Before Starting the CoC Application

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

The Collaborative Applicant is responsible for reviewing the following:

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

1A. Continuum of Care (CoC) Identification

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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1A-1. CoC Name and Number: MA-519 - Attleboro, Taunton/Bristol County CoC

1A-2. Collaborative Applicant Name: Community Counseling of Bristol County, Inc.

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Community Counseling of Bristol County, Inc.

1B. Continuum of Care (CoC) Engagement

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1B-1. CoC Meeting Participants.

For the period of May 1, 2018 to April 30, 2019, applicants must indicate whether the Organization/Person listed:
1. participated in CoC meetings;
2. voted, including selecting CoC Board members; and
3. participated in the CoC's coordinated entry system.

Organization/Person	Participates in CoC Meetings	Votes, including selecting CoC Board Members	Participates in Coordinated Entry System
Local Government Staff/Officials	Yes	Yes	Yes
CDBG/HOME/ESG Entitlement Jurisdiction	Yes	Yes	Yes
Law Enforcement	Yes	Yes	Yes
Local Jail(s)	No	No	Yes
Hospital(s)	Yes	Yes	Yes
EMS/Crisis Response Team(s)	Yes	Yes	Yes
Mental Health Service Organizations	Yes	Yes	Yes
Substance Abuse Service Organizations	Yes	Yes	Yes
Affordable Housing Developer(s)	Yes	Yes	Yes
Disability Service Organizations	Yes	Yes	No
Disability Advocates	Yes	Yes	Yes
Public Housing Authorities	Yes	Yes	Yes
CoC Funded Youth Homeless Organizations	Not Applicable	No	No
Non-CoC Funded Youth Homeless Organizations	Yes	Yes	Yes

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

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

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

1. The Greater Bristol County/Attleboro/Taunton CoC, also known as the Greater Bristol County/Attleboro/Taunton Coalition to end Homelessness (GBCATCH), has a broad and diverse membership which seeks to include many different perspectives on homelessness, as well as geographic representation of the whole CoC. 2.The governance structure has committees that were developed to meet the needs of the CoC and make efforts to recruit members with various perspectives including the Unaccompanied Homeless Youth, Veterans, Individual Services and Family Services Committees. 3. Monthly meetings are held of the larger CoC and many of the individuals and organizations involved in preventing and ending homelessness participate in the smaller committees that are work oriented and have a specific focus addressing goals and objectives in the annual work plan. Committee reports are presented at the monthly meetings, and minutes are sent for the CoC meeting by email. The CoC reviews the governance structure as well as the ten-year plan to end

homelessness annually and it is sent out to all local organizations providing homeless services as well as other local business and government offices to solicit input. The Collaborative Applicant (CA) and other providers participate in local City Council Meetings and other open forums to present findings from the PIT and need for additional resources as well as to gain input related to the ten-year plan. The CoC uses social media including Facebook, email to a large constituency, postings on the CA website, and announcement of meetings at all local events to solicit and consider all opinions to assure we address the critical issues in our CoC to prevent and end homelessness. 4. As the majority of individuals and families served have some form of a disability, it is critical the CoC also ensures that we use accessible electronic formats to be inclusive of all individuals whose information can contribute to a stronger CoC with a diverse background.

1B-2. Open Invitation for New Members.

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

1. The GBCATCH has an open invitation process on an annual basis which is done through the local media including the Taunton Gazette, the Attleboro Sun Chronicle, and through local online social media websites and Facebook pages including the GBCATCH Facebook page and the Collaborative Applicant website.
2. The CoC communicates regularly with the Mayors and City Councils as well as other public forums to update the community on the status of homelessness and the progress of the 10-year plan to end homelessness in our region. The Collaborative Applicant coordinates the annual Point in Time Count and this enables many volunteers from the community to get involved and develop a better understanding of the needs of the homeless in our region. 3.The CoC is working to develop an more effective communication plan that ensures any individuals with disabilities has access through the most appropriate form of communication or accessible electronic format to the information available related to the CoC, homeless services, and how to become more actively involved. The goal is to provide an aid or service that will be effective, given the nature of what is being communicated and the person’s method of communicating.
4. The CoC solicits new members annually, and on an ongoing basis based on the needs of the committees.
5. Regarding special outreach, a presentation is done at all local coalitions including The Prevention and Wellness Network, the Community Crisis Intervention Teams, The Suicide Prevention Coalition, the Taunton Opioid and Substance Use Task Force, and the local soup kitchens and homeless day shelter to reach out to potential new members and those who can offer a

special perspective.

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

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

1. When the competition opens the CoC sends a notice to all homeless providers regarding the potential for funds, both renewals and if there are new funds available. 2. A Request for Proposals was developed on July 19th 2019 and emailed to CoC members and other local constituents and discussed at the CoC monthly meeting. The notice was published on the Collaborative Applicant website and the CoC Facebook page asking for new applicants not previously funded. For the Permanent Housing bonus providers are asked to submit a letter of Intent which is reviewed by our Application committee. As we are a small CoC we have typically had only one or two providers submit a proposal each year. The Application Committee scores and ranks all projects including both renewals and new projects. The Application Committee read each project that was submitted to the Collaborative Applicant by the required date of August 22nd, 2019 as specified in the RFR. There was one new organization that submitted a letter of intent and submittied an application for the DV Bonus as the sub-recipient. The Application committee then completed their ranking for all Tier 1 and Tier 2 projects and this ranking was finalized on September 5th, 2019. The Application Committee approved all submissions and there were no rejections of any new applications. The full CoC conducted a final vote on the ranking given the based on performance and prior experience. Providers are always given feedback in writing if a vote is taken and then will be recorded in the minutes. 3. The dates the CoC publicly announced it was open to proposal was July 19th, 2019. 4. The CoC partners with local organizations specializing in advocacy and uses a variety of media resources to effectively communicate for those with disabilities to ensure they have accessibility to the proposal. 5. The CoC does accept and encourage organizations who have not previously received CoC Program funding to apply for funds.

1C. Continuum of Care (CoC) Coordination

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

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

Entities or Organizations the CoC coordinates planning and operation of projects	Coordinates with Planning and Operation of Projects
Housing Opportunities for Persons with AIDS (HOPWA)	Yes
Temporary Assistance for Needy Families (TANF)	Yes
Runaway and Homeless Youth (RHY)	Yes
Head Start Program	Yes
Funding Collaboratives	Yes
Private Foundations	Yes
Housing and services programs funded through U.S. Department of Justice (DOJ) Funded Housing and Service Programs	Yes
Housing and services programs funded through U.S. Health and Human Services (HHS) Funded Housing and Service Programs	Yes
Housing and service programs funded through other Federal resources	Yes
Housing and services programs funded through State Government	Yes
Housing and services programs funded through Local Government	Yes
Housing and service programs funded through private entities, including foundations	Yes
Other:(limit 50 characters)	

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

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

1.Although no cities in the CoC receive ESG funds directly for services, the state Department of Housing and Community Development distributes funds that may be used throughout the CoC. the CoC actively consults with Catholic Social Services, the (ESG) subreceipent in the planning and allocation of ESG funds. 2. As the ESG program participates in HMIS as well as Coordinated Entry the CoC has garnered additional access to the reporting and performance of the program. As Catholic Social Services is a major provider for ESG and CoC programs including PSH and Coordinated Entry the CoC is a significant part of the planning for the ESG funds usage. These interactions occur between the CoC and the ESG recipient in the planning and allocation of funds at monthly CoC meetings, as needed in specific client cases, and at annual reviews of how ESG funds were distributed and planning for the coming year. 3. The CoC is involved in the Taunton and Attleboro Consolidated Plan jurisdiction process and provides Point-in-Time (PIT) and Housing Inventory Count (HIC) data to these jurisdictions; the CoC reviews any Consolidated Plan updates from both jurisdictions. The Taunton and Attleboro Community Development staff participate in the CoC meetings and any updates to the Ten Year Plan.

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

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

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

1.The CoC is fortunate to have an experiences provider of Domestic Violence (DV) services, New Hope, the sole provider of emergency shelter in the GBCATCH CoC for individuals and families fleeing DV. When completing an assessment with the CoC's Coordinated Entry System known as The CALL, if an individual has identified DV as an issue in their lives, victims are referred immediately to New Hope. Additionally, If a client begins services in a program not specifically geared toward victims of DV and it is discovered they may be in danger the DV program is contacted immediately for placement and safety planning. New Hope also refers its own clients to The CALL if they are experiencing homelessness. New Hope uses a trauma-informed and victim-centered service model that prioritizes safety, confidentiality, and client choice to identify appropriate housing and supports for DV victims. New Hope staff connects with each participant using a supportive, non-judgmental approach which is crucial when assisting victims who have been through the trauma of DV. In some cases trauma issues and safety concerns may cause families to move earlier than hoped into less than permanent situations. The program continues to engage these families in developing safe affordable opportunities. New Hope as an active member of the CoC will provide ongoing training to providers addressing the unique needs of persons fleeing domestic violence. 2. As clients who identify as being in danger due to DV are referred to New Hope for further assessment and safety planning, The CALL ensures the most qualified program provides services for victims of DV. New Hope follows strict confidentiality laws regarding the sharing of information and it is up to the individual to determine what, if any, information is shared with other agencies. Releases of information are always completed in order to share information with client's permission that adhere to strict time limits.

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

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

1. The CoC offered training in the past year on our coordinated entry process known as The CALL, and is accessed by calling 1-800-HOMELESS. This training was given to all CoC providers and other operators of coordinated entry processes and had a section of the training which specifically focused on best

practices in serving survivors of domestic violence. The New Hope DV Agency has offered to provide additional training in the coming year on best practices for serving survivors of domestic violence. New Hope also has a training program offered to all other agencies in the CoC and on many aspects of domestic violence, a focus on LGBTQ issues, and best practices for working with DV victims. General topics include the dynamics of domestic violence, safety planning, resources/referrals, how to help a victim, trauma and trauma-informed care, and confidentiality practices. new Hope services are also presented at CoC meetings on their specific model of trauma-informed, victim-centered service provision, in which New Hope staff members meet each participant where there are, using a supportive, non-judgmental approach and the development of safety plans when looking at moving from shelter. 2. In addition, Catholic Social Services has offered specific training to staff working with Coordinated Entry on how to work with those who may be survivors of domestic violence in a trauma-informed manner and ensure they are able to access the appropriate resources for safety planning. Additionally, the program has frequent contact with a variety of domestic violence services providers to ask specific questions as to how to increase best practices for Coordinated Entry and interaction with survivors of Domestic Violence.

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

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

The CoC works closely with the agency that provides services to those who have survived domestic violence. The agency utilizes a separate system, Empower DS,to provide de-identified aggregate data to the Continuum. This assists the Continuum in program planning to serve special populations including those who are survivors of domestic violence, dating violence, sexual assault, and stalking. Through the data base the Continuum is able to see the specific needs of the population and make adjustments to programming to reflect a response to those needs.

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

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

Public Housing Agency Name	% New Admissions into Public Housing and Housing Choice Voucher Program during FY 2018 who were experiencing homelessness at entry	PHA has General or Limited Homeless Preference	PHA has a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On
Taunton Housing Authority	7.60%	Yes-Both	No
Attleboro Housing Authority		Yes-Both	No

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

Applicants must:
1. provide the steps the CoC has taken, with the two largest PHAs within the CoC's geographic area or the two PHAs the CoC has working relationships with, to adopt a homeless admission preference–if the CoC only has one PHA within its geographic area, applicants may respond for one; or
2. state that the CoC does not work with the PHAs in its geographic area. (limit 2,000 characters)

1.The CoC works closely with all Public Housing Agencies (PHA) in the geographic area especially the two largest in the cities of Taunton and Attleboro who participate regularly in the meetings and other initiatives to end homelessness. Both PHA's have a homeless preference in either public housing or through the housing choice voucher program. In addition the Continuum works closely with the housing authorities for homeless prevention services allowing those who are extremely vulnerable to homelessness to avoid entering the system other than prevention services. The housing authorities have an active role in the CoC meetings and maintain frequent contact with the agencies receiving both CoC and ESG funds to ensure the needs of the community are met.

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

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

Yes

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

Each program in the CoC works with project participants to register with all local PHA's and other low income housing programs to access these resources when they become available. This occurs when new vouchers are available or the individual or family is able to afford to move on, based on increased income, to a different form of permanent housing. The Collaborative Applicant, CCBC, worked with the Taunton Housing Authority (THA) to support their submission to HUD for Mainstream Vouchers for individuals with disabilities. The Taunton Housing Authority (THA) awarded these vouchers which will continue to assist those in PSH to "move on" and allow for additional participants to enter PSH programming. In addition, the CoC continues to work with local landlords who are hoping to develop local low-income housing and safe decent affordable mainstream housing for those clients who have stabilized with mainstream services and are able to "move on" from PSH programs and emergency shelters.

1C-5. Protecting Against Discrimination.

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

The MA-519 CoC strives to ensure all forms of discrimination are eliminated from CoC programs. Through the implementation of a housing first approach as well as a variety of different types of housing available the CoC works to ensure protected classes are afforded equal access to all services. The CoC intentionally works to ensure a diverse population serves within the CoC ensuring any issues of unintentional bias are identified and rectified quickly. Additionally, the CoC has access to Southcoast Legal Services for any questions regarding Fair Housing as well as the ability to ask for their advocacy in ensuring all tenants and clients served are treated fairly. One of the largest agencies, Catholic Social Services, held a training this year produced by Massachusetts Commission Against Discrimination to clarify and teach Fair Housing laws. This was attended by Emergency Solutions Grants Rapid Rehousing and Homeless Prevention (ESG RRH/HP) providers, CoC Permanent Supportive Housing Providers, Emergency Shelter providers, and the staff from Coordinated Entry.

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

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

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

*1C-6. Criminalization of Homelessness.

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

1. Engaged/educated local policymakers:	X
2. Engaged/educated law enforcement:	X
3. Engaged/educated local business leaders:	X
4. Implemented communitywide plans:	
5. No strategies have been implemented:	

6. Other:(limit 50 characters)	

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

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

1. The coordinated entry system used through GBCATCH is a collaborative effort among 3 CoC's to ensure full coverage of the geographic area. The system is a phone based system with a central number which is easy to remember 1-800-HOMELESS and is widely publicized throughout the continuum. 2. The coordinated entry system has taken special care to outreach to those least likely to apply for services including local schools, senior centers, and attending housing court, and businesses and agencies throughout the continuum. The system has provided outreach to local libraries, as well as agencies providing mental health services and substance use issues services that are directly tied to the CoC as well to reach as many in the community as possible. 3. At present, the emergency shelter system continues to serve those on a first come, first served basis due to the necessity for immediate placement. Coordinated Entry staff engages in diversion tactics throughout the process before utilizing homeless services in order to prioritize those most in need. Fortunately at this time there is no waitlist for rapid rehousing and homeless prevention services. The only prioritization in place and necessary at the time is for placement into a Permanent Supportive Housing program. Coordinated Entry utilizes a full SPDAT in addition to individual services meetings to determine those with the highest level of vulnerability. Those who are deemed chronic homeless are placed first into PSH units with a sub assessment prioritizing who among the chronic homeless have the highest level of need.

1D. Continuum of Care (CoC) Discharge Planning

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1D-1. Discharge Planning Coordination.

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

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

1E. Local CoC Competition

Instructions

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

Applicants must indicate whether the CoC:

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

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

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

1. Used objective criteria to review and rank projects for funding (e.g., cost effectiveness of the project, performance data, type of population served);	Yes
2. Included one factor related to improving system performance (e.g., exits to permanent housing (PH) destinations, retention of PH, length of time homeless, returns to homelessness, job/income growth, etc.); and	Yes
3. Included a specific method for evaluating projects submitted by victim services providers that utilized data generated from a comparable database and evaluated these projects on the degree they improve safety for the population served.	No

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

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

1. The Coc's Application committee responsible for developing the proposed rankings to be voted on by the CoC considered the severity of needs and vulnerabilities in establishing priority rankings for FY 2019 project applications. The criteria for ranking utilized by the GBCATCH Application Committee incorporated both HUD priorities and community priorities established through a year long planning process that included representation from the Mayor of Taunton and Attleboro's Community Development and Human Services Departments. The Committee first looked at the primary target population for each project and the projects who were serving the chronically homeless, have low or zero incomes, are living unsheltered, and/or have sever disabilities or barriers due to criminal histories were accorded higher ranking, with lower priority for those with less severe needs. Priority consideration is also given to families with children and those who might have problems accessing housing or services due to barriers, such as poor credit or inability to access state shelters.
2. A spreadsheet was also developed that looked at applicants to score them and included the following: utilization rates on a quarterly basis, funding utilization, length of stay in permanent housing, % of beds dedicated to chronically homeless, increasing housing stability, commitment to housing first principles, full participation it the SoCo/GBCATCH coordinated entry system, and percentage of clients in the following populations: chronically homeless, veterans, families with children and unaccompanied youth, and those fleeing domestic violence. The CoC also looked at the number of individuals in each project who were connected to benefits, had a steady income, and on health insurance.

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

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

Public Posting of Objective Review and Ranking Process	Public Posting of CoC Consolidated Application including: CoC Application, CoC Priority Listing, Project Listings

1. Email	X	**1. Email**	X
2. Mail		**2. Mail**	
3. Advertising in Local Newspaper(s)		**3. Advertising in Local Newspaper(s)**	
4. Advertising on Radio or Television		**4. Advertising on Radio or Television**	
5. Social Media (Twitter, Facebook, etc.)		**5. Social Media (Twitter, Facebook, etc.)**	X
6. Did Not Publicly Post Review and Ranking Process		**6. Did Not Publicly Post CoC Consolidated Application**	

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

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

Reallocation: 0%

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

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

1. Throughout the next year the CoC plans to rewrite the process for reallocation as the Collaborative Applicant has hired additional staff building capacity of the CoC. 2. Once written the CoC will place this policy as well as updated CoC policies up for a formal vote. 3. The CoC will provide the information to applicants who are interested in applying for CoC funds in the next Request for Proposal. 4. The CoC is currently a very small CoC with only three permanent Supportive Housing Programs. Additionally the CoC funds Coordinated Entry and has previously funded HMIS. It is difficult at this time due to the size of the CoC to reallocate funds. While it is difficult to reallocate funds due to the lack of participants the CoC continues to look at how each program is performing and how they can reach Continuum goals each year. Additionally, for the past two RFP's, only three agencies have stepped up to apply for funds. This year, an additional agency has applied as a sub-recipient for the DV Bonus Project. This would increase the participation of agencies by 25%. 5. Through communication with past participating agencies as well as new non-profits in the

Continuum the CoC hopes additional agencies will attempt to provide services through CoC funds as available. The hope for additional participation due to an increase in advertising and capacity building will provide greater competition and therefore allow for low performing programs to be reallocated.

DV Bonus

Instructions

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1F-1 DV Bonus Projects.

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

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

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

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

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

Need Housing or Services	8,012.00
the CoC is Currently Serving	1,300.00

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

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

1. New Hope, Inc., which is the sub-recipient for the proposed DV bonus Project, provided the number of DV survivors needing housing and services through the information they obtain during intake and case management. The Commonwealth of MA designates providers for each region, New Hope being the agency in this CoC. 2. the data source used is a comparable database approve by OVW and in compliance with the VAWA Act called EmpowerDB.

1F-3. : SSO-CE Project–CoC including an SSO-CE project for DV Bonus funding in their CoC Priority Listing must provide information in the chart below about the project applicant and respond to Question 1F-3a.

DUNS Number	781972716
Applicant Name	Community Counseling of Bristol County

1F-3a. Addressing Coordinated Entry Inadequacy.

Applicants must describe how:
1. the current Coordinated Entry is inadequate to address the needs of survivors of domestic violence, dating violence, or stalking; and
2. the proposed project addresses inadequacies identified in 1. above.
(limit 2,000 characters)

1. The Coordinated Entry system currently provides inadequate services to survivors of domestic violence, dating violence, and stalking. While those who engage with Coordinated Entry are provided referral for services it is imperative the system become more accommodating and aware of the specific needs of those who are survivors of domestic violence, et al. They way in which a household accesses confidential shelter as well as safety planning is a system operated through the Commonwealth of MA. Coordinated Entry has had little opportunity to adequately incorporate this system into the overall services offered other than a cold referral (as the providers want to speak directly with the survivor as opposed to a CE worker) 2. The proposed project would allow for additional conversation and capacity building for the CE program as well as ensure more efficient cooperation with local DV providers. The project would also increase best practices in safety planning and housing for those who are survivors of Domestic violence, dating violence, or stalking.

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

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

below.

Applicant Name	DUNS Number
This list contains no items	

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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2A-1. HMIS Vendor Identification. Caseworthy

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

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

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

Project Type	Total Number of Beds in 2019 HIC	Total Beds Dedicated for DV in 2019 HIC	Total Number of 2019 HIC Beds in HMIS	HMIS Bed Coverage Rate
Emergency Shelter (ES) beds	251	12	239	100.00%
Safe Haven (SH) beds	0	0	0	
Transitional Housing (TH) beds	50	0	12	24.00%
Rapid Re-Housing (RRH) beds	0	0	0	
Permanent Supportive Housing (PSH) beds	73	0	73	100.00%
Other Permanent Housing (OPH) beds	14	0	0	0.00%

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

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

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

The Continuum of Care currently operates at a total of 92% coverage in HMIS for beds counted in the HIC. The Domestic Violence Provider is exempt from participating in HMIS due to the Violence Against Women Act (VAWA) reauthorization in 2005 restricting HMIS data collection. Section 3 imposed nondisclosure restrictions on recipients of VAWA grants.
2. The CoC will continue to work with the local housing authority to attempt to gain participation in HMIS for the remaining beds listed on the HIC that do not participate in HMIS.

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

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

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

Applicants must enter the date the CoC submitted the 2019 Housing Inventory Count (HIC) data into the Homelessness Data Exchange (HDX). (mm/dd/yyyy)	05/31/2019

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

Instructions:

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

2B-2. PIT Count Data–HDX Submission Date. Applicants must enter the date the CoC submitted its PIT count data in HDX (mm/dd/yyyy). 05/31/2019

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

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

1. We did not change our process from 2018 in 2019 for our sheltered PIT count. There was one issue of discrepancy which was addressed when reviewing our data after submission with the ABT consultant which focused on the number of sheltered families in the Continuum. There was an issue regarding the number of families with minor children juxtaposed with the HIC reported to the Continuum. It was discovered, the Commonwealth increased the number of family units available in the Continuum and did not notify the CoC. This has since been corrected. 2. not applicable 3. not applicable

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

Applicants must select whether the CoC added or removed emergency shelter, transitional housing, or Safe-Haven inventory because of funding specific to a Presidentially-declared disaster, resulting in a change to the CoC's 2019 sheltered PIT count.	No

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

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

Not Applicable

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

Applicants must:

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

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

Applicants must describe how the CoC engaged stakeholders serving youth experiencing homelessness to:
1. plan the 2019 PIT count;
2. select locations where youth experiencing homelessness are most likely to be identified; and
3. involve youth in counting during the 2019 PIT count.
(limit 2,000 characters)

1.The CoC specifically utilized the the program staff for the state funded unaccompanied youth project in the planning for the 2019 PIT count. This provider actively engages youth from their emergency shelter as well as other contacts in the community who act as stakeholders serving youth experiencing homelessness. 2. During the PIT count teams visited specific sites where young adults may be found including the local community colleges, teen centers, and areas of the cities where youth often congregate. 3. Youth from the emergency shelter, located in a neighboring CoC but serving youth from this

CoC were encouraged to participate in the PIT count. Many of the youth in the facility did, in fact participate, within one of the 3 CoC's the shelter operates. Additionally, young adults who recently graduated from the local collage participated in the count at the school to increase likelihood unaccompanied youth would be willing to be counted.

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

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

1. The CoC adopted the prioritization notice for individuals and families experiencing chronic homelessness. Through the utilization of the waitlist for Permanent Supportive Housing the Continuum was better able locate typical places where those experiencing chronic homelessness may be found 2.Families with children are most often housed in emergency shelter through the Commonwealth's Department of Housing and Community Development. Working with the subcontractors for those shelters allowed for families with children to be located for the PIT 3.Through a Veteran's subcommittee a by name list has been created which enabled the CoC to prepare for the count and know where these individuals may be found.

3A. Continuum of Care (CoC) System Performance

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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*3A-1. First Time Homeless as Reported in HDX.

Applicants must:

Report the Number of First Time Homeless as Reported in HDX.	261

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

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

1. Our CoC has recognized that the high risk factors that contribute to individuals becoming homeless for the first time relate to the increase in substance use and co-occurring mental health and substance use disorders that are untreated. Accessing behavioral health services is difficult for many but for others it is being able to maintain housing as a result of these issues. For others it is the inability to afford the high rents in our area that are above fair marker rents and landlords that are resistant to working with individuals and families with poor credit and criminal histories. 2. Our CoC has been fortunate to have agencies who offer support to individuals and families that focus on diversion and rapid rehousing. We do not have any RRH projects listed in our

HIC but there is a program known as HomeBase in Massachusetts as well as Prevention and RRH funds through the ESG available in our CoC that can contribute to lowering numbers of first time homeless in emergency shelter. 3. Catholic Social Services oversees the Coordinated Entry project for the CoC as well as ESG and they place a major focus on prevention and diversion as much as possible.

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

Applicants must:

Report Average Length of Time Individuals and Persons in Families Remained Homeless as Reported in HDX.	150

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

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

1.Individuals and Families were also on the Catholic Social Services Coordinated Entry list for the CoC for permanent housing and many received case management services through CCBC's Community Support Program as well as access to the SAMHSA Safe Harbor Grant to Benefit Homeless Individuals (GBHI), the JRI Rapid Rehousing program all of which worked to support individuals and families who were homeless the longest to become permanently housed. 2. Additionally, the Individual Services, Unaccompanied Youth, Family Services, and veterans Committee of the CoC which are a part of the Regional South coast Network to end Homelessness identified whose who were homeless the longest using a confidential by name list process reviewed monthly to strategize how to decrease the length of time homeless. The goal to decrease the length of time homeless was supported by the organized effort between homeless providers in the CoC to provide access to housing as quickly as possible with supportive services once referred through Coordinated Entry. 3. Catholic Social Services oversees the Coordinated Entry project for the CoC as well as ESG and they place a major focus on prevention and diversion as the strategy to reduce the length of time individuals and families remain homeless. This is incorporated into the CoC's Coordinated Entry process where all agencies with openings in shelter, transitional and permanent housing communicate openings on a daily basis to make placement as quickly as possible.

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

Applicants must:

	Percentage
1. Report the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid rehousing that exit to permanent housing destinations as reported in HDX.	47%
2. Report the percentage of individuals and persons in families in permanent housing projects, other than rapid rehousing, that retain their permanent housing or exit to permanent housing destinations as reported in HDX.	100%

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

Applicants must:
1. describe the CoC's strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations;
2. provide the organization name or position title responsible for overseeing the CoC's strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations;
3. describe the CoC's strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations; and
4. provide the organization name or position title responsible for overseeing the CoC's strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations.
(limit 2,000 characters)

1. of the 282 persons who exited ES, TH in our CoC 47% went to permanent housing destinations which was the same percentage as the past year. This shows the CoC has made slight progress in implementing ways to ensure the provider agencies develop additional opportunities for PH for those individuals and families who do not meet the criteria for the PH projects operated in the CoC. The majority of those individuals who left were not chronically homeless and many had substance use disorders and needed further treatment. 2. The CoC has worked to increase communication through the individual services meetings to ensure all agencies work together to transition people from emergency shelters to permanent housing and rapid rehousing programs that will ultimately result in permanent housing. Families are served through family services meetings, in a similar capacity. Agencies are working to ensure all families who are eligible, have access to Permanent Supportive Housing, and rapid rehousing assistance to move quickly from emergency shelter to permanent housing. In addition the incorporation of HMIS with the Coordinated Entry system has allowed for the Continuum to more easily ascertain the progress of individuals throughout the year. 3. The CoC has fully adopted a Housing First approach with client's and is working cooperatively with other housing options including federal and state public housing as well as mainstream resources for case management to increase the retention of permanent housing. 4. As stated above, the CoC is working more cooperatively, especially with the individuals served, in individual service

meetings to ensure all clients are offered services needed to maintain permanent housing. Families are also served through family services meetings to obtain the same effect.

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

Applicants must:

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

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

Applicants must:
1. describe the strategy the CoC has implemented to identify individuals and persons in families who return to homelessness;
2. describe the CoC's strategy to reduce the rate of additional returns to homelessness; and
3. provide the name of the organization or position title that is responsible for overseeing the CoC's strategy to reduce the rate individuals and persons in families return to homelessness.
(limit 2,000 characters)

1.The CoC experiences a very low percentage of returns to homelessness, 3% after 2 years, 4 of the 160 who left ES, TH, or PH. With the addition of a new HMIS system that incorporates Coordinated Entry fully within the system, the CoC will be able to better identify individuals and persons in families who have returned to homelessness. The CoC providers work closely with individuals and families to prevent a return to homelessness once they are placed in Ph. Each provider works on budgeting, provides case management support and connection to mainstream benefits and employment services as well as connection to health and behavioral health treatment. 3. Catholic Social Services oversees the Coordinated Entry and ESG funds which focus on diversion, rapid rehousing, and prevention with support of all providers in the CoC.

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

Applicants must:

	Percentage
1. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their employment income from entry to exit as reported in HDX.	6%
2. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their non-employment cash income from entry to exit as reported in HDX.	36%

3A-5a. Increasing Employment Income.

Applicants must:
1. describe the CoC's strategy to increase employment income;
2. describe the CoC's strategy to increase access to employment;
3. describe how the CoC works with mainstream employment organizations to help individuals and families increase their cash income; and
4. provide the organization name or position title that is responsible for overseeing the CoC's strategy to increase jobs and income from employment.
(limit 2,000 characters)

1. The CoC has a number of strategies to increase access to employment including partnering with agencies in the CoC to leverage critical resources for clients served. 2. Housing Solutions of Southeastern MA collaborated with SER-Jobs for Progress to create the Secure Jobs Initiative for homeless families ready, willing, and able o work that are residing in state shelters and HomeBASE units. 3. Other program participants willing and able to work seek employment options for the homeless by connecting to Career Centers, Ser-Jobs for Progress, YouthBuild, and the Massachusetts Rehabilitation Commission. CoC agencies have policies that clients complete employment profiles and obtain job training and job search assistance; case managers assist clients with interview skills and job search. The Taunton Career Center hosts job/career fairs a year and CoC staff transport clients. Bristol Community College which has a campus in two of our communities, Taunton and Attleboro, host 2-3 job fairs a year. 4. The GBCATCH does not have one agency or person but rather reviews these strategies in the Individual and Family Services Committee meetings monthly.

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

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

1. The CoC has a number of strategies to increase non-employment case income including partnering with agencies tin the CoC to leverage critical resources for clients served. Every program serving those who are homeless, within the CoC first ensures clients are receiving any non employment benefits they are eligible for early in the relationship. Case managers assist with transportation when needed, and advocate for clients for services and case benefits when eligible. 2. An increasing number of agencies and case managers have been trained in SOAR (SSI/SSDI Outreach Access and Recovery) which is a national program in increase assess to disability income for eligible clients. The CoC will continue to encourage additional members become trained in the practice and utilize it with clients to increase non-employment cash for those who need it. 3. The CoC as a whole discusses these strategies during Individual and Family Service Committee meetings as

there is no specific agency responsible for these strategies.

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

Applicants must describe how the CoC:
1. promoted partnerships and access to employment opportunities with private employers and private employment organizations, such as holding job fairs, outreach to employers, and partnering with staffing agencies; and
2. is working with public and private organizations to provide meaningful, education and training, on-the-job training, internship, and employment opportunities for residents of permanent supportive housing that further their recovery and well-being.
(limit 2,000 characters)

1.The CoC continues to work to promote increased participation with private employers and employment organizations through connecting businesses with providers to establish relationships. Agencies including Southeastern Massachusetts SER-Jobs for Progress work with the families in the Continuum currently in a housing crisis who are ready, willing, and able to work. They are connected with training and employment opportunity as well as often provided transportation and uniforms decreasing the barriers to employment. In addition the agencies within the CoC partner with a variety staffing agencies and most steadily work with the local Career Center to ensure clients have access to job opportunities. 2. The PSH programs within the continuum have established a number of relationships with both private, non profit, including religious organizations, as well as public organizations including the Career Center to access resources. Residents are able to volunteer with local religious organizations as well as engage in job training through Ser-Jobs for Progress. Additionally the residents are able to access education through the local high school Adult education program as well as potential access to the local Community College.

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

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

1. The CoC trains provider organization staff on connecting program participants and people experiencing homelessness with education and job training opportunities.	☐
2. The CoC trains provider organization staff on facilitating informal employment opportunities for program participants and people experiencing homelessness (e.g., babysitting, housekeeping, food delivery).	☐
3. The CoC trains provider organization staff on connecting program participants with formal employment opportunities.	☐
4. The CoC trains provider organization staff on volunteer opportunities for program participants and people experiencing homelessness.	☐
5. The CoC works with organizations to create volunteer opportunities for program participants.	☐
6. The CoC works with community organizations to create opportunities for civic participation for people experiencing homelessness (e.g., townhall forums, meeting with public officials).	☐
7. Provider organizations within the CoC have incentives for employment.	☐

8. The CoC trains provider organization staff on helping program participants budget and maximize their income to maintain stability in permanent housing.	☐

3A-6. System Performance Measures Data–HDX Submission Date **Applicants must enter the date the CoCs submitted its FY 2018 System Performance Measures data in HDX. (mm/dd/yyyy)**	05/31/2019

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

Instructions

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3B-1. Prioritizing Households with Children.

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

1. History of or Vulnerability to Victimization (e.g. domestic violence, sexual assault, childhood abuse)	X
2. Number of previous homeless episodes	X
3. Unsheltered homelessness	X
4. Criminal History	
5. Bad credit or rental history	
6. Head of Household with Mental/Physical Disability	X

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

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

assistance ends; and
3. provide the organization name or position title responsible for overseeing the CoC's strategy to rapidly rehouse families with children within 30 days of them becoming homeless.
(limit 2,000 characters)

1.Our CoC works closely with families who may become homeless to help them follow the procedures developed by MA law which states that no family should be unsheltered. The MA DTA, DHCD, and ES and other providers work together to place homeless families into emergency shelter. GBCATCH participates in the Coordinated Entry process The CALL, operated by Catholic Social Services. Operational Standards, intake forms with a vulnerability index, real-time bed available and a centralized wait list are used. If efforts to prevent or divert a family from homelessness are unsuccessful and the family is EA (emergency Assistance) eligible the family is placed in emergency shelter. Under HomeBASE, families receive financial support to prevent homelessness or rental assistance to provide a temporary monthly rental subsidy to move families out of shelter as quickly as possible. 2. HomeBASE also provides for case management for families who have been rapidly rehoused ensuring mainstream resources are accessed during this time to ensure ongoing success. 3. JRI, Southeastern Family Services, and Catholic Social Services are the current organizations operating both emergency shelter, as well as diversion programming to move families as quickly out of homelessness as possible. Their work with the state regarding placement of families, access to resources, and advocating for client needs provide an invaluable asset to the CoC.

3B-1b. Antidiscrimination Policies.

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

1. CoC conducts mandatory training for all CoC- and ESG-funded housing and services providers on these topics.	
2. CoC conducts optional training for all CoC- and ESG-funded housing and service providers on these topics.	
3. CoC has worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients.	X
4. CoC has worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within the CoC geographic area that might be out of compliance and has taken steps to work directly with those facilities to come into compliance.	

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

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

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

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

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

1. History of, or Vulnerability to, Victimization (e.g., domestic violence, sexual assault, childhood abuse)	X
2. Number of Previous Homeless Episodes	X
3. Unsheltered Homelessness	X
4. Criminal History	
5. Bad Credit or Rental History	

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

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

1.Catholic Social Services, a significant member of the CoC was awarded a grant this program year from the Commonwealth of Massachusetts to address the specific needs of this population, to complete a needs assessment, and develop housing resources geared specifically to the need of youth experiencing homelessness. Kilian's House, which is a homeless shelter specifically for youth experiencing homeless in the county, was able to expand

services available to youth as well as create an weather related emergency shelter throughout the winter. This facility provided transportation for any youth in the county to the facility where they received temporary housing, case management, and assessment for rapid rehousing and permanent supportive housing. This increase in services and beds allowed for the youth-specific facility to serve additional households and move them toward rapid rehousing. 2. In addition the grant provided funds for a mobile outreach center which traveled throughout the county, including within the CoC to provide access for youth experiencing homeless to meet with a case manager and access mainstream resources. The mobile outreach center is a youth focused project providing a safe place for youth to learn about services offered in a non-judgmental, non-threatening manner in areas of the county where youth tend to congregate.

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

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

1. The increase in shelter beds as well as transportation and outreach activities, all funded through alternative sources including state funding, private donations, and foundations allowed for an increase in availability of housing and services for youth experiencing homelessness. Additionally, the new program does provide additional funding for rapid rehousing services. As this is a fairly new program at the time the agency providing services has not been able to provide specific outcomes to date. 2. It was shown that the youth specific program which encompasses three Continuum of Care did provide emergency shelter for 12 additional unaccompanied youth during the winter months. This measure shows an increase of services provided to unaccompanied youth for shelter. Additionally the initiation of outreach services will allow for additional opportunities for youth to engage in services and obtain housing. 3. The program will be counting the number of youth served, the services provided, the entrance into permanent housing and how long a youth is able to maintain housing. These measures will show if the program and the Continuum are effectively showing a decrease in housing crisis among the youth in the Continuum.

3B-1e. Collaboration–Education Services.

Applicants must describe:

1. the formal partnerships with:
a. youth education providers;
b. McKinney-Vento LEA or SEA; and

c. school districts; and

2. how the CoC collaborates with:
a. youth education providers;
b. McKinney-Vento Local LEA or SEA; and
c. school districts.
(limit 2,000 characters)

1.Through state contracts for family shelter each provider is required to work with the McKinney Vento liaisons to ensure the children served are able to maintain their educational track in their home school during their housing crisis. The CoC policy asks CoC funded providers to ensure homeless children be enrolled in school or an early childhood education program with services as needed. Formal partnerships have been developed with local providers of children's behavioral health services, youth education, and school districts to ensure children experiencing homelessness are served appropriately. 2. a.The providers of early childhood and Head Start including the Old Colony YMCA and other providers in the area including JRI and CCBC's Children's Behavioral Health initiative supports youth experiencing mental health issues while in school. These agencies collaborate with GBCATCH and the Family Services Committee to meet the youth education needs of those children experiencing homelessness in our CoC. b.. MV liaisons as well as the State Director for MV are often present during the Family Services Committee meetings and present education rights of homeless children. c. CoC programs communicate by phone and secure email with liaisons if needed ensuring all children are reenrolled in school and receiving appropriate transportation and services. The CoC provides liaisons with data, information, referral and training to understand the resources available to homeless families with school ate children. The CoC requires providers receive training and information about MV education services. Providers are required to ensure the staff informs families of resources to identify the appropriate school for each child. In addition, training is offered to the local school districts regarding Coordinated Entry and access to emergency shelter and rapid rehousing services through the Commonwealth.

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

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

The CoC requires that all project applicants be able to clearly demonstrate they are informing families and individuals who experience homelessness of their eligibility for education services. All project applicants attest to this in their McKinney Vento (MV) applications annually. Other agencies are educated at the Family Services Committee monthly where the MV school liaison reviews the requirements and services available. Applicants serving children must demonstrate they have policies and procedures that meet the criteria of the education subtitle of the MV Act including a designated staff to ensure students are enrolled in school and connected to appropriate resources in the community. The CoC provides local education liaisons with data, information, referral and training to understand the resources available to homeless families with school age children. DHCD is the state agency responsible for managing

the statewide networks of emergency shelter and locating overflow capacity for families with the emergency shelters are full. It also has responsibility for placing families within 20 miles of the families' community of origin whenever possible and for notifying the MA Department of education of every family emergency shelter placement when there is a school age child in the household. Providers assist in connecting families with the appropriate McKinney-Vento homeless liaison in each school district. The CoC policy asks that CoC-funded providers ensure that homeless children must be enrolled in school or an early childhood education program with services in the community as needed. Providers must distribute materials to families that children must be in school or enrolled as quickly as feasible. If possible, children who remain in their school of origin are provided transportation to the school; and that children who may be homeless are not treated any differently ensuring access to any school program or necessary services as any other students.

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

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

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

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

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

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

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

criteria for ending veteran homelessness.

3B-2b. Housing First for Veterans.

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

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

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

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

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

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources
The FY 2019 CoC Program Competition Notice of Funding Availability at: https://www.hudexchange.info/programs/e-snaps/fy-2019-coc-program-nofa-coc-program-competition/#nofa-and-notices

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

4A-1. Healthcare–Enrollment/Effective Utilization

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

Type of Health Care	Assist with Enrollment	Assist with Utilization of Benefits?
Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)	Yes	Yes
Private Insurers:	Yes	Yes
Non-Profit, Philanthropic:	Yes	Yes
Other: (limit 50 characters)		

4A-1a. Mainstream Benefits.

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

health insurance;
4. describe how the CoC provides assistance with the effective utilization of Medicaid and other benefits; and
5. provide the name of the organization or position title that is responsible for overseeing the CoC's strategy for mainstream benefits.
(limit 2,000 characters)

1.The CoC provides training in monthly meetings regarding any updates for eligibility of mainstream services. In addition, population specific training are held in the Family Services Committee meetings to ensure staff are aware of up to day information regarding mainstream resources. 2. The CoC disseminates notice of available mainstream resources through list serve emails as well a through monthly meetings for the entire CoC and committee meetings. 3. The CoC has a number of health care connectors throughout a variety of organizations. All CoC organizations are aware of where the connectors are located and can refer clients for assistance with enrolling in health insurance. In addition referrals can be made through Coordinated Entry to a health care connector. 4. Many of the clients we serve struggle with mental illness and have a difficult time with the application process and staff will accompany them to the appointment if they need support. The CoC understands the importance of accessing services needed to obtain and maintain housing. Many of the programs utilize Medicaid and other benefits to ensure clients receive the necessary medical and supportive services needed to be successful. 5. There is no specific agency responsible for overseeing the CoC's strategy for mainstream benefits but all agencies work with the households they serve to obtain and maintain mainstream benefits.

4A-2. Lowering Barriers to Entry Data:

Applicants must report:

1. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition.	4
2. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.	4
Percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects the CoC has ranked in its CoC Priority Listing in the FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.	100%

4A-3. Street Outreach.

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

1.The CoC has the involvement of the Eliot Community Human Services PATH program which coordinated 100% of the CoC's geographic area for Street Outreach. Additionally, the City of Taunton has developed a team of individuals from the Department of Human Services, the local homeless providers and the police department to conduct street outreach to the local encampments. CCBC also through the Safe Harbor program and conducts outreach to homeless veterans and individuals through a SAMHSA funded Grant to Benefit Homeless Individuals and a Community Support Program for People Experiencing Chronic Homelessness (CSPECH). 2. The outreach efforts encompass the entire CoC through collaborative efforts with local police departments, colleges and universities and other faith based programs serving those in poverty. 3. Outreach efforts are conducted daily through partners like Matthew Mission a program serving those in poverty, as well as the outreach conducted through the team built for outreach. 4. All of these initiatives work together to go to the soup kitchens, encampments, in the woods or whatever sheltered homeless have been reported to engage as respectfully and sensitively with individuals to help them potentially move from homelessness to permanent housing. Coordinated Entry also provides referrals for outreach services any caller who contacts the program for shelter or housing. The programs work to engage those who are least likely to request assistance through slow rapport building and ensuring basic needs are met as they work to engage the household in more supportive services.

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

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

	2018	2019	Difference
RRH beds available to serve all populations in the HIC	0	0	0

4A-5. Rehabilitation/Construction Costs–New Projects.

No

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

4A-6. Projects Serving Homeless under Other Federal Statutes.

No

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

other federal statutes.

4B. Attachments

Instructions:

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

Document Type	Required?	Document Description	Date Attached
_FY 2019 CoC Competition Report (HDX Report)	Yes	FY 2019 CoC Compe...	09/18/2019
1C-4.PHA Administration Plan–Moving On Multifamily Assisted Housing Owners' Preference.	No		
1C-4. PHA Administrative Plan Homeless Preference.	No		
1C-7. Centralized or Coordinated Assessment System.	Yes	CE Assessment Tool	09/18/2019
1E-1.Public Posting–15-Day Notification Outside e-snaps–Projects Accepted.	Yes	Projects Accepted...	09/18/2019
1E-1. Public Posting–15-Day Notification Outside e-snaps–Projects Rejected or Reduced.	Yes	Project Rejected/...	09/18/2019
1E-1.Public Posting–30-Day Local Competition Deadline.	Yes	Local Competition...	09/18/2019
1E-1. Public Posting–Local Competition Announcement.	Yes	Local Competition...	09/18/2019
1E-4.Public Posting–CoC-Approved Consolidated Application	Yes	1E-4.Public Posti...	09/24/2019
3A. Written Agreement with Local Education or Training Organization.	No		
3A. Written Agreement with State or Local Workforce Development Board.	No		
3B-3. Summary of Racial Disparity Assessment.	Yes	Racial Disparity ...	09/18/2019
4A-7a. Project List-Homeless under Other Federal Statutes.	No		
Other	No		
Other	No		

Other	No		

Attachment Details

Document Description: FY 2019 CoC Competition Report

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: CE Assessment Tool

Attachment Details

Document Description: Projects Accepted Notification

Attachment Details

Document Description: Project Rejected/Reduced Notification

Attachment Details

Document Description: Local Competition Deadline

Attachment Details

Document Description: Local Competition Public Announcement

Attachment Details

Document Description: 1E-4.Public Posting–CoC-Approved Consolidated Application

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Racial Disparity Assessment Summary

Attachment Details

Document Description:

Attachment Details

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Submission Summary

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

Page	Last Updated
1A. Identification	09/14/2019
1B. Engagement	09/14/2019
1C. Coordination	09/14/2019
1D. Discharge Planning	No Input Required
1E. Local CoC Competition	09/14/2019
1F. DV Bonus	09/14/2019
2A. HMIS Implementation	09/14/2019
2B. PIT Count	09/14/2019
3A. System Performance	09/14/2019
3B. Performance and Strategic Planning	09/14/2019
4A. Mainstream Benefits and Additional Policies	09/14/2019
4B. Attachments	09/24/2019

Submission Summary	No Input Required

2019 HDX Competition Report

PIT Count Data for MA-519 - Attleboro, Taunton/Bristol County CoC

Total Population PIT Count Data

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count	**243**	**234**	**208**	**256**
Emergency Shelter Total	158	170	144	213
Safe Haven Total	0	0	0	0
Transitional Housing Total	58	28	22	9
Total Sheltered Count	**216**	**198**	**166**	**222**
Total Unsheltered Count	**27**	**36**	**42**	**34**

Chronically Homeless PIT Counts

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count of Chronically Homeless Persons	**30**	**22**	**33**	**14**
Sheltered Count of Chronically Homeless Persons	18	7	8	5
Unsheltered Count of Chronically Homeless Persons	12	15	25	9

2019 HDX Competition Report

PIT Count Data for MA-519 - Attleboro, Taunton/Bristol County CoC

Homeless Households with Children PIT Counts

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count of the Number of Homeless Households with Children	**55**	**40**	**34**	**47**
Sheltered Count of Homeless Households with Children	55	40	34	47
Unsheltered Count of Homeless Households with Children	0	0	0	0

Homeless Veteran PIT Counts

	2011	2016	2017	2018	2019
Total Sheltered and Unsheltered Count of the Number of Homeless Veterans	**5**	**6**	**3**	**4**	**3**
Sheltered Count of Homeless Veterans	1	1	3	1	3
Unsheltered Count of Homeless Veterans	4	5	0	3	0

2019 HDX Competition Report

HIC Data for MA-519 - Attleboro, Taunton/Bristol County CoC

HMIS Bed Coverage Rate

Project Type	Total Beds in 2019 HIC	Total Beds in 2019 HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
Emergency Shelter (ES) Beds	251	12	239	100.00%
Safe Haven (SH) Beds	0	0	0	NA
Transitional Housing (TH) Beds	50	0	12	24.00%
Rapid Re-Housing (RRH) Beds	0	0	0	NA
Permanent Supportive Housing (PSH) Beds	73	0	73	100.00%
Other Permanent Housing (OPH) Beds	14	0	0	0.00%
Total Beds	388	12	324	86.17%

2019 HDX Competition Report

HIC Data for MA-519 - Attleboro, Taunton/Bristol County CoC

PSH Beds Dedicated to Persons Experiencing Chronic Homelessness

Chronically Homeless Bed Counts	2016 HIC	2017 HIC	2018 HIC	2019 HIC
Number of CoC Program and non-CoC Program funded PSH beds dedicated for use by chronically homeless persons identified on the HIC	30	50	67	73

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

Households with Children	2016 HIC	2017 HIC	2018 HIC	2019 HIC
RRH units available to serve families on the HIC				

Rapid Rehousing Beds Dedicated to All Persons

All Household Types	2016 HIC	2017 HIC	2018 HIC	2019 HIC
RRH beds available to serve all populations on the HIC				

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

Summary Report for MA-519 - Attleboro, Taunton/Bristol County CoC

Measure 1: Length of Time Persons Remain Homeless

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

Metric 1.1: Change in the average and median length of time persons are homeless in ES and SH projects.
Metric 1.2: Change in the average and median length of time persons are homeless in ES, SH, and TH projects.

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

	Universe (Persons)		Average LOT Homeless (bed nights)			Median LOT Homeless (bed nights)		
	Submitted FY 2017	FY 2018	Submitted FY 2017	FY 2018	Difference	Submitted FY 2017	FY 2018	Difference
1.1 Persons in ES and SH	539	358	137	150	13	88	66	-22
1.2 Persons in ES, SH, and TH	555	376	171	155	-16	92	76	-16

b. This measure is based on data element 3.17.

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

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

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

	Universe (Persons)		Average LOT Homeless (bed nights)			Median LOT Homeless (bed nights)		
	Submitted FY 2017	FY 2018	Submitted FY 2017	FY 2018	Difference	Submitted FY 2017	FY 2018	Difference
1.1 Persons in ES, SH, and PH (prior to "housing move in")	549	363	279	198	-81	170	90	-80
1.2 Persons in ES, SH, TH, and PH (prior to "housing move in")	553	381	283	202	-81	170	90	-80

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

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

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

	Total # of Persons who Exited to a Permanent Housing Destination (2 Years Prior)	Returns to Homelessness in Less than 6 Months		Returns to Homelessness from 6 to 12 Months		Returns to Homelessness from 13 to 24 Months		Number of Returns in 2 Years	
		FY 2018	% of Returns	FY 2018	% of Returns	FY 2018	% of Returns	FY 2018	% of Returns
Exit was from SO	0	0		0		0		0	
Exit was from ES	145	2	1%	1	1%	1	1%	4	3%
Exit was from TH	9	0	0%	0	0%	0	0%	0	0%
Exit was from SH	0	0		0		0		0	
Exit was from PH	6	0	0%	0	0%	0	0%	0	0%
TOTAL Returns to Homelessness	160	2	1%	1	1%	1	1%	4	3%

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

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

	January 2017 PIT Count	January 2018 PIT Count	Difference
Universe: Total PIT Count of sheltered and unsheltered persons	234	208	-26
Emergency Shelter Total	170	144	-26
Safe Haven Total	0	0	0
Transitional Housing Total	28	22	-6
Total Sheltered Count	198	166	-32
Unsheltered Count	36	42	6

Metric 3.2 – Change in Annual Counts

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

	Submitted FY 2017	FY 2018	Difference
Universe: Unduplicated Total sheltered homeless persons	556	376	-180
Emergency Shelter Total	540	358	-182
Safe Haven Total	0	0	0
Transitional Housing Total	16	19	3

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

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

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

	Submitted FY 2017	FY 2018	Difference
Universe: Number of adults (system stayers)	0	51	51
Number of adults with increased earned income	0	3	3
Percentage of adults who increased earned income		6%	

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

	Submitted FY 2017	FY 2018	Difference
Universe: Number of adults (system stayers)	0	51	51
Number of adults with increased non-employment cash income	0	9	9
Percentage of adults who increased non-employment cash income		18%	

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

	Submitted FY 2017	FY 2018	Difference
Universe: Number of adults (system stayers)	0	51	51
Number of adults with increased total income	0	11	11
Percentage of adults who increased total income		22%	

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

Metric 4.4 – Change in earned income for adult system leavers

	Submitted FY 2017	FY 2018	Difference
Universe: Number of adults who exited (system leavers)	0	14	14
Number of adults who exited with increased earned income	0	1	1
Percentage of adults who increased earned income		7%	

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

	Submitted FY 2017	FY 2018	Difference
Universe: Number of adults who exited (system leavers)	0	14	14
Number of adults who exited with increased non-employment cash income	0	5	5
Percentage of adults who increased non-employment cash income		36%	

Metric 4.6 – Change in total income for adult system leavers

	Submitted FY 2017	FY 2018	Difference
Universe: Number of adults who exited (system leavers)	0	14	14
Number of adults who exited with increased total income	0	6	6
Percentage of adults who increased total income		43%	

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

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

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

	Submitted FY 2017	FY 2018	Difference
Universe: Person with entries into ES, SH or TH during the reporting period.	407	261	-146
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	12	48	36
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time)	395	213	-182

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

	Submitted FY 2017	FY 2018	Difference
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	416	280	-136
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	16	64	48
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)	400	216	-184

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

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

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

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

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

	Submitted FY 2017	FY 2018	Difference
Universe: Persons who exit Street Outreach	0	0	0
Of persons above, those who exited to temporary & some institutional destinations	0	0	0
Of the persons above, those who exited to permanent housing destinations	0	0	0
% Successful exits			

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

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

	Submitted FY 2017	FY 2018	Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	404	282	-122
Of the persons above, those who exited to permanent housing destinations	190	133	-57
% Successful exits	47%	47%	0%

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

	Submitted FY 2017	FY 2018	Difference
Universe: Persons in all PH projects except PH-RRH	33	9	-24
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	33	9	-24
% Successful exits/retention	100%	100%	0%

2019 HDX Competition Report

FY2018 - SysPM Data Quality

MA-519 - Attleboro, Taunton/Bristol County CoC

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

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

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

2019 HDX Competition Report

FY2018 - SysPM Data Quality

	All ES, SH				All TH				All PSH, OPH				All RRH				All Street Outreach			
	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018
1. Number of non-DV Beds on HIC	158	158	158	158	57	57	55	50	90	90	85	87								
2. Number of HMIS Beds	158	158	158	158	27	27	25	12	84	84	79	73								
3. HMIS Participation Rate from HIC (%)	100.00	100.00	100.00	100.00	47.37	47.37	45.45	24.00	93.33	93.33	92.94	83.91								
4. Unduplicated Persons Served (HMIS)	517	430	540	361	30	23	16	23	84	84	84	84	0	0	0	0	0	0	0	0
5. Total Leavers (HMIS)	373	297	399	283	15	7	0	9	11	10	10	12	0	0	0	0	0	0	0	0
6. Destination of Don't Know, Refused, or Missing (HMIS)	42	77	70	15	2	0	0	1	0	0	0	0	0	0	0	0	0	0	0	0
7. Destination Error Rate (%)	11.26	25.93	17.54	5.30	13.33	0.00		11.11	0.00	0.00	0.00	0.00								

2019 HDX Competition Report

Submission and Count Dates for MA-519 - Attleboro, Taunton/Bristol County CoC

Date of PIT Count

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

Report Submission Date in HDX

	Submitted On	Met Deadline
2019 PIT Count Submittal Date	5/31/2019	No
2019 HIC Count Submittal Date	5/31/2019	No
2018 System PM Submittal Date	5/31/2019	Yes

GBCATCH

GREATER BRISTOL COUNTY ATTLEBORO TAUNTON COALITION TO END HOMELESSNESS

MA-519

CENTRALIZED OR COORDINATED ASSESSMENTSYSTEM

1C-7

Service Prioritization Decision Assistance Tool

(SPDAT)

Assessment Tool for Single Adults

VERSION 4.01

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

A. Mental Health & Wellness & Cognitive Functioning

PROMPTS	CLIENT SCORE:
• *Have you ever received any help with your mental wellness?* • *Do you feel you are getting all the help you need for your mental health or stress?* • *Has a doctor ever prescribed you pills for nerves, anxiety, depression or anything like that?* • *Have you ever gone to an emergency room or stayed in a hospital because you weren't feeling 100% emotionally?* • *Do you have trouble learning or paying attention?* • *Have you ever had testing done to identify learning disabilities?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby?* • *Have you ever hurt your brain or head?* • *Do you have any documents or papers about your mental health or brain functioning?* • *Are there other professionals we could speak with that have knowledge of your mental health?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
3	**Any** of the following: ☐ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason for screening by an expert in mental health or cognitive functioning prior to housing to fully understand capacity
1	☐ In a heightened state of recovery, has a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** is engaged with mental health supports as necessary.
0	☐ No mental health or cognitive functioning issues disclosed, suspected or observed.

B. Physical Health & Wellness

PROMPTS	CLIENT SCORE:
• How is your health? • Are you getting any help with your health? How often? • Do you feel you are getting all the care you need for your health? • Any illness like diabetes, HIV, Hep C or anything like that going on? • Ever had a doctor tell you that you have problems with blood pressure or heart or lungs or anything like that? • When was the last time you saw a doctor? What was that for? • Do you have a clinic or doctor that you usually go to? • Anything going on right now with your health that you think would prevent you from living a full, healthy, happy life? • Are there other professionals we could speak with that have knowledge of your health? • Do you have any documents or papers about your health or past stays in hospital because of your health?	NOTES

	SCORING
4	**Any** of the following: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Palliative health condition
3	Presence of a health issue with **any** of the following: ☐ Not connected with professional resources to assist with a real or perceived serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) ☐ Unable to follow the treatment plan as a direct result of homeless status
2	☐ Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements.
0	☐ No serious or chronic health condition disclosed, observed, or suspected ☐ If any minor health condition, they are managed appropriately

C. Medication

PROMPTS	CLIENT SCORE:
• *Have you recently been prescribed any medications by a health care professional?* • *Do you take any medications prescribed to you by a doctor?* • *Have you ever sold some or all of your prescription?* • *Have you ever had a doctor prescribe you medication that you didn't have filled at a pharmacy or didn't take?* • *Were any of your medications changed in the last month? If yes: How did that make you feel?* • *Do other people ever steal your medications?* • *Do you ever share your medications with other people?* • *How do you store your medications and make sure you take the right medication at the right time each day?* • *What do you do if you realize you've forgotten to take your medications?* • *Do you have any papers or documents about the medications you take?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason
3	**Any** of the following: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

D. Substance Use

PROMPTS	CLIENT SCORE:
• When was the last time you had a drink or used drugs? • Is there anything we should keep in mind related to drugs or alcohol? • (If they disclose use of drugs and/or alcohol) How frequently would you say you use (specific substance) in a week? • Ever have a doctor tell you that your health may be at risk because you drink or use drugs? • Have you engaged with anyone professionally related to your substance use that we could speak with? • Ever get into fights, fall down and bang your head, or pass out when drinking or using other drugs? • Have you ever used alcohol or other drugs in a way that may be considered less than safe? • Do you ever end up doing things you later regret after you have gotten really hammered? • Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?	NOTES

Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

	SCORING
4	☐ In a life-threatening health situation as a direct result of substance use, **or**, In the past 30 days, **any** of the following are true... ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times ☐ Substance use resulting in passing out 2+ times
3	☐ Experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or**, In the past 30 days, **any** of the following are true... ☐ Drug use reached the point of complete inebriation 12+ times ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times
2	In the past 30 days, **any** of the following are true... ☐ Drug use reached the point of complete inebriation fewer than 12 times ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times
1	☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or**, ☐ If making claims to sobriety, no substance use in the past 30 days
0	☐ In the past 365 days, no substance use

E. Experience of Abuse & Trauma

PROMPTS	CLIENT SCORE:
To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported. • *"I don't need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?"* • *"Are you currently or have you ever received professional assistance to address that abuse?"* • *"Does the experience of abuse or trauma impact your day to day living in any way?"* • *"Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?"* • *"Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?"* • *"Have you ever become homeless as a direct result of experiencing abuse or trauma?"*	**NOTES**

	SCORING
4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☐ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

F. Risk of Harm to Self or Others

PROMPTS	CLIENT SCORE:
• *Do you have thoughts about hurting yourself or anyone else? Have you ever acted on these thoughts? When was the last time?* • *What was occurring when you had these feelings or took these actions?* • *Have you ever received professional help – including maybe a stay at hospital – as a result of thinking about or attempting to hurt yourself or others? How long ago was that? Does that happen often?* • *Have you recently left a situation you felt was abusive or unsafe? How long ago was that?* • *Have you been in any fights recently - whether you started it or someone else did? How long ago was that? How often do you get into fights?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ In the past 90 days, left an abusive situation ☐ In the past 30 days, attempted, threatened, or actually harmed self or others ☐ In the past 30 days, involved in a physical altercation (instigator or participant)
3	**Any** of the following: ☐ In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 180 days, but not in the past 30 days ☐ In the past 365 days, involved in a physical altercation (instigator or participant), but not in the past 30 days
2	**Any** of the following: ☐ In the past 365 days, left an abusive situation, but no exposure to abuse in the past 180 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 365 days, but not in the past 180 days ☐ 366+ days ago, 4+ involvements in physical alterations
1	☐ 366+ days ago, 1-3 involvements in physical alterations
0	☐ Reports no instance of harming self, being harmed, or harming others

G. Involvement in Higher Risk and/or Exploitive Situations

PROMPTS	CLIENT SCORE:
• *(Observe, don't ask) Any abcesses or track marks from injection substance use?* • *Does anybody force or trick you to do something that you don't want to do?* • *Do you ever do stuff that could be considered dangerous like drinking until you pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* • *Do you ever find yourself in situations that may be considered at a high risk for violence?* • *Do you ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ In the past 180 days, engaged in 10+ higher risk and/or exploitive events ☐ In the past 90 days, left an abusive situation
3	**Any** of the following: ☐ In the past 180 days, engaged in 4-9 higher risk and/or exploitive events ☐ In the past 180 days, left an abusive situation, but not in the past 90 days
2	**Any** of the following: ☐ In the past 180 days, engaged in 1-3 higher risk and/or exploitive events ☐ 181+ days ago, left an abusive situation
1	☐ Any involvement in higher risk and/or exploitive situations occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no involvement in higher risk and/or exploitive events

H. Interaction with Emergency Services

PROMPTS	CLIENT SCORE:
• How often do you go to emergency rooms? • How many times have you had the police speak to you over the past 180 days? • Have you used an ambulance or needed the fire department at any time in the past 180 days? • How many times have you called or visited a crisis team or a crisis counselor in the last 180 days? • How many times have you been admitted to hospital in the last 180 days? How long did you stay?	NOTES

Note: Emergency service use includes: admittance to emergency room/department; hospitalizations; trips to a hospital in an ambulance; crisis service, distress centers, suicide prevention service, sexual assault crisis service, sex worker crisis service, or similar service; interactions with police for the purpose of law enforcement; interactions with fire service in emergency situations.

SCORING	
4	☐ In the past 180 days, cumulative total of 10+ interactions with emergency services
3	☐ In the past 180 days, cumulative total of 4-9 interactions with emergency services
2	☐ In the past 180 days, cumulative total of 1-3 interactions with emergency services
1	☐ Any interaction with emergency services occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no interaction with emergency services

I. Legal

PROMPTS	CLIENT SCORE:
• *Do you have any "legal stuff" going on?* • *Have you had a lawyer assigned to you by a court?* • *Do you have any upcoming court dates? Do you think there's a chance you will do time?* • *Any involvement with family court or child custody matters?* • *Any outstanding fines?* • *Have you paid any fines in the last 12 months for anything?* • *Have you done any community service in the last 12 months?* • *Is anybody expecting you to do community service for anything right now?* • *Did you have any legal stuff in the last year that got dismissed?* • *Is your housing at risk in any way right now because of legal issues?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand
3	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand
2	**Any** of the following: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)
1	☐ There are no current legal issues, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration
0	☐ No legal issues within the past 365 days, **and** currently no conditions of release

J. Managing Tenancy

PROMPTS	CLIENT SCORE:
• *Are you currently homeless?* • *(If the person is housed) Do you have an eviction notice?* • *(If the person is housed) Do you think that your housing is at risk?* • *How is your relationship with your neighbors?* • *How do you normally get along with landlords?* • *How have you been doing with taking care of your place?*	**NOTES**

Note: Housing matters include: conflict with landlord and/or neighbors, damages to the unit, payment of rent on time and in full. Payment of rent through a third party is <u>not</u> considered to be a short-coming or deficiency in the ability to pay rent.

	SCORING
4	**Any** of the following: ☐ Currently homeless ☐ In the next 30 days, will be re-housed or return to homelessness ☐ In the past 365 days, was re-housed 6+ times ☐ In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters
3	**Any** of the following: ☐ In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days ☐ In the past 365 days, was re-housed 3-5 times ☐ In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters
2	**Any** of the following: ☐ In the past 365 days, was re-housed 2 times ☐ In the past 180 days, was re-housed 1+ times, but not in the past 60 days ☐ Continuously housed for at least 90 days but not more than 180 days ☐ In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters
1	**Any** of the following: ☐ In the past 365 days, was re-housed 1 time ☐ Continuously housed, with no assistance on housing matters, for at least 180 days but not more than 365 days
0	☐ Continuously housed, with no assistance on housing matters, for at least 365 days

K. Personal Administration & Money Management

PROMPTS	CLIENT SCORE:
• How are you with taking care of money? • How are you with paying bills on time and taking care of other financial stuff? • Do you have any street debts? • Do you have any drug or gambling debts? • Is there anybody that thinks you owe them money? • Do you budget every single month for every single thing you need? Including cigarettes? Booze? Drugs? • Do you try to pay your rent before paying for anything else? • Are you behind in any payments like child support or student loans or anything like that?	NOTES

	SCORING
4	**Any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Does not have an income (including formal and informal sources) ☐ Not aware of the full amount spent on substances, if they use substances ☐ Substantial real or perceived debts of $1,000+, past due or requiring monthly payments
3	**Any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use, if they are a substance user ☐ Real or perceived debts of $999 or less, past due or requiring monthly payments
2	**Any** of the following: ☐ In the past 365 days, source of income has changed 2+ times ☐ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) ☐ Has been self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ Has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ Has been self-managing financial resources and taking care of associated acministrative tasks for at least 180 days

L. Social Relationships & Networks

PROMPTS	CLIENT SCORE:
• *Tell me about your friends, family or other people in your life.* • *How often do you get together or chat?* • *When you go to doctor's appointments or meet with other professionals like that, what is that like?* • *Are there any people in your life that you feel are just using you?* • *Are there any of your closer friends that you feel are always asking you for money, smokes, drugs, food or anything like that?* • *Have you ever had people crash at your place that you did not want staying there?* • *Have you ever been threatened with an eviction or lost a place because of something that friends or family did in your apartment?* • *Have you ever been concerned about not following your lease agreement because of your friends or family?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ In the past 90 days, left an exploitive, abusive or dependent relationship ☐ Friends, family or other people are placing security of housing at imminent risk, **or** impacting life, wellness, or safety ☐ No friends or family and demonstrates no ability to follow social norms ☐ Currently homeless and would classify most of friends and family as homeless
3	**Any** of the following: ☐ In the past 90-180 days, left an exploitive, abusive or dependent relationship ☐ Friends, family or other people are having some negative consequences on wellness or housing stability ☐ No friends or family but demonstrating ability to follow social norms ☐ Meeting new people with an intention of forming friendships ☐ Reconnecting with previous friends or family members, but experiencing difficulty advancing the relationship ☐ Currently homeless, and would classify some of friends and family as being housed, while others are homeless
2	**Any** of the following: ☐ More than 180 days ago, left an exploitive, abusive or dependent relationship ☐ Developing relationships with new people but not yet fully trusting them ☐ Currently homeless, and would classify friends and family as being housed
1	☐ Has been housed for less than 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability
0	☐ Has been housed for at least 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability

M. Self Care & Daily Living Skills

PROMPTS	CLIENT SCORE:
• *Do you have any worries about taking care of yourself?* • *Do you have any concerns about cooking, cleaning, laundry or anything like that?* • *Do you ever need reminders to do things like shower or clean up?* • *Describe your last apartment.* • *Do you know how to shop for nutritious food on a budget?* • *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* • *Do you tend to keep all of your clothes clean?* • *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* • *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ No insight into how to care for themselves, their apartment or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life
3	**Any** of the following: ☐ Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life
2	**Any** of the following: ☐ Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, accessed community resources 4 or fewer times, **and** is fully taking care of all their daily needs
0	☐ For the past 365+ days, fully taking care of all their daily needs independently

N. Meaningful Daily Activity

PROMPTS	CLIENT SCORE:
• How do you spend your day? • How do you spend your free time? • Does that make you feel happy/fulfilled? • How many days a week would you say you have things to do that make you feel happy/fulfilled? • How much time in a week would you say you are totally bored? • When you wake up in the morning, do you tend to have an idea of what you plan to do that day? • How much time in a week would you say you spend doing stuff to fill up the time rather than doing things that you love? • Are there any things that get in the way of you doing the sorts of activities you would like to be doing?	NOTES

	SCORING
4	☐ No planned, legal activities described as providing fulfillment or happiness
3	☐ Discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness
2	☐ Attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment or happiness, **or** the individual is not fully committed to continuing the activities.
1	☐ Has planned, legal activities described as providing fulfillment or happiness 1-3 days per week
0	☐ Has planned, legal activities described as providing fulfillment or happiness 4+ days per week

0. History of Homelessness & Housing

PROMPTS	CLIENT SCORE:
• How long have you been homeless? • How many times have you been homeless in your life other than this most recent time? • Have you spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your permanent address? • Have you ever spent time sleeping in a car or alleyway or garage or barn or bus shelter or anything like that? • Have you ever spent time sleeping in an abandoned building? • Were you ever in hospital or jail for a period of time when you didn't have a permanent address to go to when you got out?	NOTES

	SCORING
4	☐ Over the past 10 years, cumulative total of 5+ years of homelessness
3	☐ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of homelessness
2	☐ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of homelessness
1	☐ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of homelessness
0	☐ Over the past 4 years, cumulative total of 7 or fewer days of homelessness

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
MENTAL HEALTH & WELLNESS AND COGNITIVE FUNCTIONING	0	
PHYSICAL HEALTH & WELLNESS	0	
MEDICATION	0	
SUBSTANCE USE	0	
EXPERIENCE OF ABUSE AND/ OR TRAUMA	0	
RISK OF HARM TO SELF OR OTHERS	0	
INVOLVEMENT IN HIGHER RISK AND/OR EXPLOITIVE SITUATIONS	0	
INTERACTION WITH EMERGENCY SERVICES	0	

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
LEGAL INVOLVEMENT	0	
MANAGING TENANCY	0	
PERSONAL ADMINISTRATION & MONEY MANAGEMENT	0	
SOCIAL RELATIONSHIPS & NETWORKS	0	
SELF-CARE & DAILY LIVING SKILLS	0	
MEANINGFUL DAILY ACTIVITIES	0	
HISTORY OF HOUSING & HOMELESSNESS	0	
TOTAL		No housing intervention

Family Service Prioritization Decision Assistance Tool

(F-SPDAT)

Assessment Tool for Families

VERSION 2.01

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

A. Mental Health & Wellness & Cognitive Functioning

PROMPTS	CLIENT SCORE:
• *Has anyone in your family ever received any help with their mental wellness?* • *Do you feel that every member in your family is getting all the help they need for their mental health or stress?* • *Has a doctor ever prescribed anyone in your family pills for nerves, anxiety, depression or anything like that?* • *Has anyone in your family ever gone to an emergency room or stayed in a hospital because they weren't feeling 100% emotionally?* • *Does anyone in your family have trouble learning or paying attention, or been tested for learning disabilities?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby? What about when you were pregnant?* • *Has anyone in your family ever hurt their brain or head?* • *Do you have any documents or papers about your family's mental health or brain functioning?* • *Are there other professionals we could speak with that have knowledge of your family's mental health?*	**NOTES**

	SCORING
4	**Any** of the following among any family member: ☐ Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
3	**Any** of the following among any family member: ☐ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about the family's safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason for any member of the family to be screened by an expert in mental health or cognitive functioning prior to housing to fully understand capacity
1	☐ All members of the family are in a heightened state of recovery, have a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** are engaged with mental health supports as necessary.
0	☐ No mental health or cognitive functioning issues disclosed, suspected or observed.

B. Physical Health & Wellness

PROMPTS	CLIENT SCORE:
• *How is your family's health?* • *Are you getting any help with your health? How often?* • *Do you feel you are getting all the care you need for your family's health?* • *Any illnesses like diabetes, HIV, Hep C or anything like that going on in any member of your family?* • *Ever had a doctor tell anyone in your family that they have problems with blood pressure or heart or lungs or anything like that?* • *When was the last time anyone in your family saw a doctor? What was that for?* • *Do you have a clinic or doctor that you usually go to?* • *Anything going on right now with your family's health that you think would prevent them from living a full, healthy, happy life?* • *Are there other professionals we could speak with that have knowledge of your family's health?* • *Do you have any documents or papers about your family's health or past stays in hospital because of your health?*	**NOTES**

SCORING	
4	**Any** of the following for any member of the family: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Pallative health condition
3	Presence of a health issue among any family member with **any** of the following: ☐ Not connected with professional resources to assist with a real or perceived serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) ☐ Unable to follow the treatment plan as a direct result of homeless status
2	☐ Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition in a family member, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements.
0	☐ No serious or chronic health condition ☐ If any minor health condition, they are managed appropriately

C. Medication

PROMPTS	CLIENT SCORE:
• *Has anyone in your family recently been prescribed any medications by a health care professional?* • *Does anyone in your family take any medication, prescribed to them by a doctor?* • *Has anyone in your family ever had a doctor prescribe them a medication that wasn't filled or they didn't take?* • *Were any of your family's medications changed in the last month? Whose? How did that make them feel?* • *Do other people ever steal your family's medications?* • *Does anyone in your family ever sell or share their medications with other people it wasn't prescribed to?* • *How does your family store their medication and make sure they take the right medication at the right time each day?* • *What do you do if you realize someone has forgotten to take their medications?* • *Do you have any papers or documents about the medications your family takes?*	**NOTES**

SCORING	
4	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason.
3	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following for any family member: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following is true for **every** family member: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

D. Substance Use

PROMPTS	CLIENT SCORE:
• *When was the last time you had a drink or used drugs? What about the other members of your family?* • *Anything we should keep in mind related to drugs/alcohol?* • *How often would you say you use [substance] in a week?* • *Ever have a doctor tell you that your health may be at risk because you drink or use drugs?* • *Have you engaged with anyone professionally related to your substance use that we could speak with?* • *Ever get into fights, fall down and bang your head, do things you regret later, or pass out when drinking or using other drugs?* • *Have you ever used alcohol or other drugs in a way that may be considered less than safe?* • *Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?*	**NOTES**

Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

	SCORING
4	☐ An adult is in a life-threatening health situation as a direct result of substance use, **or**, ☐ Any family member is under the legal age but over 15 and would score a 3+, **or**, ☐ Any family member is under 15 and would score a 2+, **or** who first used drugs prior to age 12, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times ☐ Substance use resulting in passing out 2+ times
3	☐ An adult is experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or**, ☐ Any family member is under the legal age but over 15 and would score a 2, **or**, ☐ Any family member is under 15 and would score a 1, **or** who first used drugs at age 13-15, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Drug use reached the point of complete inebriation 12+ times ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times
2	☐ Any family member is under the legal age but over 15 and would otherwise score 1, **or**, In the past 30 days, **any** of the following are true for any adult in the family... ☐ Drug use reached the point of complete inebriation fewer than 12 times ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times
1	☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or**, ☐ If making claims to sobriety, no substance use in the past 30 days
0	☐ In the past 365 days, no substance use

E. Experience of Abuse & Trauma of Parents

PROMPTS	CLIENT SCORE:
To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported. ***Because this section is self-reported, if there are more than one parent present, they should each be asked individually.*** • *"I don't need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?"* • *"Are you currently or have you ever received professional assistance to address that abuse?"* • *"Does the experience of abuse or trauma impact your day to day living in any way?"* • *"Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?"* • *"Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?"* • *"Have you ever become homeless as a direct result of experiencing abuse or trauma?"*	**NOTES**

SCORING	
4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☐ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

F. Risk of Harm to Self or Others

PROMPTS	CLIENT SCORE:
• *Does anyone in your family have thoughts about hurting themselves or anyone else? Have they ever acted on these thoughts? When was the last time? What was occurring when that happened?* • *Has anyone in your family ever received professional help – including maybe a stay at hospital – as a result of thinking about or attempting to hurt themself or others? How long ago was that? Does that happen often?* • *Has anyone in your family recently left a situation you felt was abusive or unsafe? How long ago was that?* • *Has anyone in your family been in any fights recently – whether they started it or someone else did? How long ago was that? How often do they get into fights?*	**NOTES**

	SCORING
4	**Any** of the following for any family member: ☐ In the past 90 days, left an abusive situation ☐ In the past 30 days, attempted, threatened, or actually harmed self or others ☐ In the past 30 days, involved in a physical altercation (instigator or participant)
3	**Any** of the following for any family member: ☐ In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 180 days, but not in the past 30 days ☐ In the past 365 days, involved in a physical altercation (instigator or participant), but not in the past 30 days
2	**Any** of the following for any family member: ☐ In the past 365 days, left an abusive situation, but no exposure to abuse in the past 180 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 365 days, but not in the past 180 days ☐ 366+ days ago, 4+ involvements in physical alterations
1	☐ 366+ days ago, a family member had 1-3 involvements in physical alterations
0	☐ Whole family reports no instance of harming self, being harmed, or harming others

G. Involvement in Higher Risk and/or Exploitive Situations

PROMPTS	CLIENT SCORE:
• *[Observe, don't ask] Any abcesses or track marks from injection substance use?* • *Does anybody force or trick people in your family to do things that they don't want to do?* • *Do you or anyone in your family ever do stuff that could be considered dangerous like drinking until they pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* • *Does anyone in your family ever find themselves in situations that may be considered at a high risk for violence?* • *Does your family ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 10+ higher risk and/or exploitive events ☐ In the past 90 days, any member of the family left an abusive situation
3	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 4-9 higher risk and/or exploitive events ☐ In the past 180 days, any member of the family left an abusive situation, but not in the past 90 days
2	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 1-3 higher risk and/or exploitive events ☐ 181+ days ago, any member of the family left an abusive situation
1	☐ Any involvement in higher risk and/or exploitive situations by any member of the family occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no involvement by any family member in higher risk and/or exploitive events

H. Interaction with Emergency Services

PROMPTS	CLIENT SCORE:
• *How often does your family go to emergency rooms?* • *How many times have you had the police speak to members of your family over the past 180 days?* • *Has anyone in your family used an ambulance or needed the fire department at any time in the past 180 days?* • *How many times have members of your family called or visited a crisis team or a crisis counselor in the last 180 days?* • *How many times have you or anyone in your family been admitted to hospital in the last 180 days? How long did they stay?*	**NOTES**

Note: Emergency service use includes: admittance to emergency room/department; hospitalizations; trips to a hospital in an ambulance; crisis service, distress centers, suicide prevention service, sexual assault crisis service, sex worker crisis service, or similar service; interactions with police for the purpose of law enforcement; interactions with fire service in emergency situations.

	SCORING
4	☐ In the past 180 days, cumulative family total of 10+ interactions with emergency services
3	☐ In the past 180 days, cumulative family total of 4-9 interactions with emergency services
2	☐ In the past 180 days, cumulative family total of 1-3 interactions with emergency services
1	☐ Any interaction with emergency services by family members occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no interaction with emergency services

I. Legal

PROMPTS	CLIENT SCORE:
• *Does your family have any "legal stuff" going on?* • *Has anyone in your family had a lawyer assigned to them by a court?* • *Does anyone in your family have any upcoming court dates? Do you think there's a chance someone in your family will do time?* • *Any outstanding fines?* • *Has anyone in your family paid any fines in the last 12 months for anything?* • *Has anyone in your family done any community service in the last 12 months?* • *Is anybody expecting someone in your family to do community service for anything right now?* • *Did your family have any legal stuff in the last year that got dismissed?* • *Is your family's housing at risk in any way right now because of legal issues?*	**NOTES**

	SCORING
4	**Any** of the following among any family member: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand
3	**Any** of the following among any family member: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand
2	**Any** of the following among any family member: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)
1	☐ There are no current legal issues among family members, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration
0	☐ No family member has had any legal issues within the past 365 days, **and** currently no conditions of release

J. Managing Tenancy

PROMPTS	CLIENT SCORE:
• *Is your family currently homeless?* • *[If the family is housed] Does your family have an eviction notice?* • *[If the family is housed] Do you think that your family's housing is at risk?* • *How is your family's relationship with your neighbors?* • *How does your family normally get along with landlords?* • *How has your family been doing with taking care of your place?*	**NOTES**

Note: Housing matters include: conflict with landlord and/or neighbors, damages to the unit, payment of rent on time and in full. Payment of rent through a third party is not considered to be a short-coming or deficiency in the ability to pay rent.

	SCORING
4	**Any** of the following: ☐ Currently homeless ☐ In the next 30 days, will be re-housed or return to homelessness ☐ In the past 365 days, was re-housed 6+ times ☐ In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters
3	**Any** of the following: ☐ In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days ☐ In the past 365 days, was re-housed 3-5 times ☐ In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters
2	**Any** of the following: ☐ In the past 365 days, was re-housed 2 times ☐ In the past 180 days, was re-housed 1+ times, but not in the past 60 days ☐ Continuously housed for at least 90 days but not more than 180 days ☐ In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters
1	**Any** of the following: ☐ In the past 365 days, was re-housed 1 time ☐ Continuously housed, with no assistance on housing matters, for at least 180 days but not more than 365 days
0	☐ Continuously housed, with no assistance on housing matters, for at least 365 days

K. Personal Administration & Money Management

PROMPTS	CLIENT SCORE:
• *How are you and your family with taking care of money?* • *How are you and your family with paying bills on time and taking care of other financial stuff?* • *Does anyone in your family have any street debts or drug or gambling debts?* • *Is there anybody that thinks anyone in your family owes them money?* • *Do you budget every single month for every single thing your family needs? Including cigarettes? Booze? Drugs?* • *Does your family try to pay your rent before paying for anything else?* • *Is anyone in your family behind in any payments like child support or student loans or anything like that?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ No family income (including formal and informal sources) ☐ Substantial real or perceived debts of $1,000+, past due or requiring monthly payments **Or**, for the person who normally handles the household's finances, **any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Not aware of the full amount spent on substances, if the household includes a substance user
3	☐ Real or perceived debts of $999 or less, past due or requiring monthly payments, **or** For the person who normally handles the household's finances, **any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use, if the household includes a substance user
2	☐ In the past 365 days, source of family income has changed 2+ times, **or** For the person who normally handles the household's finances, **any** of the following: ☐ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) ☐ Self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ The person who normally handles the household's finances has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ The person who normally handles the household's finances has been self-managing financial resources and taking care of associated administrative tasks for at least 180 days

L. Social Relationships & Networks

PROMPTS	CLIENT SCORE:
• *Tell me about your family's friends, extended family or other people in your life.* • *How often do you get together or chat with family friends?* • *When your family goes to doctor's appointments or meet with other professionals like that, what is that like?* • *Are there any people in your life that you feel are just using you, or someone else in your family?* • *Are there any of your family's closer friends that you feel are always asking you for money, smokes, drugs, food or anything like that?* • *Have you ever had people crash at your place that you did not want staying there?* • *Have you ever been threatened with an eviction or lost a place because of something that friends or extended family did in your apartment?* • *Have you ever been concerned about not following your lease agreement because of friends or extended family?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Currently homeless and would classify most of friends and family as homeless ☐ Friends, family or other people are placing security of housing at imminent risk, **or** impacting life, wellness, or safety ☐ In the past 90 days, left an exploitive, abusive or dependent relationship ☐ No friends or family and any family member demonstrates an inability to follow social norms
3	**Any** of the following: ☐ Currently homeless, and would classify some of friends as housed, while some are homeless ☐ In the past 90-180 days, left an exploitive, abusive or dependent relationship ☐ Friends, family or other people are having some negative consequences on wellness or housing stability ☐ No friends or family but all family members demonstrate ability to follow social norms ☐ Any family member is meeting new people with an intention of forming friendships ☐ Any family member is reconnecting with previous friends or family members, but experiencing difficulty advancing the relationship
2	**Any** of the following: ☐ Currently homeless, and would classify friends and family as being housed ☐ More than 180 days ago, left an exploitive, abusive or dependent relationship ☐ Any family member is developing relationships with new people but not yet fully trusting them
1	☐ Has been housed for less than 180 days, **and** family is engaged with friends or family, who are having no negative consequences on the individual's housing stability
0	☐ Has been housed for at least 180 days, **and** family is engaged with friends or family, who are having no negative consequences on the individual's housing stability

M. Self Care & Daily Living Skills of Family Head

PROMPTS	CLIENT SCORE:
• *Do you have any worries about taking care of yourself or your family?* • *Do you have any concerns about cooking, cleaning, laundry or anything like that?* • *Does anyone in your family ever need reminders to do things like shower or clean up?* • *Describe your family's last apartment.* • *Do you know how to shop for nutritious food on a budget?* • *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* • *Do you tend to keep all of your family's clothes clean?* • *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* • *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?*	**NOTES**

SCORING	
4	**Any** of the following for head(s) of household: ☐ No insight into how to care for themselves, their apartment or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life
3	**Any** of the following for head(s) of household: ☐ Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life
2	**Any** of the following for head(s) of household: ☐ Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, family accessed community resources 4 or fewer times, **and** head of household is fully taking care of all the family's daily needs
0	☐ For the past 365+ days, fully taking care of all the family's daily needs independently

N. Meaningful Daily Activity

PROMPTS	CLIENT SCORE:
• *How does your family spend their days?* • *How does your family spend their free time?* • *Do these things make your family feel happy/fulfilled?* • *How many days a week would you say members of your family have things to do that make them feel happy/fulfilled?* • *How much time in a week would you or members of your family say they are totally bored?* • *When people in your family wake up in the morning, do they tend to have an idea of what they plan to do that day?* • *How much time in a week would you say members of your family spend doing stuff to fill up the time rather than doing things that they love?* • *Are there any things that get in the way of your family doing the sorts of activities they would like to be doing?*	**NOTES**

SCORING	
4	☐ Any member of the family has no planned, legal activities described as providing fulfillment or happiness
3	☐ Any member of the family is discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness
2	☐ Some members of the family are attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment or happiness, **or** they are not fully committed to continuing the activities.
1	☐ Each family member has planned, legal activities described as providing fulfillment or happiness 1-3 days per week
0	☐ Each family member has planned, legal activities described as providing fulfillment or happiness 4+ days per week

0. History of Homelessness & Housing

PROMPTS	CLIENT SCORE:
• *How long has your family been homeless?* • *How many times has your family experienced homelessness other than this most recent time?* • *Has your family spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your family's permanent address?* • *Has your family ever spent time sleeping in a car, alleyway , garage, barn, bus shelter, or anything like that?* • *Has your family ever spent time sleeping in an abandoned building?* • *Was anyone in your family ever been in hospital or jail for a period of time when they didn't have a permanent address to go to when they got out?*	**NOTES**

SCORING	
4	☐ Over the past 10 years, cumulative total of 5+ years of family homelessness
3	☐ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of family homelessness
2	☐ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of family homelessness
1	☐ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of family homelessness
0	☐ Over the past 4 years, cumulative total of 7 or fewer days of family homelessness

P. Parental Engagement

PROMPTS	CLIENT SCORE:
• *Walk me through a typical evening after school in your family.* • *Tell me about what role, if any, the older kids have with the younger kids. Do they babysit? Walk them to school? Bathe or put the younger kids to bed?* • *Does your family have play time together? What kinds of things do you do and how often do you do it?* • *Let's pick a day like a Saturday...do you know where your kids are the entire day and whom they are out with all day?*	**NOTES**

Note: In this section, a child is considered "supervised" when the parent has knowledge of the child's whereabouts, the child is in an age-appropriate environment, and the child is engaged with the parent or another responsible adult. "Caretaking tasks" are tasks that may be expected by a parent/caregiver such as getting children to/from school, preparing meals, bathing children, putting children to bed, etc.

	SCORING
4	☐ No sense of parental attachment and responsibility ☐ No meaningful family time together ☐ Children 12 and younger are unsupervised 3+ hours each day ☐ Children 13 and older are unsupervised 4+ hours each day ☐ In families with 2+ children, the older child performs caretaking tasks 5+ days/week
3	☐ Weak sense of parental attachment and responsibility ☐ Meaningful family activities occur 1-4 times in a month ☐ Children 12 and younger are unsupervised 1-3 hours each day ☐ Children 13 and older are unsupervised 2-4 hours each day ☐ In families with 2+ children, the older child performs caretaking tasks 3-4 days/week
2	☐ Sense of parental attachment and responsibility, but not consistently applied ☐ Meaningful family activities occur 1-2 days per week ☐ Children 12 and younger are unsupervised fewer than 1 hour each day ☐ Children 13 and older are unsupervised 1-2 hours each day ☐ In families with 2+ children, the older child performs caretaking tasks fewer than 2 days/week
1	☐ Strong sense of parental attachment and responsibility towards their children ☐ Meaningful family activities occur 3-6 days of the week ☐ Children 12 and younger are never unsupervised ☐ Children 13 and older are unsupervised no more than an hour each day
0	☐ Strong sense of attachment and responsibility towards their children ☐ Meaningful family activities occur daily ☐ Children are never unsupervised

Q. Stability/Resiliency of the Family Unit

PROMPTS	CLIENT SCORE:
• *Over the past year have there been any different adults staying with the family like a family friend, grandparent, aunt or that sort of thing? If so, can you tell me when and for how long and the changes that have occurred?* • *Other than kids being taken into care, have there been any instances where any child has gone to stay with another family member or family friend for any length of time? Can you tell me how many times, when and for how long that happened?*	**NOTES**

SCORING	
4	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relative within the family have changed 4+ times ☐ Children have left or returned to the family 4+ times
3	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 3 times ☐ Children have left or returned to the family 3 times
2	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 2 times ☐ Children have left or returned to the family 2 times
1	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 1 time ☐ Children have left or returned to the family 1 time
0	In the past 365 days, **any** of the following have occurred: ☐ No change in parental arrangements and/or other adult relatives within the family ☐ Children have not left or returned to the family

R. Needs of Children

PROMPTS	CLIENT SCORE:
• *Please tell me about the attendance at school of your school-aged children.* • *Any health issues with your children?* • *Any times of separation between your children and parents?* • *Without going into detail, have any of your children experienced or witnessed emotional, physical, sexual or psychological abuse?* • *Have your children ever accessed professional assistance to address that abuse?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 15+ days in any month ☐ School-aged children are not currently enrolled in school ☐ Any member of the family, including children, is currently escaping an abusive situation ☐ The family is homeless
3	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 7-14 days in any month ☐ School-aged children typically miss 3+ days of school per week for reasons other than illness ☐ In the last 180 days, any child(ren) in the family has experienced an abusive situation that has since ended
2	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 1-6 days in any month ☐ School-aged children typically miss 2 days of school per week for reasons other than illness ☐ In the past 365 days, any child(ren) in the family has experienced an abusive situation that has ended more than 180 days ago
1	**Any** of the following: ☐ In the last 365 days, children needed to live with friends or family for 7+ days in any month, but not in the last 90 days ☐ School-aged children typically miss 1 day of school per week for reasons other than illness
0	**All** of the following: ☐ In the last 365 days, children needed to live with friends or family for fewer than 7 days in every month ☐ School-aged children maintain consistent attendance at school ☐ There is no evidence of children in the home having experienced or witnessed abuse ☐ The family is housed

S. Size of Family Unit

PROMPTS	CLIENT SCORE:
• *I just want to make sure I understand how many kids there are, the gender of each and their age. Can you take me through that again?* • *Is anyone in the family currently pregnant?*	**NOTES**

	SCORING	
	FOR ONE-PARENT FAMILIES:	**FOR TWO-PARENT FAMILIES:**
4	**Any** of the following: ☐ A pregnancy in the family ☐ At least one child aged 0-6 ☐ Three or more children of any age	**Any** of the following: ☐ A pregnancy in the family ☐ Four or more children of any age
3	**Any** of the following: ☐ At least one child aged 7-11 ☐ Two children of any age	**Any** of the following: ☐ At least one child aged 0-6 ☐ Three children of any age
2	☐ At least one child aged 12–15.	**Any** of the following: ☐ At least one child aged 7-11 ☐ Two children of any age
1	☐ At least one child aged 16 or older.	☐ At least one child aged 12 or older
0	☐ Children have been permanently removed from the family and the household is transitioning to services for singles or couples without children	

T. Interaction with Child Protective Services and/or Family Court

PROMPTS	CLIENT SCORE:
• *Any matters being considered by a judge right now as it pertains to any member of your family?* • *Have any of your children spent time in care? When was that? For how long were they in care? When did you get them back?* • *Has there ever been an investigation by someone in child welfare into the matters of your family?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ In the past 90 days, interactions with child protective services have occurred ☐ In the past 365 days, one or more children have been removed from parent's custody that have **not** been reunited with the family at least four days per week ☐ There are issues still be decided or considered within family court
3	In the past 180 days, **any** of the following have occurred: ☐ Interactions with child protective services have occurred, but not within the past 90 days ☐ One or more children have been removed from parent's custody through child protective services (non-voluntary) **and** the child(ren) has been reunited with the family four or more days per week; ☐ Issues have been resolved in family court
2	☐ In the past 365 days, interactions with child protective services have occurred, but not within the past 180 days, and there are no active issues, concerns or investigations
1	☐ No interactions with child protective services have occurred, within the past 365 days, and there are no active issues, concerns or investigations.
0	☐ There have been no serious interactions with child protective services because of parenting concerns

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
MENTAL HEALTH & WELLNESS AND COGNITIVE FUNCTIONING	0	
PHYSICAL HEALTH & WELLNESS	0	
MEDICATION	0	
SUBSTANCE USE	0	
EXPERIENCE OF ABUSE AND/ OR TRAUMA	0	
RISK OF HARM TO SELF OR OTHERS	0	
INVOLVEMENT IN HIGHER RISK AND/OR EXPLOITIVE SITUATIONS	0	
INTERACTION WITH EMERGENCY SERVICES	0	

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
LEGAL INVOLVEMENT	0	
MANAGING TENANCY	0	
PERSONAL ADMINISTRATION & MONEY MANAGEMENT	0	
SOCIAL RELATIONSHIPS & NETWORKS	0	
SELF-CARE & DAILY LIVING SKILLS	0	
MEANINGFUL DAILY ACTIVITIES	0	
HISTORY OF HOUSING & HOMELESSNESS	0	

Client:	Worker:	Version:	Date:

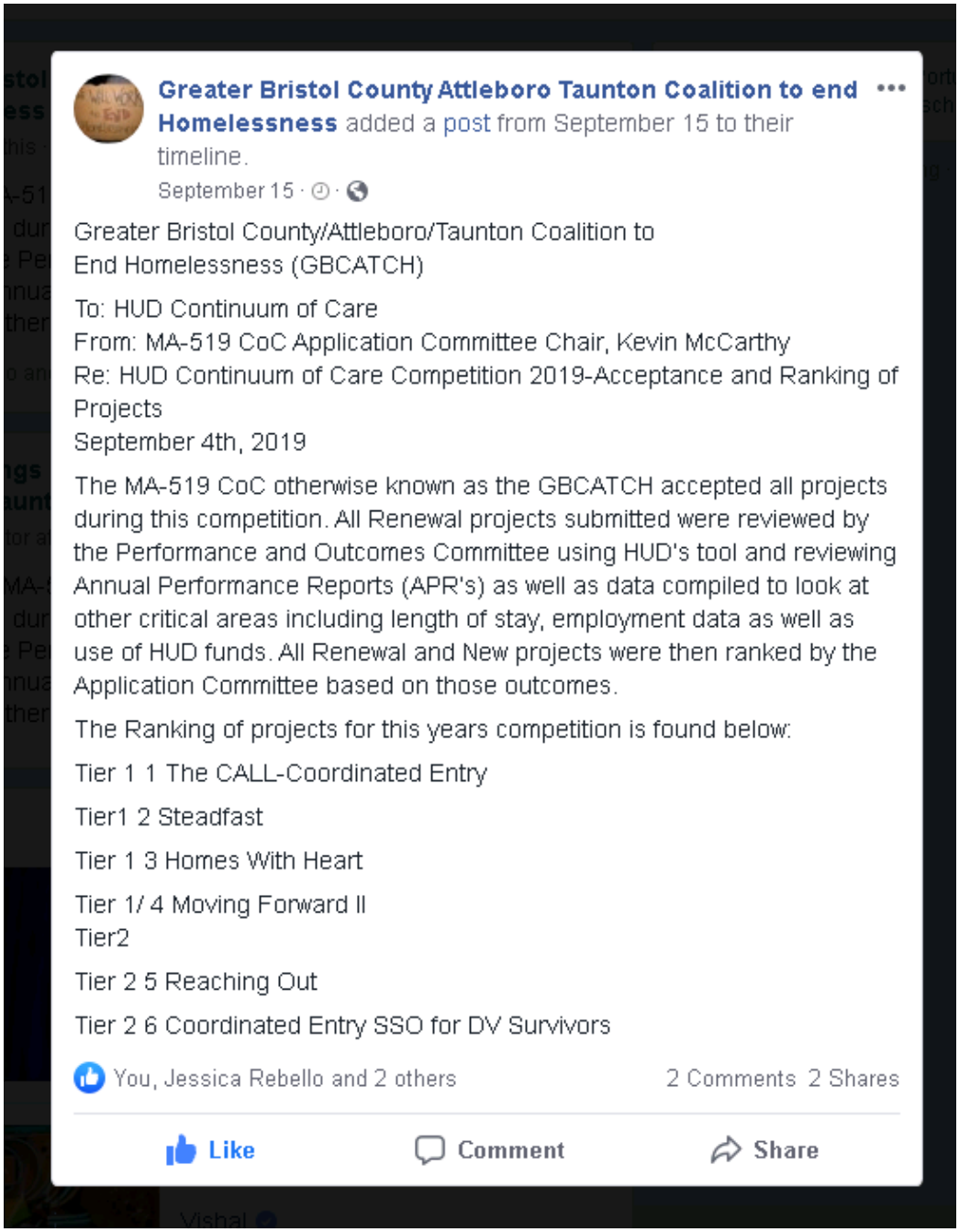
COMPONENT	SCORE	COMMENTS
PARENTAL ENGAGEMENT	0	
STABILITY/RESILIENCY OF THE FAMILY UNIT	0	
NEEDS OF CHILDREN	0	
SIZE OF FAMILY	0	
INTERACTION WITH CHILD PROTECTIVE SERVICES AND/ OR FAMILY COURT	0	
TOTAL	0	No housing intervention

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

MA-519

PROJECTS ACCEPTED NOTIFICATION

1E-1



Greater Bristol County Attleboro Taunton Coalition to end Homelessness added a post from September 15 to their timeline.

September 15 ·

Greater Bristol County/Attleboro/Taunton Coalition to
End Homelessness (GBCATCH)

To: HUD Continuum of Care
From: MA-519 CoC Application Committee Chair, Kevin McCarthy
Re: HUD Continuum of Care Competition 2019-Acceptance and Ranking of Projects
September 4th, 2019

The MA-519 CoC otherwise known as the GBCATCH accepted all projects during this competition. All Renewal projects submitted were reviewed by the Performance and Outcomes Committee using HUD's tool and reviewing Annual Performance Reports (APR's) as well as data compiled to look at other critical areas including length of stay, employment data as well as use of HUD funds. All Renewal and New projects were then ranked by the Application Committee based on those outcomes.

The Ranking of projects for this years competition is found below:

Tier 1 1 The CALL-Coordinated Entry

Tier1 2 Steadfast

Tier 1 3 Homes With Heart

Tier 1/ 4 Moving Forward II
Tier2

Tier 2 5 Reaching Out

Tier 2 6 Coordinated Entry SSO for DV Survivors

You, Jessica Rebello and 2 others 2 Comments 2 Shares

Like Comment Share

MA-519

Project Rejected/Reduced Notification

Greater Bristol County Attleboro Taunton Coalition to end Homelessness added a post from September 15 to their timeline.

September 15 ·

Greater Bristol County/Attleboro/Taunton Coalition to
End Homelessness (GBCATCH)

To: HUD Continuum of Care
From: MA-519 CoC Application Committee Chair, Kevin McCarthy
Re: HUD Continuum of Care Competition 2019
September 4th, 2019

The MA-519 CoC otherwise known as the GBCATCH did not reject any projects during this competition. All Renewal projects submitted were reviewed by the Performance and Outcomes Committee using HUD's tool and reviewing Annual Performance Reports (APR's) as well as data compiled to look at other critical areas including length of stay, employment data as well as use of HUD funds. All Renewal and New projects were then ranked by the Application Committee based on those outcomes.

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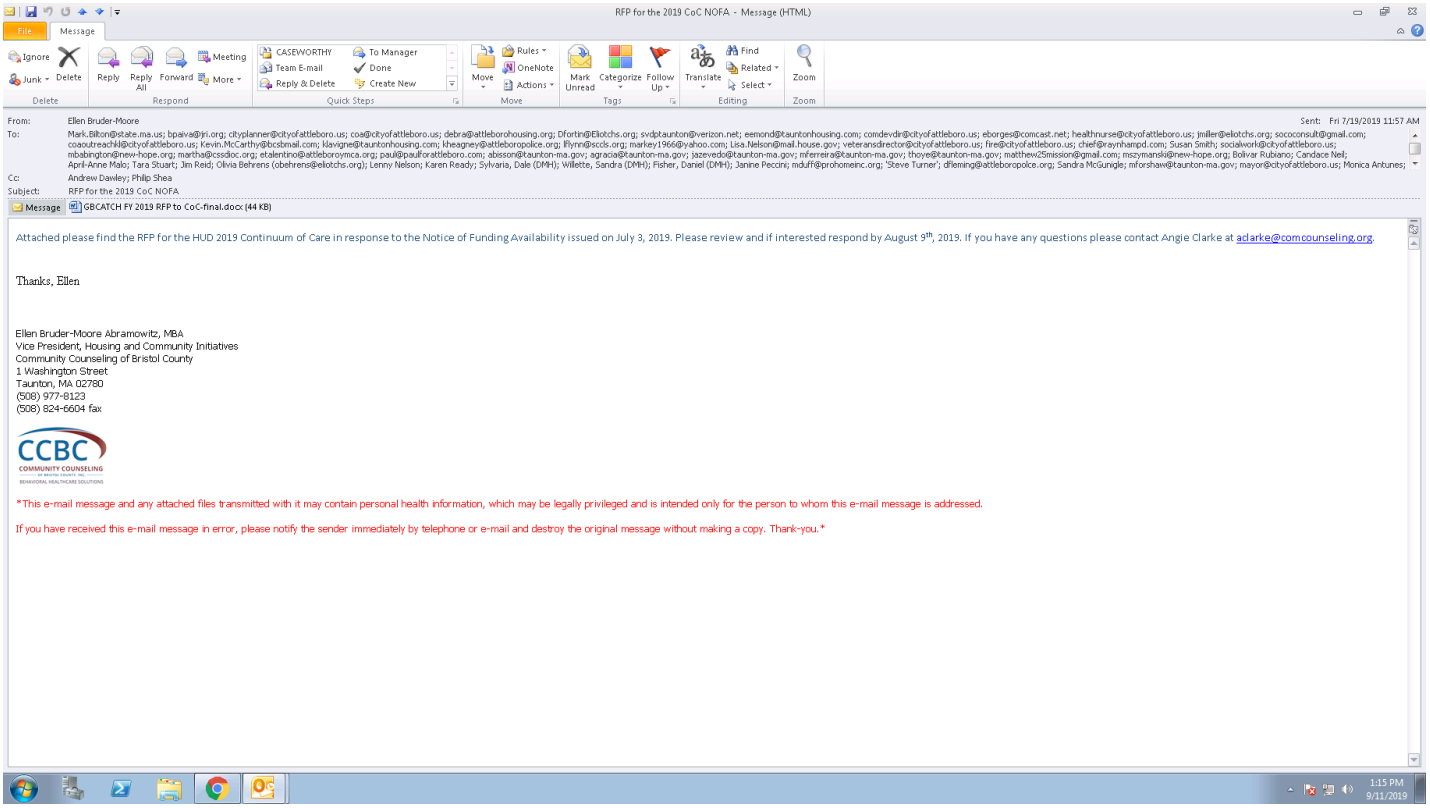
GBCATCH

GREATER BRISTOL COUNTY ATTLEBORO TAUNTON COALITION TO END HOMELESSNESS

MA-519

Public Posting – 30 Day Local Competition Deadline Public

1E-1



RFP for the 2019 CoC NOFA - Message (HTML)

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From: Ellen Bruder-Moore
Sent: Fri 7/19/2019 11:57 AM
To: Mark.Bilton@state.ma.us; bpalva@jri.org; cityplanner@cityofattleboro.us; coa@cityofattleboro.us; debra@attleborohousing.org; DFortin@Eliotchs.org; svdptaunton@verizon.net; eemond@tauntonhousing.com; comdevdir@cityofattleboro.us; eborges@comcast.net; healthnurse@cityofattleboro.us; jmiller@eliotchs.org; sococonsult@gmail.com; coaoutreachkl@cityofattleboro.us; Kevin.McCarthy@bcsbmail.com; klavigne@tauntonhousing.com; kheagney@attleboropolice.org; flynn@sccls.org; markey1966@yahoo.com; Lisa.Nelson@mail.house.gov; veteransdirector@cityofattleboro.us; fire@cityofattleboro.us; chief@raynhampd.com; Susan Smith; socialwork@cityofattleboro.us; mbabington@new-hope.org; martha@cssdioc.org; etalentino@attleboroymca.org; paul@paulforattleboro.com; abisson@taunton-ma.gov; agracia@taunton-ma.gov; jazevedo@taunton-ma.gov; mferreira@taunton-ma.gov; thoye@taunton-ma.gov; matthew25mission@gmail.com; mszymanski@new-hope.org; Bolivar Rubiano; Candace Neil; April-Anne Malo; Tara Stuart; Jim Reid; Olivia Behrens (obehrens@eliotchs.org); Lenny Nelson; Karen Ready; Sylvaria, Dale (DMH); Willette, Sandra (DMH); Fisher, Daniel (DMH); Janine Peccini; mduff@prohomeinc.org; 'Steve Turner'; dfleming@attleboropolice.org; Sandra McGunigle; mforshaw@taunton-ma.gov; mayor@cityofattleboro.us; Monica Antunes;
Cc: Andrew Dawley; Philip Shea
Subject: RFP for the 2019 CoC NOFA

Message | GBCATCH FY 2019 RFP to CoC-final.docx (44 KB)

Attached please find the RFP for the HUD 2019 Continuum of Care in response to the Notice of Funding Availability issued on July 3, 2019. Please review and if interested respond by August 9th, 2019. If you have any questions please contact Angie Clarke at aclarke@comcounseling.org.

Thanks, Ellen

Ellen Bruder-Moore Abramowitz, MBA
Vice President, Housing and Community Initiatives
Community Counseling of Bristol County
1 Washington Street
Taunton, MA 02780
(508) 977-8123
(508) 824-6604 fax

CCBC COMMUNITY COUNSELING

1:15 PM 9/11/2019

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Greater Bristol County Attleboro Taunton Coalition to end Homelessness
34 mins

INTRODUCTION
The Greater Bristol County/Attleboro/Taunton Coalition to End Homelessness (GBCATCH) is accepting proposals for Continuum of Care Homeless Assistance funding from the U.S. Department of Housing and Urban Development (HUD).

BACKGROUND
HUD publishes a CoC Notice of Funding Availability (NOFA) for each funding year. The 2019 NOFA was published on July 3, 2019, with a deadline of September 30th, 2019.

A single, consolidated submission of all selected projects in CoC MA-519 will be submitted to HUD by Community Counseling of Bristol County, Inc. (CCBC) as the Collaborative Applicant representing GBCATCH. Funding will be derived from Federal Fiscal Year 2019 allocations of HUD funds and is subject to funding availability under the NOFA. GBCATCH reserves the right to request that applicant organizations submit adjusted project budgets based on the amount of funding made available by HUD.

FUNDS AVAILABILITY
The amount of funding estimated to be available from HUD is $747,090 for Tier 1 (Estimated ARD at 94 Percent) which is based on the amount of currently funded projects eligible for renewal funding. HUD has announced that for our CoC there is $45,099 available for Permanent Housing Bonus in addition to that amount. New projects can be funded only through reallocation of existing project funding or through bonus funds. Additionally, HUD has announced that there is $90,197 for Domestic Violence Projects. The MA 519 CoC is encouraging new providers of homeless services to apply for these funds.

DEADLINE
A letter of intent is due by August 9th, 2019. Both renewal and new project proposals must be submitted to GBCATCH by 5:00 p.m. on August 22, 2019.

For a full copy of the RFP please send your request to Angela Clarke, Program Director Supportive Housing at CCBC at aclarke@comcounseling.org.

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GROUP CONVERSATIONS
Jennifer, Linda

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1:37 PM 7/29/2019

MA-519

Local Competition Public Announcement

1E-1

Note: in facebook posts and emails (provided in Local Competition Deadline) a link and attachment provided the RFR for the competition. Included in the RFR are the ranking criteria.

Request for Proposals (RFP)
HUD Continuum of Care (CoC) Homeless Assistance
Issued: July 19, 2019

INTRODUCTION

The Greater Bristol County/Attleboro/Taunton Coalition to End Homelessness (GBCATCH) is accepting proposals for Continuum of Care Homeless Assistance funding from the U.S. Department of Housing and Urban Development (HUD).

BACKGROUND

HUD publishes a CoC Notice of Funding Availability (NOFA) for each funding year. The 2019 NOFA was published on July 3, 2019, with a deadline of September 30th, 2019.

A single, consolidated submission of all selected projects in CoC MA-519 will be submitted to HUD by Community Counseling of Bristol County, Inc. (CCBC) as the Collaborative Applicant representing GBCATCH. Funding will be derived from Federal Fiscal Year 2019 allocations of HUD funds and is subject to funding availability under the NOFA. GBCATCH reserves the right to request that applicant organizations submit adjusted project budgets based on the amount of funding made available by HUD.

FUNDS AVAILABILITY

The amount of funding estimated to be available from HUD is $747,090 for Tier 1 (Estimated ARD at 94 Percent) which is based on the amount of currently funded projects eligible for renewal funding. HUD has announced that for our CoC there is $45,099 available for Permanent Housing Bonus in addition to that amount. New projects can be funded only through reallocation of existing project funding or through bonus funds. Additionally, HUD has announced that there is $90,197 for Domestic Violence Projects as described below.

KEY INFORMATION

a. Threshold Requirements -- All projects must meet the threshold criteria shown in the attached Appendix A – Threshold Criteria for Continuum of Care Grant Proposals.
b. Proposed funding for new projects cannot supplant funding from other sources.
c. Participants in CoC-funded projects must meet HUD's eligibility requirements, which vary by program component. More information on the CoC regulations is found below.
d. Permanent supportive housing projects may serve families or individuals. An adult participant in each household served in any permanent supportive housing program must be disabled.
e. Projects may not charge participants program fees in any program.
f. Funds are not available for transitional housing, except in the new component, which combines transitional housing and rapid re-housing.
g. Funds are not available for supportive services, unless they are part of a renewal project or a new project created through reallocation for coordinated entry.
h. Emergency shelter and services are not eligible for funding under the CoC Program.
i. All eligible funding costs except leasing must be matched with no less than a 25 percent cash or in-kind match. Leasing costs are not required to be matched.

j. All projects will be limited to requests for one year of assistance. Upon expiration, projects may be renewed subject to HUD requirements, local priorities, satisfactory performance, and availability of funds.
k. Collaborative efforts by community agencies are encouraged.

The HUD 2019 NOFA was published on July 3, 2019 including:
NOTICE OF FUNDING AVAILABILITY (NOFA) FOR FY 2019 CONTINUUM OF CARE PROGRAM COMPETITION

HUD 2019 NOFA additional information:
FY 2019 COC NOFA:: NEW, CHANGES AND HIGHLIGHTS FOR THIS YEAR

Description of Projects:

Renewal Projects. The total amount of funding estimated to be available for Renewal Projects (and those taking advantage of the transition grant—see Eligible Projects) from HUD is $ $794,777; this amount is based on the amount of currently funded projects eligible for renewal funding; this is also referred to as the Annual Renewal Demand (ARD) determined by HUD.

New Projects can be funded through reallocation from existing projects or through a bonus funding process, as described in this RFP. New project activities are limited by HUD to permanent supportive housing, rapid re-housing, homeless management information systems, and coordinated intake and assessment programs. HUD strictly limits the type of projects for which reallocated or bonus funds may be used.

- **New Project through a Permanent Housing Bonus.** It is anticipated that the total amount of funding to be available through a permanent housing bonus is approximately 6% of the ARD which for Greater Bristol county/Attleboro/Taunton CoC is $45,099.

- **New Project through a DV Bonus.** The total amount of funding which the Greater Bristol County/Attleboro/Taunton CoC may apply for under this bonus will be 10% of its Final Pro Rata Need (FPRN) or approximately $90,197.

Additional funds may also be available through the reallocation process as determined by the Greater Bristol County/Attleboro/Taunton CoC's Performance Review Committee (PRC).

Tier 1 will be equal to 94% of the CoC's Annual Renewal Demand (ARD) or roughly $ 747,090; Tier 2 is the difference between Tier 1 and the total ARD plus any amount available for bonus amounts. For Greater Bristol County/Attleboro/Taunton CoC, it is estimated that Tier 2 will be roughly $47,687.

DEADLINE

A letter of Intent as described below is due by **August 9th, 2019**. Both renewal and new project proposals must be submitted to GBCATCH by **5:00 p.m. on August 22, 2019.** Submission procedures are described below.

- **Renewal Projects**

Projects currently funded under the CoC Supportive Housing Program (SHP) are eligible for renewal for FY 2019 funds if they have a HUD agreement that expires in Calendar Year 2020. Projects may renew as is, or they may be part of transition, expansion or consolidated projects as further described in this section:

- "Transition Grants:" This year, HUD is permitting HUD transition grants that will allow renewal projects to "transition" from one CoC Program component to another during the CoC Program Competition. Transition Grants are not an additional source of funding but rather, would be part of the existing Annual Renewal Demand (ARD) amount for the CoC. No more than 50% of each transition grant may be used for costs of eligible activities of the program component originally funded, transition grants in this competition are eligible for renewal in subsequent fiscal years for eligible activities of the new program component and eligibility to receive a transition grant requires renewal project applicants to have the consent of its CoC and meet all other criteria and standards in the NOFA. *See Section III.C.2.u of the HUD NOFA for further details.*

- "Expansion Projects:" Projects currently funded under the CoC Supportive Housing Program (SHP) may apply to expand an existing renewal project in accordance with the NOFA. *See Section III.C.2.j of the HUD NOFA for further details*.

- "Consolidated Projects:" Eligible renewal project applicants have the ability to consolidate two or more eligible renewal projects into one project application during the application process. This means that a CoC Program recipient no longer must wait for a grant agreement amendment to be executed to consolidate two or more grants before it can apply for a single consolidated project in the CoC Competition. Consultation with the GBCATCH prior to undertaking this opportunity is required as HUD must confirm eligibility to consolidate projects. *See Section II.B.3.a(7) of the HUD NOFA for further details.*

- **New Permanent Supportive Housing (PSH) for Chronically Homeless Individuals or Families (Bonus Project)**

New permanent supportive housing projects that will serve 100% chronically homeless individuals or persons who meet the definition of Dedicated PLUS (see Section III.C.2.g) families are eligible to apply in this competition. Permanent housing is community-based housing, the purpose of which is to provide housing without a designated length of stay. Grant funds may be used for leasing, rental assistance, operating costs and supportive services; definitions and guidance for each of these items is at 24 CFR 578.43-578.63.

- New Projects providing eligible activities that the Secretary of HUD determines are critical in order to assist persons fleeing/attempting to flee domestic violence (DV Bonus Project**)**

- New projects that are dedicated to survivors of domestic violence, dating violence, sexual assault, or stalking as defined in paragraph (4) at 24 CFR 578.3 are eligible to apply for funding in this competition. The following project types are permitted to apply for a DV Bonus:

- Rapid Re-housing (PH-RRH) projects that must follow a housing first approach.

- SSO Projects for Coordinated Entry (SSO-CE) to implement policies, procedures, and practices that equip the CoC's coordinated entry to better meet the needs of survivors of domestic violence, dating violence, sexual assault, or stalking (e.g., to implement policies and procedures that are trauma-informed, client-centered or to better coordinate referrals between the CoC's coordinated entry and the victim service providers coordinated entry system where they are different).

- Joint TH and PH-RRH component projects as defined in Section II.C.3.m of this NOFA that must follow a housing first approach. Joint TH and RRH projects may request funding for construction, rehabilitation, acquisition, leasing, operating, rental assistance (must be tenant-based TBRA) as well as supportive services, and administration. See "Application Requirements" section of this RFP as it further highlights relevant project requirements and priorities. CoC funding may provide supportive services and/or short-term (up to 3 months) and/or medium-term (for 3 – 24 months) of tenant based rental assistance as necessary to help participants move as quickly as possible into permanent housing and achieve stability in that housing.

Additional information related to these projects:

- PSH projects cannot combine the following types of assistance in a single structure or housing unit:
  - Leasing and acquisition, rehabilitation or new construction;
  - Tenant-based rental assistance and acquisition, rehabilitation, or new construction;
  - Short or medium-term rental assistance and acquisition, rehabilitation or new construction;
  - Rental assistance and leasing, and
  - Rental assistance and operating
- All projects must follow the written policies and procedures established by the CoC for determining and prioritizing which eligible families and individuals will receive rapid rehousing assistance, as well as the amount or percentage of rent that each program participant must pay.

- All projects may set a maximum amount or percentage of rental assistance that a program participant may receive, a maximum number of months that a program participant may receive rental assistance, and/or a maximum number of times that a program participant may receive rental assistance. The recipient may also require program participants to share in the costs of rent.
- Rental assistance, where applicable, must be limited to no more than 24 months to a household.
- All projects may provide supportive services for no longer than 6 months after rental assistance stops.
- All projects must re-evaluate, not less than once annually, that the program participant lacks sufficient resources and support networks necessary to retain housing without Continuum of Care assistance and the types and amounts of assistance that the program participant needs to retain housing. The recipient may require each program participant receiving assistance to notify the recipient of changes in the program participant's income or other circumstances (e.g., changes in household composition) that affect the program participant's need for assistance. When notified of a relevant change, the recipient must reevaluate the program participant's eligibility and the amount/types of assistance that the program participant needs.

- All projects must require the program participant to meet with a case manager not less than once per month to assist the program participant in ensuring long-term housing stability. (The project is exempt from this requirement if the Violence Against Women Act of 1994 (42 U.S.C. 13925 *et seq.*) or the Family Violence Prevention and Services Act (42 U.S.C. 10401 *et seq.*) prohibits the recipient carrying out the project from making its housing conditional on the participant's acceptance of services.)
- All projects must meet the threshold criteria shown in the application package in Appendix D.
- New projects may only be funded through reallocation of funds from existing projects or through the permanent housing bonus process. HUD strictly limits the type of projects for which reallocated or bonus funds may be used.
- All projects will be limited to requests for one year of assistance, unless a different term is required by HUD. Upon expiration, projects may be renewed subject to HUD requirements, local priorities, satisfactory performance, and availability of funds.

Eligible Populations

Populations who may be served by each of the project types are, as follow:

1. Permanent Supportive Housing (PSH)

- All PSH projects must dedicate 100% of the units to chronically homeless individuals and/or chronically homeless families as defined by HUD or persons who meet the definition of Dedicated PLUS.
- Project applicants must demonstrate that they will first serve the chronically homeless according to the order of priority established in Notice CPD-14-012: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons.
- Disabilities: All PSH projects must serve exclusively disabled households as defined by HUD.
- PSH projects may serve survivors of domestic violence, dating violence, sexual assault, or stalking as defined in paragraph (4) at 24 CFR 578.3.

2. Rapid Re-Housing (RRH)

- All projects must serve 100% literally homeless families and/or single adults coming from emergency shelters and/or unsheltered locations or meeting the criteria of paragraph (1), (2), or (4) of the HUD definition of homeless including survivors of domestic violence, dating violence, sexual assault, or stalking as defined in paragraph (4) at 24 CFR 578.3.
- Persons in transitional housing are not eligible for either project type, even if they met the criteria described above prior to entering the Transitional Housing (TH) Program, unless they meet the criteria of category (4) definition of homelessness at 24 CFR 578.3 (survivors of domestic violence, dating violence, sexual assault, or stalking as defined). A household would meet category 4 of the definition of homelessness if they are fleeting or attempting to flee from domestic violence and meet all other requirements, regardless of where they are residing.

3. Joint Transitional Housing (TH) and Rapid Re-Housing Component Projects

- Individuals and families experiencing homelessness including those survivors of domestic violence, dating violence, sexual assault or stalking as defined in paragraph (4) at 24 CFR 578.3.
- Combines the TH and RRH components into a single project.

- Joint TH and RRH projects must provide low-barrier, temporary housing while individuals and families quickly move to permanent housing with a seamless program design. Projects must have the capacity to provide both kinds of assistance to each participant.

Eligible Costs

The following guidance indicates the costs that may be included in program budgets, to be paid for by the CoC grant or by matching funds.

Rental Assistance
Rental assistance for homeless individuals and families, including tenant-based rental assistance. Grant funds may be used for security deposits in an amount not to exceed two months of rent, as well as last month's rent.

Leasing
The costs of leasing scattered site units to provide housing to homeless persons.

Leasing: Limits on rent costs. Rents paid must be reasonable in relation to comparable space or units, and may not be more than the owner charges others for comparable units. Rents for residential units cannot exceed the HUD Fair Market Rent (FMR).

Utilities. Utilities are not a leasing line item. If utilities are not provided by the landlord, utility costs are an operating cost.

Security deposits and first and last month's rent. Grant funds may be used to pay security deposits, in an amount not to exceed two months of actual rent, as well as last month's rent.

Supportive Services
The eligible costs of supportive services that address the special needs of the program participants.

Supportive Services in PSH and RRH Programs Must Relate to Housing Stability.

Supportive services must be necessary to assist program participants obtain and maintain housing and agencies must conduct an annual assessment of the service needs of the program participants and adjust services accordingly to achieve those ends.

Eligible supportive services costs:

- Reasonable one-time moving costs
- Case management
- Food—meals or groceries for program participants
- Housing search and counseling services
- Life skills training
- Outreach services
- Transportation
- Utility deposits (one-time fee, paid to utility companies)

- Direct provision of services: 1) costs of labor, supplies, and materials; and 2) salary and benefit packages of service delivery staff.

Ineligible costs: Any cost that is not described as an eligible cost is not an eligible cost.

Operating Costs

Grant funds may be used to pay the costs of the day-to-day operation of permanent supportive housing in a single structure or individual housing units.

Eligible operating costs:

- Maintenance and repair of housing
- Property taxes and insurance
- Building security for a structure where more than 50 percent of the units or area is paid for with grant funds
- Electricity, gas, and water
- Furniture
- Equipment.

Ineligible costs Program funds may not be used for rental assistance and operating costs in the same project. Program funds may not be used for the maintenance and repair of housing where the costs of maintaining and repairing the housing are included in the lease.

Matching Funds

The grantee must match all funds, except for leasing funds, with no less than 25% of funds or in-kind contributions from other sources. Guidance regarding cash and in-kind match is at 24 CFR 578.73. Cash match must be used for the costs of activities that are eligible CoC Program costs. Appendix C provides information required to document match.

Homeless Management Information System

All successful project applicants—with the exception of entities that are victim service providers—must participate in the CoC's Homeless Management Information System (HMIS).

Coordinated Entry/Assessment System

All successful applicants must participate in the CoC's coordinated entry/assessment system.

Grant Term

Renewal and new projects may only apply for one year grant terms.

Please note: any new project application that includes leasing–either leasing alone or leasing costs plus other costs (e.g. supportive services, HMIS, etc.)–may only request up to a 1-year grant term.

BONUS FUNDS

Bonus funds may be used to create the following types of new projects:

1. New permanent supportive housing projects that will primarily serve chronically homeless individuals and families including youth experiencing chronic homelessness.
2. New rapid rehousing projects that will serve homeless individuals and families who enter directly from the streets or emergency shelters, including youth up to age 24, and includes persons fleeing violence as defined by HUD.
3. New joint component projects, which will combine transitional housing and rapid rehousing into a single project to serve individuals and families experiencing homelessness.

REALLOCATED FUNDS

Continuums of Care may reduce or eliminate funds from eligible renewal projects and reallocate the funds to create or expand the following types of projects:

1. Permanent supportive housing projects that will primarily serve chronically homeless individuals and families including youth experiencing chronic homelessness.
2. Rapid rehousing projects that will serve homeless individuals and families who enter directly from the streets or emergency shelters, including youth up to age 24, and includes persons fleeing violence as defined by HUD.
3. Joint component projects, which will combine transitional housing and rapid re-housing into a single project to serve individuals and families experiencing homelessness.
4. Homeless Management Information System (HMIS) projects.
5. Supportive Services projects for centralized or coordinated assessment systems.

PROJECT RANKING PROCESS

HUD requires that all projects be ranked and prioritized in a two-tiered list. Tier 1 will be the top priority projects. Tier 2 will be lower priority projects. Either new or renewal projects may be ranked in Tier 1 or Tier 2. The placement of each project on the priority list will be determined through a multi-stage process including review by the GBCATCH Performance and Evaluation Committee and the GBCATCH Application Committee, prior to review by the GBCATCH Continuum of Care voting membership.

Based on the highly competitive nature of the grant program, ranking of each project will be critical in determining the likelihood of funding. Projects ranked in Tier 2, particularly at the bottom of Tier 2, have a low probability of funding. New projects created through reallocation or bonus funding may be included in either Tier 1 or Tier 2.

Renewal projects will be reviewed and ranked through the CoC process based on performance. New project proposals will be reviewed in reference to organizational capacity, strategic priority, project approach and design, and cost effectiveness and ranked through the CoC process.

HUD PROGRAM INFORMATION

All parties intending to apply for funding are strongly encouraged to review the program regulations, including those organizations that are currently or were previously funded. Proposals that do not conform to the regulations will not be considered for funding. The regulations and other information for the Continuum of Care Program may be found at this link.

FUNDS AVAILABILITY

Once awarded by HUD, grant funds are estimated to be made available by HUD by **the first half of calendar year 2020**. However, the awarding of funds and the timing of awards and grant-making by HUD is outside of the control of the GBCATCH/MA-519 CoC. Agencies seeking renewal funding must be aware of all operating year start and end dates and must make arrangements to accommodate any period for which a HUD funding award is denied or delayed. It should be noted that projects created through reallocation are not renewal projects and may have different start dates than the grants from which funds were taken.

SUBMISSION PROCEDURE

Please prepare and submit a project letter of intent and submit by **August 9th at 5 pm** including the following information:

Nature of Project (Renewal Project, Bonus Project, or New Project (from reallocated funds)):
Project Title:
Project Summary (1 paragraph):
Program type (Permanent Supportive Housing, Rapid Re-Housing, New "Joint Project", Supportive Services including HMIS and Coordinated Intake):
Proposed Funding Amount:
Contact person and contact information:
Name and contact information of person responsible for preparing final application in eSNAPS:

Please submit the letter of intent on applicant's letterhead, signed by executive director (or appropriate similar position), including the items listed in Appendix A, Part II, via email or postal mail to:

By E-Mail:
ebruder-moore@comcounseling.org
Please include "2019 NOFA LOI" in the subject line.

By Postal Mail:
Attn: Ellen Bruder-Moore Abramowitz
GBCATCH c/o CCBC
1 Washington Street
Taunton, MA 02780

NOTE: The applicant will enter the formal grant application via HUD's eSNAPS online portal, following the timeline distributed by GBCATCH for the FY2019 CoC NOFA application process.

GBCATCH may request additional information for any project, if needed pursuant to the CoC NOFA or related materials. If your project is selected for submission to HUD, you may be requested to provide additional information within a timeframe to be specified by GBCATCH.

This RFP and the 2019 CoC NOFA Information will be added to the GBCATCH Facebook Page (https://www.facebook.com/Greater-Bristol-County-Attleboro-Taunton-Coalition-to-end-Homelessness-1450711035143268/?ref=bookmarks) and the CCBC Website (www.comcounseling.org) .

Please direct any questions to Kevin McCarthy, Chair, GBCATCH at Kevin.McCarthy@bcsbmail.com, or Ellen Bruder-Moore Abramowitz, Collaborative Applicant for GBCATCH, ebruder-moore@comcounseling.org.

Appendix A
Threshold Criteria for Continuum of Care Grant Proposals

I. Criteria for Continuum of Care Grant Participation

a) Must have documentation of having served HUD-eligible homeless persons or families, through activities that are eligible under the CoC Interim Rule, during the twelve months prior to the deadline stated in the Request for Proposals
b) Must propose an eligible activity for an eligible homeless population, pursuant to HUD requirements
c) Must be an eligible contractor for federal funds per https://www.sam.gov/, must have a current tax exempt status as verified by the IRS and must not owe any overdue tax debts, as documented on IRS 990 submissions to the IRS
d) Must not propose to use HUD funds to supplant current funding
e) Must identify matching funds prior to application submission
f) Must provide the information listed below in Section II and must have satisfactory organizational status, experience and capacity to submit, implement and operate the proposed project, as determined by GBCATCH

II. Information on Organizational Status

Sponsors of CoC projects must provide the following items to the GBCATCH for review:

a) Signed letter of intent to apply for CoC Funding
b) Copy of Code of Conduct
c) IRS 501(c)3 designation letter (status in place for at least one year prior to application deadline)
d) Most current APR on file with HUD (*e-snaps* prior to April 1, 2019, or SAGE after April 1, 2019.) Please indicate the date the APR was submitted.

GBCATCH

GREATER BRISTOL COUNTY ATTLEBORO TAUNTON COALITION TO END HOMELESSNESS

MA-519

The MA-519 Consolidated Application was posted on the Collaborative Applicant website, emailed to the members of the CoC and other constituents, and voted on at an in-person CoC meeting on September 20th, 2019 as well as by online voting. Screenshots of the postings are below.

Note: The CoC attempted to utilize the Rating and Ranking tool listed in the Hud Exchange this year. Due to issues with the transition of HMIS systems, there was concern the tool would not accurately reflect progress of programs throughout the year. The Coc will again look at utiizing this tool in future competitions.

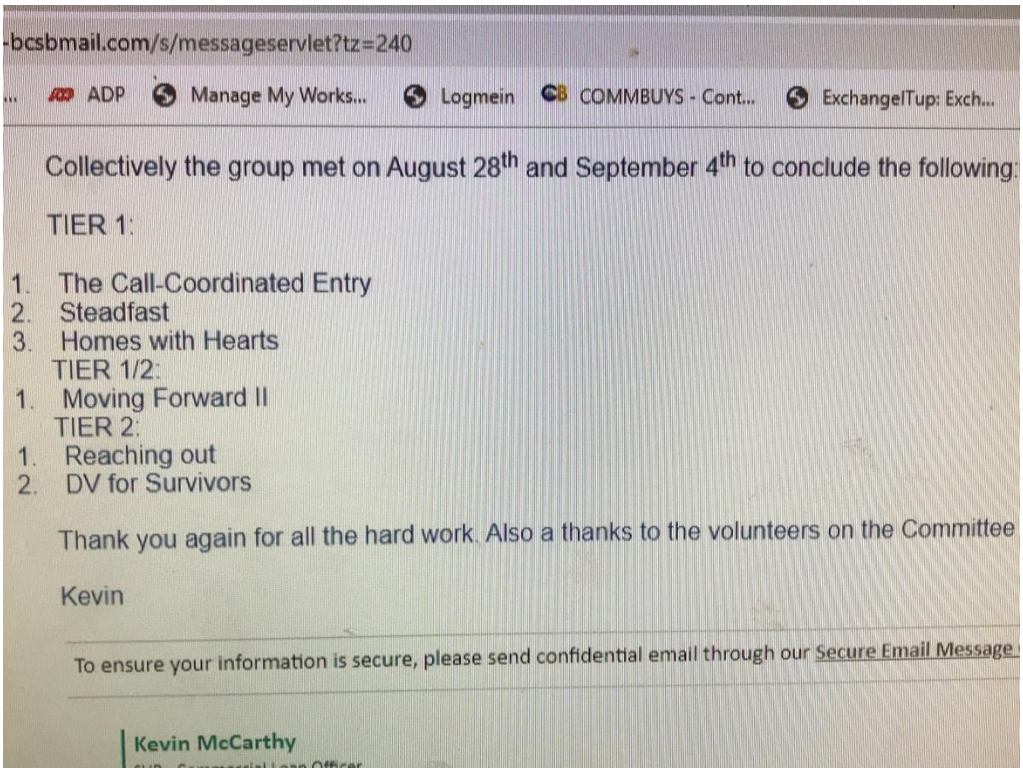
Rankings provided by Committee

	A	B	C	D	E	F	G	H	I	J	K
1	Tiers V3	Rank	Project Name	current budget	Consolidat	new budget	difference	Running Total	Perecentag	Running total to 94%	
2	Tier 1	1	**The CALL-Coordinated Entry**	$27,357.00	$0.00	$27,357.00	$0.00	$27,357.00	0.034421	$719,733.38	
3	Tier1	2	**Steadfast**	$191,813.00	$0.00	$191,813.00	$0.00	$219,170.00	0.2757629	$527,920.38	
4	Tier 1	3	**Homes With Heart**	$190,081.00	$0.00	$190,081.00	$0.00	$409,251.00	0.5149256	$337,839.38	
5	Tier 1/Tier2	4	**Moving Forward II**	$385,526.00	$0.00	$385,526.00	$0.00	**$794,777.00**	1	($47,686.62)	
6	Tier 2	5	**Reaching Out**	$0.00	$0.00	$45,099.00	$45,099.00	$839,876.00			
7	Tier 2	6	**Entry SSO for DV Survivors**	$0.00	$0.00	$67,760.00	$67,760.00	$907,636.00			
8											
9			**totals**	**$794,777.00**	$0.00	**$907,636.00**	**$112,859.00**				
10			**Project Name**								
11			**CoC Planning Application**	**$27,059.00**		**$27,059.00**		**$27,059.00**			
12											
13				**$821,836.00**			**$934,695.00**				
14											
15					**Renewals**	**$794,777.00**	**CoC Number and Name**	**PPRN**	**ARD**	**ARD at 94 %**	
16					**Eliminated**	**$0.00**	**MA-519 - Attleboro, Taun**	**$901,970**	**$794,777**	**$747,090**	
17					**Reallocated**	**$0.00**					
18					**New**	**$112,859.00**					
19		Total HUD request			**Planning**	**$27,059.00**					
20					**Total**	**$934,695.00**					
21											
22	Project Name	CH	PH	Sp Pop	New CH Tot	Ind	Families	Total			
23	**Homes With Heart**	14	14		14	14	0				
24	**Moving Forward II**	28	28	Veterans	28	28	0				
25	**Steadfast**	25	25		25	8	17				
26	**-Coordinated Entry**	0	0		0	0	0				
27	**Reaching Out**	3	3	Elders	3	3	0				
28		70	70		70	53	17	70			
29											
30											
31											

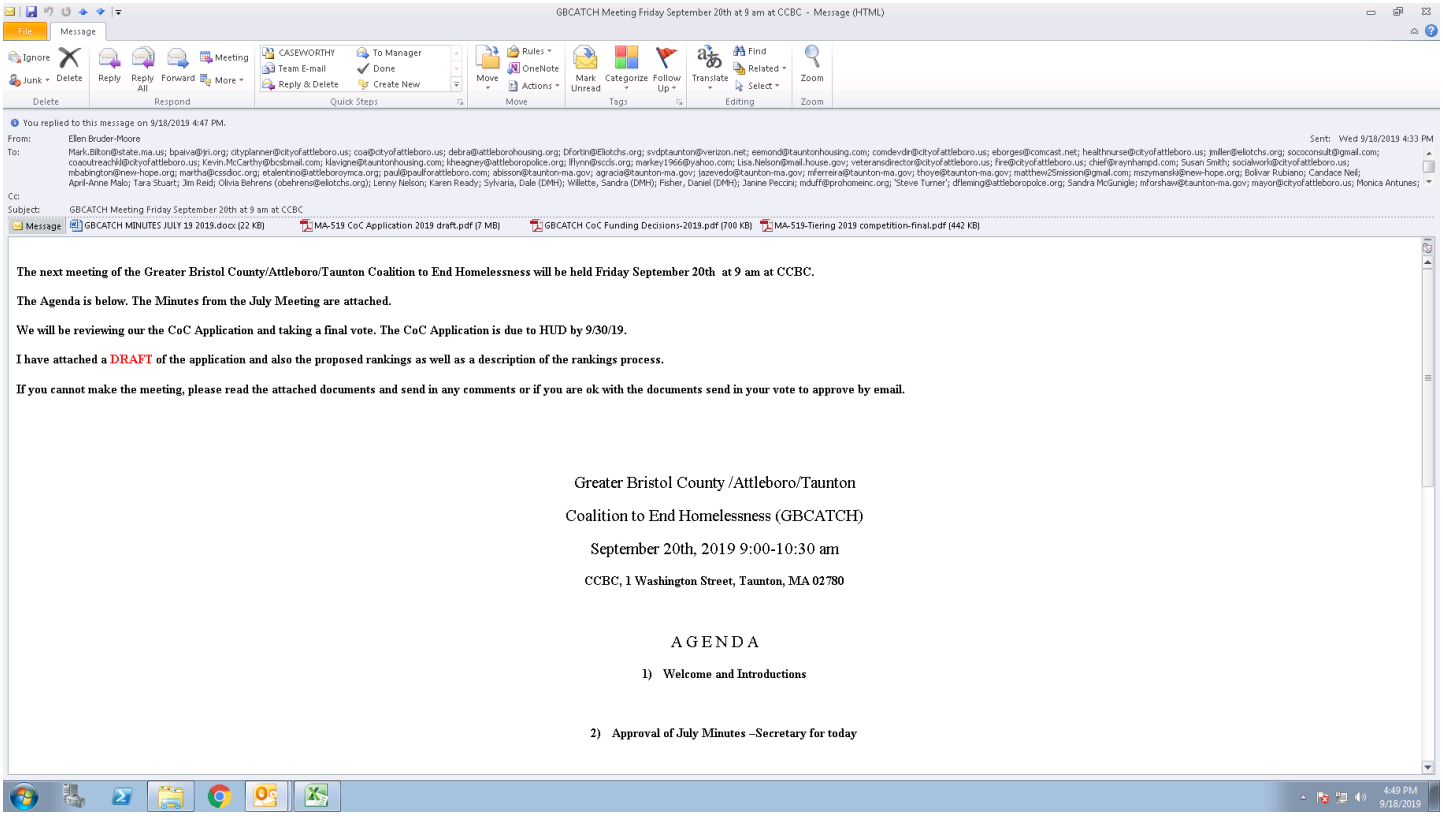
Mechanism used for determining ranking for projects

	A	B	C	D	E	F	G	H	I	J	K	L	M	N	O	P	Q	R	S	T	U	X	Y	Z
1		Performance - 2019 Application																						
2		Housing Type	Agency	Project Name	Total Served-Adults and Children	# of Adult Stayers	Number Adults Exited	SSI	SSDI	SS	GA	TANF	SCHIP	Vets Benefits	**Earned Income**	Unemploy. Benefits	Vets Health Care	Medicaid	Medicare	FS	Other - ?	NO RESOURCES	Section 8, Rental Assistance	Child Support
3	7/1/17 thru 6/30/18	PH-CH	CCBC	New Horizons	22	21	1	7	3	0	4	0	0	0	**5**	0	0	16	3	11	0	0	0	0
4	9/1/17 thru 8/31/18	PH-CH	CSS	Path to Independence	22	9	2	7	0	0	0	3	0	0	**0**	0	0	22	0	8		1	2	0
5	7/1/17 thru 6/30/18	PH-CH	CCBC	Welcome Home II	6	6	0	0	1	1	2	0	0	1	**1**	0	2	5	0	4	0	0	1	0
6	12/1/17 thru 11/30/18	PH-CH	CCBC	Moving Forward	4	4	0	3	0	0	0	0	0	0	**1**	0	0	3	0	4	1	0	0	0
7	9/1/17 thru 8/31/18	PH-CH	CSS	Beacon of Hope	11	8	3	1	2	0	5	0	0	0	**2**	0	0	11	3	8	5	1	1	0
8	4/30/17 thru 3/31/18	PH-CH	CCBC	Homes with Heart	15	13	2	8	0	1	0	0	0	0	**3**	0	0	12	1	13	0	0	0	0
9	7/1/18 thru 6/30/19	PH-CH	CCS	Keystone	9	4	0	1	0	0	0	1	0	0	**0**	0	0	9	0	3	0	1	0	0
10		**TOTAL**		**TOTALS**	**89**	**65**	**8**	**27**	**6**	**2**	**11**	**4**	**0**	**1**	**12**	**0**	**2**	**78**	**7**	**51**	**6**	**3**	**4**	**0**
11																								
12				**GBCATCH**				**36.99%**	**8.22%**	**2.74%**	**15.07%**	**####**	**0.00%**	**1.37%**	**16.44%**	**0.00%**	**2.74%**	**106.85%**	**9.59%**	**69.86%**	**8.22%**	**4.11%**	**5.48%**	**0.00%**
13																								
14				**HUD GOAL**											**20%**									
15								**Have Income**	**86.30%**				**earned income**		**16.44%**									
16													CCBC programs		47	adults	**health insurance**		**119.18%**					
17													**earned income**		**21.28%**									
18													CSS programs		26	adults								
19													**earned income**		**7.69%**									
20																								
21																								
22																								
23																								

Email screenshot of Ranking Results provided by Committee



Screen shot of consolidated plan attachments and priority listings email



GBCATCH Meeting Friday September 20th at 9 am at CCBC - Message (HTML)

You replied to this message on 9/18/2019 4:47 PM.

From: Ellen Bruder-Moore
Sent: Wed 9/18/2019 4:33 PM
To: Mark.Bilton@state.ma.us; bpaiva@jri.org; cityplanner@cityofattleboro.us; coa@cityofattleboro.us; debra@attleborohousing.org; DFortin@Eliotchs.org; svdptaunton@verizon.net; eemond@tauntonhousing.com; comdevdir@cityofattleboro.us; eborges@comcast.net; healthnurse@cityofattleboro.us; jmiller@eliotchs.org; socioconsult@gmail.com; coaoutreachkl@cityofattleboro.us; Kevin.McCarthy@bcsbmail.com; klavigne@tauntonhousing.com; kheagney@attleboropolice.org; lflynn@sccls.org; markey1966@yahoo.com; Lisa.Nelson@mail.house.gov; veteransdirector@cityofattleboro.us; fire@cityofattleboro.us; chief@raynhampd.com; Susan Smith; socialwork@cityofattleboro.us; mbabington@new-hope.org; martha@cssdoc.org; etalentino@attleboroymca.org; paul@paulfortattleboro.com; abisson@taunton-ma.gov; agracia@taunton-ma.gov; jazevedo@taunton-ma.gov; mferreira@taunton-ma.gov; thoye@taunton-ma.gov; matthew25mission@gmail.com; mszymanski@new-hope.org; Bolivar Rubiano; Candace Neil; April-Anne Malo; Tara Stuart; Jim Reid; Olivia Behrens (obehrens@eliotchs.org); Lenny Nelson; Karen Ready; Sylvaria, Dale (DMH); Willette, Sandra (DMH); Fisher, Daniel (DMH); Janine Peccini; mduff@prohomeinc.org; 'Steve Turner'; dfleming@attleboropolce.org; Sandra McGunigle; mforshaw@taunton-ma.gov; mayor@cityofattleboro.us; Monica Antunes;
Cc:
Subject: GBCATCH Meeting Friday September 20th at 9 am at CCBC

Message | GBCATCH MINUTES JULY 19 2019.docx (22 KB) | MA-519 CoC Application 2019 draft.pdf (7 MB) | GBCATCH CoC Funding Decisions-2019.pdf (700 KB) | MA-519-Tiering 2019 competition-final.pdf (442 KB)

The next meeting of the Greater Bristol County/Attleboro/Taunton Coalition to End Homelessness will be held Friday September 20th at 9 am at CCBC.

The Agenda is below. The Minutes from the July Meeting are attached.

We will be reviewing our the CoC Application and taking a final vote. The CoC Application is due to HUD by 9/30/19.

I have attached a DRAFT of the application and also the proposed rankings as well as a description of the rankings process.

If you cannot make the meeting, please read the attached documents and send in any comments or if you are ok with the documents send in your vote to approve by email.

Greater Bristol County /Attleboro/Taunton

Coalition to End Homelessness (GBCATCH)

September 20th, 2019 9:00-10:30 am

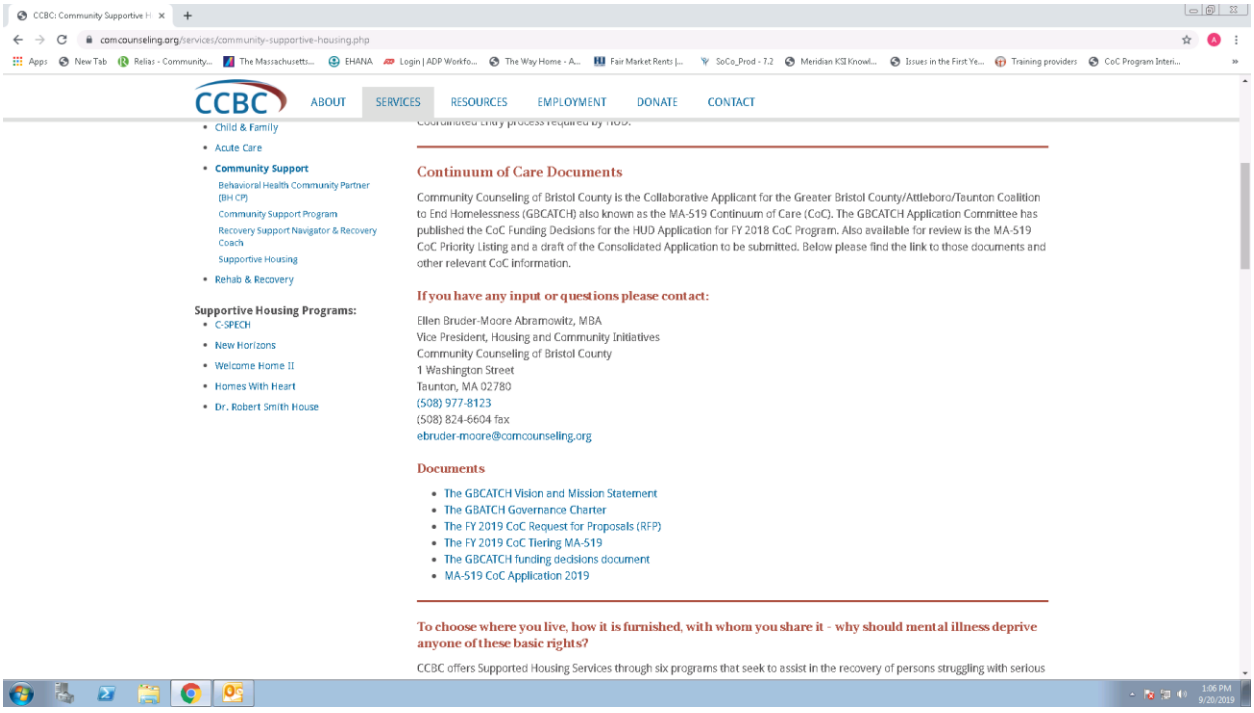
CCBC, 1 Washington Street, Taunton, MA 02780

AGENDA

1) **Welcome and Introductions**

2) **Approval of July Minutes –Secretary for today**

Screen shot Consolidated application posted on Collaborative applicant website



CCBC: Community Supportive H

comcounseling.org/services/community-supportive-housing.php

CCBC | ABOUT | SERVICES | RESOURCES | EMPLOYMENT | DONATE | CONTACT

- Child & Family
- Acute Care
- **Community Support**
  - Behavioral Health Community Partner (BH CP)
  - Community Support Program
  - Recovery Support Navigator & Recovery Coach
  - Supportive Housing
- Rehab & Recovery

Supportive Housing Programs:

- C-SPECH
- New Horizons
- Welcome Home II
- Homes With Heart
- Dr. Robert Smith House

Continuum of Care Documents

Community Counseling of Bristol County is the Collaborative Applicant for the Greater Bristol County/Attleboro/Taunton Coalition to End Homelessness (GBCATCH) also known as the MA-519 Continuum of Care (CoC). The GBCATCH Application Committee has published the CoC Funding Decisions for the HUD Application for FY 2018 CoC Program. Also available for review is the MA-519 CoC Priority Listing and a draft of the Consolidated Application to be submitted. Below please find the link to those documents and other relevent CoC information.

If you have any input or questions please contact:

Ellen Bruder-Moore Abramowitz, MBA
Vice President, Housing and Community Initiatives
Community Counseling of Bristol County
1 Washington Street
Taunton, MA 02780
(508) 977-8123
(508) 824-6604 fax
ebruder-moore@comcounseling.org

Documents

- The GBCATCH Vision and Mission Statement
- The GBATCH Governance Charter
- The FY 2019 CoC Request for Proposals (RFP)
- The FY 2019 CoC Tiering MA-519
- The GBCATCH funding decisions document
- MA-519 CoC Application 2019

To choose where you live, how it is furnished, with whom you share it - why should mental illness deprive anyone of these basic rights?

CCBC offers Supported Housing Services through six programs that seek to assist in the recovery of persons struggling with serious

MA-519

Racial Disparity Assessment Summary

3B-3

Note: The GBCATCH Continuum is continuously working to create more effective ways to monitor and rectify racial disparity issues within the continuum. A full assessment regarding racial disparity is forthcoming with the addition of staffing hours dedicated to the overarching goals of the Continuum

Racial Disparities Assessment
GBCATCH
(Greater Bristol County Attleboro/Taunton Coalition to End Homelessness)

The GBCATCH Continuum of Care (MA-519) covers all areas of Bristol County Massachusetts with the exception of two cities (New Bedford and Fall River). The Collaborative applicant for the Continuum works within the entirety of the county as well as other counties in the region.

The disparities assessment shows that the Continuum is more likely to work with those of races other than white due to the increase in poverty levels among those non-Caucasian. The Continuum will continue to work with the cities, agencies participating in the continuum including outreach programs, and as well as mental health providers to ensure outreach is conducted to all who need services. The Continuum will also continue to work overall to reduce racial disparity within the Continuum in issues surrounding poverty, mental health, and housing.

Both veterans and non-veterans in our target population are primarily male. Roughly 25% of our target population is comprised of racial/ethnic minorities, primarily African Americans (8.6%) and Hispanics (7.9%). There is a large Portuguese ethnicity represented in our population, and although most will be English-speaking, we expect to serve those who speak Spanish, Portuguese, and other languages. Most are between the ages of 31 and 61. Based on demographics only a small number will be Gay, Lesbian or Bisexual. All will be low-income. We expect that the veterans in our population will have serious physical (61%) or mental (55%) health conditions, substance abuse disorders (76%) or all three (32%). Many younger veterans may also suffer from traumatic brain injury related to their military service. We expect that non-veterans in our target group struggle with drug (49.2%) and alcohol (54%) addictions and at least 20% suffer from serious mental illness.

Veterans: Veterans comprise as much as 16% of the homeless population vs. 10% of the total population. According to the National Coalition for Homeless Veterans, an estimated 33% of homeless men are veterans and roughly 8% of homeless veterans are female. The majority of homeless veterans are single and live in urban areas. A national survey of homeless veterans found they remain homeless longer than non-veterans, and that the majority of veterans who are homeless for more than two years had serious physical (61%) or mental (55%) health conditions, substance abuse habits (76%), or all three (32%). As many as 19% of veterans from Iraq and Afghanistan may suffer from traumatic brain injury and its associated mood disorders.

According to projections by the U.S. Department of Veterans Affairs, as of September 30, 2013, some 67,889 veterans were living in Community Counseling of Bristol County (CCBC)'s service area and 22,595 veterans live in our region's six largest cities, in each of which CCBC has an office, and where we have developed extensive community resources: Taunton, Brockton, New

Bedford, Attleboro, Fall River, and Plymouth. Three of these, Brockton, Fall River and New Bedford are among the top ten largest cities in the state. While GBCATCH only covers Taunton and Attleboro cities as well as all other smaller communities in Bristol County, it is known that many who are dealing with a housing crisis in the area will go from one continuum to another as the services and resources are located in the major cities. The most recent Point in Time estimates of homelessness show that there are 133 homeless veterans in our service area. Conservatively, we estimate that 15.8% or roughly 21 of those will be chronically homeless, and that many will have high rates of physical and mental health problems and addictions. We also show that of those seeking services the following estimates reflect those currently seeking services:

- 92% will be men and roughly 25% will be people of color, primarily African Americans 98.6%) and Hispanics (7.9%);
- Very few, if any, will be Native American given that, in the six largest urban areas, Native Americans make up between .2 and 3% of the population.
- Like sheltered vets in the U.S., the majority (roughly 80%) will be ages 31 to 61.
- One or two identify as Gay, Lesbian or Bisexual (GLB) based on data collected by the Service Women's Action Network that showed roughly 4.5% of veterans are GLB.
- All are low-income due to factors that interfere with employment, including limited education and transferable skills from military to civilian life, especially among younger veterans returning from Iraq and Afghanistan; combat-related physical health issues and disabilities; combat-related mental health issues and disabilities; and higher rates of substance abuse than in the civilian population.

Other Homeless (Non-Veteran) Individuals: Based on the 2013 Point in Time estimates of homelessness in the four Continuums of Care (CoC) in our region (Attleboro/Taunton/Bristol County, Fall River, New Bedford, and Brockton/Plymouth City & County), there were 671 homeless individuals in our region of which roughly 140 are chronically homeless. Based on demographics reported in the 2013 Annual Homeless Assessment Report (AHAR) on Sheltered Homeless Persons, we believe the demographics of the chronically homeless population in the CoC areas in our region to be:

- Between 50 and 74% male.
- White (75.4%), African American (8.6%), Hispanic (7.9%) or members of other racial/ethnic groups.

Based on data from CCBC's four permanent supportive and 1 transitional housing programs, we estimate that 84.1% of the chronically homeless struggle with mental illness and/or drug (49.2%) and alcohol (54%) addictions. Roughly 20% will have severe mental illness.(11) The high rates of mental illness, addictions and other disabilities among the chronically homeless prevent the majority from maintaining jobs and being able to support themselves, which explains their low socio-economic status. We also estimate that a small percentage (3.4%) of the population is GLB. (12)

Disparities and Gaps in Services: According to the 2010 U.S. Census (6), a total of 384,700 people (more than 70% of the population) live in our service area's six largest cities. Median household incomes across the six cities ranging from $34,437 to $65,767 and rates of those living below the poverty level ranging from 8.2% to 23.2%. In four of the six cities, more than

83% of people are White. However, Brockton and New Bedford, two of the largest cities in the state, are more racially/ethnically diverse. Brockton is home to more people of color than Whites, which comprise only 42.9% of the population, and where the largest racial group is Blacks/African Americans at 31.2%. New Bedford has the largest Hispanic/Latino population in the region at 16.7%. Rates of home ownership range between 37.6% and 67%. High school completion rates range from 68.8% to 92.4% and the proportion with a Bachelor's degree range from 14.5% to 30.1%. The population in general is better off socio-economically than the homeless veterans and chronically homeless vets and non-veterans we serve, however the region is plagued with its share of public health problems. Four of the six cities rank in the top 20% in the state for substance abuse treatment rates and five-year average prevalence of poor mental health among adults. The demographics of the homeless population in our region, as described above, are similar to the overall population except that the rates of poverty, mental illness, and substance abuse are far higher among those who are homeless and chronically homeless.

There are 133 homeless veterans and 140 chronically homeless individuals in our service area, but only 113 total permanent supportive housing units. The largest gap in services to the chronically homeless population, especially with addictions and/or mental illness, is the insufficient inventory of supportive housing units. Given that the mortality rate for those experiencing chronic homelessness is four to nine times higher than for the general population, the urgency to establish additional permanent supportive housing and to engage all of the chronically homeless individuals in our area in services to improve their health, including addictions treatment and mental health services, is acute. GBCATCH will continue to address these disparities with supportive case management and extensive resources by closing the existing gap in such services, and addressing the racial and ethnic disparities which exist.

A Quality Improvement Plan

GBCATCH understands the importance of demonstrating the efficacy and effectiveness of its overall services, and has established a performance measurement and quality improvement process. Through additional staffing hours and planning grants the Continuum will monitor potential racial disparities within the specific continuum boundaries and work with the service providers to ensure these issues are addressed.

GBCATCH is committed to an approach that emphasizes the use of data to assess performance and continuously improve the quality of our services.

1. Outreach and direct treatment
2. 3. Permanent Housing
4. Case management to link with and retain clients in housing:
5. Connect to enrollment resources for Medicaid and other benefit services
6. Integrated services and supports for substance use disorders and co-occurring disorders
7. Recovery support services: Improve access to and retention in services including vocational, independent living, crisis care, medications management, self-help programs peer support
8. Education, screening and counseling for hepatitis; steps to reduce HIV/AIDS
9. Trauma Informed Services

10. Integrated primary/substance abuse/mental health care approach in service delivery plan (National Council)
11. Training in evidence-based practices

Adherence to the CLAS Standards

CCBC has incorporated the National Standards for Culturally and Linguistically Appropriate Services (CLAS Standards) in Health and Health Care into our quality improvement plan and will ensure that the Safe Harbor program adheres to these standards by insuring that:

a. Diverse cultural health beliefs and practices: Training and hiring protocols will be implemented to support the culture and language of all subpopulations, with a focus on the subpopulations served by this program.

b. Preferred languages: Interpreters and translated materials will be used for non-English speaking clients as well as those who speak English, but prefer materials in their primary language. Key documents will be translated into Spanish and Portuguese.