

Before Starting the CoC Application

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

The Collaborative Applicant is responsible for reviewing the following:

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

1A. Continuum of Care (CoC) Identification

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.

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<https://www.hudexchange.info/programs/e-snaps/fy-2019-coc-program-nofa-coc-program-competition/#nofa-and-notices>

1A-1. CoC Name and Number: TX-503 - Austin/Travis County CoC

1A-2. Collaborative Applicant Name: Ending Community Homelessness Coalition, Inc.

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Ending Community Homelessness Coalition, Inc.

1B. Continuum of Care (CoC) Engagement

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

1B-1. CoC Meeting Participants.

For the period of May 1, 2018 to April 30, 2019, applicants must indicate whether the Organization/Person listed:

1. participated in CoC meetings;
2. voted, including selecting CoC Board members; and
3. participated in the CoC's coordinated entry system.

| Organization/Person | Participates in CoC Meetings | Votes, including selecting CoC Board Members | Participates in Coordinated Entry System |
|---|------------------------------|--|--|
| Local Government Staff/Officials | Yes | Yes | Yes |
| CDBG/HOME/ESG Entitlement Jurisdiction | Yes | Yes | Yes |
| Law Enforcement | Yes | Yes | Yes |
| Local Jail(s) | Yes | No | Yes |
| Hospital(s) | Yes | Yes | Yes |
| EMS/Crisis Response Team(s) | Yes | Yes | Yes |
| Mental Health Service Organizations | Yes | Yes | Yes |
| Substance Abuse Service Organizations | Yes | Yes | Yes |
| Affordable Housing Developer(s) | Yes | Yes | Yes |
| Disability Service Organizations | Yes | Yes | Yes |
| Disability Advocates | Yes | Yes | Yes |
| Public Housing Authorities | Yes | Yes | Yes |
| CoC Funded Youth Homeless Organizations | Yes | Yes | Yes |
| Non-CoC Funded Youth Homeless Organizations | Yes | Yes | Yes |

| | | | |
|--|----------------|-----|-----|
| Youth Advocates | Yes | Yes | Yes |
| School Administrators/Homeless Liaisons | Yes | Yes | Yes |
| CoC Funded Victim Service Providers | Yes | Yes | Yes |
| Non-CoC Funded Victim Service Providers | Yes | No | No |
| Domestic Violence Advocates | Yes | No | Yes |
| Street Outreach Team(s) | Yes | Yes | Yes |
| Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates | Yes | No | Yes |
| LGBT Service Organizations | Not Applicable | No | No |
| Agencies that serve survivors of human trafficking | Yes | Yes | Yes |
| Other homeless subpopulation advocates | Yes | Yes | Yes |
| Homeless or Formerly Homeless Persons | Yes | Yes | Yes |
| Mental Illness Advocates | Yes | Yes | Yes |
| Substance Abuse Advocates | Yes | Yes | Yes |
| Other:(limit 50 characters) | | | |
| Employment & Veteran Service Providers | Yes | Yes | Yes |
| Faith Based Organizations | Yes | Yes | Yes |
| Family Service Providers & Shelter | Yes | Yes | Yes |

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

Applicants must describe how the CoC:

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

1. Diverse stakeholder opinions are enlisted via CoC-led weekly & monthly workgroups, community stakeholder meetings, CoC website, & social media. CoC Board oversees 17 committees and workgroups w/ members representing initiatives (e.g., youth, veteran, consumer feedback, employment, families, system equity). Workgroup updates report up to committees and ultimately to CoC Board. Youth and adults w/ lived homeless experience serve on the CoC Board and provide added expertise by serving in other CoC & community leader roles. CoC staff attend city/community planning meetings; informing how homelessness impacts other sectors. CoC Board voting members also represent business owners, hospitals, mental health authority, law enforcement, employment services, local government & private funders.

2. Agendas/minutes from CoC Board & Committee meetings are posted and archived on the Lead Agency's public website, along w/ the most current iterations of reports (Action Plan, Needs & Gaps Analysis, and Disparities

Analysis). CoC's website hosts schedules/lead contacts for open invitation to meetings. Semi-annual Stakeholder Meetings are held to solicit feedback on ending homelessness from community members. CoC Staff speak and present data at City Hall/City Council meetings and community forums.

3. CoC integrates feedback to improve programs, policies & plans. Policies & written standards (for housing interventions, service provisions, Coordinated Entry) are developed by workgroups and adopted by the CoC Board. Online surveys are used frequently to collect feedback. CoC Board used info from online survey to guide the FY19 CoC Funding Priorities. CoC staff assist as subject matter experts on innovative initiatives led by city and private entities.

4. Newly developed ECHO website is 508 compliant, accessible for people w/ varying abilities & has instructions to request accommodations directly. Online documents are available in accessible formats (PDF, etc.) for public download.

1B-2. Open Invitation for New Members.

Applicants must describe:

- 1. the invitation process;**
 - 2. how the CoC communicates the invitation process to solicit new members;**
 - 3. how the CoC ensures effective communication with individuals with disabilities, including the availability of accessible electronic formats;**
 - 4. how often the CoC solicits new members; and**
 - 5. any special outreach the CoC conducted to ensure persons experiencing homelessness or formerly homeless persons are encouraged to join the CoC.**
- (limit 2,000 characters)**

1. Details on CoC membership and how to join is posted on ECHO's website & is an ongoing, open invitation process. Membership related materials are posted for transparency (Governance Charter, Committee/Workgroup schedules, MOUs). The process is outlined in the Governance Charter (including process for electing CoC Board). CoC Board slate is voted on at the Fall Stakeholder event.

2. CoC has an open member invitation process all year - advertised online (website, newsletters, social media sites, local listservs/apps) & during meetings/community outreach events. Events are coordinated using online event registration site (open to the public). Marketing & social media accounts are linked. Annual CoC Board invitation is announced at CoC-hosted meetings, website, e-Newsletters and social media. Governance Charter guides memberships roles - is available to the public and used to solicit, recruit, and fill open Board seats.

3. New ECHO website is 508 compliant w/ a variety of accessible online formats and has instructions to request accommodations directly w/ CoC staff.

4. CoC outreaches to new agencies/stakeholders to ensure diverse representation in committees/workgroups who provide annual feedback on governing structure to Board. Board seats are slated during the annual Fall Stakeholder meeting; vacant seats are quickly filled/approved on an as needed basis.

5. In 2016, CoC formed the Austin Youth Collective (AYC), advisory board comprised of youth w/ lived experience of homelessness, and add to the CoC governance structure. AYC holds 2 CoC Board voting seats. In 2017, ECHO partnered w/ the city to create a consumer advisory committee of persons w/

current or former homeless experience called AHAC. In 2018, the Governance Charter was amended to add 2 CoC Board voting seats filled by AHAC members. CoC adopted the FY19 NOFA Independent Review Team (IRT) Slate; adding a member of AHAC to ensure funding decisions include people with lived experience.

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

Applicants must describe:

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

1. CoC hosted 2 events (Renewal Orientation & Bidder's Conference) announcing the competition/application proposal process for CoC funding. Events were open to public and advertised widely via online communications-posted on ECHO's website, social media accounts, and e-Newsletter listserv (over 1000 contacts). Messaging specifically stated "ECHO encourages ALL agencies to apply during the local competition and welcomes new partners to join the growing community of CoC-funded agencies." Events were held for applicants to learn about the NOFA process, funding opportunities, and community needs. Attendees are informed on how to submit applications in a local electronic platform and in ensaps. A comprehensive application guide was created and posted on the website. Renewal Orientation & Bidder's Conference presentations were live-streamed via webinar and the recording and materials were posted on the ECHO website along w/ contact info for technical assistance.
2. Outlined in the CoC Rank & Review Policy, project applications are included in the competition ranking by 1st submitting application materials within the local competition deadline. Applications completed w/in the set deadline are reviewed by the Independent Review Team (IRT). IRT, appointed by the CoC Board, rates/scores renewal & new projects using the local application and local scoring guide. IRT presents the ranking to the CoC board for approval. The ranking is posted on website. Sent emails to notify of approval/rejection w/ link ranking w/ project scores.
3. CoC publicly announced it was open to proposals for new applicants on 7/18/19.
4. New ECHO website, which included accessible competition materials, is 508 compliant and has instructions to request accommodations directly w/ CoC

staff. CoC created accessible competition materials with dedicated staff to respond to requests.
5. N/A

1C. Continuum of Care (CoC) Coordination

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

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

| Entities or Organizations the CoC coordinates planning and operation of projects | Coordinates with Planning and Operation of Projects |
|---|---|
| Housing Opportunities for Persons with AIDS (HOPWA) | Yes |
| Temporary Assistance for Needy Families (TANF) | No |
| Runaway and Homeless Youth (RHY) | Yes |
| Head Start Program | No |
| Funding Collaboratives | Yes |
| Private Foundations | Yes |
| Housing and services programs funded through U.S. Department of Justice (DOJ) Funded Housing and Service Programs | Yes |
| Housing and services programs funded through U.S. Health and Human Services (HHS) Funded Housing and Service Programs | Yes |
| Housing and service programs funded through other Federal resources | Yes |
| Housing and services programs funded through State Government | Yes |
| Housing and services programs funded through Local Government | Yes |
| Housing and service programs funded through private entities, including foundations | Yes |
| Other:(limit 50 characters) | |
| Landlords and Property Management Companies | Yes |

| | |
|----------------------------------|-----|
| Housing Providers and Developers | Yes |
|----------------------------------|-----|

1C-2. CoC Consultation with ESG Program Recipients.

Applicants must describe how the CoC:
1. consulted with ESG Program recipients in planning and allocating ESG funds;
2. participated in the evaluating and reporting performance of ESG Program recipients and subrecipients; and
3. ensured local homelessness information is communicated and addressed in the Consolidated Plan updates.
(limit 2,000 characters)

1. CoC participates in drafting the annual Action Plan and Consolidated Plan directly. Also through the public comment process; partnering w/ ESG recipients and City of Austin (CoA). The CoA attended CoC Board events; collecting feedback on the Consolidated Plan (Feb. 2019). CoC Board approved written memo w/ recommendations to CoA on using homeless service funding (e.g., ESG). CoC staff offers technical assistance to agencies w/ ESG funds and also coordinates system planning via the CoC & ESG Committee. CoC staff and members attend workgroups aimed at ESG-funded emergency shelter system improvements (housing focused); including feedback on the redesign of Austin's men's shelter. CoC also coordinated public comments to the state ESG Provider (TDHCA) in Oct. 2018 to propose changes for the FY20 ESG programming.

2. CoC analyzes the System Performance Measures (SPM) annually at the agency level; including performance of all ESG recipients and reports finds to ESG administrators. SPMs have been an integral part in driving community and program improvements. A committee of the CoC Board, the CoC & ESG Committee, ensures integration across the system (federal/funding compliance, performance evaluation and funding strategies/requirements). CoC partners w/ ESG recipients to report CAPER each year and ensures data accuracy/quality. ECHO, the HMIS Lead, provides direct assistance to CoA with collecting data and performance indicators outlined in the Consolidated Plan goals and reported through the CAPER.

3. The CoC collaborates closely with the CoA to draft homeless information for the Consolidated Plan; including narrative descriptions of the homelessness system and data analysis regarding the needs and gaps. The CoC partnered with CoA to host several presentations at CoC committees and workgroups during the comment period and emphasized ways to collect feedback from people with lived experience advisory groups.

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

Yes to both

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

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

Applicants must indicate whether the CoC ensured local homelessness information is communicated to Consolidated Plan Jurisdictions within its geographic area so it can be addressed in Consolidated Plan updates.

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

Applicants must describe:

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

1. CoC created the VAWA Housing Protections Workgroup in 2018. The group detailed procedures, instructional guides, standardized forms and other training/TA services needed to implement a system-wide response to increasing safety using best/promising practices. CoC VAWA Policy & Procedures (adopted 6/4/18) outline protocols and practice standards for all providers regardless of funding. CoC forms provide details on safety planning, internal and external emergency transfers, and confidentiality. Protocols ensure all persons are screened for victimization, offered information about VAWA protections and provided safety planning as a service or offered a warm handoff referral. Safety Plans are used to navigate housing options. Local Emergency Transfer Plan informs survivors of housing options, offer immediate safe units, and coordinates internal and external transfers when needed. Internal transfers are used as the first step in the emergency transfer process.

2. CE Assessors are required to provide a safe and confidential location for assessments of victims of abuse/violence. Survivors are prioritized for housing through the By Name List (BNL). SAFE (local VSP) manages a de-identified BNL that is integrated into the CE BNL. Survivors are informed of their options for confidentiality and decide how to be prioritized through the BNL. Survivors are informed of all potential safety concerns of choosing the CoC's shared HMIS CA system. External Emergency Transfers are processed through an online secure form completed by the referring program. De-identified information is collected and sent to the CE Director to place on the BNL for immediate prioritization. Survivors are instructed to provide the minimum amount of information needed. Housing options are provided to the referring program and then offered to the survivor. If an option is selected, the referring program will immediately contact the new program to coordinate a warm-handoff.

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

Applicants must describe how the CoC coordinates with victim services

providers to provide training, at least on an annual basis, for:

- 1. CoC area project staff that addresses safety and best practices (e.g., trauma-informed, victim-centered) on safety and planning protocols in serving survivors of domestic violence; and**
 - 2. Coordinated Entry staff that addresses safety and best practices (e.g., Trauma Informed Care) on safety and planning protocols in serving survivors of domestic violence.**
- (limit 2,000 characters)**

The CoC partners with SAFE, the largest Victim Service Provider (VSP), to provide an annual 6-hour workshop with tailored curriculum based on local policy and procedures & incorporating best and promising practices (e.g., dynamics and impact of interpersonal violence and human trafficking), safety planning, trauma-informed care, and privacy concerns. The training is taught through a trauma-informed lens and equips staff to offer services in a manner that is both affirmative and victim-centered; ensuring that local protocols provide guidance on practices for providers to follow and how to honor self-determination. In addition to safety planning, staff are expected to offer all potential avenues for connecting to survivors to VSP services, including the 24-hour SAFE emergency hotline, 24-hour SAFE chatline, and the SAFE walk-in locations. Local guides, training materials and standardized forms are hosted on ECHO's website. Additional trainings/resources are developed and coordinated in the VAWA Housing Protections Workgroup.

2. The CoC requires additional Trauma Informed Care (TIC), safety planning and VSP service training as part of the Coordinated Entry Assessor annual training. Assessors must demonstrate competency in these processes to be certified as a CE Assessor and must participate in annual refresher trainings. CE written standards require that staff offer direct assistance to individuals needing DV services. The assessment protocol includes a statement and question at the beginning of the interview to allow safe disclosure of danger/fear and offer immediate access to safe housing. Staff are trained by SAFE Alliance on how to explain services and conduct warm-handoffs in the context of a stand-alone intake. The CoC and SAFE have also developed a cross-training system between the SAFE Hotline staff and the CE staff so both intake systems are mutually well-informed; ensuring the intake information and outcomes are shared and coordinated.

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

Applicants must describe how the CoC uses de-identified aggregate data from a comparable database to assess the special needs related to domestic violence, dating violence, sexual assault, and stalking.
(limit 2,000 characters)

There are two CoC funded VSPs that share de-identified aggregate data from comparable databases: The SAFE Alliance and Green Doors. The CoC coordinates with both providers in the CoC's to ensure that all data (including information gathered from comparable databases) is used in system planning. Having VSP stakeholders play an active role on the CoC board and committees ensure their experiences, expertise, and voices are included in decision making. The CoC uses de-identified aggregate data from comparable databases to enumerate how many people are in need of housing, what their specific needs are, household composition, vulnerability factors, and recommended housing

interventions. The CoC integrates this information in: 1) Austin's Action Plan to End Homelessness which includes Needs & Gaps data, 2) the Annual Point in Time and Housing Inventory Count Reports, 3) Austin / Travis County Coordinated Community Plan to Prevent & End Youth Homelessness, 5) Quarterly Performance Scorecards for monitoring project performance (includes data on the number served, exits to and retentions of permanent housing, increases in income, and prioritization for services). The HMIS Lead meets frequently with VSPs to discuss strategies for improving data sharing and support surrounding comparable database use and reporting needs. The VAWA Housing Protections workgroup has created policies and has ongoing planning to integrate de-identified program data into system reporting to better understand the needs and outcomes beyond UDS while protecting vulnerable households. CoC is continuing to develop comprehensive procedures which include protocols on safely recording and reporting data related to Emergency Transfers (approved/denied requests and request outcomes). This includes working toward reporting de-identified aggregate data to the HMIS Lead on a semi-annual basis.

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

Applicants must submit information for the two largest PHAs or the two PHAs with which the CoC has a working relationship within the CoC's geographic area.

| Public Housing Agency Name | % New Admissions into Public Housing and Housing Choice Voucher Program during FY 2018 who were experiencing homelessness at entry | PHA has General or Limited Homeless Preference | PHA has a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On |
|---|--|--|--|
| Housing Authority of the City of Austin | 62.00% | Yes-HCV | Yes-HCV |
| Housing Authority of Travis County | 54.00% | Yes-HCV | Yes-HCV |

1C-4a. PHAs' Written Policies on Homeless Admission Preferences.

Applicants must:

1. provide the steps the CoC has taken, with the two largest PHAs within the CoC's geographic area or the two PHAs the CoC has working relationships with, to adopt a homeless admission preference—if the CoC only has one PHA within its geographic area, applicants may respond for one; or

2. state that the CoC does not work with the PHAs in its geographic area. (limit 2,000 characters)

The CoC maintains robust working relationships with both PHAs within the CoC's geographic area. Both PHA's have continued to maintain an allocation of 25% of their overall HCV programs to the homeless preference, as documented in their administrative plans and in MoU's with the CoC lead agency. In September 2018, the Housing Authority of the City of Austin (HACA) received an award of 89 Mainstream subsidies; this application was submitted in partnership with the CoC to assist in providing subsidies for eligible individuals experiencing homelessness. In May of 2019, the Housing Authority of Travis

County (HATC) was awarded 34 Family Unification Program (FUP) subsidies; this application was submitted in partnership with the CoC to assist in providing subsidies for youth and young adults to bolster the community's work to end youth homelessness. In August of 2019, the CoC again supported HACA in applying for 320 additional Mainstream subsidies. These partnerships include collaborative communication to support individuals served in their housing placement process, housing stability support services, all while adhering to a Housing First/Harm Reduction philosophy. The CoC and both PHAs meet regularly to identify strategies to strengthen partnerships to bring low barrier housing resources to Austin. Both PHAs and the CoC lead agency are committed to partnering with social service agencies that use Housing First and Harm Reduction practices when delivering care to people experiencing homelessness in Austin.

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

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

Yes

If "Yes" is selected above, describe the type of provider, for example, multifamily assisted housing owners, PHAs, Low Income Tax Credit (LIHTC) developments, or local low-income housing programs. (limit 1,000 characters)

CoC adopted a common CoC-wide Move-On Strategy supported by formal partnerships w/ both local Public Housing Authorities (City of Austin & Travis County). Housing Choice Voucher program and 7 HUD Multi-Family properties provide tenant-based subsidies. The CoC has a Move-On application process and is staffed at the Permanent Supportive Housing (PSH) workgroup. CoC continues to explore growing Move-On opportunities via HUD Multi-Family properties and the 811 PRA system. CoC receives technical assistance from the Technical Assistance Collaborative to expand opportunities. City of Austin passed its 3rd local affordable housing bond, garnering \$250 million in capital funding, and developers are heavily incentivized to dedicate units within their properties to the COC. These developments are typically also receiving Low Income Housing Tax Credits and can be leveraged by the CoC to increase PSH capacity, including other Move-On partnerships offering deeply affordable units.

1C-5. Protecting Against Discrimination.

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

The CoC requires all programs to adhere to fair housing standards and provide equal access to all community members. After an initial fidelity workshop was held in November 2016, a CoC-wide anti-discrimination policy was adopted in 2017 and updated in 2019 by the CoC Board that addresses discrimination,

including the Fair Housing Act and the Equal Access Rule. In 2018, the CoC revised the Coordinated Entry (CE) MOU to include additional language requiring compliance with the local CoC policies - specifically defining Fair Housing and Anti-Discrimination standards. The MOU is required to be signed by all system providers regardless of funding source. As a part of the policy and written standards, ECHO coordinates the following trainings on an annual basis 1) Anti-Discrimination & Fair Housing and 2) Equal Access Rule. The CoC partners with Daring Dialogues Consulting and the Texas Homeless Network to offer a tailored 4-hour Equal Access workshop (last workshop hosted on 8/16/19) focused on improving agency and program policies and increasing fidelity to best practices within programs and coaching cultural humility among services providers. The CoC partners with Austin Tenants Council (ATC) to provide a series of Fair Housing workshops (most recently on 9/4/19) which was open to all service providers. The next training is scheduled 12/4/19 and the CoC will continue to host workshops as needed to address staff turnover and ensure all program staff are offered ongoing education. Workshops are advertised through a variety of platforms (in person meetings, email, social media, Newsletters). Training materials (flyers and registration pages) offer and promote accommodations. Members of consumer advisory committees are encouraged to attend workshop opportunities in order to create advocacy opportunities for those who might be the most likely to see or experience discrimination.

***1C-5a. Anti-Discrimination Policy and Training.**

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

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

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

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

| | |
|---|-------------------------------------|
| 1. Engaged/educated local policymakers: | <input checked="" type="checkbox"/> |
| 2. Engaged/educated law enforcement: | <input checked="" type="checkbox"/> |
| 3. Engaged/educated local business leaders: | <input checked="" type="checkbox"/> |
| 4. Implemented communitywide plans: | <input checked="" type="checkbox"/> |

| | |
|---|-------------------------------------|
| 5. No strategies have been implemented: | <input type="checkbox"/> |
| 6. Other:(limit 50 characters) | |
| Provided interviews and data to local media | <input checked="" type="checkbox"/> |
| Participated in coalition against criminalization | <input checked="" type="checkbox"/> |
| | <input type="checkbox"/> |

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

Applicants must:

- 1. demonstrate the coordinated entry system covers the entire CoC geographic area;**
 - 2. demonstrate the coordinated entry system reaches people who are least likely to apply for homelessness assistance in the absence of special outreach; and**
 - 3. demonstrate the assessment process prioritizes people most in need of assistance and ensures they receive assistance in a timely manner.**
- (limit 2,000 characters)**

1. The CoC's Coordinated Entry System (CES) uses the following methods to ensure geographic coverage: a) physical walk-in locations across separate geographic areas (north, south, & central) which are accessible through public transportation, b) a universal online web portal, c) physical street outreach teams who cover the full geographic area of the CoC & are capable of completing assessments in the field, d) community education partnerships with geographically dispersed organizations such as libraries, community centers, schools, clinics, hospitals, law enforcement, & the Local Mental Health Authority.

2. To ensure the system reaches people least likely to apply, walk-in locations are co-located with complementary services such as career services, family medical services, & drop-in day resources. The web portal includes a direct contact section where people can request a phone appointment or a personalized location appointment. CE staff have a close relationship and provide on-call support to street outreach & community partner organizations who have dedicated resources to serve hard-to-reach populations (unsheltered households, families, chronically homeless veterans, unaccompanied youth, people living with HIV/AIDS, refugees/asylees, & people experiencing mental health challenges).

3. The CoC prioritizes all permanent housing resources based upon the vulnerabilities captured by the VI-SPDAT. The CoC has developed an integrated Outreach & Navigation system that actively engages & assesses individuals in the greatest need, then proactively documents eligibility & keeps households engaged throughout the referral and re-housing process. This cycle between marketing, assessment, & ongoing engagement ensures that households most in need are being actively enrolled in the system, & that they have support to access housing opportunities quickly & efficiently.

1D. Continuum of Care (CoC) Discharge Planning

Instructions:

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Resources:

The FY 2019 CoC Application Detailed Instruction can be found at:

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The FY 2019 CoC Program Competition Notice of Funding Availability at:

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

1D-1. Discharge Planning Coordination.

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

| | |
|--------------------------|-------------------------------------|
| Foster Care: | <input checked="" type="checkbox"/> |
| Health Care: | <input checked="" type="checkbox"/> |
| Mental Health Care: | <input checked="" type="checkbox"/> |
| Correctional Facilities: | <input checked="" type="checkbox"/> |
| None: | <input type="checkbox"/> |

1E. Local CoC Competition

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.

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

Applicants must indicate whether the CoC:

| | |
|--|-----|
| 1. informed project applicants in its local competition announcement about point values or other ranking criteria the CoC would use to rank projects on the CoC Project Listings for submission to HUD for the FY 2019 CoC Program Competition; | Yes |
| 2. established a local competition deadline, and posted publicly, for project applications that was no later than 30 days before the FY 2019 CoC Program Competition Application submission deadline; | Yes |
| 3. notified applicants that their project application(s) were being rejected or reduced, in writing along with the reason for the decision, outside of e-snaps, at least 15 days before the FY 2019 CoC Program Competition Application submission deadline; and | Yes |
| 4. notified applicants that their project applications were accepted and ranked on the CoC Priority Listing in writing, outside of e-snaps, at least 15 days before the FY 2019 CoC Program Competition Application submission deadline. | Yes |

1E-2. Project Review and Ranking–Objective Criteria.

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

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

1E-3. Project Review and Ranking–Severity of Needs and Vulnerabilities.

| | | |
|------------------------|---------|------------|
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|------------------------|---------|------------|

Applicants must describe:

- 1. the specific severity of needs and vulnerabilities the CoC considered when reviewing and ranking projects; and**
 - 2. how the CoC takes severity of needs and vulnerabilities into account when reviewing and ranking projects.**
- (limit 2,000 characters)**

1. All CoC-funded projects (renewal and new projects) must follow the CoC's adopted policies & procedures and Coordinated Entry (CE) Written Standards. This includes implementing Housing First (HF) standards related to project types (e.g., PSH, TH & RRH) and accepting CE referrals - prioritized by vulnerability using the VI-SPDAT tool. Vulnerabilities accounted for include but are not limited to: length of time homeless, medical/mental conditions, substance use, history of exploitation. Final scores combine items from Performance Scorecards (benchmark performance outcomes expected for project type) and items from the local application (HUD's HF Assessment, improvement initiatives, and addressing racial and ethnic disparities). Programs are monitored for CE compliance and performance serving the referred population which is reflected in Quarterly Performance Scorecards. New projects are evaluated on their ability to needs address in the Community Funding Priorities policy (local application materials).

2. During the annual funding competition, renewal projects are evaluated using two scores- 65% Performance Scorecard score and 35% Local Application score. Local application scores on ability to meet community needs and to serve vulnerable households. Application materials are reviewed by an Independent Review Team (IRT). Applicants applying for new/bonus funding submit a local application scored by IRT which consists of 100% of the final score for new/bonus funds. IRT scores items evaluating the ability to meet Local Funding Priorities - created by the CoC Board. Scored items include: need of project type/target population, ability to serve the most vulnerable households, commitment to equity, and quality of program design based on intervention type.

1E-4. Public Postings–CoC Consolidated Application. Attachment Required.

Applicants must:

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

Public Posting of Objective Review and Ranking Process

Public Posting of CoC Consolidated Application including: CoC Application, CoC Priority Listing,

| | | Project Listings | |
|---|-------------------------------------|---|-------------------------------------|
| 1. Email | <input checked="" type="checkbox"/> | 1. Email | <input checked="" type="checkbox"/> |
| 2. Mail | <input type="checkbox"/> | 2. Mail | <input type="checkbox"/> |
| 3. Advertising in Local Newspaper(s) | <input type="checkbox"/> | 3. Advertising in Local Newspaper(s) | <input type="checkbox"/> |
| 4. Advertising on Radio or Television | <input type="checkbox"/> | 4. Advertising on Radio or Television | <input type="checkbox"/> |
| 5. Social Media (Twitter, Facebook, etc.) | <input checked="" type="checkbox"/> | 5. Social Media (Twitter, Facebook, etc.) | <input checked="" type="checkbox"/> |
| 6. Did Not Publicly Post Review and Ranking Process | <input type="checkbox"/> | 6. Did Not Publicly Post CoC Consolidated Application | <input type="checkbox"/> |

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

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

Reallocation: 17%

1E-5a. Reallocation–CoC Review of Performance of Existing Projects.

Applicants must:

1. describe the CoC written process for reallocation;
 2. indicate whether the CoC approved the reallocation process;
 3. describe how the CoC communicated to all applicants the reallocation process;
 4. describe how the CoC identified projects that were low performing or for which there is less need; and
 5. describe how the CoC determined whether projects that were deemed low performing would be reallocated.
- (limit 2,000 characters)

The CoC Reallocation & Deobligation Policy informs the local process for voluntary and involuntary reallocation. Involuntary reallocation process is tied to the Performance Improvement Plan (PIP) Policy which outlines benchmark performance standards and administrative standards (cost-effective, HUD compliance). Projects complete Quarterly Performance Scorecards measuring performance on grant administration performance, data quality measures, & system performance measures. The PIP policy creates system accountability to take action toward poor performers. Projects on a PIP receive TA and must demonstrate improvement within a set timeframe. If a project is unable to demonstrate improvements, the Policy outlines the process for voluntary and/or involuntary reallocation. The most recent policy revisions added reallocation as a strategy to improve system outcomes and offers incentives around voluntary reallocation.

CoC governing board reviews the Reallocation & Deobligation Policy annually;

with recent policy revisions approved on 4/1/19. Reallocation Policy is posted on the ECHO website on the CoC page. Versions of updated policies are widely distributed via email listservs and discussed at monthly CoC and ESG Committee meetings. Files and links are shared/referenced during the competition through: Newsletters, Renewal Orientation Workshop and Bidder's Conference materials, and links on the local application.

The CoC currently has 2 projects on a PIP and have been able to demonstrate improvements on goals outlined in the PIP Agreement Plan; preventing them from involuntary reallocation.

Projects are given the opportunity to demonstrate improvements on set goals during the PIP period. Projects currently participating in the PIP process are actively receiving technical assistance from CoC staff and have met reporting requirements (improvements made on measurable goals with requirements approved by the CoC governing body).

DV Bonus

Instructions

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1F-1 DV Bonus Projects.

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

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

| | |
|--------------------------|-------------------------------------|
| 1. PH-RRH | <input checked="" type="checkbox"/> |
| 2. Joint TH/RRH | <input type="checkbox"/> |
| 3. SSO Coordinated Entry | <input type="checkbox"/> |

Applicants must click “Save” after checking SSO Coordinated Entry to view questions 1F-3 and 1F-3a.

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

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

| | |
|--------------------------|----------|
| Need Housing or Services | 1,340.00 |
|--------------------------|----------|

| | |
|------------------------------|----------|
| the CoC is Currently Serving | 2,814.00 |
|------------------------------|----------|

1F-2a. Local Need for DV Projects.

Applicants must describe:

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

1. The need is people not yet housed on the by-name list who have had contact with HMIS in the past year and have lifetime experience or are fleeing DV. Currently served is people having an active program entry in any program in the CoC.

2. Data used was collected from HMIS and 2 VSPs comparable databases through APR, which includes people receiving services and housing. Shared aggregate data from comparable databases and outcomes combined for DV rates covering geographic area.

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

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

| Applicant Name | DUNS Number |
|-----------------------|--------------------|
| The SAFE Alliance | 057515850 |

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

Applicant Capacity

| | |
|---|-------------------|
| DUNS Number: | 057515850 |
| Applicant Name: | The SAFE Alliance |
| Rate of Housing Placement of DV Survivors–Percentage: | 98.50% |
| Rate of Housing Retention of DV Survivors–Percentage: | 100.00% |

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

Applicants must describe:

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

SAFE uses a comparable HMIS database; provides aggregate data to CoC. Housing placement rates were # of people exited to permanent destinations out of all persons exiting the program over the course of a full year. For new projects, placement rates were # of people who exited to permanent housing (PH) or stayers with a move-in date. Housing retention was calculated as people who entered PH and maintained housing as of last contact. SAFE utilizes Apricot, a comparable HMIS database vendor.

1F-4b. DV Survivor Housing.

Applicants must describe how project applicant ensured DV survivors experiencing homelessness were assisted to quickly move into permanent housing. (limit 2,000 characters)

SAFE has set the standard of 80% of participants being housed within 30 days of program entry. They have demonstrated the capacity to successfully meet this goal in the Transitional Housing (TH) program which has 91% rate of positive housing placements in the most recent APR and 100% housing placement rate for their RRH programs. SAFE has partnered with the Landlord Outreach Specialist (LOS) services to match participants to immediately available units and offers a variety of housing options to meet safety needs. LOS services have shown similar successful housing placement outcomes during the Veteran and Youth 100 Day Challenge initiatives. Outcomes are achieved through strong relationships with properties providing a diverse stock of housing options and financial resources to reduce housing barriers. SAFE supports the LOS staff to ensure survivors' access to VAWA housing protections to limit barriers to long-term housing stability and timely access to housing. Unrestricted funds are used to eliminate unique barriers and challenges survivors may encounter when locating stable/safe housing. Strategies ensuring that over 85% of clients exit to PH and 90% will not return to homelessness include using best practices: Critical Time Intervention,

progressive engagement, trauma-informed care, and victim-centered services. SAFE's program designs provide a well-rounded support system and clearly defined staff roles. Examples include: Peer Support Specialists (ensure successful community referrals, facilitate connections to safe support networks, life skills coaching and mentoring), SOAR Specialist (ensure access to mainstream benefits), and Case Management (safety planning, housing stability, and parent education). With their subject matter expertise, they are well equipped to provide RRH services that combine important components of safety planning and housing stability.

1F-4c. DV Survivor Safety.

Applicants must describe how project applicant:

- 1. ensured the safety of DV survivors experiencing homelessness by:**
 - (a) training staff on safety planning;**
 - (b) adjusting intake space to better ensure a private conversation;**
 - (c) conducting separate interviews/intake with each member of a couple;**
 - (d) working with survivors to have them identify what is safe for them as it relates to scattered site units and/or rental assistance;**
 - (e) maintaining bars on windows, fixing lights in the hallways, etc. for congregate living spaces operated by the applicant;**
 - (f) keeping the location confidential for dedicated units and/or congregate living spaces set-aside solely for use by survivors; and**
 - 2. measured its ability to ensure the safety of DV survivors the project served.**
- (limit 2,000 characters)**

1a. As the largest VSP (over 400 staff), SAFE has onboarding procedures to include completing a 40-hour certification training, program-specific training on risk assessment, and safety planning. Ongoing trainings focus on best practices with Safety Planning; ensuring victim-centered approach, and a strong emphasis on providing ongoing education on VAWA protections.

1b. Intakes are conducted in a private space at the SAFE Resource Center, a secure site. Alternative settings are offered to ensure individual needs are met and to reduce exposure to trauma triggers.

1c. SAFE partners with Coordinated Entry staff to ensure persons are screened individually as a standard protocol and provides training on how to systematically use screening methods and offer safety services to those entering the homeless system.

1d. In addition to incorporating safety planning into intake and housing search; SAFE protocols ensure clients are educated on available VAWA housing protections and facilitate emergency transfers when necessary to ensure safety.

1e. SAFE operates congregate living spaces through Emergency Shelter and Transitional Housing living units with enhanced security features (gated, employ security officers, cameras) for safety measures.

1f. SAFE does not keep the location of ES or TH confidential to ensure survivors have immediate access to safe shelter with enhanced security options. SAFE does not publicize any of the PH units and follows confidentiality requirements. SAFE works with other providers to coordinate access to dedicated units if a survivor has expressed this need as a part of safety planning.

2. SAFE's internal evaluation department works with University of Texas (UT) to develop and utilize a survey measuring individual safety of those in housing

programs. The tool specifically collects survivor responses to measure safety across key life activities (home, school, work, family).

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

Applicants must describe:

- 1. project applicant's experience in utilizing trauma-informed, victim-centered approaches to meet needs of DV survivors; and**
 - 2. how, if funded, the project will utilize trauma-informed, victim-centered approaches to meet needs of DV survivors by:**
 - (a) prioritizing participant choice and rapid placement and stabilization in permanent housing consistent with participants' preferences;**
 - (b) establishing and maintaining an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures program participant staff interactions are based on equality and minimize power differentials;**
 - (c) providing program participants access to information on trauma, e.g., training staff on providing program participant with information on trauma;**
 - (d) placing emphasis on the participant's strengths, strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans include assessments of program participants strengths and works towards goals and aspirations;**
 - (e) centering on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;**
 - (f) delivering opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and**
 - (g) offering support for parenting, e.g., parenting classes, childcare.**
- (limit 4,000 characters)**

SAFE uses a trauma-informed care (TIC) approach across services with survivors being their target population. That is, to be TIC means to know the history of past and current abuse in the lives of the persons being assisted. TIC means to understand the role violence and victimization plays in the lives of most people receiving services, and to use that understanding to design services. Our service model, programs, and providers are able to respond to clients with supportive intent, and consciously avoid re-traumatization.

2a. The TIC services used address the immediate needs of survivors (e.g., medical accompaniments, counseling, case management, referral, shelter, and other basic needs). Housing First model is emphasized with the importance of permanent housing & values client choice. Peer support services are available to build survivor-to-survivor connection to support survivors in making informed choices about how best to pursue their own safety and self-sufficiency.

2b. SAFE fosters a culture of autonomy and empowerment with the survivors we serve. Staff are trained on Motivational Interviewing to facilitate behavior change through understanding Stages of Change, using collaboration, focusing on housing stability as a behavior change and promoting autonomy and self-determination. Written grievances are submitted to Program Directors or higher if needs are not met. Termination is limited to severe instances ensuring best practices inform decisions. Services are open to all persons and has inclusive enrollment policy. Households are never denied services outside of any federal requirements needed for program enrollment.

2c. SAFE counselors have advanced licensure and/or specialized training in

evidence- based trauma treatment modalities and teach trauma symptom management to our clients. TIC program services help victims rebuild confidence, safety, resiliency and personal power, which is often lost due to abuse/violence..

2d. SAFE uses therapeutic modalities such as Cognitive Behavioral Therapy, and Strengths-Based Relational Therapy. Therapeutic frameworks used help survivors establish healthy connections, safe relationships, & adaptive coping skills; improving resiliency. Assessment tools include strength-based measures. Case plans include assessments of program participants' strengths and progress toward goals.

2e. SAFE participates in the CoC's annual required trainings on non-discrimination and Equal Access policies. Staff and volunteers receive training on cultural awareness, cultural competency, disability, and other related topics. Direct service staff engage in individual and group supervision which includes discussions about societal biases/discrimination and how to practice cultural humility.

2f. Using a survivor-led approach, SAFE's peer support program is trauma-informed, survivor-centered, and empowerment-based. Survivors often experience extended periods of isolation. Peer support groups build positive relationships with others who understand the complexities of abuse and violence. Peer Support program nurtures hope and reduces isolation by creating survivor-to-survivor connections; share and access resources to support safety and self-sufficiency; and promote survivors' increased self-confidence & empowerment.

2g. The Family Tree program addresses the limited availability of trauma-informed childcare in the community and provides a safe, supportive environment for both parents and children. In the Strong Start program, parents acquire skills needed to avoid abusive/neglectful behaviors and ensure that their children's social and emotional development improves by breaking the cycle of family violence.

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

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

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

(limit 2,000 characters)

Programs and services use trauma-informed and housing first approaches at all levels so survivors quickly access safe, permanent housing (PH). Clinical Case

Management (CM) supports survivors in PH goals. Staff have unique community resources and unrestricted funds to quickly reduce barriers (physical, financial, emotional) to PH. SAFE's unique expertise allows the agency to be prepared w/ programming and services needed for survivors to safely navigate financial, medical, and educational institutions to escape abusers. Safety planning is an integral part in entering and maintaining PH. Locating and offering safe PH options also means survivors are connected w/ stabilizing services that promote overall wellbeing and "right size" the level of services to ensure long-term, independent PH and financial stability. Successful PH is paired w/ voluntary; yet intensive supportive services that address safety needs: SAFE's Legal Services staff (Advocates/Attorneys) offer direct representation/court accompaniment to survivors seeking justice and protection. Also includes legal representation/support for other legal barriers (housing, child custody, immigration, education, employment, probate). CMs assist w/ credit repair and work w/ landlords who understand and support leasing to households w/ unique criminal and/or credit histories- often a direct result of abuse, violence, and human trafficking. SAFE's Family Tree program provides a supportive environment for both parents and children through trauma-informed childcare. A health program provides medical/mental healthcare at SAFE locations - reducing barriers to safe, affordable care and works toward building a medical home in the community at program exit. A recovery counselor provides drug and alcohol support and referrals to inpatient/outpatient treatment. Education and Employment specialist provides direct services to reduce barriers and secure successful employment and education opportunities.

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.

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2A-1. HMIS Vendor Identification. WellSky ServicePoint

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

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

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

| Project Type | Total Number of Beds in 2019 HIC | Total Beds Dedicated for DV in 2019 HIC | Total Number of 2019 HIC Beds in HMIS | HMIS Bed Coverage Rate |
|---|----------------------------------|---|---------------------------------------|------------------------|
| Emergency Shelter (ES) beds | 867 | 106 | 761 | 100.00% |
| Safe Haven (SH) beds | 15 | 0 | 15 | 100.00% |
| Transitional Housing (TH) beds | 317 | 133 | 184 | 100.00% |
| Rapid Re-Housing (RRH) beds | 727 | 115 | 612 | 100.00% |
| Permanent Supportive Housing (PSH) beds | 1,083 | 16 | 1,067 | 100.00% |
| Other Permanent Housing (OPH) beds | 190 | 0 | 190 | 100.00% |

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

For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-2., applicants must describe:

**1. steps the CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and
2. how the CoC will implement the steps described to increase bed coverage to at least 85 percent.
(limit 2,000 characters)**

Not Applicable

***2A-3. Longitudinal System Analysis (LSA) Submission.**

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

***2A-4. HIC HDX Submission Date.**

**Applicants must enter the date the CoC submitted the 2019 Housing Inventory Count (HIC) data into the Homelessness Data Exchange (HDX).
(mm/dd/yyyy)** 04/30/2019

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

Instructions:

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2B-1. PIT Count Date. 01/26/2019

Applicants must enter the date the CoC conducted its 2019 PIT count (mm/dd/yyyy).

2B-2. PIT Count Data–HDX Submission Date. 04/30/2019

Applicants must enter the date the CoC submitted its PIT count data in HDX (mm/dd/yyyy).

2B-3. Sheltered PIT Count–Change in Implementation.

Applicants must describe:

1. any changes in the sheltered count implementation, including methodology or data quality methodology changes from 2018 to 2019, if applicable; and

2. how the changes affected the CoC's sheltered PIT count results; or

3. state "Not Applicable" if there were no changes.

(limit 2,000 characters)

Not Applicable

***2B-4. Sheltered PIT Count–Changes Due to Presidentially-declared Disaster.**

**Applicants must select whether the CoC No
added or removed emergency shelter,**

transitional housing, or Safe-Haven inventory because of funding specific to a Presidentially-declared disaster, resulting in a change to the CoC's 2019 sheltered PIT count.

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

Applicants must describe:

- 1. any changes in the unsheltered count implementation, including methodology or data quality methodology changes from 2018 to 2019, if applicable; and**
 - 2. how the changes affected the CoC's unsheltered PIT count results; or**
 - 3. state "Not Applicable" if there were no changes.**
- (limit 2,000 characters)**

1. The CoC changed unsheltered count implementation in 2019 to improve data quality by implementing a new PIT survey and recruiting more volunteers. The CoC worked with epidemiologists with experience counting hidden populations to update the PIT survey. Due to unreliable responses to sensitive questions and personal health information, data extrapolation from other sources is necessary to complete PIT requirements. Lack of interviewer surveying experience and the environment in which the survey is conducted adversely impact the survey's response rate and data quality regardless of interviewers' best intentions. Streamlining structure, length, and the wording of each question, and reducing survey fatigue were issues considered during the design of the new survey.

A focus group was established to systematically review factors influencing the survey response rate, survey delivery, and survey completion. Practical suggestions and future research directions were discussed using brainstorming sessions, volunteer feedback from previous years, and a review of PIT surveys from other CoCs. In addition, the local Council of persons with lived experience (AHAC) were consulted on survey design. The just-in-time training of interviewers and the effects of respondent anxiety when questions about sexuality, violence, or similar topics are asked were critical to this discussion. Based on these findings a new version of the survey was developed, approved by the CoC membership council, and used for the 2019 PIT Count.

2. An increase in volunteers to around 600 increased the number of surveys administered by 22 percent (466 surveys administered in 2018 vs. 570 surveys administered in 2019), and the percentage of unsheltered individuals surveyed increased by 14 percent (46 percent of unsheltered individuals completed a survey in 2018, vs. 52 percent in 2019--remaining individuals were counted via observation in both years).

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

Applicants must:

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

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

Applicants must describe how the CoC engaged stakeholders serving youth experiencing homelessness to:

- 1. plan the 2019 PIT count;**
 - 2. select locations where youth experiencing homelessness are most likely to be identified; and**
 - 3. involve youth in counting during the 2019 PIT count.**
- (limit 2,000 characters)**

1. The CoC engages youth stakeholders during PIT Count (PITC) planning via the PITC Workgroup. This workgroup meets monthly throughout the year and is directed by the CoC Board, which includes leadership from LifeWorks, the primary youth provider in the CoC. Members of the Austin Youth Collective are represented on the CoC Board and ensure that the PIT process takes into account how to reach the youth experiencing homelessness in our community.
2. The CoC engaged youth service organizations to identify locations where youth experiencing homelessness are most likely to be identified in the following ways:
 - Recruiting team leads from LifeWorks, the CoC's primary youth services provider, and assigning these team leads to sections where youth were known to be camping based on information from LifeWorks and CoC outreach teams,
 - Recruiting volunteers via the Austin Youth Collective, a board of youth with lived experience of homelessness,
 - Coordinating hotspot identification groups with LifeWorks at the Youth Resource Center during the week of 12/17/18 that identified twelve locations where youth were sleeping unsheltered, and
 - Coordinating a post-count magnet event on 1/28/2019 with LifeWorks to count youth who may have been missed during the unsheltered count.
3. Youth with lived experience of homelessness were involved in the PITC by serving as general volunteers. To increase engagement and response rates during the count, youth volunteers with lived experience were strategically assigned to areas they were familiar with, had slept in personally, or where they expected other youth to be found. Five individuals registered as PITC volunteers who indicated they were a) between the ages of 18 and 24, and b) had lived experience of homelessness.

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

Applicants must describe the CoC's actions implemented in its 2019 PIT count to better count:

- 1. individuals and families experiencing chronic homelessness;**
 - 2. families with children experiencing homelessness; and**
 - 3. Veterans experiencing homelessness.**
- (limit 2,000 characters)**

After collecting feedback from several community stakeholders and groups, the CoC revised the survey form in 2019, which was approved by the CoC Board, to better count the following subpopulations:

1. Individuals and families experiencing chronic homelessness: The 2019 PITC survey contains streamlined questions related to chronic homelessness. The survey now asks about the chronic status for heads of household only. The

questions about a person's disability were simplified. The length of time homeless questions were condensed to avoid survey fatigue and interviewer confusion.

2. Families and children experiencing homelessness: The 2019 survey includes a section to collect demographic information for up to 6 household members. This is an increase from 2018's survey maximum of five household members. The 2018 survey required interviewers to use a complicated column system to collect data for additional household members, leading to confusion and data quality issues.

The 2019 survey removed questions regarding domestic violence, sex work, and HIV/AIDS based on feedback from interviewers and participants, who noted that asking and/or answering these questions in the presence of family members could be problematic and/or traumatic.

3. Veterans experiencing homelessness: The 2019 PITC survey streamlined response options for Veterans. Instead of asking a complicated, multi-part question about service, branch, and type (full time, reserves, activated/deployed), the 2019 survey included one yes or no question on Veteran status.

To better count all individuals experiencing unsheltered homelessness, the CoC recruited a greater larger number of general volunteers and team leads. 72 team leads and over 600 general volunteers participated in the 2019 Point in Time Count. The increase in volunteers improved the number of surveys administered by 22%, and the percentage of unsheltered individuals surveyed by 14%.

3A. Continuum of Care (CoC) System Performance

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.

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<https://www.hudexchange.info/programs/e-snaps/fy-2019-coc-program-nofa-coc-program-competition/#nofa-and-notice>

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

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

Applicants must:

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

| |
|-------|
| 3,339 |
|-------|

3A-1a. First Time Homeless Risk Factors.

Applicants must:

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

1. CoC analyzes data of those who have entered the system as homeless for the first time to identify trends. Population trends across this subset of persons is compared to historical trends to identify current risk factors specific to our community. National data and recommendations of high risk populations are also taken into consideration and used to better understand local vs national trends. The way risk factors are determined include: a) The CoC analyzes HMIS & other local and national data to identify risk factors of first time homelessness. These risk factors are associated with homelessness locally and nationally and are adopted as risk factors used to identify persons most likely to become homeless for the 1st time.

2. Strategies include: A) Identify risk factors that inform CoC prevention strategies & programs. B) Coordinate with City-funded Prevention, a 12-agency collaborative that provides cash assistance & supportive services to households at risk. C) Increase support and collaboration efforts w/ discharge planning across systems (e.g. foster care, mental hospitals, jail, Travis County Juvenile Probation) so persons leaving systems do not enter homelessness. D) Refer to agencies that do mediation in housing courts to preserve tenancy. E) Advocate for expanded local affordable housing opportunities and other mainstream safety net programs to reduce the number of housing-cost burdened families at risk of homelessness due to poverty and advocate that new resources be uniformly low barrier and accessible. F) Maintain relationships with housing providers to aid and identify households at risk of losing housing G) Provide education opportunities and cross training to case managers across system interventions. H) Implement a YHDP funded Diversion program

3. ECHO, the CoC Lead Agency, oversees the CoC strategy to reduce and end first time homelessness.

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

Applicants must:

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

86

3A-2a. Strategy to Reduce Length of Time Homeless.

Applicants must:

1. describe the CoC's strategy to reduce the length of time individuals and persons in families remain homeless;
2. describe how the CoC identifies and houses individuals and persons in families with the longest lengths of time homeless; and
3. provide the name of the organization or position title that is responsible for overseeing the CoC's strategy to reduce the length of time individuals and families remain homeless.
(limit 2,000 characters)

1. Our community implemented a Pay for Success program in 2019 which will house 250 of the most vulnerable people experiencing chronic homelessness. Providing high-fidelity PSH services and adding more PSH units/beds supports community initiatives to reduce the average LOT. The CoC operates a Coordinated Entry System (CES) that a) prioritizes the most vulnerable for housing; b) uses assessment tools to match households to programs and interventions that are appropriate; c) works closely with first responders and outreach teams to quickly engage and link clients to resources and interventions; d) uses streamlined admission criteria and forms for PSH housing programs and e) employs diversion strategies to quickly connect people to self-resolution options. The CoC is working with our shelter system to allow for low barrier access to shelter.

2. The CoC identifies and houses persons with the longest LOT homeless using CES, prioritizing housing for persons with the greatest need. Our CoC partners

believe that length of time homeless is the data point that most correlates with vulnerability. The CES engages with persons experiencing homelessness, including long-term homelessness, by having multiple access points including through drop-in centers, shelters, street outreach programs, medical clinics, jails, and call-in phone options. The CoC created 2 new positions for in-reach to our correctional and healthcare facilities to provide access to the CES for those institutions. The CoC also leads landlord recruitment and property management partnership efforts to ensure that local landlords are willing and able to rent to households with housing barriers associated with the longest periods of homelessness. Our CoC is managing public/private partnerships with landlords in our community effectively leading to rapid housing placement despite a City wide vacancy rate of 2%.

3. ECHO, the agency that manages the CoC's Coordinated Entry system, oversees this strategy.

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

Applicants must:

| | Percentage |
|--|------------|
| 1. Report the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid rehousing that exit to permanent housing destinations as reported in HDX. | 29% |
| 2. Report the percentage of individuals and persons in families in permanent housing projects, other than rapid rehousing, that retain their permanent housing or exit to permanent housing destinations as reported in HDX. | 97% |

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

Applicants must:

1. describe the CoC's strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations;

2. provide the organization name or position title responsible for overseeing the CoC's strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations;

3. describe the CoC's strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations; and

4. provide the organization name or position title responsible for overseeing the CoC's strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations.

(limit 2,000 characters)

1. CoC's strategy to increase the rate of persons in ES, SH, TH, and RRH exiting to PH destinations: a) Using the Coordinated Entry System (CES) to connect all persons to PH and prioritizing vulnerable households, b) Supporting

shelter transformation to become housing-focused, c) improving understanding of system flow by improving HMIS data quality related to exit data for all projects, including ES where there are high rates of missing exit destination information, d) monitoring project performance by housing outcomes, e) training case managers to implement best practices that promote housing stability and preservation, f) working with local \$ to create a bridge payments and bridge housing options through hotels.

2. ECHO, the CoC Lead Agency, is responsible for overseeing the strategy to increase the rate of persons in ES, SH, TH, and RRH exiting to PH destinations.

3. CoC strategy to increase the rate of persons in PH projects, other than RRH, retaining their PH or exiting to PH, the CoC does the following: a) Monitors PH projects quarterly on successful PH retention and exits to PH destinations. PSH projects are competitively ranked for renewal based on their performance, b) Partners with landlords for expedient access to units and for lease negotiation for vulnerable people in PH projects, c) Trains case managers to implement best practices to promote housing stability and retention, d) Created a Move-On Strategy with both local Housing Authorities, streamlining access to mainstream Housing Choice Voucher for individuals in PSH for move-up housing, e) Created a robust VAWA Policy and Procedures and an Emergency Transfer Plan to ensure that households experiencing violence and abuse maintain housing stability by quickly connecting them to safe housing.

4. ECHO, the CoC Lead Agency, is responsible for the strategy to increase the rate of persons in PH projects to retain their PH or exit to PH.

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

Applicants must:

| | Percentage |
|--|------------|
| 1. Report the percentage of individuals and persons in families returning to homelessness over a 6-month period as reported in HDX. | 8% |
| 2. Report the percentage of individuals and persons in families returning to homelessness over a 12-month period as reported in HDX. | 5% |

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

Applicants must:

1. describe the strategy the CoC has implemented to identify individuals and persons in families who return to homelessness;

2. describe the CoC's strategy to reduce the rate of additional returns to homelessness; and

3. provide the name of the organization or position title that is responsible for overseeing the CoC's strategy to reduce the rate individuals and persons in families return to homelessness.

(limit 2,000 characters)

1. The CoC uses two methods to identify returns to homelessness: a) a shared, open HMIS system where returns to homelessness can be immediately identified, regardless of return location, and b) A Coordinated Entry System (CES) that, once identified, encourages households to immediately request assistance again upon a return to homelessness. The HMIS system identifies

cases where a prior exit to permanent housing now has a new emergency shelter or street outreach contact, then flags that case as a potential return to homelessness in need of active targeting for further engagement. Extensive marketing, intensive outreach, & highly accessible locations ensure that all households can request assistance quickly & conveniently & are being affirmatively offered the opportunity.

2. To reduce the rate of these returns, the CoC utilizes a CES that matches households to programs with the right combination of services to quickly return them to permanent housing & provide the support necessary for permanent success. CES offers households active choice in determining which potential option is best suited to meet their personal needs. These housing programs utilize a Progressive Engagement approach to ensure that households with higher needs receive more intensive services & increased program enrollment duration if needed to ensure stabilization before program exit, thereby reducing the risk of return. If a return does occur, then the CoC actively analyzes common factors among all returning cases on both an individual household & project-specific lens to identify areas of needed additional support, resources, or staff training, & to further inform the development & refinement of the CES matching process.

3. ECHO, as the CoC lead agency, is responsible for overseeing this strategy.

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

Applicants must:

| | Percentage |
|---|------------|
| 1. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their employment income from entry to exit as reported in HDX. | 9% |
| 2. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their non-employment cash income from entry to exit as reported in HDX. | 57% |

3A-5a. Increasing Employment Income.

Applicants must:

1. describe the CoC's strategy to increase employment income;
2. describe the CoC's strategy to increase access to employment;
3. describe how the CoC works with mainstream employment organizations to help individuals and families increase their cash income;
and

4. provide the organization name or position title that is responsible for overseeing the CoC's strategy to increase jobs and income from employment.

(limit 2,000 characters)

1. The CoC integrates strategies to increase employment income throughout the continuum of services. 1) People experiencing homelessness who complete a Coordinated Entry assessment are educated about the ability for a referral to employment services at the local workforce board; 2) The CoC has a formal agreement with the local workforce board to increase access to employment and training opportunities for referrals and all CoC agencies; 3) the CoC

coordinated training for service providers to attend a CoC Orientation and Tour at Workforce Solutions to increase referral and utilization rate of WFS services; 4) the CoC added an AmeriCorps VISTA as an Employment Navigation Specialist.

2. The CoC coordinates with Goodwill, a local employment organization, to collocate staff to ensure integration and easy access of services. The CoC has a CE assessor located at Goodwill 4 days a week and Goodwill has employment case managers located at local shelters full-time. The agreement with the local workforce board increases access to employment services. The CoC VISTA created an Employment Service Navigation Manual, posted on the CoC website to help case managers match households to existing employment services based on need and eligibility. The CoC hosted webinars with WFS. CoC developed a resource guide for use by Coordinated Entry staff during trainings with service providers such as outreach workers, community assessors and case managers to assist in connection to employment services.

3. The CoC has an agreement with the local workforce board (WFS) to increase access to employment services, to assist with increasing cash income. Cross training and referral coordination will assist referrals from the CoC to successfully navigate WFS services to increase their ability to access employment, through such services as employment case management and career skills training.

3. ECHO, the CoC Lead Agency, is responsible for overseeing this strategy.

3A-5b. Increasing Non-employment Cash Income.

Applicants must:

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

1. The CoC has two primary strategies in increasing non-employment cash income: a) developing targeted partnerships with non-employment cash income sources so that services can be affirmatively brought to the clients least able to apply for them through standard channels, and b) affirmatively advertising the availability of these income sources at all possible points of system entry and service so that barriers to existing application pathways are minimized or removed.

2. To increase access through these strategies, the CoC has implemented the following steps: a) improving access to SSI/SSDI disability benefits through SOAR, b) integrating income benefits planning into multiple steps of the Coordinated Entry System (CES), c) encouraging all housing and service providers to assist clients in applying for all cash assistance opportunities such as SNAP, WIC, TANF, and SSA Retirement Benefits, d) facilitating access to legal aid for clients struggling to access any of these mainstream cash assistance sources. To expand disability benefit access, the CoC hired a SOAR local lead responsible for strengthening the existing local SOAR network & expanding capacity intentionally to create the greatest benefit for the CoC's

population. This position works in tandem with the local lead from the Local Mental Health Authority (Integral Care), and the partnership focuses on both the local Social Security Administration System and the local Disability Determination System to both improve approval rates and expedite approval times. Pre-screening for this income pathway as well as other non-employment cash income sources is built into CES and occurs simultaneously with vulnerability and program-specific screening. Service providers such as emergency shelters, street outreach, and day resource staff are trained on these income sources and how to assist households in applying for them locally.

3. ECHO, the CoC-Lead Agency, is responsible for this income growth strategy.

3A-5c. Increasing Employment. Attachment Required.

Applicants must describe how the CoC:

1. promoted partnerships and access to employment opportunities with private employers and private employment organizations, such as holding job fairs, outreach to employers, and partnering with staffing agencies; and

2. is working with public and private organizations to provide meaningful, education and training, on-the-job training, internship, and employment opportunities for residents of permanent supportive housing that further their recovery and well-being.

(limit 2,000 characters)

1. The CoC actively promotes connections for people experiencing homelessness to employment. The CoC, in 2018, hired a VISTA Volunteer who focused on employment and income system change, that brought in new partnerships within the CoC. In 2019, the CoC created a formal MOU with Workforce Solutions (WFS) that prioritizes people experiencing homelessness for their programs, including training, child care assistance, and other employment support services. WFS has robust employment services, such as connections to employers, case management, and job fairs. In addition, CoC partner agencies provide employment services, many of which are open to the entire Continuum. Integral Care, for instance, provides supported employment services and partners with many employers in the community which results in new employment of 8-10 people monthly. They also partner with the Texas Workforce Committee - Vocational Rehabilitation to provide additional training. They held a job fair in February that was open to all employers. Front Steps provides skills training, vocational education, and linkage to job placement to veterans.

2. The CoC has a partnership with WFS who offers WERC, Work and Education Readiness Continuum, that provides clients services ranging from Adult Basic Education, ESL, job readiness instruction, and occupational training. Additional training opportunities are available for occupations with good earning potential. PSH providers in our CoC provide pathways to supported employment opportunities. Integral Care, who is the largest service provider of PSH in the Continuum, utilizes the Individual Placement and Support (IPS) model through its supported employment services, including for PSH residents. The IPS model is a person-centered employment model that focuses on shared decision making between client and employment specialists. In

addition, VASH PSH residents are connected to robust Veteran employment services.

3A-5d. Promoting Employment, Volunteerism, and Community Service.

Applicants must select all the steps the CoC has taken to promote employment, volunteerism and community service among people experiencing homelessness in the CoC's geographic area:

| | |
|---|--------------------------|
| 1. The CoC trains provider organization staff on connecting program participants and people experiencing homelessness with education and job training opportunities. | <input type="checkbox"/> |
| 2. The CoC trains provider organization staff on facilitating informal employment opportunities for program participants and people experiencing homelessness (e.g., babysitting, housekeeping, food delivery). | <input type="checkbox"/> |
| 3. The CoC trains provider organization staff on connecting program participants with formal employment opportunities. | <input type="checkbox"/> |
| 4. The CoC trains provider organization staff on volunteer opportunities for program participants and people experiencing homelessness. | <input type="checkbox"/> |
| 5. The CoC works with organizations to create volunteer opportunities for program participants. | <input type="checkbox"/> |
| 6. The CoC works with community organizations to create opportunities for civic participation for people experiencing homelessness (e.g., townhall forums, meeting with public officials). | <input type="checkbox"/> |
| 7. Provider organizations within the CoC have incentives for employment. | <input type="checkbox"/> |
| 8. The CoC trains provider organization staff on helping program participants budget and maximize their income to maintain stability in permanent housing. | <input type="checkbox"/> |

3A-6. System Performance Measures 05/30/2019 **Data–HDX Submission Date**

Applicants must enter the date the CoCs submitted its FY 2018 System Performance Measures data in HDX. (mm/dd/yyyy)

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

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.

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

3B-1. Prioritizing Households with Children.

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

| | |
|---|-------------------------------------|
| 1. History of or Vulnerability to Victimization (e.g. domestic violence, sexual assault, childhood abuse) | <input checked="" type="checkbox"/> |
| 2. Number of previous homeless episodes | <input checked="" type="checkbox"/> |
| 3. Unsheltered homelessness | <input checked="" type="checkbox"/> |
| 4. Criminal History | <input checked="" type="checkbox"/> |
| 5. Bad credit or rental history | <input checked="" type="checkbox"/> |
| 6. Head of Household with Mental/Physical Disability | <input checked="" type="checkbox"/> |

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

Applicants must:
1. describe how the CoC currently rehouses every household of families with children within 30 days of becoming homeless that addresses both housing and service needs;
2. describe how the CoC addresses both housing and service needs to ensure families with children successfully maintain their housing once

assistance ends; and

3. provide the organization name or position title responsible for overseeing the CoC's strategy to rapidly rehouse families with children within 30 days of them becoming homeless.

(limit 2,000 characters)

1. The CoC uses the following strategies to rehouse families with children in less than 30 days: a) quickly outreach to offer housing focused shelter & assess and refer to PH solutions through the Coordinated Entry System (CES), b) quickly match families to PH that is driven by client choice (e.g., diversion options, rapid rehousing, and TH or RRH w/ VSP). CES is advertised where families seek help (e.g. clinics, emergency shelters, VSP, 211 & CoC agency websites). Intensive street outreach, accessible locations and advertising ensures services are offered affirmatively. CES creates a real-time, by-name list of families using HMIS data, including date first homeless, and is used to outreach and engage in PH. CoC PH programs have formal and informal partnerships with services including, but not limited to: childcare, education, mental/physical healthcare clinics, and transportation to support housing stability needs unique to the family.

2. The CoC adopted standards in FY16 to prioritize highest need & longest unhoused households for all PH programs. Landlord outreach is used to expand housing options for families and build system-wide housing first approach to reduce housing barriers and time spent homeless. Once housed, programs utilize progressive engagement to ensure service packages match needs for successful housing stability once direct housing assistance ends. The CoC has established formal CES partnerships (e.g., mental health, substance use, HIV/AIDS, Veteran services, SSI/SSDI SOAR applications, representative payee, employment training, & medical care (through MAP, a locally funded indigent health program). CES & CoC project staff also market services such as subsidized child care (local Workforce Solutions system), education services, SNAP, TANF, WIC, subsidized housing waitlists, & Medicaid. The CoC & local housing authorities dedicated a Homeless Preference for a portion of local vouchers.

3. ECHO, the CoC Lead Agency, leads this strategy.

3B-1b. Antidiscrimination Policies.

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

| | |
|--|-------------------------------------|
| 1. CoC conducts mandatory training for all CoC- and ESG-funded housing and services providers on these topics. | <input checked="" type="checkbox"/> |
| 2. CoC conducts optional training for all CoC- and ESG-funded housing and service providers on these topics. | <input checked="" type="checkbox"/> |

| | |
|--|-------------------------------------|
| 3. CoC has worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients. | <input checked="" type="checkbox"/> |
| 4. CoC has worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within the CoC geographic area that might be out of compliance and has taken steps to work directly with those facilities to come into compliance. | <input checked="" type="checkbox"/> |

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

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

| | |
|--|-----|
| 1. Unsheltered homelessness | Yes |
| 2. Human trafficking and other forms of exploitation | Yes |
| 3. LGBT youth homelessness | Yes |
| 4. Exits from foster care into homelessness | Yes |
| 5. Family reunification and community engagement | Yes |
| 6. Positive Youth Development, Trauma Informed Care, and the use of Risk and Protective Factors in assessing youth housing and service needs | Yes |

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

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

| | |
|--|-------------------------------------|
| 1. History of, or Vulnerability to, Victimization (e.g., domestic violence, sexual assault, childhood abuse) | <input checked="" type="checkbox"/> |
| 2. Number of Previous Homeless Episodes | <input checked="" type="checkbox"/> |
| 3. Unsheltered Homelessness | <input checked="" type="checkbox"/> |
| 4. Criminal History | <input checked="" type="checkbox"/> |
| 5. Bad Credit or Rental History | <input checked="" type="checkbox"/> |

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

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

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

**youth-focused projects or modifying current projects to be more youth-specific or youth-inclusive.
(limit 3,000 characters)**

1. In 2016, the CoC was awarded a transformative \$5.2 million demonstration grant by HUD for the Youth Homelessness Demonstration Project (YHDP). The CoC and LifeWorks (the recipient of the grant and leading youth agency) are partnering together to end youth homelessness by 2020. Since November 2018, it has housed 105 youth. These youth are actively participating in supportive services, including community-based counseling (37%), workforce development (50%), and peer support (47%). LifeWorks is uniquely positioned to provide effective services that promote self-sufficiency in transition-age youth. YHDP has substantially increased housing and services through the following youth-focused projects administered by Lifeworks:

>Rapid Re-housing (RRH) for transition-age youth. RRH connects individuals and families experiencing homelessness to permanent housing through a tailored package of assistance that includes time-limited financial assistance and supportive services, including evidence-based case management. RRH helps youth and young families living on the streets or in emergency shelters solve the practical and immediate challenges to obtaining permanent housing while reducing the amount of time they experience homelessness. It links youth to community resources that enable them to achieve housing stability in the long-term.

>Deeper Diversion & Familial Supports Program (DDFSP): Assists youth and families at imminent risk of homelessness with financial support and wraparound services. Youth remain connected to support systems, stabilize and maintain current housing or connect to other safe and supported housing options. The program currently works with community school districts, and is adding diversion through juvenile justice and child welfare systems.

>Permanency through Outreach and Rapid Transitions (PORT): Temporary housing (~45 days) and permanent Rapid Re-Housing for literally homeless youth ages 18-24. Youth may live in a dormitory-style shelter (20 beds) while they are navigated into permanent Rapid Re-Housing apartments and receive supportive services.

Together, these programs are working to create a systems-level change to prevent and end youth homelessness in Austin/Travis County.

2. The new YHDP programs target both sheltered and unsheltered youth. To date, the programs have a 24% reduction in youth homelessness overall and a 58% reduction in unsheltered youth homelessness. The CoC's vision for successful growth is serving transition-age youth more effectively through well-coordinated evidence-based programming. Deepening impact requires moving beyond the homelessness crisis response system and into school districts, juvenile justice, foster care, faith-based communities, and community supports. Strengthening systems at the community-level will break down silos and divert youth from falling into homelessness. Successful growth also means increasing the capacity needed to reach and maintain "functional zero."

3B-1d.1. Youth Experiencing Homelessness—Measuring Effectiveness of

Housing and Services Strategies.

Applicants must:

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

1. The CoC created a robust methodology to measure strategies to increase resources for unaccompanied youth, including unsheltered youth, in response to the initiatives and programs created for the YHDP grant. This included a) a system evaluation of youth homelessness data sources including HMIS, schools, foster care, & juvenile justice. Results are described in the CoC's Coordinated Community Plan to Prevent & End Youth Homelessness. b) The CoC has implemented standard Universal Data Elements plus YHDP specific data elements in assessments in HMIS that seek to measure the USICH federal benchmarks and criteria to end youth homelessness. c) The CoC reports, strategizes and reviews YHDP benchmarks data at local leadership advisory meetings, task groups, housing work groups and data and evaluation committees in order to build a system capable of meeting the federal benchmarks and criteria.

2. In Oct. 2018, the CoC implemented an evaluation plan to monitor progress toward all USICH Benchmarks & Criteria for Youth Homelessness. This plan included participation in the USICH Benchmarks & Criteria pilot testing report functionality in partnership with Abt Associates to help YHDP communities track and reach functional zero. As part of this plan, The CoC a) analyzes the quantifiable needs of unaccompanied & unsheltered youth, b) analyzes the current availability of resources to meet the need, including utilization, c) implements a plan to meet unmet needs, including the specific interventions needed (diversion, shelter, RRH, PSH) & cost, d) analyzes the youth system inflow/outflow, reported monthly on A Way Home America's Dashboard, provides ongoing evaluation of strategy effectiveness, and e) measures the effectiveness of CoC funded projects through a quarterly scorecard, which will now include YHDP projects.

3. a) CoC's strategy aligns with best practices from federal partners such as HUD, USICH, NAEH, & CSH. b) The CoC receives technical assistance through YHDP, ensuring the appropriateness & effectiveness of strategies. c) Methods are rooted in USICH Benchmarks and Criteria for Youth Homelessness as the CoC is committed to ending youth homelessness by 2020. We use a modified version of our Coordinated Entry System's by-name list to identify those youth that are in need of services. Currently, LifeWorks is working to contact every youth on that by-name list to ensure that we are reaching all of those who are in need of services. We have also used proxy variables within HMIS to track progress towards the Benchmarks & Criteria through our learnings in participating in the USICH & Abt Associates pilot. We also use local data elements built out in HMIS to further track the progress of youth participating in our YHDP projects. We are also preparing to submit our APR reports for YHDP, allowing us to take a deeper dive into data quality in our projects.

3B-1e. Collaboration–Education Services.

Applicants must describe:

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

(limit 2,000 characters)

1. Formal Partnerships: a) The CoC has formal partnerships with youth education providers such as LifeWorks, Salvation Army, Austin Voices for Education and Youth; all providing services for youth education. These providers fully participate in the CoC and HMIS, with some as seated, voting members on the CoC Board and CoC planning workgroups. b) McKinney-Vento LEA/SEA: the CoC, has formal letters of agreements with Texas Homeless Education Office (THEO) and the Austin Independent School District (AISD) McKinney-Vento LEA/SEA for ending youth homelessness. Local family shelters have formal partnerships in which McKinney-Vento funding provides school aged children with resources. c) School districts: An AISD Trustee is a voting member on the CoC Board, AISD Project Help partners with LifeWorks for the ongoing planning and coordination involved with ending youth homelessness and is involved in leadership decisions related to the Action Plan to End Youth Homelessness.

2. CoC Collaboration: a) The CoC collaborates with youth education providers through leading and facilitating system initiatives aimed at ending youth homelessness. LifeWorks (largest youth provider) employs an Education Workforce Division which primarily focuses on connecting youth and families to education. Austin Voices for Education & Youth provide support services to students of AISD and participate in the CoC & HMIS. b) Representatives from THEO and AISD McKinney-Vento Homeless liaison coordinators are members of the YHDP Leadership Planning Committee. The CoC maintains contact and updates surrounding any changes that need to be implemented in CoC protocols and/or facilitating and distributing any new information or updates. c) Austin ISD and Del Valle ISD participate in the youth homelessness and family homelessness initiatives with the CoC; including leadership committees. An AISD Trustee is a voting member on the CoC Board.

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

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

The CoC has a system-wide Education Service Policy that ensures ongoing accountability across all funded programs serving families with children and youth. The Education Service Policy provides a comprehensive outline of specific program requirements and procedures agencies must adopt and implement to ensure all households are informed and understand their rights to educational services. All CoC providers are required to identify responsible staff person(s) to ensure successful connection and access to education services. The policy also provides updated links to Education Liaisons, suggested posters and printed materials to help inform program participants of their rights, and recommended steps for the grievance process. New CoC applications are evaluated based on demonstrated ability and plans to successfully make formal connections with education institutions through the use of MOUs, formal agreements and/or other contracts demonstrating formal partnerships. Both the Texas Education Office & AISD provided a letter of agreement with the CoC to participate in community planning to prevent & end youth homelessness. In addition to the requirements of the Education Service Policy, the evaluation of education status and needs is built into the Coordinated Entry assessment. Families and youth are informed of rights under McKinney-Vento and are assisted in making decisions about how to continue their education most effectively.

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

Applicant must indicate whether the CoC has an MOU/MOA or other types of agreements with listed providers of early childhood services and supports and may add other providers not listed.

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

3B-2. Active List of Veterans Experiencing Homelessness.

Applicant must indicate whether the CoC uses an active list or by-name list to identify all veterans experiencing homelessness in the CoC. Yes

3B-2a. VA Coordination–Ending Veterans Homelessness.

Applicants must indicate whether the CoC is Yes
actively working with the U.S. Department of
Veterans Affairs (VA) and VA-funded
programs to achieve the benchmarks and
criteria for ending veteran homelessness.

3B-2b. Housing First for Veterans.

Applicants must indicate whether the CoC No
has sufficient resources to ensure each
veteran experiencing homelessness is
assisted to quickly move into permanent
housing using a Housing First approach.

3B-3. Racial Disparity Assessment. Attachment Required.

Applicants must:

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

| | |
|--|-------------------------------------|
| 1. People of different races or ethnicities are more likely to receive homeless assistance. | <input checked="" type="checkbox"/> |
| 2. People of different races or ethnicities are less likely to receive homeless assistance. | <input checked="" type="checkbox"/> |
| 3. People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance. | <input checked="" type="checkbox"/> |
| 4. People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance. | <input checked="" type="checkbox"/> |
| 5. There are no racial or ethnic disparities in the provision or outcome of homeless assistance. | <input type="checkbox"/> |
| 6. The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance. | <input type="checkbox"/> |
| 7. The CoC did not conduct a racial disparity assessment. | <input type="checkbox"/> |

3B-3a. Addressing Racial Disparities.

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

| | |
|--|-------------------------------------|
| 1. The CoC is ensuring that staff at the project level are representative of the persons accessing homeless services in the CoC. | <input checked="" type="checkbox"/> |
| 2. The CoC has identified the cause(s) of racial disparities in their homeless system. | <input checked="" type="checkbox"/> |

| | |
|---|-------------------------------------|
| 3. The CoC has identified strategies to reduce disparities in their homeless system. | <input checked="" type="checkbox"/> |
| 4. The CoC has implemented strategies to reduce disparities in their homeless system. | <input checked="" type="checkbox"/> |
| 5. The CoC has identified resources available to reduce disparities in their homeless system. | <input checked="" type="checkbox"/> |
| 6: The CoC did not conduct a racial disparity assessment. | <input type="checkbox"/> |

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

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.

Please submit technical questions to the HUD Exchange Ask-A-Question at <https://www.hudexchange.info/program-support/my-question/>

Resources:

The FY 2019 CoC Application Detailed Instruction can be found at:

<https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources>

The FY 2019 CoC Program Competition Notice of Funding Availability at:

<https://www.hudexchange.info/programs/e-snaps/fy-2019-coc-program-nofa-coc-program-competition/#nofa-and-notices>

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

4A-1. Healthcare—Enrollment/Effective Utilization

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

| Type of Health Care | Assist with Enrollment | Assist with Utilization of Benefits? |
|--|------------------------|--------------------------------------|
| Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services) | Yes | Yes |
| Private Insurers: | No | No |
| Non-Profit, Philanthropic: | Yes | Yes |
| Other: (limit 50 characters) | | |
| | | |

4A-1a. Mainstream Benefits.

Applicants must:

1. describe how the CoC systematically keeps program staff up to date regarding mainstream resources available for program participants (e.g., Food Stamps, SSI, TANF, substance abuse programs) within the geographic area;
2. describe how the CoC disseminates the availability of mainstream resources and other assistance information to projects and how often;
3. describe how the CoC works with projects to collaborate with healthcare organizations to assist program participants with enrolling in

health insurance;

4. describe how the CoC provides assistance with the effective utilization of Medicaid and other benefits; and

**5. provide the name of the organization or position title that is responsible for overseeing the CoC's strategy for mainstream benefits.
(limit 2,000 characters)**

1. CoC keeps program staff up-to-date for community resources, including mainstream resources, through the following methods: a) CoC maintains online resource site AustinECHOListings.org, b) community meetings, c) community-tailored trainings and webinar trainings/recordings, d) an email listserv of over 1000 subscribers, and e) coordinates with online and telephonic resources 2-1-1 and AuntBertha.com.

2. The ECHO Listings website is available to all community staff & covers service descriptions, eligibility criteria, & application steps for various mainstream resources. Regular community meetings are held with staff from a variety of levels & agencies and are convened based on project type (e.g., RRH, PSH, or Navigation/Outreach) or subpopulation dedication.

3. CoC has worked to increase the success rate of clients receiving benefits by providing medical navigation. SOAR providers help facilitate the application process. The CoC Lead Agency employs the local SOAR Lead who is responsible for these initiatives and has monthly meetings with system medical outreach, clinic providers and leadership staff. Ongoing meetings and partnership with MCOs such as UnitedHealth Care who also provides staff for housing navigation services.

4. CoC works with MCO's to coordinate continuity of care and facilitate connections between participants to their assigned care coordinator. MCO can assist with project-based waiver enrollment, housing placements, and institutional admissions as needed. The CoC works to increase capacity for all health insurance enrollment options and programs, including Non-Medicaid/Medicare eligible insurance with HCH.

5. ECHO, the CoC Lead agency, employs the community's SOAR Lead who is responsible for increasing access and successful utilization of mainstream benefits and increasing community collaboration across medical providers, community medical services/outreach, SOAR specialists, and MCOs.

4A-2. Lowering Barriers to Entry Data:

Applicants must report:

| | |
|--|------|
| 1. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition. | 16 |
| 2. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing. | 16 |
| Percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects the CoC has ranked in its CoC Priority Listing in the FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing. | 100% |

4A-3. Street Outreach.

Applicants must:

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

1. The CoC partners with 11 different Street Outreach (SO) teams & 3 different Navigation centers through the Coordinated Entry System (CES) & all use a shared, open HMIS database. SO teams meet monthly at a CoC-wide coordination meeting to discuss coverage areas & frequency, emerging practices & concerns, & individual cases. Clients identified through these efforts are added to a community By Name List (BNL) for further engagement & housing.

2. SO covers 100% of the CoC's geographic area. One SO team is dedicated to the downtown area, & two outreach teams are dedicated to the suburban & rural areas. Other programs cover both areas, usually with a specific underserved target population, or a specific geographic area.

3. These combined SO teams conduct outreach daily, including weekends & evening hours. SO teams also partner with diverse community partners such as libraries, community centers, schools, clinics, hospitals, law enforcement, & the Local Mental Health Authority to identify additional households

4. Many SO teams are dedicated to hard-to-reach populations. CES materials are translated into Spanish, & the CoC employs assessors fluent in Spanish, Arabic, Hindi, & Nepali (and a language line). Outreach staff work closely with APD and other first responders when locating and identifying vulnerable persons who have not been connected to services. Outreach staff are trained and work closely with mental health providers and clinicians to ensure that they are competent in skills that quickly build rapport and trust. The SO teams can complete the CES assessment directly in the field using mobile technology, and they can request help from other SO teams if an area of high need is identified. Housing resources are prioritized based upon vulnerability, & the CoC has developed a CES system that uses SO teams to proactively document eligibility & keep households engaged while accessing services.

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

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

| | 2018 | 2019 | Difference |
|--|------|------|------------|
| RRH beds available to serve all populations in the HIC | 365 | 727 | 362 |

4A-5. Rehabilitation/Construction Costs–New Projects. No

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

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

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

4B. Attachments

Instructions:

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

| Document Type | Required? | Document Description | Date Attached |
|---|-----------|----------------------|---------------|
| FY 2019 CoC Competition Report (HDX Report) | Yes | FY 2019 CoC Compe... | 09/24/2019 |
| 1C-4.PHA Administration Plan–Moving On Multifamily Assisted Housing Owners' Preference. | No | Moving On Multifa... | 09/24/2019 |
| 1C-4. PHA Administrative Plan Homeless Preference. | No | PHA Administratio... | 09/24/2019 |
| 1C-7. Centralized or Coordinated Assessment System. | Yes | CE Assessment Tool | 09/24/2019 |
| 1E-1.Public Posting–15-Day Notification Outside e-snaps–Projects Accepted. | Yes | Projects Accepted... | 09/24/2019 |
| 1E-1. Public Posting–15-Day Notification Outside e-snaps–Projects Rejected or Reduced. | Yes | Project Rejected/... | 09/24/2019 |
| 1E-1.Public Posting–30-Day Local Competition Deadline. | Yes | Local Competition... | 09/24/2019 |
| 1E-1. Public Posting–Local Competition Announcement. | Yes | Local Competition... | 09/24/2019 |
| 1E-4.Public Posting–CoC-Approved Consolidated Application | Yes | | |
| 3A. Written Agreement with Local Education or Training Organization. | No | | |
| 3A. Written Agreement with State or Local Workforce Development Board. | No | | |
| 3B-3. Summary of Racial Disparity Assessment. | Yes | Racial Disparity ... | 09/24/2019 |
| 4A-7a. Project List-Homeless under Other Federal Statutes. | No | | |
| Other | No | | |
| Other | No | | |

| | | | |
|-------|----|--|--|
| Other | No | | |
|-------|----|--|--|

Attachment Details

Document Description: FY 2019 CoC Competition Report

Attachment Details

Document Description: Moving On Multifamily Preference

Attachment Details

Document Description: PHA Administration Plan Preference

Attachment Details

Document Description: CE Assessment Tool

Attachment Details

Document Description: Projects Accepted Notification

Attachment Details

Document Description: Project Rejected/Reduced Notification

Attachment Details

Document Description: Local Competition Deadline

Attachment Details

Document Description: Local Competition Public Announcement

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Racial Disparity Assessment Summary

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Submission Summary

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

| Page | Last Updated |
|---|-------------------|
| 1A. Identification | 09/19/2019 |
| 1B. Engagement | 09/24/2019 |
| 1C. Coordination | 09/24/2019 |
| 1D. Discharge Planning | No Input Required |
| 1E. Local CoC Competition | 09/23/2019 |
| 1F. DV Bonus | 09/24/2019 |
| 2A. HMIS Implementation | 09/24/2019 |
| 2B. PIT Count | 09/23/2019 |
| 3A. System Performance | 09/24/2019 |
| 3B. Performance and Strategic Planning | 09/24/2019 |
| 4A. Mainstream Benefits and Additional Policies | 09/24/2019 |
| 4B. Attachments | Please Complete |

| | | |
|------------------------|---------|------------|
| FY2019 CoC Application | Page 60 | 09/24/2019 |
|------------------------|---------|------------|

Submission Summary

No Input Required

2019 HDX Competition Report

PIT Count Data for TX-503 - Austin/Travis County CoC

Total Population PIT Count Data

| | 2016 PIT | 2017 PIT | 2018 PIT | 2019 PIT |
|---------------------------------------|----------|----------|----------|----------|
| Total Sheltered and Unsheltered Count | 2138 | 2036 | 2147 | 2255 |
| Emergency Shelter Total | 890 | 821 | 730 | 849 |
| Safe Haven Total | 16 | 11 | 15 | 13 |
| Transitional Housing Total | 416 | 370 | 388 | 307 |
| Total Sheltered Count | 1322 | 1202 | 1133 | 1169 |
| Total Unsheltered Count | 816 | 834 | 1014 | 1086 |

Chronically Homeless PIT Counts

| | 2016 PIT | 2017 PIT | 2018 PIT | 2019 PIT |
|---|----------|----------|----------|----------|
| Total Sheltered and Unsheltered Count of Chronically Homeless Persons | 742 | 553 | 498 | 602 |
| Sheltered Count of Chronically Homeless Persons | 173 | 183 | 173 | 198 |
| Unsheltered Count of Chronically Homeless Persons | 569 | 370 | 325 | 404 |

2019 HDX Competition Report

PIT Count Data for TX-503 - Austin/Travis County CoC

Homeless Households with Children PIT Counts

| | 2016 PIT | 2017 PIT | 2018 PIT | 2019 PIT |
|--|----------|----------|----------|----------|
| Total Sheltered and Unsheltered Count of the Number of Homeless Households with Children | 182 | 171 | 159 | 160 |
| Sheltered Count of Homeless Households with Children | 179 | 170 | 157 | 157 |
| Unsheltered Count of Homeless Households with Children | 3 | 1 | 2 | 3 |

Homeless Veteran PIT Counts

| | 2011 | 2016 | 2017 | 2018 | 2019 |
|--|------|------|------|------|------|
| Total Sheltered and Unsheltered Count of the Number of Homeless Veterans | 515 | 257 | 169 | 170 | 144 |
| Sheltered Count of Homeless Veterans | 293 | 150 | 102 | 102 | 107 |
| Unsheltered Count of Homeless Veterans | 222 | 107 | 67 | 68 | 37 |

2019 HDX Competition Report

HIC Data for TX-503 - Austin/Travis County CoC

HMIS Bed Coverage Rate

| Project Type | Total Beds in 2019 HIC | Total Beds in 2019 HIC Dedicated for DV | Total Beds in HMIS | HMIS Bed Coverage Rate |
|---|------------------------|---|--------------------|------------------------|
| Emergency Shelter (ES) Beds | 867 | 106 | 761 | 100.00% |
| Safe Haven (SH) Beds | 15 | 0 | 15 | 100.00% |
| Transitional Housing (TH) Beds | 317 | 133 | 184 | 100.00% |
| Rapid Re-Housing (RRH) Beds | 727 | 115 | 612 | 100.00% |
| Permanent Supportive Housing (PSH) Beds | 1083 | 16 | 1067 | 100.00% |
| Other Permanent Housing (OPH) Beds | 190 | 0 | 190 | 100.00% |
| Total Beds | 3,199 | 370 | 2829 | 100.00% |

2019 HDX Competition Report

HIC Data for TX-503 - Austin/Travis County CoC

PSH Beds Dedicated to Persons Experiencing Chronic Homelessness

| Chronically Homeless Bed Counts | 2016 HIC | 2017 HIC | 2018 HIC | 2019 HIC |
|---|----------|----------|----------|----------|
| Number of CoC Program and non-CoC Program funded PSH beds dedicated for use by chronically homeless persons identified on the HIC | 296 | 819 | 956 | 1018 |

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

| Households with Children | 2016 HIC | 2017 HIC | 2018 HIC | 2019 HIC |
|--|----------|----------|----------|----------|
| RRH units available to serve families on the HIC | 28 | 15 | 57 | 133 |

Rapid Rehousing Beds Dedicated to All Persons

| All Household Types | 2016 HIC | 2017 HIC | 2018 HIC | 2019 HIC |
|--|----------|----------|----------|----------|
| RRH beds available to serve all populations on the HIC | 201 | 254 | 365 | 727 |

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

Summary Report for TX-503 - Austin/Travis County CoC

Measure 1: Length of Time Persons Remain Homeless

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

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

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

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

| | Universe (Persons) | | Average LOT Homeless (bed nights) | | | Median LOT Homeless (bed nights) | | |
|-------------------------------|-----------------------|---------|--------------------------------------|---------|------------|-------------------------------------|---------|------------|
| | Submitted FY 2017 | FY 2018 | Submitted FY 2017 | FY 2018 | Difference | Submitted FY 2017 | FY 2018 | Difference |
| 1.1 Persons in ES and SH | 4239 | 4180 | 72 | 70 | -2 | 37 | 35 | -2 |
| 1.2 Persons in ES, SH, and TH | 4410 | 4331 | 90 | 86 | -4 | 44 | 39 | -5 |

b. This measure is based on data element 3.17.

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

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

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

| | Universe (Persons) | | Average LOT Homeless (bed nights) | | | Median LOT Homeless (bed nights) | | |
|--|-----------------------|---------|--------------------------------------|---------|------------|-------------------------------------|---------|------------|
| | Submitted FY 2017 | FY 2018 | Submitted FY 2017 | FY 2018 | Difference | Submitted FY 2017 | FY 2018 | Difference |
| 1.1 Persons in ES, SH, and PH (prior to "housing move in") | 4178 | 4343 | 346 | 406 | 60 | 124 | 136 | 12 |
| 1.2 Persons in ES, SH, TH, and PH (prior to "housing move in") | 4406 | 4563 | 362 | 421 | 59 | 144 | 153 | 9 |

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

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

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

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

| | Total # of Persons who Exited to a Permanent Housing Destination (2 Years Prior) | Returns to Homelessness in Less than 6 Months | | Returns to Homelessness from 6 to 12 Months | | Returns to Homelessness from 13 to 24 Months | | Number of Returns in 2 Years | |
|-------------------------------|--|---|--------------|---|--------------|--|--------------|------------------------------|--------------|
| | | FY 2018 | % of Returns | FY 2018 | % of Returns | FY 2018 | % of Returns | FY 2018 | % of Returns |
| Exit was from SO | 8 | 3 | 38% | 0 | 0% | 0 | 0% | 3 | 38% |
| Exit was from ES | 555 | 54 | 10% | 27 | 5% | 29 | 5% | 110 | 20% |
| Exit was from TH | 180 | 12 | 7% | 7 | 4% | 11 | 6% | 30 | 17% |
| Exit was from SH | 35 | 3 | 9% | 2 | 6% | 5 | 14% | 10 | 29% |
| Exit was from PH | 773 | 51 | 7% | 41 | 5% | 52 | 7% | 144 | 19% |
| TOTAL Returns to Homelessness | 1551 | 123 | 8% | 77 | 5% | 97 | 6% | 297 | 19% |

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

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

| | January 2017 PIT Count | January 2018 PIT Count | Difference |
|--|---------------------------|---------------------------|------------|
| Universe: Total PIT Count of sheltered and unsheltered persons | 2036 | 2147 | 111 |
| Emergency Shelter Total | 821 | 730 | -91 |
| Safe Haven Total | 11 | 15 | 4 |
| Transitional Housing Total | 370 | 388 | 18 |
| Total Sheltered Count | 1202 | 1133 | -69 |
| Unsheltered Count | 834 | 1014 | 180 |

Metric 3.2 – Change in Annual Counts

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

| | Submitted FY 2017 | FY 2018 | Difference |
|---|----------------------|---------|------------|
| Universe: Unduplicated Total sheltered homeless persons | 4491 | 4565 | 74 |
| Emergency Shelter Total | 4231 | 4259 | 28 |
| Safe Haven Total | 66 | 71 | 5 |
| Transitional Housing Total | 381 | 335 | -46 |

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

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

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

| | Submitted FY 2017 | FY 2018 | Difference |
|--|----------------------|---------|------------|
| Universe: Number of adults (system stayers) | 297 | 346 | 49 |
| Number of adults with increased earned income | 12 | 31 | 19 |
| Percentage of adults who increased earned income | 4% | 9% | 5% |

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

| | Submitted FY 2017 | FY 2018 | Difference |
|---|----------------------|---------|------------|
| Universe: Number of adults (system stayers) | 297 | 346 | 49 |
| Number of adults with increased non-employment cash income | 105 | 161 | 56 |
| Percentage of adults who increased non-employment cash income | 35% | 47% | 12% |

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

| | Submitted FY 2017 | FY 2018 | Difference |
|---|----------------------|---------|------------|
| Universe: Number of adults (system stayers) | 297 | 346 | 49 |
| Number of adults with increased total income | 114 | 184 | 70 |
| Percentage of adults who increased total income | 38% | 53% | 15% |

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

Metric 4.4 – Change in earned income for adult system leavers

| | Submitted FY 2017 | FY 2018 | Difference |
|--|----------------------|---------|------------|
| Universe: Number of adults who exited (system leavers) | 74 | 70 | -4 |
| Number of adults who exited with increased earned income | 9 | 6 | -3 |
| Percentage of adults who increased earned income | 12% | 9% | -3% |

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

| | Submitted FY 2017 | FY 2018 | Difference |
|---|----------------------|---------|------------|
| Universe: Number of adults who exited (system leavers) | 74 | 70 | -4 |
| Number of adults who exited with increased non-employment cash income | 40 | 40 | 0 |
| Percentage of adults who increased non-employment cash income | 54% | 57% | 3% |

Metric 4.6 – Change in total income for adult system leavers

| | Submitted FY 2017 | FY 2018 | Difference |
|---|----------------------|---------|------------|
| Universe: Number of adults who exited (system leavers) | 74 | 70 | -4 |
| Number of adults who exited with increased total income | 46 | 44 | -2 |
| Percentage of adults who increased total income | 62% | 63% | 1% |

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

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

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

| | Submitted FY 2017 | FY 2018 | Difference |
|---|----------------------|---------|------------|
| Universe: Person with entries into ES, SH or TH during the reporting period. | 4099 | 4103 | 4 |
| Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year. | 1375 | 1220 | -155 |
| Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time) | 2724 | 2883 | 159 |

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

| | Submitted FY 2017 | FY 2018 | Difference |
|--|----------------------|---------|------------|
| Universe: Person with entries into ES, SH, TH or PH during the reporting period. | 4634 | 4810 | 176 |
| Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year. | 1595 | 1471 | -124 |
| Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.) | 3039 | 3339 | 300 |

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

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

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

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

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

| | Submitted FY 2017 | FY 2018 | Difference |
|---|----------------------|---------|------------|
| Universe: Persons who exit Street Outreach | 231 | 736 | 505 |
| Of persons above, those who exited to temporary & some institutional destinations | 3 | 28 | 25 |
| Of the persons above, those who exited to permanent housing destinations | 7 | 73 | 66 |
| % Successful exits | 4% | 14% | 10% |

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

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

| | Submitted FY 2017 | FY 2018 | Difference |
|---|----------------------|---------|------------|
| Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing | 3943 | 3873 | -70 |
| Of the persons above, those who exited to permanent housing destinations | 1066 | 1129 | 63 |
| % Successful exits | 27% | 29% | 2% |

Metric 7b.2 – Change in exit to or retention of permanent housing

| | Submitted FY 2017 | FY 2018 | Difference |
|---|----------------------|---------|------------|
| Universe: Persons in all PH projects except PH-RRH | 1417 | 1377 | -40 |
| Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations | 1329 | 1331 | 2 |
| % Successful exits/retention | 94% | 97% | 3% |

2019 HDX Competition Report

FY2018 - SysPM Data Quality

TX-503 - Austin/Travis County CoC

This is a new tab for FY 2016 submissions only. Submission must be performed manually (data cannot be uploaded). Data coverage and quality will allow HUD to better interpret your Sys PM submissions.

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

You may enter a note about any field if you wish to provide an explanation about your data quality results. This is not required.

2019 HDX Competition Report

FY2018 - SysPM Data Quality

| | All ES, SH | | | | All TH | | | | All PSH, OPH | | | | All RRH | | | | All Street Outreach | | | |
|--|------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|--------------|-----------|-----------|-----------|-----------|-----------|-----------|-----------|---------------------|-----------|-----------|-----------|
| | 2014-2015 | 2015-2016 | 2016-2017 | 2017-2018 | 2014-2015 | 2015-2016 | 2016-2017 | 2017-2018 | 2014-2015 | 2015-2016 | 2016-2017 | 2017-2018 | 2014-2015 | 2015-2016 | 2016-2017 | 2017-2018 | 2014-2015 | 2015-2016 | 2016-2017 | 2017-2018 |
| 1. Number of non-DV Beds on HIC | 697 | 759 | 743 | 694 | 211 | 242 | 327 | 168 | 1116 | 1334 | 1283 | 1265 | 70 | 153 | 254 | 365 | | | | |
| 2. Number of HMIS Beds | 697 | 759 | 743 | 694 | 211 | 210 | 327 | 168 | 687 | 1168 | 1283 | 1265 | 70 | 153 | 254 | 365 | | | | |
| 3. HMIS Participation Rate from HIC (%) | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 86.78 | 100.00 | 100.00 | 61.56 | 87.56 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | 100.00 | | | | |
| 4. Unduplicated Persons Served (HMIS) | 4590 | 4625 | 4067 | 4212 | 449 | 459 | 384 | 341 | 1318 | 1483 | 1530 | 1566 | 1473 | 1632 | 1575 | 1590 | 1 | 85 | 143 | 1480 |
| 5. Total Leavers (HMIS) | 3840 | 3947 | 3366 | 3699 | 242 | 244 | 174 | 234 | 165 | 237 | 290 | 237 | 982 | 1005 | 926 | 854 | 0 | 10 | 14 | 455 |
| 6. Destination of Don't Know, Refused, or Missing (HMIS) | 2665 | 2456 | 2130 | 2024 | 23 | 16 | 17 | 15 | 27 | 50 | 29 | 25 | 108 | 70 | 64 | 35 | 0 | 3 | 5 | 187 |
| 7. Destination Error Rate (%) | 69.40 | 62.22 | 63.28 | 54.72 | 9.50 | 6.56 | 9.77 | 6.41 | 16.36 | 21.10 | 10.00 | 10.55 | 11.00 | 6.97 | 6.91 | 4.10 | | 30.00 | 35.71 | 41.10 |

2019 HDX Competition Report

Submission and Count Dates for TX-503 - Austin/Travis County CoC

Date of PIT Count

| | Date | Received HUD Waiver |
|-----------------------------------|-----------|---------------------|
| Date CoC Conducted 2019 PIT Count | 1/25/2019 | |

Report Submission Date in HDX

| | Submitted On | Met Deadline |
|-------------------------------|--------------|--------------|
| 2019 PIT Count Submittal Date | 4/30/2019 | Yes |
| 2019 HIC Count Submittal Date | 4/30/2019 | Yes |
| 2018 System PM Submittal Date | 5/30/2019 | Yes |



HOUSING CHOICE VOUCHER PROGRAM

ADMINISTRATIVE PLAN

February 15, 2018

near the end of the HAP contract term.

Targeted Funding [24 CFR 982.204(e)]

HUD may award HACA funding for a specified category of families on the waiting list. HACA must use this funding only to assist the families within the specified category. In order to assist families within a targeted funding category, HACA may skip families that do not qualify within the targeted funding category. Within this category of families, the order in which such families are assisted is determined according to the policies provided in Section 4-III.C.

HACA Policy

HACA administers the following types of targeted funding:

Mainstream Vouchers for Persons with Disabilities

VASH – Veterans Affairs for Supportive Housing

Family Unification Program

Non-elderly Disabled

Order of Selection – specified category vouchers

When HACA resumes voucher issuance after a funding shortfall, HACA will first issue vouchers to specified category vouchers until HACA is assisting the required number of special purpose families.

Regular HCV Funding

Regular HCV funding may be used to assist any eligible family on the waiting list. Families are selected from the waiting list according to the policies provided in Section 4-III.C.

4-III.C. SELECTION METHOD

PHAs must describe the method for selecting applicant families from the waiting list, including the system of admission preferences that HACA will use [24 CFR 982.202(d)].

Local Preferences [24 CFR 982.207; HCV p. 4-16]

PHAs are permitted to establish local preferences, and to give priority to serving families that meet those criteria. HUD specifically authorizes and places restrictions on certain types of local preferences. HUD also permits HACA to establish other local preferences, at its discretion. Any local preferences established must be consistent with HACA plan and the consolidated plan, and must be based on local housing needs and priorities that can be documented by generally accepted data sources.

HACA Policy

Families can claim eligibility for any local preference any time from the date they applied up until the time their name is drawn off the waiting list. Preference claims will be verified once they have been drawn off the waiting list during the interview process. If HACA is unable to verify a preference claim, the family will be placed back on the

waiting list without the preference.

HACA will open the waiting list or leave the waiting list open for certain preference groups as needed to meet the preference caps listed below.

1. Non-specified category vouchers will use the following local preferences for purposes of establishing priority. The local preferences are weighted differently, with the higher number representing a higher ranking. Each applicant family can be granted a maximum of one local preference plus the residency preference (if they qualify).

Weights for each preference are as follows:

| | |
|------------------------------|-----|
| Elderly | = 2 |
| Disabled | = 2 |
| Involuntarily Displaced | = 2 |
| Homeless | = 3 |
| Families with Minor Children | = 2 |
| Residency | = 1 |
| RAD Choice Mobility | = 3 |
| PH Special Accommodation | = 3 |
| FUP Youth | = 3 |
| RAD Relocation | = 4 |
| HACA VAWA Emergency | = 5 |

- (A) **Elderly Preference:** HACA will give preference to elderly families. An elderly family is a family in which the head, spouse or co-head is age 62 or older.
- (B) **Disabled Preference:** HACA will give preference to disabled families. A disabled family is a family in which the head, spouse or co-head is disabled using the current HUD definition of disability.
- (C) **Involuntary Displacement Preference:** HACA will give preference to families displaced as a result of natural disaster or government action. The following documentation will be used to verify displacement status:

Certification from a unit of government concerning displacement due to natural disaster; or

Certification from a unit of government concerning displacement due to code enforcement or public improvement/development or displacement by inaccessibility of a unit.

The displacement must have occurred within six months of requesting the involuntary displacement preference. Also, HACA will offer a preference to any family that has been terminated from its HCV program due to insufficient program funding.

- (D) **Homeless Preference:** HACA will give preference to homeless applicants. Each fiscal year HACA will give a preference to no more than 100 applicants or 25% of all applicants drawn (whichever is less) meeting all of the following criteria:

- a) Meet the HUD definition of homeless. See definitions section at the end of the Administrative Plan.
- b) Are referred to HACA by a coalition of homeless service providers with whom HACA has executed a Memorandum of Understanding (MOU) outlining the provider's responsibilities with respect to the provision of housing search assistance and supportive services for the referred household.
- c) Have received a written commitment from the referring homeless service provider for housing search / location assistance.
- d) Have received a written commitment from the homeless service provider to offer support services on an as needed basis to help the household transition from homelessness to permanent housing; and
- e) Have received a written commitment from the homeless service provider to offer supportive services to help the household maintain housing and comply with HCV rules.

While a referral from the coalition of homeless service providers is required for this preference, use of the offered supportive services is not a requirement. The choice of the applicant to refuse the offered services will not jeopardize any housing assistance for which they are eligible.

HACA will execute a Memorandum of Understanding with one entity representing a coalition of homeless service providers that will serve as the primary point of contact for communicating homeless referrals to HACA. HACA reserves the right to establish additional MOUs as necessary to ensure that homeless applicants have the opportunity to apply for housing assistance under this preference.

If it is determined that an applicant referred by a homeless service provider, as described above, does not meet the criteria described therein, the applicant will not receive the preference and:

if the applicant was only on the HCV waiting list because of the homeless referral, the applicant will be removed from the HCV waiting list

if the applicant was on the HCV waiting list through the regular application process, the applicant will return to their lottery position on the waiting list without the homeless preference.

If HACA denies an applicant's homeless preference claim, HACA will notify the applicant and referring service provider in writing, including the reason(s) for the preference denial. Applicants have the right to appeal the denial of eligibility for the homeless preference using the established process for informal hearings.

Persons transitioning out of the City of Austin's 1115 Waiver Permanent Supportive Housing Assertive Community Treatment Team program into permanent housing will be included as a priority group as part of this preference. This would require a referral from the current case manager as well as documentation that the family was homeless prior to entering into the current

program. This documentation must be provided as part of the referral.

Individuals and families transitioning, or "moving up," from Permanent Supportive Housing (PSH) units will also be included as a priority group as part of this homeless preference. These are persons that were previously homeless prior to entry into a PSH program but who no longer require that level of supportive services. Referrals could also include individuals and families participating in a Continuum of Care homeless rental assistance program, which is not renewed. This would require a referral from the current case manager or PSH provider as well as documentation that the family was homeless prior to entering into the PSH unit. This documentation must be provided as part of the referral.

- (E) **Families with Minor Children Preference:** HACA will give preference to families with minor children. A minor child is a child under age 18 who meets HUD and HACA's definition of a family member (See Section 3.I.B for the definition of Family Members).

Minor children of a live in aide do not qualify the family for this preference.

Minor children that are foster children of an authorized adult member of the assisted family do not qualify the family for this preference.

- (F) **Residency Preference:** HACA will give preference to persons who reside in the following Texas Counties: Travis, Hays, Bastrop, Caldwell and Williamson counties. The residency status will be determined at the time of the eligibility interview. This preference will not have the purpose or effect of delaying or otherwise denying admission to the program based on the race, color, ethnic origin, gender, sexual orientation, religion, disability, or age of any member of an applicant family.

Applicants who are working or who have been notified that they are hired to work in a residency preference area will be treated as residents of the residency preference area with documented proof of employment in the residency preference area. Applicants who are graduates of, or active participants in, education and training programs in a residency preference area are eligible for this preference if the education or training program is designed to prepare individuals for the job market.

- (G) **Rental Assistance Demonstration (RAD) Choice Mobility Preference:** As required by HUD and in accordance with all HUD RAD guidelines, if HACA participates in RAD, HACA will provide a Choice-Mobility option to residents of covered RAD projects in accordance with policies outlined in Chapter 18 of this HCV Administrative Plan.

- (H) **Public Housing Special Accommodation Preference:** HACA will give

Chapter 1

OVERVIEW OF THE PROGRAM AND PLAN

INTRODUCTION

The Housing Authority of Travis County (HATC) receives its funding for the Housing Choice Voucher (HCV) program from the Department of Housing and Urban Development. HATC is not a federal department or agency. A public housing agency (HATC) is a governmental or public body, created and authorized by state law to develop and operate housing and housing programs for low-income families. HATC enters into an Annual Contributions Contract with HUD to administer the program requirements on behalf of HUD. HATC must ensure compliance with federal laws, regulations and notices and must establish policy and procedures to clarify federal requirements and to ensure consistency in program operation.

This chapter contains information about HATC and its programs with emphasis on the HCV program and its various available programs. It also contains information about the purpose, intent and use of the plan and guide.

There are three parts to this chapter:

Part I: The Housing Authority of Travis County (HATC). This part includes a description of HATC, its jurisdiction, its programs, and its mission and intent.

Part II: The HCV Program. This part contains information about the Housing Choice Voucher program operation, roles and responsibilities, and partnerships.

Part III: The HCV Administrative Plan. This part discusses the purpose and organization of the plan and its revision requirements.

HATC administers the following types of targeted funding:

1. Veterans Affairs Supportive Housing (VASH)
 - o **Veterans Affairs Supportive Housing (VASH):** HATC accepts VASH applicants as referrals in the order received from the Veterans Affairs administration for the designated number of vouchers awarded by HUD.
2. Non Elderly Disabled (NED)
3. Rental Assistance Demonstration Program- Project Based Rental Assistance

Regular HCV Funding

Regular HCV funding may be used to assist any eligible family on the waiting list. Families are selected from the waiting list according to the policies provided in Section 4-III.C.

4-III.C. SELECTION METHOD

PHAs must describe the method for selecting applicant families from the waiting list, including the system of admission preferences that HATC will use [24 CFR 982.202(d)].

Per calendar year, applicant families will be selected according to random lottery number assigned from waiting list application, targeted funding, and/ or preference as described below:

- 25% of all new housing choice voucher admissions will be allocated to a homeless applicant referred by a community agency with an existing HATC Memorandum of Understanding and;
- 1/3 of HATC's turnover vouchers will be available to families exercising Choice Mobility from any of its 3 covered projects transitioning into PBRA through the Rental Assistance Demonstration (RAD). HATC will establish an agency-wide Choice Mobility waiting list for times when there are more requests for vouchers than vouchers available due to the cap.

Local Preferences [24 CFR 982.207; HCV p. 4-16]

PHAs are permitted to establish local preferences, and to give priority to serving families that meet those criteria. HUD specifically authorizes and places restrictions on certain types of local preferences. HUD also permits HATC to establish other local preferences, at its discretion. Any local preferences established must be consistent HATC plan and the consolidated plan, and must be based on local housing needs and priorities that can be documented by generally accepted data sources.

HATC POLICY

HATC will use the following preference system:

Homeless Preference:

Community agencies submitting referrals for this preference must meet the following criteria:

- a) Meet the HUD definition of Homeless;

- b) Are referred to HATC by a coalition of homeless providers with whom HATC has executed a Memorandum of Understanding (MOU) outlining the providers roles and responsibilities with respect to the provision of housing search assistance and supportive services for the referred household;
- c) Have received a written commitment from the referring homeless service provider for housing search and location assistance;
- d) Have received documentation from the referring homeless service provider regarding homeless status eligibility prior to providing housing assistance;
- e) Have received a written commitment from the homeless service provider to offer support services on an as needed basis to help the household transition from homelessness to permanent housing; and
- f) Have received written commitment from the homeless service provider to offer supportive services to help the household maintain housing and comply with HCV regulations.

While a referral from the coalition of homeless service providers is required for this preference, use of the offered supportive services is not a requirement. The choice of the applicant to refuse the offered services will not jeopardize any housing assistance for which they are eligible.

HATC will execute an MOU as necessary to ensure that homeless applicants have the opportunity to apply for housing assistance under this preference.

Individuals and families transitioning from Permanent Supportive Housing (PSH) through the Continuum of Care awarded grant, will also be included as a priority group as part of this preference. These are the persons that were previously homeless prior to entry into a PSH program but who no longer require that level of supportive services. This would require a referral from the current case manager or PSH provider as well as documentation that the family was homeless prior to entering the PSH unit. This documentation must be provided as part of the referral.

Applicants interested in project based units may apply directly to the project(s). Families who applied directly will be referred by the project to HATC and be placed on the HATC PBV site-specific waiting lists if the waiting list is open.

HATC may limit the number of vouchers issued for each preference group as needed.

Proof of preference(s) will be required at the time of selection from waiting list in order to be provided assistance.

HATC will open the waiting list or leave the waiting list open for certain preference or targeted funding groups as needed to meet the preference caps outlined in this administrative plan.

HATC maintains 4 waiting lists for admission into the Housing Choice Voucher Program:

1. **Tenant-Based Voucher (TBV):** waiting list is established for applicants, if determined eligible, to be issued vouchers. The TBV waiting list will be maintained until expiration or exhaustion, and a new list is established.
2. **Project-Based Voucher (PBV):** waiting list for applicants, if determined eligible, to be

Section 8 Administrative Plan

placed in designated project-based units approved by HATC. The PBV waiting list will open and close based upon the need for an applicant pool based on project preferences. Referrals from the project will be accepted.

3. **Rental Assistance Demonstration (RAD) Choice Mobility Preference:** As required by HUD and in accordance with all HUD RAD guidelines, HATC will provide a Choice-Mobility option to residents of covered RAD projects in accordance with policies outlined in Chapter 18 of this HCV Administrative Plan.
4. **Homeless Housing Choice Vouchers** – Referrals from community agencies will be placed on the homeless applicant waiting list and be offered a voucher according to selection method outlined above.

If it is determined that an applicant referred by a homeless service provider or an applicant who has applied for targeted funding, as described above, does not meet the criteria, the applicant will not be placed on the waiting list.

If the applicant was only on the HCV waiting list because of the homeless referral/ target funding, the applicant will be removed from the HCV waiting list or; if the applicant was on the HCV waiting list through the regular application process, the applicant will return to their lottery position on the waiting list without the preference.

If HATC denies an application, HATC will notify the applicant and referring service provider in writing, including the reason(s) for the denial. Applicants have the right to appeal the denial of eligibility using the established process for informal reviews.

Income Targeting Requirement [24 CFR 982.201(b) (2)]

HUD requires that extremely low-income (ELI) families make up at least 75% of the families admitted to the HCV program during HATC's fiscal year. ELI families are those with annual incomes at or below 30% of the area median income. To ensure this requirement is met, HATC may skip non-ELI families on the waiting list in order to select an ELI family.

Low income families admitted to the program that are "continuously assisted" under the 1937 Housing Act [24 CFR 982.4(b)], as well as low-income or moderate-income families admitted to the program that are displaced as a result of the prepayment of the mortgage or voluntary termination of an insurance contract on eligible low-income housing, are not counted for income targeting purposes [24 CFR 982.201(b) (2) (v)].

HATC POLICY

HATC will monitor progress in meeting the ELI requirement throughout the fiscal year. Extremely low-income families will be selected ahead of other eligible families on an as-needed basis to ensure the income-targeting requirement is met.

Order of Selection

HATC system of preferences may select families either according to the date and time of application, or by a random selection process [24 CFR 982.207(c)]. When selecting families from the waiting list the PHAs are required to use targeted funding to assist only those families who meet the specified criteria, and PHAs are not permitted to skip down the waiting list to a family that it can afford to



HOUSING CHOICE VOUCHER PROGRAM

ADMINISTRATIVE PLAN

February 15, 2018

near the end of the HAP contract term.

Targeted Funding [24 CFR 982.204(e)]

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HACA Policy

Families can claim eligibility for any local preference any time from the date they applied up until the time their name is drawn off the waiting list. Preference claims will be verified once they have been drawn off the waiting list during the interview process. If HACA is unable to verify a preference claim, the family will be placed back on the

waiting list without the preference.

HACA will open the waiting list or leave the waiting list open for certain preference groups as needed to meet the preference caps listed below.

1. Non-specified category vouchers will use the following local preferences for purposes of establishing priority. The local preferences are weighted differently, with the higher number representing a higher ranking. Each applicant family can be granted a maximum of one local preference plus the residency preference (if they qualify).

Weights for each preference are as follows:

| | |
|------------------------------|-----|
| Elderly | = 2 |
| Disabled | = 2 |
| Involuntarily Displaced | = 2 |
| Homeless | = 3 |
| Families with Minor Children | = 2 |
| Residency | = 1 |
| RAD Choice Mobility | = 3 |
| PH Special Accommodation | = 3 |
| FUP Youth | = 3 |
| RAD Relocation | = 4 |
| HACA VAWA Emergency | = 5 |

- (A) **Elderly Preference:** HACA will give preference to elderly families. An elderly family is a family in which the head, spouse or co-head is age 62 or older.
- (B) **Disabled Preference:** HACA will give preference to disabled families. A disabled family is a family in which the head, spouse or co-head is disabled using the current HUD definition of disability.
- (C) **Involuntary Displacement Preference:** HACA will give preference to families displaced as a result of natural disaster or government action. The following documentation will be used to verify displacement status:

Certification from a unit of government concerning displacement due to natural disaster; or

Certification from a unit of government concerning displacement due to code enforcement or public improvement/development or displacement by inaccessibility of a unit.

The displacement must have occurred within six months of requesting the involuntary displacement preference. Also, HACA will offer a preference to any family that has been terminated from its HCV program due to insufficient program funding.

- (D) **Homeless Preference:** HACA will give preference to homeless applicants. Each fiscal year HACA will give a preference to no more than 100 applicants or 25% of all applicants drawn (whichever is less) meeting all of the following criteria:

- a) Meet the HUD definition of homeless. See definitions section at the end of the Administrative Plan.
- b) Are referred to HACA by a coalition of homeless service providers with whom HACA has executed a Memorandum of Understanding (MOU) outlining the provider's responsibilities with respect to the provision of housing search assistance and supportive services for the referred household.
- c) Have received a written commitment from the referring homeless service provider for housing search / location assistance.
- d) Have received a written commitment from the homeless service provider to offer support services on an as needed basis to help the household transition from homelessness to permanent housing; and
- e) Have received a written commitment from the homeless service provider to offer supportive services to help the household maintain housing and comply with HCV rules.

While a referral from the coalition of homeless service providers is required for this preference, use of the offered supportive services is not a requirement. The choice of the applicant to refuse the offered services will not jeopardize any housing assistance for which they are eligible.

HACA will execute a Memorandum of Understanding with one entity representing a coalition of homeless service providers that will serve as the primary point of contact for communicating homeless referrals to HACA. HACA reserves the right to establish additional MOUs as necessary to ensure that homeless applicants have the opportunity to apply for housing assistance under this preference.

If it is determined that an applicant referred by a homeless service provider, as described above, does not meet the criteria described therein, the applicant will not receive the preference and:

if the applicant was only on the HCV waiting list because of the homeless referral, the applicant will be removed from the HCV waiting list

if the applicant was on the HCV waiting list through the regular application process, the applicant will return to their lottery position on the waiting list without the homeless preference.

If HACA denies an applicant's homeless preference claim, HACA will notify the applicant and referring service provider in writing, including the reason(s) for the preference denial. Applicants have the right to appeal the denial of eligibility for the homeless preference using the established process for informal hearings.

Persons transitioning out of the City of Austin's 1115 Waiver Permanent Supportive Housing Assertive Community Treatment Team program into permanent housing will be included as a priority group as part of this preference. This would require a referral from the current case manager as well as documentation that the family was homeless prior to entering into the current

program. This documentation must be provided as part of the referral.

Individuals and families transitioning, or "moving up," from Permanent Supportive Housing (PSH) units will also be included as a priority group as part of this homeless preference. These are persons that were previously homeless prior to entry into a PSH program but who no longer require that level of supportive services. Referrals could also include individuals and families participating in a Continuum of Care homeless rental assistance program, which is not renewed. This would require a referral from the current case manager or PSH provider as well as documentation that the family was homeless prior to entering into the PSH unit. This documentation must be provided as part of the referral.

- (E) **Families with Minor Children Preference:** HACA will give preference to families with minor children. A minor child is a child under age 18 who meets HUD and HACA's definition of a family member (See Section 3.I.B for the definition of Family Members).

Minor children of a live in aide do not qualify the family for this preference.

Minor children that are foster children of an authorized adult member of the assisted family do not qualify the family for this preference.

- (F) **Residency Preference:** HACA will give preference to persons who reside in the following Texas Counties: Travis, Hays, Bastrop, Caldwell and Williamson counties. The residency status will be determined at the time of the eligibility interview. This preference will not have the purpose or effect of delaying or otherwise denying admission to the program based on the race, color, ethnic origin, gender, sexual orientation, religion, disability, or age of any member of an applicant family.

Applicants who are working or who have been notified that they are hired to work in a residency preference area will be treated as residents of the residency preference area with documented proof of employment in the residency preference area. Applicants who are graduates of, or active participants in, education and training programs in a residency preference area are eligible for this preference if the education or training program is designed to prepare individuals for the job market.

- (G) **Rental Assistance Demonstration (RAD) Choice Mobility Preference:** As required by HUD and in accordance with all HUD RAD guidelines, if HACA participates in RAD, HACA will provide a Choice-Mobility option to residents of covered RAD projects in accordance with policies outlined in Chapter 18 of this HCV Administrative Plan.

- (H) **Public Housing Special Accommodation Preference:** HACA will give

Chapter 1

OVERVIEW OF THE PROGRAM AND PLAN

INTRODUCTION

The Housing Authority of Travis County (HATC) receives its funding for the Housing Choice Voucher (HCV) program from the Department of Housing and Urban Development. HATC is not a federal department or agency. A public housing agency (HATC) is a governmental or public body, created and authorized by state law to develop and operate housing and housing programs for low-income families. HATC enters into an Annual Contributions Contract with HUD to administer the program requirements on behalf of HUD. HATC must ensure compliance with federal laws, regulations and notices and must establish policy and procedures to clarify federal requirements and to ensure consistency in program operation.

This chapter contains information about HATC and its programs with emphasis on the HCV program and its various available programs. It also contains information about the purpose, intent and use of the plan and guide.

There are three parts to this chapter:

Part I: The Housing Authority of Travis County (HATC). This part includes a description of HATC, its jurisdiction, its programs, and its mission and intent.

Part II: The HCV Program. This part contains information about the Housing Choice Voucher program operation, roles and responsibilities, and partnerships.

Part III: The HCV Administrative Plan. This part discusses the purpose and organization of the plan and its revision requirements.

HATC administers the following types of targeted funding:

1. Veterans Affairs Supportive Housing (VASH)
 - o **Veterans Affairs Supportive Housing (VASH):** HATC accepts VASH applicants as referrals in the order received from the Veterans Affairs administration for the designated number of vouchers awarded by HUD.
2. Non Elderly Disabled (NED)
3. Rental Assistance Demonstration Program- Project Based Rental Assistance

Regular HCV Funding

Regular HCV funding may be used to assist any eligible family on the waiting list. Families are selected from the waiting list according to the policies provided in Section 4-III.C.

4-III.C. SELECTION METHOD

PHAs must describe the method for selecting applicant families from the waiting list, including the system of admission preferences that HATC will use [24 CFR 982.202(d)].

Per calendar year, applicant families will be selected according to random lottery number assigned from waiting list application, targeted funding, and/ or preference as described below:

- 25% of all new housing choice voucher admissions will be allocated to a homeless applicant referred by a community agency with an existing HATC Memorandum of Understanding and;
- 1/3 of HATC's turnover vouchers will be available to families exercising Choice Mobility from any of its 3 covered projects transitioning into PBRA through the Rental Assistance Demonstration (RAD). HATC will establish an agency-wide Choice Mobility waiting list for times when there are more requests for vouchers than vouchers available due to the cap.

Local Preferences [24 CFR 982.207; HCV p. 4-16]

PHAs are permitted to establish local preferences, and to give priority to serving families that meet those criteria. HUD specifically authorizes and places restrictions on certain types of local preferences. HUD also permits HATC to establish other local preferences, at its discretion. Any local preferences established must be consistent HATC plan and the consolidated plan, and must be based on local housing needs and priorities that can be documented by generally accepted data sources.

HATC POLICY

HATC will use the following preference system:

Homeless Preference:

Community agencies submitting referrals for this preference must meet the following criteria:

- a) Meet the HUD definition of Homeless;

- b) Are referred to HATC by a coalition of homeless providers with whom HATC has executed a Memorandum of Understanding (MOU) outlining the providers roles and responsibilities with respect to the provision of housing search assistance and supportive services for the referred household;
- c) Have received a written commitment from the referring homeless service provider for housing search and location assistance;
- d) Have received documentation from the referring homeless service provider regarding homeless status eligibility prior to providing housing assistance;
- e) Have received a written commitment from the homeless service provider to offer support services on an as needed basis to help the household transition from homelessness to permanent housing; and
- f) Have received written commitment from the homeless service provider to offer supportive services to help the household maintain housing and comply with HCV regulations.

While a referral from the coalition of homeless service providers is required for this preference, use of the offered supportive services is not a requirement. The choice of the applicant to refuse the offered services will not jeopardize any housing assistance for which they are eligible.

HATC will execute an MOU as necessary to ensure that homeless applicants have the opportunity to apply for housing assistance under this preference.

Individuals and families transitioning from Permanent Supportive Housing (PSH) through the Continuum of Care awarded grant, will also be included as a priority group as part of this preference. These are the persons that were previously homeless prior to entry into a PSH program but who no longer require that level of supportive services. This would require a referral from the current case manager or PSH provider as well as documentation that the family was homeless prior to entering the PSH unit. This documentation must be provided as part of the referral.

Applicants interested in project based units may apply directly to the project(s). Families who applied directly will be referred by the project to HATC and be placed on the HATC PBV site-specific waiting lists if the waiting list is open.

HATC may limit the number of vouchers issued for each preference group as needed.

Proof of preference(s) will be required at the time of selection from waiting list in order to be provided assistance.

HATC will open the waiting list or leave the waiting list open for certain preference or targeted funding groups as needed to meet the preference caps outlined in this administrative plan.

HATC maintains 4 waiting lists for admission into the Housing Choice Voucher Program:

1. **Tenant-Based Voucher (TBV):** waiting list is established for applicants, if determined eligible, to be issued vouchers. The TBV waiting list will be maintained until expiration or exhaustion, and a new list is established.
2. **Project-Based Voucher (PBV):** waiting list for applicants, if determined eligible, to be

Section 8 Administrative Plan

placed in designated project-based units approved by HATC. The PBV waiting list will open and close based upon the need for an applicant pool based on project preferences. Referrals from the project will be accepted.

3. **Rental Assistance Demonstration (RAD) Choice Mobility Preference:** As required by HUD and in accordance with all HUD RAD guidelines, HATC will provide a Choice-Mobility option to residents of covered RAD projects in accordance with policies outlined in Chapter 18 of this HCV Administrative Plan.
4. **Homeless Housing Choice Vouchers** – Referrals from community agencies will be placed on the homeless applicant waiting list and be offered a voucher according to selection method outlined above.

If it is determined that an applicant referred by a homeless service provider or an applicant who has applied for targeted funding, as described above, does not meet the criteria, the applicant will not be placed on the waiting list.

If the applicant was only on the HCV waiting list because of the homeless referral/ target funding, the applicant will be removed from the HCV waiting list or; if the applicant was on the HCV waiting list through the regular application process, the applicant will return to their lottery position on the waiting list without the preference.

If HATC denies an application, HATC will notify the applicant and referring service provider in writing, including the reason(s) for the denial. Applicants have the right to appeal the denial of eligibility using the established process for informal reviews.

Income Targeting Requirement [24 CFR 982.201(b) (2)]

HUD requires that extremely low-income (ELI) families make up at least 75% of the families admitted to the HCV program during HATC's fiscal year. ELI families are those with annual incomes at or below 30% of the area median income. To ensure this requirement is met, HATC may skip non-ELI families on the waiting list in order to select an ELI family.

Low income families admitted to the program that are "continuously assisted" under the 1937 Housing Act [24 CFR 982.4(b)], as well as low-income or moderate-income families admitted to the program that are displaced as a result of the prepayment of the mortgage or voluntary termination of an insurance contract on eligible low-income housing, are not counted for income targeting purposes [24 CFR 982.201(b) (2) (v)].

HATC POLICY

HATC will monitor progress in meeting the ELI requirement throughout the fiscal year. Extremely low-income families will be selected ahead of other eligible families on an as-needed basis to ensure the income-targeting requirement is met.

Order of Selection

HATC system of preferences may select families either according to the date and time of application, or by a random selection process [24 CFR 982.207(c)]. When selecting families from the waiting list the PHAs are required to use targeted funding to assist only those families who meet the specified criteria, and PHAs are not permitted to skip down the waiting list to a family that it can afford to

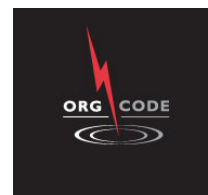
**Vulnerability Index -
Service Prioritization Decision Assistance Tool
(VI-SPDAT)**

Prescreen Triage Tool for Single Adults

CANADIAN VERSION 2.01

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

**COMMUNITY
SOLUTIONS**



Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:

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

All versions are available online at

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

SPDAT Series

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

Current versions available:

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

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

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

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

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

Current SPDAT training available:

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

Other related training available:

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

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

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

Administration

| | | |
|---|---------------------------------|---|
| Interviewer's Name _____ | Agency _____ | <input type="checkbox"/> Team <input type="checkbox"/> Staff <input type="checkbox"/> Volunteer |
| Survey Date DD/MM/YYYY ____/____/____ | Survey Time ____:____ | Survey Location _____ |

Opening Script

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

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

Basic Information

| | | |
|--|--------------------------|---|
| First Name _____ | Nickname _____ | Last Name _____ |
| In what language do you feel best able to express yourself? _____ | | |
| Date of Birth DD/MM/YYYY ____/____/____ | Age _____ | Social Insurance Number _____ Consent to participate <input type="checkbox"/> Yes <input type="checkbox"/> No |

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

SCORE:

A. History of Housing and Homelessness

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

- ☐ Shelters
☐ Couch Surfing
☐ Outdoors
☐ Other (specify): _____

☐ Refused

IF THE PERSON ANSWERS ANYTHING OTHER THAN "SHELTER", THEN SCORE 1.

SCORE:

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

☐ Refused

3. In the last year, how many times have you been homeless? _____

☐ Refused

IF THE PERSON HAS EXPERIENCED 6 OR MORE CONSECUTIVE MONTHS OF HOMELESSNESS, AND/OR 3+ EPISODES OF HOMELESSNESS, THEN SCORE 1.

SCORE:

B. Risks

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

a) Received health care at an emergency department/room? _____

☐ Refused

b) Taken an ambulance to the hospital? _____

☐ Refused

c) Been hospitalized as an inpatient? _____

☐ Refused

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

☐ Refused

e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? _____

☐ Refused

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

☐ Refused

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

SCORE:

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

6. Have you threatened to or tried to harm yourself or anyone else in the last year? ☐ Y ☐ N ☐ Refused

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

SCORE:

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

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

SCORE:

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

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

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

SCORE:

C. Socialization & Daily Functioning

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

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

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

SCORE:

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

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

SCORE:

13. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ N ☐ Refused

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

SCORE:

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

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

SCORE:

D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? ☐ Y ☐ N ☐ Refused
16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? ☐ Y ☐ N ☐ Refused
17. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help? ☐ Y ☐ N ☐ Refused
18. When you are sick or not feeling well, do you avoid getting help? ☐ Y ☐ N ☐ Refused
19. **FOR FEMALE RESPONDENTS ONLY:** Are you currently pregnant? ☐ Y ☐ N ☐ N/A or Refused

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

SCORE:

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

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

SCORE:

22. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
- a) A mental health issue or concern? ☐ Y ☐ N ☐ Refused
- b) A past head injury? ☐ Y ☐ N ☐ Refused
- c) A learning disability, developmental disability, or other impairment? ☐ Y ☐ N ☐ Refused
23. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help? ☐ Y ☐ N ☐ Refused

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

SCORE:

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

SCORE:

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

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

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

SCORE:

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

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

SCORE:

Scoring Summary

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

Follow-Up Questions

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

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

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

Appendix A: About the VI-SPDAT

In communities getting the results required to end chronic and episodic homelessness, the introduction of a coordinated access and common assessment approach has proven to be essential for success. Many communities have struggled to find evidence informed tools and strategies, which demands an investment of considerable time, resources and expertise. Others are making it up as they go along, using “gut instincts” in lieu of solid evidence. Communities need tools that enhance their ability to quickly implement an effective approach to access and assessment. The VI-SPDAT is a first-of-its-kind tool designed to fill this need, helping communities end homelessness in a quick, strategic fashion.

The VI-SPDAT

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

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

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

Version 2

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

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

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

Appendix B: Where SPDAT products are being used in Canada

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

Alberta

- Province-wide

Manitoba

- City of Winnipeg

New Brunswick

- City of Fredericton
- City of Saint John

Newfoundland and Labrador

- Province-wide

Northwest Territories

- City of Yellowknife

Ontario

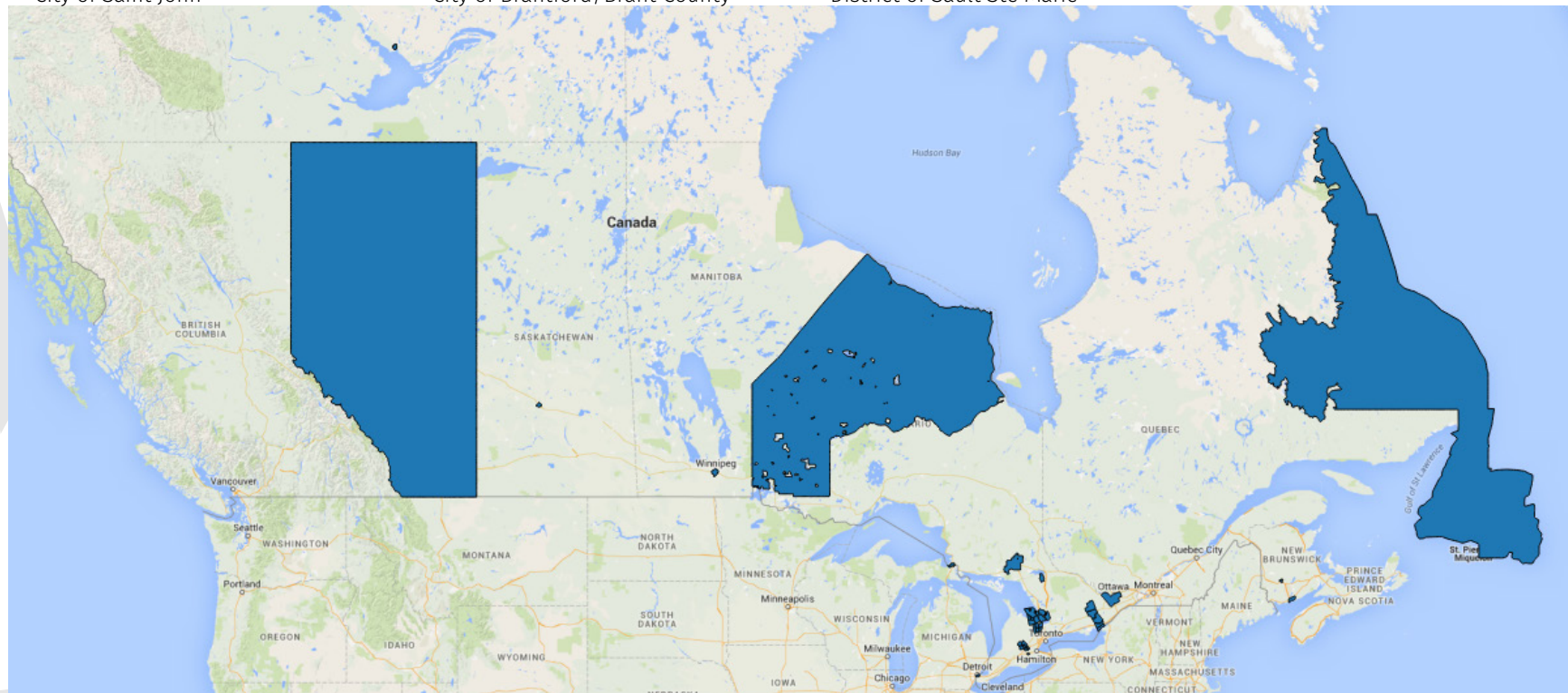
- City of Barrie/Simcoe County
- City of Brantford/Brant County

- City of Greater Sudbury
- City of Kingston/Frontenac County
- City of Ottawa
- City of Windsor
- District of Kenora
- District of Parry Sound
- District of Sault Ste Marie

- Regional Municipality of Waterloo
- Regional Municipality of York

Saskatchewan

- Saskatoon



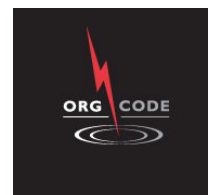
**Vulnerability Index -
Service Prioritization Decision Assistance Tool
(VI-SPDAT)**

Prescreen Triage Tool for Families

AMERICAN VERSION 2.0

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

SPDAT Series

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

Current versions available:

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

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

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

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

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

Current SPDAT training available:

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

Other related training available:

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

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

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

Administration

| | | |
|---------------------------|--------------------|--|
| Interviewer's Name | Agency | <input type="radio"/> Team <input type="radio"/> Staff <input type="radio"/> Volunteer |
| Survey Date | Survey Time | Survey Location |
| DD/MM/YYYY ____/____/____ | ____:____ | _____ |

Opening Script

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

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

Basic Information

| | | | |
|---|---|-----------------|---|
| PARENT 1 | First Name | Nickname | Last Name |
| | _____ | | |
| | In what language do you feel best able to express yourself? _____ | | |
| | Date of Birth | Age | Social Security Number |
| | DD/MM/YYYY ____/____/____ | _____ | _____ |
| | <input type="radio"/> Yes <input type="radio"/> No | | |
| PARENT 2 | <input type="checkbox"/> No second parent currently part of the household | | |
| | First Name | Nickname | Last Name |
| | _____ | | |
| | In what language do you feel best able to express yourself? _____ | | |
| | Date of Birth | Age | Social Security Number |
| | DD/MM/YYYY ____/____/____ | _____ | _____ |
| | <input type="radio"/> Yes <input type="radio"/> No | | |
| IF EITHER HEAD OF HOUSEHOLD IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1. | | | |
| | | | SCORE: <div style="border: 1px solid black; width: 100px; height: 30px;"></div> |

Children

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

| First Name | Last Name | Age | Date of Birth |
|------------|-----------|-------|---------------|
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |
| _____ | _____ | _____ | _____ |

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

SCORE:

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

0

A. History of Housing and Homelessness

- Where do you and your family sleep most frequently? (check one)
 - ☒ Shelters
 - ☐ Transitional Housing
 - ☐ Safe Haven
 - ☐ Outdoors
 - ☐ Other (specify): _____
 - ☐ Refused

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

SCORE:

0

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

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

SCORE:

0

B. Risks

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

- a) Received health care at an emergency department/room? _____ ☐ Refused
- b) Taken an ambulance to the hospital? _____ ☐ Refused
- c) Been hospitalized as an inpatient? _____ ☐ Refused
- d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? _____ ☐ Refused
- e) Talked to police because they witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told them that they must move along? _____ ☐ Refused
- f) Stayed one or more nights in a holding cell, jail or prison, whether that was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? _____ ☐ Refused

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

SCORE:

0

9. Have you or anyone in your family been attacked or beaten up since they've become homeless? ☒ Y ☐ N ☐ Refused
10. Have you or anyone in your family threatened to or tried to harm themselves or anyone else in the last year? ☒ Y ☐ N ☐ Refused

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

SCORE:

0

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

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

SCORE:

0

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

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

SCORE:

0

C. Socialization & Daily Functioning

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

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

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

SCORE:

0

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

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

SCORE:

0

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

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

SCORE:

0

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

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

SCORE:

0

D. Wellness

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

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

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

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

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

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

SCORE:

0

VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

FAMILIES

AMERICAN VERSION 2.0

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

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

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

SCORE:

0

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

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

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

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

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

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

SCORE:

0

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

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

SCORE:

0

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

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

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

SCORE:

0

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

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

SCORE:

0

E. Family Unit

32. Are there any children that have been removed from the family by a child protection service within the last 180 days? ☐ Y ☐ N ☐ Refused

33. Do you have any family legal issues that are being resolved in court or need to be resolved in court that would impact your housing or who may live within your housing? ☐ Y ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR FAMILY LEGAL ISSUES.

SCORE:

0

34. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation? ☐ Y ☐ N ☐ Refused

35. Has any child in the family experienced abuse or trauma in the last 180 days? ☐ Y ☐ N ☐ Refused

36. IF THERE ARE SCHOOL-AGED CHILDREN: Do your children attend school more often than not each week? ☐ Y ☐ N ☐ N/A or Refused

IF "YES" TO ANY OF QUESTIONS 34 OR 35, OR "NO" TO QUESTION 36, SCORE 1 FOR NEEDS OF CHILDREN.

SCORE:

0

37. Have the members of your family changed in the last 180 days, due to things like divorce, your kids coming back to live with you, someone leaving for military service or incarceration, a relative moving in, or anything like that? ☐ Y ☐ N ☐ Refused

38. Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed? ☐ Y ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, SCORE 1 FOR FAMILY STABILITY.

SCORE:

0

39. Do you have two or more planned activities each week as a family such as outings to the park, going to the library, visiting other family, watching a family movie, or anything like that? ☐ Y ☐ N ☐ Refused

40. After school, or on weekends or days when there isn't school, is the total time children spend each day where there is no interaction with you or another responsible adult...

a) 3 or more hours per day for children aged 13 or older? ☐ Y ☐ N ☐ Refused

b) 2 or more hours per day for children aged 12 or younger? ☐ Y ☐ N ☐ Refused

41. IF THERE ARE CHILDREN BOTH 12 AND UNDER & 13 AND OVER: Do your older kids spend 2 or more hours on a typical day helping their younger sibling(s) with things like getting ready for school, helping with homework, making them dinner, bathing them, or anything like that? ☐ Y ☐ N ☐ N/A or Refused

IF "NO" TO QUESTION 39, OR "YES" TO ANY OF QUESTIONS 40 OR 41, SCORE 1 FOR PARENTAL ENGAGEMENT.

SCORE:

0

Scoring Summary

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

Follow-Up Questions

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

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

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

Appendix A: About the VI-SPDAT

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

The VI-SPDAT

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

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

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

Version 2

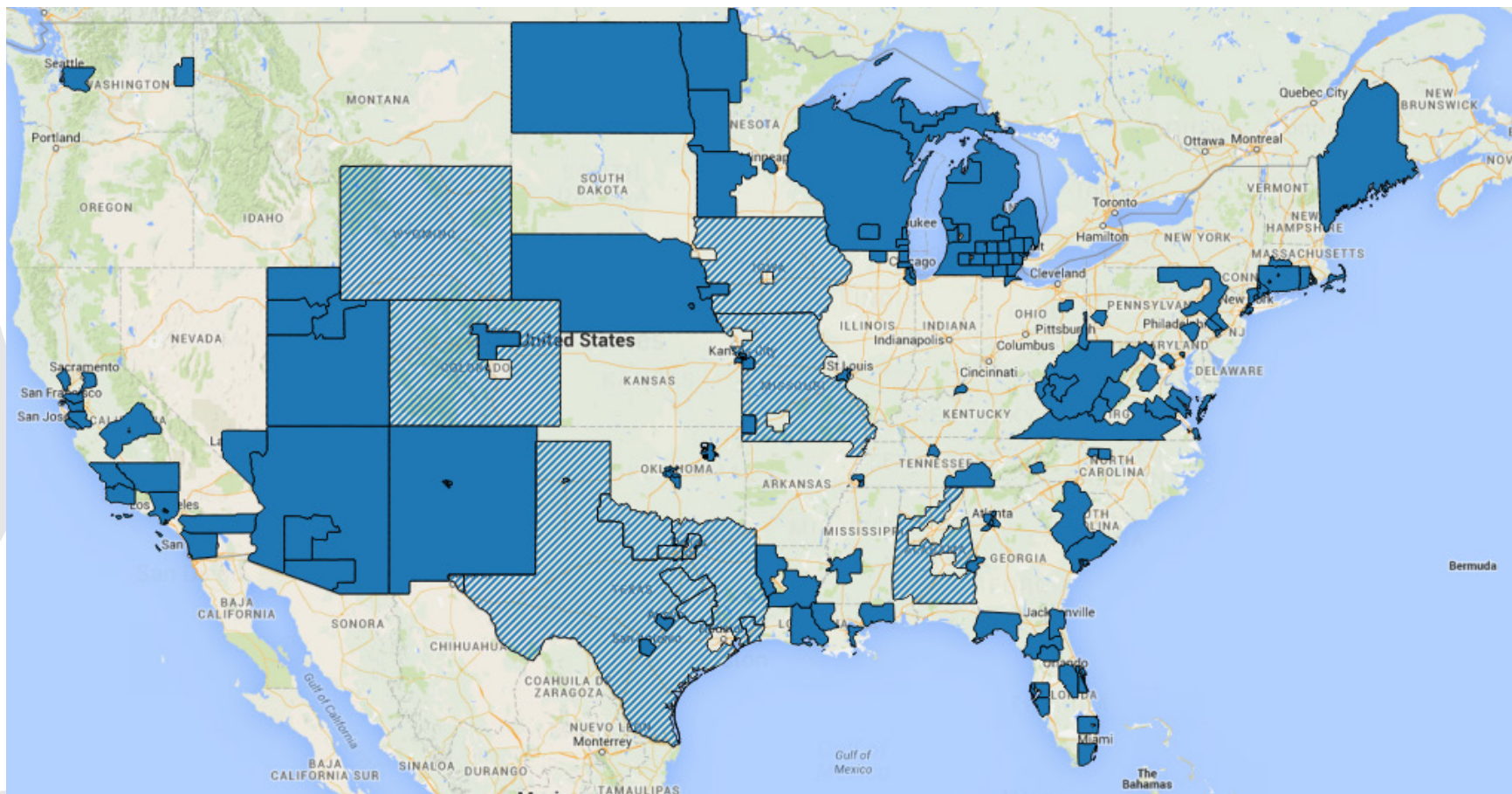
Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further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

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

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

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

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



VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

FAMILIES

AMERICAN VERSION 2.0

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

Alabama

- Parts of Alabama Balance of State

Arizona

- Statewide

California

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

Colorado

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

Connecticut

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

District of Columbia

- District of Columbia

Florida

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

Georgia

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

Hawaii

- Honolulu

Illinois

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

Iowa

- Parts of Iowa Balance of State

Kansas

- Kansas City/Wyandotte County

Kentucky

- Louisville/Jefferson County

Louisiana

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

Massachusetts

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

Maryland

- Baltimore City
- Montgomery County

Maine

- Statewide

Michigan

- Statewide

Minnesota

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

Missouri

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

Mississippi

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

North Carolina

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

North Dakota

- Statewide

Nebraska

- Statewide

New Mexico

- Statewide

Nevada

- Las Vegas/Clark County

New York

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

Ohio

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

Oklahoma

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

Pennsylvania

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

Rhode Island

- Statewide

South Carolina

- Charleston/Low Country
- Columbia/Midlands

Tennessee

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

Texas

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

Utah

- Statewide

Virginia

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

Washington

- Seattle/King County
- Spokane City & County

Wisconsin

- Statewide

West Virginia

- Statewide

Wyoming

- Wyoming Statewide is in the process of implementing

**Transition Age Youth -
Vulnerability Index -
Service Prioritization Decision Assistance Tool
(TAY-VI-SPDAT)**

“Next Step Tool for Homeless Youth”

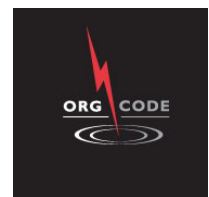
AMERICAN VERSION 1.0

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

**COMMUNITY
SOLUTIONS**



Eric Rice, PhD



Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:

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

All versions are available online at

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

SPDAT Series

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Current versions available:

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

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SPDAT Training Series

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

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

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- Objective-Based Interactions

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

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

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

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

Administration

| | | |
|---|---------------------------------|--|
| Interviewer's Name _____ | Agency _____ | <input type="radio"/> Team <input type="radio"/> Staff <input type="radio"/> Volunteer |
| Survey Date DD/MM/YYYY ____/____/____ | Survey Time ____:____ | Survey Location _____ |

Opening Script

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

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

Basic Information

| | | |
|--|--------------------------|---|
| First Name _____ | Nickname _____ | Last Name _____ |
| In what language do you feel best able to express yourself? _____ | | |
| Date of Birth DD/MM/YYYY ____/____/____ | Age _____ | Social Security Number _____ |
| | | Consent to participate <input type="radio"/> Yes <input type="radio"/> No |

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

SCORE:

1

A. History of Housing and Homelessness

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

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

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

SCORE:

0

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

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

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

SCORE:

0

B. Risks

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

- a) Received health care at an emergency department/room? _____ ☐ Refused
 b) Taken an ambulance to the hospital? _____ ☐ Refused
 c) Been hospitalized as an inpatient? _____ ☐ Refused
 d) Used a crisis service, including sexual assault crisis, mental health crisis, family/intimate violence, distress centers and suicide prevention hotlines? _____ ☐ Refused
 e) Talked to police because you witnessed a crime, were the victim of a crime, or the alleged perpetrator of a crime or because the police told you that you must move along? _____ ☐ Refused
 f) Stayed one or more nights in a holding cell, jail, prison or juvenile detention, whether it was a short-term stay like the drunk tank, a longer stay for a more serious offence, or anything in between? _____ ☐ Refused

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

SCORE:

0

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

6. Have you threatened to or tried to harm yourself or anyone else in the last year? ☐ Y ☐ N ☐ Refused

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

SCORE:

0

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

8. Were you ever incarcerated when younger than age 18? ☐ Y ☐ N ☐ Refused

IF "YES" TO ANY OF THE ABOVE, THEN SCORE 1 FOR **LEGAL ISSUES**.

SCORE:

0

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

10. Do you ever do things that may be considered to be risky like exchange sex for money, food, drugs, or a place to stay, run drugs for someone, have unprotected sex with someone you don't know, share a needle, or anything like that? ☐ Y ☐ N ☐ Refused

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

SCORE:

0

C. Socialization & Daily Functioning

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

12. Do you get any money from the government, an inheritance, an allowance, working under the table, a regular job, or anything like that? ☐ Y ☐ N ☐ Refused

IF "YES" TO QUESTION 11 OR "NO" TO QUESTION 12, THEN SCORE 1 FOR **MONEY MANAGEMENT**.

SCORE:

0

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

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

SCORE:

0

14. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that? ☐ Y ☐ N ☐ Refused

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

SCORE:

0

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

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

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

SCORE:

0

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

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

SCORE:

0

D. Wellness

- 16. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? ☐ Y ☐ N ☐ Refused
- 17. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? ☐ Y ☐ N ☐ Refused
- 18. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you? ☐ Y ☐ N ☐ Refused
- 19. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you'd need help? ☐ Y ☐ N ☐ Refused
- 20. When you are sick or not feeling well, do you avoid getting medical help? ☐ Y ☐ N ☐ Refused
- 21. Are you currently pregnant, have you ever been pregnant, or have you ever gotten someone pregnant? ☐ Y ☐ N ☐ Refused

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

SCORE:

0

NEXT STEP TOOL FOR HOMELESS YOUTH

SINGLE YOUTH

AMERICAN VERSION 1.0

22. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? ☒ Y ☐ N ☐ Refused
23. Will drinking or drug use make it difficult for you to stay housed or afford your housing? ☒ Y ☐ N ☐ Refused
24. If you've ever used marijuana, did you ever try it at age 12 or younger? ☒ Y ☐ N ☐ Refused

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

SCORE:

0

25. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
- a) A mental health issue or concern? ☒ Y ☐ N ☐ Refused
- b) A past head injury? ☒ Y ☐ N ☐ Refused
- c) A learning disability, developmental disability, or other impairment? ☒ Y ☐ N ☐ Refused
26. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help? ☒ Y ☐ N ☐ Refused

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

SCORE:

0

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

SCORE:

0

27. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? ☒ Y ☐ N ☐ Refused
28. Are there any medications like painkillers that you don't take the way the doctor prescribed or where you sell the medication? ☒ Y ☐ N ☐ Refused

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

SCORE:

0

Scoring Summary

| DOMAIN | SUBTOTAL | RESULTS |
|--------------------------------------|----------|--|
| PRE-SURVEY | 1 /1 | Score: Recommendation: 0-3: no moderate or high intensity services be provided at this time 4-7: assessment for time-limited supports with moderate intensity 8+: assessment for long-term housing with high service intensity |
| A. HISTORY OF HOUSING & HOMELESSNESS | 0 /2 | |
| B. RISKS | 0 /4 | |
| C. SOCIALIZATION & DAILY FUNCTIONS | 0 /5 | |
| D. WELLNESS | 0 /5 | |
| GRAND TOTAL: | 1 /17 | |

Follow-Up Questions

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

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

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

Appendix A: About the TAY-VI-SPDAT

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

The VI-SPDAT

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

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

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

The Youth – Transition Age Youth Tool from CSH

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

Version 2 of the VI-SPDAT

Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool.

Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

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

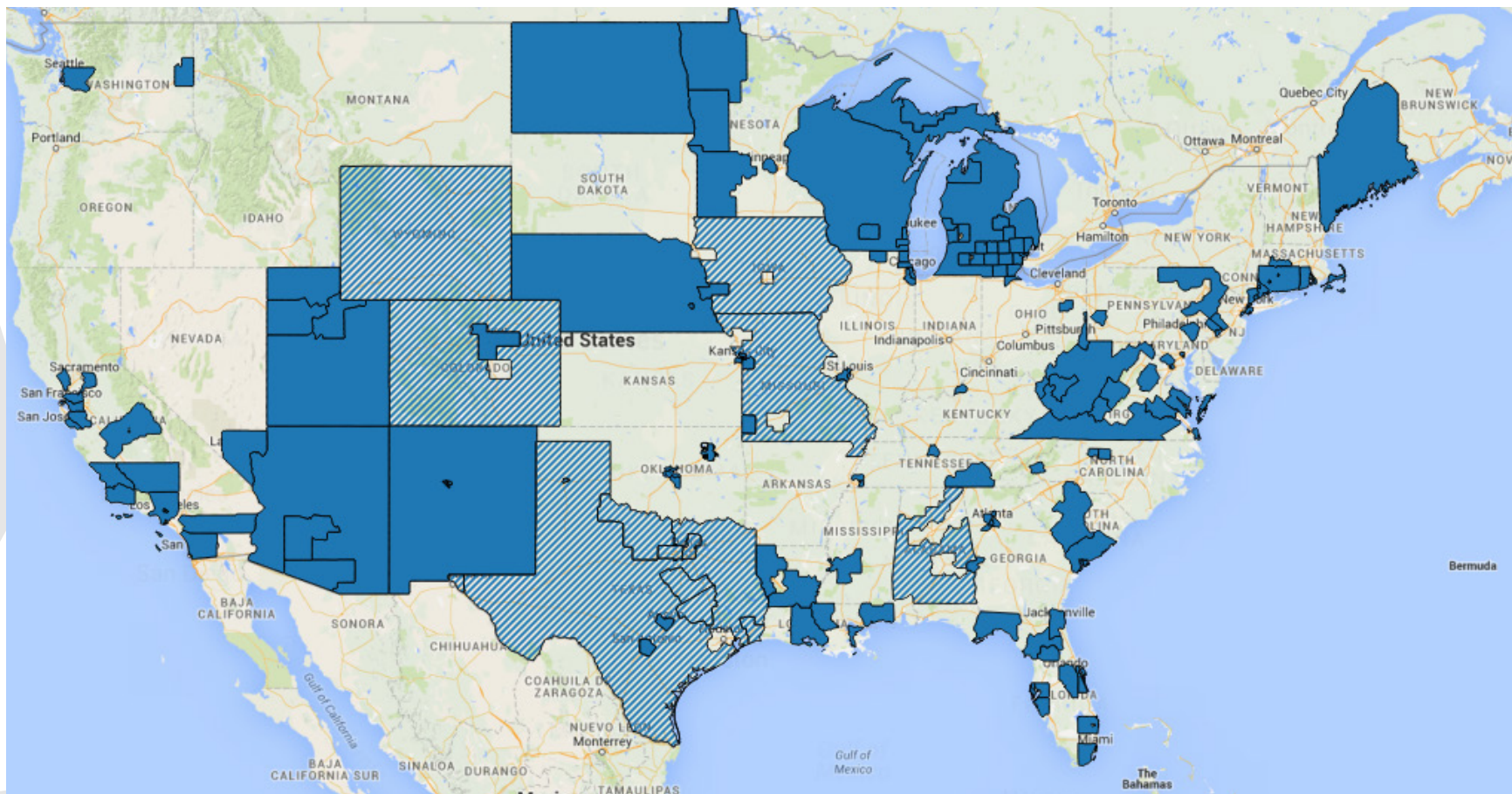
One piece of feedback was the growing concern that youth tended to score lower on the VI-SPDAT, since the Vulnerability Index assesses risk of mortality which is less prevalent among younger populations. So, in version 2 of the VI-SPDAT, OrgCode Consulting, Inc. and Community Solutions joined forces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

If you are familiar with the VI-SPDAT, you will notice some differences in the TAY-VI-SPDAT compared to VI-SPDAT version 1. Namely:

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

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

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



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

Alabama

- Parts of Alabama Balance of State

Arizona

- Statewide

California

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

Colorado

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

Connecticut

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

District of Columbia

- District of Columbia

Florida

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

Georgia

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

Hawaii

- Honolulu

Illinois

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

Iowa

- Parts of Iowa Balance of State

Kansas

- Kansas City/Wyandotte County

Kentucky

- Louisville/Jefferson County

Louisiana

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

Massachusetts

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

Maryland

- Baltimore City
- Montgomery County

Maine

- Statewide

Michigan

- Statewide

Minnesota

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

Missouri

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

Mississippi

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

North Carolina

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

North Dakota

- Statewide

Nebraska

- Statewide

New Mexico

- Statewide

Nevada

- Las Vegas/Clark County

New York

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

Ohio

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

Oklahoma

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

Pennsylvania

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

Rhode Island

- Statewide

South Carolina

- Charleston/Low Country
- Columbia/Midlands

Tennessee

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

Texas

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

Utah

- Statewide

Virginia

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

Washington

- Seattle/King County
- Spokane City & County

Wisconsin

- Statewide

West Virginia

- Statewide

Wyoming

- Wyoming Statewide is in the process of implementing

1E-1 (2) Public Posting – 30 Day Local Competition Deadline

Local Competition Deadline was publicly announced the following ways:

1. Competition Timeline was posted on the Ending Community Homelessness Coalition's (ECHO) website. The website uses links to access document uploads. The screenshot was documented on 8/5/19 showing the uploaded PDF timeline content from www.austinecho.org.

2019 CoC NOFA Timeline - Rev. 07/15/2019

| Fiscal Year 2019 ECHO Continuum of Care NOFA Timeline | |
|---|--|
| May 6 | Membership Council approves members of the Independent Review Team |
| May 28 | Local Renewal Project applications due in Community Force |
| July 3 | FY 19 CoC NOFA released by HUD |
| July 16 | Bidder's Conference for New Projects |
| August 6 | Local Deadline: New/Bonus Applications due in Community Force |
| August 23 | Local Deadline: Renewal Projects applications submitted in esnaps |
| August 30 | HUD Deadline: All Projects must be submitted in e-snaps |
| September 9 | Membership Council Meeting: Adopts Final Ranking for Priority Listing |
| September 9 | ECHO notifies all applicants in writing of acceptance/denial and ranking |
| September 12 | Appeal Policy Requirement - applicants have 3 business days to appeal Ranking/Funding Decision of Membership Council |
| September 15 | HUD Deadline: ECHO to Reject or reduce Project Applications |
| September 27 | HUD Deadline: Post CoC Application and Priority Listing on website for public review |
| September 30 | HUD deadline for NOFA submission |

2. Local application deadline for Renewal Projects posted directly on the ECHO website. Screenshot date: 5/22/19

The screenshot shows a web browser window with the address bar displaying "www.austinecho.org/coc/". A red arrow points to the address bar. The browser's taskbar at the top shows several open tabs, including "Apps", "CoC Program Inter...", "esnaps", "The McKinney-Vent...", "CoC: Continuum of...", "SolveForHomelessn...", "CoC Program Regis...", "Inbox (1,548) - rkat...", and "Welcome to Survey...".

The main content area of the website lists several links and documents:

- Governance Charter ([Link](#))
- Austin/Travis County COC Policy and Procedures (Link Pending)
- Coordinated Entry Written Standards (Link Pending)
- VAWA Policy and Procedures ([Link](#))
- 2019 Continuum of Care NOFA Funding Policy Documents
 - 1. Community Funding Priorities ([Link](#))
 - 2. Review, Rating and Ranking Policy and Procedure ([Link](#))
 - 3. Reallocation and Deobligation Policy ([Link](#))
- 2019 Continuum of Care NOFA Resources and Notices** (link to [website](#))

Below these links, a paragraph states: "CoC Renewal Applications are due in Community Force on May 28, 2019. Contact nofa@austinecho.org with any questions." A red arrow points to this paragraph.

Following this, another paragraph states: "ECHO staff will update the website throughout the competition."

A bulleted list of resources is provided:

- CommunityForce instructions slides
<https://www.dropbox.com/s/n53ldbkm12749pz/Using%20CommunityForce.pptx?dl=0>
- Renewal Orientation Slides
<https://www.dropbox.com/s/7jd89xz3098g5o5/5.%20May%201%20Renewal%20%20Orientation.pdf?dl=0>
- Renewal Orientation webinar <https://recordings.join.me/Z-uXFAbyUk6Vo55gKyzRng>
- CoC NOFA Competition Local Application FAQ
<https://www.dropbox.com/s/jaysqcaj441iob9/Renewal%20Orientation%20Q%26A%20List.docx?dl=0>

A red arrow points to the bottom right corner of the webpage content area.

The Windows taskbar at the bottom shows the search bar with the text "Type here to search", several application icons (File Explorer, Google Chrome, Microsoft Word, etc.), and the system clock displaying "1:31 PM 5/22/2019".

2. Distribution via Newsletter Email: The Local Competition Deadline was distributed through the Ending Community Homelessness Coalition's (ECHO) Newsletter. The screenshot shows the Newsletter as a received email that was sent from ECHO's account on 7/18/19. The email content shows the local competition deadline at the top of the message and in the middle of the message (in red).

CoC Funding Opportunity: New/Bonus funds - Message (HTML)

File Message Help Tell me what you want to do

Delete Archive Move Reply Reply All Forward Mark Unread Categorize Follow Up Translate Find Smart Lookup Read Aloud Zoom

CoC Funding Opportunity: New/Bonus funds

ECHO <NOFA@austinecho.org>
To: Laura Evanoff

Reply Reply All Forward

Thu 7/18/2019 12:05 PM

If there are problems with how this message is displayed, click here to view it in a web browser.
Click here to download pictures. To help protect your privacy, Outlook prevented automatic download of some pictures in this message.

[View this email in your browser](#)

FUNDING OPPORTUNITY!
TX-503 Continuum of Care (CoC) Funding for
Agencies Serving People Experiencing Homelessness!
DEADLINE: August 6, 2019

The application for funding for new Continuum of Care dollars is now available on the Ending Community Homelessness Coalition (ECHO) website.

ECHO encourages ALL agencies to apply during the local competition and welcomes new partners to join the growing community of CoC-funded agencies!

Application Deadline: August 6, 2019

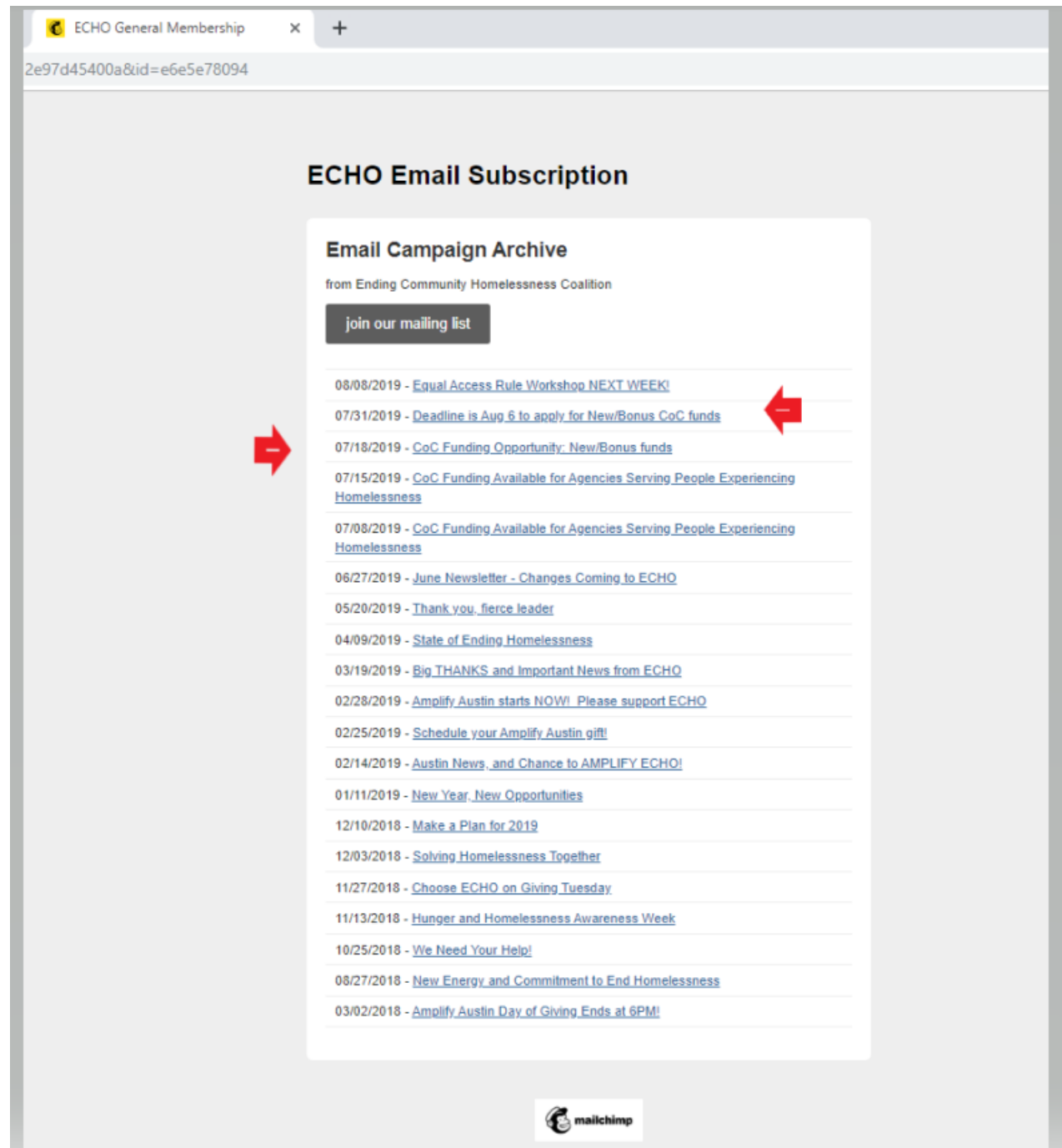
View the application and related resources on the ECHO website -[CLICK HERE](#) - scroll down to the section titled: "New/Bonus and Domestic Violence Bonus Application Resources".

Who is Eligible:

- Nonprofit organizations
- States and Local governments
- Public housing agencies

3. Newsletter – MailChimp Email Campaign Archive:

The screenshot shows the various Newsletters distributed by the Lead Agency – ECHO through the MailChimp account. The website at the top of the image shows that the emails listed were sent to the General Membership which includes over 1,000 contacts. The email on 7/18/19 (CoC Funding Opportunity: New/Bonus Funds) is the screenshot documented in the 2nd post. The Email Campaign Archive also shows that an additional email was distributed on 7/31/19 (Deadline is Aug 6 to apply for New/Bonus CoC funds).





Addressing Racial Disparities in Austin/Travis County, TX



September 2019

OVERVIEW

The Ending Community Homelessness Coalition (ECHO) is committed to proactively addressing disparities and working toward the equitable provision of homeless services in Austin/Travis County. To this end, ECHO analyzes local and national data and best practices in addressing disparities, racism, and inequality. This document provides an overview of this analysis and the current steps ECHO, the Austin/Travis County Continuum of Care, and local homeless service partner agencies are taking and considering working toward equity in all aspects of our work.

National research indicates that demographic characteristics such as race, sex, gender identity, Veteran status and sexual orientation influence pathways into and out of homelessness.¹ One of ECHO's goals is to better understand and address the root causes that place subgroups at higher risks of homelessness and facilitate community change by leading initiatives that reduce and/or eliminate individual and system barriers and create long-term solutions to end homelessness in our community.

¹ University of Maryland (2016). Dr. Moser Jones Explores Race, Discrimination and Homelessness Connections. <https://sph.umd.edu/news-item/dr-moser-jones-explores-race-discrimination-and-homelessness-connections>.

Since the 1980s, Black and African American citizens have been overrepresented among the U.S. population experiencing homelessness, comprising roughly 40 percent of the total U.S. homeless population but only 13 percent of the overall population. Our local data shows similar statistics. Residents in Austin and Travis County who are Black or African American comprise 34 percent of the Austin/Travis County population experiencing homelessness, but only eight percent of the overall county population.

LGBTQA youth also experience homelessness in greater numbers at a national level. In Austin in 2017, approximately 23 percent² of youth experiencing homelessness in Austin identified as LGBTQA, more than triple the number of LGBTQA youth in the general population.³

For ease of analysis and readability, race and ethnicity categories in this analysis have been grouped together into white non-Hispanic/Latinx (White), Black/African American non-Hispanic/Latinx (Black/African American), and Hispanic/Latinx of any race (Hispanic/Latinx).

ACTION

ECHO partners are taking proactive steps to address disparities in the provision of homeless services. The Austin Action Plan to End Homelessness lists reducing disparities as one of its five key strategies. Below is a description of current actions as well as actions under consideration for future implementation.

CURRENT ACTIONS

LEADERSHIP OPPORTUNITIES & BOARD REPRESENTATION

- ECHO provides several avenues for people with lived experience to provide feedback and influence decision-making. These include ECHO's Board, the Continuum of Care Membership Council and affiliated committees and workgroups, and the Austin Homeless Advisory Council (AHAC). AHAC is a committee comprised of 16 people with lived experience of homelessness, which is facilitated by the Downtown Austin Community Court and ECHO.
- Austin's Youth Homeless Demonstration Project (YHDP) Youth Collective is another board on which persons with lived experience can make decisions surrounding Austin's Action Plan to End Youth Homelessness.

REDUCING BARRIERS: CRIMINAL JUSTICE

- ECHO negotiates lower tenant screening criteria with landlords, property management companies, affordable housing providers, and the Austin and Travis County Public Housing Authorities. Reduced criminal screening criteria helps address the issue of disproportionate criminal justice involvement. Landlords or property management companies often use stringent screening criteria, even in cases when criminal charges pose no risk to property nor does it affect a person's ability to pay rent. Our goal is to increase housing opportunities regardless of

² Voices of Youth Count (2017). Travis County, Texas: Report on Youth Homelessness.

³ Gallup (2017). In U.S., More Adults Identifying as LGBT. <https://news.gallup.com/poll/201731/lgbt-identificationrises.aspx>.

barriers by strategically partnering with landlords. These efforts are supported by landlord incentive programs such as risk mitigation.

- ECHO and partner agencies participate in the Austin/Travis County Re-Entry Roundtable, an initiative that promotes effective reentry and reintegration of formerly incarcerated persons and individuals with criminal histories. ECHO worked in partnership with the Roundtable to create and publish a guide to aligning criminal screening policies with HUD guidance, which has led to the creation of more equitable policies (guide available here: <https://bit.ly/2Q7jfqG>).
- Following publication of the criminal screening policies guide, ECHO and community stakeholders engaged Austin's Public Housing Authority to amend and ultimately lower the criminal screening for their Housing Choice Voucher program.

ENDING HOMELESSNESS FOR HIGH UTILIZERS OF CRIMINAL JUSTICE & HEALTHCARE SYSTEMS

- ECHO is in the final stages of designing a Pay for Success supportive housing initiative to house 250 people experiencing homelessness who have had frequent interactions with the criminal justice system and the emergency medical system. There is a gap in services for the population with this overlap of needs, and this project will greatly reduce this gap.
- The Care Connections Clinic (CareCo) is a new initiative between ECHO, the SAFE Alliance (local victim services provider), CommUnity Care (local FQHC), and Integral Care (local Mental Health Authority), launched in March 2019. It will be a healthcare and navigation center for people experiencing homelessness. CareCo is a physical Healthcare for the Homeless location that provides medical services to uninsured and underinsured individuals to increase access to and reduce health disparities. The clinic also ensures that those who qualify for SOAR benefits are connected to vital resources to increase approval of submitted applications.

ENDING HOMELESSNESS FOR VULNERABLE SUB-POPULATIONS:

YOUTH

- ECHO works closely with the Texas Department of Family and Protective Services to address the needs of young people at risk of aging out of foster care and entering homelessness. ECHO regularly monitors the demographics of young people entering homelessness and evaluates program enrollment and housing outcomes to address racial disparities in youth services.
- The Youth Homelessness Demonstration Program (YHDP) funding has increased services geared toward ending youth homelessness through increased outreach efforts and piloting new diversion interventions.

DOMESTIC ABUSE, DATING VIOLENCE, SEXUAL ASSAULT, STALKING, HUMAN TRAFFICKING AND OTHER TYPES OF ABUSE

- ECHO's Community Housing staff work with landlords and Victim Service Providers to increase awareness and education around VAWA housing protections and ensure that all community members, especially minority populations who are disproportionately exposed to housing and financial instability due to violence and abuse, can access safe and affordable housing.
- ECHO is the Homeless Management Information System (HMIS) Lead Agency and works with victim service providers using comparable databases to ensure that data is being evaluated to ensure equal access and representation across housing and service interventions offered by victim service providers.

- The Violence Against Women Act (VAWA) Housing Protection Workgroup trains direct service providers and has created templates on how to inform program participants of housing protections and increase affirmative marketing to build support and encourage people of color and other minorities to access resources that increase housing stability.

EQUAL ACCESS TO DIVERSE AND AFFORDABLE HOUSING OPPORTUNITIES

- ECHO works in partnership with the Austin Tenants Council, the local fair housing advocate, to enforce fair housing protections and identify violations.
- ECHO uses rent reduction payments to ensure access to larger geographic dispersion for scattered site housing and increase capacity in high-opportunity areas.
- ECHO and community partners advocate with the City of Austin on matters related to the use of affordable housing dollars, specifically ensuring low- and no-barrier opportunities are included. The City of Austin currently has a density program that allows approval of increased density in exchange for on-site affordable units or a fee-in-lieu and is looking to expand that program through an overhaul of the land use development code.
- Austin recently passed Austin's third affordable housing bond in November 2018. This housing bond, in combination with the Low-Income Housing Tax Credit program, has empowered Austin to further catalyze the development of affordable housing.

COORDINATED ENTRY APPROACH

- The Austin/Travis County Coordinated Entry system does not consider barriers such as income when determining program referral.
- ECHO partners work closely with the local Sheriff and police departments to enable jail in-reach and discharge planning.
- The Downtown Austin Community Court, the first community court established in Texas, offers rehabilitative services and adjudication for people experiencing homelessness.
- ECHO partners do not discharge/exit clients due to incarceration unless there is a funding ineligibility issue.
- ECHO works with the City of Austin and other non-ECHO partners to ensure all programs serving populations experiencing homelessness participate in Coordinated Entry.
- Austin's Sobering Center, opened in August 2018, provides an alternative to incarceration for people who may otherwise be arrested for public intoxication.
- ECHO regularly evaluates program data, including Coordinated Entry data, referral data, shelter data, and program exit data to maintain community awareness about needs and disparities.

COMMITTEES & RESOURCES ENGAGED IN SYSTEMS CHANGE

- ECHO is committed to providing ongoing training opportunities to reduce disparities through awareness and cultural competency. ECHO coordinates an annual training to educate the

partner agencies about the Equal Access Rule which also includes materials that address the creation of safe spaces for trans and non-binary individuals.

- ECHO offered a workshop to internal staff, and partner agency leaders and direct service providers on Race and Equity which helped participants to identify Equity as a community issue and identify strategies for advocacy/system change.
- ECHO participates in a Veterans Disparities Workgroup.
- ECHO leads the Employment and Income Workgroup that focuses on strategies to increase employment opportunities. Barriers to stable employment are faced by those who are involved in the criminal justice system, who have limited employment history as youth and gaps in employment due to homelessness/disabling conditions. Most importantly, economic and racial/ethnic disparities go hand in hand resulting in limited educational opportunities that perpetuate poverty and structural inequality.

PLANNED ACTIONS

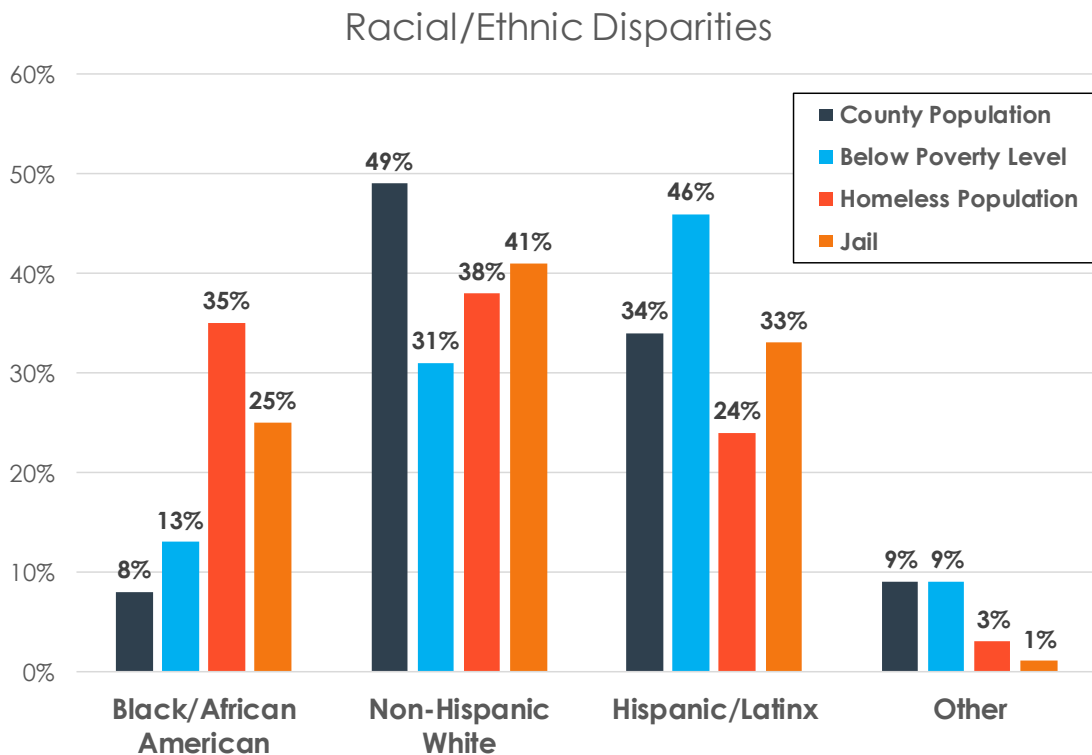
- ECHO and the Housing Authority of the City of Austin are considering using small-area market rents in Housing Choice Voucher programs. This would allow access to higher-opportunity areas, at the cost of some vouchers.
- ECHO is continually creating new partnerships with stakeholders working to address racial disparities. Future partnerships of interest include the City of Austin's Equity Office and groups like Measure, a local nonprofit working to address disparities in the criminal justice system.
- ECHO is committed to continuously improving program monitoring and evaluation and continuing to incorporate measures related to equitable enrollment and outcomes into performance discussions.
- ECHO's Pay for Success evaluation may include a participatory research component. ECHO is interested in pursuing opportunities for participatory/participatory action research with clients, community members, and local stakeholders in the future.

DATA

POPULATION DEMOGRAPHICS

The bars in each category on the graphs below represent the percentage of the specific population each group represents. For instance, on the National Data chart, white Americans make up a bit over 70 percent of the general population of the United States, and a bit under 30 percent of the total population experiencing homelessness. This means that white Americans are underrepresented in the total population experiencing homelessness in the United States relative to total population representation. On the Local Data slide, Black/African American residents account for 8 percent of Travis County's total population, but 37 percent of the population experiencing homelessness in the same area. This is a dramatic overrepresentation and a key challenge facing our homelessness response system and the Austin/Travis County community generally.

Local Data⁴



Black and African American residents of Austin/Travis County experience homelessness at disproportionate rates compared to total population percentage.

Disparities among youth experiencing homelessness are similar, with 42 percent of youth experiencing homelessness in Austin/Travis County identifying as Black or African American.⁵

In terms of age, the charts below show age information for all heads of household who were experiencing literal homelessness and interacted with the Austin/Travis County homeless response system between 2015 and 2018. In general, the population experiencing homelessness in Austin/Travis County is older compared to the general population.

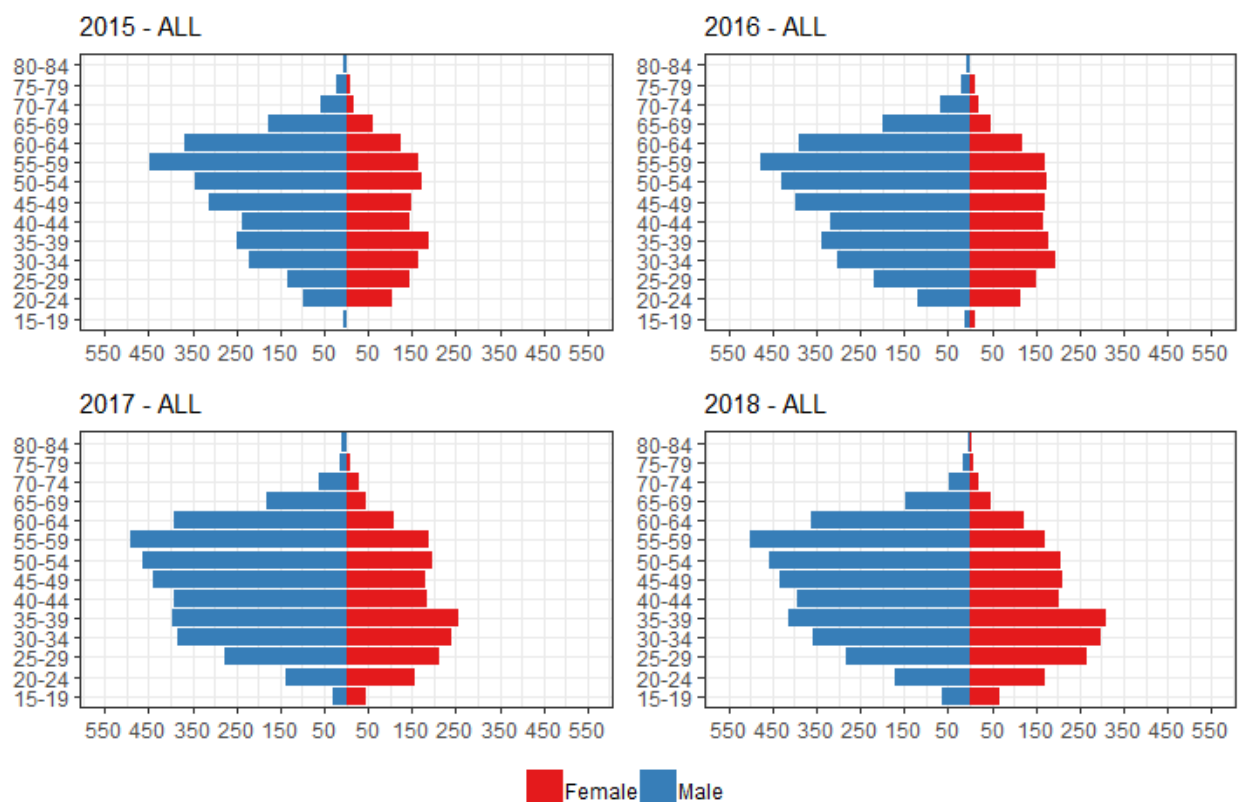
The population skews heavily toward single adult male households. The population appears to be getting proportionally younger, with a growing number of male clients in the 30-40 age range beginning in 2016

⁴ Sources include:

- US Census Bureau. "Poverty Status in the Past 12 Months." 2016 American Community Survey 1-Year Estimates, S1701.
- US Census Bureau. "Hispanic of Latino Origin by Race." 2016 American Community Survey 1-Year Estimates, B03002.
- Ending Community Homelessness Coalition (ECHO). Analysis of 2018-2019 HMIS Data, September 2019.
- Ending Community Homelessness Coalition (ECHO). Analysis of Travis County Sheriff's Office Booking Data for 2017, January 2018.
- Grassroots Leadership. "Travis County Jail in 2015: Data Points to racism and longer confinement of African Americans." 2017.

⁵ Austin/Travis County Coordinated Community Plan to Prevent and End Youth Homelessness.

and continuing in 2017 and 2018. The high number of adults over the age of 50 is in line with national trends related to the aging of the country's population experiencing homelessness. Since 2017 there appears to be a spike in women 20-39 experiencing homelessness. The reasons for this spike are unclear.

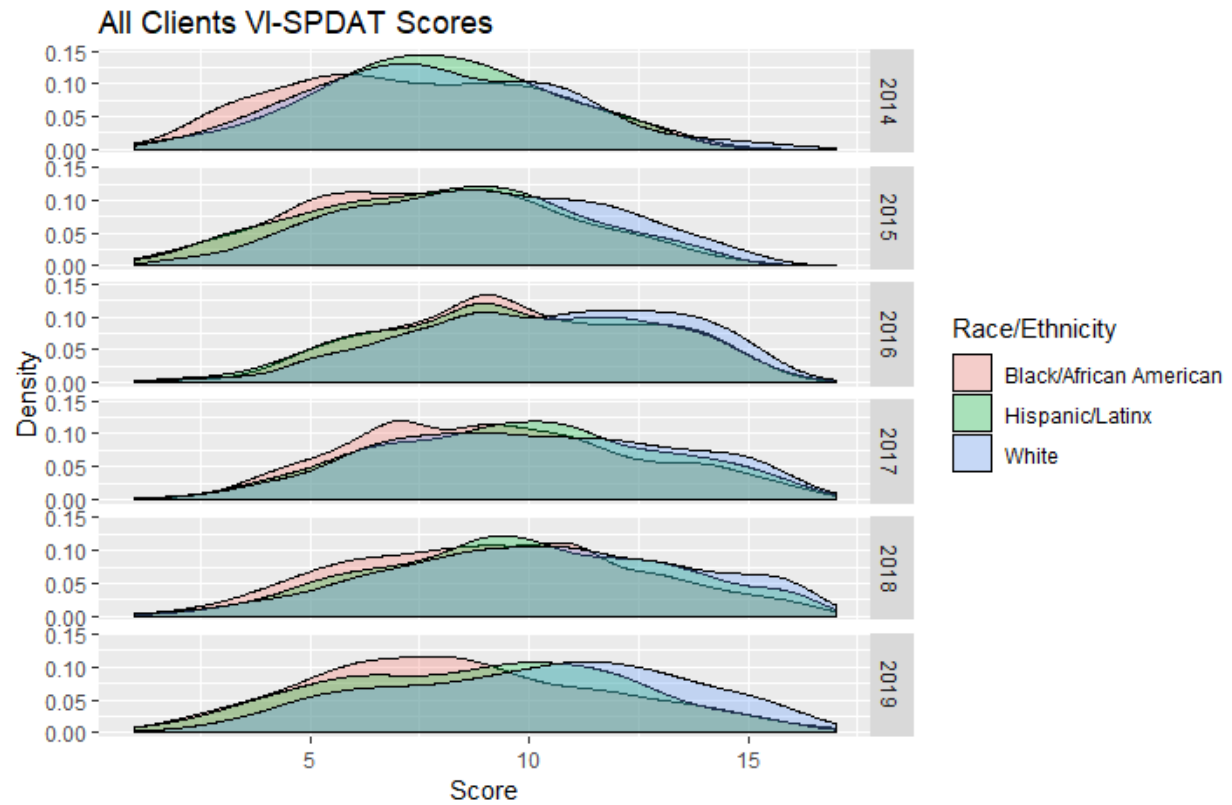


COORDINATED ENTRY

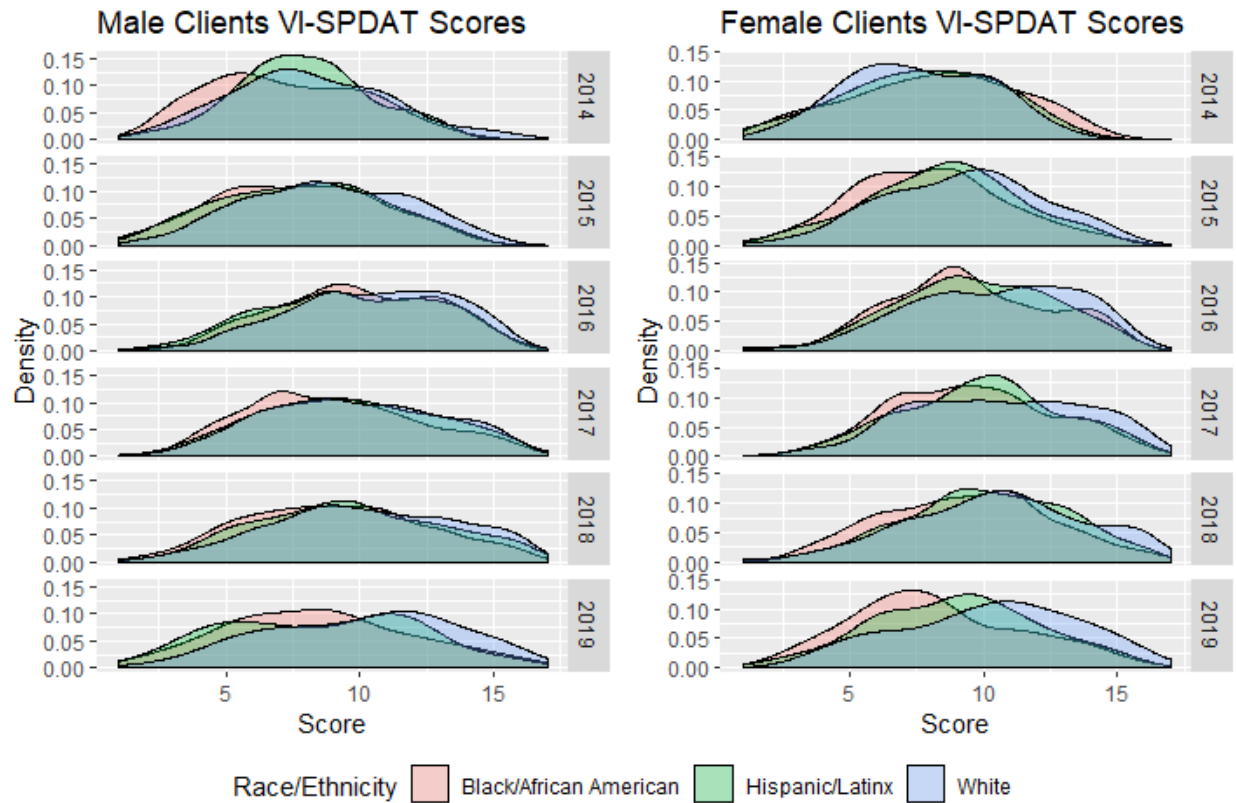
The following chart displays VI-SPDAT scores, used for Coordinated Entry prioritization, for all clients assessed from 2014 through September 2019. This data is from Austin/Travis County's Homeless Management Information System (HMIS).

This chart shows that clients identifying as non-Hispanic/Latinx and White tend to have higher prioritization scores compared to clients identifying as non-Hispanic/Latinx and Black/African American. This trend emerged in 2015 and continues through 2019.

Hispanic/Latinx-identified clients have higher scores compared to non-Hispanic/Latinx Black or African American clients, but lower scores than white non-Hispanic/Latinx clients starting in 2017. This trend appears to be continuing in 2019.



The next chart displays the same breakdown for male- and female-identifying clients. In general, the same trends are seen in the gender breakdown.

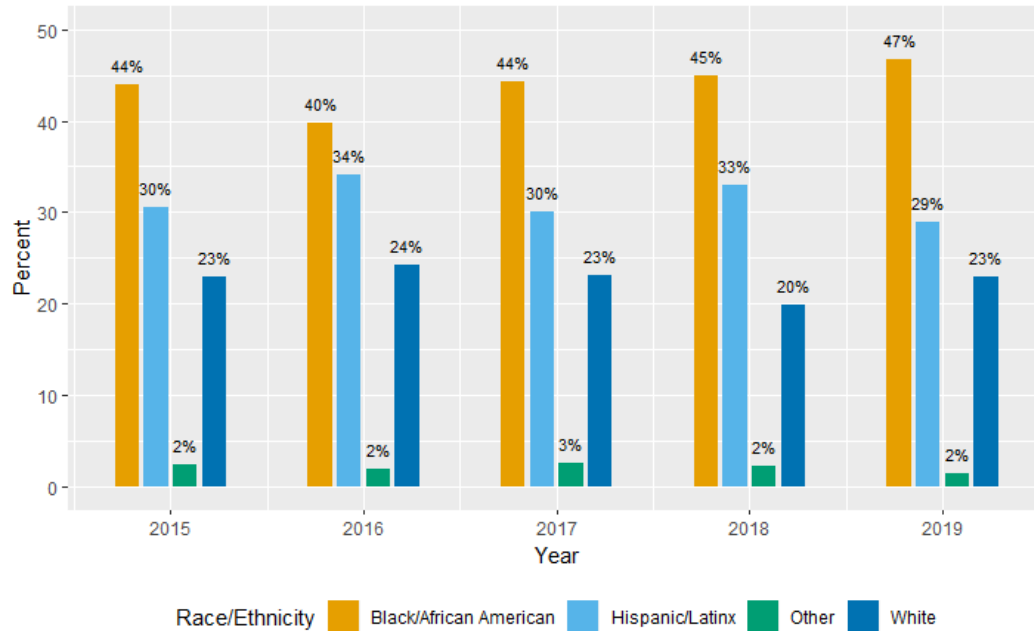


PROGRAM ENTRY

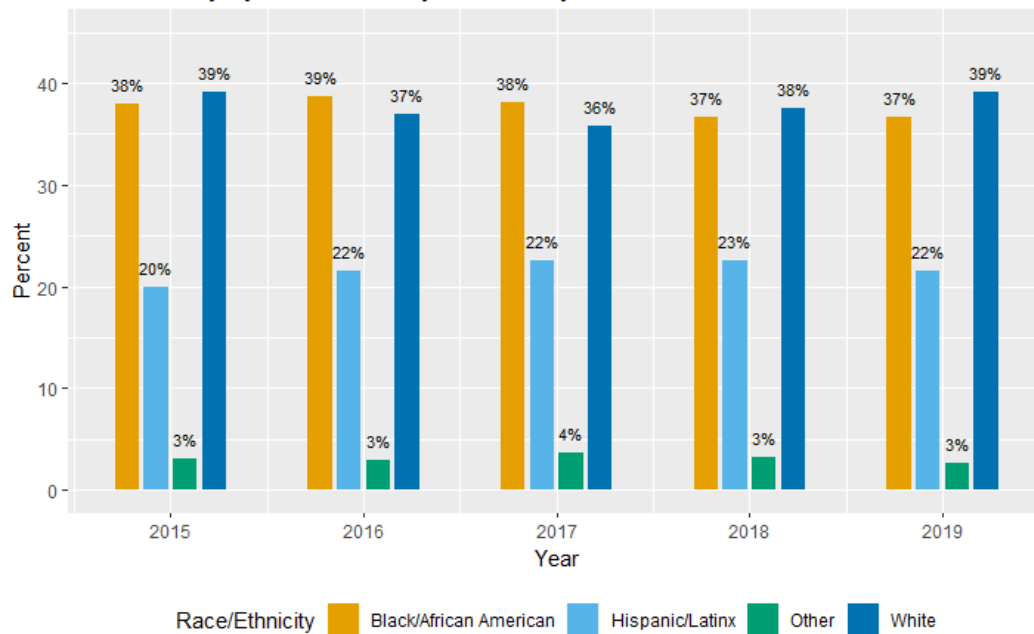
The following charts display program entry information for prevention, shelter, and housing programs. Apart from prevention programs, entry rates are roughly aligned with broad population percentages, though there appear to be discrepancies in Prevention entries, and somewhat in Housing entries. White clients enter prevention programs at much lower rates. White clients also enter Housing programs at slightly lower rates compared to population percentage.

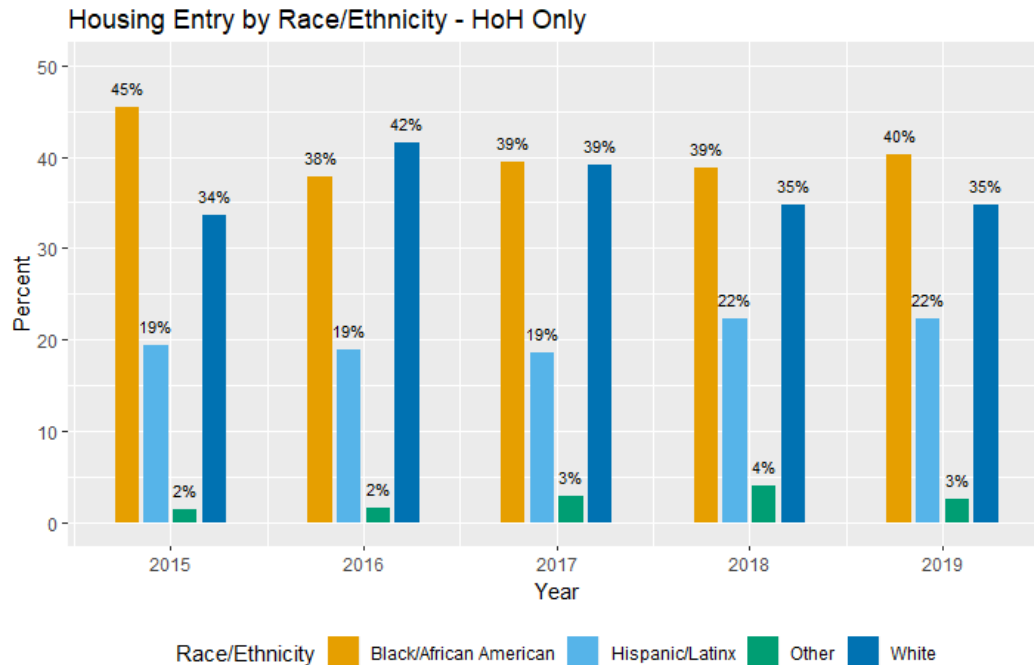
Information is provided for head of household (HoH) members only. This data is from Austin/Travis County's Homeless Management Information System (HMIS). Data is current as of September 2019.

Prevention Entry by Race/Ethnicity - HoH Only



Shelter Entry by Race/Ethnicity - HoH Only



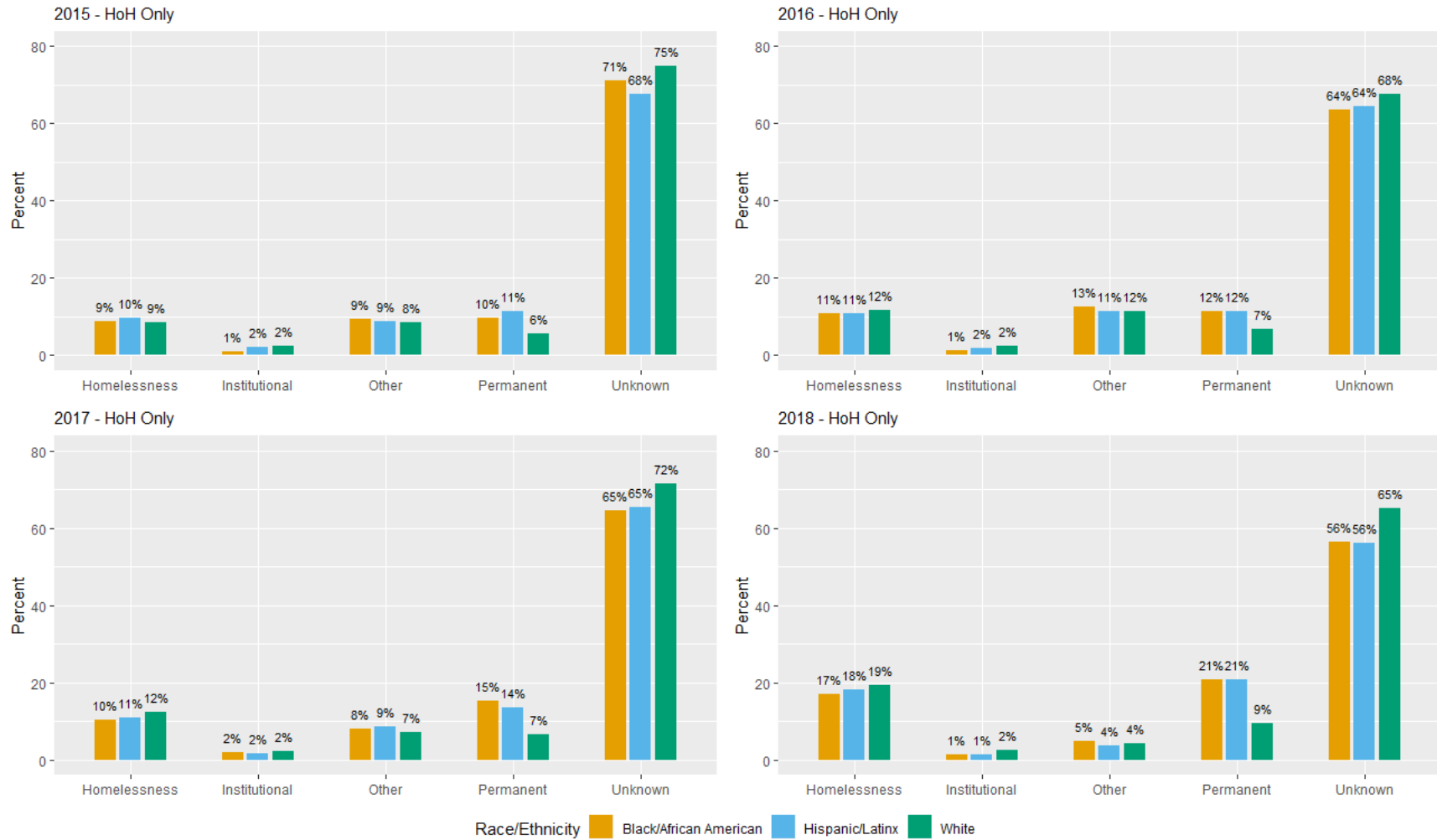


EXITS

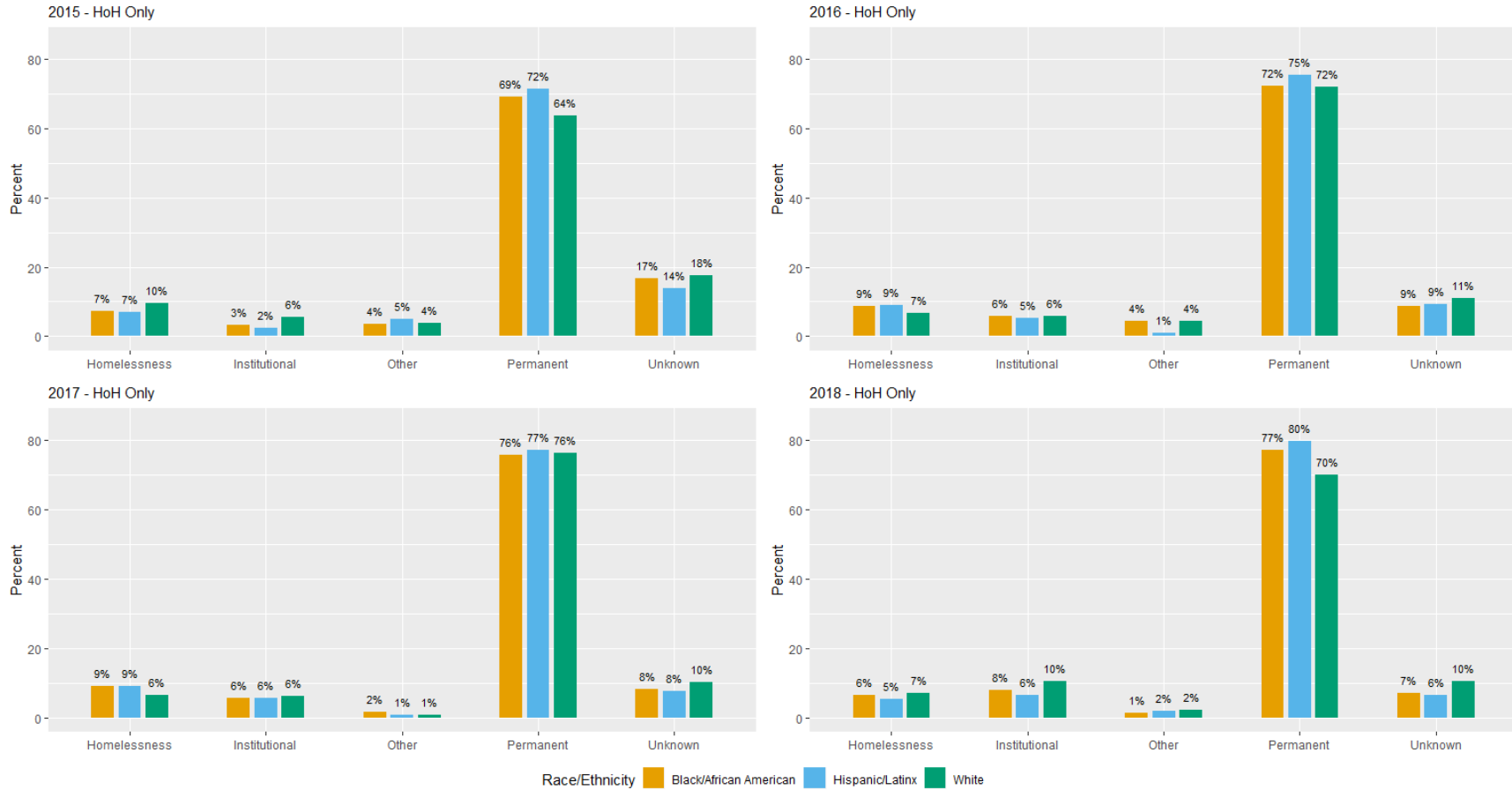
The following charts display program exit information for Shelter and Housing programs. There appears to be a slight pattern of increased negative exits and decreased positive exits for clients identifying as White that persists across years and increased slightly in 2018.

Information is provided for head of household members only. This data is from Austin/Travis County's Homeless Management Information System (HMIS). Data is current as of September 2019.

Shelter Exits



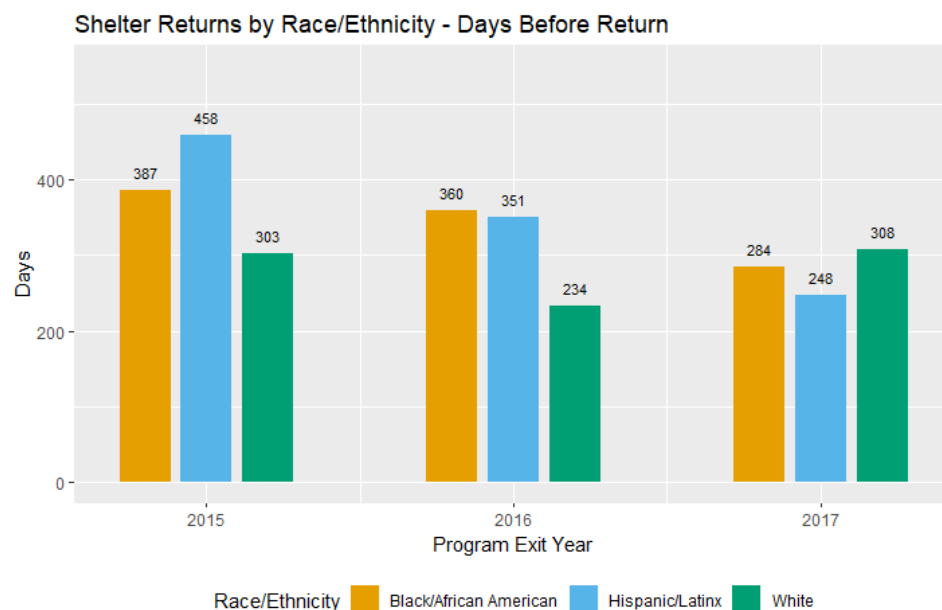
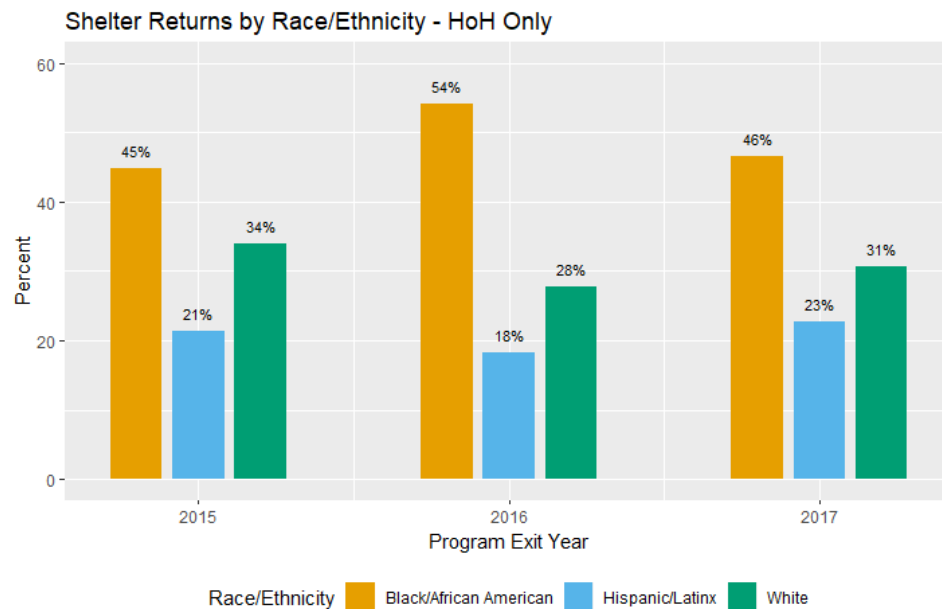
Housing Exits

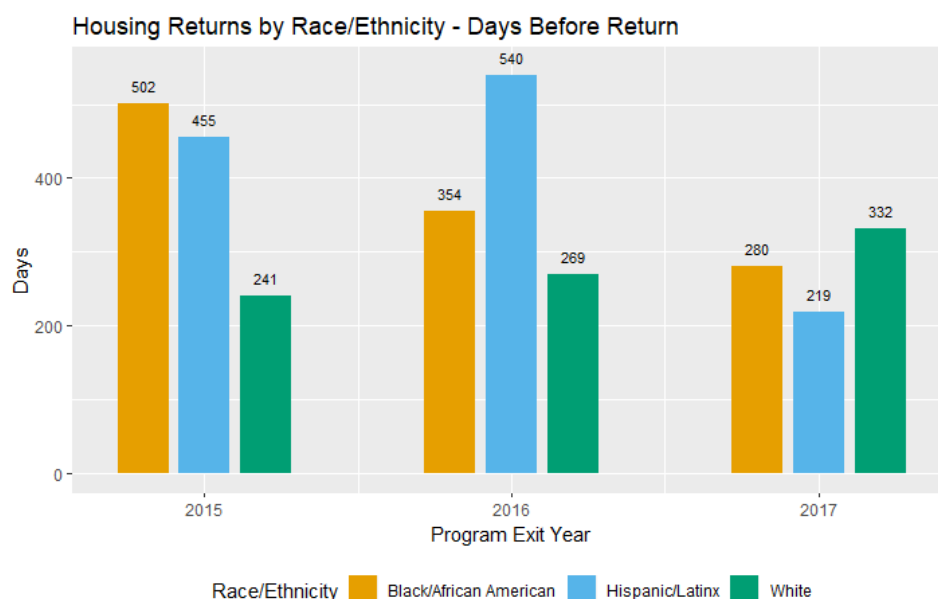
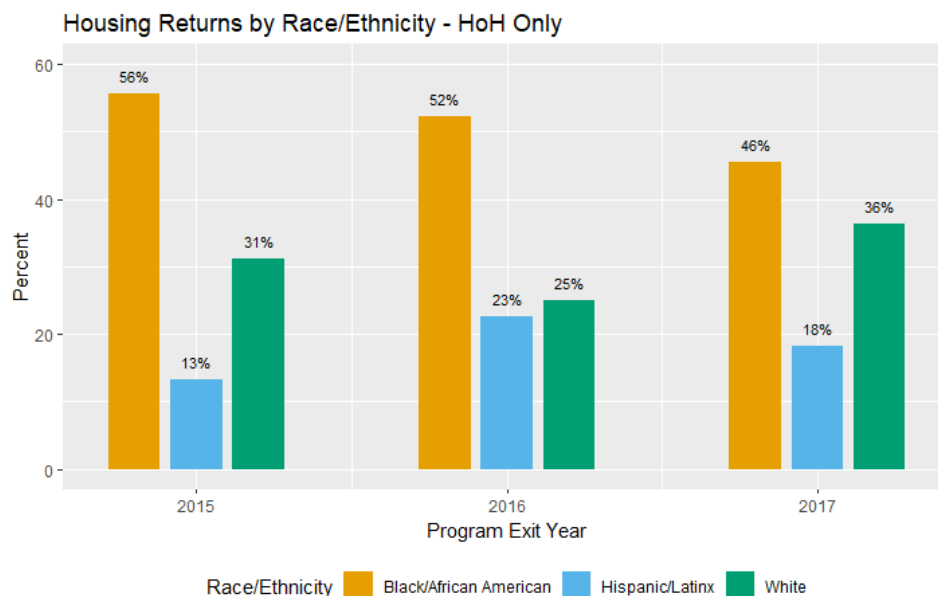


RETURNS TO HOMELESSNESS

The following charts display returns to homelessness information for Shelter and Housing programs. Both program types exhibit disparate returns to homelessness for clients identifying as Black or African American. Time before return has historically been higher for these same clients, but this trend appears to be reversing. Returns proportion differences appear to be narrowing for Housing programs.

Information is provided for head of household members only. This data is from Austin/Travis County's Homeless Management Information System (HMIS). Data is current as of September 2019.





SUMMARY OF RESULTS

Results of this analysis are mixed, and somewhat inconclusive.

- Coordinated Entry VI-SPDAT assessment scores for White clients continue to be higher compared to Black/African American clients or Hispanic/Latinx clients. This gap appears to have increased in 2019 and is more pronounced for women. This result could be due to issues with the assessment itself, with the operationalization of the assessment, or simply due to differences in vulnerability in the population experiencing homelessness. Without additional information it is difficult to determine causality for this result.

- There appear to be some disparities in program entry, concentrated mainly on prevention entries, which continue to be primarily Black and African/American clients, followed by Hispanic/Latinx clients. This disparity is likely driven by systemic racism, inequality, and resultant poverty levels, though it is again difficult to attribute causality when looking only at one data source. Entries do not reflect the county's population experiencing poverty, an interesting result.
- Shelter and Housing entries continue to roughly mirror population percentages of residents experiencing homelessness. Both program types show slightly elevated enrollment rates for Black and African American clients compared to population percentages. This is an unlikely result when paired with vulnerability information. Because the number of clients housed each year in Austin and Travis County is so low compared to the population in need, it is possible that the assessment disparity noted above does not play a role when only considering the subset of clients scoring at the highest levels. Veteran program enrollments may also play a role in this discrepancy.
- Returns to homelessness show some level of disparity. Black and African American clients return at higher rates than expected, and days before return has decreased over time. Again, causality is difficult to determine without assessing other factors such as client needs and services provided, but this is a potentially worrisome result.