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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1A-1. CoC Name and Number: MI-504 - Pontiac, Royal Oak/Oakland County CoC

1A-2. Collaborative Applicant Name: Alliance for Housing Oakland County Continuum of Care

1A-3. CoC Designation: CA

1A-4. HMIS Lead: CHN

1B. Continuum of Care (CoC) Engagement

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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	No	Yes
Local Jail(s)	Yes	No	Yes
Hospital(s)	Yes	No	Yes
EMS/Crisis Response Team(s)	Yes	No	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	No	Yes
CoC Funded Youth Homeless Organizations	Yes	Yes	Yes
Non-CoC Funded Youth Homeless Organizations	Yes	No	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	Yes	Yes
Domestic Violence Advocates	Yes	Yes	Yes
Street Outreach Team(s)	Yes	Yes	Yes
Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates	Yes	Yes	Yes
LGBT Service Organizations	Yes	Yes	Yes
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)			
NA	Not Applicable	No	No
NA	Not Applicable	No	No
NA	Not Applicable	No	No

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.CoC solicits&considers opinions from homeless/nonhomeless service providers&organizations by going to county meetings to gather&provide feedback,hosting public events inviting providers,residents&organizations who have interest in/work directly w homeless.CoC annual retreat &planning meeting is posted on website& listserv to invite public to hear successes,work on upcoming year strategies,&provide input.2.CoC conducted web survey that asked agencies the strength&weaknesses of the CoC. These were incorporated into our strategic plan&have utilized to create committees in order to work as efficiently as possible.The CoC has a Community Referral Form for organizations that do not use HMIS &want to refer someone for housing assistance. Its used to streamline CoC services to make sure everyone can get connected to the resources &supports they may need.This has increased involvement &engagement from organizations that operate outside the CoC.CoC has also engaged in cross sector meetings such as Homeless Health

Care.Every GM meeting has a guest speaker that presents about their program&how their services can help w preventing/ending homelessness.Guest speakers give opportunity to find innovative ways to prevent/end homelessness.3.CoC agencies &staff are able to engage &take info back to the CoC committee meetings to implement new processes, tweak &or change how services are offered/delivered. The CoC hosts General Membership(GM)meetings everyother mnth that are open to anyone that is interested in making connections,finding new resources&services&updates on homeless programs.CoC is apart of another listserv that consists of multiple counties that is used for Metro Region Networking,we can share and post events,activities and announcement that contribute to the well-being of the community.4.CoC works to ensure effective communication w individuals w disabilities by providing written info available in accessible literacy levels& text using large verdana font& formats ie PDF

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.CoC's invitation process is done in person at multiple community meetings, via email and on our website. 2 &3.CoC communicates the invitation process & solicits new members monthly via email listserv, personal invitations at community meetings/forums & encourages partner agencies to invite client/former clients,new staff, volunteers, individuals with disabilities & stakeholders join the CoC. We also a provide the ability to contact the CoC via our website if anyone has a question about becoming a member. 4. The CoC is always soliciting new members. A workgroup has been created with the primary focus of identifying and recruiting additional organizations to join the CoC to maximize representation. This committee intends to bring new people to the table to talk about strategies for funding & building community partnerships. This past year the CoC has recruited 1 new agency as a member as well as 2 new Board members. The CoC has revamped the website to make applying for membership more accessible to anyone that is interested including those with disabilities. They will be able to complete the membership form and pay online and accommodations are made for anyone needing assistance completing the form.The COC has the ability to wave membership dues to encourage membership. CoC is also started awarding certificates of membership for each agency/community person, which will increase reputability by providing owners with a piece of official documentation representing their participation within the CoC. The CoC has also started a monthly newsletter for CoC members. 5. CoC ED reaches out to partner agencies to review their consumer advisory committee and tenant advisory council to see if any current or past homeless individuals are interested in attending workgroups, committees & a seat on the

CoC board.

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 notifies the public that is is accepting new project applications via the CoC website and listserve.CoC also posts a timeline of events and important dates. CoC reaches out to agencies not previously funded directly to inform them of the opportunity and answer any questions. In addition throughout the year the CoC ED is doing outreach to other non-funded agencies and encouraging them to sign up for the listserve and apply for new funding opportunities, as the CoC is open to accepting new applications. The method the applications are to be submitted is via email and this is stated in the RFP/information that is posted. 2. CoC Prioritization committee uses dat and community priorities in their process to determine whether the project application will be included in the FY19 funding for new proposals based on community need via the housing registry and sub-populations. In addition to agency capacity to administer federal programs and NOFA specific requirements. 3. Monday July 15, 2019. 4. The CoC ensures effective communication with individuals with disabilities by posting via website and listserv. Individuals can makes requests for reasonable accommodations to any staff at any time.5. The COC DOES accept new proposals for agencies not previously funded.

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)	Yes
Runaway and Homeless Youth (RHY)	Yes
Head Start Program	Yes
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)	
NA	Not Applicable

NA	Not Applicable

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 consults with the following ESG recipients, MSHDA & Oakland County in the planning and allocation of ESG funds. The CoC provides detailed information of community need and the request to align funding to best serve individuals experiencing homelessness or those at imminent risk of homelessness. OC attends the COC's annual retreat to get input from homeless service providers as well as COC staff provides written and in person comment during the public comment period during OC's annual planning process. CoC staff attends the annual MSHDA homeless summit as well as provides written and in person comment during open comment periods.2.HMIS data is reviewed at the COC level to evaluate and the annual report to provide performance based feedback to the recipient and sub recipients.3. CoC ensures that local homelessness information is communicated and addressed in the CP by the COC ED attending commissioners meetings, providing written and verbal comments to full OC commissioners board as well as during public comment.

1C-2a. Providing PIT and HIC Data to Consolidated Plan Jurisdictions. **Applicants must indicate whether the CoC provided Point-in-Time (PIT) and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area.**	Yes to both
1C-2b. Providing Other Data to Consolidated Plan Jurisdictions. **Applicants must indicate whether the CoC ensured local homelessness information is communicated to Consolidated Plan Jurisdictions within its geographic area so it can be addressed in Consolidated Plan updates.**	Yes

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 policy to prioritize safety of survivors by an emergency transfer plan it adapts services to their unique circumstances through victim-centered practices,trauma informed care, participant choice, &confidentiality.CoCs screening process is designed to allow participant to go to any access point.Regardless of its dedicated population, clients will be linked to the appropriate resources. This process assures that participants can be served at all access points.If unable to meet at an access point, screening can be done via phone or agency staff can work with the client to meet with them at a location that is safe &accessible. No access point will deny a person who has or is a victim of DV, dating violence, sexual assault &stalking. Rather,the assessment will be completed, linkage will occur and services will be provided with safety considerations for the participant in mind.Lead DV shelter HAVEN connects potential participants with CoC through agencies doing outreach at the shelter and/or by asking the participant if they would like to sign an ROI. If the participant doesnt want their info shared then they will be given the resources information so they can contact them. The DV shelter helps to create safety plans for all DV households even if a shelter bed is unavailable. Survivors identified as Cat.4 are given priority status for entry, including time needed to become self-sufficient. 2.Dedicated staff member through the DV SSO/CE grant who works with DV to work with HH to discuss options on housing,services and location based on participant personal choice. When applicable, participants decide about location &type of housing within grant parameters. When educating the participant about the program options, the expectations for both program staff and clients are explained.Moveout assistance,partnering with schools to ensure any school-aged children have a safety plan in place is also provided. All information is locked and confidential.

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

Applicants must describe how the CoC coordinates with victim services providers to provide training, at least on an annual basis, for:
1. CoC area project staff that addresses safety and best practices (e.g., trauma-informed, victim-centered) on safety and planning protocols in serving survivors of domestic violence; and
2. Coordinated Entry staff that addresses safety and best practices (e.g., Trauma Informed Care) on safety and planning protocols in serving survivors of domestic violence.
(limit 2,000 characters)

1.& 2. CoC coordinates with our victim service providers to provide annual training to the CoC area projects and Coordinated Entry staff. We have a no wrong door approach for our CE. HAVEN is OC's lead agency in providing services related to domestic violence, dating violence, sexual assault and stalking. HAVEN provides training in trauma informed care,victim centered training and best practices, safety planning, domestic violence 101, strangulation and sexual assault. Training is also made available through the

Michigan Coalition to End Domestic and Sexual Violence. HAVEN also has a Prevention Education Department. This provides access to trained educators that are available to train and educate on the dynamics of domestic violence and sexual assault through training seminars. HARA staff is trained in the Danger Assessment. This allows staff to measure lethality and provide a measurement similar to how those experiencing Cat 1 Homelessness are prioritized with the Vi-SPDAT within the community.

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)

COC uses de-identified HMIS and DV data from a comparable database, crisis call center numbers, OC arrest reports and online data from the DOJ online domestic and sexual assault data resource center. All agencies within the CoC have a Public Privacy Notice that is posted and visible to clients in locations where information is collected. This is to ensure transparency between agency and client in regards to the purpose of data collection, and client rights. Also, each agency is required to have a Privacy Policy that includes specific protections for clients with increased privacy risks. For example, a client can choose to be entered under an Un-Named Record Protocol where identifying information is not recorded in the System and the record is located through a randomly generated number. The CoC works in collaboration with HAVEN, the lead organization in DV services, to collect data on persons who are homeless because they are fleeing/fled domestic violence. In addition to HMIS, HAVEN obtains data from a CSL comparable to HMIS but is specifically designed for DV, abuse, and shelter organizations.

*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
MSHDA(Michigan state housing department authority)	89.00%	Yes-HCV	Yes-HCV
Ferndale	0.00%	No	

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)

CoC works directly with the largest PHA, MSHDA, they have a homeless preference and agencies populate waitlist with homeless HH's.CoC continues to reach out to all PHA's to discuss the importance of a homeless preference within their polices. As well as invites them to attend our annual retreat and to become CoC members. provided LOS to MSHDA and reached out to Pontiac PHA to do the same for RRH preference for moving on vouchers. To date we have met with Pontiac,Ferndale and MSHDA to provide homeless community data, explain agencies services that can be offered to HH's. CoC works informally with the Detroit PHA to coordinate for homeless individuals. HARA coordinated with all PHA's, when they open up their waiting lists to infirm everyone how to apply.

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 utilizes a move on strategy to insure that the available beds of PSH are used for those that continue to need the most intensive services and assessing who may be able to move to another less intensive resource. In collaboration with our state PHA, we have Moving Up Vouchers that provide a subsidy for someone with limited fixed income and the continued need for a financial safety net, but has been assessed to be able to transition from the supportive services component of PSH. Providers complete an assessment which provides a numeric score to determine the strengths in place. The names are reviewed at the Housing reg. meeting to prioritize those with the highest score as slots become available, reviewed quarterly. Additionally all PSH providers work with current program participants to apply for other PHA waitlists when public notice is received and a waitlist is accepting new names. Case managers also work with these program participants, as they become more self-sufficient to apply for subsidized housing units in other projects including LIHTC.

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)

CoC implemented a Coc wide anti-discrimination policy that applies to all projects regardless of funding source. CoC also conducted an annual CoC wide training with providers on how to effectively implement Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity. CoC is working to fund a year long racial Equity framework which would include community training, focus groups with community stakeholders, community leaders and clients of homeless services recommendations, coaching and action plan development. At the state level MCAH hosted a racial equity and homelessness training that CoC partners attended.

*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:	X
2. Engaged/educated law enforcement:	X
3. Engaged/educated local business leaders:	X
4. Implemented communitywide plans:	X
5. No strategies have been implemented:	
6. Other:(limit 50 characters)	

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.CoC has a no wrong door approach with CE to ensure the entire geographic area is covered. CoC has created a Community Referral Form to ensure that all agencies that do not have the capacity to be formal access points, or that do not use HMIS have the ability to easily connect individuals to the CoC. This enables the clients to access any agency to obtain help. This approach ensures that all agencies within the CoC respond to the individual's stated and assessed needs through either direct services or linkage to other appropriate programs. The initial screening can be done via phone to eliminate barriers, such as transportation. This is standard process across the CoC, especially at the HARA. 2.The CoC's PATH program conducts special street outreach to provides access to those least likely to apply. Such as, persons with active addictions or criminal history. 3.CoC uses a phased approach of assessment; this process has integrated housing first principles focusing on rapidly housing clients without precondition to services. The initial screening includes a VISPDAT for those that are literally homeless. After screened and are potentially eligible for a program, a face to face assessment occurs, accommodations are made to meet the person if there are barriers. More detailed information is collected at this time including housing/homeless history, barriers, goals, preferences. This assessment supports the evaluation of the client's vulnerability and prioritization of assistance using the full SPDAT. This process will assist in the prioritization of housing those with the highest needs first.

1D. Continuum of Care (CoC) Discharge Planning

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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:	X
Health Care:	X
Mental Health Care:	X
Correctional Facilities:	X
None:	

1E. Local CoC Competition

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.

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.Prioritization committee takes into consideration the following needs and vulnerabilities, low/no income, current/past sub. abuse, criminal background,sig.health and behavioral issues during the scoring and ranking process. 2. For example, chronic projects sometimes have a higher turnover rate or lower successful housing placement. With housing first those that may have current substance abuse issues take longer to stabilize and so income growth is delayed so the increased income category would be taken into consideration. Some youth take longer to stabilize or may be able to get back into school so the income growth category is again not as high. DV is another area we review to as they are working to rebuild, stabilize and earned income category may be a lower threshold.

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	X	1. Email	X
2. Mail		2. Mail	
3. Advertising in Local Newspaper(s)		3. Advertising in Local Newspaper(s)	
4. Advertising on Radio or Television		4. Advertising on Radio or Television	
5. Social Media (Twitter, Facebook, etc.)	X	5. Social Media (Twitter, Facebook, etc.)	X

6. Did Not Publicly Post Review and Ranking Process	☐	**6. Did Not Publicly Post CoC Consolidated Application**	☐

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: 0%

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)

1. Each year the Alliance monitors each sub-grantee as well as prioritizes projects when the funding round opens up. The CoC prioritization committee, made up of non CoC HUD-funded community partners reviews all submitted sub-grantee application documents as well as a review of APR reports. If a project is not meeting threshold determined by the Alliance and HUD NOFA the project risks having funding reduced and/or cut. This allows the CoC to create new projects through reallocation to be in align with current community needs. There may be times when a grantee requests that their CoC funded project be reallocated into a new project and they will still serve as the grantee. This will require a written request of project reallocation with specific project changes as well as a new budget and proposed number served. This will be submitted to the Alliance for Housing Executive Director via email who will then forward to the Oakland County CoC board for a documented vote. The board will review community wide data, including our community priorities. If the CoC board denies or accepts this request the sub-grantee will be informed via email. 2.3.4.Because our projects perform at high levels based on our project performance reviews we are not re-allocation at this time.

DV Bonus

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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1F-1 DV Bonus Projects.

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

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

1. PH-RRH	
2. Joint TH/RRH	X
3. SSO Coordinated Entry	

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	9,888.00

the CoC is Currently Serving	627.00

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 for housing services is calculated by a deidentified All Client Count Report for CY18 along with data provided from lead DV agency,HAVEN. 2.The report wascreated w HMIS data that pulls in all persons served in OC for the year along w deidentified data from HAVENs comparable database. Served,essentially means the persons coming through the CE system. The number pulls on whether the person has made contact w a CoC,was entered into HMIS&answered Yes to "Domestic violence victim/survivor"

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
Lighthouse/SOS	608786125

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

Applicant Capacity

DUNS Number:	608786125
Applicant Name:	Lighthouse/SOS
Rate of Housing Placement of DV Survivors–Percentage:	97.00%
Rate of Housing Retention of DV Survivors–Percentage:	85.00%

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)

1)When calculating the rate of Housing Retention of DV Survivors,LH looked at our current performance levels with DV survivors enrolled in our transitional housing programs. Currently, 85% of our DV survivor clients have been able to maintain their housing. 2)The data source used is HMIS.

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)

Currently receives program referrals from emergency shelters, shelters for DV survivors along with other community partner agencies. We will prioritize DV survivors experiencing homelessness by implementing as the screening tool and utilizing The Danger Assessment, an Evidence Based Tool that provides a weighted score to determine the level of danger for a victim experiencing DV. Clients whose score indicate an elevated threat of danger will be prioritized first. One FT staff person will specifically concentrate on providing permanent housing/ services to these DV clients in identifying housing barriers and challenges and ways to resolve them; or connecting them to resources to resolve them in an effort to streamline or expedite the placement process. This staff person will also assist clients in applying for any housing subsidies applicable, such as the HPCV.

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)

1) Staff will do an assessment & safety plan w a client. a. Staff is trained in addressing the physical, emotional & spiritual health of client. Staff is trained in developing a safety plan that includes strategies to pursue if the batterer is encountered in public, if batterer comes to their place of residence & how to deal with batterer w drug/alcohol additions. b) Every person will be taken into a private room for the intake process c) To ensure safety all couples will be interviewed separately and together d&e)TH placements are in staffed buildings that can only be accessed via assigned pass-point/keyless entry; there is also a 24-hour video surveillance for safety. Rental unit is client choice in a safety secure location & participant knows abuser is not aware of the location. f) All property files are de-identified & kept in a locked cabinet; units are mixed with regular population. 2) LH/SOS is able to measure the ability to ensure the safety DV survivors by taking in to consideration of the safety of the scattered site apartments before they are chosen, the sites will contain secured entrance & intercom systems. If a client does not own a personal cell phone, they have opportunity to receive one.

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)

1)Staff Is trained for using trauma-informed, victim-centered approaches to meet the needs of DV survivors by understanding the physical emotional and psychological implications and impact DV has on individuals & families. LH/SOS has over 30 yrs of experience in understanding & responding to the effects of trauma.2)If funded the project will continue to use trauma-informed, victim-centered approaches as well as on-going training to meet the needs of DV survivors by a) prioritizing participant choice & rapid placement, and stabilization in permanent housing consistent with the needs and participants preferences. All interactions between survivors & casemangers are trauma-informed & victim-centered to make sure clients feel safe & supported to enable open communication for their housing needs. b) LH has established &maintained an environment of mutual respect, positivity and support by not using punitive interventions. Staff ensures that they do not re-traumatize clients, as on-going training is provided. Staff holds client preferences for housing & services at high regard. c) LH/SOS is part of the CE sytem and has partnerships with behavioral & physical health care providers. Referral can be made to these resources as needed. HAVEN our lead DV agency will provide access to resources for staff and clients that support survivors with information on trauma. d) Motivational interviewing is used as well as strength-based approaches when staff interacts w clients. Through the assessment tools used clients are encouraged to set goals working towards housing and non-housing goals, then are provided links to community resources. Long term housing plans that include goals related to safety, health care and employment are created by clients and staff. e)Staff receives on going training in nondiscrimination & cultural responsiveness and inclusivity. Staff also receives on-going equal access training. Services are made available to any person or group that is asking for assistance with or without children, regardless of martial status/relationship, actual/perceived sexual orientation or gender identity, age, relationship, or disability. f)LH/SOS encourages building the clients community connections in encouraged through self help groups, peer to peer mentoring & spiritual developments at institutions. g) LH/SOS will connect clients to child care services & parenting classes/resources as needed. LH/SOS also provides on site child care for those in need. Staff will continue to work with community partners that aid pregnant women in parenting classes & resources before and after birth.

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)

This program ensures that clients arent screened out of service participation based on income, substance abuse use/history or criminal record.Program focus on addressing the issue of housing first &will engage client in intensive CM to address underlying causes of homelessness.Support services are avail for adults&kids impacted by DV. To address safety needs,we leverage services via support of community partnerships & other internal programs.Partnership has broughtEarly Childhood Education Program onsite to TH localation, more accessible highquality childcare &early learning for PATHfamilies.For adults, Lighthouse offers a spectrum of supportive services including:Intensive CM to address the psychological&emotional wellbeing of each family impacted by DV. Families can access referrals &direct supports to support theneeds of each family;staff available to help with personal safety planning, goal setting and work-life balance;Individual and group counseling to address issues of DV, depression and anxiety;Access to non-legal advocacy support and resources for pro bono lawyers and/or legal aid;Assistance with accessing benefits, e.g., Medicare, Medicaid, SSI, food stamps, etc.Life skill classes to help improve parenting, self esteem and communication skills;Access to transportation;Workforce development and employment coaching to improve employability skills;Financial coaching to reinforce the importance of sound credit and financial responsibility;Referrals to mainstream area support resources such as Catholic Social Services, Maternal Infant Health Programs, Oakland Family Services, Lighthouse Crisis Resolution Services, and others;Access to other Lighthouse Self-sufficiency services, such as our annual Thanksgiving basket sign-up, holiday party and Adopt-a-family Christmas program;A comprehensive exit plan to provide referrals for housing, furniture, and some limited assistance with moving costs

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. Mediware Information Systems, Inc.

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	266	55	211	100.00%
Safe Haven (SH) beds	0	0	0	
Transitional Housing (TH) beds	120	0	120	100.00%
Rapid Re-Housing (RRH) beds	102	0	102	100.00%
Permanent Supportive Housing (PSH) beds	662	0	603	91.09%
Other Permanent Housing (OPH) beds	44	0	0	0.00%

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)

OPH includes 5 LIHTC projects that have set-asides for cat. 1. 1) The HMIS Administrator has worked with the agencies and data has already been put into HMIS. All persons referred to these units enter through the coordinated entry process and are prioritized by need. 2)Since March 2019 the agency has begun to add an entry into HMIS and complete a client profile to assure all the information is reported in the system.

*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)	06/24/2019

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

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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2B-1. PIT Count Date. Applicants must enter the date the CoC conducted its 2019 PIT count (mm/dd/yyyy). 01/30/2019

2B-2. PIT Count Data–HDX Submission Date. Applicants must enter the date the CoC submitted its PIT count data in HDX (mm/dd/yyyy). 04/29/2019

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 added or removed emergency shelter, No

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)

Not Applicable

*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. COC partnered with stakeholders, PIT team leaders, and in-shelter homeless youth to create an identification and engagement plan. 2. Older (in shelter) youth helped stakeholders and PIT team leaders identify priority search areas, such as after-school hangouts and encampments where homeless youth might sleep. The COC consulted with stakeholders to create a list of places where homeless youth are likely to be. Our youth provider also highlighted "hot spot" information on PIT maps where additional homeless youth might be found, engaged and identified. 3. Involving youth in planning allowed the local count to enhance their coverage, accuracy, and acceptability to other homeless youth, as well as giving those in-shelter a chance to have their contributions valued. PIT team leaders and stakeholders partnered with youth during the count, helping them engage youth at given locations (working both on the street, as well as at the deployment sites).

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

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

1)Through working with our PATH outreach, communication with our local shelters & providers the CoC has continued over the past year to identify target areas to improve and productivity use PATH outreach data into the PIT count. We also used feedback from last year's PIT night to update our maps for this year's PIT, updating locations that have changed. Each week partners review an active list of chronically homeless individuals & families; this list is cross-referenced with the 2019 client-level PIT count. 2) The CoC is committed to ensuring access to emergency shelter for families with children. All families that encountered our system are included in HMIS. Standard HMIS data collection and standard protocols for emergency shelter & street in reach & outreach give the opportunity to identify sheltered/unsheltered families.The CoC also works closely with OC schools homeless student manager; she is on the CoC Board and offers input and best practices for helping families experiencing homelessness.3) The CoC has committed to making sure Veterans have access to shelter. Last year we were very close to reaching 'functional zero' for our chronic veteran numbers.Case conferencing is used in conjunction with Veteran by-name-list is reviewed each week aiding us in identifying Veterans accurately for the PIT count. Standardized HMIS data collection &protocols for emergency shelter and street outreach allow us to reliably identify sheltered and unsheltered Veterans.

3A. Continuum of Care (CoC) System Performance

Instructions

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

Applicants must:

Report the Number of First Time Homeless as Reported in HDX.	1,247

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.The COC uses a number of processes to identify risk factors for first-time homelessness, including consulting with foster care, eviction prevention, foreclosure prevention, Oakland schools homeless liaison, PATH outreach, and MDHHS court services for individuals/families, including families with children that may be facing eviction. 2. In order to reduce or end the number of people experiencing homelessness for the first time, the COC offers transportation, bus tickets, increase affordable housing through landlord outreach and prevention services, early intake hours, and integration of MDHHS staff to the overall intake process to ensure efficiency and that full service needs are met. The COC also works with communities in OC to develop locally-centered prevention

strategies that suit residents needs. 3. The Alliance for Housing's executive director and Community Housing Network (HARA) director of community programs, oversees, manages, and regularly reviews this process and its outcomes to reduce/end individuals/families experiencing homelessness for the first time.

*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.	220

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. The actions the CoC has implemented to reduce the LOT individuals and families remain homeless include: increased case management, CoC project wide housing first practices, MDHHS same day denial to speed the process along, landlord outreach, as well as fee waiver for birth certificate and SOS expedited ID, & supporting development of affordable housing. 2. CoC identifies and houses individuals and families with the longest length-of-time homeless through weekly housing registry meetings by prioritizing & using the VI-SPDAT. Taking the following factors into consideration while prioritizing: if individual or family is chronically homeless, sheltered or un-sheltered, if they can't be served by other projects, or if CPS is involved. 3.Alliance for Housing, ED and Performance Outcome committee w/board chair are responsible for overseeing these strategies.

*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.	67%
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.	98%

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 has a higher placement/retention rate with RRH and TH. Increase the permanent housing rate at which individuals/families leave shelter providers are increasing case management, embedding emergency housing assistance into our shelter program, everyone completes HCP/HPV application at entry. Each ES, TH or RRH project work together and have weekly call in meetings then once a month in person, as well as work on building landlord relationships. We utilize Moving Up vouchers provided by our PHA, and use a length of time in project as well as a matrix to assist in this placement process and move HH to this permanent voucher and follow up at least at the 180 day mark. Case management is key to assisting getting individuals housed, case managers work with individuals to increase income, make connections to healthcare/supportive services as well as address any barriers the individual may be facing and help with identifying ways to break those barriers down. 2.The COC ED, Performance Outcome committee which includes a board chair, are responsible for overseeing these strategies and include shelter, CoC funded agencies and non-funded agencies in this process. 3. The CoC's strategies to increase the rate of people in permanent supportive housing (PSH) stay in PSH or leave for PH destination includes using termination only as a last resort once all other options have been exhausted, strong relationships with supportive services, landlord liaison's, case management assistance and income supports to maintain client housing. Those who are leave PSH are able to maintain connections to supportive services. The CoC's goal is to assist individuals through bringing awareness to the services and supports that are available in their community to create a sustainable living environment. PSH households also have the ability to transition to Section 8 HCV to be secure financially and maintain their housing when the support services are no longer needed. 4. (Same as #2)

*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.	11%
2. Report the percentage of individuals and persons in families returning to homelessness over a 12-month period as reported in HDX.	4%

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 identifies individuals and persons in families who return to homelessness by implementing a 60,90&180 day follow up contact. Working to re-engage the individuals in services and adding them back on to the housing registry, linking them back to services providers such as back to MDHHS, original housing provider, and shelter referral if needed. 2. The strategies that the CoC will use
within the next 12 months to reduce returns to homelessness include: using the information from the 60,90,&180 day follow up we will increase engagement to reduce risk factors so they don't return to homelessness. We will also discuss returns to homeless at the monthly Outcomes meeting and follow up with housing providers to reengage. 3. The Alliance for Housing ED and board chair for the Outcomes committee are responsible for overseeing this strategy to reduce the rate of individuals/families return to homelessness.

*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.	11%
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.	17%

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. CoC strategy to increase employment income is by partnering with MI Works, workforce development to teach employment skills, resume building, offer transportation, encourage the businesses to develop relationships within our CoC and post open positions. This encourages businesses to hire individuals that may have barriers to employment. Increase partnership with MRS who presents to shelter guests the services offered to increase income through employment. 2. COC partners with SMART to offer 'get a job get a ride' program which increases access to employment for those without transportation.3. CoC has an MOU with MI Works that spells out services offered to help individuals and families increase income. See MOU in attachments 4. The Alliance for Housing CoC ED, Leah McCall

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. CoC strategy to increase non-employment income by linking those eligible with a SOAR CM and assisting in the completing of paperwork and collecting documents to obtain SSI, Community partners work in coordination with AmeriCorps employment specialist to increase access to non-employment cash sources for individuals. We also provide a streamlined process with MDHHS to non employment cash .All CM are trained annually in non-employment cash income.
2. CoC strategy to increase access to non-employment case by linking to MDHHS for SNAP & cash assistance and child care assistance. 3. The Alliance for Housing CoC ED, Leah McCall

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 works to create partnerships with private employers and

employment organizations through the COC agencies that are working directly with business to help people with employment and job placement to increase cash income. CoC agencies attend and promote job fairs and ask for employers to share open positions with the CoC to send out via listserve. In addition we have a written agreement with the workforce development board, see MOU in attachments. 2.CoC is working w/public/private orgs for education & training. All PSH residents have a goal to increase skills and or income in their housing plans. The CoC has developed multiple relationships with public and private organizations. For example many of our residents get hired as peer support specialist with behavioral health providers. This increases their well-being and recovery.

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

3A-6. System Performance Measures Data–HDX Submission Date

05/30/2019

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.
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.

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)	X
2. Number of previous homeless episodes	X
3. Unsheltered homelessness	X
4. Criminal History	
5. Bad credit or rental history	
6. Head of Household with Mental/Physical Disability	X

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. CoC current strategy is to mobilize immediately upon Household presenting as homeless to triage with VI-SPDAT. We work to identify landlords while collecting any necessary documentation to rehouse individuals/families within 30 days when possible. 2. The COC addresses both housing and services needs to ensure families maintain housing once assistance ends by linking to long term subsidies like HCV and PSH and connecting to services (mental health, sub.abuse, education etc) that best fit the needs of the individual/family. CoC's Executive Director work closely with CE for shelters, housing registry and RRH projects and uses HMIS data within the Outcomes committee to review current process and tweak strategies to decrease length of time homeless for families. 3. Alliance for Housing, ED is responsible for implementing and overseeing 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.	
2. CoC conducts optional training for all CoC- and ESG-funded housing and service providers on these topics.	X
3. CoC has worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients.	X
4. CoC has worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within the CoC geographic area that might be out of compliance and has taken steps to work directly with those facilities to come into compliance.	

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

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

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)	X
2. Number of Previous Homeless Episodes	X
3. Unsheltered Homelessness	X
4. Criminal History	
5. Bad Credit or Rental History	

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

Applicants must describe how the CoC increased availability of housing and services for:
1. all youth experiencing homelessness, including creating new youth-focused projects or modifying current projects to be more youth-specific or youth-inclusive; and
2. youth experiencing unsheltered homelessness including creating new youth-focused projects or modifying current projects to be more youth-specific or youth-inclusive.
(limit 3,000 characters)

1.The CoC's youth provider added aDOJ grant to provide mentoring services to runaway and homeless youth who are at-risk or survivors of human trafficking. With these funds the agency was able to implement a mentoring program that matches at-risk youth with a mentor who advocates, encourages, and is a positive role-model for the youth.The mentor also seeks to connect the youth to natural resources within their family, schools, and community to help build their support system. 2.DOJ grant also supports the efforts of the youth shelter and ensures that youth in our geographic area are not experiencing unsheltered homelessness, which decreases their risk for exposure to traffickers and others looking to exploit them. The youth agency was also awarded the federal DHHS Transitional Living Program (TLP) grant through the Family &Youth Services Bureau.TLP grant is being used in conjunction w HUD funding to provide transitional housing &services to youth between the ages of 18-24 who are experiencing homelessness, they are prioritized via CE housing registry.TLP award has increased the ability to house more youth and hire an additional case

manager to provide clients with intensive supportive services. Eligible youth are immediately added to the HCV/HPV waitlist to provide an ongoing housing subsidy.

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 uses monthly, quarterly and yearly data review/follow ups and monitoring to measure youth experiencing homelessness and unsheltered homelessness within our youth projects. This is measured against community outcomes and funder outcomes to tweak existing resources and link to available other community resources. 2. To measure the effectiveness of youth provider discharge destination of youth from the youth shelter and their housing status is tracked at 90 and 180 days post discharge through HMIS Exit Forms and HYR Follow-Up Forms. The mentoring program's effectiveness is evaluated by assessing the youth's level of resilience at the beginning and end of services through the Child and Youth Resilience Measure. The youth's connection to the community and family is specifically looked at as well. 3. The CoC believes that measuring housing status over time and the connection to resources predicts long-term housing stability.

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. The CoC has a strong partnership with the local education providers. Oakland Schools (OS) the LEA, is the consortium lead for all Oakland County school districts,is represented at both the CoC GM meetings as well as a seat on the CoC board.OS is involved with making sure that pertinent information is funneled from the CoC to school districts and homeless families. OS has printed materials(posters and flyers) that are provided to CoC members that can be

posted and/or distributed to families that may qualify for McKinney-Vento services. CoC members also contact school district liaisons and/or Oakland Schools directly to help link families to school services. All COC projects have a identified student homeless liaisons staff so they can be immediately connected with homeless school services. 2.COC has a formal MOU with education provider and schools districts to collaborate and make sure that homeless youth are served. Please see MOU in attachments.

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 implemented the Oakland County CoC homeless Student Policy which states the following: All funded CoC grantees, including ESG and CoC program-funded agencies, are required to inform families and unaccompanied youth of their educational rights and to collaborate with their local school homeless liaison as a matter of policy when a new child or youth enters the program. In addition all funded CoC and ESG recipient and or sub-recipients are required to identify at least one staff member responsible for coordinating education activities, services and referrals. Oakland Schools will provide at least one training annually of how to access McKinney-Vento education service. Oakland Schools attends many COC committee and GM meetings to provide ongoing education to providers to share with their clients about education services.

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	No	Yes
Head Start	No	Yes
Early Head Start	No	Yes
Child Care and Development Fund	No	No
Federal Home Visiting Program	No	No
Healthy Start	No	Yes
Public Pre-K	No	Yes
Birth to 3 years	No	Yes
Tribal Home Visting Program	No	No
Other: (limit 50 characters)		
NA	No	No

NA	No	No

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 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.	Yes

3B-2b. Housing First for Veterans.

Applicants must indicate whether the CoC has sufficient resources to ensure each veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach.	Yes

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.	X
2. People of different races or ethnicities are less likely to receive homeless assistance.	
3. People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.	
4. People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.	
5. There are no racial or ethnic disparities in the provision or outcome of homeless assistance.	
6. The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.	
7. The CoC did not conduct a racial disparity assessment.	

3B-3a. Addressing Racial Disparities.

Applicants must select all that apply to indicate the CoC's strategy to

address any racial disparities identified in its Racial Disparities Assessment:

1. The CoC is ensuring that staff at the project level are representative of the persons accessing homeless services in the CoC.	☐
2. The CoC has identified the cause(s) of racial disparities in their homeless system.	☐
3. The CoC has identified strategies to reduce disparities in their homeless system.	☐
4. The CoC has implemented strategies to reduce disparities in their homeless system.	☐
5. The CoC has identified resources available to reduce disparities in their homeless system.	☐
6: The CoC did not conduct a racial disparity assessment.	☐

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

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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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	Yes
Non-Profit, Philanthropic:	No	No
Other: (limit 50 characters)		
NA	No	No

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. & 2. CoCkeeps project staff up to date and provides training at bi monthly GM/CIST meetings. Some CoC agencies have a MDHHS rep present at their offices regularly to directly help clients in applying/renewing benefits &answer questions clients/case managers have. CoC agencies who implement various housing programs including PSH, are charged with the task of leveraging mainstream benefits throughout the application, leasing & housed program phases. For example, every RRH &PSH household also applies for emergency housing assistance through the State Emergency Relief (SER) program implemented by MDHHS. Many CoC agencies implement SOAR, &are actively working on connecting eligible households to SS benefits. 3. &4 . The CoC works collaboratively with a network of agencies including representation of mainstream resources such as Michigan Works, Medicaid, and MRS. Participants are trained in effective utilization in Medicaid by being linked with a primary care physician and training to go to doctors office instead of ERs. This includes maintaining "payee of last resort" for any HUD financial assistance. Program participants are routinely required to apply for assistance through
MDHHS first as well as demonstrate denial from two other funding sources before HUD funds are used. CoC members also utilize programs such as MI Bridges to assist program participants in accessing and applying for benefits. SOAR assistance is also provided to those who are eligible as capacity allows. 5. Alliance for Housing ED, CIST workgroup members and CoC performance and Outcomes committee, which includes the CoC VP are responsible.

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.	19
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.	19
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. COC/PATH conducts outreach daily &actively seek out people rather than waiting for a person to reach out. Outreach removes barriers like lack of transportation or having phones &has interpreter services as needed.Staff have a network of relationships w/community partners &is routinely contacted about a person on the street w/ the location 2. CoC outreach covers 100% of OC and post monthly calendar of outreach locations. 3. Each area in the COC receives outreach 4 days a week. PATH provides a large portion of the street outreach & follow up with existing clients on a weekly basis. The team focuses on areas that are known locations for those who are homeless to congregate to or frequent & tips/referrals to actively seek anyone reported in need. 4. Staff work w/community partners who serve those least likely to request assistance including ppl w/cognitive & physical disabilities, mental illness, substance use, veterans, LGBTQ+,ESL community & other vulnerable populations. PIT data is also used to develop areas to canvass. This year the CoC developed a community referral form for other community members who may have contact w/ on the street homeless that are not engaged in the CoC system to get in contact w/the outreach team quickly. This allows us to mobilize & visit areas where a potential client may be identified. This has been provided to churches, food banks, &community partners who work with our system infrequently.

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	343	102	-241

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...	09/25/2019
1C-4.PHA Administration Plan–Moving On Multifamily Assisted Housing Owners' Preference.	No	Moving On Multifa...	09/17/2019
1C-4. PHA Administrative Plan Homeless Preference.	No	PHA Admin Plan Pr...	09/17/2019
1C-7. Centralized or Coordinated Assessment System.	Yes	CE Assessment Tool	09/18/2019
1E-1.Public Posting–15-Day Notification Outside e-snaps–Projects Accepted.	Yes	Projects Accepted...	09/25/2019
1E-1. Public Posting–15-Day Notification Outside e-snaps–Projects Rejected or Reduced.	Yes	Project Rejected/...	09/25/2019
1E-1.Public Posting–30-Day Local Competition Deadline.	Yes	Local Competition...	09/25/2019
1E-1. Public Posting–Local Competition Announcement.	Yes	Local Competition...	09/25/2019
1E-4.Public Posting–CoC-Approved Consolidated Application	Yes	Consolidated Appl...	09/25/2019
3A. Written Agreement with Local Education or Training Organization.	No	Local Education A...	09/27/2019
3A. Written Agreement with State or Local Workforce Development Board.	No	Local Workforce A...	09/27/2019
3B-3. Summary of Racial Disparity Assessment.	Yes	Racial Disparity ...	09/25/2019
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 Admin Plan Preference

Attachment Details

Document Description: CE Assessment Tool

Attachment Details

Document Description: Projects Accepted Notificiation

Attachment Details

Document Description: Project Rejected/Reduced Notification

Attachment Details

Document Description: Local Competition Deadline

Attachment Details

Document Description: Local Competition Announcement

Attachment Details

Document Description: Consolidated Application

Attachment Details

Document Description: Local Education Agreement

Attachment Details

Document Description: Local Workforce Agreement

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	09/13/2019
1B. Engagement	09/20/2019
1C. Coordination	09/25/2019
1D. Discharge Planning	No Input Required
1E. Local CoC Competition	09/23/2019
1F. DV Bonus	09/25/2019
2A. HMIS Implementation	09/24/2019
2B. PIT Count	09/24/2019
3A. System Performance	09/25/2019
3B. Performance and Strategic Planning	09/24/2019
4A. Mainstream Benefits and Additional Policies	09/24/2019
4B. Attachments	09/27/2019

Submission Summary	No Input Required

2019 HDX Competition Report

PIT Count Data for MI-504 - Pontiac, Royal Oak/Oakland County CoC

Total Population PIT Count Data

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count	**438**	**412**	**427**	**425**
Emergency Shelter Total	233	258	260	262
Safe Haven Total	0	0	0	0
Transitional Housing Total	129	107	96	120
Total Sheltered Count	**362**	**365**	**356**	**382**
Total Unsheltered Count	**76**	**47**	**71**	**43**

Chronically Homeless PIT Counts

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count of Chronically Homeless Persons	**37**	**45**	**42**	**47**
Sheltered Count of Chronically Homeless Persons	34	37	32	42
Unsheltered Count of Chronically Homeless Persons	3	8	10	5

2019 HDX Competition Report

PIT Count Data for MI-504 - Pontiac, Royal Oak/Oakland 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	**54**	**42**	**39**	**54**
Sheltered Count of Homeless Households with Children	54	42	39	50
Unsheltered Count of Homeless Households with Children	0	0	0	4

Homeless Veteran PIT Counts

	2011	2016	2017	2018	2019
Total Sheltered and Unsheltered Count of the Number of Homeless Veterans	**9**	**8**	**18**	**8**	**11**
Sheltered Count of Homeless Veterans	9	6	17	8	11
Unsheltered Count of Homeless Veterans	0	2	1	0	0

2019 HDX Competition Report

HIC Data for MI-504 - Pontiac, Royal Oak/Oakland 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	**172**	**55**	**117**	**100.00%**
Safe Haven (SH) Beds	**0**	**0**	**0**	**NA**
Transitional Housing (TH) Beds	**120**	**0**	**120**	**100.00%**
Rapid Re-Housing (RRH) Beds	**102**	**0**	**102**	**100.00%**
Permanent Supportive Housing (PSH) Beds	**662**	**0**	**603**	**91.09%**
Other Permanent Housing (OPH) Beds	**44**	**0**	**0**	**0.00%**
Total Beds	1,100	55	942	90.14%

2019 HDX Competition Report

HIC Data for MI-504 - Pontiac, Royal Oak/Oakland 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	162	271	288	303

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	8	21	73	23

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	36	87	343	102

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

Summary Report for MI-504 - Pontiac, Royal Oak/Oakland 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	967	913	48	47	-1	25	29	4
1.2 Persons in ES, SH, and TH	1117	1064	95	83	-12	32	42	10

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")	980	896	134	186	52	51	65	14
1.2 Persons in ES, SH, TH, and PH (prior to "housing move in")	1144	1044	180	220	40	73	90	17

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	140	16	11%	7	5%	9	6%	32	23%
Exit was from ES	384	61	16%	20	5%	21	5%	102	27%
Exit was from TH	70	0	0%	0	0%	3	4%	3	4%
Exit was from SH	0	0		0		0		0	
Exit was from PH	294	17	6%	10	3%	9	3%	36	12%
TOTAL Returns to Homelessness	888	94	11%	37	4%	42	5%	173	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	412	427	15
Emergency Shelter Total	258	260	2
Safe Haven Total	0	0	0
Transitional Housing Total	107	96	-11
Total Sheltered Count	365	356	-9
Unsheltered Count	47	71	24

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	1148	1109	-39
Emergency Shelter Total	984	933	-51
Safe Haven Total	0	0	0
Transitional Housing Total	178	194	16

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)	349	337	-12
Number of adults with increased earned income	34	37	3
Percentage of adults who increased earned income	10%	11%	1%

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)	349	337	-12
Number of adults with increased non-employment cash income	84	124	40
Percentage of adults who increased non-employment cash income	24%	37%	13%

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)	349	337	-12
Number of adults with increased total income	112	151	39
Percentage of adults who increased total income	32%	45%	13%

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)	171	288	117
Number of adults who exited with increased earned income	33	31	-2
Percentage of adults who increased earned income	19%	11%	-8%

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)	171	288	117
Number of adults who exited with increased non-employment cash income	35	50	15
Percentage of adults who increased non-employment cash income	20%	17%	-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)	171	288	117
Number of adults who exited with increased total income	61	76	15
Percentage of adults who increased total income	36%	26%	-10%

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.	1015	1028	13
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.	174	202	28
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)	841	826	-15

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.	1558	1542	-16
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.	241	295	54
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.)	1317	1247	-70

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	733	619	-114
Of persons above, those who exited to temporary & some institutional destinations	235	223	-12
Of the persons above, those who exited to permanent housing destinations	436	364	-72
% Successful exits	92%	95%	3%

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	1095	1513	418
Of the persons above, those who exited to permanent housing destinations	747	1013	266
% Successful exits	68%	67%	-1%

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	655	674	19
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	644	659	15
% Successful exits/retention	98%	98%	0%

2019 HDX Competition Report

FY2018 - SysPM Data Quality

MI-504 - Pontiac, Royal Oak/Oakland 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	109	112	112	113	147	133	107	96	1049	1908	2195	680	34	36	87	343				
2. Number of HMIS Beds	100	109	112	113	147	133	107	96	625	586	690	588	34	36	87	343				
3. HMIS Participation Rate from HIC (%)	91.74	97.32	100.00	100.00	100.00	100.00	100.00	100.00	59.58	30.71	31.44	86.47	100.00	100.00	100.00	100.00				
4. Unduplicated Persons Served (HMIS)	752	867	972	958	213	202	179	201	774	752	722	782	386	435	656	957	273	457	918	653
5. Total Leavers (HMIS)	649	775	868	846	108	96	99	95	175	137	130	135	350	389	290	819	172	215	724	608
6. Destination of Don't Know, Refused, or Missing (HMIS)	51	99	21	70	3	2	1	3	9	13	12	9	21	36	2	108	2	8	0	10
7. Destination Error Rate (%)	7.86	12.77	2.42	8.27	2.78	2.08	1.01	3.16	5.14	9.49	9.23	6.67	6.00	9.25	0.69	13.19	1.16	3.72	0.00	1.64

2019 HDX Competition Report

Submission and Count Dates for MI-504 - Pontiac, Royal Oak/Oakland County CoC

Date of PIT Count

	Date	Received HUD Waiver
Date CoC Conducted 2019 PIT Count	1/30/2019	

Report Submission Date in HDX

	Submitted On	Met Deadline
2019 PIT Count Submittal Date	4/29/2019	Yes
2019 HIC Count Submittal Date	4/29/2019	Yes
2018 System PM Submittal Date	5/30/2019	Yes

ATTACHMENT B
FY 2019-20 ANNUAL PHA PLAN FOR HCV ONLY PHAs
MICHIGAN STATE HOUSING DEVELOPMENT AUTHORITY
(MSHDA) (MI-901)

B. Annual Plan

B.1 Revision of PHA Plan Elements:

Statement of Housing Needs and Strategy for Addressing Housing Needs

MSHDA is dedicated to serving the needs of the homeless and very-low and extremely low income Michigan residents. This is demonstrated in its administration of the Housing Choice Voucher Program via the following:

- designating a homeless preference for county HCV waiting lists.
- designating a disabled preference for county HCV waiting lists.
- commitment to the Michigan Campaign to End Homelessness.
- working with partner agencies serving the elderly, families with disabilities, households of various races and ethnic groups.
- working with Continuum of Care groups across the State of Michigan.
- policy of exceeding federal income targeting requirements by establishing that 80% of new admissions must be extremely low-income families and up to 20% of new admissions must be very low-income families.
- administration of the HCV VASH Program at four VA medical facility sites across the State of Michigan (presently Battle Creek, Detroit, Saginaw, and Iron Mountain).
- administration of Mainstream 1 (now called Non-Elderly Disabled or NED) and Mainstream 5 (MS5) vouchers.
- administration of MSHDA's pilot program, Affordable Assisted Housing Program (AAHP), in Macomb and Oakland Counties; which combines an HCV with the Michigan Medicaid Waiver to provide housing as an alternative to nursing home care.
- expansion of the 2014-2015 Moving-Up Pilot that partners with the Michigan Department of Community Health (MDCH) and provides a resource for previously homeless populations utilizing Permanent Supportive Housing; MSHDA commits 710 of its HCV vouchers to this pilot program.
- leveraging 100 HCVs with the Section 811 Project Rental Assistance Program.
- creation of a State Innovation Model (SIM) Pilot Program that partners with the Michigan Department of Health and Human Services (MDHHS) to provide housing and supportive services to citizens that have very high utilization levels of emergency departments and emergency services that are also experiencing homelessness. MSHDA has committed up to 200 vouchers for this pilot program.
- administration of more than 3,000 Project-Based Vouchers across the state.
- offering a PBV waiting list preference in designated PBV properties for individuals and/or families meeting the definition of Chronic Homeless, United States Veteran and Homeless Frequent Emergency Department Users with Care Need.
- implementing a recertification of homelessness at the time of PBV waiting list draw, to ensure the applicant still meets the definition of homelessness.
- administrating more than 1,200 vouchers at 22 RAD Projects across the state which converts tenant-based RAP and Rent Supplement Assistance to tenants in HUD 236 properties to Project-Based Vouchers.
- continuation of outreach efforts to find affordable and good quality units for its voucher holders.
- identification of when to open and close county waiting lists as needed across the state to maintain up-to-date lists.
- implementing biennial HQS inspections for HCV housing units.
- administration of an initiative with the Michigan Department of Corrections (MDOC) to enhance housing opportunities for persons exiting correctional facilities. MSHDA has allocated up to 200 HCVs for returning citizens that need long-term rental assistance.
- administration of the Mainstream Voucher Program in collaboration with the MDHHS. The program will provide voucher assistance to non-elderly and disabled households and partnering agencies will

provide support services based on the individual's needs and MDHHS affiliated program. MSHDA was awarded 99 vouchers from HUD for this program.

- administration of the Family Unification Program (FUP) in collaboration with the MDHHS. The program will provide voucher assistance to FUP-eligible families and FUP-eligible youth experiencing housing barriers. MSHDA was awarded 81 vouchers from HUD for this program.

Deconcentration and Other policies that Govern Eligibility, Selection and Admissions

MSHDA promotes deconcentration of poverty and promotes income mixing in all areas by educating applicants at the time of their briefing on these issues.

Waiting lists exist for all 83 Michigan counties and are opened or closed as necessary. Applications are taken electronically. As of January 2, 2019, there are 37,215 applicants on the waiting list; 32,907 are extremely low income; 3,104 are very low income; and 1,204 are low income. Families with children make up 39% of waiting list applicants; 8% are elderly and 16% are disabled.

MSHDA has a homeless preference and applications are taken from homeless families and added to the homeless preference waiting list when certified.

A disability preference is given for those applicants where the head of household, co-head or spouse are disabled. Verification of disability is obtained upon selection from the waiting list.

A county residency preference is given for those applicants who either live or work in the county and can prove residency through a verified current address or verification from an employer.

A Michigan residency preference is given for those applicants who either live or work in the state of Michigan and can prove residency through a verified current address or verification from an employer.

PBV applicants must apply through the Lead Agency/HARA or property management staff. Referrals are sent directly to the MSHDA contracted Housing Agent for placement on the PBV Waiting List.

Financial Resources

Financial Resources: Planned Sources and Uses		
Sources	**Planned $**	**Planned Uses**
1. **Federal Grants (FY 2019 grants)**		
a) Public Housing Operating Fund	Not applicable	
b) Public Housing Capital Fund	Not applicable	
c) Annual Contributions for Section 8 Tenant-Based Assistance	$190,598,141	Section 8 Eligible expenses
d) Community Development Block Grant (CDBG)	Not applicable	
e) HOME	Not applicable	
Other Federal Grants (list below)		
FSS Program	$ 971,313	FSS Program
Sec 811 Program	$ 5,516,950	Sec 811 PRA Program
2. Prior Year Federal Grants (unobligated funds only) (list below)	None	
3. Public Housing Dwelling Rental Income	Not applicable	
4. Other income (list below)	None	
5. Non-federal sources (list below)	None	
Total resources	$197,086,404	

Rent Determination:

MSHDA will continue to have a $50 Minimum Total Tenant Payment (TTP). If the MSHDA HCV budget is significantly increased, the minimum TTP amount may be adjusted downward.

Payment standards will be maintained at 110% of Fair Market Rent (FMR). MSHDA will conduct an annual review to determine payment standard levels and if necessary, may request an exception payment standard of between 111-120% of FMR for one or more counties if appropriate.

Homeownership:

MSHDA will continue administering its Section 8 Homeownership Program entitled the *Key to Own* Homeownership Program which has been operating since March 2004. The MSHDA *Key to Own* Homeownership Program has no set limits on the maximum number of participants. Currently, MSHDA has over 1,000 participants in the *Key to Own* Homeownership Program who are working on program requirements; i.e. credit scores, finding employment, debt reduction, etc. Since the program's inception, 497 MSHDA HCV participants have become homeowners.

Substantial Deviation:
MSHDA defines a substantial deviation from the 5-Year Plan to be a change in its policy, activity or program that redirects MSHDA's mission, goals, or objectives; and/or the addition of new policies, activities or programs not included in the current PHA Plan.

Significant Amendment:
The addition of new policies, activities or programs not included in the current PHA Plan may qualify as a Significant Amendment.

Safety and Crime Prevention:
The MSHDA Office of Rental Assistance and Homeless Solutions (RAHS) is committed to the implementation of the VAWA of 2013. MSHDA will continue to undertake actions to meet this requirement in the administration of the Housing Choice Voucher (HCV) Program.

MSHDA's contracted Housing Agents participate in local Continuum of Care meetings and use those contacts and others known to them through the Family Self-Sufficiency Program to assist survivors of domestic violence (including dating violence, sexual assault, or stalking) and their children when cases are made known to them.

Many of the agencies participating in the Continuum of Care groups provide temporary housing/shelter to survivors of domestic violence and their children. MSHDA staff and Housing Agents work with the partnering Continuum of Care service agencies and partnering Housing Assessment and Resource Agencies (HARAs) to find resources for domestic violence survivors, and children and adult victims of dating violence, sexual assault, or stalking to make sure the family is able to maintain their housing assistance.

MSHDA provides the Notice of Occupancy Rights under VAWA (HUD 5380) and the Certification of Domestic Violence, Dating Violence, Sexual Assault, or Stalking (HUD 5382) when a family is denied admission to the program, when a family is admitted to the program and when the family is terminated from the program. In addition, MSHDA has created an Emergency Move Plan for HCV and PBV participants and provides the Emergency Transfer Request for Certain Victims of Domestic Violence, Dating Violence, Sexual Assault and Stalking (HUD 5383) upon request.

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Overview of the Alliance and the Coordinated Entry System

FINAL 1.24.18

Background

The Alliance for Housing (Oakland County's Continuum of Care) consists of a network of organizations providing services to those in housing crisis. Through a variety of grants and funding streams, the continuum of care and the organizations that are part of this membership, has an array of programs that provide a comprehensive response to housing crisis which includes immediate emergency shelter, transitional housing, short term financial assistance and housing stabilization services, permanent supportive housing, prevention, diversion and linkage to other long term subsidies such as housing choice vouchers, special needs units and subsidized housing. Operating within a coordinated entry system model, the programs work together to serve the needs of the community.

Funding comes from a variety of resources, including directly from HUD (Housing and Urban Development), as well as from the state housing authority (MSHDA) and local government, as well as linkage to other resources in the community. Additional funds may come into the community through grants and foundations, as well as other funding sources, which may change year to year.

Partnerships

There are multiple providers receiving funding for specific housing programs within the Alliance. There are multiple agencies and organizations working together to meet the needs of the community and to provide a network of support. Below is a list of all the agencies and organizations, which includes entities that are receiving funding directly through the CoC as well as those that are funded differently.

Baldwin Center
Catholic Community Response Team (CCRT)
Common Ground
Community Housing Network (CHN)
Community Network Services (CNS)
Community Sharing Outreach Center
Covenant Community Care
Disability Network of Michigan (DNOM)
Easter Seals Michigan

Gary Bernstein Clinic
HAVEN
Hope Network/New Passages
HOPE, Inc.
Jewish Family Service
John Dingell VA Medical Center
Lakeshore Legal Aid
Lighthouse of Oakland County
Macomb Oakland Regional Center (MORC)
Michigan Department of Health and Human Services (MDHHS)
Michigan State Housing Development Authority (MSHDA)
Oakland County Health Division
Oakland Community Health Network (OCHN)
Oakland County Veteran's Services
Oakland County Schools
Oakland County Sheriff's Office – Program Services Unit
Oakland Family Services
Oakland Integrated Health Network (OIHN)
Oakland Livingston Human Service Agency (OLHSA)
Rochester Neighborhood House
South Oakland Shelter (SOS)
Training and Treatment Innovations (TTI)
Welcome Inn/South Oakland Citizens for the Homeless

Geographic Area

Through the above list of providers it is the intention of the Alliance to provide coverage to all areas of the CoC which encompasses all of Oakland County. The CoC will continue to promote and solicit new membership to ensure that those in housing crisis are able to easily access services through linkage in their local area.

This includes the following cities, townships and villages that are within the borders of the county:

Addison
Auburn Hills
Berkley
Beverly Hills
Bingham Farms
Birmingham
Bloomfield
Brandon
Clarkston
Clawson
Commerce
Farmington
Farmington Hills
Fenton
Ferndale
Franklin
Groveland
Hazel Park
Highland
Holly
Holly Township
Huntington Woods
Independence
Keego Harbor
Lake Angelus
Lake Orion
Lathrup Village

Leonard	Oxford	Southfield
Lyon Township	Oxford Township	Southfield Township
Madison Heights	Pleasant Ridge	Springfield
Milford	Pontiac	Sylvan Lake
Milford Township	Rochester Hills	Troy
Northville	Rochester	Walled Lake
Novi	Rose Township	Waterford
Oak Park	Royal Oak	West Bloomfield
Orchard Lake	Royal Oak Township	White Lake
Orion Township	South Lyon	Wixom
Ortonville	South Lyon Township	Wolverine Lake

Access and Accessibility

This system is intended to be responsive to the various needs and demographics of those in the community in housing crisis. For those that are in outlying areas of the county, there needs to be a way to get quickly linked to the system. The Continuum of Care will continue to solicit new members to build upon the safety network. For those agencies and organizations that do not have the capacity to be formal access points, referral partnerships will be established, allowing them to easily connect the potential program participant that they are working with to the Continuum of Care. This begins with consent and basic demographics to quickly link and triage the presenting individual or household to services.

Additional accessibility considerations include:

- Language:
  Accommodations will be provided to those that may have English as a second language or are unable to read materials that are provided. Participating agencies will ensure that interpreter services are made available either through internal resources or by contracting with another agency for these services. Depending on the situation this may require assistance via phone, or face to face, based on the forum on the circumstance. Best practices suggest that an "I Speak" poster or written materials be provided to all potential clients on walk in at any participating agency with ability to simply point at the language that the person speaks so appropriate interpreter services can be provided.

  It should be noted that in all cases an interpreter must be offered to the individual. It should never be assumed that a family member can interpret on behalf of the program participant. This resource must be offered to allow the individual an opportunity to communicate freely and without bias.

- Visual/Hearing:
  To ensure equal access to individuals and households that present with a disability, accommodations will also be made. For those with visual impairments, an agency representative will read all written materials, or provide audio copies or alternative forms of written materials (i.e. large sans-serif font like Arial or Tahoma) to the potential program participant or existing program participant. For those with hearing impairments, the use of sign language interpreters or alternative modes of communication such as text to relay systems will be utilized.

- Physical:
  Participating agencies within the Continuum of Care will work to ensure that physical locations are accessible to all from a facility's structural standpoint. While there are instances where buildings may not be accessible in all features, accommodations will be made as soon as possible. This may mean locating a person temporarily to an office on the ground level of a building for shelter although typical services are on a different floor, meeting with a potential program participant in an alternative/community location for assessment, etc.

- Transportation
  It is recognized that transportation is often a barrier to those needing access to this crisis response system. This may be due to limited public transportation or due to the cost of transportation resources. Participating agencies within the Continuum of Care will work closely with individuals and households by either providing transportation resources (i.e. bus tickets or connection with transportation services that are low cost/free) or by arranging for meetings to take place within community locations more accessible to the individual or household.

Affirmative Marketing and Outreach

To ensure that anyone in a housing crisis in Oakland County is aware of the resources available to them, and can access these services easily, the Alliance for Housing implements a marketing plan that includes promotion of the services provided by the network of agencies. The Continuum of Care provides these services to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, and disability.

It is recognized that often those with the most need and the most vulnerable may not reach out to this network of their own initiative. Those least likely to apply will remain an important component to reach these groups, including outreach directly to potential program participants in housing crisis, but also to partnering agencies across the Continuum of Care's geographic area so that

those in need that come in contact with those agencies or faith based organizations can quickly link these households to services.

The CoC put together a Help Card. The Help Card is a small portable card that has emergency/crisis numbers that are answered 24/7. The Help Card also has general, non-emergency services information listed. These include housing, shelters, food pantries, soup kitchens and Latino services. These cards have been given out to the police department as well as agencies, shelters, and volunteers. They are used as an immediate resource to provide information to those in need.

The Alliance arranges a yearly Community Resource Day (CRD). This event is a one-day community oriented event to offer help. The CoC draws in all the resources in the community that can support people and families in times of crisis to one area. These can range from housing assistance, veteran services, and employment services to hair-cuts. The purpose of the event is to promote services made available to clients and help explain how people can apply for them. CRD is also an opportunity to raise awareness in the community. It creates the ability to inform about the need as well as offer an opportunity to address it.

The CoC also coordinates an annual Point in Time Count (PIT) in January of each year, to not only meet the HUD requirements for funding but in addition to reach out to those with the most need, often unsheltered in the coldest time of year. The coordinating body utilizes feedback from community members, both service providers and those who are or have previously been homeless, to target efforts and outreach to the places where those on the street would seek shelter from the elements. This allows the community teams to provide direct outreach and engagement to those who would not seek out assistance without these efforts.

The CoC utilizes social media to connect with other agencies, as well as individuals seeking services. Anyone who has access to social media can go to our page to find out information about upcoming events, services and resources they may be interested in. The Alliance for Housing website also offers an array of information pertaining to each agency as well as documents and information relating to the CoC.

Screening

Access/ Referral Points:

As noted previously in this document there are agencies and organizations that are formal partners that share information within HMIS to allow for a coordinated system, utilizing a QSOBAA (Qualified Service Organization Business Associate Agreement) as well as consents from potential program participants to share the information within the network and HMIS. These

partners are able to utilize a community wide assessment in HMIS to assess and refer those presenting as homeless or at risk of homelessness. This assessment was tailored to include the essentials (including HUD standard questions related to homeless history and other factors, as well as the VI SPDAT[1] for those who present as literally homeless) to determine potential eligibility for variety of programs and resources, and to streamline the system without duplication. Each partner agency, with the exception of the DV Shelter, has the ability to make a referral to quickly link the potential program participant with appropriate services. If a potential program participant qualifies for services offered within the CoC based on the assessment, a referral is made in HMIS to the appropriate program or agency.

These access/referral points will be strategically placed in the community and will routinely be evaluated to ensure accessibility across the Continuum of Care. The Continuum of Care will also utilize referral partners, not formally in the HMIS system, but community partners that can provide quick standardized information in case a family in crisis, in need of RRH or Prevention funds, presents at their location.

Households that present at any access/referral point, regardless of whether it is an access/referral point dedicated to the population to which the household belongs, can easily access an appropriate assessment process that provides the Continuum of Care with enough information to make prioritization decisions about this household. The household will then be linked to appropriate resources. To ensure that this information is collected in a consistent manner, all access/referral points will use a standardized screening tool for basic information needed to determine eligibility and prioritization.

This process assures that households who are included in more than one population (for example unaccompanied youth also fleeing DV) can be served at all access/referral points. This also allows for standardized decision making. Additionally no access/referral point can deny a person who has or is a victim of domestic violence, dating violence, sexual assault and stalking. Rather, the assessment will be completed, linkage occur and services will be provided with safety considerations for the individual or household in mind.

There may be situations where transportation or other challenges prevent the person from meeting with a screener face to face. The program participant can complete a screening to begin the process via phone to eliminate such barriers and this is often a standard process across the Continuum of Care, especially at

[1] SPDAT stands for Service Prioritization Decision Assistance Tool (SPDAT) and is a full assessment. The VI – SPDAT is the Vulnerability Index which provides a screening to determine need. Both assessments are used to assess need and risk factors for persons that present as homeless.

the HARA. Additionally agency staff at access/referral points will work with potential program participants to meet at a location that is easily accessible for the program participant. This may include issues with transportation, being already temporarily housed at a community partner's location, or utilization of street outreach services. Additionally those with disabilities may have a need for the staff to come to them for additional reasons.

All providers that are HMIS licensed users in the Coordinated System will be considered ACCESS points for potential program participants presenting in housing crisis to link with services. The agencies utilize a CoC level QSOBAA[2] (Qualified Services Organization Business Associates Agreement) that provides the ability to coordinate services and share data entered in to the Service-Point HMIS data system, between the listed partner agencies for Oakland County. The QSOBAA only includes sharing data captured within HMIS. The agreement is signed by each agency, local Lead HMIS Agency, MCAH, and MSHDA that governs the privacy standards for all those that can see multiple organization data.

The agencies participating in this agreement include:

Participating Agency	**Subpopulation/Specialty**
Common Ground	Youth
Community Housing Network	HARA for OC, Housing Provider
HOPE	Low barrier shelter
Lighthouse	Emergency Services, Housing Provider
Oakland Integrated Health Network	FQHC
South Oakland Shelter	Shelter and Housing Provider
Training and Treatment Innovations	Housing Provider, Veteran Services

** Please note that HAVEN is a shelter and one stop for individuals and households that are experiencing domestic violence. Based on regulations they do not enter information into HMIS but connect potential program participants with the CoC.*

Referral:
The CoC is developing a referral system for all non HMIS agencies to use with individuals that are trying to connect with the coordinated system. A one page community wide referral sheet will be available for agencies that do not use HMIS. This will be implemented by January 28th, 2018

[2] Oakland County-Alliance for Housing, Qualified Service Organization Business Associate Agreement (QSOBAA) 2017

Eligibility and Prioritization:
Any individual or household in housing crisis is able to access the CoC for housing resources and referral. Due to the high need and capacity to serve, prioritization is used to insure that those with the most need receive limited resources first. The community utilizes established thresholds to meet the needs while balancing capacity and available resources. These thresholds are community established and routinely reviewed to ensure that they are appropriate.

Thresholds have been established, along with a prioritization policy, that provides guidance and structure for determine eligibility and prioritization for prevention, rapid rehousing, permanent supportive housing and transitional housing. These policies both honor HUD guidelines and regulations, as well as unique funding requirements based on the program and grantor guidelines.[3]

Rapid Rehousing:

- Individuals and families that present who are literally homeless, who are under 30% AMI are potentially eligible for rapid rehousing from one of the Continuum of Care partners. Based on specific grant parameters, programs have some differences in assistance that can be provided in specific line items. The Continuum of Care develops an annual grid that spells out the allowable items and parameters of each program funding. This includes nuances with percentage or amount of rent that a program will assist.

- To ensure that those with the most need are served, the community established thresholds with a minimum vulnerability score to be eligible for RRH. Over time this changes, with community input and feedback. This is based on capacity and level of funding. When there are less resources to serve everyone that presents as eligible, the community raises threshold to ideally be in line with VI SPDAT guidelines (6+ for individuals and families) but when more funding is available will relax this requirement as long as the presenting household would remain homeless "if not for this assistance" has increased the threshold when those with higher scores cannot access more intensive programs due to availability to ensure rapid rehousing.

Permanent Supportive Housing:

- Individuals and families that present who are literally homeless, who are under 30% AMI are potentially eligible for permanent supportive housing from one of the Continuum of Care partners. The community has

[3] Alliance policies and supplements: Oakland County Centralized Housing Registry Policies and Procedures, Prevention Program Overview Grid, Community Established Thresholds

established a prioritization registry to ensure that those with the most need are served first as part of the CES.

Transitional Housing:
Common Ground and Lighthouse are agencies under the CoC that provide transitional housing.

- Common Ground Graduated Apartment Program: This consists of providing housing subsidies and supportive services to homeless adult for up to two years. This program helps people develop a greater level of self-sufficiency, interpersonal skills, and housing readiness. During this time residents must maintain employment and an education plan.

- Lighthouse PATH: PATH is a two year transitional housing and empowerment program for homeless women and their children. The program offers comprehensive case management, including parenting, life skills, help with personal finance, job training and workforce development.

- Both transitional housing programs have representation at the Prioritized Housing workgroup and utilize this forum to access referrals.

Assessment

The CoC uses a phased approach to assessment that includes multiple stages. This process has integrated housing first principles focusing on rapidly housing program participants without preconditions to services. This process strives to be person centered focusing on a participant's individual strengths, goals, risks and other factors. Questions are asked in a way that are easily understood by the participant and are sensitive to the diverse experiences that program participants have. When applicable, individuals and households are offered choice in decisions about location and type of housing within specific available grant parameters. When educating program participants about the program options, staff explains expectations for both program staff and program participants.

Initial Triage**:**
As noted earlier an initial screen provides the initial triage, working with potential program participants to resolve the immediate housing crisis and linking with the appropriate systems to address the immediate needs. For those that are literally homeless this will include a VI-SPDAT when working with a participating access point.

Diversion and/or Prevention Screening:
All presenting households and individuals in housing crisis will be assisted with identifying diversion and prevention resources. Every effort will be made to avoid entering the homeless services system by exploring options that may

include linkage with natural supports, more affordable housing options or mainstream community resources.

Crisis Services Intake:
For those in housing crisis, intake includes identification of individuals housing and service needs in an effort to resolve the program participants' immediate situation.

Comprehensive Assessment:
After potential program participants are screened as potentially eligible for a program a full face to face assessment occurs. In a face to face assessment accommodations are made to meet the person in a location that will not present barriers and will also allow for safety and confidentially as the presenting individual or household will be relaying sensitive information. At this time more information is collected to continue to build on the information already collected in the previous phases. This includes more detailed information about housing and homeless history, barriers, goals and preferences. The assessment supports the evaluation of the participant's vulnerability and prioritization of assistance utilizing the full SPDAT in this process.

In this process the individual or household is informed of the ability to file a non-discrimination complaint as well as an overview of the assessment process. During this assessment potential program participants are freely allowed to decide what information they provide during the assessment process. This includes the ability to refuse to answer questions on the assessment, and refused housing and service options, without limiting their access to other resources and programs. Rejection of a form of assistance will lead to the potential program participants being removed from prioritization for that specific resource but will allow them to access any other eligible resources without any additional consequence.[4]

Next Step Move On Assessment:
Opportunities to reassess potential program participants often occur throughout routine interaction with the individual or household. This may include an updated VI-SPDAT after six months or in situations where a significant life event had been reported. Additionally, full SPDATs occur on a regular and consistent basis at scheduled intervals to insure continued tracking towards progress and goals and to evaluate reduction of intensive services and assistance. Additional tools like the moving up assessment are utilized in specific programs to gauge transition from cost and service intense programs such as PSH.

[4]CoC Anti-Discrimination Policies & Equal Access Rule

Privacy and Protection

The CoC only shares program participants information and documents when the program participants provides written consent with either an ROI or coordinated services agreement. It should be noted that initial screening with HMIS entry may be limited to a verbal consent as the interaction may not be face to face. The CoC partners comply with privacy and protection for all HMIS entries in accordance per MCAH under the operational rule HIPAA[5]. Similar precautions are taken with all hard copy documentation; program participants chart files and any other electronic data storage requiring all participating agencies to securely maintain information. This includes locking of filing cabinets and doors as well as restrictions places on electronic files. Additionally, when utilizing e-mail between agencies only non-identifying information is used or e-mail is protected with encrypted software.

As mentioned earlier in this document, the assessment process is a phased approach which includes an initial screening and triage with a follow up assessment as applicable. Through the assessment process program participants are not required to disclose information regarding specific disabilities or diagnoses. Rather broad categories are utilized in accordance with universal data elements established by HUD/HMIS however a specific diagnosis for disability may be required to determine specific program eligibility in order to make an appropriate referral. For instance, a PSH program may require a disability of severe and persistent mental illness in order to qualify due to the specific grant parameters. Additionally all PSH program require a disability of all deration.

As referenced in 'Access/Referral Points' on page 5, a QSOBAA was put in place to allow for sharing of information for those that share data in HMIS as well as PSH partners that work with those experiencing domestic violence. However, because of the need to share information beyond the partners covered in the QSOBAA, a community MOU has been put in place that allows for the partners to share coordinating services. Additionally, changes will be made to the Alliance's HMIS Release of Information to allow for continued coordinated assessment and services.

Assessor Training

Oakland County HMIS System administrators provide training for new users in Oakland County. Updated workflows are provided via Alliance's website. Required as a part of the MSHMIS User Requirement & Documentation[6] HMIS Users are informed and understand the privacy rules associated with collection, management and reporting of client data. Users of HMIS are trained to

[5] 2016 MSHMIS Operating Policies and Procedures, Part III. Privacy, p 8-14
[6] 2016 MSHMIS Operating Policies and Procedures, Part II. B & Appendix A.

complete the coordinated entry assessments, enter data into HMIS, and obtain signed required confidentiality agreements. Training for HMIS users and agency staff serving as access points will be held at minimum annually and more frequently as needed.

Marketing

In accordance with several civil rights and fair housing laws[7], The Alliance for Housing affirmatively markets housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, handicap or least likely to apply in the absence of special outreach. This includes ensuring that all people, various populations and subpopulations in the geographic area, are served. While this is not an exhaustive list, the CoC has addressed the needs of those experiencing chronic homelessness, veterans, families with children, youth and those fleeing domestic violence[8].

24 Access with the Help Card as mentioned on page 5. Additionally the local 211 offered through United Way contains information about housing and other crisis resources. The Continuum of Care will maintain an up to date listing to provide a global entry for all housing resources with access points available.

Access

Please see information about screening and assessment located on page 3 for information about access models and accessibility.

Emergency Services

A potential program participant that presents in housing crisis, in need of emergency services, is not limited by the business hours of an access or referral partner. All after hours lines will provide information about who to call when the person is presenting after hours for services. Additionally, a Help Card with emergency information has been printed with resources that provide 24/7 access to a low barrier shelter, see page 5. If the potential program participant is seeking emergency shelter after hours we have a designated shelter that is able to take them 24/7 and connect them to the appropriate service/agency during regular business hours.

Prevention Services

The same process is utilized for all RRH and Prevention Services. The same intake and screening are used consistently across the Continuum of Care with the exception being the VI which is only used for those who present as literally homeless. As noted in other sections of this document prevention services are also included in prioritization and community established thresholds.

[7] Fair Housing Act, Section 504 of the Rehabilitation Act, Title VI of the Civil Rights Act, Title II and III of the American with Disabilities Act.

[8] CoC Anti-Discrimination Policies and Equal Access Rule

Street Outreach Teams

Any street outreach services working with the Continuum of Care will be integrated into the standardize screening and assessment tools. Outreach workers will at minimum provide an agreed upon screening as a referral partner with a consent filled out to share information. Those who are also access/referral points will complete the coordinated assessment and prioritization tools as appropriate.

Mainstream Resources

Screening and Intake routinely discusses and links with any available resources in the mainstream. This includes assistance with income and food assistance.

Virtual Entry

24 Access with the Help Card provides virtual access to providers that can assist with linkage and access/referral points. Additionally the local 211 offered through United Way contains information about housing and other crisis resources. The Continuum of Care will maintain an up to date listing to provide a global entry for all housing resources with access points available.

Training

The CoC will be offering LGBTQ+ sensitivity training for all agencies. This training will take place annually with updated trainings as needed. Every year at the annual retreat policies and procedures are sent out on the list serve for review and asked for feedback for any updates as well as discussion at the meeting. The CoC also takes part in webinars provided by the HUD Exchange whenever applicable to stay up to date with HUD policies.

Evaluation

The CoC evaluates all state and federal grants yearly with the sub grantees. Agencies receive a set of requirements, federal and state guidelines and community specific goals. The CoC evaluates the agencies' paperwork and documents so making sure that program participants are eligible, rents are being collected as well as the processes the agencies use throughout the program. Agencies are also evaluated on their participation within the CoC events and meetings. The CoC also uses HUD and MSHDA documents to assure they are operating at an efficient level as HUD and MSHDA guidelines require. Every agency receives a follow up letter with evaluation results so they can see what is effective and what needs improvement.

The Alliance for Housing also has an Operations Committee which consists of a minimum of one Board Member and other members of the Alliance at large. This committee focuses on reviewing other operations within the CoC, coordinates the CoC process as well other consolidated and/or collaborative applications throughout the year. The Operation Committee assesses the

current projects the CoC is working on and determines what is effective and what needs to be improved upon.

The Alliance for Housing is developing a plan to conduct CoC evaluations with current and past program participants through CoC funded agencies to get feedback regarding their experience with the programs.

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.01

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

COMMUNITY SOLUTIONS

ORG CODE

Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:

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

All versions are available online at

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

SPDAT Series

The Service Prioritization Decision Assistance Tool (SPDAT) was developed as an assessment tool for 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/

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

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**	☐ Team ☐ Staff ☐ 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 or the assessor does not understand the question that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

First Name	**Nickname**	**Last Name**
_____	_____	_____

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

Date of Birth	**Age**	**Social Security Number**	**Consent to participate**	
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes	☐ No

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

SCORE:

A. History of Housing and Homelessness

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

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

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

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

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

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

B. Risks

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

a) Received health care at an emergency department/room? ____ ☐ Refused

b) Taken an ambulance to the hospital? ____ ☐ Refused

c) Been hospitalized as an inpatient? ____ ☐ Refused

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

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

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

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

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

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

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

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

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

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

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

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

C. Socialization & Daily Functioning

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

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

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

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

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

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

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

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

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

D. Wellness

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

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

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

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

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

a) A mental health issue or concern?	☐ **Y**	☐ N	☐ Refused
b) A past head injury?	☐ **Y**	☐ N	☐ Refused
c) A learning disability, developmental disability, or other impairment?	☐ **Y**	☐ N	☐ Refused
24. Do you have any mental health or brain issues that would make it hard for you to live independently because you'd need help?	☐ **Y**	☐ N	☐ Refused

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

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

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

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

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

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

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

Scoring Summary

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

RESULTS	
Score:	**Recommendation:**
0-3:	no housing intervention
4-7:	an assessment for Rapid Re-Housing
8+:	an assessment for Permanent Supportive Housing/Housing First

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?	☐ Yes ☐ No ☐ Refused

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

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

Appendix A: About the VI-SPDAT

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

The VI-SPDAT

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

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

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

Version 2

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

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

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

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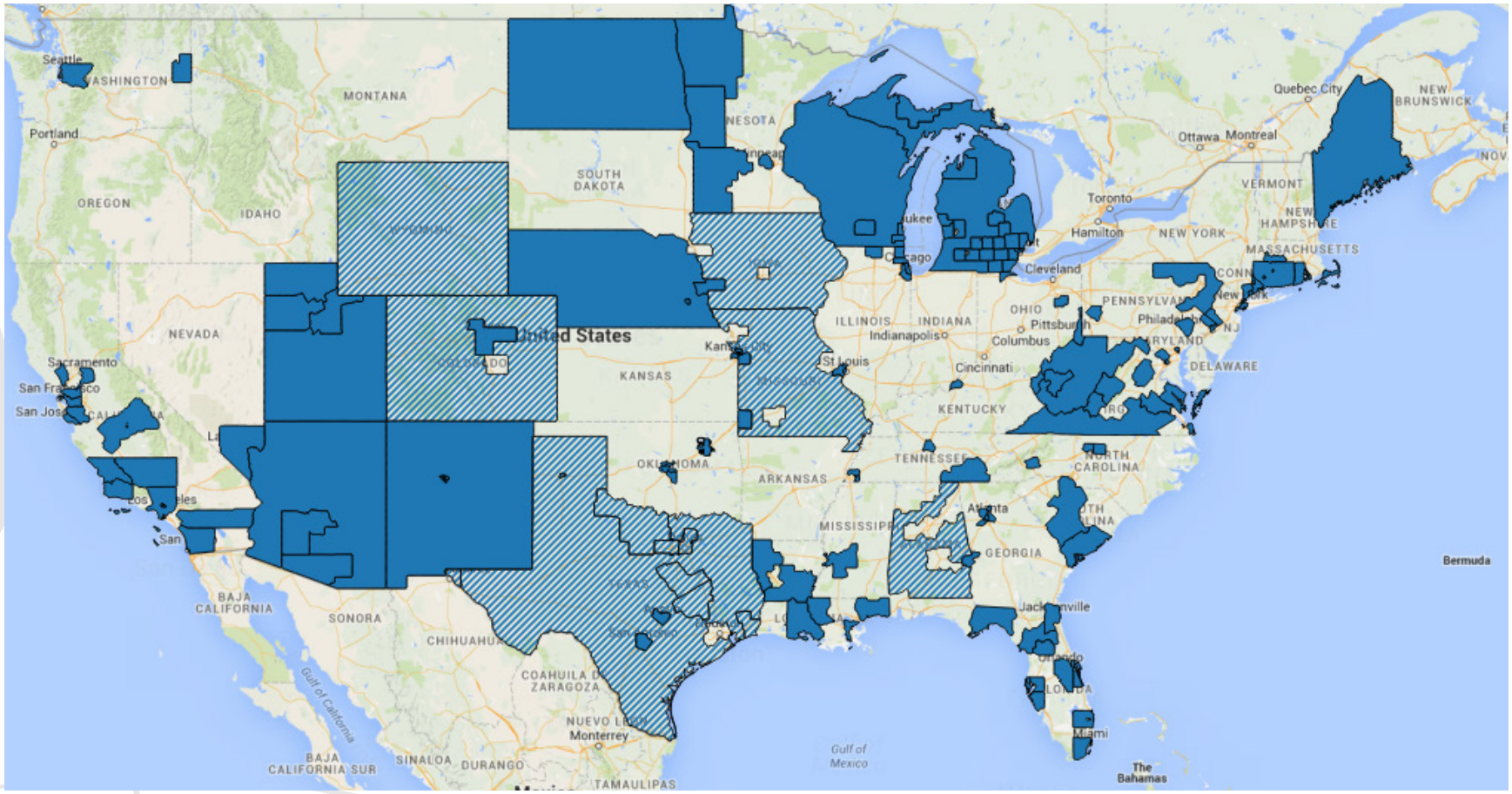
Appendix B: Where the VI-SPDAT is being used in the United States

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



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

Vulnerability Index -

Service Prioritization Decision Assistance Tool

(VI-SPDAT)

Prescreen Triage Tool for Families

AMERICAN VERSION 2.0

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

COMMUNITY SOLUTIONS

ORG CODE

Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:

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

All versions are available online at

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

SPDAT Series

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

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/

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

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/

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Administration

Interviewer's Name	**Agency**	☐ Team ☐ Staff ☐ 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**	**Consent to participate**	
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes	☐ No

PARENT 2

☐ 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**	**Consent to participate**	
DD/MM/YYYY ____/____/_____	_____	_____	☐ Yes	☐ No

IF EITHER HEAD OF HOUSEHOLD IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE:

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Children

1. How many children under the age of 18 are currently with you? _____ ☐ Refused
2. 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
3. *IF HOUSEHOLD INCLUDES A FEMALE:* Is any member of the family currently pregnant? ☐ **Y** ☐ N ☐ Refused
4. 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**.

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**.

SCORE:

A. History of Housing and Homelessness

5. 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:

6. How long has it been since you and your family lived in permanent stable housing? _____ ☐ Refused
7. 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:

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:**

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 themself 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:**

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:**

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:**

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:**

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:**

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:**

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:**

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:**

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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:**

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:**

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:**

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:**

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:**

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:**

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:**

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:**

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:**

Scoring Summary

DOMAIN	SUBTOTAL	RESULTS
PRE-SURVEY	/2	
A. HISTORY OF HOUSING & HOMELESSNESS	/2	**Score:** **Recommendation:**
B. RISKS	/4	0-3 no housing intervention
C. SOCIALIZATION & DAILY FUNCTIONS	/4	4-8 an assessment for Rapid Re-Housing
D. WELLNESS	/6	9+ an assessment for Permanent Supportive Housing/Housing First
E. FAMILY UNIT	/4	
GRAND TOTAL:	/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
Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?	phone: (_____) _____ - _____ email: _____
Ok, now I'd like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?	☐ Yes ☐ No ☐ Refused

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

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

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.

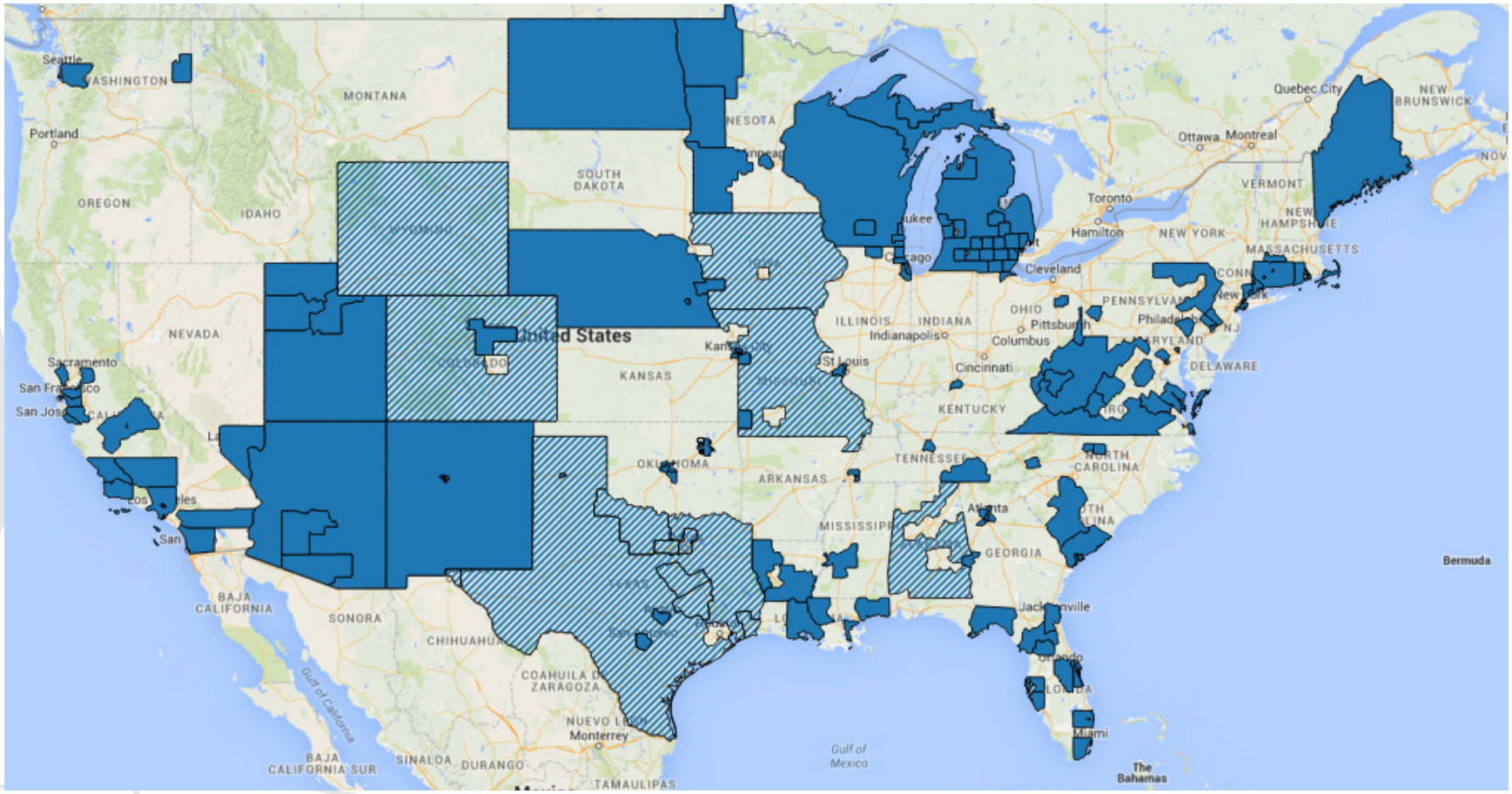
You will notice some differences in Version 2 compared to Version 1. Namely:

- 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).

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

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

Group settings have been updated. If you are experiencing issues, check the FAQ for help. Visit FAQ

Alliance for Housing, Oakland County Continuum of Care ›

Alliance/HUD FY19 Tier 1 & 2, Bonus and Planning grant information

1 post by 1 author

Assign

me (Ashley Burton change) 10:58 AM (1 minute ago)

Good Morning,

Please see attached for the Alliance/HUD FY19 ranking information. You can also find it posted on the Alliance website at https://www.oaklandhomeless.org/hud-fy2019

If you have any questions please contact Leah at lmccall-alliance@oaklandhomeless.org

Thank you,

Attachments (1)

HUD FY2019 Documents

Alliance for Housing FY2019 Timeline

Ashley Burton uploaded on 7.10.19

Alliance/HUD FY2019 Renewal Application & Scoring

- Application Document
- Scoring Document

Ashley Burton uploaded on 7.11.19

Alliance/HUD FY2019 Bonus RFPs

- TH RRH DV Bonus FY2019
- SSO-CE Bonus FY2019
- PSH Bonus FY2019

Ashley Burton uploaded on 7.15.19

Alliance/HUD FY19 Tier 1 & 2, Bonus and Planning grant information

- Ranking Sheet

Ashley Burton uploaded on 7.31.2019

ALLIANCE FOR HOUSING

August 1, 2019

Dear Ms Poma,

The purpose of this letter is to inform you that the evaluation of proposals submitted in response to the subject RFP has been completed.

The Prioritization Committee evaluated all proposals in strict accordance with the evaluation criteria set forth in the RFP. We regret to inform you that the PSH proposal was not selected for award.

We want to thank you for your proposal and your interest in this engagement, and we look forward to your future participation in future RFPs for similar engagements.

Should you have any questions about this matter, please feel free to contact lmccall-alliance@oakalndhomeless.org.

Sincerely,

Leah McCall

Leah McCall, MA
Alliance for Housing, ED
248-221-1854
www,oaklandhomeless.org

EQUAL HOUSING OPPORTUNITY

LM

Leah McCall

Thu 8/1/2019 11:56 AM

Jenny Poma <jenny@lighthousemi.org>; rhertz@oaklandshelter.org; Ashley Burton

HUD FY19 denial letter.pdf

187 KB

Alliance for Housing HUD FY2019 Timeline and Important Dates

The NOFA for FY2019 funding portion of the FY2019 Continuum of Care (CoC) Program competition has been released. The Alliance for Housing of Oakland County is the HUD-approved Consolidated Applicant for the FY2019 Continuum of Care Application. In this role, the Alliance for Housing is responsible for leading and managing the decision-making and application process for the FY2019 HUD Continuum of Care Homeless Assistance Funding application for projects seeking both renewal and new HUD funding.

- **Thursday, July 11, 2019**-Alliance for Housing application/scoring document issued to the community via listserve and the Alliance for Housing's website www.oaklandhomeless.org

- **Monday, July 15, 2019-** Alliance for Housing issues RFP for HUD bonus dollars via listserve and Alliance for Housing's website www.oaklandhomeless.org

- **Monday, July 22, 2019-** Alliance for Housing renewal or new applications AND RFP application due to Leah McCall by 5:00 pm via email lmccall-alliance@oaklandhomeless.org

- **Monday, July 29, 2019-** Alliance for Housing prioritization committee ranking meeting and potential grantee/agency presentations in the Waterford room, Oakland County Executive Building, 2100 Pontiac Lake Rd, Waterford.

- **Wednesday, July, 31, 2019 -** Alliance for Housing will provide priority and ranking of projects via listserve and on the Alliance for Housing website by 5:00pm

- **Monday, August 12, 2019-** Grantee/agency applications completed in ESNAPS by 5:00pm. Provide the Alliance for Housing a PDF copy to Leah McCall by 5:00pm, lmccall-alliance@oaklandhomeless.org

- **Tuesday, August 20, 2019-** Grantee/agency revisions completed in ESNAPS (if revisions are needed, you will be notified). Confirmation of revisions completed sent via email to Leah McCall, lmccall-alliance@oaklandhomeless.org

- **Friday, September 27, 2019-** Alliance for Housing will complete and submit the CoC HUD consolidated application via ESNAPS

- **Monday, September 30, 2019-** HUD deadline for CoC applications submitted in ESNAPS

Alliance for Housing FY2019 Timeline

Ashley Burton uploaded on 7.10.19

Group settings have been updated. If you are experiencing issues, check the FAQ for help. Visit FAQ

Alliance for Housing HUD FY2019 Timeline

1 post by 1 author

Assign

me (Ashley Burton change) Jul 10

Good afternoon, please see the attached Alliance for Housing timeline for HUD FY2019 . Any questions please contact Leah at lmccall-alliance@oaklandhomeless.org or Ashley at aburton-alliance@oaklandhomeless.org

Also, please visit our website for all Alliance HUD2019 important documents! https://www.oaklandhomeless.org/hud-fy2019

Thank you

Attachments (1)

Alliance for Housing, Oakland County Continuum of Care ›

Alliance/HUD FY2019 RFP for DV TH RRH Bonus

1 post by 1 author

Assign

me (Ashley Burton change) 1:40 PM (23 minutes ago)

Good afternoon,

The Alliance for Housing is requesting proposals for funding under the U.S. Department of Housing and Urban Development (HUD) Continuum of Care Homeless Assistance Program.

This is for new projects for additional community bonus dollars to support those experiencing domestic violence (DV) in the community. The CoC is looking for proposals to expand these services to include a project that will provide an existing Transitional Housing (TH) project for expansion to add a Rapid Rehousing (RRH) component specifically for the DV population. Please see the FY2019 NOFA for full requirements. The bonus amount for Oakland County is estimated at $463,408. Out of the proposals received the Alliance prioritization committee will choose the DV TH-RRH project to be added to the new applications to be ranked in the FY19 HUD Tier 1& Tier 2 ranking process.

If you have any questions please email Leah at lmccall-alliance@oaklandhomeless.org

Thank you,

Alliance for Housing
Oakland's County Continuum of Care

HUD FY2019 Documents

Alliance for Housing FY2019 Timeline
Ashley Burton uploaded on 7.10.19

Alliance/HUD FY2019 Renewal Application & Scoring

- Application Document
- Scoring Document

Ashley Burton uploaded on 7.11.19

Alliance/HUD FY2019 Bonus RFPs

- TH RRH DV Bonus FY2019
- SSO-CE Bonus FY2019
- PSH Bonus FY2019

Ashley Burton uploaded on 7.15.19

Component # 4: Program Performance
75 points (RRH & PSH)
65 points (TH)

Performance will be evaluated and scored using data from a variety of sources. Comments are added to each box to describe where you can find the element. Cells highlighted in grey will autocalculate. Only answer the questions relevant to the specific project type for each renewal. *It is recommended to complete this application in Excel and save as PDF for submission.*

Reports need to be run for **6/1/2018 to 5/31/2019** regardless of the grant term. Reports required to complete this section:

[ ] **CoC - APR (canned report)**

*** Canned reports need to be submitted as a PDF and can be done directly in the browser settings.

Please contact hmishelp@chninc.net if you have HMIS or ART related questions.

---

1. Length of Stay 20 points		**Factor/Goal**	**Max Point Value**
#DIV/0!	**RRH** - Percentage of persons with length of time between entry & move-in less than 60 days. [ ] Total persons with length of time between entry & move-in date less than 60 days. / [ ] Total	60 days	20 points
[ ]	**PSH** - Average length of stay in project for leavers.	365 days	20 points
[ ]	**TH** - Average length of stay in project leavers.	180 days	20 points

2. Exits to Positive Housing Destination (25 pts)		**Factor/Goal**	**Max Point Value**
	RRH/PSH/TH – Percent exited to positive housing destination	90%	25 points
0	[ ] Total persons exiting to positive housing destination (90+ days) +		

		Total persons exiting to positive housing destination (90 days or less)
0		Total persons whose destinations excluded them from the calculation (90+ days)
	+	
		Total persons whose destinations excluded them from the calculation (90 days or less)
0		Total persons (90+ days)
	+	
		Total persons (90 days or less)
#DIV/0!		Total Percentage

3. New or Increased Non-Employment Income or Earned Income (10 pts)

			Factor/Goal	Max Point Value
A.		**RRH/PSH/TH** - Minimum % of adults with any income for project *stayers*	20%	5 points
B.		**RRH/PSH/TH** - Minimum % of adults with any income for project *leavers*	20%	5 points

4. Project Effectiveness (10 pts TH) (20 pts RRH & PSH)

				Factor/Goal	Max Point Value
A.	#DIV/0!	**RRH/PSH/TH** - Minimum % leavers with health insurance.		85%	10 points
			1 Source of Health Insurance		
	+		More than 1 Source of Health Insurance		
		/			
			Number of Leavers		
B.	#DIV/0!	**RRH -** Cost Effectiveness		>$2500	10 points
			Total Cost of Project		
		/			
			Total persons exiting to positive housing destination (90+ days)		

+

Total persons exiting to positive housing destination (90 days or less)

#DIV/0! **PSH-** Cost Effectiveness >$5500 10 points

Total Cost of Project

/

Total Persons Served

#DIV/0! **TH -** Cost Effectiveness Test Year

Total Cost of Project

/

Total persons exiting to positive housing destination (90+ days)

+

Total persons exiting to positive housing destination (90 days or less)

Component # 5: HMIS Compliance
34 Points

HMIS compliance will be evaluated and scored using data from a variety of sources. Comments are added to each box to describe where you can find the element. Cells highlighted in grey will autocalculate. Cells highlighted in black will be provided by the HMIS SA1 or CoC Director. Only answer the questions relevant to the specific project type for each renewal.

Reports need to be run for **6/1/2018 to 5/31/2019** regardless of the grant term. Reports required to complete this section:

CoC - APR (canned report)

FY 17 Application

Please contact hmishelp@chninc.net if you have HMIS or ART related questions.

1. HMIS Operation	**Factor/Goal**	**Max Point Value**
A. Average utilization rate.	98%	4 Points

		Total Beds Written in FY17 Application
#DIV/0!		January
#DIV/0!		April
#DIV/0!		July
#DIV/0!		October

B.		Clients entering project have a completed VI-SPDAT.	95%	4 Points
C.		Was your most recent APR submitted to SAGE on time?	Yes	2 Points

2. Data Quality			**Factor/Goal**	**Max Point Value**
A.		Were the Reports Required for this Application Run Correctly?	Yes	2 Points
B.		Was this Application Completed Correctly?	Yes	2 Points
C.		Attended 12 monthly Agency Administrator/Data Quality meetings.	Yes	2 Points
D.		Submitted all monthly data quality reports to the Oakland County HMIS System Administrators.	Yes	2 Points

E. Personally Identifiable Information- % Error Rate

%	Name	<5%	1 Point
%	SSN	<5%	1 Point

%	Date of Birth	<5%	1 Point
%	Race	<5%	1 Point
%	Ethnicity	<5%	1 Point
%	Gender	<5%	1 Point

F. Universal Data Elements % Error Rate

%	Veteran	<5%	1 Point
%	Project Start Date	<5%	1 Point
%	Relationship to HoH	<5%	1 Point
%	Client Location	<5%	1 Point
%	Disabling Condition	<5%	1 Point

G. Income and Housing Data Quality % Error Rate

%	Destination	<5%	1 Point
%	Income and Sources at Start	<5%	1 Point
%	Income and Sources at Annual Assessment	<5%	1 Point
%	Income and Sources at Exit	<5%	1 Point

H. Chronic Homlessness % Of Records Unable to Calculate

%	TH or PH (RRH & PSH)	<5%	1 Point

The Alliance for Housing 2019 renewal application and scoring
Continuum of Care Program Competition

The Alliance for Housing developed a renewal process to determine if Permanent Housing and Transitional Housing projects are performing in accordance with HUD requirements and CoC expectations. This year, grants will be renewable under the CoC Program Competition as set forth in 24 CFR 578.33 to continue ongoing leasing operating, rental assistance, HMIS, and project administration costs. Projects are eligible for renewal if they are currently in operation and have a signed grant agreement with HUD expiring between January 1, 2020 and December 31, 2020. Renewal grants will be limited to 1 year of funding.

Annually, the Alliance for Housing reviews these projects and provides guidance for renewal project funding. Scoring guidelines are listed within this document to determine if agencies comply with renewal criteria and meet the required threshold. The Alliance for Housing will provide explanations for projects that are rejected.

The deadline for submitting this scoring application and supplemental information is due **Monday, July 22, 2019 at 5PM** to the CoC Executive Director (lmccall-alliance@oaklandhomeless.org). Applicants that do not meet this deadline may be subject to funding reallocation or loss of funding.

The Alliance for Housing will meet, review and provide priority and ranking of projects on **Monday, July 29, 2019.** During this meeting applicants will have an opportunity to talk about their application and answer any questions the committee may have. The priority ranking (tier 1 tier 2 and bonus) will be sent out via listserve and posted on the Alliance for Housing Website on **Wednesday, July 31, 2019 at 5PM.**

The deadline for submitting all project renewal applications in ESNAPS as well as submitting an email pdf copy of the ESNAPS application to the Alliance for Housing, Executive Director is **Monday, August, 12, 2019 at 5PM.**

Ranking
In alignment with the 2019 CoC Program NOFA, existing projects will not be automatically renewed during the FY 2019 competition. As stated in the FY 2019 NOFA, projects will be divided into two tiers, wherein Tier 1 applicants will have funding priority over Tier 2. Tier 1 applicants will be prioritized by their ranking score, HUD/CoC determined high priority projects (Chronically Homeless, Youth, Veteran, and Families with Children), high performance, and meeting the needs and gaps as identified by the CoC. This year the CoC will review new baseline performance measures related to the projects.

Based on guidelines set forth by HUD, ranking will also be prioritized for projects in the following order:

Renewal/new projects.

a. HMIS
b. PSH
c. RRH
d. TH
e. New projects created through bonus (ranking of bonus application priority TBD by board/prioritization committee)

Refer to 2019 Notice of Funding Availability (NOFA) for the Continuum of Care Program Competition for a more detailed description of applicant updates.

The FY2019 CoC planning grant will not be ranked per the NOFA therefore will not be tiered.

Renewal Project Threshold Score

Renewal projects are scored on 5 components: program performance, financial performance, HMIS compliance, consumer satisfaction, and CoC participation. Total scoring depends on project type. The threshold for renewal is 65%. Projects below this threshold may not be eligible for refunding and will be offered technical assistance to improve project performance for future applicability.

The Alliance for Housing reserves the right to make decisions on which projects should receive funding and/or the amount awarded based upon recommendations of the Prioritization Committee and the Alliance for Housing Board of Directors.

Renewal Project Scoring Overview

ATTACHMENT 1		Points
#1	Financial Performance	14
#2	Consumer Satisfaction	8
#3	CoC Participation	8
ATTACHMENT 2		
#4	Program Performance	65 (TH) 75 (RRH/PSH)
#5	HMIS Compliance	34
Total Points Possible		129 (TH) 139 (RRH/PSH)

Threshold: All Projects must score 65% or higher to be eligible for renewed funding.

Agency Name:	
Grant Name:	
Grant Type (PSH/RRH/TH):	
Grant Number:	

Component #1 Financial Performance 14 Points

Financial performance is measured by the extent to which each project has expended its budgeted grant during the last project year fully completed.

- Applicants are responsible for submitting information from the Line of Credit Control System (LOCCS) from your HUD representative, and financial performance evidence from an Independent Auditor Report.

Renewal projects must draw project funds, at a minimum, on a quarterly basis. Instances where drawdown is delayed or not serving participants may result in the project not being funded in the FY2019 CoC Program Competition.

1) What percentage of your project's grant funding has been expended? During the projects most recently completed year.*

2) How often has your project completed a drawn down from ELOCCS?

- 98% grant funding expensed: 10 points
- 97% - 0% grant funding expensed: 0 points
- Evidence of drawdown of funds at least quarterly: 4 point

***Projects expending less than 100% of their grant are required to provide a written explanation. Depending on explanation, the Alliance for Housing will determine whether to target follow-up technical assistance or to deem the project ineligible.

Component #2 Consumer Satisfaction- 8 Points

Projects will be scored on their submission of the following items:

Category	Points Possible
A. Provide a copy of your client satisfaction/feedback form or survey.	2
B. Project enhancement or change via feedback narrative	2
C. Narrative of the results of the survey's outcome	2
D. Participant involvement in decision-making or other role within the organization	2
TOTAL	8

A. Who do you give your survey to, leavers? Current participants?
Submission of form/survey w/ explanation of those surveyed: 2 point
No submission: 0 point

B. Submission of narrative of the results of the agency or program's most recent survey.
****Total number of forms sent-total number of forms returned= outcome PER QUESTION (with narrative of explanation if needed)**
Yes: 2 point
No: 0 points

C. In what way(s) does your agency use your survey results to enhance your project(s)?
Narrative with examples: 2 points
No narrative or example: 0 points

D. Participant involvement in decision-making or other role within the organization
Does the organization have a participant or former participant involved in: a position on the organization's Board of Directors, peer counselor (or similar role), or a participant advisory council (or similar role)

Yes, there is demonstrated participant involvement and their involvement is described: 2 points
No, there is not participant involvement: 0 points

Component #3: Continuum of Care Participation
8 Points

An agency's participation is measured by the number of Continuum of Care meetings attended during 2018-2019 as well as 2019 PIT and ending homelessness response.

Agency's Participation in the CoC Meetings (applies to only one category)	**Possible Points**	
A. Agency participation on at least one CoC committee	1	
B. General membership attendance/Annual retreat	1	
C. Organization represented at 5 or more meetings	2	
D. Organization had a team on the street count/committee	2	
E. Narrative of CE agency involvement.	2	
Total:	8	

A. Does your agency participate in at least one CoC committee, and, if so, which one (s)?

Yes: participated: 1 point
No: 0 points

B. How many CoC general membership meetings including the annual retreat was your organization represented at in the last fiscal year?

Yes: participated in meeting(s): 1 point
No: 0 points

C. Was the organization represented at five or more Alliance meetings (GM, board, committee or workgroup)?

Yes: participated in 5 or more: 2 points
Less than 5: 0 points

D. Organization participated in the January 2019 Point-in-Time Count? Team on street.

Yes: participated: 2 point
No: 0 points

E. How does your agency provide equal access within Coordinated Entry?

Narrative provided: 2 points
No narrative: 0 points

Agencies *may* also provide, in one-half page or less, an explanation or commentary on the project's performance outcomes for the scored questions in Component #4.
TH in Component #4, question 4, will not be scored this year.

Additional Narrative

Note: This is not a scored area for this year.

F. Please describe the mainstream and other community-based resources and partnerships your agency has to sustain permanent exits from the program (ex: job training, life skills, treating substance abuse, etc.).

G. Does your agency use data and evidence to measure cost-effectiveness, impact of homelessness programs on positive

outcomes, recovery, self-sufficiency, and reducing homelessness? If yes, please explain in detail.

H. Does your agency work with local employment agencies and employers for training and employment opportunities for persons in project? If yes, please explain in detail.

Appeals Process

An appeals process will be available for renewal projects that do not pass the scoring threshold (65%).

All appeals will be reviewed by a group established by the Alliance for Housing Board of Directors and Project Review Committee. Members of the Appeals Committee will not have any projects that receive HUD CoC Homeless Assistance Program funding.

- Appeals must to be submitted in writing via email to lmccall-alliance@oaklandhomeless.org . Address all appeals to the Appeals Committee/prioritization committee and submit the following details: the issue being appealed, the argument for overturning the score, and evidence to support the argument. Please ensure that your appeal is concise and includes appropriate detail to process the review. Changes made to the project after application will not be considered.

- The appeal must be received by the close of the business day within 5 business days of the communication of denial of eligibility to submit for funding. Submission must be received in a type written format (with attachments if appropriate) electronically.

- The decisions of the Appeal/prioritization Committee are final.

- Applicants that are rejected may also appeal directly to HUD by submitting a Solo Application prior to the deadline per the 2019 NOFA.

Attachment Checklist:

- ☐ HMIS Reports- Run report for 6/1/2018-5/31/2019
  - CoC - APR (canned report)
- ☐ Line of Credit Control System (ELOCCS print out from draws)
  - Evidence of drawdown of funds at least quarterly
- ☐ Financial Performance Evidence from an Independent Auditor Report
- ☐ FY2017 ESNAPS HUD Application

_____
_____
_____
_____
_____
_____

_____ (agency) confirms it has read, reviewed and is in compliance with the FY2019 NOFA. Please sign and date below.

_____ _____

(Sign) (Date)

ALLIANCE FOR HOUSING
OAKLAND COUNY'S CONTINUUM OF CARE

REQUEST FOR PROPOSALS-New DV Bonus Project

The Alliance for Housing is requesting proposals for funding under the U.S. Department of Housing and Urban Development (HUD) Continuum of Care Homeless Assistance Program. This is for new projects for additional community bonus dollars to support those experiencing domestic violence (DV) in the community. The CoC is looking for proposals to expand these services to include a project that will provide an existing Transitional Housing (TH) project for expansion to add a Rapid Rehousing (RRH) component specifically for the DV population. Please see the FY2019 NOFA for full requirements. The bonus amount for Oakland County is estimated at $463,408. Out of the proposals received the Alliance prioritization committee will choose the DV TH-RRH project to be added to the new applications to be ranked in the FY19 HUD Tier 1& Tier 2 ranking process.

- Potential sub-recipients must meet the eligibility requirements of the CoC Program as described in 24 CFR part 578 and provide evidence of eligibility required in the application (e.g., nonprofit documentation).
- Potential sub-recipients must demonstrate the financial and management capacity and experience to carry out the project as detailed in the project application and to administer Federal funds. Demonstrating capacity may include a description of the sub-recipient experience with domestic violence, dating violence, sexual assault, or stalking as define in paragraph (4) at 24 CFR 587.3.
- Potential sub-recipients must address their involvement or process to become involved with HMIS (Homeless Management Information System)/comparable system.
- Project applicants must submit the required certifications as specified in the NOFA, for example, SAM registration, DUNS number. Eligible project applicants for the CoC Program Competition are found at 24 CFR 578.15.

The project that the Alliance for Housing will be accepting applications for in the HUD FY2019 new bonus DV expansion application are:

1. **Joint TH and PH-RRH component projects**, as defined in Section V.C.3.a.5 and Section III.C.2.n in the NOFA. Projects must follow a Housing First approach. The applicant must be a current transitional housing (TH) provider. If the agency is not a HUD funded TH provider, a complete description of the operating transitional housing project and budget for the TH component must be a part of the proposal. This TH-RRH project will be funding the TH/RRH component of project, that can include admin and support services in additional

to the housing portion. Please include numbers of households estimated to be served within the TH/RRH component in the proposal.

Interested applicants are requested to submit a two-page concept paper for the description projects above, with a proposed budget. All proposed projects may only request HUD funding for activities and services as allowed under the HUD FY2019 NOFA under the above category. TH and RRH project information is available at 24 CFR 578.37. Respondents must meet the continuum requirements for funding applicants. Please read the Continuum of Care FY2019 NOFA in its entirety before submission. Your concept paper should address the following components:

- Description of the proposed project
- Housing First approach
- Community need
- Capacity/Experience
- Performance measurement outcomes
- Leveraging
- Linkage to mainstream resources

Concept papers can be submitted to Leah McCall via email at lmccall-alliance@oaklandhomeless.org by Monday, July 22, 2019 at 5:00 p.m. No proposals will be accepted after this timeline

Concept papers will be judged by an independent panel of Alliance Board Members. The committee will only fund one project.

For additional information please contact Leah McCall at (248) 221-1854 lmccall-alliance@oaklandhomeless.og or Kathy Williams at (248) 858-1189 Williamska@oakgov.com

Issued: July 15 2019
Bonus scoring
Scoring for project proposals for the HUD FY19 DV bonus:

1. 5-10 points:
   TH/RRH:
   Provide data to quantify the need for this project and how adding RRH to expand your TH project will fill that gap specifically for Cat 4.

2. 5-10 points:
   TH/RRH:
   Provide previous TH performance or how you as a new applicant are currently serving survivors of DV, dating violence, sexual assault or stalking and how your agencies ability to house survivors and meet safety concerns will be met.

Alliance for Housing, Oakland County Continuum of Care ›

Alliance/HUD FY2019 renewal scoring application 2 documents

1 post by 1 author

Assign

me (Ashley Burton change) Jul 11

Good afternoon,

Please see the attached renewal application. There are two parts to this renewal process and both must be completed and emailed to lmccall-alliance@oaklandhomeless.org with any needed attachments by **5PM Monday, July 22, 2019.**

Click HERE for all documents related to Alliance/HUD documents for FY2019.

Thank you,

Ashley Burton

Attachments (2)

me (Ashley Burton change) 1:46 PM (18 minutes ago)

Good afternoon,

The Alliance for Housing is requesting proposals for funding under the U.S. Department of Housing and Urban Development (HUD) Continuum of Care Homeless Assistance Program.

SSO-CE Bonus Project

This RFP is for current state or federal Alliance for Housing, OC CoC funded partners to work with the Alliance as a sub-contract for a project that will provide **SSO-CE** (Support Services Only Projects for Coordinated Entry). Please see the FY2019 NOFA for full requirements. The Alliance will fund no more than two applicants for this award in total for $288,847.50. The Alliance will keep the allowable 5% or $15,202.50 out of the total grant amount estimated at $304,050 to fund a PT position to coordinate this process) and the sub grantees may take a combined total of 5% available in administrative dollars for this grant. The applicant must be able to meet 25% of asked budget in match per requirements of HUD ($76,012.50 total match for grant) grant in their proposal.

New PSH project or PSH expansion Bonus Project

The Alliance for Housing is requesting proposals for funding under the U.S. Department of Housing and Urban Development (HUD) Continuum of Care Homeless Assistance Program. This is for new projects for permanent supportive housing serving 100% chronically homeless families, individuals and unaccompanied youth. See the FY2019 NOFA for full requirements. This may also be a new Chronic PSH expansion project please review the FY19 NOFA Section III.C.2.j. The bonus amount for Oakland County is estimated at $304,050.00.

If you have any question please contact Leah at lmccall-alliance@oaklandhomeless.org

Thank you,

Ashley Burton

Alliance for Housing

Grants and Community Manager

Alliance/HUD FY2019 Renewal Application & Scoring

- Application Document
- Scoring Document

Ashley Burton uploaded on 7.11.19

ALLIANCE FOR HOUSING

ALLIANCE FOR HOUSING
OAKLAND COUNY'S CONTINUUM OF CARE

REQUEST FOR PROPOSALS-New PSH project or PSH expansion- Bonus Project

The Alliance for Housing is requesting proposals for funding under the U.S. Department of Housing and Urban Development (HUD) Continuum of Care Homeless Assistance Program. This is for new projects for permanent supportive housing serving 100% chronically homeless families, individuals and unaccompanied youth. See the FY2019 NOFA for full requirements. This may also be a new Chronic PSH expansion project please review the FY19 NOFA Section III.C.2.j. The bonus amount for Oakland County is estimated at $304,050.00.

- Potential sub-recipients must meet the eligibility requirements of the CoC Program as described in 24 CFR part 578 and provide evidence of eligibility required in the application (e.g., nonprofit documentation).
- Potential sub-recipients must demonstrate the financial and management capacity and experience to carry out the project as detailed in the project application and to administer Federal funds. Demonstrating capacity may include a description of the sub-recipient experience with similar projects and with successful administration of PSH, S+C, or CoC Program funds for renewing projects or other Federal funds.
- Potential sub-recipients must address their involvement or process to become involved with the HMIS (Homeless Management Information System).
- Project applicants must submit the required certifications as specified in the FY2019 NOFA.
- As defined in the FY19 NOFA section III 2.b. the only persons who may be served by a prioritized permanent supportive housing bed are persons experiencing chronic homelessness as defined in 24 CFR 578.3, including individuals, families, and unaccompanied youth.

Interested applicants are requested to submit a two-page concept paper and proposed budget. All proposed projects may only request HUD funding for activities and services as allowed under the HUD Permanent Housing Programs. Regulations for the HUD Supportive Housing Programs at 24 CFR 578.37 Subpart D. Respondents must meet the continuum requirements for funding applicants. Please read the Continuum of Care FY2019 NOFA in its entirety before submission. Your concept paper should address the following components:

- Description of the proposed project, including percentage of housing versus supportive services
- Community Need

- Capacity/Experience
- Performance Measurement Outcomes
- Leveraging
- Linkage to mainstream resources

Concept papers can be submitted to Leah McCall via email lmccall-alliance@oaklandhomeless.org. No proposals will be accepted after Monday, July 22, 2019 at 5:00 p.m.

Concept papers will be judged by an independent panel of Alliance Board Members. There can more than one project or agency selected for funding collaboration applications are encouraged.

For additional information please contact Leah McCall at (248) 221-1854 lmccall-alliance@oaklandhomeless.og or Kathy Williams at (248) 858-1189 (Williamska@oakgov.com).

Issued: July 15, 2019

NOFA Section V.C.3.c- scoring for new projects- Permanent Housing: Permanent Supportive Housing or Rapid Rehousing

New permanent housing projects must receive at least 3 out of the 4 points available for this project type and must receive the point under the third criteria. Projects that do not receive at least 3 points and the point under the third criteria will be rejected.

1 point- The type of housing proposed, including the number and configuration of units, will fit the needs of the program participants (e.g., two or more bedrooms for families).

1 point- The type of supportive services that will be offered to program participants will ensure successful retention in or help to obtain permanent housing, including all supportive services regardless of funding source.

1 point- The proposed project has a specific plan to coordinate and integrate with other mainstream health, social services, and employment programs and ensure that program participants are assisted to obtain benefits from the mainstream programs for which they may be eligible (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education).

1 point- Program participants are assisted to obtain and remain in permanent housing in a manner that fits their needs (e.g., provides the participant with some type of transportation to access needed services, safety planning, case management, additional assistance to ensure retention of permanent housing).

**To apply for an expansion grant, project applicants must submit separate renewal and new project applications and a renewal application that includes the information from the renewal new project application that combines the activities, and budgets into one renewal project application. While the renewal and new projects will be ranked by the CoC, the combined expansion project will not be ranked and, if selected for conditional award, will take the ranked position of the stand-alone renewal project, and the separate new project will be removed from the ranking resulting in project applications below to slide up one ranked position. However, if the combined renewal expansion project is also part of a consolidation project application, HUD will follow the ranking process for consolidated projects outlined in Section II.B.5 and if the combined expansion and consolidation is selected for conditional award, the ranked position of the stand-alone renewal project and the new project will be removed from the ranking, resulting in project applications below to slide up. If HUD determines the combined expansion project is ineligible, HUD will review the renewal and new project applications separately as these projects will retain their ranked position on the CoC Project listings.

ALLIANCE FOR HOUSING
OAKLAND COUNY'S CONTINUUM OF CARE

REQUEST FOR PROPOSALS SSO/CE Bonus

The Alliance for Housing is requesting proposals for funding under the U.S. Department of Housing and Urban Development (HUD) Continuum of Care Homeless Assistance Program.

This RFP is for current state or federal Alliance for Housing, OC CoC funded partners to work with the Alliance as a sub-contract for a project that will provide SSO-CE (Support Services Only Projects for Coordinated Entry). Please see the FY2019 NOFA for full requirements. The Alliance will fund no more than two applicants for this award in total for $288,847.50. The Alliance will keep the allowable 5% or $15,202.50 out of the total grant amount estimated at $304,050 to fund a PT position to coordinate this process) and the sub grantees may take a combined total of 5% available in administrative dollars for this grant. The applicant must be able to meet 25% of asked budget in match per requirements of HUD ($76,012.50 total match for grant) grant in their proposal.

Interested applicants are requested to submit a concept paper (minimum of two pages, up to 10 pages) for each of the proposed projects, with an accompanying budget. All proposed projects must meet the continuum requirements for funding applicants. Please read the Continuum of Care FY2019 NOFA in its entirety before submission, must also comply with SSO requirements at 24 CFR 578.37. The concept paper should address the following components:

- Description of the proposed project- with detail of activities included for CE with mandatory outreach component.
- Describe in detail how your agency will assist with in linking non-CoC funded partners to coordinated entry (i.e MOU, scheduled outreach plan, marketing/advertisement strategy).
- Complete required data entry into the Homeless Management Information System (HMIS).
- Community Need

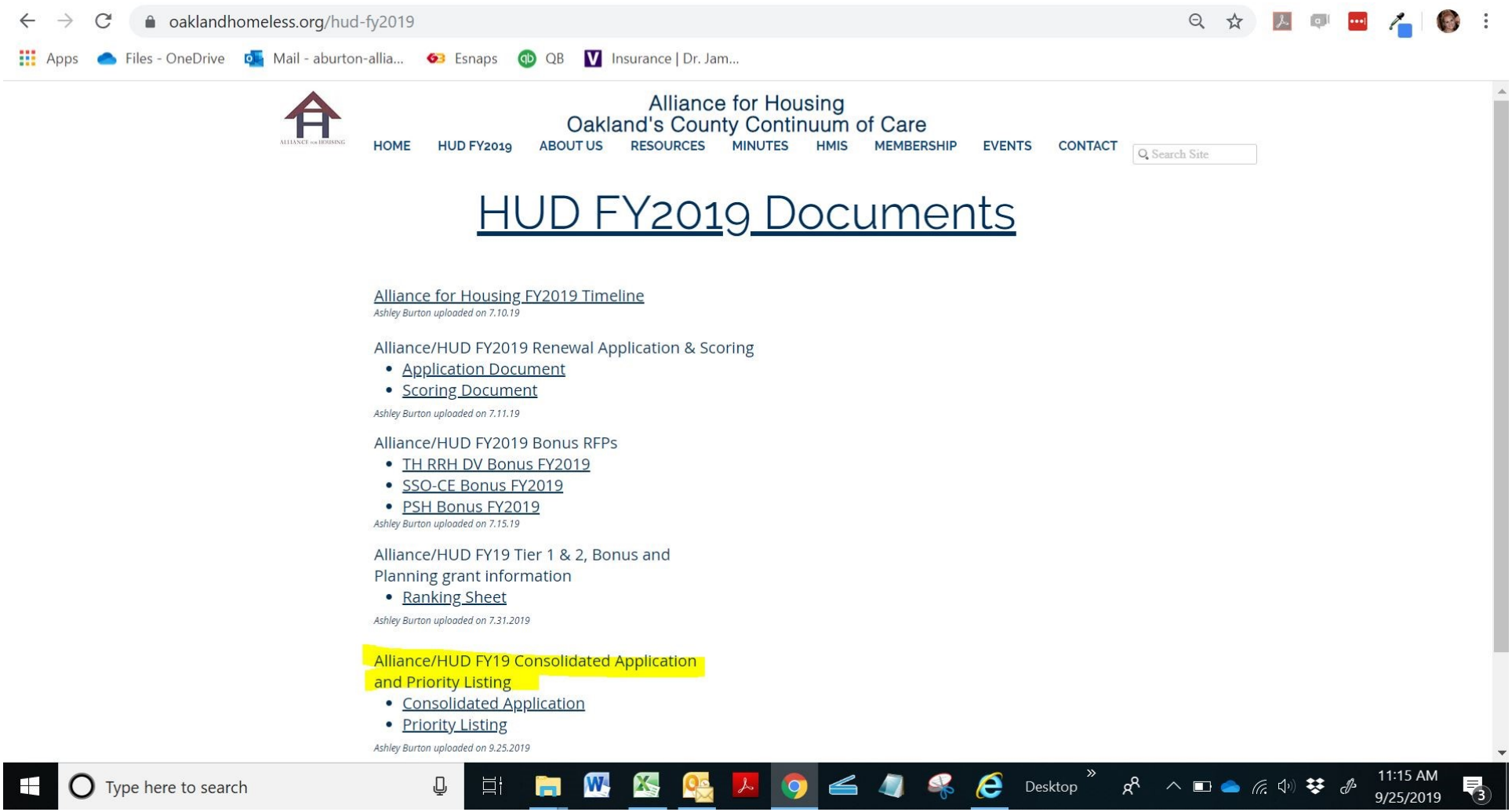
- Describe the process to work collaboratively with the Alliance and other partners to deliver effective and efficient coordinated entry services.
- For purposes of this sub-grantee funding opportunity, describe these funds will directly impact those in need of housing and what steps your agency/staff will take to link to housing opportunities. For example, complete VI's, assist in obtaining needed documentation, refer to housing registry or Veteran BNL, and assist in paperwork completion of HCV applications, housing application and, transportation.
- Work with the Alliance for Housing to update and add to existing CE policies and procedures.
- Address:
    - housing first approach
    - racial disparities
    - equal access to housing regardless of sexual orientation or gender identity
    - decriminalization of homelessness
    - limited English proficiency
    - Advertisement strategy for those with the highest barriers, least likely to apply for housing assistance.
    - Ensure individuals are directed to appropriate housing/services that fit their needs.
    - Specific plan to coordinate and integrate with other mainstream health, social services, employment, and benefits.
- Explain how being a sub grantee will provide additional community support services to individuals experiencing homelessness.
- Capacity/Experience
- Performance measurement outcomes that directly relate to additional coordinating dollars/staffing, number of persons served etc.
- Timeframe for project milestones: new staff hired from time of signed grant agreement, describe process to assist on documented 100% coverage of CoC's service area (Oakland County).

Concept papers can be submitted to Leah McCall via email at lmccall-alliance@oaklandhomeless.org by Monday, July 22, 2019 at 5:00 p.m. No proposals will be accepted after this timeline.

Concept papers will be reviewed by an independent panel of Alliance Board Members/prioritization committee members.

For additional information please contact Leah McCall at (248) 221-1854 lmccall-alliance@oaklandhomeless.og or Kathy Williams at (248) 858-1189 Williamska@oakgov.com

Issued: July 15, 2019


oaklandhomeless.org/hud-fy2019
Apps
Files - OneDrive
Mail - aburton-allia...
Esnaps
QB
Insurance | Dr. Jam...
Alliance for Housing
Oakland's County Continuum of Care
HOME
HUD FY2019
ABOUT US
RESOURCES
MINUTES
HMIS
MEMBERSHIP
EVENTS
CONTACT
Search Site
HUD FY2019 Documents
Alliance for Housing FY2019 Timeline
Ashley Burton uploaded on 7.10.19
Alliance/HUD FY2019 Renewal Application & Scoring
Application Document
Scoring Document
Ashley Burton uploaded on 7.11.19
Alliance/HUD FY2019 Bonus RFPs
TH RRH DV Bonus FY2019
SSO-CE Bonus FY2019
PSH Bonus FY2019
Ashley Burton uploaded on 7.15.19
Alliance/HUD FY19 Tier 1 & 2, Bonus and Planning grant information
Ranking Sheet
Ashley Burton uploaded on 7.31.2019
Alliance/HUD FY19 Consolidated Application and Priority Listing
Consolidated Application
Priority Listing
Ashley Burton uploaded on 9.25.2019
Type here to search
Desktop
11:15 AM
9/25/2019

MEMORANDUM OF UNDERSTANDING
BETWEEN Alliance for Housing
AND Oakland Schools

1. **Parties.** This Memorandum of Understanding (hereinafter referred to as "MOU") is made and entered into by and between the Alliance, whose address is 1 N. Saginaw Suite 208 Pontiac, MI 48342 and Oakland Schools, whose address is 2111 Pontiac Lake Rd, Waterford MI 48328.

2. **Purpose.** The purpose of this MOU is to establish the terms and conditions under which the Alliance and community agencies/partners will refer to Oakland Schools in Oakland County, MI.

3. **Term of MOU.** This MOU is effective upon the day and date last signed and executed by the duly authorized representatives of the parties to this MOU and the governing bodies of the parties' respective counties or municipalities and shall remain in full force and effect for not longer than 3years. This MOU may be terminated, without cause, by either party via written notice, which notice shall be delivered by hand or by certified mail to the address listed above.

4. **Responsibilities of Alliance and Oakland Schools**

Alliance and community agencies/partners will refer homeless students to Oakland Schools homeless student Manager/liaisons.

Oakland Schools agrees to:
- coordinate educational services for school-aged youth who meet the McKinney-Vento Homeless Assistance Act (Education) definition
- provide school supplies, backpacks, and temporary transportation assistance to students in need
- Short-term emergency motel assistance to fill gaps between other providers
- provide homeless verification letters when requested

7. **General Provisions**

A. Amendments. Either party may request changes to this MOU. Any changes, modifications, revisions or amendments to this MOU which are mutually agreed upon by and between the parties to this MOU shall be incorporated by written instrument, and effective when executed and signed by all parties to this MOU.

8. Signatures. In witness whereof, the parties to this MOU through their duly authorized representatives have executed this MOU on the days and dates set out below, and certify that they have read, understood, and agreed to the terms and conditions of this MOU as set forth herein.

The effective date of this MOU is the date of the signatures.

Alliance for Housing

9/12/19

Leah McCall, ED Date

Oakland Schools

Sara Orris 9/26/2019

Sara Orris, Homeless student Manager Date

MICHIGAN WORKS! SYSTEM
MEMORANDUM OF UNDERSTANDING
BETWEEN

The Alliance for Housing, Oakland County Continuum of Care

AND THE

OAKLAND COUNTY
WORKFORCE DEVELOPMENT BOARD

Part I
General Information

This Memorandum of Understanding (hereinafter referred to as the MOU) establishes the terms and conditions between the Alliance for Housing, Oakland County Continuum of Care (CoC) (hereinafter referred to as the Partner) and the local Workforce Development Board (hereinafter referred to as the WDB) for the Oakland County Michigan Works! Agency. The Partner operates a homeless assistance program.

This MOU is entered into for the purpose of delineating the respective roles and responsibilities of the Partner as a one-stop partner, in compliance with the provisions of the Workforce Innovation and Opportunity Act (WIOA) of 2014, Section 121(c)(2) . By signing this MOU, the parties agree to abide by the terms, conditions, goals, and principles set forth herein.

This MOU is designed to ensure the efficient and effective coordination and delivery of services in the Oakland County Michigan Works! service delivery area, to prevent duplication and maximize available resources. In addition, this MOU establishes joint processes and procedures that will enable all parties to integrate the current delivery system. This integration shall result in a more seamless and comprehensive array of education, human service, job training and other workforce development services.

Part II
Service Provision and Coordination

The Partner's Roles and Responsibilities:

Section 121 (b)(1)(A) of the WIOA and Section 678.420 of the WIOA's Final Rule stipulate that required WIOA one-stop partners must assume specific roles and responsibilities. Accordingly, the Partner shall:

- "provide access to its programs or activities through the one-stop delivery system";
- "use a portion of funds made available to its program to:
    - "provide applicable career services that are described in Sections 134(c)(2) of the WIOA and 678.425 of the WIOA's Final Rule, and that are authorized to be provided under [the] Partner's program"; and

- "work collaboratively with the WDB to establish and maintain the one-stop delivery system"; and

- "participate in the operation of the Oakland County MWA's one-stop delivery system, consistent with the terms of this MOU, the requirements [of the Partner's] authorizing laws, the Federal cost principles, and all other applicable legal requirements".

- In accordance with Section 678.305(d)(3) of the WIOA's Final Rule, the Partner shall "provide access to its programs or activities" by "making available a direct linkage through technology to program staff who can provide meaningful information or services". Section 678.305(d)(3)(i) of the WIOA's Final Rule defines "direct linkage" as "providing direct connection at the one-stop center, within a reasonable time, by phone or through a real-time Web-based communication to a program staff member who can provide program information or services to the customer". Section 678.305(d)(3)(ii) of the WIOA's Final Rule stipulates that a "'direct linkage' cannot exclusively be providing a phone number or computer Web site or providing information, pamphlets, or materials".

- Specifically, the Partner shall provide homeless assistance under the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (hereinafter referred to as the HEARTH Act). The Partner's purpose is to 1.) create a collective response that addresses homelessness and affordable housing in Oakland County; 2.) develop a local system that identifies gaps in homeless services and creates solutions to overcome those barriers; and 3.) end homelessness in Oakland County by linking people in need with the services they require.

- To ensure that people who are experiencing homelessness can access homeless assistance services through the MWA's One-Stop System, the Partner shall comply with the following provisions:

    - The Partner shall identify the name, telephone number, and e-mail address of a specific program staff member to whom the One-Stop Operator can refer customers who desire, need, or seek information about homeless assistance. This staff member shall provide these services and information at a level -- and within a timeframe -- that is comparable to assistance the referral would receive if the staff member were assisting the referral in person at the MWA's One-Stop Center.

    - To facilitate referrals the Partner makes to -- or receives from -- the MWA's One-Stop Operators, the Partner shall, together with the Operators, develop a referral form. This form shall identify:

        - the referral's contact information;

        - services the referral has received (or is receiving) and the dates on which he/she received them;

        - the referral's signed consent to share information with the Partner and the One-Stop Operators;

        - services and/or information the referral seeks; and

- the Partner's and the One-Stop Operator's contact information.

- The Partner shall coordinate its services with the One-Stop Operator's services. As, for example, the Partner's customer is securing adequate and affordable housing, the One-Stop Operator shall provide him/her job search assistance and placement services.

- To apprise the MWA's One Stop Operator about the status of the services the Partner is providing the referral, the Partner shall make appropriate entries on the foregoing referral form.

Additional information about referrals is provide in Part IV of this MOU.

The WDB's Roles and Responsibilities:

- Sections 107(d)(10)(A),121(a)(2), and 121(d) of the WIOA and Section 678.605 of the WIOA's Final Rule stipulate that "the local WDB must, with the agreement of the Oakland County MWA's Chief Elected Official (CEO), select and certify one-stop operator(s)". Accordingly, the WDB shall competitively procure, select, and certify the Oakland County MWA's Michigan Works! one-stop Service Center(s) (hereinafter referred to as the one-stop operator(s)) at least every four years. In accordance with Section 121(a)(3) of the WIOA, the WDB, in agreement with the CEO, shall also "conduct oversight with respect to the [Oakland County MWA's] one stop delivery system".

- Section 678.620 of the WIOA's Final Rule describes the one-stop operator's role. Accordingly, the WDB shall ensure that the Oakland County MWA's one-stop operator(s):

  - "coordinate(s) the service delivery of the required one-stop partners"; and

  - is/are "the primary provider of services within the Center(s)".

- Specifically, the MWA's One-Stop Operators shall provide people who are experiencing homelessness with prioritized access to employment opportunities and co-enrollment in workforce development programs under Title I of the WIOA, "Adult, Dislocated Worker, and Youth Services". Title I provides funds for "Career Services" (e.g., specialized assessments, career counseling, individual employment plan development, and work experience); "training services" (e.g., occupational on-the-job and classroom training); and "supportive services" (e.g., transportation and child care).

- The MWA's One-Stop Operators shall provide the foregoing individuals access to workshops on various topics, including resume writing and interviewing.

- If the foregoing individuals are eligible, the MWA's One-Stop Operators shall provide them various supportive services, including transportation assistance.

- The MWA's One Stop Operators shall refer customers who desire, need, or seek information about housing assistance to the program staff member whom the Partner has identified.

- To facilitate referrals the One-Stop Operators make to -- or receive from -- the Operators shall, together with the Partner, develop a referral form. This form shall identify the information that is described above.

this MOU is effective on the date it is signed by the Oakland County WDB and the Partner, as system partners. This MOU shall remain in effect until June 30, 2020, or unless otherwise terminated by mutual agreement of all signing parties, under the following condition:

Any party may withdraw from this MOU by giving written notice of intent to withdraw at least thirty (30) calendar days in advance of the effective date of the withdrawal. Notice of withdrawal shall be given to all parties covered by this agreement. Should any partner withdraw, this MOU shall remain in effect in its entirety with respect to the remaining partners until the expiration date of this agreement, or until a new MOU is executed, whichever occurs first.

All signing parties assure that this MOU shall be reviewed and renewed at least once every three years, or when substantial changes occur.

Part VIII
Procedure for Amendment or Assignment

This MOU may be amended at any time by written agreement of the parties. Such amendments shall require the signature of all parties affected by such amendment. Assignment of responsibilities under this MOU by any of the parties shall be effective upon written notice to the other parties. Any assignee shall also commit in writing to the terms of this MOU.

Part IX
Certification

The undersigned hereby agree to abide by all terms and conditions outlined in this agreement, or in any amended version of this agreement, for the duration of this agreement.

Approval on behalf of Partner: The Alliance for Housing, Oakland County Continuum of Care (CoC)

(Partner Entity Name)

Leah McCall, Executive Director
Print Name and Title

Leah McCall
Signature of Partner

9/20/19
Date

Approval on behalf of the WDB:

Christina Tribuzio
Print Name of WDB Board Chair

X
Signature of WDB Board Chair

9.22.19
Date

Approval on behalf of the Chief Elected Official:

David Coulter, Oakland County Executive
Print Name and Title of Chief Elected Official

X Dan Hall

9/25/19

Signature of Chief Elected Official

Date

The COC is in process of obtaining funding to complete a racial equity training to establish a baseline of understanding of the connection between racial disparity and homelessness/poverty. The COC recognizes the need and in looking at current data, in our County population is 14% African American but in our shelters and program AA make up 66%.

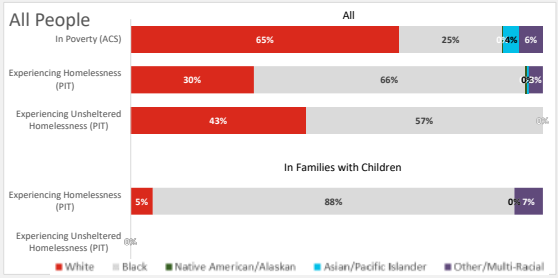
CoC Racial Equity Analysis Tool

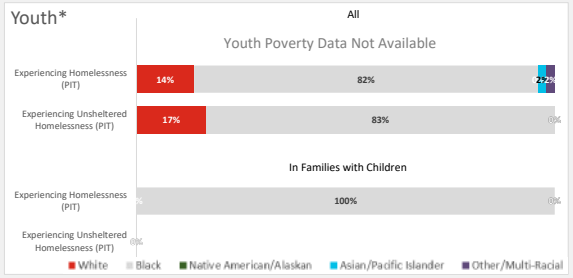
Homelessness and poverty counts at the CoC and State level

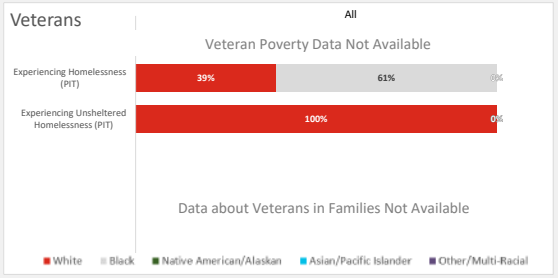
Select your CoC

MI-504 **Pontiac/Royal Oak/Oakland County CoC**

Distribution of Race

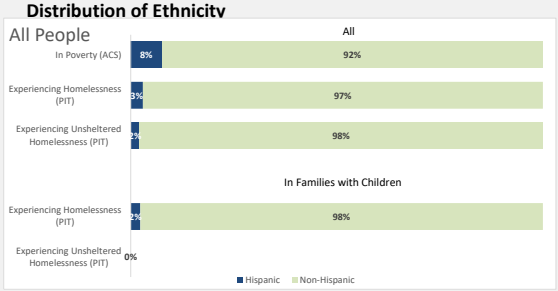


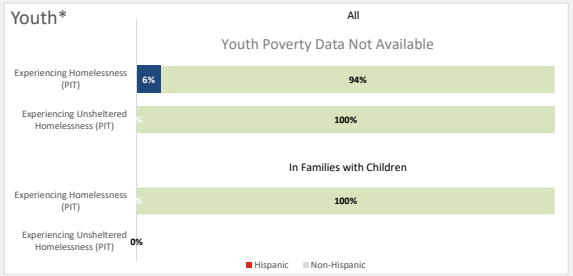


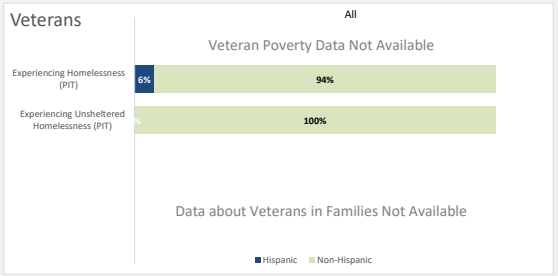


*Youth are individuals under the age of 25 who are unaccompanied or parenting.

Distribution of Ethnicity







*Youth experiencing homelessness is limited to unaccompanied and parenting youth persons under 25.

CoC Data

	All (ACS)[1]				In Poverty (ACS)[1]				Experiencing Homelessness (PIT)[2]				Experiencing Sheltered Homelessness (PIT)[2]				Experiencing Unsheltered Homelessness (PIT)[2]			
	All		In Families with Children		All		In Families with Children		All		In Families with Children		All		In Families with Children		All		In Families with Children	
Race and Ethnicity	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
All People	**1,229,503**		**1,011,490**		**123,086**		**86,740**		**412**		**131**		**365**		**131**		**47**		**0**	
Race																				
White	938,156	76%	782,058	77%	80,218	65%	56,530	65%	123	30%	7	5%	103	28%	7	5%	20	43%	0	0%
Black	170,706	14%	134,864	13%	30,736	25%	21,660	25%	271	66%	115	88%	244	67%	115	88%	27	57%	0	0%
Native	3,312	0%	2,962	0%	374	0%	264	0%	2	0%	0	0%	2	1%	0	0%	0	0%	0	0%
Asian/Pacific Islander	77,267	6%	68,742	7%	4,708	4%	3,298	4%	2	0%	0	0%	2	1%	0	0%	0	0%	0	0%
Other/Multi-Racial	40,062	3%	22,864	2%	7,050	6%	4,988	6%	14	3%	9	7%	14	4%	9	7%	0	0%	0	0%
Ethnicity																				
Hispanic	45,569	4%	32,885	3%	9,340	8%	6,582	8%	12	3%	3	2%	11	3%	3	2%	1	2%	0	0%
Non-Hispanic	1,183,934	96%	978,605	97%	113,746	92%	80,158	92%	400	97%	128	98%	354	97%	128	98%	46	98%	0	0%
Youth <25	**374,994**		**NOT AVAILABLE**						**51**		**13**		**45**		**13**		**6**		**0**	
Race																				
White	267,190	71%	--	--	--	--	--	--	7	14%	0	0%	6	13%	0	0%	1	17%	0	0%
Black	58,978	16%	--	--	--	--	--	--	42	82%	13	100%	37	82%	13	100%	5	83%	0	0%
Native	1,198	0%	--	--	--	--	--	--	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Asian/Pacific Islander	25,028	7%	--	--	--	--	--	--	1	2%	0	0%	1	2%	0	0%	0	0%	0	0%
Other/Multi-Racial	22,600	6%	--	--	--	--	--	--	1	2%	0	0%	1	2%	0	0%	0	0%	0	0%
Ethnicity																				
Hispanic	21,437	6%	--	--	--	--	--	--	3	6%	0	0%	3	7%	0	0%	0	0%	0	0%
Non-Hispanic	353,557	94%	--	--	--	--	--	--	48	94%	13	100%	42	93%	13	100%	6	100%	0	0%
Veterans	**122,728**		**NOT AVAILABLE**						**18**		**NOT AVAILABLE**		**17**		**NOT AVAILABLE**		**1**	**100%**	**NOT AVAILABLE**	
Race																				
White	102,058	83%	--	--	--	--	--	--	7	39%	--	--	6	35%	--	--	1	100%	--	--
Black	16,802	14%	--	--	--	--	--	--	11	61%	--	--	11	65%	--	--	0	0%	--	--
Native	0	0%	--	--	--	--	--	--	0	0%	--	--	0	0%	--	--	0	0%	--	--
Asian/Pacific Islander	1,194	1%	--	--	--	--	--	--	0	0%	--	--	0	0%	--	--	0	0%	--	--
Other/Multi-Racial	2,674	2%	--	--	--	--	--	--	0	0%	--	--	0	0%	--	--	0	0%	--	--

State Data

	All (ACS)[1]				In Poverty (ACS)[1]				Experiencing Homelessness (PIT)[2]			
	All		In Families with Children		All		In Families with Children		All		In Families with Children	
Race and Ethnicity	#	%	#	%	#	%	#	%	#	%	#	%
All People	**9,900,571**		**7,992,376**		**1,616,870**		**1,152,830**		**9,051**		**3,423**	
Race												
White	7,823,875	79%	6,320,645	79%	1,003,986	62%	671,793	58%	3,826	42%	1,220	36%
Black	1,381,388	14%	1,077,560	13%	459,716	28%	359,312	31%	4,693	52%	1,941	57%
Native	53,951	1%	43,180	1%	12,664	1%	9,233	1%	112	1%	40	1%
Asian/Pacific Islander	268,766	3%	227,140	3%	37,974	2%	25,024	2%	27	0%	9	0%
Other/Multi-Racial	372,591	4%	323,851	4%	102,530	6%	87,468	8%	393	4%	213	6%
Ethnicity												
Hispanic	467,021	5%	407,895	5%	123,640	8%	106,278	9%	497	5%	292	9%
Non-Hispanic	9,433,550	95%	7,584,481	95%	1,493,230	92%	1,046,552	91%	8,554	95%	3,131	91%
Youth <25	**3,247,906**		**NOT AVAILABLE**		**790,134**		**NOT AVAILABLE**		**809**		**201**	
Race												
White	2,378,524	73%	--	--	456,709	58%	--	--	317	39%	44	22%
Black	535,333	16%	--	--	238,643	30%	--	--	442	55%	148	74%
Native	19,679	1%	--	--	5,905	1%	--	--	10	1%	1	0%
Asian/Pacific Islander	98,692	3%	--	--	20,051	3%	--	--	2	0%	0	0%
Other/Multi-Racial	215,678	7%	--	--	68,826	9%	--	--	38	5%	8	4%
Ethnicity												
Hispanic	236,561	7%	--	--	76,636	10%	--	--	54	7%	14	7%
Non-Hispanic	3,011,345	93%	--	--	713,498	90%	--	--	755	93%	187	93%
Veterans	**626,722**				**NOT AVAILABLE**				**773**		**NOT AVAILABLE**	
Race												
White	545,073	87%	--	--	--	--	--	--	298	39%	--	--
Black	65,712	10%	--	--	--	--	--	--	438	57%	--	--
Native	3,579	1%	--	--	--	--	--	--	10	1%	--	--
Asian/Pacific Islander	1,995	0%	--	--	--	--	--	--	1	0%	--	--
Other/Multi-Racial	10,363	2%	--	--	--	--	--	--	26	3%	--	--

Ethnicity																		
Hispanic	0	0%	--	--	--	--	--	--	1	6%	--	--	1	6%	--	--	0	0%	--	--
Non-Hispanic	122,728	100%	--	--	--	--	--	--	17	94%	--	--	16	94%	--	--	1	100%	--	--

Ethnicity												
Hispanic	11,826	2%	--	--	--	--	--	--	24	3%	--	--
Non-Hispanic	614,896	98%	--	--	--	--	--	--	749	97%	--	--

Sources:

[1] American Community Survey (ACS) 2011-2015 5-yr estimates; Veteran CoC data comes from the ACS 2015 1-yr estimates; Total youth in the American Community Survey is a rollup of race estimates of all persons under 25.

[2] Point-In-Time (PIT) 2017 data

Note: Race estimates of individuals in families with children are based on the race of the householder.