

Before Starting the CoC Application

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

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

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

1. The FY 2026 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2026 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

Your CoC Must Approve the Consolidated Application before You Submit It

- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2026 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

1A. Continuum of Care (CoC) Identification

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

1A-1. CoC Name and Number: CA-508 - Watsonville/Santa Cruz City & County CoC

1A-2. Collaborative Applicant Name: County of Santa Cruz

1A-3. CoC Designation: CA

1A-4. HMIS Lead: County of Santa Cruz

1B. Coordination and Engagement–Accountable Structure and Participation

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

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- Frequently Asked Questions

1B-1.	Accountable Structure and Participation.	
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In the chart below for the period from June 1, 2025 to May 31, 2026:

1.	select 'Yes' or 'No' in the chart below if the entity listed participated in CoC meetings or select 'Nonexistent' if the entity does not exist in your CoC's geographic area, and
2.	enter the number of persons on the board for each category where you answered 'Yes' in the Participated in CoC Meetings column.

You must click Save at the bottom of the form before entering the number of persons for each category where you answered 'Yes'.

	Entity	Participated in CoC Meetings	Number of Board Members
1.	Affordable Housing Developer(s)	Yes	1
2.	CDBG/HOME/ESG Entitlement Jurisdiction(s)	Yes	2
3.	Certified Community Behavioral Health Clinic (CCBHC)	Yes	2
4.	Community Mental Health Center (CMHC)	Yes	2
5.	Disability Advocate(s)	Yes	0
6.	Disability Service Organization(s)	Yes	2
7.	Emergency Medical Services (EMS)/Crisis Response Team(s)	Yes	0
8.	Employment Assistance Program(s) (e.g., Local Workforce Development, American Job Center)	Yes	0
9.	Faith-based Organization(s)	Yes	1
10.	Homeless or Formerly Homeless Person(s)	Yes	2
11.	Hospital(s)	Yes	0
12.	Other Primary Healthcare Provider(s) (e.g., Federally Qualified Health Center, Healthcare for the Homeless)	Yes	2
13.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	No	
14.	Law Enforcement	Yes	2
15.	Local Court Systems, Including Specialty Courts (e.g., Mental Health Court, Drug Court, Care Court)	Yes	1
16.	Local Government Staff/Official(s)	Yes	8

17.	State Government Staff/Official(s)	No	
18.	State or Local Elected Public Official(s)	Yes	4
19.	Local Jail(s)	Yes	0
20.	Mental Health Service Organization(s)	Yes	2
21.	Mental Illness Advocate(s)	Yes	0
22.	Organization(s) led by and serving people with disabilities	Yes	2
23.	Other homeless subpopulation advocate(s)	Yes	2
24.	Other nonprofit homeless assistance provider(s)	Yes	2
25.	Other social service provider(s)	Yes	4
26.	Public Housing Agencies	Yes	0
27.	Recovery Housing or Sober Living Provider(s)	Yes	2
28.	School Administrators/Homeless Liaison(s)	Yes	1
29.	School District(s)	Yes	0
30.	Street Outreach Team(s)	Yes	2
31.	Substance Abuse Advocate(s)	Yes	0
32.	Substance Abuse Service Organization(s)	Yes	2
33.	Universities	Yes	0
34.	Veteran Serving Organization(s)	Yes	1
35.	Agencies Serving Survivors of Human Trafficking	Yes	1
36.	Victim Service Provider(s)	Yes	1
37.	Domestic Violence Advocate(s)	Yes	0
38.	Other Victim Service Organization(s)	Yes	1
39.	State Domestic Violence Coalition	No	
40.	State Sexual Assault Coalition	No	
41.	Youth Advocate(s)	Yes	3
42.	Youth Homeless Organization(s)	Yes	3
43.	Youth Service Provider(s)	Yes	3
44.	Other Homeless Assistance Provider(s)	Yes	0
45.	Local Business or Chamber of Commerce or a Member of a Business Improvement District	Yes	1
	Other: (limit 50 characters)		
46.	Managed Care Provider	Yes	0
47.	Neighborhood Community Groups	Yes	0

1B-2.	Open Invitation for New Members.	
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Describe your CoC's transparent process (e.g., communicated to the public on the CoC's website) to invite new members to join the CoC at least annually.

(limit 2,500 characters)

1. The CoC uses a variety of techniques which together ensure that our invitation for new members is transparent and publicly available throughout the CoC's geography. For example, invitations to join are (1) sent to a long, regularly updated list of community organizations and persons through the CoC's newsletter; (2) sent out via the CoC's Facebook and Instagram accounts; (3) communicated orally during a broad range of community meetings (such as faith community and affordable housing month events) attended by CoC staff in Santa Cruz, Watsonville, and other parts of the county; (4) posted on the CoC's website in prominent locations such as on the opening page. The CoC's website helps inform the public through broad-ranging content on homelessness and CoC activities, as well as an easy-to-see link to sign up for the regular newsletter. Under the website's Get Involved tab, the CoC specifically invites applications from any person or organization committed to a collaborative impact effort focused on ensuring all residents within the County have stable, safe, and healthy places to live. Interested applicants can easily apply by completing the simple, accessible online membership form and will automatically receive all CoC-related mailing list notices, including invitations to twice-yearly CoC-wide meetings.

2. Because the invitation process is continual, it occurs more often than annually. For example, invitations to join with instructions for how to apply are sent out 22 times per year on average via the CoC newsletter to a long and growing list of community organizations and persons in the county known to be interested in homelessness issues and are also posted on average 22 times per year on the CoC Facebook and Instagram accounts.

1B-3.	CoC's Strategy to Solicit and Consider Opinions on Preventing and Ending Homelessness.	
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Describe your CoC's transparent process (e.g., communicated to the public on the CoC's website) to solicit and consider opinions regarding the CoC's general performance, strategies, and priority setting process from a broad array of individuals and organizations that have knowledge of homelessness or an interest in preventing or ending homelessness in the CoC's geographic area.

(limit 2,500 characters)

1. The CoC solicits and considers opinions on CoC performance, strategies, and priorities through a broad range of CoC community, committee, and workgroup meetings, as well as workshop and training opportunities. In addition, requests for input and feedback are communicated via the website and social media, direct outreach by CoC staff and the CoC mailing list, which includes more than 200 interested agencies or persons. Also, at CoC Policy Board meetings public comment is allowed and requested for each agenda item. Finally, CoC staff provide regular updates at meetings of the County Board of Supervisors and City Councils, where members of the public can comment on CoC items.

During virtual and in-person meetings, the CoC communicates orally and in writing in the form of written staff memoranda or presentations and background information for each agenda item. The agenda and written materials are sent via newsletter to a long list of agencies a few days before the meeting and are posted on the website. People can provide input by participating in the meeting online or in person or emailing their comments.

2. Public input is received from a broad universe of interested persons and organizations, including affordable housing developers, homeless assistance providers, County and city elected representatives and agencies, faith groups, neighborhood groups, health care providers, business representatives, education providers, persons with lived experience of homelessness, and more. Public input has positively impacted a broad array of issues, including CoC governance, funding priorities, CoC rating criteria, unsheltered homelessness, emergency shelter protocols, CoC policies and procedures, updates and reports on strategic plans, federal and state funding sources, public engagement and information, and more.

1B-4.	Public Notification for Proposals from Organizations Not Previously Awarded CoC Program Funding.	
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Describe your CoC's transparent process to accept and consider proposals from organizations that have not previously received CoC Program funding including faith-based organizations.
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(limit 2,500 characters)

1. As in previous years, the CoC public solicitation of applications and related process actively sought, accepted, and considered proposals from organizations not previously awarded CoC funds. On June 11, 2026, the CoC issued a public solicitation of CoC applications and an invitation to participate in an Applicant Orientation open to all interested applicants, including those that had never received CoC funding. The invitation, process timeline, and application materials were posted on the CoC's website, its social media accounts, and sent to the CoC's mailing list of all known interested organizations. The solicitation explicitly encouraged applications from organizations that had not previously received CoC Program funding, including faith-based organizations, Indian Tribes, and tribally designated housing entities (TDHEs).

An open applicant orientation session was held on June 16, 2026. The orientation session and the written CoC application policies and procedures document included information and explanations about how exactly to complete and submit the HUD and local application forms, HUD and local priorities and requirements, the deadlines for submitting local and e-snaps applications, and the process and objective criteria for selecting applications. The CoC consultant actively invited, offered, and provided ongoing technical assistance to new applicants to help them better understand CoC processes and application requirements.

2. As a result of this outreach, the CoC did receive proposals from the following organizations that have not previously received CoC funds: Janus of Santa Cruz and Safe Families for Children Monterey Bay. A third organization, Salty Sheep Sailing Ministries, decided not to apply after receiving substantial technical assistance.

1B-5	Plan for Comprehensive Strategies for Reducing Homelessness.
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Describe how your CoC will incorporate comprehensive strategies for reducing homelessness, including interventions in 42 U.S.C. 11386b(d) and other targeted projects for specific subpopulations, by providing a plan to address a gap in the CoC's current homelessness system.

(limit 2,500 characters)

Our CoC has a Regional Homelessness Action Plan, incorporating strategies and interventions for subpopulations (e.g., persons with disabilities, seniors, families, youth, and unsheltered persons) and for addressing system gaps. The plan includes 36 key actions across interim housing, permanent housing, services, health, planning, and encampment resolution domains.

A.IDENTIFYING GAPS was accomplished using a gaps analysis that used quantitative information from the most current HMIS, PIT, HIC, and encampment location and outreach data. In addition, qualitative gaps-related information was gathered through 5 stakeholder engagement meetings, which include youth and adults with lived experience of homelessness, relevant local government representatives, nonprofit affordable housing and services providers, managed care plans, street medicine providers, and tribes.

B.SUBPOPULATION NEEDS are addressed through the specific subpopulation housing and service interventions in the plan, including persons with SMI, SUD, other health, and/or HIV/AIDS conditions, DV and other violence survivors, unsheltered persons, chronically homeless persons, unaccompanied youth, and families.

C.PERFORMANCE MEASURES - Each key action has one or more specific quantified performance measures linked to HUD's SPMs.

D.TIMELINES - Each key action has specific dates for key milestones and completion.

E.FUNDING SOURCES - Each key action lists all expected funding sources that will contribute to completing the action.

F.RESPONSIBILITY - Each key action lists the lead agency and all collaborating agencies for implementing the action.

The key actions include: landlord engagement, supporting PSH and RRH, increasing affordable housing and market housing opportunities, prevention assistance and housing retention services, Behavioral Health system partnerships including for a range of SUD treatment options, employment programs, enhanced City-County coordination, improving access to information on assistance available, school system partnerships, faith community partnerships and support, encampment response and resolution, increasing interim housing solutions (ES and TH), including for youth, sober living environments, recuperative care, addressing persons living in vehicles, improving CES and problem solving, increasing street outreach and enhancing law enforcement coordination, and implementing encampment response protocols.

1B-5a Confirmation of Plan Coverage.

Select 'Yes' or 'No' in the chart below to indicate whether your narrative in question 1B-5 addresses the following aspects of your plan to address a gap in the CoC's current homelessness system.

1. Identifies the gap, using data or stakeholder feedback	Yes
2. The strategy to address the needs of all relevant subpopulations	Yes
3. Sets quantifiable performance measures	Yes

4. Identifies timelines for the completion of specific tasks	Yes
5. Identifies specific funding sources for planned activities	Yes
6. An individual or body responsible for overseeing implementation of specific strategies	Yes

1C. Coordination and Engagement

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

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1C-1.	Treatment and Recovery Services—On-site Substance Use Treatment Availability.	
	You must upload the List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment attachment to the 4A. Attachments Screen.	
	What percent of your TH/RRH/PSH projects have substance use treatment available on site?	46%

If you are a rural CoC, describe what substance use treatment is available in your CoC and how people you serve access those services.

(limit 2,500 characters)

Not Applicable

1C-1a. Treatment and Recovery Services—Outpatient Treatment for Mental Health and Substance Use Disorders.

Describe how your CoC partners with, or has projects that provide, outpatient treatment for mental health and substance use disorders with a range of appropriate levels of care, psychosocial interventions, medication management, suicide prevention, and recovery supports.

(limit 2,500 characters)

The CoC Policy Board includes representatives from the County Health Services Agency and Behavioral Health. Partnership agreements coordinate behavioral health and housing resources for people experiencing homelessness. HMIS and behavioral health data matching identifies people served by both systems. Collaborative projects include:

- Site-based and scattered-site permanent supportive housing with wraparound mental health and substance use treatment supports, including housing supported by a flexible housing subsidy pool.
- Training for coordinated entry staff, known as connectors, to link participants with mental health and substance use services.
- A centralized list of recovery residences and sober living facilities with real-time availability.
- SAMHSA PATH-funded street outreach that connects people with treatment and coordinated entry.
- Low-barrier navigation centers with on-site outpatient behavioral health services, and shelter and housing programs offering individual and group counseling and peer recovery groups, including NA and AA.
- A multidisciplinary outreach team with a substance use disorder specialist, a peer housing and recovery specialist, and two additional outreach workers, coordinating with law enforcement and behavioral health crisis services.
- A Medi-Cal transitional rent program combining time-limited rental assistance with outpatient behavioral health and housing services for eligible participants experiencing homelessness.
- Behavioral Health Services Act-funded housing interventions that record data in HMIS to strengthen coordination.
- California behavioral health infrastructure grants also support projects under development to expand outpatient and residential substance use treatment capacity, with a focus on people experiencing homelessness.

1C-1b. Treatment and Recovery Services—Peer Support and Recovery Navigation.

Describe how your CoC partners with, or has projects that provide access to, peer recovery specialists or other forms of peer support and recovery navigation.

(limit 2,500 characters)

Our CoC supports two lived expertise action groups – one for youth and one for adults – that include individuals who have experienced homelessness locally. The groups also include individuals with histories of recovery from behavioral health challenges. These groups provide input into CoC policies and procedures, make recommendations on how to improve services, provide and promote peer support, and provide guidance on how to improve engagement efforts.

The Mental Health Client Action Network (MHCAN) operates a peer-run recovery program in our community. MHCAN is moving toward full implementation of an evidence-based clubhouse model to serve individuals struggling with serious mental health issues, including individuals with and without stable housing.

The local County Behavioral Health Department supports a peer-run respite program known as Second Story that provides a temporary place for individuals with serious mental illness to seek out peer recovery supports and avoid hospitalization. Individuals can remain in the program for up to 15 days. The program participates in our local HMIS and CoC because it frequently serves individuals experiencing homelessness.

Many of our CoC street outreach programs intentionally recruit, train, and hire individuals with lived experiences of homelessness and/or behavioral health challenges to serve as part of our outreach teams. This includes a SAMHSA PATH-funded outreach team that conducts targeted outreach to individuals experiencing serious mental health challenges.

Our behavioral health-focused permanent supportive housing programs in the County include peer specialist roles as part of the support team associated with the housing sites and programs. Most of the peer staff on these teams have been trained and certified as peer recovery specialists according to state standards.

Several of our temporary and permanent housing sites within the County offer peer recovery and support groups, including 12-step model groups. Our community partners with Miracle Messages, a nonprofit organization that helps connect people experiencing homelessness with family, friends, or volunteer supporters. Miracle Messages is part of our local coordinated entry system and works with several local shelters.

1C-1c. Treatment and Recovery Services—Connecting Individuals Experiencing Serious Mental Illness with the Services Necessary to Promote Stability.

Describe how your CoC identifies individuals experiencing Serious Mental Illness and connects them with the services necessary to promote stability, such as Assertive Community Treatment teams and other models that combine intensive care coordination and assertive outreach with comprehensive treatment.

(limit 2,500 characters)

Our CoC has an existing partnership with our County Behavioral Health Department that includes HMIS and Behavioral Health data matching infrastructure. Individuals enrolled in programs within HMIS are matched against Behavioral Health data to identify individuals with serious mental illness that have received specialty mental health outpatient services in the last six months. We also receive data on individuals that received a specialty mental health or substance use disorder treatment service in the last 24 months. These data matches help us identify individuals served by these separate and collaborating systems.

Our coordinated entry system trains staff known as “connectors” on the eligibility and referral process for specialty mental health services, i.e., for those with a serious mental illness. There are connectors embedded within geographically focused street outreach teams that cover most areas of the County. The referral process to Behavioral Health involves a clinical assessment by trained behavioral health clinicians who determine eligibility for services and an appropriate level of care within the behavioral health system. Our behavioral health department is transitioning to use of the Level of Care Utilization System (LOCUS) to determine the appropriate level of mental health service for referred individuals, and is currently planning for implementation of Assertive Community Treatment (ACT) and Forensic ACT.

Our County Behavioral Health Department has established a dedicated Integrated Housing and Recovery Team (IHRT) that provides outreach, engagement, and intensive case management for individuals with a serious mental illness experiencing homelessness. This team has a program set up within HMIS to allow for cross-system data sharing and coordination. IHRT partners with a SAMHSA PATH-funded street outreach team, operated by a contracted nonprofit community partner, Front Street, Inc. Front Street, Inc. staff are trained as coordinated entry connectors. This ensures that individuals with serious mental illness are considered for CoC-managed housing services and resources.

The Behavioral Health Department also has partnerships with the County Sheriff to identify individuals with serious mental illness who are involved in the criminal justice system. This partnership seeks to link individuals with care prior to release and to explore potential housing resources at exit through the Behavioral Health Department or CoC.

1C-1d. Treatment and Recovery Services—Coordination with Providers in Connection with Drug or Other Specialty Courts.

Identify at least one partnership the CoC has with a provider or entity providing services in connection with Drug Courts and other specialty courts serving individuals with mental and substance use disorders, Assisted Outpatient Treatment (AOT) programs, and inpatient civil commitment.

(limit 500 characters)

Our CoC partners with County Behavioral Health to support implementation of the Community Assistance Recovery and Empowerment (CARE) Act. The CARE Act provides a civil court process to deliver community-based behavioral health services, including AOT, with severe mental illnesses, aiming to prevent hospitalization, incarceration, or conservatorship. A County CARE Act services team provides support qualifying participants in all local Specialty Courts, including Behavioral Health Court.

Describe how your CoC coordinates with the provider or entity identified above to support housing stability and movement towards independence, including by leveraging court orders.

(limit 2,500 characters)

Our CoC has a low-barrier navigation center for individuals with serious mental illness that prioritizes CARE Act participants. Our coordinated entry prioritizes individuals with disabling health conditions and justice system involvement. Our CoC has permanent supportive housing slots for individuals with a serious mental illness, including CARE Act participants. Our CoC works closely with Behavioral Health, leveraging Collaborative Court orders to connect CARE Act participants with housing.

1C-1e. Treatment and Recovery Services—Partnership with Local Crisis System of Care.

Identify at least one partnership the CoC has with the local crisis system of care including 988 and crisis contact centers, mobile crisis and outreach services, and crisis stabilization services.

(limit 500 characters)

The CoC partners with County Behavioral Health and its crisis response teams. Coordinated entry staff receive training on crisis resources, including on use of local 988. A multidisciplinary outreach team under development brings together mobile crisis response, a law enforcement mental health liaison, a substance use treatment outreach worker, and three coordinated entry connectors to engage people experiencing homelessness who are associated with frequent calls for crisis services.

1C-1f.	Treatment and Recovery Services—Availability of Units for Persons Reporting Chronic Substance Use.	
	You must upload the List of CoC Program Projects and the Number of Units that require Substance Abuse Treatment attachment to the 4A. Attachments Screen.	
	Identify the number of CoC Program-funded units that require program participant engagement in substance abuse treatment services as a condition of continued participation in the program in accordance with 24 CFR 578.75.	3

1C-1g.	Treatment and Recovery Services—24/7 Access to Detox, Residential, or Inpatient Treatment.	
Is there 24/7 access to detox, residential, and inpatient behavioral health treatment within the geographic area of your CoC?		Yes

1C-1h. Treatment and Recovery Services—Formal Partnership with Behavioral and Mental Health Facilities.

Identify at least one formal partnership the CoC has with a Certified Community Behavioral Health Clinic (CCBHC), Community Mental Health Center (CMHC), SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider, Grants for the Benefit of Homeless Individuals (GBHI) provider, or a similar facility if none of the above are located in the geographic area.

(limit 500 characters)

The CoC formally partners with Front Street, Inc., the local SAMHSA Projects for Assistance in Transition from Homelessness (PATH) provider. Its outreach program engages people experiencing homelessness with serious mental illness. All program staff are trained as coordinated entry connectors and enter PATH and coordinated entry data in HMIS.

1C-1i. Treatment and Recovery Services—Sober Housing Availability.

Identify at least one new or existing CoC Program-funded project that operates sober housing in accordance with 24 CFR 578.93(b)(5).

(limit 500 characters)

Our CoC has included a proposal for a transitional housing sober living program expansion as a proposed CoC bonus project in this NOFO. Also, our CoC region operates multiple recovery residences. Our local 2-1-1 operator maintains a website that list of sober living facilities and openings within the programs. Our CoC also operates a Medi-Cal transitional rent benefit that can pay for sober living/recovery residence stays.

1C-1j. Treatment and Recovery Services—Warm Hand-Offs to Stable Housing Providers.

Describe how your CoC coordinates with the programs named in questions 1C-1a through 1C-1i to facilitate warm hand-offs to stable housing providers and prevent entry into homelessness.

(limit 2,500 characters)

Our CoC has multiple collaborative projects and relationships with our colleagues in the County Behavioral Health Department. We have an MOU outlining shared roles and responsibilities with specific projects and we meet on a regular basis to match and prioritize individuals for limited behavioral health and housing resources. There are at least monthly care coordination meetings at shelters and permanent supportive housing projects that target individuals with behavioral health challenges. We have a network of Behavioral Health providers that utilize both HMIS and the Behavioral Health data system to increase communication and data sharing across systems. Our County is building out a new system for integrating information across multiple systems – Sheriff, Probation, Behavioral Health, Health Clinics & Hospitals, Public Defender, and the CoC (HMIS). This project is initially focused on pre-release planning for individuals being released from county jail to help them access public benefits, health, and housing services.

Warm hand-offs of care are prioritized in our collaborative conversations. This is supported by intentional cross-system relationship building, data sharing, the development of shared project plans, and a commitment to continuous quality improvement.

1C-2.	Supportive Services Investment.	
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	Number
1. Enter your CoC's FY 2026 Annual Renewal Demand (ARD).	\$7,609,846
2. Of projects your CoC proposed to be funded in the FY 2026 CoC Program Competition, enter the total amount of funding for the supportive services budget line items.	\$2,282,148
3. Percent of your CoC's FY 2026 ARD (from element 1 above) that is supportive services funding (from element 2 above).	30%
4. Enter the amount of funding, leverage, match, and funding commitment from other formal partnerships in supportive services for the projects included in your CoC's FY 2026 ARD.	\$1,835,761
5. Percent of your CoC's FY 2026 ARD (from element 1 above) that is the supportive services funding in proposed projects (from element 2 above) plus the amount of funding, leverage, match, and funding commitment from other formal partnerships in supportive services (from element 4 above).	54%

1C-3.	Participation Requirements for Supportive Services.	
	You must upload the Language from Project Supportive Service Agreements attachment to the 4A. Attachments Screen.	
	What percent of your housing projects (TH, PH-PSH, PH-RRH, and Joint projects) require program participants to take part in supportive services (e.g. case management, employment training, substance use disorder treatment) in line with 24 CFR 578.75(h)?	100.00%

1C-4. Consulting with ESG Recipients.

Describe how your CoC has and will continue to consult with ESG recipients in the planning and allocation of ESG funds.

(limit 2,500 characters)

The CoC regularly consults, and will continue to consult, with the State of California ESG Program (the only ESG recipient serving the CoC) on planning and allocation of ESG funds, including through ESG workshops, webinars, weekly office hours, trainings, phone/email interactions, written comment, and survey input on policy and funding allocations. Within the past year, the CoC members have also provided public comment on or completed surveys relating to ESG funding and allocations for the State's 2025-29 Consolidated Plan, amendment to the 2025-29 Consolidated Plan, 2026-27 annual action plan, 1st substantial amendment to the 2026-2027 annual action plan, the 2025-26 CAPER, the 1/22/25 ESG Balance of State webinar, and monthly ESG office hours.

The CoC has played and will continue to play a major role in the State's planning and allocation of ESG funds for projects in Santa Cruz County. For example, under State procedures, competitive local ESG projects are assessed, scored, and ranked by the CoC and submitted to the State competition, while the CoC directly assesses, scores, and selects noncompetitive RRH projects. The CoC Policy Board makes these project recommendations based on need, priorities, performance, and design. In addition, the CoC works with the State ESG Program to evaluate ESG project performance across a range of performance factors, such as PH placement success, length of stay, cost efficiency, and adherence to ESG program standards.

The CoC has supported and will continue to support State ESG Program funding and allocations by providing the State with Santa Cruz County HIC, PIT, and HMIS performance data. The CoC also provides these data to the Santa Cruz and Watsonville Consolidated Plan jurisdictions (even though they do not have their own ESG allocations).

1C-4a. Coordination with Emergency Shelter Providers.

Describe how your CoC coordinates with shelter providers to connect individuals and families with CoC assistance.

(limit 2,500 characters)

Our CoC has well-developed processes and procedures for coordinating and integrating emergency shelter providers with CoC and other programs participating in our overall homeless assistance system. Contracted emergency shelter providers are required to use CES in referring participants to other CoC programs. A key strategy is to use CES to directly connect emergency shelter participants to the CoC system and programs. We do so by recruiting and training emergency shelter staff to become CES connectors, whose role is to conduct CES assessments, provide shelter participant information to CES for use in prioritizing them for specific housing interventions, and work with participants to develop and implement a housing action plan. In this way, emergency shelters become CES access points, and connectors work directly to align the work of emergency shelters, CES, and the CoC and other programs receiving participant referrals through CES. The CoC also leverages its partnership with the local 2-1-1 system to bridge non-contracted emergency shelter providers with detailed information about all relevant CoC and other programs.

The CoC uses a variety of additional strategies that result in stronger and smoother connections for individuals and families seeking to move from emergency shelter to CoC and other programs. For example, the CoC provides numerous opportunities during CoC meetings, CES meetings, staff training, and case conferencing for emergency shelter staff to meet their counterparts in CoC and other programs, develop close collaborative relationships, participate in cross-learning, and work directly together on participant referrals, documentation, and warm handoffs. Likewise, the CoC works to standardize and streamline workflows, referrals, and coordination between emergency shelter providers and CoC programs through CoC policies and procedures, emergency shelter program standards, HMIS modules and processes, a comprehensive 2-1-1 information and referral database, and funding and training for emergency shelter providers on housing stability-focused approaches to case management.

1C-5. Data Sharing to Inform the Homelessness Response System.

Describe how your CoC has or will share PIT, HIC, HMIS, and System Performance data with state and local government as permitted by law in order to inform the homelessness response system.

(limit 2,500 characters)

1. The CoC has consulted its HMIS Privacy Policy (last updated 10/19/22), which allows data sharing or disclosures of PII to provide or coordinate services, for payment/reimbursements, for administrative and planning purposes, for creating de-identified data, as required by law, to prevent imminent threats to health or safety, to report abuse or domestic violence, for academic research/evaluation, and for certain law enforcement purposes.
2. Consistent with our HMIS Privacy Policy, the CoC has and will continue to share deidentified PIT, HIC, HMIS, and System Performance data in the following ways with the state and local government to inform program and policy planning and responses:

STATE of CA:

- Monthly exports of full HMIS data sets to the State Homeless Data Integration System (HDIS) data warehouse for use by the State in a broad range of planning and informational purposes.
- HIC, PIT, HMIS, and SPM data to the State ESG Program to inform funding and allocations.
- Annual reports with HIC, PIT, HMIS, and SPM data to the State HHAP Program to track progress and inform future programs, policies, and allocations.

LOCAL GOVERNMENTS:

- Posting annual PIT reports and dashboard reports using HMIS, HIC, PIT, SPM and affordable housing data on the CoC website, and regularly reporting this information to the CoC Policy Board, which includes local government elected and appointed officials.
- HIC, PIT, HMIS, and SPM data to the Cities of Santa Cruz and Watsonville for use in Consolidated Annual Action Plans and CAPER reports, as well as for local program planning and funding allocations.
- HIC, PIT, HMIS, and SPM data in periodic homelessness status update reports to the Santa Cruz County Board of Supervisors and City Councils.
- HMIS data shared with the County Health Services Agency and Medi-Cal providers to support collaboration on CalAIM and other program integration initiatives, such as the CalAIM justice-involved initiative.

1C-5a. Using Other Data Sources Alongside HMIS to Improve Care.

Describe how your CoC utilizes other data sources alongside HMIS to improve care (e.g., health care utilization and claims data, electronic health care record data; admission, discharge, and transfer data; and law enforcement and corrections system data).

(limit 2,500 characters)

Our CoC is managed by staff working in the Housing for Health Division of the County of Santa Cruz Human Services Department. The Department includes a Planning and Evaluation Division that provides support to our CoC in utilizing HMIS data in concert with other data systems. Some examples of how our CoC utilizes HMIS and other data:

- Pairing HMIS and County Behavioral Health Department data to identify individuals with serious mental illness and/or substance use disorders to determine eligibility for behavioral-health targeted supportive housing and Medi-Cal housing-related supportive services, including transitional rent.
- Sharing HMIS data with our local child welfare department to identify families and youth eligible for specific programs targeting these populations.
- Matching HMIS data with data from our Employment and Benefits Services Division (EBSD) to identify individuals for specific benefit programs and housing programs linked with these public benefits. These data also support individuals in enrolling or reenrolling in programs, such as General Assistance, CalWORKs (TANF), CalFresh (SNAP), and Medi-Cal (Medicaid).
- Establishing a special population assessment within HMIS to identify individuals that meet special population criteria, such as individuals that are frequent users of one or more of our local hospitals.
- Partnering with one of our local cities to identify individuals experiencing homelessness in the city with frequent interactions with law enforcement and health care crisis response teams.
- Our CoC also participates in a data integration effort that will bring together HMIS, health, behavioral health, probation, public defender, jail and sheriff police data to support cross-system data analytics and increased care coordination. The data system will utilize an information sharing authorization form developed and promoted by the California Department of Health Care Services.

1C-6. Employment and Workforce Development Partnership.

Identify at least one partnership the CoC has with employment and workforce development programs and organizations such as the Local Workforce Development Board, State Workforce Agency, American Job Center (also known as One-Stop Career Centers), registered apprenticeship program, community and technical college, union training program, adult education provider, or State Vocational Rehabilitation agency.

(limit 2,500 characters)

The CoC partners with the County Human Services Department (HSD), Employment and Benefits Division, Santa Cruz County Workforce Development Board, and the California Department of Social Services (DSS) to provide employment and training programs onsite at CoC providers. Eligible participants are people experiencing homelessness who are eligible for CalFRESH (Food Stamps) benefits. CalFRESH Employment and Training program funds are linked with a local employment service managed by the Volunteer Center of Santa Cruz County to provide eligible participants with employment-focused case management, intake assessment, employability assessment, coordination with service providers, and progress tracking. Participants also receive access to a variety of services to help them overcome barriers to employment, including workforce education, resume assistance, interview coaching, job training, transition employment, job placement, job retention resources, and SUD treatment referrals.

The Volunteer Center operates an Individualized Placement and Support (IPS) evidenced-based practice employment services for mutual CoC and Behavioral Health clients interested in pursuing employment. Our CoC plans to offer employment outreach workshops at one of our PSH sites for those interested in IPS employment services.

The Workforce Development Board partnered with our CoC to create specific internship opportunities for youth experiencing homelessness that include stipends, job coaching and matching, mentoring, and access to educational resources.

1C-7. Street Outreach—Cooperation with First Responders and Law Enforcement.

Describe in the field below how your CoC's street outreach projects (including co-response) cooperate with first responders and law enforcement to increase positive interactions in order to increase housing and service engagement and promote use of CoC services.

(limit 2,500 characters)

Our CoC has several street outreach projects that involve partnerships with first responders and law enforcement. The City of Santa Cruz funds a street outreach team that works closely with local law enforcement to respond to calls for service, to engage individuals experiencing homelessness, and to manage referrals into city-supported safe parking, safe sleeping, and shelter programs. The street outreach team also has access to HMIS and has received training to participate in the coordinated entry system. The County funds a street outreach team to cover unincorporated areas of the County. This team partners with the Sheriff to respond to and outreach to individuals experiencing homelessness within these regions. The Sheriff has also assigned a community policing liaison to support shelters operating in unincorporated areas. Our County also funds a multidisciplinary street outreach team that works with the City of Watsonville police department. This team includes a substance use outreach specialist, coordination with the local mental health liaison embedded within the police department, and three additional staff. This team focuses on reaching and engaging individuals experiencing homelessness identified as high-priority individuals by the Watsonville police department.

1C-8. Family or Support Network Reunification.

Describe how your CoC, or your recipients, assist with family or support-network reunification efforts for individuals experiencing homelessness or living in CoC Program-funded housing (e.g., case management, travel costs, arrangement of assistance in another geographic area).

(limit 2,500 characters)

Our CoC is staffed by individuals working in our County Human Services Department. The Department also includes a Family and Children's Services Division (FCS) focused on family support, preservation, and reunification. Our CoC coordinates several programs with our FSC unit. These programs include: (1) Bringing Families Home (BFH) - a rapid rehousing program for child welfare involved families; (2) Family Unification Program (FUP) - a permanent supportive housing program partnership with our local Housing Authority for families in the child welfare system that qualify; (3) Foster youth rapid rehousing programs - for youth exiting foster care at risk of homelessness; (4) FUP and Foster Youth to Independence (FYI) - a permanent supportive housing program partnership with our local Housing Authority for youth exiting foster care. In addition to these programs, our CoC works with a nonprofit organization, Miracle Messages, as part of our coordinated entry system. Miracle Messages mobilizes volunteers to help connect and re-connect people experiencing homelessness with family, friends, or volunteer buddies. Our CoC also maintains a centralized housing assistance fund that can cover the cost of travel for individuals interested in leaving the area to reconnect with family and friends as a pathway toward increased stability and housing.

1C-9	Partnering with Public Housing Agencies—Agreement to Enable Transition to HUD Assisted Housing.		
	Does your CoC have an agreement with at least one public housing agency to enable participants to transition from Transitional Housing, Rapid Re-Housing, and Permanent Supportive Housing to HUD assisted housing?	Yes	

1C-10. Protecting Public Safety—Cooperation with Law Enforcement.

You must upload the Evidence of Coordination and Non-Interference with Local Efforts to Advance Protecting Public Safety attachment to the 4A. Attachments Screen.

Describe how your CoC cooperates and does not interfere with or impede local efforts to advance the objectives below, and assists first responders in providing services to homeless individuals.

(limit 2,500 characters)

- A. Our CoC and County developed Encampment Response Guidelines approved by our CoC policy board and County Board of Supervisors. The guidelines outline how the County triages responses to encampments and coordinates outreach with CoC-supported outreach teams and supportive service providers.
- B. Our CoC maintains policies and procedures that prohibit illegal activities and drugs within housing programs and coordinates interventions with local law enforcement agencies when necessary.
- C. Our CoC partners with our County Behavioral Health Department to provide information and training to CoC staff on how to request and coordinate with local mental health crisis response teams. In partnership with County Behavioral Health, our CoC prioritizes access to some shelter beds for individuals authorized for CARE Act, a civil court process for individuals with a serious mental illness. Our CoC partners with our Behavioral Health Department to prioritize access to limited housing resources and coordinate service responses to clients enrolled in CoC programs that may require crisis intervention and potentially involuntary treatment.
- D. Housing programs within our CoC check the sex offender registry prior to program admission to ensure individuals admitted to programs are not violating terms of their probation, parole, or applicable residency restrictions.

1C-10a. Protecting Public Safety—Plan to Quickly Clear Tents and Encampments.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to quickly clear tents and encampments on public property and connect individuals who are camping in public with appropriate services and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

A. The City of Watsonville, within our CoC region, recently passed an ordinance precluding camping in specific areas of the city near waterways and other city defined-sensitive areas. Individuals camping in these zones can be removed from these locations without the city's standard 72-hour encampment notice. The ordinance will go into effect when signage is posted in all these areas.

B. Our plan to leverage beneficial policies to overcome harmful ones includes coordinating with Watsonville's police department, which is represented on our CoC Policy Board and works closely with CoC-supported outreach efforts within the region. The police department staff also utilize CoC-developed resource guides to inform individuals they contact about available programs and services for people experiencing homelessness. The police department developed a list of high-priority individuals experiencing homelessness within the city for targeted outreach and engagement. Preventing encampment formation in highly sensitive areas makes policy clearer for individuals experiencing homelessness in the region.

Our CoC's ability to respond to the request for services and support is limited by the number of available street outreach and coordinated entry staff that can engage and build relationships with those experiencing homelessness.

C. Our plan is helping to create beneficial effects. According to our 2026 PIT count data, on a single night in our County, there are an estimated 1,290 unsheltered individuals. Our current providers' outreach and engagement capacity can only intensively serve an estimated 500 individuals at a point in time. We anticipate this will improve over time. In addition, our community has limited short- and long-term housing stock and residential treatment program capacity that limits provider access to safe residential opportunities for those living without shelter.

1C-10b. Protecting Public Safety—Current Status of Tents and Encampments.

Describe the current status of tents and encampments in the CoC's geographic area.

(limit 2,500 characters)

Currently, there are few large encampments within our CoC region. Most unsheltered individuals within the County are camping and sleeping near waterways, including the San Lorenzo and Pajaro River levees. The City of Santa Cruz recently increased enforcement of no camping regulations near a shelter for people experiencing homelessness. Law enforcement outreach and enforcement activities near the levee areas typically increase prior to the winter rainy season. Outreach providers also increase outreach to these areas to the extent resources are available.

1C-10c. Protecting Public Safety—Plan to Decrease the Public Use of Illicit Drugs.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to decrease the public use of illicit drugs and quickly connect individuals who are using illicit drug in public with appropriate services and/or law enforcement and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

A. On November 5, 2024, California voters passed Proposition 36, "The Homelessness, Drug Addiction, and Theft Reduction Act," which added substantive charges and enhancements to laws regarding theft, property damage, and drug-related crimes. The changes include: (1) the creation of new felony theft and drug crimes targeting recidivist offenders; (2) removal of eligibility for the sentences of certain offenses to be served in county jail; and (3) alignment of the punishment for crimes involving fentanyl with that of other similar controlled substances.

B. Our CoC's plan to leverage beneficial policies to overcome harmful policies includes collaborating with a sheriff-funded sobering center that allows for law enforcement to bring intoxicated individuals into an environment that supports access to treatment services. Our probation department recently procured an outreach van to ensure individuals on probation experiencing homelessness receive the support necessary to comply with the terms of their probation.

In response to a sharp rise in fentanyl-related deaths within the County, the Sheriff created a Fentanyl Crisis Response Team in March of 2024. This team is made up of a Lieutenant, a Sergeant, five detectives and a drug detection K9.

The team is collaborating with our local and federal justice partners and aims to apprehend drug dealers responsible for distributing Fentanyl, thus holding them accountable for the lives lost.

The Sheriff's Office is also partnering with our local schools, treatment providers, religious organizations and community to take a comprehensive approach to addressing this crisis. Education, prevention, and support services are crucial components in mitigating the impact of Fentanyl on individuals and families.

Limited residential and general substance use disorder treatment capacity is a significant challenge. Our CoC maintains a public list of available recovery residence and sober living facilities throughout the County. These facilities require a monthly rental payment of \$800-\$1,000/month that few people experiencing homelessness can afford. Limited subsidies for the residential component limit access to these opportunities. Our CoC will be exploring pathways to address this gap through California Medi-Cal transitional rent benefit.

C. Our CoC's plan has helped reduce the annual overdose deaths in the County from a peak of 134 in 2023 to 66 in 2025.

1C-10d. Protecting Public Safety—Current Status of Overdoses and Illicit Drug Use in Public Spaces.

Describe the current status of overdoses and illicit drug use in public spaces in the CoC's geographic area.

(limit 2,500 characters)

Our Sheriff maintains a public dashboard of overdose deaths within the County. Drug offense arrest data is available from a statewide Department of Justice website. Annual overdose deaths within the County have declined from a peak of 134 in 2023 to 66 in 2025. Preliminary data from the first half of 2026 shows continued levels of decline in overdose deaths. Our local, federally designated Health Care for the Homeless program has also noted a decline in overdose deaths among people experiencing homelessness within the same data range. Arrest for drug-related offenses have ranged from a high of 267 in 2016 to a low of 146 in 2022. There were 206 arrests in 2025. In the past 30 days within the City of Santa Cruz, 201 out of 1754 filed police reports were for drug-related activities. Overdose deaths have been in decline and arrest rates and calls for drug-related activities have remained relatively steady.

1C-10e. Protecting Public Safety—Standards to Address Danger to Self or Others.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to utilize standards that address homeless individuals who are a danger to themselves or others (e.g., involuntary commitment) and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

A. California has various beneficial laws, including the Lanterman-Petris-Short Act, which allows law enforcement and mental health professions to detain a person in mental health crisis who is a danger to self or others.

B. Our CoC's and community's plan to leverage beneficial policies to overcome harmful policies embedding mental health liaisons within local enforcement agencies and maintains a 24 hours/7 day per week mobile mental health crisis unit. The mental health liaisons and crisis response team members can initiate involuntary holds on individuals when warranted. The CoC has sponsored training and shares resources related to access to mental health and substance use disorder treatment resources. Treatment capacity for those experiencing a mental health or substance use crisis is limited.

C. Accurate data on the number of involuntary holds for danger to self or others among people experiencing homelessness has not been consistently tracked and reported locally. However, we know that the County Sheriff's Department tracked 183 contacts relating to involuntary psychiatric holds during the year from August 2025 to July 2026.

1C-10f. Protecting Public Safety—Share Information in Accordance with SORNA.

Identify local laws, policies, or other practices that help or hinder the CoC's ability to comprehensively share information, including location information, in accordance with the Sex Offender Registry and Notification Act (SORNA) and provide a plan explaining how the CoC will leverage beneficial policies while overcoming the harmful effects of restrictive ones. If you cannot provide any mitigating steps, please explain why.

(limit 2,500 characters)

A. The California 2025 Sex Offenders Registration Act requires registration of California residents convicted of certain crimes and implements three tiers of registration based upon the severity of the offence.

B. Our CoC's plan to leverage beneficial policies to overcome harmful policies includes promoted a practice among shelter operators and housing providers to check the California sex offender registry prior to admitting an individual into a program. Our CoC maintains a partnership with law enforcement to gather additional information on individuals that show up on the registry to determine the appropriateness of a specific housing opportunity for that individual. The exclusion of registrants from specific housing programs increases the likelihood of them remaining unsheltered. A study in California showed that individuals with a history of committing sexual offenses are more likely to reoffend if they are transient or living without shelter. When an individual experiencing homelessness is found with a registration requirement, our CoC works with the individual and law enforcement to identify potential residential situations that may be appropriate for the individual to reduce the likelihood of recidivism.

C. A publicly available statewide database indicates there are 343 individuals required to publicly register as a sex offender within the County.

1C-11. Outreach Strategy.

Describe your CoC's strategy to outreach to all individuals and families experiencing homelessness across your geographic area.

(limit 2,500 characters)

Street outreach in Santa Cruz County is countywide and works to engage and assist all persons experiencing homelessness, including those not otherwise engaged in services. Street outreach is closely linked to and coordinated with a broad variety of organizations, including emergency shelters, law enforcement, fire department, behavioral health integrated teams, PSH and RRH programs, CES, VA, youth programs, the County Office of Education, community action programs, faith organizations, healthcare clinics and hospitals, City homelessness program and public works staff, County mainstream service programs, businesses, and more. Outreach workers use peer contacts and a trauma-informed approach to build trust, offer basic healthcare and personal care items, and make referrals to shelter, housing, and services.

Outreach teams provide on-the-spot CES connections, safety assessments, psychosocial assessments, and stay engaged with the person to help facilitate housing referral and placement. Key goals are to connect each person to needed healthcare, housing, and other services. Outreach is provided countywide where hard-to-reach persons congregate, such as encampments, downtown locations, parks, parking lots, and other unsheltered locations; safe parking sites; emergency shelters and food programs, County service offices, and libraries.

Several teams conduct outreach to specific hard-to-reach subpopulations as follows: 1) HPHP mobile street medicine team visit 23 sheltered and unsheltered locations per month countywide, offering services and referrals; 2) the Encompass Downtown Outreach Team engages 30 homeless individuals per month in the downtown Santa Cruz area and connects them to a range of resources; 3) the Front St. - SAMHSA PATH program focuses on outreach to individuals with serious mental illness experiencing homelessness; 4) Community Action Board offers youth and unsheltered persons outreach in the southern part of the County, including a multi-disciplinary outreach team targeting individuals with frequent emergency system calls for service; and 5) Encompass offers TAY outreach and County Veterans Services offers veteran outreach.

All outreach programs provide bilingual services (Spanish-English), referrals, transportation, and warm handoffs when needed. CAB provides disabled communication tools and has a bilingual toll-free hotline. 2-1-1 I&R is available 24/7/365 by phone or internet in more than 170 languages.

1C-12.	Collaboration Related to Children and Youth–Written Agreements with Early Childhood Services Providers.	
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Select 'Yes' or 'No' in the chart below to indicate whether your CoC or HUD-funded projects in the CoC have written agreements with the listed providers of educational supports and services for children ages 0-5:

		Written Agreement
1.	Child Care (including Child Care and Development Fund)	Yes
2.	Early Childhood Providers	Yes
3.	Early Head Start	Yes

4.	Home Visiting Program (including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)	Yes
5.	Head Start	Yes
6.	Healthy Start	Yes
7.	Public Pre-K	Yes
8.	Tribal Home Visiting Program	No
	Other (limit 150 characters)	
9.	First 5 Starlight Center - Infant/Toddler Program	Yes

1C-12a.	Collaboration Related to Children and Youth—Formal Partnerships with Schools and Youth Education Providers.	
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Select 'Yes' or 'No' in the chart below to indicate the youth education providers your CoC has a formal partnership with:

1.	McKinney-Vento Liaison(s) (including State Education Agency (SEA) or Local Education Agency (LEA))	Yes
2.	School District(s)	Yes
3.	General Education Development (GED) Program(s)	Yes
4.	Community College(s)	Yes
5.	Technical College(s)	Yes
6.	Other Post-Secondary Education Provider(s)	Yes

1C-12b.Collaboration Related to Children and Youth—Informing Individuals and Families who Become Homeless about Eligibility for Educational Services.

Describe your CoC's written policies and procedures to inform individuals and families who become homeless of their eligibility for educational services.

(limit 2,500 characters)

The CoC has a section in our CoC and ESG Written Standards on McKinney-Vento rights, liaisons, and educational policies to ensure that individuals and families experiencing homelessness are informed of their eligibility for educational services. The policy and procedures to implement it are summarized as follows:

All programs serving families and unaccompanied youth are mandated to prioritize student educational needs and to prevent disruptions in school continuity by placing families and unaccompanied youth in shelter and housing as close to their school of origin as possible.

Upon intake, families with children and unaccompanied youth are informed of their educational rights, supported with written materials, and assisted in enrollment, including referrals to McKinney-Vento Liaisons. The CoC ensures families have the right to choose their school placement, without mandating new school enrollment as a condition for receiving services. Programs cannot require children to attend supplementary education programs that may interfere with regular school attendance, safeguarding continuity in education. Notices detailing student rights are posted in appropriate languages across program sites serving homeless families and youth to increase awareness.

Designated staff within each program are responsible for supporting these educational policies, specifically by ensuring homeless children and youth are enrolled in school and accessing available services. These staff members actively coordinate with the CoC, the Department of Social Services, the Santa Cruz County Office of Education (SCCOE), and McKinney-Vento Coordinators and Liaisons to facilitate access to educational services and resources.

Led by SCCOE SIT, the CoC collaborates with schools, public agencies, nonprofits, businesses, and the community to implement these policies effectively. Each year, SCCOE SIT provides training on these and other policies for school district liaisons and distributes informational materials, ensuring that disadvantaged students and their families are reached and supported through consistent, comprehensive outreach efforts.

1C-12c. Collaboration Related to Children and Youth—Coordination with Foster Care or Child Welfare Services.

Describe how your CoC coordinates with foster care or child welfare services to assist youth transitioning from public systems of care.

(limit 2,500 characters)

Our CoC partners with our intradepartmental Family and Children's Services (FCS) Division to support youth exiting foster care and the child welfare system. Our CoC manages a youth homelessness collaborative that includes representation from FCS and its partners. The CoC manages Family Unification Program (FUP) and Foster Youth to Independence (FYI) rental assistance programs in partnership with our local housing authority. We also utilize state funds to provide rapid rehousing services for youth exiting probation and/or the foster care system. One of our project applications included in this CoC NOFO response includes a request for transitional housing funding to support a new youth-focused transitional housing project that can serve youth exiting foster care.

1C-12d. Collaboration Related to Children and Youth—Coordination with Runaway and Homeless Youth (RHY)-funded Providers.

Describe how your CoC coordinates with RHY-funded providers including Street Outreach Programs, Basic Center Programs, Transitional Living Programs, and Maternity Group Homes where such providers exist.

(limit 2,500 characters)

Our CoC does not currently have any HHS RHY-funded programs in our region.

1C-13. Collaboration Related to Families with Children—TH or RRH Project Dedicated to Serving Families with Children.

Identify at least one Rapid Rehousing (RRH) or Transitional Housing (TH) project in the CoC that primarily or exclusively serves families with children experiencing homelessness in accordance with 24 CFR 578.93(b).

(limit 500 characters)

Projects serving families with children include the proposed Monarch Transitional Housing Program and First Step-Scattered Site TH for Families with Children. State-funded programs include Bringing Families Home, which provides rapid rehousing for families involved in child welfare, and the CalWORKs Housing Support Program, which serves families experiencing homelessness who receive CalWORKs benefits.

1C-13a. Collaboration Related to Families with Children—Supportive Services to Improve Income to Pay Rent.

Describe how the project(s) identified in 1C-13 provides supportive services focused on improving incomes to pay rent, such as workforce development, job training, or registered apprenticeship programs.

(limit 2,500 characters)

The projects mentioned above utilize local education, employment, and child care resources to support families. Our CoC partners with our local United Way 2-1-1 information and referral services to maintain a list of available local resources for families. Our CalWORKs Housing Support Program targets families currently receiving CalWORKs (TANF) benefits. Families in the program are eligible for mainstream CalWORKs employment services (CWES). CWES services include: job training scholarships up to \$5,000; paid employment with local employers; child care; transportation support; job search workshops; referrals to legal services; self-employment assistance; counseling; referrals to substance use treatment and mental health services; educational support; and parenting resources.

1C-13b. Collaboration Related to Families with Children—Leveraging Funding from Mainstream Family Service Systems.

Describe how the project(s) identified in 1C-13 leverages funding from mainstream family service systems, such as Temporary Assistance for Needy Families (TANF).

(limit 2,500 characters)

Our CoC is staffed by individuals working in the County Human Services Department. The department oversees access to the TANF program. We have several projects to support families experiencing homelessness that are eligible for or are currently receiving TANF. For example, we operate a Housing Support Program that utilizes state-funded to provide rapid rehousing services and expand shelter capacity for CalWorks (TANF) families experiencing homelessness. As part of this program, we utilize emergency housing and employment services available for participating families. For example, the Human Services Department co-locates eligibility workers and case monitoring teams with Families in Transition (FIT) to help bridge the gap between county-administered public assistance programs (such as CalWORKs, CalFresh, and Medi-Cal) and the community-based housing stabilization services provided by FIT.

1C-13c. Collaboration Related to Families with Children—Combining Housing Assistance with Parental Support.

Describe how the project(s) identified in 1C-13 combines housing assistance with childcare, parenting support, pregnancy-related and child healthcare, and education.

(limit 2,500 characters)

Our CoC partners with Siena House and the Health Service Agency's Nurse Family Partnership Program. Siena House is a transitional housing program for current and future parents experiencing homelessness that provides temporary housing, linkages to health care, childcare, parental support, and education. The Nurse Family Partnership utilizes an evidenced-based practice nurse home visiting program that empowers first-time parents to transform their lives and create better futures for themselves and their children. The program focuses on families with the greatest social and economic needs and provides support during the critical early years of life. The program is available to first-time mothers or pregnant individuals up through the second year of a child's life. Our CoC refers families into these programs and helps those enrolled in these programs link with CoC-specific programs through coordinated entry.

1C-14. Collaboration with Veteran Serving Organizations—Partnership with the U.S. Department of Veterans Affairs or Veteran Serving Organization.

Identify at least one partnership the CoC has with the Department of Veterans Affairs or other Veteran Serving Organizations.

(limit 500 characters)

The CoC partners with the County Veterans Services Office, Housing Matters and Nation's Finest through their Supportive Services for Veteran Families programs, and the local VA office through VA Supportive Housing. These partnerships connect veterans with benefits, homelessness prevention, outreach, rapid rehousing, and permanent supportive housing. The CoC receives quarterly VA HOMES data for upload into HMIS.

1C-14a	Collaboration with Veteran Serving Organizations.	
	Select 'Yes' or 'No' in the chart below to indicate whether the partnership(s) identified in 1C-14 does the following:	

1.	Refers veterans identified by the CoC to VA or other Veteran Serving Organizations for assistance?	Yes
2.	Coordinates the provision of emergency shelter, supportive services, and housing for veterans?	Yes
3.	Ensures access to a full spectrum of employment and career pathway opportunities?	Yes
4.	Shares data with the Department of Veterans Affairs as appropriate?	Yes
5.	Identifies service gaps for veterans?	Yes
6.	Fills service gaps for veterans?	Yes

1C-15. Collaboration with Organizations who Address the Needs of Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking.

Identify at least one partnership your CoC has with victim service providers, state domestic violence coalitions, state sexual assault coalitions, anti-trafficking service providers or other organizations who help provide shelter, housing, and services to individuals and families of persons experiencing trauma or a lack of safety related to fleeing or attempting to flee domestic violence, dating violence, sexual assault, and stalking.

(limit 500 characters)

The CoC partners with Monarch Services and Walnut Avenue Family & Women's Center to serve survivors of domestic violence, dating violence, sexual assault, and stalking. Both have received CoC DV Bonus awards and participate in coordinated entry using anonymous data entry protocols. They also train local providers on referrals and available services.

1C-16. Collaboration with Justice System Re-entry Partners.

Identify at least one partnership your CoC has to prevent homelessness among people transitioning from prisons, jails, or court-ordered programs.

(limit 500 characters)

The CoC partners with the County Public Defender, which serves on the CoC Policy Board and connects people leaving the justice system with coordinated entry, housing, health, and human services. The CoC also partners with the Sheriff on a pre-release project scheduled to launch in October 2026 to connect people leaving jail with health insurance and supportive services.

1C-17. Collaboration with Partners to Address High Utilizers of Healthcare Systems.

Identify at least one partnership or project your CoC has to provide specialized supportive services for homeless individuals with a high level of medical needs.

(limit 500 characters)

The CoC partners with local Medi-Cal managed care plans and hospitals to expand shelter and recuperative care or respite beds for people experiencing homelessness who are discharged from hospitals, skilled nursing facilities, or emergency departments. The CoC also participates in a hospital's monthly care coordination meeting for people with high medical service use.

1C-18. Collaboration with Partners to Address the Needs of Aging and Elderly Individuals Experiencing Homelessness.

Identify at least one partnership or project your CoC has to serve aging and elderly individuals experiencing homelessness, such as with a provider of residential care, assisted living, or medical respite services.

(limit 500 characters)

The CoC partners with the County Human Services Department's Adult and Long-Term Care Program on Home Safe, which helps older adults and people with disabilities served by Adult Protective Services prevent or address homelessness. Home Safe staff use HMIS and coordinate referrals with the CoC. County Behavioral Health also subsidizes residential care and assisted living for people with serious mental illness and coordinates referrals through HMIS.

1C-19. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Project that Prioritizes Individuals Experiencing Chronic Homelessness.

Identify at least one Rapid Rehousing (RRH) or Permanent Supportive Housing (PSH) project that prioritizes individuals experiencing chronic homelessness.

(limit 500 characters)

The CoC-funded MATCH permanent supportive housing program targets households experiencing chronic homelessness with at least one household member with serious mental illness. All CoC-funded permanent supportive housing programs prioritize people experiencing chronic homelessness.

1C-19a. Permanent Supportive Housing for Chronically Homeless Individuals and Families—On-site Behavioral Healthcare.

Describe how the project(s) identified in 1C-19 provides on-site behavioral healthcare.

(limit 2,500 characters)

Several of our permanent supportive housing projects involve explicit partnerships with County-funded behavioral health care services, including on-site services. The MATCH program involves master leasing of scattered-site permanent supportive housing units throughout the region. Each participant in the program is paired with specialty mental health services provided by a contract mental health provider organization. The organization offers home-visit case management, nursing, occupational therapy, counseling, and coordination with prescribing providers. Several of our PSH programs include behavioral health set-aside units in larger affordable housing developments. These locations include on-site supportive services office space where behavioral health individual and group services are provided based on need.

1C-19b. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Assesses Need for Higher Level of Care.

Describe how the project(s) identified in 1C-19 has a policy for assessing program participant need for higher level of care (i.e., assisted living, residential treatment).

(limit 2,500 characters)

Our CoC manages referrals into permanent supportive housing, including MATCH, through coordinated entry. Our coordinated entry assessment process includes questions related to a client's ability to live independently without support. Prior to referral into a temporary housing program, program operators evaluate if an individual can manage their daily needs without support or if they have a home care provider that can help with those needs. Staff working within the CoC receive information about daily living assessment tools and how to make referrals into In-Home Supportive Services (IHSS). Coordinated entry connectors working with individuals help identify the appropriateness of an available service or housing resource for a given individual. Our CoC also tracks accessible permanent supportive housing units within the community to ensure they are made available to those who need them.

1C-19c. Permanent Supportive Housing for Chronically Homeless Individuals and Families—Assesses Readiness for Moving On.

Describe how the project(s) identified in 1C-19 has a policy for assessing program participant readiness for moving on to unsubsidized or other permanent housing.

(limit 2,500 characters)

Our CoC supports a wide range of permanent supportive housing programs throughout the region. “Moving on” assessments are incorporated into annual reassessments for PSH participants, including those residing in MATCH housing, or sooner if re-assessments are required by supportive services funding agencies. “Moving on” can occur by stepping people down from intensive services to lower level or no services and by exploring possible exits or transfers to other programs. Our CoC operates permanent supportive housing programs for youth exiting foster care in partnership with our local Housing Authority. These programs require supportive services for a period of up to 36 months, if needed. At the end of the 36-month period, participants are eligible for a “moving on” or transition to a regular Housing Choice Voucher (HCV) program slot. This process enables the participant to retain housing affordability and creates an opening for another young person to enter the program. This “moving on” process is limited by available funding in the HCV and other programs that provide affordable housing options for participants.

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

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- Frequently Asked Questions

1D-1.	Project Review and Ranking Process Your CoC Used in Its Local Competition. We use the response to this question along with the required attachment as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria below.	
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You must upload the Local Competition Scoring Tool attachment to the 4A. Attachments Screen.

Select 'Yes' or 'No' in the chart below to indicate how your CoC reviewed, rated, and ranked project applications during your local competition:

1.	Established total points available for each project application type.	Yes
2.	At least 50 percent of the total available points were based on objective criteria to review, rate, and rank project applications.	Yes
3.	At least 25 percent of the total available points were based on system performance measures to review, select and rate project applications.	Yes
4.	Considered returns to homelessness in reviewing, rating, and ranking housing projects (TH, PH-PSH, PH-RRH).	Yes
5.	Considered employment income in reviewing, rating, and ranking housing projects (TH, PH-PSH, PH-RRH).	Yes
6.	Considered supportive service participation requirements in reviewing, rating, and ranking housing projects (TH, PH-PSH, PH-RRH).	Yes

1D-2.	New Proposals.	
	Does your CoC invite new proposals from entities that have not previously received funding, if such eligible entities exist?	Yes

1D-2a.	Web Posting of CoC-Approved Consolidated Application Before the CoC Program Competition Application Submission Deadline.	
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	Enter the date your CoC posted all parts of the CoC-approved Consolidated Application on the CoC's website or partner's website—which included: 1. the CoC Application, and 2. Project Priority Listings.	09/29/2026
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1D-2b.	Notification to Community Members and Key Stakeholders by Email that the CoC-Approved Consolidated Application is Posted on the Website.	
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	Enter the date your CoC notified community members and key stakeholders that the CoC-approved Consolidated Application was posted on your CoC's website or partner's website.	09/29/2026
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1D-2c.	Local Competition Selection Results for All Projects.	
	You must upload the Local Competition Selection Results attachment to the 4A. Attachments Screen.	

	Does your attachment include: 1. Project Names, 2. Project Scores, 3. Project Rank, 4. Project Status—Accepted, Rejected, Reduced Reallocated, Fully Reallocated, 5. Amount Requested from HUD, and 6. Reallocated Funds +/-.	Yes
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1D-2d.	Projects Rejected/Reduced—Notification Outside of e-snaps.	
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1.	Did your CoC reject or reduce any project application(s) submitted for funding during its local competition?	Yes
2.	If you selected 'Yes' for element 1 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.	09/21/2026
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	Yes

1D-2e.	Projects Accepted—Notification Outside of e-snaps.	
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	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	09/21/2026
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1D-3.	Reallocation—Reviewing Performance of Existing Projects.	
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	Describe:
1.	your CoC's reallocation process to reallocate from lower performing projects to create new high performing projects, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed,
2.	whether your CoC identified any low performing or less needed projects through the process described in element 1 of this question during your CoC's local competition this year,
3.	whether your CoC reallocated any low performing or less needed projects during its local competition this year; and
4.	why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable.

(limit 2,500 characters)

1. The CoC has an explicit policy to reallocate funds from renewal projects that are under-performing, obsolete, ineffective, not cost efficient, not spending all funds, less needed, or if reallocation to another project type such as TH would better reduce homelessness. The CoC Board sets the written reallocation policy, and reallocation recommendations are made by the Rating and Ranking Subcommittee based upon its review, scoring, and assessment of the of the project, which includes reviewing APRs, Audits, HUD monitoring results if any, local CoC compliance risk assessments, and any local on-site monitoring. RRH and Joint projects that are no longer viewed as good use of funds, and projects which score 70 or below out of 100, or which show especially poor performance in a key area such as housing stability or spend down rates, will be considered for reallocation. The reallocation policy applies to all renewals, including DV and YHDP projects. Also, the CoC has a self-reallocation of transition grant policy option allowing otherwise well-performing providers that voluntarily give up TH or Joint (or other less effective projects) to create a more effective TH or SSO project type.

2. The CoC identified eight competitive renewal projects that were less needed or had performance issues. Three RRH projects were determined to be less needed project types and two Joint projects were determined to be less needed project types. had significant under-spending issues. One HMIS project was determined to need less CoC funding. One YHDP youth CES project was determined to be less needed and underspending. One YHDP Shared Housing TH was determined to be less needed due to the difficulty in implementing the program model in Santa Cruz County.

3. Yes, the CoC fully reallocated seven projects and partially reallocated one project.

4. The CoC decided to fully reallocate (or transition) all seven of the above RRH, Joint, YHDP youth CES, and YHDP Shared Housing TH projects because they were less needed less needed or lower performing. All were reallocated (or transitioned) to more effective new TH projects. The CoC also decided to partially reallocate a portion of the HMIS project because the total funding was no longer needed. The unneeded funds were reallocated to an effective new TH project focused on SUD treatment.

1D-3a.	Reallocation Between FY 2021 and FY 2026.	
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	Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2021 and FY 2026?	Yes
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2A. Homeless Management Information System (HMIS) and System Performance

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

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

	Enter the name of the HMIS Vendor your CoC is currently using.(limit 75 characters)	BitFocus Clarity
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2A-2.	HMIS Implementation Coverage Area.	
	Not Scored—For Information Only	

	Select from dropdown menu your CoC's HMIS coverage area.	Single CoC
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2A-3.	PIT Count—Methodology Change.	
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	Describe:
1.	any changes your CoC made to your unsheltered PIT count implementation, including methodology or data quality changes between 2025 and 2026, if applicable, and
2.	how the changes affected your CoC's PIT count results.

(limit 2,500 characters)

Not Applicable – Our CoC conducted a 2026 PIT count, but there were no methodology or data quality changes.

2A-4. Reduce Encampments—Actions to Reduce Encampments.

Describe in the field below the actions your CoC took to reduce the number of encampments or the number of people residing in encampments during your evaluation period.

(limit 2,500 characters)

Our CoC does not maintain a database of the total number of encampments and individuals living in encampments. Information provided in response to this question includes estimates based on field reports from outreach workers.

We have participated in multiple partnerships to address encampments within the region. Most recently, we partnered with the City of Santa Cruz to address encampments in a particular neighborhood. For this question, the evaluation period will be October 1, 2024, to September 30, 2025.

The project involved securing state Encampment Resolution Funding (ERF), expanding street outreach in the neighborhood, increasing enforcement, expanding shelter capacity for this target population, and increasing referrals into shelter. In the past 90 days, the number of multi-person encampments in the region have gone to zero. The data provided below only applies to the targeted encampment response region within the County, not the entire City of Santa Cruz area or the County.

2A-4a.	Reduce Encampments—Number of Encampments.	
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1. Enter the estimated number of encampments in the beginning of your evaluation period.	5
2. Enter the reduction in the number of encampments during your evaluation period.	0

2A-4b.	Reduce Encampments—Number of People in Encampments.	
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1. Enter the estimated number of people in encampments in the beginning of your evaluation period.	50
2. Enter the reduction in the number of people in encampments during your evaluation period.	5

2A-4c.	Reduce Encampments—Plans to Reduce Encampments.
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If there has been no reduction in encampments or persons in encampments in your CoC, describe the plans your CoC has to participate in efforts to reduce these numbers.

(limit 2,500 characters)

Not Applicable.

Note about our success: We are pleased to have seen a reduction in the number of camps and individuals living in the targeted area for the City of Santa Cruz and the CoC. Individuals from the original encampment have been provided opportunities to move into shelter and some have moved into permanent housing. Ongoing enforcement activities are preventing encampments from being reformed within the neighborhood. However, unsheltered individuals and encampments have started forming in other areas of the city. The CoC is partnering with the City of Santa Cruz and other community partners to identify a subset of unsheltered individuals in the region that receive the most calls for police and emergency response services. The goals are to create a more coordinated, focused approach to engaging and supporting these individuals through a combination of enforcement and supportive resources. By targeting these individuals, the City and CoC hope to reduce the number of encampments and unsheltered individuals engaging in unhealthy, criminal, and unsafe behaviors in public spaces.

2A-5. Reducing the Number of First Time Homeless—CoC's Plan.

Describe your CoC's plan to decrease the number of individuals and families becoming homeless for the first time.

(limit 2,500 characters)

The CoC's Regional Homelessness Action Plan referenced under 1B5 above includes a detailed action plan and steps for decreasing the number of families and individuals losing their housing and becoming homeless for the first time as follows:

- Setting and tracking system performance targets for reducing first-time homelessness by 20%.
- Maintaining and funding a centralized housing assistance fund operated by CAB, with Community Foundation support, that helps individuals with housing-related financial barriers to maintaining housing.
- Implementing and funding a separate south county targeted homelessness prevention program, partnering with CAB.
- Continuing and expanding funding for an eviction prevention legal assistance contract with Tenant Sanctuary to reduce evictions.
- Continuing and funding a program to help Adult Protective Services (APS) clients at-risk of homelessness to maintain stable housing, reducing entries and returns to homelessness, partnering with APS and CAB.
- Operating and funding a new program with Front Street, Inc. to provide supportive services to people with HIV/AIDS living in subsidized housing to reduce returns to homelessness and numbers becoming homeless for the first time.
- Including County Office of Education leadership on the CoC Policy Board with the goal to increase collaboration between school district McKinney-Vento liaisons and CoC-supported efforts to prevent homelessness among school-aged children and their families.

Each action includes details on gaps and needs data, quantifiable measures, timelines for completing specific tasks and the entire action, proposed funding sources, and responsible and collaborating agencies.

2A-6. Reducing Length of Time Homeless—CoC's Plan.

Describe your CoC's plan to reduce the length of time individuals and families remain homeless.

(limit 2,500 characters)

The CoC's Regional Homelessness Action Plan also includes a detailed action plan and steps for decreasing the length of time (LOT) families and individuals remain homeless as follows:

- Tracking system performance targets for decreasing LOT, including requiring CoC applicants to demonstrate year-over-year progress.
- Sustaining landlord incentives, risk management, and support programs, partnering with the Housing Authority, Abode, and Front Street.
- Increasing information sharing to support move-ins to affordable housing units funded by NPLH, MHSA, & CoC ext., including providing street outreach programs with direct access to PSH units, partnering with County Behavioral Health, housing development partners, and outreach teams.
- Expanding rental assistance to reduce LOT homeless, partnering with County Behavioral Health & Medi-Cal managed care plans.
- Working with the Central California Alliance for Health and Housing Accelerator Fund to establish a revolving supportive housing investment loan fund.
- Helping affordable housing projects secure financing to complete projects, partnering with affordable housing developers and Housing Authority, and VA.
- Co-facilitating local affordable housing pipeline meetings, including efforts to track progress on RHNA goals, partnering with Housing Santa Cruz County.
- Increasing transparency and coordination of information about affordable housing and wait list status, partnering with United Way/2-1-1, local housing development and planning staff, and housing developers.
- Pursuing ADU creation and shared living models such as co-housing, rooming houses, SROs, roommate matching, etc., partnering with Housing Santa Cruz County.
- Funding a range of existing and new housing-focused emergency shelters, navigation centers and TH projects, partnering with developers and operating agencies.
- Funding, and training a broad variety of emergency shelter, navigation center, and TH staff to provide problem solving, housing-focused case management and housing navigation services, partnering with providers.
- Enhancing housing access through improvements to United Way / 2-1-1 resources.

Each action identifies gaps and needs data, quantifiable measures, timelines for completing specific tasks, and the entire action, proposed funding sources, and responsible and collaborating agencies.

2A-7.	Successful Permanent Housing Placement—Exits to Unsubsidized Housing.
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Based on HMIS data, what percent of program participants exited from TH/RRH/PSH collectively to unsubsidized housing?	33.28%
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Describe how you calculated the data for this response.

(limit 2,500 characters)

The CoC ran a collective HMIS APR report, limited to the universe of TH, RRH, Joint, and PSH projects, for the 12-month period from January 1, 2025, to December 31, 2025.

The below data elements in Q23c Exit Destination of the report were used in the calculation:

1. Sum the total persons in four exit destinations: staying or living with family, permanent tenure (44); staying or living with friends, permanent tenure (5); rental by client, no ongoing housing subsidy (137); and owned by client, no ongoing housing subsidy (12). Total: 198 people exiting to unsubsidized permanent housing.

2. Total persons exiting to any destination: 595.

3. Percent calculation: $198 \div 595 \times 100 = 33.28\%$ of people exiting to unsubsidized housing, rounded to two decimal places.

2A-8.	Housing Inventory Count (HIC) and Point-in-Time (PIT) Count Date.	
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	Enter the date your CoC conducted its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count.	01/29/2026
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2A-8a.	HIC and PIT Count Data—HDX 2.0 Submission Date.	
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	Did your CoC submit its 2026 Housing Inventory Count (HIC) and Point-in-Time (PIT) count data in HDX 2.0 by April 30, 2026, 8:00 p.m. EDT?	Yes
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2A-8b.	Longitudinal System Analysis (LSA) Data—HDX 2.0 Submission Date.	
	You must upload your CoC's FY 2026 HDX Competition Report to the 4A. Attachments Screen.	

	Did your CoC submit at least two usable LSA data files to HUD in HDX 2.0 by January 16, 2026, 11:59 p.m. EST?	Yes
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2A-8c.	System Performance Measures (SPM) Data—HDX 2.0 Submission Date.	
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	Did your CoC submit its FY 2025 System Performance Measures data in HDX 2.0 by March 4, 2026, 8:00 p.m. EDT?	Yes
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2A-9.	HMIS and Comparable Database Participation—Bed Coverage Rate.	
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Using the FY 2026 HDX Competition Report we issued your CoC, enter data in the chart below by project type:

Project Type	Adjusted Total Year-Round, Current Non-VSP Beds	Adjusted Total Year-Round, Current VSP Beds	Total Year-Round, Current, HMIS Beds and VSP Beds in an HMIS Comparable Database	HMIS and Comparable Database Coverage Rate
1. Emergency Shelter (ES) beds	359	21	380	100.00%
2. Safe Haven (SH) beds	0	0	0	0.00%
3. Transitional Housing (TH) beds	84	9	93	100.00%
4. Rapid Re-Housing (RRH) beds	338	63	63	100.00%
5. Permanent Supportive Housing (PSH) beds	1,038	0	767	73.89%
6. Other Permanent Housing (OPH) beds	692	0	17	2.46%

2A-9a.	Partial Credit for Bed Coverage Rates of 84.99 Percent or Lower for Any Project Type in Question 2A-9.	
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For each project type with a bed coverage rate that is 84.99 percent or lower in question 2A-9, describe:

1.	steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type, and
2.	how your CoC will implement the steps described to increase bed coverage to at least 85 percent.

(limit 2,500 characters)

1. CoC and HMIS staff will meet with leadership of each PSH and OPH program not participating in HMIS in the next 12 months to educate them about the benefits of HMIS participation, address any concerns they have, and offer them the following support:

- HMIS training on how to use HMIS and reports that can be generated.
- Offer free (paid by the CoC) HMIS user licenses.
- Offer free (paid by the CoC) ongoing technical assistance and troubleshooting and access to all HMIS meetings and every HMIS data entry, data quality, reporting, privacy, and security training available.
- Offer to pay for a contractor to enter the data for the agency.

2. Key steps for implementing this plan will include:

A. Setting up meetings within the next 4 months with the following providers:

- U.S. Department of Veterans Affairs – VASH Program (more than 400 PSH beds).
- Housing Authority – Homeless-Targeted Mainstream Voucher, DMV Vouchers, EHV Vouchers, and FUP Vouchers (872 total PSH and OPH beds).
- Faith-based emergency shelters (33 total beds not entered into HMIS).

B. Continuing discussions as needed and develop a written implementation plan and steps needed for each agency that agrees to participate within 5-8 months.

C. Carrying out the plan with each agreeing agency by providing MOUs (including the free benefits to be provided to support the agency) and other documentation and by scheduling program setup and startup training within 9-12 months.

3A. Policy Initiatives

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- Frequently Asked Questions

3A-1.	Supporting Activities within an Opportunity Zone.	
	You must upload the HUD-2996 Certification for Opportunity Zone Preference Points attachment to the 4A. Attachments Screen.	

1.	Will the proposed activities/projects occur within Opportunity Zone Census Tracts?	Yes
2.	Do you expect to use at least 50% of the proposed activities/projects in Opportunity Zones Census Tracts?	No

3A-2	Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.
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Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes? No

4A. Attachments Screen For All Application Questions

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants; and
- Frequently Asked Questions

We have provided the following guidance to help you successfully upload attachments and get maximum points:

1. You must include a Document Description for each attachment you upload; if you do not, the Submission Summary screen will display a red X indicating the submission is incomplete.
2. You must upload an attachment for each document listed where 'Required?' is 'Yes'.
3. We prefer that you use PDF files, though other file types are supported—please only use zip files if necessary. Converting electronic files to PDF, rather than printing documents and scanning them, often produces higher quality images. Many systems allow you to create PDF files as a Print option. If you are unfamiliar with this process, you should consult your IT Support or search for information on Google or YouTube.
4. Attachments must match the questions they are associated with.
5. Only upload documents responsive to the questions posed—including other material slows down the review process, which ultimately slows down the funding process.
6. If you cannot read the attachment, it is likely we cannot read it either.
 - . We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).
 - . We must be able to read everything you want us to consider in any attachment.
7. After you upload each attachment, use the Download feature to access and check the attachment to ensure it matches the required Document Type and to ensure it contains all pages you intend to include.
8. Only use the 'Other' attachment option to meet an attachment requirement that is not otherwise listed in these detailed instructions.

Document Type	Required?	Document Description	Date Attached
01. 1C-1. List of TH/RRH/PSH Projects and Treatment Providers with On-Site Substance Use Treatment	Yes	List of TH/RRH/PS...	09/27/2026
02. 1C-1f. List of CoC Program Projects and Number of Units that require Substance Abuse Treatment	Yes	List CoC Program ...	09/27/2026
03. 1C-3. Language from Project Supportive Service Agreements	Yes	Language from Pro...	09/28/2026
04. 1C-10. Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety	Yes	Evidence of Coord...	09/29/2026
05. 1D-1. Local Competition Scoring Tool	Yes	Local Competition...	09/27/2026

06. 1D-2c. Local Competition Selection Results	Yes	Local Competition...	09/27/2026
07. 2A-8b. FY 2026 HDX Competition Report	Yes	2026 HDX Competit...	09/20/2026
08. 3A-1. HUD-2996 Certification for Opportunity Zone Preference Points	No	HUD-2996 Certific...	09/28/2026
09. 3A-2a. Project List for Other Federal Statutes	No		
10. 3A-DP. Your CoC's Policy or Statement to Advance Recovery	No	CoC's Policy to A...	09/28/2026
11. Other	No		

Attachment Details

Document Description: List of TH/RRH/PSH Projects On-Site SUD Treatment

Attachment Details

Document Description: List CoC Program Projects With Units Requiring SUD Treatment

Attachment Details

Document Description: Language from Project Supportive Services Agreements

Attachment Details

Document Description: Evidence of Coordination and Non-Interference with Local Efforts to Advance Public Safety

Attachment Details

Document Description: Local Competition Scoring Tool

Attachment Details

Document Description: Local Competition Selection Results

Attachment Details

Document Description: 2026 HDX Competition Report

Attachment Details

Document Description: HUD-2996 Certification for Opportunity Zone
Preference Points

Attachment Details

Document Description:

Attachment Details

Document Description: CoC's Policy to Advance Recovery

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/26/2026
1B. Coordination and Engagement–Accountable Structure and Participation	09/29/2026
1C. Coordination and Engagement	09/29/2026
1D. Project Review/Ranking	09/29/2026
2A. HMIS Implementation	09/29/2026
3A. Policy Initiatives	09/29/2026
4A. Attachments Screen	09/29/2026
Submission Summary	No Input Required

2026 Santa Cruz County CoC List of TH, RRH, PSH, and Treatment Providers Onsite SUD Services						
No.	Applicant Name	Project Name	New or Renewal	Project Component	Onsite Treatment?	Treatment Provider
1	Housing Matters	801 River Street PSH	Renewal	PSH	Yes	Homeless Persons Health Project
2	Housing Matters	180 Together PSH	Renewal	PSH	No	
3	Housing Authority of Santa Cruz County	Shelter+Care Consolidate PSH	Renewal	PSH	Yes	County Behavioral Health & Homeless Persons Health Project
4	Housing Matters	Harvey West Studios	Renewal	PSH	No	
5	Santa Cruz County HSA	MATCH PSH	Renewal	PSH	Yes	County Behavioral Health & Homeless Persons Health Project
6	Monarch Services	Monarch Transitional Housing Program	New - DV Realloc	TH	No	
7	Bill Wilson Center	Casa Sankofa	New - replacement	TH	Yes	County Behavioral Health
8	Families In Transition	First Step-Scattered Site TH for Families with Children	New - transition	TH	No	
9	Families In Transition of Santa Cruz County, Inc.	Y.A.A.S. (Young Adults Achieving Success) TH	New - replacement	TH	No	
10	Walnut Avenue Family & Women's Center	Housing & Employment Program TH	New - DV transition	TH	No	
11	Encompass Community Services	Drop-In Center	YHDP Renewal	SSO	Yes	Encompass Community Services
12	Community Action Board of Santa Cruz County, Inc.	YHDP - Youth Homeless Response Team (YHRT)	Renewal	SSO	No	
13	Janus of Santa Cruz	Recovery to Support Permanent Housing	CoC Bonus & Realloc New	TH	Yes	Janus of Santa Cruz
14	Housing Matters	Housing Matters Transitional Housing	CoC Bonus New	TH	Yes	County Behavioral Health & Homeless Persons Health Project
15	Monarch Services	Monarch DV Bonus TH Expansion Project	New DV Bonus	TH	No	

No. of TH, RRH, & PSH Projects: **13**

No. of TH, RRH, & PSH Projects w/Onsite SUD Treatment: **6**

% TH, RRH, & PSH Projects w/Onsite SUD Treatment: **46.15%**

No. of Standalone SSO Projects: **2**

No. of Standalone SSO Projects w/Onsite SUD Treatment: **1**

*% of Standalone SSO Projects w/Onsite SUD Treatment: **50.00%***

*Combined No. Projects: **15***

*Combined No. of Projects w/Onsite SUD Treatment: **7***

*Combined % of Projects w/Onsite SUD Treatment: **46.67%***

2026 Santa Cruz County CoC List of Projects Requiring SUD Services							
No.	Applicant Name	Project Name	New or Renewal	Project Component	Required SUD Treatment?	No. Units Requiring SUD Treatment	No. Beds Requiring SUD Treatment
1	Housing Matters	801 River Street PSH	Renewal	PSH	N	0	0
2	Housing Matters	180 Together PSH	Renewal	PSH	No	0	0
3	Housing Authority of Santa Cruz County	Shelter+Care Consolidate PSH	Renewal	PSH	No	0	0
4	Housing Matters	Harvey West Studios	Renewal	PSH	No	0	0
5	Santa Cruz County HSA	MATCH PSH	Renewal	PSH	No	0	0
6	Santa Cruz County HSD	Coordinated Entry Expansion	CoC Renewal	SSO	N/A	N/A	N/A
7	Santa Cruz County HSD	County of Santa Cruz Homeless Management Information System	CoC Renewal	HMIS	N/A	N/A	N/A
8	Monarch Services	Monarch Transitional Housing Program	New - DV Realloc	TH	No	0	0
9	Bill Wilson Center	Casa Sankofa	New - replacement	TH	No	0	0
10	Families In Transition	First Step-Scattered Site TH for Families with Children	New - transition	TH	No	0	0
11	Families In Transition of Santa Cruz County, Inc.	Y.A.A.S. (Young Adults Achieving Success) TH	New - replacement	TH	No	0	0
12	Walnut Avenue Family & Women's Center	Housing & Employment Program TH	New - DV transition	TH	No	0	0
13	Encompass Community Services	Drop-In Center	YHDP Renewal	SSO	No	0	0
14	Community Action Board of Santa Cruz County, Inc.	YHDP - Youth Homeless Response Team (YHRT)	Renewal	SSO	No	0	0
15	Janus of Santa Cruz	Recovery to Support Permanent Housing	CoC Bonus & Realloc New	TH	Yes	3	33
16	Housing Matters	Housing Matters Transitional Housing	CoC Bonus New	TH	No	0	0
17	Monarch Services	Monarch DV Bonus TH Expansion Project	New DV Bonus	TH	No	0	0
Total Projects/Units/Beds Requiring SUD Treatment:					1	3	33

2026 Santa Cruz County CoC List of PSH/RRH/TH/Joint Projects With Service Participation Requirements

No.	Applicant Name	Project Name	New or Renewal	Project Compo- nent	Total HUD Budget	Services Required & Language Attached
1	Housing Matters	801 River Street PSH	CoC Renewal	PSH	\$302,619	Yes
2	Housing Matters	180 Together PSH	CoC Renewal	PSH	\$402,561	Yes
3	Housing Authority of Santa Cruz County	Shelter+Care Consolidate PSH	CoC Renewal	PSH	\$1,910,598	Yes
4	Housing Matters	Harvey West Studios	CoC Renewal	PSH	\$351,891	Yes
5	Santa Cruz County HSA	MATCH PSH	CoC Renewal	PSH	\$1,240,542	Yes
6	Monarch Services	Monarch Transitional Housing Program	DV Realloc New	TH	\$142,583	Yes
7	Bill Wilson Center	Casa Sankofa	YHDP Realloc New	TH	\$764,447	Yes
8	Families In Transition	First Step-Scattered Site TH for Families with Children	CoC New (Transition)	TH	\$671,530	Yes
9	Families In Transition of Santa Cruz County, Inc.	Y.A.A.S. (Young Adults Achieving Success) TH	YHDP Realloc New	TH	\$328,896	Yes
10	Walnut Avenue Family & Women's Center	Housing & Employment Program TH	CoC New (Transition)	TH	\$749,441	Yes
11	Janus of Santa Cruz	Recovery to Support Permanent Housing	CoC Bonus & Realloc New	TH	\$750,942	Yes
12	Housing Matters	Housing Matters Transitional Housing	CoC Bonus New	TH	\$416,849	Yes
13	Monarch Services	Monarch DV Bonus TH Expansion Project	DV Bonus New	TH	\$210,762	Yes

1. Housing Matters

801 River St. PSH (Casa Azul)



Casa Azul

Required Supportive Services Participation Agreement

Participant Name: _____

Date of Enrollment: _____

Purpose and Goal

The primary objective of **Casa Azul** is to help you achieve self-sufficiency, defined as the ability to meet your basic needs, including stable housing, without public or private assistance. This agreement is designed to provide the structure and accountability necessary to help you reach your unique health, wellness, and financial goals.

Mandatory Participation Requirement

In accordance with 24 CFR 578.75(h), **Casa Azul** requires program participants to take part in supportive services as a condition of continued participation and occupancy. These services are tailored to your individual needs based on your initial and annual assessments.

Service Engagement

Unless you are over the age of 62 or have a qualifying disability or developmental disability, you agree to engage in at least 20 hours per week of services, activities, or employment. Qualifying activities include:

- **Enhanced Case Management:** Meeting with staff to address barriers to stable housing and problem solve solutions.
- **Treatment and Counseling:** Participating in behavioral healthcare, substance use disorder treatment, or support groups.
- **Employment and Education:** Engaging in job training, vocational rehabilitation, or GED programs.
- **Community Building:** Participating in work therapy, volunteering, or other activities designed to increase self-sufficiency.
- **Employment:** Paid employment counts directly toward your weekly engagement hours.



Casa Azul

Required Supportive Services Participation Agreement

Individualized Service Plan

Your specific schedule, the services to be provided, and the designated providers are documented in your Individualized Service Plan, which is attached to this agreement and will be updated at least annually. You agree to work toward the specific target dates and benchmarks established in that plan.

Safety and VAWA Protections

Consistent with 24 CFR 5.2005(b)(1), your assistance, participation, or occupancy will not be denied or terminated solely because you are or have been a victim of domestic violence, dating violence, sexual assault, or stalking. If you have safety concerns, staff will work with you on a specialized safety plan.

Drug-Free Policy and Sobriety

[TH Project Name] maintains a drug-free environment to promote recovery. While you are required to participate in treatment and services as outlined in your plan, you will not be evicted or exited from assistance solely for a first-time violation of a drug-related program policy or lease requirement, provided you remain engaged in your recovery plan.

Participant Acknowledgment

I understand that my participation in the supportive services identified in my Individualized Service Plan is a mandatory condition of my enrollment in this program. I agree to collaborate with staff to achieve the goals of housing stability and self-sufficiency.

Participant Signature: _____ **Date:** _____

Staff Signature

I certify that the participant's service needs have been assessed and that the required services have been individualized to support their progress toward self-sufficiency.

Staff Signature: _____ **Date:** _____

2. Housing Matters

180 Together PSH



180 Together Required Supportive Services Participation Agreement

Participant Name: _____

Date of Enrollment: _____

Purpose and Goal

The primary objective of **180 Together** is to help you achieve self-sufficiency, defined as the ability to meet your basic needs, including stable housing, without public or private assistance. This agreement is designed to provide the structure and accountability necessary to help you reach your unique health, wellness, and financial goals.

Mandatory Participation Requirement

In accordance with 24 CFR 578.75(h), **180 Together** requires program participants to take part in supportive services as a condition of continued participation and occupancy. These services are tailored to your individual needs based on your initial and annual assessments.

Service Engagement

Unless you are over the age of 62 or have a qualifying disability or developmental disability, you agree to engage in at least 20 hours per week of services, activities, or employment. Qualifying activities include:

- **Enhanced Case Management:** Meeting with staff to address barriers to stable housing and problem solve solutions.
- **Treatment and Counseling:** Participating in behavioral healthcare, substance use disorder treatment, or support groups.
- **Employment and Education:** Engaging in job training, vocational rehabilitation, or GED programs.
- **Community Building:** Participating in work therapy, volunteering, or other activities designed to increase self-sufficiency.
- **Employment:** Paid employment counts directly toward your weekly engagement hours.



180 Together Required Supportive Services Participation Agreement

Individualized Service Plan

Your specific schedule, the services to be provided, and the designated providers are documented in your Individualized Service Plan, which is attached to this agreement and will be updated at least annually. You agree to work toward the specific target dates and benchmarks established in that plan.

Safety and VAWA Protections

Consistent with 24 CFR 5.2005(b)(1), your assistance, participation, or occupancy will not be denied or terminated solely because you are or have been a victim of domestic violence, dating violence, sexual assault, or stalking. If you have safety concerns, staff will work with you on a specialized safety plan.

Drug-Free Policy and Sobriety

180 Together maintains a drug-free environment to promote recovery. While you are required to participate in treatment and services as outlined in your plan, you will not be evicted or exited from assistance solely for a first-time violation of a drug-related program policy or lease requirement, provided you remain engaged in your recovery plan.

Participant Acknowledgment

I understand that my participation in the supportive services identified in my Individualized Service Plan is a mandatory condition of my enrollment in this program. I agree to collaborate with staff to achieve the goals of housing stability and self-sufficiency.

Participant Signature: _____ **Date:** _____

Staff Signature

I certify that the participant's service needs have been assessed and that the required services have been individualized to support their progress toward self-sufficiency.

Staff Signature: _____ **Date:** _____

**3. Housing Authority of
Santa Cruz County
Shelter + Care Consolidated
PSH**

County of Santa Cruz - Health Services Agency

HOMELESS PERSONS HEALTH PROJECT RESIDENT SUPPORT PLAN

We encourage you to contact your case manager at any time if you are experiencing personal difficulties, issues with a neighbor or friend, or any other situation where we can provide support.

We also ask you to let us know the good things happening in your life, as one of our goals is to provide support and encouragement for you in all aspects of your housing.

1. What are your goals for the coming year?
2. What do you need help with the most? (scheduling/keeping appointments, transportation, applying for benefits, finding employment, etc.)
3. We suggest having a regularly scheduled time to meet with your case manager. How often would you like to meet? (Once a week is preferred; once a month is the minimum.)
4. Do you want support in maintaining sobriety? (schedule for meeting places, sign-in sheets, sponsor, etc.) Are you willing to contact our on-call support number in the event you feel triggered to use?
5. Do you need help with a budget? Would you consider having a payee (free of charge) assist with your money management? Would you like a debit card instead of carrying around cash? If you need cash, you can still get it when you go to the store, pharmacy, etc.
6. Are there any medical issues we can help with? Do you currently go for regular checkups at a county clinic? Do you obtain a flu vaccine each year?
7. Do you need or want assistance in a job search/job training?
8. What are some daily activities you engage in? Would you like a list of places/groups for daily activities you can attend?

Client Signature

Date

4. Housing Matters

Harvey West Studios PSH



Harvey West Studios Required Supportive Services Participation Agreement

Participant Name: _____

Date of Enrollment: _____

Purpose and Goal

The primary objective of **Harvey West Studios** is to help you achieve self-sufficiency, defined as the ability to meet your basic needs, including stable housing, without public or private assistance. This agreement is designed to provide the structure and accountability necessary to help you reach your unique health, wellness, and financial goals.

Mandatory Participation Requirement

In accordance with 24 CFR 578.75(h), **Harvey West Studios** requires program participants to take part in supportive services as a condition of continued participation and occupancy. These services are tailored to your individual needs based on your initial and annual assessments.

Service Engagement

Unless you are over the age of 62 or have a qualifying disability or developmental disability, you agree to engage in at least 20 hours per week of services, activities, or employment. Qualifying activities include:

- **Enhanced Case Management:** Meeting with staff to address barriers to stable housing and problem solve solutions.
- **Treatment and Counseling:** Participating in behavioral healthcare, substance use disorder treatment, or support groups.
- **Employment and Education:** Engaging in job training, vocational rehabilitation, or GED programs.
- **Community Building:** Participating in work therapy, volunteering, or other activities designed to increase self-sufficiency.
- **Employment:** Paid employment counts directly toward your weekly engagement hours.



Harvey West Studios Required Supportive Services Participation Agreement

Individualized Service Plan

Your specific schedule, the services to be provided, and the designated providers are documented in your Individualized Service Plan, which is attached to this agreement and will be updated at least annually. You agree to work toward the specific target dates and benchmarks established in that plan.

Safety and VAWA Protections

Consistent with 24 CFR 5.2005(b)(1), your assistance, participation, or occupancy will not be denied or terminated solely because you are or have been a victim of domestic violence, dating violence, sexual assault, or stalking. If you have safety concerns, staff will work with you on a specialized safety plan.

Drug-Free Policy and Sobriety

Harvey West Studios maintains a drug-free environment to promote recovery. While you are required to participate in treatment and services as outlined in your plan, you will not be evicted or exited from assistance solely for a first-time violation of a drug-related program policy or lease requirement, provided you remain engaged in your recovery plan.

Participant Acknowledgment

I understand that my participation in the supportive services identified in my Individualized Service Plan is a mandatory condition of my enrollment in this program. I agree to collaborate with staff to achieve the goals of housing stability and self-sufficiency.

Participant Signature: _____ **Date:** _____

Staff Signature

I certify that the participant's service needs have been assessed and that the required services have been individualized to support their progress toward self-sufficiency.

Staff Signature: _____ **Date:** _____

5. Santa Cruz County HSA MATCH PSH

Santa Cruz County – Housing for Health Partnership
Supportive Housing Participation Agreement

Welcome! You are being offered a spot in the supportive housing program.

Supportive Housing = Rent-subsidized and property managed housing + Supportive services to help you keep your housing and meet your personal needs and goals.

Santa Cruz County has two types of supportive housing. Your program's type is checked below:

☐ Community based housing where subsidy follows the tenant	☐ Building-based housing where the subsidy belongs to the building
• You receive financial support to help pay rent for a room, apartment, or house • You need to start using your housing subsidy by a set deadline • Program staff will help you search for housing • Program staff are located off site	• Your housing rental subsidy is for a specific building (it is not transferable to other places) • Services and supports are often located in the building (or close to the building)
• You need to follow the building rules, the housing subsidy rules, and your lease (for example, pay 30% of your income, annual inspections) • You may have property management inspections of your unit with appropriate notice • You will have up to weekly check-ins or home visits from supportive program staff at mutually convenient times • The frequency of your check-ins or home visits may change based on your needs and preferences	

Tenant Rights: You are a tenant in a supportive housing program. Your program is required to follow standard California landlord-tenant laws. Information about these laws and your rights and responsibilities can be found online at [Landlord/Tenant Rights](#) or provided to you in written form if requested.

Program Participant Rights: Your supportive services provider(s) do not share confidential and private information about you without your permission. If you have concerns about the program, first try to address them with your supportive service provider or housing management staff. If your concerns are not getting addressed and you would like additional support to address them, you can contact the Housing for Health Division of Santa Cruz County at (831) 454-7312 or via email at info@housingforhealthpartnership.org or online at [Contact Us](#).

As a tenant of a supportive housing program, you agree to:

- 1) Stay in regular contact with your support team, if needed, to help with your housing and well-being. Services should be available to visit you in your home at least once per week.
- 2) Request or accept the support you need, if any, to help with daily living – food shopping, cooking, laundry, cleaning, paying bills, taking medications, scheduling appointments, transportation, using appliances, or other day to day needs.
- 3) Work with supportive services staff to develop a wellness/safety plan, for example, a Wellness Recovery Action Plan to address potential health/safety situations that might impact you.
- 4) Use your housing as your primary residence.
- 5) Talk with your Property Manager before adding or changing household members and when your income or financial situation changes.
- 6) Provide financial information to your Property Manager and/or Subsidy Provider as part of your subsidy review. when requested.
- 7) Allow your Property Manager and/or Subsidy Provider to inspect your unit when necessary (with 24-hour notice or at mutually convenient times).
- 8) Follow the rules in your lease, any house rules, and housing subsidy financial assistance agreement, for example:
 - a. Pay your portion of rent and utilities on time
 - b. Keep your unit clean and in good condition, including appropriate storage use
 - c. Make sure you and your guests follow the lease and house rules, including overnight limits
 - d. Repair damage caused by you or your guests
 - e. Do not disturb, harass, or engage in violence or use of weapons with neighbors and staff
 - f. Do not smoke in your unit or engage in illegal activities, such as selling drugs
 - g. Follow rules regarding pet policies
- 9) Tell your Support Team if you receive any written warnings from your Property Manager and work with your Team to address concerns.
- 10) Provide complete and accurate information and documentation when asked.
- 11) Inform your Property Manager and/or Subsidy Provider if you will be away from your unit:
 - a. If you are away less than 90 days, they may be able to help you keep your housing
 - b. If you are away more than 90 days, your rental assistance may stop, and you may lose your housing and will need to reapply to the program.

If problems come up...

- Your Support Team wants to help you address issues impacting on your health, safety, and housing stability.
- If you violate your lease and cannot effectively correct the issue, work with your Support Team to move out before a formal eviction is filed. This may help you find other housing options.
- If you are formally evicted, your Support Team can still offer services, but finding new housing will be more difficult.

Your Support Team

Below are the names and contact information for:

Supportive Services Provider	Housing Management
Health Support Provider =	Housing Subsidy Provider =
Housing Services Provider =	Property Manager / Landlord =

Agreement

The Supportive Housing Participation Agreement document for the <blank> supportive housing program has been reviewed with me by the staff person listed below and they have answered my questions about what is expected.

By signing, I confirm that I understand my rights and responsibilities as a supportive housing tenant. I have a copy of this agreement and access to the California Guide to Residential Tenants' and Landlords' Rights and Responsibilities.

Partner Name (Print) _____ Staff Name (Print) _____

Partner Signature _____ Staff Signature _____

Date _____ Date _____

6. Monarch Services

Monarch Services TH



Transitional Housing Program Participant Service Agreement

Participant Name: _____

Program: Transitional Housing Program

Date: _____

Monarch Services' Transitional Housing Program is designed to support participants in achieving safety, stability, healing, and long-term independence. Participation in supportive services is a encouraged part of the program and helps ensure each resident receives the full benefit of available resources.

Supportive Services Participation Commitment

I understand and agree to participate in up to 20 hours per week of supportive services, which may include:

- Substance Use Disorder (SUD) Support Services (assessment, counseling, groups, relapse-prevention support, referrals)
- Educational Opportunities (school enrollment support, GED/college planning, tutoring, skills courses)
- Employment Readiness and Career Development (job search assistance, resume development, interview preparation, workforce training)
- Life Skills and Empowerment Activities (financial literacy, parenting support, wellness activities, safety planning, leadership development)
- Case Management and Housing Support (goal planning, progress reviews, community referrals, advocacy)
- Other services as identified in my individualized service plan

Participant Responsibilities

- Actively engage in assigned supportive services and scheduled appointments.
- Maintain regular communication with my case manager.
- Work collaboratively on my individualized service plan and update goals as needed.
- Notify staff in advance if I am unable to attend a scheduled activity or service.



- Participate in services in good faith and with a commitment to personal growth, healing, and independence.

Program Commitment

- Provide trauma-informed, culturally responsive supportive services.
- Collaborate with me to create a personalized service plan tailored to my goals.
- Offer ongoing support, referrals, advocacy, and resource navigation.
- Maintain confidentiality within the limits of the law and program policy.

Acknowledgment and Agreement

I have read or had this agreement read to me. I understand the expectations of the Transitional Housing Program and agree to participate in supportive services as outlined above.

Participant Signature: _____

Date: _____

Staff Signature: _____

Date: _____

7. Bill Wilson Center

Casa Sankofa TH



**Transitional Housing
(TH)
Program Benefits, Expectations and Rules**

What is TH?

A transitional housing program for young adults and young families aged 18-24 who are facing homelessness. We provide housing support, case management, supportive services, and referrals to help you transition. The goal is a successful transition to independent, long-term housing. Staff are here to provide support and encouragement for you along the way, and ultimately it is your willingness and self-determination that will dictate what outcomes and successes are achieved.

BENEFITS OF HOUSING PROGRAMS:

Supportive environment

While in our programs you can expect to live in a safe and stable environment. You will participate in weekly meetings which will help you build and maintain relationships with your case manager

Assistance with setting and achieving goals

Our housing program is designed to support you as you set and achieve your personal goals. You'll work closely with your case manager to create a personalized plan of action during your time here

Learn independent living skills

In addition to setting goals, you'll acquire practical skills for independent living. Topics of discussion include essential areas such as managing your finances, managing household upkeep, understanding nutrition, and navigating independent living

Saving money

The case manager will help you open a savings account if you do not already have one and review your financial progress with you each month

Linkage to community resources such as:

Employment, education, counseling, mental health, advocacy, basic needs, and transportation

As a participant in the housing program, I will be expected to:

- Follow all program rules
- Participate in 20 hours of services per week
- Respect other clients and staff
- Follow a Needs and Services plan, as discussed with my case manager
- Attend all meetings, classes and/or appointments as discussed with my case manager
- Be on time and inform the case manager if I will be late or absent due to emergency circumstances



As a participant in the housing program I can expect to:

- Be treated with respect and courtesy
- Have staff honor confidentiality to the limits of the law
- Be exposed to new ideas and new ways of doing things
- Have input into decisions and setting goals
- Make positive changes in my life

Program Expectations and Rules for Cooperative Living

EMPLOYMENT/EDUCATION EXPECTATIONS:

- Clients should be employed within the first 60 days of entry date. Clients may choose **one** of the following:
 - Employed full-time (30-40 hrs. weekly)
 - or
 - Employed part-time (20 hrs. weekly) **and** enrolled in a minimum of 2 courses
- Employment will be verified by your case manager and it must comply with federal/state expectations. For example, tax deductions, W-4 forms, weekly hours, and compliance with state wages must apply to the job.
- If you are paid in cash, you are still responsible for retrieving proof of payment and a schedule/record of hours worked from that employer.
- Once employed or you begin your educational journey you are required to submit proof of verification to your case manager, this includes but not subjected to, an acceptance letter, a schedule or an enrollment form.
- You will also be required to submit bank statements along with budget information

Household:

Should a family member exit the program, either voluntarily or due to termination, they cannot re-enroll while you are still participating. It is your continuous responsibility to maintain your eligibility by ensuring all required family members remain officially enrolled with you for the duration of the program.

Case Management Meetings:

All household participants will meet with the case manager ongoing while in the program to fulfill all program requirements and meet client needs. You and your assigned worker will use your case management meetings to review your progress across several areas, including *employment, finances, educational goals, and your physical and mental health*. Your Case Manager is committed to supporting you every step of the way, meeting you where you are at in the program.

Housing:

To ensure a smooth move to permanent housing, clients are **required** to meet with the Housing Specialist, ongoing. This is when you will discuss your budget, review housing options, and start the application and viewing process. During this time, you will be given a housing addendum to review the expectations and responsibilities during the housing search.

Confidentiality:



To protect everyone's privacy, clients must make every effort not to share program information with other clients or people outside the program. This includes basic details, like the names of clients, as well as any confidential information shared in group settings.

Mail:

While in transitional housing, your mail will be distributed by staff as it arrives . By exit, you must change the mailing address to your next destination.

Security & House Safety Policy:

All clients are responsible for maintaining the security and safety. In the event of suspicious behavior or a clear house rule violation, clients should inform staff immediately so that it can be addressed in real time in order to maintain a safe environment. *Any behavior that threatens the safety of yourself, other clients, or staff will not be tolerated.*

Security cameras are installed throughout the property and are continuously monitored by staff to ensure safety.

Please note that staff members have the right to thoroughly search bedrooms on any suspicion of survival rule violation, with or without the client present.

To ensure the physical safety of the clients and property, clients will participate in fire drills to ensure preparedness in the event of an emergency. Each property contains an emergency kit in the event of a disaster or emergency. These items are not to be tampered with and should only be opened in the event of an actual emergency. Each property contains a red binder with instructions and guidelines on what to do in the event of an emergency.

Keys:

You will be given a key to the house as well as one for your personal bedroom. In the event you should lose your key you will need to pay a fee of \$5.00 to replace each lost key. If you lock yourself out of your room or house, you will need to wait for your roommate or house mate to let you in, you may also call the On-call case manager for assistance. You are allowed one lock out service free of charge.

Medications:

You may only possess prescription medication that is legally in your name. It is illegal to possess, use, or share prescription medication that is not prescribed to you. Please note that *staff will not administer any form of medication* to clients, even upon request

Respect:

Bill Wilson Center maintains an emotionally safe environment for all participants. At all times, clients will be expected to treat staff and each other with courtesy and respect. Clients should respect the privacy of the other people living at the site. **Verbal and/or physical abuse will not be tolerated.** (Verbal abuse includes but is not limited to: yelling or cursing at someone, making fun of someone because of their background or abilities, using language which insults people based on their race/ethnic background, their gender, or their sexuality).

Personal Belongings:



Bill Wilson Center assumes no responsibility for replacing or repairing any personal items that are stolen or damaged while you are in the program. This applies to all property in your bedroom as well as any items placed outdoors.

Borrowing/loaning:

Any act of theft or borrowing without authorization from other clients and staff, is a direct violation of program rules and threatens the community's security. It is strongly discouraged to borrow or loan of personal possessions (such as clothing, money, or supplies) between clients to avoid conflict and misunderstandings

Room Expectations:

You are required to keep your unit clean and do your laundry at least once per week. Staff will conduct regular room inspections for cleanliness and any property damages, which may occur with or without you present.

While living at Casa Sankofa, we encourage you to create a home-like space. We strive to create an environment that is safe and respectful of others. If you are uncertain about a given poster or decoration, ask a staff member. Any posters, pictures and other personal possessions promoting gang activity, violence or drug use, pornographic materials, or conveying messages of hatred will not be tolerated.

Candles/Flammable Items:

For the safety of all residents, open flames (such as from candles, incense, or sage) are not allowed anywhere on the property due to the risk of fire.

Music:

Please be considerate of your fellow neighbor. Music played inside the house must not be heard outside the house.

Utilities:

You will be provided basic utilities including water, PG&E, garbage removal and monitored internet usage. Residents are not permitted to subscribe to any additional utilities.

Residency:

To maintain the integrity of the program, clients are required to live onsite for the full duration of the program. Any exceptions must be discussed with and approved by staff in advance. Failure to do so will put you at risk of a 14-day corrective action or violation.

Curfew:

While in transitional housing, clients must be in the house by 8:00 PM Sunday thru Thursday and 1:00 AM on Friday and Saturday. Only exceptions are valid work schedules.

Visitors:

Visitors are allowed during the following times **only**:

Friday: 5 pm – 10pm Saturday: 12pm – 10pm Sunday: 12pm – 5 pm

Visitors are required to follow the house rules during their visit. **No overnight visitors are allowed for any reason.**

**Pets:**

While in transitional housing, **pets are not allowed**. This policy is in place to respect the needs of all clients, as well as to prevent potential property damage or health concerns.

Smoking:

Smoking of any kind is strictly prohibited on all Bill Wilson Center property, both indoors and outdoors, except within designated smoking areas.

Dress Code:

Clients must be fully dressed when meeting with staff; this means no exposed under garments. Please be aware that if staff determine you are dressed inappropriately you will be asked to change or cover up.

SURVIVAL RULES

The following rules are viewed as significant to the successful operation of our housing programs. Violations of these rules compromise the safety of everyone in the program. Clients who break any of these rules risk immediate dismissal from the program.

1. Possession or use of drugs, drug paraphernalia or alcohol is strictly prohibited. Clients who are suspected of being under the influence will be asked to keep to themselves in their room to avoid causing any disturbances.
2. Possession or use of weapons and physical violence is not allowed under any circumstances. Verbal, written or physical threats will also not be tolerated.
3. Please be respectful of your environment and neighbors. Do not cause or become involved in neighborhood disturbances, property destruction or loitering.
4. No stealing or theft.
5. Do not dismantle or tamper with the fire/smoke detectors and fire extinguishers. Property damage of any kind is prohibited.
6. All guests must adhere to all rules. You will be held responsible for their behavior.

OCCUPANCY AGREEMENT

- The length of stay while in the TH program is dependent on your standing with the program expectations
- Clients violating program rules/expectations will be given program violations. If you get 5 program violations, you will be exited from the program

NON-COMPLAINE / TERMINATION PROCESS

Failure to comply with program guidelines may lead to the termination of your services. The process starts with a verbal warning. If the non-compliant behavior persists, you will receive a 14-day Corrective Action Plan. Should the behavior still continue, you will then receive an official program violation. Accumulating your third program violation will result in a **30-day notice to vacate the property and immediate termination of services**. Concerns regarding safety may skip the verbal warning phase and go directly into a program violation or



notice to vacate depending on the severity. Refusal to vacate the property after receiving this notice will lead to an official eviction. Furthermore, staff members have the discretion to issue violations for behaviors not explicitly noted in these guidelines.

Program participants may present written or verbal objections to a termination before a BWC staff member other than the person making/approving the decision to terminate. In most cases this would be the Program Manager or the Division Director. Notice in writing of the final decision will be provided to the participant promptly.

I understand that this program is **VOLUNTARY** and I am under no obligation to participate in this program and am free to leave the program at any time. I also understand that the program is not obligated to keep me in the program and that my continuation in the program depends on my compliance with the program rules and expectations.

I acknowledge with my signature my willingness and agreement to abide by these and all other program rules and expectations. I have had all of my questions answered. If I have any questions about these rules, I will ask my case manager.

Client signature

Date

8. Families in Transition

First Step Scattered Site TH



Families In Transition of Santa Cruz County, Inc.
406 Main St. #326, Watsonville, CA
PH# 831-728-9791
Fax: 831-728-9793
www.fitsantacruz.org

First Step Transitional Housing Program

Participant Supportive Services Agreement

Participant Information

Participant Name: _____

Case Manager: _____

Effective Date: _____

Purpose

The First Step Transitional Housing Program provides individualized supportive services to assist participants in achieving and maintaining permanent housing, increasing self-sufficiency, and improving overall well-being.

Supportive services are tailored to each participant's unique strengths, needs, goals, and circumstances. Every participant's Supportive Services Agreement and Individualized Service Plan will be different, reflecting their personal priorities and housing stabilization goals. While the specific services provided may vary, many of the housing-related expectations and core program requirements are consistent across all participants.

This agreement outlines the partnership between the participant and Families in Transition of Santa Cruz County, Inc. (FIT) and describes the responsibilities of both parties throughout program participation.

Individualized Supportive Services

Working together, the participant and case manager will develop an Individualized Service Plan that identifies goals, action steps, referrals, and supportive services designed to promote housing stability and long-term success.

Services may include, but are not limited to:

- Housing search and landlord engagement
- Housing stabilization and tenancy support
- Budgeting and financial capability
- Employment and career development
- Education and vocational training
- Childcare resources
- Physical and behavioral health services
- Substance use treatment and recovery services
- Domestic violence services
- Parenting education
- Benefits enrollment and public assistance
- Legal services
- Transportation assistance
- Credit improvement and debt reduction
- Life skills development
- Community resource navigation
- Other services identified through the participant's individualized planning process

The Individualized Service Plan will be reviewed regularly and updated as goals are achieved or circumstances change.

Participant Responsibilities

To support progress toward individualized goals and permanent housing, the participant agrees to:

- Participate in developing and reviewing their Individualized Service Plan.
- Meet with their assigned case manager as required by the program.
- Maintain communication with FIT regarding changes in household circumstances, income, employment, or service needs.
- Actively participate in mutually agreed-upon supportive services and housing stabilization activities.
- Complete a minimum of **20 hours per week of participation in approved activities** designed to support housing stability, self-sufficiency, and personal goals.
- Meet the 20-hour weekly participation requirement through a combination of activities such as employment, school, vocational training, job search activities, or supportive services activities identified in the participant's Individualized Service Plan.
- Notify the case manager as soon as possible if unable to attend scheduled appointments or complete planned participation activities.
- Communicate barriers that prevent access to services or meeting participation goals so that FIT may assist in resolving them.
- Work collaboratively with FIT staff to achieve identified housing and self-sufficiency goals.

The participant understands that they have the right to participate in decisions affecting their service plan and may request modifications whenever their needs or goals change. FIT will work with participants to identify appropriate activities and reasonable adjustments when barriers affect their ability to meet participation expectations.

Families in Transition Responsibilities

FIT is committed to providing respectful, participant-centered, trauma-informed, and strengths-based supportive services.

FIT agrees to:

- Treat participants with dignity, respect, and cultural responsiveness.
- Assist participants in identifying strengths, barriers, and goals.

- Develop individualized service plans based upon participant choice and identified needs.
- Coordinate supportive services that promote housing stability.
- Provide housing-focused case management.
- Maintain confidentiality consistent with applicable laws and agency policies.
- Provide advocacy and problem-solving assistance to reduce barriers to permanent housing.
- Support participants in developing the knowledge and skills necessary to maintain long-term housing stability.
- Collaborate with participants to identify appropriate employment, education, training, and supportive service activities that meet the 20-hour weekly participation requirement.

Referral and Service Coordination

FIT provides a hands-on referral process designed to help participants successfully access community resources and supportive services.

Our referral process generally includes:

- Contacting agencies before making referrals to confirm service availability and determine current eligibility requirements, documentation requirements, and waiting lists.
- Assisting participants in gathering all required documentation needed to complete referrals or applications.
- Helping participants schedule appointments or providing information regarding available walk-in services.
- Offering to accompany participants to appointments if they would like additional support. If participants choose to attend independently, FIT will follow up afterward to ensure they were able to access the services and determine whether additional assistance is needed.
- Advocating on behalf of participants throughout the referral process by assisting them in overcoming barriers, responding to requests for additional

documentation, communicating with service providers when appropriate, and helping resolve issues that may delay or prevent access to services.

Our goal is to provide comprehensive support, coordination, and advocacy that increases participants' ability to successfully connect with community resources and achieve lasting housing stability.

Participant Choice

FIT recognizes that participants are the experts in their own lives and encourages active participation in all aspects of service planning.

Participants have the right to:

- Participate in identifying goals and priorities.
- Request changes to their Individualized Service Plan.
- Ask questions and receive information about available services and referrals.
- Choose whether to accept or decline referrals or services, except where participation is required by applicable program regulations or funding requirements.
- Receive services in a respectful, non-discriminatory, and trauma-informed environment.

FIT will discuss with participants how accepting or declining certain services may affect progress toward housing goals or compliance with program requirements.

Housing Stability and Permanent Housing Planning

The primary objective of supportive services is to assist participants in obtaining and maintaining safe, stable, and affordable permanent housing.

Throughout program participation, FIT and the participant will work collaboratively to:

- Identify barriers to permanent housing.
- Develop strategies to overcome those barriers.
- Increase financial stability and budgeting skills.
- Strengthen independent living skills.

- Increase access to employment, education, healthcare, and community resources.
 - Participate in activities that support personal growth, self-sufficiency, and housing stability.
 - Prepare for a successful transition from transitional housing to permanent tenant-based housing.
-

Agreement

This Supportive Services Agreement reflects a collaborative partnership between the participant and Families in Transition. Both parties acknowledge that progress toward housing stability is an ongoing process and that service plans may be modified at any time through mutual agreement to reflect changing needs, goals, or circumstances.

The participant understands that supportive services are intended to provide guidance, advocacy, resource coordination, and encouragement while supporting participant choice, independence, and long-term housing success. The participant also understands that active participation of at least 20 hours per week through employment, education, training, or supportive services activities is an important component of the program's goal of promoting housing stability and self-sufficiency.

Signatures

I acknowledge that I have reviewed this Participant Supportive Services Agreement, understand its purpose, and agree to work collaboratively toward my individualized housing stabilization goals.

Participant Signature: _____

Date: _____

Case Manager Signature: _____

Date: _____

Program Supervisor Signature: _____

Date: _____

9. Families in Transition

YAAS TH (YHDP)



Families In Transition of Santa Cruz County, Inc.
406 Main St. #326, Watsonville, CA
PH# 831-728-9791
Fax: 831-728-9793
www.fitsantacruz.org

YAAS Transitional Housing Program

Participant Supportive Services Agreement

Participant Information

Participant Name: _____

Case Manager: _____

Effective Date: _____

Purpose

The Young Adults Achieving Success (YAAS) Transitional Housing Program provides individualized supportive services to assist participants in achieving and maintaining permanent housing, increasing self-sufficiency, and improving overall well-being.

Supportive services are tailored to each participant's unique strengths, needs, goals, and circumstances. Every participant's Supportive Services Agreement and Individualized Service Plan will be different, reflecting their personal priorities and housing stabilization goals. While the specific services provided may vary, many of the housing-related expectations and core program requirements are consistent across all participants.

This agreement outlines the partnership between the participant and Families in Transition of Santa Cruz County, Inc. (FIT) and describes the responsibilities of both parties throughout program participation.

Individualized Supportive Services

Working together, the participant and case manager will develop an Individualized Service Plan that identifies goals, action steps, referrals, and supportive services designed to promote housing stability and long-term success.

Services may include, but are not limited to:

- Housing search and landlord engagement
- Housing stabilization and tenancy support
- Budgeting and financial capability
- Employment and career development
- Education and vocational training
- Childcare resources
- Physical and behavioral health services
- Substance use treatment and recovery services
- Domestic violence services
- Parenting education
- Benefits enrollment and public assistance
- Legal services
- Transportation assistance
- Credit improvement and debt reduction
- Life skills development
- Community resource navigation
- Other services identified through the participant's individualized planning process

The Individualized Service Plan will be reviewed regularly and updated as goals are achieved or circumstances change.

Participant Responsibilities

To support progress toward individualized goals and permanent housing, the participant agrees to:

- Participate in developing and reviewing their Individualized Service Plan.
- Meet with their assigned case manager as required by the program.
- Maintain communication with FIT regarding changes in household circumstances, income, employment, or service needs.
- Actively participate in mutually agreed-upon supportive services and housing stabilization activities.
- Complete a minimum of **20 hours per week of participation in approved activities** designed to support housing stability, self-sufficiency, and personal goals.
- Meet the 20-hour weekly participation requirement through a combination of activities such as employment, school, vocational training, job search activities, or supportive services activities identified in the participant's Individualized Service Plan.
- Notify the case manager as soon as possible if unable to attend scheduled appointments or complete planned participation activities.
- Communicate barriers that prevent access to services or meeting participation goals so that FIT may assist in resolving them.
- Work collaboratively with FIT staff to achieve identified housing and self-sufficiency goals.

The participant understands that they have the right to participate in decisions affecting their service plan and may request modifications whenever their needs or goals change. FIT will work with participants to identify appropriate activities and reasonable adjustments when barriers affect their ability to meet participation expectations.

Families in Transition Responsibilities

FIT is committed to providing respectful, participant-centered, trauma-informed, and strengths-based supportive services.

FIT agrees to:

- Treat participants with dignity, respect, and cultural responsiveness.
- Assist participants in identifying strengths, barriers, and goals.

- Develop individualized service plans based upon participant choice and identified needs.
- Coordinate supportive services that promote housing stability.
- Provide housing-focused case management.
- Maintain confidentiality consistent with applicable laws and agency policies.
- Provide advocacy and problem-solving assistance to reduce barriers to permanent housing.
- Support participants in developing the knowledge and skills necessary to maintain long-term housing stability.
- Collaborate with participants to identify appropriate employment, education, training, and supportive service activities that meet the 20-hour weekly participation requirement.

Referral and Service Coordination

FIT provides a hands-on referral process designed to help participants successfully access community resources and supportive services.

Our referral process generally includes:

- Contacting agencies before making referrals to confirm service availability and determine current eligibility requirements, documentation requirements, and waiting lists.
- Assisting participants in gathering all required documentation needed to complete referrals or applications.
- Helping participants schedule appointments or providing information regarding available walk-in services.
- Offering to accompany participants to appointments if they would like additional support. If participants choose to attend independently, FIT will follow up afterward to ensure they were able to access the services and determine whether additional assistance is needed.
- Advocating on behalf of participants throughout the referral process by assisting them in overcoming barriers, responding to requests for additional

documentation, communicating with service providers when appropriate, and helping resolve issues that may delay or prevent access to services.

Our goal is to provide comprehensive support, coordination, and advocacy that increases participants' ability to successfully connect with community resources and achieve lasting housing stability.

Participant Choice

FIT recognizes that participants are the experts in their own lives and encourages active participation in all aspects of service planning.

Participants have the right to:

- Participate in identifying goals and priorities.
- Request changes to their Individualized Service Plan.
- Ask questions and receive information about available services and referrals.
- Choose whether to accept or decline referrals or services, except where participation is required by applicable program regulations or funding requirements.
- Receive services in a respectful, non-discriminatory, and trauma-informed environment.

FIT will discuss with participants how accepting or declining certain services may affect progress toward housing goals or compliance with program requirements.

Housing Stability and Permanent Housing Planning

The primary objective of supportive services is to assist participants in obtaining and maintaining safe, stable, and affordable permanent housing.

Throughout program participation, FIT and the participant will work collaboratively to:

- Identify barriers to permanent housing.
- Develop strategies to overcome those barriers.
- Increase financial stability and budgeting skills.
- Strengthen independent living skills.

- Increase access to employment, education, healthcare, and community resources.
 - Participate in activities that support personal growth, self-sufficiency, and housing stability.
 - Prepare for a successful transition from transitional housing to permanent tenant-based housing.
-

Agreement

This Supportive Services Agreement reflects a collaborative partnership between the participant and Families in Transition. Both parties acknowledge that progress toward housing stability is an ongoing process and that service plans may be modified at any time through mutual agreement to reflect changing needs, goals, or circumstances.

The participant understands that supportive services are intended to provide guidance, advocacy, resource coordination, and encouragement while supporting participant choice, independence, and long-term housing success. The participant also understands that active participation of at least 20 hours per week through employment, education, training, or supportive services activities is an important component of the program's goal of promoting housing stability and self-sufficiency.

Signatures

I acknowledge that I have reviewed this Participant Supportive Services Agreement, understand its purpose, and agree to work collaboratively toward my individualized housing stabilization goals.

Participant Signature: _____

Date: _____

Case Manager Signature: _____

Date: _____

Program Supervisor Signature: _____

Date: _____

**10. Walnut Avenue
Housing & Employment
Program TH**



Participant Supportive Services Participation Agreement

This Participant Agreement outlines the expectations, responsibilities, and service participation requirements for all individuals enrolled in the Walnut Avenue Housing & Employment Program, funded through the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) program.

Participant Name: _____

Unit Address and Number: _____

Effective Date: _____

1. Purpose

The goal of this program is to support participants in achieving housing stability, self-sufficiency, and overall well-being through supportive services and case management. Participation in supportive services is a condition of program enrollment and continued housing assistance.

2. Required Service Participation

All participants agree to actively engage to a minimum of 20 hours per week in supportive services as outlined below:

- Employment or employment training
- Vocational rehabilitation services, if applicable
- Life skills education (e.g., budgeting, household management, communication)
- Substance abuse treatment, if the participant actively uses substances
- Behavioral health or mental health services, as indicated by assessment
- Case management meetings as scheduled
- Other appropriate social services identified by program staff and the participant

Participants will collaborate with their assigned case manager to develop and maintain an individualized service plan tailored to their goals and needs.

Exceptions of 20-hour customized services commitment may be made for participants over 62 or with a physical disability/impairment. Reduction of 20-hour customized services commitment may be made proportionality as participant is in employment, employment training, or volunteering.



3. Rental Contribution

Participants agree to pay 30% of their adjusted gross income toward rent, utilities, and other housing costs as determined according to HUD regulations. Participants agree to submit income documentation as requested for rent calculation and recertification purposes.

4. Participant Responsibilities

Participants agree to:

- Notify their case manager within 10 days of any changes in:
 - Income or employment status
 - Household composition
 - Participation in supportive services
 - Physical or behavioral health needs
- Report any landlord/tenant issues, legal concerns, arrests, or citation-related incidents promptly to their case manager.
- Maintain their housing unit in a safe, clean, and sanitary condition.
- Cooperate with property management and program staff to support a positive living environment.
- Participate in required meetings, trainings, and reviews related to their service plan and housing stability.
- Abide by program policies, lease terms, and applicable laws.

5. Confidentiality and Consent

All personal information collected by the program will be kept confidential and used solely for program administration and service delivery in accordance with HUD requirements, VAWA, federal regulations (including HIPAA, when applicable), and agency policy. When staff need to share my information with other organizations for legitimate business purposes, they must first get my signature on a written Release of Information.



6. Acknowledgment and Agreement

By signing below, the participant acknowledges that they have read, understand, and agree to comply with the terms of this Participant Supportive Services Participation Agreement as a condition of participation in the Walnut Avenue Housing & Employment Program. Failure to engage meaningfully in required services or to meet program expectations may result in a review of eligibility or termination of housing assistance, consistent with program policy and due process requirements. Program participants have the right to file grievances and appeals - the procedures for which are found in the Grievance and Termination Policy.

Participant Print Name: _____

Participant Signature: _____ Date: _____

Case Manager Print Name: _____

Case Manager Signature: _____ Date: _____

11. Janus of Santa Cruz
Recovery to Support
Permanent Housing TH

Janus of Santa Cruz

Client Admission Financial Responsibility

Patient Name	Date of Birth	Gender	ID No.	Intake Date
Client, Test	01/01/1990	M	00000701	9/26/2023

Requirement Information

Date/Time []	Staff Responsible	Facility	Program Providing Service
7/16/2026 2:00 PM	Ferrero, Amber	JMIOT_440003AN (OP) - Janus Main Intensive Outpatient (Lic.# JMIOT_440003AN (OP))	WM - Withdrawal Management

Consent Form

CLIENT ADMISSION FINANCIAL RESPONSIBILITY FORM

Thank you for choosing Janus of Santa Cruz. We are honored by your choice and are committed to providing you with the highest quality care. We ask that you read and initial this form to acknowledge your understanding of your financial responsibilities. If you are a cosigner or paying on someone's behalf, we ask that both parties (client & cosigner) initial.

Financial Responsibilities:

Please select the following statements and sign below

- ☐ I understand that I am responsible for all treatment related charges regardless of any assignment of benefits if insurance denies coverage.
- ☐ I understand that I am required to provide Janus with correct and updated information about my insurance and will be responsible for any charges incurred if the information provided is not correct or updated.
- ☐ I understand it is my responsibility to coordinate benefits with my current insurance carrier and recognize that if I do not do so my insurance carrier will withhold payment to Janus of Santa Cruz and I will then be responsible for the full cost of the treatment.
- ☐ I understand that payment of deductibles, co-pays, co-insurance, and all other treatment not covered by the insurance plan is due at the time of admission. Acceptable methods of payment include cash, check, and most major credit cards. I understand that my treatment may be paused if my insurance does not cover and/or I cannot pay for additional treatment services.
- ☐ I understand that my insurance carrier may cease to authorize my care at any time. If I choose to stay in treatment after authorization ceases, I understand that I am financially responsible for my treatment after that point and payment is due immediately.
- ☐ I understand that if Incidental Medical Services are provided to me, my insurance will be billed for them.
- ☐ I understand that this account may incur, and am responsible for the payment of additional charges at the discretion of Janus of Santa Cruz, including but not limited to: Charges may include: \$50.00 Charge for returned checks. \$200 charge if account is referred to our collection agency.
- ☐ I understand that Janus of Santa Cruz does not discriminate against race, religion, sex, gender, and gender identity, health status including pregnancy ethnicity, age, disability, sexual preference, and ability to pay.
- ☐ I understand that if I am asked to leave by Janus Staff, due to violation of rules there will be a 30-day waiting period for re-admission.
- ☐ I understand that if I leave treatment against staff advice Janus of Santa Cruz will charge a \$500 ASA fee and a \$500 administrative fee.
- ☐ I understand that all payments are final. There are NO REFUNDS. If there is a remaining balance, it will remain on clients account for future use.

Attachments

Refer to attached form below (form was filled out on paper):

☐ Yes

Attached Document

No document attached.

Signatures

Patient/Parent/Conservator Name (Print)



Janus of Santa Cruz
Recovery Residence
Guidelines and Contract



Dear New Resident,

Welcome to this Recovery Residence! It is our hope that you will find here a healthy and stable living environment where you can focus on your inner strengths and recovery goals.

This house has been set up as a temporary safe and sober residence for people in recovery. It is a three-month program targeted to participants who need a temporary housing solution while they complete Intensive Outpatient Treatment (IOT). In this supportive sober living environment, you can access free room and board, weekly enhanced care management, and peer support. Assistance is available for connecting to multiple resources, including applying for long-term housing funding, support obtaining employment or other income, and setting goals. The target population of this residential program are individuals who need sober housing to sustain their recovery, can participate in keeping the house tidy with daily and weekly chores, are interested in practicing a healthy lifestyle through nutrition and physical activity, and are willing to work, volunteer, or go back to school. Join us in the belief that with time, care, and respect, anything can be accomplished.

We invite you to spend your time wisely in this house so you can build a solid foundation in recovery and find yourself confident in your path to sobriety and self-sufficiency. The residence guidelines must be adhered to in order to sustain a safe and nurturing space for all. Consider this as a tool for 'learning to live orderly', where you gain skills that will later serve you in work, with family and in other areas of your life.

As with any group of people living together, this house requires organization and positive teamwork to function smoothly. The House Manager will orient you to the structure of the house, which operates as a 'mini organization', and will uphold the expectations of living in this house. These expectations include your participation in a weekly house meeting where house issues are discussed, and weekly chores are rotated. This is an appropriate time for you to talk about any accomplishments, obstacles, or issues you may be encountering in your recovery, and for collaborative problem solving.

You are a terrific individual who has set good standards for others. We appreciate you and are grateful for the value you will add to this home. May you continue to serve as encouragement for others wherever you find your personal path to a healthy life.



(Source: Janus website [Residential Treatment | Janus of Santa Cruz \(janussc.org\)](https://www.janussc.org))

Janus of Santa Cruz provides Supportive Housing services for individuals in the process of recovering from addictions. These residences are a safe and comfortable environment where individuals are treated respectfully and actively engage in self-care, healing, and recovery. Residential treatment at Janus is evidence-based with proven positive outcomes.

In these residences, individuals start on the path to successful recovery from substance use. Services combine individualized treatment with participation in group process and education, mainly in an Intensive Outpatient Treatment program. They connect individuals with support systems within the community to promote stability and full recovery. The program is designed to develop and support individuals' motivation to recover and to instill in them a consistent commitment to health and self-care.

What is Treatment at Janus?

People entering residential treatment sometimes use words such as *frustration*, *pain*, and *failure* to describe their lives. As they live with others and focus on the guidance provided, they start to replace those words with *hope*, *strength*, *opportunity*, and *happiness*. This is how we define success.

In Janus, each individual works in partnership with a Janus Case Manager to create an *Individual Care Treatment Plan*, which is a guide of personal goals and objectives. Enrollment in a Janus residential program includes individual and group counseling sessions, education initiatives, and assignments designed to improve knowledge of the addiction and recovery processes. Participants develop life skills and obtain key information favorable to recovery by attending outpatient services, support groups, and listening to motivational speakers share their recovery experiences.

Janus Recovery Residence (RR)

This house is a recovery environment with a focus on resident health and safety. It allows residents the time and space to focus on their recovery, learn life skills, and practice successful community living. It has regular operations and follows health and safety protocols. The expectation is that everyone living here will do their best to ensure the house runs seamlessly. House Managers supervise daily chores, which is consistent with the best substance use disorder treatment practices. House Managers also communicate regularly with Janus administrators to address issues of concern that may come up, either from individual residents or the whole house. Residents should strive to maintain a good-spirited atmosphere in the house, which includes consistently responding to challenges with a positive outlook and creative problem solving.

Expectations for participants

- Refrain from using drugs and alcohol.
- If there is active substance use in the house, immediately report it to the House Manager.
- Treat your housemates and others in the house with respect.
- Take all medications as prescribed. Report any changes in medications to the House Manager.
- Complete daily chores, weekly schedules, and other daily household responsibilities.
- Attend House Meetings.
- Do your part to ensure that the house is kept clean and tidy.
- Consistently attend SUD Intensive Outpatient Treatment (IOT).
- Communicate regularly with your Janus Case Manager and stay active in Case Management.
- Be open to getting drug tested randomly and when needed.
- Observe quiet time guidelines (9PM-7AM).
- Respect the confidentiality and privacy of others.
- The length of stay is 90 days, based on regular assessments and tailored to individual needs.
- Be actively engaged in your recovery. Focus on recovery goals and reach out if you are having any challenges.
- Work towards self-sufficiency.
- If you need assistance with specific needs, contact your Janus Case Manager or a peer support specialist. They are here to support you.

Instructions: Please go over the following RR guidelines pertaining to the Program, Contract, and Health and Safety. Your signature at the end will verify your understanding of these guidelines and your agreement to abide by them.

At the end of this form there are key concepts and principles regarding our services for your knowledge.

This Contract and Guidelines are subject to change by Janus without prior notice at any time.

Conditions of Residency

Housing in a Janus RR provides Residents with a substance free environment. Resident hereby agrees to not use any alcohol or other drug while residing in the RR. Resident hereby waives any right to the 3-Day and 30-Day Notice requirements for discharge regarding any removal from the RR in Civil Code Section 1946 and Code of Civil Procedure Section 1161.

Resident further waives the right to judicial determination of good cause for discharge from the RR based on alcohol and/or other drug use. Based on a finding of alcohol or other drug use, Resident hereby agrees to voluntarily withdraw from the RR upon being asked to do so. Otherwise, local authorities will be called to assist their exit. Resident hereby authorizes Janus Staff to test Resident for the purpose of determining whether Resident has in any way used alcohol or other drugs. Testing procedure may analyze breath or urine. Resident agrees that if a test is positive for any amount of alcohol or other drugs (not prescribed by a doctor and approved for use by Janus Staff) or if Resident refuses to be tested, Resident may be immediately discharged from the house.

Important: By placing signature at the conclusion of this paragraph, Resident indicates understanding and accepts the conditions of residency relating to refraining from the use of alcohol and other drugs and acknowledges and confirms the waiver contained in the above paragraph. Breaking these guidelines will result in a review and possible discharge from the house and termination of residence. Upon discharge, personal belongings must be picked up within (10) ten days or the belongings become the property of Janus of Santa Cruz.

Resident _____ Date _____

House Manager _____ Date _____

Janus Staff _____ Date _____

Terms

This agreement shall begin on _____ and shall remain in effect until Resident vacates the RR and/or Termination of residence.

Loss or Damage

All the Resident’s personal property shall be the sole risk and responsibility of the Resident. Neither Janus of Santa Cruz nor the County of Santa Cruz shall be liable for any Resident’ property which may be lost, stolen, damaged, or destroyed by fire, water, steam, defective refrigeration, or other means while on the premises.

Attorney’s Fees and Costs of Suit

Should any legal action become necessary to interpret or enforce the terms, covenants, and conditions of the above mentioned agreement as it relates to a Resident’s stay in the Recovery Residence, the prevailing party shall be entitled to recover, in addition to any other relief afforded by the Court or other fact-finding body, reasonable attorney’s fees and costs of suit incurred in connection with said legal action. Legal action, or these purposes, shall include but not be limited to arbitration, mediation, Janus-Resident dispute resolution bodies, or organizations as well as actions filed in state or federal courts.

Waivers

Any waivers or modifications of the conditions of this agreement or the underlying shall be in writing.

Resident	_____	Date	_____
House Manager	_____	Date	_____
Janus Staff	_____	Date	_____

Some Specifics

Random drug and alcohol screenings. Upon admission and at any time, if the staff deems it necessary, Residents' room and personal belongings may be searched for alcohol, drugs, or other contraband. Residents will be subject to random drug and alcohol screenings each week. Any resident who is found to be tampering with the Urine Analysis will be immediately discharged. Any Resident found using alcohol or drugs may be **immediately discharged and the agreement terminated.**

The use of any alcohol or unauthorized mood-altering chemicals is not allowed, neither on nor off the premises. Continuous abstinence is necessary for Residents of Janus Recovery Residences. Should a Resident resume usage, residency will be terminated immediately. If a Resident thinks another Resident has been drinking or using drugs, the House Manager or Janus staff must be informed so that they can confront said Resident in a sensitive way and take appropriate action. Anonymity will be respected. A drug screen (UA) may be requested when there is suspected chemical use.

Physical violence directed at a Resident or any other person on Janus Recovery Residence property will be grounds for immediate termination. In addition, any language or gestures determined by staff to be abusive or threatening may be grounds for termination. It is expected that Residents will not engage in non-recovery-based behavior.

Leaving overnight requires requesting a pass (24 hours in advance) and turning it in to the House Manager. You may request an overnight pass after being at the Janus Recovery Residence for at least (30) thirty days. If approved, you may take up to 2 overnight passes per month. You are responsible for getting another Resident to cover any Recovery Residence House responsibilities you may have during your overnight out.

Curfew Hour is at 10:00 pm. You are expected to be back on time. You are not permitted to leave the house again until 6:00 am. If working hours conflict, prior arrangements must be made. If you anticipate being late, call the House Manager as soon as possible. **Infractions will result in consequences and possible termination of residency.**

Attend a minimum of 4 self-help meetings weekly. This includes scheduled IOT/IOP groups. Residents are required to arrive on time and stay for the entire meeting. Acceptable meetings include aftercare, spiritual meetings, self-help meetings, outside 12-Step meetings, and IOT/IOP.

Residents must attend RR house meetings and arrive on time; failure to comply will result in consequences.

All Residents must be seeking employment, employed, attending school, volunteering, or doing something conducive to recovery.

Illegal behavior on or off the premises is not allowed and will be grounds for termination. This includes vandalism, dealing drugs, driving without a current license, registration, and insurance, etc.

Residents are expected to abide by confidentiality and anonymity of peers. Residents are expected to be responsible, respectful, and considerate of themselves, other Residents, and the RR at all times.

Romantic Relationships with other Residents will be grounds for termination. Residents are not allowed in another Resident's bedroom. Only the House Manager, Janus Staff and the current residing Resident are allowed in that bedroom. Residents may not have any physical contact with another Resident **or guest** on the property. Exceptions are a handshake or a 'greeting hug'.

Pets may not live in the Janus Recovery Residence.

Furniture

Residents are **not allowed** to remove or move any furniture or fixtures from the RR. This includes moving them from one room to another. **Residents may not** bring any outside furniture onsite without first asking Janus Staff.

Resident Grievance

If a Resident has a grievance, they should speak with the House Manager. If the situation has not been resolved, Janus Staff should be contacted.

Recovery Residence Meeting

The residential meetings are closed meetings. Guests are not allowed.

Medications

Residents may not consume or bring onto the property anything that contains alcohol or ephedrine. This includes but is not limited to over-the-counter medications and mouthwash. Residents must bring all medications to House Manager for approval before use. This includes all over-the-counter medications. All medications must be listed on the Resident’s Medication Record and all controlled medications are to be stored with the House Manager. Any changes in the dosage must be confirmed in writing or by telephone to the House Manager or Janus Staff from the issuing doctor. Medications that have been approved for Residents to keep in their possession must not be left unprotected or out in the open. Medications must always be kept on the Resident’s person or in a safe place that is hidden from view, such as a dresser drawer. Residents are responsible for protecting all allowed medications. Any deviations from the above directions are considered abuse. **Abuse of medications will be considered a relapse and will lead to termination of residency.**

Resident	_____	Date	_____
House Manager	_____	Date	_____
Janus Staff	_____	Date	_____

Contract of Residency

Janus Recovery Residence is a transitional living environment for individuals who are recovering from alcohol or substance use disorders. **Residents are subject to substance testing at any time while living at Janus Recovery Residence.**

THE USE AND/OR POSSESSION OF DRUGS AND/OR ALCOHOL IS GROUNDS FOR IMMEDIATE DISCHARGE

All policies and procedures outlined within this contract and any applicable subsequent amendments are in full force and effect during the Resident's entire stay at Janus Recovery Residence. **Violation of any policy or procedure outlined within this contract and any applicable subsequent amendments will result in disciplinary actions including but not limited to Action Agreement/restriction, lock down, and possible discharge.**

Upon Arrival

- Read and sign the Recovery Residence Guidelines, RR Contract, and Health and Safety Forms.
- Residents will be given drug and alcohol test(s).
- Residents will receive an orientation to the house from the House Manager.
- Residents will begin a 30-day stabilization period.

During Initial 30 days of Residency

- Obtain employment, a school schedule, or volunteering hours.
- Residents may not go on any overnight stays for the first 30 days.
- Residents must enroll in Intensive Outpatient Treatment.
- Residents must obtain a signature for each self-help meeting attended.

Duration of Residency

- The Recovery Residence is a 90-day program, with a **maximum duration of four months (120 days)**.
 - This is based on regular assessments and tailored to meet individual needs.
- Residents must remain enrolled and engaged in Intensive Outpatient Treatment.
- Residents are expected to work with their Janus Case Manager to secure long-term housing.

Employment Obligations

- Residents seeking employment in an establishment that serves alcohol must receive prior approval from the House Manager or Janus Staff.
- Review employment progress with your Janus Case Manager.

Any of the Following May Lead to Immediate Dismissal

- Any type of violence (including but not limited to verbal behavior) or threats of violence.
- Theft.
- Arson.
- Destruction of Janus property.
- Breaking confidentiality.
- Violation of RR policy and procedure.
- Use of drugs or alcohol on or off the property.
- Possession and/or use of weapons.
- Refusal to provide a urine sample and/or alcohol test.

If you are administratively discharged from the Recovery Residence, you may be ineligible for readmission. The clinical team will determine appropriateness for future admission.

The Following Behaviors Are Not Allowed and May Result in Consequences (up to and including discharge):

- Loud music, television, radio, or instrument(s).
- Not informing management when you know that a Resident is using drugs or alcohol.
- Disruptive behavior.
- Arguments between residents.
- Taking another resident's food.

Resident Responsibilities**Clients are expected to:**

- Respect the anonymity of all Residents.
 - Resident information and RR business are confidential and must not be discussed outside of the RR.
 - **Violation of this policy may be grounds for immediate discharge.**
- Observe quiet time guidelines (9:00PM-7:00AM). Always maintain a respectful noise level while in the RR.
- Consistently attend an SUD Outpatient Treatment (IOT).
 - A full Release of Information (ROI) must be completed for IOT programs outside of Janus.
- Adhere to room inspections at any time by the House Manager or Janus Staff.
- Complete Sunday deep clean by noon unless previously approved.
- Maintain responsibility for assigned chores.
 - The chores will be assigned by the House manager and are rotated every two weeks.
 - Chores must be checked off by the House Manager or Janus staff.
 - Plan their schedule to allow enough time to complete chores on time.
- Be aware that food preparation and clean-up is their own responsibility.
- Consume all food and beverages at the dining table, not on the couches.
 - No food or beverages except water are allowed in the bedrooms
- Sleep in their own bed.
 - Lying down on the couch is not allowed.
 - Sleeping in the common area is not allowed.
- Keep their rooms clean at all times.
 - Each morning before leaving, Residents must make their bed and put away their clothes.
- Perform all car maintenance off the premises.
 - Car maintenance is prohibited on the RR property.
- Meet with Janus Case Manager regularly
 - Meet with Janus Case Manager **in person** for **at least one hour** per month.
 - If you'd like to meet more frequently, your Janus Case Manager will meet with you as often as their schedule allows
 - Failure to communicate with Janus Case Manager may result in disenrollment from Case Management. Enrollment in Case Management is a requirement for residing in the Recovery Residence.

Overnights

- Overnights are 24 hours
- Overnight stays are not permitted during the thirty (30) day stabilization period.
- Overnight stays require requesting a pass, turning it in to the House Manager, and receiving approval.
 - Overnight requests must be received at least 24 hours before the requested date.
- Two overnights allowed per month. They may not be accumulated unless pre-approved by House Manager.
- If any RR responsibilities (chores, etc.) will be missed while on an overnight pass, the Resident is responsible for finding someone in the house to cover these responsibilities.

16. Housing Matters

Housing Matters TH



Housing Matters Transitional Housing Required Supportive Services Participation Agreement

Participant Name: _____

Date of Enrollment: _____

Purpose and Goal

The primary objective of **Housing Matters Transitional Housing** is to help you achieve self-sufficiency, defined as the ability to meet your basic needs, including stable housing, without public or private assistance. This agreement is designed to provide the structure and accountability necessary to help you reach your unique health, wellness, and financial goals.

Mandatory Participation Requirement

In accordance with 24 CFR 578.75(h), **Housing Matters Transitional Housing** requires program participants to take part in supportive services as a condition of continued participation and occupancy. These services are tailored to your individual needs based on your initial and annual assessments.

Service Engagement

Unless you are over the age of 62 or have a qualifying disability or developmental disability, you agree to engage in at least 20 hours per week of services, activities, or employment. Qualifying activities include:

- **Housing Case Management:** Meeting with staff to address barriers to stable housing.
- **Treatment and Counseling:** Participating in behavioral healthcare, substance use disorder treatment, or support groups.
- **Employment and Education:** Engaging in job training, vocational rehabilitation, or GED programs.
- **Community Building:** Participating in work therapy, volunteering, or other activities designed to increase self-sufficiency.
- **Actual Employment:** Paid employment counts directly toward your weekly engagement hours.



Housing Matters Transitional Housing Required Supportive Services Participation Agreement

Individualized Service Plan

Your specific schedule, the services to be provided, and the designated providers are documented in your Individualized Service Plan, which is attached to this agreement and will be updated at least annually. You agree to work toward the specific target dates and benchmarks established in that plan.

Safety and VAWA Protections

Consistent with 24 CFR 5.2005(b)(1), your assistance, participation, or occupancy will not be denied or terminated solely because you are or have been a victim of domestic violence, dating violence, sexual assault, or stalking. If you have safety concerns, staff will work with you on a specialized safety plan.

Drug-Free Policy and Sobriety

Housing Matters Transitional Housing maintains a drug-free environment to promote recovery. While you are required to participate in treatment and services as outlined in your plan, you will not be evicted or exited from assistance solely for a first-time violation of a drug-related program policy or lease requirement, provided you remain engaged in your recovery plan.

Participant Acknowledgment

I understand that my participation in the supportive services identified in my Individualized Service Plan is a mandatory condition of my enrollment in this program. I agree to collaborate with staff to achieve the goals of housing stability and self-sufficiency.

Participant Signature: _____ **Date:** _____

Staff Signature

I certify that the participant's service needs have been assessed and that the required services have been individualized to support their progress toward self-sufficiency.

Staff Signature: _____ **Date:** _____

13. Monarch Services

DV Bonus TH



Transitional Housing Program Participant Service Agreement

Participant Name: _____

Program: Transitional Housing Program

Date: _____

Monarch Services' Transitional Housing Program is designed to support participants in achieving safety, stability, healing, and long-term independence. Participation in supportive services is a encouraged part of the program and helps ensure each resident receives the full benefit of available resources.

Supportive Services Participation Commitment

I understand and agree to participate in up to 20 hours per week of supportive services, which may include:

- Substance Use Disorder (SUD) Support Services (assessment, counseling, groups, relapse-prevention support, referrals)
- Educational Opportunities (school enrollment support, GED/college planning, tutoring, skills courses)
- Employment Readiness and Career Development (job search assistance, resume development, interview preparation, workforce training)
- Life Skills and Empowerment Activities (financial literacy, parenting support, wellness activities, safety planning, leadership development)
- Case Management and Housing Support (goal planning, progress reviews, community referrals, advocacy)
- Other services as identified in my individualized service plan

Participant Responsibilities

- Actively engage in assigned supportive services and scheduled appointments.
- Maintain regular communication with my case manager.
- Work collaboratively on my individualized service plan and update goals as needed.
- Notify staff in advance if I am unable to attend a scheduled activity or service.



- Participate in services in good faith and with a commitment to personal growth, healing, and independence.

Program Commitment

- Provide trauma-informed, culturally responsive supportive services.
- Collaborate with me to create a personalized service plan tailored to my goals.
- Offer ongoing support, referrals, advocacy, and resource navigation.
- Maintain confidentiality within the limits of the law and program policy.

Acknowledgment and Agreement

I have read or had this agreement read to me. I understand the expectations of the Transitional Housing Program and agree to participate in supportive services as outlined above.

Participant Signature: _____

Date: _____

Staff Signature: _____

Date: _____

County of Santa Cruz

Encampment Response Guidelines



September 2025

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PURPOSE

Unsheltered homelessness creates health and safety stressors for the entire community, but particularly for those living without shelter. The County of Santa Cruz (County) and its partners recognize that strategies to address these stressors must address the concerns of both unsheltered individuals and the larger community. The most effective long-term solution for addressing encampments is strong collaboration to help people secure stable, safe, and healthy living situations.

This document provides guidelines for engaging with individuals living in homeless encampments within the unincorporated areas of Santa Cruz County, specifically in situations involving health, safety, or environmental concerns. These guidelines are not intended to override, impede, or restrict law enforcement's ability to respond in a timely manner to calls for service as required by law.

For the purposes of this document, an encampment is defined as:

1. Two or more tents, structures, or assembly of camping equipment or personal property that appears to be used for shelter in areas not designated for that purpose; or
2. A grouping of multiple vehicles (of any type or size) not abandoned and being used by residents as their primary dwellings.

Nationwide, encampments have been removed in the past without adequate coordination between local governments, service providers, and the encampment residents themselves. At the same time, some encampments and their residents have been allowed to stay in locations resulting in health and safety issues for the encampment residents and other community members, environmental impacts, and potential violations of environmental protection regulations. Moving forward, these guidelines call for a balanced approach that upholds the needs and vulnerabilities of unsheltered residents, addresses health, safety, and environmental risks in a timely fashion, and ensures an appropriate coordinated response involving service providers, residents, and County government departments.

These guidelines outline three major processes:

- 1) Recommendations for assessing encampments for health and safety conditions and environmental impacts;
- 2) Recommendations for assessing encampment resident needs and making connections to available housing and community service resources to help them secure a stable home as quickly as possible; and
- 3) If health and safety conditions or environmental impacts warrant encampment closure, how residents (and their belongings) are assisted in the closure process.

These guidelines include the following:

- A recommended Health, Safety & Environmental Assessment Tool and proposed levels of response to address health and safety concerns, if any;
- Review of possible impacts to protected environmental resources;
- Recommended coordination of County departments and service providers, and interaction with those living in encampments; and

- Specifics related to desired roles, outreach and engagement provision, notice requirements, storage of personal belongings, and coordination of available resources.

These guidelines do not supersede local jurisdiction emergency response plans for declared and emerging emergency response operations. These guidelines do not supersede obligations of the County to respond to trespassing, calls for service, or other urgent complaints from private property owners as required under County Code or State law. These guidelines were developed to inform the County's approach rather than mandate a specific response to an individual encampment. The ability of the County to implement these guidelines depends on a range of factors including, but not limited to, the availability of resources, timing, locations, and partners involved. The guidelines are intended to be updated periodically to reflect lessons learned, policy changes, and resource availability.

BACKGROUND

The County first adopted the Housing for a Healthy Santa Cruz Strategic Framework for Addressing Homelessness in Santa Cruz County in March of 2021 with an updated version adopted in March of 2024. Among the specific goals and activities outlined in the Framework, one specifically states, "work together with city jurisdictions and other County departments to identify and implement best practices for collaborative responses to unmanaged homeless encampments and community health and safety issues that arise from people living without shelter in public places." This document brings together information gathered from multiple local jurisdictions and national technical assistance organizations to outline some collaborative practices that show promise of more positive outcomes for unhoused individuals and other community members.

According to the Santa Cruz County point-in-time count of persons experiencing homelessness conducted in January 2025, an estimated 1,122 individuals were living unsheltered on the day of the count. According to a few research studies, unsheltered individuals inhabiting encampments are more likely to be adults with multiple chronic health issues including behavioral health conditions. The California Policy Lab reported that individuals experiencing unsheltered homelessness are 25 times more likely to report they suffer from the tri-morbid combination of physical health conditions, a mental health issue, and a substance-use condition than individuals experiencing sheltered homelessness (50% compared to 2%). Given these needs coupled with a lack of appropriate shelter, affordable housing, and supportive service options appropriate to meet these needs, it can take significant time to engage and connect unsheltered individuals to accessible and appropriate resources to end their homelessness.

Until there is enough safe, decent, affordable, and accessible temporary and permanent housing for everyone, people will continue to live in unsheltered environments. The Housing for a Healthy Santa Cruz framework provides a general outline of the additional investments, and system improvements necessary to move the community closer to a goal of ensuring homelessness is rare and brief.

All sectors of the community must work together to mitigate and address health and safety hazards experienced by unsheltered individuals. Protecting the health and safety of all residents, both housed and unhoused, will create a healthier community for all. We need to work together to end our neighbors' homelessness rather than simply relocating unsheltered people from one area to another. Working toward ending rather than managing homelessness, requires medium and long-term strategies developed in coordination with multiple levels of government and community partners including,

people with lived experience of homelessness, affordable housing developers, human services and public benefits, community mental health, substance-use treatment providers, hospitals, law enforcement, public health, community foundations, faith-based organizations, and others.

Short-term, crisis-oriented outreach efforts to address immediate health, safety, and environmental issues related to encampments and the individuals living in them are sometimes necessary. However, helping individuals on a pathway to long-term housing and stability requires more consistent and proactive outreach, engagement, and relationship building efforts focused on understanding individual needs, goals, strengths, and resources. Outreach efforts in a geographic region must find an appropriate balance between responding to urgent health and safety needs and goal-directed relationship building and engagement efforts.

Individuals with criminal histories frequently experience significant barriers to securing employment and housing. Fines and citations, encampment clearings, and other municipal practices and policies that disrupt and displace people create additional barriers and setbacks for people experiencing homelessness, making it more likely that people will remain homeless even longer. Enforcement actions for criminal activity and health and safety violations should be consistently applied to housed and unhoused individuals. Decisions about when enforcement actions are necessary should weigh the impacts and consequences of not addressing immediate health and safety needs against the impacts associated with displacement and enforcement activities with unhoused individuals.

GUIDING PRINCIPLES

Guiding principles provide a framework for expectations and decision-making. The following principles can help guide approaches to meet the needs of those living in encampments and their housed neighbors.

Principle 1: Delivery of municipal services must respect the needs of all residents, with special considerations for serving the unsheltered population.

- A) *Meet people where they are.* People experiencing unsheltered homelessness may need multiple positive engagements before trust is built. Respect autonomy and a person's decision about whether to engage or to accept services and resources. People may refuse offers initially and change their mind once a trusting relationship is built. Maintain consistency and ensure all commitments are realistic and achievable. Be patient and consult with the individual to identify their needs, how to best meet them, and how to ensure the individual and community can remain safe and healthy.
- B) *Be guided by compassion and empathy in all interactions.* Take special consideration of a person's immediate needs, including making appropriate and reasonable accommodations for people living with physical and mental disabilities. Provide guidance on desired and appropriate behaviors when setting limits.
- C) *Acknowledge a person's unique context and experiences.* Offer services sensitively and appropriately when interacting with individuals, with an awareness of how race, ethnicity, culture, disability, gender identity, sexual orientation, housing status, and other personal

characteristics impact perceptions and levels of trust. Mental illness and other health conditions may limit a person's ability to understand communications and to communicate effectively.

- D) *Consult with unsheltered residents meaningfully.* Work to listen to the perspective of a person experiencing homelessness and their personal story. Partner together to identify gaps in and opportunities for improved practices. Provide avenues for meaningful feedback. Develop clear grievance procedures and make those known publicly and to individuals when requested.

Principle 2: People experiencing homelessness have the same civil rights as housed residents and should not be subject to discrimination or arbitrary treatment based on housing status.

- A) *Serve the needs of housed and unhoused residents equitably.* People experiencing homelessness are residents who deserve the same access to public services-such as sanitation, restroom and hygiene facilities, and protection by law enforcement-as their housed neighbors. Commit to protecting the civil rights and safety of all people in the community, with the recognition that people living on the streets are at greater risk of violence and victimization.
- B) *Consider the special needs and circumstances of the situation.* When approaching a person experiencing homelessness to conduct municipal services, consider the activity they are undertaking and approach with respect; limit the interruption of life-sustaining behavior such as sleeping in public. The activities of persons experiencing homelessness should not be subject to more scrutiny than that of a housed person.
- C) *Approach with a goal of engagement, not enforcement.* Interactions focused on engagement are more likely to build trust and rapport than those that lead with the goal of enforcement.
- D) *Municipal ordinances should not criminalize homelessness.* Ordinances that limit necessary, life-sustaining activities such as sitting, sleeping, or eating in public spaces unfairly target people living on the streets. In the absence of adequate alternative or private places to undertake those activities, people have a right to perform these activities in public. Evaluate ordinances for disparate impacts on persons experiencing homelessness.
- E) *Pursue alternatives to enforcement, citation, and arrest.* Citing and arresting unsheltered residents for low-level or quality of life infractions and/or life-sustaining activities can be emotionally and physically traumatizing - as well as disruptive to progress toward ending homelessness. Law enforcement officers should use citation or arrest as a last resort and instead promote referrals to services and resources, even when they may have been previously declined.
- F) *Develop policies and integrate systems in support of diversion practices.* Fines and jail time make it more challenging for an unhoused resident to achieve stability, work toward their goals, and secure employment and/or long-term housing. Consider systems improvements such as pre-arrest diversion programs and programs that dismiss citations for low-level, non-violent crimes and connect unhoused residents to services and resources in lieu of fines and/or jail.

Principle 3: All people, both housed and unhoused, deserve access to safe public spaces as well as services that promote health and safety for all.

- A) *Take an outreach-focused approach to encampments and unsheltered persons.* Mobilize outreach staff specially trained to build relationships over time, learn what people need, and connect them to those resources. Coordinate the delivery of municipal services with existing regional resources and services infrastructure with as much advance notice as possible. Existing resources and services often have limited capacity so additional notice time increases the chances of truly connecting unsheltered individuals with meaningful, long-term assistance.
- B) *Explore ways to increase access to public health resources for the public that are also accessible to people experiencing homelessness.* Ensuring that sheltered and unsheltered residents have regular access to clean water, personal hygiene, and sanitation resources, as well as containers for safe needle disposal and hazardous waste promotes public health for all.
- C) *Explore ways to help people without shelter safeguard their important possessions and receive communications.* Provide individuals with information about storage facilities. Help individuals increase their financial resources and access to banking. Assist people with getting and keeping important public documents and storing them in an electronic form or with supportive contact people. Assist individuals with obtaining phones, phone service, and email accounts. Help individuals access general mail services from the post office. Prior to clearing encampments urge individuals to secure all their important possessions before the date of the clearing. Follow storage protocols outlined in this framework. Hours, location, and identification requirements should support the needs of unsheltered residents.
- D) *Ensure public areas are accessible to all by providing clear guidance about access and egress.* Ensure that unsheltered residents are aware of the local standards through adequate notice, and that measures are in place to support their consistent application.
- E) *Follow clear and person-centered protocols when conducting sanitation activities to ensure consistency and regularity.* These guidelines represent some best practices for outreach, notice, and handling of personal property.
- F) *Facilitate opportunities for community education on homelessness.* The expectation for immediate resolutions to unsheltered homelessness drives short-term, counterproductive responses that often fail to resolve homelessness for unhoused residents and may prolong issues of concern in the general community. Publicly share information about the unique needs and stories of people experiencing homelessness. Provide information about the primary contributors to homelessness in the United States and locally. Encourage community members to engage in efforts to address the lack of accessible and affordable long-term residential and housing options in the community.

Principle 4: Local, state, and federal protections for environmental resources still apply when an encampment is in an environmentally sensitive area.

- A) *Educate people experiencing homelessness and community members about environmental concerns and standards.* Local governments are subject to federal, state, and local laws intended to protect the environment. Examples include the federal Endangered Species Act, federal and state water quality standards, and local ordinances.
- B) *Provide people experiencing homelessness and other community members with clear guidance on how to meet environmental standards.* Provide individuals with alternatives that ensure appropriate environmental stewardship while also meeting some of their needs.
- C) *Include the evaluation of environmental resources in developing responses to encampments.* Utilize an assessment tool that evaluates environmental impacts, particularly water quality and habitat near riparian areas and buffers. When making decisions about encampment responses, include staff and agencies with environmental expertise in the process.
- D) *Environmental restoration as deterrent.* Work with public agencies and private property owners to ensure compliance with environmental regulations and restoration of impacted sensitive areas and buffers.
- E) *Environmental hazards.* Ensure that all residents are protected from environmental hazards and hazardous materials. Fire hazards exist in multiple areas throughout the County and fire safety should be considered in encampment assessment and decision-making.

ROLES AND RESPONSIBILITIES

The County's response to encampments requires a coordinated effort across County departments and will involve non-County organizations, and potentially in the future, other jurisdictions. Implementing entities must ensure federal and state regulations related to encampment response are followed. County departments and community organizations involved in planning for and executing responses include:

County Departments

- County Executive Office {CEO} (team coordination, centralized reporting);
- CEO - Public Information Officer, with support from departmental Public Information Officers (public communications);
- Human Services Department - Housing for Health {H4H} {housing services, coordination with community partners};
- Sheriff's Office - Community Policing (noticing, closure enforcement, safety);
- Health Services Agency {HSA} - Behavioral Health (mental health and substance use disorder treatment services and crisis response);
- HSA- Environmental Health Water Resources (water quality, environmental protection and restoration);
- HSA- Public Health (population health assessment and recommendations);
- Community Development & Infrastructure {CDI}- Code Compliance (coordination with private property owners);
- CDI - Environmental Planning {habitat protection and environmental restoration};
- CDI - Public Works (responses in public rights-of-way);

- Mosquito and Vector Control (pest control); and
- Parks Department (responses in County parks).

Response Team

The above County departments will assign a representative to be part of a Response Team to support the CEO in planning for and organizing responses, facilitating Assessments, prioritizing responses based on risk levels, identifying resident needs and potential resources, outreach, post-encampment restoration, post-encampment reporting and evaluation, and continuous improvement of the process. When an encampment response is proposed, the Response Team will assign a member most associated with the risks identified in the Assessment to coordinate the response.

Community Partners

- Continuum of Care (Coe) Housing for Health Partnership (community input, coordination);
- Resident Outreach Team (contracted entity) (resident outreach);
- Relevant County Fire Districts (fire safety);
- Housing Authority (housing services and resources);
- Housing service providers (housing services);
- Tow Service (contracted) for vehicle encampments;
- Clean up entity (contracted); and
- California Department of Fish and Wildlife (CDFW) (environmental restoration).

A broader range of additional partners may be engaged as needs arise with specific encampments or during implementation of the guidelines, including the cities of Capitola, Santa Cruz, Scotts Valley, and Watsonville.

ENCAMPMENT RESPONSE PROTOCOL

STEP 1: NOTIFICATION AND RESPONSE TEAM COORDINATION

While reports or notifications of encampments may be received by several different entities, the process followed to organize the Response Team and assess the health, safety, and environmental conditions of an encampment should remain consistent. CEO staff will prioritize which notifications should move forward with initial action, taking into consideration factors such as the number of complaints received, the size of the encampment reported, location, etc. Once prioritized, CEO staff will route notifications to staff designated by the CEO to begin the Response Protocol. Designated staff will notify key departments about the need to gather Health, Safety & Environmental Assessment information (Step 2). Along with regular coordination meetings, CEO staff will oversee the development of a process for public reporting of encampments of concern.

Timeline goal: 1-2 business days after action prioritization is determined.

STEP 2 : HEALTH, SAFETY & ENVIRONMENTAL ASSESSMENT

County staff from different departments with different areas of expertise will be assigned to visit the site and gather information for a Health, Safety, & Environmental Assessment (Appendix A). The Assessment is adapted from guidance provided by the Benioff Homeless and Housing Initiative at the University of

California, San Francisco. The Assessment documents the location, number of residents, accessibility, safety, public health concerns, and environmental impacts associated with a particular encampment. The Assessment provides information to help with assessing the need for, and level of, appropriate response. It may not always be feasible to gather all the information included in the Assessment. The Assessment should serve as a guide rather than a required, formulaic, rigid, decision-making tool. The Assessment provides an outline of the areas that County staff will consider in developing response plans for a given encampment. County departments typically engaged in the Assessment process include staff from the following departments:

- Human Services Department - Housing for Health;
- Sheriffs Office;
- Health Services Agency- Public Health, Environmental Health, Behavioral Health, Clinics (Health Care for the Homeless);
- CDI - Environmental Planning.

Staff from CDI - Code Compliance, CDI - Public Works, Mosquito and Vector Control, and the Parks Department may accompany those conducting the Assessment, depending on location and/or encampment type. County supported ArcGIS software may be used to help collect and share Assessment information across County departments.

Resident Engagement/Outreach

Some or all the above staff will work with a designated Resident Outreach Team to help engage with residents. The Resident Outreach Team may consist of County staff and/or contracted representatives from one of the County's community organizations that specialize in assessing resident needs and facilitating access to housing, services, and other resources. The Resident Outreach Team will receive details of the encampment and its residents so they can engage with residents to provide support and connection to resources. Initial engagement will occur as soon as the Team has availability and after any immediate safety concerns are addressed. The goal of outreach is to assess resident needs, connect them with appropriate resources and services, and, in the event of a necessary resident displacement, determine the best next steps for residents and their belongings in coordination with other participating departments.

Timeline goal: 3-5 business days after Step 1.

STEP 3 : PRIORITIZATION AND RECOMMENDATIONS

Based on Assessment information gathered, the response to an encampment will be determined by the CEO and the Response Team based on the presence and severity of the following factors: population needs, locational factors, public health concerns, safety risks, and environmental impact to sensitive habitat/riparian areas. Utilizing the Assessment tool in Appendix A, encampments will be allocated a high, medium, or low risk level based on - the size, structures, and vehicles involved; the needs of those living in the encampment; the level of organization; location; public health risks; safety issues; and environmental impacts and risks.

- High Priority: High risk levels, including resident safety, imminent health concerns, and severe weather; requires immediate resolution and relocation of residents.
- Moderate Priority: Moderate risk levels; requires removal at non-emergent timeline.

- Low Priority: Low risk levels; no removal or immediate action required, continue outreach and supportive services to help residents transition to stable living situations.

Recommendations

Recommendations will be based on the priority ranking above and include reasons behind the recommended action and next steps required. Recommendations may involve mitigation strategies that require follow-up to determine if any further action is needed, as well as any other entities that would need to be engaged beyond the Resident Outreach Team (e.g., other health, housing, or community service providers).

STEP 4: RESIDENT COMMUNICATIONS AND NOTICE

Targeted notice to residents is critical, as is communication with service providers and other relevant departments for successful implementation of these guidelines. All communication, whether verbal or written, will be done with consideration for the needs of vulnerable unsheltered residents, including the following:

- Language used should be clear and population appropriate and consistent with the language used by encampment residents.
- Multiple verbal and in-person notifications are critical, especially to address any literacy and language barriers, as well as to accommodate thinking in day-to-day or hour-to-hour terms.

For encampments with more than 10 individuals, notices shall be distributed throughout the encampment and posted on each tent, structure, and/or vehicle in both English and Spanish.

For encampments with vehicles, staff will follow noticing requirements outlined in Chapter 9.57 of the Santa Cruz County Code Relating to Abandonment, Wrecked, Dismantled or Inoperative Vehicles.

High Priority Response

If the Assessment determines a high level of risk, health and safety assessors will notify the CEO staff and share the Assessment and recommendations. Communications and notice protocol to residents are as follows:

1. The Sheriff's Office will post written 3-day (72-hour) notices (Appendix B) in visible locations that communicate date/time individuals are expected to vacate the area, how belongings will be handled, and where belongings can be retrieved. Notices will be printed in English and Spanish. If residents are present when signs are posted, the posting entity will also verbally notify residents of these details. Outreach and service provider contact information should also be provided to residents.
2. Concurrently, the Resident Outreach Team will attempt to contact all residents. The Resident Outreach Team is responsible for engaging with residents and determining and tracking next steps for the individuals and their belongings. This will also help residents prepare for and understand the official notice, the reason for the urgency, and help enforce the timeline.

Moderate Priority Response

If the Assessment determines a moderate Level of risk, health and safety assessors will notify the CEO staff and share the Assessment and recommendations. Moderate risk level communication and notice protocol is as follows:

1. The Sheriff's Office will verbally notify residents of specific health, safety, and environmental concerns that need to be addressed to avoid a formal 72-hour closure notification and other citations for illegal activity.
2. Concurrently, the Resident Outreach Team will attempt to contact all residents. The Resident Outreach Team is responsible for engaging with residents and determining how to best support them with complying with health, safety, and environmental expectations.
3. The Response Team will re-evaluate the status of a moderate priority response encampment area at least every 30 days and more frequently if needed. If health, safety, and environmental issues persists, the high priority response protocol will get activated.

STEP 5: RESIDENT PLAN AND CLOSURE

If encampment closure is recommended, CEO staff will ensure careful coordination with all required departments as needed. These policies recognize that additional coordination and resources may be required for encampments of 10 or more individuals. In larger encampments, there are often multiple entities already assisting residents with meeting their daily needs. It will be critical for these entities to understand the closure process as outlined in this document, as well as be involved in closure efforts. Housing for Health will coordinate with additional health, housing, and human services providers that may be required.

Outreach Expectations

During a recommended resident relocation, the Resident Outreach Team is responsible for helping determine next steps for residents and their belongings, in coordination with other key entities involved in the relocation.

The following are expectations of the Resident Outreach Team, to the extent resources are available:

- Engage with encampment residents regarding the need to relocate and the reasons for the closure and offer services and resources as soon as possible after an encampment has been identified;
- Respond to resident questions regarding the contents of the written notice and what to expect;
- Compile a list of encampment residents and details about individuals that will be relevant to successful engagement and linkage to housing and community resources;
- Use list to track engagement efforts and resource linkages;
- Connect individuals to available resources and services based on needs and preferences (e.g., mental health, medical);
- Ensure individuals are linked with the coordinated entry system and complete a connection services request form when needed and appropriate;

- Participate in scheduled meetings with relevant partners as appropriate to track and review needs and status updates for encampment residents, as well as connect residents to housing and community resources when possible;
- Help individuals to move themselves and their belongings to an identified, safe location as soon as possible, while honoring client choice in available options. These options may include a safe parking program, shelter, transitional housing, residential treatment, sober living or recovery residence, or other safe sleeping or living situation options;
- Efforts should not direct or advise individuals to move to another government jurisdiction unless a sustainable housing option, such as residing with friends or relatives, has been confirmed. Guidance should focus on understanding the needs and resources available and helping them develop and implement individualized action plans that support movement toward long-term, stable, housing.

The recommended closure time of day is in the morning while residents are likely still present. Resident Outreach staff shall be present as much as possible before, during, and after relocation activities to help individuals connect with resources. Resident Outreach activities should remain separated from enforcement activities in terms of timing and messaging.

Waste receptacles and bins should be made available to allow residents to choose to discard items or belongings for removal from the site.

Post-Closure Notices (Appendix B) should be posted by the Sheriff's Office in a visible location where the encampment or campsite existed prior to relocation. Notices shall be posted for a minimum of 10 days after the closure and state:

1. The day closure was performed
2. Whether personal property was stored or towed
3. Where personal property will be stored or towed
4. How personal property may be claimed by its owner
5. Contact information for supportive services and housing resources

STEP 6 : STORAGE OF BELONGINGS AND SITE CLEANUP

Storage of Belongings

When residents must vacate an area, they are encouraged to take all their belongings. In respecting personal property, some items (see below) that are not removed by residents or left unattended for more than 24 hours will be stored. The County will maintain a log of dates and locations of any closures that occur. Personal property shall be kept for at least 90 days from the date of collection to allow for recovery by its owner. Property left for longer than 90 days from the date it was stored will be discarded.

Items that maybeStored if Found

- Identification documents
- Deeds or other legal documents
- Prescribed medication or essential medical supplies
- Cell phones or other small electronic devices
- Cash or credit cards

Items Subject to Immediate Disposal

- Property that is damaged, broken, or used to an extent such that it cannot be used for its intended or original purposes, as well as any other typical alternative uses
- Property that is severely soiled, stained, torn, damaged or extensively used particularly for an item of clothing
- Property that is not likely to be reclaimed, such as torn or soiled clothing, shoes, blankets, or sleeping bags, damaged or extensively used books or papers
- There is reasonable evidence the owner does not intend to return to claim the property or that the owner intended to dispose of the property as refuse or trash. For example, property that was found in or near a trash can or dumpster or the fact that the property has been left for an extended period of days
- Item is so infested with vermin that it would present a health and safety risk to store
- Bulky items such as mattresses and sheds
- Perishable items such as food
- Controlled substances and contraband

Storage and item recovery will be at no cost to the individual that owns the property. Those wishing to collect their belongings can provide a date and location from which the property was taken and must verify their identity. Individuals will be asked to describe the personal property with particularity. Personal property that is retrieved will be reflected in the log.

Site Clean-Up and Restoration

Sites shall be cleaned up and restored as necessary after all residents vacate the area. CEO staff will identify a department, contracted entity, or community organization to assist with clean-up. The Sheriff's Office will also be present if there are safety concerns. Depending on the health or safety conditions, other entities may be engaged to participate.

If damage to protected habitats has been identified either through the assessment process or during closure, CDFW, Environmental Health, COI-Environmental Planning, and/or CDI-Public Works will document the extent of damage and necessary restoration depending on the location. Riparian areas and buffers shall be restored, and signage posted to protect resources and prevent further encampments. If located on private property, CDI-Code Compliance may utilize the County's code

enforcement procedures to ensure that the private property owner restores the property, which may include a lien procedure for clean-up/restoration costs. The Parks Department will be lead on restoration in public parks, and CDI-Public Works will be lead on restoration within the public right-of-way. Restoration assistance from contracted partners, the CDFW and/or other state agencies may be necessary. Mosquito and Vector Control will assist with pest control. Public Health will advise on universal precautions and efforts to reduce the spread of any infectious diseases.

STEP 7 : DOCUMENTATION AND EVALUATION

CEO staff with support from the Response Team will gather from the participating departments documentation of the entire closure process, including the Health, Safety & Environmental Assessments and recommendation(s), notes from the Resident Outreach Team, and any notes from the clean-up entity.

Within 30 days of closure, CEO staff will schedule a meeting with all entities involved in the relocation to assess any challenges and opportunities for improvement. Improvements to the guidelines will be made if determined through this process. Part of the ongoing evaluation will be to collect and analyze data on residents and the results associated with implementing these guidelines (e.g., how many were housed, how many returned to an unsheltered setting, etc.).

APPENDIX A: HEALTH, SAFETY & ENVIRONMENTAL ASSESSMENT TOOL

Instructions: Gather as much information as possible within the timeframe available to complete this collaborative assessment. Individuals involved in the Assessment should only complete sections they feel qualified to complete and for which they have accurate and updated information to report. If an individual does not have enough information to complete part of the assessment, they should note that in the description/notes section of each response area. Responses will be combined to create a more comprehensive assessment of health, safety, and environmental issues impacting people living in encampments and the surrounding community.

Assessment Date:

Assessor Name:

Assessor Department:

Assessor Phone #:

Assessor Email:

Location

Location (Draw on map)

Location General Description/Notes:

Size of Encampment

of estimated people:

of estimated animals:

of estimated tents/dwelling unit structures:

Encampment type (Tent/physical structure, vehicle, or both):

Approximate square footage of accumulated items:

Size Description/Notes:

Questions specific to Encampments with Vehicles:

What types of vehicles are present (i.e. cars, vans, RVs, trucks, bus, combo.):

Estimated number of Vehicles and Operational Status:

Vehicle(s) Registration Status (if known):

Driver License Status of Vehicle Occupants (if known):

Insurance Coverage for Vehicle(s) (if known):

Are there signs of mechanical problems that could make the vehicles unsafe (leaks, flat tires, smoke, strange smells):

Are there other conditions that make the vehicles unsafe (signs of drug manufacturing, use of toxic or hazardous chemicals, pesticides, etc.):

Does it appear that residents are cooking inside vehicles (risk of fire or carbon monoxide)?

Is waste or greywater being stored or disposed of safely?

Are generators or car engines running for long-periods?

Are residents using vehicle batteries, propane or generators for electricity?

Are vehicles hooked up to an electrical or water source?

Vehicle Encampment Notes:

Population Needs

Age. What percentage of the residents are 50 years old or above in the encampment?

☐ 75% or more ☐ 50-74% ☐ 25-49% ☐ Less than 25%

What percentage of the residents are under 21 years old in the encampment?

☐ 75% or more ☐ 50-74% ☐ 25-49% ☐ Less than 25%

Are there minors (under 18 years old) residing in the encampment? If so, estimate number of children and age/s:

Severe Medical Needs. What percentage of residents have severe medical needs that likely require attention before entering housing, e.g., end stage liver disease, unmanaged diabetes, unmanaged kidney disease or need for dialysis, severe lung disease, cancer, etc., in the encampment?

☐ 75% or more ☐ 50-74% ☐ 25-49% ☐ Less than 25%

Severe Behavioral Health Needs. What percentage of residents have severe mental health or substance use disorder needs that require attention (e.g. experiencing psychosis, expressing thoughts of self-harm or suicidal ideation, overdose risks, etc.)?

☐ 75% or more ☐ 50-74% ☐ 25-49% ☐ Less than 25%

Activities of Daily Living. What percentage of residents struggle with 2 or more activities of daily living (bathing, dressing, toileting, transferring, and eating)?

☐ 75% or more ☐ 50-74% ☐ 25-49% ☐ Less than 25%

Number of residents with service animals?

Population Description/Notes:

Encampment Organization

Group Cohesion (Scale of 1-5 with 5 being most cohesive and 1 being the least). *Degree to which the encampment operates as a group or as a collection of individuals. High degree of cohesion indicates the entire encampment understands itself as a group and will seek to remain together or near each other versus individually}*

Self-Management (Scale of 1-5 with 5 being most capable and 1 being the least). *High degree of self-management would include formal or semi-formal leadership structures, adopted camp rules or requirements, organization of chores/activities, collective negotiations for camp members.*

Provider Engagement (Scale of 1-5 with 5 being most engaged and 1 being the least). *Degree to which outreach or service providers routinely engage with residents of the encampment. Low engagement {1} = contact once per month or less. High engagement= at least weekly, regular contact.*

Organization Description/Notes:

Location Factors

Proximity to Sensitive Use. Is the encampment near the **main** entrance of a private property OR within 0.2 miles of schools, daycares, nursing homes, playgrounds, ballfields, public gardens, tourist attractions, or hospitals? (Yes/No)

Accessibility Issues. Is the encampment impairing ADA access by blocking ramps, sidewalks, or ADA specific transit infrastructure, e.g., elevators to or from transit stations? (Yes/No)

Challenge to Frequent Public Use. Is the encampment in a location often used by the public, e.g., frequently used park, tourist attraction, highly used walkway or path? (Yes/No)

Construction Zone. Is the encampment within 0.1 mile of a property slated for development of buildings, roadways, utilities, or other infrastructure or near a staging area for a construction project (Yes/No)?

Danger to Encampment Residents. Is the encampment in a location that presents an extremely high risk of serious injury and safety risk for the residents, e.g., on or near freeways, floodplains during rainy seasons, path of an active wildfire, etc. (Yes/No)? If yes, activate hazard protocol.

Public Service Access. Is the encampment in the way of entry or access for public agencies - blocking fire, law enforcement, utility service, etc.? (Yes/No)

Location Description/Notes:

Public Health

Hygiene. Is the location away from any hand hygiene or functional/sufficient sinks?

Sanitation. Is the encampment away from toilets and wastewater disposal? Does the location pose a barrier to proper solid waste storage and disposal?

Infestation. Does the site have large numbers of insects or animals that may cause property damage, create a nuisance, and/or increase the risk or spread of disease, e.g., body lice, rats, mice, bed bugs, fleas, rodents, etc. (Yes/No)? If yes, contact Public Health and/or vector control.

Infectious Disease. Does the encampment contain individuals known to have the presence of diseases that are easily transmittable and create a risk to other encampment residents or the surrounding neighborhood, e.g., shigella, tuberculosis, Hepatitis A, COVID-19, and others. (Yes/No)? If yes, activate public health response.

Public Health Description/Notes:

Safety Risks

Sexual Violence. Have there been reports of forced, unwanted, and/or violent sexual activity in the camp? (Yes/No)

Physical Violence. Have there been reports or observed incidents of physical violence in the camp? (Yes/No)

Weapons. Have there been reports of firearms, knives, bows, swords, or other weapons? (Yes/No)

Uncontrolled Fires. Have there been reports or observed incidents of uncontrolled fires in or near the camp? Unsafe use of camp stoves and barbecues in high fire risk areas? (Yes/No)

Theft. Have there been reports or observed incidents of theft at the camp? (Yes/No)

Conflict. Have there been reports or observed incidents of interpersonal conflict among residents in the camp? (Yes/No)

Hazardous Materials. Are hazardous materials, such as chemicals, paints, oils, or other materials present?(Yes/No)

Safety Description/Notes:

Environmental Resource Impacts

Environmental Resource Areas. Is the encampment within a riparian area, wetland area, protected buffer, or flood area? (Yes/No)

Water Quality Impacts. Are there noted water quality impacts, such as sediment, pathogens, graywater, fecal material, trash, runoff? (Yes/No)

Wastewater Disposal. Is there adequate and effective wastewater disposal for the encampment? (Yes/No)

Vegetation/Habitat Impacts. Is vegetation or protected habitat areas at the site impacted? (Yes/No)

Environmental Resource Description/Notes:

SANTA CRUZ COUNTY
SHERIFF'S OFFICE

<72-HOUR> NOTICE TO VACATE PROPERTY

THIS IS AN OFFICAL NOTICE

PERSONS REMAINING ON THIS PROPERTY AFTER THE
DATE LISTED IN THIS <72-HOUR> NOTICE MAY BE
SUBJECT TO CITATION, ARREST, AND/OR PROSECUTION
FOR TRESPASS AND/OR UNLAWFUL LODGING
PURSUANT TO PENAL CODE SECTIONS 602 AND 647(e)

Date Posted: _ _ _ _ _

Deputy: _____

**PROPERTY LEFT IN THIS POSTED AREA AFTER 0500AM FOLLOWING
THE DATE OF THIS <72-HOUR> NOTICE IS SUBJECT TO
REMOVAL/DISPOSAL**

A. Personal items that objectively appear to be temporarily unattended, and not abandoned, will be stored for a period of 90 days. These items can be claimed by scheduling an appointment with the <County Storage Entity>. Stored items that remain unclaimed after 90 days (by [_date_]) will be considered abandoned and will be disposed of.

B. The following classes of items will be subject to immediate disposal: (i) trash; (ii) items that are objectively determined to be intentionally abandoned by their owners; and (iii) items that would present a health hazard to store.

If you have any questions or need assistance, please contact

The storage facility will be open by appointment only Monday through Friday. If you intend on picking up your stored items, please call the storage facility (phone number _____) ahead of time so the storage facility can facilitate pickup.

Date Posted: _____

Deputy: _____

SANTA CRUZ COUNTY

THIS IS AN OFFICAL NOTICE

On [], the <County Storage Entity> removed and stored personal items from this property that objectively appeared to be temporarily unattended and not abandoned. The foregoing items are being stored and can be claimed by Contacting the <County Storage Entity> and will be stored there for a period of 90 days. Stored items that remain unclaimed after 90 days (by [_dote_]) will be considered abandoned and will be disposed of.

The following classes of items were subject to immediate disposal: (i) trash; (ii) items that were objectively determined to be intentionally abandoned by their owners; and (iii) items that presented a health hazard to store.

If you have any questions or need assistance, please contact

The storage facility will be open by appointment only, Monday through Friday. If you intend on picking up your stored items, please call the storage facility (phone number _____) ahead of time so the storage facility can facilitate pickup.

Date Posted: _ _ _ _ _

Deputy: _____



**Santa Cruz County 2026 CoC Local Competition Scoring Tool for New and Renewal Projects, Including:
PSH, RRH, TH, Joint, HMIS, SSO Standalone, and SSO CES**

Reviewer: _____ Check that not conflicted per CoC policy ____

Agency/Project: _____

See end of document for summary of maximum points available

No.	Scoring Criteria	Points Possible	Reviewer Points
1	Housing/Project Type 15 pts for: - PSH renewals - CES renewal (CoC only) 7 ½ pts for: - DV TH new (created through <i>transition</i> of DV RRH renewals, or <i>DV bonus</i>) - CoC TH new (created through <i>transition</i> of CoC RRH or joint RRH-TH renewals, <i>reallocation</i> of other CoC funds, or <i>CoC bonus</i>) - YHDP TH new (created through <i>replacement</i> of YHDP RRH, joint TH-RRH, or Shared Housing, or <i>reallocation</i> of other YHDP funds) - YHDP TH and SSO renewals 0 pts for: – All other projects.	15 PTS POSSIBLE 15 pts: - PSH and CoC CES renewals 7 ½ pts: - New TH projects and YHDP SSO renewals 0 pts: Other	
2	Priority Population Served –Chronically Homeless, DV, or youth population served by project The project meets the needs of a high priority population as described below: - Experiencing chronic homelessness with disability - Survivors or domestic violence - Youth - Seniors	5 PTS POSSIBLE CH w/disability, DV, Youth, Senior pops: 5 pts – 100% 4 pts –70-99% 3 pts – 50-69% 2 pts –25-49% 1 pt – 1-24% 0 pts – 0%. (CES & HMIS 5 pts)	
3	PERFORMANCE MEASURES The project has met or exceeded measurable performance expectations in the below areas based on HMIS APR data for renewals and other projects that use HMIS (or other data systems where the project does not yet participate in HMIS)	26 PTS POSSIBLE (CES & HMIS 20 pts), including: 25 Pts HUD System Performance 1 Pt Other Performance	
	<i>HUD System Performance Measure (3A-3D) 25 pts possible:</i>		
3A	Housing Stability and Exits (residential and SSO projects): - For PSH renewals, did you meet the standard in helping leavers and stayers combined retain PH for 7 months or more? – at least 90% - For RRH renewals, did you meet the standard in helping leavers find and move into housing? – at least 80%	10 Pts Available PSH: 9 pts –90% + 5 pts –80-89% 0 pts - <80% TH: 9 pts –80% +	

No.	Scoring Criteria	Points Possible	Reviewer Points
	- For new TH, have you previously met in prior RRH, TH, or other comparable project(s) the standard in helping leavers find and move into PH? – at least 85% - For SSO renewals, did you meet the standard in helping leavers fund and move into PH? For new SSO, have you previously met in prior comparable project(s) the standard in helping leavers find and move into PH? – at least 40% - For all renewals, did you meet the standard in helping leavers exit to unsubsidized housing? – at least 20%. For all new projects, have you previously met in prior RRH, TH, SSO, or other comparable project(s) the standard in helping leavers exit to unsubsidized housing? – at least 20% - For all renewals, did you meet the standard in avoiding leavers with unknown destinations? – no more than 10%. For all new projects, have you previously met in prior RRH, TH, SSO, or other comparable project(s) the standard in avoiding leavers with unknown destinations? – no more than 10%.	5 pts–70-79% 0 pts - <70% RRH: 9 pts –85% + 5 pts–75-84% 0 pts - <75% SSO: 9 pts –40% + 5 pts–30-39% 0 pts - <30% All projects: ½ pt – at least 20% leavers to unsubsidized housing ½ pt – no more than 10% leavers to unknown dest. 0 pts – did not meet either standard	
3B	Employment Income (residential and SSO projects): For all PSH, TH, RRH, and SSO projects, did you meet the standard in helping ADULT leavers and stayers combined gain or increase income from employment ONLY? – at least 25%	8 Pts Available Employment 8 pts – 25% + 5 pts – 12-24% 3 pts – 4-11% 1 pt – 2-4% 0 pts – 0-1%	
3C	Returns to Homelessness (residential and SSO projects): For all projects except HMIS, did you meet the standard in ensuring that leavers did not exit to non-permanent destinations (e.g., shelters, TH, hotels, motels, and the streets)? – no more than 20%	5 Pts Available 5 pts –20% max 3 pt – 21-30% 0 pts - >30%	
3D	Length of Stay/Participation (residential and SSO projects): - For PSH only, did you meet the standard by <u>increasing</u> the annual average LOS in PH for leavers and stayers combined? – higher LOS average than previous APR year - For TH, RRH, & SSO, did you meet the standard by <u>decreasing</u> the annual average LOS/participation in TH, RRH, or SSO for leavers? – lower LOS/ participation ave. than previous year	2 Pt Available PSH: 2 pt – + LOS 0 pts – - LOS TH, RRH, & SSO: 2 pt – - LOS 0 pts – + LOS	
	<i>Non-System Performance Measure (3E-3F) 1 pt possible</i>		
3E	Program Occupancy/Enrollment (residential and SSO projects): For all projects, did you meet the standard in ensuring that average program occupancy / enrollment met CoC standard. – at least 90% for the year	1 Pt Available 1 pt – 90% + ½ pt – 80-89% 0 pts - <80%	
3F	Victim Service Providers only - Safety: Propose at least one measure of the degree of participant safety that you will commit to using in the future.	Not Scored This Year	
4	PROGRAM EFFECTIVENESS	19 PTS POSSIBLE (CES & HMIS 14 pts)	
4A	Coordinated Entry Participation: The minimum percentage of new clients since 1/1/25 who came from CES referral, or who were enrolled in CES for SSO project serving people experiencing homelessness at the time of enrollment.	2 Pts Available 2 pts–95% + 1 pts –85- 94% 0 pts – - 85%.	
4B	Required Supportive Services Participation (all projects):	10 Pts Available Yes – 10 pts	

No.	Scoring Criteria	Points Possible	Reviewer Points
	- The project will require supportive services participation as evidenced by a participant services agreement (e.g., contract, occupancy agreement, lease, or equivalent). Please attach. - In the case of TH focused 100% on SUD Treatment, the project will require SUD treatment as evidenced by a participant SUD treatment participation agreement (please attach).	No 0 pts	
4C	New TH only: The project commits to making available 20 hours of customized services per program participant, except for participants over 62 or with a physical disability/impairment, or reduced proportionally for employment, school, or volunteering.	4 Pts Available - Yes – 4 pts - No – 0 pts (non-TH 4 pts)	
4D	The project will provide SUD services onsite.	3 Pts Available - Yes – 3 pts - No – 0 pts	
5	FINANCIAL AND COST EFFECTIVENESS	15 PTS POSSIBLE	
5A	Prioritizing Supportive Service Funding: The percentage of CoC funding proposed to be used on Supportive Services funding.	5 Pts Available 5 pts – 50 - 100% 3 pt – 30 - 49% 0 pts – - 30%. (HMIS 4 pts)	
5B	Leveraging Supportive Services: Does the project leverage (leverage, match, and service partnerships combined) total at least 50% of the HUD funds requested	5 Pts Available - Yes – 5 pts - No – 0 pts	
5C	Drawdown Completeness: - The percentage of overall HUD grant drawn down in the most recent completed program year recorded in the most recent APR. - Applicants with no previous HUD grants may use comparable evidence from another similar government funding source (please attach evidence from the funding source that includes the amount budgeted and the amount spent)	5 Pts Available 5 pts – 100% 3 pts – 95- 99% 1 pt – 86 - 94% 0 pts – - 86%.	
6	AGENCY EXPERIENCE/CAPACITY	10 PTS POSSIBLE	
6A	Agency Yrs of Experience: Number of yrs of agency experience in implementing the proposed program OR similar program type (PSH, RRH, TH, SSO, Outreach, CES, HMIS, etc.)	5 Pts Available 5 pts – 8+ yrs 4 pts – 5 to 7 yrs 3 pts – 4 to 6 yrs 2 pts – 2 to 3 yrs 1 pts – 1 to 2 yrs 0 pts – - 1 yr	
6B	Capacity Issues: - Points will be deducted if in the past year (7/1/25-present): (1) the agency has unresolved <i>H4HP</i> monitoring findings in CoC programs, (2) the agency has unresolved <i>HUD</i> monitoring findings in CoC programs, (3) the agency has significant findings <i>in most recent audit</i>, (4) the agency has been late in submitting a CoC APR, or (5) the agency has one or more unresolved participant or public complaints. - Applicants with no previous CoC grants may use comparable evidence from another similar government funding source (please attach evidence from the funding source regarding any monitoring findings, and latest funder report showing due date and submission date)	-5 Pts Deduction Possible 1 pts deduction – unresolved H4HP findings 1 pts deduction – unresolved HUD findings 1 pts deduction – significant audit findings 1 pts deduction – late APR 1 pts deduction – unresolved complaint	
6C	Narrative Responses - Experience in Key Areas:	5 Pts Available 1 pt – Priority population	

No.	Scoring Criteria	Points Possible	Reviewer Points
	Please describe your agency's prior experience and success in the following key areas: • Priority Population Served - Serving clients who are experiencing chronic homelessness, are survivors of domestic violence, are youth, or are seniors • Program Design – Operating a similar type of program • CES Participation – Accepting and successfully housing program referrals through CES • Treatment and Recovery – Providing or assisting participants to access treatment and recovery services • Employment & Self-sufficiency – Providing services or referrals for client to become and remain employed and attain self-sufficiency through employment and childcare.	• 1 pt – Program design • 1 pt – CES participation • 1 pt – Treatment • 1 pt – Employment & self-sufficiency	
7	Mainstream Resources The number of strategies the program has identified to help clients access federal mainstream benefits, including Medicaid; State Children's Health Insurance Program; TANF (CalWORKS); Food Stamps; SSI; Workforce Investment Act; <i>Employment Income</i>; Welfare to Work Grant Programs and Veterans Health Care. Narrative Description: Description of how project completes each of the above strategies must support each strategy checked.	7 PTS POSSIBLE • 7 pts – 7 - 8 • 5 pts – 5 - 6 • 3 pt – 3 - 4 • 2 pts – 2 • 1 pt – 1 • 0 pts – 0	
8	Community Collaboration and Participation (3 pts possible) To what extent does the applicant agency support the Housing for Health Partnership (H4HP) by: (1) participating in meetings of the H4HP general membership, (2) participating in HMIS by entering client data into HMIS for 100% of its programs that are listed in the 2025 Housing Inventory Chart (HIC); and (3) participating in CES with no housing referral denials except if there is an appropriate reason for denial under the CES P&Ps OR for SSO projects enrolling participants experiencing homelessness in CES? <i>Sub-scores will be determined by H4HP staff based upon appropriate H4HP and documentation for the period from July 1, 2025, to the present time.</i>	3 PTS POSSIBLE H4HP meetings: • 1 pt: 75-100% • 0 pts: 0-74% HMIS participation: • 1 pt: 100% • 0 pts: - 100% CES participation: • 1 pt: Receives referrals, no inappropriate denials • 0 pts: No referrals OR has inappropriate denials	
TOTAL PTS (100 possible)			

Summary of Maximum Points Available

Category	Maximum Points Available	Percentage of Maximum Points
Maximum points for each project	100	100%
Maximum points for objective criteria for rating and ranking (all Qs except 6C above use objective criteria)	95	95%
Maximum points for system performance measures for rating and ranking (Qs 3A-3D - 25 pts.)	25	25%
Maximum points for based on returns to homelessness (Q 3C), employment income performance (Q 3B) & on supportive services participation requirements (Q 4B) for PSH/RRH/TH as follows:	23	23%
-Returns to homelessness	5	5%
-Employment income performance	8	8%
-Supportive services participation requirements	10	10%

2026 Santa Cruz County CoC Local Competition Results

No.	Applicant Name	Project Name	New or Renewal	Project Component	Score	Status	Rank	Funding Requested Amount	Reallocated Funds
1	Housing Matters	801 River Street PSH	CoC Renewal	PH	84	Accepted	1	\$302,619	\$0
2	Housing Matters	180 Together PSH	CoC Renewal	PH	80	Accepted	2	\$402,561	\$0
3	Housing Authority of Santa Cruz County	Shelter+Care Consolidate PSH	CoC Renewal	PH	78	Accepted	3	\$1,910,598	\$0
4	Housing Matters	Harvey West Studios	CoC Renewal	PH	74	Accepted	4	\$351,891	\$0
5	Santa Cruz County HSA	MATCH PSH	CoC Renewal	PH	71.5	Accepted	5	\$1,240,542	\$0
6	Santa Cruz County HSD	Coordinated Entry Expansion	CoC Renewal	SSO	83	Accepted	6	\$259,896	\$0
7	Santa Cruz County HSD	County of Santa Cruz Homeless Management Information System	CoC Renewal	HMIS	61	Accepted Reduced Reallocated	7	\$50,000	-\$26,314
8	Monarch Services	Monarch Transitional Housing Program	DV Realloc New	TH	86	Accepted	8 Straddling	\$142,583	\$142,583
9	Bill Wilson Center	Casa Sankofa	YHDP Realloc New	TH	84.5	Accepted	9	\$764,447	\$764,447
10	Families In Transition	First Step-Scattered Site TH for Families with Children	CoC Transition New	TH	81	Accepted	10	\$671,530	\$671,530
11	Families In Transition of Santa Cruz County, Inc.	Y.A.A.S. (Young Adults Achieving Success) TH	YHDP Replacement New	TH	79	Accepted	11	\$328,896	\$328,896
12	Walnut Avenue Family & Women's Center	Housing & Employment Program TH	CoC Transition New	TH	71.5	Accepted	12	\$749,441	\$749,441
13	Encompass Community Services	Drop-In Center	YHDP Renewal	SSO	82	Accepted	13	\$296,167	\$0
14	Community Action Board of Santa Cruz County, Inc.	YHDP - Youth Homeless Response Team (YHRT)	YHDP Renewal	SSO	77.5	Accepted	14	\$112,361	\$0
15	Janus of Santa Cruz	Recovery to Support Permanent Housing	CoC Bonus & Realloc New	TH	62	Accepted	15	\$750,942	\$26,314
16	Housing Matters	Housing Matters Transitional Housing	CoC Bonus New	TH	60	Accepted	16	\$416,849	\$0
17	Monarch Services	Monarch DV Bonus TH Expansion Project	DV Bonus New	TH	86	Accepted	17	\$210,762	\$0
18	County of Santa Cruz	CoC Planning Grant	CoC Planning New	Planning	Not scored	Accepted	Not ranked	\$380,492	\$0
19	Monarch Services	Monarch DV Bonus RRH	DV Renewal	PH	Not scored	Fully Reallocated	Not ranked	\$0	-\$142,583
20	Bill Wilson Center	YHDP_Santa_Cruz_Renewal_2024 RRH	YHDP Renewal	PH	Not scored	Fully Reallocated	Not ranked	\$0	-\$527,125

[illegible]

Public Reporting Burden Statement: This collection of information is estimated to average 0.20 hours per response, including the time for reviewing instructions, searching existing data sources, gathering, and maintaining the data needed, and completing and reviewing the collection of the requested information. Comments regarding the accuracy of this burden estimate and any suggestions for reducing this burden can be sent to: U.S. Department of Housing and Urban Development, Office of the Chief Data Officer, R, 451 7th St SW, Room 8210, Washington, DC 20410-5000. Do not send completed forms to this address. This Agency may not conduct or sponsor, and a person is not required to respond to, a collection of information unless the collection displays a valid OMB control number. This Agency is authorized to collect this information under Section 102 of the Department of Housing and Urban Development Reform Act of 1989. The information you provide will enable this Agency to carry out its responsibilities under this Act and ensure greater accountability and integrity in the provision of certain types of assistance administered by this Agency. The information collected via this form is required to obtain the benefit sought in the grant program. Failure to provide any required information may delay the processing of your application and may result in sanctions and penalties including the administrative and civil money penalties specified under 24 CFR §4.38. This information will not be held confidential and may be made available to the public in accordance with the Freedom of Information Act (5 U.S.C. §552). The information collected via this form is not retrieved by a personal identifier, therefore it does not meet the threshold for a Privacy Act Statement.

Type or clearly print the following information.

****Warning:** *Anyone who knowingly submits a false claim or makes a false statement is subject to criminal and/or civil penalties, including confinement for up to 5 years, fines, and civil and administrative penalties (18 U.S.C §§ 287, 1001, 1010, 1012, 1014; 31 U.S.C. § 3729, 3802; 24 CFR § 28.10(b)(1)(iii)).*

Applicant Organization:

Assistance Listing number and Federal Program name to which the Applicant is applying:

Include the funding opportunity number and name exactly as it appears in the applicable funding opportunity announcement (example: 14.896, Family Self-Sufficiency Program).

Opportunity Zone Census Tract(s), which the proposed activities/projects will benefit:

Include below the full 11-digit census tract number (example: 06067001101). Designated Opportunity Zone Census Tracts can be found at: <https://opportunityzones.hud.gov/resources>. Select the "CDFI Fund Opportunity Zones Resources" link and then select the "List of designated Qualified Opportunity Zones."

The application meets which of the following criteria (please select one):

- ☐ The proposed activities/projects will occur solely within the Opportunity Zone Census Tract(s) listed above.
- ☐ The proposed activities/projects will occur within the Opportunity Zone Census Tract(s) listed above and other communities.
- ☐ The proposed activities/projects will occur outside Opportunity Zone Census Tracts, but substantial and direct benefits will accrue within the Opportunity Zone Census Tracts listed above.

Note: Projects which substantially and directly benefit Opportunity Zone Census Tracts, but which do not consist of activities delivered within Opportunity Zone Census Tracts may be considered for competitive preference. If applicable, the respective Federal Agency will clearly define "substantially and directly" in the relevant funding announcement.

Estimated Funding Allocations

Estimate a percentage of the total dollar amount of federal funding awarded that would result in a direct benefit within the Opportunity Zone Census Tracts listed above:

- ☐ 76% - 100%
- ☐ 51% - 75%
- ☐ 26% - 50%
- ☐ 11% - 25%
- ☐ 1% - 10%

Provide a narrative explaining and/or reference the section in the application that explains how the project will support public and private investment in urban and economically distressed areas, specifically qualified Opportunity Zones (300-word limit):

Example: "The Main Street project described in this application will stimulate economic opportunity and mobility, encourage entrepreneurship, expand quality educational opportunities, and promote workforce development for those families residing within the XYZ Opportunity Zone."

Check the following boxes that accurately reflect the nature or purpose of the proposed project:

- | | |
|--|---|
| ☐ Access to Capital | ☐ Workforce Development |
| ☐ Asset Building | ☐ Low Income Housing Tax Credit (LIHTC) or other rent restricted housing |
| ☐ Business Assistance | ☐ Market rate housing |
| ☐ Community Capacity Building | ☐ Industrial development |
| ☐ Economic Development | ☐ Commercial or retail development |
| ☐ Education | ☐ Other business development |
| ☐ Healthy Food Access | ☐ "Above ground" infrastructure — streets, sidewalks, lighting |
| ☐ Health | ☐ "Below ground" infrastructure — water, sewer, gas, electric |
| ☐ Housing | ☐ Schools or other educational facilities |
| ☐ Human Services and Family Support | ☐ Hospitals or other health care facilities |
| ☐ Community Infrastructure | |
| ☐ Public Safety | |

Certification of Authorized Representative for the Applicant:

****Under penalty of perjury, I certify on behalf of the Applicant that**

- (1) all information provided on this form is true, complete, and accurate, and
(2) the Applicant will notify the Agency immediately upon learning of any change in the information provided on this form, and
(3) I am authorized to speak for the Applicant regarding all information provided on this form.

Prefix: _____ First Name: _____ Middle Initial: _____ Last Name: _____ Suffix: _____

Title: _____ Organization: _____

Signature: Robert Ratner Date: _____



Policy on Advancing Recovery by Prohibiting Illicit Drug Enablement

At its June 4, 2026 meeting, the Housing for Health Partnership Policy Board (Policy Board or CoC) approved the preparation of this policy regarding Advancing Recovery by Prohibiting Illicit Drug Enablement.

Consistent FY 2026 Continuum of Care Competition and Youth Homelessness Demonstration Program Grants NOFO (NOFO), the CoC hereby prohibits CoC-funded housing projects from:

- Operating drug injection sites or "safe consumption sites" in violation of 21 U.S.C. 856(a)(1);
- Knowingly distributing drug paraphernalia on or off property under their control in violation of 21 U.S.C. 856(a)(2), or
- Knowingly permitting the use or distribution of illicit drugs on property under their control, or conducting any of these activities under "harm reduction" in violation of 21 U.S.C. 863.

The NOFO also required each CoC housing project submitted to the Watsonville/Santa Cruz City & County CoC affirmatively certify to the above as a threshold requirement. The CoC hereby affirms that each CoC housing project submitted did affirmatively certify to the above.

Following are the remedies the CoC will pursue if any CoC-funded housing project is determined to be in violation of the above policy:

- A CoC-funded housing project found to be in violation will be offered technical assistance to resolve the issue; and
- a CoC-funded housing project that does not take part in technical assistance or does not work to resolve the issues may face transfer or reallocation in the next NOFO cycle, or violations may be reported to HUD.

In addition, consistent with the NOFO the CoC hereby:

- Encourages and does not prohibit the provision of substance use disorder treatment and recovery housing within or outside of the CoC; and
- Does not restrict or prohibit CoC-funded housing projects that require program participants to be sober or to participate in treatment as a condition of assistance.