tr>
<tr>
<td>Head Start</td>
<td>No</td>
</tr>
<tr>
<td>Early Head Start</td>
<td>No</td>
</tr>
<tr>
<td>Child Care and Development Fund</td>
<td>No</td>
</tr>
<tr>
<td>Federal Home Visiting Program</td>
<td>No</td>
</tr>
<tr>
<td>Healthy Start</td>
<td>No</td>
</tr>
<tr>
<td>Public Pre-K</td>
<td>No</td>
</tr>
<tr>
<td>Birth to 3 years</td>
<td>No</td>
</tr>
<tr>
<td>Tribal Home Visiting Program</td>
<td>No</td>
</tr>
<tr>
<td>Other: (limit 50 characters)</td>
<td></td>
</tr>
</tbody>
</table>

3B-2. Active List of Veterans Experiencing Homelessness.
Applicant must indicate whether the CoC uses an active list or by-name list to identify all veterans experiencing homelessness in the CoC.

3B-2a. VA Coordination—Ending Veterans Homelessness.
Applicants must indicate whether the CoC is actively working with the U.S. Department of Veterans Affairs (VA) and VA-funded programs to achieve the benchmarks and criteria for ending veteran homelessness.

3B-2b. Housing First for Veterans.
Applicants must indicate whether the CoC has sufficient resources to ensure each veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach.

Applicants must:
1. select all that apply to indicate the findings from the CoC’s Racial Disparity Assessment; or
2. select 7 if the CoC did not conduct a Racial Disparity Assessment.

1. People of different races or ethnicities are more likely to receive homeless assistance.
2. People of different races or ethnicities are less likely to receive homeless assistance.

3. People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.

4. People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.

5. There are no racial or ethnic disparities in the provision or outcome of homeless assistance.

6. The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance. ✗

7. The CoC did not conduct a racial disparity assessment.

### 3B-3a. Addressing Racial Disparities.

Applicants must select all that apply to indicate the CoC’s strategy to address any racial disparities identified in its Racial Disparities Assessment:

1. The CoC is ensuring that staff at the project level are representative of the persons accessing homeless services in the CoC. ✗

2. The CoC has identified the cause(s) of racial disparities in their homeless system.

3. The CoC has identified strategies to reduce disparities in their homeless system. ✗

4. The CoC has implemented strategies to reduce disparities in their homeless system.

5. The CoC has identified resources available to reduce disparities in their homeless system.

6. The CoC did not conduct a racial disparity assessment.
4A. Continuum of Care (CoC) Accessing Mainstream Benefits and Additional Policies

Instructions:
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

4A-1. Healthcare—Enrollment/Effective Utilization

Applicants must indicate, for each type of healthcare listed below, whether the CoC assists persons experiencing homelessness with enrolling in health insurance and effectively utilizing Medicaid and other benefits.

<table>
<thead>
<tr>
<th>Type of Health Care</th>
<th>Assist with Enrollment</th>
<th>Assist with Utilization of Benefits?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Private Insurers:</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-Profit, Philanthropic:</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other: (limit 50 characters)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Applicants must:
1. describe how the CoC systematically keeps program staff up to date regarding mainstream resources available for program participants (e.g., Food Stamps, SSI, TANF, substance abuse programs) within the geographic area;
2. describe how the CoC disseminates the availability of mainstream resources and other assistance information to projects and how often;
3. describe how the CoC works with projects to collaborate with healthcare organizations to assist program participants with enrolling in...
health insurance;
4. describe how the CoC provides assistance with the effective utilization of Medicaid and other benefits; and
5. provide the name of the organization or position title that is responsible for overseeing the CoC’s strategy for mainstream benefits.

(limit 2,000 characters)

1) The CoC collaborates with local stakeholders and several service providers to promote utilization and share information regarding mainstream resources. These providers share updates to resources in our meetings. Mainstream resource information is also shared through the CoC’s email list serve. 2) Our CoC disseminates the availability of resources and other information to projects via email, bi-monthly meetings and posting on our CoC website. 3) The CoC partners with local healthcare systems to assist program participants with enrolling in health insurance. Faith Community Nurses of NWPA’s Health Care for the Homeless Partnerships (HC4HP) offers healthcare resources. They partner with housing agencies and offer the Wellness Clinic, a healthcare service available every Friday. Their volunteer nurses also conduct a basic health screening and provide outreach at emergency shelters. ECCM also assists clients enroll in health insurance. The CoC aids in the enrollment and utilization of benefits through several sources. Case managers from both MH and homeless providers assist participants with scheduling medical appointments, obtaining a primary care physician, medication monitoring and facilitating transportation to appointments. 4) The CoC collaborates with service providers to promote utilization of mainstream resources. Case managers, including those SOAR trained, assist with completing applications for benefits including Medicaid, Medicare, Food Stamps, and TANF. To promote rapid access to services and encourage successful exits, clients are referred to local resources for medical, behavioral health, and dental care. Free care is offered through St. Paul’s Free Clinic and Faith Community Nurses’ Wellness Connection Clinic. These clinics offer services such as basic primary healthcare, behavioral health, and case management. 5) The CoC oversees the strategy for aligning mainstream benefits and is responsible for updating program staff with new resources.

4A-2. Lowering Barriers to Entry Data:

Applicants must report:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition.</td>
<td>12</td>
</tr>
<tr>
<td>2. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.</td>
<td>12</td>
</tr>
<tr>
<td>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 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.</td>
<td>100%</td>
</tr>
</tbody>
</table>


Applicants must:
1. describe the CoC’s street outreach efforts, including the methods it
uses to ensure all persons experiencing unsheltered homelessness are identified and engaged;
2. state whether the CoC’s Street Outreach covers 100 percent of the CoC’s geographic area;
3. describe how often the CoC conducts street outreach; and
4. describe how the CoC tailored its street outreach to persons experiencing homelessness who are least likely to request assistance.
(limit 2,000 characters)

1) Our CoC currently has two types of ongoing street outreach services that identify and assist sheltered and unsheltered homeless individuals; the PATH program and Faith Community Nurses (FCN). The PATH program is administered by our local lead agency who is also our Coordinated Entry provider. The PATH case managers reach out to individuals who are homeless to offer referrals for case management and services. FCN provide outreach services to individuals who are homeless in the community and require medical care. They also link the homeless individual with CE. In addition, during the PIT count, volunteers conduct street outreach by disseminating resources to unsheltered individuals, directing them to CE and potential services. 2) The CoC's street outreach services are available anywhere throughout Erie County where the need exists, therefore making the services cover 100% of our CoC’s geographic area. 3) PATH case managers visit area shelters regularly (daily, weekly or as needed) to reach out to participants, assist them with finding permanent housing, and access additional services (employment, benefits etc.). The FCN's outreach is daily. These providers work with the CoC and refer all individuals with housing needs to CE. The PIT is annually. 4) Erie is a nationally designated refugee resettlement community resulting in many barriers. This population is least likely to request assistance and therefore the CoC providers must contact at least annually one of the following organizations: International Institute of Erie, Multicultural Community Resource Center, Saint Martin Center, and Multi-Cultural Health Evaluation Delivery Systems, Inc. (MHEDS). These agencies are contacted to inform them of services available for those with housing needs.

4A-4. RRH Beds as Reported in HIC.

Applicants must report the total number of rapid rehousing beds available to serve all household types as reported in the Housing Inventory Count (HIC) for 2018 and 2019.

<table>
<thead>
<tr>
<th>RRH beds available to serve all populations in the HIC</th>
<th>2018</th>
<th>2019</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>170</td>
<td>178</td>
<td>8</td>
</tr>
</tbody>
</table>


Applicants must indicate whether any new project application the CoC ranked and submitted in its CoC Priority Listing in the FY 2019 CoC Program Competition is requesting $200,000 or more in funding for housing

No
rehabilitation or new construction.

4A-6. Projects Serving Homeless under Other Federal Statutes. No

Applicants must indicate whether the CoC is requesting to designate one or more of its SSO or TH projects to serve families with children or youth defined as homeless under other federal statutes.
4B. Attachments

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

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Required?</th>
<th>Document Description</th>
<th>Date Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>1C-4.PHA Administration Plan–Moving On Multifamily Assisted Housing Owners’ Preference.</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1C-4. PHA Administrative Plan Homeless Preference.</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1C-7. Centralized or Coordinated Assessment System.</td>
<td>Yes</td>
<td>CE Assessment Tool</td>
<td>09/04/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting–15-Day Notification Outside e-snaps–Projects Accepted.</td>
<td>Yes</td>
<td>Projects Accepted</td>
<td>09/09/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting–15-Day Notification Outside e-snaps–Projects Rejected or Reduced.</td>
<td>Yes</td>
<td>Project Rejected/...</td>
<td>09/09/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting–30-Day Local Competition Deadline.</td>
<td>Yes</td>
<td>Local Competition</td>
<td>08/28/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting–Local Competition Announcement.</td>
<td>Yes</td>
<td>Local Competition</td>
<td>08/28/2019</td>
</tr>
<tr>
<td>1E-4. Public Posting–CoC-Approved Consolidated Application</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A. Written Agreement with Local Education or Training Organization.</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A. Written Agreement with State or Local Workforce Development Board.</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3B-3. Summary of Racial Disparity Assessment.</td>
<td>Yes</td>
<td>Racial Disparity ...</td>
<td>09/10/2019</td>
</tr>
<tr>
<td>4A-7a. Project List-Homeless under Other Federal Statutes.</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td>Rating and Rankin...</td>
<td>08/28/2019</td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
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<td></td>
<td></td>
</tr>
</tbody>
</table>

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Attachment Details

Document Description: FY 2019 CoC Competition Report

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: CE Assessment Tool

Attachment Details

Document Description: Projects Accepted Notification

Attachment Details

Document Description: Project Rejected/Reduced Notification
Attachment Details

Document Description:  Local Competition Deadline

Attachment Details

Document Description:  Local Competition Public Announcement

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.

<table>
<thead>
<tr>
<th>Page</th>
<th>Last Updated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A. Identification</td>
<td>08/26/2019</td>
</tr>
<tr>
<td>1B. Engagement</td>
<td>09/11/2019</td>
</tr>
<tr>
<td>1C. Coordination</td>
<td>09/11/2019</td>
</tr>
<tr>
<td>1D. Discharge Planning</td>
<td>No Input Required</td>
</tr>
<tr>
<td>1E. Local CoC Competition</td>
<td>09/10/2019</td>
</tr>
<tr>
<td>1F. DV Bonus</td>
<td>09/10/2019</td>
</tr>
<tr>
<td>2A. HMIS Implementation</td>
<td>09/12/2019</td>
</tr>
<tr>
<td>2B. PIT Count</td>
<td>09/12/2019</td>
</tr>
<tr>
<td>3A. System Performance</td>
<td>09/12/2019</td>
</tr>
<tr>
<td>3B. Performance and Strategic Planning</td>
<td>09/10/2019</td>
</tr>
<tr>
<td>4A. Mainstream Benefits and Additional Policies</td>
<td>09/10/2019</td>
</tr>
<tr>
<td>4B. Attachments</td>
<td>Please Complete</td>
</tr>
<tr>
<td>Submission Summary</td>
<td>No Input Required</td>
</tr>
<tr>
<td>-----------------------------</td>
<td>-------------------</td>
</tr>
</tbody>
</table>

**Applicant:** Erie City & County CoC  
**Project:** PA-605 CoC Registration FY2019  
**Project Code:** COC_REG_2019_170595  
**Application:** FY2019 CoC Application  
**Page:** 54  
**Date:** 09/12/2019
# Total Population PIT Count Data

<table>
<thead>
<tr>
<th></th>
<th>2016 PIT</th>
<th>2017 PIT</th>
<th>2018 PIT</th>
<th>2019 PIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sheltered and Unsheltered Count</td>
<td>377</td>
<td>369</td>
<td>336</td>
<td>356</td>
</tr>
<tr>
<td>Emergency Shelter Total</td>
<td>219</td>
<td>241</td>
<td>238</td>
<td>246</td>
</tr>
<tr>
<td>Safe Haven Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>8</td>
</tr>
<tr>
<td>Transitional Housing Total</td>
<td>148</td>
<td>120</td>
<td>94</td>
<td>96</td>
</tr>
<tr>
<td>Total Sheltered Count</td>
<td>367</td>
<td>361</td>
<td>332</td>
<td>350</td>
</tr>
<tr>
<td>Total Unsheltered Count</td>
<td>10</td>
<td>8</td>
<td>4</td>
<td>6</td>
</tr>
</tbody>
</table>

# Chronically Homeless PIT Counts

<table>
<thead>
<tr>
<th></th>
<th>2016 PIT</th>
<th>2017 PIT</th>
<th>2018 PIT</th>
<th>2019 PIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sheltered and Unsheltered Count of Chronically Homeless Persons</td>
<td>11</td>
<td>29</td>
<td>20</td>
<td>38</td>
</tr>
<tr>
<td>Sheltered Count of Chronically Homeless Persons</td>
<td>11</td>
<td>29</td>
<td>17</td>
<td>36</td>
</tr>
<tr>
<td>Unsheltered Count of Chronically Homeless Persons</td>
<td>0</td>
<td>0</td>
<td>3</td>
<td>2</td>
</tr>
</tbody>
</table>
2019 HDX Competition Report
PIT Count Data for PA-605 - Erie City & County CoC

### Homeless Households with Children PIT Counts

<table>
<thead>
<tr>
<th></th>
<th>2016 PIT</th>
<th>2017 PIT</th>
<th>2018 PIT</th>
<th>2019 PIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sheltered and Unsheltered Count of the Number of Homeless Households with Children</td>
<td>42</td>
<td>34</td>
<td>39</td>
<td>31</td>
</tr>
<tr>
<td>Sheltered Count of Homeless Households with Children</td>
<td>42</td>
<td>34</td>
<td>39</td>
<td>31</td>
</tr>
<tr>
<td>Unsheltered Count of Homeless Households with Children</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
</tbody>
</table>

### Homeless Veteran PIT Counts

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sheltered and Unsheltered Count of the Number of Homeless Veterans</td>
<td>36</td>
<td>23</td>
<td>29</td>
<td>29</td>
<td>25</td>
</tr>
<tr>
<td>Sheltered Count of Homeless Veterans</td>
<td>28</td>
<td>22</td>
<td>27</td>
<td>27</td>
<td>25</td>
</tr>
<tr>
<td>Unsheltered Count of Homeless Veterans</td>
<td>8</td>
<td>1</td>
<td>2</td>
<td>2</td>
<td>0</td>
</tr>
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</table>
### HMIS Bed Coverage Rate

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Total Beds in 2019 HIC</th>
<th>Total Beds in 2019 HIC Dedicated for DV</th>
<th>Total Beds in HMIS</th>
<th>HMIS Bed Coverage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shelter (ES) Beds</td>
<td>267</td>
<td>54</td>
<td>213</td>
<td>100.00%</td>
</tr>
<tr>
<td>Safe Haven (SH) Beds</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>100.00%</td>
</tr>
<tr>
<td>Transitional Housing (TH) Beds</td>
<td>137</td>
<td>28</td>
<td>109</td>
<td>100.00%</td>
</tr>
<tr>
<td>Rapid Re-Housing (RRH) Beds</td>
<td>178</td>
<td>0</td>
<td>178</td>
<td>100.00%</td>
</tr>
<tr>
<td>Permanent Supportive Housing (PSH) Beds</td>
<td>397</td>
<td>0</td>
<td>295</td>
<td>74.31%</td>
</tr>
<tr>
<td>Other Permanent Housing (OPH) Beds</td>
<td>90</td>
<td>0</td>
<td>90</td>
<td>100.00%</td>
</tr>
<tr>
<td><strong>Total Beds</strong></td>
<td><strong>1,079</strong></td>
<td><strong>82</strong></td>
<td><strong>895</strong></td>
<td><strong>89.77%</strong></td>
</tr>
</tbody>
</table>
### PSH Beds Dedicated to Persons Experiencing Chronic Homelessness

<table>
<thead>
<tr>
<th>Chronically Homeless Bed Counts</th>
<th>2016 HIC</th>
<th>2017 HIC</th>
<th>2018 HIC</th>
<th>2019 HIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CoC Program and non-CoC Program funded PSH beds dedicated for use by chronically homeless persons identified on the HIC</td>
<td>71</td>
<td>21</td>
<td>196</td>
<td>177</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Households with Children</th>
<th>2016 HIC</th>
<th>2017 HIC</th>
<th>2018 HIC</th>
<th>2019 HIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRH units available to serve families on the HIC</td>
<td>0</td>
<td>6</td>
<td>38</td>
<td>38</td>
</tr>
</tbody>
</table>

### Rapid Rehousing Beds Dedicated to All Persons

<table>
<thead>
<tr>
<th>All Household Types</th>
<th>2016 HIC</th>
<th>2017 HIC</th>
<th>2018 HIC</th>
<th>2019 HIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRH beds available to serve all populations on the HIC</td>
<td>2</td>
<td>29</td>
<td>170</td>
<td>178</td>
</tr>
</tbody>
</table>
Measure 1: Length of Time Persons Remain Homeless

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

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

a. This measure is of the client's entry, exit, and bed night dates strictly as entered in the HMIS system.
### FY2018 - Performance Measurement Module (Sys PM)

<table>
<thead>
<tr>
<th>1.1 Persons in ES and SH</th>
<th>Universe (Persons)</th>
<th>Average LOT Homeless (bed nights)</th>
<th>Median LOT Homeless (bed nights)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>1392</td>
<td>1415</td>
<td>1355</td>
</tr>
<tr>
<td>1.2 Persons in ES, SH, and TH</td>
<td>1591</td>
<td>1589</td>
<td>1514</td>
</tr>
</tbody>
</table>

b. This measure is based on data element 3.17.

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

The construction of this measure changed, per HUD’s specifications, between FY 2016 and FY 2017. HUD is aware that this may impact the change between these two years.
Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness

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

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

<table>
<thead>
<tr>
<th>Exit was from SO</th>
<th>Total # of Persons who Exited to a Permanent Housing Destination (2 Years Prior)</th>
<th>Returns to Homelessness in Less than 6 Months</th>
<th>Returns to Homelessness from 6 to 12 Months</th>
<th>Returns to Homelessness from 13 to 24 Months</th>
<th>Number of Returns in 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revised FY 2017</td>
<td>FY 2018</td>
<td>Revised FY 2017</td>
<td>FY 2018</td>
<td>% of Returns</td>
</tr>
<tr>
<td>Exit was from SO</td>
<td>9</td>
<td>23</td>
<td>0</td>
<td>5</td>
<td>22%</td>
</tr>
<tr>
<td>Exit was from ES</td>
<td>196</td>
<td>319</td>
<td>43</td>
<td>54</td>
<td>17%</td>
</tr>
<tr>
<td>Exit was from TH</td>
<td>157</td>
<td>149</td>
<td>31</td>
<td>9</td>
<td>6%</td>
</tr>
<tr>
<td>Exit was from SH</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>Exit was from PH</td>
<td>128</td>
<td>315</td>
<td>4</td>
<td>28</td>
<td>9%</td>
</tr>
<tr>
<td>TOTAL Returns to Homelessness</td>
<td>490</td>
<td>806</td>
<td>78</td>
<td>96</td>
<td>12%</td>
</tr>
</tbody>
</table>

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts
This measures the change in PIT counts of sheltered and unsheltered homeless person as reported on the PIT (not from HMIS).

<table>
<thead>
<tr>
<th></th>
<th>January 2017 PIT Count</th>
<th>January 2018 PIT Count</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Total PIT Count of sheltered and unsheltered persons</td>
<td>369</td>
<td>336</td>
<td>-33</td>
</tr>
<tr>
<td>Emergency Shelter Total</td>
<td>241</td>
<td>238</td>
<td>-3</td>
</tr>
<tr>
<td>Safe Haven Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transitional Housing Total</td>
<td>120</td>
<td>94</td>
<td>-26</td>
</tr>
<tr>
<td>Total Sheltered Count</td>
<td>361</td>
<td>332</td>
<td>-29</td>
</tr>
<tr>
<td>Unsheltered Count</td>
<td>8</td>
<td>4</td>
<td>-4</td>
</tr>
</tbody>
</table>

Metric 3.2 – Change in Annual Counts

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Unduplicated Total sheltered homeless persons</td>
<td>1626</td>
<td>1606</td>
<td>1553</td>
<td>-53</td>
</tr>
<tr>
<td>Emergency Shelter Total</td>
<td>1403</td>
<td>1397</td>
<td>1352</td>
<td>-45</td>
</tr>
<tr>
<td>Safe Haven Total</td>
<td>0</td>
<td>0</td>
<td>23</td>
<td>23</td>
</tr>
<tr>
<td>Transitional Housing Total</td>
<td>351</td>
<td>337</td>
<td>261</td>
<td>-76</td>
</tr>
</tbody>
</table>
Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults</td>
<td>104</td>
<td>122</td>
<td>108</td>
<td>-14</td>
</tr>
<tr>
<td>with increased earned income</td>
<td>12</td>
<td>18</td>
<td>17</td>
<td>-1</td>
</tr>
<tr>
<td>Percentage of adults who</td>
<td>12%</td>
<td>15%</td>
<td>16%</td>
<td>1%</td>
</tr>
<tr>
<td>increased earned income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults</td>
<td>104</td>
<td>122</td>
<td>108</td>
<td>-14</td>
</tr>
<tr>
<td>with increased non-employment cash income</td>
<td>25</td>
<td>24</td>
<td>24</td>
<td>0</td>
</tr>
<tr>
<td>Percentage of adults who</td>
<td>24%</td>
<td>20%</td>
<td>22%</td>
<td>2%</td>
</tr>
<tr>
<td>increased non-employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cash income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults</td>
<td>104</td>
<td>122</td>
<td>108</td>
<td>-14</td>
</tr>
<tr>
<td>with increased total income</td>
<td>36</td>
<td>33</td>
<td>32</td>
<td>-1</td>
</tr>
<tr>
<td>Percentage of adults who</td>
<td>35%</td>
<td>27%</td>
<td>30%</td>
<td>3%</td>
</tr>
<tr>
<td>increased total income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

Metric 4.4 – Change in earned income for adult system leavers

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults who exited (system leavers)</td>
<td>159</td>
<td>157</td>
<td>192</td>
<td>35</td>
</tr>
<tr>
<td>Number of adults who exited with increased earned income</td>
<td>21</td>
<td>23</td>
<td>16</td>
<td>-7</td>
</tr>
<tr>
<td>Percentage of adults who increased earned income</td>
<td>13%</td>
<td>15%</td>
<td>8%</td>
<td>-7%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults who exited (system leavers)</td>
<td>159</td>
<td>157</td>
<td>192</td>
<td>35</td>
</tr>
<tr>
<td>Number of adults who exited with increased non-employment cash income</td>
<td>21</td>
<td>21</td>
<td>25</td>
<td>4</td>
</tr>
<tr>
<td>Percentage of adults who increased non-employment cash income</td>
<td>13%</td>
<td>13%</td>
<td>13%</td>
<td>0%</td>
</tr>
</tbody>
</table>

Metric 4.6 – Change in total income for adult system leavers

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults who exited (system leavers)</td>
<td>159</td>
<td>157</td>
<td>192</td>
<td>35</td>
</tr>
<tr>
<td>Number of adults who exited with increased total income</td>
<td>40</td>
<td>41</td>
<td>38</td>
<td>-3</td>
</tr>
<tr>
<td>Percentage of adults who increased total income</td>
<td>25%</td>
<td>26%</td>
<td>20%</td>
<td>-6%</td>
</tr>
</tbody>
</table>
**Measure 5: Number of persons who become homeless for the 1st time**

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universe:</strong> Person with entries into ES, SH or TH during the reporting period.</td>
<td>1445</td>
<td>1426</td>
<td>1409</td>
<td>-17</td>
</tr>
<tr>
<td>Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.</td>
<td>424</td>
<td>419</td>
<td>404</td>
<td>-15</td>
</tr>
<tr>
<td>Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)</td>
<td>1021</td>
<td>1007</td>
<td>1005</td>
<td>-2</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universe:</strong> Person with entries into ES, SH, TH or PH during the reporting period.</td>
<td>1775</td>
<td>1748</td>
<td>1763</td>
<td>15</td>
</tr>
<tr>
<td>Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.</td>
<td>529</td>
<td>523</td>
<td>525</td>
<td>2</td>
</tr>
<tr>
<td>Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)</td>
<td>1246</td>
<td>1225</td>
<td>1238</td>
<td>13</td>
</tr>
</tbody>
</table>
Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD’s Homeless Definition in CoC Program-funded Projects

This Measure is not applicable to CoCs in FY2018 (Oct 1, 2017 - Sept 30, 2018) reporting period.

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

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Persons who exit Street Outreach</td>
<td>242</td>
<td>197</td>
<td>5</td>
<td>-192</td>
</tr>
<tr>
<td>Of persons above, those who exited to temporary &amp; some institutional destinations</td>
<td>133</td>
<td>109</td>
<td>1</td>
<td>-108</td>
</tr>
<tr>
<td>Of the persons above, those who exited to permanent housing destinations</td>
<td>25</td>
<td>18</td>
<td>3</td>
<td>-15</td>
</tr>
<tr>
<td>% Successful exits</td>
<td>65%</td>
<td>64%</td>
<td>80%</td>
<td>16%</td>
</tr>
</tbody>
</table>

Metric 7b.1 – Change in exits to permanent housing destinations
## Metric 7b.2 – Change in exit to or retention of permanent housing

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universe:</strong> Persons in all PH projects except PH-RRH</td>
<td>458</td>
<td>448</td>
<td>423</td>
<td>-25</td>
</tr>
<tr>
<td>Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations</td>
<td>413</td>
<td>413</td>
<td>393</td>
<td>-20</td>
</tr>
<tr>
<td>% Successful exits/retention</td>
<td>90%</td>
<td>92%</td>
<td>93%</td>
<td>1%</td>
</tr>
</tbody>
</table>
This is a new tab for FY 2016 submissions only. Submission must be performed manually (data cannot be uploaded). Data coverage and quality will allow HUD to better interpret your Sys PM submissions.

Your bed coverage data has been imported from the HIC module. The remainder of the data quality points should be pulled from data quality reports made available by your vendor according to the specifications provided in the HMIS Standard Reporting Terminology Glossary. You may need to run multiple reports into order to get data for each combination of year and project type.

You may enter a note about any field if you wish to provide an explanation about your data quality results. This is not required.
<table>
<thead>
<tr>
<th></th>
<th>All ES, SH</th>
<th>All TH</th>
<th>All PSH, OPH</th>
<th>All RRH</th>
<th>All Street Outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of non-DV Beds on HIC</td>
<td>176</td>
<td>180</td>
<td>174</td>
<td>192</td>
<td>199</td>
</tr>
<tr>
<td>2. Number of HMIS Beds</td>
<td>176</td>
<td>180</td>
<td>174</td>
<td>187</td>
<td>199</td>
</tr>
<tr>
<td>3. HMIS Participation Rate from HIC (%)</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>97.40</td>
<td>100.00</td>
</tr>
<tr>
<td>4. Unduplicated Persons Served (HMIS)</td>
<td>1200</td>
<td>1333</td>
<td>1397</td>
<td>1376</td>
<td>403</td>
</tr>
<tr>
<td>5. Total Leavers (HMIS)</td>
<td>1048</td>
<td>1170</td>
<td>1233</td>
<td>1223</td>
<td>270</td>
</tr>
<tr>
<td>6. Destination of Don't Know, Refused, or Missing (HMIS)</td>
<td>299</td>
<td>163</td>
<td>228</td>
<td>195</td>
<td>0</td>
</tr>
<tr>
<td>7. Destination Error Rate (%)</td>
<td>28.53</td>
<td>13.93</td>
<td>18.49</td>
<td>15.94</td>
<td>0.00</td>
</tr>
</tbody>
</table>
# 2019 HDX Competition Report

## Submission and Count Dates for PA-605 - Erie City & County CoC

### Date of PIT Count

| Date CoC Conducted 2019 PIT Count | 2/1/2019 | No |

### Report Submission Date in HDX

<table>
<thead>
<tr>
<th>Submitted On</th>
<th>Met Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 PIT Count Submittal Date</td>
<td>4/26/2019</td>
</tr>
<tr>
<td>2019 HIC Count Submittal Date</td>
<td>4/26/2019</td>
</tr>
<tr>
<td>2018 System PM Submittal Date</td>
<td>5/30/2019</td>
</tr>
</tbody>
</table>
Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:
• VI-SPDAT V 2.0 for Individuals
• VI-SPDAT V 2.0 for Families
• VI-SPDAT V 1.0 for Youth

All versions are available online at
www.orgcode.com/products/vi-spdat/

SPDAT Series

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

Current versions available:
• SPDAT V 4.0 for Individuals
• SPDAT V 2.0 for Families
• SPDAT V 1.0 for Youth

Information about all versions is available online at
www.orgcode.com/products/spdat/
SPDAT Training Series

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

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

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

Current SPDAT training available:

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

Other related training available:

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

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

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

<table>
<thead>
<tr>
<th>Interviewer’s Name</th>
<th>Agency</th>
<th>Team</th>
<th>Staff</th>
<th>Volunteer</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey Date</th>
<th>Survey Time</th>
<th>Survey Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD/MM/YYYY</td>
<td><em><strong>/</strong></em>____</td>
<td>___ ___ ___</td>
</tr>
</tbody>
</table>

**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 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**

<table>
<thead>
<tr>
<th>First Name</th>
<th>Nickname</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Age</th>
<th>Social Security Number</th>
<th>Consent to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD/MM/YYYY</td>
<td>___</td>
<td>___</td>
<td>○Yes ○No</td>
</tr>
</tbody>
</table>

**SCORE:**

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

SCORE: 0
A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)
   - Shelters
   - Transitional Housing
   - Safe Haven
   - Outdoors
   - Other (specify):
   - Refused


   SCORE: 0

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

   ___ Years
   - 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: 0

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: 0

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: 0
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

**SCORE:** 0

**IF “YES,” THEN SCORE 1 FOR LEGAL ISSUES.**

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

**SCORE:** 0

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

**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

**SCORE:** 0

**IF “YES” TO QUESTION 10 OR “NO” TO QUESTION 11, THEN SCORE 1 FOR MONEY MANAGEMENT.**

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

**SCORE:** 0

**IF “NO,” THEN SCORE 1 FOR MEANINGFUL DAILY ACTIVITY.**

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

**SCORE:** 0

**IF “NO,” THEN SCORE 1 FOR SELF-CARE.**

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

**SCORE:** 0

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

0

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:**

0

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:**

0

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

**SCORE:**

0
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: 0

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: 0

Scoring Summary

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

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 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
Family Service Prioritization Decision Assistance Tool
(F-SPDAT)

Assessment Tool for Families

VERSION 2.01

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1 (800) 355-0420  info@orgcode.com  www.orgcode.com
Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:
• VI-SPDAT V 2.0 for Individuals
• VI-SPDAT V 2.0 for Families
• VI-SPDAT V 1.0 for Youth

All versions are available online at
www.orgcode.com/products/vi-spdat/

SPDAT Series

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

Current versions available:
• SPDAT V 4.0 for Individuals
• SPDAT V 2.0 for Families
• SPDAT V 1.0 for Youth

Information about all versions is available online at
www.orgcode.com/products/spdat/
SPDAT Training Series

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

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

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

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

Other related training available:
- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

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

http://www.orgcode.com/product-category/training/sdatap/
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.
# A. Mental Health & Wellness & Cognitive Functioning

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Has anyone in your family ever received any help with their mental wellness?</td>
<td></td>
</tr>
<tr>
<td>• Do you feel that every member in your family is getting all the help they need for their mental health or stress?</td>
<td></td>
</tr>
<tr>
<td>• Has a doctor ever prescribed anyone in your family pills for nerves, anxiety, depression or anything like that?</td>
<td></td>
</tr>
<tr>
<td>• Has anyone in your family ever gone to an emergency room or stayed in a hospital because they weren’t feeling 100% emotionally?</td>
<td></td>
</tr>
<tr>
<td>• Does anyone in your family have trouble learning or paying attention, or been tested for learning disabilities?</td>
<td></td>
</tr>
<tr>
<td>• 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?</td>
<td></td>
</tr>
<tr>
<td>• Has anyone in your family ever hurt their brain or head?</td>
<td></td>
</tr>
<tr>
<td>• Do you have any documents or papers about your family’s mental health or brain functioning?</td>
<td></td>
</tr>
<tr>
<td>• Are there other professionals we could speak with that have knowledge of your family’s mental health?</td>
<td></td>
</tr>
</tbody>
</table>

## SCORING

<table>
<thead>
<tr>
<th>Any of the following among any family member:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>4 ❑ 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</td>
<td></td>
</tr>
<tr>
<td>3 ❑ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability</td>
<td></td>
</tr>
<tr>
<td>2 ❑ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition</td>
<td></td>
</tr>
<tr>
<td>1 ❑ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>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:</td>
<td></td>
</tr>
<tr>
<td>2 ❑ No major concerns about the family’s safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning</td>
<td></td>
</tr>
<tr>
<td>1 ❑ No major concerns for the health and safety of others because of mental health or cognitive functioning ability</td>
<td></td>
</tr>
<tr>
<td>0 ❑ 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</td>
<td></td>
</tr>
<tr>
<td></td>
<td></td>
</tr>
<tr>
<td>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.</td>
<td></td>
</tr>
<tr>
<td>0 ❑ No mental health or cognitive functioning issues disclosed, suspected or observed.</td>
<td></td>
</tr>
</tbody>
</table>
## B. Physical Health & Wellness

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
</tr>
</thead>
</table>
| • 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? |

### SCORING

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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  
☐ Palliative 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 |
### C. Medication

**PROMPTS**

- 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? Who’s? 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?

**CLIENT SCORE:**

<table>
<thead>
<tr>
<th>Score</th>
<th>Prompt</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Any of the following for any family member:</td>
</tr>
<tr>
<td></td>
<td>☐ In the past 30 days, started taking a prescription which <strong>is</strong> having any negative impact on day to day living, socialization or mood</td>
</tr>
<tr>
<td></td>
<td>☐ Shares or sells prescription, but keeps <strong>less</strong> than is sold or shared</td>
</tr>
<tr>
<td></td>
<td>☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high)</td>
</tr>
<tr>
<td></td>
<td>☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason.</td>
</tr>
<tr>
<td>3</td>
<td>Any of the following for any family member:</td>
</tr>
<tr>
<td></td>
<td>☐ In the past 30 days, started taking a prescription which <strong>is not</strong> having any negative impact on day to day living, socialization or mood</td>
</tr>
<tr>
<td></td>
<td>☐ Shares or sells prescription, but keeps <strong>more</strong> than is sold or shared</td>
</tr>
<tr>
<td></td>
<td>☐ 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)</td>
</tr>
<tr>
<td></td>
<td>☐ Medications are stored and distributed by a third-party</td>
</tr>
<tr>
<td>2</td>
<td>Any of the following for any family member:</td>
</tr>
<tr>
<td></td>
<td>☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week</td>
</tr>
<tr>
<td></td>
<td>☐ Self-manages medications except for requiring reminders or assistance for refills</td>
</tr>
<tr>
<td></td>
<td>☐ Successfully self-managing medication for fewer than 30 consecutive days</td>
</tr>
<tr>
<td>1</td>
<td>☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days</td>
</tr>
<tr>
<td>Any</td>
<td>Any of the following is true for <strong>every</strong> family member:</td>
</tr>
<tr>
<td>0</td>
<td>☐ No medication prescribed to them</td>
</tr>
<tr>
<td></td>
<td>☐ Successfully self-managing medication for 181+ consecutive days</td>
</tr>
</tbody>
</table>
**D. Substance Use**

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

**Notes:**

*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 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
E. Experience of Abuse & Trauma of Parents

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
</tr>
</thead>
<tbody>
<tr>
<td><em>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.</em></td>
<td></td>
</tr>
<tr>
<td><em>Because this section is self-reported, if there are more than one parent present, they should each be asked individually.</em></td>
<td></td>
</tr>
<tr>
<td>• “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?”</td>
<td></td>
</tr>
<tr>
<td>• “Are you currently or have you ever received professional assistance to address that abuse?”</td>
<td></td>
</tr>
<tr>
<td>• “Does the experience of abuse or trauma impact your day to day living in any way?”</td>
<td></td>
</tr>
<tr>
<td>• “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?”</td>
<td></td>
</tr>
<tr>
<td>• “Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?”</td>
<td></td>
</tr>
<tr>
<td>• “Have you ever become homeless as a direct result of experiencing abuse or trauma?”</td>
<td></td>
</tr>
</tbody>
</table>

| 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 |
| **Any** of the following:                                                                                                                           |
| 2  □ 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                                                                                                    |
### F. Risk of Harm to Self or Others

**PROMPTS**

- 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**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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 altercations |
| 1     | 366+ days ago, a family member had 1-3 involvements in physical altercations |
| 0     | Whole family reports no instance of harming self, being harmed, or harming others |
### G. Involvement in Higher Risk and/or Exploitive Situations

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
</tr>
</thead>
</table>
| [Observe, don’t ask] Any abscesses 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? | |

<table>
<thead>
<tr>
<th>SCORING</th>
</tr>
</thead>
</table>
| 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 |
| 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 |
| 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 |
| 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 |
| In the past 365 days, no involvement by any family member in higher risk and/or exploitive events |
H. Interaction with Emergency Services

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
<th>NOTES</th>
</tr>
</thead>
</table>
| • 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? | | |

**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.

<table>
<thead>
<tr>
<th>SCORING</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>4</strong></td>
<td>□ In the past 180 days, cumulative family total of 10+ interactions with emergency services</td>
</tr>
<tr>
<td><strong>3</strong></td>
<td>□ In the past 180 days, cumulative family total of 4-9 interactions with emergency services</td>
</tr>
<tr>
<td><strong>2</strong></td>
<td>□ In the past 180 days, cumulative family total of 1-3 interactions with emergency services</td>
</tr>
<tr>
<td><strong>1</strong></td>
<td>□ Any interaction with emergency services by family members occurred more than 180 days ago but less than 365 days ago</td>
</tr>
<tr>
<td><strong>0</strong></td>
<td>□ In the past 365 days, no interaction with emergency services</td>
</tr>
</tbody>
</table>
I. Legal

**PROMPTS**

- 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?

**SCORING**

<table>
<thead>
<tr>
<th>Score</th>
<th>Scoring Criteria</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Any of the following among any family member:</td>
</tr>
<tr>
<td></td>
<td>□ Current outstanding legal issue(s), likely to result in fines of $500+</td>
</tr>
<tr>
<td></td>
<td>□ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand</td>
</tr>
<tr>
<td>3</td>
<td>Any of the following among any family member:</td>
</tr>
<tr>
<td></td>
<td>□ Current outstanding legal issue(s), likely to result in fines less than $500</td>
</tr>
<tr>
<td></td>
<td>□ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand</td>
</tr>
<tr>
<td>2</td>
<td>Any of the following among any family member:</td>
</tr>
<tr>
<td></td>
<td>□ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s)</td>
</tr>
<tr>
<td></td>
<td>□ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)</td>
</tr>
<tr>
<td>1</td>
<td>□ 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</td>
</tr>
<tr>
<td>0</td>
<td>□ No family member has had any legal issues within the past 365 days, and currently no conditions of release</td>
</tr>
</tbody>
</table>
### J. Managing Tenancy

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
</tr>
</thead>
</table>
| • 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? |   |

**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 not considered to be a short-coming or deficiency in the ability to pay rent.

**SCORING**

<table>
<thead>
<tr>
<th>Score</th>
<th>Prompts</th>
</tr>
</thead>
</table>
| 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 |
### K. Personal Administration & Money Management

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

#### 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
**L. Social Relationships & Networks**

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Tell me about your family’s friends, extended family or other people in your life.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• How often do you get together or chat with family friends?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• When your family goes to doctor’s appointments or meet with other professionals like that, what is that like?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Are there any people in your life that you feel are just using you, or someone else in your family?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Have you ever had people crash at your place that you did not want staying there?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Have you ever been threatened with an eviction or lost a place because of something that friends or extended family did in your apartment?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Have you ever been concerned about not following your lease agreement because of friends or extended family?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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

- 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
### M. Self Care & Daily Living Skills of Family Head

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Do you have any worries about taking care of yourself or your family?</td>
<td></td>
</tr>
<tr>
<td>• Do you have any concerns about cooking, cleaning, laundry or anything like that?</td>
<td></td>
</tr>
<tr>
<td>• Does anyone in your family ever need reminders to do things like shower or clean up?</td>
<td></td>
</tr>
<tr>
<td>• Describe your family’s last apartment.</td>
<td></td>
</tr>
<tr>
<td>• Do you know how to shop for nutritious food on a budget?</td>
<td></td>
</tr>
<tr>
<td>• Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?</td>
<td></td>
</tr>
<tr>
<td>• Do you tend to keep all of your family’s clothes clean?</td>
<td></td>
</tr>
<tr>
<td>• Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?</td>
<td></td>
</tr>
<tr>
<td>• 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?</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>SCORING</th>
</tr>
</thead>
<tbody>
<tr>
<td>Any of the following for head(s) of household:</td>
</tr>
<tr>
<td>4</td>
</tr>
<tr>
<td>□ No insight into how to care for themselves, their apartment or their surroundings</td>
</tr>
<tr>
<td>□ 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</td>
</tr>
<tr>
<td>□ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life</td>
</tr>
</tbody>
</table>

Any of the following for head(s) of household:

3

□ 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

Any of the following for head(s) of household:

2

□ 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
N. Meaningful Daily Activity

**PROMPTS**

- 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 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?

**SCORING**

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Any member of the family has no planned, legal activities described as providing fulfillment or happiness</td>
</tr>
<tr>
<td>3</td>
<td>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</td>
</tr>
<tr>
<td>2</td>
<td>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</td>
</tr>
<tr>
<td>1</td>
<td>Each family member has planned, legal activities described as providing fulfillment or happiness 1-3 days per week</td>
</tr>
<tr>
<td>0</td>
<td>Each family member has planned, legal activities described as providing fulfillment or happiness 4+ days per week</td>
</tr>
</tbody>
</table>
### O. History of Homelessness & Housing

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
</tr>
</thead>
<tbody>
<tr>
<td>• How long has your family been homeless?</td>
<td></td>
</tr>
<tr>
<td>• How many times has your family experienced homelessness other than this most recent time?</td>
<td></td>
</tr>
<tr>
<td>• 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?</td>
<td></td>
</tr>
<tr>
<td>• Has your family ever spent time sleeping in a car, alleyway, garage, barn, bus shelter, or anything like that?</td>
<td></td>
</tr>
<tr>
<td>• Has your family ever spent time sleeping in an abandoned building?</td>
<td></td>
</tr>
<tr>
<td>• 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?</td>
<td></td>
</tr>
</tbody>
</table>

#### SCORING

<table>
<thead>
<tr>
<th></th>
<th>OVER THE PAST 10 YEARS, CUMULATIVE TOTAL OF 5+ YEARS OF FAMILY HOMELESSNESS</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>Over the past 10 years, cumulative total of 5+ years of family homelessness</td>
</tr>
<tr>
<td>3</td>
<td>Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of family homelessness</td>
</tr>
<tr>
<td>2</td>
<td>Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of family homelessness</td>
</tr>
<tr>
<td>1</td>
<td>Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of family homelessness</td>
</tr>
<tr>
<td>0</td>
<td>Over the past 4 years, cumulative total of 7 or fewer days of family homelessness</td>
</tr>
</tbody>
</table>
### P. Parental Engagement

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Walk me through a typical evening after school in your family.</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Does your family have play time together? What kinds of things do you do and how often do you do it?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

**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.

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

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
</tr>
</thead>
</table>
| • 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

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
<tbody>
<tr>
<td>4</td>
<td>In the past 365 days, any of the following have occurred:</td>
</tr>
<tr>
<td></td>
<td>- Parental arrangements and/or other adult relatives within the family have changed 4+ times</td>
</tr>
<tr>
<td></td>
<td>- Children have left or returned to the family 4+ times</td>
</tr>
<tr>
<td>3</td>
<td>In the past 365 days, any of the following have occurred:</td>
</tr>
<tr>
<td></td>
<td>- Parental arrangements and/or other adult relatives within the family have changed 3 times</td>
</tr>
<tr>
<td></td>
<td>- Children have left or returned to the family 3 times</td>
</tr>
<tr>
<td>2</td>
<td>In the past 365 days, any of the following have occurred:</td>
</tr>
<tr>
<td></td>
<td>- Parental arrangements and/or other adult relatives within the family have changed 2 times</td>
</tr>
<tr>
<td></td>
<td>- Children have left or returned to the family 2 times</td>
</tr>
<tr>
<td>1</td>
<td>In the past 365 days, any of the following have occurred:</td>
</tr>
<tr>
<td></td>
<td>- Parental arrangements and/or other adult relatives within the family have changed 1 time</td>
</tr>
<tr>
<td></td>
<td>- Children have left or returned to the family 1 time</td>
</tr>
<tr>
<td>0</td>
<td>In the past 365 days, any of the following have occurred:</td>
</tr>
<tr>
<td></td>
<td>- No change in parental arrangements and/or other adult relatives within the family</td>
</tr>
<tr>
<td></td>
<td>- Children have not left or returned to the family</td>
</tr>
</tbody>
</table>
R. Needs of Children

**PROMPTS**

- 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?

**CLIENT SCORE:**

**NOTES**

**SCORING**

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

4

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

3

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

2

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

1

Any 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

0
### S. Size of Family Unit

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
<th>NOTES</th>
</tr>
</thead>
</table>
| • 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? | | |

### SCORING

<table>
<thead>
<tr>
<th>FOR ONE-PARENT FAMILIES:</th>
<th>FOR TWO-PARENT FAMILIES:</th>
</tr>
</thead>
</table>
| **4**  
Any of the following:  
☐ A pregnancy in the family  
☐ At least one child aged 0-6  
☐ Three or more children of any age | **4**  
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 | **3**  
Any of the following:  
☐ At least one child aged 0-6  
☐ Three children of any age |
| **2**  
☐ At least one child aged 12–15. | **2**  
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. | **1**  
☐ 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 | **0** |
## T. Interaction with Child Protective Services and/or Family Court

<table>
<thead>
<tr>
<th>PROMPTS</th>
<th>CLIENT SCORE:</th>
<th>NOTES</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Any matters being considered by a judge right now as it pertains to any member of your family?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• 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?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>• Has there ever been an investigation by someone in child welfare into the matters of your family?</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

### SCORING

<table>
<thead>
<tr>
<th>Score</th>
<th>Description</th>
</tr>
</thead>
</table>
| 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;  
<p>|       | - 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 |</p>
<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>SCORE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>MENTAL HEALTH &amp; WELLNESS AND COGNITIVE FUNCTIONING</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>PHYSICAL HEALTH &amp; WELLNESS</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>MEDICATION</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>SUBSTANCE USE</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>EXPERIENCE OF ABUSE AND/OR TRAUMA</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>RISK OF HARM TO SELF OR OTHERS</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>INVOLVEMENT IN HIGHER RISK AND/OR EXPLOSIVE SITUATIONS</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>INTERACTION WITH EMERGENCY SERVICES</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>COMPONENT</td>
<td>SCORE</td>
<td>COMMENTS</td>
</tr>
<tr>
<td>------------------------------------------------</td>
<td>-------</td>
<td>----------</td>
</tr>
<tr>
<td>LEGAL INVOLVEMENT</td>
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<td></td>
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<tr>
<td>MANAGING TENANCY</td>
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<tr>
<td>PERSONAL ADMINISTRATION &amp; MONEY MANAGEMENT</td>
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<tr>
<td>SOCIAL RELATIONSHIPS &amp; NETWORKS</td>
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<tr>
<td>SELF-CARE &amp; DAILY LIVING SKILLS</td>
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<tr>
<td>MEANINGFUL DAILY ACTIVITIES</td>
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<tr>
<td>HISTORY OF HOUSING &amp; HOMELESSNESS</td>
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</table>
## COMPONENT SCORE COMMENTS

<table>
<thead>
<tr>
<th>COMPONENT</th>
<th>SCORE</th>
<th>COMMENTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PARENTAL ENGAGEMENT</td>
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<tr>
<td>STABILITY/RESILIENCY OF THE FAMILY UNIT</td>
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<td></td>
</tr>
<tr>
<td>NEEDS OF CHILDREN</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>SIZE OF FAMILY</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>INTERACTION WITH CHILD PROTECTIVE SERVICES AND/OR FAMILY COURT</td>
<td>0</td>
<td></td>
</tr>
<tr>
<td>TOTAL</td>
<td>0</td>
<td>No housing intervention</td>
</tr>
</tbody>
</table>
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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1 (800) 355-0420 info@orgcode.com www.orgcode.com
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/
**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/](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.
Administration

<table>
<thead>
<tr>
<th>Interviewer's Name</th>
<th>Agency</th>
<th>Group</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
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<td>Team</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Volunteer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey Date</th>
<th>Survey Time</th>
<th>Survey Location</th>
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</thead>
<tbody>
<tr>
<td>DD/MM/YYYY</td>
<td><strong>/</strong>/______</td>
<td>__ : __</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Nickname</th>
<th>Last Name</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Age</th>
<th>Social Security Number</th>
<th>Consent to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD/MM/YYYY</td>
<td><em><strong>/</strong>/</em>_____</td>
<td>________________</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

SCORE: 0
A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)
   - Shelters
   - Transitional Housing
   - Safe Haven
   - Couch surfing
   - Outdoors
   - Refused
   - Other (specify): 

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

   **SCORE:** 0

2. How long has it been since you lived in permanent stable housing?
   - __________ Years
   - 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:** 0

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:** 0

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:** 0
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: 0

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: 0

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: 0

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: 0

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: 0
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:
   0

   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:
   0

**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:
   0
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: 0

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: 0

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

SCORE: 0

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: 0

Scoring Summary

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>SUBTOTAL</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE-SURVEY</td>
<td>0 / 1</td>
<td>Score: Recommendation:</td>
</tr>
<tr>
<td>A. HISTORY OF HOUSING &amp; HOMELESSNESS</td>
<td>0 / 2</td>
<td>0-3: no moderate or high intensity services be provided at this time</td>
</tr>
<tr>
<td>B. RISKS</td>
<td>0 / 4</td>
<td>4-7: assessment for time-limited supports with moderate intensity</td>
</tr>
<tr>
<td>C. SOCIALIZATION &amp; DAILY FUNCTIONS</td>
<td>0 / 5</td>
<td>8+: assessment for long-term housing with high service intensity</td>
</tr>
<tr>
<td>D. WELLNESS</td>
<td>0 / 5</td>
<td></td>
</tr>
<tr>
<td><strong>GRAND TOTAL:</strong></td>
<td>0 / 17</td>
<td></td>
</tr>
</tbody>
</table>
Follow-Up Questions

<table>
<thead>
<tr>
<th>Follow-Up Questions</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>On a regular day, where is it easiest to find you and what time of day is easiest</strong></td>
</tr>
<tr>
<td><strong>to do so?</strong></td>
</tr>
<tr>
<td>place: ___________________________</td>
</tr>
<tr>
<td>time: ___ : ___ or Night</td>
</tr>
<tr>
<td><strong>Is there a phone number and/or email where someone can get in touch with you or</strong></td>
</tr>
<tr>
<td><strong>leave you a message?</strong></td>
</tr>
<tr>
<td>phone: (___) _____ - ____________</td>
</tr>
<tr>
<td>email: ____________________________</td>
</tr>
<tr>
<td><strong>Ok, now I’d like to take your picture so that it is easier to find you and confirm</strong></td>
</tr>
<tr>
<td><strong>your identity in the future. May I do so?</strong></td>
</tr>
<tr>
<td>☑ Yes ☑ No ☑ Refused</td>
</tr>
</tbody>
</table>

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
From: Dimitrovski, Kristine
Sent: Friday, September 6, 2019 5:58 PM
To: Scheu, Debra; Amy Clabatzz; Andrea Siva; Ashley Franklin; Barbara Ann Lewis; Barry Kohler; Beatriz Torres; Betsy Wiest; Brad Whitman; Brian McLaughlin; Burke, Peter; Carl Hull; Carla Storrs; Charles Barber; Chris Tombaugh; Clara Holden; Clark, Tyronne; Clifton McNair III; Colleen Hammon; Craig Ulmer; Cris Taylor; Danielle Szkierski; Darrell Smith; David Gonzalez; David Woledge; Debbie Dillon; Debbie Smith; Deirdre Tate; Diana Ames; DiMattio, John; Don Orlando; Dusti Dennis; Eddie Martin; Emily Francis; Emily Goodwin; Pushic, Emily; Eric McGrath; Connelly, Erin; Fred Williams; Gail and Chris Detar; George Fickenworth; Gina Allison; Grace Kennedy; Holland, Bridget; Jacqueline Williams; Jason Sargent; Jay Bowes; Jeff McDonald; Jennie Hagerty; Jennifer Malone; Jerry Gill; Berdis, Joe; Joe Cancilla; Korns, Shelby; Kate (Elsbeth) Koehle; Kathy Hubbard; Kathy Wyrosclick; Katie Schaaf; Kennedy, Patricia; Kim Stucke; KristieRhoades; Kurt Crays; Lee Prindle; Lee, Gary; Linda (Lyons) King; Karl, Lisa; Liz McCormick; Lori Palisin; Luz Merchant; Major Colin DeVault; Margaret Simms; Margie Olszewski; Marissa Thomas; Mark Alexa; Mark Jasinski; Mary Gollmer; Matthew Good; Maureen Dunn; Lyon, Melissa; Michael Wehrer; Michelle Swarm; Migdalia Lavenbein; Mike Jaruszewicz; Monica Stanford; Nancy J. Brown; Nate McGee; Neal Brokman; Nicole Johnson; Paige Baiocchi; Pat Herr; Pat Tracey; Patricia Lindeman; Patti Palotas; Perry Wood; Richard Novotny; Rita Scrimenti; Rush, Christine; Saunders McLaurin; Schember, Joe; Sean O'Neil; Sheila Silman; Sheila Sterrett; Sherry Braswell; Shirley Schell; Shona Eakin; Sister Phyllis Hilbert; Steve Westbrook; Tania Bogatova; Tanya Smith; Terri Lash; Tim Hilton; Tom Schlaudecker; Weidner, Tracey; Franklin, Twanisha; Viveralli, Cynthia; Jacobs, Wendy; Yolanda Arrington
Subject: 2019 HUD Ranking Results

Dear Home Team Members,

The ranking results for the 2019 HUD Continuum of Care competition are complete, attached and are now available on the Home Team Website and The DHS County Facebook page.

http://www.eriehometeam.org/resources/
https://www.facebook.com/eriecountydhs/

Thank you,

Krissy Dimitrovski, MSW
Housing Program Director
Dept of Human Services MH/ID
154 W. 9th St.
Erie, PA 16501
Phone: 814-451-6823
Fax: 814-451-6868
kdimitrovski@eriecountypa.gov
<table>
<thead>
<tr>
<th>RANKING</th>
<th>PROJECT TYPE</th>
<th>PROJECT NAME</th>
<th>AMOUNT</th>
<th>TIER</th>
<th>STATUS</th>
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<tbody>
<tr>
<td>1</td>
<td>HMIS</td>
<td>HMIS</td>
<td>$146,027</td>
<td>1</td>
<td>Renewal</td>
</tr>
<tr>
<td>2</td>
<td>SSO</td>
<td>Coordinated Entry</td>
<td>$12,000</td>
<td>1</td>
<td>Renewal</td>
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<td>3</td>
<td>SSO</td>
<td>Coordinated Entry Expansion</td>
<td>$133,121</td>
<td>1</td>
<td>New - Expansion - CoC Bonus</td>
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<tr>
<td>4</td>
<td>**DV CE</td>
<td>DV Coordinated Entry</td>
<td>$97,827</td>
<td>**1</td>
<td>New - DV bonus</td>
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<tr>
<td>5</td>
<td>RRH</td>
<td>ECCM Rapid Rehousing 1</td>
<td>$158,198</td>
<td>1</td>
<td>Renewal</td>
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<td>6</td>
<td>RRH</td>
<td>Independence</td>
<td>$209,540</td>
<td>1</td>
<td>Renewal</td>
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<tr>
<td>C6</td>
<td>*RRH - Consolidation</td>
<td>My Way Home RH</td>
<td>$571,146</td>
<td>*1</td>
<td>Consolidation</td>
</tr>
<tr>
<td>7</td>
<td>PSH</td>
<td>Lighting the Candle I</td>
<td>$247,283</td>
<td>1</td>
<td>Renewal</td>
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<tr>
<td>8</td>
<td>PSH</td>
<td>Self Start I</td>
<td>$429,683</td>
<td>1</td>
<td>Renewal</td>
</tr>
<tr>
<td>C8</td>
<td>*PSH - Consolidation</td>
<td>Self Start PSH</td>
<td>$719,001</td>
<td>*1</td>
<td>Consolidation</td>
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<tr>
<td>9</td>
<td>PSH</td>
<td>Self Start III</td>
<td>$145,596</td>
<td>1</td>
<td>Renewal</td>
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<tr>
<td>10</td>
<td>PSH</td>
<td>Self Start II</td>
<td>$143,722</td>
<td>1</td>
<td>Renewal</td>
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<tr>
<td>11</td>
<td>RRH</td>
<td>My Way Home</td>
<td>$261,606</td>
<td>1</td>
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<tr>
<td>12</td>
<td>PSH</td>
<td>Fresh Start</td>
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<td>1</td>
<td>Renewal</td>
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<tr>
<td>13</td>
<td>PSH</td>
<td>Make It a Home Always I</td>
<td>$109,030</td>
<td>1</td>
<td>($61,789) &amp; 2 ($47,301)</td>
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<tr>
<td>14</td>
<td>PSH</td>
<td>Finally Home</td>
<td>$74,112</td>
<td>2</td>
<td>Renewal</td>
</tr>
<tr>
<td>15</td>
<td>**DV RRH</td>
<td>Passage to Safety</td>
<td>$167,422</td>
<td>**2</td>
<td>New - DV bonus</td>
</tr>
</tbody>
</table>

Renewals: $2,181,765
New (Bonus): $598,370 CoC Bonus $133,121
DV Bonus $256,343
Planning Grant (not ranked) $79,873

Total HUD Request: $2,660,008

*Consolidations are pending HUD approval. If approved, the amounts for Self Start I, II and III will be combined ($719,001), and the consolidated project will be ranked #C8. If approved, the amounts for My Way Home and Independence will be combined ($571,146) and the consolidated project will be ranked #C6.

**If a DV Bonus project is conditionally selected by HUD, HUD will remove the ranked DV bonus project and all other projects ranked below will slide up one rank position. If the DV Bonus project is not conditionally selected, the project will remain in its ranked position.
Homeless resources for Erie County, PA

Resources

RESOURCES

2019 HUD Continuum of Care Application
2019 HUD NOFA Announcement for PA-665
2019 PH RII and SSO CE DV Bonus Application
HUD CoC Program Interim Rule

2019 HUD Continuum of Care Rating and Ranking Tools
2019 Rating and Ranking New Projects
2019 Rating and Ranking Renewal PSH
2019 Rating and Ranking Renewal RRI
2019 CoC New Project Application – scoring
2019 CoC Renewal Project Application – scoring

2019 HUD Continuum of Care Priority Listing
2019 HUD Priority Listing for Erie City & Erie County CoC PA-665

2018 Single Point in Time Count
ECCM,

Attached, please find your ranking and scoring results for the 2019 HUD CoC competition.

Thank you,

_Krissy Dimitrovski, MSW_

Housing Program Director
Dept of Human Services MH/ID
154 W. 9th St.
Erie, PA 16501
Phone: 814-451-6823
Fax: 814-451-6868
kdimitrovski@eriecountypa.gov
9/6/19

Mr. Barry Kohler  
Erie County Care Management  
1640 Sassafras St.  
Erie, PA 16501

Re: 2019 HUD Continuum of Care Competition  
Self Start I, II, III Renewal, Consolidation, DV CE Bonus & ECCM RRH 1 Application Ranking and Scoring Results

Dear Mr. Kohler:

I am pleased to inform you that your 2019 renewal project applications for Self Start I, II & III and RRH 1, your 2019 new DV CE Bonus, as well as your 2019 consolidated project application combining the Self Start programs have been accepted for ranking on the Continuum of Care Priority Listing. The total request for these projects will be $975,026. Please note that if HUD accepts your consolidated application, your separate renewal applications will be removed from the ranking list. Results of the CoC Priority Listing will be sent via email and made available on the Home Team website as well as on Erie County’s DHS Facebook page.

If you have any questions, please contact me at (814)451-6823.

Sincerely,

[Signature]

Krissy Dimitrovski  
Housing Program Director  
Erie County DHS
From: Dimitrovski, Kristine
Sent: Friday, September 6, 2019 5:45 PM
To: 'Kurt Crays'; Lori Lewis
Cc: Karle, Lisa; Burke, Peter
Subject: 2019 HUD CoC Ranking Results

EUMA,

Attached, please find your ranking and scoring results for the 2019 HUD CoC competition.

Thank you,

Krissy Dimitrovski, msw
Housing Program Director
Dept of Human Services MH/ID
154 W. 9th St.
Erie, PA 16501
Phone: 814-451-6823
Fax: 814-451-6868
kdimitrovski@eriecountypa.gov
9/6/19

Mr. Kurt Crays
Eric United Methodist Alliance
1033 E. 26th St.
Erie, PA 16504

Re: 2019 HUD Continuum of Care Competition
My Way Home, Independence & Consolidated Application Ranking and Scoring Results

Dear Mr. Crays:

I am pleased to inform you that your 2019 renewal project applications for My Way Home, Independence, as well as your 2019 consolidated project application combining the RRH programs have been accepted for ranking on the Continuum of Care Priority Listing. The total request for these projects will be $571,146. Please note that if HUD accepts your consolidated application, your separate renewal applications will be removed from the ranking list. Results of the CoC Priority Listing will be sent via email and made available on the Home Team website as well as on Erie County’s DHS Facebook page.

If you have any questions, please contact me at (814)451-6823.

Sincerely,

[Signature]

Krissy Dimitrovski
Housing Program Director
Erie County DHS
From: Dimitrovski, Kristine
Sent: Friday, September 6, 2019 5:47 PM
To: 'Mark Alexa', Rich Turri
Cc: Karie, Lisa; Burke, Peter
Subject: 2019 HUD Ranking Results

CSS,

Attached, please find your ranking and scoring results for the 2019 HUD CoC competition.

Thank you,

Krissy Dimitrovski, MSW
Housing Program Director
Dept of Human Services MH/ID
154 W. 9th St.
Erie, PA 16501
Phone: 814-451-6823
Fax: 814-451-6868
kdimitrovski@eriecountypa.gov
9/6/19

Mr. Mark Alexa
Community Shelter Services
655 W. 16th St.
Erie, PA 16502

Re: 2019 HUD Continuum of Care Competition
Lighting the Candle I Application Ranking and Scoring Results

Dear Mr. Alexa:

I am pleased to inform you that your 2019 renewal project applications for Lighting the Candle I has been accepted for ranking on the Continuum of Care Priority Listing. The total request for this project will be $247,283. Results of the CoC Priority Listing will be sent via email and made available on the Home Team website as well as on Erie County’s DHS Facebook page.

If you have any questions, please contact me at (814)451-6823.

Sincerely,

[Signature]

Krissy Dimitrovski
Housing Program Director
Erie County DHS
Guadenzia,

Attached, please find your ranking and scoring results for the 2019 HUD CoC competition.

Thank you,

_Krissy Dimitrovski, MSW_
Housing Program Director
Dept of Human Services MH/ID
154 W. 9th St.
Erie, PA 16501
Phone: 814-451-6823
Fax: 814-451-6868
kdimitrovski@eriecountypa.gov
9/6/19

Mr. Jesse Hayward
Gaudenzia Erie
2005 W. 8th St.
Erie, PA 16505

Re: 2019 HUD Continuum of Care Competition
Fresh Start Application Ranking and Scoring
Results

Dear Mr. Hayward:

I am pleased to inform you that your 2019 renewal project applications for Fresh Start has been accepted for ranking on the Continuum of Care Priority Listing. The total request for this project will be $144,908. Results of the CoC Priority Listing will be sent via email and made available on the Home Team website as well as on Erie County’s DHS Facebook page.

If you have any questions, please contact me at (814)451-6823.

Sincerely,

Krisz Dimitrovski
Housing Program Director
Erie County DHS
MHA,

Attached, please find your ranking and scoring results for the 2019 HUD CoC competition.

Thank you,

Krissy Dimitrovski, MSW
Housing Program Director
Dept of Human Services MH/ID
154 W. 9th St.
Erie, PA 16501
Phone: 814-451-6823
Fax: 814-451-6868
kdimitrovski@eriecountypa.gov
9/6/19

Ms. Pat Stucke, CEO
Mental Health Association
1101 Peach St.
Erie, PA 16503

Re: 2019 HUD Continuum of Care Competition
Make It a Home Always Application Ranking and Scoring Results

Dear Ms. Stucke:

Thank you for the submission of your renewal project application for Make It a Home Always I. After review of the 2019 HUD Continuum of Care Competition projects, ranking placed a portion of funding for MIHA I into Tier 2. The scoring process was very competitive this year. Some of the factors that impacted this decision were low fund utilization, data quality and poor outcomes related to new or increased income and earned income for program participants. Project MIHA I could receive a maximum award of $109,090 as your application will be included in the 2019 consolidated application. Of this maximum award amount, $47,301 is straddled into Tier 2. As in previous years, Tier 2 funding is at risk of being cut if HUD has insufficient funds. Results of the CoC Priority Listing will be sent via email and made available on the Home Team website as well as on Erie County’s DHS Facebook page.

If you have any questions, please contact me at (814)451-6823.

Sincerely,

Krissy Dimitrovski
Housing Program Director
Erie County DHS
Community of Caring,

Attached, please find your ranking and scoring results for the 2019 HUD CoC competition.

Thank you,

Krissy Dimitrovski, msw
Housing Program Director
Dept of Human Services MH/ID
154 W. 9th St.
Erie, PA 16501
Phone: 814-451-6823
Fax: 814-451-6868
kdimitrovski@eriecountypa.gov
9/6/19

Grace Kennedy  
Executive Director  
Community of Caring  
245 E. 8th St.  
Erie, PA 16503

Re: 2019 HUD Continuum of Care Competition  
Finally Home Application Ranking and Scoring Results

Dear Ms. Kennedy:

Thank you for the submission of your renewal project application for Finally Home. After review of the 2019 HUD Continuum of Care Competition projects, ranking placed Finally Home into Tier 2. The scoring process was very competitive this year. Some of the factors that impacted this decision were low fund utilization, data quality and poor outcomes related to new or increased income and earned income for program participants. While your project will be included in the 2019 consolidated application, Tier 2 projects are at risk of being cut if HUD has insufficient funds. The total request for this project will be $74,112. Results of the CoC Priority Listing will be sent via email and made available on the Home Team website as well as on Erie County’s DHS Facebook page.

If you have any questions, please contact me at (814)451-6823.

Sincerely,

[Signature]

Krissy Dimitrovski  
Housing Program Director  
Erie County DHS
SafeNet,

Attached, please find your ranking and scoring results for the 2019 HUD CoC competition.

Thank you,

*Krissy Dimitrovski, MSW*
Housing Program Director
Dept of Human Services MH/ID
154 W. 9th St.
Erie, PA 16501
Phone: 814-451-6823
Fax: 814-451-6868
kdimitrovski@eriecountypa.gov
9/6/19

Linda Lyons King, CEO
SafeNet
1702 French St.
Erie, PA 16501

Re: 2019 HUD Continuum of Care Competition
Passage to Safety DV Bonus Application Ranking
and Scoring Results

Dear Ms. Lyons King:

Thank you for the submission of your new 2019 Passage to Safety DV Bonus application. After review of the 2019 HUD Continuum of Care Competition projects, ranking placed Passage to Safety into Tier 2. The scoring process was very competitive this year and some of the factors that impacted this decision were; poorly written overall application and budget errors. While your project will be included in the 2019 consolidated application, Tier 2 projects are at risk of being cut. The total request for this project will be $167,422. Results of the CoC Priority Listing will be sent via email and made available on the Home Team website as well as on Erie County’s DHS Facebook page.

If you have any questions, please contact me at (814)451-6823.

Sincerely,

Krissy Dimitrovski
Housing Program Director
Erie County DHS
9/6/19

To whom it may concern,

Erie City & County CoC (PA-605) did not reject or reduce any project applications in the 2019 HUD CoC competition.

Sincerely,

[Signature]

Krissy Dimitrovski
Housing Program Director
Erie County DHS
154 W. 9th St.
Erie, PA 16501
814-451-6823
From: Scheu, Debra
To: Amy Clabbatz; Andrea Sliva; Ashley Franklin; Barbara Ann Lewis; Barry Kohler; Beatriz Torres; Betsy West; Brad Whitman; Brian McLaughlin; Burke, Peter; Carl Hull; Carla Storns; Charles Barber; Chris Tombaugh; Clara Holder; Clark, Tyrang; Clifton McNair III; Colleen Hannors; Craig Utter; Kris Taylor; Danielle Szklenak; Darrell Smith; David Gonzalez; David Woolelge; Debbie Dillon; Debbie Smith; Deidre Tako; Diana Ames; DMattio, John; Dimitrovski, Kristina; Don Orlando; Dusti Dennis; Eddie Martin; Emily Francis; Emily Goodwin; Pushie, Emily; Eric McGrath; Connelly, Erin; Fred Williams; Gail and Chris Detar; George Fickerworth; Gina Allison; Grace Kennedy; Holland, Bridget; Jacqueline Williams; Jason Sargent; Lay Bowes; Jeff McDonald; Jennie Harper; Jennifer Malone; Jerry Gill; Berdis, Joe; Joe Canzola; Kanne, Shelby; Kate (Elspeth) Koehler; Kathy Hubbard; Kathy Wyrozkicki; Katie Schade; Kennedy, Patricia; Kim Stucker; Kristie Rhoades; Kurt Crays; Lee Prindle; Lee, Gary; Linda (Lyon) King; Karle, Lisa; Liz McCormick; Lori Paliesin; Luz Merchant; Maior Colin Devault; Margaret Simms; Margie Olszewski; Marissa Thomas; Mark Alexa; Mark Lasinski; Mary Gollmer; Matthew Good; Maureen Dunn; Lyon, Melissa; Michael Wehrer; Michelle Swamin; Migdalia Lavenheim; Mike Laruszewicz; Monica Stanford; Nancy J. Brown; Nate McGee; Neal Brokman; Nicole Johnson; Paige Baiocchi; Pat Henn; Pat Tracey; Patricia Linderman; Patti Palotas; Perry Wood; Richard Novotny; Rita Schriner; Rush, Christine; Saunders McLaurie; Schember, Joe; Sean O'Neill; Sheila Silmon; Sheila Storhart; Sherry Braswell; Shirley Schell; Shona Eakin; Sister Phylis Hilbert; Steve Westbrook; Tania Bogatova; Tanya Smith; Terri Lash; Tim Hilton; Tom Schlaudecker; Weidner, Tracey; Franklin, Twanisha; Viveralli, Cynthia; Jacobs, Wendy; Yolanda Arrington
Subject: 2019 HUD CoC Competition- Deadlines and Application Details and Instructions
Date: Friday, August 2, 2019 1:12:45 PM
Attachments: CoCProgramInterimRule.pdf
PH RRH and SSO CE DV Bonus Application 2019 in Word.docx

Dear Home Team Members,

The deadline for submission of any renewal project application for the 2019 HUD Continuum of Care (CoC) Competition was due to the County back on May 3rd. At this time, all renewals have been received by the providers.

For new project applications for the 2019 competition, you may begin working on your project applications using the attached HUD CoC-PH RRH and SSO CE DV Bonus Application (attached). Erie County is able to apply for two types of new funding, CoC Bonus and DV Bonus. For the CoC Bonus money, we have up to $133,121 and can apply to expand an existing grant. Based on the local need, the County will be the only one applying for the CoC bonus money to fill in the much needed financial gap of Coordinated Entry. At this time, we only receive $12,000 from HUD for Coordinated Entry so we are going to take advantage of this opportunity available to our County. For the DV Bonus, applicants can apply for a minimum of $50,000 and up to $266,243. For the DV Bonus, we will only accept applications that have PH-RRH or SSO-CE as a project type. Based on our local needs, we will not accept the Joint TH-RRH project type. All new DV bonus applications will be due electronically back to the county (Krissy Dimitrovski, kdimitrovski@eriecountypa.gov) no later than 5:00 PM on Friday, August 23, 2019.

Included in this email, you will find the following:

2. Attached: 24 CFR Part 578- Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program; Final Rule

3. Link to HUD required forms for each project you are applying for:
   b. SF-LLL- [https://www.hudexchange.info/resources/documents/HUD-Form-Sflll.pdf](https://www.hudexchange.info/resources/documents/HUD-Form-Sflll.pdf)

Instructions for 2019 New Project Applications:

1. Read the 2019 HUD CoC NOFA to make certain to understand all requirements (link above).

2. Fill in your new 2019 HUD CoC project application using the attached template and forward back to me via email. Read the instructions above each section carefully.

3. Review 24 CFR 578.73 for detailed HUD Match requirements. Please note that match sources for all grant funds must be matched with either cash or In-Kind and must be no less than 25% of project budget except for leasing. For In-Kind services, make sure to include a Memorandum of Understanding (MOU) if the services are being provided by a third party. *Remember that match contributions must be actual funds spent or goods/services used for program participants in the HUD-funded program. Match is not funds kept in cash reserves. Make certain that your match contribution is for eligible activities as per 24 CFR Part 578.

4. Using the link for forms, complete and sign forms for each project you intend to apply for: HUD 2880, SF-LLL, and
Documents needed to submit for a new project application:

1. Completed 2019 HUD CoC new application template (attached)
2. Match letter dated and signed by agency director.
3. MOU letters if applicable for In-Kind match
4. Completed and signed HUD forms: 2880, SF-LLL, and 50070- complete each form for each new project you are applying for
5. Proof of nonprofit status.

**NOTE: Please understand that while you will see in the NOFA that the due date of the consolidated application is 9/30/19, there are multiple other internal deadlines that our CoC must meet prior to this date. In addition, the ranking and scoring committee needs sufficient time to review all of your project applications to ensure that all are reviewed in a thorough and fair manner. Thank you in advance for your understanding of this.

Krissy Dimitrovski, MSW
Housing Program Director
Dept of Human Services MH/ID
154 W. 9th St.
Erie, PA 16501
Phone: 814-451-6823
Fax: 814-451-6868
kdimitrovski@eriecountypa.gov