Before Starting the CoC Application

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

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

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

1. The FY 2021 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2021 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

Your CoC Must Approve the Consolidated Application before You Submit It

- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2021 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

Answering Multi-Part Narrative Questions

Many questions require you to address multiple elements in a single text box. Number your responses to correspond with multi-element questions using the same numbers in the question. This will help you organize your responses to ensure they are complete and help us to review and score your responses.

Attachments

Questions requiring attachments to receive points state, “You Must Upload an Attachment to the 4B. Attachments Screen.” Only upload documents responsive to the questions posed—including other material slows down the review process, which ultimately slows down the funding process. Include a cover page with the attachment name.

- Attachments must match the questions they are associated with—if we do not award points for evidence you upload and associate with the wrong question, this is not a valid reason for you to appeal HUD’s funding determination.
- We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).
1A. Continuum of Care (CoC) Identification

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1A-1. CoC Name and Number: CA-500 - San Jose/Santa Clara City & County CoC

1A-2. Collaborative Applicant Name: County of Santa Clara by and through Office of Supportive Housing

1A-3. CoC Designation: CA

1A-4. HMIS Lead: County of Santa Clara by and through Office of Sup
1B. Coordination and Engagement–Inclusive Structure and Participation

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1B-1. Inclusive Structure and Participation–Participation in Coordinated Entry.

NOFO Sections VII.B.1.a.(1), VII.B.1.e., VII.B.1.n., and VII.B.1.p.

In the chart below for the period from May 1, 2020 to April 30, 2021:

1. select yes or no in the chart below if the entity listed participates in CoC meetings, voted–including selecting CoC Board members, and participated in your CoC’s coordinated entry system; or

2. select Nonexistent if the organization does not exist in your CoC’s geographic area:

<table>
<thead>
<tr>
<th>Organization/Person</th>
<th>Participated in CoC Meetings</th>
<th>Voted, Including Electing of CoC Board Members</th>
<th>Participated in CoC’s Coordinated Entry System</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Affordable Housing Developer(s)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Agencies serving survivors of human trafficking</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3. CDBG/HOME/ESG Entitlement Jurisdiction</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>4. CoC-Funded Victim Service Providers</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>5. CoC-Funded Youth Homeless Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Disability Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>7. Disability Service Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>8. Domestic Violence Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>9. EMS/Crisis Response Team(s)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>10. Homeless or Formerly Homeless Persons</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>11. Hospital(s)</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>12. Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)</td>
<td>No</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>13. Law Enforcement</td>
<td>Yes</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>14. Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>15. LGBT Service Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>16. Local Government Staff/Officials</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>17. Local Jail(s)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>18. Mental Health Service Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>---</td>
<td>---------------------------</td>
<td>-----</td>
<td>-----</td>
</tr>
<tr>
<td>19.</td>
<td>Mental Illness Advocates</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>20.</td>
<td>Non-CoC Funded Youth Homeless Organizations</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>21.</td>
<td>Non-CoC-Funded Victim Service Providers</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>22.</td>
<td>Organizations led by and serving Black, Brown, Indigenous and other People of Color</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>23.</td>
<td>Organizations led by and serving LGBT persons</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>24.</td>
<td>Organizations led by and serving people with disabilities</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>25.</td>
<td>Other homeless subpopulation advocates</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>26.</td>
<td>Public Housing Authorities</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>27.</td>
<td>School Administrators/Homeless Liaisons</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>28.</td>
<td>Street Outreach Team(s)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>29.</td>
<td>Substance Abuse Advocates</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>30.</td>
<td>Substance Abuse Service Organizations</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>31.</td>
<td>Youth Advocates</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>32.</td>
<td>Youth Service Providers</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>33.</td>
<td>Foster youth service organizations</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>34.</td>
<td>Homelessness Prevention Providers</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

**1B-2. Open Invitation for New Members.**

NOFO Section VII.B.1.a.(2)

<table>
<thead>
<tr>
<th></th>
<th></th>
<th>Yes</th>
<th>Yes</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>33.</td>
<td>Foster youth service organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>34.</td>
<td>Homelessness Prevention Providers</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

1) NEW MEMBERS ARE INVITED TO JOIN by attending any CoC mtg, joining the CoC email list, or telling the CoC they want to join. The CoC solicits new members at public CoC mtgs AT LEAST MONTHLY & in email abt CoC mtgs sent AT LEAST MONTHLY to the Service Providers Network & CoC listservs (1,067 & 880 members). Online CoC calendar gives details abt all mtgs. The CoC uses funding announcements & ongoing CE/HMIS outreach to invite new members. The CoC drafted a contract addendum for use by City of San Jose, the County, & other funders, which requires local grantees to join HMIS & CE. The CoC publicizes its work in monthly system reports & annual Community Plan reports. 2) Mtg announcements are plain-text email READABLE BY ASSISTIVE TECH. In-person mtgs are PHYSICALLY ACCESSIBLE & SIGN-LANGUAGE INTERPRETERS are available on request; remote mtgs offer CLOSED CAPTIONING. The CoC website is reviewed against Web Content Accessibility Guidelines & errors are addressed. 3) The CoC targets outreach for new members to people w/ experience of homelessness thru dedicated seats on the Review & Rank panel & CoC Board & thru a relationship w/ the LIVED EXPERIENCE ADVISORY BOARD (LEAB), an independent board w/ up
to 38 members w/ experience of homelessness. A CoC representative attends all LEAB meetings & provides trainings on CoC systems & the Community Plan to End Homelessness. In 2019, the CoC attended mtgs of 3 lived experience groups & convened 5 focus groups as part of its Community Plan process. 4) Since 2019, the CoC increased outreach to CBOs w/ ties to groups over-represented in the homeless pop. In 2020, Destination: Home (D:H) engaged a network of 72 providers to distribute COVID-19 financial assistance, targeting smaller orgs w/ ties to groups disproportionately impacted by COVID-19 (people of color & low-income households). In 2021, D:H & the Collaborative Applicant met w/ the Si Se Puede Collective, 4 CBOs from San Jose’s Mayfair neighborhood, abt CoC system barriers.

1B-3. CoC’s Strategy to Solicit/Consider Opinions on Preventing and Ending Homelessness. NOFO Section VII.B.1.a.(3)

Describe in the field below how your CoC:

1. solicited and considered opinions from a broad array of organizations and individuals that have knowledge of homelessness, or an interest in preventing and ending homelessness;

2. communicated information during public meetings or other forums your CoC uses to solicit public information; and

3. took into consideration information gathered in public meetings or forums to address improvements or new approaches to preventing and ending homelessness.

(limit 2,000 characters)

1,2) SOLICIT & CONSIDER OPINIONS & COMMUNICATE INFO: A)Public Performance Management Work Group, NOFA Comm., Coordinated Assessment Work Group (CAWG), HMIS Admins, Gen Membership mtgs distribute info, best practices, & new policies; gather input on all areas of CoC operations; track system perf; develop policies; & respond to challenges. All mtgs are widely advertised via the CoC & Service Provider Network (880 & 1,067 members) email lists & on the CoC’s public online calendar. Attendees in 2019-2021 included healthcare, VSPs, youth providers, child welfare, educ, behavioral health, veterans services, private funders, affordable housing developers, local gov’t., employment, & more. B)The CoC attends monthly Lived Experience Advisory Board mtgs & solicits input for proposed policies, funding decisions, & system design. C)In 2019, the CoC’s Community Plan process gathered extensive input through 8 lived experience input sessions; community survey in 4 languages (5,000+responses); three open-invitation community summits; 3 subject matter expert convenings (families, single adults, youth); 8 key stakeholder interviews with business, healthcare, educ, philanthropy, & advocacy leaders; neighborhood associations; County safety net & criminal justice agencies; city housing depts, & other community mtgs. Info re the Community Planning process & drafts was shared on the CoC website. D)The CoC works w/ cross-system partners on CE, data sharing, youth system planning, Pay for Success, Vets campaign, discharge plans, Jail Diversion initiative, service co-location, LL Engagement, & employment. 3) FEEDBACK IN PUBLIC MTGS IS A PRIMARY CATALYST FOR CHANGES to CoC policies & practices, & new policies are vetted by CoC committees. E.g., The Community Plan to End Homelessness adopted strategies suggested in public Planning mtgs. In 2021, the CoC Board affirmed the CAWG recommendation to design a more equitable CES process, including to develop a new assessment & prioritization tool.
1B-4. Public Notification for Proposals from Organizations Not Previously Funded.

NOFO Section VII.B.1.a.(4)

Describe in the field below how your CoC notified the public:

1. that your CoC’s local competition was open and accepting project applications;
2. that your CoC will consider project applications from organizations that have not previously received CoC Program funding;
3. about how project applicants must submit their project applications;
4. about how your CoC would determine which project applications it would submit to HUD for funding; and
5. how your CoC effectively communicated with individuals with disabilities, including making information accessible in electronic formats.

(limit 2,000 characters)

1) PUBLIC NOTICE OF FUNDING: The CoC funding opportunity is open to all and widely advertised to agencies across Santa Clara County through a NOFA Announcement & TA Workshop invitation (7/10) emailed to the CoC and SPN listservs (880 & 1,067 members), and announcements at CoC committee mtgs. 2) ALL ANNOUNCEMENTS EXPRESSLY WELCOMED AGENCIES NOT CURRENTLY RECEIVING COC FUNDING and made clear that new project funding is available. The CoC’s Intro to CoC Funding training, prior to the competition period (4/22), was attended by 6 non-CoC-funded agencies & encouraged new applicants to apply. 3) Application materials were provided at a 2-hour public TA Workshop (9/7), posted on the CoC website (9/8) and emailed to the CoC & SPN lists. 1 hour of the TA Workshop was dedicated to new project applicants. On-call TA was provided by phone & email to help applicants understand HUD requirements & complete the e-snaps application. 10 non-CoC funded agencies attended the TA Workshop, 3 expressed intent to apply, & 1 applied. 4) The TA Workshop TRAINED APPLICANTS ON THE REVIEW & RANK PROCESS: Applications for new project funding are scored by the R&R panel based on the extent the new project will contribute to system performance. Scoring includes: Project readiness; Plan for services; Performance outcomes & data quality for past projects; Supports for Fair Housing; Housing First; Agency capacity to administer grant funding; and Extent of client participation in program design and policy-making. Like renewals, new projects are ranked in the priority listing based on total score. There is no point bonus for prior experience with CoC funding. 5) CoC funding announcements & TA Workshop meeting invitations (plain-text email) and scoring tool PDFs were formatted to be READABLE BY ASSISTIVE TECH. The TA Workshop was on Zoom & LIVE CAPTIONING was provided. The CoC’s website is actively reviewed against Web Content Accessibility Guidelines and errors are addressed.
1C. Coordination and Engagement—Coordination with Federal, State, Local, Private, and Other Organizations

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1C-1. Coordination with Federal, State, Local, Private, and Other Organizations.

NOFO Section VII.B.1.b.

In the chart below:
1. select yes or no for entities listed that are included in your CoC’s coordination, planning, and operations of projects that serve individuals, families, unaccompanied youth, persons who are fleeing domestic violence who are experiencing homelessness, or those at risk of homelessness; or
2. select Nonexistent if the organization does not exist within your CoC’s geographic area.

<table>
<thead>
<tr>
<th>Entities or Organizations Your CoC Coordinates with for Planning or Operations of Projects</th>
<th>Coordinates with Planning or Operations of Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Funding Collaboratives</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Head Start Program</td>
<td>No</td>
</tr>
<tr>
<td>3. Housing and services programs funded through Local Government</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Housing and services programs funded through other Federal Resources (non-CoC)</td>
<td>Yes</td>
</tr>
<tr>
<td>5. Housing and services programs funded through private entities, including Foundations</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Housing and services programs funded through State Government</td>
<td>Yes</td>
</tr>
<tr>
<td>7. Housing and services programs funded through U.S. Department of Health and Human Services (HHS)</td>
<td>Yes</td>
</tr>
<tr>
<td>8. Housing and services programs funded through U.S. Department of Justice (DOJ)</td>
<td>Yes</td>
</tr>
<tr>
<td>9. Housing Opportunities for Persons with AIDS (HOPWA)</td>
<td>Yes</td>
</tr>
<tr>
<td>10. Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)</td>
<td>No</td>
</tr>
<tr>
<td>11. Organizations led by and serving Black, Brown, Indigenous and other People of Color</td>
<td>Yes</td>
</tr>
<tr>
<td>12. Organizations led by and serving LGBT persons</td>
<td>No</td>
</tr>
<tr>
<td>13. Organizations led by and serving people with disabilities</td>
<td>No</td>
</tr>
<tr>
<td>14. Private Foundations</td>
<td>Yes</td>
</tr>
<tr>
<td>15. Public Housing Authorities</td>
<td>Yes</td>
</tr>
<tr>
<td>16. Runaway and Homeless Youth (RHY)</td>
<td>Yes</td>
</tr>
<tr>
<td>17. Temporary Assistance for Needy Families (TANF)</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Other:(limit 50 characters)
1C-2. CoC Consultation with ESG Program Recipients.

NOFO Section VII.B.1.b.

Describe in the field below how your CoC:

1. consulted with ESG Program recipients in planning and allocating ESG and ESG-CV funds;
2. participated in evaluating and reporting performance of ESG Program recipients and subrecipients;
3. provided Point-in-Time (PIT) count and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area; and
4. provided information to Consolidated Plan Jurisdictions within your CoC’s geographic area so it could be addressed in Consolidated Plan update.

(limit 2,000 characters)

1) THE CoC CONSULTS WITH BOTH ESG RECIPIENT IN THE COC: the City of San Jose (CSJ) & the California Department of Housing and Community Development (HCD). CSJ is an active member of the CoC & CoC staff regularly communicate w/ CSJ regarding the use of ESG funding to fill capacity gaps & attend CSJ City Council meetings to report on homeless system efforts. CSJ was on the Community Plan Steering Committee & currently co-leads Community Plan implementation. The CoC provides detailed custom data reports to CSJ throughout the year for use in planning. HCD subcontracts ESG funding to the County Office of Supportive Housing (OSH), the CoC Collaborative Applicant. OSH makes all local decisions for award of HCD ESG & ESG-CV funding based on HCD funding requirements and priorities. CoC staff participate in HCD listening sessions & other opportunities for input into the HCD’s ESG Annual Plan & funding allocation. DURING THE COVID-19 PANDEMIC, OSH & CSJ STAFF CO-LOCATED at a Joint Departmental Operations Center to coordinate support for the unhoused population for the first several months of the pandemic and MET WEEKLY to coordinate all COVID response funding. 2) EVALUATION & REPORTING: The HMIS Lead assists CSJ to generate an annual ESG CAPER and provides custom HMIS reports with city-specific outcomes used to monitor CSJ programs, including ESG-funded. OSH administers all HCD ESG funding & tracks performance of subgrantees w/ CoC performance metrics. CoC and ESG written standards include a process for monitoring ESG subrecipients using HMIS data. 3) The CoC PROVIDES PIT AND HIC DATA to Con Plan jurisdictions via the CoC website. 4) The CoC provides MONTHLY SYSTEM PERFORMANCE REPORTS to Con Plan jurisdictions via the CoC website. The CoC presented the 2020-2024 Community Plan to County and cities; 11 of 17 jurisdictions endorsed. So far, the CoC has provided TA to 3 cities to develop implementation plans aligned with the Community Plan.

1C-3. Ensuring Families are not Separated.

NOFO Section VII.B.1.c.

Select yes or no in the chart below to indicate how your CoC ensures emergency shelter, transitional housing, and permanent housing (PSH and RRH) do not deny admission or separate family members regardless of each family member’s self-reported gender:
1. Conducted mandatory training for all CoC- and ESG-funded service providers to ensure families are not separated. No

2. Conducted optional training for all CoC- and ESG-funded service providers to ensure families are not separated. No

3. Worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients. Yes

4. Worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within your CoC’s geographic area that might be out of compliance and took steps to work directly with those facilities to bring them into compliance. Yes

5. Sought assistance from HUD by submitting AAQs or requesting technical assistance to resolve noncompliance of service providers. No

6. Other. (limit 150 characters)

1C-4. CoC Collaboration Related to Children and Youth–SEAs, LEAs, Local Liaisons & State Coordinators.

NOFO Section VII.B.1.d.

Describe in the field below:

1. how your CoC collaborates with youth education providers;

2. your CoC’s formal partnerships with youth education providers;

3. how your CoC collaborates with State Education Agency (SEA) and Local Education Agency (LEA);

4. your CoC’s formal partnerships with SEAs and LEAs;

5. how your CoC collaborates with school districts; and

6. your CoC’s formal partnerships with school districts.

(limit 2,000 characters)

1) YOUTH EDUCATION PROVIDERS: Youth-serving housing providers refer youth and young adults seeking high school diplomas to the Opportunity Youth Academy, which has 5 sites across the CoC providing individualized teaching and support to youth. Providers also connect eligible families to Head Start and First 5 early childhood resources. 2) The Office of Supportive Housing (OSH), Collaborative Applicant, partners with the San Jose Conservation Corps & Charter School to provide paid job training & education support for youth. BWC (the CoC’s primary TAY housing provider), Opportunity Youth Academy, and 3 high schools collaborate within the Opportunity Youth Partnership collective impact initiative. BWC has partnered with San Jose State University and Airbnb to provide temporary housing to college students experiencing homelessness, while BWC works with students to obtain permanent housing. 3) OSH hosts a weekly coordination call with the COUNTY OFFICE OF EDUCATION (OED) foster & homeless youth liaison and local family & youth providers. OSH and all partners share guidance and resources, including COVID-19 updates. 4) The CoC engaged the OED in the YHDP application and community planning process. The OED sits on the YHDP Leadership Committee currently working with the Youth Action Board to develop a youth-focused coordinated community plan, along with the Collaborative Applicant, the local child welfare agency, SSA, Probation, County Department of Behavioral Health, and the County hospital system. 5) SCHOOL DISTRICTS: The CoC works with schools to complete the bi-annual PIT Count. 6) Campbell Union School District is an HMIS Participating Agency and participates in Coordinated Entry. BWC provides Family Advocacy Services, including resource linkages, case management, budgeting and financial management assistance to students and

NOFO Section VII.B.1.d.

Describe in the field below written policies and procedures your CoC adopted to inform individuals and families who become homeless of their eligibility for educational services.

(limit 2,000 characters)

CoC POLICIES AND PROCEDURES REQUIRE PROGRAMS to: 1) Inform families with children and unaccompanied youth of their educational rights, including providing written materials, help with enrollment, and linkage to McKinney Vento Liaisons as part of intake procedures; 2) Post notices of student's rights at each program site that serves homeless children and families in appropriate languages; 3) Designate staff that will be responsible for ensuring that homeless children and youth in their programs are in school and are receiving all educational services they are entitled to and to coordinate with the CoC, the Department of Social Services, the County Office of Education, the McKinney Vento Coordinator, the McKinney Vento Educational Liaisons, and other mainstream providers as needed; 4) Take the educational needs of children into account when placing families in housing and place families with children as close as possible to their school of origin so as not to disrupt such children's education; 5) Allow parents or the youth (if unaccompanied) to make decisions about school placement; 6) Not require children and unaccompanied youth to attend after-school or educational programs that would replace/interfere with regular day school or prohibit them from staying enrolled in their original school.

CoC Collaboration Related to Children and Youth–Educational Services–Written/Formal Agreements or Partnerships with Early Childhood Services Providers.

NOFO Section VII.B.1.d.

Select yes or no in the chart below to indicate whether your CoC has written formal agreements or partnerships with the listed providers of early childhood services:

<table>
<thead>
<tr>
<th>Provider</th>
<th>MOU/MOA</th>
<th>Other Formal Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Birth to 3 years</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>2. Child Care and Development Fund</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>3. Early Childhood Providers</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>4. Early Head Start</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>5. Federal Home Visiting Program–(including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>6. Head Start</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>7. Healthy Start</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>8. Public Pre-K</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>9. Tribal Home Visiting Program</td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>
NOFO Section VII.B.1.e.

Describe in the field below how your CoC coordinates to provide training for:

1. 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 indicate the frequency of the training in your response (e.g., monthly, semi-annually); 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 and indicate the frequency of the training in your response (e.g., monthly, semi-annually).

(limit 2,000 characters)

1) The COC partners with local VSPs to provide FREE ANNUAL TRAINING FOR HOUSING & SERVICES STAFF, open to all providers in the CoC area and Coordinated Entry access points, on best practices for serving survivors of intimate partner violence, human trafficking, sexual assault, and stalking, and VAWA requirements. The Collaborative Applicant co-presented the most recent 5-hour training (March 2021) with Community Solutions (VSP & housing provider), Step Forward Foundation (family law & immigration legal services), and Morgan Hill Family Justice Center. Community Solutions covered: relevant definitions; importance of power and control; recognizing abuse and trafficking; trauma-informed responses and approaches; survivor-centered and intersectional approaches; survivor’s rights; safety and confidentiality; and local resources for persons with immediate safety needs. Step Forward covered: legal remedies for survivors; local legal & safety resources. The Collaborative Applicant covered VAWA and CoC requirements, Coordinated Entry policies, the CoC’s Emergency Transfer Plan, and relevant state regulations. 2) The CoC Lead partners with members of the Domestic Violence Advocacy Consortium (5 local VSPs) on MONTHLY TRAININGS FOR COORDINATED ASSESSMENT SYSTEM (CAS) ASSESSORS. All staff who administer the CAS assessment are required to attend this training annually. The training covers relevant definitions; trauma-informed care; importance of victim-centered and culturally-responsive approaches; use of the CoC’s DV Pre-screening Tool to identify potential need for specialized services, and referral options for non-VSPs serving clients fleeing DV who need safety planning and other victim services. As the CoC developed a new shelter referral hotline in 2020-21, hotline staff were trained to identify survivors and offer warm referrals to the YWCA, a VSP that connects referred survivors to DV shelter.

NOFO Section VII.B.1.e.

Describe in the field below how your 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 survivors.

(limit 2,000 characters)
The Office of Supportive Housing (OSH), the Collaborative Applicant, collects APR reports quarterly for each CoC-funded project operated by a VSP and uses those reports to track outcomes for survivors and occupancy trends. OSH and VSP partner YWCA discuss quarterly outcomes to identify opportunities for project improvement as well as underlying barriers and unmet needs unique to survivors, including impacts of trauma, challenges obtaining identity documentation, and child care supports. Through these discussions, OSH and the YWCA have identified strategies to maximize program occupancy and decrease time to housing. DURING THE COVID-19 PANDEMIC, OSH and the Domestic Violence Advocacy Consortium (DVAC), a collaborative of the 5 VSPs in the CoC, used VSP service data to track and meet shelter demand for people fleeing violence during shelter in place. In 2021, OSH used occupancy and outcomes data from comparable databases, and the number of survivors on the Confidential Queue, to identify a need for additional RRH resources; based on that need, the OSH submitted a DV Bonus application to add RRH for people who are fleeing. OSH used data provided by VSPs in an April 2021 presentation to a joint session of the County Board of Supervisors & San Jose City Council, and provided data to the County Office of Women’s Policy for a March 2021 report to the Board of Supervisors, to support recommendations for increased resources and housing for survivors. These reports highlighted unmet shelter and housing need, increasing shelter stays, the need for affordable housing, and the importance of daycare funds in housing programs.


NOFO Section VII.B.1.e.

Describe in the field below how your CoC’s coordinated entry system protocols incorporate trauma-informed, victim-centered approaches while maximizing client choice for housing and services that:

1. prioritize safety;
2. use emergency transfer plan; and
3. ensure confidentiality.

(limit 2,000 characters)

1) The CoC’s CE policies & procedures were developed in consultation with VSPs to PRIORITIZE CLIENT SAFETY AND AUTONOMY. VSPs are CE access points, & all survivors seeking victim services are assessed for housing need & connected to CE as needed. VSP access point staff are trained in trauma-informed care, victim-centered services, & safety planning to address immediate safety needs & the CE assessment. VSPs partner in development & delivery of training for all CE assessors on trauma-informed response to DV crisis & use of the CoC’s DV Pre-screening Tool to identify potential need for survivor services. Non-VSP access points refer to DV Crisis Hotline staffed by VSPs for support/resources for clients’ immediate safety needs. As the CoC developed a shelter referral hotline in 2020-21, hotline staff were trained to identify survivors & offer warm referrals to the YWCA, a VSP that connects referred survivors to DV shelter. 2) The CoC’s EMERGENCY TRANSFER PLAN creates a process for survivors in imminent danger of violence or who experienced sexual assault on the premises in the past 90 days. Client choice is prioritized, & clients can request external and/or internal transfer. If external, the client has first priority for a CE referral. If internal, the program must take immediate steps to transfer the client to a safe unit, or if not available to inform
the client & explain options. Programs must prevent disclosure of new location. 3) The CoC ENSURES CONFIDENTIALITY by operating a parallel Confidential DV Queue, outside of HMIS, which ensures survivors’ Personally Identifying Info is known only to the assessing VSP. Survivors who present at non-VSP CE access points are given the option to continue CE assessment w/ the non-VSP, w/ the option to be anonymous in HMIS, or receive a warm referral to a VSP for assessment & the DV Queue. The Confidential Queue and main Community Queue give survivors access to DV-dedicated PSH, RRH, and RH, as well as all housing option in CE.


NOFO Section VII.B.1.f.

1. Did your CoC implement a written CoC-wide anti-discrimination policy ensuring that LGBT individuals and families receive supportive services, shelter, and housing free from discrimination? Yes
2. Did your CoC conduct annual CoC-wide training with providers on how to effectively implement the Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity (Equal Access Final Rule)? Yes
3. Did your CoC conduct annual CoC-wide training with providers on how to effectively implement Equal Access to Housing in HUD Programs in Accordance with an Individual’s Gender Identity (Gender Identity Final Rule)? Yes


NOFO Section VII.B.1.g.

Enter information in the chart below for the two largest PHAs highlighted in gray on the CoC-PHA Crosswalk Report at https://files.hudexchange.info/resources/documents/FY-2020-CoC-PHA-Crosswalk-Report.pdf or the two PHAs your CoC has a working relationship with—if there is only one PHA in your CoC’s geographic area, provide information on the one:

<table>
<thead>
<tr>
<th>Public Housing Agency Name</th>
<th>Enter the Percent of New Admissions into Public Housing and Housing Choice Voucher Program During FY 2020 who were experiencing homelessness at entry</th>
<th>Does the PHA have a General or Limited Homeless Preference?</th>
<th>Does the PHA have a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Clara County Housing Authority</td>
<td>52%</td>
<td>Yes-HCV</td>
<td>No</td>
</tr>
<tr>
<td>Housing Authority of the City of San Jose</td>
<td>34%</td>
<td>Yes-HCV</td>
<td>No</td>
</tr>
</tbody>
</table>

1C-7a. Written Policies on Homeless Admission Preferences with PHAs.

NOFO Section VII.B.1.g.

Describe in the field below:

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

2. state that your CoC has not worked with the PHAs in its geographic area to adopt a homeless admission preference.
1) The Santa Clara County Housing Authority (SCCHA), which also administers programs for the Housing Authority of the City of San Jose, is a long-time and integral CoC partner, and SCCHA Executive Director has sat on the CoC Board for 8 years. The Office of Supportive Housing (OSH), the Collaborative Applicant, has a close partnership with SCCHA. OSH, SCCHA, and other CoC leaders communicate regularly about unmet needs and CoC priorities to identify strategic ways to allocate funding and resources. As a result, SCCHA prioritizes Housing Choice Voucher and Project Based Vouchers for vulnerable populations experiencing homelessness in a range of ways that align with other funding in the community. The Chronically Homeless Direct Referral Program, SCCHA’s longest-running formal homeless preference, began in 2015 and allows OSH to bypass the SCCHA waitlist for chronically homeless households referred to PSH projects through Coordinated Entry. The Special Needs Direct Referral Program is a parallel program targeting vulnerable households outside of the CH definition that are referred to PSH. In 2016, the SCCHA made available 477 Project-Based Vouchers and 126 HUD-VASH through a joint RFP for PSH with the County of Santa Clara and the City of San Jose. Since 2017, the SCCHA has committed 1,347 additional Project-Based Vouchers to new PSH developments built with County Measure A Supportive Housing Bond funding. These homeless preference programs and commitments are the result of SCCHA’s deep CoC partnership and its leadership in CoC planning and priorities.

1C-7b. Moving On Strategy with Affordable Housing Providers.  
Not Scored–For Information Only

Select yes or no in the chart below to indicate affordable housing providers in your CoC’s jurisdiction that your recipients use to move program participants to other subsidized housing:

| 1. Multifamily assisted housing owners | No |
| 2. PHA | Yes |
| 3. Low Income Tax Credit (LIHTC) developments | Yes |
| 4. Local low-income housing programs | Yes |
| Other (limit 150 characters) | 

1C-7c. Including PHA-Funded Units in Your CoC’s Coordinated Entry System.

NOFO Section VII.B.1.g.

Does your CoC include PHA-funded units in the CoC’s coordinated entry process? Yes

1C-7c.1. Method for Including PHA-Funded Units in Your CoC’s Coordinated Entry System.

NOFO Section VII.B.1.g.
If you selected yes in question 1C-7c., describe in the field below:

1. how your CoC includes the units in its Coordinated Entry process; and
2. whether your CoC’s practices are formalized in written agreements with the PHA, e.g., MOUs.

(limit 2,000 characters)

1&2) THE COC INCLUDES PHA-FUNDED UNITS IN CE in multiple ways. A) The Collaborative Applicant (OSH) has a FORMAL AGREEMENT with the Santa Clara County Housing Authority (SCCHA) to operate the Chronically Homeless Direct Referral Program and the Special Needs Direct Referral Program. Under the CHDR and SNDR programs, OSH identifies clients referred to PSH through CE who are eligible for a SCCHA Housing Choice Voucher or Project Based Voucher. OSH refers the client to the SCCHA, allowing the client to bypass the SCCHA waiting list. B) Since 2017, the SCCHA has committed 1,347 Project-Based Vouchers to new PSH developments built or rehabilitated with County Measure A Supportive Housing Bond funding, all of which participate in CE. C) AN MOU BETWEEN OSH AND THE SCCHA establishes that referrals for all 1,033 Emergency Housing Vouchers will come through CE and allocate a portion of the EHV housing navigation funding to OSH to support housing search.

1C-7d. Submitting CoC and PHA Joint Applications for Funding for People Experiencing Homelessness.

NOFO Section VII.B.1.g.

Did your CoC coordinate with a PHA(s) to submit a joint application(s) for funding of projects serving families experiencing homelessness (e.g., applications for mainstream vouchers, Family Unification Program (FUP), other non-federal programs)?

Yes

1C-7d.1. CoC and PHA Joint Application–Experience–Benefits.

NOFO Section VII.B.1.g.

If you selected yes to question 1C-7d, describe in the field below:

1. the type of joint project applied for;
2. whether the application was approved; and
3. how your CoC and families experiencing homelessness benefited from the coordination.

(limit 2,000 characters)

1) YOUTH EDUCATION PROVIDERS: Youth-serving housing providers refer youth and young adults seeking high school diplomas to the Opportunity Youth Academy, which has 5 sites across the CoC providing individualized teaching and support to youth. Providers also connect eligible families to Head Start and First 5 early childhood resources. 2) The Office of Supportive Housing (OSH), Collaborative Applicant, partners with the San Jose Conservation Corps & Charter School to provide paid job training & education support for youth. BWC (the CoC’s primary TAY housing provider), Opportunity Youth Academy, and 3 high schools collaborate within the Opportunity Youth Partnership collective impact initiative. BWC has partnered with San Jose State University and Airbnb to provide temporary housing to college students experiencing homelessness, while BWC works with students to obtain permanent housing. 3) OSH hosts a
weekly coordination call with the COUNTY OFFICE OF EDUCATION (OED) foster & homeless youth liaison and local family & youth providers. OSH and all partners share guidance and resources, including COVID-19 updates. 4) The CoC engaged the OED in the YHDP application and community planning process. The OED sits on the YHDP Leadership Committee currently working with the Youth Action Board to develop a youth-focused coordinated community plan, along with the Collaborative Applicant, the local child welfare agency, SSA, Probation, County Department of Behavioral Health, and the County hospital system. 5) SCHOOL DISTRICTS: The CoC works with schools to complete the bi-annual PIT Count. 6) Campbell Union School District & SJ Conservation Corps & Charter School are HMIS Participating Agencies & participate in Coordinated Entry. BWC provides Family Advocacy Services, including resource linkages, case management, budgeting and financial management assistance to students and families of Mt. Pleasant and Lincoln High Schools

<table>
<thead>
<tr>
<th>1C-7e.</th>
<th>Coordinating with PHA(s) to Apply for or Implement HCV Dedicated to Homelessness Including American Rescue Plan Vouchers.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>NOFO Section VII.B.1.g.</td>
</tr>
</tbody>
</table>

Did your CoC coordinate with any PHA to apply for or implement funding provided for Housing Choice Vouchers dedicated to homelessness, including vouchers provided through the American Rescue Plan? Yes

<table>
<thead>
<tr>
<th>1C-7e.1.</th>
<th>Coordinating with PHA(s) to Administer Emergency Housing Voucher (EHV) Program–List of PHAs with MOUs.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Not Scored–For Information Only</td>
</tr>
</tbody>
</table>

Did your CoC enter into a Memorandum of Understanding (MOU) with any PHA to administer the EHV Program? Yes

If you select yes, you must use the list feature below to enter the name of every PHA your CoC has entered into a MOU with to administer the Emergency Housing Voucher Program.

<table>
<thead>
<tr>
<th>PHA</th>
</tr>
</thead>
<tbody>
<tr>
<td>Santa Clara County...</td>
</tr>
<tr>
<td>Housing Authority...</td>
</tr>
</tbody>
</table>
1C-7e.1. List of PHAs with MOUs

Name of PHA: Santa Clara County Housing Authority

1C-7e.1. List of PHAs with MOUs

Name of PHA: Housing Authority of the City of San Jose
1C. Coordination and Engagement—Coordination with Federal, State, Local, Private, and Other Organiza

1C-8. Discharge Planning Coordination.

NOFO Section VII.B.1.h.

Select yes or no in the chart below to indicate whether your 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.

<table>
<thead>
<tr>
<th>System</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Foster Care</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>2. Health Care</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>3. Mental Health Care</td>
<td>Yes</td>
<td></td>
</tr>
<tr>
<td>4. Correctional Facilities</td>
<td>Yes</td>
<td></td>
</tr>
</tbody>
</table>

1C-9. Housing First—Lowering Barriers to Entry.

NOFO Section VII.B.1.i.

1. Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects your CoC is applying for in FY 2021 CoC Program Competition.

2. Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects your CoC is applying for in FY 2021 CoC Program Competition that have adopted the Housing First approach.

3. This number is a calculation of the 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 2021 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.

1C-9a. Housing First—Project Evaluation.

NOFO Section VII.B.1.i.

Describe in the field below how your CoC regularly evaluates projects to ensure those that commit to using a Housing First approach are prioritizing rapid placement and stabilization in permanent housing and are not requiring service participation or preconditions of program participants.

(limit 2,000 characters)

THE COC USES EVALUATION & TECHNICAL ASSISTANCE to ensure that all projects committed to using a Housing First (HF) approach prioritize rapid placement & stabilization in PH & do not require service participation or preconditions of participants. A) The CoC conducts annual TA site visits to
every CoC-funded agency, during which providers & the Collaborative Applicant (OSH) discuss outcomes data, challenges to housing placement & retention, project policies & procedures, & alignment with CoC priorities such as HF & client leadership. TA visits help agencies identify areas to increase HF alignment & client empowerment. B) The CoC evaluates HF alignment through the annual local competition process. A HF scoring factor evaluates each project’s written policies & procedures for clear HF alignment (not screening out based on income, substance use, criminal background, or experience of DV; not exiting clients for failure to make progress, failure to participate in services, loss of income, or experience of DV). The factor also evaluates a written statement from the applicant describing “proactive steps to minimize barriers to entry and retention.” In a separate factor, the CoC evaluates projects on their “clear, comprehensive service delivery strategy/plan,” looking for client-centered planning & voluntary services. C) The CoC’s Coordinated Entry System monitors client exits. Before exiting a client, a project must notify their CE matchmaker, who reviews the reasons for exit & can approve or, if appropriate, help the provider problem-solve to keep a client enrolled. D) OSH, as Collaborative Applicant, administers the CoC’s grievance process. If a pattern of grievances reveals a lack of housing first alignment or need for staff training, OSH would raise the issue to the CoC Board for review & approval of recommended actions, which may include required training, enhanced monitoring, reviewing of termination policies & procedures, and/or placement on a corrective action plan.

1C-9b. Housing First–Veterans.

Not Scored–For Information Only

Does your CoC have sufficient resources to ensure each Veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach? No

1C-10. Street Outreach–Scope.

NOFO Section VII.B.1.j.

Describe in the field below:

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

(limit 2,000 characters)

1) OUTREACH ENSURES ALL PEOPLE ARE ENGAGED through geographic coverage, population-specific outreach, & mtg basic needs: HomeFirst outreach operates CoC-wide, routinely at 19 sites & dispatched to ad-hoc locations as needed. Daily vets outreach identifies unhoused vets & encampment locations where vets reside CoC-wide. BWC, CoC-funded youth provider, does outreach across the CoC Tue-Fri. In downtown San José, PATH daily outreach targets encampments & Downtown Streets Team uses peer outreach. Daily CoC-wide HEAT team targets hard-to-reach individuals. The Valley Homeless Healthcare
Program conducts medical outreach in encampments CoC-wide & led COVID-19 testing & vaccine outreach to unsheltered residents. Mobile hygiene units bring showers & toilets to encampment locations daily. DURING THE COVID-19 PANDEMIC, community groups partnered w/ the City of San José to provide outreach, meals & PPE to encampments across the CoC. July 2021 through June 2022, PATH, Homefirst, & Abode provide CoC-wide COVID-19 vaccine outreach & educ. OSH’s Client Engagement Team conducts CoC-wide outreach to locate people referred to housing through CE, provides connections to basic needs services, & conducts CE assessments. 2&3) DAILY OUTREACH COVERS 100% OF THE COC. 4) REACHING THOSE LEAST LIKELY TO REQUEST ASSISTANCE: A) Outreach teams are trained to build trust w/ evidence-based practices (CTI, Trauma Informed Care, harm reduction) & warm hand-offs to resources (ES beds, food/hygiene, medical services) & to repeatedly engage those least likely to access services. B) Outreach includes multilingual, medical, psychiatric, & peer staff (e.g. youth, LGBTQ, vets, formerly homeless) to target most vulnerable. C) Diversified approach includes medical outreach to people w/out healthcare (including w/ disabling conditions) & street-based mental health care. D) Sign language interpreters & physically accessible transport are available. E) Youth outreach & drop-in include LGBTQ-targeted services.

1C-11. Criminalization of Homelessness.

NOFO Section VII.B.1.k.

Select yes or no in the chart below to indicate strategies your CoC implemented to prevent the criminalization of homelessness in your CoC’s geographic area:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Engaged/educated local policymakers</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Engaged/educated law enforcement</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Engaged/educated local business leaders</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Implemented communitywide plans</td>
<td>Yes</td>
</tr>
<tr>
<td>5. Other: (limit 500 characters)</td>
<td></td>
</tr>
</tbody>
</table>

1C-12. Rapid Rehousing–RRH Beds as Reported in the Housing Inventory Count (HIC).

NOFO Section VII.B.1.l.

Enter the total number of RRH beds available to serve all populations as reported in the HIC–only enter bed data for projects that have an inventory type of “Current.”

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>2020</td>
<td>1,486</td>
</tr>
<tr>
<td>2021</td>
<td>1,529</td>
</tr>
</tbody>
</table>


NOFO Section VII.B.1.m.
Indicate in the chart below whether your CoC assists persons experiencing homelessness with enrolling in health insurance and effectively using Medicaid and other benefits.

<table>
<thead>
<tr>
<th>Type of Health Care</th>
<th>Assist with Enrollment?</th>
<th>Assist with Utilization of Benefits?</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>2. Private Insurers</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>3. Nonprofit, Philanthropic</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Other (limit 150 characters)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

1C-13a. Mainstream Benefits and Other Assistance–Information and Training.

NOFO Section VII.B.1.m

Describe in the field below how your CoC provides information and training to CoC Program-funded projects by:

1. systemically providing up-to-date information on mainstream resources available for program participants (e.g., Food Stamps, SSI, TANF, substance abuse programs) within your CoC's geographic area;
2. communicating information about available mainstream resources and other assistance and how often your CoC communicates this information;
3. working with projects to collaborate with healthcare organizations to assist program participants with enrolling in health insurance; and
4. providing assistance with the effective use of Medicaid and other benefits.

(limit 2,000 characters)

1,2) TO KEEP STAFF UP-TO-DATE & COMMUNICATE INFO: A) The CoC Lead offers ANNUAL free open-invitation mainstream benefits trainings for providers CoC-wide. Co-presented by the CoC, local benefits offices & advocates, and legal services partners, the training covers eligibility, the application process and best practices, and how to maintain benefits for high-priority benefits. Trainings have covered SSI/SSDI, GA, SNAP, WIC, TANF, Medicaid & Medicare, CAPI, & CalWorks. B) CoC & SSA staff inform the Service Providers Network of updates/changes to benefits program via the SPN email list and at MONTHLY SPN meetings. C) DURING THE COVID-19 PANDEMIC, the CoC hosted weekly or bi-weekly all-provider calls to disseminate real-time info, including availability of emergency financial assistance, unemployment, & other COVID-related benefits. 3) The Collaborative Applicant (OSH) partners closely w/ the Valley Homeless Healthcare Program (VHHP) to ensure homeless & PSH clients connect w/ health insurance & care. VHHP medical outreach & dedicated PSH clinical team assist eligible clients w/ Medicaid enrollment. All PSH & RRH housing case managers assess Medicaid eligibility at enrollment & help clients to apply. 4) VHHP medical outreach & dedicated PSH clinical team facilitate access to Medicaid-eligible care. The CoC is working w/ PSH providers to become Medicaid certified, to use Medicaid for eligible services such as on-site behavioral health. Outreach & housing case managers connect clients to a medical home, provide transportation to medical & behavioral health services. Once clients are enrolled in benefits, case managers educate clients on the scope of assistance & how to access & use those benefits. The CoC is working w/ local Health Plans to maximize new CalAIM benefits for CoC projects,
including housing search & navigation, & housing stability support. As health plans develop policies for accessing CalAIM, the CoC will provide training & assistance to CoC partners.

<table>
<thead>
<tr>
<th>1C-14. Centralized or Coordinated Entry System–Assessment Tool. You Must Upload an Attachment to the 4B. Attachments Screen.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOFO Section VII.B.1.n.</td>
</tr>
<tr>
<td>Describe in the field below how your CoC’s coordinated entry system:</td>
</tr>
<tr>
<td>1. covers 100 percent of your CoC’s geographic area;</td>
</tr>
<tr>
<td>2. reaches people who are least likely to apply for homeless assistance in the absence of special outreach;</td>
</tr>
<tr>
<td>3. prioritizes people most in need of assistance; and</td>
</tr>
<tr>
<td>4. ensures people most in need of assistance receive assistance in a timely manner.</td>
</tr>
</tbody>
</table>

(limit 2,000 characters)

1) The CE SYSTEM COVERS THE ENTIRE GEOGRAPHIC AREA of the CoC w/ a no-wrong-door access model. Over 70 access points (incl. outreach, prevention, shelters, VSPs, schools, resource centers, & correctional facilities), covering every local jurisdiction. 2) CE REACHES PEOPLE LEAST LIKELY TO APPLY FOR ASSISTANCE by leveraging existing service centers with ties to target subpopulations (people with developmental disabilities, TAY & young-parent families, families with children, fleeing DV, limited English proficiency) as access points & through extensive street & medical outreach, including encampments. Outreach includes diverse multilingual staff, peers (e.g. youth, LGBTQ, vets, experience of homelessness), mental health clinicians, to target subpops less likely to seek services. CE assessment & outreach materials are translated into commonly spoken languages. At least 13 CE access points have staff to assess in commonly spoken languages; ASL & spoken language interpreters are available to all access points. 3) CE PRIORITIZES THE MOST VULNERABLE using the Single Adult, Family, TAY, & Justice Discharge VI-SPDATs, assessing vulnerability based on history of homelessness; medical, legal, & safety risks; social supports; health needs; experience of abuse. Prioritization considers length of time homeless & high use of County medical services. 4) TO ENSURE TIMELY ASSISTANCE, CE communicates daily w/ programs abt vacancies, often making referrals prior to expected vacancies. CE uses local assessment questions to minimize ineligible referrals & quickly match clients to openings. Dedicated outreach locates clients referred from CE to PSH, documents eligibility to expedite enrollment, & provides a warm hand-off to PSH. The CoC provides best practice guidance for RRH & TH providers locating clients after referral, & two specialists assist w/ RRH client location. In 2022, the CoC will pilot an HMIS Client Portal to allow clients to update their contact info & connect w/ providers.

<table>
<thead>
<tr>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>NOFO Section VII.B.1.o.</td>
</tr>
<tr>
<td>Did your CoC conduct an assessment of whether disparities in the provision or outcome of homeless assistance exists within the last 3 years?</td>
</tr>
</tbody>
</table>

FY2021 CoC Application
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11/12/2021
### 1C-15a. Racial Disparities Assessment Results.

**NOFO Section VII.B.1.o.**

Select yes or no in the chart below to indicate the findings from your CoC’s most recent racial disparities assessment.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. People of different races or ethnicities are more likely to receive homeless assistance.</td>
<td>Yes</td>
</tr>
<tr>
<td>2. People of different races or ethnicities are less likely to receive homeless assistance.</td>
<td>Yes</td>
</tr>
<tr>
<td>3. People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.</td>
<td>Yes</td>
</tr>
<tr>
<td>4. People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.</td>
<td>Yes</td>
</tr>
<tr>
<td>5. There are no racial or ethnic disparities in the provision or outcome of homeless assistance.</td>
<td>No</td>
</tr>
<tr>
<td>6. The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.</td>
<td>No</td>
</tr>
</tbody>
</table>

---

### 1C-15b. Strategies to Address Racial Disparities.

**NOFO Section VII.B.1.o.**

Select yes or no in the chart below to indicate the strategies your CoC is using to address any racial disparities.

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The CoC’s board and decisionmaking bodies are representative of the population served in the CoC.</td>
<td>No</td>
</tr>
<tr>
<td>2. The CoC has identified steps it will take to help the CoC board and decisionmaking bodies better reflect the population served in the CoC.</td>
<td>Yes</td>
</tr>
<tr>
<td>3. The CoC is expanding outreach in geographic areas with higher concentrations of underrepresented groups.</td>
<td>Yes</td>
</tr>
<tr>
<td>4. The CoC has communication, such as flyers, websites, or other materials, inclusive of underrepresented groups.</td>
<td>Yes</td>
</tr>
<tr>
<td>5. The CoC is training staff working in the homeless services sector to better understand racism and the intersection of racism and homelessness.</td>
<td>No</td>
</tr>
<tr>
<td>6. The CoC is establishing professional development opportunities to identify and invest in emerging leaders of different races and ethnicities in the homelessness sector.</td>
<td>Yes</td>
</tr>
<tr>
<td>7. The CoC has staff, committees, or other resources charged with analyzing and addressing racial disparities related to homelessness.</td>
<td>Yes</td>
</tr>
<tr>
<td>8. The CoC is educating organizations, stakeholders, boards of directors for local and national nonprofit organizations working on homelessness on the topic of creating greater racial and ethnic diversity.</td>
<td>Yes</td>
</tr>
<tr>
<td>9. The CoC reviewed coordinated entry processes to understand their impact on people of different races and ethnicities experiencing homelessness.</td>
<td>Yes</td>
</tr>
<tr>
<td>10. The CoC is collecting data to better understand the pattern of program use for people of different races and ethnicities in its homeless services system.</td>
<td>Yes</td>
</tr>
<tr>
<td>11. The CoC is conducting additional research to understand the scope and needs of different races or ethnicities experiencing homelessness.</td>
<td>Yes</td>
</tr>
<tr>
<td>Other:(limit 500 characters)</td>
<td></td>
</tr>
</tbody>
</table>

---
Promoting Racial Equity in Homelessness Beyond Areas Identified in Racial Disparity Assessment.

Describe in the field below the steps your CoC and homeless providers have taken to improve racial equity in the provision and outcomes of assistance beyond just those areas identified in the racial disparity assessment.

(limit 2,000 characters)

CoC & census data show that Black/African American, American Indian/Alaskan Native, & Hispanic/Latinx people are overrepresented in the CoC's homeless population. One of 5 targets of the CoC’s Community Plan to End Homelessness 2020-2024 is to “Address the racial inequities present among unhoused people and families and track progress toward reducing disparities.” To reach this goal, the CoC is planning & implementing strategies w/in the 3-part Community Plan framework: 1) Address the Root Causes of Homelessness. The CoC is exploring strategies to address social, economic, & policy factors that disproportionately impact people of color. In 2021, Destination: Home & Somos Mayfair announced a 2-year GUARANTEED INCOME PILOT targeting ELI families & women of color to support housing access & stability. The City of Mountain View is planning a $1M Guaranteed Income Pilot. Community Plan implementation leads are assessing LAND USE & HOUSING POLICIES to propose a set of recommendations for local cities. 2) Expand Prevention & Housing Resources. The CoC has begun a process, recommended by the Coordinated Assessment Work Group & approved by the CoC Board, to holistically REDESIGN COORDINATED ENTRY WITH A RACIAL EQUITY LENS, including the assessment, prioritization, & referral processes. In 2020, the CoC expanded beyond its 18 prevention partners to a network of 72, intentionally targeting CBOs w/ ties to communities of color & low-income areas, to distribute a total of $71.7 million in COVID ASSISTANCE TO 18,393 HOUSEHOLDS, 94% PEOPLE OF COLOR. 3) Increase Street Outreach & Basic Needs Services to Match Need. In 2021, a team of CoC representatives (100% BIPOC, 55% w/ lived experience) participated in a Racial Equity Action Lab (REAL). Members attended 7 workshops on racial equity concepts & are currently conducting interviews & surveys to develop policy recommendations & training curricula to strengthen CULTURALLY RELEVANT OUTREACH TO ENGAGE OVER-REPRESENTED POPULATIONS.

Persons with Lived Experience–Active CoC Participation.

Enter in the chart below the number of people with lived experience who currently participate in your CoC under the five categories listed:

<table>
<thead>
<tr>
<th>Level of Active Participation</th>
<th>Number of People with Lived Experience Within the Last 7 Years or Current Program Participant</th>
<th>Number of People with Lived Experience Coming from Unsheltered Situations</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Included and provide input that is incorporated in the local planning process.</td>
<td>80</td>
<td>25</td>
</tr>
</tbody>
</table>
2. Review and recommend revisions to local policies addressing homelessness related to coordinated entry, services, and housing. | 9 | 1
3. Participate on CoC committees, subcommittees, or workgroups. | 3 | 1
4. Included in the decisionmaking processes related to addressing homelessness. | 9 | 1
5. Included in the development or revision of your CoC’s local competition rating factors. | 2 | 1

1C-17. Promoting Volunteerism and Community Service.

| NOFO Section VII.B.1.r. |

Select yes or no in the chart below to indicate steps your CoC has taken to promote and support community engagement 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. | Yes |
| 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, data entry). | No |
| 3. The CoC works with organizations to create volunteer opportunities for program participants. | No |
| 4. The CoC works with community organizations to create opportunities for civic participation for people experiencing homelessness (e.g., townhall forums, meeting with public officials). | Yes |
| 5. Provider organizations within the CoC have incentives for employment and/or volunteerism. | Yes |
| 6. Other:(limit 500 characters) |

CoC provides staffing & financial support for Lived Experience Advisory Board, an independent board that supports members w/ advocacy, civic engagement, and consulting projects | Yes |
1D. Addressing COVID-19 in the CoC’s Geographic Area

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1D-1. Safety Protocols Implemented to Address Immediate Needs of People Experiencing Unsheltered, Congregate Emergency Shelter, Transitional Housing Homelessness.

NOFO Section VII.B.1.q.

Describe in the field below protocols your CoC implemented during the COVID-19 pandemic to address immediate safety needs for individuals and families living in:

1. unsheltered situations;
2. congregate emergency shelters; and
3. transitional housing.

(limit 2,000 characters)

The Office of Supportive Housing (OSH), Collaborative Applicant, worked w/ County Public Health (PH) to implement safety protocols in line w/ CDC, state, & local PH recs. 1) UNSHELTERED SAFETY: All jurisdictions stopped encampment sweeps 3/2020-7/2021 to limit mvmnt & exposure. Hand-washing stations, toilets, water, & trash pickup provided for encampments across the CoC. PPE was required for all outreach. OSH & the City of San Jose (CSJ) coordinated food delivery & hand sanitizer/masks for encampments, via outreach team, volunteer & lived experience grps. Starting 5/2020, Valley Homeless Healthcare Program (VHHP) did wkly COVID testing at encampments w/ 10+ residents. Starting 12/2020, VHHP hosted clinics & vaccinated at all large encampments. VHHP & PH continue vaccination at clinics & events for the unhoused. OSH expanded vaccine outreach & educ in 6/2021, w/ up to 30 peer outreach to provide educ, help w/ appointments, transport, & incentives. 2) CONGREGATE ES SAFETY: In 3/2020 OSH required cong ES to reduce capacity to put at least 6 ft btwn beds (distance changed over time w/PH recs), & opened 4 temp cong ES to increase capacity. OSH & PH set isolation & testing protocols, w/ high-risk, exposed, symptomatic, & positive residents immediately moved to non-congr. Starting 5/2020, COVID testing was onsite at cong ES weekly; current testing freq. based on local transmission rates. Starting 11/2020, COVID vaccine offered at all ES, starting w/ 65+ or at high risk of complication; open to all residents in 2/2021. 3) TH SAFETY: Scattered-site & small shared hsg programs established P&Ps, provided residents w/ info, & supported compliance w/ shelter-in-place & mask mandates. For high risk, exposed, or
symptomatic clients, OSH & PH set isolation & testing protocols, including isolation placement for TH clients in shared hsg. Congregate TH used protocols for cong ES.

### 1D-2. Improving Readiness for Future Public Health Emergencies.

**NOFO Section VII.B.1.q.**

Describe in the field below how your CoC improved readiness for future public health emergencies. (limit 2,000 characters)

The CoC improved readiness by developing a public health emergency response structure, replicable processes & written policies, models for coordination w/ healthcare system, & protocols for rapidly standing up ES. Within 2 weeks after the first local shelter-in-place, starting March 16, 2021, the County Office of Supportive Housing (OSH), Collaborative Applicant, the City of San Jose (CSJ), County Behavioral Health Services Department (BHSD), & the Valley Homeless Healthcare Project (VHHP) developed a HOUSING & HOMELESSNESS EMERGENCY OPERATIONS CENTER, called the Joint Departmental Operations Center (JDOC), which is QUICKLY REPLICABLE in response to future public health crises. OSH, CSJ, BHSD, & VHHP co-located staff at the JDOC to coordinate emergency response, & County Public Health (PH) attended daily JDOC coordination mtgs. The JDOC, in collaboration w/ PH, developed a comprehensive HANDBOOK FOR OPERATING NON-CONGREGATE SHELTERS, STANDARDS FOR CONGREGATE SHELTERS, & SHELTER INTAKE & REFERRAL PROCESSES based on health risk, exposure, symptoms, & testing. County Disaster Support Workers (DSWs) were rapidly deployed & trained on the homelessness response system & shelter operations. These written policies & training materials remain available for adaptation to future crises. The SHELTER REFERRAL HOTLINE developed to handle congregate & non-congregate placements is being adapted & expanded into a permanent shelter hotline, so that infrastructure will already be in place for future public health needs. The JDOC partners successfully stood up & staffed 4 temporary congregate shelters & 11 hotel-based isolation shelters within 5 weeks of the first shelter in place order. The steps involved in identifying & obtaining appropriate sites, deploying Disaster Service Workers & contractors, coordinating funding across jurisdictions, coordinating with health care providers, & leveraging federal resources were documented & can be replicated more efficiently in future.

### 1D-3. CoC Coordination to Distribute ESG Cares Act (ESG-CV) Funds.

**NOFO Section VII.B.1.q**

Describe in the field below how your CoC coordinated with ESG-CV recipients to distribute funds to address:

1. safety measures;
2. housing assistance;
3. eviction prevention;
4. healthcare supplies; and
5. Sanitary Supplies.

(limit 2,000 characters)

AND CSJ MET WEEKLY beginning April 2020, along with non-profit partner Destination: Home, to coordinate COVID response funding from all sources and ensure all needs were met. ESG-CV funding was used to fill key funding gaps. City of San Jose and County staff were co-located at the housing branch of the County’s EOC. 1. SAFETY MEASURES: As part of the coordinated community funding strategy, ESG-CV funds were used to keep cold weather shelters open 24 hours, year-round, to accommodate social distancing and sheltering-in-place in congregate shelters. CSJ allocated the bulk of their ESG-CV to operate new shelters and interim housing, to provide safe and socially distanced places to shelter in place. 2. HOUSING ASSISTANCE: ESG-CV funded shelter beds offer housing-focused case management and housing search assistance. County ESG-CV funds are supporting RRH for up to 200 unhoused individuals or families residing in temporary non-congregate shelter (hotels) programs. 3. EVICTION PREVENTION: ESG-CV funds were not prioritized for eviction prevention, as the CoC obtained over $172 million in rent and financial assistance from private donations, County funding, and other dedicated state and federal programs. 4. HEALTHCARE SUPPLIES: OSH used ESG-CV funding to expand public health outreach with 30 vaccine ambassadors, most of whom are peer outreach workers, who were trained to communicate with unsheltered residents about COVID-19 vaccination safety, efficacy, and access, provide assistance with appointments, transportation, and vaccine incentives. 5. SANITARY SUPPLIES: ESG-CV funds were available & offered to all providers for one-time costs, including ventilation systems, PPE, hazard pay, and other supplies to improve safety for staff and clients.

1D-4. CoC Coordination with Mainstream Health.

NOFO Section VII.B.1.q.

Describe in the field below how your CoC coordinated with mainstream health (e.g., local and state health agencies, hospitals) during the COVID-19 pandemic to:

1. decrease the spread of COVID-19; and
2. ensure safety measures were implemented (e.g., social distancing, hand washing/sanitizing, masks).

(limit 2,000 characters)

The CoC coordinated closely w/ County Public Health (PH) & Valley Homeless Healthcare Project (VHHP) to decrease the spread of COVID-19 & ensure safety measures were implemented. The Collaborative Application (OSH), the City of San Jose (CSJ), County Behavioral Health Services Department (BHSD), & VHHP developed a Joint Departments Operations Center (JDOC) focused on housing & homelessness, which co-located staff at a central operations center. PH dedicated staff to collaborate closely w/ the JDOC & joined daily coordination calls. 1. As soon as testing was available, tests were allocated to VHHP for use in shelters & via outreach to unsheltered residents. As soon as vaccines were available, VHHP utilized their experience deploying testing to roll out vaccination for sheltered & unsheltered unhoused residents. At peak periods of community transmission, VHHP provided at least weekly surveillance testing at all congregate shelters & encampments w/ over 10 residents. Throughout the pandemic & continuing today, VHHP & PH provide response testing multiple times a week following a COVID-19 case at any
congregate shelter. In April 2020 when COVID-19 hospitalizations w/in the CoC were high, the JDOC collaborated with the County Health & Hospital System to establish a temporary field hospital in Santa Clara, to care for patients requiring COVID-19 isolation but who did not require hospital care, including unhoused residents. 2. OSH & PH worked closely w/ shelter providers to implement program policies in line w/ CDC & local public health guidance, through regular calls w/ all shelter providers. OSH & PH made regular site visits to congregate & non-congregate shelters, during which they consulted w/ shelter providers on initial physical reorganization of shelter spaces to ensure social distancing & at least one isolation room; monitored for compliance w/ social distancing, mask, hand-washing, testing, & other protocols; & gave recommendations for improved safety measures.

<table>
<thead>
<tr>
<th>1D-5.</th>
<th>Communicating Information to Homeless Service Providers.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOFO Section VII.B.1.q.</td>
<td>Describe in the field below how your CoC communicated information to homeless service providers during the COVID-19 pandemic on:</td>
</tr>
<tr>
<td></td>
<td>1. safety measures;</td>
</tr>
<tr>
<td></td>
<td>2. changing local restrictions; and</td>
</tr>
<tr>
<td></td>
<td>3. vaccine implementation.</td>
</tr>
</tbody>
</table>

(limit 2,000 characters)

The CoC communicated info to homeless services providers at regular all-provider calls. The Collaborative Applicant (OSH) hosted calls twice weekly from 3/17/20 to 6/16/20, weekly from 6/16/20 to 8/4/20, & bi-weekly from 8/4/20 - present. Attendance at calls included County Public Health, housing & shelter providers, outreach, community-based service providers, healthcare, property management, Public Defender’s Office, & local governments. 1) INFO ABOUT IMPLEMENTING SAFETY MEASURES was provided at all-providers calls 3/17/20 – 10/5/21. Presenters covered how to access hand sanitizer, disinfectant, & PPE; cleaning protocols; social distancing requirements; mask mandates; transportation options; mobile hygiene; hand-washing stations; non-congregate shelter access & referral; isolation & quarantine protocols; testing availability & mandates; vaccine availability & access; & more. 2) INFO ABOUT CHANGES TO LOCAL RESTRICTIONS was provided at all-providers calls 3/17/20 – 10/5/21 as relevant. OSH & County Public Health provided updates, clarification, & guidance on local restrictions, including: shelter-in-place; curfews; social distancing in ES & when non-congregate placement is required; public bathroom closure/availability; eviction moratoria; public benefits office closures, access by phone, & remote applications; mask mandates; & vaccine eligibility. 3) INFO ABOUT VACCINE IMPLEMENTATION was provided at all-providers calls 1/26/21 – 10/5/21. Providers were notified as vaccine eligibility expanded to include 65+, unsheltered people, shelter residents, and provider staff; when medical outreach began vaccinating shelter residents; the plan & process for providing vaccines to all shelters; the amount and type of vaccines available, and doses administered; mobile medical vaccination for SNFs, low-income & special needs housing; vaccine outreach & education efforts; implementation of vaccination/weekly testing mandate for ES staff; & availability of booster shots.

NOFO Section VII.B.1.q.

Describe in the field below how your CoC identified eligible individuals and families experiencing homelessness for COVID-19 vaccination based on local protocol.

(limit 2,000 characters)

As part of the joint emergency response by the Collaborative Applicant (OSH), County Behavioral Health, the City of San Jose, and Valley Homeless Healthcare Project (VHHP), VHHP led a coordinated effort to identify people experiencing homelessness as they became eligible for vaccination. VHHP used health and shelter records to identify people 65+ or with qualifying conditions, for the initial eligibility phase, and expanded outreach as eligibility expanded. VHHP conducted proactive and continued outreach to within shelters and in encampments of 10+ people across the CoC, with staff familiar with unhoused residents and experienced medical outreach, to identify those eligible and provide vaccine education. For all clients VHHP had prior contact with, contact information was used for direct outreach to inform and offer vaccination. Beginning in February, 2021, OSH, with input from the Lived Experience Advisory Board, developed a “Vaccine Ambassador” program to supplement VHHP outreach and provide vaccine incentives, prioritizing lived experience outreach to provide vaccine education. Vaccination was available on-site at shelters and in encampments.

1D-7. Addressing Possible Increases in Domestic Violence.

NOFO Section VII.B.1.e.

Describe in the field below how your CoC addressed possible increases in domestic violence calls for assistance due to requirements to stay at home, increased unemployment, etc. during the COVID-19 pandemic.

(limit 2,000 characters)

The CoC increased its collaboration with the Domestic Violence Advocacy Consortium (DVAC), a partnership of the CoC’s 5 VSPs, during the COVID-19 pandemic. The Office of Supportive Housing (OSH), the Collaborative Applicant, and the DVAC increased their check-in meetings from quarterly to monthly. These meetings ensured that the CoC remained up to date on trends in housing and shelter need for survivors and gaps in funding and resources, and DVAC members identified the potential for increased risk for survivors early in the pandemic. In response, the DVAC and OSH focused on ensuring quick access to safe shelter through INCREASED USE OF HOTEL-BASED SHELTER and COORDINATED SHELTER REFERRAL. As existing funding for hotel sheltering ran low, OSH worked with DVAC agencies to identify additional resources, including re-allocating funding from OSH TH contracts that had reduced capacity due to social distancing to fund expanded hotel shelter. To allow the quickest access to safe shelter for survivors, the CoC also included a DVAC partner, the YWCA, in its new shelter referral hotline. DVAC agencies continued to operate their own shelter hotlines, but the CoC was also able to identify people fleeing violence who called the main shelter hotline and provide
a warm referral to the YWCA for the most appropriate shelter and services. The YWCA coordinated enrollment in YWCA shelter or in another DVAC shelter.

<table>
<thead>
<tr>
<th>1D-8. Adjusting Centralized or Coordinated Entry System.</th>
</tr>
</thead>
<tbody>
<tr>
<td>NOFO Section VII.B.1.n.</td>
</tr>
</tbody>
</table>

Describe in the field below how your CoC adjusted its coordinated entry system to account for rapid changes related to the onset and continuation of the COVID-19 pandemic.

(limit 2,000 characters)

The CoC rapidly adjusted its coordinated assessment and referral to ensure uninterrupted, safe, and appropriate connections to shelter and housing programs. A) The CoC developed a SHELTER REFERRAL HOTLINE as a new single point of entry for XX% of emergency shelter beds. The shelter hotline screened people for high risk (65+ or underlying health condition), COVID-19 symptoms or exposure, or positive tests for referral to hotel-based non-congregate shelters. Other people seeking shelter were referred to socially-distanced congregate shelters. The hotline was established within 16 days of Public Health’s first shelter in place order and is a permanent addition to the community’s system for accessing ES & other resources. B) The CoC changed Coordinated Entry assessment protocols to allow remote assessment, including new policies on how to effectively assess remotely. This allowed the CoC to continue assessing and referring the most vulnerable clients throughout the pandemic, administering over 6,500 assessments in the first year of the pandemic (4/1/20-3/31/21) including over 3,000 people assessed for the first time.
To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578


NOFO Section VII.B.2.a. and 2.g.

1. Enter the date your CoC published the 30-day submission deadline for project applications for your CoC’s local competition.  
09/08/2021

2. Enter the date your CoC publicly posted its local scoring and rating criteria, including point values, in advance of the local review and ranking process.  
09/08/2021

1E-2. Project Review and Ranking Process Your CoC Used in Its Local Competition. You Must Upload an Attachment to the 4B. Attachments Screen. We use the response to this question as a factor when determining your CoC’s eligibility for bonus funds and for other NOFO criteria listed below.

NOFO Section VII.B.2.a., 2.b., 2.c., and 2.d.

Select yes or no in the chart below to indicate how your CoC ranked and selected project applications during your local competition:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Established total points available for each project application type.</td>
<td>Yes</td>
</tr>
<tr>
<td>2. At least 33 percent of the total points were based on objective criteria for the project application (e.g., cost effectiveness, timely draws, utilization rate, match, leverage), performance data, type of population served (e.g., DV, youth, Veterans, chronic homelessness), or type of housing proposed (e.g., PSH, RRH).</td>
<td>Yes</td>
</tr>
<tr>
<td>3. At least 20 percent of the total points were based on system performance criteria for the project application (e.g., exits to permanent housing destinations, retention of permanent housing, length of time homeless, returns to homelessness).</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Used data from a comparable database to score projects submitted by victim service providers.</td>
<td>Yes</td>
</tr>
<tr>
<td>5. Used objective criteria to evaluate how projects submitted by victim service providers improved safety for the population they serve.</td>
<td>Yes</td>
</tr>
<tr>
<td>6. Used a specific method for evaluating projects based on the CoC’s analysis of rapid returns to permanent housing.</td>
<td>Yes</td>
</tr>
</tbody>
</table>


<p>| | |</p>
<table>
<thead>
<tr>
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</tr>
</thead>
<tbody>
<tr>
<td>FY2021 CoC Application</td>
<td>Page 32</td>
</tr>
</tbody>
</table>
NOFO Section VII.B.2.d.

Describe in the field below how your CoC reviewed, scored, and selected projects based on:

1. the specific severity of needs and vulnerabilities your CoC considered when ranking and selecting projects; and
2. considerations your CoC gave to projects that provide housing and services to the hardest to serve populations that could result in lower performance levels but are projects your CoC needs in its geographic area.

(limit 2,000 characters)

1) The CoC’s R&R process takes into account the following needs and vulnerabilities: disabling conditions, chronic homelessness, criminal history, low/no income, experience of DV/assault, current or history of substance use. 2) The CoC prioritizes serving clients with the highest barriers but recognizes that may result in lower performance levels. The CoC considers severity of barriers through objective scored criteria, the scoring discretion of the R&R panel, and threshold requirements. Projects are SCORED on: A) being PSH (disabling condition required); B) dedicating beds to CH; C) Housing First P&Ps (no barriers for criminal history, low or no income, experience of DV/assault, substance use); D) serving a priority population (including DV survivors); and E) program design targeting clients with the highest level of need. R&R panelists are experts in homelessness and housing in the community and are instructed that they MAY ADJUST SCORES AS APPROPRIATE BASED ON THE SEVERITY OF NEEDS AND VULNERABILITIES of a project’s client population, as specified on the scoring tool: “Keep in mind that outcomes will naturally be lower in a population with more severe needs. Such populations include persons with low or no income, current or past substance abuse, a history of victimization (e.g., domestic violence, sexual assault, childhood abuse), criminal histories, chronic homelessness.” Panelists receive a WRITTEN REPORT ON RENEWAL PROJECTS with demographic info, including rates of mental illness, substance abuse, HIV/AIDs, chronic conditions, developmental and physical disability, multiple health conditions, history of DV, and level of income. As part of the application process, applicants may provide additional client data and EXPLAIN HOW A PARTICULARLY HIGH-NEED CLIENT POPULATION IMPACTED OUTCOMES. Participation in Coordinated Entry is a threshold requirement in the R&R process for all new & renewal projects, ensuring that all projects accept the most vulnerable households.


NOFO Section VII.B.2.e.

Describe in the field below how your CoC:

1. obtained input and included persons of different races, particularly those over-represented in the local homelessness population, when determining the rating factors used to review project applications;
2. included persons of different races, particularly those over-represented in the local homelessness population, in the review, selection, and ranking process;
3. rated and ranked projects based on the degree to which their program participants mirror the homeless population demographics (e.g., considers how a project promotes racial equity where individuals and families of different races are over-represented).

(limit 2,000 characters)

1) The CoC obtained input and included people of different races WHEN
DEVELOPING RATING FACTORS through active efforts to increase diversity among CoC membership, widely publicized meetings, and racial diversity on the CoC Board. In 2019-2021, the CoC has taken steps to increase diversity of participation in the CoC. The CoC has offered an annual Introduction to CoC Funding; this live training session targets providers, partners, and staff who are new to the CoC and covers CoC structure and committees, CoC funding basics, and system requirements (HMIS, CE). The purpose of the intro training is to lower barriers to active CoC participation for partners and community members who have historically not participated, including smaller CBOs with deep ties to communities over-represented in the homeless pop. In 2020, the CoC, led by Destination: Home, specifically targeting smaller CBOs w/ ties to communities disproportionately impacted by COVID-19 (people of color and low-income households) when recruiting the 72-agency COVID financial assistance distribution network. Average participation in the NOFA Committee, which reviews & revises draft scoring & ranking process annually, increased from 10 in 2019 to 23 in 2021. NOFA Committee is open-membership & open-attendance. Meetings are announced on the CoC’s online calendar & via email to the CoC & SPN listservs (880 & 1,067 members). Announcements specify that meetings are open to all and outline the purpose of each meeting. The CoC does not collect demographic information from NOFA Committee attendees, but attendance is racially diverse. Finally, the CoC does not collect demographic information from the 9-member CoC Board that reviews and approves the local scoring factors and process, but the Board is racially diverse and 1/3 of members have lived experience of homelessness, 2) The CoC Board, which reviewed and approved the final Priority Listing, is racially diverse. 3) Projects were not rated or ranked on demographics.

1E-4. Reallocation—Reviewing Performance of Existing Projects. We use the response to this question as a factor when determining your CoC’s eligibility for bonus funds and for other NOFO criterion below.

Describe in the field below:

1. your CoC’s reallocation process, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed;
2. whether your CoC identified any projects through this process during your local competition this year;
3. whether your CoC reallocated any low performing or less needed projects during its local competition this year;
4. why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable; and
5. how your CoC communicated the reallocation process to project applicants.

(limit 2,000 characters)

1) Under the CoC’s written PROCESS FOR REALLOCATION, the R&R panel will consider the following when discussing reallocation: underspending, impact on system performance, recent grant reductions, alternative funding sources, community needs, & new project applications. The R&R panel reviews outcomes for all renewals (utilization, grant spend-down, housing stability, returns to homelessness, income, benefits, Housing First, client input, service design, grant compliance) in specialized data reports. Preliminary scores are assigned based on scales in the CoC’s scoring tool, & applicants respond to scaled scores in written narratives & interviews. R&R panel may adjust scores based on applicant explanations of severity of needs & other relevant context.
R&R panel reviews lowest-scoring projects & projects with the lowest spend-down for possible reallocation, based on the written process, against the need for the new projects proposed. If the R&R recommends reallocation, all applicants are notified of the recommendation, which is appealable. If the Appeals Committee affirms the recommendation, it is included in the Ranked List sent to the CoC Board for a vote. The CoC Board has final authority to approve or reject reallocation. Final decisions on reallocation are posted publicly w/ the final Ranked List. 2) The R&R panel did not recommend reallocation. 3) No reallocation 4) The CoC followed its written process, including R&R panel discussion of potential reallocation. The panel determined that each renewal provides needed capacity & is performing as well as or better than expected of lower-ranked new projects. 5) The CoC COMMUNICATED THE REALLOCATION PROCESS to applicants at a 2-hour public TA Workshop (9/7) which was advertised to agencies through a NOFA Announcement & TA Workshop invitation (8/23) emailed to the CoC & SPN listservs (880 & 1,067 members) & the CoC website. The written process was posted on the CoC website (9/8) & emailed to the CoC & SPN lists.

1E-4a. Reallocation Between FY 2016 and FY 2021. We use the response to this question as a factor when determining your CoC’s eligibility for bonus funds and for other NOFO criterion below.

NOFO Section VII.B.2.f.

Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2016 and FY 2021? No

1E-5. Projects Rejected/Reduced–Public Posting. You Must Upload an Attachment to the 4B. Attachments Screen if You Select Yes.

NOFO Section VII.B.2.g.

1. Did your CoC reject or reduce any project application(s)? Yes

If you selected yes, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps. 10/29/2021

1E-5a. Projects Accepted–Public Posting. You Must Upload an Attachment to the 4B. Attachments Screen.

NOFO Section VII.B.2.g.

Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps. 10/29/2021

1E-6. Web Posting of CoC-Approved Consolidated Application. You Must Upload an Attachment to the 4B. Attachments Screen.

NOFO Section VII.B.2.g.
Enter the date your CoC’s Consolidated Application was posted on the CoC’s website or affiliate’s website—which included:
1. the CoC Application;
2. Priority Listings; and
3. all projects accepted, ranked where required, or rejected.

<table>
<thead>
<tr>
<th>Date</th>
</tr>
</thead>
<tbody>
<tr>
<td>11/12/2021</td>
</tr>
</tbody>
</table>

**Applicant:** San Jose/Santa Clara City & County CoC

**Project:** CA-500 CoC Registration FY 2021
2A. Homeless Management Information System (HMIS) Implementation

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

2A-1. HMIS Vendor.
Not Scored–For Information Only
Enter the name of the HMIS Vendor your CoC is currently using. Bitfocus, Inc

2A-2. HMIS Implementation Coverage Area.
Not Scored–For Information Only
Select from dropdown menu your CoC’s HMIS coverage area. Single CoC

2A-3. HIC Data Submission in HDX.
NOFO Section VII.B.3.a.
Enter the date your CoC submitted its 2021 HIC data into HDX. 05/12/2021

2A-4. HMIS Implementation–Comparable Database for DV.
NOFO Section VII.B.3.b.
Describe in the field below actions your CoC and HMIS Lead have taken to ensure DV housing and service providers in your CoC:
1. have a comparable database that collects the same data elements required in the HUD-published 2020 HMIS Data Standards; and
2. submit de-identified aggregated system performance measures data for each project in the comparable database to your CoC and HMIS lead.

(limit 2,000 characters)
1) Within the CoC, 4 of 5 VSPs provide housing or services that require HMIS data entry and currently have comparable databases that collect the data elements required in the 2020 HMIS Data Standards. Before the projects requiring HMIS data were implemented, the Collaborative Applicant, the County Office of Supportive Housing (OSH), provided technical assistance to the VSPs to ensure they understood the comparable database requirement, including ensuring the software selected by the VSPs (ETO, EmpowerDB, Osnium) complied with HMIS Data Standards. OSH connected the VSPs to the HMIS Admin and Vendor, Bitfocus, for additional TA while implementing their comparable databases. OSH collects APRs from the VSPs quarterly and monitors data quality to ensure compliance with HMIS data standards. The CoC has engaged in extensive conversation with all members of the Domestic Violence Advocacy Consortium (DVAC), a collaborative of the 5 VSPs within the CoC, regarding expanding comparable database use across all agencies and projects, including offering County funding for database implementation. 2) OSH collects APR reports for each CoC-funded project operated by a VSP quarterly and uses those reports to track outcomes for survivors, identify occupancy trends, and monitor spend-down of CoC funding. In 2021, OSH used occupancy data from comparable databases, and the number of survivors on the Confidential Queue, to identify a need for additional RRH resources; based on that need, the OSH submitted a DV Bonus application. OSH used data provided by VSPs in an April 2021 presentation to a joint session of the County Board of Supervisors & San Jose City Council, and in a March 2021 report to the Board of Supervisors, to support recommendations for increased resources and housing for survivors.


NOFO Section VII.B.3.c. and VII.B.7.

Enter 2021 HIC and HMIS data in the chart below by project type:

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Total Beds 2021 HIC</th>
<th>Total Beds in HIC Dedicated for DV</th>
<th>Total Beds in HMIS</th>
<th>HMIS Bed Coverage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Emergency Shelter (ES) beds</td>
<td>1,438</td>
<td>99</td>
<td>1,339</td>
<td>100.00%</td>
</tr>
<tr>
<td>2. Safe Haven (SH) beds</td>
<td>20</td>
<td>0</td>
<td>20</td>
<td>100.00%</td>
</tr>
<tr>
<td>3. Transitional Housing (TH) beds</td>
<td>470</td>
<td>24</td>
<td>446</td>
<td>100.00%</td>
</tr>
<tr>
<td>4. Rapid Re-Housing (RRH) beds</td>
<td>1,529</td>
<td>0</td>
<td>1,529</td>
<td>100.00%</td>
</tr>
<tr>
<td>5. Permanent Supportive Housing</td>
<td>4,414</td>
<td>163</td>
<td>2,282</td>
<td>53.68%</td>
</tr>
<tr>
<td>6. Other Permanent Housing (OPH)</td>
<td>126</td>
<td>0</td>
<td>126</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

2A-5a. Partial Credit for Bed Coverage Rates at or Below 84.99 for Any Project Type in Question 2A-5.

NOFO Section VII.B.3.c.

For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-5, describe:

1. steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and
2. how your CoC will implement the steps described to increase bed coverage to at least 85 percent.
The CoC has maintained 100% HMIS coverage for all non-PSH beds (ES, SH, TH, and RRH). As of the 2021 HIC, 1969 of 4251 non-DV PSH beds were listed as not in HMIS. 198 of those beds are in three PSH projects UNDER DEVELOPMENT, and therefore not currently entering data into HMIS, but all 198 beds will be in HMIS when the projects begin operating. 56 beds are in a PSH project for survivors, not operated by a VSP, that does enter information into HMIS. Those beds bring the true PSH bed coverage rate up to 60%. The greatest challenge to full PSH coverage has been the 1487 HUD-VASH beds, which account for approximately 35% of the CoC’s non-DV PSH inventory and were not in HMIS as of the 2021 HIC submission. After extensive collaboration with the VA and the Santa Clara County Housing Authority (SCCHA) prior to the COVID-19 pandemic, a plan was established to begin HUD-VASH data entry in 2020. Beginning March 2020, staff and resources across the CoC were re-directed to emergency response, and public health safety measures created barriers to the necessary ROI collection. 1) PLAN FOR NEXT 12 MONTHS: The SCCHA will contract or increase staffing to manage on-boarding of HUD-VASH beds into HMIS, including collecting HMIS ROIs from HUD-VASH clients and entering client information into HMIS. 2) IMPLEMENTATION: The SCCHA will solicit and select a contractor, through the SCCHA’s procurement process. If the selected contractor is not already an HMIS-participating agency, it will be onboarded to HMIS and staff will receive HMIS training. The contractor will develop a strategy to obtain ROIs from current HUD-VASH clients and will begin entering data into HMIS after consent is obtained. In the interim, the HMIS Lead has already added custom fields to the HMIS that allow the CoC to track HUD-VASH enrollment for any client who is on the CE Community Queue.

2A-5b. Bed Coverage Rate in Comparable Databases.

Enter the percentage of beds covered in comparable databases in your CoC’s geographic area. 50.37%

2A-5b.1. Partial Credit for Bed Coverage Rates at or Below 84.99 for Question 2A-5b.

If the bed coverage rate entered in question 2A-5b is 84.99 percent or less, describe in the field below:

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

1) In the NEXT 12 MONTHS, the CoC will: A) Continue to identify opportunities to integrate the Domestic Violence Advocacy Consortium (DVAC) providers & systems with the CoC (building on previous efforts such as joint operation of housing programs, warm handoffs from the CoC shelter hotline to VSP shelter, and incorporation of VSPs into the Homelessness Prevention System.) B) Continue quarterly meetings between the Collaborative Applicant, the DVAC, and the County Office of Gender-Based Violence. C) Continue to engage with VSPs to identify their concerns and barriers to comparable database implementation, including ways the CoC could support implementation. D)
Increase coordination with the County Office of Gender-Based Violence, another local funder receiving regular data from VSPs, to identify opportunities to align data requests. 2) The CoC WILL IMPLEMENT THESE STEPS using current Collaborative Applicant staffing and in collaboration and community with the DVAC. The CoC will prioritize relationship-building and seek to identify ways it can provide resources and support.

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

| NOFO Section VII.B.3.d. |

| Did your CoC submit LSA data to HUD in HDX 2.0 by January 15, 2021, 8 p.m. EST? | Yes |
### 2B. Continuum of Care (CoC) Point-in-Time (PIT) Count

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

#### 2B-1. Sheltered and Unsheltered PIT Count–Commitment for Calendar Year 2022

<table>
<thead>
<tr>
<th>NOFO Section VII.B.4.b.</th>
</tr>
</thead>
</table>

**Does your CoC commit to conducting a sheltered and unsheltered PIT count in Calendar Year 2022?** Yes

#### 2B-2. Unsheltered Youth PIT Count–Commitment for Calendar Year 2022.

<table>
<thead>
<tr>
<th>NOFO Section VII.B.4.b.</th>
</tr>
</thead>
</table>

**Does your CoC commit to implementing an unsheltered youth PIT count in Calendar Year 2022 that includes consultation and participation from youth serving organizations and youth with lived experience?** Yes
2C. System Performance

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

2C-1. Reduction in the Number of First Time Homeless–Risk Factors.

NOFO Section VII.B.5.b.

Describe in the field below:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>how your CoC determined which risk factors your CoC uses to identify persons becoming homeless for the first time;</td>
</tr>
<tr>
<td>2.</td>
<td>how your CoC addresses individuals and families at risk of becoming homeless; and</td>
</tr>
<tr>
<td>3.</td>
<td>provide the name of the organization or position title that is responsible for overseeing your CoC’s strategy to reduce the number of individuals and families experiencing homelessness for the first time or to end homelessness for individuals and families.</td>
</tr>
</tbody>
</table>

(limit 2,000 characters)

1) The CoC used local & national data to ID RISK FACTORS. PIT data since 2011 shows eviction, lack of employment, low or no income as primary causes of homelessness. The CoC’s Homelessness Prevention System (HPS) data identified DV as a risk factor for families. Local housing data show extreme costs & lack of affordable housing disproportionately impact very low-income residents. National research indicates various risk factors, including low or no income, mental illness, abuse, criminal justice involvement. Based on this data, HPS set eligibility criteria: low income; self-report that housing will be lost w/in 14 days or housing is unsafe; & a score of 8+ on the Prevention VI-SPDAT, which scores income & financial health, history of homelessness, eviction risk, abuse &/or trafficking, interaction w/ emergency services, including criminal justice, acuity of mental & physical health needs. DURING THE COVID-19 PANDEMIC, national data showed that low-income & people of color were at higher risk for health & economic impacts. 2) STRATEGIES TO ADDRESS THOSE AT RISK: A)CoC-wide HPS coordinates 18 agencies to offer financial assistance & case management to meet each client’s needs, w/ ongoing evaluation of outcomes. HPS housing specialists help clients retain housing or relocate. From HPS launch in 2017 to Sept 2021, 96% of 2,726 households served remained housed 1 year after exit & capacity has increased to 1,500 households per year. B)The CoC partners w/ Law Foundation of Silicon Valley for eviction prevention & HPS staff refer directly. C)CalWORKS & SSVF provide HP financial assistance, case management, connections to benefits & job training. D)DURING THE PANDEMIC, the CoC expanded beyond the HPS to a network of 72 orgs to distribute financial assistance to high-risk neighborhoods & communities. Of a total $71.7 million in COVID assistance to 18,393 households, 81% went to ELI households & 94% were people of color. 3)
RESPONSIBLE: OSH, CoC Quality Improvement Manager

2C-2. Length of Time Homeless–Strategy to Reduce.

NOFO Section VII.B.5.c.

<table>
<thead>
<tr>
<th>Describe in the field below:</th>
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</thead>
<tbody>
<tr>
<td>1. your CoC’s strategy to reduce the length of time individuals and persons in families remain homeless;</td>
</tr>
<tr>
<td>2. how your CoC identifies and houses individuals and persons in families with the longest lengths of time homeless; and</td>
</tr>
<tr>
<td>3. provide the name of the organization or position title that is responsible for overseeing your CoC’s strategy to reduce the length of time individuals and families remain homeless.</td>
</tr>
</tbody>
</table>

(limit 2,000 characters)

1) STRATEGIES TO REDUCE: A) High rents & lack of affordable housing are primary barriers to housing. Since 2017: The CoC added over 1,900 new homeless-dedicated units/vouchers; & the County Office of Supportive Housing (OSH) awarded over $546 million of a $950 million aff. housing bond for 35 housing developments, adding 3,056 aff. units, including 1,458 PSH & 387 RRH-dedicated, to be completed by Jan 2025. The housing bond will fund at least 1,740 more aff. units over 7 years. B) In 2020-21, the CoC added 188 units of interim housing to stabilize PH clients during housing search. C) CE prioritizes LOTH & vulnerability. The CoC provides tools & training to reduce time locating clients after CE referral. In 2022, the CoC will launch a HMIS Client Portal to allow clients to update their own contact info & connect directly w/ providers. D) OSH Client Engagement Team conducts outreach to locate clients referred to PSH & documents eligibility to reduce time from referral to enrollment. E) All CoC, ESG, County, & City of San Jose-funded PSH & RRH programs are Housing First, removing barriers for clients w/ long history of homelessness. F) In 2021, the CoC provided free trainings on: Tenant Rights & Fair Housing; Working w/ Clients w/ Criminal Histories; Equal Access & Cultural Competency; RRH Workshop; Working w/ Survivors. G) In 2021, the CoC is expanding Housing Problem Solving w/ flexible funds from COVID shelters & the shelter hotline to all ES & providers, to rapidly resolve housing crises & avoid/shorten ES stays. H) The CoC uses a landlord engagement & incentive program to shorten housing search.

2) ID LONGEST TIME HL: Outreach covers the entire CoC using evidence-based practices (CTI, Harm Reduction, TIC) to reach longest-time homeless. Outreach & CE access points administer VI-SPDAT & enter responses (including time homeless) into HMIS. CE uses County hospital database to ID long-term high utilizers for specialized PSH.

3) RESPONSIBLE: OSH ES, RRH & PSH Program Managers

2C-3. Exits to Permanent Housing Destinations/Retention of Permanent Housing.

NOFO Section VII.B.5.d.

<table>
<thead>
<tr>
<th>Describe in the field below how your CoC will increase the rate that individuals and persons in families residing in:</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. emergency shelter, safe havens, transitional housing, and rapid rehousing exit to permanent housing destinations; and</td>
</tr>
<tr>
<td>2. permanent housing projects retain their permanent housing or exit to permanent housing destinations.</td>
</tr>
</tbody>
</table>

(limit 2,000 characters)
The CoC’s 2020-25 Community Plan to End Homelessness sets a goal to house 20,000 people. 1) ES, TH, RRH: A) Persistent gap between high rents & stagnant wages is a primary barrier to housing. The CoC’s Living Wage Employment Initiative prioritizes RRH & RRH-eligible clients on the CE queue for job training & employment programs. Affordable housing developed with County Housing Bond & other funds includes 387 units set aside for RRH clients, w/ 1,213 more RRH units planned over 7 years. B) In 2021, CoC partners Destination: Home & Somos Mayfair announced a 2-year Guaranteed Income Pilot targeting ELI families & women of color on the RRH queue, to support housing access & stability. C) The CoC’s landlord incentive programs bring in new landlords & retain existing as they have new vacancies. 2015-2020, the All the Way Home vets program engaged 904 new landlords to house 1,940 vets. D) RRH programs offer housing-focused case management from program entry. E) Since 2016, the CoC has expanded housing case management to more ES, to increase exits to PH. F) During COVID-19 PANDEMIC, TH & RRH providers swiftly implemented strategies to help clients to find & maintain housing, e.g. remote CM & subsidy step-down adjustments. F) In 2021, the CoC is expanding Housing Problem Solving w/ flex funds from COVID ES & the shelter hotline to all ES, to rapidly resolve crises & avoid/shorten ES stays. 2) THE COC’S PSH maintains high housing stability (99% in 2020 SPM, +7% from 2019) via Housing First, intensive case management & a no-fail approach. A) Staff trained in evidence-based practices (trauma-informed care, motivational interviewing, harm reduction). B) Meaningful daily activity programs build social supports. C) High-utilizer PSH programs integrate medical & psychiatric services to meet housing & healthcare needs. D) The CoC partners w/ SSA for dedicated SSI advocates, Law Foundation for legal services, Valley Homeless Healthcare Program for dedicated medical team.

2C-4. Returns to Homelessness--CoC’s Strategy to Reduce Rate.

NOFO Section VII.B.5.e.

Describe in the field below:

1. how your CoC identifies individuals and families who return to homelessness;
2. your 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 your CoC’s strategy to reduce the rate of additional returns to homelessness.

(limit 2,000 characters)

Returns decreased w/in 12 mo for ES & SH (ES -3%, SH -2%), & w/in 6 months for SO (-5%). 1) ID HOUSEHOLDS WHO RETURN & COMMON FACTORS: The CoC uses HMIS reports, CE & Homelessness Prevention System (HPS) data to track returns system-wide, by project type, & by subpopulation, & by individual client. The CoC analyzes demographic & service history data to identify common factors across clients who return to homelessness. 2) STRATEGIES: A) Housing case managers build relationship with landlords & support tenants to prevent eviction, aided by CoC-wide trainings on landlord engagement & tenant rights. B) The County Office of Supportive Housing (OSH) & housing providers partner with the Law Foundation for anti-eviction legal services & mediation. C) PSH housing programs offer Housing First no-fail support for clients even after evictions, working with clients to address causes of eviction & find better-fit housing. RESULT: 99% PSH housing stability. D) In
2020, the CoC offered a 6-hour RRH Workshop for provider staff focused on housing stability planning and employment strategies. RRH Workshops are offered annually. E) The CoC’s Living Wage Employment Initiative engages job training & employment partners in living-wage industries to prioritize RRH clients, enhancing stability after RRH ends. F) RRH offers flexible length of assistance responsive to client need, up to 2 yrs. G) For clients fleeing DV, trauma-informed care & prioritizing client choice & safety support housing stability. H) For TAY, Positive Youth Development & trauma-informed care; family reconciliation; GED & diploma programs, vocational training, & higher ed; & diverse housing options (TH, RRH, host homes, PSH) promote long-term stability. J) HPS serves clients who exited homelessness & are at risk of return. K) 10 pts on CoC scoring tool for renewal projects based on returns to homelessness.

2) RESPONSIBLE: County OSH RRH & PSH Program Managers & Destination: Home Director of Employment Strategies

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td>NOFO Section VII.B.5.f.</td>
<td></td>
</tr>
</tbody>
</table>

Describe in the field below:

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

(limit 2,000 characters)

1) The CoC’s strategy to INCREASE EMPLOYMENT INCOME targets full-time living-wage employment. The CoC’s LIVING WAGE EMPLOYMENT INITIATIVE (LWEI) engages job training & employment partner JobTrain to prioritize RRH clients & those in ES, TH & unsheltered for training & employment. The LWEI’s goal is to connect participants “with living-wage employment leading to careers in high-growth industries” such as healthcare, technology, advanced manufacturing, building & construction. JobTrain offers resume support, career exploration, interview skills, job search assistance, & youth-targeted paid work experience, as well as job training in healthcare, construction trades, IT, culinary arts, digital literacy, & financial literacy. In 2021, the CoC added a standard Employment Assessment into HMIS to facilitate assessment & referral of clients for employment services. In June 2021, JobTrain partnered w/ Goodwill of SV to host a job fair targeting people w/ high barriers to employment. In 2020 & 2021, the County of Santa Clara & the City of San Jose (CSJ) expanded employment opportunities for unhoused & formerly unhoused adults w/ RFP/contract incentives, e.g. for shelter hotline, vaccination outreach, & interim housing staffing. 2) The LWEI’s direct partnership w/ a mainstream employment service org allows the CoC to offer comprehensive, coordinated employment services that target the unique needs & barriers of unhoused & newly housed people. Employment & training are targeted to homeless & formerly homeless adults through a contract w/ JobTrain. Housing provider & employment partner staff attend LWEI mtgs for case conferencing & info sharing abt employment opportunities. In addition to formal partnerships, JobTrain maintains connections with local employers & training programs and provides regular updates to housing providers on employment-related resources and opportunities. 3. RESPONSIBLE: County OSH RRH Program
Managers & Destination: Home Director of Employment Strategies


NOFO Section VII.B.5.f.

Describe in the field below how your 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, internships, and employment opportunities for program participants.

(limit 2,000 characters)

1) PRIVATE EMPLOYERS & EMPLOYMENT ORGS: A) The County Office of Supportive Housing (OSH) & non-profit partner Destination: Home coordinate the CoC’s Living Wage Employment Initiative (LWEI), which prioritizes job training for RRH, ES & TH clients & unsheltered adults through a formal partnership w/ JobTrain, a mainstream job training org. LWEI staff invite employers to attend monthly LWEI meetings w/ housing providers & present information about employment opportunities. B) The CoC shares job fairs & job opportunities from private employers via the LWEI & SPN email lists. C) JobTrain cultivates RELATIONSHIPS WITH LOCAL EMPLOYERS & TRAINING PROGRAMS, in order to help clients access job opportunities & provide regular employment-related updates to housing providers. In June 2021, JobTrain partnered w/ Goodwill of SV to host a job fair, w/ virtual & in-person sessions, targeted to people w/ high barriers to employment. D) At annual CoC-wide RRH Workshop trainings & w/ ongoing TA, the CoC trains providers to prioritize income conversations w/ clients & cultivate relationships w/ employers. 2) A) The LWEI provides direct connections to job training in industries w/ living wage & career growth potential, e.g. healthcare, construction, IT, culinary arts, digital literacy, & financial literacy. In 2021, OSH partnered w/ SSA paid work experience program to staff Shelter Hotline w/ people w/ experience being unhoused, w/ opportunity for permanent position w/ hotline operator. B) With support from Destination: Home & OSH, the Lived Experience Advisory Board (LEAB) provides professional development & income opportunities for up to 38 voting & non-voting members, including Board leadership roles, professional skills training, & stipended roles as outreach & system trainers. C) In 2020-21, OSH & the City of San Jose (CSJ) created hiring preferences for unhoused & formerly unhoused adults through RFP/contract incentives (e.g. vaccine outreach, interim housing, & Beautify SJ contracts).

2C-5b. Increasing Non-employment Cash Income.  

NOFO Section VII.B.5.f.

Describe in the field below:

1. your CoC’s strategy to increase non-employment cash income;

2. your CoC’s strategy to increase access to non-employment cash sources; and

3. provide the organization name or position title that is responsible for overseeing your CoC’s strategy to increase non-employment cash income.

(limit 2,000 characters)
1) INCREASING NON-EMPLOYMENT INCOME: A) All housing providers assess clients for benefits eligibility and help clients apply for and maintain federal, state, and local public benefits (SSI, SSDI, GA, VA benefits, TANF, CAPI, etc) B) The CoC offers annual CoC-wide trainings on connecting clients to public benefits co-presented with the local legal aid providers and other benefit-specific specialists. Trainings cover eligibility, application process & best practices, common barriers & problem solving, and peer sharing. In 2021, annual training targeted high-priority training needs identified by the CoC including 1 hour on CalFresh (SNAP) and 3 hours on Medicare, Medi-Cal, and Covered CA. 2) ACCESS TO NON-EMPLOYMENT CASH SOURCES: A) The CoC partners with SSA to provide dedicated SSI advocates for PSH clients. B) In 2018, the County Office of Supportive Housing and SSA partnered to implement the state-funded Homeless Disability Advocacy Program, which co-locates behavioral health clinicians at the GA office for Coordinated Entry intake & help with documentation for SSI applications. Highly vulnerable homeless GA recipients are targeted to HDAP-aligned PSH funds. C) The CoC notifies homeless providers of changes to benefits availability, eligibility, & application requirements via the SPN email list. D) DURING THE COVID-19 PANDEMIC, the CoC provided info to providers on COVID-related stimulus, unemployment benefits, and emergency financial & rental assistance via the 1,060-person Service Providers Network email list and weekly or twice-weekly all-provider calls. E) Coordinated Entry & homeless service providers coordinate with the VA to ensure homeless veterans are identified & assessed for eligibility for VA medical care & benefits

3) RESPONSIBLE: County Office of Supportive Housing PSH Program Managers
3A. Coordination with Housing and Healthcare Bonus Points

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

NOFO Section VII.B.6.a.

Is your CoC applying for a new PSH or RRH project(s) that uses housing subsidies or subsidized housing units which are not funded through the CoC or ESG Programs to help individuals and families experiencing homelessness? Yes

NOFO Section VII.B.6.a.

Select yes or no in the chart below to indicate the organization(s) that provided the subsidies or subsidized housing units for the proposed new PH-PSH or PH-RRH project(s).

<table>
<thead>
<tr>
<th>1. Private organizations</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. State or local government</td>
<td>No</td>
</tr>
<tr>
<td>3. Public Housing Agencies, including use of a set aside or limited preference</td>
<td>Yes</td>
</tr>
<tr>
<td>4. Faith-based organizations</td>
<td>No</td>
</tr>
<tr>
<td>5. Federal programs other than the CoC or ESG Programs</td>
<td>No</td>
</tr>
</tbody>
</table>

NOFO Section VII.B.6.b.

Is your CoC applying for a new PSH or RRH project that uses healthcare resources to help individuals and families experiencing homelessness? No

**NOFO Section VII.B.6.b.**

<table>
<thead>
<tr>
<th>Q1</th>
<th>Did your CoC obtain a formal written agreement that includes: (a) the project name; (b) value of the commitment; and (c) specific dates that healthcare resources will be provided (e.g., 1-year, term of grant, etc.)?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
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</tbody>
</table>

<table>
<thead>
<tr>
<th>Q2</th>
<th>Is project eligibility for program participants in the new PH-PSH or PH-RRH project based on CoC Program fair housing requirements and not restricted by the health care service provider?</th>
</tr>
</thead>
<tbody>
<tr>
<td>No</td>
<td></td>
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</tbody>
</table>


**NOFO Sections VII.B.6.a. and VII.B.6.b.**

If you selected yes to question 3A-1. or 3A-2., use the list feature icon to enter information on each project you intend for HUD to evaluate to determine if they meet the bonus points criteria.

<table>
<thead>
<tr>
<th>Project Name</th>
<th>Project Type</th>
<th>Rank Number</th>
<th>Leverage Type</th>
</tr>
</thead>
<tbody>
<tr>
<td>Immanuel-Sobrato</td>
<td>PSH</td>
<td>7</td>
<td>Housing</td>
</tr>
</tbody>
</table>

1. **What is the name of the new project?** Immanuel-Sobrato Community

2. **Select the new project type:** PSH

3. **Enter the rank number of the project on your CoC’s Priority Listing:** 7

4. **Select the type of leverage:** Housing
3B. New Projects With Rehabilitation/New Construction Costs

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

<table>
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<tbody>
<tr>
<td>NOFO Section VII.B.1.r.</td>
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</table>

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<tbody>
<tr>
<td>NOFO Section VII.B.1.s.</td>
</tr>
</tbody>
</table>

Is your CoC requesting funding for any new project application requesting $200,000 or more in funding for housing rehabilitation or new construction? **No**


<table>
<thead>
<tr>
<th>NOFO Section VII.B.1.s.</th>
</tr>
</thead>
</table>

If you answered yes to question 3B-1, describe in the field below actions CoC Program-funded project applicants will take to comply with:

1. Section 3 of the Housing and Urban Development Act of 1968 (12 U.S.C. 1701u); and
2. HUD’s implementing rules at 24 CFR part 75 to provide employment and training opportunities for low- and very-low-income persons, as well as contracting and other economic opportunities for businesses that provide economic opportunities to low- and very-low-income persons.

(limit 2,000 characters)
3C. Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3C-1. Designating SSO/TH/Joint TH and PH-RRH Component Projects to Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.

NOFO Section VII.C.

Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes?

No

3C-2. Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes. You Must Upload an Attachment to the 4B. Attachments Screen.

NOFO Section VII.C.

If you answered yes to question 3C-1, describe in the field below:

1. how serving this population is of equal or greater priority, which means that it is equally or more cost effective in meeting the overall goals and objectives of the plan submitted under Section 427(b)(1)(B) of the Act, especially with respect to children and unaccompanied youth than serving the homeless as defined in paragraphs (1), (2), and (4) of the definition of homeless in 24 CFR 578.3; and

2. how your CoC will meet requirements described in Section 427(b)(1)(F) of the Act.

(limit 2,000 characters)
4A. DV Bonus Application

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions—essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578


NOFO Section II.B.11.e.

Did your CoC submit one or more new project applications for DV Bonus Funding? Yes

4A-1a. DV Bonus Project Types.

NOFO Section II.B.11.

Select yes or no in the chart below to indicate the type(s) of new DV Bonus project(s) your CoC included in its FY 2021 Priority Listing.

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. SSO Coordinated Entry</td>
<td>No</td>
</tr>
<tr>
<td>2. PH-RRH or Joint TH/RRH Component</td>
<td>Yes</td>
</tr>
</tbody>
</table>

You must click “Save” after selecting Yes for element 1 SSO Coordinated Entry to view questions 4A-3 and 4A-3a.


NOFO Section II.B.11.

1. Enter the number of survivors that need housing or services: 3,200
2. Enter the number of survivors your CoC is currently serving: 1,012
3. Unmet Need: 2,188


NOFO Section II.B.11.

Describe in the field below:

FY2021 CoC Application Page 53 11/12/2021
1. How your CoC calculated the number of DV survivors needing housing or services in question 4A-2 element 1 and element 2; and

2. The data source (e.g. comparable database, other administrative data, external data source, HMIS for non-DV projects); or

3. If your CoC is unable to meet the needs of all survivors please explain in your response all barriers to meeting those needs.

(limit 2,000 characters)

1) ELEMENT ONE includes all survivors needing housing and services, including those the CoC is already serving. In July 2021, 210 people were being served by VSPS within the CoC. An additional 802 people with experience of DV were enrolled in housing projects in HMIS. These are the estimated 1,012 people currently being served in the CoC. Coordinated Entry data is compiled in two lists, the Community Queue in HMIS & a confidential de-identified DV Queue. The Queue in HMIS is linked to HMIS data, allowing the HMIS Lead to run a deduplicated list of 2,188 households active on the Queue as of 11/8/21 with experience of DV (HMIS Data Element 4.11). The DV Queue included XX unique households fleeing DV as of 11/12/21. Some overlap may exist, but, due to underreporting of DV, it’s likely the combined number is still an undercount. In total, there are at least 2,608 people in need of housing services within the CoC. ELEMENT TWO includes the 802 people enrolled in housing projects in HMIS and the 210 people served by VSPS within the CoC in July 2021.

2) Data came from HMIS, Coordinated Entry DV Confidential Queue and VSP databases (both HMIS-comparable and other). 3) Barriers to meeting the needs of all survivors include an expensive and low-vacancy housing market, lack of affordable units, and insufficient resources in the community for case management, services, & subsidies to assist all survivors.

Applicant Name
County of Santa C...
Project Applicants Applying for New PH-RRH and Joint TH and PH-RRH DV Bonus Projects

<table>
<thead>
<tr>
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</thead>
<tbody>
<tr>
<td></td>
<td>NOFO Section II.B.11.</td>
</tr>
</tbody>
</table>

Enter information in the chart below on the project applicant applying for one or more New PH-RRH and Joint TH and PH-RRH Component DV Bonus Projects included on your CoC’s FY 2021 Priority Listing:

<table>
<thead>
<tr>
<th>1. Applicant Name</th>
<th>County of Santa Clara by and through the Office of Supportive Housing</th>
</tr>
</thead>
<tbody>
<tr>
<td>2. Rate of Housing Placement of DV Survivors–Percentage</td>
<td>70.54%</td>
</tr>
<tr>
<td>3. Rate of Housing Retention of DV Survivors–Percentage</td>
<td>96.20%</td>
</tr>
</tbody>
</table>

4A-4a. Calculating the Rate of Housing Placement and the Rate of Housing Retention–Project Applicant Experience.

NOFO Section II.B.11.

Describe in the field below:

1. how the project applicant calculated the rate of housing placement and rate of housing retention reported in question 4A-4; and
2. the data source (e.g. comparable database, other administrative data, external data source, HMIS for non-DV projects).

(limit 1,000 characters)

Housing Placement and Retention data is provided for the applicant, the Santa Clara County Office of Supportive Housing (OSH). 1) HOUSING PLACEMENT: The universe is unique individuals who exited any of the applicant’s RRH programs 10/1/20– 9/30/21 who reported experience of DV (HMIS Data Element 4.11), plus all unique individuals who exited a RRH project jointly operated by OSH and the YWCA during their most recent operating years. Of those clients, the percentage who exited to a permanent destination. HOUSING RETENTION: The universe is unique individuals served in any of the applicant’s PSH programs 10/1/20– 9/30/21 who reported experience of DV. Of those clients, the percentage who exited to a permanent destination during that time period or remained enrolled as of 9/30/21. 2) DATA SOURCE: HMIS and the YWCA’s HMIS-comparable database.

4A-4b. Providing Housing to DV Survivor–Project Applicant Experience.

NOFO Section II.B.11.

Describe in the field below how the project applicant:

1. ensured DV survivors experiencing homelessness were assisted to quickly move into safe affordable housing;
The grant will be administered by OSH, the CoC’s most experienced CoC recipient, and supportive services provided by the YWCA-Golden Gate SV, a VSP with decades of experience serving survivors of sexual assault, trafficking, intimate partner violence & DV. OSH & YWCA-Golden Gate SV currently collaborate on CoC-funded RRH for survivors. 1) To ensure CLIENTS MOVE QUICKLY INTO HOUSING, YWCA-Golden Gate SV brings its core value of empowering survivors w/ a survivor-centered, trauma-informed, Housing First approach. RRH clients complete a Housing Barriers Assessment & work w/ case managers on a housing plan. Housing Specialists build relationships with landlords to ensure access to safe & appropriate housing, assess client housing preferences, educate clients on housing laws & tenant rights, help w/ housing search & applications, & accompany clients to meet landlords. Case managers target housing barriers by assessing eligibility for benefits & offering financial literacy counseling, medical advocacy, help building life skills (driving, meal planning), systems navigation, & transportation. 2) All RRH clients are prioritized & referred through the CoC’s COORDINATED ENTRY SYSTEM. 3) SERVICES at YWCA-Golden Gate SV or by referral target housing barriers & include job training & employment; mental health & primary medical care; credit repair; direct services for kids & parenting support; emotional support for assault & trauma; links to civil, family, & immigration law services; & ESL classes. Service participation is client-driven & voluntary, & staff are trained in Motivational Interviewing. 4) YWCA-Golden Gate SV prioritizes LONG-TERM STABILITY for clients through employment support, including childcare & job training, benefits assessment, & connections to YWCA-SV & other community resources that continue after RRH assistance ends. RRH clients are offered connections the CoC’s Living Wage Employment Initiative, which prioritizes RRH clients for living-wage job training.

Describe in the field below examples of how the project applicant ensured the safety of DV survivors experiencing homelessness by:

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

Safety is a primary focus of all YWCA-Golden Gate SV services, including the
RRH that it operates in collaboration with OSH, and its emergency housing, counseling, advocacy, and 24/7 crisis response. 1) All RRH staff have completed a 75-hr STATE CERTIFIED DV & SEXUAL ASSAULT COUNSELOR TRAINING plus on-going in-house training covering SAFETY PLANNING, a danger assessment tool, trauma informed care, survivor-defined advocacy, cultural humility, confidentiality, harm reduction, housing. 2) Intake is conducted in a PRIVATE ROOM with a trained DV & sexual assault counselor. 3) If a household includes a couple, assessment and intake are conducted separately with each member of the couple. 4) Safety planning begins at first contact with the Domestic Violence Advocacy Consortium member that refers the client to Coordinated Entry & a warm handoff to YWCA-Golden Gate SV ensures safety plan continuity. Legal Services Specialists help obtain TROs and protective orders, when desired by the client. During housing planning, case managers work with clients to identify safety factors (location, type of unit and building, and physical safety features) and to identify units that meet the client’s safety needs. CMs check in regularly w/ clients and track client perception of safety. Services are recorded in confidential client files under double lock and in a secure HMIS-comparable database. 5) All of YWCA-Golden Gate SV’s physical locations are designed to protect safety and privacy, with locked entrance gates, access badges, alarms, security cameras, lighting, and confidential emergency housing locations. Over 5 years, the YWCA-Golden Gate SV has invested over $50K in security improvements across all physical sites. 6) A written protocol ensures confidentiality of all info, including addresses of congregate and scattered-site units, from collection to destruction. Services are recorded in confidential client files under double lock and in a secure HMIS-comparable database.

4A-4c.1. Evaluating Ability to Ensure DV Survivor Safety–Project Applicant Experience.

NOFO Section II.B.11.

Describe in the field below how the project evaluated its ability to ensure the safety of DV survivors the project served.

(limit 2,000 characters)

Survivor safety is a high priority for all YWCA-Golden Gate SV services and housing programs, and it is ensured during & after assistance through safety planning, survivor-centered housing search/services, & data privacy safeguards. The YWCA-Golden Gate SV continually evaluates its ability to ensure survivor safety in several ways: WHILE SURVIVORS ARE ENROLLED, safety planning and progress are tracked in a secure database, and trained Certified DV & Sexual Assault Counselors check in regularly with clients, track survivor perception of safety, and adjust safety plans for clients on a regular basis dependent on their needs and situation. This data is used to evaluate success in ensuring safety of clients during enrollment. In response to incidents impacting client safety, YWCA-Golden Gate SV conducts lethality assessments and responds swiftly, in collaboration with law enforcement as necessary depending on the severity of the risk. Incidents are tracked and responses are reviewed for efficacy and to improve future safety planning.
NOFO Section II.B.11.

Describe in the field below examples of the project applicant’s experience in using trauma-informed, victim-centered approaches to meet needs of DV survivors in each of the following areas:

<p>| | | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1.</td>
<td>prioritizing program participant choice and rapid placement</td>
<td>and stabilization in permanent housing consistent with participants’ preferences;</td>
</tr>
<tr>
<td>2.</td>
<td>establishing and maintaining an environment of agency and</td>
<td>mutual respect, e.g., the project does not use punitive</td>
</tr>
<tr>
<td></td>
<td>mutual respect, e.g., the project does not use punitive</td>
<td>interventions, ensures program participant staff interactions are</td>
</tr>
<tr>
<td></td>
<td>interventions, ensures program participant staff interactions</td>
<td>based on equality and minimize power differentials;</td>
</tr>
<tr>
<td></td>
<td>are based on equality and minimize power differentials;</td>
<td></td>
</tr>
<tr>
<td>3.</td>
<td>providing program participants access to information on</td>
<td>trauma, e.g., training staff on providing program</td>
</tr>
<tr>
<td></td>
<td>trauma, e.g., training staff on providing program</td>
<td>participants with information on trauma;</td>
</tr>
<tr>
<td></td>
<td>participants with information on trauma;</td>
<td></td>
</tr>
<tr>
<td>4.</td>
<td>emphasizing program participants’ strengths, e.g., strength-</td>
<td>based coaching, questionnaires and assessment tools include</td>
</tr>
<tr>
<td></td>
<td>based coaching, questionnaires and assessment tools</td>
<td>strength-based measures, case plans include assessments of</td>
</tr>
<tr>
<td></td>
<td>include strength-based measures, case plans include</td>
<td>program participants strengths and works towards goals and</td>
</tr>
<tr>
<td></td>
<td>assessments of program participants strengths and works</td>
<td>aspirations;</td>
</tr>
<tr>
<td></td>
<td>towards goals and aspirations;</td>
<td></td>
</tr>
<tr>
<td>5.</td>
<td>centering on cultural responsiveness and inclusivity, e.g.,</td>
<td>training on equal access, cultural competence, nondiscrimination;</td>
</tr>
<tr>
<td></td>
<td>training on equal access, cultural competence,</td>
<td></td>
</tr>
<tr>
<td></td>
<td>nondiscrimination;</td>
<td></td>
</tr>
<tr>
<td>6.</td>
<td>providing opportunities for connection for program</td>
<td>participants, e.g., groups, mentorships, peer-to-peer,</td>
</tr>
<tr>
<td></td>
<td>participants, e.g., groups, mentorships, peer-to-peer,</td>
<td>spiritual needs; and</td>
</tr>
<tr>
<td></td>
<td>spiritual needs; and</td>
<td></td>
</tr>
<tr>
<td>7.</td>
<td>offering support for parenting, e.g., parenting classes,</td>
<td>childcare.</td>
</tr>
<tr>
<td></td>
<td>childcare.</td>
<td></td>
</tr>
</tbody>
</table>

(limit 5,000 characters)

The YWCA-Golden Gate SV has decades of experience serving survivors of sexual assault, human trafficking, intimate partner violence & DV in the CoC & brings its core value of empowering survivors to all of its RRH programs with a survivor-centered, trauma-informed, Housing First approach. All RRH staff are certified Confidential DV Counselors & have completed a 75-hr State Certified DV & Sexual Assault Counselor training plus on-going in-house training, covering trauma informed care, survivor-defined advocacy, cultural humility, safety planning, confidentiality, harm reduction, & housing. Safety planning, housing planning, and selection of services are survivor-led, with support from DV & Sexual Assault counselors trained in evidence-based trauma-informed approaches and Motivational Interviewing. 1) Using these best practice and survivor-led approaches, survivors are empowered to choose the services and housing options they feel meet their needs, including full client choice in service participation and to direct the housing search to find a scattered-site permanent unit that meets their needs. The YWCA- Golden Gate SV respects participants as the experts on their own lives and staff are trained to use motivational interviewing to assist survivors to explore their goals and create their own service and housing plans. 2 & 4) The YWCA-Golden Gate SV practices Survivor-Defined Advocacy, where self-determination and choice are prioritized and the means to empowerment. Program staff are trained to recognize the unique importance of autonomy, empowerment, and respect in the trauma recovery and healing process. Staff believe and affirm a survivor’s experience, respect confidentiality, acknowledge injustice, respect autonomy, promote access to resources and help plan for safety, rather than act as the expert. The survivor and the advocate are partners; they work together to identify strengths and existing resources, and the survivor’s experience and choices are validated, their network and resources acknowledged and expanded, and issues are understood within a sociopolitical context. This approach helps mitigate the power differential between the service provider and survivor, while focusing on each client’s strengths and ability to determine for themselves the best path to healing. 3) Training for program staff includes extensive information about the impacts of trauma and the experience of recovery from trauma, which staff share with clients to ensure they are informed and empowered leaders in identifying their own needs and goals. Trauma-informed behavioral health
services are available to all clients to support this process. 5) The YWCA-Golden Gate SV’s mission is to eliminate racism and empower women and this mission guides the organization’s culturally responsive approaches. 75-hr State Certified DV & Sexual Assault Counselor training and ongoing follow-up training for all program staff covers cultural humility and responsiveness. At least yearly trainings on Equal Access and on Fair Housing protections are provided by OSH and were attended by YWCA staff in 2020/21. 6) Program staff work with survivors to identify their needs and goals for community connection and peer support. YWCA-Golden Gate SV facilitates survivor support groups, with a range of topics, including: healing from trauma, building life skills, self-care, wellness, among others. Staff help survivors identify community and faith groups, school activities, and other opportunities for connection within the survivor’s chosen neighborhood or community, and work with survivors to identify and mitigate any safety concerns or transportation barriers 7) Services provided in-house at YWCA-Golden Gate SV and available to all RRH clients include direct services for kids, parenting support and parenting classes, and childcare. Staff remain up to date on all sources of subsidized, affordable, and mainstream childcare in the community.

---

4A-4e. Meeting Service Needs of DV Survivors—Project Applicant Experience.

NOFO Section II.B.11.

Describe in the field below:

| 1. | supportive services the project applicant provided to domestic violence survivors experiencing homelessness while quickly moving them into permanent housing and addressing their safety needs; and |
| 2. | provide examples of how the project applicant provided the supportive services to domestic violence survivors. |

(limit 5,000 characters)

1) YWCA-Golden Gate SV clients have access to services to meet their specific need, including safety planning; housing search; case management; job training & employment opportunities; education; mental health services; primary medical care; credit repair & financial education; childcare & parenting support; civil, family, & immigration legal services; and help with TROs & protective orders. All housing search, case management, and other in-house services are provided by certified Confidential DV Counselors with 65+ hours of State Certified DV & Sexual Assault Counselor training, who can leverage both CoC & DV system resources. Case managers assess eligibility for benefits & offer financial literacy counseling, medical advocacy, help building life skills (driving, meal planning), systems navigation, & transportation. The YWCA provides the following services in-house: Assessment of Service Needs; Assistance with Moving Costs; Case Management; Childcare; Education Services; Employment Assistance; Food; Housing Search; Counseling Services; Legal Services; Mental Health Services; Outreach Services; Transportation; Utility Deposits. Other services are available through referral to other organizations specializing in serving survivors: Asian Americans for Community Involvement; Community Solutions; Santa Clara County’s Victim Witness Assistance Program. The following services are provided through referral to mainstream providers: San Jose PD (public safety and legal services); Santa Clara County District Attorney’s Office (legal services); Valley Medical Center (health services); Santa Clara County Superior Court (legal services). 2) As a result of the COVID 19 pandemic, the YWCA Golden Gate SV had to pivot its delivery options for
providing support services to survivors in a virtual space. Since the start of the pandemic, the YWCA Golden Gate SV had an increase of calls to our crisis support line of 36% compared to same period pre-pandemic. The YWCA Golden Gate SV responded to an over 400% increase in demand for emergency housing for survivors. There was no reduction in the services survivors received during the pandemic; in fact interaction between case managers and clients was strengthened during this time period because of the increased need for support services that clients were requesting. Survivors were provided options to interface with their case managers through virtual meetings or limited in person meetings. In-house services were provided in the safest and most accessible manner available, with an emphasis on client choice and safety, and case managers assisted clients to navigate benefits, employment, medical, and other resources in the community as access changed during the pandemic. The YWCA Golden Gate SV worked with landlords to identify alternative options for housing searches and securing housing for clients during the pandemic, to reduce the risk to survivors and our community. In response to long wait times at heavily impacted local legal services providers, the YWCA Golden Gate SV was able to utilize in-house legal services to meet increased demand.


Provide examples in the field below of how the new project will:

1. prioritize program participant choice and rapid placement and stabilization in permanent housing consistent with participants’ preferences;
2. establish and maintain 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; 
3. provide program participants access to information on trauma, e.g., training staff on providing program participants with information on trauma;
4. place emphasis on program participants’ strengths, e.g., 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;
5. center on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;
6. provide opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and
7. offer support for parenting, e.g., parenting classes, childcare.

(limit 5,000 characters)

This application will expand an existing CoC-funded RRH project for people fleeing domestic violence and human trafficking and will continue to align with the YWCA-Golden Gate SV’s core value of empowering survivors with a survivor-centered, trauma-informed, Housing First approach. All staff will be certified Confidential DV Counselors & complete a 75-hr State Certified DV & Sexual Assault Counselor training plus on-going in-house training, covering trauma informed care, survivor-defined advocacy, cultural humility, safety planning, confidentiality, harm reduction, & housing. 1) Using the best practice and survivor-led approaches that OSH and the YWCA-Golden Gate SV implement in existing projects, clients will be empowered to choose the services and housing options they feel meet their needs, including full client choice in service participation and to direct the housing search to find a scattered-site
permanent unit that meets their needs. The YWCA-Golden Gate SV respects participants as the experts on their own lives and staff will be trained to use motivational interviewing to assist survivors to explore their goals and create their own service and housing plans. 2 & 4) The YWCA-Golden Gate SV practices Survivor-Defined Advocacy, where self-determination and choice are prioritized and the means to empowerment. Program staff will be trained to recognize the unique importance of autonomy, empowerment, and respect in the trauma recovery and healing process. Staff believe and affirm a survivor's experience, respect confidentiality, acknowledge injustice, respect autonomy, promote access to resources and help plan for safety, rather than act as the expert. The survivor and the advocate are partners, they work together to identify strengths and existing resources, and the survivor’s experience and choices are validated, their network and resources acknowledged and expanded, and issues are understood within a sociopolitical context. This approach helps mitigate the power differential between the service provider and survivor, while focusing on each client’s strengths and ability to determine for themselves the best path to healing. 3) Training for program staff will include extensive information about the impacts of trauma and the experience of recovery from trauma, which staff will share with clients to ensure they are informed and empowered leaders in identifying their own needs and goals. Trauma-informed behavioral health services will be available to all clients to support this process. 5) The YWCA-Golden Gate SV’s mission is to eliminate racism and empower women, and this mission will guide the expansion project’s culturally responsive approaches. 75-hr State Certified DV & Sexual Assault Counselor training and ongoing follow-up training for all program staff will cover cultural humility and responsiveness. At least yearly trainings on Equal Access and on Fair Housing protections are provided by OSH. 6) Program staff will work with survivors to identify their needs and goals for community connection and peer support. YWCA-Golden Gate SV facilitates survivor support groups, with a range of topics, including: healing from trauma, building life skills, self-care, wellness, among others. Staff will help survivors identify community and faith groups, school activities, and other opportunities for connection within the survivor’s chosen neighborhood or community, and work with survivors to identify and mitigate any safety concerns or transportation barriers. 7) Services provided in-house at YWCA-Golden Gate SV, which will be available to all expansion project clients, include direct services for kids, parenting support and parenting classes. Staff will remain up to date on all sources of subsidized, affordable, and mainstream childcare in the community.
4B. Attachments Screen For All Application Questions

We prefer that you use PDF files, though other file types are supported. Please only use zip files if necessary.

Attachments must match the questions they are associated with.

Only upload documents responsive to the questions posed—including other material slows down the review process, which ultimately slows down the funding process.

We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Required?</th>
<th>Document Description</th>
<th>Date Attached</th>
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<tbody>
<tr>
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<td>CE Assessment Tool</td>
<td>11/08/2021</td>
</tr>
<tr>
<td>1C-7. PHA Homeless Preference</td>
<td>No</td>
<td>PHA Homeless Pref...</td>
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<tr>
<td>1C-7. PHA Moving On Preference</td>
<td>No</td>
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<td>1E-1. Local Competition Announcement</td>
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<td>1E-2. Project Review and Selection Process</td>
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<td>1E-6. Web Posting–CoC-Approved Consolidated Application</td>
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<td>3A-1a. Housing Leveraging Commitments</td>
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<tr>
<td>3A-2a. Healthcare Formal Agreements</td>
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<td></td>
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<tr>
<td>3C-2. Project List for Other Federal Statutes</td>
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Attachment Details

Document Description: Public Posting-Projects Accepted

Attachment Details

Document Description:

Attachment Details

Document Description: Housing Leveraging Commitments

Attachment Details

Document Description:
Submission Summary

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

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<td>1B. Inclusive Structure</td>
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<td>1C. Coordination</td>
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<td>1C. Coordination continued</td>
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<td>1D. Addressing COVID-19</td>
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<td>1E. Project Review/Ranking</td>
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<td>2B. Point-in-Time (PIT) Count</td>
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<td>2C. System Performance</td>
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<td>3A. Housing/Healthcare Bonus Points</td>
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<td>3B. Rehabilitation/New Construction Costs</td>
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<tr>
<td>3C. Serving Homeless Under Other Federal Statutes</td>
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## ATTACHMENT: CE Assessment Tool

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<td>Santa Clara County Transition Age Youth VI-SPDAT</td>
<td>17–23</td>
</tr>
<tr>
<td>Santa Clara County VI-SPDAT for Justice Discharges</td>
<td>24–30</td>
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Santa Clara County VI-SPDAT for Single Adults

This packet includes:

- Local Instructions & Script for using the VI-SPDAT
- VI-SPDAT for Single Adults
- Additional Questions for assessing Program Eligibility

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

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.0

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1 (800) 355-3420 info@orgcode.com www.orgcode.com
Santa Clara County VI-SPDAT Instructions

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2. Upload a Signed Client Consent Form into HMIS: No information, including the VI-SPDAT, may be entered into HMIS until a signed client consent form (aka Release of Information or ROI) is uploaded into HMIS.

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1. Select the appropriate version of the VI-SPDAT:
   a. VI-SPDAT for Single Adults – Use this version for adults age 25 or older with no children in the household.
   b. VI-SPDAT for Families – Use this version for households with at least one child under the age of 18.
   c. TAY VI-SPDAT – Use this version for transition age youth (age 18-24) and unaccompanied minors.

2. Introduce the VI-SPDAT: Explain to the client what you are doing using the introductory script on the next page.

3. Complete All Questions: Complete the VI-SPDAT and follow-up questions, including the additional questions on the last page of this packet.

4. Enter the VI-SPDAT in HMIS: You can find the VI-SPDAT under the Assessments tab in the menu bar at the top of the screen in HMIS. This is a universal assessment that is not connected to any specific program.
   a. If the Assessment Score is 4 or Higher: Refer the assessment to the community queue in HMIS.

After Completing the VI-SPDAT:
1. Collect Contact Information: Collect as much contact information as possible (phone, email, service provider or case manager that the individual/family works with, locations that they frequent, etc.). It is critical that we have as much contact information as possible in case any referrals become available for the individual/family. Ask them to come back and update their contact information if it changes.

2. Share information with the individual/family: Do NOT share the numerical score from the VI-SPDAT. If the person is interested, you can provide an explanation of the type of housing program that looks like the best fit for the individual/family.

3. If the score falls into the “no housing intervention” category (0-3): Explain that the assessment shows that they have the skills and ability to get back into housing with limited assistance. Refer the individual/family to resources in the community that will help them address barriers, such as: public benefits, employment programs, security deposit assistance, etc.
Santa Clara County Introductory Script:

I am going to go through a short survey with you that will provide us with more information about your situation. The answers will help us determine how we can best support you. Some of the survey questions are personal in nature, but they only require a Yes/No or one word answer. I really only need that one word answer. You don’t need to feel any pressure to provide more detail. You can also skip or refuse to answer any question. Skipping multiple questions may make it harder for us to identify services for you, but it is your right to refuse to answer questions you don’t feel comfortable with.

Please do your best to answer all of the questions as honestly and accurately as possible. Honest, accurate answers are important to help us identify the right services for you. In addition, if we are able to refer you to any services based on the information in this survey, that program will still need to verify all eligibility information. So, if your answers aren’t honest, it could prevent you from being accepted into a program.

The information that I collect with this survey will be stored in HMIS along with the rest of the intake information you provided. Sometimes we are able to identify services that might be a good match for you based on the information you provide. If that happens we will try to contact you, so it’s really important that you provide current contact information. This could include phone numbers, locations you frequent, case managers or organizations that you work with, or any other information that might help us find you.

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

Single Adults – American Version 2.0

The VI-SPDAT is created and copyrighted by OrgCode Consulting, Inc. and Community Solutions (Copyright 2015). The VI-SPDAT is used in Santa Clara County by permission of OrgCode Consulting, Inc. Please do not alter any of the questions, including the order in which they are asked. For more information about the VI-SPDAT or OrgCode visit www.orgcode.com. Please complete all questions. The VI-SPDAT will be scored automatically when it is entered into HMIS.

Date: ______________________

Name & Phone # of Staff Person Completing the VI-SPDAT: ________________________________

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: ________ -- ________ -- ________ □ Don’t Have/Don’t Know □ Refused

Consent to participate? □ Yes □ No

VI-SPDAT – Single Adults
SCC Packet – 12/15/16
SCORED DOMAINS

A. HISTORY OF HOUSING AND HOMELESSNESS

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

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

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 offense, or anything in between? _________ □ Refused

5. Have you been attacked or beaten up since you’ve become homeless? □ YES □ NO □ Refused

6. Have you threatened to or tried to harm yourself or anyone else in the last year? □ YES □ NO □ Refused

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? □ YES □ NO □ Refused

8. Does anybody force or trick you to do things that you do not want to do? □ YES □ NO □ 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? □ YES □ NO □ Refused

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? □ YES □ NO □ 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? □ YES □ NO □ Refused

12. Do you have any planned activities, other than just surviving, that make you feel happy and fulfilled? □ YES □ NO □ Refused

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? □ YES □ NO □ Refused

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? □ YES □ NO □ Refused

D. WELLNESS

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? □ YES □ NO □ Refused

16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? □ YES □ NO □ 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? □ YES □ NO □ 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? □ YES □ NO □ Refused

19. When you are sick or not feeling well, do you avoid getting help? □ YES □ NO □ Refused

20. **FOR FEMALE RESPONDENTS ONLY:** Are you currently pregnant? □ YES □ NO □ Refused

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? □ YES □ NO □ Refused
22. Will drinking or drug use make it difficult for you to stay housed or afford your housing?  
☐ YES  ☐ NO  ☐ Refused

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?  
      ☐ YES  ☐ NO  ☐ Refused
   b. A past head injury?  
      ☐ YES  ☐ NO  ☐ Refused
   c. A learning disability, developmental disability, or other impairment?  
      ☐ YES  ☐ NO  ☐ 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?  
☐ YES  ☐ NO  ☐ Refused

25. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking?  
☐ YES  ☐ NO  ☐ Refused

26. Are there any medications like painkillers that you don’t take the way the doctor prescribed or where you sell the medication?  
☐ YES  ☐ NO  ☐ Refused

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?  
☐ YES  ☐ NO  ☐ Refused

**CONTACT INFORMATION:**

Please enter all contact information at the end of the VI-SPDAT in HMIS. In addition, please update contact information in the Location Tab in HMIS. COMPLETE AND UP TO DATE CONTACT INFORMATION IS CRITICAL TO MAKE SURE PEOPLE CAN BE FOUND WHEN A HOUSING REFERRAL IS AVAILABLE!

On a regular day, where is it easiest to find you and what time of day is easiest to do so?

   Where:

   When:

Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?

   Phone:  
   Email:

Is there someone that you trust and communicate with regularly that we can contact when we look for you? (Please include name and phone number if possible)

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
Santa Clara County – Additional Questions:

Please complete the following additional questions. These questions are not part of the VI-SPDAT assessment; however, they may be used to identify programs for which the individual or household might be eligible. Please note that documentation will be required to verify eligibility if an individual or household is referred to a program based on responses to these questions.

1. Are you a veteran? □ Yes □ No □ Don’t Know □ Refused
   a. If yes, which military service era did you serve in?
      □ Post September 11th (September 11, 2001 – Present)
      □ Vietnam Era (August 1968 – April 1975)
      □ Between Korean and Vietnam Wars (February 1955 – July 1964)
      □ Korean War (June 1950 – January 1955)
      □ Between WWII and Korean War (August 1947 – May 1950)
      □ WWII Era (September 1940 – July 1947)
      □ Don’t Know
      □ Refused
   b. If yes, what is your discharge status?
      □ Honorable □ General under Honorable Conditions
      □ Bad Conduct □ Under other than Honorable Conditions (OTH)
      □ Dishonorable □ Uncharacterized
      □ Don’t Know □ Refused

2. How many total years have you been homeless? ____________________________________________

3. Which city did you live in prior to becoming homeless? ________________________________

4. If you are employed, in which city is your work place? __________________________________

5. If you go to school, in which city is your school? ________________________________

6. In which city do you spend most of your time? __________________________________________

7. Have you ever been in foster care? □ Yes □ No □ Don’t Know □ Refused

8. Have you ever been in jail? □ Yes □ No □ Don’t Know □ Refused

9. Have you ever been in prison? □ Yes □ No □ Don’t Know □ Refused

10. Do you have a permanent physical disability that limits your mobility? (i.e. wheelchair, amputation, unable to climb stairs?) □ Yes □ No □ Don’t Know □ Refused

11. What type of health insurance do you have, if any?
    □ Medicaid □ Private Insurance
    □ Medicare □ No Health Insurance
    □ VA Medical □ Other

VI-SPDAT – Single Adults
SCC Packet – 12/15/16
Page 7 of 7
Santa Clara County VI-SPDAT for Families with Children

This packet includes:

- Local Instructions & Script for using the VI-SPDAT
- VI-SPDAT for Families with Children
- Additional Questions for assessing Program Eligibility

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

Prescreen Triage Tool for Families

AMERICAN VERSION 2.0

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Please do your best to answer all of the questions as honestly and accurately as possible. Honest, accurate answers are important to help us identify the right services for you. In addition, if we are able to refer you to any services based on the information in this survey, that program will still need to verify all eligibility information. So, if your answers aren’t honest, it could prevent you from being accepted into a program.

The information that I collect with this survey will be stored in HMIS along with the rest of the intake information you provided. Sometimes we are able to identify services that might be a good match for you based on the information you provide. If that happens we will try to contact you, so it’s really important that you provide current contact information. This could include phone numbers, locations you frequent, case managers or organizations that you work with, or any other information that might help us find you.

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

Families with Children – American Version 2.0

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Date: ______________________

Name & Phone # of Staff Person Completing the VI-SPDAT: ______________________

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: ________ -- -- ______________________ □ Don’t Have/Don’t Know □ Refused

Consent to participate? □ Yes □ No
**PARENT 2:**

**First Name:** __________________________  **Nickname:** __________________________

**Last Name:** __________________________

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

**Date of Birth:** _____ / _____ / _________  **Age:** _________

**Social Security Number:** _______ -- _______ -- ___________  □ Don’t Have/Don’t Know  □ Refused

**Consent to participate?** □ Yes □ No

### 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?** □ YES □ NO □ Refused

4. **Please provide a list of children’s names and ages:**

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<th>First Name:</th>
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SCORED DOMAINS

A. HISTORY OF HOUSING AND HOMELESSNESS

5. Where do you and your family sleep most frequently? (Check One)
   □ Shelters   □ Safe Haven   □ Other (specify): _____________________________
   □ Transitional Housing   □ Outdoors   □ Refused

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

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 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 offense, or anything in between? __________ □ Refused

9. Have you or anyone in your family been attacked or beaten up since they’ve become homeless? □ YES □ NO □ Refused

10. Have you or anyone in your family threatened to or tried to harm themself or anyone else in the last year? □ YES □ NO □ Refused

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? □ YES □ NO □ Refused

12. Does anybody force or trick you or anyone in your family to do things that you do not want to do? □ YES □ NO □ 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?

☐ YES ☐ NO ☐ Refused

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?

☐ YES ☐ NO ☐ 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?

☐ YES ☐ NO ☐ Refused

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

☐ YES ☐ NO ☐ Refused

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?

☐ YES ☐ NO ☐ Refused

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?

☐ YES ☐ NO ☐ Refused

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?

☐ YES ☐ NO ☐ Refused

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

☐ YES ☐ NO ☐ 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?

☐ YES ☐ NO ☐ 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?

☐ YES ☐ NO ☐ Refused

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

☐ YES ☐ NO ☐ Refused
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?  
☐ YES ☐ NO ☐ Refused

25. Will drinking or drug use make it difficult for your family to stay housed or afford your housing?  
☐ YES ☐ NO ☐ Refused

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:
   g. A mental health issue or concern?  ☐ YES ☐ NO ☐ Refused
   h. A past head injury?  ☐ YES ☐ NO ☐ Refused
   i. A learning disability, developmental disability, or other impairment?  ☐ YES ☐ NO ☐ 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?  
☐ YES ☐ NO ☐ Refused

28. Does any single member of your household have a medical condition, mental health concerns, AND experience with substance use?  
☐ YES ☐ NO ☐ Refused

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?  
☐ YES ☐ NO ☐ 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?  
☐ YES ☐ NO ☐ Refused

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?  
☐ YES ☐ NO ☐ Refused

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?  
☐ YES ☐ NO ☐ 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?  
☐ YES ☐ NO ☐ Refused

34. In the last 180 days have any children lived with family or friends because of your homelessness or housing situation?  
☐ YES ☐ NO ☐ Refused
35. Has any child in the family experienced abuse or trauma in the last 180 days?  □ YES  □ NO  □ Refused

36. **IF THERE ARE SCHOOL-AGED CHILDREN:** Do your children attend school more often than not each week?  □ YES  □ NO  □ N/A or Refused

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?  □ YES  □ NO  □ Refused

38. Do you anticipate any other adults or children coming to live with you within the first 180 days of being housed?  □ YES  □ NO  □ Refused

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?  □ YES  □ NO  □ 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?  □ YES  □ NO  □ Refused
   b. 2 or more hours per day for children aged 12 or younger?  □ YES  □ NO  □ 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?  □ YES  □ NO  □ Refused

**CONTACT INFORMATION:**

Please enter all contact information at the end of the VI-SPDAT in HMIS. In addition, please update contact information in the Location Tab in HMIS. COMPLETE AND UP TO DATE CONTACT INFORMATION IS CRITICAL TO MAKE SURE PEOPLE CAN BE FOUND WHEN A HOUSING REFERRAL IS AVAILABLE!

On a regular day, where is it easiest to find you and what time of day is easiest to do so?

*Where:*  
*When:*  

Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?

*Phone:*  
*Email:*  

Is there someone that you trust and communicate with regularly that we can contact when we look for you? (Please include name and phone number if possible)

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
Santa Clara County – Additional Questions:

Please complete the following additional questions. These questions are not part of the VI-SPDAT assessment; however, they may be used to identify programs for which the individual or household might be eligible. Please note that documentation will be required to verify eligibility if an individual or household is referred to a program based on responses to these questions.

1. Are you a veteran? □ Yes □ No □ Don’t Know □ Refused
   
   a. If yes, which military service era did you serve in?
      □ Post September 11th (September 11, 2001 – Present)
      □ Between Korean and Vietnam Wars (February 1955 – July 1964)
      □ Korean War (June 1950 – January 1955)
      □ Between WWII and Korean War (August 1947 – May 1950)
      □ WWII Era (September 1940 – July 1947)
      □ Don’t Know
      □ Refused
   
   b. If yes, what is your discharge status?
      □ Honorable □ General under Honorable Conditions
      □ Bad Conduct □ Under other than Honorable Conditions (OTH)
      □ Dishonorable □ Uncharacterized
      □ Don’t Know □ Refused

2. How many total years have you been homeless? _____________________________

3. Which city did you live in prior to becoming homeless? _______________________

4. If you are employed, in which city is your work place? _______________________

5. If you (or your children) go to school, in which city is the school? _______________

6. In which city do you spend most of your time? _________________________________

7. Have you ever been in foster care? □ Yes □ No □ Don’t Know □ Refused

8. Have you ever been in jail? □ Yes □ No □ Don’t Know □ Refused

9. Have you ever been in prison? □ Yes □ No □ Don’t Know □ Refused

10. Do you have a permanent physical disability that limits your mobility? (i.e. wheelchair, amputation, unable to climb stairs?) □ Yes □ No □ Don’t Know □ Refused

11. What type of health insurance do you have, if any?
      □ Medicaid □ Private Insurance
      □ Medicare □ No Health Insurance
      □ VA Medical □ Other
Santa Clara County Transition Age Youth VI-SPDAT

This packet includes:

- Local Instructions & Script for using the TAY-VI-SPDAT
- TAY-VI-SPDAT for Transition Age Youth (ages 18-24)
- Additional Questions for assessing Program Eligibility

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

“Next Step Tool for Homeless Youth”

AMERICAN VERSION 1.0

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COMMUNITY SOLUTIONS  CSH  USC SCHOOL OF SOCIAL WORK

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Santa Clara County VI-SPDAT Instructions

Before Completing the VI-SPDAT:

1. Check in HMIS to see if the individual/family has already completed a VI-SPDAT by looking under the Assessments Tab.

2. Upload a Signed Client Consent Form into HMIS: No information, including the VI-SPDAT, may be entered into HMIS until a signed client consent form (aka Release of Information or ROI) is uploaded into HMIS.

Completing the VI-SPDAT:

1. Select the appropriate version of the VI-SPDAT:
   a. VI-SPDAT for Single Adults – Use this version for adults age 25 or older with no children in the household.
   b. VI-SPDAT for Families – Use this version for households with at least one child under the age of 18.
   c. TAY-VI-SPDAT – Use this version for transition age youth (age 18-24) and unaccompanied minors.

2. Introduce the VI-SPDAT: Explain to the client what you are doing using the introductory script on the next page.

3. Complete All Questions: Complete the VI-SPDAT and follow-up questions, including the additional questions on the last page of this packet.

4. Enter the VI-SPDAT in HMIS: You can find the VI-SPDAT under the Assessments tab in the menu bar at the top of the screen in HMIS. This is a universal assessment that is not connected to any specific program.
   a. If the assessment score is 4 or higher: Refer the assessment to the community queue in HMIS.

After Completing the VI-SPDAT:

1. Collect Contact Information: Collect as much contact information as possible (phone, email, service provider or case manager that the individual/family works with, locations that they frequent, etc.). It is critical that we have as much contact information as possible in case any referrals become available for the individual/family. Ask them to come back and update their contact information if it changes.

2. Share information with the individual/family: Do NOT share the numerical score from the VI-SPDAT. If the person is interested, you can provide an explanation of the type of housing program that looks like the best fit for the individual/family.

3. If the score falls into the “no housing intervention” category: Explain that the assessment shows that they have the skills and ability to get back into housing with limited assistance. Refer the individual/family to resources in the community that will help them address barriers, such as: public benefits, employment programs, security deposit assistance, etc.
**Santa Clara County Introductory Script:**

I am going to go through a short survey with you that will provide us with more information about your situation. The answers will help us determine how we can best support you. Some of the survey questions are personal in nature, but they only require a Yes/No or one word answer. I really only need that one word answer. You don’t need to feel any pressure to provide more detail. You can also skip or refuse to answer any question. Skipping multiple questions may make it harder for us to identify services for you, but it is your right to refuse to answer questions you don’t feel comfortable with.

Please do your best to answer all of the questions as honestly and accurately as possible. Honest, accurate answers are important to help us identify the right services for you. In addition, if we are able to refer you to any services based on the information in this survey, that program will still need to verify all eligibility information. So, if your answers aren’t honest, it could prevent you from being accepted into a program.

The information that I collect with this survey will be stored in HMIS along with the rest of the intake information you provided. Sometimes we are able to identify services that might be a good match for you based on the information you provide. If that happens we will try to contact you, so it’s really important that you provide current contact information. This could include phone numbers, locations you frequent, case managers or organizations that you work with, or any other information that might help us find you.

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

**“Next Step Tool for Homeless Youth”**

American Version 1.0

The TAY-VI-SPDAT is created and copyrighted by OrgCode Consulting, Inc., Corporation for Supportive Housing, Community Solutions, and Eric Rice, USC School of Social Work (Copyright 2015). The TAY-VI-SPDAT is used in Santa Clara County by permission of OrgCode Consulting, Inc. Please do not alter any of the questions, including the order in which they are asked. For more information about the TAY-VI-SPDAT or OrgCode visit [www.orgcode.com](http://www.orgcode.com). Please complete all questions. The TAY-VI-SPDAT will be scored automatically when it is entered into HMIS.

Date: ______________________

Name & Phone # of Staff Person Completing the VI-SPDAT: ________________________________

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### 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: ______ -- ______ -- _______ □ Don’t Have/Don’t Know □ Refused

Consent to participate? □ Yes □ No

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TAY-VI-SPDAT
SCC Packet – 12/15/16
SCORED DOMAINS

A. HISTORY OF HOUSING AND HOMELESSNESS

1. Where do you sleep most frequently? (Check One)
   - [ ] Shelters
   - [ ] Couch surfing
   - [ ] Transitional Housing
   - [ ] Safe Haven
   - [ ] Other (specify): ________________________________

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

B. RISKS

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

5. Have you been attacked or beaten up since you’ve become homeless?  [ ] YES  [ ] NO  [ ] Refused

6. Have you threatened to or tried to harm yourself or anyone else in the last year?  [ ] YES  [ ] NO  [ ] Refused

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?  [ ] YES  [ ] NO  [ ] Refused

8. Were you ever incarcerated when younger than age 18?  [ ] YES  [ ] NO  [ ] Refused

9. Does anybody force or trick you to do things that you do not want to do?  [ ] YES  [ ] NO  [ ] Refused
10. Do you ever do things that may be considered to be risky like exchange sex for money, food, drugs, or a place to stay, run drugs for someone, have unprotected sex with someone you don’t know, share a needle, or anything like that? □ YES □ NO □ Refused

C. SOCIALIZATION & DAILY FUNCTIONING

11. Is there any person, past landlord, business, bookie, dealer, or government group like the IRS that thinks you owe them money? □ YES □ NO □ Refused

12. Do you get any money from the government, a pension, an inheritance, an allowance, working under the table, a regular job, or anything like that? □ YES □ NO □ Refused

13. Do you have any planned activities, other than just surviving, that make you feel happy and fulfilled? □ YES □ NO □ Refused

14. Are you currently able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and things like that? □ YES □ NO □ Refused

15. Is your current lack of stable housing...
   a. Because you ran away from your family home, a group home or a foster home? □ YES □ NO □ Refused
   b. Because of a difference in religious or cultural beliefs from your parents, guardians or caregivers? □ YES □ NO □ Refused
   c. Because your family or friends caused you to become homeless? □ YES □ NO □ Refused
   d. Because of conflicts around gender identity or sexual orientation? □ YES □ NO □ Refused
   e. Because of violence at home between family members? □ YES □ NO □ Refused
   f. Because of an unhealthy or abusive relationship, either at home or elsewhere? □ YES □ NO □ Refused

D. WELLNESS

16. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? □ YES □ NO □ Refused

17. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? □ YES □ NO □ Refused

18. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you? □ YES □ NO □ Refused

19. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you’d need help? □ YES □ NO □ Refused
20. When you are sick or not feeling well, do you avoid getting medical help?  □ YES  □ NO  □ Refused

21. Are you currently pregnant, have you ever been pregnant, or have you ever gotten someone pregnant?  □ YES  □ NO  □ Refused

22. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past?  □ YES  □ NO  □ Refused

23. Will drinking or drug use make it difficult for you to stay housed or afford your housing?  □ YES  □ NO  □ Refused

24. If you’ve ever used marijuana, did you ever try it at age 12 or younger?  □ YES  □ NO  □ Refused

25. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
   a. A mental health issue or concern?  □ YES  □ NO  □ Refused
   b. A past head injury?  □ YES  □ NO  □ Refused
   c. A learning disability, developmental disability, or other impairment?  □ YES  □ NO  □ Refused

26. Do you have any mental health or brain issues that would make it hard for you to live independently because you’d need help?  □ YES  □ NO  □ Refused

27. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking?  □ YES  □ NO  □ Refused

28. Are there any medications like painkillers that you don’t take the way the doctor prescribed or where you sell the medication?  □ YES  □ NO  □ Refused

CONTACT INFORMATION:

Please enter all contact information at the end of the VI-SPDAT in HMIS. In addition, please update contact information in the Location Tab in HMIS. COMPLETE AND UP TO DATE CONTACT INFORMATION IS CRITICAL TO MAKE SURE PEOPLE CAN BE FOUND WHEN A HOUSING REFERRAL IS AVAILABLE!

On a regular day, where is it easiest to find you and what time of day is easiest to do so?
   Where:  When:

Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?
   Phone:  Email:

Is there someone that you trust and communicate with regularly that we can contact when we look for you? (Please include name and phone number if possible)

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
Santa Clara County – Additional Questions:

Please complete the following additional questions. These questions are not part of the VI-SPDAT assessment; however, they may be used to identify programs for which the individual or household might be eligible. Please note that documentation will be required to verify eligibility if an individual or household is referred to a program based on responses to these questions.

1. **Are you a veteran?** ☐ Yes ☐ No ☐ Don’t Know ☐ Refused
   
   a. **If yes, which military service era did you serve in?**
      ☐ Post September 11th (September 11, 2001 – Present)
      ☐ Between Korean and Vietnam Wars (February 1955 – July 1964)
      ☐ Korean War (June 1950 – January 1955)
      ☐ Between WWII and Korean War (August 1947 – May 1950)
      ☐ WWII Era (September 1940 – July 1947)
      ☐ Don’t Know
      ☐ Refused

   b. **If yes, what is your discharge status?**
      ☐ Honorable ☐ General under Honorable Conditions
      ☐ Bad Conduct ☐ Under other than Honorable Conditions (OTH)
      ☐ Dishonorable ☐ Uncharacterized
      ☐ Don’t Know ☐ Refused

2. **How many total years have you been homeless?** __________________________________________

3. **Which city did you live in prior to becoming homeless?** _________________________________

4. **If you are employed, in which city is your work place?** _________________________________

5. **If you go to school, in which city is your school?** ______________________________________

6. **In which city do you spend most of your time?** _________________________________________

7. **Have you ever been in foster care?** ☐ Yes ☐ No ☐ Don’t Know ☐ Refused

8. **Have you ever been in jail?** ☐ Yes ☐ No ☐ Don’t Know ☐ Refused

9. **Have you ever been in prison?** ☐ Yes ☐ No ☐ Don’t Know ☐ Refused

10. **Do you have a permanent physical disability that limits your mobility?** (i.e. wheelchair, amputation, unable to climb stairs?) ☐ Yes ☐ No ☐ Don’t Know ☐ Refused

11. **What type of health insurance do you have, if any?**
    ☐ Medicaid ☐ Private Insurance
    ☐ Medicare ☐ No Health Insurance
    ☐ VA Medical ☐ Other
Santa Clara County VI-SPDAT for Justice Dischargees

This packet includes:

- Local Instructions & Script for using the VI-SPDAT
- JD-VI-SPDAT for Justice Dischargees
- Additional Questions for assessing Program Eligibility

Justice Discharge - 
Vulnerability Index - 
Service Prioritization Decision Assistance Tool 
(JD-VI-SPDAT)

Prescreen Triage Tool for Justice Dischargees

AMERICAN VERSION 1.0.1

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COMMUNITY SOLUTIONS
Santa Clara County VI-SPDAT Instructions

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Completing the VI-SPDAT:
1. Select the appropriate version of the VI-SPDAT:
   a. VI-SPDAT for Single Adults – Use this version for adults age 25 or older with no children in the household.
   b. VI-SPDAT for Families – Use this version for households with at least one child under the age of 18.
   c. TAY VI-SPDAT – Use this version for transition age youth (age 18-24) and unaccompanied minors.
   d. JD-VI-SPDAT - Use this version for households coming out of jail through Custody Health and Rehabilitation Officers.

2. Introduce the VI-SPDAT: Explain to the client what you are doing using the introductory script on the next page.

3. Complete All Questions: Complete the VI-SPDAT and follow-up questions, including the additional questions on the last page of this packet.

4. Enter the VI-SPDAT in HMIS: You can find the VI-SPDAT under the Assessments tab in the menu bar at the top of the screen in HMIS. This is a universal assessment that is not connected to any specific program.
   a. If the Assessment Score is 4 or Higher: Refer the assessment to the community queue in HMIS.

After Completing the VI-SPDAT:
1. Collect Contact Information: Collect as much contact information as possible (phone, email, service provider or case manager that the individual/family works with, locations that they frequent, etc.). It is critical that we have as much contact information as possible in case any referrals become available for the individual/family. Ask them to come back and update their contact information if it changes.

2. Share information with the individual/family: Do NOT share the numerical score from the VI-SPDAT. If the person is interested, you can provide an explanation of the type of housing program that looks like the best fit for the individual/family.

3. If the score falls into the “no housing intervention” category (0-3): Explain that the assessment shows that they have the skills and ability to get back into housing with limited assistance. Refer the individual/family to resources in the community that will help them address barriers, such as: public benefits, employment programs, security deposit assistance, etc.
**Santa Clara County Introductory Script:**

I am going to go through a short survey with you that will provide us with more information about your situation. The answers will help us determine how we can best support you. Some of the survey questions are personal in nature, but they only require a Yes/No or one word answer. I really only need that one word answer. You don’t need to feel any pressure to provide more detail. You can also skip or refuse to answer any question. Skipping multiple questions may make it harder for us to identify services for you, but it is your right to refuse to answer questions you don’t feel comfortable with.

Please do your best to answer all of the questions as honestly and accurately as possible. Honest, accurate answers are important to help us identify the right services for you. In addition, if we are able to refer you to any services based on the information in this survey, that program will still need to verify all eligibility information. So, if your answers aren’t honest, it could prevent you from being accepted into a program.

The information that I collect with this survey will be stored in HMIS along with the rest of the intake information you provided. Sometimes we are able to identify services that might be a good match for you based on the information you provide. If that happens we will try to contact you, so it’s really important that you provide current contact information. This could include phone numbers, locations you frequent, case managers or organizations that you work with, or any other information that might help us find you.

---

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

**Prescreen Triage Tool for Justice Dischargees**

**AMERICAN VERSION 1.0.1**

The VI-SPDAT is created and copyrighted by OrgCode Consulting, Inc. and Community Solutions (Copyright 2015). The VI-SPDAT is used in Santa Clara County by permission of OrgCode Consulting, Inc. Please do not alter any of the questions, including the order in which they are asked. For more information about the VI-SPDAT or OrgCode visit [www.orgcode.com](http://www.orgcode.com). Please complete all questions. The VI-SPDAT will be scored automatically when it is entered into HMIS.

Date: _______________________

Name & Phone # of Staff Person Completing the VI-SPDAT: ______________________________________

---

**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: __________ -- __________ -- __________  □ Don’t Have/Don’t Know  □ Refused

Consent to participate? □ Yes □ No
A. HISTORY OF HOUSING AND HOMELESSNESS

1. Prior to being incarcerated, where did you sleep most frequently? (Check One)
   - ☐ Shelters
   - ☐ Safe Haven
   - ☐ Other (specify): ____________________________
   - ☐ Transitional Housing
   - ☐ Outdoors
   - ☐ Refused

2. Prior to being incarcerated, how long has it been since you lived in permanent stable housing?
   ____________________________ ☐ Refused

3. Thinking back to the three years prior to your incarceration, how many times have you been homeless?
   ____________________________ ☐ Refused

B. RISKS

4. During your incarceration, how many times have you...
   a. Received medical care at an infirmary/health clinic?
      ☐ Refused
   b. Been hospitalized?
      ☐ Refused
   c. Been placed on suicide watch?
      ☐ Refused

5. Thinking back to the six months prior to your incarceration, 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

6. Have you been attacked or beaten up since becoming incarcerated? ☐ YES ☐ NO ☐ Refused

7. Were you ever attacked or beaten up while homeless before your incarceration? ☐ YES ☐ NO ☐ Refused

8. Have you threatened to or tried to harm yourself or anyone else since becoming incarcerated? ☐ YES ☐ NO ☐ Refused

9. Did you ever try to harm yourself or anyone else while homeless before you were incarcerated? ☐ YES ☐ NO ☐ Refused

10. Do you anticipate any conditions being placed upon you upon your release such as where you are allowed to live, the people you are allowed to hang out with or speak to, registering your address with police, or checking in with a parole officer? ☐ YES ☐ NO ☐ Refused
11. Considering both your time incarcerated and your time homeless prior to your incarceration, has anybody forced or tricked you into doing things that you did not want to do?

12. Considering both your time incarcerated and your time homeless prior to your incarceration, have you done things considered to be risky like exchange sex for money, food, drugs, or a place to stay, run drugs for someone, have unprotected sex with someone you don’t know, share a needle, or anything like that?

C. SOCIALIZATION & DAILY FUNCTIONING

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

14. When you get out, do you have a guaranteed source of income like a job waiting for you, a pension, or an inheritance?

15. Prior to your incarceration, did you have any planned activities each day other than just surviving that brought you feel happiness and fulfillment?

16. Thinking about your release, at this point do you have activities planned that will bring you happiness and fulfillment?

17. Prior to your incarceration were you able to take care of basic needs like bathing, changing clothes, using a restroom, getting food and clean water and other things like that?

18. Do you have any concerns about taking care of those basic needs upon your release?

19. Prior to your incarceration, was your 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?

20. Do you feel that you will have a positive network of family or friends that can provide you all the support you need with housing, income, and emotional support once you are released?

D. WELLNESS

21. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health?

22. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart?

23. 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?

24. 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?

25. When you are sick or not feeling well, do you avoid getting (medical) help?

26. FOR FEMALE RESPONDENTS ONLY: Are you currently pregnant?

☐ YES ☐ NO ☐ Refused

☐ YES ☐ NO ☐ Refused

☐ YES ☐ NO ☐ Refused

☐ YES ☐ NO ☐ Refused

☐ YES ☐ NO ☐ Refused

☐ YES ☐ NO ☐ Refused

☐ YES ☐ NO ☐ Refused

☐ YES ☐ NO ☐ Refused

☐ YES ☐ NO ☐ Refused

☐ YES ☐ NO ☐ Refused

☐ YES ☐ NO ☐ Refused
27. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? □ YES □ NO □ Refused

28. Will drinking or drug use make it difficult for you to stay housed or afford your housing? □ YES □ NO □ Refused

29. 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? □ YES □ NO □ Refused
   b. A past head injury? □ YES □ NO □ Refused
   c. A learning disability, developmental disability, or other impairment? □ YES □ NO □ Refused

30. Do you have any mental health or brain issues that would make it hard for you to live independently because you’d need help? □ YES □ NO □ Refused

31. Are there any medications that a doctor said you should be taking that, for whatever reason, you are not taking? □ YES □ NO □ Refused

32. Are there any medications you are supposed to be taking that you have not been able to access while incarcerated? □ YES □ NO □ Refused

33. Are there any medications like painkillers that you don’t take the way the doctor prescribed or where you sell the medication? □ YES □ NO □ Refused

34. 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? □ YES □ NO □ Refused

CONTACT INFORMATION:

Please enter all contact information at the end of the VI-SPDAT in HMIS. In addition, please update contact information in the Location Tab in HMIS. COMPLETE AND UP TO DATE CONTACT INFORMATION IS CRITICAL TO MAKE SURE PEOPLE CAN BE FOUND WHEN A HOUSING REFERRAL IS AVAILABLE!

On a regular day, where is it easiest to find you and what time of day is easiest to do so?

   Where:

   When:

Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?

   Phone:  Email:

Is there someone that you trust and communicate with regularly that we can contact when we look for you? (Please include name and phone number if possible)

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
Santa Clara County – Additional Questions:

Please complete the following additional questions. These questions are not part of the VI-SPDAT assessment; however, they may be used to identify programs for which the individual or household might be eligible. Please note that documentation will be required to verify eligibility if an individual or household is referred to a program based on responses to these questions.

1. Are you a veteran? ☐ Yes ☐ No ☐ Don’t Know ☐ Refused
   a. If yes, which military service era did you serve in?
      ☐ Post September 11th (September 11, 2001 – Present)
      ☐ Vietnam Era (August 1968 – April 1975)
      ☐ Between Korean and Vietnam Wars (February 1955 – July 1964)
      ☐ Korean War (June 1950 – January 1955)
      ☐ Between WWII and Korean War (August 1947 – May 1950)
      ☐ WWII Era (September 1940 – July 1947)
      ☐ Don’t Know
      ☐ Refused
   b. If yes, what is your discharge status?
      ☐ Honorable ☐ General under Honorable Conditions
      ☐ Bad Conduct ☐ Under other than Honorable Conditions (OTH)
      ☐ Dishonorable ☐ Uncharacterized
      ☐ Don’t Know ☐ Refused

2. How many total years have you been homeless? ____________________________________

3. Which city did you live in prior to becoming homeless? ________________________________

4. If you are employed, in which city is your work place? ________________________________

5. If you go to school, in which city is your school? ______________________________________

6. In which city do you spend most of your time? _________________________________________

7. Have you ever been in foster care? ☐ Yes ☐ No ☐ Don’t Know ☐ Refused

8. Have you ever been in jail? ☐ Yes ☐ No ☐ Don’t Know ☐ Refused

9. Have you ever been in prison? ☐ Yes ☐ No ☐ Don’t Know ☐ Refused

10. PFN/CDCR Number (if applicable) _______________________

11. Do you have a permanent physical disability that limits your mobility? (i.e. wheelchair, amputation, unable to climb stairs?) ☐ Yes ☐ No ☐ Don’t Know ☐ Refused

12. What type of health insurance do you have, if any?
    ☐ Medicaid ☐ Private Insurance
    ☐ Medicare ☐ No Health Insurance
    ☐ VA Medical ☐ Other
ATTACHMENT: PHA HOMELESS PREFERENCE

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<td>Housing Choice Voucher Administrative Plan: Housing Authorities of the County of Santa Clara &amp; City of San Jose, Chapter 2, Revised 7/28/2021</td>
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<td>o Homeless preference for Housing</td>
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CHAPTER 2
WAITING LIST ADMINISTRATION

2.1 INTRODUCTION
This chapter describes the policies for completing registration for housing assistance, criteria related to placement on the waiting list and removal from the list, and limitations as to who may apply.

2.2 WAITING LIST: ADMINISTRATION OF WAITING LIST
24 CFR 982.204 (a): “Except for special admissions, participants must be selected from the PHA waiting list. The PHA must select participants from the waiting list in accordance with admission policies in the PHA administrative plan.”

24 CFR 983.251 (c)(3): “The PHA may use separate waiting lists for PBV units in individual projects or buildings (or for sets of such units) or may use a single waiting list for the PHA’s whole PBV program.”

24 CFR 882.513 (b): “Waiting list. The PHA must maintain a waiting list for applicants for the Moderate Rehabilitation Program.”

Policy:

Applicants Registered on the 2006 Waiting Lists: Families are given a position number and placed on the waiting list in an order determined by computerized random selection. The HA selects applicants from the 2006 waiting list based on their position number. The HA will not draw applicants from the interest lists until the 2006 Waiting Lists are exhausted.

Applicants Registered on the Interest Lists Opened 2020: The Housing Authority administers permanently open interest lists. Families who wish to be considered for any of the Housing Authority’s federally funded rental assistance programs must register on its interest lists. Registration forms will be made available in an accessible format upon request from a person with a disability. Paper registration forms will be made available to persons with no access to technology.

The HA maintains one interest list for its Housing Choice Voucher program and separate site-based lists for all properties that have a Property Voucher (Project Based Voucher or Moderate Rehabilitation program) Housing Assistance Payment contract.

An applicant remains active on the interest list for one year. An interest list applicant may renew their application or reactivate an inactive application for another year at any time.

As Housing Choice Vouchers and/or Property vouchers (Project Based Voucher or Moderate Rehabilitation program units) become available, active applicants are drawn from the interest list by computerized random selection and placed on a waiting list based on the date and time of the draw.
2.3 WAITING LIST: DIFFERENT PROGRAMS

24 CFR 982.205 (a) (1): “A PHA may merge the waiting list for tenant-based assistance with the PHA waiting list for admission to another assisted housing program...”

MTW Plan:

“[The HA will] continue to operate one combined waiting list for both the County of Santa Clara and the City of San José for the Housing Choice Voucher (HCV) Program and the Project-Based Voucher (PBV) Program.”

2.4 WAITING LIST: LOCAL PREFERENCES

24 CFR 982.207 (a) (1): “The PHA may establish a system of local preferences for selection of families admitted to the program. PHA selection preferences must be described in the PHA administrative plan.”

24 CFR 982.207 (b) (3): “The PHA may adopt a preference for admission of families that include a person with disabilities. However, the PHA may not adopt a preference for admission of persons with a specific disability.”

24 CFR 982.207 (b) (5): “The PHA may adopt a preference for admission of single persons who are age 62 or older, displaced, homeless, or persons with disabilities over other single persons.”

MTW Plan:

“SCCHA will explore various means to target increased assistance to the chronically homeless including... taking steps to provide vouchers to chronically homeless families that are actively participating in supportive programs with designated service providers.”

“Based on community need and subject to State and Federal Fair Housing laws and MTW statutory authorizations, SCCHA may propose to receive direct referrals of chronically homeless families from non-profit agencies and community-based organizations.”

“With its Moving to Work (MTW) authority, and similar to activity 2009-5, which created a direct referral program for the chronically homeless, SCCHA and designated community partners will target vouchers to [the] Special Needs Population (SNP) as follows: (1) SCCHA will...determine program eligibility and provide rental assistance; (2) A community partner will provide referrals of clients to SCCHA and case management to the designated SNP.”
Policy:
Based on the availability of voucher funding, the HA recognizes the following separate local preferences to its Section 8 Housing Choice Voucher Waiting List.

- A preference for applicants who lived or worked in Santa Clara County within the last five years from the date they were randomly drawn to a waiting list to be offered assistance. The Executive Director has the authority to turn off the preference if data analysis of applicant demographics suggests that the preference is unintentionally impacting protected classes; and

- A preference for very-low income applicants who are Santa Clara County renters and have become homeless due to a State of California-declared disaster, for the length of time and/or the number of vouchers as the Executive Director determines is appropriate and available.

In accordance with PIH Notice 2020-01 issued on January 22, 2020, the HA will issue available Mainstream 5-year vouchers (Increment 59-MS5) to eligible Section 8 Housing Choice Voucher waiting list households that include one or more non-elderly persons (ages 18-61) with verified disabilities.

In accordance with PIH Notice 2021-15 issued on May 5, 2021, the HA will issue 1,033 Emergency Housing Vouchers (EHV), awarded by HUD, to eligible applicants referred by the Santa Clara County Continuum of Care. The applicants referred bypass the Section 8 Housing Choice Voucher waiting list.

The HA will receive direct referrals of applicants from partnering agencies for the following programs as stipulated in HUD program regulations, Notice of Funding Availability Awards (NOFA) or by an approved MTW activity. The applicants referred to these programs bypass the Section 8 Housing Choice Voucher or Project Based Voucher waiting lists:

- **Chronically Homeless Direct Referral (CHDR) Program:** Chronically homeless families who participate in supportive programs and utilize case management services.
- **Special Needs Population Direct Referral (SNDR) Program:** Persons with disabilities who experience multiple barriers to housing and who require intensive supportive services.
- **Veterans Affairs Supportive Housing (VASH) Program:** Homeless veterans who receive case management and clinical services through the Veterans Affairs Palo Alto Health Care System.

The HA may draw from the waiting or interest list and/or receive direct referrals of applicants (bypassing the Section 8 Housing Choice Voucher or Project Based Voucher waiting or interest lists) by the Santa Clara County Office of Supportive Housing for the following special program as stipulated in HUD program regulations or Notice of Funding Availability Awards (NOFA):

- **Mainstream Voucher Program (Mainstream 59-MS811):** Household that includes one or more non-elderly person (ages 18-61) with verified disabilities. Preference for assistance will be given to individuals/families who are transitioning out of institutional
or other segregated setting, at serious risk of institutionalization, homeless or at risk of becoming homeless.

2.5 OPENING THE WAITING LIST

24 CFR 982.206 (a) (1): “When the PHA opens a wait list, the PHA must give public notice that families may apply for tenant-based assistance. The public notice must state where and when to apply.”

Policy:

The HA will advertise the interest lists through public notice in newspapers, minority publications and other media entities and through mailings and/or presentations to community organizations including those organizations serving populations of persons with disabilities.

Information provided will include the telephone number, and website of the HA, how to apply on the interest lists, and information on eligibility requirements.

The HA will open its Section 8 Housing Choice Voucher waiting list for the following populations in accordance with the Notice of Funding Availability Award (NOFA) instructions issued for these programs:

- Family Unification Program (FUP)- Families or youth referred by the Santa Clara County Department of Family and Children’s Services (DFCS) and/or Office of Supportive Housing (OSH) as FUP- eligible.
- Foster Youth to Independence (FYI) Initiative – Youth referred by the Santa Clara County Department of Family and Children’s Services (DFCS) and/or Office of Supportive Housing (OSH) as FYI- eligible.
- Category 2 Non-Elderly Disabled (NED) Program- Non-elderly, disabled families referred by the Silicon Valley Independent Living Center and transitioning out of nursing homes or other health care institutions.

2.6 REMOVING APPLICANT NAMES FROM THE WAITING LIST

24 CFR 982.204 (c) (1): “The PHA administrative plan must state PHA policy on when applicant names may be removed from the waiting list. The policy may provide that the PHA will remove names of applicants who do not respond to PHA requests for information or updates.”

Policy:

For applicants on a waiting list, the HA will make two attempts to notify applicants of assistance availability. The HA will request an intake eligibility appointment or complete the intake process by mail, if necessary. If the HA schedules an appointment with the waiting list applicant, the applicant may reschedule their appointment once (either the first or final appointment) by calling HA in advance of the appointment. If the HA conducts the intake process by mail, the applicant will be offered two opportunities to complete and
submit the intake process by mail. If an applicant fails to respond within the specified timeframe or fails to attend their final appointment, the application will be canceled and withdrawn and the applicant will be notified in writing.

Applicants Registered on the 2006 Waiting Lists: The HA will make one attempt to notify applicants of an offer of a Project Based Voucher or Moderate Rehabilitation unit availability. If the applicant does not respond, or declines the offer, they will be withdrawn from the Project Based Voucher or Moderate Rehabilitation waiting list and notified in writing of the withdrawal.

2.7 REINSTATEMENT TO THE WAITING LIST

24 CFR 982.204 (c) (2): “If the applicant did not respond to the PHA request for information or updates because of the family member’s disability, the PHA must reinstate the applicant in the family’s former position on the waiting list.”

Policy:

The HA may reevaluate its decision to remove the applicant from the waiting list if the applicant family was unable to respond to the HA’s notices of assistance or declined an offer of an available Project Based Voucher or Moderate Rehabilitation unit due to:

- Homelessness,
- Hospitalization during the period outreach efforts were made,
- Disability, or
- Other mitigating circumstances, such as domestic violence.

Any of the above circumstances must be verified through independent sources, and applicable mitigating circumstances must be clearly demonstrated prior to evaluation for reinstatement. The HA will provide a written response specifying the outcome and final determination at the conclusion of its review.

If the request for reinstatement is approved, the cancelled application will be restored to its original placement of registration on the waiting list. If the request for reinstatement was not approved, the application remains cancelled.

2.8 SPECIAL ADMISSIONS (NON-WAITING LIST)

24 CFR 982.203 (a) (1) & (2): “If HUD awards a PHA program funding that is targeted for families living in specified units, the PHA must use the assistance for families living in these units. The PHA may admit a family that is not on the PHA waiting list or without considering the family’s waiting list position.”

Policy:

The following are examples of types of program funding that may be targeted for a family living in a specified unit:

- A family displaced because of demolition or disposition of a public housing project;
• A family residing in a multifamily rental housing project when HUD sells, forecloses or demolishes the project;

• For housing covered by the Low Income Housing Preservation and Resident Homeownership Act of 1990;

• A family residing in a project subject to a homeownership program (under 24 CFR 238.173);

• A family residing in a project covered by a project-based Section 8 HAP contract at or near the end of the HAP contract term;

• A non-purchasing family residing in a HOPE 1 or HOPE 2 project; and

• Very low income families who have been displaced due to a natural disaster, government or private actions. If a city or county is involved, a family may be eligible for admission to the program subject to a funding allocation.

2.9 OTHER HOUSING ASSISTANCE

24 CFR 982.205 (b) (1) & (2): “For the purposes of this section, ‘other housing subsidy’ means a housing subsidy other than assistance under the voucher program. Housing subsidy includes subsidy assistance under a federal housing program, a state housing program or a local housing program. The PHA may not take any of the following actions because an applicant has applied for, received or refused other housing assistance:

• Refuse to list the applicant on the PHA waiting list for tenant-based assistance;
• Deny any admission preference for which the applicant is currently qualified;
• Change the applicant’s place on the waiting list based on preference, date and time of application, or other factors affecting selection under the HA selection policy; or
• Remove applicant from the waiting list.”

24 CFR 983.251 (e) (3): “The PHA may not take any of the following actions against an applicant who has applied for, received, or refused an offer of PBV assistance: (iv) Remove the applicant from the waiting list for tenant-based voucher assistance.”

Policy:

Applicants Registered on the 2006 Waiting Lists: If an applicant is withdrawn from the Housing Choice Voucher waiting list (including withdrawals due to being determined ineligible for assistance according to Section 8 initial eligibility criteria in place at the time), or housed under the Housing Choice Voucher program, the HA will remove the applicant from the Mainstream, Project-Based Voucher and Moderate Rehabilitation assistance waiting lists.

Applicants Registered on the 2006 Waiting Lists: If an applicant is determined ineligible
<table>
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<th>Chapter 2</th>
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<td>for assistance for the Project Based Voucher or Moderate Rehabilitation programs according to Section 8 initial eligibility criteria in place at the time under the Project Based Voucher or Moderate Rehabilitation programs, the HA will withdraw the applicant from the Housing Choice Voucher, Mainstream, Project Based Voucher and Moderate Rehabilitation assistance waiting lists.</td>
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**Applicants Registered on the 2006 Waiting Lists:** If an applicant is housed under the Moderate Rehabilitation program or withdrawn from the Project Based Voucher and/or Moderate Rehabilitation assistance waiting lists due to non-responsiveness to an offer of PBV or Moderate Rehabilitation assistance, the HA will not remove the applicant from the Housing Choice Voucher waiting list.

**Applicants Registered on the Interest Lists Opened 2020:** If an applicant is housed under the Moderate Rehabilitation programs and is drawn from the interest list for a Housing Choice Voucher and determined eligible for assistance, the HA will offer them the opportunity to move with Housing Choice Voucher assistance.

**Applicants Registered on the Interest Lists Opened 2020:** If an applicant is drawn from the interest list for a Housing Choice Voucher, the applicant will be inactivated from the Housing Choice Voucher and property voucher interest lists and must reactivate themselves on the interest lists to be considered for additional opportunities.

**Applicants Registered on the Interest Lists Opened 2020:** If an applicant is drawn from one of the property voucher interest lists, they will not be inactivated from the Housing Choice Voucher interest list; however, they will be inactivated from all property voucher interest lists and must reactivate themselves on the interest lists to be considered for additional opportunities.

If an applicant is housed with a Housing Choice Voucher through the Chronically Homeless Direct referral program, Special Needs Population Direct Referral program, the Family Unification Program, the Non-Elderly Disabled Program, the Veterans Affairs Supportive Housing or the Mainstream Program, the HA will withdraw the applicant from the Housing Choice Voucher, Project Based Voucher, Moderate Rehabilitation or site-based property voucher waiting lists.

If an applicant reaches the top of the 2006 Housing Choice Voucher waiting list or is drawn from the interest list for a Housing Choice Voucher, but is currently housed under the Project Based Voucher program for less than two years (or one year with a VASH Project Based Voucher), the HA will withdraw the applicant from the Housing Choice Voucher waiting list.

If an applicant reaches the top of the 2006 Housing Choice Voucher waiting list or is drawn from the interest list for a Housing Choice Voucher, and is currently housed under the Project Based Voucher program for more than two years (or one year with a VASH Project Based Voucher), the HA will offer them the opportunity to move with Housing Choice Voucher assistance.
**ATTACHMENT:** Local Competition Announcement

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<td>Screenshot of posting on CoC Website of Local Competition Deadline &amp; Scoring Criteria – dated September 8, 2021</td>
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<tr>
<td>o Posting on CoC Website included written review &amp; rank process and all scoring criteria.</td>
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<tr>
<td>o Posting clearly states <strong>local competition deadline</strong>: October 1, 2021</td>
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<td><strong>2021 SCC CoC NOFO Local Process &amp; Scoring Tools</strong></td>
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<td>o Detailed Application Submission Timeline – <strong>includes local competition deadline</strong></td>
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<td>o Renewal Housing Projects Scoring Tool – <strong>includes point values for objective criteria</strong></td>
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<tr>
<td>o New/Transfer/First Time Renewal/First Time Renewal After Transfer Scoring Tool – <strong>includes point values for objective criteria</strong></td>
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Housing and Urban Development (HUD) Continuum of Care (CoC) Program Funding in Santa Clara County

The County of Santa Clara Office of Supportive Housing is responsible for distributing funding to local communities through the Continuum of Care (CoC) Program. This page contains information about the funding received by local CoC programs, as well as information for the annual funding competition.

2021 HUD CoC Consolidated Application

- To be posted on or before September 19, 2021

2021 HUD CoC Competition - Final Ranked List

- To be posted by November 1, 2021

2021 HUD CoC Competition - Local Competition Materials

- The annual CoC Program Funding Application process is open to local application submissions due to the CoC on October 8, 2021.

- 2021 SCC CoC Competition Timeline (PDF)
- 2021 SCC CoC NOFA Technical Assistance Handbook (PDF)
- 2021 SCC CoC NOFA Local Materials (PDF)
- 2021 SCC CoC NOFA List of Eligible Projects (PDF)
- 2021 SCC CoC NOFA Project Point Person Contact Form
- 2021 SCC CoC Supplemental Applications (New Projects)
- 2021 SCC CoC Supplemental Applications (Renewal Projects)
- 2021 SCC CoC Application with Attachments

- 2020 SCC HUD CoC Application with Attachments
- 2020 SCC HUD CoC Priority Listing
- 2020 SCC HUD CoC NOFA Technical Assistance Handbook (PDF)
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2021 Continuum of Care Program Grants
DETAILED APPLICATION SUBMISSION TIMELINE

This timeline highlights the steps that your agency will take to participate in the local competition for NOFA funding. Please mark these dates in your calendar!

9/7 at 3:00-5:00pm  TA Workshop for all new and renewal grant recipients
During this session, Homebase will review all application materials. Materials will be posted on the CoC website.

9/7  Enter E-SNAPS and start your project application (formerly Exhibit 2).
• E-snaps can be accessed at http://www.hud.gov/esnaps
• Please read all HUD-published guidance and training modules before calling HomeBase for technical assistance. The training modules can be accessed at https://www.hudexchange.info/programs/e-snaps/
• Additional and updated information about the 2021 competition can be found at https://www.hudexchange.info/programs/e-snaps/fy-2021-coc-program-nofa-coc-program-competition/

10/1 by Noon  Submit Complete Application Package via email for Review and Rank
• Please see the 2021 Supplemental Application Form for a list of all the materials to submit.

PLEASE SUBMIT THESE MATERIALS to sccnofa@homebaseccc.org

10/18 – 10/25  Review and Rank Interviews:
• Applicants will participate in an interview (via Zoom) with the Review and Rank Panel during the assigned time slots. These sessions are designed to permit the Review and Rank Panel to ask questions about your applications and to give applicants ideas about how to improve applications. You do not need to prepare a presentation; come prepared to engage in a discussion. You may bring as many people as you feel is necessary to represent your project well, but please be sure to bring those who know the most about the application and supplemental materials.
• Applicants will be assigned a specific time to meet with the Review & Rank Panel. All appointments will be held on Zoom.

10/25 by midnight Applicant Notification
• Applicants will receive email notification of the results of the Review and Rank process.
• If you receive notification that your project will be placed on the ranked list, you should begin finalizing your application for submission.

10/26 by 12pm (noon) Notification of Appeals Due
• Applicants who intend to appeal should contact HomeBase at sccnofa@homebaseccc.org to request scoring information.

10/28 by 12pm (noon) Appeals Due
• Appeals to the Review and Rank decision must be submitted in writing to HomeBase at sccnofa@homebaseccc.org.
• The Appeals Panel will meet on October 28, 2021 and applicants who submit appeals will be notified of the Appeals Panel decision by 9pm on October 28, 2021

10/29 at 10:00am NOFA Committee
• The NOFA Committee will meet to review Tier Two and develop recommendations regarding strategic allocation of CoC funding.

11/5 by 5pm HUD Project Applications Finalized in E-Snaps
• THIS INCLUDES ENSURING THAT ALL NECESSARY ATTACHMENTS ARE UPLOADED TO E-SNAPS. HomeBase will review every submission for omissions or inconsistencies and work with grant recipients to correct them. During the final two weeks, please be sure that someone at your agency is available to answer last minute application questions!

11/10 CoC Consolidated Application Posted.
• Complete consolidated application is posted on CoC website for public review.

11/16 HUD deadline for submission of the CoC’s full Consolidated Application.
This section is intended to explain the Review and Rank Process that is used to review and evaluate all project applications submitted in the local competition.

Prior to NOFA release:

- The 2021 NOFA Committee met, reviewed and made recommendations based on feedback from FY 2020 applicants and the 2020 Review and Rank Panel Committee to modify the competition process and scoring materials.
- The Executive Committee of the CoC Board reviewed and approved the NOFA Committee’s recommended changes to the process and scoring materials, subject to necessary changes due to the NOFA.
- At least 4-5 non-conflicted Review and Rank panelists will be recruited by Homebase and the Collaborative Applicant. The panel will include at least one CoC Board member and a non-conflicted provider (ideally a provider with experience administering Federal, non-CoC grants). In addition, a Collaborative Applicant representative will attend panel meetings to act as a resource (leaving the room when a conflict requires it).
  - For purposes of Review and Rank panel participation, conflict will not extend to a substantially independent program or arm of a CoC recipient, subrecipient, or applicant organization, so long as the program is controlled by an independent board and does not receive or directly benefit from CoC funding or the potential award of a CoC grant in the 2021 competition.
- Homebase will assemble supplemental information for the Review and Rank Committee, including HMIS performance data.
- Renewal Applicants will respond to the Pre-NOFA Agency Capacity Panel request for information (RFI).
- The Pre-NOFA Review and Rank Panel meets and creates preliminary scores for pre-NOFA factors for agencies with renewal projects.
  - Homebase will distribute a summary of general panel feedback to assist applicants in responding to scores.

The Ranking and Reviewing process will proceed as follows:

- TA Workshop to release information about 2021 CoC NOFA and Local Competition open to all prospective applicants will be held, date to be determine based on NOFA release.
- Renewal housing project applicants will receive a report with Pre-NOFA Panel scores and preliminary scaled scores.
- All applicants will prepare and submit project application materials.
  - Late Applications. Applications received after the deadline will receive zero points in the scoring process. Since this may result in the project not being funded, this can be considered an appealable ranking decision.
Administrative Errors. Panelists shall have discretion to deduct up to 10 points from a project’s total score for administrative errors, taking into consideration factors such as the extent of the error, due diligence in resolving the error, impact on the competition, and other factors subject to panelist discretion.

- Low performing projects will be encouraged to reallocate and potential applicants are encouraged to apply for new projects through reallocation.
- Review and Rank Panel members will be oriented to the process and will receive applications, project performance data and scoring materials.
- Review and Rank Panel Committee members will review and tentatively score the applications prior to their first meeting in a Homebase-developed web-based platform called PRESTO.
  - Homebase/CoC staff will ensure all applications meet certain Threshold Requirements (additional detail below).
  - New housing projects, first-time renewals, transfer housing projects, and first-time renewals after transfer will be scored using the New/Transfer Scoring Tool.
  - Housing projects without a full year of data for the evaluation year will be scored using the New/Transfer Scoring Tool.
  - New Expansion projects will be scored using the New/Transfer scoring tool. However, a New Expansion project will not be ranked above the renewal project that it proposes to expand. If a New Expansion project receives a higher score than the associated renewal project, it will be ranked directly below the renewal project.
  - All other renewal housing projects will be scored using the Renewal Scoring Tool.
    - Projects that scored in the top 25% of renewal housing projects with at least a year of data, based on Pre-NOFA Panel and preliminary scaled scores, will not receive further review by the Review and Rank Panel. They will be ranked in Tier 1.
  - New HMIS and Coordinated Entry projects will be automatically ranked at the top of Tier Two, immediately below the project that straddles Tier One and Two.
- Review and Rank Panel will meet over the course of 2-3 days to jointly discuss each application, conduct short in-person interview sessions with applicants to have questions answered and to provide feedback on ways to improve the application, and individually score applications:
  - Ranked list(s) will be prepared based on raw scores, then translated to a tiered list.
  - Renewal HMIS and Coordinated Entry projects will be automatically ranked in Tier One, immediately above the project that straddles Tier One and Two, if any. Another mechanism will be used to evaluate HMIS and Coordinated Entry outside the CoC NOFA Review and Rank process.
The Panel will consider reallocating renewal projects. (See additional detail below). In the event that the Review and Rank Panel identifies a renewal project (or projects) whose funding should not be renewed (or funding should be decreased), the Panel will then determine whether any new proposed projects should be awarded and will proceed with reallocation (see detail below).

- Panel releases scoring results to applicants with reminder of appeals process. Homebase will distribute a summary of general panel feedback on select scoring factors.
- Appellate hearings are held, if requested. Results from appeal(s) are distributed.
- CoC Board or its designee considers and modifies/approves Priority List of Projects, which is then included in the County’s Consolidated NOFA Application.
- Projects are given feedback from Committee on quality of application and ways to improve.
- County’s Consolidated NOFA Application is made available for public review and reference.
- 2021 Process Debriefs are held with Review and Rank Panel Committee members, project applicants, and the collaborative applicant. This information will support the 2022 NOFA Committee in making recommendations for improvement for the 2022 competition.

Requests to alter an application post-submission:
The CoC expects applicants to submit final project proposals for consideration by the Review and Rank Panel, and applicants should not plan to change their proposed program design during the local review and rank process.

However, an applicant may submit a request to the CoC Board to change a proposed project after the Review and Rank Panel Meeting, if:
- The change is the result of unforeseen circumstances that arose during or after the Review and Rank Panel Meeting; and
- The change does not substantially alter the scope of the proposed project, other than to increase the project’s capacity.

To request a change to a proposed project, the applicant must submit an application supplement form provided by the Collaborative Applicant. If the CoC Board determines that the requested change meets the criteria above, they may forward the request to the NOFA Committee for consideration at the post-appeals NOFA Committee meeting.

All other changes to project design may be pursued with HUD during or after contracting and may require a HUD grant amendment.

Reallocation
It is possible that funds will be reallocated from projects that will not receive renewal funding, or whose funding will be reduced. This is a decision made by the Review and Rank Panel after extensive deliberation. Only eligible renewal projects that have previously been renewed under the CoC Program will be considered for reallocation. When considering reallocation, the Review and Rank Panel will:

- Consider unspent funds and the ability to cut grants without cutting service/housing levels.
  - Panel members will receive training about the limitations related to spending CoC funds.
  - For projects receiving leasing or rental assistance, information about unspent funds will be presented together with information about agency capacity (serving the number of people the project is designed to serve).
  - Spend-down Threshold:
    - If a recipient spends 85% or less of their most recent grant, they will be required to submit a narrative explanation.
    - If a recipient spends 85% or less of two consecutive grants, the Collaborative Applicant will send them a written warning and instruct them to take steps to resolve the underspending.
    - If a recipient spends 85% or less of three consecutive grants, the Review and Rank Panel will discuss reallocation. The Review and Rank Panel should seek input from the recipient about the feasibility and impact of partial reallocation for their project.

- Consider history of reductions (e.g., if grant reduced one year, will not be apparent in spending the following year)

- Consider specific new permanent supportive housing or rapid re-housing project(s) and specific renewal project(s) at risk of not being funded

- Consider alternative funding sources available to support either new or renewal project(s) at risk of not being funding

- Consider renewal HUD “covenant” concerns

- Consider impact on system performance and consolidated application’s score

- Consider impact on the community in light of community needs

The impact of this policy is that high scoring projects may be reallocated if these considerations warrant that decision. In addition, if a project receives less than 75 points, then the Panel should strongly consider reallocation of funding.

Threshold
In addition to the scoring criteria, all new and renewal projects must meet a number of threshold criteria. A threshold review will take place prior to the review and rank process to ensure baseline requirements are met. These threshold criteria may be found in the Scoring Factors in the sections below.

Strategic Allocation of CoC Funding
The CoC is committed to using Continuum of Care Program funding efficiently and strategically as a component of the community’s broader continuum of homeless housing and services, to maximize availability of high performing programs to end homelessness.

Following the Appeals Committee, the 2021 NOFA Committee will convene to review the Appeals Committee Ranked List and may make recommendations to the CoC Board regarding changes to the ranking of projects in Tier Two. Recommendations may address ranking only; recommendations regarding reallocation developed by the Review and Rank Panel and sustained by the Appeals Committee may not be considered or modified by the NOFA Committee after appeals are complete.

In recommending changes to the ranking of Tier Two projects, the NOFA Committee may consider the following:

- The project’s ability to continue operations by accessing alternative sources of funding that are available if HUD CoC Program funding is not awarded.
- The impact on the CoC’s bed or unit inventory and overall resources to address homelessness if a project is not awarded CoC funding. Information will be provided regarding number of beds and units, amount of grant request, operating year dates, population served, and current unit utilization rate.

Homebase will develop a process for providing information about projects to the NOFA Committee and guidelines for participation by applicants.

Any NOFA Committee recommendations to the CoC Board must be either:

- Consensus recommendations, or
- Recommendations based on a vote of at least 60% of the NOFA Committee members in attendance, in which case the vote must be recorded and given to the CoC Board alongside the recommendation of the voting majority as well as the grounds for opposition.
  - Each organization in attendance may cast one vote; each individual in attendance not representing an organization may cast one vote.

The CoC Board or its designee will approve the final project list for submission. The decision of the CoC Board will be final.
2021 Continuum of Care Program Grants
APPEALS PROCESS

The Review and Rank Panel Committee reviews all applications and ranks them for funding recommendations to HUD. That ranking decision will be communicated to all applicants by email by midnight on October 25, 2021. All applicants are directed to contact HomeBase at sccnofa@homebaseccc.org or 415-788-7961, ext. 305, if no email notice is received.

1. Who May Appeal

An agency may appeal an “appealable ranking decision,” defined in the next paragraph, made by the Review and Rank Panel concerning a project application submitted by that agency. If the project was submitted by a collaboration of agencies, only one joint appeal may be made.

2. What May Be Appealed

“An appealable ranking decision" is a rank assigned by the Review and Rank Panel to a project that meets any of the following criteria:
   a) likely to result in the project not being funded, in whole or in part,
   b) places the project in the bottom 15% of Tier 1, or
   c) places the project in Tier 2.

3. Timing:

The ranking decision is communicated to all applicants by midnight on October 25, 2021. Applicants have until 12:00pm (noon) on October 26, 2021 to decide if they are going to appeal and notify HomeBase (sccnofa@homebaseccc.org) for more information, with a formal written appeal (no longer than 2 pages) due by October 28, 2021 at 12:00pm (noon). If an appeal will be filed, other agencies whose rank may be affected will be notified as a courtesy. Such agencies will not be able to file an appeal after the appeals process is complete. They may file an appeal within the original appeals timeline.

4. Initiating the Formal Appeal

The Formal Appeal must be submitted by 12:00pm (noon) on October 28, 2021 to Homebase at sccnofa@homebaseccc.org. The appeal document must consist of a short, written (no longer than 2 pages) statement of the agency’s appeal of the Review and Rank Panel Committee’s decision. The statement can be in the form of a letter, a memo, or an email transmittal.
5. Members of the Appeal Panel

A 3-member Appeals Panel will be selected from the CoC Board or its designees. These individuals have no conflict of interest in serving, as defined by the existing Review and Rank Panel Committee conflict of interest rules. Voting members of the Appeal Panel shall not serve simultaneously on the Review and Rank Panel Committee; however, a Review and Rank Panel member and a staff person of the Collaborative Applicant will participate in the Appeals Panel meeting to inform discussion.

6. The Appeal Process, Including Involvement of Other Affected Agencies

The Appeal Panel will conduct a telephone meeting with a representative or representatives of the agency/collaborative who filed the appeal to discuss it on October 28, 2021 if needed. The Panel will then deliberate.

The Appeal Panel will inform appealing agencies of its decision by October 28, 2021 at 9:00pm.

The CoC Board or its designee will approve the final project list for submission. The decision of the CoC Board will be final.
2021 Continuum of Care Grants
RENEWAL HOUSING PROJECTS
Scoring Tool
Approved: September 1, 2021

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<th>Summary of Factors</th>
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<tr>
<td>Threshold Requirements</td>
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<tr>
<td>1. Outcomes Supporting System Performance Measures¹</td>
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<tr>
<td>2. Agency/Collaborative Capacity</td>
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<tr>
<td>3. HMIS Data Quality</td>
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<tr>
<td>Total</td>
</tr>
<tr>
<td>Component/Population-Type Prioritization Bonus Points²</td>
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I. **Threshold Requirements**

- **Threshold Criteria**
  - These factors are required, but not scored. If the project indicates “no” for any threshold criteria, it is ineligible for CoC funding.

- **HMIS Implementation**: Projects are required to participate in HMIS, unless the project is a victim-service agency, serving survivors of domestic violence, or a legal services agency.

- **Coordinated Entry**: Projects are required to participate in Coordinated Entry, when it is available for the project type.

- **HUD Threshold**: Projects will be reviewed for compliance with the eligibility requirements of the CoC Interim Rule and Subsequent Notices and must meet the threshold requirements outlined in the 2020 Notice of Funding Availability.

- **HUD Policies**: Projects are required to have policies regarding termination of assistance, client grievances, Equal Access, ADA and fair housing requirements, VAWA protection, and confidentiality that are compliant with HUD CoC Program requirements.

¹ All of the scoring factors in this tool measure projects’ contribution to improving Santa Clara County’s System Performance by strengthening the overall system of care, through data collection, coordination, prioritization and increasing resources available to end homelessness in Santa Clara County. Certain scoring factors relate to specific Performance Measures, as enumerated in each factor. Projects will be scored based on data in the CoC’s HMIS, except for projects operated by victim service providers which will be scored based on data from the victim service provider’s comparable database.

² Bonus points help ensure fairness and equal footing across scoring tools, which otherwise strongly advantage projects without data, and support prioritization of proven strong performers, while encouraging reallocation of projects not advancing system performance.
II. Detail

1. Outcomes Supporting System Performance Measures: 60 Points

Overall, has the project been performing satisfactorily and effectively addressing the need(s) for which it was designed? Keep in mind that outcomes will naturally be lower in a population with more severe needs. Such populations include persons with low or no income, current or past substance abuse, a history of victimization (e.g., domestic violence, sexual assault, childhood abuse), criminal histories, and chronic homelessness.

1A: Utilization
- Report average utilization of total project beds based on four points during the year
- Informed by supplemental information submitted as part of the proposal

Criteria:
Is the project serving the number of homeless people it was designed to serve?

Panelists are encouraged to exercise discretion based on factors including but not limited to average annual occupancy HMIS data provided by the applicant, occupancy rate trending up or down, project size, population served, and facility status issues beyond the project’s sphere of influence.

HUD System Performance Measures 1, 3

Calculation: Average Number of Households Served Across Four Points in Time ÷ Units Funded

Data Sources: [(APR 8b January Total + APR 8b April Total + APR 8b July Total + APR 8b October Total) ÷ 4] ÷ Project Application 4B Total Units OR 6A Total Households

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Scale for Older Projects

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1B: Housing Stability (PSH Only)

- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

For permanent supportive housing: The percentage of formerly homeless individuals who remain housed in the HUD permanent supportive housing project or exited to other permanent housing, excluding participants who passed away and participants who exited to non-psychiatric hospitals, foster care, or long-term care or nursing homes.

- Panelists may exercise discretion based on factors including but not limited to project size, population served and severity of barriers, and circumstances beyond the project’s sphere of influence.

2020-21 Community Benchmark: 98%

HUD System Performance Measures 3, 7

Calculation: (Total Stayers + Total Exits to PH) ÷ (Total Clients - Total Deceased)

**APR Sources:**

\[\text{[APR 5a Stayers + APR 23c Permanent Dest. Subtotal] + [APR 5a Persons Served - APR Q23c Deceased - APR Q23c Hospital – APR 23c Foster Care – APR 23c Long-term Care or Nursing Home]}\]

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1B: Housing Stability (RRH/Youth TH Only)

- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

For rapid rehousing/transitional housing: The percentage of homeless persons who exited the project to/in a form of permanent housing, excluding participants who passed away and participants who exited to non-psychiatric hospitals, foster care, or long-term care or nursing homes.

- Panelists may exercise discretion based on factors including but not limited to project size, the number of persons who exited the project, population served and severity of barriers, and circumstances beyond the project’s sphere of influence.

- Projects with no leavers will receive full points.

2020-21 Community Benchmark:

RRH: 80%
TH: 50%
**HUD System Performance Measures 1, 3, 7**

**Calculation:** Total Exits to PH ÷ (Total Leavers - Total Deceased)

**APR Sources:**
APR 23c Permanent Destinations Subtotal ÷ [APR 5a Leavers - APR 23c Deceased - APR Q23c Hospital – APR 23c Foster Care – APR 23c Long-term Care or Nursing Home]

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**Year One Scale**

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<tr>
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**RRH Scale**

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<tr>
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</tr>
</tbody>
</table>

**Youth TH Scale**
1C: Returns to Homelessness Within 12 Months (Non-DV Projects Only)

- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

Criteria:
The percentage of leavers to permanent housing destinations in the year prior to the measurement period who returned to a homeless project in HMIS within 12 months.
- Panelists may exercise discretion based on factors including but not limited to project size, household size, and the number of persons who exited the project in the prior year.
- Projects with no leavers in the prior year and projects without at least 2 years of performance data will receive full points.

2020-21 Community Benchmarks:
PSH: 5%
RRH: 8%
TH: 8%

HUD System Performance Measure 2

Calculation: Number of People Who Exited to PH in 2017 who Returned to Programs in HMIS ÷ Number of Exits to PH in 2016

Data Sources: [Looker Project Exit Date is in Exit Year; Exit Destination is permanent; Next Entry Without Stable Housing Date is within 12 months of exit] ÷ [Looker Project Exit Date is in Exit Year; Exit Destination is permanent]

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<td>2</td>
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<tr>
<td>50-60%</td>
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</table>

15
### 1C1: Improving Safety through Safety Planning (DV Projects Only)
- Calculated based on HMIS data and supplemental information submitted as part of the proposal

**Criteria:**
The percentage of survivors for whom a safety plan was completed.
- Panelists may exercise discretion based on factors including but not limited to project size and the number of households served.

**Calculation:** Number of Survivors with Completed Safety Plans ÷ Number of Households Served

**Data Sources:** Number of Completed Safety Plans Reported by Project + APR 8 Households Served

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<td>3 points</td>
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<tr>
<td>&lt;90%</td>
<td>0 points</td>
</tr>
</tbody>
</table>

### 1C2: Improving Safety through Services Provided
- Calculated based on supplemental information submitted as part of the proposal

**Criteria:**
The number of supportive services categories available to clients on a voluntary basis, through referral or provided by the program, to support clients’ physical, emotional, and economic safety and autonomy. Applicant will indicate which of the following services are available to clients enrolled in the project:
- Individual Counseling
- Group Counseling
- Criminal Justice Advocacy and Court Accompaniment
- Social Services Advocacy (e.g. Cal WORKS, schools, benefits applications, etc)
- Legal Assistance
- Employment Services
- Childcare
- Transportation
- Landlord Outreach and Education
- Education Advocacy and Support for School-Aged Children

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<tr>
<td>&lt;5 Service Categories</td>
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**1D: Client Cash Income Change**
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
The percentage of adult stayers/leavers that increase cash income from entry to latest annual assessment/exit, excluding all stayers not yet required to have an annual assessment.
- Panelists may exercise discretion based on factors including but not limited to project size, population served and severity of barriers, and circumstances beyond the project’s sphere of influence.

2020-21 Community Benchmarks:
- Stayers: 35%
- Leavers: 40%

**HUD System Performance Measure 4**

**Calculation:**
\[
\frac{\text{Adults Who Gained Income} + \text{Adults Who Increased Amount of Income}}{\text{Adults} - \text{Stayers Not Required to Have Assessment}}
\]

**APR Sources:**
[ APR19a3 Row 5 Column 4 + APR19a3 Row 5 Column 5 ] ÷ [ APR5a Adults - APR18 Stayers Not Yet Required to Have an Annual Assessment ]

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<tr>
<td>&lt;10%</td>
<td>0 points</td>
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</tbody>
</table>
### 1E: Non-Cash Mainstream Benefits
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
The percentage of adult stayers/leavers with non-cash benefit sources, excluding all stayers not yet required to have an annual assessment.
- Panelists may exercise discretion based on factors including but not limited to project size, population served, and circumstances beyond the project's sphere of influence.

No Related Community Benchmarks

**HUD System Performance Measure 2, 7b**

**Calculation:**
\[
\frac{\text{(Adult Leavers with At Least 1 Benefit + Adult Stayers with At Least 1 Benefit)}}{\text{(Total Adults - Adult Stayers Not Yet Required to Have an Assessment)}}
\]

**APR Sources:**
\[
\frac{\text{[ APR 20b 1Plus Sources Leavers + APR 20b 1Plus Sources Stayers ]}}{\text{[ APR 5a Adults - APR 18 Adult Stayers Not Yet Required to Have an Assessment ]}}
\]

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<td>15-19.9%</td>
<td>1 point</td>
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<tr>
<td>&lt;15%</td>
<td>0 points</td>
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</tbody>
</table>
1F: Health Insurance

- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

Criteria:
The percentage of stayers/leavers with health insurance, excluding all stayers not yet required to have an annual assessment.
- Panelists may exercise discretion based on factors including but not limited to project size, population served, and circumstances beyond the project's sphere of influence.

No Related Community Benchmarks

HUD System Performance Measure 2, 7b

Calculation:
\[
\frac{(\text{Adult Stayers with 1 or More Sources of Health Insurance} + \text{Adult Leavers with 1 or More Sources of Health Insurance})}{(\text{Total Adults} - \text{Adult Stayers Not Yet Required to Have an Assessment})}
\]

APR Sources:
[ APR 21 Stayers 1 Source of Health Insurance + APR 21 Stayers More than 1 Source of Health Insurance + APR 21 Leavers 1 Source of Health Insurance + APR 21 Leavers More than 1 Source of Health Insurance ] + [ APR 5a Adults - APR 18 Adult Stayers Not Yet Required to Have an Assessment ]

Scale

<table>
<thead>
<tr>
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<td>1 point</td>
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<td>&lt;55%</td>
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1G: Alignment with Housing First Principles

- Based on written policies and procedures and narrative response submitted as part of the proposal.
- This factor is scored by the Pre-NOFA Panel.

Total Points: 15

Criteria:
5 Points: To what extent do the project’s written policies and procedures ensure that participants are not screened out based on the following criteria?
- Having too little or no income
- Active, or history of, substance use or a substance use disorder
- Having a criminal record (with exceptions for state-mandated restrictions)
- History of domestic violence (e.g., lack of a protective order, period of separation from abuser, or law enforcement involvement)

5 Points: To what extent do the project’s written policies and procedures ensure that participants are not terminated from the program for the following reasons?
- Failure to participate in supportive services (with exception for HUD-mandated monthly case management meeting for RRH program participants)
- Failure to make progress on a service plan
- Loss of income or failure to improve income
• Being a survivor of domestic violence
• Any other activity not covered in a lease agreement typically found in the project’s geographic area

5 Points: Does the project take proactive steps to minimize barriers to entry and retention?

*HUD System Performance Measures 1, 3, 7*

2. **Agency/Collaborative Capacity: 23 Points**

**2A: Compliance**
- Based on any financial audit, HUD monitoring report and correspondence, and supplemental information submitted as part of the proposal.
- This factor is scored by the Pre-NOFA Panel.

**Total Points: 5**

**Criteria:**
To what extent do the agencies (especially the lead agency) does the agency have:
- Any outstanding financial audit findings or concerns?
- Any outstanding HUD monitoring findings or concerns and/or any history of sanctions imposed by HUD, including – but not limited to – suspending disbursements (e.g., freezing LOCCS), requiring repayment of grant funds, or de-obligating grant funds due to performance issues?
- If yes, what steps is the agency taking to resolve the findings or concerns and to what extent has the program advised the Collaborative Applicant of issues identified by HUD?

If an agency has no outstanding audit or monitoring findings or concerns and no history of sanctions imposed by HUD, the agency should receive full points.

**2B: Unspent Grant Funds**
- Based on supplemental information submitted as part of the proposal

**Criteria:**
Has the agency left project grant funds unspent in the past 3 years?
- Consider if the program is running at capacity (at four points during the year), and if the project receives leasing or rental assistance funding.

Panelists may score programs up or down from the scaled score.

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<thead>
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<td>3.1-9%</td>
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<td>1 points</td>
</tr>
<tr>
<td>15-100%</td>
<td>0 points</td>
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</tbody>
</table>
2C: Alignment with CoC Priorities

- Based on narrative submitted as part of the proposal
- This factor is scored by the Pre-NOFA Panel.

**Total Points:** 8

**Criteria:**
Do the project and agency align with and support CoC priorities, including but not limited to:

**1 Point:** CoC participation (meeting and training attendance)

**3 Points:** Services provided or described are adequate to meet the needs of the population served, as indicated by:
- Case manager to client ratio
- The type of services provided (housing navigation, substance use treatment, trauma informed care, youth-targeted programming, etc.)
- A clear, comprehensive service delivery strategy/plan
- For projects dedicated to serving survivors of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking, the degree to which agency’s program design promotes client safety.

**3 Points:** The project contributes to the community plan goal of 6,000 new housing opportunities and maximizes the number of people exiting homelessness. For example:
- Project employs landlord engagement strategies
- Project proposes to increase the number of persons served
- Contribution of project to improving system performance
- Project has or participates in a move on program or strategy

**1 Point:** Sources of match funding are stable and sustainable

---

2D: Client Participation in Program Design and Policy-Making

- This will be scored based on a narrative response demonstrating client participation in program design and policy-making.
- This factor is scored by the Pre-NOFA Panel.

**Total Points:** 5

**Criteria:**
Does the agency engage homeless and formerly homeless clients in program design and policy-making?

**2 Points:** Agency has at least one strategy for gathering client feedback and input. Strategies may include, but are not limited to:
- Having at least one homeless or formerly homeless person on its staff or board
- Having a consumer advisory board that meets regularly
- Administering consumer satisfaction surveys
- Convening client focus groups

**3 Points:** Agency incorporates client feedback in program design and/or policy-making.
3. **HMIS Data Quality: 17 Points**

### 3A: Exits to Known Destinations
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
Percentage of clients who exit to known destinations.
- Panelists may exercise discretion based on factors including but not limited to limited project exits and circumstances beyond the project’s sphere of influence.

PSH with 0 exits receive full points.

**Calculation:**
\[
\frac{( \text{Total Leavers} - \text{Leavers With Don't Know/Refused Destinations} - \text{Leavers With Missing Destinations} )}{\text{Total Leavers}}
\]

**APR Sources:**
\[
[ \text{APR5a Leavers} - \text{APR23a Total Client Doesn't Know/Client Refused} - \text{APR23b Total Client Doesn't Know/Client Refused} - \text{APR23a Total Data Not Collected} - \text{APR23b Total Data Not Collected} ] ÷ \text{APR5a Leavers}
\]

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<td>1</td>
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<tr>
<td>&lt;60%</td>
<td>0</td>
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### 3B: Complete Data
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
Percentage of complete data (not null/missing, “don’t know” or “refused” data, “data issues” or “error”), as reported in APR 6a, 6b, and 6c, except for Social Security numbers.
- Panelists may exercise discretion based on factors including but not limited to limited project exits and circumstances beyond the project’s sphere of influence.

Community Performance Measure: 95%

**Calculation:**
\[
\frac{( \text{Sum of Client Doesn't Know/Refused} + \text{Information Missing} + \text{Data Issues} + \text{Error Count for 14 data elements in APR Questions 6a-6c, excluding SSN} )}{(14 \times \text{Total Served})}
\]

**APR Sources:**
\[
[ \text{APR6a Client Don't Know Refused} \text{ for Name, Date of Birth, Race, Ethnicity, Gender } + \\
\text{APR6a Information Missing} \text{ for Name, Date of Birth, Race, Ethnicity, Gender } + \\
\text{APR6a Data Issues} \text{ for Name, Date of Birth, Race, Ethnicity, Gender } + \\
\text{APR 6b Error Count} \text{ for Veteran Status, Project Start Date, Relationship to Head of Household, Client Location, Disabling Condition } + \\
\text{APR 6c Error Count} \text{ for Destination, Income and Sources at Start, Income and Sources at Annual Assessment, Income and Sources at Exit } ] ÷ \\
[ 14 \times \text{APR5a Total Served} ]
\]
### 3C: Known Income

- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
Percentage of adult clients with known income at latest annual assessment or exit, excluding all stayers not yet required to have an annual assessment.
- Panelists may exercise discretion based on factors including but not limited to small project size and circumstances beyond the project’s sphere of influence.

**Calculation:**
\[
\frac{\text{Adult Stayers With Known Income + Adult Leavers With Known Income}}{\text{Adults - Stayers Not Yet Required to Have an Annual Assessment}}
\]

**APR Sources:**
\[
\frac{[\text{APR18 Adults with Income Information at Annual Assessment} + \text{APR18 Adults with Income Information at Exit}]}{[\text{APR5a Adults} - \text{APR18 Stayers Not Yet Required}]}
\]

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### 3D: Known Benefits

- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
Percentage of adult clients with known benefits at latest annual assessment or exit, excluding all stayers not yet required to have an annual assessment.
- Panelists may exercise discretion based on factors including but not limited to small project size and circumstances beyond the project’s sphere of influence.

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<tr>
<td>60-79.9%</td>
<td>1</td>
</tr>
<tr>
<td>&lt;60%</td>
<td>0</td>
</tr>
</tbody>
</table>
Calculation:
( Adult Stayers With Known Non-Cash Benefits + Adult Leavers With Known Non-Cash Benefits ) ÷ ( Total Adults - Stayers Not Yet Required to Have Annual Assessments )

APR Sources:
[ APR20b Adult Leavers No Sources + APR20b Adult Leavers 1Plus Sources + APR20b Adult Stayers No Sources + APR20b Adult Stayers 1Plus Sources ] ÷ [ APR 5a Adults - APR18 Stayers Not Yet Required ]

<table>
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<tr>
<td>&lt;60%</td>
<td>0</td>
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3E: Data Accuracy

Penalty: -1

Criteria:
- Applicants who request to correct HMIS data past the APR review deadline and during the evaluation report review process will be penalized by 1 point.

4. Component/Population Type Prioritization: Up to 17 Bonus Points

4A: Permanent Housing

Total Points: 10

Criteria:
10 Points: Permanent supportive housing will be awarded 10 bonus points to demonstrate the CoC’s funding priorities.

5 Points: Rapid rehousing projects will be awarded 5 bonus points to demonstrate the CoC’s funding priorities.

4B: Chronic Homelessness

Total Points: 5

Criteria:
Percentage of beds dedicated to/prioritized for chronically homeless persons.
- DedicatedPLUS PSH projects receive full points.

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### 4C: Other Priority Populations

<table>
<thead>
<tr>
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</table>

**Criteria:**
Is the program dedicated to a priority population?
- Youth
- Survivors of Domestic Violence
- Families with Children
- Veterans
2021 Continuum of Care Grants
NEW/TRANSFER PROJECTS AND PROJECTS WITHOUT A FULL YEAR OF DATA
Approved: September 1, 2021

<table>
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<th>Summary of Factors</th>
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<td>Threshold Requirements</td>
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<tr>
<td>1. Project’s Work Consistent with Community Needs</td>
</tr>
<tr>
<td>2. Project Ability to Enhance System Performance*</td>
</tr>
<tr>
<td>3. Agency/Collaborative Capacity to Enhance System Performance</td>
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<td>4. HMIS Participation</td>
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<tr>
<td>5. Component/Population-Type Prioritization Bonus Points†</td>
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I. Threshold Requirements

Threshold Criteria
- These factors are required, but not scored. If the project indicates “no” for any threshold criteria, it is ineligible for CoC funding.

HMIS Implementation: Projects are required to participate in HMIS, unless the project is a victim-service agency, serving survivors of domestic violence, or a legal services agency.

Coordinated Entry: Projects are required to participate in Coordinated Entry, when it is available for the project type.

Eligible Applicant: Applicants and subrecipients (if any) are eligible to receive CoC funding, including non-profit organizations, States, local governments, and instrumentalities of state and local governments.

Eligible New Project Type: If the project is a new project in 2021, it is an eligible new project type authorized by the FY 2021 CoC Program Notice of Funding Opportunity (NOFO): Permanent Supportive Housing (PSH), Rapid Re-Housing (RRH), or joint Transitional Housing-Rapid Re-Housing (TH-RRH) serving eligible populations; Homeless Management Information System (HMIS); or Supportive Services Only for Coordinated Entry (CE).

HUD Threshold: All projects will be reviewed for compliance with the eligibility requirements of the CoC Interim Rule and Subsequent Notices and must meet the threshold requirements outlined in the 2021 NOFO.

* All of the scoring factors in this tool measure projects’ anticipated contribution to improving Santa Clara County’s System Performance by strengthening the overall system of care, through data collection, coordination, prioritization and increasing resources available to end homelessness in Santa Clara County. Certain scoring factors relate to specific Performance Measures, as enumerated in each factor.

† Bonus points help ensure fairness and equal footing across scoring tools, which otherwise strongly advantage projects without data, and support prioritization of proven strong performers, while encouraging reallocation of projects not advancing system performance.
HUD Policies: Projects are required to have compliant policies regarding termination of assistance, client grievances, Equal Access, ADA and fair housing requirements, VAWA protection, and confidentiality.

Renewable Activities: Projects are required to utilize the grant funds for renewable activities (e.g., leasing rental subsidies, and housing operations) as opposed to non-renewable ones (e.g., acquisition, construction, and rehabilitation).

II. Detail

1. Project’s Work Consistent with Community Needs: 10 Points

1A: Project Readiness

Total Points: 10

Criteria:
The project will be ready to start by HUD’s statutory deadlines. Consider:
- Regulatory obstacles such as tenant displacement or relocation, environmental or zoning issues anticipated;
- Whether the agency has a feasible timeline for staffing the project, establishing site control, beginning to draw down funds, and otherwise complying with CoC Program deadlines;
Whether the agency already has policies and procedures that can be used as-is or easily adapted for use in a CoC-funded project.

2. Project Ability to Enhance System Performance: 47 Points

Consider the overall design of the project in light of its outcome objectives, and the Continuum of Care’s goal that permanent housing programs for homeless people result in stable housing and increased income (through benefits or employment).

2A: Program Design

Total Points: 15

Criteria:
Program design includes provision of comprehensive/intensive case management and appropriate supportive services of the appropriate type, scale and location to meet the needs of program participants (as well as transportation if necessary), using a Housing First model.† Consider:

7 Points: Has the agency developed a concrete plan for providing services to clients and/or referring clients to outside services for support*, including:
- What is the step-by-step process for connecting clients to services outside the agency?
- What types of services will be provided in-house?
- What types of services will require referrals?
- What agencies will accept referrals?
- What is the step-by-step process for developing client service plans and matching clients with services? What tools and evidence-based practices will be used?

* For RRH applicants: Will services described adequately support clients in securing employment and achieving long-term housing stability?

3 Points: Will the project be staffed appropriately to provide the services?

2 Points: Will the staff be trained to meet the needs of the population to be served?
3 Points: To what extent will the program be able to effectively serve eligible clients of different backgrounds, experiences, cultures, abilities, and language proficiencies?

† For projects dedicated to serving survivors of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking, safety is a primary need of the population served. Among other needs, the panel should consider the extent to which program design promotes client safety. It is considered a best practice for programs serving survivors of domestic violence to have certified domestic violence, sexual assault, and/or human trafficking advocates (40- or 65-hour training course) to provide confidential supportive services.

*HUD System Performance Measures 2, 3, 7b*

2B: Program Outcomes

Total Points: 15

Criteria: Has the agency demonstrated, through past performance, the ability to successfully carry out the work proposed and effectively provide services to people experiencing housing crises? † Consider:

5 Points: The agency’s experience and outcomes related to the following or comparable measures of housing stability and increased income in any prior housing projects:

- **For permanent supportive housing**: The percentage of formerly homeless individuals who remain housed in the HUD permanent supportive housing project or exited to other permanent housing, excluding participants who passed away;
- **For rapid rehousing/transitional housing**: The percentage of homeless persons who exited the project to/in a form of permanent housing, excluding participants who passed away;
- **For all projects**: The percentage of stayers/leavers that increase cash income from entry to latest status/exit;
- **For all projects**: The percentage of stayers/leavers with non-cash benefit sources.

5 Points: How the agency has analyzed the outcomes and improved program design and service delivery.

5 Points: The extent to which the agency has taken proactive steps to minimize barriers to housing placement and retention and actively support highly vulnerable and high-needs clients to obtain and maintain housing in prior housing projects.

† For projects dedicated to serving survivors of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking, the agency should provide examples of outcomes and program operations for existing or prior housing projects that serve(d) a similar population.

*HUD System Performance Measures 2, 3, 4, 7b*

2C: Affirmatively Furthering Fair Housing

Total Points: 5

Criteria: The program design ensures that housing will be available and accessible to the diverse population of persons experiencing homelessness, and the agency will take proactive steps to promote fair access to housing without regard to race, ancestry, religion, disability, sex, sexual orientation, gender identity, gender expression, genetic information, marital status, familial status, and source of income. Consider:

- How will the program ensure clients receive reasonable accommodations whenever they are needed?
• How will the program ensure that clients know their housing rights and are protected from housing discrimination based on race, ancestry, religion, disability, sex, sexual orientation, gender identity, gender expression, genetic information, marital status, familial status, and source of income?

*HUD System Performance Measures 2, 3, 7b*

### 2D: Alignment with Housing First Principles

- This will be scored based on written policies and procedures submitted by the project and responses to supplemental questions.
- This factor is scored by the Pre-NOFA Panel.

**Total Points:** 15

#### Criteria:

**5 Points:** To what extent do the project’s written policies and procedures ensure that participants will not be screened out based on the following criteria?

- Having too little or no income;
- Active, or history of, substance use or a substance use disorder;
- Having a criminal record (with exceptions for state-mandated restrictions);
- History of domestic violence (e.g., lack of a protective order, period of separation from abuser, or law enforcement involvement).

**5 Points:** To what extent do the project’s written policies and procedures ensure that participants will not be terminated from the program for the following reasons?

- Failure to participate in supportive services (with exception for HUD-mandated monthly case management meeting for RRH program participants);
- Failure to make progress on a service plan;
- Loss of income or failure to improve income;
- Being a survivor of domestic violence;
- Any other activity not covered in a lease agreement typically found in the project’s geographic area.

**5 Points:** What proactive steps does the agency propose to take to minimize barriers to housing placement and retention in the proposed project?

*HUD System Performance Measures 1, 3, 7*

### 3. **Agency/Collaborative Capacity to Enhance System Performance: 28 Points**

#### 3A: Administrative Capacity

**Total Points:** 10

#### Criteria:

Do the agencies (especially the lead agency)/does the agency have the expertise, staff, procedural, and administrative structure needed to meet all administrative requirements? Consider:

- Has the agency successfully handled at least one other federal grant or other major grant of this size and complexity, either in or out of the CoC?
- Does the agency have a clear staffing plan and a project budget that covers grant management?
- Does the budget show that the project will have enough resources to provide high-quality, reliable services to the target population?
• Does the budget show that the project will leverage significant outside resources (funding, staff, building space, volunteers, etc.) rather than rely entirely on CoC funds?

Does the budget show that the project is taking appropriate measures to promote cost effectiveness?

<table>
<thead>
<tr>
<th>3B: Compliance</th>
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</thead>
<tbody>
<tr>
<td>• This factor is scored by the Pre-NOFA Panel.</td>
</tr>
<tr>
<td><strong>Total Points:</strong> 5</td>
</tr>
<tr>
<td><strong>Criteria:</strong></td>
</tr>
<tr>
<td>To what extent do the agencies (especially the lead agency) have:</td>
</tr>
<tr>
<td>• Any outstanding financial audit findings or concerns?</td>
</tr>
<tr>
<td>• Any outstanding HUD monitoring findings or concerns and/or any history of sanctions imposed by HUD, including – but not limited to – suspending disbursements (e.g., freezing LOCCS), requiring repayment of grant funds, or de-obligating grant funds due to performance issues?</td>
</tr>
<tr>
<td>• If yes, what steps is the agency taking to resolve the findings or concerns and to what extent has the program advised the Collaborative Applicant of issues identified by HUD?</td>
</tr>
</tbody>
</table>

If an agency has no outstanding audit or monitoring findings or concerns and no history of sanctions imposed by HUD, the agency should receive full points.

<table>
<thead>
<tr>
<th>3C: Alignment with CoC Priorities</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Agencies can submit an essay answer demonstrating CoC alignment.</td>
</tr>
<tr>
<td>• This factor is scored by the Pre-NOFA Panel.</td>
</tr>
<tr>
<td><strong>Total Points:</strong> 10</td>
</tr>
<tr>
<td><strong>Criteria:</strong></td>
</tr>
<tr>
<td>Do the project and agency align with and support CoC priorities, including but not limited to:</td>
</tr>
<tr>
<td><strong>1 Point:</strong> CoC participation (meeting and training attendance)</td>
</tr>
<tr>
<td><strong>5 Points:</strong> Services provided or described are adequate to meet the needs of the population served, as indicated by:</td>
</tr>
<tr>
<td>• Case manager to client ratio;</td>
</tr>
<tr>
<td>• The type of services provided (housing navigation, substance use treatment, trauma informed care, youth-targeted programming, etc.);</td>
</tr>
<tr>
<td>• A clear, comprehensive service delivery strategy/plan;</td>
</tr>
<tr>
<td>• For projects dedicated to serving survivors of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking, the degree to which agency’s program design promotes client safety.</td>
</tr>
<tr>
<td><strong>3 Points:</strong> The project will contribute to the community plan goal of 6,000 new housing opportunities and maximize the number of people exiting homelessness. For example:</td>
</tr>
<tr>
<td>• Project will employ landlord engagement strategies;</td>
</tr>
<tr>
<td>• Project will contribute to improving system performance;</td>
</tr>
<tr>
<td>• Project has a move on program or strategy.</td>
</tr>
<tr>
<td><strong>1 Point:</strong> Sources of match funding are stable and sustainable.</td>
</tr>
</tbody>
</table>
### 3D: Client Participation in Program Design and Policy-Making

- This will be scored based on written policies and procedures submitted by the project and a narrative response demonstrating client participation in program design and policy-making.
- This factor is scored by the Pre-NOFA Panel.

**Total Points:** 9

**Criteria:**
Does the agency engage homeless and formerly homeless clients in program design and policy-making?

**6 Points:** Agency commits to having one or more of the following strategies for gathering client feedback and input.

**High-Priority Strategies**
- Having at least one homeless or formerly homeless person on its board;
- Having a consumer advisory board that meets regularly.

**Additional Strategies**
- Having at least one homeless or formerly homeless person on its staff;
- Administering consumer satisfaction surveys;
- Convening client focus groups;
- Other strategies

**3 Points:** Agency has a plan for incorporating client feedback in program design and/or policy-making.

---

### 4. HMIS Participation: 6 Points

**4: HMIS Participation**

**Total Points:** 6

**Criteria:**
If the agency has other programs, do they demonstrate HMIS participation or participation in a similar database? The panel may consider:
- Percentage of null/missing, “don’t know,” or “refused” data
- The percentage of clients that exit to known destinations
- The percentage of clients with known income and benefits
- Percent of clients who are required to have annual assessments and do not have them
- Average length of time between when a client enters or exits a program and when the project records the entry or exit
- Other data quality measures provided by the agency

Does the agency have a process for analyzing and improving data quality?

---

### 5. Component/Population-Type Prioritization: Up to 15 Bonus Points

#### 5A: Permanent Supportive Housing

**Total Points:** 10

**Criteria:**
Permanent supportive housing serving chronically homeless individuals and families will be awarded bonus points to demonstrate the CoC’s funding priorities.
### 5B: Rapid Rehousing

**Total Points:** 5

**Criteria:**
Rapid rehousing projects serving high priority populations (such as families and transition-aged youth coming directly from streets, shelter, or other places not meant for human habitation, or persons fleeing domestic violence or trafficking) will be awarded bonus points to demonstrate the CoC’s funding priorities. These points will not be awarded to joint TH-RRH projects.

### 5C: Leveraging Housing or Healthcare Resources

**Total Points:** 5

**Criteria:**
Permanent supporting housing or rapid rehousing projects that submit at least one written commitment that meets **at least one** of the criteria below will be awarded bonus points. The written commitment can be a letter of commitment, contract, or other formal written documents that demonstrates one of the criteria below.

**Criteria 5C1: Leveraging Housing Resources:**
Housing subsidies or subsidized housing units not funded through the CoC or ESG programs that account for:
- 25% of PSH units; **OR**
- Housing for 25% of RRH participants.

**Criteria 5C1: Leveraging Healthcare Resources:**
Resources from a healthcare provider or public or private health insurance provider of at least:
- In the case of a substance abuse treatment or recovery provider, access to treatment or recovery services for all qualifying and interested program participants; **OR**
- An amount that is equivalent to 25% of the funding being requested for the project will be covered by the healthcare organization.

Sources of health care resources include direct contributions from a public or private health insurance provider to the project, or provision of health care services by a private or public organization tailored to the program participants of the project.

**Partial Points:**
New PSH and RRH project applications will receive 2 of the 5 bonus points for attaching any written commitment of housing or healthcare resources, even if they do not meet the threshold for amount of commitment (e.g. a housing commitment of fewer than 25% of PSH units).
## ATTACHMENT: Project Review and Selection Process

<table>
<thead>
<tr>
<th>DOCUMENT SATISFYING REQUIREMENT</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>2021 Renewal Housing Projects Scoring Tool</strong></td>
<td>1 – 15</td>
</tr>
<tr>
<td>- 84 of 117 points for objective criteria (1A, 1B, 1C, 1C1, 1C2, 1D, 1E, 1F, 2B, 3A, 3B, 3C, 3D, 4A, 4B, 4C)</td>
<td>2 – 10, 12 – 15</td>
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<tr>
<td>- 32 of 117 points for criteria related to HUD SPMs (1B, 1C, 1D)</td>
<td>3 – 6</td>
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<tr>
<td>- Projects evaluated based on data from comparable databases</td>
<td>1</td>
</tr>
<tr>
<td>- Objective criteria based on how DV projects improve safety (1C1, 1C2)</td>
<td>6 – 7</td>
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<tr>
<td>- Evaluation of successful housing placements (1B)</td>
<td>3 – 4</td>
</tr>
<tr>
<td>- Consideration of severity of barriers: Populations with more severe needs identified on p. 2.</td>
<td>2 – 9, 12-15</td>
</tr>
<tr>
<td>Panelists invited to use discretion in scoring for factors 1A, 1B, 1C, 1D, 1E, 1F, 3A, 3B, 3C, 3D</td>
<td></td>
</tr>
<tr>
<td><strong>2021 New/Transfer Projects and Projects Without a Full Year of Data Scoring Tool</strong></td>
<td>16 – 22</td>
</tr>
<tr>
<td>- 15 of 110 points for objective criteria (5A/5B, 5C)</td>
<td>21 – 22</td>
</tr>
<tr>
<td>- 50 of 110 points for criteria related to HUD SPMs (2A, 2B, 2C, 2D)</td>
<td>17 – 19</td>
</tr>
<tr>
<td>- Projects evaluated based on data from comparable databases (2B, 4)</td>
<td>18, 21</td>
</tr>
<tr>
<td>- Evaluation of successful housing placements (2B)</td>
<td>18</td>
</tr>
<tr>
<td><strong>Full Scorecard for One Renewal PSH Project</strong></td>
<td>23 – 39</td>
</tr>
<tr>
<td>- Includes all scoring criteria with maximum point values and points awarded.</td>
<td></td>
</tr>
<tr>
<td><strong>Final Priority Listing</strong></td>
<td>40</td>
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<tr>
<td>- Includes final project scores for ranked new and renewal projects.</td>
<td></td>
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</table>
Summary of Factors

<table>
<thead>
<tr>
<th>Threshold Requirements</th>
<th>Not Scored</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Outcomes Supporting System Performance Measures¹</td>
<td>60 points</td>
</tr>
<tr>
<td>2. Agency/Collaborative Capacity</td>
<td>23 points</td>
</tr>
<tr>
<td>3. HMIS Data Quality</td>
<td>17 points</td>
</tr>
<tr>
<td>Total</td>
<td>100 points</td>
</tr>
<tr>
<td>Component/Population-Type Prioritization Bonus Points²</td>
<td>Up to 17 points per project</td>
</tr>
</tbody>
</table>

I. Threshold Requirements

Threshold Criteria
- These factors are required, but not scored. If the project indicates “no” for any threshold criteria, it is ineligible for CoC funding.

HMIS Implementation: Projects are required to participate in HMIS, unless the project is a victim-service agency, serving survivors of domestic violence, or a legal services agency.

Coordinated Entry: Projects are required to participate in Coordinated Entry, when it is available for the project type.

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HUD Policies: Projects are required to have policies regarding termination of assistance, client grievances, Equal Access, ADA and fair housing requirements, VAWA protection, and confidentiality that are compliant with HUD CoC Program requirements.

¹ All of the scoring factors in this tool measure projects’ contribution to improving Santa Clara County’s System Performance by strengthening the overall system of care, through data collection, coordination, prioritization and increasing resources available to end homelessness in Santa Clara County. Certain scoring factors relate to specific Performance Measures, as enumerated in each factor. Projects will be scored based on data in the CoC’s HMIS, except for projects operated by victim service providers which will be scored based on data from the victim service provider’s comparable database.

² Bonus points help ensure fairness and equal footing across scoring tools, which otherwise strongly advantage projects without data, and support prioritization of proven strong performers, while encouraging reallocation of projects not advancing system performance.
II. Detail

1. Outcomes Supporting System Performance Measures: 60 Points

Overall, has the project been performing satisfactorily and effectively addressing the need(s) for which it was designed? Keep in mind that outcomes will naturally be lower in a population with more severe needs. Such populations include persons with low or no income, current or past substance abuse, a history of victimization (e.g., domestic violence, sexual assault, childhood abuse), criminal histories, and chronic homelessness.

1A: Utilization

- Report average utilization of total project beds based on four points during the year
- Informed by supplemental information submitted as part of the proposal

Criteria:
- Is the project serving the number of homeless people it was designed to serve?

Panelists are encouraged to exercise discretion based on factors including but not limited to average annual occupancy HMIS data provided by the applicant, occupancy rate trending up or down, project size, population served, and facility status issues beyond the project’s sphere of influence.

HUD System Performance Measures 1, 3

Calculation: Average Number of Households Served Across Four Points in Time ÷ Units Funded

Data Sources: [ ( APR 8b January Total + APR 8b April Total + APR 8b July Total + APR 8b October Total ) ÷ 4 ] + Project Application 4B Total Units OR 6A Total Households

<table>
<thead>
<tr>
<th>Year 1 Scale</th>
<th></th>
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<tbody>
<tr>
<td>85 – 100%</td>
<td>10 points</td>
</tr>
<tr>
<td>70 – 84.9%</td>
<td>8 points</td>
</tr>
<tr>
<td>55 – 69.9%</td>
<td>6 points</td>
</tr>
<tr>
<td>30 – 54.9%</td>
<td>2 points</td>
</tr>
<tr>
<td>0 – 29.9%</td>
<td>0 points</td>
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Scale for Older Projects

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
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<tbody>
<tr>
<td>90 – 100%</td>
<td>10 points</td>
</tr>
<tr>
<td>80 – 89.9%</td>
<td>8 points</td>
</tr>
<tr>
<td>70 – 79.9%</td>
<td>6 points</td>
</tr>
<tr>
<td>50 – 69.9%</td>
<td>2 points</td>
</tr>
<tr>
<td>0 – 50%</td>
<td>0 points</td>
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</tbody>
</table>
**1B: Housing Stability (PSH Only)**
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**For permanent supportive housing:** The percentage of formerly homeless individuals who remain housed in the HUD permanent supportive housing project or exited to other permanent housing, excluding participants who passed away and participants who exited to non-psychiatric hospitals, foster care, or long-term care or nursing homes.
  - *Panelists may exercise discretion* based on factors including but not limited to project size, population served and severity of barriers, and circumstances beyond the project’s sphere of influence.

2020-21 Community Benchmark: 98%

**HUD System Performance Measures 3, 7**

**Calculation:** \((\text{Total Stayers} + \text{Total Exits to PH}) / (\text{Total Clients} - \text{Total Deceased})\)

**APR Sources:**
\[\text{[APR 5a Stayers + APR 23c Permanent Dest. Subtotal]} + \text{[APR 5a Persons Served - APR Q23c Deceased - APR Q23c Hospital – APR 23c Foster Care – APR 23c Long-term Care or Nursing Home]}\]

<table>
<thead>
<tr>
<th>Scale</th>
<th>Points</th>
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<tbody>
<tr>
<td>≥98%</td>
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<tr>
<td>96-97.9%</td>
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<tr>
<td>60-67.4%</td>
<td>1</td>
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<tr>
<td>&lt;60%</td>
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</tbody>
</table>

**1B: Housing Stability (RRH/Youth TH Only)**
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**For rapid rehousing/transitional housing:** The percentage of homeless persons who exited the project to/in a form of permanent housing, excluding participants who passed away and participants who exited to non-psychiatric hospitals, foster care, or long-term care or nursing homes.
  - *Panelists may exercise discretion* based on factors including but not limited to project size, the number of persons who exited the project, population served and severity of barriers, and circumstances beyond the project’s sphere of influence.
  - Projects with no leavers will receive full points.

2020-21 Community Benchmark:
- RRH: 80%
- TH: 50%
**HUD System Performance Measures 1, 3, 7**

**Calculation:** Total Exits to PH ÷ (Total Leavers - Total Deceased)

**APR Sources:**
APR 23c Permanent Destinations Subtotal ÷ [APR 5a Leavers - APR 23c Deceased - APR Q23c Hospital – APR 23c Foster Care – APR 23c Long-term Care or Nursing Home]

<table>
<thead>
<tr>
<th><strong>Year One Scale</strong></th>
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<tbody>
<tr>
<td>≥95%</td>
<td>15 points</td>
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<tr>
<td>75-94.9%</td>
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<tr>
<td>60-74.9%</td>
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<td>45-59.9%</td>
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<td>40-44.9%</td>
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<table>
<thead>
<tr>
<th><strong>RRH Scale</strong></th>
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<table>
<thead>
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<th><strong>Youth TH Scale</strong></th>
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<td>9 points</td>
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<tr>
<td>70-74.9%</td>
<td>7 points</td>
</tr>
<tr>
<td>65-69.9%</td>
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<tr>
<td>60-64.9%</td>
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<tr>
<td>50-59.9%</td>
<td>1 points</td>
</tr>
<tr>
<td>&lt;50%</td>
<td>0 points</td>
</tr>
</tbody>
</table>
### 1C: Returns to Homelessness Within 12 Months (Non-DV Projects Only)

- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
The percentage of leavers to permanent housing destinations in the year prior to the measurement period who returned to a homeless project in HMIS within 12 months.
- Panelists may exercise discretion based on factors including but not limited to project size, household size, and the number of persons who exited the project in the prior year.
- Projects with no leavers in the prior year and projects without at least 2 years of performance data will receive full points.

2020-21 Community Benchmarks:
- PSH: 5%
- RRH: 8%
- TH: 8%

**HUD System Performance Measure 2**

**Calculation:** Number of People Who Exited to PH in 2017 who Returned to Programs in HMIS ÷ Number of Exits to PH in 2016

**Data Sources:** [Looker Project Exit Date is in Exit Year; Exit Destination is permanent; Next Entry Without Stable Housing Date is within 12 months of exit] ÷ [Looker Project Exit Date is in Exit Year; Exit Destination is permanent]

<table>
<thead>
<tr>
<th>PSH Scale</th>
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<td>60-70%</td>
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<td>8-9.9%</td>
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<td>30-39.9%</td>
<td>3</td>
</tr>
<tr>
<td>40-49.9%</td>
<td>2</td>
</tr>
<tr>
<td>50-60%</td>
<td>1</td>
</tr>
</tbody>
</table>
### 1C1: Improving Safety through Safety Planning (DV Projects Only)
- Calculated based on HMIS data and supplemental information submitted as part of the proposal

**Criteria:**
The percentage of survivors for whom a safety plan was completed.
- **Panelists may exercise discretion** based on factors including but not limited to project size and the number of households served.

**Calculation:** Number of Survivors with Completed Safety Plans ÷ Number of Households Served

**Data Sources:** Number of Completed Safety Plans Reported by Project ÷ APR 8 Households Served

| Youth TH Scale | | |
|----------------|---------------------------|
|               | 7% | 6 points |
| <5%            | 6% | 5 points |
| 5-9.9%         | 5% | 4 points |
| 10-14.9%       | 4% | 3 points |
| 15-34.9%       | 3% | 2 points |
| 35-44.9%       | 2% | 1 points |
| 45-54.9%       | 1% | 0 points |
| >70%           | 0% | 0 points |

### 1C2: Improving Safety through Services Provided
- Calculated based on supplemental information submitted as part of the proposal

**Criteria:**
The number of supportive services categories available to clients on a voluntary basis, through referral or provided by the program, to support clients’ physical, emotional, and economic safety and autonomy. Applicant will indicate which of the following services are available to clients enrolled in the project:
- Individual Counseling
- Group Counseling
- Criminal Justice Advocacy and Court Accompaniment
- Social Services Advocacy (e.g. Cal WORKS, schools, benefits applications, etc)
- Legal Assistance
- Employment Services
- Childcare

<table>
<thead>
<tr>
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<th></th>
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</thead>
<tbody>
<tr>
<td>100%</td>
<td>4 points</td>
</tr>
<tr>
<td>90-99.9%</td>
<td>3 points</td>
</tr>
<tr>
<td>&lt;90%</td>
<td>0 points</td>
</tr>
</tbody>
</table>
- Transportation
- Landlord Outreach and Education
- Education Advocacy and Support for School-Aged Children

<table>
<thead>
<tr>
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<th>Points</th>
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<td>9-10 Service Categories</td>
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<td>5-6 Service Categories</td>
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<tr>
<td>&lt;5 Service Categories</td>
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</tbody>
</table>

**1D: Client Cash Income Change**
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
The percentage of adult stayers/leavers that increase cash income from entry to latest annual assessment/exit, excluding all stayers not yet required to have an annual assessment.
- Panelists may exercise discretion based on factors including but not limited to project size, population served and severity of barriers, and circumstances beyond the project’s sphere of influence.

2020-21 Community Benchmarks:
- Stayers: 35%
- Leavers: 40%

**HUD System Performance Measure 4**

**Calculation:**
\[
\frac{\text{Adults Who Gained Income} + \text{Adults Who Increased Amount of Income}}{\text{Adults} - \text{Stayers Not Required to Have Assessment}}
\]

**APR Sources:**
\[
\frac{\text{APR19a3 Row 5 Column 4} + \text{APR19a3 Row 5 Column 5}}{\text{APR5a Adults} - \text{APR18 Stayers Not Yet Required to Have an Annual Assessment}}
\]

<table>
<thead>
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<tbody>
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<tr>
<td>35-54.9%</td>
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</tr>
<tr>
<td>25-34.9%</td>
<td>3 points</td>
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<tr>
<td>10-14.9%</td>
<td>1 point</td>
</tr>
<tr>
<td>&lt;10%</td>
<td>0 points</td>
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</tbody>
</table>

**Scale for Older Projects**
1E: Non-Cash Mainstream Benefits

- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

Criteria:
The percentage of adult stayers/leavers with non-cash benefit sources, excluding all stayers not yet required to have an annual assessment.
- Panelists may exercise discretion based on factors including but not limited to project size, population served, and circumstances beyond the project's sphere of influence.

No Related Community Benchmarks

HUD System Performance Measure 2, 7b

Calculation:
\[
\frac{(\text{Adult Leavers with At Least 1 Benefit} + \text{Adult Stayers with At Least 1 Benefit})}{\text{(Total Adults} - \text{Adult Stayers Not Yet Required to Have an Assessment})}
\]

APR Sources:
\[
\left[ \frac{\text{APR 20b 1Plus Sources Leavers} + \text{APR 20b 1Plus Sources Stayers}}{\text{APR 5a Adults} - \text{APR 18 Adult Stayers Not Yet Required to Have an Assessment}} \right]
\]

<table>
<thead>
<tr>
<th>Scale</th>
<th>Points</th>
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<tbody>
<tr>
<td>≥60%</td>
<td>3 points</td>
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<tr>
<td>40-59.9%</td>
<td>2 points</td>
</tr>
<tr>
<td>10-39.9%</td>
<td>1 points</td>
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<td>&lt;10%</td>
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<table>
<thead>
<tr>
<th>Scale</th>
<th>Points</th>
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</thead>
<tbody>
<tr>
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<tr>
<td>40-54.9%</td>
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<tr>
<td>30-39.9%</td>
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<tr>
<td>20-29.9%</td>
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</tr>
<tr>
<td>15-19.9%</td>
<td>1 point</td>
</tr>
<tr>
<td>&lt;15%</td>
<td>0 points</td>
</tr>
</tbody>
</table>
1F: Health Insurance
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

Criteria:
The percentage of stayers/leavers with health insurance, excluding all stayers not yet required to have an annual assessment.
- Panelists may exercise discretion based on factors including but not limited to project size, population served, and circumstances beyond the project's sphere of influence.

No Related Community Benchmarks

HUD System Performance Measure 2, 7b

Calculation:
( Adult Stayers with 1 or More Sources of Health Insurance + Adult Leavers with 1 or More Sources of Health Insurance ) ÷ ( Total Adults - Adult Stayers Not Yet Required to Have an Assessment )

APR Sources:
[ APR 21 Stayers 1 Source of Health Insurance + APR 21 Stayers More than 1 Source of Health Insurance + APR 21 Leavers 1 Source of Health Insurance + APR 21 Leavers More than 1 Source of Health Insurance ] ÷ [ APR 5a Adults - APR 18 Adult Stayers Not Yet Required to Have an Assessment ]

Scale

<table>
<thead>
<tr>
<th>%</th>
<th>Points</th>
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</thead>
<tbody>
<tr>
<td>≥95%</td>
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<td>85-94.9%</td>
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<td>75-84.9%</td>
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<tr>
<td>65-74.9%</td>
<td>2</td>
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<tr>
<td>55-64.9%</td>
<td>1</td>
</tr>
<tr>
<td>&lt;55%</td>
<td>0</td>
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</table>

1G: Alignment with Housing First Principles
- Based on written policies and procedures and narrative response submitted as part of the proposal.
- This factor is scored by the Pre-NOFA Panel.

Total Points: 15

Criteria:
5 Points: To what extent do the project's written policies and procedures ensure that participants are not screened out based on the following criteria?
- Having too little or no income
- Active, or history of, substance use or a substance use disorder
- Having a criminal record (with exceptions for state-mandated restrictions)
- History of domestic violence (e.g., lack of a protective order, period of separation from abuser, or law enforcement involvement)

5 Points: To what extent do the project's written policies and procedures ensure that participants are not terminated from the program for the following reasons?
- Failure to participate in supportive services (with exception for HUD-mandated monthly case management meeting for RRH program participants)
- Failure to make progress on a service plan
- Loss of income or failure to improve income
• Being a survivor of domestic violence
• Any other activity not covered in a lease agreement typically found in the project’s geographic area

5 Points: Does the project take proactive steps to minimize barriers to entry and retention?

_HUD System Performance Measures 1, 3, 7_

2. **Agency/Collaborative Capacity: 23 Points**

2A: Compliance
• Based on any financial audit, HUD monitoring report and correspondence, and supplemental information submitted as part of the proposal.
• This factor is scored by the Pre-NOFA Panel.

Total Points: 5

Criteria:
To what extent do the agencies (especially the lead agency)/does the agency have:
• Any outstanding financial audit findings or concerns?
• Any outstanding HUD monitoring findings or concerns and/or any history of sanctions imposed by HUD, including – but not limited to – suspending disbursements (e.g., freezing LOCCS), requiring repayment of grant funds, or de-obligating grant funds due to performance issues?
• If yes, what steps is the agency taking to resolve the findings or concerns and to what extent has the program advised the Collaborative Applicant of issues identified by HUD?

If an agency has no outstanding audit or monitoring findings or concerns and no history of sanctions imposed by HUD, the agency should receive full points.

2B: Unspent Grant Funds
• Based on supplemental information submitted as part of the proposal

Criteria:
Has the agency left project grant funds unspent in the past 3 years?
• Consider if the program is running at capacity (at four points during the year), and if the project receives leasing or rental assistance funding.

Panelists may score programs up or down from the scaled score.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Points</th>
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<tbody>
<tr>
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<tr>
<td>3.1-9%</td>
<td>3 points</td>
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<tr>
<td>9.1-15%</td>
<td>1 points</td>
</tr>
<tr>
<td>15-100%</td>
<td>0 points</td>
</tr>
</tbody>
</table>
2C: Alignment with CoC Priorities

- Based on narrative submitted as part of the proposal
- This factor is scored by the Pre-NOFA Panel.

**Total Points:** 8

**Criteria:**
Do the project and agency align with and support CoC priorities, including but not limited to:

1 Point: CoC participation (meeting and training attendance)

3 Points: Services provided or described are adequate to meet the needs of the population served, as indicated by:
- Case manager to client ratio
- The type of services provided (housing navigation, substance use treatment, trauma informed care, youth-targeted programming, etc.)
- A clear, comprehensive service delivery strategy/plan
- For projects dedicated to serving survivors of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking, the degree to which agency’s program design promotes client safety.

3 Points: The project contributes to the community plan goal of 6,000 new housing opportunities and maximizes the number of people exiting homelessness. For example:
- Project employs landlord engagement strategies
- Project proposes to increase the number of persons served
- Contribution of project to improving system performance
- Project has or participates in a move on program or strategy

1 Point: Sources of match funding are stable and sustainable

2D: Client Participation in Program Design and Policy-Making

- This will be scored based on a narrative response demonstrating client participation in program design and policy-making.
- This factor is scored by the Pre-NOFA Panel.

**Total Points:** 5

**Criteria:**
Does the agency engage homeless and formerly homeless clients in program design and policy-making?

2 Points: Agency has at least one strategy for gathering client feedback and input. Strategies may include, but are not limited to:
- Having at least one homeless or formerly homeless person on its staff or board
- Having a consumer advisory board that meets regularly
- Administering consumer satisfaction surveys
- Convening client focus groups

3 Points: Agency incorporates client feedback in program design and/or policy-making.
### 3. HMIS Data Quality: 17 Points

#### 3A: Exits to Known Destinations
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
Percentage of clients who exit to known destinations.
- **Panelists may exercise discretion** based on factors including but not limited to limited project exits and circumstances beyond the project’s sphere of influence.

PSH with 0 exits receive full points.

**Calculation:**
\[
\frac{\text{Total Leavers} - \text{Leavers With Don't Know/Refused Destinations} - \text{Leavers With Missing Destinations}}{\text{Total Leavers}}
\]

**APR Sources:**
\[
\left[ \text{APR5a Leavers} - \text{APR23a Total Client Doesn't Know/Client Refused} - \text{APR23b Total Client Doesn't Know/Client Refused} - \text{APR23a Total Data Not Collected} - \text{APR23b Total Data Not Collected} \right] \div \text{APR5a Leavers}
\]

<table>
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<tr>
<td>60-79.9%</td>
<td>1</td>
</tr>
<tr>
<td>&lt;60%</td>
<td>0</td>
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</tbody>
</table>

#### 3B: Complete Data
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
Percentage of complete data (not null/missing, “don’t know” or “refused” data, “data issues” or “error”), as reported in APR 6a, 6b, and 6c, except for Social Security numbers.
- **Panelists may exercise discretion** based on factors including but not limited to limited project exits and circumstances beyond the project’s sphere of influence.

Community Performance Measure: 95%

**Calculation:**
\[
\frac{\text{Sum of Client Doesn't Know/Refused} + \text{Information Missing} + \text{Data Issues} + \text{Error Count for 14 data elements in APR Questions 6a-6c, excluding SSN}}{\text{14} \times \text{Total Served}}
\]

**APR Sources:**
\[
\left[ \text{APR6a Client Don't Know Refused} \text{ for Name, Date of Birth, Race, Ethnicity, Gender} + \text{APR6a Information Missing} \text{ for Name, Date of Birth, Race, Ethnicity, Gender} + \text{APR6a Data Issues} \text{ for Name, Date of Birth, Race, Ethnicity, Gender} + \text{APR 6b Error Count} \text{ for Veteran Status, Project Start Date, Relationship to Head of Household, Client Location, Disabling Condition} + \text{APR 6c Error Count} \text{ for Destination, Income and Sources at Start, Income and Sources at Annual Assessment, Income and Sources at Exit} \right] \div \text{14} \times \text{APR5a Total Served}
\]
### Scale

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</tr>
<tr>
<td>&lt;90%</td>
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</tbody>
</table>

### 3C: Known Income
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
Percentage of adult clients with known income at latest annual assessment or exit, excluding all stayers not yet required to have an annual assessment.
- Panelists may exercise discretion based on factors including but not limited to small project size and circumstances beyond the project’s sphere of influence.

**Calculation:**
\[
\frac{( \text{Adult Stayers With Known Income} + \text{Adult Leavers With Known Income} )}{( \text{Adults} - \text{Stayers Not Yet Required to Have an Annual Assessment} )}
\]

**APR Sources:**
\[
\frac{\text{[ APR18 Adults with Income Information at Annual Assessment + APR18 Adults with Income Information at Exit ]}}{\text{[ APR5a Adults - APR18 Stayers Not Yet Required ]}}
\]

### Scale

<table>
<thead>
<tr>
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<tbody>
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<tr>
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</tbody>
</table>

### 3D: Known Benefits
- Calculated based on HMIS data
- Informed by supplemental information submitted as part of the proposal

**Criteria:**
Percentage of adult clients with known benefits at latest annual assessment or exit, excluding all stayers not yet required to have an annual assessment.
- Panelists may exercise discretion based on factors including but not limited to small project size and circumstances beyond the project’s sphere of influence.
**Calculation:**

\[
\frac{\text{(Adult Stayers With Known Non-Cash Benefits + Adult Leavers With Known Non-Cash Benefits)}}{\text{(Total Adults - Stayers Not Yet Required to Have Annual Assessments)}}
\]

**APR Sources:**

\[
\frac{\text{[APR20b Adult Leavers No Sources + APR20b Adult Leavers 1Plus Sources + APR20b Adult Stayers No Sources + APR20b Adult Stayers 1Plus Sources]}}{\text{[APR 5a Adults - APR18 Stayers Not Yet Required]}}
\]

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<tr>
<td>60-79.9%</td>
<td>1</td>
</tr>
<tr>
<td>&lt;60%</td>
<td>0</td>
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</tbody>
</table>

**3E: Data Accuracy**

**Penalty:** -1

**Criteria:**
- Applicants who request to correct HMIS data past the APR review deadline and during the evaluation report review process will be penalized by 1 point.

**4. Component/Population Type Prioritization: Up to 17 Bonus Points**

**4A: Permanent Housing**

**Total Points:** 10

**Criteria:**
- **10 Points:** Permanent supportive housing will be awarded 10 bonus points to demonstrate the CoC’s funding priorities.
- **5 Points:** Rapid rehousing projects will be awarded 5 bonus points to demonstrate the CoC’s funding priorities.

**4B: Chronic Homelessness**

**Total Points:** 5

**Criteria:**
- Percentage of beds dedicated to/prioritized for chronically homeless persons.
  - DedicatedPLUS PSH projects receive full points.

<table>
<thead>
<tr>
<th>Scale</th>
<th>Points</th>
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</thead>
<tbody>
<tr>
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<td>5</td>
</tr>
<tr>
<td>&gt;75%</td>
<td>3</td>
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</tbody>
</table>
## 4C: Other Priority Populations

**Total Points: 2**

**Criteria:**
Is the program dedicated to a priority population?
- Youth
- Survivors of Domestic Violence
- Families with Children
- Veterans
2021 Continuum of Care Grants
NEW/TRANSFER PROJECTS AND PROJECTS WITHOUT A FULL YEAR OF DATA
Approved: September 1, 2021

<table>
<thead>
<tr>
<th>Summary of Factors</th>
<th>Not Scored</th>
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<tbody>
<tr>
<td>Threshold Requirements</td>
<td></td>
</tr>
<tr>
<td>1. Project’s Work Consistent with Community Needs</td>
<td>10 points</td>
</tr>
<tr>
<td>2. Project Ability to Enhance System Performance*</td>
<td>50 points</td>
</tr>
<tr>
<td>3. Agency/Collaborative Capacity to Enhance System Performance</td>
<td>34 points</td>
</tr>
<tr>
<td>4. HMIS Participation</td>
<td>6 points</td>
</tr>
<tr>
<td>Total</td>
<td>100 points</td>
</tr>
<tr>
<td>5. Component/Population-Type Prioritization Bonus Points†</td>
<td>Up to 10 points Per Project</td>
</tr>
</tbody>
</table>

I. Threshold Requirements

**Threshold Criteria**
- These factors are required, but not scored. If the project indicates “no” for any threshold criteria, it is ineligible for CoC funding.

**HMIS Implementation:** Projects are required to participate in HMIS, unless the project is a victim-service agency, serving survivors of domestic violence, or a legal services agency.

**Coordinated Entry:** Projects are required to participate in Coordinated Entry, when it is available for the project type.

**Eligible Applicant:** Applicants and subrecipients (if any) are eligible to receive CoC funding, including non-profit organizations, States, local governments, and instrumentalities of state and local governments.

**Eligible New Project Type:** If the project is a new project in 2021, it is an eligible new project type authorized by the FY 2021 CoC Program Notice of Funding Opportunity (NOFO): Permanent Supportive Housing (PSH), Rapid Re-Housing (RRH), or joint Transitional Housing-Rapid Re-Housing (TH-RRH) serving eligible populations; Homeless Management Information System (HMIS); or Supportive Services Only for Coordinated Entry (CE).

**HUD Threshold:** All projects will be reviewed for compliance with the eligibility requirements of the CoC Interim Rule and Subsequent Notices and must meet the threshold requirements outlined in the 2021 NOFO.

* All of the scoring factors in this tool measure projects' anticipated contribution to improving Santa Clara County's System Performance by strengthening the overall system of care, through data collection, coordination, prioritization and increasing resources available to end homelessness in Santa Clara County. Certain scoring factors relate to specific Performance Measures, as enumerated in each factor.

† Bonus points help ensure fairness and equal footing across scoring tools, which otherwise strongly advantage projects without data, and support prioritization of proven strong performers, while encouraging reallocation of projects not advancing system performance.
HUD Policies: Projects are required to have compliant policies regarding termination of assistance, client grievances, Equal Access, ADA and fair housing requirements, VAWA protection, and confidentiality.

Renewable Activities: Projects are required to utilize the grant funds for renewable activities (e.g., leasing rental subsidies, and housing operations) as opposed to non-renewable ones (e.g., acquisition, construction, and rehabilitation).

II. Detail

1. Project’s Work Consistent with Community Needs: 10 Points

1A: Project Readiness

Total Points: 10

Criteria:
The project will be ready to start by HUD’s statutory deadlines. Consider:
- Regulatory obstacles such as tenant displacement or relocation, environmental or zoning issues anticipated;
- Whether the agency has a feasible timeline for staffing the project, establishing site control, beginning to draw down funds, and otherwise complying with CoC Program deadlines;
- Whether the agency already has policies and procedures that can be used as-is or easily adapted for use in a CoC-funded project.

2. Project Ability to Enhance System Performance: 47 Points

Consider the overall design of the project in light of its outcome objectives, and the Continuum of Care’s goal that permanent housing programs for homeless people result in stable housing and increased income (through benefits or employment).

2A: Program Design

Total Points: 15

Criteria:
Program design includes provision of comprehensive/intensive case management and appropriate supportive services of the appropriate type, scale and location to meet the needs of program participants (as well as transportation if necessary), using a Housing First model. † Consider:

7 Points: Has the agency developed a concrete plan for providing services to clients and/or referring clients to outside services for support*, including:
- What is the step-by-step process for connecting clients to services outside the agency?
- What types of services will be provided in-house?
- What types of services will require referrals?
- What agencies will accept referrals?
- What is the step-by-step process for developing client service plans and matching clients with services? What tools and evidence-based practices will be used?

* For RRH applicants: Will services described adequately support clients in securing employment and achieving long-term housing stability?

3 Points: Will the project be staffed appropriately to provide the services?

2 Points: Will the staff be trained to meet the needs of the population to be served?
3 Points: To what extent will the program be able to effectively serve eligible clients of different backgrounds, experiences, cultures, abilities, and language proficiencies?

† For projects dedicated to serving survivors of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking, safety is a primary need of the population served. Among other needs, the panel should consider the extent to which program design promotes client safety. It is considered a best practice for programs serving survivors of domestic violence to have certified domestic violence, sexual assault, and/or human trafficking advocates (40- or 65-hour training course) to provide confidential supportive services.

_HUD System Performance Measures 2, 3, 7b_

2B: Program Outcomes

Criteria: Has the agency demonstrated, through past performance, the ability to successfully carry out the work proposed and effectively provide services to people experiencing housing crises? † Consider:

5 Points: The agency’s experience and outcomes related to the following or comparable measures of housing stability and increased income in any prior housing projects:

- **For permanent supportive housing:** The percentage of formerly homeless individuals who remain housed in the HUD permanent supportive housing project or exited to other permanent housing, excluding participants who passed away;
- **For rapid rehousing/transitional housing:** The percentage of homeless persons who exited the project to/in a form of permanent housing, excluding participants who passed away;
- **For all projects:** The percentage of stayers/leavers that increase cash income from entry to latest status/exit;
- **For all projects:** The percentage of stayers/leavers with non-cash benefit sources.

5 Points: How the agency has analyzed the outcomes and improved program design and service delivery.

5 Points: The extent to which the agency has taken proactive steps to minimize barriers to housing placement and retention and actively support highly vulnerable and high-needs clients to obtain and maintain housing in prior housing projects.

† For projects dedicated to serving survivors of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking, the agency should provide examples of outcomes and program operations for existing or prior housing projects that serve(d) a similar population.

_HUD System Performance Measures 2, 3, 4, 7b_

2C: Affirmatively Furthering Fair Housing

Criteria: The program design ensures that housing will be available and accessible to the diverse population of persons experiencing homelessness, and the agency will take proactive steps to promote fair access to housing without regard to race, ancestry, religion, disability, sex, sexual orientation, gender identity, gender expression, genetic information, marital status, familial status, and source of income. Consider:

- How will the program ensure clients receive reasonable accommodations whenever they are needed?
• How will the program ensure that clients know their housing rights and are protected from housing discrimination based on race, ancestry, religion, disability, sex, sexual orientation, gender identity, gender expression, genetic information, marital status, familial status, and source of income?

_HUD System Performance Measures 2, 3, 7b_

**2D: Alignment with Housing First Principles**

- This will be scored based on written policies and procedures submitted by the project and responses to supplemental questions.
- This factor is scored by the Pre-NOFA Panel.

**Total Points: 15**

**Criteria:**

**5 Points:** To what extent do the project’s written policies and procedures ensure that participants will not be screened out based on the following criteria?

- Having too little or no income;
- Active, or history of, substance use or a substance use disorder;
- Having a criminal record (with exceptions for state-mandated restrictions);
- History of domestic violence (e.g., lack of a protective order, period of separation from abuser, or law enforcement involvement).

**5 Points:** To what extent do the project’s written policies and procedures ensure that participants will not be terminated from the program for the following reasons?

- Failure to participate in supportive services (with exception for HUD-mandated monthly case management meeting for RRH program participants);
- Failure to make progress on a service plan;
- Loss of income or failure to improve income;
- Being a survivor of domestic violence;
- Any other activity not covered in a lease agreement typically found in the project’s geographic area.

**5 Points:** What proactive steps does the agency propose to take to minimize barriers to housing placement and retention in the proposed project?

_HUD System Performance Measures 1, 3, 7_

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3. **Agency/Collaborative Capacity to Enhance System Performance: 28 Points**

**3A: Administrative Capacity**

**Total Points: 10**

**Criteria:**

Do the agencies (especially the lead agency)/does the agency have the expertise, staff, procedural, and administrative structure needed to meet all administrative requirements? Consider:

- Has the agency successfully handled at least one other federal grant or other major grant of this size and complexity, either in or out of the CoC?
- Does the agency have a clear staffing plan and a project budget that covers grant management?
- Does the budget show that the project will have enough resources to provide high-quality, reliable services to the target population?
• Does the budget show that the project will leverage significant outside resources (funding, staff, building space, volunteers, etc.) rather than rely entirely on CoC funds?

Does the budget show that the project is taking appropriate measures to promote cost effectiveness?

3B: Compliance
• This factor is scored by the Pre-NOFA Panel.

Total Points: 5

Criteria:
To what extent do the agencies (especially the lead agency) have:
• Any outstanding financial audit findings or concerns?
• Any outstanding HUD monitoring findings or concerns and/or any history of sanctions imposed by HUD, including – but not limited to – suspending disbursements (e.g., freezing LOCCS), requiring repayment of grant funds, or de-obligating grant funds due to performance issues?
• If yes, what steps is the agency taking to resolve the findings or concerns and to what extent has the program advised the Collaborative Applicant of issues identified by HUD?

If an agency has no outstanding audit or monitoring findings or concerns and no history of sanctions imposed by HUD, the agency should receive full points.

3C: Alignment with CoC Priorities
• Agencies can submit an essay answer demonstrating CoC alignment.
• This factor is scored by the Pre-NOFA Panel.

Total Points: 10

Criteria:
Do the project and agency align with and support CoC priorities, including but not limited to:

1 Point: CoC participation (meeting and training attendance)

5 Points: Services provided or described are adequate to meet the needs of the population served, as indicated by:
• Case manager to client ratio;
• The type of services provided (housing navigation, substance use treatment, trauma informed care, youth-targeted programming, etc.);
• A clear, comprehensive service delivery strategy/plan;
• For projects dedicated to serving survivors of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking, the degree to which agency’s program design promotes client safety.

3 Points: The project will contribute to the community plan goal of 6,000 new housing opportunities and maximize the number of people exiting homelessness. For example:
• Project will employ landlord engagement strategies;
• Project will contribute to improving system performance;
• Project has a move on program or strategy.

1 Point: Sources of match funding are stable and sustainable.
3D: Client Participation in Program Design and Policy-Making

- This will be scored based on written policies and procedures submitted by the project and a narrative response demonstrating client participation in program design and policy-making.
- This factor is scored by the Pre-NOFA Panel.

**Total Points:** 9

**Criteria:**

Does the agency engage homeless and formerly homeless clients in program design and policy-making?

**6 Points:** Agency commits to having one or more of the following strategies for gathering client feedback and input.

**High-Priority Strategies**

- Having at least one homeless or formerly homeless person on its board;
- Having a consumer advisory board that meets regularly.

**Additional Strategies**

- Having at least one homeless or formerly homeless person on its staff;
- Administering consumer satisfaction surveys;
- Convening client focus groups;
- Other strategies

**3 Points:** Agency has a plan for incorporating client feedback in program design and/or policy-making.

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4. **HMIS Participation: 6 Points**

**4: HMIS Participation**

**Total Points:** 6

**Criteria:**

If the agency has other programs, do they demonstrate HMIS participation or participation in a similar database? The panel may consider:

- Percentage of null/missing, “don’t know,” or “refused” data
- The percentage of clients that exit to known destinations
- The percentage of clients with known income and benefits
- Percent of clients who are required to have annual assessments and do not have them
- Average length of time between when a client enters or exits a program and when the project records the entry or exit
- Other data quality measures provided by the agency

Does the agency have a process for analyzing and improving data quality?

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5. **Component/Population-Type Prioritization: Up to 15 Bonus Points**

**5A: Permanent Supportive Housing**

**Total Points:** 10

**Criteria:**

Permanent supportive housing serving chronically homeless individuals and families will be awarded bonus points to demonstrate the CoC’s funding priorities.
### 5B: Rapid Rehousing
**Total Points:** 5

**Criteria:**
Rapid rehousing projects serving high priority populations (such as families and transition-aged youth coming directly from streets, shelter, or other places not meant for human habitation, or persons fleeing domestic violence or trafficking) will be awarded bonus points to demonstrate the CoC’s funding priorities. These points will not be awarded to joint TH-RRH projects.

### 5C: Leveraging Housing or Healthcare Resources
**Total Points:** 5

**Criteria:**
Permanent supporting housing or rapid rehousing projects that submit at least one written commitment that meets at least one of the criteria below will be awarded bonus points. The written commitment can be a letter of commitment, contract, or other formal written documents that demonstrates one of the criteria below.

**Criteria 5C1: Leveraging Housing Resources:**
Housing subsidies or subsidized housing units not funded through the CoC or ESG programs that account for:
- 25% of PSH units; or
- Housing for 25% of RRH participants.

**Criteria 5C1: Leveraging Healthcare Resources:**
Resources from a healthcare provider or public or private health insurance provider of at least:
- In the case of a substance abuse treatment or recovery provider, access to treatment or recovery services for all qualifying and interested program participants; or
- An amount that is equivalent to 25% of the funding being requested for the project will be covered by the healthcare organization.

Sources of health care resources include direct contributions from a public or private health insurance provider to the project, or provision of health care services by a private or public organization tailored to the program participants of the project.

**Partial Points:**
New PSH and RRH project applications will receive 2 of the 5 bonus points for attaching any written commitment of housing or healthcare resources, even if they do not meet the threshold for amount of commitment (e.g. a housing commitment of fewer than 25% of PSH units).
Opportunity Center of the Midpeninsula (PSH)
Abode Services

Factor 1A: Utilization

Is the project serving the number of homeless people it was designed to serve?

- Panelists are encouraged to exercise discretion based on factors including but not limited to average annual occupancy HMIS data provided by the applicant, occupancy rate trending up or down, project size, population served, and facility status issues beyond the project’s sphere of influence.

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<tr>
<th>Factor 1A: Utilization</th>
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HUD System Performance Measures 1, 3
Factor 1B: PSH Housing Stability

The percentage of formerly homeless individuals who remain housed in the HUD permanent supportive housing project or exited to other permanent housing, excluding participants who passed away.

- Panelists may exercise discretion based on factors including but not limited to project size, population served, and circumstances beyond the project's sphere of influence.

Community Benchmark: 95%

HUD System Performance Measures 3, 7
Factor 1C: PSH Returns to Homelessness Within 12 Months

The percentage of leavers to permanent housing destinations in the year prior to the measurement period who returned to a homeless project in HMIS within 12 months.

- Panelists may exercise discretion based on factors including but not limited to project size, household size, and the number of persons who exited the project in the prior year.
- Projects with no leavers in the prior year and projects without at least 2 years of performance data will receive full points.

Community Benchmark: 2%

HUD System Performance Measure 2

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Factor 1D: Client Cash Income Change

The percentage of stayers/leavers that increase cash income from entry to latest annual assessment/exit, excluding all stayers not yet required to have an annual assessment.

- Panelists may exercise discretion based on factors including but not limited to project size, population served, and circumstances beyond the project's sphere of influence.

No Related Community Benchmark

HUD System Performance Measure 4

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(4.0 Points) 5.00 4.09 4.00 4.00 4.00 4.00 4.00
### Factor 1E: Non-Cash Mainstream Benefits

The percentage of stayers/leavers with non-cash benefit sources, excluding all stayers without annual assessments.

- Panelists may exercise discretion based on factors including but not limited to project size, population served, and circumstances beyond the project's sphere of influence.

No Related Community Benchmark

HUD System Performance Measure 2, 7b
### Factor 1F: Health Insurance

The percentage of stayers/leavers with health insurance, excluding all stayers not yet required to have an annual assessment.

Panelists may exercise discretion based on factors including but not limited to project size, population served, and circumstances beyond the project's sphere of influence.

No Related Community Benchmarks

HUD System Performance Measure 2, 7b

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### Factor 1G: Alignment with Housing First Principles

5 Points: To what extent do the project's written policies and procedures ensure that participants are not screened out based on the following criteria?

- Having too little or no income
- Active, or history of, substance use or a substance use disorder

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<tr>
<td>Having a criminal record (with exceptions for state-mandated restrictions)</td>
<td>5 Points: To what extent do the project's written policies and procedures ensure that participants are not terminated from the program for the following reasons?</td>
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<td>History of domestic violence (e.g., lack of a protective order, period of separation from abuser, or law enforcement involvement)</td>
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<td>Failure to participate in supportive services (with exception for HUD-mandated monthly case management meeting for RRH program participants)</td>
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<td>Failure to make progress on a service plan</td>
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<td>Loss of income or failure to improve income</td>
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<td>Being a survivor of domestic violence</td>
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<td>Any other activity not covered in a lease agreement typically found in the project's geographic area</td>
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<td>5 Points</td>
<td>Does the project take proactive steps to minimize barriers to entry and retention?</td>
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HUD System Performance Measures 1, 3, 7
### Factor 2A: Compliance

To what extent do the agencies (especially the lead agency) have:

- Any outstanding financial audit findings or concerns?
- Any outstanding HUD monitoring findings or concerns and/or any history of sanctions imposed by HUD, including – but not limited to – suspending disbursements (e.g., freezing LOCCS), requiring repayment of grant funds, or de-obligating grant funds due to performance issues?
- If yes, what steps is the agency taking to resolve the findings or concerns and to what extent has the program advised the Collaborative Applicant of issues identified by HUD?

If an agency has no outstanding audit or monitoring findings or concerns and no history of sanctions imposed by HUD, the agency should receive full points.

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<tr>
<th>Scaled Score</th>
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</table>
## Factor 2B: Unspent Grant Funds

Has the agency left project grant funds unspent in the past 3 years?

- Consider if the program is running at capacity (at four points during the year), and if the project receives leasing or rental assistance funds.
- Panelists may score programs up or down one point from the scaled score.

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## Factor 2C: Alignment with CoC Priorities

Do the project and agency align with and support CoC priorities, including but not limited to:

1 Point: CoC participation (meeting and training attendance)

3 Points: Services provided or described are adequate to meet the needs of the population served, as indicated by:

<table>
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<th>Scaled Score</th>
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</table>
- Case manager to client ratio
- The type of services provided (housing navigation, substance use treatment, trauma informed care, youth-targeted programming, etc.)
- A clear, comprehensive service delivery strategy/plan
- For projects dedicated to serving survivors of domestic violence, dating violence, sexual assault, stalking, and/or human trafficking, the degree to which agency's program design promotes client safety.

3 Points: The project contributes to the community plan goal of 6,000 new housing opportunities and maximizes the number of people exiting homelessness. For example:

- Project employs landlord engagement strategies
- Project proposes to increase the number of persons served
- Contribution of project to improving system performance
- Project has or participates in a move on program or strategy

**1 Point:** Sources of match funding are stable and sustainable
<table>
<thead>
<tr>
<th>Factor 2D: Client Participation in Program Design and Policy-Making</th>
</tr>
</thead>
<tbody>
<tr>
<td>Does the agency engage homeless and formerly homeless clients in program design and policy-making?</td>
</tr>
<tr>
<td><strong>2 Points:</strong> Agency has at least one strategy for gathering client feedback and input. Strategies may include, but are not limited to:</td>
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<tr>
<td>• Having at least one homeless or formerly homeless person on its staff or board</td>
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<td>• Having a consumer advisory board that meets regularly</td>
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<td>• Administering consumer satisfaction surveys</td>
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<td>• Convening client focus groups</td>
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<tr>
<td><strong>3 Points:</strong> Agency incorporates client feedback in program design and/or policy-making.</td>
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<th>Scaled Score</th>
<th>Max Points</th>
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</table>
### Factor 3A: Exits to Known Destinations

Percentage of clients who exit to known destinations.

- Panelists may exercise discretion based on factors including but not limited to limited project exits and circumstances beyond the project's sphere of influence.
- PSH with 0 exits receive full points.

<table>
<thead>
<tr>
<th>Factor 3A</th>
<th>Scaled Score</th>
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<th>Average for Project Type</th>
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### Factor 3B: Complete Data

Percentage of complete data (not null/missing, “don't know” or “refused” data, “data issues” or “error”), as reported in APR 6a, 6b, and 6c, except for Social Security numbers.

- Panelists may exercise discretion based on factors including but not limited to limited project exits and circumstances beyond the project's sphere of influence.

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<tr>
<th>Factor 3B</th>
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<td></td>
<td></td>
<td>5.00</td>
<td>5.00</td>
</tr>
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<td></td>
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<td>5.00</td>
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<td></td>
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<td>5.00</td>
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</tr>
<tr>
<td></td>
<td></td>
<td>5.00</td>
<td>5.00</td>
</tr>
<tr>
<td>Average Panel Score</td>
<td>5.00</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Factor 3C: Known Income</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>------------------------</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of adult clients with known income at latest annual assessment or exit, excluding all stayers not yet required to have annual assessments.</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

- Panelists may exercise discretion based on factors including but not limited to small project size and circumstances beyond the project's sphere of influence.

<table>
<thead>
<tr>
<th>Factor 3D: Known Benefits</th>
</tr>
</thead>
<tbody>
<tr>
<td>Percentage of adult clients with known benefits at latest annual assessment or exit, excluding all stayers not yet required to have annual assessments.</td>
</tr>
</tbody>
</table>

- Panelists may exercise discretion based on factors including but not limited to small project size and circumstances beyond the project's sphere of influence.
<table>
<thead>
<tr>
<th>Factor 4A: Permanent Housing</th>
<th>Scaled Score</th>
<th>Max Points</th>
<th>Average for Project Type</th>
<th>Panelist 1</th>
<th>Panelist 2</th>
<th>Panelist 3</th>
<th>Panelist 4</th>
<th>Average Panel Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Permanent supportive housing will be awarded 10 bonus points to demonstrate the CoC's funding priorities.</td>
<td>10.00</td>
<td>10.00</td>
<td>10.00</td>
<td>10.00</td>
<td>10.00</td>
<td>10.00</td>
<td><strong>10.00</strong></td>
<td></td>
</tr>
<tr>
<td>Rapid rehousing projects will be awarded 5 bonus points to demonstrate the CoC's funding priorities.</td>
<td>5.00</td>
<td>4.12</td>
<td>5.00</td>
<td>5.00</td>
<td>5.00</td>
<td>5.00</td>
<td><strong>5.00</strong></td>
<td></td>
</tr>
</tbody>
</table>

**Factor 4B: Chronic Homelessness**

Percentage of beds dedicated to/prioritized for chronic homeless persons.

- DedicatedPLUS PSH projects receive full points.
### Factor 4C: Other Priority Populations

Is the program dedicated to a priority population?

- **Youth**
- Survivors of Domestic Violence
- Families with Children
- Veterans

<table>
<thead>
<tr>
<th></th>
<th>Scaled Score</th>
<th>Max Points</th>
<th>Average for Project Type</th>
<th>Panelist 1</th>
<th>Panelist 2</th>
<th>Panelist 3</th>
<th>Panelist 4</th>
<th>Average Panel Score</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>(2.0 Points)</strong></td>
<td>2.00</td>
<td>0.71</td>
<td>2.00</td>
<td>2.00</td>
<td>2.00</td>
<td>2.00</td>
<td>2.00</td>
<td></td>
</tr>
</tbody>
</table>

**Total Project Score**  
74.00  117.00  102.04  111.00  112.00  110.00  111.00  111.00
### Tier 1 Recommended List

<table>
<thead>
<tr>
<th>Score</th>
<th>Project</th>
<th>Applicant</th>
<th>Type</th>
<th>Grant Amount</th>
<th>Tier 1 Running Total</th>
</tr>
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<tr>
<td>111.000</td>
<td>Opportunity Center of the Midpeninsula (PSH)</td>
<td>Abode Services</td>
<td>PSH</td>
<td>$43,936</td>
<td>$43,936</td>
</tr>
<tr>
<td>110.750</td>
<td>CASA 260 (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$1,308,870</td>
<td>$1,352,806</td>
</tr>
<tr>
<td>109.750</td>
<td>Housing Case Management for the Homeless (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$887,231</td>
<td>$2,220,037</td>
</tr>
<tr>
<td>109.000</td>
<td>Peacock Commons (PSH)</td>
<td>Bill Wilson Center</td>
<td>PSH</td>
<td>$352,567</td>
<td>$3,357,123</td>
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<tr>
<td>107.750</td>
<td>Samaritan Fins (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$711,382</td>
<td>$4,068,505</td>
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<tr>
<td>104.938</td>
<td>Immmanuel Sobrato Community</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$888,177</td>
<td>$4,956,682</td>
</tr>
<tr>
<td>104.250</td>
<td>Gilroy Place (PSH)</td>
<td>St Joseph’s Family Center</td>
<td>PSH</td>
<td>$493,013</td>
<td>$5,449,695</td>
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<tr>
<td>103.750</td>
<td>CCP Placement Project (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$6,726,403</td>
<td>$12,176,098</td>
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<tr>
<td>103.000</td>
<td>Mission Rebuild (PSH)</td>
<td>Abode Services</td>
<td>PSH</td>
<td>$653,152</td>
<td>$12,829,250</td>
</tr>
<tr>
<td>101.750</td>
<td>Rapid Rehousing Youth (RRH)</td>
<td>Bill Wilson Center</td>
<td>RRH</td>
<td>$593,248</td>
<td>$13,422,498</td>
</tr>
<tr>
<td>100.750</td>
<td>Sunset Leasing (PSH)</td>
<td>Abode Services</td>
<td>PSH</td>
<td>$315,782</td>
<td>$13,738,280</td>
</tr>
<tr>
<td>100.500</td>
<td>Renascent Place (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$670,911</td>
<td>$14,409,191</td>
</tr>
<tr>
<td>99.938</td>
<td>Calabazas Apartments (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$696,682</td>
<td>$15,105,873</td>
</tr>
<tr>
<td>99.938</td>
<td>Leath Ave (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$573,580</td>
<td>$15,679,463</td>
</tr>
<tr>
<td>99.000</td>
<td>CoC GRANT 5022 (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$4,791,531</td>
<td>$20,470,994</td>
</tr>
<tr>
<td>99.000</td>
<td>Second Street Studios (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$577,827</td>
<td>$21,048,821</td>
</tr>
<tr>
<td>97.750</td>
<td>RHS Rental Assistance Program #2 (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$217,256</td>
<td>$21,068,080</td>
</tr>
<tr>
<td>95.750</td>
<td>CoC PSH GRANT (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>PSH</td>
<td>$897,792</td>
<td>$22,163,871</td>
</tr>
<tr>
<td>94.250</td>
<td>Transitional Housing Program for Youth and Young Families North (TH)</td>
<td>Bill Wilson Center</td>
<td>TH</td>
<td>$309,348</td>
<td>$22,473,219</td>
</tr>
<tr>
<td>94.500</td>
<td>Our New Place (PSH)</td>
<td>St Joseph’s Family Center</td>
<td>PSH</td>
<td>$539,372</td>
<td>$23,012,591</td>
</tr>
<tr>
<td>93.938</td>
<td>DH-RRH Project (TH-RRH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>TH-RRH</td>
<td>$987,528</td>
<td>$24,000,119</td>
</tr>
<tr>
<td>93.750</td>
<td>SCC RRH for Families &amp; Youth (RRH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>RRH</td>
<td>$2,566,696</td>
<td>$26,566,815</td>
</tr>
<tr>
<td>92.750</td>
<td>RRH for Domestic Violence &amp; Human Trafficking (RRH)</td>
<td>County of Santa Clara by and through Office of Supportive Hol</td>
<td>RRH</td>
<td>$572,104</td>
<td>$27,138,919</td>
</tr>
<tr>
<td>91.250</td>
<td>TH-RRH Youth (TH-RRH)</td>
<td>Bill Wilson Center</td>
<td>TH-RRH</td>
<td>$315,124</td>
<td>$27,454,043</td>
</tr>
</tbody>
</table>

#### Tier 1 + Tier 2 Total

- **Tier 1 Total:** $30,815,705
- **Tier 2 Total:** $1,540,785
- **Total:** $32,356,490

### New Projects Not Recommended For Funding

The following project was the lowest-ranked new project application for CoC Bonus funding. There is insufficient CoC Bonus funding available to submit this application to HUD.

**RRH for Domestic Violence & Human Trafficking Expansion**

- Applicant: Bill Wilson Center
- Type: TH-RRH
- Grant Amount: $585,198
- (HUD May Fund $855,198)
- Tier 2 Running Total: $28,039,241

### DV Bonus Applications

**($1,586,811)**

- **DV Bonus Applications**
  - Applicant: Razing the Bar
  - Type: TH-RRH
  - Grant Amount: $1,679,550

If not selected for DV Bonus funding by HUD, there is insufficient CoC bonus funding available to fund this project.
**ATTACHMENT:** Public Posting-Projects Rejected-Reduced

<table>
<thead>
<tr>
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<tbody>
<tr>
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<tr>
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<td>2</td>
</tr>
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<td>o System-generated date and time in bottom right corner.</td>
<td></td>
</tr>
<tr>
<td><strong>Final Priority List From CoC Website Posting</strong></td>
<td>3</td>
</tr>
<tr>
<td>o The final priority list, attached to the above email and posted on the CoC Website, indicating projects rejected under:</td>
<td></td>
</tr>
<tr>
<td>▪ New Projects Not Recommended for Funding</td>
<td></td>
</tr>
<tr>
<td>o All other applications were accepted and ranked.</td>
<td></td>
</tr>
</tbody>
</table>
FY2021 CoC Priority Listing

SCCNOFA <sccnofa@homebaseccc.org>  Fri, Oct 29, 2021 at 3:29 PM

To: CoC@santaclaracountycoc.org, SPN@santaclaracountycoc.org
Cc: "Kaminski, Kathryn" <kathryn.kaminski@hhs.sccgov.org>, "Kong, Ben" <Ben.Kong@hhs.sccgov.org>, "Chan, Jimmy" <jimmy.chan@hhs.sccgov.org>, "Ochoa, Trang" <trang.ochoa@hhs.sccgov.org>, Laura Foster <lfoster@bwcmail.org>, Pilar Furlong <PFurlong@bwcmail.org>, Benaifer Dastoor <benaiferd@wvcommunityservices.org>, Tami Moore <tmoore@bwcmail.org>, Janet Dolezal <jdolezal@bwcmail.org>, Diana Lin <dlin@abodeservices.org>, David Cox <davidc@stjosephsgilroy.org>, Sujatha Venkatraman <sujathav@wvcommunityservices.org>, Shobana Raghupathy <SRaghupathy@bwcmail.org>, Julian Leiserson <jleiserson@abodeservices.org>, Donvae Lartigue <dontae.lartigue@razingthebar.org>, Katherine Lartigue <katherine.lartigue@razingthebar.org>

CoC Members and FY 2021 Project Applicants,

Thank you to those of you who participated in the Santa Clara County CoC local funding competition. The CoC received 34 applications for funding for housing and system infrastructure projects. All projects were reviewed and ranked by the CoC Review and Rank Panel according to the CoC's written process. On October 29, the CoC Board approved the attached FY 2021 CoC Priority Listing. This is the priority ranked order that will be submitted to the Department of Housing and Urban Development (HUD) as part of the CoC's FY 2021 funding application.

The FY 2021 CoC Priority Listing is also available on the CoC's website.

Again, thank you to all applicants for the work you put into this process and for the vital work you do every day to serve your project participants.

Best,

Eli

--

Homebase | CoC NOFA Competition Team | Santa Clara County CoC

Legal and Technical Assistance | Policy | Advocacy | Planning

*Note: All communications with Homebase regarding the 2019 CoC Program Competition in the Santa Clara County CoC should be directed to sccnofa@homebaseccc.org
Housing and Urban Development (HUD) Continuum of Care (CoC) Program Funding in Santa Clara County

One of the programs through which the US Department of Housing and Urban Development (HUD) distributes funding to Santa Clara County is the Continuum of Care (CoC) Program. This page contains information about the funding we receive locally, as well as information for the annual funding competition.

2021 HUD CoC Consolidated Application

- To be posted the week of November 8-12, 2021

2021 HUD CoC Competition - Final Ranked List

- 2021 SCC CoC Final Priority Listing

2021 HUD CoC Competition - Local Competition Materials

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- 2019 CoC HUD CoC NOFA Technical Assistance Handbook (PDF)
- 2019 CoC HUD CoC NOFA Local Materials (PDF)
- 2019 SCC CoC NOFA List of Eligible Projects (PDF)
- 2019 SCC CoC NOFA Project Point Person Contact Form
- 2019 SCC Supplemental Applications (New Projects)
- 2019 SCC Supplemental Applications (Renewal Projects)
Santa Clara County Continuum of Care
2021 Continuum of Care Final Priority Listing
October 29, 2021

Annual Renewal Demand (ARD) $30,815,705
CoC Bonus $1,540,785
DV Bonus $1,586,811.00
Planning $924,471
Tier 1 $30,815,705
Tier 2 $1,540,785
Tier 1 + Tier 2 Total $32,356,490
Total SCC Funding Available $34,867,772

Score Project Applicant Type Grant Amount Tier 1 Running Total
110.000 Opportunity Center of the Midpeninsula (PSH) Abode Services PSH $43,936 $43,936
110.750 CASA 200 (PSH) County of Santa Clara by and through Office of Supportive Housing PSH $1,308,870 $1,353,806
110.000 Housing Case Management for the Homeless (PSH) County of Santa Clara by and through Office of Supportive Housing PSH $867,231 $2,220,037
109.750 Housing Case Management for Medical Respite (PSH) County of Santa Clara by and through Office of Supportive Housing PSH $784,519 $3,004,556
109.000 Peacock Commons (PSH) Bill Wilson Center PSH $352,567 $3,357,123
105.750 Samarian Inn (PSH) County of Santa Clara by and through Office of Supportive Housing PSH $711,382 $4,068,505
104.938 Immanuel Sobrato Community Abode Services PSH $888,177 $4,956,682
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103.750 CCP Placement Project (PSH) County of Santa Clara by and through Office of Supportive Housing PSH $6,726,403 $12,176,098
103.000 Mission Rebuild (PSH) Abode Services PSH $553,152 $12,829,250
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97.750 RHS Rental Assistance Program #2 (PSH) County of Santa Clara by and through Office of Supportive Housing PSH $271,259 $21,260,080
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91.250 TH-RRH Youth (TH-RRH) Bill Wilson Center TH-RRH $572,104 $27,138,919
89.438 RRH for Domestic Violence & Human Trafficking Expansion County of Santa Clara by and through Office of Supportive Housing RRH $315,124 $27,454,043
88.500 CoC Grant 5320 (PSH) County of Santa Clara by and through Office of Supportive Housing PSH $539,853 $29,138,017
88.500 Transitional Housing Program for Youth and Young Families (TH) Bill Wilson Center TH $558,923 $28,598,164
86.000 CoC Grant 5320 (PSH) County of Santa Clara by and through Office of Supportive Housing PSH $539,853 $29,138,017
N/A SCC HMIS County of Santa Clara by and through Office of Supportive Housing HMIS $984,321 $30,102,338
N/A SCC Coordinated Assessment System County of Santa Clara by and through Office of Supportive Housing CE $130,241 $30,232,579
79.000 Haven to Home (RRH) West Valley Community Services RRH $583,126 $30,815,705

The following project was the lowest-ranked new project application for CoC Bonus funding. There is insufficient CoC Bonus funding available to submit this application to HUD.

New Projects Not Recommended For Funding

If not selected for DV Bonus funding by HUD, there is insufficient CoC bonus funding available to fund this project

Not Ranked Per NOFA Guidelines
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<td></td>
</tr>
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</table>
FY2021 CoC Priority Listing

SCCNOFA <sccnofa@homebaseccc.org>  Fri, Oct 29, 2021 at 3:29 PM

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Eli

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Homebase | CoC NOFA Competition Team | Santa Clara County CoC
p: 415-788-7961 ext. 342  w: www.homebaseccc.org
a: 870 Market Street, Suite 1228, San Francisco, CA 94102

Advancing Solutions to Homelessness
Legal and Technical Assistance | Policy | Advocacy | Planning

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- 2019 SCC Supplemental Applications (Renewal Projects)
## Santa Clara County Continuum of Care

### 2021 Continuum of Care Final Priority Listing

**October 29, 2021**

### Tier 1 Recommended List

<table>
<thead>
<tr>
<th>Score</th>
<th>Project Description</th>
<th>Applicant</th>
<th>Type</th>
<th>Grant Amount</th>
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<td>PSH</td>
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<td>$43,936</td>
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<td>PSH</td>
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<td>$3,004,556</td>
</tr>
<tr>
<td>109.000</td>
<td>Peacock Commons (PSH)</td>
<td>Bill Wilson Center</td>
<td>PSH</td>
<td>$352,567</td>
<td>$3,357,123</td>
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<tr>
<td>105.750</td>
<td>Samaritan Inn (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$711,382</td>
<td>$4,068,505</td>
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<tr>
<td>104.938</td>
<td>Immanuel Sobrato Community</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$888,177</td>
<td>$4,956,682</td>
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<tr>
<td>104.250</td>
<td>Gilroy Place (PSH)</td>
<td>St. Joseph's Family Center</td>
<td>PSH</td>
<td>$493,013</td>
<td>$5,449,695</td>
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<td>103.750</td>
<td>CCP Placement Project (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$6,726,403</td>
<td>$12,176,088</td>
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<td>103.000</td>
<td>Mission Rebuild (PSH)</td>
<td>Abode Services</td>
<td>PSH</td>
<td>$553,152</td>
<td>$12,829,250</td>
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<td>101.750</td>
<td>Rapid Rehousing Youth (RRH)</td>
<td>Bill Wilson Center</td>
<td>RRH</td>
<td>$593,248</td>
<td>$13,422,498</td>
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<td>100.750</td>
<td>Sunset Leasing (PSH)</td>
<td>Abode Services</td>
<td>PSH</td>
<td>$315,782</td>
<td>$13,738,280</td>
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<td>100.500</td>
<td>Renascent Place (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$670,911</td>
<td>$14,409,191</td>
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<tr>
<td>99.938</td>
<td>Calabazas Apartments (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$696,682</td>
<td>$15,105,873</td>
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<td>99.938</td>
<td>Lехал Ave (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$573,580</td>
<td>$15,679,463</td>
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<td>99.000</td>
<td>CoC GRANT 5022 (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$4,791,531</td>
<td>$20,470,994</td>
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<tr>
<td>99.000</td>
<td>Second Street Studios (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$577,827</td>
<td>$21,108,481</td>
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<tr>
<td>97.750</td>
<td>HHS Rental Assistance Program #2 (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$217,259</td>
<td>$21,266,080</td>
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<tr>
<td>96.750</td>
<td>CoC PSH GRANT (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$897,797</td>
<td>$22,163,781</td>
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<tr>
<td>94.750</td>
<td>Transitional Housing Program for Youth and Young Families North (TH)</td>
<td>Bill Wilson Center</td>
<td>TH</td>
<td>$309,348</td>
<td>$22,473,219</td>
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<tr>
<td>94.500</td>
<td>Out New Place (PSH)</td>
<td>St. Joseph’s Family Center</td>
<td>PSH</td>
<td>$539,372</td>
<td>$23,012,591</td>
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<td>94.398</td>
<td>RRH for Domestic Violence &amp; Human Trafficking Expansion</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>RRH</td>
<td>$2,566,696</td>
<td>$23,056,815</td>
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<tr>
<td>92.750</td>
<td>RRH for Domestic Violence &amp; Human Trafficking (RRH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>RRH</td>
<td>$572,104</td>
<td>$25,138,919</td>
</tr>
<tr>
<td>92.000</td>
<td>TH-RRH Youth (TH-RRH)</td>
<td>Bill Wilson Center</td>
<td>TH-RRH</td>
<td>$572,104</td>
<td>$27,138,919</td>
</tr>
<tr>
<td>91.250</td>
<td>TH-RRH Youth (TH-RRH)</td>
<td>Bill Wilson Center</td>
<td>TH-RRH</td>
<td>$315,124</td>
<td>$27,454,043</td>
</tr>
<tr>
<td>89.438</td>
<td>RRH for Domestic Violence &amp; Human Trafficking Expansion</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>RRH</td>
<td>$585,198 (HUD May Fund Through DV Bonus)</td>
<td>$28,039,241</td>
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<tr>
<td>88.500</td>
<td>Transitional Housing Program for Youth and Young Families (TH)</td>
<td>Bill Wilson Center</td>
<td>TH</td>
<td>$558,923</td>
<td>$28,568,164</td>
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<tr>
<td>80.000</td>
<td>CoC GRANT 5320 (PSH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>PSH</td>
<td>$539,853</td>
<td>$29,138,017</td>
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<tr>
<td>N/A</td>
<td>SCC HMIS</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>HMIS</td>
<td>$964,321</td>
<td>$30,102,338</td>
</tr>
<tr>
<td>N/A</td>
<td>SCC Coordinated Assessment System</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>CE</td>
<td>$130,241</td>
<td>$30,232,579</td>
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<tr>
<td>79.000</td>
<td>Haven to Home (RRH)</td>
<td>West Valley Community Services</td>
<td>RRH</td>
<td>$583,126</td>
<td>$30,815,705</td>
</tr>
</tbody>
</table>

### Tier 2 Recommended List

<table>
<thead>
<tr>
<th>Score</th>
<th>Project Description</th>
<th>Applicant</th>
<th>Type</th>
<th>Grant Amount</th>
<th>Tier 2 Running Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>78.000</td>
<td>Haven to Home</td>
<td>West Valley Community Services</td>
<td>RRH</td>
<td>$283,413</td>
<td>$283,413</td>
</tr>
<tr>
<td>69.750</td>
<td>DV Collaborative (RRH)</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>RRH</td>
<td>$1,189,962</td>
<td>$1,473,375</td>
</tr>
<tr>
<td>N/A</td>
<td>HMIS Expansion 2021</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>HMIS</td>
<td>$440,000</td>
<td>$1,913,375</td>
</tr>
</tbody>
</table>

### New Projects Not Recommended For Funding

The following project was the lowest-ranked new project application for CoC Bonus funding. There is insufficient CoC bonus funding available to submit this application to HUD.

<table>
<thead>
<tr>
<th>Project</th>
<th>Applicant</th>
<th>Type</th>
<th>Grant Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>Razing the Bar</td>
<td>TH-RRH</td>
<td>$1,679,550</td>
<td></td>
</tr>
</tbody>
</table>

### DV Bonus Applications

<table>
<thead>
<tr>
<th>Score</th>
<th>Project Description</th>
<th>Applicant</th>
<th>Type</th>
<th>Grant Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>($1,586,811)</td>
<td>DV Bonus Applications</td>
<td>TH-RRH</td>
<td>$1,679,550</td>
<td></td>
</tr>
</tbody>
</table>

If not selected for DV Bonus funding by HUD, there is insufficient CoC bonus funding available to fund this project.

### Not Ranked Per NOFA Guidelines

<table>
<thead>
<tr>
<th>Project</th>
<th>Applicant</th>
<th>Type</th>
<th>Grant Amount</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 Planning Grant</td>
<td>County of Santa Clara by and through Office of Supportive Housing</td>
<td>Planning</td>
<td>$924,471</td>
</tr>
</tbody>
</table>

### Summary

- **Total SCC Funding Available:** $34,867,772
- **Annual Renewal Demand (ARD):** $30,815,705
- **CoC Bonus:** $1,540,785
- **DV Bonus:** $1,586,811
- **Planning Grant:** $924,471
- **Tier 1 + Tier 2 Total:** $32,356,490

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**Note:**

- Tier 2 recommended list includes projects with scores of 89.438 or less.
- Projects marked with “N/A” are not recommended for funding due to insufficient CoC bonus funding.
- DV Bonus applications are subject to HUD approval.
- Projects not ranked per NOFA guidelines are not recommended for funding.
ATTACHMENT: Housing Leveraging Commitments

<table>
<thead>
<tr>
<th>DOCUMENTS SATISFYING REQUIREMENT</th>
<th>PAGE</th>
</tr>
</thead>
<tbody>
<tr>
<td>Written Agreement from Santa Clara County Housing Authority to provide Project Based Vouchers for Immanuel Sobrato Community</td>
<td>1–2</td>
</tr>
<tr>
<td>o Project name (new PSH): Immanuel Sobrato Community</td>
<td></td>
</tr>
<tr>
<td>o Number of PBVs: 97 (91.5% of total project units)</td>
<td></td>
</tr>
<tr>
<td>o Vouchers available: for up to 20 years, with potential for extension up to 20 years</td>
<td>1</td>
</tr>
</tbody>
</table>
March 11, 2021

Jan Lindenthal
MidPen Housing Corporation
303 Vintage Park Drive
Foster City, CA 94404

RE: Request for Project Based Vouchers through Measure A

Project Name: Immanuel-Sobrato Community (formerly 1710 Moorpark)
Project Location: 1710 Moorpark Avenue, San Jose, CA 95128

Dear Ms. Lindenthal:

This letter is to notify you of the Santa Clara County Housing Authority’s (SCCHA’s) selection of your project for the conditional award of Project Based Vouchers (PBVs) as follows:

<table>
<thead>
<tr>
<th>Total Units in Project:</th>
<th>106</th>
</tr>
</thead>
<tbody>
<tr>
<td>PBVs Requested:</td>
<td>106</td>
</tr>
<tr>
<td>Total PBVs Conditionally Awarded:</td>
<td>97</td>
</tr>
<tr>
<td>Special Population Allocation:</td>
<td>97 for the Chronically Homeless Direct Referral Program</td>
</tr>
<tr>
<td>Tenants for PBV units will come from:</td>
<td>County of Santa Clara, Office of Supportive Housing</td>
</tr>
</tbody>
</table>

The initial Housing Assistance Payments (HAP) contract term for the PBVs is up to 20 years. Within two (2) years of the conclusion of the initial HAP contract term, SCCHA will analyze the project to determine whether it is eligible for an extension term of up to 20 years. The extension is conditional upon SCCHA finding that annual appropriations are sufficient to support the extension, that the project meets applicable United States Department of Housing and Urban Development (HUD) requirements, and that the project meets all SCCHA policies and requirements, including financial underwriting analysis.

The full award of these PBVs to this Project is contingent upon:

1. Compliance with the National Environmental Policy Act of 1969 (NEPA), to be completed in conjunction with SCCHA and the Responsible Entity, the unit of local government which exercises land use authority over the property on which the Project is located;

2. Under the direction of SCCHA, obtaining an approved and certified Subsidy Layering Review from the applicable Housing Credit Agency;

3. Customary HUD requirements for executing the Agreement to Enter into Housing Assistance Payments (AHAP) and Housing Assistance Payments (HAP) contracts;

4. The project being ready to enter into an AHAP contract **within 18 months of the date of this Conditional Award** (SCCHA is not permitted to execute the AHAP until the NEPA and Subsidy Layering Review have been approved by HUD and the Housing Credit Agency respectively);
5. Determination of initial contract rent;

6. Completion of a Site & Neighborhood Review to ensure the housing site is consistent with the goal of deconcentrating poverty and expanding housing and economic opportunities;

7. SCCHA’s approval of the Tenant Selection Criteria and the Affirmative Fair Housing Marketing Plan;

8. If the project will have 9 or more PBVs attached, the developer or owner must submit quarterly evidence of compliance with the Davis-Bacon Act to SCCHA; and

9. Submittal of any other additional documentation as required by SCCHA in order to complete your application.

Please be aware that construction may not begin until the AHAP between you and SCCHA is executed; pursuant to 24 CFR §983.152 and §983.153, SCCHA is prohibited from entering into an AHAP if construction has started.

Please contact John Lo, Senior Housing Policy Analyst, at 408-993-2970 or john.lo@scchousingauthority.org, to begin the planning process to insure timely completion of the above-referenced items.

Sincerely,

Sharon Jones
Acting Executive Director

CC: Heather Miller, SCCHA
    Consuelo Hernandez, County of Santa Clara
    Rachel VanderVeen, City of San Jose