89Housing for Health Partnership Policy Board
Regular Meeting Agenda
Virtual/Teleconference

Zoom Link: https://zoom.us/j/99934002501

TELEPHONE: +1 669 900 6833 WEBINAR ID: 999 3400 2501

April 20, 2022; 4-7 pm

INTRODUCTORY ITEMS (4 – 4:30 PM)

1. Call to Order/Roll Call
2. Additions and Deletions to the Agenda
3. Approval of Minutes – Not Applicable
4. Announcements/Information Sharing
5. Public Comment

REGULAR ITEMS PART 1 (4:30 – 5:15 PM)

6. City of Santa Cruz staff requests Continuum of Care (CoC) Policy Board Member input on proposed uses of a $1,434,354 allocation of federal Housing and Urban Development (HUD) HOME American Rescue Plan Program (HOME-ARP) funds to serve households at-risk of or experiencing homelessness. Includes review of HOME-ARP survey results and next steps.

    a HOME-ARP Overview

7. Housing for Health Division staff request initial Policy Board feedback on Housing Homeless, Assistance and Prevention (HHAP)-3 required Local Homelessness Action Plan and Application and the selection of a Policy Board working group to support staff in preparing final materials for Board review on June 8, 2022 Board meeting and submission for funding by June 30, 2022. HHAP-3 funding available includes Watsonville/Santa Cruz City & County CoC allocation of $3,243,331 and Santa Cruz County allocation of $3,027,108 with minimum of 10% for services for unaccompanied youth between 12 and 24 years old.

    a HHAP Round 1 to 4 Comparison
    b HHAP Round 3 Action Plan and Application Template
    c HHAP Round 3 – Baseline Data for Outcome Goals Companion Guide
    d HHAP Round 3 – CA-508 Baseline Data for Outcome Goals

MEETING BREAK (15 MINUTES)

SANTA CRUZ COUNTY
Housing for Health
PARTNERSHIP

REGULAR ITEMS PART 2 (5:30 – 7 PM)

8. Housing for Health Division staff request initial Policy Board feedback on proposed changes to the Continuum of Care (CoC) Homeless Management Information System (HMIS) policies, procedures, and associated forms. Input requested on feedback gathering process, DRAFT documents, and Board needs for formally considering and voting on proposed changes on June 8, 2022, Board meeting.

    a County of Santa Cruz HMIS Proposed Changes March 2022
    b Housing for Health Partnership DRAFT HMIS Policies and Procedures March 2022

9. Housing for Health Division staff request initial Policy Board feedback on proposed changes to the Continuum of Care (CoC) Coordinated Entry System policies, procedures, and associated forms.

    a Coordinated Entry Core Elements
    b Allocating Homeless Services After the Withdrawal of the VI-SPDAT-AJPH Opinion
    c Santa Cruz County Housing for Health Coordinated Entry Redesign Summary
    d DRAFT Housing Needs Assessment and Housing Action Plan

MEETING ADJOURNED (7 PM)

Agenda Item #6a: HOME-ARP Overview

Eligible Grantees

The 651 State and local Participating Jurisdictions (PJs) that qualified for an annual HOME Investment Partnerships Program (HOME) allocation for FY 2021 are eligible to receive HOME American Rescue Plan (HOME-ARP) grants. HOME-ARP funds will be allocated using the HOME Program formula. The **HOME-ARP allocations** were **announced on April 8, 2021**.

Eligible Populations

HOME-ARP funds must be used to primarily benefit individuals or families from the following qualifying populations:

- Homeless, as defined in section 103(a) of the McKinney-Vento Homeless Assistance Act (**42 U.S.C. 11302(a)**);
- At-risk of homelessness, as defined in section 401(1) of the McKinney-Vento Homeless Assistance Act (**42 U.S.C. 11360(1)**);
- Fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking, as defined by the Secretary;
- In other populations where providing supportive services or assistance under section 212(a) of the Act (**42 U.S.C. 12742(a)**) would prevent the family's homelessness or would serve those with the greatest risk of housing instability;
- Veterans and families that include a veteran family member that meet one of the preceding criteria.

Eligible Activities

HOME-ARP funds can be used for four eligible activities:

- Production or Preservation of Affordable Housing
- Tenant-Based Rental Assistance (TBRA)
- Supportive Services, including services defined at **24 CFR 578.53(e)**, Homeless Prevention Services, and Housing Counseling
- Purchase and Development of Non-Congregate Shelter. These structures can remain in use as non-congregate shelter or can be converted to: 1) emergency shelter under the **Emergency Solutions Grants (ESG) Program**; 2) permanent housing under the **Continuum of Care (CoC) Program**; or 3) affordable housing under the **HOME Program**.

Administrative and Operating Funding

HOME-ARP provides up to 15 percent of the allocation for administrative and planning costs of the PJ and subrecipients administering all or a portion of the grant. In addition, HOME-ARP can provide up to 5 percent of its allocation for operating costs of Community Housing Development Organizations (CHDOs), other non-profit organizations, and homeless providers. Additional HOME-ARP funding is available to these organizations for capacity building activities.

Homeless Housing, Assistance, and Prevention (HHAP) Grant Program

Side-by-Side Comparison of HHAP Rounds 1–4

Document Published: 12/17/2021

I. Authority, Eligible Applicants, Allocations, and Disbursements

	HHAP-1 (Round 1)	HHAP-2 (Round 2)	HHAP-3 (Round 3)	HHAP-4 (Round 4)
Authority	Chapter 159, Statutes of 2019, (AB 101)	Chapter 15, Statutes of 2020, (AB 83)	Chapter 111, Statutes of 2021, (AB 140)	Chapter 111, Statutes of 2021, (AB 140)
Chaptered	Cal. Health & Safety Code §§ 50216–50223	Cal. Health & Safety Code §§ 50216–50223	Cal. Health & Safety Code §§ 50216–50223	Cal. Health & Safety Code §§ 50216–50223
Appropriation	$650 M in **FY 19–20**	$300 M in **FY 20–21**	$1 B in **FY 21–22**	$1 B in **FY 22–23**
Eligible Applicants	13 Largest Cities (300,000+ population) 58 Counties 44 CoC	13 Largest Cities (300,000+ population) 58 Counties 44 CoC	13 Largest Cities (300,000+ population) 58 Counties 44 CoC Federally recognized Tribal Governments	13 Largest Cities (300,000+ population) 58 Counties 44 CoC Federally recognized Tribal Governments
Allocations & Disbursements	Cities $275 M Counties $175 M CoC $190 M	Cities $130 M Counties $80 M CoC $90 M	Cities $336 M Counties $224 M CoC $240 M	Cities $336 M Counties $224 M CoC $240 M
	*Palm Springs received $10 M		Tribal[1] $20 M	Tribal $20 M
			Bonus $180 M	Bonus $180 M
	1 Disbursement	1 Disbursement	2, potentially 3 Disbursements: 1st "Initial" Disbursement: • 20% of base if applying individually • 25% of base if applying jointly 2nd "Remainder" Disbursement • 80% of base if applying individually • 75% of base if applying jointly Potential "Bonus" Disbursement: Dependent on meeting performance conditions. Amount will vary depending on number of eligible recipients.	2, potentially 3 Disbursements: 1st "Initial" Disbursement: • 50% of base 2nd "Remainder" Disbursement • 50% of base – dependent on sufficient spenddown and projected performance Potential "Bonus" Disbursement: Dependent on meeting performance conditions. Amount will vary depending on number of eligible recipients

[1] Guidance for Tribal Governments will be released at a future date.

II. Application Timelines

	HHAP-1 (Round 1)	HHAP-2 (Round 2)	HHAP-3 (Round 3)	HHAP-4 (Round 4)
Application's Statutory Required Timeline for Cities, Counties, and CoCs	Application Release: • **12/6/19** Application Due: • **2/15/20** Award Determinations By: • **4/1/20**	Application Release: • **11/24/20** Application Due: • **60 days after** App. available (no later than **1/23/21**)	2 Parts to the Application: **Part 1: Standard Agreement to Apply** (Determines "initial" disbursement amount) • Release no later than **9/15/21** • Applicant submits to HCFC within **30 days** **Part 2: HHAP-3 Application** (Application for "remainder" disbursement) • **Due 6/30/22** App. due for "remainder" disbursement (includes local homelessness action plan, specific outcome goals, and narrative) Applicant must engage with HCFC before submitting a complete App.	Application Release: • **9/30/22** "Initial" Disbursement Application • **Due 60 days** from date available Applicant must engage with HCFC before submitting a complete App.
		Approve or request amended App. • **Within 60 days** from receiving completed App. (no later than **3/24/21**)	HCFC approves or returns App. If approved, posts notice of award to disburse • **30 days** from receipt	HCFC approves or returns App. If approve, posts notice of award to disburse • **30 days** from receipt
		Respond to request for amended App. • **Within 45 days** from request (latest **5/8/21**)	If returned, respond and submit revised of App. • **30 days** from receipt	If returned, respond and submit revised of App. • **30 days** from receipt
		Approve amended App. • **Within 30 days** from receipt (latest **6/7/21**)	HCFC evaluates revised App., posts notice of award to disburse • **30 days** from receipt HCFC and grantees post approved App. • **30 days** from disbursement	HCFC evaluates revised App., posts notice of award to disburse • **30 days** from receipt HCFC and grantees post approved App. • **30 days** from disbursement

III. Application Requirements

	HHAP-1 (Round 1)	HHAP-2 (Round 2)	HHAP-3 (Round 3)	HHAP-4 (Round 4)
Application Requirements	• Demonstration of regional coordination to identify jurisdiction's share of regional need and how HHAP funds will meet that need • Identification of all homelessness funds currently being used and information on programs supported by those funds • Assessment of existing programs and identification of gaps in housing and homeless services in the jurisdiction, as identified by the CoC, including those provided by entities other than the applicant • Outline of proposed uses of funds and identification of how HHAP funds will complement existing funds, close identified gaps, and serve the jurisdiction's homeless population • Measurable goals, including number of people served and percentage of people successfully placed in permanent housing with HHAP funds • Evidence of connection to CoC's CES • Agreement to participate in statewide HMIS when it becomes available and provide data elements to the system • For cities and counties: a plan demonstrating how funds will *(continued)*	• Demonstration of continuing regional coordination to identify jurisdiction's share of regional need and how HHAP funds will meet that need and coordinate with other regional funding • Identification of all homelessness funds currently being used or anticipated to be used, including federal ESG, CDBG, and Coronavirus Relief Fund • Assessment of current number of people experiencing homelessness, existing programs and funding, and detailed identification of gaps in housing and homeless services in the jurisdiction, using any relevant and available data from PIT count, CoC housing inventory count, longitudinal systems analysis, and Stella tools, and any recently conducted local needs assessments • Outline of proposed uses of funds and explanation of how proposed funds will complement existing funds and equitably close identified gaps • Clearly defined measurable goals, including number of people served and number of people successfully placed in permanent housing with HHAP funds	To apply for the "remainder" disbursement, jurisdictions must submit an Application that includes a (i)local homelessness action plan, (ii)specific outcome goals, and (iii) narrative. **Local Homelessness Action Plan Req.:** • Applicants to engage with the council on its local plan and outcome goals before submitting a complete Application. • Applicants to agendize local plan and outcome goals at a regular meeting of the governing body, including receiving public comment, before being submitted to the council. **Specific Outcome Goals Req.:** • 3-year outlook. • Metrics based on the United States Department of Housing and Urban Development's system performance measures and local homelessness action plan. (I) Reducing the number of persons experiencing homelessness. (II) Reducing the number of persons who become homeless for the first time. (III) Increasing the number of people exiting homelessness into permanent housing. (IV) Reducing the length of time persons remain homeless. (V) Reducing the number of persons who return to homelessness after exiting homelessness to permanent housing. (VI) Increasing successful placements from street outreach.	To apply for the "initial" disbursement, jurisdictions must submit an Application that includes an updated (i)local homelessness action plan, (ii)specific outcome goals, and (iii) narrative. **Local Homelessness Action Plan Req.:** • Applicants to engage with the council on its local plan and outcome goals before submitting a complete Application. • Applicants to agendize Application at a regular meeting of the governing body, including receiving public comment, before being submitted to the council. **Updated Specific Outcome Goals Req.:** • 3-year outlook. • Metrics based on the United States Department of Housing and Urban Development's system performance measures and local homelessness action plan. (I) Reducing the number of persons experiencing homelessness. (II) Reducing the number of persons who become homeless for the first time. (III) Increasing the number of people exiting homelessness into permanent housing. (IV) Reducing the length of time persons remain homeless. (V) Reducing the number of persons who return to homelessness after exiting homelessness to permanent housing. (VI) Increasing successful placements from street outreach.

	complement regional needs in the CoC's plan for coordinated housing and service system • For CoCs: data on demographics and characteristics of the homeless population and on current programs and services as reported through HMIS and PIT counts	• Evidence of connection with the local homeless CES • Agreement to participate in statewide HDIS and to enter individuals served by this funding into the local HMIS	Homeless Management Information System trackable data goals related to the outcome goals listed above as they apply to underserved populations and over-represented populations disproportionately impacted by homelessness.	Homeless Management Information System trackable data goals related to the outcome goals listed above as they apply to underserved populations and over-represented populations disproportionately impacted by homelessness.

IV. Eligible Uses

	HHAP-1 (Round 1)	HHAP-2 (Round 2)	HHAP-3 (Round 3)	HHAP-4 (Round 4)
Eligible Uses	**Rental assistance and rapid rehousing**.	**Rapid rehousing**, including rental subsidies and incentives to landlords, such as security deposits and holding fees.	**Rapid rehousing,** including rental subsidies and incentives to landlords, such as security deposits and holding fees.	**Rapid rehousing**, including rental subsidies and incentives to landlords, such as security deposits and holding fees.
	Incentives to landlords, including, but not limited to, security deposits and holding fees.			
	Operating subsidies in new and existing affordable or supportive housing units, emergency shelters, and navigation centers. Operating subsidies may include operating reserves.	**Operating subsidies** in new and existing affordable or supportive housing units, emergency shelters, and navigation centers. Operating subsidies may include operating reserves.	**Operating subsidies** in new and existing affordable or supportive housing units, emergency shelters, and navigation centers. Operating subsidies may include operating reserves.	**Operating subsidies** in new and existing affordable or supportive housing units, emergency shelters, and navigation centers. Operating subsidies may include operating reserves.
	Outreach and coordination, which may include access to job programs, to assist vulnerable populations in accessing permanent housing and to promote housing stability in supportive housing.	**Street outreach** to assist persons experiencing homelessness to access permanent housing and services.	**Street outreach** to assist persons experiencing homelessness to access permanent housing and services.	**Street outreach** to assist persons experiencing homelessness to access permanent housing and services.
		Services coordination, which may include access to workforce, education, training programs, or other services needed to promote housing stability in supportive housing.	**Services coordination**, which may include access to workforce, education, training programs, or other services needed to promote housing stability in supportive housing.	**Services coordination**, which may include access to workforce, education, training programs, or other services needed to promote housing stability in supportive housing.
	Systems support for activities necessary to create regional partnerships and maintain a homeless services and housing delivery system, particularly for vulnerable populations including families and homeless youth.	**Systems support** for activities necessary to create regional partnerships and maintain a homeless services and housing delivery system, particularly for vulnerable populations including families and homeless youth.	**Systems support** for activities necessary to create regional partnerships and maintain a homeless services and housing delivery system, particularly for vulnerable populations, including families and homeless youth.	**Systems support** for activities necessary to create regional partnerships and maintain a homeless services and housing delivery system, particularly for vulnerable populations, including families and homeless youth.
	Delivery of permanent housing and innovative housing solutions such as hotel and motel conversions.	**Delivery of permanent housing and innovative housing solutions**, such as hotel and motel conversions.	**Delivery of permanent housing and innovative housing solutions**, such as hotel and motel conversions.	**Delivery of permanent housing and innovative housing solutions**, such as hotel and motel conversions.
	Prevention and shelter diversion to permanent housing.	**Prevention and shelter diversion** to permanent housing, including rental subsidies.	**Prevention and shelter diversion** to permanent housing, including rental subsidies.	**Prevention and shelter diversion** to permanent housing, including rental subsidies.

	New navigation centers and emergency shelters based on demonstrated need.	**New navigation centers and emergency shelters** based on demonstrated need.	**Interim sheltering, limited to** newly developed clinically enhanced congregate shelters, new or existing non-congregate shelters, and operations of existing navigation centers and shelters based on demonstrated need Any new interim sheltering funded by round 3 funds must be low barrier, comply with Housing First as provided in Chapter 6.5 (commencing with Section 8255) of Division 8 of the Welfare and Institutions Code, and prioritize interventions other than congregate shelters.	**Interim sheltering, limited to** newly developed clinically enhanced congregate shelters, new or existing non-congregate shelters, and operations of existing navigation centers and shelters based on demonstrated need Any new interim sheltering funded by round 4 funds must be low barrier, comply with Housing First as provided in Chapter 6.5 (commencing with Section 8255) of Division 8 of the Welfare and Institutions Code, and prioritize interventions other than congregate shelters.
			Improvements to existing emergency shelters **to lower barriers and increase privacy.**	**Improvements** to existing emergency shelters **to lower barriers and increase privacy.**
	Up to **5 percent** of an applicant's program allocation may be expended for the following uses that are intended to meet federal requirements for housing funding: (1) **Strategic homelessness plan**, as defined in section 578.7(c) of Title 24 of the Code of Federal Regulations. (2) **Infrastructure development** to support coordinated entry systems and Homeless Management Information Systems.	Up to **5 percent** of an applicant's round 2 program allocation may be expended for the following uses that are intended to meet federal requirements for housing funding: (1) **Strategic homelessness plan**, as defined in Section 578.7(c) of Title 24 of the Code of Federal Regulations. (2) **Infrastructure development** to support coordinated entry systems and Homeless Management Information Systems.		
	The applicant shall not use more than **7 percent** of a program allocation for **administrative costs** incurred by the city, county, or continuum of care to administer its program allocation. For purposes of this subdivision, "administrative costs" does not include staff or other costs directly related to implementing activities funded by the program allocation.	The applicant shall not use more **than 7 percent** of a program allocation for **administrative costs** incurred by the city, county, or continuum of care to administer its program allocation. For purposes of this subdivision, "administrative costs" does not include staff or other costs directly related to implementing activities funded by the program allocation.	The applicant shall not use more than **7 percent** of a program allocation for **administrative costs** incurred by the city, county, or continuum of care to administer its program allocation. For purposes of this subdivision, "administrative costs" does not include staff or other costs directly related to implementing activities funded by the program allocation.	The applicant shall not use more than **7 percent** of a program allocation for **administrative costs** incurred by the city, county, or continuum of care to administer its program allocation. For purposes of this subdivision, "administrative costs" does not include staff or other costs directly related to implementing activities funded by the program allocation.

			"Initial" allocation **may** be used for technical assistance or contracted entities **to support the completion of the homeless action plan**. **Priority** for initial funds, **above the costs of completing the application, shall** be for **systems improvement**, including, but not limited to, all of the following: (A) Capacity building and workforce development for the jurisdiction's administering staff and providers, including technical assistance to culturally specific providers. (B) Funding existing evidence-based programs serving people experiencing homelessness. (C) Investing in data systems to meet reporting requirements or strengthen the recipient's Homeless Management Information System. (D) Improving homeless point-in-time counts. (E) Improving coordinated entry systems to eliminate racial bias or to create a youth-specific coordinated entry system.	
Youth Set Aside	At least **8%** of the allocation must be expended on services for **unaccompanied youth** between 12 and 24 years old experiencing homelessness	At least **8%** of the allocation must be expended on services for **unaccompanied youth** between 12 and 24 years old experiencing homelessness	A program recipient shall use at least **10%** of the funds allocated under this section for services for **homeless youth** populations	A program recipient shall use at least **10%** of the funds allocated under this section for services for **homeless youth** populations
Demonstrated Need for New Shelters / Interim Housing, Based On:	The number of available shelter beds; shelter vacancy rate in the summer and winter months; percentage of exits from emergency shelters to permanent housing solutions; and a plan to connect residents to permanent housing	The number of available shelter beds; shelter vacancy rate in the summer and winter months; percentage of exits from emergency shelters to permanent housing solutions; and a plan to connect residents to permanent housing	The number of available shelter beds; *number of people experiencing unsheltered homelessness in the PIT count*; shelter vacancy rate in the summer and winter months; percentage of exits from emergency shelters to permanent housing solutions; and a plan to connect residents to permanent housing	The number of available shelter beds; *number of people experiencing unsheltered homelessness in the PIT count*; shelter vacancy rate in the summer and winter months; percentage of exits from emergency shelters to permanent housing solutions; and a plan to connect residents to permanent housing

V. Reporting and Accountability

	HHAP-1 (Round 1)	HHAP-2 (Round 2)	HHAP-3 (Round 3)	HHAP-4 (Round 4)
Reporting Deadlines	Disbursed: Spring 2020	Disbursed: Fall 2021	Disbursed: Winter / Spring '22("Initial")	Disbursed: Winter / Spring '23 ("Initial")
	December 31, 2020 - Annual Report			
	December 31, 2021 - Annual Report	December 31, 2021 - Annual Report		
	December 31, 2022 - Annual Report	December 31, 2022 - Annual Report	December 31, 2022 - Annual Report	
	December 31, 2023 - Annual Report	December 31, 2023 - Annual Report	December 31, 2023 - Annual Report	December 31, 2023 - Annual Report
	December 31, 2024 - Annual Report	December 31, 2024 - Annual Report	December 31, 2024 - Annual Report	December 31, 2024 - Annual Report
	December 31, 2025 - Annual Report	December 31, 2025 - Annual Report	December 31, 2025 - Annual Report	December 31, 2025 - Annual Report
	December 31, 2025 - Final Report	December 31, 2025 - Annual Report	October 1, 2026 - Final Report	December 31, 2026 - Annual Report
		December 31, 2026 - Final Report		October 1, 2027 - Final Report
	June 30, 2025 - Exp. Deadline	**June 30, 2026 - Exp. Deadline**	**June 30, 2026 - Exp. Deadline**	**June 30, 2027 - Exp. Deadline**
Reporting and Accountability Metrics	• Ongoing tracking of specific uses and expenditures of program funds by eligible uses • Number of people served that year, total number served in all years of the program, and the homeless population served • Types of housing assistance provided broken out by number of people • Outcome data for individuals served with program funds, including the type of housing an individual exited to, percentage of successful housing exits, and exit types for unsuccessful housing exits • Data collection, including demographic information regarding individuals and families served, partnerships among entities (or lack	• Ongoing tracking of specific uses and expenditures of program funds by eligible uses • Number of people served that year, total number served in all years of the program, and the homeless population served • Types of housing assistance provided broken out by number of people • Outcome data for individuals served with program funds, including the type of housing an individual exited to, percentage of successful housing exits, and exit types for unsuccessful housing exits • Data collection, including demographic information regarding individuals and families	• Metrics required from HHAP-1 and 2 • <u>Additionally</u>, accountability metrics based on the United States Department of Housing and Urban Development's system performance measures and local homelessness action plan. (I) Reducing the number of persons experiencing homelessness. (II) Reducing the number of persons who become homeless for the first time. (III) Increasing the number of people exiting homelessness into permanent housing. (IV) Reducing the length of time persons remain homeless. (V) Reducing the number of persons who return to homelessness after exiting homelessness to permanent housing. (VI) Increasing successful placements from street outreach.	• Metrics required from HHAP-1 and 2 • <u>Additionally</u>, accountability metrics based on the United States Department of Housing and Urban Development's system performance measures and local homelessness action plan. (I) Reducing the number of persons experiencing homelessness. (II) Reducing the number of persons who become homeless for the first time. (III) Increasing the number of people exiting homelessness into permanent housing. (IV) Reducing the length of time persons remain homeless. (V) Reducing the number of persons who return to homelessness after exiting homelessness to permanent housing. (VI) Increasing successful placements from street outreach.

	thereof), and participant and regional outcomes • Clear metrics, including number of exits to permanent housing from unsheltered environments and interim housing, racial equity, and any other metrics deemed appropriate by HCFC in consultation with the legislature and stakeholders	served, partnerships among entities (or lack thereof), and participant and regional outcomes • Clear metrics, including number of exits to permanent housing from unsheltered environments and interim housing, racial equity, and any other metrics deemed appropriate by HCFC in consultation with the legislature and stakeholders	Homeless Management Information System trackable data goals related to the outcome goals listed above as they apply to underserved populations and over-represented populations disproportionately impacted by homelessness.	Homeless Management Information System trackable data goals related to the outcome goals listed above as they apply to underserved populations and over-represented populations disproportionately impacted by homelessness.
Goals and Performance Evaluation Timeline	*Not discussed here for this round of funding.*	*Not discussed here for this round of funding.*	• Each applicant shall determine its outcome goals in consultation with the council, and will only submit final outcomes goals after approval from the council • Initial outcome goals should be met no later than **6/30/24**, and outcome goals shall be updated regularly, as funding continues. • If by **7/1/24** that a grantee met its outcome goals as approved by the council that grantee shall be eligible for bonus funding. • HCFC shall determine whether a grantee met its outcome goals. • HCFC shall award bonus funding pursuant to this section as soon as data becomes available, but no later than **11/1/24**. • HCFC may provide exceptions to the performance requirement to meet	• Each applicant shall determine its outcome goals that build upon prior year goals in consultation with the council, • Initial outcome goals should be met no later than **6/30/25**, and outcome goals shall be updated regularly, as funding continues. • If by **7/1/25** that a grantee met its outcome goals as approved by the council that grantee shall be eligible for bonus funding. • HCFC shall determine whether a grantee met its outcome goals. • HCFC shall award bonus funding pursuant to this section as soon as data becomes available, but no later than **11/1/25**. • HCFC may provide exceptions to the performance requirement to meet outcome goals pursuant if grantee demonstrates hardship by a disaster for which a state of emergency is proclaimed

			outcome goals pursuant if grantee demonstrates hardship by a disaster for which a state of emergency is proclaimed • Jurisdictions that have not met their outcome goals shall not be eligible for bonus funding and shall accept technical assistance from council staff. In addition, jurisdictions that have not met their outcome goals may also be required to limit the allowable uses of these program funds, as determined by the council.	• Jurisdictions that have not met their outcome goals shall not be eligible for bonus funding and shall accept technical assistance from council staff. In addition, jurisdictions that have not met their outcome goals may also be required to limit the allowable uses of these program funds, as determined by the council. • Remainder allocation of 50% of 80% base. Upon demonstration by a recipient city, county, or continuum of care that it has complied with the requirement to contractually obligated and expend a minimum amount of its round 4 program allocation, and remains on track to meet its outcome goals, as determined by the HCFC, HCFC shall disburse to that recipient the remaining 50%.
Bonus Funding Methodology			The council shall determine bonus award allocations based on the proportionate share of the homeless population based on PIT relative to the total homeless population of all jurisdictions eligible for bonus funding, and using other factors necessary, so that the award allocation is equitable and reasonable for the mix of jurisdictions eligible for bonus funding.	The council shall determine bonus award allocations based on the proportionate share of the homeless population based on PIT relative to the total homeless population of all jurisdictions eligible for bonus funding, and using other factors necessary, so that the award allocation is equitable and reasonable for the mix of jurisdictions eligible for bonus funding.

VI. Fiscal Deadlines

	HHAP-1 (Round 1)	HHAP-2 (Round 2)	HHAP-3 (Round 3)	HHAP-4 (Round 4)
Obligation Deadline	Counties 100% by **5/31/23** Cities / CoCs 50% by **5/31/23**	Counties 100% by **5/31/23** Cities / CoCs 50% by **5/31/23**	Counties 100% by **5/31/24** All but Counties 50% by **5/31/24**	75% of "initial" disbursement by **5/31/25**
Expenditure Deadline	**6/30/25** w/ remaining funds reverting to GF	**6/30/26** w/ remaining funds reverting to GF	**6/30/26** w/ unexpended available for HHAP-4	• 50% of "initial" disbursement by **5/31/25** • 100% of all disbursements including bonus by **6/30/27**
County Failure to Obligate	If a county obligates less than 100% by **5/31/23**, any funds not contractually obligated by this date will be reverted to the CoC that serves the county	If a county obligates less than 100% by **5/31/23**, any funds not contractually obligated by this date will be reverted to the CoC that serves the county	If a county obligates less than 100% of allocations awarded to them by the council on or before **5/31/24**, any funds not contractually obligated by this date will be reverted to the CoC that serves the county	
Alternative Disbursement Plan	• If a city or CoC obligates less than 50% by **5/31/23**, the jurisdiction must not expend any remaining portion of the 50% of Round 1 allocations until they submit an alternative disbursement plan (which must be submitted by **6/30/23**) that includes an explanation for the delay which must be approved by HCFC • Any funds not expended pursuant to the approved alternative disbursement plan by **12/31/23** will be returned to HCFC for a subsequent round of awards	• If a city or CoC obligates less than 50% by **5/31/23**, the jurisdiction must not expend any remaining portion of the 50% of Round 2 allocations until they submit an alternative disbursement plan (which must be submitted by **6/30/23**) that includes an explanation for the delay which must be approved by HCFC • Any funds not expended pursuant to the approved alternative disbursement plan by **12/31/23** will be returned to HCFC for a subsequent round of awards	If less than 50% is obligated by **5/31/24**, recipients that are continuums of care and cities shall cease expending until both of the following occur: (A) On or before **6/30/24**, the recipient submits an alternative disbursement plan that includes an explanation for the delay. (B) The council approves the alternative disbursement plan submitted pursuant to subparagraph (A).	If less than 75% is obligated or less than 50% is expended by **5/31/25**, the recipient shall not contractually obligate or expend any remaining allocation and HCFC shall not allocate to the recipient the remaining 50%, until both of the following occur: (A) On or before **6/30/25**, the recipient submits an alternative disbursement plan that includes an explanation for the delay. (B) The council approves the alternative disbursement plan submitted pursuant to subparagraph (A).
Result of Untimely Obligating or Expending	• HCFC may request repayment of funds or pursue any legal remedies available for failure to comply with program requirements	• HCFC may request repayment of funds or pursue any legal remedies available for failure to comply with program requirements	• HCFC may request repayment of funds or pursue any legal remedies available for failure to comply with program requirements • Recipients that do not meet the obligation requirements shall not be eligible for HHAP-3 "bonus" funding	• HCFC may request repayment of funds or pursue any legal remedies available for failure to comply with program requirements • Recipients that do not meet the obligation requirements shall not be eligible for HHAP-4 "bonus" funding

			• By **12/31/24**, recipients that are continuums of care and cities shall return to HCFC any unexpended funds pursuant to an alternative disbursement plan. These monies are to be allocated towards bonus awards. • Any remaining amounts of HHAP-3 program allocation funds not expended by **6/30/26**, shall be available for HHAP-4	• By **12/31/26**, recipients that are continuums of care and cities shall return to HCFC any unexpended funds pursuant to an alternative disbursement plan. These monies are to be allocated towards bonus awards. • Any remaining amounts of HHAP-4 program allocation funds, including bonus funds, not expended by **6/30/27**, shall revert to, and be paid and deposited in, the General Fund.

LOCAL HOMELESSNESS ACTION PLAN AND APPLICATION TEMPLATE

HOMELESS HOUSING, ASSISTANCE AND PREVENTION PROGRAM ROUND 3 (HHAP-3)

February 15, 2022

Purpose of this Template

The California Interagency Council on Homelessness (Cal ICH) is providing this Local Homelessness Action Plan and Application Template as optional for use by jurisdictions seeking the disbursement of remaining funding under Round 3 of the Homeless Housing, Assistance and Prevention Program (HHAP-3). This Template is intended to support the development and submission of information required for approval by Cal ICH as required in AB 140 (Health & Safety Code § 50218.6, et seq.), collectively referred to as a Local Homelessness Action Plan.

This Template is also intended to support the streamlined presentation of information required to be agendized at a local governing board meeting and available for public comment as stated in Health and Safety Code Section 50220.7(b)(2). Statute does not require local governing boards to take action on or formally adopt the agendized content, however, local governments may choose to do so. If the information in the section is a requirement to be agendized at a regular meeting by the governing body, including receiving public comment, that section is labeled "**AGENDIZE**".

- **PART I: LANDSCAPE ANALYSIS OF NEEDS, DEMOGRAPHICS, AND FUNDING**
  This section provides a format for providing the following required information:

  (i) A **local landscape analysis** that assesses the current number of people experiencing homelessness and existing programs and funding which address homelessness.

  (ii) **Identification of the number of individuals and families served**, including demographic information and intervention types provided, and demographic subpopulations that are underserved relative to their proportion of individuals experiencing homelessness.

  (iii) **Identification of funds, currently being used, and budgeted to be used, to provide housing and homelessness-related services** to persons experiencing homelessness or at imminent risk of homelessness, how this funding serves subpopulations, and types of interventions funded.

- **PART II: OUTCOME GOALS AND STRATEGIES FOR ACHIEVING THOSE GOALS**

  This section of the Template provides applicants with a format for providing Outcome Goals, and strategies for achieving those goals, across the following performance measures:
  - Reducing the number of persons experiencing homelessness.
  - Reducing the number of persons who become homeless for the first time.
  - Increasing the number of people exiting homelessness into permanent housing.
  - Reducing the length of time persons remain homeless.
  - Reducing the number of persons who return to homelessness after exiting homelessness to permanent housing.
  - Increasing successful placements from street outreach.
  - Trackable data goals related to the Outcome Goals as they apply to underserved populations and populations disproportionately impacted by homelessness.

- **PART III: APPLICATION NARRATIVE RESPONSES**
  This section includes the required narrative responses for the HHAP-3 application. These narrative responses are to provide additional information on regional coordination, capacity building, and equity related efforts in alignment with local action plan goals and strategies.

- **PART IV: HHAP-3 FUNDING PLAN**
  This section provides a format for describing the specific allowable activities to be supported with HHAP-3 funds.

APPLICANT INFORMATION

List the eligible applicant(s) submitting this application for HHAP-3 funding below and check the corresponding box to indicate whether the applicant(s) is/are applying individually or jointly.

Eligible Applicant(s) and Individual or Joint Designation

This application represents ☐ an **individual** ☐ a **joint** application for HHAP-3 funding on behalf of the following eligible applicant jurisdiction(s):

Eligible Applicant Name
Choose an item.
Choose an item.
Choose an item.
Choose an item.
Choose an item.
Choose an item.
Choose an item.

Funds awarded based on this application will be administered by the following **Administrative Entity**:

Administrative Entity Information	
Administrative Entity:	
Contact Person:	
Title:	
Contact Phone Number:	
Contact Email Address:	

PART I: LANDSCAPE ANALYSIS OF NEEDS, DEMOGRAPHICS, AND FUNDING (AGENDIZE)

A. Landscape Analysis of Needs and Demographics

Please use TABLE 1 in the HHAP-3 Data Tables Template to provide key data regarding people experiencing homelessness in your jurisdiction. An example can be seen below.

The information provided in Table 1 should reflect your most current and accurate way of estimating the number and demographics of people experiencing homelessness on the day that you are preparing the data, which could rely on utilizing: data from the Homeless Data Integration System (HDIS); point-in-time count (PIT) data; Continuum of Care Housing Inventory Count (HIC) data; longitudinal systems analysis (LSA); HUD's Stella tools; as well as any recently conducted local needs assessments, analyses, or other data sources.

TABLE 1 (EXAMPLE ONLY):

	People Experiencing Homelessness	Source and Timeframe of Data
Population and Living Situations		
TOTAL # OF PEOPLE EXPERIENCING HOMELESSNESS	721	HUD 2020 PIT Count
# of People Who are **Sheltered** (ES, TH, SH)	202	HUD 2020 PIT Count
# of People Who are **Unsheltered**	519	HUD 2020 PIT Count

B. Landscape Analysis of People Being Served

Please use TABLE 2 in the HHAP-3 Data Tables Template to report the number of individuals and families served. The data provided within Table 2 should represent **your most current and accurate way of estimating the annual number and demographics** of people participating within or being served by the different intervention types, including subpopulations that are underserved relative to their proportion of individuals experiencing homelessness in the jurisdiction. It is important to note that intervention types are not mutually exclusive, and individuals and households may be counted in multiple categories.

Grantees are encouraged to utilize existing documentation, including but not limited to: data from the Homeless Data Integration System (HDIS); point-in-time count (PIT) data; Continuum of Care Housing Inventory Count (HIC) data; longitudinal systems analysis (LSA); HUD's Stella tools; as well as data from the CoC's local HMIS and any recently conducted needs assessments, analyses, or other data sources. An example can be seen below.

Table 2 uses the following abbreviations:

- PSH – Permanent Supportive Housing
- RRH – Rapid Rehousing
- TH – Transitional Housing
- IH / ES – Interim Housing or Emergency Shelter
- DIV – Diversion Services and Assistance
- HP – Homelessness Prevention Services and Assistance
- O/R – Outreach and Engagement Services

TABLE 2 (EXAMPLE ONLY):

	Permanent Supportive Housing (PSH)	Rapid Rehousing (RRH)	Transitional Housing (TH)	Intermin Housing or Emergency Shelter (IH / ES)	Diversion Services and Assistance (DIV)	Homelessness Prevention Services & Assistance (HP)	Outreach and Engagement Services (O/R)	Other: [Identify]	Source(s) and Timeframe of Data
Household Composition									
# of Households **without Children**	216	1230	654	6746			6123		FY 2020-21 LSA
# of Households with **At Least 1 Adult & 1 Child**	55	61	125	324			485		FY 2020-21 LSA
# of Households with **Only Children**	19								FY 2020-21 LSA

C. Landscape Analysis of State, Federal, and Local Funding

Please use TABLE 3 in the HHAP-3 Data Tables Template to identify and document all funds including state, federal and local funds, currently being used, and budgeted to be used, to provide homelessness-related services and housing opportunities. Funding sources should indicate the fiscal year that the funds are budgeted to be used.

This information provided should not focus on funding only being expended directly alongside HHAP funding, but rather should document the full range of funding being used within your jurisdiction's efforts to prevent and end homelessness while identifying the housing and services programming that is supported with those funds.

The "Total Amount" should include the total funds invested into homelessness interventions from that source of funding in the designated fiscal year(s). Please also select all intervention types that apply and provide a brief program description, indicating services provided and subpopulations served.

Applicants should add as many rows as necessary to identify and document the full range of funding being used within your jurisdiction's efforts to prevent and end homelessness. An example can be referenced below.

If your jurisdiction has a current list (developed within the last 3 years) of available funding that includes all the criteria listed below, you may submit that to meet this requirement.

Table 3: Landscape Analysis of State, Federal, and Local Funding (EXAMPLE ONLY)

Funding Program *(choose from drop down options)*	Fiscal Year *(select all that apply)*	Total Amount Invested into Homelessness Interventions	Funding Source*	Intervention Types Supported with Funding *(select all that apply)*		Brief Description of Programming and Services Provided	Populations Served *(please "x" the appropriate population[s])*							
Homekey (via HCD)	FY 2021-2022 FY 2022-2023 FY 2023-2024	$ 1,150,000.00	State Agency	Non-Congregate Shelter/ Interim Housing Permanent Supportive and Service-Enriched Housing Diversion and Homelessness Prevention		Utilize Homekey to purchase hotels or other buildings to provide Interim Housing with an exit strategy for all residents and/ or plan to convert housing in the near future.	X	ALL PEOPLE EXPERIENCING HOMELESSNESS	TARGETED POPULATIONS (*please "x" all that apply*)					
									People Exp **Chronic Homelessness**		Veterans		Parenting Youth	
									People Exp **Severe Mental Illness**		People Exp **HIV/ AIDS**		Children of Parenting Youth	
									People Exp **Substance Abuse Disorders**		Unaccompanied Youth		Other (*please enter here*)	

PART II: OUTCOME GOALS AND STRATEGIES FOR ACHIEVING THOSE GOALS (AGENDIZE)

HHAP-3 applicant jurisdictions are required to establish Outcome Goals for the progress that they will make in preventing and reducing homelessness over the three-year period of July 1, 2021 through June 30, 2024, informed by the findings from the local landscape analysis information completed above and the jurisdiction's base system performance measures from the 2020 calendar year data in the Homeless Data Integration System.

Please note that these Outcomes Goals are not intended to be related to HHAP-3-funded activities alone, but rather are intended to represent jurisdictional or system-wide goals for making progress on preventing and ending homelessness through the implementation of the full range of federal, state, and local funding sources and through many other kinds of strategies and activities.

HHAP-3 applicant jurisdictions must set goals for each of the following Outcome Goals:

- Reducing the number of persons experiencing homelessness.
- Reducing the number of persons who become homeless for the first time.
- Increasing the number of people exiting homelessness into permanent housing.
- Reducing the length of time persons remain homeless.
- Reducing the number of persons who return to homelessness after exiting homelessness to permanent housing.
- Increasing successful placements from street outreach.

Further, applicant jurisdictions are required to establish Homeless Management Information System trackable data goals related to each of the Outcome Goals as they apply to underserved populations and populations disproportionately impacted by homelessness.

Cal ICH will provide applicant jurisdictions with baseline data on each of these measures. Grantees, in partnership with Cal ICH, will develop outcome goals established from the baseline data provided. Information on how these outcomes are being measured will be provided with the baseline data. Cal ICH will also provide grantees with quarterly HDIS data in order to monitor progress on outcome goals.

Outcome Goals

Please use TABLE 4 in the HHAP-3 Data Tables Template to develop outcome goals. An example has been provided below.

Table 4: Outcome Goals (EXAMPLE ONLY)

Outcome Goal #2: Reducing the number of persons who become homeless for the first time.		
Baseline Data: **Annual Estimate of # of people who become homeless for the first time**	**Outcome Goals July 1, 2021 - June 30, 2024**	
	Reduction in # of People	**Reduction as % of Baseline**
*2,250 people annually** **Actual baseline to be provided by Cal ICH from HDIS: can use local data as placeholder in the meantime*	450 fewer people will become homeless for the first time annually	20% reduction
Describe Your Related Goals for **Underserved Populations and Populations Disproportionately Impacted by Homelessness**		
Describe any underserved and/ or disproportionately impacted population(s) that your community will especially focus on related to this Outcome Goal and how this focus has been informed by data in your landscape assessment:		**Describe the trackable data goal(s) related to this Outcome Goal:**
Analysis of local data shows that while Black people represent 10% of the population in our CoC's geographic area, Black people represent approximately 42% of individuals who become homeless for the first time each year and approximately 44% of families with children who become homeless for the first time each year have a Black head of household.		Reduce the number of Black individuals and families with children with Black heads of household who become homeless for the first time annually by 30%, exceeding our overall 20% reduction in the number of people who become homeless for the first time annually.

A. Strategies for Achieving Outcome Goals

In this section, applicants must describe actionable strategies they will implement to meet the Outcome Goals identified above. Because individual strategies to address homelessness usually contribute to meeting more than one desired outcome, applicants are asked to identify the strategy and then to indicate all the outcome goals for which the strategy will help drive progress and to indicate if it will help drive progress on goals for underserved populations and populations disproportionately impacted by homelessness.

Please use TABLE 5 in the HHAP-3 Data Tables Template as an option for documenting the strategies that will be implemented. An example has been provided below.

Applicants are expected to identify and describe local strategies that include but extend beyond the current and planned use of HHAP funding to be inclusive of, but not limited to, strategies for:

- Strategic uses of other sources of funding;
- Increasing investments into, or otherwise scaling up, specific interventions or program types;
- Expanding and strengthening cross-system partnerships;
- Expanding and strengthening partnerships with people with lived expertise;
- Reaching underserved and historically marginalized communities and populations; and
- Other equity-focused strategies.

In describing these strategies, **applicants are strongly encouraged to use and/or adapt content from**:

- Current local strategic plans or actions plans for preventing and ending homelessness;
- Prior HHAP applications and reporting;
- Recent applications under HUD's Continuum of Care program; and/or
- Other relevant local policy documents or plans.

Applicants choosing to use the format provided should complete as many of the formatted boxes as needed.

Applicants who choose to use another format should ensure they address the wide range of strategies identified above, include the information noted below, and must also clearly identify the performance measures to be impacted.

Table 5: Strategies to Achieve Outcome Goals (EXAMPLE ONLY)

Strategy	Performance Measure to Be Impacted (Check all that apply)
Description Expand the supply of permanent supportive housing by utilizing funding from ABC Program to purchase and renovate 2 hotels to be operated as permanent supportive housing. **Timeframe** By December 2022 **Entities with Lead Responsibilities** XYZ Housing Agency **Measurable Targets** 85 additional permanent supportive housing units occupied by December 2022	☑ 1. Reducing the number of persons experiencing homelessness. ☐ 2. Reducing the number of persons who become homeless for the first time. ☑ 3. Increasing the number of people exiting homelessness into permanent housing. ☑ 4. Reducing the length of time persons remain homeless. ☐ 5. Reducing the number of persons who return to homelessness after exiting homelessness to permanent housing. ☐ 6. Increasing successful placements from street outreach. ☐ Focused on equity goals related to underserved populations and populations disproportionately impacted by homelessness.

PART III. NARRATIVE RESPONSES

In preparing these narrative responses, applicants are strongly encouraged to use and/or adapt content from: their current local strategic plans or actions plans for preventing and ending homelessness; prior HHAP applications and reporting; their most recent applications under HUD's Continuum of Care program; and/or other relevant local policy documents or plans.

1. A demonstration of how the jurisdiction has coordinated, and will continue to coordinate, with other jurisdictions, including the specific role of each applicant in relation to other applicants in the region.

2. A demonstration of the applicant's partnership with, or plans to use funding to increase partnership with:
   - Local health care and managed care plans
   - Public health systems
   - Behavioral health
   - Social services
   - Justice entities
   - People with lived experiences of homelessness
   - Other (workforce system, services for older adults and people with disabilities, Child Welfare, education system)

3. A description of specific actions the applicant will take to ensure racial and gender equity in service delivery, housing placements, and housing retention and changes to procurement or other means of affirming racial and ethnic groups that are overrepresented among residents experiencing homelessness have equitable access to housing and services.
   - *Note: These actions should be aligned with the equity-focused Outcome Goals and related strategies described in previous Parts, but should not need to be limited to those strategies.*

4. A description of how the applicant will make progress in preventing exits to homelessness from institutional settings, including plans to leverage funding from mainstream systems for evidence-based housing and housing-based solutions to homelessness.
   - *Note: Such mainstream systems could include:*
     - Physical and behavioral health care systems and managed care plan organizations
     - Public health system
     - Criminal legal system and system for supporting re-entry from incarceration
     - Child welfare system
     - Affordable housing funders and providers
     - Income support programs
     - Education system
     - Workforce and employment systems
     - Other social services and human services systems

5. Specific and quantifiable systems improvements that the applicant will take to improve the delivery of housing and services to people experiencing homelessness or at risk of homelessness, including, but not limited to, the following:

   (I) Capacity building and workforce development for service providers within the jurisdiction, including removing barriers to contracting with culturally specific service providers and building the capacity of providers to administer culturally specific services.

   (II) Strengthening the data quality of the recipient's Homeless Management Information System.

   (III) Increasing capacity for pooling and aligning housing and services funding from existing, mainstream, and new funding.

   (IV) Improving homeless point-in-time counts.

   (V) Improving coordinated entry systems to strengthen coordinated entry systems to eliminate racial bias, to create a youth-specific coordinated entry system or youth-specific coordinated entry access points, or to improve the coordinated entry assessment tool to ensure that it contemplates the specific needs of youth experiencing homelessness.

6. Evidence of connection with the local homeless Coordinated Entry System.

PART IV. HHAP-3 FUNDING PLANS

In TABLE 6 of the HHAP-3 Data Tables Template, applicants will describe the specific activities they intend to support with HHAP-3 funds by providing a Funding Plan list, Demonstrated Need (for Interim Housing only), and Budget Template. In each of these documents, applicants will include detailed information about all activities funded with their **entire HHAP-3 allocation** (initial and remainder disbursements combined), and will indicate the amount of funds attributed to the initial and remainder disbursements in the Budget Template.

Table 6: Funding Plans (EXAMPLE ONLY)

Activity to be funded by HHAP-3	Eligible Use Categories Used to Fund Activity										Total Funds Requested:	Description of Acitivity
	1. Rapid rehousing	2. Operating subsidies	3. Street outreach	4. Services coordination	5. Systems support	6. Delivery of permanent housing	7. Prevention and diversion	8. Interim sheltering (new and existing)	9. Shelter improvements to lower barriers and increase privacy	10. Administrative (up to 7%)		
Systems Support Activities	$ -	$ -	$ -	$ -	$ 50,000.00	$ -	$ -	$ -	$ -	$ -	$ 50,000.00	Provide stipends to participants on a Lived Experience Board.
Administrative Activities	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ 20,000.00	$ 20,000.00	Pay .25 FTE of a grant analyst to administer and monitor HHAP funds.
Permanent Supportive and Service-Enriched Housing	$ -	$ 100,000.00	$ -	$ -	$ -	$ 150,000.00	$ -	$ -	$ -	$ -	$ 250,000.00	Support Project Homekey PSH project with $100k in Operating Subsidies. Support NPLH with $150k in capital costs.
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -	
Totals:	**$ -**	**$ 100,000.00**	**$ -**	**$ -**	**$ 50,000.00**	**$ 150,000.00**	**$ -**	**$ -**	**$ -**	**$ 20,000.00**	**$ 320,000.00**	

IF you are funding an Interim Housing activity, you must provide demonstrated need in **Table 7**.

Table 7: Demonstrated Need (EXAMPLE ONLY)

Demonstrated Need	
# of available shelter beds	*200*
# of people experiencing unsheltered homelessness in the homeless point-in-time count	*1000*
Shelter vacancy rate (%) in the summer months	*13%*
Shelter vacancy rate (%) in the winter months	*7%*
% of exits from emergency shelters to permanent housing solutions	*60%*
Describe plan to connect residents to permanent housing.	
The Emergency Shelter has partnered with the local NPLH project opening in October 2022 to move participants into permanent supportive housing as quickly as possible. In addition, the County and CoC have jointly funded a landlord engagement program that is building connections and making it easier to utilize a rapid rehousing model by moving emergency shelter residents into permanent housing.	

Table 8: Budget Template (EXAMPLE ONLY)

California Interagency Council on Homelessness

HOMELESS HOUSING, ASSISTANCE AND PREVENTION PROGRAM (HHAP) - Round 3
BUDGET TEMPLATE

APPLICANT INFORMATION

CoC / Large City / County Name:		Applying Jointly? Y/N	N
Administrative Entity Name:		Total Allocation	$ 320,000.00

HHAP FUNDING EXPENDITURE PLAN

ELIGIBLE USE CATEGORY	FY21/22	FY22/23	FY23/24	FY24/25	FY25/26	TOTAL	Initial	Remainder
Rapid rehousing	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Rapid rehousing: youth set aside	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Operating subsidies	$ -	$ 100,000.00	$ -	$ -	$ -	$ 100,000.00	$ 40,000.00	$ 60,000.00
Operating subsidies: youth set aside	$ -	$ 40,000.00	$ -	$ -	$ -	$ 40,000.00	$ 40,000.00	$ -
Street outreach	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Street outreach: youth set aside	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Services coordination	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Services coordination: youth set aside	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Systems support	$ -	$ -	$ 50,000.00	$ -	$ -	$ 50,000.00	$ 24,000.00	$ 26,000.00
Systems support: youth set aside	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Delivery of permanent housing	$ -	$ 150,000.00	$ -	$ -	$ -	$ 150,000.00	$ -	$ 150,000.00
Delivery of permanent housing: youth set aside	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Prevention and shelter diversion	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Prevention and shelter diversion: youth set aside	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interim sheltering	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Interim sheltering: youth set aside	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Shelter improvements to lower barriers and increase privacy	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Shelter improvements: youth set aside	$ -	$ -	$ -	$ -	$ -	$ -	$ -	$ -
Administrative (up to 7%)	$ -	$ 10,000.00	$ 10,000.00	$ -	$ -	$ 20,000.00	$ -	$ 20,000.00
					TOTAL FUNDING ALLOCATION	$ 320,000.00	$ 64,000.00	$ 256,000.00

	FY21/22	FY22/23	FY23/24	FY24/25	FY25/26	TOTAL		
Youth Set Aside (at least 10%)	$ -	$ 40,000.00	$ -	$ -	$ -	$ 40,000.00	$ 40,000.00	$ -

Baseline Data for Outcome Goals Companion Guide

Table of Contents

Purpose of the Baseline Data for Outcome Goals Spreadsheet

The ***Baseline Data for Outcome Goals*** spreadsheet was prepared to provide standardized baseline data about each Continuum of Care (CoC) in the State on all six of the Outcome Goals required within jurisdictions' Local Homelessness Action Plans, as well as information that can be used by applicants to identify underserved populations and to establish Homeless Management Information System (HMIS) trackable data goals related to each of the Outcome Goals as they apply to underserved populations and populations disproportionately impacted by homelessness. The baseline data are generated from the State's Homeless Data Integration System (HDIS), as required in statute. The spreadsheet also includes prior performance data for the performance measures used for each Outcome Goal, as well as more detailed supporting data, to provide more information for HHAP applicants as they develop their Outcome Goals and determine Homeless Housing, Assistance and Prevention (HHAP) investments that will maximize impact on performance and the achievement of these system level Outcome Goals.

The data included in the ***Baseline Data for Outcome Goals*** spreadsheet may be useful in completing the Landscape Analysis within the Local Homelessness Action Plan, but grantees are not limited to using this data. Applicants can use locally generated quantitative and qualitative data for the Landscape Analysis. While the baseline data are based on CoC geography, the Landscape Analysis can be produced for the jurisdiction's geographic area.

Going forward, California Interagency Council on Homelessness (Cal ICH) will provide grantees with quarterly reports on their performance related to their Outcome Goals using these templates, which they can use for on-going performance management and planning.

As required by statute, the Outcome Goal Performance Measures are based on the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) System Performance Measures, but the measures do differ in some ways. At the end of this document, a crosswalk is provided to explain the ways in which the HDIS-

generated Outcome Goal Performance Measures and the HUD CoC System Performance Measures differ. The primary difference is that the HDIS-generated measures consistently include data from non-residential projects, such as street outreach, coordinated entry, and other supportive services, to ensure that the measures include information about people experiencing unsheltered homelessness who would not otherwise be captured in some of the HUD measures. The HDIS measures also include some adjustments to account for several key data quality issues. For both HDIS and HUD, the performance measures are limited to data collected in HMIS, so the performance results will not reflect the experience of people who do not interact with HMIS participating providers.

Data related to the CoC's Outcome Goals and performance measures should be considered as a set. Performance measures are inter-related, so changing performance on one measure may impact performance on another measure (ex. increasing exits to permanent housing without the financial and service support needed to maintain housing may lead to an increase in subsequent returns to homelessness). Also, since the State's HDIS is based on local HMIS data, which is limited to data on people accessing services within each CoC, expansions in programming within a CoC may increase the number of people reported in HMIS as experiencing homelessness. Other changes in local HMIS participation, such as expanding the number of programs that report data in the local HMIS, may also affect the numbers reported in the baseline and subsequent quarterly reports. It will be important for applicants to understand the nature of the data recorded in their local HMIS, in order to reasonably interpret performance results over time and their progress toward the achievement of their Outcome Goals.

This companion guide is provided to help applicants understand the performance measurement data that are being generated by Cal ICH and to offer ideas to HHAP applicants on ways to use the baseline and prior performance data to inform their setting of Outcome Goals and HHAP investments.

Overview of the Baseline Data for Outcome Goals Spreadsheet

The data in the ***Baseline Data*** spreadsheet are generated from the CoC's HMIS upload of CY 2018, 2019 and 2020 data to HDIS. A glossary of terms can be found at the end of this document and on the Glossary tab of the ***Baseline Data*** spreadsheet. The spreadsheet also includes Table 4 Outcome Goals from the HHAP-3 Data Tables Template for reference. Baseline and prior performance data are provided on six tabs, described below.

- **Overview of tabs**
    - Glossary – Definition of terms and concepts used in the Baseline Data for Outcome Goals spreadsheet.
    - HHAP-3 TBL 4. Outcome Goals – Copied from the HHAP-3 Data Tables Template for reference purposes.
    - CY2020 Baseline Data for Goals – CY2020 baseline data, and related CY2019 and CY2018 data, for the Outcome Goal performance measures for each CoC. Baseline data are generated from HDIS, using the HMIS data submitted by each CoC to HDIS. Also provides the percent change from CY2018 to CY2020 that can inform development of Outcome Goals.
    - Detail tabs for each Measure (Measure 1a&2 – Count Detail, Measure 3&6 – Exit Detail, Measure 4 – LOTH Detail, Measure 5 – Returns Detail) – Additional data by project type and other characteristics for each measure.
    - Population Groups Detail – Data for persons by household composition, gender, and ethnicity and race, and other characteristics for CY 2018, 2019 and 2020 for each measure.

- **How to Use the 'Population Groups Detail' Tab**
    - In the HHAP-3 Data Tables Template, applicants are asked to describe any underserved and/ or disproportionately impacted population(s) that your community will especially focus on related to each Outcome Goal. While applicants are not required to use HDIS-generated baseline data to identify underserved and/or disproportionately impacted populations, the data on this tab may help to understand the relative size of different groups (which could be compared with other data sources to determine if specific groups are over-represented among people experiencing homelessness) and their outcomes in relation to the six Outcome Goal performance measures.
    - Within the context of what they know about their system, stakeholders can assess whether the data illuminates concerns or opportunities for the system to expand or adjust strategies to better meet the needs of specific groups.

- **How to Use the 'CY2020 Baseline Data for Goals' Tab to Populate the HHAP-3 Table 4. Outcome Goals Template**
    - Applicants can find CY2020 Baseline performance in column B of the CY2020 Baseline Data for Goals tab. This is the baseline data point that Cal ICH will use to assess the Outcome Goals that communities set for their HHAP-3 funding and to determine a community's performance toward the achievement of those Outcome Goals for the purposes of awarding bonus funding.
    - The change in performance over the three-year period from CY2018 to CY2020 for each measure is in column G – this timeframe mirrors the three-year HHAP-3 performance period (July 1, 2021-June 30, 2024). Communities can use this information to inform the development of their Outcome Goals.

GRAPHIC #1: Relationship between the HHAP-3 Data Tables Template and Baseline Data for Outcome Goals Spreadsheet

HHAP-3 Data Tables Template – TBL 4 Outcome Goals

Outcome Goal #1a: Reducing the number of persons experiencing homelessness.		
Baseline Data: Annual estimate of number of people accessing services who are experiencing homelessness	Outcome Goals July 1, 2021 - June 30, 2024	
	Decrease/Increase in # of People	Decrease/Increase as % Change from Baseline
1,000		

CY2020 Baseline Data for Goals Tab

Measure #1a: Reducing the number of persons experiencing homelessness.				
Baseline Data for CY2020: Annual estimate of number of people accessing services who are experiencing homelessness	Baseline and Prior Performance Data			
	CY2018	CY2019	CY2020	% Change from CY2018
1,000	833	900	1,000	20%

- Graphic #1 illustrates the relationship between the HHAP-3 Data Tables Template and the CY2020 Baseline Data for Goals tab. The CY2020 baseline data point for each measure should be transferred directly into the HHAP-3 Data Tables (solid red arrows). The percent change in performance from CY2018 to CY2020 should inform the development of the Outcome Goals for each measure (dotted blue arrows).
- For example, if the CY2020 annual number of people accessing services is 1,000 people, applicants should put that number in the HHAP-3 Data Tables Template in the first box on the left under the box that says Baseline Data. The percent change from CY2018 to CY2020 is 20%, meaning that in CY202 there were 20%, or 167, more people experiencing homelessness than in CY2018. Applicants should take into account this historical data, changes in local housing market conditions, investments in the homelessness system including HHAP-3 investments, and other factors impacting the inflow of people into homelessness to estimate the number of people who will access services from July 1, 2021 to June 30, 2024. Once applicants have that estimate they can calculate the percent change from baseline they are setting as their Outcome Goal during the HHAP-3 performance period.

Using the Data: Measures 1a, 1b, and 2 – Counts

The first two Outcome Goal performance measures describe the number of people experiencing homelessness within your CoC. Measures 1a and 2 are generated from data in HDIS, but Measure 1b is based on 2020 Point in Time data.

- Measure 1a –Annual estimate of the number of people accessing services while experiencing homelessness in the CoC.
- Measure 1b – Count of the number of people who were unsheltered on the 2020 Point in Time Count.
- Measure 2 –Annual estimate of the number of people who became homeless for the first time in the CoC.

- **Measure 1a&2-Count Detail tab:**
    - This tab provides information on the counts of people accessing services, reported separately in three groups: people experiencing homelessness who are active in a project on January 1st, people entering the system who are newly homeless, and people returning to the system. Newly homeless in this measure means someone who was not served in the prior two-year period and returning to the system means someone who was served at some point in the prior two-year period. People are only included once in these counts, meaning people who are counted as active on January 1st are not counted in the returner column, even if they exit and subsequently return to the system within the year.
    - The baseline numbers from the 'CY2020 Baseline Data for Goals' tab for Measure 1a are shown in the total column (column E) and Measure 2 is shown in the newly homeless column (column C) of the systemwide row (line 6).
    - This tab also provides detail to illuminate how people are served within the system. The number of people who are served only in non-residential projects, such as street outreach, coordinated entry and supportive service only projects (line 7), represents people who are assumed to be unsheltered while accessing services. The number of people served in residential only programs only (line 8) represents people served in emergency shelter, safe havens, and transitional housing, or with time prior to move-in while enrolled in permanent housing programs. The number of people reported as receiving both types of services (line 9) allows the CoC to understand the overlap of people observed to be unsheltered and served within the system. The overlap information may help the CoC estimate the extent to which people who are counted as unsheltered in the point-in-time count are expected to be served within residential programs at some point in the year versus those that are only encountered by non-residential projects and therefore would be excluded by many HMIS-based reports on those "sheltered" by the system.
    - Detail is also provided about the types of projects in which people are served during the reporting year. Since people may be served in more than one project type, the sum of the rows for distinct project types is expected to be larger than the deduplicated counts reported in lines 6-9.
    - All of the performance data is also provided for CY2019 and CY2018.

- **How to Read this Data**
  - Applicants should review their performance data, including the additional data on the Measure 1a&2 Count Detail tab, to explore how the system served people entering homelessness each year in relation to the number of people who experienced unsheltered homelessness on the day of the PIT count. Within the context of what they know about their system, stakeholders should assess whether the data illuminates concerns or opportunities for the system to expand services to meet the needs of those experiencing homelessness within the CoC.
  - The table below shows three examples of how a community may interpret their baseline data on the Detail tab and how they might use that analysis as the basis for HHAP-3 investment strategies and the development of their Outcome Goals. Based on the opportunities identified and the level of funding available to invest in new strategies, the applicant should set their Outcome Goals for the FY2021-FY2024 timeframe.

Table #1: Sample Inflow Data Analysis and Strategy Development

Analysis	Interpretation	Additional Analysis	Strategy	Expected Outcome
Newly homeless have increased over the three years (measure 2) & newly homeless make up a substantial portion of the number of people accessing services in a year (measure 1a).	Homelessness prevention programs are not reaching the people who are most likely to become homeless.	Review prevention screening tools and access locations; analyze characteristics of people receiving prevention assistance compared to characteristics of people who become homeless.	Invest additional prevention funds targeted to people and geographies most likely to enter homelessness.	Reduction in new homelessness (measure 2).
Newly homeless people in measure 2 are not active in ES programs, mainly they are active in SO programs (line 10).	Community either lacks shelter programs, shelters are screening people out or are not seen as meaningful options by people who are unsheltered, or shelter programs are full, and beds are not turning over.	Review shelter inventory, utilization, and length of stay. Also explore barriers to entering shelter (qualitative analysis – focus groups, review shelter policies, etc.).	Depending on findings from additional analysis, either increase shelter inventory, improve shelter flow, or reduce barriers to shelter entry.	Reduction in unsheltered homelessness (measure 1b).
People active in non-residential programs (presumed to be experiencing unsheltered homelessness) on January 1 are less likely than newly homeless people to be served in the RRH or PSH housing programs in the system.	Either newly homeless are prioritized for housing referrals over longer-term homeless OR program barriers to entry in RRH or PSH are reducing the number of effective housing placements for unsheltered people.	Analyze coordinated entry assessment and referral data. Collect qualitative data on groups that are not entering RRH or PSH at a proportionate rate.	Coordinated entry or program-level improvements to increase housing placements for long-term homeless and unsheltered homeless.	Increase in housing placement for people who were experiencing homelessness on one day: reduction in daily unsheltered homelessness (measure 1b) and/or total number of homeless (measure 1a).

Using the Data: Measures 3 and 6 – Exits from the Homelessness System

The third and sixth measures and supporting detail describe people's destinations when they either exit the homelessness system ("system exits") or exit projects within the homelessness system ("project exits") and calculate the number who exit to destinations deemed successful out of all exits.

- Measure 3 - Number of people exiting the homelessness system to permanent housing.
- Measure 6 - Number of people served in street outreach with successful exits, which includes exits to an emergency shelter, safe haven, transitional housing, or permanent housing destinations in the CoC.

- **Measures 3&6 – Exit Detail tab:**
    - The data in this tab report the number of people who exited to successful destinations for each measure, the number of people who exited to any destination, and the exit success rate for the year.
    - For Measure 3, performance for all people with system exits is reported in line 6. A "system exit" is the last exit of a person's continuous involvement with the homelessness system, meaning the person does not have an enrollment in any project for at least 14 days (the time period defined as a break in homelessness system involvement). Often people receive assistance from multiple projects to help them resolve their experience of homelessness, so reporting a destination from the first or the second project enrollment would not reveal how the homelessness system as a whole performed in helping the person exit to a permanent destination. A person with a system exit may have a subsequent enrollment in the homelessness system (at least 14 days after the system exit), but that later exit would be considered a return to the homelessness system (reported in Measure 5) versus a continuation of the same episode of homelessness system involvement.
    - The detail for Measure 3 separately reports performance on exits for people based on the project type from which they were last served prior to their system exit (lines 7-11). This information can help applicants see which parts of the system are most successful at helping people move to permanent housing. The data for people whose "System exit is from Permanent Supportive Housing or other permanent housing projects, with a Move-In Date" reflect people's destinations when they exit from the homelessness system (which occurs when they are no longer being served by the permanent supportive housing project) versus when they ended their homelessness (which occurred at the point at which they moved into the permanent supportive housing project.) This group, as evidenced by the presence of a "move-in date" within the HMIS project enrollment, was housed and assisted in permanent housing while they were still enrolled in the permanent supportive housing project; they are no longer considered to be experiencing homelessness after their permanent housing move-in date. This measure reports on their destination when they leave the project and are no longer being served by the homelessness system.
    - Measure 3 also includes detail (line 13) to allow the CoC to understand how many people have been permanently housed, even if they haven't exited the homelessness system yet. Information is on people who are still active in rapid rehousing, permanent supportive housing, or other permanent housing projects on the last day of the reporting period and the subset of those individuals with a permanent housing move-in date. The unduplicated total of people who have exited the homelessness system and those still active in permanent housing projects and the subset within that group who exited to permanent housing or were housed is reported in line 15.
    - Measure 6 reports data on people served in street outreach projects who exited to a temporary or permanent destination, such as emergency shelter, safe haven, transitional housing, or permanent housing destinations. For purposes of this measure, a person's exit from street outreach is based on

their destination when they finished receiving assistance from street outreach (e.g., their last street outreach enrollment) within the reporting period.

- The detailed performance data is also provided for CY2019 and CY2018.

- **How to Read this Data**
  - Applicants should review their performance data including the additional data on the Detail tab and explore the extent to which people exited the homelessness system to permanent housing or not, and how performance varied based on the project from which they exited (e.g., where they received the last support.) Within the context of what they know about their system, stakeholders should assess whether the data illuminates concerns or opportunities for the system to improve the rate of people exiting to permanent housing.
  - The table below shows two examples of how a community may interpret their baseline data on the Detail tab and how they might use that analysis as the basis for HHAP-3 investment strategies and the development of their Outcome Goals. Based on the opportunities identified and the level of funding available to invest in new strategies, the applicant should set their Outcome Goals for the FY2021-FY2024 timeframe.

Table #2: Sample Exits Data Analysis and Strategy Development

Analysis	Interpretation	Additional Analysis	Strategy	Expected Outcome
Exit success rates (column D) for Measure 3 on the Measure 3&6-Exit Detail tab have decreased over the past three years for people in ES, SH and TH projects (line 7).	More households are leaving shelter and TH to temporary or unknown destinations instead of permanent housing.	Explore whether households are either exiting to unknown destinations (data quality issue) or temporary destinations (performance issue). For the latter, explore what system, program, or external factors changed during the time period that could have resulted in a reduction in exits to permanent housing.	Increase housing resources and improve connections between shelter programs and housing resources. If many shelter exits are to unknown destinations, provide data quality training. Ensure shelter programs have housing focused policies and practices.	Increase in exits to permanent housing from ES, SH, and TH projects (measure 3).
Exits to permanent housing from Rapid Rehousing (line 8) on the Measure 3&6-Exit Detail tab are not achieving expected placement rates.	Households are leaving RRH projects to unknown or temporary destinations.	Explore program policies, length of stay, and exit destination data. Are households exiting RRH too soon? What type of non-permanent exit destinations are most common? Examine returns data about people who exiting RRH projects from temporary and unknown destinations (Measure 5) to explore long-term housing stability.	Address program policies and practices that may be prematurely exiting households from RRH. Consider increasing investment in RRH to provide additional months' rental assistance or case management.	Increase in exits to permanent housing from RRH projects (measure 3).

Using the Data: Measure 4 – Length of Time Homeless (LOTH)

The fourth measure and supporting detail describe how long people in your CoC access services during their experience of homelessness and how much time they are receiving assistance from different parts of the system.

- Measure 4 –Average length of time people experience homelessness in the CoC.

- **Measure 4 – LOTH Detail tab:**
    - This tab includes the same baseline averages as on the CY2020 Baseline Data for Goals tab in line 6 as well as the median length of time homeless. This tab also shows the average and median length of time homeless for people when they are: served in emergency shelters or safe havens (line 7); served in transitional housing (line 8); cumulative days homeless in emergency shelter, safe havens and transitional housing combined (line 9); additional days served in street outreach or other services only projects, when homeless and not already counted in prior sections (line 10); and, additional days served in RRH or PSH prior to move-in date, not already counted in prior sections (line 11).
    - When calculating lengths of time people are homeless, all overlapping time recorded in homelessness project enrollments is unduplicated.
    - In night-by-night emergency shelter projects, people are assumed to be active in the project between their first and last night recorded during project enrollment. In the event that a person does not have any nights recorded, the person is assumed to have stayed on the night of the project start date, as well as the 15 days following that date (per the buffer concept described in the glossary).
    - Since some non-residential projects serve people who are experiencing homelessness as well as those who are not, only timeframes associated with contacts when a person has a current living situation in a homeless setting are counted as periods of homelessness.
    - Since non-residential projects do not typically contact people daily, the calculations assume that people are homeless for the month in which the contact occurs (two weeks before and two weeks after the contact); this is called a buffer period.
    - Often non-residential projects neglect to formally exit people from their project in HMIS, since a project does not necessarily know in advance when a person is going to complete their assistance. As part of calculating HDIS performance measures, if there is a break of more than 60 days after a service contact, the client is considered to have exited. If there's a later service contact (more than 60 days from the prior contact), the person is considered to have re-entered the project.
    - The detailed performance data is also provided for CY2019 and CY2018.

- **How to Read this Data**
    - Applicants should review their performance data including the additional data on the Detail tab and determine whether the lengths of stay, particularly in specific project settings, are aligned with the community's performance goals for the system. Within the context of what they know about their system, stakeholders should assess whether the data illuminates concerns or opportunities for the system to reduce the length of time people spend in homeless settings.
    - The table below shows three examples of how a community may interpret their baseline data on the Detail tab and how they might use that analysis as the basis for HHAP-3 investment strategies and

the development of their Outcome Goals. Based on the opportunities identified and the level of funding available to invest in new strategies, the applicant should set their Outcome Goals for the FY2021-FY2024 timeframe.

Table #3: Sample Length of Time Homeless Data Analysis and Strategy Development

Analysis	Interpretation	Additional Analysis	Strategy	Expected Outcome
Higher than expected length of time homeless in ES/SH (line 6 on Detail on LOTH tab)	Households in shelter are not being quickly referred to housing resources.	Explore shelter policies and procedures to identify barriers to timely housing referrals and opportunities for more proactive housing planning or linkage to RRH or other housing resources.	Invest in additional housing navigation or other housing resources to increase shelter flow.	Reduce length of time homeless in ES/SH.
Higher than expected length of time homeless prior to an RRH/PSH move-in date.	Either programs have missing or inaccurate RRH/PSH move-in dates in HMIS OR housing programs are taking a long time to house people.	Explore data quality to ensure that move-in dates are accurately captured in HMIS. If HMIS is accurate, explore with RRH and PSH providers what the barriers to housing are.	Consider increasing staffing ratio, providing landlord incentives, or a landlord outreach campaign to speed up housing placements.	Reduce length of time homeless after RRH/PSH enrollment.
Lower than expected length of time homeless in ES/SH (line 6 on Detail on LOTH tab) AND lower than expected Exits to PH (Measure 3)	Households in shelter may be exiting before they can be linked to housing resources.	Explore whether shelter environment or practices are leading people to leave without viable housing options. Consider ways to create more proactive housing planning or linkage to RRH or other housing resources.	Refine shelter practices. Invest in additional housing navigation or other housing resources to increase shelter flow.	Increase length of time homeless in ES/SH (Measure 4) but increase exits to permanent housing (Measure 3) and potentially reduce subsequent returns.

Using the Data: Measure 5 - Returns

- Measure 5 - Percent of people who returned to the homelessness system (e.g., emergency shelter, safe haven, transitional housing, rapid rehousing or permanent supportive housing projects or other non-residential projects while homeless) within 6 months after having exited the homelessness system to permanent housing in the CoC.

- **Measure 5 – Returns detail tab:**
  - This tab provides the baseline number of households returning to homelessness within 6 months (column D, line 7) of system exit to a permanent destination and the return rate for that group (column E, line 7). Performance is measured based on the number of people with system exits in CY2020 (column C) and the extent to which any of these people had a return, meaning a subsequent enrollment in a homelessness project, within 6 months of the person's original system exit. Additional columns are provided to report whether any people in this group returned to the homelessness system within 12 months (column F) or 24 months (column H) of their original system exit, but the Outcome Goal is to be set regarding returns to the homelessness system within 6 months of original system exit. Returns within 12 or 24 months are not available for the CY2020 dataset because there has not been sufficient time since the cohort's exit to calculate returns. These columns will be filled in as the data is available.
  - The tab also includes information about all people with a system exit in CY2020 (line 6), people with a system exit to a temporary destination (line 8), and people with a system exit to an unknown destination (line 9), and the subset of these groups who returned.
  - The data in lines 10-24 show the exit and returns data exits for people based on the project type from which they were last served prior to their system exit. For each project type, performance data is provided based on the type of destination reported for the person at the time of their system exit.
  - This performance data is also provided for CY2019 and CY2018.

- **How to Read this Data**
  - Applicants should review their performance data including the additional data on the Detail tab and examine whether the return rates feel commensurate with the type of assistance provided to people accessing the homelessness system and the extent to which annual inflow is affected by returns (Measure 1). CoCs typically have more confidence that people who exit homelessness systems to a permanent destination are less likely to return, but these data will provide insight to the CoC about whether people who exit to other situations experience the same rate of returns. Within the context of what they know about their system, stakeholders should assess whether the data illuminates concerns or opportunities for the system to reduce the likelihood of a subsequent return. While homelessness systems may have less influence over returns that occur after an extended absence from the homelessness system, they may want to consider offering deeper interventions or targeting different interventions to returners if they identify persistently high rates of returns to homelessness.
  - The table below shows two examples of how a community may interpret their baseline data on the Detail tab and how they might use that analysis as the basis for HHAP-3 investment strategies and the development of their Outcome Goals. Based on the opportunities identified and the level of funding available to invest in new strategies, the applicant should set their Outcome Goal for the FY2021-FY2024 timeframe.

Table #4: Sample Returns to Homelessness Data Analysis and Strategy Development

Analysis	Interpretation	Additional Analysis	Strategy	Expected Outcome
Higher than expected returns to homelessness (measure 5) despite an increase in permanent exits (measure 3).	Exits to permanent housing have increased but a larger percentage of people are returning to homelessness within 6 months.	Examine whether they are leaving after receiving short or long-term rental assistance or are exiting directly from shelter. Examine the types of permanent housing that people are exiting to.	Explore: improving the quality and increasing the intensity of services available to participants; increasing funding for rental assistance and potentially to offer longer periods of assistance.	Reduction in rate of return to homelessness (measure 5).
Rate of return to homelessness from PSH or OPH has increased (measure 5).	People exiting from PSH or OPH have a higher rate of return than people exiting from emergency shelters or transitional housing programs.	Explore whether clients are being exited from PSH or OPH too quickly or without having adequate supports in the community.	Consider implementing or expanding services for people who have recently exited from PSH/OPH to ensure they remain stably housed.	Reduction in rate of return to homelessness (measure 5).

Crosswalk of HDIS-based Outcome Goal Performance Measures and HUD's CoC System Performance Measures

The State of California requires local jurisdictions seeking HHAP-3 funding to set Outcome Goals for seven performance measures within Local Homelessness Action Plans. As required by statute, the Outcome Goal Performance Measures are based on the U.S. Department of Housing and Urban Development (HUD) Continuum of Care (CoC) System Performance Measures, but the measures do differ in some ways, in order to ensure that a fuller range of people experiencing homelessness are included within the data. The baseline data for the Outcome Goal Performance Measures are based on Calendar Year 2020 data generated from the State's Homeless Data Integration System (HDIS), which was also specified by statute.

This crosswalk specifies the ways in which the HDIS-generated Outcome Goal Performance Measures and the HUD CoC System Performance Measures differ. The primary difference is that the HDIS-generated measures consistently include data from non-residential projects, such as street outreach, coordinated entry, and other supportive services, to ensure that the measures include information about people experiencing unsheltered homelessness who would not otherwise be captured in some of the HUD measures. The HDIS measures also include some adjustments to account for several key data quality issues. For both HDIS and HUD, the performance measures are limited to data collected in HMIS, so the performance results will not reflect the experience of people who do not interact with HMIS participating providers.

HDIS-based Outcome Goal Performance Measures	**HUD CoC System Performance Measures**
Baseline Reporting Period: Calendar Year 2020 (Per statute)	**Reporting Period:** Federal Fiscal Year (October to September)
Universe: The homelessness *system* rather than specific project types. Measures include data related to all of the project types included in the HUD CoC System Performance Measures, as well as information from Coordinated Entry (CE) and other supportive services (SSO), such as access centers and day shelters. Cumulatively, SO, CE, and SSO projects are referred to as "non-residential projects."	**Universe**: Specific project types -- Emergency Shelter (ES), Safe Havens (SH), Transitional Housing (TH), Rapid Rehousing (RRH), Permanent Supportive Housing (PSH) and Street Outreach (SO). Measures do not include people who only accessed services in other non-residential project types.
Measure 1a: Annual estimate of number of people accessing services who are experiencing homelessness.	**Metric 3.2: Annual counts of sheltered homeless persons in HMIS.**
• Includes people who were enrolled in ES, SH, TH • Includes people who were enrolled in RRH, PSH, and Other Permanent Housing (OPH) projects, if they were enrolled and not housed (meaning, they did not have a recorded move-in date) at some point during the year.	• Only includes people enrolled in ES, SH, or TH. • Does not consider data from RRH or PSH projects.

HDIS-based Outcome Goal Performance Measures	HUD CoC System Performance Measures
• Includes people enrolled in non-residential projects (Street Outreach, Coordinated Entry, Services Only, Day Shelter, other non-res) with a Current Living Situation indicating homelessness.*	• Does not consider data from non-residential projects.
Measure 1b: Estimate of number of people experiencing unsheltered homelessness on the 2020 Point-in Time (PIT) Count.	**Metric 3.1: PIT counts of sheltered and unsheltered homeless persons.**
• PIT count of *unsheltered* homelessness. Does not include the sheltered PIT count.	• Includes the PIT counts of both sheltered and unsheltered homelessness.
Measure 2: Annual Estimate of the number of people who become homeless for the first time.	**Metric 5.2: The number of persons entering ES, SH, TH, and PH projects with no prior enrollment in HMIS**
• Includes people who entered the homelessness *system* with an entry into ES, SH, TH, RRH, PSH, OPH project, or homelessness in a non-residential project (based on Current Living Situation)* who did not have HMIS entries into any of these types of projects (while experiencing homelessness) in the previous 24 months.	• Includes persons who entered ES, SH, TH, and RRH, or PSH projects in the year who did not have entries into ES, SH, TH, RRH, or PSH projects during the previous 24 months. Does not include entries into non-residential projects.
Measure 3: Annual Estimate of number of people exiting homelessness into permanent housing.	**Metric 7b.1: Exits to permanent housing destinations.**
• Counts the last *system* exit from the homelessness *system*. A system exit is an exit from any project in HMIS in which the person was documented as experiencing homelessness while accessing services in the project and did not return to any other project in the system within 14 days following the exit.	• Counts the last *project* exit from ES, SH, TH and RRH, as well as PSH in which there was no housing move-in date. (Note, the PSH exits are limited to those without a housing move-in date, because there is a separate SPM that counts the number of people in PSH who are currently housed in PSH or who exited PSH after moving into housing.)
• Includes any system exit from PSH or OPH projects where the person did not return to the homelessness system within 14 days after the exit.	• Only includes exits from PSH or OPH where there was no housing move-in date. Excludes exits from PSH/OPH where there was a housing move-in date.
• Includes system exits from non-residential projects and street outreach.	• Excludes project exits from non-residential projects. (Metric 7b.1 does not include SO.)
• Includes people who were active on the last day of the reporting period, IF they have a prior system exit within the reporting period.	• Excludes people who were active on the last day of the reporting period, even if they have a prior project exit within the period.

HDIS-based Outcome Goal Performance Measures	HUD CoC System Performance Measures
Measure 4: Average length of time (in # of days) persons enrolled in street outreach or other non-residential projects (while homeless), emergency shelter, transitional housing, safe haven projects and time prior to move-in for persons enrolled in rapid rehousing and permanent housing projects.	**Measure 1a, Metric 2: Length of Time Persons Remain Homeless (ES, SH, and TH)**
• Includes days enrolled in ES, SH, TH projects, as well as days people are enrolled in RRH and PSH days but are not yet housed (e.g., between project start and move-in date).	• Includes days enrolled in ES, SH, and TH projects between project start and move-in date.
• For night-by-night shelters, includes documented days homeless based on bed nights recorded between the entry date and exit date (or report end date, if earlier). If there are no bed nights between the person's entry and exit dates, they are counted as homeless on the project entry date and for 15 days after or through the project exit date, whichever is earlier.	• For night-by-night shelters, includes days homeless from Prior Living Situation until the earliest bed night and days between bed nights recorded between the entry date and exit date (or report end date, if earlier). There is no accommodation for project enrollments without a bed night recorded.
• Includes days experiencing homelessness in non-residential projects – counts days with documented homeless Current Living Situation plus additional buffers.*	• Excludes days experiencing homelessness in non-residential projects.
• Calculation includes continuous time that starts before the report period and overlaps the report start date. Periods of less than seven days between project enrollments are not considered a break in the continuity of homelessness. Days between continuous enrollments (less than 7 days apart) are counted toward length of time homeless.	• Calculation includes continuous time that starts before the report period and overlaps with the report start date. Project enrollments must be *contiguous* (no days between one enrollment end and the next enrollment start dates) to be considered continuous. Time between non-contiguous enrollments is not counted toward length of time homeless.
Measure 5: Percent of people who return to homelessness within 6 months of exiting homelessness to permanent housing.	**Measure 2a and 2b: The Extent to which Persons Who Exit Homelessness to Permanent Housing Destinations**
• Measure 5 focuses on returns within 6 months of exiting the homelessness system from any project type.	• Measures include returns within 6, 12, and 24 months of exiting the homelessness system from specific project types only.
• Exits and returns include system exits from all projects in the homelessness system, including non-residential projects (when Current Living Situation indicates homelessness).	• Exits and returns include exits only from ES, SH, TH, SO, and RRH/PSH (where homeless at entry) projects. Does not include services only non-residential projects.

HDIS-based Outcome Goal Performance Measures	HUD CoC System Performance Measures
Measure 6: Annual number of people served in street outreach projects who exit to emergency shelter, safe haven, transitional housing, or permanent housing destinations.	**Metric 7a.1: Street Outreach exits to permanent housing destinations.**
• Includes people who were active in SO on the last day of the reporting period, IF they have a prior project exit from a SO project during the project year.	• Excludes people who were active in a SO project on the last day of the reporting period.

**Non-residential projects use calculations of "breaks" and "buffers" to determine a person's homelessness timeframe, which is used across all HDIS measures. For people enrolled in non-residential projects while experiencing homelessness (based on their Current Living Situation), homelessness starts and end dates are determined by contact dates within the year plus an additional 15 days "buffer" before and after the contact date, so one recorded date of homelessness is counted as 30 days of homelessness. "Breaks" of 60 days or longer between contact dates would create separate enrollment records. Less than 60 days between contact dates would be considered one episode of homelessness.*

HDIS Performance Measures Report Glossary

TERM	DEFINITION
Average length of time homeless	The average cumulative, unduplicated number of days that households were served in specified homelessness projects. For, ES, SH, or TH projects that document enrollment based on entry and exit dates, the person is considered homeless for the entire enrollment. For night-by-night shelters, the person is considered homeless on any night recorded in HMIS and any time between nights recorded. In RRH or PSH projects, the person is considered homeless from the project start date to the PH move-in date or project exit date (whichever is earlier). For non-residential projects, the person is considered homeless for any day on which a contact is recorded and the person's current living situation is marked as a homeless situation, plus the 15-day period before and after that date, within the parameters of the recorded project start and end date. All periods of homelessness are unduplicated and summed across project enrollments, including any continuous enrollment timeframes that occurred prior to the reporting period. Periods of less than seven days between project enrollments are not considered a break in the continuity of homelessness.
Baseline data	Calendar Year 2020 (CY2020) performance data for each jurisdiction, based on the HMIS data uploaded into HDIS by the CoC
Breaks	A break is defined as a period of 60 days or more between recorded service contacts within a non-residential project. In non-residential homelessness projects, projects should enroll clients when they begin receiving assistance and then should record discreet service contacts each time assistance is provided, exiting the client when the assistance is complete. Often non-residential projects have a large number of missing exits since a project does not necessarily know in advance when the person is going to complete their assistance. As part of calculating HDIS performance measures, if there is a break of more than 60 days after a service contact, the client is considered to have exited. If there's a later service contact (more than 60 days from the prior contact), the person is considered to have re-entered the project.
Buffers	A buffer is a methodological concept that has been incorporated into the HDIS performance measurement analysis in order to infer how long someone has experienced homelessness using the non-residential service contacts and night-by-night shelter records in HMIS. Since most non-residential projects are not expected to interact with someone every day they experience homelessness, a buffer of 15 days is added before and after each service contact that has a current living situation in a homeless setting. The buffer is programmed so it does not exceed someone's recorded project start and exit dates. The "buffered" service contacts are then counted towards a client's period of homelessness, unduplicating for time already recorded in a different homelessness project enrollment. A buffer is also applied to night-by-night shelter enrollments under very limited circumstances. (See the Night-by-night shelter definition for more information.)

TERM	DEFINITION
Current living situation - homeless and non-homeless	Most residential project types (e.g., emergency shelters) in homelessness systems only serve people experiencing homelessness, but non-residential project types (e.g., outreach teams and coordinated entry projects) may serve people who are homeless AND those who are not homeless. The Current Living Situation (CLS) field in HMIS is the place where non-residential projects record whether people are staying in homeless or non-homeless settings. CLS is supposed to be recorded by non-residential projects at every contact to track a person's current living situation over time.
Client record	Homelessness system projects record data about the clients they serve in their CoC's HMIS. Every client who receives assistance should have a single record in the HMIS with the individual's basic identifiers and demographics. When an agency provides services, a project enrollment should be created for the client to record information about the services provided for the person and other information about the client related to the time period in which the client is enrolled in the project.
Continuum project	When a project is set up in HMIS, it is identified as a 'Continuum' project or a non-Continuum project. A 'Continuum' project is a project within the geographic boundaries of the Continuum(s) of Care served by the HMIS whose primary purpose is to meet the specific needs of people who are homeless by providing lodging and/or services. A Continuum project is not limited to those projects funded by HUD and should include all federally or non-federally funded projects functioning within the continuum. A project that is NOT a Continuum project is not designed to primarily serve people experiencing homelessness, so a CoC cannot assume that all people served in the project were homeless at project entry.
Enrollment	An enrollment, also referred to as a project enrollment, represents a period of assistance provided by a specific project to a client, as defined by a project start date and project exit date. A client in HMIS must have at least one project enrollment to be reported in the Baseline Data for Outcome Goals, even if it's a single contact with a street outreach project.
Experiencing homelessness	The number of people experiencing homelessness is limited to data known from HMIS and is determined by having an enrollment in an HDIS project type. For project types that serve people who are experiencing homelessness and those who are housed, data on a client's current living situation at the time of each project interaction is used to determine if they are experiencing homelessness within a specified report period. For example, a client who is enrolled in a permanent housing project type but who has not yet moved into housing would be considered to be experiencing homelessness, but after they have moved into housing, they would no longer be considered as experiencing homelessness, although they remain enrolled in the project.

TERM	DEFINITION
Homelessness end date	To define the period of a project enrollment when a client is assumed to be homeless, HDIS calculates a homelessness start date and a homelessness end date. The homelessness end date is the date at which the client is no longer recorded as homeless. For purposes of emergency shelters using entry/exit tracking, TH and SH, the homelessness end date is set to the project exit date. For purposes of RRH, PSH and OPH, the homelessness end date is set to the PH move-in date or project exit date, whichever is earlier. For purposes of night-by-night emergency shelters, the homelessness end date is set to the last night of shelter recorded in the project. For purposes of non-residential projects, if the last service contact in a homeless setting was more than 15 days from the project exit date, the homelessness end date is set to fifteen days after the last service contact. [When calculating someone's length of homelessness, overlapping enrollments are unduplicated, and any period in which someone is recorded as being housed supersedes homeless enrollments.]
Homeless for the first time	A household that enrolled in a homelessness system project during the report period and was not enrolled in such projects at any point in the two years prior to entry. (This designation is determined at the time of the first enrollment of the report period, in order to distinguish outcomes between those who are first-time homeless compared with those who are returning to homelessness.)
Move-in date	The date when the client or household moves into any type of permanent housing. This data element is used to distinguish between the pre-move-in time of RRH and PSH when the person is still homeless and the period after move-in, when the person is housed but still enrolled in the project. After the move-in date, the period is no longer considered to be experiencing homelessness, even though they are still receiving assistance from the project.
Night-by-night shelters	When an emergency shelter project is set up in HMIS, there is an indicator to show whether someone's length of participation in the project should be measured using the entry-exit method or the night-by-night method. Per the data standards, "The night-by-night method relies on creating a separate record of each individual date on which a client is present in the shelter as a means for calculating length of stay". Although shelters using this method are supposed to record each night stayed in the project, for purposes of the HDIS performance measures, people are assumed to be active between their first and last night recorded during project enrollment. In the event that a person does not have any nights recorded, the person is assumed to have stayed on the night of the project start date, as well as the 15 days following that date (per the buffer concept described in this glossary).
Non-residential projects	Non-residential projects accounted for in the HDIS performance measures include: street outreach, coordinated entry, day shelters, and other supportive service only projects. In a non-residential project, services are recorded for each date on which the project has contact with a client. Since non-residential projects may serve people who are not homeless, the performance measures use the current living situation associated with each service contact to determine whether the person was homeless at the time of each contact.

TERM	DEFINITION
Overlapping enrollments	Overlapping enrollments are enrollments where a client's entry/exit date range for one project enrollment overlaps wholly or partially with their entry/exit date range for another project. Many people experiencing homelessness receive assistance from more than one project within a homelessness system, such as someone enrolled in emergency shelter and rapid re-housing (pre-move-in), or street outreach and emergency shelter. For purposes of calculating the HDIS performance measures, overlapping enrollments are analyzed for each individual to count unduplicated lengths of time homeless and system exits.
People accessing services	The baseline data for the HDIS performance measures is almost entirely generated from HDIS (all but Measure 1b), which are limited to data about people who are accessing services from the projects that report client data in HMIS. These projects are referred to as "HMIS participating projects". People who are experiencing homelessness in the jurisdiction but are not receiving services from HMIS participating projects will not be represented in the baseline data.
Populations disproportionately impacted	Each community will need to identify populations that are over-represented among those experiencing homelessness in comparison to their representation within the community as a whole or in comparison to the group's representation among whose experiencing poverty. (In this use, a population is considered a group of people with a shared characteristic that enable the community to measure their experience as a whole.) In addition, communities should examine the performance measures to determine if the system is achieving lower rates of positive outcomes for different populations. If specific groups have over-representation or disproportionate impact, local stakeholders (representative of those in the impacted group) should review results and identify strategies to achieve equitable outcomes for the impacted group. When designing strategies to remedy disproportionate impacts, CoCs should also consider whether the impacted group is underserved within the homelessness system.
Project enrollment	In HMIS, each project enrollment has a ‘homelessness start date’ and ‘homelessness end date’, when the person is no longer enrolled in the project. Homelessness start and end dates are established for each enrollment based on the project type.
Project exit date	In HMIS, each project is expected to enter a project exit date when the client is no longer enrolled and therefore has ended participation in the project. For project types that provide services to people while they are experiencing homelessness and after they are placed in housing, the person's homelessness end date occurs during project enrollment and the project exit date represents the date when the person is no longer receiving assistance from the project. Exit destination is supposed to be recorded in HMIS at the time of any project exit.
Project exit to permanent housing	At the time of every project exit, the agency attempts to record the participant's exit. Permanent housing exits include the following responses: permanent housing (other than RRH) for formerly homeless people; rental by client, no ongoing housing subsidy; owned by client, no ongoing housing subsidy; rental by client, with VASH housing subsidy; rental by client, with other ongoing housing subsidy; owned by client, with ongoing housing subsidy; staying or living with family, permanent tenure; staying or living with friends, permanent tenure; moved from one HOPWA funded project to HOPWA PH; rental by client, with GPD TIP housing subsidy; rental by client, with RRH or equivalent subsidy; rental by client, with Housing Choice Voucher (HCV) (tenant or project based); or, rental by client in a public housing unit.

TERM	DEFINITION
Project types (include list)	HDIS includes data on clients served in the following homelessness residential project types, in which people's homelessness is assumed during the project enrollment: emergency shelter (ES - note nuances for measuring length of stays in night-by-night shelter), transitional housing (TH), safe haven (SH) projects; data from the following non-residential projects, during which homelessness is determined based on current living situation: street outreach (SO), day shelter (DS), coordinated entry (CE), and services only (SSO); data from the following permanent housing project types, during which people are assumed to be homeless prior to PH move-in date: PH-rapid rehousing (RRH), PH-permanent supportive housing (PSH); data from other permanent housing (OPH) projects, during which people are assumed to be homeless prior to PH move-in date IF their prior living situation was in a homeless setting or the project is designated as a Continuum project.
Report period	The time period in which all of the HDIS performance measures is being applied. For measure 1 and 2, someone must be recorded as homeless during the report period to be counted in the measure. For measure 3, a person's system exit must be within the report period to be counted in the measure. For measure 5, a person's system exit must be within the report period to be counted in the universe of the measure. The return does not need to occur within the report period, since the 6-month window for a subsequent return is measured relative to each person's exit. For measure 6, a person's project exit from street outreach must be within the report period to be counted in the measure.
Residential projects	Residential projects in HDIS include homelessness residential project types and permanent housing project types. Homelessness residential project types in which people's homelessness is assumed during the project enrollment are: emergency shelter (ES - note nuances for measuring length of stays in night-by-night shelter), transitional housing (TH), safe haven (SH) projects. Permanent housing project types during which people are assumed to be homeless prior to PH move-in date are: PH-rapid rehousing (RRH), PH-permanent supportive housing (PSH). Time spent in other permanent housing (OPH) projects are included in performance measures IF their prior living situation was in a homeless setting or the project is designated as a Continuum project.

TERM	DEFINITION
Return to homelessness after exiting to permanent housing	Returns are measured for all people in a system exit cohort who have a subsequent return to the homelessness system after exiting the homelessness system. The HDIS returns performance measure is limited to the system exit cohort of people with system exits to permanent housing who returned to the homelessness system within six months of their system exit. Baseline data is provided on a larger universe of system exiters (those who exited to temporary and unknown destinations) and returns that occur over a longer time period (within 24 months of their system exit), to provide more information about people's ongoing involvement with the homelessness system after initial system exit. *Timeframe to Measure Returns:* The time period after a household exits from the homelessness system during which a return to the homelessness system is counted in the Returns measure. *Returns in 6 Months:* Returns to homelessness projects within 6 months after the household first exited the homelessness system. *Returns in 12 Months:* Returns to homelessness projects within 12 months after the household first exited the homelessness system. 12 month returns are only available for the system exit cohort of households that exited 1-12 months before the current report period. *Returns in 24 Months:* Returns to homelessness projects within 24 months after the household first exited the homelessness system. 24 month returns are only available for the system exit cohort of households that exited 13-24 months before the current report period.
Sheltered homelessness	The number of people sheltered during the report period represents people served in emergency shelter, safe havens, and transitional housing. [Note sheltered homelessness is not synonymous with being served in a residential project, since permanent housing projects are also considered residential projects.]
Successfully placed from street outreach	People served in street outreach projects are considered to have a successful placement if they exited to a temporary or permanent destination, such as emergency shelter, safe haven, transitional housing, or permanent housing destinations. For purposes of this measure, an exit is the last enrollment from street outreach within the reporting period.
System exit	An exit from any project where there is no subsequent enrollment in any project type for the person in the 14 days following the exit. When looking at system exits during the report period, the determination of whether someone is moving into permanent housing or another temporary or unknown destination type is based on the recorded destination of this "last exit".
System exit cohort	A system exit cohort is the group of people with a system exit in a defined reporting period. The subset of exiters who exit to permanent housing is the denominator for Measure 3: Exits to Permanent Housing and for Measure 5: Returns to Homelessness after exit. (Note that people who die during the time they are enrolled in a homelessness project are excluded from exit and returns performance measures.)
System exit cohort period	A system exit cohort period is the period of time during which people with system exits are identified. The HDIS baseline performance data is based on a calendar year 2020 system exit cohort period. Therefore, anyone with a system exit in calendar year 2020 is considered part of the HDIS baseline system exit cohort. The HDIS baseline performance data also includes data for the calendar year 2019 and 2018 system exit cohort periods.

TERM	DEFINITION
System exit to permanent housing	System exit outcomes are based on the destination recorded for the project enrollment associated with a person's system exit, meaning the person did not enroll in any other project for 14 days or more following the project exit. Permanent housing exits include the following responses: permanent housing (other than RRH) for formerly homeless people; rental by client, no ongoing housing subsidy; owned by client, no ongoing housing subsidy; rental by client, with VASH housing subsidy; rental by client, with other ongoing housing subsidy; owned by client, with ongoing housing subsidy; staying or living with family, permanent tenure; staying or living with friends, permanent tenure; moved from one HOPWA funded project to HOPWA PH; rental by client, with GPD TIP housing subsidy; rental by client, with RRH or equivalent subsidy; rental by client, with Housing Choice Voucher (HCV) (tenant or project based); or, rental by client in a public housing unit.
Time prior to move-in	In permanent housing projects, time prior to move-in is the period between project start date and PH move-in date. This time is counted as a period of homelessness, whereas the period after move-in is counted as "housed", even though they are still enrolled in the project.
Underserved population	Each community will need to identify populations that are underserved in the homelessness system, or in parts of the homelessness system. (In this use, a population is considered a group of people with a shared characteristic that enable the community to measure their experience as a whole.) Being underserved means the group is not served in alignment with their representation among everyone experiencing homelessness or the system is achieving lower rates of positive outcomes for different groups of people. When designing strategies to provide equitable access to services, CoCs should also consider whether underserved populations are disproportionately impacted within the homelessness system.
Unsheltered homelessness	People experiencing unsheltered homelessness are only identified in HDIS if they receive assistance from a homelessness project at some point in a reporting period. For purposes of HDIS performance measures, people are assumed to be unsheltered while accessing homelessness services, if they are served only in non-residential projects, such as street outreach, coordinated entry and supportive service only projects (with a current living situation in a homeless setting). HDIS does not have information on people experiencing unsheltered homelessness who do not access assistance that is recorded in HMIS; therefore HDIS data is not used to populate performance for Measure 1b.

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Table 4. Outcome Goals

Outcome Goal #1a: Reducing the number of persons experiencing homelessness.		
Baseline Data: Annual estimate of number of people accessing services who are experiencing homelessness	Outcome Goals July 1, 2021 - June 30, 2024	
	Decrease/Increase in # of People	Decrease/Increase as % Change from Baseline
2,629		
Describe Your Related Goals for Underserved Populations and Populations Disproportionately Impacted by Homelessness		
Describe any underserved and/ or disproportionately impacted population(s) that your community will especially focus on related to this Outcome Goal and how this focus has been informed by data in your landscape assessment:	Describe the trackable data goal(s) related to this Outcome Goal:	

Outcome Goal #1b: Reducing the number of persons experiencing homelessness on a daily basis		
Baseline Data: Daily Estimate of # of people experiencing unsheltered homelessness	Outcome Goals July 1, 2021 - June 30, 2024	
	Reduction in # of People	Reduction as % Change from Baseline
1,700		
Describe Your Related Goals for Underserved Populations and Populations Disproportionately Impacted by Homelessness		
Describe any underserved and/ or disproportionately impacted population(s) that your community will especially focus on related to this Outcome Goal and how this focus has been informed by data in your landscape assessment:	Describe the trackable data goal(s) related to this Outcome Goal:	

Outcome Goal #2: Reducing the number of persons who become homeless for the first time.		
Baseline Data: Annual Estimate of # of people who become homeless for the first time	Outcome Goals July 1, 2021 - June 30, 2024	
	Reduction in # of People	Reduction as % Change from Baseline
1,229		
Describe Your Related Goals for Underserved Populations and Populations Disproportionately Impacted by Homelessness		
Describe any underserved and/ or disproportionately impacted population(s) that your community will especially focus on related to this Outcome Goal and how this focus has been informed by data in your landscape assessment:	Describe the trackable data goal(s) related to this Outcome Goal:	

Outcome Goal #3: Increasing the number of people exiting homelessness into permanent housing.		
Baseline Data: Annual Estimate of # of people exiting homelessness into permanent housing	Outcome Goals July 1, 2021 - June 30, 2024	
	Increase in # of People	Increase as % Change from Baseline
558		
Describe Your Related Goals for Underserved Populations and Populations Disproportionately Impacted by Homelessness		
Describe any underserved and/ or disproportionately impacted population(s) that your community will especially focus on related to this Outcome Goal and how this focus has been informed by data in your landscape assessment:	Describe the trackable data goal(s) related to this Outcome Goal:	

Outcome Goal #4: Reducing the length of time persons remain homeless.		
Baseline Data: Average length of time (in # of days) persons enrolled in street outreach, emergency shelter, transitional housing, safe haven projects and time prior to move-in for persons enrolled in rapid rehousing and permanent housing projects	Outcome Goals July 1, 2021 - June 30, 2024	
	Decrease in Average # of Days	Decrease as % Change from Baseline
152		
Describe Your Related Goals for Underserved Populations and Populations Disproportionately Impacted by Homelessness		
Describe any underserved and/ or disproportionately impacted population(s) that your community will especially focus on related to this Outcome Goal and how this focus has been informed by data in your landscape assessment:	Describe the trackable data goal(s) related to this Outcome Goal:	

Outcome Goal #5: Reducing the number of persons who return to homelessness after exiting homelessness to permanent housing.		
Baseline Data: % of people who return to homelessness after having exited homelessness to permanent housing	Outcome Goals July 1, 2021 - June 30, 2024	
	Decrease in % of People who return to Homelessness	Decrease as % Change from Baseline
6%		
Describe Your Related Goals for Underserved Populations and Populations Disproportionately Impacted by Homelessness		
Describe any underserved and/ or disproportionately impacted population(s) that your community will especially focus on related to this Outcome Goal and how this focus has been informed by data in your landscape assessment:	Describe the trackable data goal(s) related to this Outcome Goal:	

Outcome Goal #6: Increasing successful placements from street outreach.		
Baseline Data: Annual # of people served in street outreach projects who exit to emergency shelter, safe haven, transitional housing, or permanent housing destinations.	Outcome Goals July 1, 2021 - June 30, 2024	
	Increase in # of People Successfully Placed from Street Outreach	Increase as % of Baseline
0		
Describe Your Related Goals for Underserved Populations and Populations Disproportionately Impacted by Homelessness		
Describe any underserved and/ or disproportionately impacted population(s) that your community will especially focus on related to this Outcome Goal and how this focus has been informed by data in your landscape assessment:	Describe the trackable data goal(s) related to this Outcome Goal:	

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Measure #1a: Reducing the number of persons experiencing homelessness.

Baseline Data for CY2020: Annual estimate of number of people accessing services who are experiencing homelessness
2,629

Baseline and Prior Performance Data

CY2018	CY2019	CY2020	% Change from CY2018
1,985	2,436	2,629	32%

Measure #1b: Reducing the number of persons experiencing unsheltered homelessness on a daily basis

Baseline Data for 2020: Estimate of # of people experiencing unsheltered homelessness on the 2020 PIT Count
1,700

Baseline and Prior Performance Data

2018 PIT	2019 PIT	2020 PIT	% Change from 2018 PIT
1,799	1,700	1,700	-6%

Measure #2: Reducing the number of persons who become homeless for the first time.

Baseline Data for CY2020: Annual Estimate of # of people who become homeless for the first time
1,229

Baseline and Prior Performance Data

CY2018	CY2019	CY2020	% Change from CY2018
908	1,188	1,229	35%

Measure #3: Increasing the number of people exiting homelessness into permanent housing.

Baseline Data for CY2020: Annual Estimate of # of people exiting homelessness into permanent housing
558

Baseline and Prior Performance Data

CY2018	CY2019	CY2020	% Change from CY2018
362	479	558	54%

Measure #4: Reducing the length of time persons remain homeless.

Baseline Data for CY2020: Average length of time (in # of days) persons enrolled in street outreach or other non-residential projects (while homeless), emergency shelter, transitional housing, safe haven projects and time prior to move-in for persons enrolled in rapid rehousing and permanent housing projects
152

Baseline and Prior Performance Data

CY2018	CY2019	CY2020	% Change from CY2018
127	134	152	20%

Measure #5: Reducing the number of persons who return to homelessness after exiting homelessness to permanent housing.

Baseline Data for CY2020: % of people who return to homelessness within 6 months of exiting homelessness to permanent housing
6%

Baseline and Prior Performance Data

CY2018	CY2019	CY2020	% Change from CY2018
5%	7%	6%	1%

Measure #6: Increasing successful placements from street outreach.

Baseline Data for CY2020: Annual # of people served in street outreach projects who exit to emergency shelter, safe haven, transitional housing, or permanent housing destinations.
0

Baseline and Prior Performance Data

CY2018	CY2019	CY2020	% Change from CY2018
0	2	0	#DIV/0!

CA-508 Watsonville/Santa Cruz City & County CoC

Supporting data to understand how people who are experiencing homelessness are accessing services within the CoC

Measures 1a and 2: Number of people accessing services, while experiencing homelessness, within CY2020	CY2020			
	Number of people experiencing homelessness who are active in a project on January 1 (continuously homeless)	Number of people entering the system who are newly homeless during the CY (Measure 2)	Number of people returning to the system during the CY	Total number of people accessing services who are experiencing homelessness during the CY (Measure 1a)
Systemwide (all projects, all clients)	883	1,229	517	2,629
Served in non-residential projects only, while homeless (e.g. street outreach, coordinated entry, SSO projects)	-	1	15	16
Served in residential projects only, while homeless	859	1,183	374	2,416
Served in residential and non-residential projects at some point in the reporting year	24	45	128	197
Number of people who used this project type while experiencing homelessness:				
Active in SO	-	-	-	
Active in CE	-	43	61	104
Active in ES	376	1,040	475	1,891
Active in SH	-	-	-	
Active in TH	111	29	23	163
Active in RRH	421	269	139	829
Active in PSH	43	9	16	68
Active in any other permanent housing	17	-	7	24
Active in Services, Day Shelter, or Other	-	4	110	114

Note: The data provided does not include information related to Measure 1b, which is based on a CoC's point-in-time unsheltered count, rather than HDIS data.

Number of people accessing services, while experiencing homelessness, within CY2019	CY2019			
	people experiencing homelessness who are active in a project on January 1 (continuously homeless)	Number of people entering the system newly homeless during the CY	Number of people returning to the system during the CY	Total number of people accessing services who are experiencing homelessness during the CY
Systemwide (all projects, all clients)	742	1,188	506	2,436
Served in non-residential projects only, while homeless (e.g. street outreach, coordinated entry, SSO projects)	-	3	1	4
Served in residential projects only, while homeless	739	1,173	412	2,324
Served in residential and non-residential projects at some point in the reporting year	3	12	93	108
Number of people who used this project type while experiencing homelessness:				
Active in SO	-	4	1	5
Active in CE	-	-	-	
Active in ES	304	863	444	1,611
Active in SH	-	-	-	
Active in TH	116	81	30	227
Active in RRH	296	401	180	877
Active in PSH	59	12	13	84
Active in any other permanent housing	18	-	-	18
Active in Services, Day Shelter, or Other	-	11	96	107

Number of people accessing services, while experiencing homelessness, within CY2018	CY2018			
	people experiencing homelessness who are active in a project on January 1 (continuously homeless)	Number of people entering the system newly homeless during the CY	Number of people returning to the system during the CY	Total number of people accessing services who are experiencing homelessness during the CY
Systemwide (all projects, all clients)	740	908	337	1,985
Served in non-residential projects only, while homeless (e.g. street outreach, coordinated entry, SSO projects)	-	-	-	
Served in residential projects only, while homeless	740	908	337	1,985
Served in residential and non-residential projects at some point in the reporting year	-	-	-	
Number of people who used this project type while experiencing homelessness:				
Active in SO	-	-	-	
Active in CE	-	-	-	
Active in ES	210	660	303	1,173
Active in SH	-	-	-	
Active in TH	134	68	16	218
Active in RRH	393	298	96	787
Active in PSH	66	17	39	122
Active in any other permanent housing	11	7	2	20
Active in Services, Day Shelter, or Other	-	-	-	

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Supporting data to understand successful exit outcomes from homelessness projects

Measure 3: The number of persons served within the homelessness system who exited to permanent housing, in relation to all exits, listed separately based on the setting in which the person was last served	CY2020		
	Exits to Permanent Housing (#)	All Exits (#)	Exit Success Rate (%)
Unduplicated system exits (i.e. the last exit date within the report period for clients)	558	1,494	37%
System exit is from Emergency Shelter, Safe Haven, or Transitional Housing projects	332	1,100	30%
System exit is from Rapid Rehousing (RRH)	207	284	73%
System exit is from Permanent Supportive Housing (PSH) or other permanent housing (OPH) projects, with a Move-In Date	16	22	73%
System exit is from Permanent Supportive Housing (PSH) or other permanent housing (OPH) projects, without a Move-In Date	2	4	50%
System exit is from Street Outreach, Services Only, Day Shelter, Coordinated Entry, or "Other" project types	1	84	1%
Number of active clients housed in permanent housing	Housed (#)	All Active Clients	Housed (%)
People who are still enrolled in RRH, PSH or OPH on the last day of the reporting period, who have moved into housing (meaning they have a recorded move-in date)	51	815	6%
Number of people who exited to permanent housing or are currently housed in a permanent housing project, unduplicated	Exited to Permanent Housing or Currently Housed in PH project (#)	All Exited and Active Clients (unduplicated)	PH Placement Rate (%)
Persons who exit the homelessness system to permanent housing + People who are still enrolled in RRH, PSH or OPH on the last day of the year and have moved into permanent housing (unduplicated)	2,527	8,083	31%

Measure 6: The number of persons who exited street outreach projects to successful exits, in relation to all exits	CY2020		
	Successful Placements (#)	All Exits (#)	Exit Success Rate (%)
Street Outreach exits to emergency shelter, safe haven, transitional housing, or permanent housing destinations (based on last street outreach exit in reporting period)	-	-	

The number of persons served within the homelessness system who exited to permanent housing, in relation to all exits, listed separately based on the setting in which the person was last served	CY2019		
	Exits to Permanent Housing (#)	All Exits (#)	Exit Success Rate (%)
Unduplicated system exits (i.e. the last exit date within the report period for clients)	479	1,610	30%
System exit is from Emergency Shelter, Safe Haven, or Transitional Housing projects	191	1,178	16%
System exit is from Rapid Rehousing (RRH)	264	380	69%
System exit is from Permanent Supportive Housing (PSH) or other permanent housing (OPH) projects, with a Move-In Date	13	18	72%
System exit is from Permanent Supportive Housing (PSH) or other permanent housing (OPH) projects, without a Move-In Date	-	6	0%
System exit is from Street Outreach, Services Only, Day Shelter, Coordinated Entry, or "Other" project types	11	28	39%
Number of active clients housed in permanent housing	Housed (#)	All Active Clients	Housed (%)
People who are still enrolled in RRH, PSH or OPH on the last day of the reporting period, who have moved into housing (meaning they have a recorded move-in date)	85	756	11%
Number of people who exited to permanent housing or are currently housed in a permanent housing project, unduplicated	Exited to Permanent Housing or Currently Housed in PH project (#)	All Exited and Active Clients (unduplicated)	PH Placement Rate (%)
Persons who exit the homelessness system to permanent housing + People who are still enrolled in RRH, PSH or OPH on the last day of the year and have moved into permanent housing (unduplicated)	2,105	7,397	28%

The number of persons who exited street outreach projects to successful exits, in relation to all exits	CY2019		
	Successful Placements (#)	All Exits (#)	Exit Success Rate (%)
Street Outreach exits to emergency shelter, safe haven, transitional housing, or permanent housing destinations (based on last street outreach exit in reporting period)	2	5	40%

The number of persons served within the homelessness system who exited to permanent housing, in relation to all exits, listed separately based on the setting in which the person was last served	CY2018		
	Exits to Permanent Housing (#)	All Exits (#)	Exit Success Rate (%)
Unduplicated system exits (i.e. the last exit date within the report period for clients)	362	1,240	29%
System exit is from Emergency Shelter, Safe Haven, or Transitional Housing projects	137	788	17%
System exit is from Rapid Rehousing (RRH)	216	426	51%
System exit is from Permanent Supportive Housing (PSH) or other permanent housing (OPH) projects, with a Move-In Date	7	15	47%
System exit is from Permanent Supportive Housing (PSH) or other permanent housing (OPH) projects, without a Move-In Date	2	11	18%
System exit is from Street Outreach, Services Only, Day Shelter, Coordinated Entry, or "Other" project types	-	-	
Number of active clients housed in permanent housing	Housed (#)	All Active Clients	Housed (%)
People who are still enrolled in RRH, PSH or OPH on the last day of the reporting period, who have moved into housing (meaning they have a recorded move-in date)	97	765	13%
Number of people who exited to permanent housing or are currently housed in a permanent housing project, unduplicated	Exited to Permanent Housing or Currently Housed in PH project (#)	All Exited and Active Clients (unduplicated)	PH Placement Rate (%)
Persons who exit the homelessness system to permanent housing + People who are still enrolled in RRH, PSH or OPH on the last day of the year and have moved into permanent housing (unduplicated)	1,852	6,536	28%

The number of persons who exited street outreach projects to successful exits, in relation to all exits	CY2018		
	Successful Placements (#)	All Exits (#)	Exit Success Rate (%)
Street Outreach exits to emergency shelter, safe haven, transitional housing, or permanent housing destinations (based on last street outreach exit in reporting period)	-	-	

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Supporting data to understand whether people return to homelessness after exiting the homelessness system

Measure 5: Of those who exited from the homelessness system, the number who returned to the homelessness system within 6, 12 or 24 months of the person's exit date	CY2020							
	Type of destination person exited TO	Number of people with a system exit in CY2020	Number of people who returned within 6 months of exit date	Return Rate (%) within 6 months of prior exit date	Number of people who returned within 12 months of exit date*	Return Rate (%) within 12 months of prior exit date	Number of people who returned within 24 months of exit date*	Return Rate (%) within 24 months of prior exit date
System exit from any project type (based on the last exit date within the exit cohort period)	All Exits	1,500	353	24%				
	To Perm	564	36	6%				
	To Temp	632	233	37%				
	To Unk	304	84	28%				
System exit is from Emergency Shelter, Safe Haven, or Transitional Housing projects	To Perm	333	25	8%				
	To Temp	544	199	37%				
	To Unk	172	48	28%				
System exit is from Rapid Rehousing	To Perm	206	8	4%				
	To Temp	38	17	45%				
	To Unk	50	7	14%				
System exit is from Permanent Supportive Housing or other permanent housing projects, with a Move-In Date	To Perm	17	2	12%				
	To Temp	4	1	25%				
	To Unk	2	-	0%				
System exit is from Permanent Supportive Housing or other permanent housing projects, without a Move-In Date	To Perm	-	-					
	To Temp	2	-	0%				
	To Unk	-	-					
System exit is from Street Outreach, Services Only, Day Shelter, Coordinated Entry, or "Other" project types	To Perm	6	1	17%				
	To Temp	44	16	36%				
	To Unk	80	29	36%				

Note: Returns are based on a subsequent enrollment in an emergency shelter, safe haven, transitional housing, rapid re-housing, or permanent supportive housing project. Subsequent enrollments in non-residential projects and other permanent housing projects are also counted as a return if the person's current living situation is a homeless setting at the time of the contact.

*Since returns are measured based on the date each person exits, HMIS data on returns over periods longer than 6 months are not yet available for people who exited in CY2020.

Of those who exited from the homelessness system, the number who returned to the homelessness system within 6, 12 or 24 months of the person's exit date	CY2019							
	Type of destination person exited TO	Number of people with a system exit in CY2019	Number of people who returned within 6 months of exit date	Return Rate (%) within 6 months of prior exit date	Number of people who returned within 12 months of exit date	Return Rate (%) within 12 months of prior exit date	Number of people who returned within 24 months of exit date*	Return Rate (%) within 24 months of prior exit date
System exit from any project type (unduplicated, based on the last exit date within the exit cohort period)	All Exits	1,602	315	20%	466	29%		
	To Perm	483	32	7%	50	10%		
	To Temp	943	256	27%	366	39%		
	To Unk	176	27	15%	50	28%		
System exit is from ES, SH, or TH, unduplicated	To Perm	196	20	10%	27	14%		
	To Temp	833	229	27%	327	39%		
	To Unk	86	17	20%	29	34%		
System exit is from Rapid Rehousing	To Perm	268	11	4%	22	8%		
	To Temp	59	13	22%	22	37%		

	To Unk	58	4	7%	10	17%		
System exit is from PSH or OPH, unduplicated, and with a Move-In Date	To Perm	13	-	0%	-	0%		
	To Temp	4	1	25%	1	25%		
	To Unk	1	-	0%	-	0%		
System exit is from PSH or OPH, unduplicated, and without a Move-In Date	To Perm	-	-		-			
	To Temp	3	1	33%	1	33%		
	To Unk	3	1	33%	2	67%		
System exit is from Street Outreach, Services Only, Day Shelter, Coordinated Entry, or "Other" project types	To Perm	6	1	17%	1	17%		
	To Temp	44	12	27%	15	34%		
	To Unk	28	5	18%	9	32%		

*Since returns are measured based on the date each person exits, HMIS data on returns over periods longer than 12 months are not yet available for people who exited in CY2019.

Of those who exited from the homelessness system, the number who returned to the homelessness system within 6, 12 or 24 months of the person's exit date	**CY2018**							
	Type of destination person exited TO	Number of people with a system exit in CY2018	Number of people who returned within 6 months of exit date	Return Rate (%) within 6 months of prior exit date	Number of people who returned within 12 months of exit date*	Return Rate (%) within 12 months of prior exit date	Number of people who returned within 24 months of exit date*	Return Rate (%) within 24 months of prior exit date
System exit from any project type (unduplicated, based on the last exit date within the exit cohort period)	All Exits	1,239	203	16%	352	28%	462	37%
	To Perm	363	18	5%	41	11%	58	16%
	To Temp	588	144	24%	222	38%	288	49%
	To Unk	288	41	14%	89	31%	116	40%
System exit is from ES, SH, or TH, unduplicated	To Perm	131	15	11%	23	18%	29	22%
	To Temp	456	103	23%	170	37%	222	49%
	To Unk	197	34	17%	63	32%	85	43%
System exit is from Rapid Rehousing	To Perm	223	3	1%	18	8%	29	13%
	To Temp	124	40	32%	49	40%	63	51%
	To Unk	82	6	7%	22	27%	25	30%
System exit is from PSH or OPH, unduplicated, and with a Move-In Date	To Perm	8	-	0%	-	0%	-	0%
	To Temp	4	-	0%	2	50%	2	50%
	To Unk	4	-	0%	1	25%	2	50%
System exit is from PSH or OPH, unduplicated, and without a Move-In Date	To Perm	1	-	0%	-	0%	-	0%
	To Temp	4	1	25%	1	25%	1	25%
	To Unk	5	1	20%	3	60%	4	80%
System exit is from Street Outreach, Services Only, Day Shelter, Coordinated Entry, or "Other" project types	To Perm	-	-		-		-	
	To Temp	-	-		-		-	
	To Unk	-	-		-		-	

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Supporting data to understand how long people experience homelessness

Measure 4: Length of Time people were known to be homeless, as documented within the CoC's HMIS	CY2020	
	Average	Median
Cumulative system days homeless recorded in HMIS continuous with or during the report period	152	109
Days homeless in ES/SH continuous with or during the report period	102	69
Days homeless in TH continuous with or during the report period	232	268
Cumulative days homeless in sheltered situations (ES/SH/TH) continuous with or during the report period	115	76
Additional days homeless in SO/DS/CE continuous with or during the report period	1	1
Additional days homeless prior to an RRH/PSH move-in date continuous with or during the report period	213	204

Length of Time people were known to be homeless, as documented within the CoC's HMIS	CY2019	
	Average	Median
Total system days homeless recorded in HMIS continuous with or during the report period	134	99
Days homeless in ES/SH continuous with or during the report period	92	63
Days homeless in TH continuous with or during the report period	178	138
Total days homeless in sheltered situations (ES/SH/TH) continuous with or during the report period	106	70
Additional days homeless in SO/DS/CE continuous with or during the report period	2	1
Additional days homeless prior to an RRH/PSH move-in date continuous with or during the report period	165	149

Length of Time people were known to be homeless, as documented within the CoC's HMIS	CY2018	
	Average	Median
Total system days homeless recorded in HMIS continuous with or during the report period	127	76
Days homeless in ES/SH continuous with or during the report period	64	31
Days homeless in TH continuous with or during the report period	199	170
Total days homeless in sheltered situations (ES/SH/TH) continuous with or during the report period	89	44
Additional days homeless in SO/DS/CE continuous with or during the report period	0	0
Additional days homeless prior to an RRH/PSH move-in date continuous with or during the report period	160	142

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Baseline data for specific population groups

This table provides CoC-level baseline data for all measures for the population groups identified in Table 1 of the HHAP template. These results may help CoCs identify population groups that have disparate outcomes.

CoC-level baseline data for specific population groups	CY2020						
	Measure 1a: Annual estimate of number of people accessing services who are experiencing homelessness	Measure 1b: Estimate of # of people experiencing unsheltered homelessness on the 2020 PIT	Measure 2: Annual estimate of # of people who become homeless for the first time	Measure 3: Annual estimate of # of people exiting homelessness into permanent housing	Measure 4: Average length of time (in # of days) persons enrolled in street outreach, emergency shelter, transitional housing, safe haven projects and time prior to move-in for persons enrolled in rapid rehousing and permanent housing projects	Measure 5: % of people who return to homelessness within 6 months of exiting homelessness to permanent housing	Measure 6: Annual # of people served in street outreach projects who exit to emergency shelter, safe haven, transitional housing, or permanent housing destinations.
Performance by Household Composition*							
All persons	2,629	1,700	1,229	558	152	6%	-
Persons in HHs without children	1,854	1,477	931	330	121	6%	-
Persons in HHs with at least 1 adult and 1 child	842	223	315	218	215	7%	-
Persons in HHs with only children	137	26	36	***	220	5%	-
Performance by Gender							
Woman/Girl	1,071	503	508	261	160	7%	-
Male/Boy	1,522	1,197	708	293	147	6%	-
People who are Transgender	***	-	***	***	178	0%	-
People with No Single Gender	***	-	***	***	88	0%	-
People who are Questioning	***	-	***	***	-	0%	-
People with Unknown Gender (e.g. doesn't know Gender, refused to respond, or data were not collected)	22	-	***	***	95	0%	-
Performance by Ethnicity and Race							
People who are Hispanic/Latino	1,181	513	581	314	157	6%	-
People who are Non-Hispanic/ Non-Latino	1,326	1,187	562	215	153	7%	-
People with Unknown Ethnicity (client doesn't know ethnicity, refused to repond, or data were not collected)	122	-	86	29	79	0%	-
People who are American Indian or Alaska Native	111	139	34	26	139	0%	-
People who are Asian	15	16	***	***	58	11%	-
People who are Black or African American	125	139	61	25	138	0%	-
People who are Native Hawaiian or Other Pacific Islander	32	22	***	***	167	0%	-
People who are White	1,984	1,125	883	347	163	9%	-
People who are Multiple Races	109	259	31	14	200	0%	-
People with Unknown Race (client doesn't know race, refused to respond, or data not collected)	253	-	195	135	58	2%	-

People who are American Indian or Alaska Native AND Hispanic/Latino	73	-	21	***	140	0%	-
People who are American Indian or Alaska Native AND Non-Hispanic/Non-Latino	34	-	11	***	147	0%	-
People who are Asian AND Hispanic/Latino	***	-	***	***	36	0%	-
People who are Asian AND Non-Hispanic/Non-Latino	***	-	***	***	77	25%	-
People who are Black or African American AND Hispanic/Latino	12	-	***	-	250	0%	-
People who are Black or African American AND Non-Hispanic/Non-Latino	109	-	***	25	128	0%	-
People who are Native Hawaiian or Other Pacific Islander AND Hispanic/Latino	15	-	***	***	180	0%	-
People who are Native Hawaiian or Other Pacific Islander AND Non-Hispanic/Non-Latino	17	-	***	***	156	0%	-
People who are White AND Hispanic/Latino	860	-	374	171	182	10%	-
People who are White AND Non-Hispanic/Non-Latino	1,063	-	460	168	153	9%	-
People who are Multiple Races AND Hispanic/Latino	23	-	***	***	189	0%	-
People who are Multiple Races AND Non-Hispanic/Non-Latino	82	-	***	***	207	0%	-
People with Unknown Race (doesn't know race, refused to respond, or data not collected) AND Hispanic/Latino	196	-	***	***	48	3%	-
People with Unknown Race (doesn't know race, refused to respond, or data not collected) AND Non-Hispanic/Non-Latino	11	-	***	***	115	0%	-
Performance for various Sub-Populations and Other Characteristics**							
# of Adults who are Experiencing Significant Mental Illness	420	-	139	48	113	11%	-
# of Adults who are Experiencing Substance Abuse Disorders	306	-	118	22	121	25%	-
# of Adults who are Veterans	183	128	76	62	108	7%	-
# of Adults with HIV/AIDS	***	-	-	-	108	0%	-
# of Adults who are Currently Fleeing Domestic Violence	110	-	41	17	121	6%	-
# of Unaccompanied Youth (18- 24 years old)	141	564	89	45	119	0%	-
# of Parenting Youth (18-24 years old)	79	8	31	20	206	0%	-

* People may be served in different household configurations over the course of a year, so the sum of the rows reported by household composition may exceed the total number of persons reported.

** Data required to identify some sub-population groups are only collected from a subset of projects within HMIS; therefore, these data will not identify everyone with these characteristics who accessed the homeless services.

*** Data suppressed due to the small number of people reported in this category and State of California privacy policies

	CY2019

CoC-level baseline data for specific population groups	Measure 1a: Annual estimate of number of people accessing services who are experiencing homelessness	Measure 1b: Estimate of # of people experiencing unsheltered homelessness on the 2019 PIT	Measure 2: Annual estimate of # of people who become homeless for the first time	Measure 3: Annual estimate of # of people exiting homelessness into permanent housing	Measure 4: Average length of time (in # of days) persons enrolled in street outreach, emergency shelter, transitional housing, safe haven projects and time prior to move-in for persons enrolled in rapid rehousing and permanent housing projects	Measure 5: % of people who return to homelessness within 6 months of exiting homelessness to permanent housing	Measure 6: Annual # of people served in street outreach projects who exit to emergency shelter, safe haven, transitional housing, or permanent housing destinations.
Performance by Household Composition*							
All persons	2,436	1,700	1,188	479	134	7%	***
Persons in HHs without children	1,625	1,477	805	218	107	10%	***
Persons in HHs with at least 1 adult and 1 child	912	223	416	242	181	3%	***
Persons in HHs with only children	197	26	85	17	167	2%	***
Performance by Gender							
Woman/Girl	970	503	460	234	147	3%	***
Male/Boy	1,402	1,197	690	239	129	11%	***
People who are Transgender	***	-	***	***	152	0%	***
People with No Single Gender	***	-	***	***	70	0%	***
People who are Questioning	***	-	***	***	-	0%	***
People with Unknown Gender (e.g. doesn't know Gender, refused to respond, or data were not collected)	50	-	29	***	28	0%	***
Performance by Ethnicity and Race							
People who are Hispanic/Latino	1,021	513	510	249	161	3%	***
People who are Non-Hispanic/ Non-Latino	1,327	1,187	631	223	118	11%	***
People with Unknown Ethnicity (client doesn't know ethnicity, refused to repond, or data were not collected)	88	-	47	***	53	0%	***
People who are American Indian or Alaska Native	133	139	50	38	162	0%	***
People who are Asian	15	16	***	***	117	20%	***
People who are Black or African American	113	139	36	25	130	12%	***
People who are Native Hawaiian or Other Pacific Islander	29	22	***	***	127	0%	***
People who are White	1,886	1,125	958	360	134	7%	***
People who are Multiple Races	124	259	52	23	152	4%	***
People with Unknown Race (client doesn't know race, refused to respond, or data not collected)	136	-	71	22	94	11%	***
People who are American Indian or Alaska Native AND Hispanic/Latino	100	-	33	***	172	0%	***
People who are American Indian or Alaska Native AND Non-Hispanic/Non-Latino	31	-	17	***	132	0%	***
People who are Asian AND Hispanic/Latino	***	-	***	***	96	0%	***
People who are Asian AND Non-Hispanic/Non-Latino	***	-	***	***	127	33%	***

People who are Black or African American AND Hispanic/Latino	16	-	***	***	169	0%	***
People who are Black or African American AND Non-Hispanic/Non-Latino	95	-	***	***	126	15%	***
People who are Native Hawaiian or Other Pacific Islander AND Hispanic/Latino	***	-	***	***	135	0%	***
People who are Native Hawaiian or Other Pacific Islander AND Non-Hispanic/Non-Latino	***	-	***	***	128	0%	***
People who are White AND Hispanic/Latino	793	-	419	183	163	4%	***
People who are White AND Non-Hispanic/Non-Latino	1,075	-	531	175	113	11%	***
People who are Multiple Races AND Hispanic/Latino	34	-	16	***	119	0%	***
People who are Multiple Races AND Non-Hispanic/Non-Latino	89	-	35	***	165	7%	***
People with Unknown Race (doesn't know race, refused to respond, or data not collected) AND Hispanic/Latino	***	-	***	***	146	8%	***
People with Unknown Race (doesn't know race, refused to respond, or data not collected) AND Non-Hispanic/Non-Latino	***	-	***	***	98	50%	***
Performance for various Sub-Populations and Other Characteristics**							
# of Adults who are Experiencing Significant Mental Illness	509	-	239	45	92	17%	***
# of Adults who are Experiencing Substance Abuse Disorders	288	-	141	14	90	21%	***
# of Adults who are Veterans	192	128	86	68	88	9%	***
# of Adults with HIV/AIDS	12	-	***	***	81	0%	***
# of Adults who are Currently Fleeing Domestic Violence	128	-	73	23	85	5%	***
# of Unaccompanied Youth (18- 24 years old)	125	564	77	28	104	12%	***
# of Parenting Youth (18-24 years old)	87	8	53	18	154	0%	***

* People may be served in different household configurations over the course of a year, so the sum of the rows reported by household composition may exceed the total number of persons reported.

** Data required to identify some sub-population groups are only collected from a subset of projects within HMIS; therefore, these data will not identify everyone with these characteristics who accessed the homeless services.

*** Data suppressed due to the small number of people reported in this category and State of California privacy policies

	CY2018						
CoC-level baseline data for specific population groups	**Measure 1a: Annual estimate of number of people accessing services who are experiencing homelessness**	**Measure 1b: Estimate of # of people experiencing unsheltered homelessness on the 2018 PIT**	**Measure 2: Annual estimate of # of people who become homeless for the first time**	**Measure 3: Annual estimate of # of people exiting homelessness into permanent housing**	**Measure 4: Average length of time (in # of days) persons enrolled in street outreach, emergency shelter, transitional housing, safe haven projects and time prior to move-in for persons enrolled in rapid rehousing and permanent housing projects**	**Measure 5: % of people who return to homelessness within 6 months of exiting homelessness to permanent housing**	**Measure 6: Annual # of people served in street outreach projects who exit to emergency shelter, safe haven, transitional housing, or permanent housing destinations.**
Performance by Household Composition*							
All persons	1,985	1,799	908	365	127	5%	-
Persons in HHs without children	1,208	1,630	596	150	88	6%	-

Persons in HHs with at least 1 adult and 1 child	816	169	319	204	186	4%	-
Persons in HHs with only children	134	161	75	***	163	0%	-
Performance by Gender							
Woman/Girl	802	380	361	159	149	2%	-
Male/Boy	1,134	1,418	507	202	114	8%	-
People who are Transgender	***	***	-	***	237	0%	-
People with No Single Gender	***	***	-	***	-	0%	-
People who are Questioning	***	***	-	***	-	0%	-
People with Unknown Gender (e.g. doesn't know Gender, refused to respond, or data were not collected)	43	***	40	***	41	0%	-
Performance by Ethnicity and Race							
People who are Hispanic/Latino	743	580	314	144	170	8%	-
People who are Non-Hispanic/ Non-Latino	1,164	1,219	536	212	101	3%	-
People with Unknown Ethnicity (client doesn't know ethnicity, refused to repond, or data were not collected)	78	-	58	9	79	0%	-
People who are American Indian or Alaska Native	131	84	39	33	166	9%	-
People who are Asian	21	***	***	***	107	0%	-
People who are Black or African American	129	139	64	23	96	0%	-
People who are Native Hawaiian or Other Pacific Islander	17	***	***	***	111	0%	-
People who are White	1,466	999	664	272	129	5%	-
People who are Multiple Races	107	569	51	22	114	5%	-
People with Unknown Race (client doesn't know race, refused to respond, or data not collected)	114	-	75	***	112	0%	-
People who are American Indian or Alaska Native AND Hispanic/Latino	100	-	21	***	196	12%	-
People who are American Indian or Alaska Native AND Non-Hispanic/Non-Latino	30	-	17	***	66	0%	-
People who are Asian AND Hispanic/Latino	***	-	***	***	121	0%	-
People who are Asian AND Non-Hispanic/Non-Latino	***	-	***	***	102	0%	-
People who are Black or African American AND Hispanic/Latino	14	-	***	***	145	0%	-
People who are Black or African American AND Non-Hispanic/Non-Latino	111	-	***	***	91	0%	-
People who are Native Hawaiian or Other Pacific Islander AND Hispanic/Latino	***	-	***	***	125	0%	-
People who are Native Hawaiian or Other Pacific Islander AND Non-Hispanic/Non-Latino	***	-	***	***	101	0%	-
People who are White AND Hispanic/Latino	542	-	251	108	168	6%	-
People who are White AND Non-Hispanic/Non-Latino	908	-	405	162	104	4%	-
People who are Multiple Races AND Hispanic/Latino	26	-	***	***	151	17%	-
People who are Multiple Races AND Non-Hispanic/Non-Latino	81	-	***	***	102	0%	-
People with Unknown Race (doesn't know race, refused to respond, or data not collected) AND Hispanic/Latino	***	-	***	***	176	0%	-
People with Unknown Race (doesn't know race, refused to respond, or data not collected) AND Non-Hispanic/Non-Latino	***	-	***	***	115	0%	-

Performance for various Sub-Populations and Other Characteristics**							
# of Adults who are Experiencing Significant Mental Illness	302	-	143	27	66	0%	-
# of Adults who are Experiencing Substance Abuse Disorders	194	-	91	***	65	13%	-
# of Adults who are Veterans	245	217	122	82	65	8%	-
# of Adults with HIV/AIDS	***	-	***	***	118	0%	-
# of Adults who are Currently Fleeing Domestic Violence	85	-	41	***	100	0%	-
# of Unaccompanied Youth (18- 24 years old)	80	414	49	***	122	13%	-
# of Parenting Youth (18-24 years old)	66	10	37	***	139	0%	-

* People may be served in different household configurations over the course of a year, so the sum of the rows reported by household composition may exceed the total number of persons reported.

** Data required to identify some sub-population groups are only collected from a subset of projects within HMIS; therefore, these data will not identify everyone with these characteristics who accessed the homeless services.

*** Data suppressed due to the small number of people reported in this category and State of California privacy policies

County of Santa Cruz
Housing for Health Partnership
Highlight of Proposed HMIS Policy and Procedure Updates
April 20, 2022 Policy Board – Agenda Item #8a

- Shifting funding approach to invoice user agencies but hold "admin" funds in central budget
- Ensure equipment being used has proper security features in place
- Prioritize licensing for programs required to use HMIS and getting more users for "real-time" data utilization and coordination
- Establish a foundation for increasing data sharing and coordination with health and human service agencies
- "Reboot" of agency and user onboarding – annual recertification and training
- Expand and deepen training offerings for users
- Formalize HMIS lead role to oversee HMIS within a given organization
- Updated and comprehensive CoC HMIS policy and procedure manual to make publicly available
- Shifting from release of information approach to notice of privacy practices approach
- Data breach reporting process
- Data quality standards and reporting - <5% mystery responses goal
- Data timeliness – within two business days of intake standard
- Data showing progress - every 90 days at least – living situation, status updates, annual updates
- Learning to use reports for supporting programs and sharing impact of efforts

Coordinated Entry
CORE ELEMENTS

Coordinated entry is an important process through which people experiencing or at risk of experiencing homelessness can access the crisis response system in a streamlined way, have their strengths and needs quickly assessed, and quickly connect to appropriate, tailored housing and mainstream services within the community or designated region. Standardized assessment tools and practices used within local coordinated assessment processes take into account the unique needs of children and their families as well as youth. When possible, the assessment provides the ability for households to gain access to the best options to address their needs, incorporating participants' choice, rather than being evaluated for a single program within the system. The most intensive interventions are prioritized for those with the highest needs.

Opening Doors, p. 57

Contents

About This Guidebook

About This Guidebook

The U.S. Department of Housing and Urban Development (HUD) requires that Continuums of Care (CoCs) establish and operate a coordinated entry process. Most recently, HUD's Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System (CPD-17-01) established new requirements for coordinated entry that CoCs and projects funded by either the CoC Program or the Emergency Solutions Grants (ESG) Program must meet. Ideally, any local organization providing housing and services to households experiencing homelessness, regardless of funding source(s) supporting that organization, will participate.

Designing and implementing a coordinated entry process that complies with the requirements established in this Notice can seem like an overwhelming challenge to a CoC. Many choices need to be considered. Some new approaches will require changes to the CoC's governance and potentially can include significant changes to projects serving people experiencing a housing crisis. HUD acknowledges these challenges and supports CoCs in the transition to a housing crisis response system that ends current homelessness for all households and ensures that future homelessness is rare, brief, and non-recurring.

Purpose of This Guidebook

This Guidebook and related coordinated entry tools and materials are designed to help CoCs:

- Understand the core components of coordinated entry by outlining what HUD requires
- Plan and implement a coordinated entry process appropriate to their needs, resources, and the vision of the CoC's membership
- Consider implementing additional elements beyond basic requirements

Coordinated entry's core concepts make practical sense to persons experiencing a housing crisis. Those concepts also promote more efficient and effective systems of care. HUD recommends that CoCs review this Guidebook as they begin planning for coordinated entry, look to improve the local system they have begun building, or as a check that their existing coordinated entry process complies with updated HUD requirements.

Key Coordinated Entry Documents

In addition to this Guidebook, HUD has issued several documents that provide information about requirements and recommendations for designing and implementing coordinated entry. Some of these are referenced throughout the Guidebook by the names indicated below. CoCs and other stakeholders involved in planning, implementing, and operating a coordinated entry process should be familiar with each of them.

- CoC Program interim rule
- Coordinated Entry Notice
- Coordinated Entry Policy Brief
- ESG Program interim rule

- 2014 Prioritization Notice / 2016 Prioritization Notice
- Assessment Tools (Expert Convenings Report)

Note that this Guidebook references and provides hyperlinks to both the 2014 and the 2016 Prioritization Notices. The 2016 Prioritization Notice updates the 2014 version with clarifications and additional guidance related to HUD's revised definition of ***chronically homeless persons.*** The 2014 Prioritization Notice identifies qualities of effective assessment tools in an appendix. Both are important; this Guidebook might reference one or the other separately depending on the context.

Examples of how to apply the information contained in these resources in community-specific settings, as well as answers to more complicated questions, are provided in additional coordinated entry tools, products, and technical assistance materials. Full bibliographic information for all of these useful resources, including a link to each document online when available, is provided in Appendix A.

Understanding Key Terms

CoCs need to understand several concepts and terms as part of their planning, implementing, and operating a coordinated entry process.

Definition of "Coordinated Entry"

Over the last few years, the coordinated entry process has been described variously using some combination of the words ***centralized*** or ***coordinated; intake, assessment,*** or ***entry;*** and ***process*** or ***system***. Some of these names have emphasized just one aspect—such as intake or assessment—or have seemed to imply that coordinated entry can only be conducted in one central place.

In HUD's vision, the coordinated entry process is an approach to coordination and management of a crisis response system's resources that allows users to make consistent decisions from available information to efficiently and effectively connect people to interventions that will rapidly end their homelessness.

In the Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System, HUD indicated that although the regulatory term is "centralized and coordinated assessment system," for policy reasons HUD and other federal partners refer to it as the "coordinated entry process"—and to the document itself as the "Coordinated Entry Notice." This change emphasizes that the process is not just about assessment but also about facilitating entry into the crisis response system and exit into housing. This Guidebook uses the term "coordinated entry" throughout.

More Terms

The Guidebook uses the following other definitions:

- **Crisis response system** denotes all the services and housing available to persons who are at imminent risk of experiencing literal homelessness and those who are homeless, whereas **homeless system** refers specifically to the services and housing available only to persons who are literally homeless.
- People in a housing crisis who are accessing or being assessed by coordinated entry are referred to as **people** or **persons**; once they are referred to and enroll in housing or supportive services, they are **program participants**.

- The term **household** is intended to cover any configuration of persons in crisis, whatever their age or number (adults, youth, or children; singles or couples, with or without children).
- Housing or supportive services intended to help a program participant to rapidly exit homelessness are called **projects**.
- Organizations that serve program participants in projects funded by CoC Program or ESG Program grants are called **recipients** or **subrecipients**.

How to Use This Guidebook

This Guidebook is intended to be a comprehensive tool for CoCs that are designing and implementing coordinated entry. The Guidebook and the related tools can be used as a roadmap for CoC discussions during planning. Over the course of a few months, the CoC's coordinated entry planning group might review and discuss every chapter of the Guidebook and begin to gather information, develop policy and processes, and select entities to perform various roles in the coordinated entry process.

This Guidebook also is intended for CoCs that have already made significant progress in planning coordinated entry, as well as those that have already implemented it. They can use it as a reference to ensure that their coordinated entry process complies with all of HUD's requirements. They also can learn from the advanced approaches discussed throughout.

Guidebook Icons

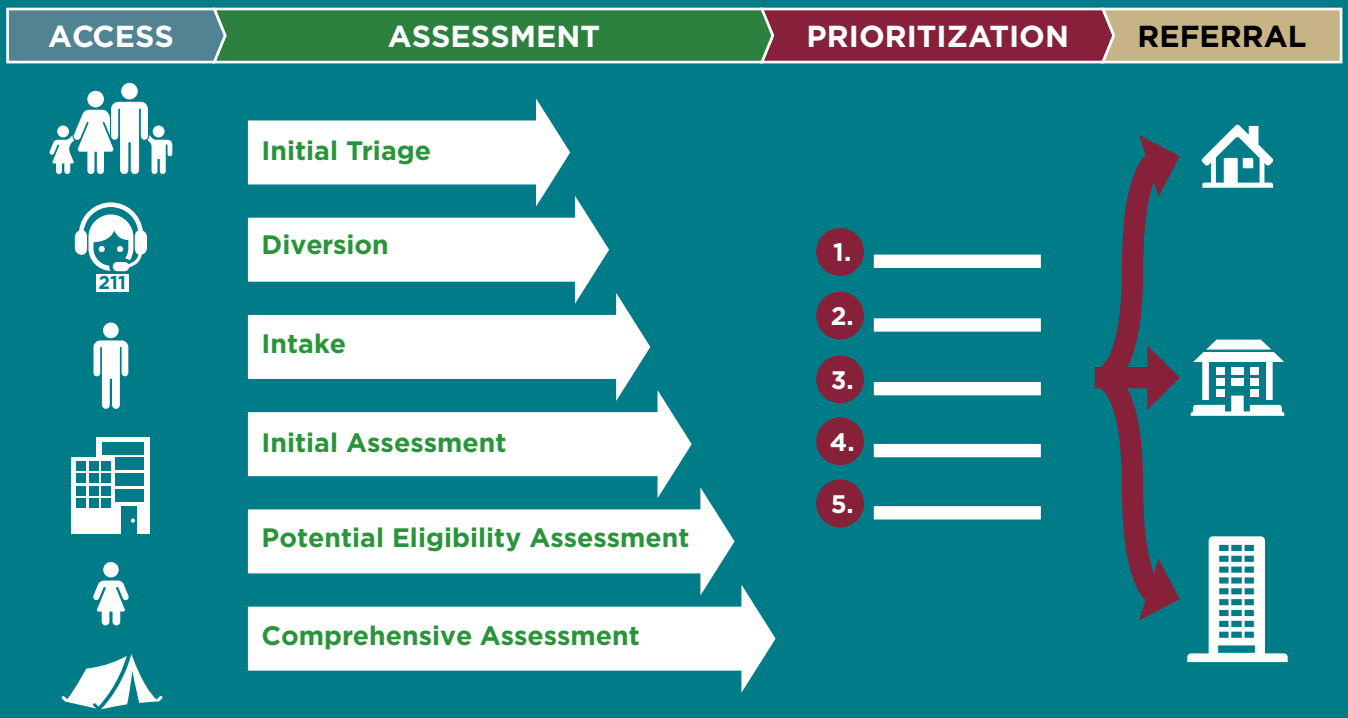
Text throughout the Guidebook is marked with icons to help readers quickly find information:

Guidebook Structure

Each of the Guidebook's chapters discusses one of the four core elements of the coordinated entry process.

- **Introduction**—Provides an overview of coordinated entry concepts and establishes coordinated entry as a framework for achieving CoC systems change.
- **Chapter 1: Access**—Different access models, core components, and planning and implementation.
- **Chapter 2: Assessment**—Elements included in assessment; core components, including the assessment tool; and planning and implementation.
- **Chapter 3: Prioritization**—Elements included in prioritization; core components, including how to identify the most vulnerable or highest priority people; and planning and implementation.
- **Chapter 4: Referral**—Elements included in a referral; core components, including policies for managing referrals; and planning and implementation.

Coordinated Entry Core Elements



The figure above shows how coordinated entry's core elements might relate to one another.

- **Access**, the engagement point for persons experiencing a housing crisis, could look and function differently depending on the specific community. Persons (families, single adults, youth) might initially access the crisis response system by calling a crisis hotline or other information and referral resource, walking into an access point facility, or being engaged through outreach efforts.

- Upon initial access, CoC providers associated with coordinated entry likely will begin assessing the person's housing needs, preferences, and vulnerability. This coordinated entry element is referred to as **Assessment**. It is progressive; that is, potentially multiple layers of sequential information gathering occurring at various phases in the coordinated entry process, for different purposes, by one or more staff.

- During assessment, the person's needs and level of vulnerability may be documented for purposes of determining **Prioritization**. Prioritization helps the CoC manage its inventory of community housing resources and services, ensuring that those persons with the greatest need and vulnerability receive the supports they need to resolve their housing crisis.

- The final element is **Referral**. Persons are referred to available CoC housing resources and services in accordance with the CoC's documented prioritization guidelines.

Introduction

This chapter of the Guidebook focuses on the historical context of coordinated entry development and describes the regulatory role of the U.S. Department of Housing and Urban Development (HUD) in establishing requirements that Continuums of Care (CoCs) must adopt and follow for coordinated entry planning and implementation. The chapter also provides an overview of key elements of coordinated entry and describes some of the benefits CoCs will likely experience upon successful implementation and operation of their reconfigured crisis response system.

Purpose of Coordinated Entry

Coordinated entry changes a CoC from a project-focused system to a person-focused system by asking that ***"communities prioritize people who are most in need of assistance" and "strategically allocate their current resources and identify the need for additional resources"*** (Coordinated Entry Notice, p. 2).

Coordinated entry is a consistent, streamlined process for accessing the resources available in the homeless crisis response system. Through coordinated entry, a CoC ensures that the highest need, most vulnerable households in the community are prioritized for services and that the housing and supportive services in the system are used as efficiently and effectively as possible.

Ideally, coordinated entry can be the framework that transforms a CoC, from a network of projects making individual decisions about whom to serve, into a fully integrated crisis response system. By gathering information through a standardized assessment process, coordinated entry provides a CoC with data that it can use for system and project planning and resource allocation.

Differences in Focus Before and After Implementation of Coordinated Entry

BEFORE COORDINATED ENTRY IMPLEMENTATION	AFTER COORDINATED ENTRY IMPLEMENTATION
Should we accept this person into our project?	*What housing and service assistance strategy among all available is best for this household?*
• Project-centric • Different forms and assessment for each organization or small subgroup of projects • Project-specific decision-making • Ad hoc referral process between projects • Uneven knowledge about available housing and service interventions in the CoC's geographic area	• Person-centric • Standard forms and assessment used by every project for every participant • Community agreement on how to triage based on the household's needs • Coordinated referral process across the CoC's geographic area based on written standards for administering CoC assistance

Historically, CoCs allowed each project to develop and implement its admission criteria and processes, which were usually focused on identifying the people it perceived to be most likely to succeed in that project, and to manage its own waiting list. This approach meant that people in a housing crisis often had to find projects on their own, without knowing which projects they were eligible for or which projects were appropriate for their situation. Once people were on a project's waiting list, they were usually served on a first-come, first-served basis without regard to their level of vulnerability.

As a result, some program participants received assistance that was more extensive than they needed, some participants received less assistance than they needed, and many people, often those with the highest needs, received no assistance at all because they were screened out by exclusionary admission criteria or preferences set by the projects.

Instead, coordinated entry aims to "orient the community to one or two central prioritizing principles by which the community can make decisions about how to utilize its resources most effectively" (Coordinated Entry Policy Brief, p. 4). These principles should focus the coordinated entry process on prioritizing people who are most likely to need assistance because of physical or behavioral health issues, vulnerability to death or victimization while homeless, or the circumstances of their homelessness. These prioritization approaches ensure that across all subpopulations and people with various types of disabilities, those most vulnerable, at highest risk of continued homelessness, or with the most severe service needs will be prioritized for assistance.

When resources are scarce, the coordinated entry process can prioritize who will receive assistance based on need. Coordinated entry should not result in prolonged stays on waiting lists for housing assistance. When many more people are assessed as needing a particular intervention than there are openings for that intervention, the CoC should adjust prioritization standards to more precisely differentiate and identify resources for those persons with the greatest needs and highest vulnerability.

Rules and Guidance on Implementing Coordinated Entry

The 2009 Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act consolidated several of HUD's separate homeless assistance programs into a single grant program, the Continuum of Care Program (CoC Program). The Act also codified into law the CoC planning process.

The CoC Program interim rule requires that CoCs establish and operate a "***centralized or coordinated assessment system***," hereafter referred to as

> ***a coordinated entry process.***[1] ***The rule defines coordinated entry as a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. [Such a] system covers the [CoC's] geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool. (24 CFR part 578.3)***

1 Though "centralized or coordinated assessment system" remains the regulatory term, HUD has since substituted "coordinated entry" or "coordinated entry process" as its preferred descriptor—according to the Coordinated Entry Notice, for ***"purposes of consistency with phrasing used in other Federal guidance and in HUD's other written materials"*** (p. 2). Accordingly, this Guidebook and related coordinated entry tools and materials follow that preference.

Both the CoC Program interim rule and the Emergency Solutions Grants (ESG) Program interim rule require that projects operated by recipients and subrecipients of CoC Program or ESG Program grant funds must participate in the established coordinated entry process.

To hasten the "retooling" called for in the *Opening Doors* report and to apply lessons learned since 2012 about what makes a coordinated entry system most effective, in 2017 HUD published the Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System (CPD-17-01). The Coordinated Entry Notice establishes new requirements for coordinated entry that CoCs and recipients and subrecipients of CoC Program or ESG Program grants must meet as of January 23, 2018. It also describes practice approaches and principles ("elements") that HUD strongly encourages CoCs to incorporate into their written coordinated entry policies and procedures.

The Coordinated Entry Notice establishes new requirements for coordinated entry that CoCs and recipients and subrecipients of CoC Program or ESG Program grants must meet as of January 23, 2018.

Additional related guidance is provided in HUD's 2014 Prioritization Notice and 2016 Prioritization Notice, which provide guidance to CoCs about prioritizing persons for permanent supportive housing (PSH) in a coordinated entry process, and HUD's Coordinated Entry Policy Brief, which provides additional considerations for CoCs as they develop a coordinated entry process. Various FAQs addressing coordinated entry and specific subpopulations (e.g., youth, survivors of domestic violence) or topics (e.g., HMIS) also have been released or are in development (see Appendix A).

How Coordinated Entry Works

Coordinated entry works by establishing a common process to assess the situation of all households who request help through the housing crisis response system.

Core Elements

Established (1) **access** points use a standardized (2) **assessment** process to gather information on people's needs, preferences, and the barriers they face to regaining housing. Once the assessment has identified the most vulnerable people with the highest needs, the CoC follows established policies and procedures to (3) **prioritize** households for (4) **referral** to appropriate and available housing and supportive services resources ("projects"). The rest of this Guidebook provides more detail about each of these four system functions.

Roles and Responsibilities

Numerous stakeholders have roles and responsibilities in designing and implementing, and then once it is operating, in ensuring the crisis response system is functioning well. The CoC must establish policies and procedures governing the operation of coordinated entry and ensure that those policies and procedures align with CoC Program and ESG Program written standards for the administration of CoC and ESG Program-funded projects. The CoC should designate some entity or working group to support the planning of the coordinated entry process itself and to ensure alignment of coordinated entry policies and procedures with ESG Program and CoC Program written standards. Once the coordinated entry process is established, the planning group or another entity should also be responsible for overseeing it, including reporting on its effectiveness to the CoC and to HUD.

Another important role associated with a coordinated entry process is the ongoing **management**, including ongoing **data collection** and the annual **evaluation** of the coordinated entry process required by HUD. Perhaps most critically, CoC Program- and ESG Program-funded housing and supportive services projects in the CoC are required by the terms of their grant to accept referrals only from the CoC's designated coordinated entry process. All other homeless assistance projects are strongly encouraged to accept coordinated entry referrals for vacancies in their projects, as well. The CoC also will need to consider a resource development plan to ensure adequate **funding** is available for coordinated entry development and provide ongoing financial support to operate the coordinated entry process.

A secondary set of HUD guides, planned for publication in 2017, will address the roles and responsibilities associated with coordinated entry infrastructure, including management, technology, evaluation, and funding.

Benefits of Coordinated Entry

Coordinated entry changes the way people experiencing a housing crisis access resources in the crisis response system, resulting in benefits for all of the system's stakeholder groups:

- Persons at risk of or experiencing homelessness are able to
  - locate housing or services they need faster;
  - be referred only to projects that they are likely eligible for;
  - get access to projects once referred; and
  - appeal rejections by projects through a transparent procedure.
- Housing and supportive services projects are able to
  - avoid inappropriate or ineligible referrals for their projects;
  - better manage prospective project participants through a centralized prioritization list; and
  - comply with CoC Program and ESG Program requirements.
- Public and private funders are able to
  - be confident that housing and supportive services projects are serving the intended people ("side doors" to projects are closed);
  - see increased compliance with eligibility requirements;
  - have access to better data for system and project planning; and
  - experience improved reporting.
- CoC or homeless system planners are able to
  - identify areas for improvement and take action on better outcomes specific to McKinney-Vento Act system performance measures;
  - comply with CoC Program and ESG Program requirements;
  - identify areas for improvement and take action on increased efficiency of local crisis response activities;
  - improve fair access and ease of access to resources, including mainstream resources (mainstream housing and service providers include public housing

agencies; affordable housing operators; Veterans Affairs (VA) Medical Centers; public child welfare agencies; providers of mental, physical, or behavioral health services; schools; out-of-school care providers; hospitals; correctional facilities; and workforce investment programs);

- improve data for system and project planning and resource allocation to facilitate system change; and
- standardize understanding of who will be served, which will help system and project monitoring.

Coordinated Entry and System Change

Implementing coordinated entry is a requirement under the CoC Program interim rule and an essential strategy for HUD, other federal partners, and CoCs to use in achieving the national strategic goals of the *Opening Doors* report.

Unrealistic expectations for coordinated entry should be managed throughout the CoC's planning and implementation of a coordinated entry process. That is, increasing the effectiveness of referrals in the crisis response system alone will not increase housing, services, or other resources, nor will it reduce the challenges of serving households who have multiple barriers to obtaining and maintaining housing.

CoC working groups and other community stakeholders should approach the development of coordinated entry as just one element in the transformation of the crisis response system. The other elements are increased performance measurement, strategic resource allocation and reallocation, and development of collaborative partnerships with mainstream systems. Once these other elements are in place, coordinated entry can ensure that the resources in the homeless system are used as effectively as possible.

Coordinated entry is an evolving practice. New research, models, and assessment tools are continually being created. A CoC's coordinated entry process must be flexible and responsive to new information about more effective approaches. It must incorporate the changes and improvements recommended through its annual evaluation and consider additional guidance from public and private funders.

Chapter 1: Access

Access

Access refers to how people experiencing a housing crisis learn that coordinated entry exists and access crisis response services. The first contact that most people experiencing a housing crisis will have with the crisis response system is through a coordinated entry access point. Access points play a critical role in engaging people in order to address their most immediate needs through referral to emergency services. Access points also play a critical role in beginning to determine (through assessment; see Chapter 2: Assessment) which intervention might be most appropriate to rapidly connect those people to housing.

When adopting an access model for its coordinated entry process, a CoC's planning group must ensure that the model meets the HUD requirements for access, as well as consider the local geography, service patterns, and capacity of its crisis response system. The purpose of designating access points is to ensure that all people in a community have equal access to all crisis response system resources in the CoC. Equal access is an important part of the overall strategy of coordinated entry, which shifts the system from a project-centric focus to a person-centric focus.

This chapter explains the planning and implementing of the access element of coordinated entry and provides an overview of key considerations and common challenges that CoCs could encounter when selecting an access model.

1.1 Access Fundamentals

The coordinated entry process must cover the CoC's entire geographic area with access points that are accessible and well advertised to the people living there. In addition, the Coordinated Entry Notice provides new and more specific requirements for these access points.

1.1.1 Full Coverage

The CoC must ensure that the crisis response system is accessible throughout its geographic area. Where that area is large, this could mean that a CoC's coordinated entry process uses multiple points of access to achieve the full coverage required. CoCs that cover smaller areas might join together to share a regional coordinated entry process to achieve both efficiencies and full geographic coverage.

Required: Written policies and procedures must describe the relationship of the CoC(s) to the coordinated entry process, addressing at a minimum how the core elements of ensuring access, standardizing assessments, and implementing uniform referral will operate in situations where the geographic boundaries of the CoC(s) and the boundaries of the crisis response system do not exactly align.

1.1.2 Outreach

CoC Program- and ESG Program-funded street outreach efforts must be linked to the coordinated entry process. A CoC might decide whether to incorporate assessment in part or whole into its street outreach or to separate its assessment element so that process is conducted only by assessment workers who are not part of street outreach efforts. Additionally, a CoC might decide to meet HUD's requirement that coordinated entry reach the CoC's entire geographic area by designating outreach as a defined access point, one that can flexibly navigate to reach homeless persons wherever they reside.

However, not all outreach services are defined as mobile teams whose primary goal is to reach and engage the unsheltered population. Some communities might define outreach more broadly as any combination of programs, services, or staff likely to encounter persons who are experiencing a housing crisis, but whose regular focus is much broader than homelessness. This broader definition of outreach could include homeless liaison staff associated with public schools, workers at social service offices, fire protection staff, or police and other first responders, for example. A broad and flexible network of outreach services can serve an effective access point function for many coordinated entry systems.

Required: Written policies and procedures must detail a process by which street outreach staff ensure that persons experiencing a housing crisis who are encountered on the streets are prioritized for assistance in the same manner as any other person who accesses and is assessed through coordinated entry.

1.1.3 Emergency Services

The coordinated entry process must allow for people experiencing a housing crisis to access emergency services with as few barriers as possible. HUD expects CoC-designated coordinated entry access points to provide "unqualified" emergency access, meaning access is not limited to certain populations. Emergency access point service providers could include all types of emergency services such as homelessness prevention assistance, domestic violence and emergency services hotlines, drop-in service programs, emergency shelters, and other short-term crisis residential programs. Persons must be able to access emergency services independent of the operating hours of the CoC's coordinated entry processes for intake and assessment.

Required: Written policies and procedures must document how persons are ensured access to emergency services during hours when coordinated entry's intake and assessment processes are not operating. Additionally, written policies and procedures must describe the process by which persons will be prioritized for referrals to homelessness prevention services.

1.1.4 Standardized Access and Assessment

The coordinated entry process must use the same assessment process at all access points. A CoC is prohibited from using multiple and different assessment processes, including completely different assessment questions or scoring criteria.

A CoC may, however, operate multiple access points—as long as all of them provide equal access to emergency services, use common assessment approaches and tools, and prioritize persons for available resources using the standardized approach as determined by the CoC in its coordinated entry policies and procedures. Among its multiple access points, a CoC is allowed to designate separate access points for all households within the given subpopulations identified below (again, as long as the same assessment process is used at each access point). Only the following five subpopulations may have access points that are separate and distinct from the general access points:

- Adults without children
- Adults accompanied by children
- Unaccompanied youth
- Households fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions (including human trafficking)

- Persons at imminent risk of literal homelessness, for purposes of administering homelessness prevention assistance

HUD has partnered with the U.S. Department of Veterans Affairs to define designated access points for homeless veterans, but only if the access points are operated by VA or VA partners and the methods for providing access are documented in the CoC's coordinated entry policies and procedures.

HUD recognizes that many CoCs might have access points with specialized services or proficiency in addressing the needs of special populations. Specialization among individual access points is allowable as long as those access points with specialized services are also able to provide access to the coordinated entry process for persons who do not need specialized assistance. For example, many CoCs are partnering with community mental health clinics that provide specialized assistance for persons living with a mental illness. Access points that are mental health clinics certainly offer specialized assistance to mentally ill persons, but as coordinated entry access points, they must also ensure access to the coordinated entry process regardless of a person's mental health status.

That is, CoCs must ensure that households who present at any access point, regardless of whether the location provides specialized services, must have access to the standard functions of access, such as offering places—either virtual or physical—where persons in need of assistance can access available housing and services via the CoC's coordinated entry process.

HUD expects access points to develop and promote effective diversion strategies and approaches. Diversion is itself an important part of coordinated entry, helping potential program participants to explore all safe and appropriate alternative housing options and only enroll in crisis housing projects such as emergency shelter after all other alternatives have been exhausted.

Required: Written policies and procedures must detail the CoC's standardized assessment process, including documentation of the criteria used for uniform decision-making across access points and across staff conducting assessments. If the CoC is differentiating access points for any of the HUD-designated subpopulations listed above, written policies and procedures must separately document the criteria for uniform decision-making for each subpopulation.

1.1.5 Marketing and Non-Discriminatory Access

CoCs and recipients of HUD CoC Program and ESG Program funding are required to affirmatively market their housing and supportive services projects to eligible persons who are least likely to apply in the absence of special outreach. This is regardless of race, color, national origin, religion, sex, age, familial status, marital status, handicap, actual or perceived sexual orientation, or gender identity. To ensure the coordinated entry process assists CoC Program and ESG Program recipients in meeting this requirement, a CoC must develop an affirmative marketing strategy for its coordinated entry process as evidenced by written policies and procedures.

Required: Written policies and procedures must include guidelines for how the CoC will ensure that all populations and subpopulations in the CoC's geographic area have non-discriminatory access to the coordinated entry process. This applies to people experiencing chronic homelessness, veterans, adults with children, youth, and survivors of domestic violence, and regardless of the location or method by which they access the crisis response system. Written policies and procedures must also document steps taken to ensure that access points are accessible to people with disabilities as well as those people in the CoC who are least likely to access homeless system assistance.

CoCs and recipients of federal funds must provide appropriate auxiliary aids and services necessary to ensure effective communication with persons accessing the homeless response system, which includes ensuring that information is provided in appropriate accessible formats as needed, such as Braille, audio, large type, assistive listening devices, and sign language interpreters, as well as accommodation for persons with limited English proficiency.

1.1.6 Safety Planning

The CoC's access process must ensure the safety of persons who are fleeing, or attempting to flee, domestic violence (as well as dating violence, sexual assault, trafficking, or stalking).

The ESG Program and CoC Program rules provide several safeguards and exceptions to using coordinated entry for victims of domestic violence, dating violence, sexual assault, and stalking. The ESG Program rule does not require ESG-funded victim service providers to use the CoC's coordinated entry process, but allows them to do so. The CoC Program rule does not require CoC-funded victim service providers to use the CoC's coordinated entry process, if they use an alternative coordinated entry process for victim service providers in the area that meets all HUD requirements for coordinated entry.

Required: Written policies and procedures must establish protocols that ensure at a minimum that people fleeing, or attempting to flee, domestic violence have safe and confidential access to coordinated entry and that data collection conforms to the applicable requirements of the Violence Against Women Act, CoC Program, and/or HMIS Data Standards. Written policies and procedures must also describe the CoC's protocol for extending coordinated entry safety planning and protections to victims of domestic violence who are staying at non victim service provider projects. In addition, written policies and procedures for coordinated entry must include protocols that ensure at a minimum that people fleeing, or attempting to flee, domestic violence and victims of trafficking have safe and confidential access to the coordinated entry process and victim services, including access to the comparable process used by victim service providers, as applicable, and immediate access to emergency services such as domestic violence hotlines and shelters.

1.1.7 Privacy

The coordinated entry process must ensure adequate privacy protections are extended to and enforced for all participants from the first point of access, through assessment and prioritization, and after participants have been offered permanent housing and even exited CoC projects. Collecting and sharing participants' personal protected information is often a necessary aspect of helping persons to resolve their housing crisis. However, the collection and disclosure of participant data among CoC providers affiliated with the coordinated entry process must always be managed in a manner that ensures privacy, provides participants choice about what and how to share their information, and does not result in repercussions when participants decide not to disclose or share data.

Maintaining the confidentiality of participants' sensitive information is an important way of gaining trust from project participants and ensuring vulnerable populations are protected from potential harm resulting from the collection and disclosure of sensitive information about their lives.

Required: Written policies and procedures must include protocols for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the coordinated entry process. Written policies and procedures must also

ensure participants can freely abstain from disclosing and sharing information without fear of denial of services resulting from the refusal. Certain funders might require disclosure of certain pieces of information for purposes of establishing or documenting program eligibility.

1.2 Components of an Access Process

The four most common access models for coordinated entry are described in Exhibit 1-1. Coordinated Entry Access Models. In some CoCs, the assessment hotline is used for initial triage and initial referrals and then other access approaches are used in later stages of the coordinated entry process.

Exhibit 1-1. Coordinated Entry Access Models

	SINGLE POINT OF ACCESS	MULTISITE CENTRALIZED ACCESS	NO WRONG DOOR	ASSESSMENT HOTLINE
Site Location	Centralized	Located at population centers, high-volume providers, and possibly separated by subpopulation	All existing provider locations	Telephone based or Internet
Number of Access Points	1	Variable, based on geography (2 to 4)	Many	1 telephone number or website access through Internet
Services Offered	Primarily access and assessment; may include triage services, emergency services, or other mainstream services	Primarily access and assessment; may include the services of a co-located provider; may be targeted to one of several subpopulations	Access, at least limited assessment, referrals, and the standard services of each provider	Access to the homeless system, often includes access to mainstream services; limited assessment capability
Operating Entity, Staffing	Permanent independent access specialists; may be shared staff of a central shelter or other organization	Mobile or permanent independent access specialists or shared staff of co-located providers	Independently operated by each provider	Local 211 or other designated hotline agency
Hours of Operation	Hours of the central location	Hours of each access site	Hours depend on and vary with each provider	Typically 24-hour operation, 7 days a week

	SINGLE POINT OF ACCESS	MULTISITE CENTRALIZED ACCESS	NO WRONG DOOR	ASSESSMENT HOTLINE
Considerations	Highest level of control over implementation and compliance for the CoC; also known as "centralized" intake or assessment	Moderate level of control over implementation and compliance for the CoC; the most adaptable model, sometimes called a "hybrid" system	Lowest level of control over implementation and compliance for the CoC; however, still requires standardized forms and coordinated referrals for all	211 is the most popular example; sometimes combined as an initial triage tool with any of the other models; often must build a relationship with an outside provider

1.3 Planning for an Access Process

Access planning requires careful consideration of the CoC's geography, resources, and capacity in order to select an approach that will be most accessible for people facing a housing crisis. Effective planning requires a clear and formal decision-making process that is inclusive, well documented, and responsive to new information learned through implementation.

1.3.1 Planning Decisions

The coordinated entry planning group should address the following steps and decisions. However, not all of these pieces need to be in place for implementation to begin. Many CoCs opt to implement their coordinated entry process in stages.

Identify access points

Considering the geography of the CoC, the planning group should select the location(s), type of organization, hours, and other descriptive traits of the access point(s) the CoC will use for coordinated entry. Depending on the needs of the CoC, any of the access models shown in Exhibit 1-1. Coordinated Entry Access Models could be appropriate, or a combination of approaches to form a hybrid access model.

Determine whether specialized access points will be developed

The planning group should consider whether any specialized access points for subpopulations would be beneficial for the coordinated entry process. A CoC must keep in mind that HUD's Coordinated Entry Notice allows for separately designated access points for only certain subpopulations—single adults, adults with children, unaccompanied youth, persons accessing homelessness prevention assistance, and domestic violence survivors—and only after the CoC has carefully considered the benefits of establishing and maintaining separate access for those subpopulations.

Considerations for Separate Access Points:

- The CoC might want to have different access points for those HUD-designated subpopulations, with staff conducting assessments in a culturally sensitive and informed manner but making referrals according to the standards established by the CoC.
- If the community has pre-existing networks for subpopulation groups, the CoC might want to choose to have a partially separated coordinated entry process with a separate access point. CoC policies and standards would still apply. Examples might be a youth drop-in center or a domestic violence hotline.
- Multiple access points or methods (e.g., crisis hotline) can be safer for domestic violence survivors, as a single, well-known location can put them at risk.
- The CoC might want to offer mobile access to people in subpopulations who might resist going to a centralized access point. This mobile access might be through trained outreach staff who are prepared to assess people in phases.

Coordinate with outreach teams

How outreach teams will best interface with the access points depends on the access model selected. A CoC should incorporate outreach projects in its planning. This includes developing a strategy for communicating requirements to outreach staff throughout the CoC.

Define staffing needs for access points

A CoC often determines that it will need additional staff capacity to ensure that the access point can handle demand at full capacity. The planning group should consider whether staff need additional training or skills in areas such as the assessment process, language proficiency, cultural competency, and crisis intervention. Specialized training needs could also be a factor of the subpopulation focus of the access point. For example, access points dedicated to youth or to persons fleeing, or attempting to flee, domestic violence could require specialized staff with training in trauma-informed care, safety needs, or other population-specific care coordination considerations.

Design a supervision and feedback loop

The coordinated entry planning group should consider how the access point staff will be supervised, particularly if more than one agency's staff will be used. How will the CoC ensure that every access point is using a standardized approach? Can representatives from all access point agencies participate in case conferencing or case file review, to share what they are learning?

Map flow of people through the system

The planning group should consider mapping the ideal flow and volume of how persons will access the CoC's crisis response services. Mapping the intended flow into and through the crisis response system ensures all participating coordinated entry partners understand their role and can ensure that all access points share expectations for timeliness of appointments and follow-up, needs during the process (such as childcare during assessment), and the hours/availability of the access points.

Develop a communications plan

The CoC should create a strategy to share information about the access points with stakeholders, providers, community referral sources, and people experiencing a housing crisis who are likely to seek crisis response services from the CoC. CoCs are required to ensure coordinated entry services are well advertised; for example, through print media, signage in public spaces, public transportation, Internet, radio, television, etc. The CoC must also create an affirmative marketing plan for coordinated entry that ensures that all persons experiencing a housing crisis, regardless of their protected class status as defined in Fair Housing or other applicable civil rights laws (e.g., sex, disability status, familial status, etc.), receive information about the coordinated entry process and its related resources.

Classes Protected by Fair Housing and Related Rules:

- Race
- Color
- Religion
- Sex
- National Origin
- Disability
- Familial Status
- Marital Status
- Sexual Orientation
- Gender Identity

The coordinated entry planning group should inventory all possible referral sources by category and develop specific strategies for each that ensure communications and referral processes are well defined and understood by everyone involved. This communications plan could include potential referral sources such as public schools, hospitals, public libraries, first responders, and homeless assistance providers within the CoC.

So they know where to refer someone who is homeless, information from the coordinated entry communications plan should be shared with mainstream resource providers serving people who might experience a housing crisis or who are at risk of experiencing a housing crisis. During initial implementation, the communications strategy should include information about how existing waiting lists at housing and supportive services projects will be transitioned to the coordinated entry process.

Document requirements for access points

The CoC should document in its coordinated entry policies and procedures the operational and programmatic practices of the access points.

1.3.2 Key Questions

Some key planning questions can include the following:

- What types of access points are already in place? Should they be retained? Are they accessible to all persons throughout the geography of the CoC?
- Are there variations within the geographic area of the CoC that inform how the access points are set up, how they operate, or whom they target?
- What are the most frequently used points of entry into the crisis response system? How are prevention resources coordinated with these access points?
- How do access points interact with outreach projects? With shelter intake?
- How are shelter diversion and prevention activities incorporated into the CoC?

- What agencies and/or staff will operate the access points? What qualities or qualifications do they need to have to be designated as an access point?
- What are the staffing needs of each access point, and how much will it cost to operate the access points?
- What training is required for staff at access points?
- How will frequent users of crisis services (e.g., jails, hospitals, detox facilities, and other institutional settings) be integrated into coordinated entry?
- Do local factors support centralized intake?
- What is the extent and scope of homelessness, and what are the characteristics of people experiencing a housing crisis in the local community?
- How will the access strategies and protocols reflect current conditions documented during coordinated entry planning, and then be updated after coordinated entry is operational?
- Do any special subpopulations have access points that only they can access?
- Do any of five subpopulations allowed by HUD to have a separate access point need to have one established because of safety or other concerns?

1.4 Recommended Access Approaches

1.4.1 Accessibility to Local Subpopulations

Language

Marketing materials should be written to be sensitive to minority racial and ethnic groups in the community. For example, if the CoC provides housing and supportive services to individuals from a tribal nation near its jurisdiction, it can be important to have brochures in the language of the majority of people in the community ***and*** in the language of the tribal nation. If possible, materials should be translated by someone who is local and fluent in the language, as culture and language can differ across communities within the same racial or ethnic group.

Literacy

Coordinated entry materials should be written at a literacy level that is appropriate for people seeking services. If available, a local literacy expert should review them.

1.4.2 Physical Accessibility

A key consideration when a CoC selects access points is to choose locations that are physically accessible or are able to make modifications such as adding ramps or elevators for persons who require them. The CoC should also consider the availability of public transportation and the proximity of access points to other frequently used resources such as local emergency shelters, drop-in centers, soup kitchens, and other crisis response service locations.

1.4.3 Connection to Mainstream Resources

Access points also can provide critical connections to mainstream and community-based emergency assistance services (e.g., supplemental food assistance programs). The most effective coordinated entry systems will facilitate these resource connections for persons experiencing homelessness. It might even be feasible, certainly advantageous, for mainstream resource providers to also serve as coordinated entry access points.

1.4.4 Understanding the Needs of Persons Not Served

Access points in the most effective coordinated entry systems gather information about persons requesting homeless system services who do not enroll in a CoC project (e.g., persons diverted from the crisis response system). The reasons for persons not enrolling are tracked in HMIS or another database selected by the CoC for coordinated entry. Over time, the CoC can analyze this information against any subsequent entries by these same people into the homeless system in order to determine whether the CoC needs to adjust its system or its coordinated entry process.

1.5 Common Implementation Challenge: Coordinated Entry in Rural and Suburban CoCs

CoCs can be grouped by geographic composition—primarily urban; urban centers surrounded by a large suburban area; primarily rural; and large areas comprising a mix of rural, suburban, and urban areas (e.g., Balance of State CoCs). Compositional mix can present unique access challenges when a CoC is developing and implementing a coordinated entry process. Homelessness in rural and suburban communities can look very different from homelessness in urban communities. For example, research shows that compared with urban populations, the rural homeless population:

- Often has a higher proportion of families
- Is more likely to be working, experiencing homelessness for the first time, and already receiving government assistance
- Tends to be less "visible" and more transient
- More likely to live in vehicles or structures not meant for human habitation such as sheds or garages

In rural communities, their expansive geography and the hidden nature of their homeless population often make it hard to get an accurate count or understanding of the extent of the needs. A rural-serving CoC also can have natural barriers such as mountains or bodies of water that can create challenges both to people experiencing a housing crisis in accessing services and to staff coordinating services.

The crisis response systems in suburban and rural communities also tend to be different from those in urban communities. There are often fewer homeless system providers, particularly agencies that serve exclusively people experiencing homelessness; and providers can be isolated and very spread out geographically. In some communities, the only resources available might be informal assistance from churches or food pantries. In rural communities spanning large geographic areas, characteristics and needs of the people experiencing a housing crisis could critically differ from one locale to another.

The CoC must consider the geographic characteristics of the community when planning coordinated entry. Exhibit 1-2. Common Challenges for CoCs by Geographic Composition lists some of the most common challenges.

RURAL AND BALANCE OF STATE COCS	SURBURBAN	MIX OF URBAN, SUBURBAN, AND RURAL
• Fewer homeless service providers and resources • Wide distances between providers • Lack of connectedness or collaboration between providers • Limited visibility of homeless populations • Limited public transportation • Limited jobs and affordable housing • Lack of awareness about issue of homelessness	• Fewer homeless service providers and resources • Limited visibility of homeless population • Limited public transportation • Lack of awareness about issue of homelessness	• Variation in availability of homeless service providers and resources • Variation in needs of homeless population(s) in different areas of the CoC • Variation in key stakeholders and access points across the CoC • Lack of awareness about issue of homelessness outside urban areas

Exhibit 1-2. Common Challenges for CoCs by Geographic Composition

Some CoCs that cover large geographic areas where available resources vary (including Balance of State CoCs) choose to adopt a regional approach to address these challenges. They design access to allow for multiple sites or multiple access technologies to save prospective participants from traveling long distances to access crisis services. Such a CoC must define common requirements and standardized assessment tools, but within those standards allow locales to develop different protocols for implementing coordinated entry access points in their part of the CoC. The approach can increase stakeholder buy-in and provider collaboration within the region because it feels more local.

In implementing a regional approach, the CoC's leadership and planning group should clearly identify how each locale will ensure consistency of access to resources. For example, some CoCs have established CoC-wide committees to review and approve regional plans and to handle any complaints about local processes.

Chapter 2: Assessment

Assessment

Assessment is the process of gathering information about a person presenting to the crisis response system. Assessment includes documenting information about the barriers the person faces to being rapidly housed and any characteristics that might make him or her more vulnerable while homeless.

Historically, assessment of persons experiencing a housing crisis included inordinately long and intrusive interviews, even if they were only seeking temporary emergency assistance. Persons might have to undergo the assessment process multiple times, at every place they accessed. With coordinated entry, assessment can collect information in phases—initially collecting only the information essential to ascertaining the person's immediate needs and to connecting that person to appropriate interventions.

The assessment practice a CoC implements is critical to that CoC's overall coordinated entry process because assessment determines how people are prioritized and referred to housing and supportive services projects. In addition to identifying a person's overall needs and preferences, the assessment also must appropriately triage the person by asking about immediate needs (e.g., "Are you safe where you are right now?" "Do you need medical services?"), accurately evaluating his or her vulnerability and barriers to housing, and providing information to support accurate referrals.

2.1 Assessment Fundamentals

HUD requires that each CoC incorporate a standardized assessment practice across its coordinated entry process. Different assessment tools and approaches use different methodologies for collecting information and documenting people's needs. What approach the CoC planning group chooses depends on the structure of the CoC, its goals for coordinated entry, the capacity of its staff to administer the assessment, and the resources available to support its assessment practice. Regardless of the specifics of the CoC's assessment, its coordinated entry process must collect sufficient information to make prioritization decisions consistently and facilitate access to housing and supportive services across the CoC's coverage area.

2.1.1 Assessment Requirements

The Coordinated Entry Notice details several specific requirements relating to the assessment process:

Standardized access and assessment tool

A CoC's coordinated entry process must use the same assessment process at all access points. A CoC is prohibited from using different assessment processes and scoring criteria for any subpopulation(s) other than the five HUD-designated subpopulations:

- Adults without children
- Adults accompanied by children
- Unaccompanied youth
- Households fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions (including human trafficking)

- Persons at imminent risk of literal homelessness for purposes of administering homelessness prevention assistance

This means a CoC may, for example, use a youth-specific assessment tool and process that differs from an adult-only tool and process. An assessment tool and process may include some questions or categories of questions that are applicable only to certain subpopulations, such as questions about armed services participation for veterans. Because a young person under the age of 18 would not be eligible for veteran services, the CoC's assessment process may use skip logic to avoid asking questions that are not applicable. However, the CoC, for example, may not use a female-only tool or a veterans-only tool.

A CoC's coordinated entry process may allow Veterans Affairs partners to conduct assessments and make direct placements into homeless assistance programs, including those funded by the CoC and ESG Programs, provided (1) that the method for doing so is a collaboration between those VA partners and the CoC and (2) that the method is included in the CoC's coordinated entry policies and procedures and in the written standards for the affected programs.

Required: Written policies and procedures must detail the standardized assessment process, including documentation of the criteria used for uniform decision-making across access points and staff. If the CoC is differentiating access points and assessment tools for any of the five HUD-designated subpopulations, written policies and procedures must separately document the criteria for uniform decision-making for each subpopulation. The criteria must be based on the prioritization standards adopted by the CoC that are used for its different access points and assessment processes.

Participant autonomy

The coordinated entry process must allow people presenting to the crisis response system to refuse to answer assessment questions and to reject housing and service options offered without their suffering retribution or limiting their access to assistance. Assessment staff should always engage participants in an appropriate and respectful manner to collect only necessary assessment information, but some participants might choose not to answer some questions or could be unable to provide complete answers in some circumstances. The lack of a response to some questions potentially can limit the variety of referral options. When this is the case, coordinated entry staff should communicate to those participants the impact of incomplete assessment responses. Assessment staff should still make every effort to assess and resolve the person's housing needs based on a participant's responses to assessment questions no matter how limited those responses. A participant's unresponsiveness may not affect future assessments or referral options.

Required: Written policies and procedures must outline a process whereby necessary information may be obtained when a person being assessed refuses to answer one or more assessment questions. (Similarly, during referral, there also must be a policy that allows the person to maintain his or her place in the priority list after rejecting service options that are offered. See Section 4.5.4.)

Assessor training

The CoC must provide training protocols and at least one annual training opportunity to organizations that serve as access points or otherwise conduct assessments. The training may be in person, a live or recorded online session, or self-administered. It must provide all assessors with materials that clearly describe how assessments are

to be administered with fidelity to the written policies and procedures of the CoC's coordinated entry process. The training protocols must include the requirements for prioritization and the criteria for uniform decision-making and referrals.

Required: After staff receive initial training on the CoC's assessment protocols, further training is required once annually.

2.1.2 Additional Considerations for Assessment

The Coordinated Entry Notice suggests several additional considerations related to the assessment element of the coordinated entry process. HUD's Coordinated Entry Policy Brief and 2016 Prioritization Notice also describe key considerations and recommended qualities for assessment tools (see Appendix C). These are not requirements; rather they provide some guidance related to HUD's intent for a coordinated entry process and best practices in the field.

Use a person-centered approach

Ways to incorporate a person-centered approach into policies and procedures include the following:

- Design assessments based in part on people's strengths, goals, risks, and protective factors
- Show sensitivity to people's lived experiences, including developing assessment tools and administration protocols that minimize risk and harm and address potential psychological impacts
- Use tools and processes that the people being assessed (and referred) can easily understand

Incorporate cultural and linguistic competencies

All staff administering assessments should use culturally and linguistically competent practices. HUD strongly encourages CoCs to incorporate cultural and linguistic competency training into the required annual assessor training. Assessments should include trauma-informed culturally and linguistically competent questions for special subpopulations, including immigrants, refugees, and other first-generation subpopulations; youth; persons fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking; and LGBTQ persons.

Use community-specific assessment processes and tools

Although the CoC must use standardized assessment tools across its access points, the actual tools can be locally developed or selected from among the many publicly available tools. Whatever tool the CoC implements, if the CoC differentiates among the five HUD-designated subpopulations, the language and questions in the assessment should be tailored accordingly (e.g., include questions about school enrollment for adults with children).

A community-specific assessment tool should be valid and reliable, and the assessment process should only gather information necessary to determine the person's severity of need and potential match for housing and supportive services. That is, the assessment can be conducted in phases, to capture information as needed and limit how frequently the person being assessed must repeat his or her personal story. (Once the person is referred to housing and supportive services, project staff may conduct more-

sophisticated assessments to evaluate that participant's specialized needs.) This phased approach to assessment is intended not to replace more-specialized assessments but rather to connect people to the appropriate housing solution as quickly as possible.

Assessment tools may be customized to reflect an assessment approach and prioritization process specific to each subpopulation. For example, a CoC may establish one assessment tool for all youth, another for all families, and still another for single adults. Or a CoC might have a single tool that is used consistently across all subpopulations. Either approach is acceptable. The goal is to ensure the most vulnerable or needy within each subpopulation rise to a common level of prioritization across all subpopulations. Note that vulnerability scores and level of need as determined by a subpopulation-specific assessment process can more readily support consistent prioritization within each subpopulation while allowing CoCs to ensure common prioritization approaches across subpopulations. For example, youth might not have had the opportunity to experience long bouts of homelessness simply due to their young age. A CoC that factors length of time homeless into its prioritization process should not consistently prioritize chronically homeless adults over youth. A customized assessment process for youth will account for the lived experience of young persons, consider their particular vulnerabilities and needs, and prioritize accordingly.

2.2 Components of an Assessment Process

What a person encountering the coordinated entry process is assessed for and ***with what tool,*** as well as ***when*** that assessment occurs, can vary depending on the coordinated entry access model selected by the CoC (see Exhibit 1-1. Coordinated Entry Access Models). For example, a multisite centralized access model might collect more in-depth information at the point of access. A no-wrong-door model might collect limited information at access, due to limited resources and a focus on resolving an immediate housing crisis; then, if the person is unable to resolve his or her homelessness independently, a more comprehensive assessment might be conducted.

2.2.1 Assessment Tools

HUD requires that a CoC use a standardized assessment tool(s) across all access points, but HUD does not endorse any specific tool or assessment approach. At the meeting described in the Assessment Tools: Expert Convenings Report, attendees agreed that existing assessment tools are limited in their ability to definitely select the best intervention for a person experiencing a housing crisis or to predict who would be most successful in which intervention.

Though untested for their predictive value, several off-the-shelf tools are in use in the field, and a CoC could elect to employ one of them as is. Many CoCs are already using these assessment tools quite successfully and do not necessarily need to change approaches now. However, a CoC's probability of success with the assessment element of coordinated entry improves when locally specific assessment approaches and protocols are used. These approaches and protocols should reflect the design considerations and standards for assistance and prioritization that a CoC formalizes when developing its written standards during initial planning for coordinated entry.

Each CoC should consider an assessment tool(s) and approach that acknowledges its unique system configuration, capacity, and goals in relation to the needs, risks, and vulnerabilities of different populations such as families, single adults, youth, persons fleeing, or attempting to flee, domestic violence, and people at imminent risk of literal homelessness. Thus, assessment tools should reflect local needs, including the CoC's prioritization criteria,

written standards for CoC Program and ESG Program assistance, and the goals and preferences of the person being assessed. Tools should focus on collecting the information appropriate for identifying the person's housing and supportive services needs, determining the person's level of vulnerability or need, and referral criteria for project enrollment.

As outlined in the 2016 Prioritization Notice and reinforced in the Coordinated Entry Notice, any tool used by a CoC for its coordinated entry process should have, to the greatest extent possible, the following qualities:

- Tested, valid, and appropriate
- Reliable (provide consistent results)
- Comprehensive (provide access to all housing and supportive services within the CoC)
- Person-centered (focused on resolving the person's needs, instead of filling project vacancies)
- User-friendly for both the person being assessed and the assessor
- Strengths-based (focused on the person's barriers to and strengths for obtaining sustainable housing)
- Housing First–oriented (focused on rapidly housing participants without preconditions)
- Sensitive to lived experiences (culturally and situationally sensitive, focused on reducing trauma and harm)
- Transparent in the relationship between the questions being asked and the potential options for housing and supportive services

Note that a prioritization tool is not the same thing as an assessment tool. Some prioritization tools and approaches might be incorporated into the CoC's assessment process, but no single universal assessment tool or process has emerged as the de facto model for every CoC. See Chapter 3: Prioritization for more discussion about prioritization and the relationship between assessment and prioritization elements.

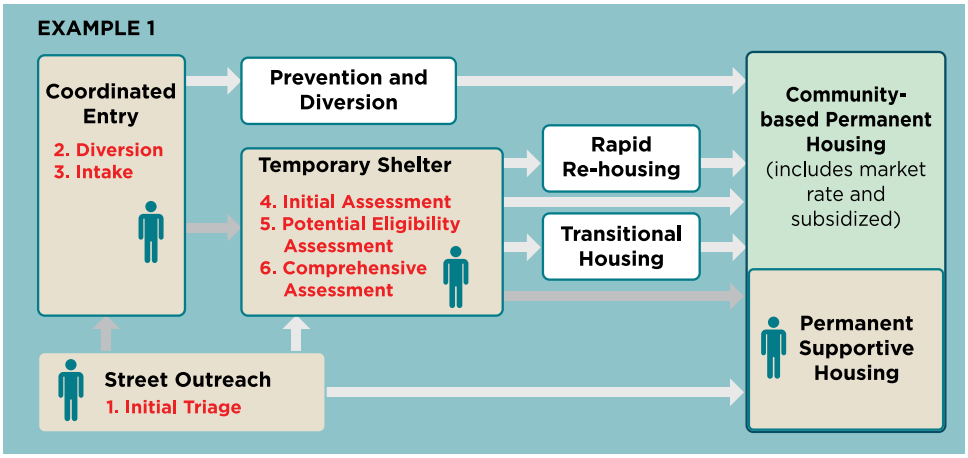
2.2.2 Assessment across Stages of Coordinated Entry

A CoC can incorporate assessment tools and activities at any of several stages throughout a person's interaction with the coordinated entry process. The goal is to build an accurate and concise picture of that person's needs and preferences in order to connect him or her to an appropriate intervention. Assessment completed in phases may be most efficient and effective in achieving this goal.

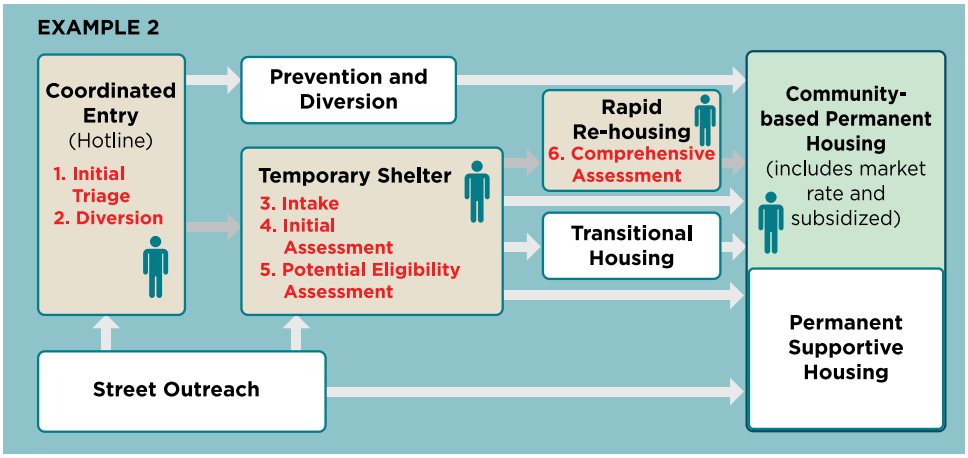
Note that a data-sharing agreement among homeless assistance agencies conducting assessments is required when the CoC's protocols allow for phased assessment (i.e., when one homeless assistance provider initiates the assessment with only the most pertinent questions relative to the immediate needs of the participant, and then staff at different agencies subsequently collect additional information that builds on and complements the previous responses). Sharing of assessment data (only when necessary, and always accompanied by the proper system security and data protections) can play a critical role in a CoC designing an effective assessment process.

Exhibit 2-1. Assessment across Stages: 3 Examples

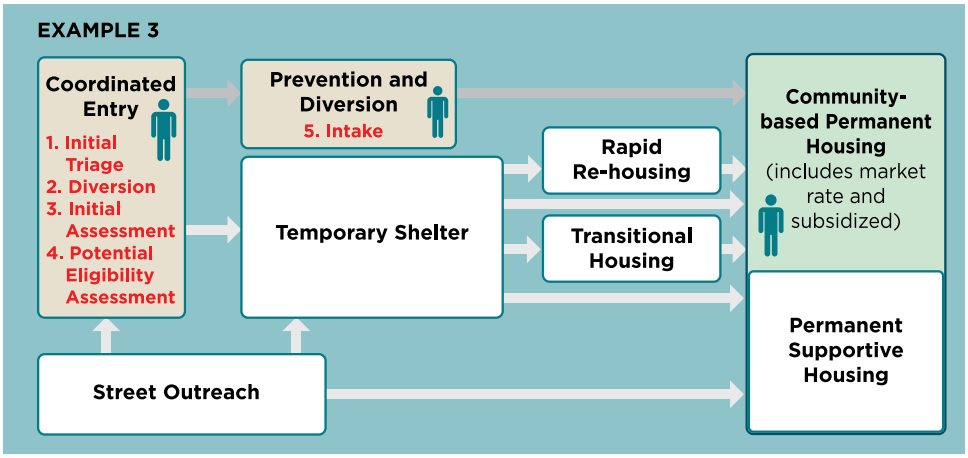
Three possible assessment combinations and approaches:



Participant receives an (1) initial triage assessment through street outreach and, from identified and trained coordinated entry staff, an attempt at (2) diversion, followed by (3) intake into coordinated entry. While in temporary shelter, participant receives an (4) initial assessment, perhaps (5) eligibility assessment, and (6) comprehensive assessment, before being referred to permanent supportive housing.



Participant follows a similar assessment pathway as Example 1, but first engagement is a call to the CoC's hotline and referral is to rapid rehousing, where (6) a comprehensive assessment is conducted before the participant is final-exited into permanent housing.



Participant engages in the coordinated entry process, before enrolling in a residential-based CoC project. Through (2) diversion, (3) initial assessment, and (4) eligibility assessment, the participant is identified as a candidate for homelessness prevention assistance.

Conducting assessment at various stages of coordinated entry is designed to limit data collection to only the information necessary to assist a person to resolve his or her immediate housing crisis. At any stage among those listed below, the coordinated entry process might have enough assessment information to connect or refer a participant to a permanent housing placement. A phased approach does not presuppose that assessment must occur at ***every*** stage nor be completed in ***sequence*** before a person is able to resolve the housing crisis, although at each progressive stage, completion might be appropriate depending on the person's individual circumstances.

Note that some CoCs combine or completely integrate some of the stages described separately below into a single assessment stage or a single participant interaction within the coordinated entry process. Collapsing or integrating stages in assessment can be appropriate depending on the design of the CoC's access points and roles defined for assessors.

- **Initial triage.** Likely focused on defining the nature of the current crisis and ensuring the person's immediate safety.
- **Diversion.** Can occur as part of initial triage or separately; is likely focused on assisting the person to examine his or her resources and options other than entering the homeless system.
- **Intake.** Likely occurs when the person accepts crisis assistance, such as emergency shelter. Assessment is likely limited to collecting information necessary to enroll the person in a homeless assistance project (i.e., the homeless assistance project could be coordinated entry itself or an emergency shelter, depending on how the CoC has structured and defined crisis response interventions).
- **Initial assessment.** The initial assessment might incorporate a prioritization component that indicates the level of risk, vulnerability, and the person's barriers, goals and preferences, or need based on the responses to the assessment questions. The person's responses to initial assessment can be used to help define risk and prioritize the person for further CoC Program or ESG Program assistance such as street outreach, emergency shelter, rapid rehousing (RRH), and PSH.

  Note that some of the initial assessment questions might be asked multiple times throughout project enrollment, as the person's barriers, goals, and preferences evolve as a result of his or her immediate crisis needs being addressed.
- **Potential eligibility assessment.** Eligibility screening (predetermination) considers the potential participant's likelihood of being eligible for admission to a project based on its specific eligibility requirements and the CoC's written standards for prioritizing assistance.

  Collecting required information and documentation regarding eligibility can occur at any assessment stage, but ***determining*** eligibility occurs separately from the prioritization process. Responsibility for collecting and maintaining eligibility documentation rests with the specific homeless assistance project.
- **Comprehensive assessment.** Typically a follow-on to initial assessment. Refines, clarifies, and verifies the person's history, barriers, goals, and preferences. Together, staff and the person develop a housing and services plan, including a strategy for exiting homelessness. Comprehensive assessments often involve some level of case conferencing, which includes conversations with staff from multiple

projects and agencies and the participant himself/herself to ensure the outcomes of the assessment align with the CoC's prioritization process. Case conferencing allows for consideration of unique, person-specific vulnerabilities and risk factors to be included in the participant's housing plan.

- **Next-step / moving on assessment.** Re-evaluates program participants who have been stably housed for some time and who are ready for less intensive housing or services, perhaps even an exit to self-sufficiency. Can also be used when new information about a person is revealed during enrollment in a project and the new information suggests a different service strategy might be warranted.

2.3 Planning for an Assessment Process

Planning for the assessment process requires the CoC to consider its written standards, as well as those of ESG Program recipients operating projects within its geographic area, for assistance and prioritization, needs and preferences of persons experiencing a housing crisis, and availability of resources. Additionally, if the CoC is implementing coordinated entry in stages, it might need to develop more than one assessment tool or to use an existing tool strategically and compartmentally. Effective planning requires clear and formal decision-making that is inclusive, well documented, and responsive to new information learned through implementation.

2.3.1 Planning Decisions

The coordinated entry planning group charged with planning the assessment element should make decisions about the following aspects of assessment. Not all of these pieces need to be in place for implementation to begin, however. Many CoCs opt to implement coordinated entry in stages.

Information collected through assessment

The assessment practices of a CoC can differ based on its prioritization standards, but those CoCs that have successfully implemented coordinated entry tend to collect information in several major categories:

- Identifiers, characteristics, and attributes
- Family members and dependents
- Housing and homeless history
- Employment history
- Legal history
- Physical and behavioral health considerations that can indicate vulnerability
- Goals and preferences

These categories focus on identifying and documenting the person's housing crisis, as well as the person's barriers to being rapidly housed and their level of vulnerability. Coordinated entry being implemented in stages might collect this information over a series of assessments, as the information is needed to make decisions about referrals.

Selection of assessor

In tandem with deciding which access model to use (recall Exhibit 1-1. Coordinated Entry Access Models-1), the CoC must decide which agency or agencies are best positioned to conduct its assessment. Where assessment occurs in phases, one agency potentially could conduct the assessments across all phases, or a host of agencies could participate to varying degrees with each phase.

In evaluating any agency's fitness for conducting any phase of assessment, the CoC should examine the following characteristics:

- Staffing capacity
- Financial capacity
- Accessibility (physical location and hours of operation)
- Experience serving specific populations
- Knowledge of community resources
- Ability to collaborate with stakeholders throughout the community
- Reputation for fairness and transparency
- Cultural and linguistic competency with specific populations (e.g., LGBTQ, members of Native American tribal nations, etc.)
- Fair and objective application of the CoC's defined assessment and prioritization standards

Selection or development of assessment tool

A good first step in deciding whether to use an existing assessment tool or to develop one would be for the CoC to examine the many intake and assessment forms already in use by providers in its community and those used by other CoCs. Most important, the assessment tool must be able to collect information to establish the person's priority within the CoC's prioritization structure, as well as identify the person's needs and preferences.

Note, as stated previously, the assessment and documentation process for purposes of prioritization must occur separately from the eligibility determination. Eligibility determinations are a project-level activity and must occur independently from prioritization.

Assessor training

As described in Section , HUD requires that all staff conducting assessments be trained at least annually on how to conduct the assessment, including what questions to ask. Each phase of assessment might entail unique training protocols, such as mediation training for staff conducting diversion assessments. (CoCs should consider instituting conflict resolution or de-escalation training for any staff involved in coordinated entry.) Skilled assessors should be able to identify signs of trauma and stress among persons entering the crisis response system and then work to mitigate those conditions by conducting assessments in the most sensitive and respectful manner possible.

Staffing levels

Each assessment phase can have a unique staffing requirement. A quality diversion assessment might require a skilled clinician and take 20 to 30 minutes, whereas a

basic shelter intake assessment typically does not require clinical skills and might take only 5 to 10 minutes. To identify the staffing levels needed to meet demand, the CoC should examine the average length of time needed to complete each assessment phase and estimate the number of assessments to be done each day.

Staff background requirements

Each assessment phase could require a different level of staff education and experience. Frontline shelter staff might need less education and experience to adequately triage people experiencing a housing crisis than might case managers who are identifying a person's housing resources and barriers, who in turn might be less skilled than clinicians who are conducting behavioral health assessments in a later assessment phase.

Peer counselors (i.e., people formerly homeless) can play a valuable role in certain aspects of phased assessment because of their shared experiences with the persons undergoing coordinated entry. However, peer counselors also require rigorous training and oversight.

CoCs might want to consider having highly skilled and experienced staff involved in the early phases of assessment. Having more-accurate assessments up front could result in providers being less resistant to referrals they receive later.

Data management

Because each phase of assessment potentially builds on the previous phase, CoCs need to decide what information to collect at each, as well as how or whether the data collected at one phase will be passed along to staff at the next. Data management processes should balance a person's right to privacy with the benefit to the CoC of sharing important information.

Budget

CoCs should estimate costs for each phase of assessment. Costs to consider include staffing, assessment tools, augmenting or developing a data management system, operational costs associated with facilities where coordinated entry activities are conducted or managed, and training staff (e.g., on the assessment processes, data management processes, and conflict resolution).

2.3.2 Key Questions

Some key planning questions can include the following:

- How many phases of assessment does the CoC need?
- What is the focus of each phase, and what does that phase expect to achieve?
- How does having multiple phases of assessment affect engagement?
- How does having multiple phases of assessment affect data accuracy?
- Does any data need to be re-asked/confirmed?
- How will inconsistent data be identified and reconciled during a multiple-phase assessment process?
- Who will have authority to verify and update inconsistent or incorrect data?
- What changes might be needed for HMIS or data collection and sharing protocols to support multi-phase assessments?

2.4 Recommended Assessment Approaches

HUD allows a CoC to customize its assessment processes and tools for five designated subpopulations—single adults, adults with children, unaccompanied youth, households fleeing, or attempting to flee, domestic violence, and persons at imminent risk of literal homelessness (which, as described in Section 2.1.1, may also include veterans). The purpose is to remove population-specific barriers to accessing the coordinated entry process and to account for the different needs, vulnerabilities, and risk factors of these subpopulations in assessment processes and prioritization. Any customizations should begin with the standardized assessment process that the CoC is using and that already reflects the CoC's values and standardized approach. For other subpopulations not explicitly designated, the CoC must use its standardized assessment; however, the wording or order of its questions can change to reflect the experiences or perspectives of those other subpopulations.

The following adaptations to the assessment process can address negative impacts experienced by some subpopulations:

- **Progressive and phased assessment.** Some subpopulations might benefit from being assessed in phases, as engagement could be difficult because such persons are reluctant to share information (e.g., substance abuse disorders, health status). Their reluctance could be a result of trauma, and building their trust can take time.
- **Trauma-informed assessment protocols.** A trauma-informed assessment approach is a best practice that should be used universally with all subpopulations regardless of the participant's history.
- **Trauma-informed training for assessors.** All assessors should be trained in how to conduct assessments with victims of domestic violence or sexual assault to reduce the chance of re-traumatization.
- **Safety planning.** Assessors should be trained on safety planning and other next-step procedures if the assessment uncovers safety issues in situations such as domestic violence, sexual assault, child abuse or neglect, stalking, and trafficking.
- **Private space for assessments.** The assessment space and experience should be designed to allow people to safely reveal sensitive information or safety issues. The space should allow for both visual and auditory privacy, and the CoC's policies and procedures should allow assessors to gather information from each adult in the household in separate interviews, if appropriate. Sensitive information might include the disclosure of mental illness, physical disabilities, gender identity, or abuse.
- **Skip-logic for unnecessary or irrelevant assessment questions.** Assessment questions should be adjusted to be appropriate for specific subpopulations; for example:
  - For unaccompanied youth aged 17 or younger, questions for veterans can be eliminated.
  - For men, questions regarding pregnancy and prenatal care can be eliminated.

- **Accessible language.** Assessment instructions and questions for children and youth should reflect their level of development and be administered in a culturally competent manner.
- **Translation services.** Multiple language options should be available. The CoC might want to use confidential phone interpreters or translators if face-to-face language options are limited.

2.5 Common Implementation Challenges

2.5.1 Provider Concerns

Coordinated entry represents significant system change for CoCs. Providers of housing and supportive services might be understandably apprehensive about giving up their accustomed methods of assessment. The CoC planning group should establish a strong monitoring and evaluation team to regularly review assessment processes and staff conducting assessments. The monitoring team should be especially vigilant during the initial implementation, because early failures can erode confidence in the new system and further inhibit providers from actively participating and adopting coordinated entry.

Monitoring assessment should include checking assessment results for accuracy and their predictive value against program participant files and the data management system to see whether the results are supported. The monitoring team also should examine assessment decisions, program participant admission rates, and project outcomes to identify and then remedy any assessment failures. Assessment process failures should be documented to support ongoing analysis of gaps, inform systems change efforts, and identify opportunities for system improvements.

2.5.2 The Right Amount of Information

The purpose of assessment in coordinated entry is to gather only the information necessary to connect a person experiencing a housing crisis to a service strategy and housing plan that best meets the person's needs as rapidly as possible. The amount and type of information collected through the assessment will vary depending on the coordinated entry access model a CoC has selected (recall Exhibit 1-1. Coordinated Entry Access Models). When developing its standardized assessment, the CoC should focus on limiting the intrusiveness of the assessment and on gathering only what information is necessary for prioritization and referral. Remember, for many persons, diversion from the crisis response system is an appropriate and successful service strategy.

Once program participants have enrolled in a project, however, that provider might need to collect additional information to assist participants in obtaining and maintaining housing—but that additional information might not be needed for coordinated entry itself. For example, the funding guidelines for permanent supportive housing projects require that program participants have a documented disability to qualify—but PSH project staff are responsible for documenting the disability of program participants; that is not the responsibility of coordinated entry staff. Coordinated entry staff do not need to conduct a full psychosocial assessment to determine whether a person is likely to have a PSH-qualifying disability. As described below, the focus of the assessment process in coordinated entry is the matching of persons to housing they are likely to qualify for, rather than predetermining eligibility. After the person is referred to and enrolls in a PSH project, then that project's staff might conduct a psychosocial assessment, if psychosocial support is part of the services the project offers.

2.5.3 Assessments and Eligibility Determination Combined

Coordinated entry assessment (for prioritization and referral) and project eligibility determination are two different processes with different purposes and requirements. As discussed above, assessment conducted under coordinated entry collects only enough information to see whether a person is likely to qualify for housing and supportive services projects. The assessment especially checks for significant barriers to eligibility, such as sex offender status. It is not the purpose of coordinated entry assessment to determine a person's eligibility for each project.

Some CoCs, however, choose to combine the assessment process and eligibility determination process to increase efficiency or to ensure compliance. A CoC should do this, however, only after considering the impact on coordinated entry of adding the time-consuming task of obtaining documentation to establish eligibility.

If a CoC decides to include eligibility determination within coordinated entry, then eligibility determination might be more appropriately carried out during referral (rather than assessment), when the specific project the person might enroll in has been identified. For more information, see Chapter 4: Referral.

Chapter 3: Prioritization

Prioritization

Once a person experiencing a housing crisis has been assessed, the coordinated entry process moves on to determining his or her priority for housing and supportive services. The person's level of vulnerability or need is determined by analyzing the information obtained from the assessment against the CoC's prioritization standards. It is the person's prioritization status (and other information from the assessment) that determines where the person will be referred in the next coordinated entry step. In referral, the group of persons with the highest priority is offered housing and supportive services projects first.

This chapter provides a brief overview of the prioritization requirements, discusses approaches to establishing and managing priority lists, and describes the prioritization planning process.

3.1 Prioritization Fundamentals

HUD requires that CoCs use the coordinated entry process to prioritize homeless persons for referral to housing and services. Policies documenting the prioritization process must align with existing CoC Program and ESG Program written standards established under HUD regulations 24 CFR 578(a)(9) and 24 CFR 576.400(e). The CoC's coordinated entry policies and procedures must describe the factors and assessment information with which prioritization decisions are made for all homeless assistance in the CoC.

3.1.1 Prioritization Requirements

The Coordinated Entry Notice establishes several requirements for the prioritization process.

The CoC must use the coordinated entry process to prioritize homeless persons within the CoC's geographic area for access to housing and supportive services. Prioritization must be based on a specific and definable set of criteria that are made publicly available through the CoC's written prioritization standards and that must be applied consistently throughout the CoC. CoCs should refer to the 2016 Prioritization Notice for detailed guidance on prioritizing in PSH projects.

A CoC's prioritization criteria may include any of the following factors:

- Significant health or behavioral health challenges or functional impairments that require a significant level of support for the person to maintain permanent housing
- High use of crisis or emergency services to meet basic needs, including emergency rooms, jails, and psychiatric facilities
- Extent to which people, especially youth and children, are unsheltered
- Vulnerability to illness or death
- Risk of continued homelessness
- Vulnerability to victimization, including physical assault, trafficking, or sex work
- Other factors determined by the community and based on severity of needs

Required: Written policies and procedures must include the process by which the CoC staff will make prioritization decisions for each project type (e.g., PSH, RRH) and the criteria used for prioritization decisions.

3.2 Components of a Prioritization Process

The prioritization process is the coordinated entry step before working with a person to determine the most appropriate referral(s). Using the prioritization standards and coordinated entry policies and procedures the CoC developed, the entity charged with prioritizing reviews information collected during assessment and determines the person's priority level. Often this determination uses criteria that relate the person's service intensity needs and vulnerability to a score, which is then used to inform a referral.

The scoring and other processes used by CoCs to establish a person's level of priority based on his or her vulnerability most often use multiple considerations such as length of time homeless, number of times homeless, number and severity of behavioral and/or medical problems, age, and other factors that vary by community.

Like the untested predictive value of existing assessment tools, no single scoring or other prioritization method has been proven to reliably predict what housing and supportive services project(s) will end homelessness for a specific person. Assessment tools that generate a prioritization score are a good place to start, but additional factors need to be considered such as individual participant circumstances and the manner in which individuals respond to challenges and circumstances of their lived experience. For example, a particular person might be eligible for PSH but actually prefer, and in fact respond just as successfully to, a less intensive intervention such as RRH.

3.2.1 Determining a Priority Level

When reviewing existing or new assessment tools that have a scoring component, a CoC must review the prioritization recommendations made by the tools against the CoC's prioritization and assistance standards. This review should continue during implementation to ensure the prioritization process is functioning as planned and not routinely leaving out any one category of people in crisis (e.g., women as a whole scoring "too low" to be identified for PSH). The CoC should consider how other information, including assessor judgement, can be included in its prioritization process without jeopardizing the integrity of that process.

HUD has strongly encouraged CoCs to adopt the prioritization approach for PSH in the 2016 Prioritization Notice. This approach ensures that PSH resources are made available to the highest need people in the CoC.

3.2.2 Managing the Priority List

When a CoC faces a scarcity of needed housing and services resources, it is especially important that it use coordinated entry to prioritize people for assistance. A CoC's prioritization approach has to be balanced with HUD's recommendation to avoid creating long waiting lists of potential program participants for resources that do not exist or are not available. How a CoC might reduce long wait times and avoid overly populated waiting lists is discussed in Section .

In order to manage prioritization for referral and placement in CoC resources, many CoCs maintain a priority list. The priority list generally lists persons by name or identification code, and it serves as the basis for coordinated entry's referral process. People on the priority list have already been assigned scores (if the CoC is one that assigns scores); perhaps a

This Guidebook uses the term "priority list," but HUD considers "priority list," "master list," and "by-name list" as interchangeable terms, and no distinction or merit is suggested in this use of one term over the others.

placement ranking level (if applicable) and/or placement date; and perhaps an indication of their priority condition, such as high risk of mortality or heavy use of emergency health services. Thus, the CoC can provide people in its coordinated entry system with accurate and timely referrals, in order of priority, to the project(s) they need and prefer.

Some CoCs will choose to maintain a single priority list with all known homeless persons throughout the CoC included on that centralized list. Other CoCs will maintain separate priority lists by subpopulation or by CoC component type. HUD allows both approaches; however, CoCs can gain efficiencies by maintaining a single priority list, thereby streamlining coordination of the prioritization and referral management processes. If the CoC maintains separate priority lists for different subpopulations or different CoC component types, the CoC should enable persons to be cross-referenced among all prioritization processes to ensure maximum flexibility and consideration of referral options.

Some CoCs manage priority lists of veterans and persons who are chronically homeless by creating flags or notations for them within existing single adult and/or adult with children priority lists. This is an appropriate strategy for managing a CoC's veterans resources and beds or units designated for veterans or those experiencing chronic homelessness.

3.2.3 Using the Priority List to Fill All Vacancies

In addition to making sure persons with the highest priority are offered housing and supportive services projects first, the priority list also is meant to ensure that all project vacancies are filled through coordinated entry's prioritization and referral processes. Agreement by providers in the CoC to follow prioritization in making and accepting referrals ensures fairness, transparency, and consistency in providing services to all people in need. It closes the side doors to the homeless system that people might have used in the past to enter from "non-homeless locations," and it establishes norms for equitable referrals across providers.

3.3 Planning for a Prioritization Process

The coordinated entry prioritization process combines the individual person's assessment results with the CoC's prioritization policies and procedures to determine that person's level of vulnerability. The person's assessed vulnerability will establish his or her level of priority for resources in the homeless system and lead to identification of vacancies at housing and supportive services projects that the person can be referred to.

Applying the CoC prioritization standards and managing the priority list often require a management approach that considers multiple factors, reconciles competing interests, and makes difficult choices about who should receive referrals first. The best strategy for managing this complex and dynamic process is often "case conferencing"—a meeting of relevant staff from multiple projects and agencies to discuss cases; resolve barriers to housing; and make decisions about priority, eligibility, enrollment, termination, and appeals. As the priority list grows and persons wait longer for referrals, the case conferencing approach is best equipped to adjust prioritization so that persons are offered other, potentially less intensive interventions rather than waiting for inordinate periods of time for more intensive interventions that might not exist or be available.

The prioritization process involves several steps and can be challenging to plan and implement because it is the heart of the system change work to be accomplished by establishing coordinated entry. Effective planning requires

clear and formal decision-making that is inclusive, well documented, and responsive to new information learned through implementation.

3.3.1 Planning Decisions

The coordinated entry planning group charged with planning the prioritization process should make decisions about the following aspects of prioritization. Not all of these pieces need to be in place for implementation to begin, however. Many CoCs might opt to implement coordinated entry in stages.

The prioritizing entity

This entity will be responsible for determining the level of priority for a household requesting assistance through coordinated entry and for managing the priority list. Using information gathered through the assessment and from other sources, the prioritizing agency will determine the level of vulnerability of each household. Other sources of information include mainstream service providers (e.g., hospitals, criminal justice system, Medicaid), if their data are part of the CoC's coordinated entry assessment process.

In some CoCs, prioritization is performed by the same entity that conducts the assessment; in others, prioritization is performed by the CoC or another coordinated entry workgroup. If referrals will be made by an entity different from the prioritizing agency, the prioritizing agency must transmit information about the household to the referring agency, including the household's level of priority, housing needs and barriers, preferences, and other information as appropriate.

Establishing the prioritization method

A clear process will need to be established for translating assessment data into a priority list, to be based on the assessment tool selected and the CoC's prioritization standards. The planning group also will need to consider how provider input, in addition to assessment data, will be incorporated into the prioritization process.

3.3.2 Key Questions

Some key planning questions can include the following:

- What types of prioritization decisions are already being made? Are they based on level of need, time spent waiting for available resources, or provider agency preferences?
- Do variations in housing and supportive services availability and accessibility throughout the CoC's geography require varied prioritization strategies?
- Can prioritization be scored, quantified, or valued such that the priority list can be regularly reviewed and updated?
- How will prioritization determinations be documented and communicated among CoC housing and services providers?
- How will a person's priority level be updated when new information is revealed or becomes available after the initial assessment?
- Will frequent users of CoC resources and/or mainstream resources be prioritized differently; and if so, how?

- How will multiple existing and independently maintained waiting lists be consolidated into a centralized priority list?
- What are the potentially different prioritization requirements established by funders (e.g., VA prioritization expectations for the Supportive Services for Veteran Families program) that must be accommodated during the referral process?

3.4 Common Implementation Challenge: List Conversion

A CoC's transition from project-level waiting lists to coordinated entry's centralized prioritization and referral process and priority list will likely involve several of the following elements:

- An in-depth overview and comparison of the people on the existing waiting lists
- Business rules and agreements on what information is put on the priority list and which staff at which provider are authorized to do so
- Agreement by individual providers to discontinue agency-specific waiting lists
- A consistent and fair process to reevaluate the people on existing waiting lists to determine their placement on the new centralized priority list
- Negotiation with and amended contract language associated with certain funders that might anticipate that use of agency-specific or project-specific waiting lists would continue
- A full assessment of the privacy and security implications of participant information collected and managed in a centralized manner that could be accessible to multiple CoC partners

Case conferencing is a useful strategy for merging multiple waiting lists maintained by multiple projects into a centralized priority list managed inside the coordinated entry process.

Chapter 4: Referral

Referral

Once a person experiencing a housing crisis has been assessed, the coordinated entry process moves on to determining his or her priority for housing and supportive services. The person's level of vulnerability or need is determined by analyzing the information obtained from the assessment against the CoC's prioritization standards. It is the person's prioritization status (and other information from the assessment) that determines where the person will be referred in the next coordinated entry step.

In referral, the group of persons with the highest priority is offered housing and supportive services projects first. As required by the Coordinated Entry Notice, that referral process must be guided by an intentional protocol that follows the CoC's prioritization standards as documented in its written policies and procedures. This chapter outlines requirements established in the Notice, describes the components of a referral process, and provides an overview of referral management—eligibility screening, monitoring project availability, enrollment coordination, managing referral rejections, and tracking the status of the referral throughout the referral process.

4.1 Referral Fundamentals

The group of persons with the highest priority must be offered housing and supportive services projects first. To make an efficient and effective referral requires information about the person's history, barriers to housing, and level of vulnerability, as well as data about the availability of projects of various types in the CoC.

To be consistent with HUD's policy priorities in recent Notices of Funding Availability, providers should remove barriers to entry into projects. Likewise, coordinated entry operators may not use the coordinated entry process to screen people out due to perceived barriers related to housing or services. Such barriers could include, but are not limited to,

- too little or no income
- active or a history of substance use disorders
- domestic violence history
- resistance to receiving services
- the type or extent of disability-related services or supports needed
- history of evictions or poor credit
- lease violations or history of not being a leaseholder
- a criminal record

Referral can occur at various points in the coordinated entry process, depending on which approach to coordinated entry the CoC chooses to implement. Depending on the type of project, referrals can occur at initial triage, after initial assessment, while enrolled in emergency shelter, or even after enrollment in a CoC project. Referral can occur throughout the person's involvement with the homeless system. How and when referrals occur depend on many factors, such as the person's needs and preferences, local priorities, and available resources.

Based on the person's priority level, referrals to available housing and supportive services projects are suggested, with the prospective participant making the final decision of which intervention to enroll in. For enrollment to be final, however, the project must establish that the referred person meets its entry requirements; if not, the person retains his or her priority placement on the priority list while other housing and service options are explored.

4.1.1 Referral Requirements

The Coordinated Entry Notice establishes several requirements for the referral process:

Lowering barriers / Housing First

To be consistent with HUD's expectations, the CoC's coordinated entry process and participating projects must continually strive to identify and lower barriers to project entry. The coordinated entry process is prohibited from screening people out based on perceived barriers. Perceived barriers could include those listed above, as well as sexual orientation or gender identity and expression. Exceptions are state or local restrictions that prohibit projects from serving people with certain criminal convictions or other specified attributes.

Referrals to projects

The CoC must implement a referral process that applies to all beds and services available at participating projects funded by the CoC Program or ESG Program. The process should also apply to housing and supportive services projects operated by entities not funded by HUD and those that do not actively participate in coordinated entry but receive and accept a CoC's referrals.

Required: Written policies and procedures must document the uniform referral process for all participating projects, including allowable entry requirements and protocol for a project rejecting a referral.

List of referral resources

HUD strongly encourages CoCs to maintain an inventory list, updated at least annually, of all housing and supportive services projects that can be accessed through referrals from the coordinated entry process.

Nondiscrimination

Through the coordinated entry process, the CoC must continue to comply with the nondiscrimination provisions of federal civil rights laws, including the Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, and Titles II and III of the Americans with Disabilities Act, as well as HUD's Equal Access and Gender Identity Rules, as applicable. Under these laws and rules, the following classes are protected from discrimination:

- Race
- Color
- Religion
- National origin
- Sex

- Actual or perceived sexual orientation or gender identity
- Disability
- Familial status
- Marital status

4.1.2 Additional Considerations for Referral and Prioritization

Impacts on eligibility status

The CoC's referral process should take into account how a person's enrollment in certain projects might affect that person's eligibility status for future assistance. For example, enrollment into a transitional housing (TH) project generally results in the loss of "chronically homeless" status, which can limit a person's future eligibility for PSH that is dedicated to persons experiencing chronic homelessness. Therefore, the coordinated entry process should identify potential eligibility considerations of each referral project and assist the potential participant in making an informed and careful decision about where to enroll.

Wait times and coordinated entry

PSH is almost always the most effective resource for highly vulnerable people with high service needs, including those experiencing chronic homelessness. But the lack of available PSH, for example, should not result in people languishing in shelters or on the streets without other assistance. If no PSH resources are available, the highest need or highest prioritized persons should be offered other appropriate resources the CoC has available. The CoC should apply this dynamic approach to inventory monitoring and referral management to all its component types, including TH and RRH.

Person-centered approach

The CoC should incorporate a person-centered approach into its referral policies and procedures, which can include the following:

- Ensuring potential program participants have choices regarding location and type of housing, level and type of services, and other project characteristics. This includes ensuring that assessment processes provide options and recommendations that guide and inform participants' choosing and don't make rigid decisions about what households need.
- Setting clear expectations concerning where program participants are being referred, entry requirements, and services provided.
- In the rare instance when a person is rejected by a project, having a process to support the person in identifying and accessing another suitable project.

Fair Housing

Some CoCs have raised concerns about their ability to make referrals through a coordinated entry process in a manner that also complies with Fair Housing laws. The CoC should closely review federal, state, and local Fair Housing laws and regulations as it plans and implements its coordinated entry process and incorporate Fair Housing principles into its assessment processes and trainings. The CoC should be aware that local laws can vary within its geographic area.

In general, the law prohibits people from being "steered" toward any particular housing facility or neighborhood because of their race, color, national origin, religion, sex, disability, or the presence of children. As such, the most common practice is for the CoC's referral process to provide potential participants with a list of all available units and projects for which they likely are eligible and then support them in making their own choices about which options to pursue.

Staff making referrals also can be well positioned to notice any potential housing discrimination among participating providers, and they should be prepared to note and report such activity. More information about Fair Housing issues can be found on HUD's website "Fair Housing–It's Your Right."

4.2 Components of a Referral Process

The Coordinated Entry Notice (p. 2) states:

> ***Coordinated entry processes are intended to help communities prioritize people who are most in need of assistance. They also provide information to CoCs and other stakeholders about service needs and gaps to help communities strategically allocate their current resources and identify the need for additional resources.***

The referral process consists of the critical components discussed below.

4.2.1 Eligibility Screening and Determination

The coordinated entry process may initiate the collection of required eligibility documentation—but it is not required to, nor is the coordinated entry process responsible for determining project eligibility or maintaining eligibility documentation after a referral has been made. As described in Section 2.5.3, the focus of the assessment process in coordinated entry is the matching of persons to housing they are likely to qualify for, rather than predetermining their eligibility.

Individual CoC ***projects*** have ultimate responsibility for determining the eligibility of prospective participants in their programs and for collecting and maintaining eligibility documentation. From a practical perspective, however, the coordinated entry process is often well positioned to screen preliminarily for presumptive eligibility. In fact, it may do so by design of the CoC's coordinated entry process. Presumptive eligibility screening is often necessary to inform a referral process that adequately considers the likelihood of a prospective participant's eligibility before making a referral. Note that some funders establish specific prioritization requirements for their funded programs (e.g., VA's Supportive Services for Veteran Families program) that can differ from the prioritization standards established by the CoC. If funders institute their own prioritization standards and preferences, the CoC's coordinated entry process must accommodate these potential differences at the point of referral.

The coordinated entry system ensures that potential program participants are referred to all of the available resources for which they are prioritized and eligible, and for which a vacancy exists. An effective and efficient referral process will consider the written standards for prioritizing assistance developed by the CoC and the ESG Program recipients and individual project eligibility requirements, such as those established by funders other than HUD, or the requirements of nontraditional service providers that are participating in the coordinated entry process.

Eligibility determination can be incorporated into the coordinated entry process in various ways:

- The assessment process might presumptively determine eligibility for housing and supportive services. In such cases, receiving projects can be required to accept the referral regardless of the person's past history or other factors.
- Eligibility might be presumed during assessment as highly likely, but actual eligibility is not documented until the person is being enrolled in the receiving project. Eligibility then is verified through project-specific verification requirements and processes.

It is critical to note that documentation collected for purposes of eligibility determination, if collected earlier during assessment, may not be used in prioritizing persons or in screening persons out of the coordinated entry process. Additionally, persons during assessment should not have to wait to be prioritized while project-level eligibility documentation is compiled or verified.

- Collection of documents to determine eligibility might be ongoing, starting at initial triage and building over time as more in-depth assessments are completed as needed. In this third model, eligibility might be determined as part of the assessment process and/or by the agency receiving the referral. In these instances, documentation and eligibility might be initially determined, but would need to be re-established at the point of project entry, especially if a long period of time has passed between assessment and project entry.

Individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking must have access to referrals to the CoC's coordinated entry system and to an alternative coordinated entry system operated by victim service providers if both exist in the CoC.

4.2.2 Participating Project List

The organization selected by the CoC to manage the referral process should have a list of all the resources accessible and currently available through referral. This means that a mechanism will need to be established for service providers to regularly update their information, including geographic area covered, entry requirements, service model, and preferences for specific subpopulations.

The CoC needs to develop a process by which projects notify the referring entity about housing and supportive services availability when a vacancy opens (i.e., when a current program participant leaves) or new resources are brought online. This can be accomplished through real-time tracking in HMIS or another data system, by electronic communications, or by other means.

4.2.3 Referral Rejection Protocols

The CoC's referral process should also account for occasions when a referral is rejected by the potential participant, or when the housing or supportive services provider rejects a referral under the criteria established by the CoC in its coordinated entry policies and procedures. Many factors or issues can precipitate a rejection.

Sometimes potential participants perceive the referral as representing a housing or services option that does not address their immediate housing goals and

preferences. In those instances, the coordinated entry process should make every effort to identify other referral options. If none exists, the CoC should document such limitations of the currently available housing and services options for system planning purposes. Meanwhile, coordinated entry staff should continue to work with the potential participant to find alternative accommodations.

Sometimes the project receiving the referral through the coordinated entry process is the source of the referral rejection. For example, a project might be experiencing situational staffing constraints. Programmatic changes or funding issues might necessitate a temporary hold on accepting referrals. Or after considering the unique housing barriers and attributes of a particular referral, the project receiving the referral might decide the project does not have sufficient programmatic capacity or expertise to provide the housing and services necessary to resolve the person's housing crisis.

Regardless of the specific circumstances of the project's rejection, in all situations the project should communicate the decision clearly and quickly to the entity making the referral. This communication should include the reason for the rejection, any factors or a change in circumstances that could allow the project to reconsider and actually accept the referral, and other pertinent information that came to light during the referral review that might affect the potential participant's referral standing at other CoC housing and services projects.

Many CoCs with advanced coordinated entry experience have realized significant success with a case conferencing approach to referral rejections. HUD encourages all CoCs to explore this approach and determine whether referral rejections could be managed with a case conferencing protocol in which the entity making the referral, the project rejecting the referral, and potentially the participant meet to share information and collectively consider alternative referral options. The goal of the referral process is to quickly and successfully connect persons experiencing a housing crisis to available CoC housing and services. A case conferencing meeting among all parties concerned is often the most effective way to achieve this goal when the standard referral process breaks down.

4.2.4 Referral Data Management and Efficiency Tracking

The amount and type of client data accompanying a referral from one provider to another depends on specific data-sharing agreements between the referring agency and the receiving project. In general, referral of a person experiencing a crisis for housing and services requires the following:

- Referral date/time
- Identity of the agency currently serving the person, including contact information (name, phone)
- Identity of the receiving project, including follow-up contact information (name, phone)
- Person's name
- List of services the person is being referred for
- Person's prioritization score, if applicable
- Project eligibility or entry requirements
- Person's preferences

- Special considerations, including housing-related information such as desired location, unit size needed, and restrictions on housing
- Verification documentation, as appropriate and if applicable
- Expectations for follow-up

Often the referral is transmitted electronically, with information provided both to the entity in contact with the potential participant (the assessor or another agency) and to the receiving project that has the vacancy. HMIS often provides an existing CoC resource that enables management of electronic referrals. (More discussion and guidance about the use of HMIS in managing coordinated entry referral information is discussed in a separate HUD guidebook on coordinated entry infrastructure elements.)

The CoC's coordinated entry planning group should develop timeliness targets for each of the referral, project enrollment, and move-in stages. A strong referral process will keep these stages as short as possible to facilitate rapidly rehousing people who are homeless, including diversion where possible.

The coordinated entry process also should have established protocols for the level and duration of effort a receiving agency must make to locate a person who has been referred before it can request a new referral.

4.3 Planning for the Referral Process

The referral process is essentially a match that coordinated entry makes between the needs and prioritization level of the person experiencing the housing crisis and the housing and supportive services projects that are available in the crisis response system. Implementing a referral process can take time and often requires complex planning. Effective planning requires clear and formal decision-making that is inclusive, well documented, and responsive to new information learned through implementation.

4.3.1 Planning Decisions

The coordinated entry planning group should address the following planning steps and decisions. Not all of these pieces need to be in place for implementation to begin; many CoCs opt to implement their coordinated entry system, including the referral element, in stages.

Creating a list of project resources and entry requirements

The initial steps in developing a referral process include conducting an inventory of the housing and supportive services projects available in the CoC for persons experiencing a housing crisis and determining each project's level of participation in the coordinated entry process. This initial scan of CoC projects can be done in conjunction with examining the entry requirements for each of the projects.

The CoC planning group should collect information from each provider on its entry requirements (including targeting, income, disability, and household size or characteristics), as well as its location, services, and expectations of program participants. Each provider might also identify any special capacity it has to serve certain subpopulations (e.g., youth, LGBTQ persons, parents, or Native Americans).

This inventory will help the CoC establish a list of referral resources available through coordinated entry. It also will identify resources that do not participate in coordinated

entry but should receive active CoC marketing to participate as providers who will accept referrals from the coordinated entry process. The CoC will need to create a process for regularly reviewing entry requirements and updating the inventory of projects.

Prioritization and referral roles and responsibilities

As part of prioritization and referral planning, the CoC should consider which entity or entities should perform each task described below, how information will be communicated between the entities, and what other expectations it will place on the entities and processes. In many communities, the CoC itself performs some or all of these roles; other CoCs formally consider and select an entity or entities for each task.

Interactions between referring and receiving entities should be transparent, documented, and easy to understand. Expectations for each step in the prioritization and referral processes should be described in the CoC's coordinated entry policies and procedures. The CoC should also develop protocols to address conflicts of interest. It might want to develop a Memorandum of Understanding with the entity or entities.

- **Referring agency.** This is the entity responsible for referring a person experiencing a housing crisis to available housing and supportive services, based on the person's priority level or score and the CoC's prioritization and assistance standards. In some CoCs, the referring agency is the Collaborative Applicant or another central entity responsible for coordinating information about people needing referrals with information about project vacancies. In other CoCs, referrals occur virtually, with prioritizing agencies posting information about people needing housing and supportive services, and receiving agencies selecting from among the postings when they have vacancies in their projects. Whatever approach the CoC uses to structure the referral process must be documented in its coordinated entry policies and procedures.
- **Receiving agency.** All housing and supportive services providers participating in coordinated entry must fill vacancies that have been committed to coordinated entry with people referred through the coordinated entry referral process. To receive an appropriate referral, the receiving agency must have a process for identifying and communicating its vacancies to the referring agency. Usually the receiving agency must notify the referring agency or some other entity whenever it has enrolled a program participant and its vacancy has been filled.
- **Housing Navigator (or Housing Locator).** Some CoCs have implemented a Housing Navigator function to ensure efficient and effective enrollment and subsequent movement of program participants from crisis response to stable housing. Specific staff duties might vary, but a Housing Navigator can perform a variety of functions to reduce the time it takes persons in crisis to obtain housing. Examples of Housing Navigator functions follow:
  - Work closely with referring agencies to determine a person's likely eligibility
  - Develop a Housing Stability Plan
  - Assist the program participant with completing housing applications
  - Perform housing search and enrollment
  - Perform outreach to and negotiate with landlords
  - Assist the program participant with submitting rental applications and understanding leases

- Address barriers to project entry
- Collect documentation for housing eligibility determinations
- Assist the program participant with obtaining utilities and making moving arrangements
- Coordinate resources such as federal, state, and local benefits
- Assist with mediation between the program participant and owner/landlord
- Assist the program participant with credit/budget counseling
- Provide renter education (e.g., landlord/tenant rights, maintenance, care of the home)

Expectations for referrals

The referral process must ensure that program participants receive clear information about the project they have been referred to, what the project will expect of them, and what they can expect from the project. The coordinated entry management entity should ensure that the referral agency is familiar with all the projects in the crisis response system; the management entity might want to develop written material about each of the projects to ensure that consistent information is provided with each referral.

Alternate referrals

Coordinated entry requires that the CoC plan for alternative referral options, and it should have an alternate referral ready if a project rejects a referral. Likewise, the CoC should have a process in place for identifying suitable alternatives if a potential program participant rejects a referral.

4.3.2 Key Questions

Some key planning questions can include the following:

- Which entity or entities will manage the referral process? What resources will be needed to ensure consistency and uniformity in the application of referral decisions?
- How will the CoC's change-management culture affect the complexity of the coordinated entry referral system and its accuracy?
- How will providers handle letting go of paper and other manual processes associated with the referral process? Will "backup" manual systems be tolerated; if so, for how long?
- What are the expectations if the receiving agency takes too long to make a final eligibility determination about a potential program participant? Will there be exceptions for projects that are bound by eligibility verification requirements that cannot be quickly facilitated?
- What happens when the accepted referral ends up not being the best service strategy for that participant? Can the receiving agency send the program participant back to the referral entity or even back to assessment? And how will this process be documented?

- Do scenarios and protocols need to be put in place for making referrals to agencies that operate outside the CoC? What concessions on oversight, quality assurance, acceptance policies and timeframes, and the use of data might be needed in order to accommodate these additional resources? How will these protocols and exceptions be documented in policies and procedures?
- How might the referral process need to respond to assessment that collected inaccurate data about a potential participant, or to additional data disclosed by the program participant late in the process?

4.4 Recommended Referral Approaches

4.4.1 "Warm Handoff" Referrals

A promising practice is assisted referral, also known as "warm handoff" referral. In this model, the CoC approaches referral as more than just handing people off or providing them a list of places to go and providers to contact. Some CoCs require that referrals be made directly between the referring agency and the receiving agency, with the former providing the latter with the information the receiving agency needs to take action on the referral. In some cases, follow-up might be required to help the person connect with the receiving agency and/or complete necessary paperwork.

Often, this "warm handoff" model of referral is accompanied by a Housing Navigator function, which identifies staff to support people experiencing a housing crisis throughout the process, including ensuring their applications are completed and submitted and barriers to enrollment are reduced.

4.4.2 Referral Considerations for Subpopulations

If a CoC chooses to develop a separate access and assessment process for one or more of the five HUD-designated subpopulations, it should ensure those agencies know about and can refer to the full array of housing and supportive services projects available in the CoC.

- Victim service provider staff can assess which resources are likely to be safe and appropriate based on the person's need and level of risk.
- Youth providers in consultation with youth participants can determine which housing and service projects are best suited for young people and youth who are transitioning into adulthood.

It can be important to adjust referral criteria to reflect the life experiences of those subpopulations.

4.5 Common Implementation Challenges

4.5.1 Provider Concerns

Understandably, some housing and supportive services providers express concern about relinquishing control of referral to and enrollment in their programs as coordinated entry shifts a CoC from a project-centric focus to a person-centric one. Before coordinated entry, a provider usually made decisions about which people to enroll in its project based on its best judgement about who would succeed there. To screen out people it did not expect to be successful, the provider usually unnecessarily added eligibility criteria other than those required by the project's funders.

Coordinated entry, with the requirement that all vacancies be filled with referrals from its process, can mean that projects must enroll program participants who often are more challenging to serve than before. The CoC needs to support providers in capacity building to ensure that participating projects can meet program participants' needs, as it also reinforces the benefits and requirements of coordinated entry.

4.5.2 Different Referral Strategies within the Same CoC

Large, rural, or suburban jurisdictions often fund housing and supportive services projects through a patchwork of sources tied to local geography. These local differences might translate to referral options or service strategies that differ from one part of the CoC to another. Different locales in a single CoC's area might have very different referral strategies based on available resources and housing options. Forming a more integrated network of diverse service providers in rural and large CoC geographies will ensure persons are considered for as many possible service options as feasible.

4.5.3 Lack of Appropriate Housing or Services

In some cases, resources in a CoC are insufficient to meet the level of need for a particular type of housing or supportive service; in other cases, no resources are available and such projects need to be developed. Regardless, the coordinated entry process still should focus on prioritizing the highest need people for whatever resources are available and on developing alternative referral strategies until new resources are added. Coordinated entry can play a critical role in helping to document these gaps in the crisis response system and justify increased funding to meet the need.

People in a housing crisis who are not likely to be rapidly housed by a project should not be put on a waiting list and told that it is the resource they are waiting for that will end their homelessness. Instead, case managers at shelters and in the community should work with people on alternative housing plans, including applying for affordable housing in the community, increasing income from employment and benefits, and exploring other housing opportunities available through the person's personal support network. Alternatively, if a person is prioritized for PSH but only RRH resources are available, coordinated entry should have that person access RRH as a bridge or temporary placement, without it negatively affecting their PSH eligibility.

4.5.4 Preference- and Circumstance-Based Incompatibilities

Sometimes potential program participants might feel strongly that they want to be referred to one type of project, but their assessment results suggest a different type. Similarly, assessment protocols might send a provider referrals it does not feel able or well suited to accommodate. Coordinated entry requires the referral system to include a mechanism for addressing such incompatibility concerns. CoCs use various approaches to resolve them, including the following:

Case counseling and reconciliation

This approach allows both program participants and providers to voice concerns and to request an alternative referral. Some CoCs mediate program participant or provider differences through an inclusive counseling session organized by the referring agency. Such a counseling session proceeds like mediation and aims to specify the best service outcome to which both the program participant and provider are amenable.

Program participant's right to reject

Coordinated entry requires that potential program participants have the right to reject housing and services for which they are eligible. In these cases, the referring agency should explore alternative service strategies and identify new referrals.

Provider's right to refuse

As an interim solution to circumstance-based compatibility concerns, some CoCs allow receiving agencies the right to refuse housing or services to a person referred to them. HUD requires the CoC to have written policies and procedures for determining whether the agency's rejection of the referral is appropriate and how the referring agency will integrate the person's choice for services into the referral process to ensure that he or she is afforded the next-best referral. The CoC should document evidence of the conditions to support the rejection.

Allowing providers the right to reject referrals could allay their concerns about relinquishing control and expedite their early adoption of the coordinated entry process. As implementation proceeds and the referral process is refined, and providers are comfortable with its use, the CoC could either replace the rejection procedure with case counseling or eliminate it.

Appendix A. Key Coordinated Entry Regulations and Resources

RESOURCE TYPE	NAME	FULL CITATION, WITH URL IF AVAILABLE
Regulation	**CoC Program interim rule**	Homeless Emergency Assistance and Rapid Transition to Housing: Continuum of Care Program Interim Final Rule, 24 CFR part 578. HUD, July 2012. http://www.ecfr.gov/cgi-bin/retrieveECFR?gp=1&SID=e4f06ab361471f8aaaec25cc35a236be&ty=HTML&h=L&r=PART&n=pt24.3.578#se24.3.578_17
Notice, Implementing Regulation	**Coordinated Entry Notice**	Notice Establishing Additional Requirements for a Continuum of Care Centralized or Coordinated Assessment System. Notice CPD-17-01. HUD January 2017. https://www.hudexchange.info/resource/5208/notice-establishing-additional-requirements-for-a-continuum-of-care-centralized-or-coordinated-assessment-system/
Regulation	**Emergency Solutions Grants (ESG) Program interim rule**	Homeless Emergency Assistance and Rapid Transition to Housing: Emergency Solutions Grants Program and Consolidated Plan Conforming Amendments, 76 FR part 75953. HUD, December 2011. https://www.hudexchange.info/resources/documents/HEARTH_ESGInterimRule&ConPlanConformingAmendments.pdf
Guidance, Notice	**HMIS Proposed Rule**	Homeless Management Information Systems Requirements, 24 CFR Parts 91, 576,580, and 583. HUD, December 2011. https://www.hudexchange.info/resources/documents/HEARTH_HMISRequirementsProposedRule.pdf

RESOURCE TYPE	NAME	FULL CITATION, WITH URL IF AVAILABLE
Guidance, Notice	**Prioritization Notice, 2016**	Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing. Notice CPD-16-11. HUD, November 2016. https://www.hudexchange.info/resource/5108/notice-cpd-16-11-prioritizing-persons-experiencing-chronic-homelessness-and-other-vulnerable-homeless-persons-in-psh/
Guidance, Notice	**Prioritization Notice, 2014**	Notice on Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homelessness Status, Notice CPD-14-012. HUD, July 2014. https://www.hudexchange.info/resources/documents/Notice-CPD-14-012-Prioritizing-Persons-Experiencing-Chronic-Homelessness-in-PSH-and-Recordkeeping-Requirements.pdf
Guidance, Report	**Achieving the Goal of Ending Veteran Homelessness: Criteria and Benchmarks**	United States Interagency Council on Homelessness. 2015. Achieving the Goal of Ending Veteran Homelessness: Criteria and Benchmarks (Ver. 3, October 1, 2015). Washington, DC: Author. https://www.usich.gov/resources/uploads/asset_library/Achieving_the_Goal_Ending_Veteran_Homelessness_v3_10_01_15.pdf
Guidance, Report	**Assessment Tools (Expert Convenings Report)**	Assessment Tools for Allocating Homelessness Assistance: State of the Evidence. February 2015. PD&R Expert Convenings, Summary Report. Washington, DC: U.S. Department of Housing and Urban Development, Office of Policy Development and Research. https://www.huduser.gov/portal/publications/reports/Assessment_tools_Convening_Rpt.html
Guidance, Report	**Criteria and Benchmark for Achieving the Goal of Ending Chronic Homelessness**	United States Interagency Council on Homelessness. 2016. Criteria and Benchmark for Achieving the Goal of Ending Chronic Homelessness (Ver. 1, June 2016). Washington, DC: Author. https://www.usich.gov/resources/uploads/asset_library/Chronic_Homelessness_Criteria_and_Benchmark_June16.pdf
Guidance, Report	**Opening Doors report**	U.S. Interagency Council on Homelessness. 2015. Opening Doors: Federal Strategic Plan to Prevent and End Homelessness. As Amended in 2015. Washington, DC: Author. https://www.usich.gov/opening-doors

RESOURCE TYPE	NAME	FULL CITATION, WITH URL IF AVAILABLE
TA Materials	**Coordinated Entry and HMIS FAQs**	Coordinated Entry and Homeless Management Information System (HMIS). HUD, March 2015. https://www.hudexchange.info/resource/4430/coordinated-entry-and-hmis-faqs/
TA Materials	**Coordinated Entry and Victim Service Providers FAQs**	Coordinated Entry and Victim Service Providers. HUD, November 2015. https://www.hudexchange.info/resource/4831/coordinated-entry-and-victim-service-providers-faqs/
TA Materials	**Coordinated Entry and Youth FAQs**	Youth Specific FAQs for Coordinated Entry. HUD, August 2016. https://www.hudexchange.info/resource/5135/coordinated-entry-and-youth-faqs/
TA Materials	**Coordinated Entry Policy Brief**	Coordinated Entry Policy Brief. HUD, February 2015. https://www.hudexchange.info/resources/documents/Coordinated-Entry-Policy-Brief.pdf
TA Materials	**Prioritization FAQs**	Frequently Asked Questions on the Notice CPD-14-012: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing and Recordkeeping Requirements for Documenting Chronic Homeless Status. HUD, March 2015. https://www.hudexchange.info/resources/documents/FAQs-Notice-CPD-14-012.pdf
TA Materials	**System Performance Measures**	U.S. Department of Housing and Urban Development. May 2015. System Performance Measures: An Introductory Guide to Understanding System-Level Performance Measures (Ver. 2). Washington, DC: Author. https://www.hudexchange.info/resources/documents/System-Performance-Measures-Introductory-Guide.pdf
Website	**Opening Doors**	U.S. Interagency Council on Homelessness. "Opening Doors" [website]. https://www.usich.gov/opening-doors
Website	**System Performance Measures**	U.S. Department of Housing and Urban Development. "System Performance Measures" [website]. https://www.hudexchange.info/programs/coc/system-performance-measures/

Appendix B. Recommended Qualities of a Good Standardized Assessment Tool

As described in the 2014 Prioritization Notice:

While HUD requires that CoCs use a standardized assessment tool, it does not endorse any specific tool or approach, there are universal qualities that any tool used by a CoC for their coordinated assessment process should include.

1. **Valid** — Tools should be evidence-informed, criteria-driven, tested to ensure that they are appropriately matching people to the right interventions and levels of assistance, responsive to the needs presented by the individual or family being assessed, and should make meaningful recommendations for housing and services.
2. **Reliable** — The tool should produce consistent results, even when different staff members conduct the assessment or the assessment is done in different locations.
3. **Inclusive** — The tool should encompass the full range of housing and services interventions needed to end homelessness, and where possible, facilitate referrals to the existing inventory of housing and services.
4. **Person-centered** — Common assessment tools put people — not programs — at the center of offering the interventions that work best. Assessments should provide options and recommendations that guide and inform client choices, as opposed to rigid decisions about what individuals or families need. High value and weight should be given to clients' goals and preferences.
5. **User-friendly** — The tool should be brief, easily administered by non-clinical staff including outreach workers and volunteers, worded in a way that is easily understood by those being assessed, and minimize the time required to utilize.
6. **Strengths-based** — The tool should assess both barriers and strengths to permanent housing attainment, incorporating a risk and protective factors perspective into understanding the diverse needs of people.
7. **Housing First–orientation** — The tool should use a Housing First frame. The tool should not be used to determine "housing readiness" or screen people out for housing assistance, and therefore should not encompass an in-depth clinical assessment. A more in-depth clinical assessment can be administered once the individual or family has obtained housing to determine and offer an appropriate service package.
8. **Sensitive to lived experiences** — Providers should recognize that assessment, both the kinds of questions asked and the context in which the assessment is administered, can cause harm and risk to individuals or families, especially if they require people to relive difficult experiences. The tool's questions should be worded and asked in a manner that is sensitive to the lived and sometimes traumatic experiences of people

experiencing homelessness. The tool should minimize risk and harm, and allow individuals or families to refuse to answer questions. Agencies administering the assessment should have and follow protocols to address any psychological impacts caused by the assessment and should administer the assessment in a private space, preferably a room with a door, or, if outside, away from others' earshot. Those administering the tool should be trained to recognize signs of trauma or anxiety.

Additionally, the tool should link people to services that are culturally sensitive and appropriate and are accessible to them in view of their disabilities, e.g., deaf or hard of hearing, blind or low vision, mobility impairments

9. **Transparent** — The relationship between particular assessment questions and the recommended options should be easy to discern. The tool should not be a "black box" such that it is unclear why a question is asked and how it relates to the recommendations or options provided.

Allocating Homeless Services After the Withdrawal of the Vulnerability Index–Service Prioritization Decision Assistance Tool

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See also Kapadia, p. 372.

Until there are sufficient resources to end homelessness in the United States, communities will struggle with how to allocate limited homeless services. The Department of Housing and Urban Development (HUD) requires communities to establish a coordinated assessment system using a standardized tool to prioritize services.[1] Until recently, the most widely used tool was the VI-SPDAT (Vulnerability Index–Service Prioritization Decision Assistance Tool) for single adults or a modification for youths and families.[2] The tool assesses individuals' level of vulnerability across their history of housing and homelessness, individual risk factors, socialization and daily functions, and wellness. It then prioritizes people with the highest scores for permanent supportive housing, those with intermediate scores for short-term, rapid-rehousing subsidies, and those with the lowest scores for minimal services.

Typically, use of the VI-SPDAT conflates risk assessment with allocation of services, where only the vulnerability score is used to match people to housing and services. The tool has been criticized as invalid and unreliable[3] and racially biased,[4] but also defended as predicting returns to homelessness.[5] There is little justification for the cutoffs between recommended housing options (although, frequently, communities lack sufficient resources to follow these recommendations). Ultimately, widespread concerns led the VI-SPDAT's creators to stop supporting its use.[2] This change requires communities to confront both empirical and ethical questions that the availability and near field-wide adoption of a tool, however flawed, allowed them to avoid. To aid communities as they confront these questions, we discuss three issues central to the design of a coordinated assessment processes: risk assessment (what should count as risk?), prioritization (who should get services first?), and matching (who should receive what?). In addition, we draw on bioethical frameworks for allocating scarce medical interventions to inform decisions.

WHAT SHOULD COUNT AS RISK?

Most homeless service systems seek to assess risk and prioritize resources accordingly. But how should risk be defined? It is useful to contrast decisions about allocation of services to people who are currently homeless with the situation of homelessness prevention. In the case of prevention, the outcome of interest is clear: homelessness. Given a data set of predictors (say, questionnaire responses from applicants for services, or information about use of other services), it is not hard to build an empirical predictive model identifying people most likely to become homeless.[6–8] One must still choose whether to offer scarce prevention services to those at highest risk or where they make the most difference. (If some people are likely to become homeless regardless of the help they receive, communities might want to adopt a triage model, serving those at moderate risk.) In the case of homelessness prevention, research shows that these decisions coincide: all types of services studied (whether cash for eviction prevention, casework to connect households to resources, or long-term housing vouchers) prevent the most homelessness when given to applicants at highest risk.[7,9,10]

In the case of restoring currently homeless people to housing, it is less clear what sort of risk matters. Characteristics associated with becoming

homeless in the first place? Risk for mortality on the streets? Physical or mental harms that may result from homelessness? These criteria are what the field typically calls vulnerability. However, evaluations of the VI-SPDAT have examined only returns to homelessness as a criterion, with mixed results. Brown et al. found no significant relationship between VI-SPDAT scores and returns to homelessness in one community,[3] whereas Petry et al. did find a relationship in a multicommunity sample.[5] Both found that type of housing assistance provided was a significant predictor. Allegheny County, Pennsylvania has recently developed a decision tool designed to measure need based on risk of harm using local administrative data rather than self-report. It combines three empirical predictive models for jail bookings, inpatient behavioral health stays, and frequent emergency room use, and is superior to the VI-SPDAT in predicting these outcomes.[11] Current data show that the new tool prioritizes more African American clients and men than the VI-SPDAT. However, most jurisdictions lack access to the integrated data systems that would allow this approach.

HUD describes the types of risk that communities can consider in assessments,[12] but local systems must decide the outcomes they deem most important, such as vulnerability to illness, victimization, risk of continued homelessness, or use of emergency services (and associated costs). Communities must also make two more decisions: how to prioritize those assessed, and which services to provide to which individuals and families.

WHO SHOULD GET SERVICES FIRST?

Should systems prioritize interventions to those at highest risk (however defined), determine where services make the most difference, or base allocation on some other value criterion? Although HUD states that homeless service systems should "prioritize people who are more likely to need some form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness,"[12] other values often play in policy decisions. For example, as a nation, the United States has given priority to military veterans, with special resources made available by HUD, the Department of Veterans Affairs, and cities that participated in the Mayor's Challenge. Setting these priorities cut veteran homelessness nearly in half from 2010 to 2019,[13] while rates of homelessness among other groups stagnated. Privileging veterans is a value proposition (people who serve their country should not be homeless) that is not one based on risk or maximizing program effects. But one could argue the ethics of prioritizing other populations. Following are a few of many possible examples:

- Infants, to prevent consequences to early development.
- African Americans and Native Americans, to advance racial justice and redress past harms and ongoing discrimination that put them at heightened risk of homelessness.
- Youths, or perhaps young people aging out of foster care, to set their lives on a better trajectory.
- People exiting incarceration whose risk of homelessness and recidivism are high without help.
- People fleeing violence, to provide safety and security.
- People with mental illnesses and other disabilities, who may be more likely to become chronically homeless.
- People who have been homeless the longest, who have suffered the longest.
- People who are not merely unhoused but also unsheltered (e.g., living on the streets), to protect them from the environmental hazards of living in places not meant for human habitation.

Advocates and policymakers might endorse many or all of these criteria. However, many conflict in both obvious ways (infants cannot be veterans) and more subtle ones. For example, because African Americans are more likely to use shelters than their White counterparts,[13] a rule that prioritizes unsheltered people also favors White people.

WHO SHOULD GET WHAT?

Finally, communities must determine how to allocate different interventions. Many coordinated assessment systems, including typical use of the VI-SPDAT, assume that a single spectrum of service needs matches neatly onto tiered service intensity. The top tier is usually long-term housing assistance, with or without services. Randomized control trials have found that such assistance is most effective at ending homelessness. In the case of families, the 12-site Family Options randomized controlled trial showed that long-term subsidies that hold rental costs to 30% of income both end homelessness and have radiating benefits for other aspects of family life, without any dedicated services. Neither short-term rapid-rehousing subsidies with modest services nor midterm transitional housing with extensive social services were much more effective for

reducing homelessness or enhancing other aspects of well-being than usual care.[14] In the case of individuals with serious mental illnesses and co-occurring substance use disorders, the five-site At Home Chez-Soi randomized controlled trial showed that permanent supportive housing following a Housing First approach with no prerequisites for entry, and with an emphasis on consumer choice, helped people get and stay housed better than programs that focused on changing behavior.[15,16]

These studies showed average effects across all people studied. But does everyone need long-term interventions? Might some people flourish with more modest and less expensive services? If so, more people could be served. The Family Options study examined this question and found no evidence that interventions were differentially effective for families with more or fewer housing barriers, such as a history of eviction, or for families with more or fewer psychosocial challenges, such as substance abuse.[14] One descriptive study of the VI-SPDAT found that returns to homelessness were higher for people with higher scores regardless of housing destination, but it did not test whether the associations differed depending on housing type.[5] In general, the field lacks evidence about differential effects of interventions based on recipients' characteristics.

Cost savings, across all publicly funded systems, may also be less than supposed. In the Family Options study, offering families open-ended housing vouchers led to costs across all housing programs only 9% greater than for usual care over 37 months. Offering short-term rapid-rehousing subsidies cost 9% less than usual care.[14] In the case of permanent supportive housing, a National Academies report found the evidence of cost–benefit too weak to support any conclusion.[17]

Two approaches separate assessments from decisions about how to allocate interventions. The Canadian Homelessness Partnering Secretariat advocates two stages.[18] The first stage assesses severity of need and risk of harm to self or others, along with patterns of homelessness and service use. The second involves planning for supportive services, including individual goals and preferences, strengths as well as problems, and past history of actions and responses. Community resources are an additional constraint. This procedure departs in critical ways from assigning resources based on an assessment score. Perhaps most importantly, once a person qualifies for services, individual choice matters. The Allegheny model similarly uses two phases.

Another possibility, known as progressive engagement, forgoes the assessment phase altogether and makes allocation decisions over time.[19] It starts by offering minimal, inexpensive services to everyone. People who fail when given those minimal services get something more, with the most extensive and expensive services reserved for those who do not succeed at earlier stages. Starting with a "light touch" permits serving more people. Offering cheaper, less effective treatments to more people under conditions of scarcity may be justified ethically,[20] but has psychological costs. Mothers assigned to rapid rehousing following a progressive engagement model in the Family Options experiment found the uncertainty about the length of assistance "nerve-wracking," and that the program was "designed to keep you down, because the minute you make too much money they start taking everything away from you."[21(p377)]

INSIGHTS FROM BIOETHICS

To grapple with these questions, the homeless services field might benefit from literature in public health and bioethics concerned with allocating scarce medical interventions, where experts have named, debated, and tested principles for resource allocation. Seminal pieces argue that no criteria are value-free, and no single principle can allocate scarce interventions justly.[22] Instead, the best processes are multiprinciple allocation systems to incorporate the complexity of our moral values. The most common principles used in medical resource allocation include treating people equally (lottery and first-come-first-served), favoring the worst off (or "prioritarianism"; e.g., sickest first or those who have had the least life), maximizing total benefits (or "utilitarianism"; e.g., benefiting the greatest number of people or maximizing the years of life saved), and, finally, rewarding social usefulness (e.g., past-oriented "reciprocity" or future-oriented "instrumental value" for essential workers or others seen to carry out important societal tasks).[22]

Although most assessments and prioritization processes in the homelessness field have multiple ways to earn "points," they may not integrate multiple principles. For example, the VI-SPDAT follows prioritarianism, favoring the most vulnerable first. Prioritizing veterans follows "reciprocity," rewarding social usefulness or societal values. Most public housing authorities use a mix of "treating people equally" and prioritarianism, using random lottery waiting lists and point-based eligibility to move up the list.

Other scholars have proposed using "categorized priority systems," or reserve systems, to divide resources across multiple categories of flexible size, and allow for the use of different priorities across them.[23,24] Such systems have been used to manage school choice, allocate H-1B visas, assign marathon slots, and implement affirmative action policies. In the case of scarce medical resources, medical ethicists have promoted reserve categories for people with disabilities and essential personnel, based on different principles.[23] Such systems give everyone a chance but increase chances based on multiple, sometimes even incommensurable principles. For example, Allegheny County separates estimation of risk from a set of "business rules" that prioritize by risk, chronicity, and special eligibility categories (families, people fleeing domestic violence, and veterans).[11]

Finally, recent work in public health in light of the COVID-19 pandemic can help the homeless service system integrate racial equity into decision frameworks. One study evaluated the efficacy, ethicality, and legality of different methods to reduce racial and ethnic disparities in COVID-19 treatments.[25] After reviewing decades of legal precedent, the article concluded that individual-level prioritization by race or ethnicity (excepting Native American tribal status) is likely to lead to legal challenges, but prioritizing factors associated with race, such as zip codes, and lowering age-based eligibility in disadvantaged neighborhoods (with lower life expectancy) can reduce racial disparities and meet legal scrutiny. Finally, it suggested that across frameworks, systems should be explicit about the value choices inherent in the allocation of scarce resources, rather than outsourcing decisions to an instrument.

CONCLUSION

Research has provided substantial evidence about how to prevent and end homelessness, if policymakers are willing to devote the resources to do so.[9] As long as funding remains insufficient, departure from the VI-SPDAT requires communities to confront difficult questions regarding the allocation of scarce resources to end homelessness, from assessment of risk to prioritization and matching. Some questions, such as risk factors for mortality, chronicity, or returns to homelessness after housing, are empirical. But the most important questions involve values and system design. What outcomes does the community seek to avoid? Who should be prioritized against those outcomes? Persad et al. write, "Many allocation systems do not make their content explicit, nor do they justify their choices about inclusion, balancing, and specification. Elucidating, comparing, and evaluating allocation systems should be a research priority."[22(p426)] These conclusions apply as well to homeless services as to the medical decisions Persad et al. describe.

In contexts of limited resources, we suggest that communities adopt trauma-informed assessment procedures that examine the risk of outcomes that collaborators with experience of homelessness seek to avoid. For prioritization, we suggest that communities use multiprinciple allocation decisions. Two groups that might receive categorical priority are families with children and individuals with disabilities. Additional categorical allocations might go where services are likely to make the most difference with respect to outcomes that communities have chosen. Groups at high risk of harm include people whose medical conditions are sensitive to housing,[17] people exiting incarceration, or youths exiting foster care. For the large remaining group, prioritizing on length of homelessness would give everyone a chance, although realistically, scarce resources may make that chance small. Communities could choose differently. Throughout, communities should be vigilant that systems are equitable racially and counteract structural disadvantage. To determine service type, systems should incorporate consumer choice, case conferencing, and evidence of effectiveness. Although departure from the VI-SPDAT presents a challenge, it also presents an opportunity to design better systems. AJPH

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CONFLICTS OF INTEREST

The authors have no conflicts of interest to declare.

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SANTA CRUZ COUNTY
Housing for Health
PARTNERSHIP

WATSONVILLE/SANTA CRUZ CITY & COUNTY CONTINUUM OF CARE (COC)

HOMELESS MANAGEMENT INFORMATION SYSTEM (HMIS)

Policies and Procedures

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I. INTRODUCTION

The Watsonville/Santa Cruz City & County CoC's Covered Homeless Organizations (CHOs) utilize a computerized record-keeping system that captures information about people experiencing or at-risk of homelessness called the Watsonville/Santa Cruz City & County CoC Homeless Management Information System (Watsonville/Santa Cruz CoC HMIS). The CoC uses HMIS data to: improve housing and services quality; identify patterns and monitor trends over time; conduct needs assessments and prioritize services and housing resources for subpopulations experiencing or at-risk of homelessness or living with very low incomes; enhance inter-agency coordination; and monitor and report on the delivery, impact, and quality of housing and services. HMIS creates an unduplicated count of individuals and households at-risk of or experiencing homelessness and develops aggregate information that assists in developing policies and programs to end homelessness. In addition, the Watsonville/Santa Cruz CoC HMIS allows CHOs to share information electronically about consumers, including their service needs, to better coordinate services and housing.

The lead entity for the CoC implementation of HMIS is the County of Santa Cruz Human Services Department Housing for Health Division (H4H) and the system is administered by Bitfocus. Bitfocus is also the current Watsonville/Santa Cruz CoC HMIS Software as a Service (SaaS) vendor and works to make HMIS an effective tool for all CHOs.

Aggregated, anonymous data from the Watsonville/Santa Cruz CoC HMIS is used to generate reports for federal, state, and local funders; it is used to produce reports for the annual Point-in-Time (PIT), Longitudinal System Analysis (LSA), the Annual Homeless Assessment Report, Annual Performance Reports (APRs), System Performance Measures (SPMs), and other required reports provided to federal, state, and local funders.

Effective implementation of the Watsonville/Santa Cruz CoC HMIS can benefit individuals and families at-risk of or experiencing homelessness, CHOs, public policy planners, and the community. This document provides an overview of current policies, procedures, guidelines, and standards that govern Watsonville/Santa Cruz CoC HMIS operations, as well as the responsibilities for CHOs and HMIS End Users. The Appendices provide the specific current applicable policies.

II. GOVERNING PRINCIPLES

Described below are the overall governing principles upon which all decisions pertaining to the Watsonville/Santa Cruz CoC HMIS are based. Agencies, programs, and individual users are expected to read, understand, and adhere to the spirit of these principles, even when the Policies and Procedures do not provide specific direction.

Confidentiality

The rights and privileges of consumers are crucial to the success of HMIS. These policies will ensure consumers' privacy without impacting the delivery of services and housing resources, which are the primary focus of programs participating in HMIS.

Policies regarding consumer data are founded on the premise that a consumer owns their own personal information; these policies will provide the necessary safeguards to protect consumer, agency, and policy level interests. Collection, access, and disclosure of consumer data through HMIS is only permitted by the procedures set forth in this document.

Data Integrity

Consumer data is the most valuable and sensitive asset of the Watsonville/Santa Cruz CoC HMIS. These policies ensure integrity and protect this asset from accidental or intentional unauthorized modification, destruction, or disclosure.

System Availability

The availability of a centralized data repository is necessary to achieve the service, housing, and outcome goals of people experiencing or at risk of homelessness, H4H, the CHOs, and the CoC. Bitfocus, as the System Administrator, is responsible for ensuring the broadest deployment and availability of the HMIS data system necessary to capture collective efforts to address homelessness in Santa Cruz County.

III. HMIS BENEFITS

Use of the Watsonville/Santa Cruz CoC HMIS can provide numerous benefits for persons at-risk of or experiencing homelessness, H4H, CHOs, and the CoC.

Benefits for persons at-risk of or experiencing homelessness:

- Intake information and needs assessments are maintained, reducing the number of times persons at-risk of or experiencing homelessness must repeat their stories to multiple staff members or to multiple CHOs
- Multiple services can be coordinated, and referrals can be streamlined to ensure consumers are matched appropriately to services and housing resources to end their housing crisis as quickly as possible
- Ensures consumer confidentiality by providing information in a secured system.

Benefits for H4H, CHOs and the CoC:

- Provides online, real-time information about consumer needs and the services and housing resources available for persons at-risk of or experiencing homelessness
- Ensures consumer confidentiality by providing a secured system to help CHOs avoid data breaches and misuse of HMIS data
- Decreases duplicative consumer intakes and assessments
- Tracks consumer outcomes and service and housing history
- Generates data reports for local, state, and federal reporting requirements
- Facilitates the coordination of services and housing resources within and among CHOs
- Assists in defining and understanding the extent of homelessness throughout the CoC
- Can be used to evaluate the effectiveness of specific interventions and projects, as well as services and housing provided
- Can be used for developing data-informed solutions to reduce and end homelessness.

IV. ROLES AND RESPONSIBLITIES

A. Housing for Health Partnership – Operations Committee

- Project direction, guidance, participation, and feedback
- Advise on funding strategies
- Review of performance metrics, data quality and compliance issues

B. Housing for Health

- CHO oversight, coordination, and liaison for use of HMIS
- Development and maintenance of Policies & Procedures
- Development and maintenance of forms and documentation
- End user license monitoring
- Data quality and performance metrics monitoring

C. Bitfocus

- Maintenance of Watsonville/Santa Cruz CoC HMIS Website
- Central Server Administration
    - Server security, configuration, and availability
    - Setup and maintenance of hardware
    - Configuration of network and security layers
    - Anti-virus protection for server configuration
    - System backup and disaster recovery
    - User administration and license management
    - System uptime and performance monitoring
- Adherence to HUD Data Standards
- Maintain list of all Partner Agencies and make it available to the public including posting it on the Watsonville/Santa Cruz CoC HMIS portal
- Aggregate data reporting and extraction
- Watsonville/Santa Cruz CoC HMIS Help Desk
- HMIS Training
- Breach reporting to H4H
- Liaison with HUD on required federal data collection and reporting standards and expectations

D. Covered Homeless Organizations (CHOs)

- CHO Executive Director
    - Authorizing agent for Organization Partnership and Data Sharing Agreement
    - Designation of CHO HMIS Lead

    - Ensuring agency compliance with Policies & Procedures
- CHO HMIS Lead
    - Liaison with H4H and Bitfocus
    - Request new user ID and licenses from Bitfocus
    - Maintain agency/program data in HMIS Application
    - End user adherence to privacy and security policies
    - Breach reporting to Bitfocus
    - First level end user support
    - Ensure use of most current policies and forms
    - Ensuring quality of HMIS data collection and entry by CHO staff/end users
- CHO Staff/End User
    - Sign the Watsonville/Santa Cruz CoC HMIS User Agreement and complete required Watsonville/Santa Cruz CoC HMIS training for staff/end users
    - Take appropriate measures to prevent unauthorized data disclosure
    - Report all privacy and/or security violations to HMIS lead
    - Comply with relevant policies and procedures
    - Collection and input required data fields in a consistent, accurate, and timely manner
    - Ensure a minimum standard of data quality by accurately answering the Universal Data Elements and required program-specific data elements for every individual and household entered into the Watsonville/Santa Cruz CoC HMIS
    - Inform consumers about the CHO's use of the Watsonville/Santa Cruz CoC HMIS
    - Take responsibility for any actions undertaken with one's username and password

E. HMIS License Availability

CHOs may request end user licenses at any time from Bitfocus. H4H is informed when a CHO requests an end user license and makes the decision on whether to grant that request, based upon licenses available, licenses already assigned to the CHO, HMIS data requirements associated with a program and program funding, CHO staff and data management capacity

and need, and funding available. The CoC reserves the right to change the license acquisition and allocation process based upon CoC funding availability. If a lack of CoC funding limits CHO access and the CHO has funding to support additional users, H4H staff can enter into financial agreements to support additional users for that CHO.

V. REQUIREMENTS FOR PARTICIPATION

A. CHO General Requirements

Participation Agreement Documents

CHOs must complete the following documents:

1. *Organization Partnership and Data Sharing Agreement*: Must be signed by each CHO's Executive Director on an annual basis. The Organization Partnership and Data Sharing Agreement states the Organization's commitment to adhere to the policies and procedures for effective use of the Watsonville/Santa Cruz CoC HMIS.
2. *HMIS User Agreement and Code of Ethics*: Details the HMIS User policies and responsibilities and is signed by each authorized end user prior to receiving an HMIS user license and then annually thereafter.

Assign HMIS Lead

1. The CHO shall designate a primary contact, the HMIS Lead, for communications regarding Watsonville/Santa Cruz CoC HMIS within the CHO and shall notify Bitfocus of their name and contact information.
2. Bitfocus will maintain a list of all designated HMIS Leads.

End User Access

1. All potential end users must undergo a criminal background check completed by the CHO, as detailed in the Organization Partnership and Data Sharing Agreement. Individuals with a history of fraud, identity theft, or misuse of confidential information, or an individual who is under investigation for such issues, shall not be permitted an HMIS user license.
2. End users must be paid staff or official volunteers of a CHO. An official volunteer must complete a volunteer application with the CHO, undergo Organization training, pass a

criminal background check, and record volunteer hours with the Organization. Individuals who are solely contracting with a CHO are prohibited from receiving a user license. All end users must be at least 18 years old.

3. The CHO HMIS Lead will submit a request for new end user access to Bitfocus. Each HMIS end user must have their own username and password to access the system.
4. Prior to the end user gaining access to HMIS, the HMIS Lead will assess the operational security of the user's workspace and confirm that workstation has virus protection properly installed and that a full-system scan has been performed within the last week.
5. All end users must complete training before access to the system is granted (see below). All end users shall commit to abide by the governing principles of the Watsonville/Santa Cruz CoC HMIS and adhere to the terms and conditions of the HMIS User Agreement and Code of Ethics.

B. CHO Training Requirements

New User Training

1. All end users are required to attend a new end user privacy and security training and basic HMIS system training with Bitfocus prior to receiving access to the system.
2. Upon their first log in to Clarity, end users are asked to sign a confidentiality agreement that acknowledges they received the HMIS Privacy Policy and of which they pledge to comply. All electronically signed new user agreements are stored in the system.
3. Users must complete training and pass a knowledge-based quiz prior to gaining HMIS access.

Ongoing Training

1. All end users are required to attend annual privacy trainings to retain their Watsonville/Santa Cruz CoC HMIS license. The annual training will include re-signing the user agreement and passing a knowledge-based quiz.
2. Bitfocus will provide regular trainings for the CHOs and can provide specialized trainings when necessary. Refer to the HMIS website (**Santa Cruz HMIS Home (bitfocus.com)**) for the latest schedule of classes.

C. CHO Security Requirements

System Security

1. *Equipment Security*. A CHO must apply system security provisions to all systems where Personally Identifiable Information (PII) is stored, including, but not limited to, their networks, desktops, laptops, mini-computers, mainframes, and servers. PII is any information about an individual which can be used to distinguish, trace, or identify their identity, including personal information like name, address, date of birth or social security number.
2. U*ser Authentication*. Each user accessing a machine that contains HMIS data must have a unique username and password that can't be used by or shared with others. Passwords must be at least eight characters long and meet reasonable industry standard requirements. These requirements include, but are not limited to:
    a. Using at least one number and one letter or symbol
    b. Not using, or including, the username, the HMIS name, vendor's name, or any of these above spelled backwards.
    c. Not consisting entirely of any word found in the common dictionary.

    Written information specifically pertaining to user access, e.g., username and password must not be stored or displayed in any publicly accessible location. Individual users must not be able to log on to more than one workstation at a time or to the network at more than one location at a time.
3. *Virus Protection*. A CHO must protect HMIS and any electronic device used to store PII from viruses by using commercially available virus protection software. Virus protection must include automated scanning of files as they are accessed by users on the system where the HMIS application is housed. A CHO must regularly update virus definitions from the software vendor.
4. *Firewalls*. A CHO must protect HMIS and any electronic device used to store PII from malicious intrusion behind a secure firewall. Each individual workstation does not need its own firewall, so long as there is a firewall between that workstation and any systems located outside of the organization, including the Internet and other computer networks.

    For example, a workstation that accesses the Internet through a modem would need its own firewall. A workstation that accesses the Internet through a central server

would not need a firewall so long as the server has a firewall. Firewalls are commonly included with all new operating systems. Older operating systems can be equipped with secure firewalls that are available both commercially and for free on the internet.

5. *Public Access*. HMIS and any electronic device used to store PII that use public forums for data collection or reporting must be secured to allow only connections from previously approved computers and systems through Public Key Infrastructure (PKI) certificates, or extranets that limit access based on the Internet Provider (IP) address, or similar means. A public forum includes systems with public access to any part of the computer through the internet, modems, bulletin boards, public kiosks or similar arenas. The CHO must maintain a fixed Internet Protocol (IP) address.
6. *Physical Access to Systems with Access to HMIS Data.* A CHO must always staff computers stationed in public areas that are used to collect and store HMIS data. When workstations are not in use and staff are not present, steps should be taken to ensure that the computers and data are secure and not accessible by unauthorized individuals. Workstations should automatically turn on a password-protected screensaver when the workstation is temporarily not in use. Password-protected screensavers are a standard feature with most operating systems and the amount of time can be regulated by a CHO. If staff from a CHO will be gone for more than five minutes from their workstation, staff should log off the data entry system and shut down the computer.
7. *Disaster Protection and Recovery.* The Service Administrator (Bitfocus) copies HMIS data on a regular basis to another medium and stores this data in a secure off-site location where the required security standards apply. The data is stored in a central server in a secure room with appropriate temperature control and fire suppression systems. Surge suppressors are used to protect systems used for collecting and storing all the HMIS data.
8. *Disposal.* To delete all HMIS data from a data storage medium, a CHO must reformat the storage medium. A CHO should reformat the storage medium more than once before reusing or disposing the medium.
9. *System Monitoring*. A CHO must use appropriate methods to monitor security systems. Systems that have access to any HMIS data must maintain a user access log. Many new operating systems and web servers are equipped with access logs and

some allow the computer to email the log information to a designated user, usually a system administrator. Logs must be checked routinely to ensure appropriate individuals access and utilize the data. The CHO HMIS Lead is responsible for communicating to end users proper workstation configuration and the importance of protecting access to HMIS data among all Agency users.

Application Security

1. *Applicability*. A CHO must apply application security provisions to the HMIS software during data entry, storage, review, and all other processing functions.
2. *User Authentication*. A CHO must secure all electronic HMIS data with, at a minimum, a user authentication system consisting of a username and a password. Passwords must be at least eight characters long and meet reasonable industry standard requirements. These requirements are noted earlier in D. CHO Security Requirements.
3. *Electronic Data Transmission*. A CHO must encrypt all HMIS data that are electronically transmitted over the Internet, publicly accessible networks, or phone lines to current industry standards. The current standard is 128-bit encryption. Unencrypted data may be transmitted over secure direct connections between two systems. A secure direct connection is one that can only be accessed by users who have been authenticated on at least one of the systems involved and does not utilize any tertiary systems to transmit the data. A secure network has secure direct connections.
4. *Electronic Data Storage*. A CHO must store all HMIS data in a binary, not text, format. A CHO that uses one of several common applications, e.g., Microsoft Access, Microsoft SQL Server, or Oracle, are already storing data in binary format and no other steps need to be taken.

Hard Copy Security

1. *Applicability*. A CHO must secure any paper or other hard copy containing PII that is either generated by or for HMIS, including, but not limited to reports, data entry forms, and case / client notes. Hard copies should be stored in a locked and secure file cabinet in an area not accessible to non-CHO staff.
2. *Security*. A CHO must always supervise any paper or other hard copy generated by or for HMIS that contains PII when the hard copy is in a public area. When CHO staff are not present, the information must be secured in areas that are not publicly accessible.

Written information specifically pertaining to user access, e.g., username and password, must not be stored or displayed in any publicly accessible location.

D. CHO Violation of HMIS Operating Policies

Compliance with these Policies and Procedures is mandatory for participation in the Santa Cruz County HMIS system.

Violation of the Policies and Procedures

Violation of the policies and procedures contained within this document may have serious consequences.

1. Any deliberate action resulting in a breach of confidentiality or loss of data integrity will result in the withdrawal of system access for the offending individual.
2. Any unintentional action resulting in a breach of confidentiality or loss of data integrity may result in the withdrawal of system access for the offending individual.
3. All such actions, either intentional or unintentional, must be reported to Bitfocus and H4H for review and resolution via data breach reporting requirements.

HMIS Data Misuse and Breach Reporting

1. A breach is defined as any of the following:
1. An incident involving unsecured PII, if that PII was, or is reasonably believed to have been accessed or acquired by an unauthorized person
2. A suspected security incident, intrusion, or unauthorized access, use, or disclosure of PII in violation of signed agreements
2. Breaches must be reported using HMIS Data Misuse and Breach Incident Reporting form (Appendix J) found at **santacruz@bitfocus.com**.

VI. PRIVACY

A. Consumer Acknowledgement of Privacy Practices

CHO staff are responsible for explaining the CoC's privacy practices to all people experiencing or at risk of homelessness prior to entering their information into the Watsonville/Santa Cruz CoC HMIS. Specific responsibilities include:

1. Ensure that an HMIS Consumer Notice is posted or available at any location consumer intake services are provided and personally identifiable information (PII) is entered into HMIS. Field based workers should have a copy of the notice available for review in the field
2. Provide consumers with a copy of the CoC Consumer Notice
3. Request the consumer sign an Acknowledgement of the receipt of the CoC Consumer Notice and upload the signed acknowledgement into the HMIS
4. Ensure the Acknowledgement of the receipt of Privacy Practices is current and is signed at least once every three years.

If a consumer is hesitant to sign the Acknowledgement, CHO staff should explain the benefits and value of HMIS participation to the consumer using strategies learned in Bitfocus training and briefly summarized on the Approaches to Responding to Consumer Concerns About Data Sharing (Appendix K) found at **santacruz@bitfocus.com**. The consumer also has the option to request limitations on the sharing of their information.

B. Allowable HMIS Uses and Disclosures of Consumer Information

A CHO may use or disclose Personally Identifiable Information (PII) from the Santa Cruz County HMIS under the following circumstances:

1. To provide or coordinate services for an individual or household related to keeping or finding a permanent home
2. Functions related to payment or reimbursement for services and housing provided
3. To carry out administrative functions, including but not limited to legal, audit, personnel, oversight, and management functions
4. For creating deidentified PII.

CHOs, like other institutions that maintain personal information about individuals, have obligations that may transcend the privacy interests of consumers. The following additional uses and disclosures recognize those obligations to use or share personal information by balancing competing interests in a responsible and limited way. Under this Policy, these additional uses and disclosures are allowed but not required.

A CHO may also use or disclose PII from the Santa Cruz County HMIS under the following special circumstances:

1. Uses and Disclosures Required by Law. A CHO may use or disclose PII when required by law to the extent that the use or disclosure complies with and is limited to the requirements of the law.

2. Uses and Disclosures to Avert a Serious Threat to Health or Safety. A CHO may, consistent with applicable law and standards of ethical conduct, use or disclose PII if:
   - The CHO, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public; and
   - The use or disclosure is made to a person reasonably able to prevent or lessen the threat, including the target of the threat.

3. Uses and Disclosures About Victims of Abuse, Neglect, or Domestic Violence. A CHO may disclose PII about an individual whom the CHO reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority including a social service or protective services organization authorized by law to receive reports of abuse, neglect, or domestic violence under the following circumstances:
   - Where the disclosure is required by law and the disclosure complies with and is limited to the requirements of the law
   - If the individual agrees to the disclosure or
   - To the extent that the disclosure is expressly authorized by statute or regulation; and the CHO believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or if the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the PII for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

A CHO that makes a permitted disclosure about victims of abuse, neglect or domestic violence must promptly inform the individual that a disclosure has been or will be made, except if:

- The CHO, in the exercise of professional judgment, believes informing the individual would place the individual or other individuals at risk of serious harm or
- The CHO would be informing a personal representative, such as a family member or friend, and the CHO reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing the personal representative would not be in the best interests of the individual as determined by the CHO, in the exercise of professional judgment.

4. Uses and Disclosures for Academic Research or Evaluation Purposes. Any research or evaluation on the nature and patterns of homelessness that uses PII HMIS data will take place only based on specific agreements between researchers and the HMIS lead agency, H4H. These agreements must be approved by the Housing for Health (H4H) Division staff members according to guidelines approved by the H4H Partnership Policy Board of the CoC and must reflect adequate standards for the protection of confidential data.

   Provided H4H Division staff approves, a CHO may use or disclose PII from its own program for academic research or evaluation conducted by an individual or institution that has a formal contractual relationship with the CHO if the research / evaluation is conducted either:

   - By an individual employed by or affiliated with the organization for use in a research / evaluation project conducted under a written research / evaluation agreement approved in writing by a CHO program administrator, other than the individual conducting the research or evaluation, designated by the CHO or
   - By an institution for use in a research or evaluation project conducted under a written research or evaluation agreement approved in writing by a program administrator designated by the CHO.

A written research or evaluation agreement must:

- Establish rules and limitations for the processing and security of PII during the research or evaluation
- Provide for the return or proper disposal of all PII at the conclusion of the research or evaluation
- Restrict additional use or disclosure of PII, except where required by law and
- Require that the recipient of data formally agree to comply with all terms and conditions of the agreement.

A written research or evaluation agreement is not a substitute for approval of a research project by an Institutional Review Board, Privacy Board, or other applicable human subjects protection institution. Such approval of a proposed research project may be required for some proposed uses of HMIS data. H4H staff members in consultation with the CoC Policy Board will make this determination.

5. Disclosure for Law Enforcement Purposes. A CHO may, consistent with applicable law and standards of ethical conduct, disclose PII for the following law enforcement purposes:
   - Legal processes and otherwise required by law
   - Limited information requests for identification and location purposes
   - Pertaining to victims of crime
   - Suspicion that death has occurred because of criminal conduct
   - If a crime occurs on the premises of the CHO and
   - Medical emergency, not on CHO's premises, and it is likely that a crime has occurred.

C. Use of a Comparable Database by Victim Services Providers

Victim services providers, private nonprofit agencies whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking, must not directly enter or provide personally identifying information in the Watsonville/Santa Cruz CoC HMIS if they are legally prohibited from participating in an HMIS. Victim service providers that

are recipients of funds requiring participation in the HMIS but are prohibited from entering data in an HMIS, must use a comparable database to enter consumer information. A comparable database is a database that can be used to collect consumer-level data over time and generate unduplicated aggregated reports based on the consumer information entered into the database. The reports generated by a comparable database must be accurate and provide the same information as the reports generated by the Watsonville/Santa Cruz CoC HMIS.

D. End User Conflict of Interest

End users who are also consumers with records in the Watsonville/Santa Cruz CoC HMIS are prohibited from entering or editing information in their own record. All end users are also prohibited from entering or editing information in records of immediate family members. All end users must sign the Watsonville/Santa Cruz CoC HMIS End User Agreement, which includes a statement describing this limitation, and report any potential conflict of interest to their Program Director or Executive Director. H4H may run the audit trail report to determine if there has been a violation of the conflict-of-interest agreement.

VII.DATA QUALITY

Data quality is a term that refers to the reliability and validity of consumer-level data in HMIS. It is measured by the extent to which data in the system represents authentic characteristics within a community. With good data quality, the Watsonville/Santa Cruz City & County CoC can accurately provide a full picture of the individuals and families accessing local housing and homelessness response system resources.

Data quality can be measured by data completeness, the extent to which all expected data elements are entered for all consumers; data timeliness, the amount of time that passes between data collection and entry into HMIS, and data accuracy, the extent to which data are entered accurately and consistently.

A. Data Completeness

Complete HMIS data is necessary to fully understand the demographic characteristics and service and housing resource use of persons with information in HMIS and to identify ways to improve services. Complete data facilitates confident reporting and analysis of the experience of homelessness in the CoC region. Data is considered complete if ALL consumers are entered into HMIS and all required data elements are captured.

The CoC's goal is to collect 100% of all data elements; however, it recognizes that this may not be possible in all cases. HUD HMIS data standards expect no null (missing) data for required data elements, and "Don't Know" or "Refused" or "Other" responses should not exceed 5%.

A null or missing rate of below 5 percent represents an ideal goal, and the CoC should work toward accomplishing this level of data completeness for all programs. For large-scale night-by-night shelters, alternate targets for data completeness will be considered based on past performance.

B. Data Accuracy

Data should be entered accurately into HMIS. Accuracy depends on the consumer's ability to provide the data and staff's ability to accurately enter the data in HMIS. Although HMIS data accuracy can be hard to assess, CHOs should audit approximately 5% of active consumer records monthly. The audit should check that data recorded in the consumer file matches data recorded in HMIS (e.g., entry and exit dates, household type, demographic characteristics, and history of homelessness) and that consumer data is in alignment with project characteristics (e.g., a family is not entered in a program for single adult men).

C. Data Consistency

Data consistency refers to all data entry staff understanding, collecting, and entering data consistently across all programs in HMIS. Data consistency requires data entry staff to have a common understanding of each data element, its response categories, and meaning. To facilitate data consistency, H4H in partnership with Bitfocus will ensure the availability of

trainings and materials that outline basic data elements, response categories, rationale, and definitions.

D. Data Timeliness

Entering data into HMIS in a timely manner is important because it: facilitates up-to-date information for resource availability, allows data to be accessible when needed (service planning for people experiencing homelessness, monitoring or funding purposes, or for responding to requests for information), and reduces human error that occurs when too much time elapses between the provision of a service (data collection) and data entry. Expectations regarding timely data entry by project type are provided in the Data Quality and Improvement Process and Plan (Appendix H) and can be found at **santacruz@bitfocus.com.** To ensure that system-wide data is as accurate as possible, all Universal Data Elements and Program-specific Data Elements should be entered according to the standards outlined in that document.

In addition to timely data entry, the CoC requires that CHO staff follow the expectations for conducting assessment as follows:

- Current Living Situation assessments are used to document the housing status during the first interaction with each consumer, and any subsequent consumer interactions if their housing situation changed. All consumers with an active/open HMIS enrollment that experience a significant status change in income, employment, non-cash benefits, living situation, or other key characteristics require an Update Assessment within 30 days of learning of the status change. At a minimum, the Current Living Situation and Update Assessments must be completed every 90 days.

- All HMIS enrollments that are active/open require an annual assessment within 30 days of participants' project start anniversary date each year (30 days prior to or after the anniversary date or a 60-day window).

VIII. TECHNICAL SUPPORT

Technical Support is an important component of the success of an HMIS system; Bitfocus is available to provide Technical Support quickly and professionally. Requests for Technical Support may include the reporting of problems with the HMIS Software, requests for enhancements, or other general Technical Support.

The Watsonville/Santa Cruz CoC HMIS Help Desk < **Santa Cruz HMIS Home (bitfocus.com)**> is operated by Bitfocus, the System Administrator, and is available Monday through Friday, 8am to 5pm, except County holidays at **santacruz@bitfocus.com** or 831.713.2288.

IX. GLOSSARY

Aggregated Public Data: Data that is published and available publicly. This type of data does not identify individual consumers.

Confidential Data: Information that contains personally identifiable information.

Covered Homeless Organization (CHO): Any organization (including its employees, volunteers, affiliates, contractors, and associates) that records, uses, or processes PII on consumers at-risk of or experiencing homelessness for an HMIS. This definition includes both organizations that have direct access to the Watsonville/Santa Cruz CoC HMIS data system, as well as those organizations who do not have direct access but record, use, or process PII.

End User: An individual at a Covered Homeless Organization who has an end user license to enter data into the Watsonville/Santa Cruz CoC HMIS.

HMIS System Administrator: The Watsonville/Santa Cruz CoC HMIS system administrator is Bitfocus. Bitfocus designs the Watsonville/Santa Cruz CoC HMIS, provides ongoing support to the HMIS Lead Agency, and is the vendor for the HMIS software product called Clarity.

Housing for Health (H4H): Division of the County of Santa Cruz Human Services Department that serves as the HMIS Lead Agency for the CoC.

Minimum Data Entry Standards: A mandatory set of data elements that must be collected and entered into the Watsonville/Santa Cruz CoC HMIS for each consumer served by projects. These standards include both the Universal Data Elements (UDEs) and the Program-Specific Data Elements (PSDEs).

Personally Identifiable Information (PII): Any information maintained by or for a CHO about a consumer at-risk of or experiencing homelessness that: (1) identifies, either directly or indirectly, a specific individual; (2) can be manipulated by a reasonably foreseeable method to identify a specific individual; or (3) can be linked with other available information to identify a specific individual.

Santa Cruz County Privacy Policy: The Policy that governs allowable uses and disclosures of personally identifiable information for the purposes of the Watsonville/Santa Cruz CoC HMIS.

Santa Cruz CoC Security Policy: The Policy that governs how equipment used to access the Watsonville/Santa Cruz CoC HMIS must be protected from misuse, a breach, or a violation of personally identifiable information.

Watsonville/Santa Cruz CoC HMIS: A web-based database that is used by homeless service organizations across the Watsonville/Santa Cruz CoC to record and store consumer-level information on the characteristics and needs of persons at-risk of or experiencing homelessness.

Shared Data: Unrestricted information entered by one CHO and visible to another CHO using the Watsonville/Santa Cruz CoC HMIS. Shared data also includes data s disclosed from the Watsonville/Santa Cruz CoC HMIS for purposes laid out in the Privacy Policy.

Unpublished Restricted Access Data: Information scheduled, but not yet approved, for publication.

Victim Services Provider: A nonprofit organization whose primary mission is to provide services to victims and survivors of domestic violence, dating violence, sexual assault, or stalking.

APPENDIX A: CONSUMER ACKNOWLEDGEMENT

APPENDIX B: CONSUMER NOTICE

APPENDIX C: ORGANIZATION PARTNERSHIP & DATA SHARING AGREEMENT

APPENDIX D: PARTICIPATING COVERED HOMELESS ORGANIZATIONS

APPENDIX E: PRIVACY POLICY

APPENDIX F: SECURITY POLICY

APPENDIX G: CONSENT TO DATA SHARING FOR RUNAWAY AND HOMELESS YOUTH

APPENDIX H: DATA QUALITY AND IMPROVEMENT PROCESS AND PLAN

APPENDIX I: USER AGREEMENT AND CODE OF ETHICS

APPENDIX J: HMIS DATA MISUSE AND BREACH REPORTING FORM

APPENDIX K: APPROACHES TO RESPONDING TO CONSUMER CONCERNS ABOUT DATA SHARING

SANTA CRUZ COUNTY
Housing for Health
PARTNERSHIP

Watsonville/Santa Cruz City & County Continuum of Care (CoC)

ACKNOWLEDGEMENT OF RECEIPT OF CONSUMER NOTICE

I acknowledge that I have received a copy of the Consumer Notice of the Housing for Health Partnership CoC.

_____	OR	_____
Consumer Name (Please Print)		Name of Personal Representative
_____		_____
Consumer Signature		Signature of Personal Representative
_____		_____
Date		Relationship to Consumer
		_____
		Date

Program Use Only

1. I attempted to obtain written acknowledgement of the Consumer Notice, but acknowledgement could not be obtained because:
   - ☐ An emergency prevented us from obtaining acknowledgement
   - ☐ A communication barrier prevented us from obtaining acknowledgement
   - ☐ The individual was unwilling to sign
   - ☐ The interaction was completed over the phone or remotely and verbal acknowledgement was obtained
   - ☐ Other: _____

2. The consumer requested the following data sharing limitations:

   ☐ No limitations requested **OR**

   Check one or more of the following requested limits:

   ☐ Private to organization

   ☐ De-identified or anonymized data

   ☐ Limited responses to some questions

_____ _____

Staff Member Printed Name Staff Member Signature

_____

Date

Note to Staff: Please ensure a signed copy of this form is uploaded into HMIS ***prior to*** entering consumer information in HMIS.

SANTA CRUZ COUNTY
Housing for Health
PARTNERSHIP

Watsonville/Santa Cruz City & County Continuum of Care (CoC)

CONSUMER NOTICE

This Organization provides services for individuals and families at-risk of or experiencing homelessness. This Organization participates in the Housing for Health Partnership (Watsonville/Santa Cruz City & County) CoC Homeless Management Information System (Watsonville/Santa Cruz CoC HMIS).

The Watsonville/Santa Cruz CoC HMIS is used to collect basic information about consumers receiving services from this Organization. This helps the Organization get a more accurate count of individuals and families experiencing homelessness and identify the need for different services and housing resources. The information also helps to connect individuals and families at-risk of or experiencing homelessness to the services and housing resources they need.

This Organization only collects information that is considered appropriate and necessary. The collection and use of all personal information are guided by strict standards of privacy and security.

This Organization may use or disclose information from the Watsonville/Santa Cruz CoC HMIS under the following circumstances:

- To provide or coordinate services and housing resources for an individual or families;
- For functions related to payment or reimbursement for services or housing resources;
- To carry out administrative functions;
- When required by law;
- For research and/or evaluation; or
- For creating de-identified (anonymous) data.

A copy of the Watsonville/Santa Cruz City & County CoC Privacy Policy, describing allowable uses and disclosures of data collected for the purposes of the Watsonville/Santa Cruz CoC HMIS is available to all consumers upon request.

Watsonville/Santa Cruz City & County Continuum of Care (CoC)
Homeless Management Information System (HMIS)
Organization Partnership and Data Sharing Agreement

The Watsonville/Santa Cruz City & County CoC's Covered Homeless Organizations (CHOs) utilize a computerized record-keeping system that captures information about people experiencing or at-risk of homelessness. The Watsonville/Santa Cruz City & County CoC Homeless Management Information System (Watsonville/Santa Cruz CoC HMIS) creates an unduplicated count of individuals and households at-risk of or experiencing homelessness and develops aggregate information that assists in developing policies to end homelessness. In addition, the Watsonville/Santa Cruz CoC HMIS allows CHOs to share information electronically about consumers, including their service needs, to better coordinate services.

Personally identifiable information (PII) can only be shared between and among CHOs that have established this Agreement with the County. Allowable uses and disclosures of PII are described in the Watsonville/Santa Cruz City & County CoC Privacy Policy. Any uses and disclosures of PII not described in the CoC Privacy Policy is only allowable with written consumer consent.

A list of organizations covered by this Agreement can be found at https://santacruz.bitfocus.com/participating-agencies . Please note that this list of organizations will be updated over time.

The lead entity for the CoC implementation of HMIS is the County of Santa Cruz Human Services Department Housing for Health Division (H4H) and the system is administered by Bitfocus. In this Agreement, H4H is the "HMIS Lead", "Covered Homeless Organization (CHO)" is an organization participating in HMIS, "Consumer" is a consumer of services, and "Organization" is the covered homeless organization named in this Agreement.

The signature of the Executive Director of the Organization indicates agreement with the terms set forth before an HMIS account can be established for the Organization and its staff members.

I. Confidentiality

A. The Organization shall uphold relevant federal and state confidentiality regulations and laws that protect consumer records and will only release consumer records in accordance with this Agreement and the Santa Cruz County HMIS Policies and Procedures.

B. The Organization **shall not** solicit or input information from consumers into the HMIS

database unless it is essential to provide or coordinate services, to develop reports and provide data, or to conduct evaluation or research. Furthermore,

1. The Organization shall provide its consumers a verbal explanation of the HMIS database and the allowable uses and disclosures of the data therein and shall arrange for a qualified interpreter or translator if an individual is not literate in English or has difficulty understanding the CoC Privacy Policy.
2. The Organization agrees to abide by the allowable uses and disclosures of personally identifiable information (PII), as laid out in the CoC Privacy Policy. Any other uses and disclosures of PII by the Organization requires written consumer consent.
3. Services are not contingent upon consumers' participation in the HMIS database. Services should be provided to consumers regardless of HMIS participation, provided the consumers would otherwise be eligible for the services.

C. The Organization is responsible for ensuring that its users comply with the requirements laid out in the CoC Privacy Policy and the CoC Security Policy.
    1. The Organization shall ensure that all staff and volunteers issued a User ID and password for HMIS will comply with the following:
        a. Read and abide by this Organization Partnership Agreement;
        b. Read and abide by the Santa Cruz County HMIS Policies and Procedures;
        c. Read and sign the Santa Cruz County HMIS User Agreement;
        d. Participate in new user privacy and security training and on-going security training on an annual basis;
        e. Participate in additional trainings as required by the Santa Cruz County HMIS Policies and Procedures;
        f. Maintain a unique User ID and password, and not share or reveal that information to anyone;

D. The Organization shall conduct criminal background checks on all staff and volunteers before requiring potential users to attend a new user training. Individuals with a history of perpetrating fraud, identity theft, or misuse of confidential information, or an individual who is under investigation for such issues, shall not be permitted a user license.

E. The Organization shall not be denied access to consumer data entered by the Organization. CHOs are bound by all restrictions placed upon the data by the CoC Privacy Policy. The Organization shall not knowingly enter false or misleading data under any circumstances.

F. Display of Notice: Pursuant to the notice published by the Department of Housing and Urban Development (HUD) on July 30, 2004, the Organization will prominently display at each intake desk (or comparable location) the Santa Cruz County HMIS Consumer Notice that explains generally the reasons for collecting identified information in the HMIS and the consumer rights associated with providing Organization staff with identified data. The

Organization will ensure consumers' understanding of their rights.

G. If this Agreement is terminated, the Watsonville/Santa Cruz City & County CoC shall maintain the right to the use of all consumer data previously entered by the terminating Organization; this use is subject to any restrictions laid out in the CoC Privacy Policy.

II. HMIS Use and Data Entry

A. The Organization shall follow, comply with, and enforce the Santa Cruz County HMIS User Agreement and the Santa Cruz County HMIS Policies and Procedures (located santacruz@bitfocus.com.) Modifications to the User Agreement and Policies and Procedures needed for the purpose of smooth and efficient operation of the HMIS and to meet HUD requirements shall be established in consultation with the H4H Program Manager, with final approval made by the Watsonville/Santa Cruz City & County CoC Policy Board. H4H will announce approved modifications in a timely manner via mailing list communications maintained by the Housing for Health Partnership and the BitFocus HMIS team.

    1. The Organization shall only enter individuals in the HMIS database that exist as consumers of the Organization. The Organization shall not misrepresent its consumer base in the HMIS database by knowingly entering inaccurate information.
    2. The Organization shall use consumer information in the HMIS database, as provided to the Organization or CHOs, to assist the Organization in providing adequate and appropriate services to the consumer.

B. The Organization shall consistently enter information into the HMIS database and will strive for real-time data entry. Data must be entered into the HMIS database within two business days, as outlined by the Santa Cruz Data Quality Improvement Process and Plan.

C. The Organization will not alter information in the HMIS database that is entered by another covered homeless organization with inaccurate information (i.e. Organization will not purposefully enter inaccurate information to over-ride information entered by another CHO).

D. The Organization shall not include profanity or offensive language in the HMIS database. This does not apply to the input of direct quotes by the consumer if the Organization believes that it is essential to enter these comments for assessment, service, and treatment purposes.

E. The Organization shall utilize the HMIS database for business purposes only.

F. The Organization shall not use the HMIS database with intent to defraud federal, state, or local governments, individuals, or entities, or to conduct any illegal activity.

G. Bitfocus will provide initial training and periodic updates to that training to Organization staff on the use of the HMIS.
H. Watsonville/Santa Cruz CoC HMIS Help Desk < Santa Cruz HMIS Home (bitfocus.com)> or 831.713.2288) should be utilized for technical assistance.
I. The transmission of material in violation of any federal or state regulations is prohibited. This includes, but is not limited to, copyright material, material legally judged to be threatening or obscene, and material considered protected by trade secrets.
J. The Organization must be an active participant in the Watsonville/Santa Cruz City & County CoC.

III. Reports

A. The Organization shall retain access to identifying and statistical data on the consumers it serves.
B. The Organization's access to reports containing data on consumers it does not serve shall be limited to non-identifying and statistical data.
C. The Organization may make aggregate data available to other entities for funding or planning purposes pertaining to providing services to persons experiencing or at-risk of homelessness. The aggregate data shall not directly identify individual consumers.
D. The CoC will use only de-identified, aggregate HMIS data for homeless policy and planning decisions; in preparing federal, state, or local applications for homeless funding; to demonstrate the need for and effectiveness of programs; and to obtain a system-wide view of program utilization within the CoC.
E. Once a report containing confidential consumer information is downloaded from HMIS, it is the responsibility of the Organization to protect all confidential information.
F. An Organization may distribute a report containing PII for the express purpose of referring its own consumers to a community housing program or other service intended to benefit its consumers.

IV. Proprietary Rights

A. The Organization shall not give or share assigned usernames and / or passwords of the HMIS database with any other covered homeless organization, business, or individual.
B. The Organization shall not cause in any manner, or way, corruption of the HMIS database.

IV. Data Sharing

A. By establishing this Agreement, the collaborating CHOs agree, within the confines of the Watsonville/Santa Cruz City & County CoC's CHOs and in accordance with the Santa Cruz CoC Privacy Policy, that:

1. In transmitting, receiving, storing, processing, or otherwise dealing with any PII,

they are fully bound by state and federal regulations governing confidentiality of consumer records and cannot use or disclose the information except as permitted or required by this Agreement, the CoC Privacy Policy, or by law.

2. They are prohibited from making any further disclosure of this information unless further disclosure is expressly permitted by the CoC Privacy Policy or as otherwise permitted by state and federal regulations governing confidentiality of patient records.
3. They will use appropriate safeguards to prevent the unauthorized use or disclosure of the PII.
4. They will notify the Watsonville/Santa Cruz CoC HMIS Help Desk < Santa Cruz HMIS Home (bitfocus.com)> | 831.713.2288) immediately of any breach, use, or disclosure of PII not provided for by this Agreement or the CoC Privacy Policy. Within one business day, they will have submitted the HMIS Data Misuse and Breach Reporting form found here: santacruz@bitfocus.com.
5. PII that is used or disclosed will not be used to harm or deny any services to a consumer.
6. The CHO shall not solicit information from consumers to enter into the Watsonville/Santa Cruz CoC HMIS unless it is essential to provide services or to meet funding requirements.
7. Consumers have the right to request information about to whom their PII is released in the Watsonville/Santa Cruz City & County CoC's CHOs.
8. CHOs will notify County H4H staff of their intent to terminate their participation in this Agreement.
9. They will resist, through judicial proceedings, any judicial or quasi-judicial effort to obtain access to PII pertaining to consumers, unless expressly provided for in state and/or federal regulations.

A violation of the above will result in immediate disciplinary action by the Watsonville/Santa Cruz City & County CoC.

V. Terms and Conditions

A. The County shall not transfer or assign any rights or obligations without the written consent of the other party.
B. This Agreement shall be in-force until revoked in writing by either party provided funding is available.
C. This Agreement may be terminated with 30 days written notice.

The signature below constitutes acceptance of the Organization and Partnership Data Sharing Agreement:

_____	_____
Executive Director Signature	Date
_____	_____
Executive Director Printed Name	Organization Name

Watsonville/Santa Cruz City & County Continuum of Care (CoC)
Interorganizational Data Sharing
Participating Covered Homeless Organizations

The following Organizations have signed a CoC Interorganizational Data Sharing and Coordinated Services Agreement to use and disclose consumer-level information through the Watsonville/Santa Cruz City & County CoC Homeless Management Information System (Watsonville/Santa Cruz CoC HMIS) for the purposes of coordinating and providing services to consumers. Please note that this list of Organizations may change over time.

Association of Faith Communities
Bill Wilson Center
Cabrillo College
Central Coast Center for Independent Living
City of Santa Cruz
Community Action Board of Santa Cruz County
Community Bridges
Downtown Streets Team
Encompass Community Services
Families In Transition
Front Street Housing, Inc.
Homeless Garden Project
Housing Authority of the County of Santa Cruz
Housing Choices
Housing Matters
Janus of Santa Cruz
Mental Health Client Action Network
Nation's Finest
Pajaro Rescue Mission
Pajaro Valley Shelter Services
Salvation Army
Salud Para La Gente
Santa Cruz Community Health Centers
Santa Cruz County Health Services Agency
Santa Cruz County Human Services Department
Santa Cruz Public Libraries
Siena House
US Department of Veterans Affairs
Wings Homeless Advocacy

Consumer personally identifiable information (PII) is bound by strict confidentiality, through the CoC Privacy Policy and CoC Consumer Notice.

Watsonville/Santa Cruz City & County Continuum of Care (CoC)
Homeless Management Information System (HMIS) Privacy Policy

This Policy describes standards for the privacy of personally identifiable information (PII) collected and stored in the Watsonville/Santa Cruz City & County CoC HMIS. The standards seek to protect the confidentiality of personal information while allowing for reasonable, responsible, and limited uses and disclosures of data that support efforts to prevent and end homelessness in the County. This HMIS Privacy Policy (hereinafter referred to as "Policy") is based on principles of fair information practices recognized by the information privacy and technology communities and federal Housing and Urban Development (HUD) department HMIS guidance: (https://www.hudexchange.info/resources/documents/2004HUDDataandTechnicalStandards.pdf).

This Policy defines the privacy standards required of any organization within the CoC that records, uses, or processes personally identifiable information (PII) on consumers at-risk of or experiencing homelessness for the Watsonville/Santa Cruz CoC HMIS. Organizations must also comply with federal, state, and local laws that require additional confidentiality protections, where applicable.

This Policy recognizes the broad diversity of organizations participating in HMIS, and the differing programmatic and organizational realities that may demand a higher standard for some activities. Some organizations, e.g., such as those serving victims of domestic violence, may choose to implement higher levels of privacy standards because of the nature of the consumers served or specific services provided. Others, e.g., large emergency shelters, may find higher standards overly burdensome or impractical. At a minimum, however, all organizations must meet the privacy standards described in this Policy. This Policy provides a uniform minimum standard of data privacy and security protection for consumers at-risk of or experiencing homelessness with the possibility of more restrictive protections for organizations with additional needs or capacities.

The following sections discuss the Watsonville/Santa Cruz CoC HMIS privacy standards.

Watsonville/Santa Cruz CoC HMIS Privacy Standards: Definition of Terms

1. *Personally Identifiable Information (PII):* Any information maintained by or for a Covered Homeless Organization about a consumer at-risk of or experiencing homelessness that: (1) identifies, either directly or indirectly, a specific individual; (2) can be manipulated by a reasonably foreseeable method to identify a specific individual; or (3) can be linked with other available information to identify a specific

individual.

2. *Covered Homeless Organization (CHO):* Any organization, including its employees, volunteers, affiliates, contractors, and associates, that records, uses, or processes PII on consumers at-risk of or experiencing homelessness for HMIS. This definition includes both organizations that have direct access to HMIS, as well as those organizations who do not have direct access but do record, use, or process PII from HMIS.
3. *Processing:* Any operation or set of operations performed on PII, whether by automated means or not, including but not limited to collection, maintenance, use, disclosure,transmission, and destruction of the information.
4. *Watsonville/Santa Cruz CoC HMIS Uses and Disclosures:* The uses and disclosures of PII that are allowed by this Policy.
5. *Uses and Disclosures:* Uses are those activities internal to any given CHO that involves interaction with PII, whereas disclosures are those activities in which a CHO shares PII externally with non-CHO entities

Applying the Watsonville/Santa Cruz CoC HMIS Privacy Policy

This Policy applies to any Covered Homeless Organization (CHO) that records, uses, or processes personally identifiable information (PII) for the Watsonville/Santa Cruz CoC HMIS. All PII maintained by a CHO is subject to these standards.

Allowable HMIS and CES Uses and Disclosures of Personally Identifiable Information (PII)

Consumer consent for any uses and disclosures defined in this section is assumed when organizations follow HUD HMIS Standards for notifying consumers of privacy policies. See Appendix A for specific policy associated with Runaway and Homeless Youth (RHY) programs and services.

A CHO may use or disclose PII from the Watsonville/Santa Cruz CoC HMIS under the following circumstances:

1. To provide or coordinate services for an individual or household related to assistance with keeping or finding a permanent home;
2. For functions related to payment or reimbursement for services;
3. To carry out administrative functions, including but not limited to legal, audit, personnel, oversight, and management functions; or
4. For creating deidentified PII. CHOs, like other institutions that maintain personal information about individuals, have obligations that may transcend the privacy interests of consumers. The following additional uses and disclosures recognize those obligations to use or share personal information by balancing competing interests in a responsible and limited way. Under this Policy, these additional uses and disclosures

are permissive and not mandatory except for first party access to information and any required disclosures for oversight of compliance with this Policy. However, nothing in this Policy modifies an obligation under applicable law to use or disclose personal information.

A CHO may also use or disclose PII from the Watsonville/Santa Cruz CoC HMIS under the following special circumstances:

Uses and Disclosures Required by Law. A CHO may use or disclose PII when required by law to the extent that the use or disclosure complies with and is limited to the requirements of the law.

Uses and Disclosures to Avert a Serious Threat to Health or Safety. A CHO may, consistent with applicable law and standards of ethical conduct, use or disclose PII if:

1. The CHO, in good faith, believes the use or disclosure is necessary to prevent or lessen a serious and imminent threat to the health or safety of an individual or the public; and
2. The use or disclosure is made to a person reasonably able to prevent or lessen the threat, including the target of the threat.

Uses and Disclosures About Victims of Abuse, Neglect, or Domestic Violence. A CHO may disclose PII about an individual whom the CHO reasonably believes to be a victim of abuse, neglect, or domestic violence to a government authority including a social service or protective services organization authorized by law to receive reports of abuse, neglect, or domestic violence under the following circumstances:

1. Where the disclosure is required by law and the disclosure complies with and is limited to the requirements of the law;
2. If the individual agrees to the disclosure; or
3. To the extent that the disclosure is expressly authorized by statute or regulation; and the CHO believes the disclosure is necessary to prevent serious harm to the individual or other potential victims; or if the individual is unable to agree because of incapacity, a law enforcement or other public official authorized to receive the report represents that the PII for which disclosure is sought is not intended to be used against the individual and that an immediate enforcement activity that depends upon the disclosure would be materially and adversely affected by waiting until the individual is able to agree to the disclosure.

A CHO that makes a permitted disclosure about victims of abuse, neglect or domestic violence must promptly inform the individual that a disclosure has been or will be made, except if:

1. The CHO, in the exercise of professional judgment, believes informing the individual would place the individual at risk of serious harm; or

2. The CHO would be informing a personal representative, such as a family member or friend, and the CHO reasonably believes the personal representative is responsible for the abuse, neglect, or other injury, and that informing the personal representative would not be in the best interests of the individual as determined by the CHO, in the exercise of professional judgment.

Uses and Disclosures for Academic Research or Evaluation Purposes. Any research or evaluation on the nature and patterns of homelessness that uses PII HMIS data will take place only based on specific agreements between researchers and the HMIS lead agency, the Housing for Health Division of the County of Santa Cruz Human Services Department. These agreements must be approved by the Housing for Health (H4H) Partnership staff members according to guidelines approved by the H4H Partnership Policy Board of the CoC and must reflect adequate standards for the protection of confidential data.

Provided H4H approves, a CHO may use or disclose PII from its own program for academic research or evaluation conducted by an individual or institution that has a formal relationship with the CHO if the research / evaluation is conducted either:

1. By an individual employed by or affiliated with the organization for use in a research / evaluation project conducted under a written research / evaluation agreement approved in writing by a program administrator, other than the individual conducting the research or evaluation, designated by the CHO; or
2. By an institution for use in a research or evaluation project conducted under a written research or evaluation agreement approved in writing by a program administrator designated by the CHO.

A written research or evaluation agreement must:

1. Establish rules and limitations for the processing and security of PII in the course of the research or evaluation;
2. Provide for the return or proper disposal of all PII at the conclusion of the research or evaluation;
3. Restrict additional use or disclosure of PII, except where required by law; and
4. Require that the recipient of data formally agree to comply with all terms and conditions of the agreement.

A written research or evaluation agreement is not a substitute for approval of a research project by an Institutional Review Board, Privacy Board, or other applicable human subjects protection institution.

Disclosure for Law Enforcement Purposes. A CHO may, consistent with applicable law and standards of ethical conduct, disclose PII for the following law enforcement purposes:

1. Legal processes and otherwise required by law;
2. Limited information requests for identification and location purposes;

3. Pertaining to victims of crime;
4. Suspicion that death has occurred as a result of criminal conduct;
5. If a crime occurs on the premises of the CHO; and
6. Medical emergency, not on CHO's premises, and it is likely that a crime has occurred.

Privacy Requirements

All CHOs involved with the Watsonville/Santa Cruz CoC HMIS must comply with the privacy requirements described in this Notice with respect to:

1. Data collection limitations;
2. Data quality;
3. Purpose and use limitations;
4. Openness;
5. Access and correction; and
6. Accountability.

A CHO must comply with federal, state, and local laws that require additional confidentiality protections. All additional protections must be described in the CHO's privacy notice. A CHO must comply with all privacy protections in this Notice and with all additional privacy protections included in its organization specific privacy notice, where applicable.

A CHO may maintain a common data storage medium with another organization, including but not limited to another CHO, that includes the sharing of PII. When PII is shared between organizations, responsibilities for privacy may reasonably be allocated between the organizations. Organizations sharing a common data storage medium and PII may adopt differing privacy policies as they deem appropriate, administratively feasible, and consistent with this Policy, which allows for the de-duplication of consumers at-risk of or experiencing homelessness at the CoC level.

Data Collection Limitations

A CHO may collect PII only when appropriate to the purposes for which the information is obtained or when required by law. A CHO must collect PII by lawful and fair means and, where appropriate, with the knowledge of the individual. A CHO must post a sign at each intake desk or comparable location that explains generally the reasons for collecting this information (Watsonville/Santa Cruz City & County CoC Consumer Notice). Consent of the individual for data collection may be assumed when the Watsonville/Santa Cruz City & County CoC Consumer Notice is made available to each consumer prior to data collection, a consumer acknowledges receipt of the Notice via a signed acknowledgement form, and the notice is properly displayed and made available according to this Policy.

Data Quality

PII collected by a CHO must be relevant to the purpose for which it is to be used. To the extent necessary for those purposes, PII should be accurate, complete, and timely, as defined by the Santa Cruz County Data Quality Improvement Process and Plan. A CHO must develop and implement a plan to dispose of, or remove identifiers from, PII that is not in current use seven years after the PII was created or last changed unless a statutory, regulatory, contractual, or other requirement mandates longer retention.

Purpose and Use Limitations

A CHO may use or disclose PII only if the use or disclosure is allowed by this Policy. A CHO may assume consent for all uses and disclosures specified in this Policy and for uses and disclosures determined by the CHO to be compatible with those specified in this Policy. This Policy limits the disclosure of PII to the minimum information necessary to accomplish the purpose of the disclosure. Uses and disclosures not specified in this Notice can be made only with the consent of the consumer or when required by law.

A CHO processing PII for the purposes of the Watsonville/Santa Cruz CoC HMIS will agree to additional restrictions on the use or disclosure of the consumer's PII at the request of the consumer, where it is reasonable to do so. This can include, but is not limited to, the following additional restrictions:

1. Entering consumer PII into the Watsonville/Santa Cruz CoC HMIS so that it is not shared with any other CHO; or
2. Using de-identified consumer information when coordinating services through HMIS; or
3. Limiting responses to HMIS questions to those the consumer is willing to share with other CHOs.

A CHO, in the exercise of professional judgment, will communicate with a consumer who has requested additional restrictions, when it is reasonable to agree to these and alternatives in situations where it is not reasonable.

Openness

A CHO must adhere to this Policy describing its practices for the processing of PII and must provide a copy of this Policy to any individual upon request. A CHO must physically post the HMIS CoC Consumer Notice stating the availability of this Policy to any individual who requests a copy.

This Policy may be amended at any time and amendments may affect PII obtained by a CHO before the date of the change. An amendment to this Policy regarding use or disclosure will be effective with respect to information processed before the amendment, unless otherwise stated.

CHOs are obligated to provide reasonable accommodations for persons with disabilities throughout the data collection process. This may include but is not limited to, providing qualified sign language interpreters, readers, or materials in accessible formats such as Braille, audio, or large type, as needed by the individual with a disability. See 24 CFR 8.6; 28 CFR 36.303. Note: This obligation does not apply to CHOs who do not receive federal financial assistance and who are also exempt from the requirements of Title III of the Americans with Disabilities Act because they qualify as ''religious entities'' under that Act.

In addition, CHOs that are recipients of federal financial assistance shall provide required information in languages other than English that are common in the community, if speakers of these languages are found in significant numbers and come into frequent contact with the program. *See HUD Limited English Proficiency Recipient Guidance* published on December 18, 2003 (68 FR 70968).

Access and Correction

In general, a CHO must allow an individual to inspect and to have a copy of any PII about the individual. A CHO must offer to explain any information that the individual may not understand. A CHO must consider any request by an individual for correction of inaccurate or incomplete PII pertaining to the individual. A CHO is not required to remove any information but may, in the alternative, mark information as inaccurate or incomplete and may supplement it with additional information.

A CHO may reserve the ability to rely on the following reasons for denying an individual inspection or copying of the individual's PII:

1. Information compiled in reasonable anticipation of litigation or comparable proceedings;
2. Information about another individual other than a health care or homeless provider would be compromised;
3. Information obtained under a promise of confidentiality, other than a promise from a health care or homeless provider, if disclosure would reveal the source of the information; or
4. Information, the disclosure of which would be reasonably likely to endanger the life or physical safety of any individual.

A CHO can reject repeated or harassing requests for access or correction. A CHO that denies an individual's request for access or correction must explain the reason for the denial to the individual and must include documentation of the request and the reason for the denial as part of the PII about the individual.

Accountability

A CHO must establish a procedure for collecting questions or complaints about this Policy to share with Housing for Health, the HMIS lead agency. Housing for Health requires each HMIS

user, including employees, volunteers, affiliates, contractors and associates, to sign a confidentiality agreement that acknowledges receipt of a copy of this Policy and that pledges to comply with this Policy. Users must complete a Privacy Training and pass a knowledge-based quiz prior to granting them HMIS access. This training must be completed annually.

Appendix A

This appendix addresses special considerations for Runaway and Homeless Youth (RHY) Program service providers, per the RHY Program HMIS Manual.

No Consent Required for Data Collection

Data collection is the process of collecting and entering information into the Watsonville/Santa Cruz CoC HMIS by RHY program staff. All RHY projects are required to collect specific data elements,including the HUD Universal Data Elements and program-specific data elements for the RHY-funded project for which they receive funding (Street Outreach Program, Basic Center Program, Transitional Living Program).

The Runaway and Homeless Youth Act requires that a RHY grantee "keep adequate statistical records profiling the youth and family members whom it serves (including youth who are not referred to out-of- home shelter services)."

RHY grantees are not required to obtain youth or parental consent to collect and enter youth data into the Watsonville/Santa Cruz CoC HMIS.

Consent Needed for Data Sharing

Data sharing refers to the sharing of consumer information per the Policy laid out in this document. For RHY grantees, data can only be shared if written consent is obtained from the parent or legal guardian of a youth who is under age 18, or with written consent from a youth who is 18 or older.

The RHY rule states the following regarding data sharing: Pursuant to the Act, no records containing the identity of individual youth served by a Runaway and Homeless Youth grantee may be disclosed except:

1. For Basic Center Program grants, records maintained on individual youth shall not be disclosed without the informed consent of the youth and parent or legal guardian to anyone other than another organization compiling statistical records, or a government organization involved in the disposition of criminal charges against the youth;
2. For Transitional Living Programs, records maintained on individual youth shall not be disclosed without the informed consent of the youth to anyone other than an organization compiling statistical records;
3. Research, evaluation, and statistical reports funded by grants provided under section 343 of the Act are allowed to be based on individual youth data, but only if such data are de-identified in ways that preclude disclosing information on identifiable youth;
4. Youth served by a Runaway and Homeless Youth grantee shall have the right to review their records; to correct a record or file a statement of disagreement; and to be apprised of the individuals who have reviewed their records;
5. The Department of Health and Human Services (HHS) policies regarding confidential

information and experimentation and treatment shall not apply if HHS finds that state law is more protective of the rights of youth;

6. Procedures shall be established for the training of RHY program staff in the protection of these rights and for the secure storage of records. 45 CFR § 1351.21.

Special Consideration for RHY-Funded Programs

In consideration of the guidance laid out in the RHY Program HMIS Manual, RHY-funded grantees shall enter data into the Watsonville/Santa Cruz CoC HMIS for youth served and seeking services that will not be shared with any other CHO, unless the grantee receives written consent from the youth or parent / legal guardian of the youth served that allows the disclosure of the youth's PII for the permissible purposes laid out in this Policy.

Watsonville/Santa Cruz City & County Continuum of Care (CoC)
Homeless Management Information System (HMIS) Security Policy

This Policy describes standards for the security of personally identifiable information collected and stored in the Watsonville/Santa Cruz City & County CoC HMIS. The standards seek to ensure the security of personal information. This Security Policy ("Policy") is based on principles of fair information practices recognized by the information security and technology communities and federal Housing and Urban Development (HUD) department HMIS guidance: (https://www.hudexchange.info/resources/documents/2004HUDDataandTechnicalStandards.pdf).

This Policy defines the security standards required of any organization within the CoC that records, uses, or processes personally identifiable information (PII) on consumers at-risk of or experiencing homelessness for HMIS. Organizations must also comply with federal, state, and local laws that require additional security protections, where applicable.

This Policy recognizes the broad diversity of organizations participating in HMIS, and the differing programmatic and organizational realities that may demand a higher standard for some activities. Some organizations, e.g., such as those serving victims of domestic violence, may choose to implement higher levels of security standards because of the nature of the consumers served or specific services provided. Others, e.g., large emergency shelters, may find higher standards overly burdensome or impractical. At a minimum, however, all organizations must meet the security standards described in this Policy. This approach provides a uniform *minimum standard* of data privacy and security protection for consumers at-risk of or experiencing homelessness with the possibility of more restrictive protections for organizations with additional needs or capacities.

The following sections discuss HMIS security standards.

HMIS Security Standards: Definitions

1. *Personally Identifiable Information (PII):* Any information maintained by or for a Covered Homeless Organization about a consumer at-risk of or experiencing homelessness that: (1) Identifies, either directly or indirectly, a specific individual; (2) can be manipulated by a reasonably foreseeable method to identify a specific individual; or (3) can be linked with other available information to identify a specific individual.
2. *Covered Homeless Organization (CHO):* Any organization, including its employees, volunteers, affiliates, contractors, and associates, that records, uses, or processes PII on consumers at-risk of or experiencing homelessness for HMIS. This definition

includes both organizations that have direct access to HMIS, as well as those organizations who do not, but do record, use, or process PII from HMIS.

3. *Processing:* Any operation or set of operations performed on PII, whether by automated means or not, including but not limited to collection, maintenance, use, disclosure, transmission, and destruction of the information.

Security Standards

This section describes the standards for system, application, and hard copy security. All CHOs must comply with these requirements.

System Security

1. *Equipment Security*. A CHO must apply system security provisions to all the systems where PII is stored, including, but not limited to, a CHO's networks, desktops, laptops, mini-computers, mainframes, and servers.
2. *User Authentication*. Each user accessing a machine that contains HMIS data must have a unique username and password. Passwords must be at least eight characters long and meet reasonable industry standard requirements. These requirements include, but are not limited to:
    a. Using at least one number and one letter or symbol;
    b. Not using, or including, the username, the HMIS name, or the HMIS vendor's name; and / or
    c. Not consisting entirely of any word found in the common dictionary or any of the above spelled backwards.

    Written information specifically pertaining to user access, e.g., username and password must not be stored or displayed in any publicly accessible location. Individual users must not be able to log on to more than one workstation at a time or be able to log on to the network at more than one location at a time.
3. *Virus Protection*. A CHO must protect HMIS and any electronic device used to store PII from viruses by using commercially available virus protection software. Virus protection must include automated scanning of files as they are accessed by users on the system where the HMIS application is housed. A CHO must regularly update virus definitions from the software vendor.
4. *Firewalls*. A CHO must protect HMIS and any electronic device used to store PII from malicious intrusion behind a secure firewall. Each individual workstation does not need its own firewall, so long as there is a firewall between that workstation and any systems, including the Internet and other computer networks, located outside of the organization.

    For example, a workstation that accesses the Internet through a modem would need its own firewall. A workstation that accesses the Internet through a central server would not need a firewall so long as the server has a firewall. Firewalls are commonly included with all new operating systems. Older operating systems can be equipped

with secure firewalls that are available both commercially and for free on the internet.

5. *Public Access*. HMIS and any electronic device used to store PII that use public forums for data collection or reporting must be secured to allow only connections from previously approved computers and systems through Public Key Infrastructure (PKI) certificates, or extranets that limit access based on the Internet Provider (IP) address, or similar means. A public forum includes systems with public access to any part of the computer through the internet, modems, bulletin boards, public kiosks or similar arenas.
6. *Physical Access to Systems with Access to HMIS Data*. A CHO must always staff computers stationed in public areas that are used to collect and store HMIS data. When workstations are not in use and staff are not present, steps should be taken to ensure that the computers and data are secure and not usable by unauthorized individuals. Workstations temporarily not in use should automatically turn on a password-protected screensaver. Password-protected screensavers are a standard feature with most operating systems and the amount of time can be regulated by a CHO. If staff from a CHO will be gone for an extended period, staff should log off the data entry system and shut down the computer.
7. *Disaster Protection and Recovery*. HMIS data is copied on a regular basis to another medium and stored in a secure off-site location where the required security standards apply. The CHO that stores the data (Bitfocus) in a central server stores that central server in a secure room with appropriate temperature control and fire suppression systems. Surge suppressors are used to protect systems used for collecting and storing all the HMIS data.
8. *Disposal*. To delete all HMIS data from a data storage medium, a CHO must reformat the storage medium. A CHO should reformat the storage medium more than once before reusing or disposing the medium.
9. *System Monitoring*. A CHO must use appropriate methods to monitor security systems. Systems that have access to any HMIS data must maintain a user access log. Many new operating systems and web servers are equipped with access logs and some allow the computer to email the log information to a designated user, usually a system administrator. Logs must be checked routinely.

Application Security

1. *Applicability*. A CHO must apply application security provisions to the software during data entry, storage, and review or any other processing function.
2. *User Authentication*. A CHO must secure all electronic HMIS data with, at a minimum, a user authentication system consisting of a username and a password. Passwords must be at least eight characters long and meet reasonable industry standard requirements. These requirements include, but are not limited to:
    a. Using at least one number and one letter or symbol;
    b. Not using, or including, the username, the HMIS name, or the HMIS vendor's name; and

c. Not consisting entirely of any word found in the common dictionary or any of the above spelled backwards.

Written information specifically pertaining to user access, e.g., username and password, may not be stored or displayed in any publicly accessible location. Individual users should not be able to log on to more than one workstation at a time or be able to log on to the network at more than one location at a time.

3. *Electronic Data Transmission*. A CHO must encrypt all HMIS data that are electronically transmitted over the Internet, publicly accessible networks, or phone lines to current industry standards. The current standard is 128-bit encryption. Unencrypted data may be transmitted over secure direct connections between two systems. A secure direct connection is one that can only be accessed by users who have been authenticated on at least one of the systems involved and does not utilize any tertiary systems to transmit the data. A secure network would have secure direct connections.
4. *Electronic Data Storage*. A CHO must store all HMIS data in a binary, not text, format. A CHO that uses one of several common applications, e.g., Microsoft Access, Microsoft SQL Server, or Oracle, are already storing data in binary format and no other steps need to be taken.

Hard Copy Security

1. *Applicability*. A CHO must secure any paper or other hard copy containing PII that is either generated by or for HMIS, including, but not limited to reports, data entry forms, and case / consumer notes. Hard copies should be stored in a locked and secure file cabinet in an area not accessible to non-CHO staff.
2. *Security*. A CHO must, always, supervise any paper or other hard copy generated by or for HMIS that contains PII when the hard copy is in a public area. When CHO staff are not present, the information must be secured in areas that are not publicly accessible. Written information specifically pertaining to user access, e.g., username and password, must not be stored or displayed in any publicly accessible location.

DRAFT

Watsonville/Santa Cruz City & County Continuum of Care (CoC)

Homeless Management Information System (HMIS)

Data Quality Improvement Process and Plan

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Data Quality Defined

Data quality is a term that refers to the reliability and validity of consumer-level data in HMIS. It is measured by the extent to which data in the system represents authentic characteristics within a community. With good data quality, the Watsonville/Santa Cruz City & County Continuum of Care (CoC) can accurately provide a full picture of the individuals and families accessing local homelessness response system resources. HMIS data is used to: improve housing and services quality; identify patterns and monitor trends over time; conduct needs assessments and prioritize services for subpopulations experiencing or at-risk of homelessness or living with very low incomes; enhance inter-agency coordination; and monitor and report on the delivery, impact, and quality of housing and services.

Data Quality Standards

Data quality can be measured by data completeness, the extent to which all expected data elements are entered for all consumers; data timeliness, the amount of time that passes between data collection and entry into HMIS, and data accuracy, the extent to which data are entered accurately and consistently.

Data Completeness

Complete HMIS data is necessary to fully understand the demographic characteristics and service use of persons with information in HMIS and to identify ways to improve services. Complete data facilitates confident reporting and analysis of the experience of homelessness in the CoC region. Data is considered complete if ALL consumers are entered into HMIS and all required data elements are captured.

The CoC's goal is to collect 100% of all data elements; however, it recognizes that this may not be possible in all cases. HUD HMIS data standards expect no null (missing) data for required data elements, and "Don't Know" or "Refused" or "Other" responses should not exceed the percentages listed in the table below.[1]

[1] Programs serving those experiencing domestic violence will have much higher data incompleteness rates for name, social security number and date of birth. Programs serving persons who are not documented residents of this country will likely have higher rates of data incompleteness for social security numbers. These programs should focus on other areas of data quality.

A missing rate of below 5 percent represents an ideal goal, and the CoC should work toward accomplishing this level of data completeness for all programs. For large-scale night-by-night shelters, alternate targets for data completeness will be considered based on past performance.

Data Element	Applies to:	Don't Know/ Refused Should Not Exceed
First Name*	All Consumers	5%
Last Name*	All Consumers	5%
SSN*	All Consumers	5%
Date of Birth*	All Consumers	5%
Race	All Consumers	5%
Ethnicity	All Consumers	5%
Gender	All Consumers	5%
Veteran Status	Adults Only	5%
Disabling Condition	All Consumers	5%
Living Situation	Adults & Heads of Households (HoH)	5%
Zip Code of Last Permanent Address	All Consumers	5%
Income and Sources (at entry)	Adults & HoH	5%
Income and Sources (at annual update)	Adults & HoH enrolled in program 365 days or more	5%
Income and Sources (at exit)	Leavers - Adults & HoH	5%
Non-Cash Benefits (at entry)	Adults & HoH	5%

Data Element	Applies to:	Don't Know/ Refused Should Not Exceed
Non-Cash Benefits (at annual update)	Adults & HoH enrolled in program 365 days or more	5%
Non-Cash Benefits (at exit)	Leavers - Adults & HoH	5%
Physical Disability	All Consumers	5%
Developmental Disability	All Consumers	5%
Chronic Health Condition	All Consumers	5%
Mental Health	All Consumers	5%
Substance Abuse	All Consumers	5%
Domestic Violence	Adults & HoH	5%
Destination	Leavers - Adults & HoH	5%
Move-in Date	Adults & HoH enrolled in PH with move-in date	5%

*For anonymized consumers the following data elements will be exempted from the 95% completeness standard: (1) Social Security Number; (2) first name; (3) last name; (4) date of birth. However, all "canned" (pre-programmed) reports in Clarity Human Services software will still show those elements as "missing" for anonymized consumers.

Data Accuracy

Data should be entered accurately into HMIS. Accuracy depends on the consumer's ability to provide the data and staff's ability to document and accurately enter it. Although HMIS data accuracy can be hard to assess, providers should audit approximately 5% of active consumer records monthly. The audit should check that data recorded in the consumer file matches data recorded in HMIS (e.g., entry and exit dates, household type, demographic characteristics, history of homelessness, etc.) and that consumer data is in alignment with project characteristics (e.g., a family is not entered in a program for single adult men).

Data Consistency

Data consistency refers to all data entry staff understanding, collecting, and entering data consistently across all programs in HMIS. Data consistency requires data entry staff have a common understanding of each data element, its response categories, and meaning. To facilitate data consistency, Santa Cruz County H4H will ensure the availability of training procedures and materials that outline basic data elements, response categories, rationale, and definitions.

Data Timeliness

Entering data into HMIS in a timely manner is important for a number of reasons: it facilitates up-to-date information for resource availability, allows data to be accessible when needed (service planning for people experiencing homelessness, monitoring or funding purposes, or for responding to requests for information), and reduces human error that occurs when too much time elapses between the provision of a service (data collection) and data entry. Expectations regarding timely data entry are defined in the next table by project type. To ensure that system-wide data is as accurate as possible, all Universal Data Elements and Program-specific Data Elements should be entered according to the following timeliness standards.

Entry/Exit Data

Program Type	Data Timeliness Standard: At Entry	Data Timeliness Standard: At Exit
Emergency Shelter	Within two business days of intake	**Night by Night**: at or before 30 calendar days after the last service date. Exit date backdated to last service **Entry/Exit**: Within two business days of exit
Transitional Housing Permanent Supportive Housing Homelessness Prevention Services Only	Within two business days of intake	Within two business days of exit
Outreach	Within two business days of intake	At or before 30 calendar days after last service date.

Program Type	Data Timeliness Standard: At Entry	Data Timeliness Standard: At Exit
		Exit date backdated to last service
Day Shelter	Within two business days of intake	At or before 90 calendar days after last service date. Exit date backdated to last service

Service Data

All participating programs should enter services into HMIS within two workdays as described in the chart below

Program Type	Service Requirement
Night-by-night Emergency Shelters	Services to track bed nights and others as required by local funders
Street Outreach	Services required by local funders, where applicable
Day Shelters	Services required by local funders, where applicable
RHY-funded Programs	Additional data elements and services (see RHY HMIS Manual)
PATH-funded Programs	Additional data elements and services (see PATH HMIS Manual)

Current Living Situation Assessments

Current Living Situation assessments are used to document the housing status during the first interaction with each consumer, as well as any subsequent consumer

interactions if the housing situation has changed. At a minimum, the Current Living Situation Assessment must be completed every 90 days

Status Update Assessments

All consumers with an active/open HMIS enrollment that experience a significant status change in income, employment, non-cash benefits, living situation, or other key characteristics require an Update Assessment within 30 days of learning of the status change. All consumers with an active/open HMIS enrollment that experience a significant status change in income, employment, non-cash benefits, or other key characteristics require an Update Assessment within 30 days of learning of the status change. At a minimum, the Update Assessment must be completed every 90 days.

Annual Assessments

All HMIS enrollments that are active/open require an annual assessment within 30 days of participants' project start anniversary date each year (a 60-day window).

Continuous Data Quality Improvement Process

A continuous data quality monitoring and improvement process facilitates the ability of the CoC to achieve valid and reliable data. It sets expectations for both the community and end users to capture accurate data on persons accessing agency programs and services.

Roles & Responsibilities

Bitfocus, as the HMIS System Administrator, with input from Housing for Health (H4H), the HMIS lead, will provide the following services to assist agencies in correctly entering data into HMIS, and in addressing data quality issues:

- Work with Agency management to identify at least one agency employee as an HMIS agency lead.
- Provide end user trainings and workflow documents.
- Produce data quality reports and information on how to correct identified data quality issues.
- Work to identify and, in conjunction with agencies, resolve data quality issues that will impact local or federal reporting.

- Provide technical assistance to agencies requesting assistance in identifying steps to correct data quality issues.
- Provide other services as directed by the HMIS Lead, H4H.

Working with their HMIS lead, agencies will take primary responsibility for entering, verifying, and correcting data entry

- Agency staff will measure completeness by running recommended data quality reports and distributing those reports to staff tasked with improving data quality and completeness.
- It is the responsibility of Agency management to ensure staff tasked with correcting data quality issues do so in a timely manner.

Data Quality Review

At the CoC level, data are reviewed regularly, and issues are identified for follow up. Follow-up on system wide issues will include a discussion at the monthly HMIS Provider Meeting. Other agency-specific follow up will also be done by Bitfocus and H4H.

Monthly
Data quality dashboards, listing records with missing data or other data quality issues, are provided in the HMIS Data Analysis Tab or sent in scheduled emails monthly to assist agencies in identifying data errors. Staff reports are emailed monthly to all agency leads to assist in monitoring agency staff usage of the system.

Quarterly
On a quarterly basis, Bitfocus will review staff HMIS utilization and data quality statistics and inform agencies of compliance issues.

Reporting Preparation
Approximately two months before any significant local or federal reporting deadlines, data impacting the reports are thoroughly reviewed by Bitfocus, with agency follow up and technical assistance as needed.

Participating agencies should run data quality reports (HUDX-225, described below) monthly. In the weeks prior to submitting a report (e.g. APR), data quality reports may need to be run on a daily basis to ensure that any issues identified by the agency or Bitfocus are being addressed.

Agencies that review data regularly are likely to have higher levels of data quality in general and are usually not correcting significant data issues during the timeframe of federal reporting deadlines.

Minimizing Data Quality Issues

How to minimize data quality issues:

- Enter consumer data as soon as possible. The more time that passes between collecting data and entering the data into HMIS, the greater the odds that there will be data quality issues (see section above for data timeliness standards).
- Whenever possible, enter data during consumer visits so that consumers may help identify potential inaccuracies.
- Review Data Quality once a month and address any issues as soon as possible.
- Problem-solve with Program and HMIS staff around any ongoing issues.

Support for Agencies and HMIS Users

To ensure that agencies and HMIS users have the tools necessary to address data quality issues efficiently, H4H and Bitfocus provide a range of support resources.

Recommended Reports for Data Review

HMIS includes an extensive library of reports. The following reports are recommended as a starting place for reviewing data and identifying data quality issues:

- **[HUDX-225] HMIS Data Quality Report** (HUD Reports) is tied directly to HUD data quality standards and provides a concise assessment of data quality issues according to those standards.

- **[OUTS-101] Program Outcome Measures Report** provides program outcomes that includes consumer exit information, housing status of exited consumers, and efficiency/process measures. It also provides agency participation totals, and unduplicated counts of consumers exited from either each program category and/or collectively.

- **[GNRL-106] Program Roster** (Program Based Reports) allows users to identify all individuals and families currently enrolled in a program, and to confirm correct household configuration.

- **[GNRL-220] Program Details Report** (Program Based Reports) allows users to efficiently review all data collected at enrollment, annual update, and/or exit for consumers enrolled in a program and is particularly useful for identifying missing or unexpected data.

- **[GNRL-400] Program Linked Service Review** (Program Based Reports) can be used to ensure that programs are providing consumer services as expected.

- **[OUTS-102] Performance Monitoring** and **[DQXX-103] Monthly Staff Report** contain sections that measure timeliness of data entry for some fields.

Technical Assistance

When agencies either need assistance identifying data quality issues or have identified issues and are unsure how to proceed, there are several avenues of technical assistance available. The Watsonville/Santa Cruz CoC HMIS Helpdesk can provide initial troubleshooting assistance and escalate issues to the Watsonville/Santa Cruz CoC HMIS System Administration team as needed. The System Administration team may proactively reach out to agencies directly or at the request of funders, H4H, or the agency itself to identify and address data quality issues. Additionally, the System Administration team offers guides, trainings, dashboards, and other resources to help agencies proactively identify and resolve data quality issues on their own.

Key Reports and Processes that Rely on Data Quality

Data quality is essential to several reports and processes that are produced for individual program reporting to funders as well as CoC-level information for system improvement. Data quality issues such as high rates of missing consumer data, missing or inaccurate enrollment, annual assessment and exit data can impact program and CoC funding. Data quality issues prevent H4H from producing accurate reports for funders, elected officials, and other constituents. The Continuous Data Quality Improvement Process described above supports accurate HMIS information for these reports and processes, including but not limited to:

Annual Performance Review (APR) - Program

Recipients of HUD funding through the homeless CoC grant competition are required to submit an Annual Performance Report (APR) electronically to HUD via Sage (formerly e-snaps) every operating year.

Coordinated Entry APR

The Coordinated Entry (CE) program is required to submit a special CE Annual Performance Report (APR) electronically to HUD, via Sage every operating year. The CE APR includes data from the HMIS as well as narrative responses.

HMIS APR

In Watsonville/Santa Cruz CoC HMIS is a recipient of HUD funding through the homeless grant competition; consequently, H4H is required to submit a special HMIS Annual Performance Report (APR) electronically to HUD, via Sage every operating year. The HMIS APR includes data from the HMIS as well as narrative responses.

Annual CoC Competition Application to HUD

The CoC competes in an annual national competition for HUD CoC Program funds. System-wide data is required as part of that application, as is aggregate data for all projects receiving CoC funding.

Point in Time Count (PIT)

The Point-in-Time (PIT) count is an enumeration of sheltered and unsheltered homeless persons typically on a single night in January. HUD requires that the sheltered portion of the county be generated from HMIS data. The sheltered portion consists of consumers sheltered in emergency shelter and transitional housing on this single night.

Approximate due date: April 30

Housing Inventory Count (HIC)

The Housing Inventory Count (HIC) is a comprehensive inventory of all housing dedicated to serving homeless and formerly homeless individuals and families within a CoC. All beds/units/bed vouchers should be included.

Approximate due date: April 30

System Performance Measures (SysPM)

HUD System Performance Measures are a tool used to measure the local homeless response as a coordinated system rather than individual programs and funding sources. HUD uses the system-level performance information as a competitive element in its annual CoC Program Competition and to gauge the state of the homeless response system nationally.

Approximate due date: Feb/March

Longitudinal Systems Analysis Report (LSA)

A major purpose of the Longitudinal Systems Analysis Report (LSA) is to produce the Annual Homeless Assessment Report (AHAR), a HUD report to the U.S. Congress that provides nationwide estimates of homelessness, including information about the demographic characteristics of homeless persons, service use patterns, and the capacity to house homeless persons. The LSA data provided by CoCs contains community-level information on people and households served by continuum projects over the course of one year. The LSA data is submitted in the form of CSV files uploaded to HUD's Homeless Data Exchange.

Stella is a strategy and analysis tool that helps CoCs understand how their system is performing and models an optimized system that fully addresses homelessness in their area. This tool can be useful in evaluation and planning a homeless assistance system only to the extent that LSA data is complete and accurate.

Approximate draft due date: Oct 31
Approximate final due date: Dec 31

In preparation for each of these processes, agencies and Bitfocus employ the continuous data quality improvement practices described above. Specifically:

- Throughout the year:
  - Bitfocus: conduct data quality reviews based on feedback from H4H staff and from agencies, following up with agencies as needed.
  - Bitfocus: provide Agencies regularly with dashboards and other information about specific data quality issues that need to be addressed.
  - Bitfocus: provide trainings on data quality topics.
  - Agencies: follow up on data issues as identified by Bitfocus and/or H4H staff.

    - Agencies: ensure staff understand issues related to data quality through ongoing training and support.

- As a report deadline approaches:
    - Agencies: begin data quality review well in advance, focused on ensuring the correct number of consumers are enrolled and there are no null values. Make corrections as needed. For example, ensure that no required information, such as veteran status, is missing.
    - Bitfocus: help agencies with data quality issues upon request.

Watsonville/Santa Cruz City & County Continuum of Care (CoC)

Consent for Data Sharing for Runaway and Homeless Youth (RHY)-Funded Programs

The Santa Cruz County Homeless Management Information System (HMIS) is a shared database and software application which confidentially shares consumer-level information related to homelessness in Santa Cruz County. We ask you to consent to the sharing of your information to help the Watsonville/Santa Cruz City & County Continuum of Care (CoC) provide quality housing and services to people at risk of or experiencing homelessness and/or who have very low-income.

Your information will be released to housing and services providers ("Covered Homeless Organizations (CHOs)"), which include community-based organizations and government agencies. CHOs use the information in HMIS to: improve the quality of housing and services; identify patterns and monitor trends over time; conduct needs assessments and prioritize services for subpopulations at risk of or experiencing homelessness or with very low-income; enhance inter-agency coordination; and monitor and report on the delivery, impact, and quality of housing and services.

BY CHECKING AND SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

☐ I understand the following on *the sharing of my basic information with CHOs*:

- CHOs may change over time; a current list of CHOs has been provided to me and I may request an updated list at any time or view the list at https://santacruz.bitfocus.com/participating-agencies.
- Basic information includes: Name, Social Security Number, Date of Birth, Race, Ethnicity, and Gender.
- The collection, use, and release of this information is for the purpose of assessing my needs for housing, counseling, food, utility assistance, or other services.

☐ I understand that the information shared may include the following types of protected personal information (PPI):

- Identifying information (e.g., name, birth date, gender, race, ethnicity, social security number, phone number, residence address, or other similar identifying information)
- Medical, mental health and substance use information included in my responses to questions asked as part of the standard HMIS intake
- Financial and benefits information (e.g., employment status, income verification, public assistance payments or allowances, food stamp allotments, health care coverage, or other similar financial or benefits information)
- Housing status and related information
- Information about services provided by Partner Agencies (e.g., intake date,

duration, and type of service)

☐ I understand CHOs use the PPI collected in HMIS to assess, prioritize, and refer me to housing options and other services. I also understand that CHOs communicate with each other to coordinate prioritization, placement, and determine eligibility for housing and other services.

☐ I understand the CHOs and individual staff have signed agreements to maintain the security and confidentiality of my information.

☐ I understand that I may refuse to sign this Consent. My refusal will not affect my eligibility for benefits or services, or my ability to obtain services or receive support. My refusal does not disqualify me from receiving services or support.

☐ I understand that I may sign the Consent and still refuse to provide specific information that I do not want to share.

☐ I can revoke this Consent at any time, but I must do so in writing. Revoking the Consent is not retroactive and will not affect any information shared while I gave my consent. I understand that this consent is valid for 3 years from the date listed below.

☐ My PPI is protected by federal, state, and local regulations governing the confidentiality of consumer records. My information cannot be released without my written consent, except when the rules say otherwise.

☐ I have the right to review my records, to correct a record or file a statement of disagreement, and to be notified of the people who have reviewed my records, except in limited circumstances to protect the health and safety of myself or others.

SIGNATURE

_____ _____

Print Name of Consumer or Legal Guardian **Signature of Consumer or Legal Guardian**

_____

Date

Watsonville/Santa Cruz City & County Continuum of Care (CoC)
Individual HMIS User Agreement and Code of Ethics

The primary focus in the design and management of the Watsonville/Santa Cruz CoC HMIS is to help consumers get and keep permanent homes. Achievement of this goal requires continual quality improvement of programs and services and the maintenance of consumer confidentiality by treating personal data with respect and care.

As the guardians entrusted with this personally identifiable information (PII), Watsonville/Santa Cruz CoC HMIS users have a moral and legal obligation to ensure that appropriate methods are practiced with the collection, access, and utilization of data. Each user must ensure that consumer data is only used for the purpose for which it is collected. Proper user training, adherence to the Watsonville/Santa Cruz City & County CoC Privacy Policy, and a clear understanding of consumer confidentiality are vital to achieving these goals. All Users are required to attend a CoC approved training class prior to their first use of the HMIS and annually thereafter.

Please check each box below to indicate your understanding and acceptance of the proper use of the HMIS system and data. PLEASE READ CAREFULLY. Failure to uphold the confidentiality standards set forth below is grounds for immediate termination from HMIS access and may result in disciplinary action from the CHO as defined in the CHO's personnel policies.

BY CHECKING <u>EACH BOX</u> AND SIGNING THIS FORM, I UNDERSTAND THE FOLLOWING:

I agree to maintain the confidentiality of Consumer information in the HMIS in the following manner:

☐ My user ID and password are for my use only and must not be shared with anyone.
☐ I must take all reasonable means to keep my password physically secure.
☐ I understand that the only individuals who can view information in HMIS are authorized users and the consumers to whom the information pertains.
☐ I may only view, obtain, disclose, or use the database information that is necessary to perform the official duties of my job.
☐ I acknowledge that it is a consumer's decision about which information to share for entry into HMIS and the data will only be shared with authorized HMIS partner agencies.
☐ I will ensure that an HMIS Consumer Notice is posted at any location consumer intake services are provided and personally identifiable information (PII) is entered into HMIS.
☐ I will always provide consumers with a copy of the CoC Consumer Notice and an Acknowledgement of its receipt shall be signed at least every three years. A copy of the signed Acknowledgement will be uploaded and stored in the HMIS system.

☐ If I have a conflict of interest in entering data within HMIS, I will disclose that to my supervisor. If I am a consumer with information in the Watsonville/Santa Cruz CoC HMIS, or if I have immediate family members with information in the Watsonville/Santa Cruz CoC HMIS, I will not make changes to those files.

To prevent casual observers from seeing or hearing HMIS Consumer information:

☐ If I am logged into HMIS and must leave the work area where the computer is located, I must log off HMIS before leaving the work area. Failure to log off HMIS may result in a breach of consumer confidentiality and system security.
☐ Hard copies of HMIS information must be kept in a secure file. When hard copies of HMIS information are no longer needed, they must be properly destroyed to maintain confidentiality.
☐ I will not discuss HMIS confidential Consumer information with staff, Consumers, or Consumer family members in a public area.
☐ I will not discuss HMIS confidential Consumer information on the telephone in any areas where the public might overhear my conversation.
☐ I will not transmit confidential consumer or identifying information via unsecured and unencrypted email.
☐ I will not leave messages on my agency's answering machine or voicemail system that contains HMIS confidential Consumer information.
☐ If I notice or suspect a security breach, I must immediately notify my Agency Administrator and Bitfocus.

As an HMIS User, I understand and will abide by the following Code of Ethics:

☐ Users must be prepared to answer Consumer questions regarding HMIS.
☐ Users must faithfully respect Consumer preferences about the sharing of their information within the HMIS.
☐ Users must accurately record Consumer's preferences by making the proper designations as to sharing of Consumer information and/or any restrictions on the sharing of Consumer information.
☐ Users must not refuse services to a Consumer, or potential Consumer, if that Consumer refuses to allow sharing personal information with other agencies via the HMIS.
☐ The User has primary responsibility for information entered by the User. Information that Users enter must be truthful, accurate and complete to the best of User's knowledge.
☐ Users will not solicit from, or enter information about, Consumers into the HMIS unless the information is required for a legitimate business purpose, such as providing services to the Consumer, and/or is required by the program funder.
☐ Users will not use the HMIS database for violation of any law, to defraud any entity or to conduct any illegal activity.
☐ Upon Consumer written request, Users must allow a Consumer to inspect and obtain a copy of the Consumer's own information kept within the HMIS, unless sharing this

information could result in significant harm to the health and safety of the consumer or others.

☐ Information compiled in reasonable anticipation of, or for use in, a civil, criminal or administrative action or proceeding need not be provided to the Consumer.

☐ Users must permit Consumers to file a written complaint regarding the use or treatment of their personal information within the HMIS. Consumers may complete an HMIS Data Misuse and Breach Reporting form located at santacruz@bitfocus.com. Consumer will not be retaliated against for filing a complaint.

I understand and agree to comply with all the statements listed above.

Print Name	**Signature**	**Date**
Agency Name	**Work Phone Number**	**Email Address**

Watsonville/Santa Cruz City & County Continuum of Care (CoC)

HMIS Data Misuse and Breach Incident Reporting Form

This form is used to notify the Watsonville/Santa Cruz City & County CoC of any of the following in relation to its Homeless Management Information System (HMIS) and the use of data from HMIS:

- An incident involving unsecured Personally Identifiable Information (PII), if that PII was, or is reasonably believed to have been accessed or acquired by an unauthorized person; or
- A suspected security incident, intrusion, or unauthorized access, use, or disclosure of PII in violation of signed agreements

PII is any information about an individual which can be used to distinguish, trace, or identify their identity, including personal information like name, address, date of birth or social security number.

Please complete as much of this form as possible. Depending on the specific nature of the incident, Bitfocus (the HMIS Administrator) or a Housing for Health (H4H) Division staff member (the HMIS Lead) will contact you.

Person Reporting the Incident

First Name | Last Name

Phone Number (include area code) | Email

Agency | Title (if applicable)

Incident Details

Organization:

Organization Street Address:

Organization City and Zip:

Date and time of incident:

Date and time you learned of the incident:

SANTA CRUZ COUNTY
Housing for Health
PARTNERSHIP

Type of Incident (Check all that apply)

- ☐ Unauthorized Access
- ☐ Unauthorized Disclosure
- ☐ Loss
- ☐ Theft
- ☐ Other (describe)

Location of Incident (Check all that apply)

- ☐ Desktop computer
- ☐ Laptop computer
- ☐ Other electronic device
- ☐ Paper
- ☐ Other (describe)

Brief Description of Incident (specific data accessed, used, or disclosed in ways that constitute a breach, specific consumer(s) involved):

IF YOU ARE A CONSUMER REPORTING AN INCIDENT, YOU DO NOT NEED TO COMPLETE THE REST OF THIS FORM.

Estimated # of client data records breached:

Safeguards in Place Prior to Incident (Check all that apply)

- ☐ None
- ☐ Privacy safeguards (Training, Policies and Procedures, etc.)
- ☐ Security administrative safeguards (Risk Analysis, Risk Management, etc.)
- ☐ Security physical safeguards (Facility Access Controls, Workstation Security, etc.)
- ☐ Security technical safeguards (Access Controls, Transmission Security, etc.)

Actions Taken in Response to Incident (Check all that apply)

- ☐ Adopted encryption technologies
- ☐ Changed password/strengthened password requirements
- ☐ Created a new/updated Security Risk Management Plan
- ☐ Implemented new technical safeguards
- ☐ Implemented periodic technical and nontechnical evaluations
- ☐ Improved physical security
- ☐ Performed a new/updated Security Risk Analysis
- ☐ Provided individuals with free credit monitoring
- ☐ Revised policies and procedures
- ☐ Sanctioned workforce members involved (including termination)
- ☐ Took steps to mitigate harm
- ☐ Trained or retrained workforce members
- ☐ Other (describe)

SANTA CRUZ COUNTY
Housing for Health
PARTNERSHIP

Watsonville/Santa Cruz City & County Continuum of Care (CoC)

Approaches to Responding to Consumer Concerns about Data Sharing

- Explain importance of data sharing
    - helps streamline the application and intake process, especially if client is working with other homeless providers who use HMIS
    - Important documents can be saved into electronic file so they the same information doesn't have to be collected again
    - Helps to not miss out on housing opportunities –we can notify you of permanent housing opportunities
    - HMIS allows linking people to valuable resources by matching information with the eligibility criteria for resources such as benefits linkage, rental assistance, shelters, street outreach, housing navigation, veteran services, HOPWA, PATH, and runaway homeless youth services.
- Explain privacy and security; everyone gets retrained every year
- Explain de-identified/aggregate data is reported and used
    - Provides statistical and demographic information necessary to continue receiving funding for services and housing for people experiencing homelessness
    - Helps us understand the needs of our community to identify gaps and services that would benefit our community further
    - Helps us identify and make the case for more housing, more services, and more funding for the community
- Role play with a colleague
- Options if client doesn't want some/all data shared
    - Only enter data client is willing to share
    - Set the client record to "private"; allows sharing only within agency
    - Create an anonymous client record

SANTA CRUZ COUNTY Housing for Health PARTNERSHIP

Watsonville/Santa Cruz County CoC
Coordinated Entry Redesign Summary

Introduction: Coordinated Entry Purpose and Requirements

Coordinated Entry is the process by which people experiencing homelessness access services and housing programs of the homelessness response system. Because housing resources are so limited compared to the number of households who need them, Coordinated Entry is used to identify who is prioritized for housing support.

Under HUD's requirements Coordinated Entry must cover the entire geographic area claimed by a Continuum of Care. It must be easily accessed by individuals and families seeking housing or services. It should include a standardized assessment process and it should prioritize resources based on criteria that include vulnerability and time homeless. Within these requirements, each community must assess its resources and needs and adopt or design a process that meets local needs.

The current Smart Path system uses a standardized tool, the VI-SPDAT, to assess every person experiencing homelessness regardless of whether they are likely to receive assistance. The score is used to determine what resources someone might be offered, but most people added to the list will not be offered any housing assistance because there is not enough housing for all people experiencing homelessness. HUD Publishes Coordinated Entry Requirements and Checklist of Essential Elements - HUD Exchange

Why Redesign Now?

The Watsonville/Santa Cruz City & County CoC (CoC) has operated Smart Path for close to 5 years. Most communities review and redesign their coordinated entry process within the first 3-5 years, as the challenges of the original system become better understood. Today, the CoC has a new Strategic Framework and a new Policy Board. The HMIS system is being improved to support the work of the system and agencies better, including reviewing performance metrics and coordinating resources. In a recent focus group held with people experiencing homelessness, participants were more interested in a truthful understanding of their likelihood of getting housing then being added to a list that does not lead to help.

At the same time nationally new information about how to implement Coordinated Entry has been emerging nationally. Findings related to the VI-SPDAT indicate that this tool often results in racial disparities in who gets limited resources. There is also recognition that with limited resources communities may want to use a phased approach to coordinated entry that does not necessarily assess every person. Housing Problem Solving has emerged as a critical early step to help people resolve their homelessness quickly before being assessed for the system's limited resources.

Goals of the Coordinated Entry Redesign

- Create a system that more accurately reflects existing and planned housing inventory, which is largely population-based.
- Focus on helping people identify immediate solutions rather than sitting on lists.
- Improve trust in the system/buy in by participants and providers.
- Improve efficiency by using HMIS better.

Framework of the Redesign Proposal

The proposal for the Coordinated Entry Redesign focuses on several changes to the current process.

1. Everyone will be offered a Housing Problem Solving conversation and can receive support for an immediate solution if one can be identified (move-in assistance, support to live with family or friends, transportation to a community where they have place to live).
2. Everyone without an immediate resolution can be assisted to create a Housing Action Plan with steps that can help lead to a housing resolution over time (increasing income, addressing credit or legal barriers, getting personal documents, etc. that increase ability to apply for and get housing).
3. Questions asked for the Housing Action Plan will be about housing related matters – they are less personal than many questions in the VI-SPDAT and relate to specific needs.
4. The questions for the Housing Action Plan feed into a scored Housing Review that Housing for Health can use to place high priority people onto housing "queues." The number of people on queues will be limited based on the anticipated resource availability by population (Families, Transition Age Youth, Veterans, disabled adults) to make sure that those who are added to a queue will get a referral.
5. People will know if they are on a queue and what to expect. People who are not added to a queue can continue to receive support for their Housing Acton Plan but understand that they are not on a wait list for homeless system resources such as PSH and Rapid Rehousing.

Timing and Next Steps

This proposal is being developed with feedback from participants and providers.

- March - Community Meeting feedback
- April – Refine proposal and test Problem Solving and Housing Acton Plan questions
    - Bring proposal to Policy Board
- May – Develop HMIS versions of process
    - Test Problem Solving and Housing Acton Plan questions
    - Bring proposal to Operations Committee
- June – Finalize and train community on new process
    - Bring final design to Operations Committee and Policy Board
- July – Implement redesigned process
- 2023 – Review and evaluate new process

SANTA CRUZ COUNTY Housing for Health PARTNERSHIP

Key to colors/bolding:
- May come from Enrollment or Profile (not necessarily as worded on enrollment/profile forms)
- **Bolded = Scored item**

Housing Needs Assessment (HNA) and Housing Action Plan (HAP)

Document Description: This document details the questions people experiencing homelessness will be asked to assess housing need and support access to housing resources (i.e., the Housing Needs Assessment). It also demonstrates how information from this assessment connects directly to tailored housing action plans (i.e., the Housing Action Plan). Following the finalization of this document, a hard copy and electronic version will be developed that Housing Problem Solvers will use when engaging with participants.

Participant name: Connector name:

HMIS ID (if known): Date:

HNA Section 1: Household Composition	Response	Notes
1. **Including yourself, how many total members are in your current household?** • In notes, indicate whether this number may change as they search for housing.		
2. **Are you or anyone in your household currently pregnant?** • If yes, please indicate who is pregnant in notes • If yes, what is the expected due date?	☐ Yes ☐ No	
3. **Do you currently have any children (under age 18) in your household?** • If yes, provide details (name, DOB/age, gender, school, and school district). *** may be in a table format for ease of entry*	☐ Yes ☐ No	

4. Do you have pets? • If yes, in the notes section, indicate the type of pet (e.g., dog, cat, etc.), if they are service animals, emotional support animals, or companions. • If they are service animals, what are they trained to do? • If yes, provide information about their shots, license, vets, food, and whether they are spayed/neutered in the notes. • If yes, indicate in notes whether they will only accept housing that allows pets (i.e., would they be willing/able to find another home for their pet if available housing did not allow pets)?	☐ Yes ☐ No	

HAP Section 1: Household Composition	
If anything from the household composition portion of the HNA is a priority for us to work on together to help you find and get a permanent place to live, please identify the following:	
Goal(s)	
Action Steps:	
Time Frame:	

HNA Section 2: Housing History	**Response**	**Notes**
5. **When was the last time you or any adult household member had a lease or owned a home in your or their own name?**	☐ Never or more than 5 years ago ☐ Within last 1-5 years ☐ Within last year ☐ Currently	
6. **Have you or any adult in your household had a formal eviction in the**	☐ Two or more prior	

last five years (had a legal paper taped to your front door, or might show in your credit report, court records, tenant screening databases)?	rental evictions ☐ One prior rental eviction ☐ No prior rental evictions	
7. Have you or any adult household members currently or previously had housing <u>in</u> Santa Cruz County? • If yes, provide details (who, when, where, for how long).	☐ Yes ☐ No	
8. Have you or any adult household members had housing <u>outside</u> of Santa Cruz County? • If yes, provide details (who, when, where, for how long).	☐ Yes ☐ No	

HAP Section 2: Housing History	
If anything from the <u>housing history</u> portion of the HNA is a priority for us to work on together to help you find and get a permanent place to live, please identify the following:	
Goal(s):	
Action Steps:	
Time Frame:	

HNA Section 3: Social Support	**Response**	**Notes**
9. **Do you have a former property manager or landlord who can provide you with a positive reference?**	☐ Yes ☐ No	

10. **Do you or any adult household members have relationships with others who support you and you feel connected to (family, friends, other communities of support)?**	☐ Yes ☐ No	
11. Are there friends or family members you'd like to reconnect with?	☐ Yes ☐ No	
12. Are there any friends or family members that could help you/your household with housing, like providing a place to live, be a roommate, help cover housing costs?	☐ Yes ☐ No ☐ Maybe	
13. If yes to the previous question, if we could provide you some short-term assistance such as a contribution toward rent, groceries, utilities, or a rental deposit, do you think you could live with any of these people for a while?	☐ Yes ☐ No ☐ Maybe ☐ N/A	

HAP Section 3: Social Support	
If anything from the social support portion of the HNA is a priority for us to work on together to help you find and get a permanent place to live, please identify the following:	
Goal(s):	
Action Steps:	
Time Frame:	

HNA Section 4: Income, Employment, Benefits, Health Insurance, and Credit	**Response**	**Notes**
14. **What is the total amount of cash income that you and other household members receive from any source each month?**	☐ $0 ☐ $1 - $2,385 ☐ $2,386 - $4,770	

• **Provide details (source and amount).**	☐ > $4,770	
15. Are you or any other adult household members currently employed or enrolled and attending school?	☐ Yes ☐ No	
16. Are you or other adult household members looking for work or planning on enrolling in school?	☐ Yes ☐ No	
17. Do you or anyone in your household receive any non-cash benefits, i.e. CalFresh (Food Stamps), WIC, CalWorks services, etc.?	☐ Yes ☐ No	
18. Do you have active health insurance coverage? • If yes, please provide the type of insurance:	☐ Yes ☐ No	
19. **Do you or other household members have any problematic outstanding debt, financial, or credit issues that might show up on your credit report?** • If yes, please provide details (who, what)	☐ Yes ☐ No	

HAP Section 4: Income, Employment, Benefits, Health Insurance, and Credit	
If anything from the income, employment, benefits, health insurance, and credit portion of the HNA is a priority for us to work on together to help you find and get a permanent place to live, please identify the following:	
Goal(s):	
Action Steps:	

Time Frame:	

HNA Section 5: Documentation	Response	Notes
20. **Do you or any adults in your household need help to get or store copies of critical documents, i.e., ID card, Driver's License, Social Security Card, Birth Certificate, etc.?**	☐ Yes ☐ No	

HAP Section 5: Documentation	
If anything from the documentation portion of the HNA is a priority for us to work on together to help you find and get a permanent place to live, please identify the following:	
Goal(s):	
Action Steps:	
Time Frame:	

HNA Section 6: Legal Issues	Response	Notes
21. **How many times in the past five years have you or other adults in your household been arrested or picked up by police (more than a warning or citation)?**	☐ 5 or more ☐ 1 – 4 ☐ None	
22. **Do you or any other adult household members have a criminal record for arson, drug dealing or manufacture, or felony offense against persons or property?**	☐ Yes ☐ No	
23. Do you or other household members have other legal matters that are not felonies that need support to resolve? (i.e., record clearing,	☐ Yes ☐ No	

expungements, debts, etc).		

HAP Section 6: Legal Issues	
If anything from the legal issues portion of the HNA is a priority for us to work on together to help you find and get a permanent place to live, please identify the following:	
Goal(s):	
Action Steps:	
Time Frame:	

HNA Section 7: Health	**Response**	**Notes**
24. **Do you or any household members have disabling conditions (physical disability, developmental disability, chronic health condition, HIV-AIDS, mental health disorder or substance use disorder)?**	☐ Yes ☐ No	
25. **Do you or anyone in your household need help with any activities of daily living? (bathing, feeding, cleaning, etc.)**	☐ Yes ☐ No	
26. **Do any of your or a household member's health challenges interfere with your ability to get or stay housed?**	☐ Yes ☐ No	
27. **Does any member of your household have a condition that requires housing for those struggling with a mobility, hearing, or visual impairment?**	☐ Yes ☐ No	

HAP Section 7: Health

If anything from the legal issues portion of the HNA is a priority for us to work on together to help you find and get a permanent place to live, please identify the following:	
Goal(s):	
Action Steps:	
Time Frame:	

The following section will be included in the Housing Action Plan.

HAP Section 8: Housing Preferences	Response	Details
28. Which of the following unit types would you be willing to accept?	☐ 2+ Bedroom Unit ☐ 1 Bedroom Unit ☐ Studio Apartment ☐ Shared Housing (bedroom) ☐ Shared Housing (common areas, eg., kitchen, bathroom) ☐ Single Room Occupancy (SRO) ☐ Studio/Efficiency ☐ Any of the above ☐ None of the above	
29. Think of all the different geographic places you would be willing to live including places in and outside of Santa Cruz County. Where would you consider living?		
30. What school district(s) are your children attending? Is it important to keep them in the same school/school district?		

This section should be completed by the Connector after completing the development of a housing plan, based upon their interactions with the participant.

Interviewer Observations	Response	Notes (mandatory if "yes" response)
31. **Does the participant, or any member of their household, appear to be particularly fragile or at high risk of suffering from an illness that makes them particularly vulnerable to staying outdoors?**	☐ Yes ☐ No	
32. **Does the participant or any members of their household, have any observed <u>but not reported</u> disabilities (mental health, physical health, substance use issue, etc.) that may impact their ability to find or maintain housing?**	☐ Yes ☐ No	
33. **Do you have significant concerns about the safety of the participant, and/or any member of their household? For example, if they are newly unsheltered &/or homeless, unable to protect themselves, isolated vs. part of a larger group etc.?**	☐ Yes ☐ No	
34. **ADMINISTRATIVE DATA. Based on analysis of available administrative data what is the health and safety risk level for this participant?**		

Proposed Scoring Rubric and Information for the Housing Assessment

To Be Eligible for any Queue	Source	Options
Current Living Situation	Current Living	Must be Homeless
To Determine Which Queue	**Source**	**Options**
HH Type	Client Profile	TAY, Families, Adults, Vet, CH
Preference for Housing Match	**Source**	**Options**
Last permanent Address	Client Enrollment	Santa Cruz vs. Other

HNA #	Scored Items	Source	Options	Minimum	Maximum
1	HH Size	Client Profile	1 point if HH is 3 or more	0	1
2	Pregnant Household member	HNA Review	0 = No 1= Yes	0	1
3	Children in Household under 5 years old	Client Profile	0 = No 2 = Yes	0	2
NA	Fleeing DV	Enrollment	0 = No 2 = Yes	0	2
NA	Age	Client Profile	2 points if 62+ or 18-24	0	2
NA	# Times Homeless in 3 years	Enrollment	0 = 1 time	0	2

			1 = 2 or 3 times 2 = 4 or more times		
NA	# Months Homeless in 3 years	Enrollment	0 = < 6 mos 1 = 6-12 mos 2 = > 12 mos	0	2
14	Total HH Income	Enrollment	2 = $0 - $2,385 1 = $2,386-$4,770 0 = > $4,770	0	2
NA	# Disabilities	Enrollment	0 = No 1 = One 2 = 2 or more	0	3
5 6 9 10 19 20 21 22 25 27	Resources/Barriers • History of lease • Evictions • Negative/no rental reference • Lack presence of social support • Credit issues • Need for documents • Arrests • Felonies • ADL support • Accessibility needs	HNA Review	5 = 9/10 barriers 4 = 7/8 barriers 3 = 5/6 barriers 2 = 3/4 barriers 1 = 1/2 barriers 0 = 0 barriers	0	5
24	Disability Impact - Participant	HNA Review	0 = Not at all 1 = Some 2 = A lot	0	2
31	Physical Acuity – Connector	HNA Review	0=not at all, 1=some, 2=a lot	0	2

32	Disability Impact – Connector	HNA Review	0=not at all, 1=some, 2=a lot	0	2
33	Safety - Connector	HNA Review	0=not at all, 1=some, 2=a lot	0	2
34	Health System High Need/Risk (Placeholder)	Data Match	TBD	0	2
		Total		**0**	**27/32**