

1A. Continuum of Care (CoC) Identification

Instructions:

The fields on this screen are read only and reference the information entered during the CoC Registration process. Updates cannot be made at this time. If the information on this screen is not correct, contact the e-snaps help desk.

CoC Name and Number (From CoC Registration): IL-511 - Cook County CoC

CoC Lead Organization Name: Alliance to End Homelessness in Suburban Cook County

1B. Continuum of Care (CoC) Primary Decision-Making Group

Instructions:

The following questions are related to the CoC primary decision-making group. The primary responsibility of this group is to manage the overall planning effort for the entire CoC, including, but not limited to:

- Setting agendas for full Continuum of Care meetings
- Project monitoring
- Determining project priorities
- Providing final approval for the CoC application submission.

This body is also responsible for the implementation of the CoC's HMIS, either through direct oversight or through the designation of an HMIS implementing agency. This group may be the CoC Lead Agency or may authorize another entity to be the CoC Lead Agency under its direction.

Name of primary decision-making group: Alliance to End Homelessness in Suburban Cook County

Indicate the frequency of group meetings: Monthly or more

If less than bi-monthly, please explain (limit 500 characters):

NA

Indicate the legal status of the group: 501(c)(3)

Specify "other" legal status:

NA

Indicate the percentage of group members that represent the private sector: (e.g., non-profit providers, homeless or formerly homeless persons, advocates and consumer interests) 78%

*** Indicate the selection process of group members: (select all that apply)**

Elected:	<input checked="" type="checkbox"/>
Assigned:	<input type="checkbox"/>
Volunteer:	<input type="checkbox"/>
Appointed:	<input type="checkbox"/>

Other:

Specify "other" process(es):

NA

Briefly describe the selection process of group members. Description should include why this process was established and how it works (limit 750 characters):

The Alliance has three regional councils representing the north, west, and south sections of our county. Each of the three councils elects 8 representatives to the Alliance board of directors, where up to four represent homeless provider agencies and at least one is a homeless consumer. The Alliance nominating committee recruits up to 15 additional countywide representatives, including a mix of public and private sector representatives. The board elects officers annually from among the directors who have served on the board one year or longer. The Alliance covers a broad geography, and this process ensures both geographical representation and a mix of nonprofit organizations, homeless consumers, public and private sector representatives.

*** Indicate the selection process of group leaders: (select all that apply):**

Elected:	<input checked="" type="checkbox"/>
Assigned:	<input type="checkbox"/>
Volunteer:	<input type="checkbox"/>
Appointed:	<input type="checkbox"/>
Other:	<input type="checkbox"/>

Specify "other" process(es):

NA

If administrative funds were made available to the CoC, would the primary-decision making body, or its designee, have the capacity to be responsible for activities such as applying for HUD funding and serving as a grantee, providing project oversight, and monitoring. Explain (limit 750 characters):

Based on the HEARTH Act signed into law in May 2009, the Alliance has the expertise and is well positioned to act as the "Collaborative Applicant," continuing to design and implement a collaborative application process, evaluate program outcomes, participate in Consolidated Plans, and ensure HMIS operation and participation. The Alliance is an incorporated 501(c)3 organization that currently administers its own SHP funding for HMIS. With additional administrative funds and technical assistance, the Alliance can develop the capacity to take on "Unified Funding Agency" responsibilities of applying for and accepting funds, ensuring project sponsors have proper fiscal controls and systems, and monitoring their financial records annually.

1C. Continuum of Care (CoC) Committees, Subcommittees and Work Groups

Instructions:

Provide information on up to five of the CoCs most active CoC-wide planning committees, subcommittees, and workgroups. CoCs should only include information on those groups that are directly involved in CoC-wide planning activities such as project review and selection, discharge planning, disaster planning, completion of the Exhibit 1 application, conducting the point-in-time count, and 10-year plan coordination. For each group, briefly describe the role and how frequently the group meets. If one of more of the groups meet less than quarterly, please explain.

Committees and Frequency

Name of Group	Role of Group (limit 750 characters)	Meeting Frequency
Continuum of Care Development Committee	During HUD's Continuum of Care application season, the Committee facilitates the completion of Exhibit 1, articulating goals and accomplishments for the Alliance's response. During the balance of the year, the Committee focuses on implementing the Alliance's strategic plan and promoting the Community Plan to End Homelessness. The Committee organizes a homeless count every other year.	Monthly or more
Homelessness Prevention Committee	This Committee coordinates use of homelessness prevention funds within suburban Cook County. This has included an annual \$1.35 million in state funding and, currently, the \$6 million in HPRP allocations in suburban Cook County. This committee has played a central role in HPRP program design and targeting. The charge of this Committee also includes coordinating prevention funding from various sources, advocacy issues related to prevention/affordable housing, and identifying best practices. Over the past two years, this committee has been exploring the feasibility of a homelessness prevention call center, and with the partial support of HPRP, this call center will be launched in November 2009.	Monthly or more
Outcome Evaluation Committee	This Committee has been responsible for developing an outcome measurement tool to evaluate project performance and conducting performance evaluations of Continuum projects. The committee completed a pilot of its new Outcome Evaluation tool in 2009. This Committee is separate and in addition to the Project Review and Prioritization Committee that annually reviews and ranks HUD-funded projects, translating Alliance goals into project review criteria. In 2009-2010, the committee is working with a team of university students to incorporate a revised Outcome Evaluation tool more directly into the annual Project Review process.	Monthly or more
HMIS Committee	This Committee guides the operation of the homeless management information system, including reviewing HMIS Policies & Procedures annually for the Alliance. The Committee cultivates ways in which future data measurement can fulfill the goals of our Strategic Plan.	Monthly or more
Executive Committee	This Committee acts on behalf of the Alliance board of directors in between meetings when timely action is required. The Executive Committee is made up of board officers and a chair from each of the three regional councils.	Monthly or more

If any group meets less than quarterly, please explain (limit 750 characters):

The Alliance has six committees that meet monthly (these five, plus a Finance Committee), plus five additional committees that meet 2-6 times per year. Descriptions of all committees are available at:
<http://www.suburbancook.org/Committees.html>

1D. Continuum of Care (CoC) Member Organizations

Identify all CoC member organizations or individuals directly involved in the CoC planning process. To add an organization or individual, click on the icon.

Organization Name	Membership Type	Organization Type	Organization Role	Subpopulations
Housing Authority of the County of Cook (HACC)	Public Sector	Public	Primary Decision Making Group, Committee/Sub-committee/Work Group	Seriously Mentally Ill
Alexian Center for Mental Health	Private Sector	Non-profit	Committee/Sub-committee/Work Group, Attend Consolidated Plan	Seriously Mentally Ill
Aunt Martha's Youth Service Center	Private Sector	Non-profit	Committee/Sub-committee/Work Group	Youth
BEDS PLUS	Private Sector	Non-profit	Committee/Sub-committee/Work Group	Seriously Mentally Ill
Bethel Community Facility	Private Sector	Faith-based	Primary Decision Making Group, Committee/Sub-committee/Work Group	NONE
Bethel Human Resources	Private Sector	Faith-based	Attend 10-year planning meetings during past 12 months, Committee/Sub-committee/Work Group	Veterans, Seriously Mentally Ill
Catholic Charities	Private Sector	Faith-based	Primary Decision Making Group, Attend Consolidated Plan	Veterans, Seriously Mentally Ill
CEDA Bloom-Rich	Private Sector	Non-profit	Attend Consolidated Plan planning meetings during past 12 months	Veterans
CEDA Center for Community Action	Private Sector	Non-profit	Committee/Sub-committee/Work Group	NONE
CEDA Near West	Private Sector	Non-profit	Committee/Sub-committee/Work Group	NONE
CEDA Neighbors at Work	Private Sector	Non-profit	Committee/Sub-committee/Work Group	NONE
CEDA Northwest Self-Help Center	Private Sector	Non-profit	Primary Decision Making Group, Attend Consolidated Plan	Veterans, Seriously Mentally Ill
CEDA Central	Private Sector	Non-profit	Primary Decision Making Group, Attend 10-year planning meetings	Youth, Domiciliary
Proviso-Leyden Center for Community Action	Private Sector	Non-profit	Primary Decision Making Group, Committee/Sub-committee/Work Group	NONE

CEDA Southeast	Private Sector	Non-pro..	None	NONE
CEDA Southwest	Private Sector	Non-pro..	Committee/Sub-committee/Work Group	NONE
Center of Concern, The	Private Sector	Non-pro..	Primary Decision Making Group, Attend Consolidated Plan p...	NONE
Connections for the Homeless	Private Sector	Non-pro..	Primary Decision Making Group, Attend 10-year planning me...	Seriously Me...
Fellowship Housing Corporation	Private Sector	Faith-b...	Committee/Sub-committee/Work Group	Youth, Domes..
Grand Prairie Services	Private Sector	Non-pro..	Attend Consolidated Plan planning meetings during past 12...	Seriously Me...
Hines VA Hospital	Public Sector	Othe r	Primary Decision Making Group, Attend Consolidated Plan p...	Veteran s, Su...
IL Department of Corrections - Placement Resour...	Public Sector	Stat e g...	Primary Decision Making Group	NONE
IL Department of Human Services - Division of M...	Public Sector	Stat e g...	Primary Decision Making Group, Attend 10-year planning me...	Seriously Me...
Interdependent Living Solutions Center	Private Sector	Non-pro..	Committee/Sub-committee/Work Group	NONE
Jewish Federation South Suburban Community Serv...	Private Sector	Non-pro..	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Journeys from PADS to HOPE	Private Sector	Non-pro..	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
Madden Mental Health Center	Public Sector	Stat e g...	Committee/Sub-committee/Work Group	Seriously Me...
Pillars	Private Sector	Non-pro..	Primary Decision Making Group, Attend Consolidated Plan p...	Seriously Me...
Respond Now	Private Sector	Non-pro..	Committee/Sub-committee/Work Group	NONE
Thornton Township	Public Sector	Loca l g...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Sarah's Inn	Private Sector	Non-pro..	Attend Consolidated Plan planning meetings during past 12...	Youth, Domes..
South Suburban Council on Alcoholism & Substanc...	Private Sector	Non-pro..	Committee/Sub-committee/Work Group	Substan ce Abuse
South Suburban Family Shelter	Private Sector	Non-pro..	Primary Decision Making Group, Attend 10-year planning me...	Domesti c Vio...

South Suburban PADS	Private Sector	Non-pro..	Primary Decision Making Group, Attend 10-year planning me...	NONE
Thresholds	Private Sector	Non-pro..	Primary Decision Making Group, Committee/Sub-committee/Wo...	Seriously Me...
Together We Cope	Private Sector	Non-pro..	Committee/Sub-committee/Work Group	NONE
Town of Cicero	Public Sector	Local g...	Primary Decision Making Group, Attend 10-year planning me...	NONE
Village of Skokie - Human Services	Public Sector	Local g...	Committee/Sub-committee/Work Group, Authoring agency for ...	NONE
Vital Bridges	Private Sector	Non-pro..	Attend Consolidated Plan planning meetings during past 12...	Seriously Me...
West Suburban PADS	Private Sector	Non-pro..	Primary Decision Making Group, Attend 10-year planning me...	Veterans, HI...
New Foundation Center	Private Sector	Non-pro..	Primary Decision Making Group, Attend 10-year planning me...	Seriously Me...
WINGS Program, Inc.	Private Sector	Non-pro..	Committee/Sub-committee/Work Group	Domestic Vio...
YMCA Network	Private Sector	Non-pro..	Primary Decision Making Group, Committee/Sub-committee/Wo...	Youth, Subst...
Harbour, Inc., The	Private Sector	Non-pro..	Committee/Sub-committee/Work Group	Youth
Maine Township	Public Sector	Local g...	None	NONE
Proviso Township	Public Sector	Local g...	None	NONE
IL Department of Human Services - West Suburban...	Public Sector	State g...	Committee/Sub-committee/Work Group	NONE
IL State Senator, Maggie Crotty, 19th District	Public Sector	State g...	None	NONE
Cook County Department of Planning and Development	Public Sector	Local g...	Attend 10-year planning meetings during past 12 months, A...	NONE
Village of Oak Park - Community Development	Public Sector	Local g...	Committee/Sub-committee/Work Group, Authoring agency for ...	NONE
Oak Park Housing Authority	Public Sector	Public ...	Committee/Sub-committee/Work Group	Seriously Me...
Suburban Cook County Regional Office of Education	Public Sector	School ...	Attend 10-year planning meetings during past 12 months, C...	Youth
Cook County Workforce Investment Act Board	Public Sector	Local w...	None	NONE

Chicago Community Trust	Private Sector	Funder ...	Attend 10-year planning meetings during past 12 months	NONE
Corporation for Supportive Housing	Private Sector	Funder ...	Primary Decision Making Group, Committee/Sub-committee/Wo...	Veterans, Se...
NAMI Barrington Area	Private Sector	Funder ...	Primary Decision Making Group, Committee/Sub-committee/Wo...	Seriously Me...
NAMI Northwest Suburban - Arlington Heights	Private Sector	Funder ...	Committee/Sub-committee/Work Group	Seriously Me...
Reade Industrial Fund	Private Sector	Funder ...	None	NONE
Supportive Housing Providers Association	Private Sector	Funder ...	Attend 10-year planning meetings during past 12 months	Seriously Me...
United Way - South Suburban	Private Sector	Funder ...	Committee/Sub-committee/Work Group	NONE
United Way of Metropolitan Chicago	Private Sector	Funder ...	Primary Decision Making Group, Attend 10-year planning me...	NONE
West Suburban Landlords Association	Private Sector	Businesses	Primary Decision Making Group, Attend Consolidated Plan p...	Veterans, Se...
L. Perkins	Individual	Formerl. ..	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
US Social Security Administration	Public Sector	Other	Primary Decision Making Group, Committee/Sub-committee/Wo...	Seriously Me...
Office of Congresswoman Melissa Bean, 8th Distr...	Public Sector	Other	Committee/Sub-committee/Work Group	NONE
Regional Roundtable on Homelessness of Northeast...	Private Sector	Funder ...	Committee/Sub-committee/Work Group, Attend 10-year planni...	NONE
Emergency Fund, The	Private Sector	Non-pro.. .	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
Ford Heights Hope Center	Private Sector	Non-pro.. .	Committee/Sub-committee/Work Group	Seriously Me...
S. Jensen	Individual	Homeles. ..	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
IL Department of Human Services - Blue Island O...	Public Sector	State g...	Primary Decision Making Group, Committee/Sub-committee/Wo...	NONE
R. Nichols	Individual	Homeles. ..	Primary Decision Making Group, Committee/Sub-committee/Wo...	Seriously Me...

1E. Continuum of Care (CoC) Project Review and Selection Process

Instructions:

The CoC solicitation of projects and project selection should be conducted in a fair and impartial manner. For each of the following items, indicate all of the methods and processes the CoC used in the past year to assess all new and renewal project(s) performance, effectiveness, and quality. In addition, indicate if any written complaints have been received by the CoC regarding any CoC matter in the last 12 months, and how those matters were addressed and/or resolved.

**Open Solicitation Methods:
(select all that apply)**

- f. Announcements at Other Meetings, e. Announcements at CoC Meetings, c. Responsive to Public Inquiries, b. Letters/Emails to CoC Membership, d. Outreach to Faith-Based Groups

**Rating and Performance Assessment Measure(s):
(select all that apply)**

- k. Assess Cost Effectiveness, q. Review All Leveraging Letters (to ensure that they meet HUD requirements), c. Review HUD Monitoring Findings, r. Review HMIS participation status, d. Review Independent Audit, p. Review Match, i. Evaluate Project Readiness, e. Review HUD APR for Performance Results, n. Evaluate Project Presentation, o. Review CoC Membership Involvement, f. Review Unexecuted Grants, a. CoC Rating & Review Committee Exists, m. Assess Provider Organization Capacity, l. Assess Provider Organization Experience

**Voting/Decision-Making Method(s):
(select all that apply)**

- a. Unbiased Panel/Review Committee, d. One Vote per Organization, b. Consumer Representative Has a Vote, f. Voting Members Abstain if Conflict of Interest

Were there any written complaints received by the CoC regarding any matter in the last 12 months?

No

If yes, briefly describe complaint and how it was resolved (limit 750 characters):

NA

1F. Continuum of Care (CoC) Housing Inventory--Change in Beds Available

For each housing type, indicate if there was any change (increase or reduction) in the total number of beds in the 2009 electronic Housing Inventory Chart (e-HIC) as compared to the 2008 e-HIC. If there was a change, please describe the reasons in the space provided for each housing type.

Emergency Shelter: Yes

Briefly describe the reason(s) for the change in Emergency Shelter beds, if applicable (limit 750 characters):

This year's inventory shows a decrease of 44 year-round emergency beds (20%) and an increase of 29 seasonal beds (10%). A majority of the 44 lost year-round beds were actually 30 beds re-classified to seasonal emergency beds by our largest emergency shelter provider. The changes also include one 10-bed shelter program being re-classified as transitional housing. Emergency Shelter in our Continuum is characterized by a high proportion of seasonal, overflow, and motel voucher beds. These programs expand and contract according to funding availability, weather, and need. The number of organizations with motel vouchers in use decreased from 5 agencies in the 2008 count to just 1 agency in the 2009 count.

Safe Haven: No

Briefly describe the reason(s) for the change in Safe Haven beds, if applicable (limit 750 characters):

NA

Transitional Housing: Yes

Briefly describe the reason(s) for the change in Transitional Housing beds, if applicable (limit 750 characters):

Overall, TH inventory decreased slightly by 20 beds, less than 3%. Because many of the TH programs are scattered-site housing, the number of beds can vary according to household sizes and need at any given time. A high number of lost beds can be traced directly to 3 programs having noticeably smaller families. While an emergency shelter became a new transitional housing program and several programs showed larger numbers of TH beds, a high number of beds became unavailable due to building rehabs and several programs decreased their number of TH beds.

Permanent Housing: Yes

Briefly describe the reason(s) for the change in Permanent Housing beds, if applicable (limit 750 characters):

The Continuum had an increase of 33 PH beds including 18 beds for individuals and 15 for families. This represents a 21% increase in permanent supportive housing. Some of the beds can be attributed to larger household sizes as this varies from year to year. We also had one program expand to provide PH for more households, and the first few VASH vouchers out of 70 in Round 1 were filled in time for the January count. There was a 4 bed increase in Chronic Homeless beds (7%) at the time of the count. Although this was a smaller than expected increase in CH beds, Alliance members have since added 29 CH beds this year, with 15 more expected to open in the next three months.

CoC certifies that all beds for homeless persons are listed in the e-HIC regardless of HMIS participation and HUD funding: Yes

1G. Continuum of Care (CoC) Housing Inventory Chart Attachment

Instructions:

Each CoC must complete and attach the electronic Housing Inventory Chart, or e-HIC. Using the version of the document that was sent electronically to the CoC, verify that all information is accurate and make any necessary additions or changes. Click on "Housing Inventory Chart" below to upload the document . Each CoC is responsible for reading the instructions in the e-HIC carefully.

Document Type	Required?	Document Description	Date Attached
Housing Inventory Chart	Yes	Suburban Cook Cou...	11/24/2009

Attachment Details

Document Description: Suburban Cook County IL-511 e-HIC 2009

1H. Continuum of Care (CoC) Housing Inventory Chart (HIC) - Data Sources and Methods

Instructions:

Complete the following items based on data collection methods and reporting for the electronic Housing Inventory Chart (e-HIC), including Unmet need determination. The information should be based on a survey conducted in a 24-hour period during the last ten days of January 2009.

Indicate the date on which the housing inventory count was completed: 01/22/2009
(mm/dd/yyyy)

Indicate the type of data or methods used to complete the housing inventory count: HMIS plus housing inventory survey
(select all that apply)

Indicate the steps taken to ensure data accuracy for the Housing Inventory Chart: Follow-up, Instructions, Updated prior housing inventory information, Confirmation, Training, HMIS
(select all that apply)

Must specify other:
NA

Indicate the type of data or method(s) used to determine unmet need: Unsheltered count, Other, Housing inventory, National studies or data sources, Stakeholder discussion
(select all that apply)

Specify "other" data types:

Other: Methodology based on the publication, Martha Burt and Carol Wilkins, Estimating the Need (Corporation for Supportive Housing, March 2005, www.csh.org), as explained below.

If more than one method was selected, describe how these methods were used together (limit 750 characters):

For the past five years, the Alliance has used a methodology to calculate unmet need adapted from the Corporation for Supportive Housing (CSH) publication, Estimating the Need (Burt & Wilkins, March 2005). The CSH methodology is similar to the HUD unmet need worksheet in that it begins with an estimate of how many people (individuals, families, sheltered, unsheltered) would best be served in a particular housing type. The method annualizes the point-in-time numbers to account for inflow throughout the year. It adjusts for vacancy rates and expected turnover to avoid overestimating the need. A committee then reviews and discusses the resulting calculations to see how well they match the reality of unmet need and our local planning estimates.

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

CoCs should complete the following information in conjunction with the HMIS Lead Agency. All information is to be current as of the date in which this application is submitted. For additional instructions, refer to the detailed instructions available on the left menu bar.

Select the HMIS implementation type: Regional (multiple CoCs)

Select the CoC(s) covered by the HMIS: IL-505 - Evanston CoC, IL-511 - Cook County CoC
(select all that apply)

Does the CoC Lead Organization have a written agreement with HMIS Lead Organization? No

If yes, the agreement (e.g., contract, Memorandum of Understanding, etc.) must be submitted with the application.

Is the HMIS Lead Organization the same as CoC Lead Organization? Yes

Has the CoC selected an HMIS software product? Yes

If "No" select reason:

If "Yes" list the name of the product: ServicePoint

What is the name of the HMIS software company? Bowman Systems

Does the CoC plan to change HMIS software within the next 18 months? No

Indicate the date on which HMIS data entry started (or will start): 06/16/2008
(format mm/dd/yyyy)

Is this an actual or anticipated HMIS data entry start date? Actual Data Entry Start Date

Indicate the challenges and barriers impacting the HMIS implementation: Other
(select all the apply):

If CoC indicated that there are no challenges or barriers impacting HMIS implementation, briefly describe either why CoC has no challenges or how all barriers have been overcome (limit 1000 characters).

NA

If CoC identified one or more challenges or barriers impacting HMIS implementation, briefly describe how the CoC plans to overcome them (limit 1000 characters).

The Alliance's previous HMIS partnership with neighboring DuPage County did not give our HMIS team full direct access to client level data. We were dependent upon DuPage HMIS staff, making it difficult to monitor data quality, run reports and troubleshoot problems in a timely manner.

Early in 2009, we chose to end our partnership with DuPage County and instead partner with the Evanston Alliance on Homelessness. Evanston is the only suburb in Cook County with its own Continuum. As in DuPage, Evanston had an existing ServicePoint HMIS.

In summer 2009, our data was moved from the DuPage HMIS to the Evanston HMIS, giving us the direct access to data we needed. Although we lost almost a month of data entry time, data entry is now up-to-date. Also, the migration process took a great deal of HMIS staff time, delaying our development of a data quality plan. We just recently finalized a formal data quality plan and have trained users to run their own data quality reports.

2B. Homeless Management Information System (HMIS) Lead Organization

Enter the name and contact information for the HMIS Lead Agency. This is the organization responsible for implementing the HMIS within a CoC. There may only be one HMIS Lead Agency per CoC.

Organization Name Alliance to End Homelessness in Suburban Cook County

Street Address 1 1107 S. Mannheim Road, Suite 304

Street Address 2

City Westchester

State Illinois

Zip Code 60154

Format: xxxxx or xxxxx-xxxx

Organization Type Non-Profit

If "Other" please specify NA

Is this organization the HMIS Lead Agency in more than one CoC? No

2C. Homeless Management Information System (HMIS) Contact Person

Enter the name and contact information for the primary contact person at the HMIS Lead Agency.

Prefix: Ms.

First Name Peggy

Middle Name/Initial

Last Name Troyer

Suffix

Telephone Number: 708-345-4035
(Format: 123-456-7890)

Extension 02

Fax Number: 708-345-7855
(Format: 123-456-7890)

E-mail Address: peggy@suburbancook.org

Confirm E-mail Address: peggy@suburbancook.org

2D. Homeless Management Information System (HMIS) Bed Coverage

Instructions:

HMIS bed coverage measures the level of participation in a CoC's HMIS. It is calculated by dividing the total number of year-round non-DV HMIS-participating beds available in the CoC by the total number of year-round non-DV beds available in the CoC. Participation in HMIS is defined as collection and reporting of client level data either through direct data entry into the HMIS or into an analytical database that includes HMIS data at least annually.

HMIS bed coverage is calculated by dividing the total number of year-round non-DV HMIS-participating beds in each housing type by the total number of non-DV beds available in each program type. For example, the bed coverage rate for Emergency Shelters (ES) is equal to the total number of year-round, non-DV HMIS-participating ES beds divided by the total number of non-DV ES beds available in the CoC. CoCs can review or assess HMIS bed coverage by calculating their rate monthly, quarterly, semiannually, annually, or never. CoCs are considered to have low bed coverage rates if they only have a rate of 0-64% among any one of the housing types. CoCs that have a housing type with a low bed coverage rate should describe the CoCs plan to increase bed coverage in the next 12-months in the space provided.

The 2005 Violence Against Women Act (VAWA) Reauthorization bill restricts domestic violence provider participation in HMIS unless and until HUD completes a public notice and comment process. Until the notice and comment process is completed, HUD does not require nor expect domestic violence providers to participate in HMIS. HMIS bed coverage rates are calculated excluding domestic violence provider beds from the universe of potential beds.

Indicate the HMIS bed coverage rate (%) for each housing type within the CoC. If a particular housing type does not exist anywhere within the CoC, select "Housing type does not exist in CoC" from the drop-down menu.

* Emergency Shelter (ES) Beds	86%+
* Safe Haven (SH) Beds	86%+
* Transitional Housing (TH) Beds	86%+
* Permanent Housing (PH) Beds	86%+

How often does the CoC review or assess its HMIS bed coverage? Quarterly

If bed coverage is 0-64%, describe the CoC's plan to increase this percentage during the next 12 months:

NA

2E. Homeless Management Information System (HMIS) Data Quality

Instructions:

Enter the percentage of missing or unknown records AND the percentage of records where the value is "refused" or unknown ("don't know") for each Universal Data Element listed below. Universal Data Elements are information fields that HUD requires all homeless service providers participating in a local HMIS to collect on all homeless clients seeking housing and/or services. They include personal identifying information as well as information on a client's demographic characteristics and recent residential history. The elements target data that are essential to the administration of local homeless assistance programs as well as obtaining an accurate picture of the extent, characteristics and the patterns of service use of the local homeless population.

Where the collection of Social Security Numbers is not authorized by law, failure to collect this data element will not competitively disadvantage an application. Additionally, in lieu of the actual SSN, the response categories of "Don't Know" and "Refused" are considered valid response categories, per the HMIS Data and Technical Standards.

For additional instructions, refer to the detailed instructions available on the left menu bar.

Indicate the percentage of unduplicated client records with null or missing values on a day during the last ten days of January 2009.

Universal Data Element	Records with no values (%)	Records where value is refused or unknown (%)
* Social Security Number	14%	13%
* Date of Birth	12%	0%
* Ethnicity	14%	0%
* Race	15%	0%
* Gender	13%	0%
* Veteran Status	22%	4%
* Disabling Condition	57%	1%
* Residence Prior to Program Entry	36%	2%
* Zip Code of Last Permanent Address	37%	11%
* Name	0%	0%

Instructions:

The Annual Homeless Assessment Report (AHAR) is a national report to Congress on the extent and nature of homelessness in America. The AHAR uses data from Homeless Management Information Systems (HMIS) to estimate the number and characteristics of people who use homeless residential services and their patterns of service use. The data collection period for AHAR 4 began on October 1, 2007 and ended on September 30, 2008. Communities must have had a minimum bed coverage rate of 65 percent throughout the entire reporting period in two or more reporting categories; i.e., emergency shelters for individuals (ES-IND), emergency shelters for families (ES-FAM), transitional housing for individuals (TH-IND), and transitional housing for families (TH-FAM) to be eligible to participate in AHAR 4.

Did the CoC or subset of CoC participate in AHAR 4? Yes

Did the CoC or subset of CoC participate in AHAR 5? Yes

How frequently does the CoC review the quality of client level data? Monthly

How frequently does the CoC review the quality of program level data? Quarterly

Describe the process, extent of assistance, and tools used to improve data quality for agencies participating in the HMIS (limit 750 characters):

Agencies have the ability and have been trained to run reports that identify data completeness and quality issues and are expected to do so on a monthly basis. Also, we hold frequent user group meetings and trainings where data quality issues and procedures are discussed. HMIS staff members also regularly run data quality reports and work closely with agencies to remedy identified data issues.

We have recently redesigned the data entry screens to make it easier for users to know which data elements are required for which clients.

Describe the existing policies and procedures used to ensure that valid program entry and exit dates are recorded in the HMIS (limit 750 characters):

Users have been trained with an emphasis on recording valid program entry and exit dates and will be trained in reporting methods to track the entry of those dates. We have developed report programs that allow us to monitor program dates at the continuum level. We are exploring ways to use these reports in conjunction with bed utilization tools such as HUDs tool or the ShelterPoint feature of ServicePoint.

2F. Homeless Management Information System (HMIS) Data Usage

Instructions:

HMIS can be used for a variety of activities. These include, but are not limited to:

- Data integration/data warehousing to generate unduplicated counts; Involves assembling HMIS data from multiple data collection systems into a single system in order to de-duplicate client records.
- Use of HMIS for point-in-time count of sheltered persons
- Use of HMIS for point-in-time count of unsheltered persons
- Use of HMIS for performance measurement; Using HMIS to evaluate program or system-level performance, focusing on client-level outcomes, or measurable changes in the well-being of homeless clients.
- Use of HMIS for program management; Using HMIS data for grant administration, reporting, staff supervision, or to manage other program activities.
- Integration of HMIS data with mainstream system; Merging HMIS data with data from other mainstream systems, such as welfare, foster care, educational, or correctional systems.

Indicate the frequency in which each of the following activities is completed:

- Data integration/data warehousing to generate unduplicated counts:** Never
- Use of HMIS for point-in-time count of sheltered persons:** Monthly
- Use of HMIS for point-in-time count of unsheltered persons:** Never
- Use of HMIS for performance assessment:** Annually
- Use of HMIS for program management:** Annually
- Integration of HMIS data with mainstream system:** Never

2G. Homeless Management Information System (HMIS) Data and Technical Standards

Instructions:

- For each item, indicate whether the activity is completed monthly, quarterly (once each quarter), semiannually (two times per year), annually (every year), or never.
- Unique user name and password: CoC assesses that system user name and password protocols are followed and meet HMIS technical standards.
 - Secure location for equipment: CoC manages physical access to systems with access to HMIS data in compliance with HMIS technical standards.
 - Locking screen savers: CoC makes HMIS workstations and HMIS software automatically turn on password-protected screen savers when a workstation is temporarily not in use.
 - Virus protection with auto update: CoC protects HMIS systems from viruses by using virus protection software that regularly updates virus definitions from the software vendor.
 - Individual or network firewalls: CoC protects systems from malicious intrusion behind a secure firewall.
 - Restrictions on access to HMIS via public forums: CoC allows secure connections to HMIS data only through PKI certificate or IP filtering as defined in the HMIS technical standards.
 - Compliance with HMIS Policy and Procedures manual: CoC ensures HMIS users are in compliance with community-defined policies and protocols for HMIS use.
 - Validation of off-site storage of HMIS data: CoC validates that off-site storage of HMIS data is secure.

Indicate the frequency in which the CoC or HMIS Lead completes a compliance assessment for each of the following HMIS privacy and security standards:

* Unique user name and password	Quarterly
* Secure location for equipment	Annually
* Locking screen savers	Annually
* Virus protection with auto update	Annually
* Individual or network firewalls	Annually
* Restrictions on access to HMIS via public forums	Annually
* Compliance with HMIS Policy and Procedures manual	Quarterly
* Validation of off-site storage of HMIS data	Annually

How often does the CoC assess compliance with HMIS Data and Technical Standards? Monthly

How often does the CoC aggregate data to a central location (HMIS database or analytical database)? Never

Does the CoC have an HMIS Policy and Procedures manual? Yes

If 'Yes' indicate date of last review or update by CoC: 11/04/2009

If 'No' indicate when development of manual will be completed (mm/dd/yyyy):

2H. Homeless Management Information System (HMIS) Training

Instructions:

An important component of a functioning HMIS is providing comprehensive training to homeless assistance providers that are participating in the HMIS. In the section below, indicate the frequency in which the CoC and/or HMIS Lead Agency offers each of the following training activities:

- Privacy/Ethics training: Training to homeless assistance program staff on established community protocols for ethical collection of client data and privacy protections required to manage clients' PPI (protected personal information).
- Data Security training: Training to homeless assistance program staff on established community protocols for user authentication, virus protection, firewall security, disaster protection, and controlled access to HMIS.
- Using HMIS data locally: Training on use of HMIS data to understand the local extent and scope of homelessness.
- Using HMIS data for assessing program performance: Training on use of HMIS to systematically evaluate the efforts programs are making to address homelessness.
- Basic computer skills training: Training on computer foundation skills such as mouse and keyboard functions, web searching, document saving, and printing.
- HMIS software training: Training on use and functionality of HMIS software including adding new clients, updating client data, running reports, and managing client cases.

Indicate the frequency in which the CoC or HMIS Lead Agency offers each of the following training activities:

Privacy/Ethics training	Quarterly
Data Security training	Quarterly
Data Quality training	Quarterly
Using HMIS data locally	Annually
Using HMIS data for assessing program performance	Annually
Basic computer skills training	Never
HMIS software training	Quarterly

2I. Continuum of Care (CoC) Point-in-Time Homeless Population

Instructions:

This section must be completed using statistically reliable, unduplicated counts or estimates of homeless persons in sheltered and unsheltered locations on a single night. Because 2009 was a required point-in-time count year, CoCs were required to conduct a one day, point-in-time count during the last 10 days of January--January 22nd to 31st. Although point-in-time counts are only required every other year, HUD requests that CoCs conduct a count annually if resources allow. Data entered in this chart must reflect a point-in-time count that took place during the last 10 days of January 2009, unless a waiver was received by HUD.

Additional instructions on conducting the point-in-time count can be found in the detailed instructions, located on the left hand menu.

Indicate the date of the most recent point-in-time count (mm/dd/yyyy): 01/22/2009

For each homeless population category, the number of households must be less than or equal to the number of persons.

Households with Dependent Children				
	Sheltered		Unsheltered	Total
	Emergency	Transitional		
Number of Households	28	154	4	186
Number of Persons (adults and children)	90	473	15	578
Households without Dependent Children				
	Sheltered		Unsheltered	Total
	Emergency	Transitional		
Number of Households	333	132	140	605
Number of Persons (adults and unaccompanied youth)	336	135	141	612
All Households/ All Persons				
	Sheltered		Unsheltered	Total
	Emergency	Transitional		
Total Households	361	286	144	791
Total Persons	426	608	156	1,190

2J. Continuum of Care (CoC) Point-in-Time Homeless Subpopulations

Instructions:

Enter the number of sheltered and unsheltered adults who belong in each subpopulation category. As in the Homeless Populations chart, this chart must be completed using statistically reliable and unduplicated counts or estimates of homeless persons based on the point-in-time count conducted during the last ten days of January 2009. Only adults should be included in the counts for this chart, except for the Unaccompanied Youth (those under age 18) category. Subpopulation data is required for sheltered persons and optional for unsheltered persons, with the exception of Chronically Homeless.

	Sheltered	Unsheltered	Total
* Chronically Homeless (Federal definition)	159	67	226
* Severely Mentally Ill	132	41	173
* Chronic Substance Abuse	175	58	233
* Veterans	90	25	115
* Persons with HIV/AIDS	7	2	9
* Victims of Domestic Violence	245	10	255
* Unaccompanied Youth (under 18)	6	0	6

2K. Continuum of Care (CoC) Sheltered Homeless Population & Subpopulation: Point-In-Time (PIT) Count

Instructions:

CoCs are only required to conduct a one-day point-in-time count every two years (biennially) however, HUD strongly encourages CoCs to conduct an annual point-in-time count, if resources allow. Below, select the time period that corresponds with how frequently the CoC plans to conduct a point-in-time count:

- biennially (every other year);
- annually (every year);
- semi-annually (twice a year); or
- quarterly (once each quarter).

CoCs will separately calculate and enter the percentage of emergency shelter and transitional housing providers that provided data for the Homeless Population and Subpopulation charts. For example, if 9 out of 12 transitional housing programs provided point-in-time data, enter 75%. If all providers for a program type contributed data, enter 100%.

How frequently does the CoC conduct a point-in-time count? Biennially

Enter the date in which the CoC plans to conduct its next point-in-time count: (mm/dd/yyyy) 01/27/2011

Indicate the percentage of homeless service providers supplying population and subpopulation data that was collected via survey, interview, and/or HMIS.

Emergency shelter providers: 100%

Transitional housing providers: 100%

2L. Continuum of Care (CoC) Sheltered Homeless Population and Subpopulation: Methods

Instructions:

CoCs may use one or more methods to count sheltered homeless persons. Indicate the method(s) used to gather and calculate population data on sheltered homeless persons. Check all applicable methods:

- Survey Providers; Providers counted the total number of clients residing in each program on the night designated as the point-in-time count.
- HMIS; The CoC used HMIS to complete the point-in-time sheltered count.
- Extrapolation; The CoC used extrapolation techniques to estimate the number and characteristics of sheltered homeless persons from data gathered at emergency shelters and transitional housing programs. CoCs that use extrapolation techniques are strongly encourage to use the HUD General Extrapolation worksheet.

Indicate the method(s) used to count sheltered homeless persons during the last point-in-time count:
(Select all that apply):

Survey Providers:	<input checked="" type="checkbox"/>
HMIS:	<input checked="" type="checkbox"/>
Extrapolation:	<input type="checkbox"/>
Other:	<input type="checkbox"/>

If Other, specify:

NA

Describe how the data on the sheltered homeless population, as reported on 2I, was collected and the sheltered count produced (limit 1500 characters):

The Alliance sent a survey and instructions to each homeless housing provider requesting point-in-time information on beds, persons in the beds, and the characteristics needed to complete HUD's subpopulation chart. The Alliance collected and tabulated the information. We provide training to all providers on the survey, and we follow up to ensure accuracy. We also compare survey results with HMIS reports and reconcile any discrepancies, program by program.

Comparing the 2009 point-in-time count to the previous point-in-time count (2008 or 2007), describe any factors that may have resulted in an increase, decline, or no change in the sheltered population count (limit 1500 characters):

The numbers from our Sheltered Homeless counts in 2007 and 2009 are remarkably similar. Compared to 1,069 sheltered homeless reported in 2007, the 2009 total dropped only 35 persons, or 3.3%.

In 2007 we had 305 sheltered households with children. In 2009 we had 182 sheltered households with children, a 40% decrease in households. There may be a number of reasons for this. Prevention services across the Continuum are being better coordinated, and reducing family homelessness has become a priority for the Continuum. Another factor may be the increasing priority that Permanent Supportive housing has become, taking families out of the transitional shelter system and into a more permanent solution ending their experience of homelessness.

There was a rise of 42 sheltered homeless individuals (10%) between the two counts. Most of this rise was within transitional housing. This is further evidence of a trend toward smaller household sizes being served within our transitional housing programs.

2M. Continuum of Care (CoC) Sheltered Homeless Population and Subpopulation Data

Instructions:

Check all methods used by the CoC to produce the sheltered subpopulations data reported in the subpopulation table.

- HMIS: The CoC used HMIS to gather subpopulation information on sheltered homeless persons without extrapolating for any missing data.
- HMIS data plus extrapolation: The CoC used HMIS data and extrapolation techniques to estimate the number and subpopulation characteristics of sheltered homeless persons in the CoC. Extrapolation techniques accounted for missing HMIS data and the CoC completed HUD's Extrapolation Tool.
- Sample of PIT interviews plus extrapolation: The CoC conducted interviews with a random or stratified sample of sheltered homeless adults and unaccompanied youth to gather subpopulation information. The results from the interviews were extrapolated to the entire sheltered homeless population to provide statistically reliable subpopulation estimates for all sheltered persons. CoCs that made this selection are encourage to used the applicable HUD Sample Strategy tool.
- Interviews: The CoC conducted interviews with every homeless person staying in an emergency shelter or transitional housing program on the night designated for the point-in-time count.
- Non-HMIS client level information: Providers used individual client records (e.g., case management files) to provide the CoC with subpopulation data for each adult and unaccompanied youth living in a sheltered program on the night designated for the point-in-time count.

Additional instructions on this section can be found in the detailed instructions, located on the left hand menu. Also, for more information about any of the techniques listed above, see: [A Guide for Counting Sheltered Homeless People](http://www.hudhre.info/documents/counting_sheltered.pdf) at http://www.hudhre.info/documents/counting_sheltered.pdf.

Indicate the method(s) used to gather and calculate subpopulation data on sheltered homeless persons (select all that apply):

HMIS	X
HMIS plus extrapolation:	
Sample of PIT interviews plus extrapolation:	
Sample strategy:	
Provider expertise:	
Non-HMIS client level information:	X
None:	
Other:	

If Other, specify:

NA

Describe how data on sheltered subpopulations, as reported on 2J, was collected and the subpopulation data produced (limit 1500 characters):

The Alliance sends a survey and instructions to each homeless housing provider requesting point-in-time information on beds, persons in the beds, and the characteristics needed to complete HUD's subpopulation chart. The Alliance collects and tabulates the information. We provide training to all providers on the survey, and we follow up to ensure accuracy. We also compare survey results with HMIS reports, reconciling any discrepancies, program by program.

Comparing the 2009 point-in-time count to the previous point-in-time count (2008 or 2007), describe any factors that may have resulted in an increase, decline, or no change in the sheltered subpopulations data. Response should address changes in all sheltered subpopulation data (limit 1500 characters):

When comparing 2009 with 2007 sheltered data we see a significant rise reported in four of the subpopulations. Veterans increased by 31 individuals, a 53% increase over 2007. Chronic Substance Abuse increased by 45 individuals (35%). Severely Mentally Ill increased by 27 (26%), and Chronically Homeless increased by 18 (13%). The rise of these subpopulations may be largely due to the economic recession the country has experienced. The higher stress placed on families and individuals can lead to increased substance abuse or mental illness. Current US military activity abroad may be contributing to the increase in sheltered homeless veterans. Notably, the number of unsheltered persons with severe mental illness, chronic substance abuse, and the veteran subpopulations went down slightly, implying these subpopulations are finding their way to shelter at a greater rate. There was a slight 2% decline in victims of domestic violence within our sheltered count, which is not surprising due to the significant decrease in homeless families reported in 2009. Finally, a 91% decrease in unaccompanied youth under the age of 18 may be due to a definition mix-up in 2007. Many of our Youth Shelters may have understood homeless youth to be under 20 or 24 because of State program definitions. Many shelters designated as Youth Shelters under these definitions are serving 18-20 year olds. This year's data was recorded for only those unaccompanied youth under 18.

2N. Continuum of Care (CoC) Sheltered Homeless Population and Subpopulation: Data Quality

Instructions:

CoCs often undertake a variety of steps to improve the quality of the sheltered population and subpopulation data. These include, but are not limited to:

- Instructions: The CoC provided written instructions to providers to explain protocol for completing the sheltered PIT count.
- Training: The CoC trained providers on the protocol and data collection forms used to complete the sheltered PIT count.
- Remind/Follow-up: The CoC reminded providers about the count and followed up with providers to ensure the maximum possible response rate from all programs.
- HMIS: The CoC used HMIS to verify data collected from providers for the sheltered count.
- Non-HMIS De-duplication techniques: The CoC used strategies to ensure that each sheltered and unsheltered homeless person was not counted more than once during the point in time count. The non-HMIS de-duplication techniques must be explained in the box below.

CoCs that select "Non-HMIS de-duplication techniques" must describe the techniques used. De-duplication is the process by which information on the same homeless clients within a program or across several programs is combined into unique records.

**Indicate the steps used by the CoC to ensure the data quality of the sheltered persons count:
 (select all that apply)**

Instructions:	<input checked="" type="checkbox"/>
Training:	<input checked="" type="checkbox"/>
Remind/Follow-up	<input checked="" type="checkbox"/>
HMIS:	<input checked="" type="checkbox"/>
Non-HMIS de-duplication techniques:	<input type="checkbox"/>
None:	<input type="checkbox"/>
Other:	<input type="checkbox"/>

If Other, specify:

NA

Describe the non-HMIS de-duplication techniques, if selected (limit 1000 characters):

NA

20. Continuum of Care (CoC) Unsheltered Homeless Population and Subpopulation: Methods

Instructions:

CoCs can use a number of methodologies to count unsheltered homeless persons. These include, but are not limited to:

- Public places count: The CoC conducted a point-in-time count based on observation of unsheltered homeless persons, but without interviews.
- Public places count with interviews: The CoC conducted a point-in-time count and either interviewed all unsheltered homeless persons encountered during the public places count or a sample of these individuals.
- Service-based count: The CoC interviewed people using non-shelter services, such as soup kitchens and drop-in centers, screened for homelessness, and counted those that self-identified as unsheltered homeless persons. In order to obtain an unduplicated count, every person interviewed in a service-based count must be asked where they were sleeping on the night of the last point-in-time count.
- HMIS: The CoC used HMIS in some way to collect, analyze, or report data on unsheltered homeless persons. For example, the CoC entered respondent information into HMIS in an effort to check personal identifying information to de-duplicate and ensure persons were not counted twice.

For more information on any of these methods, see *A Guide to Counting Unsheltered Homeless People* at: http://www.hudhre.info/documents/counting_unsheltered.pdf.

Indicate the method(s) used to count unsheltered homeless persons: (select all that apply)

Public places count:	<input type="checkbox"/>
Public places count with interviews:	<input checked="" type="checkbox"/>
Service-based count:	<input checked="" type="checkbox"/>
HMIS:	<input type="checkbox"/>
Other:	<input type="checkbox"/>

If Other, specify:

NA

2P. Continuum of Care (CoC) Unsheltered Homeless Population and Subpopulation - Level of Coverage

Instructions:

Depending on a number of factors, the level of coverage for a count of unsheltered persons may vary from place to place. Below, indicate which level of coverage best applies to the count of unsheltered homeless persons in the CoC.

¿ Complete coverage means that every part of a specified geography, such as an entire city or a downtown area, every street is canvassed by enumerators looking for homeless people and counting anyone who is found.

¿ Known locations means counting in areas where unsheltered homeless people are known to congregate or live.

¿ A combined approach merges complete coverage with known locations by counting every block in a portion of the jurisdiction (e.g. central city) AND conducting counts in other areas of the jurisdiction where unsheltered persons are known to live or congregate.

Indicate the level of coverage of unsheltered homeless persons in the point-in-time count: Complete Coverage and Known Locations

If Other, specify:

NA

2Q. Continuum of Care (CoC) Unsheltered Homeless Population and Subpopulation - Data Quality

Instructions:

CoCs may undertake one or more methods to improve data quality of the unsheltered population and subpopulation data, as reported on 2I and 2J, respectively. Check all steps that the CoC has taken to ensure data quality:

- Training: The CoC conducted trainings(s) for point-in-time enumerators or CoC staff.
- HMIS: The CoC used HMIS to check for duplicate entries or for some other purpose.
- De-duplication techniques: The CoC used strategies to ensure that each unsheltered homeless person was not counted more than once during the point-in-time count.

All CoCs should have a strategy for reducing the occurrence of counting persons more than once during a point-in-time count, also known as de-duplication. De-duplication techniques should always be implemented when the point-in-time count extends beyond one night or takes place during the day at service locations used by homeless people that may or may not use shelters.

For more information on de-duplication and other techniques used to improve data quality, see [¿A Guide for Counting Unsheltered Homeless People¿](http://www.hudhre.info/documents/counting_unsheltered.pdf) at: www.hudhre.info/documents/counting_unsheltered.pdf.

Indicate the steps used by the CoC to ensure the data quality of the unsheltered persons count. (select all that apply)

Training:	X
HMIS:	
De-duplication techniques:	X
Other:	

If Other, specify:

NA

Describe the techniques used by the CoC to reduce duplication, otherwise known as de-duplication (limit 1500 characters):

Date of birth, gender and race are collected and compared to eliminate duplicates within the unsheltered data.

Describe the CoCs efforts to reduce the number of unsheltered homeless household with dependent children. Discussion should include the CoCs outreach plan (limit 1500 characters):

The Alliance identified four families with children through its unsheltered count in 2009, representing 15 persons. These vulnerable families were of great concern to the Alliance, as this represented slightly more persons in families than identified in previous counts. The 2007 count identified 4 unsheltered families with 14 persons. The 2005 count identified no unsheltered families. Four families is still a small enough number that our approach remains to address the needs of these families on a case by case basis. The creation of a homelessness prevention call center, expected to launch in November 2009, will help prevent the homelessness of more families in suburban Cook County.

Describe the CoCs efforts to identify and engage persons that routinely sleep on the streets or other places not meant for human habitation (limit 1500 characters):

Emergency shelter providers use the knowledge of their current shelter guests and their case management team to identify and engage unsheltered homeless individuals. Agencies that serve community dinners use them as an opportunity to engage people who sleep in forest preserves and other unsheltered locations into services.

The Alliance significantly improved the methodology and coverage of its 2009 unsheltered count. We included more consumer participation in count design and implementation, which increased our knowledge of potential unsheltered locations and informed our approach to interviewing unsheltered homeless people. Alliance staff conducted six (6) focus groups with currently homeless shelter guests and recently homeless consumers in advance of the count to identify potential locations of unsheltered persons, as well as glean other helpful information on survey design and approach. Volunteers on the night of the count handed out gift bags to unsheltered homeless people, providing some basic necessities and a resource guide of available services nearby.

Comparing the 2009 point-in-time count to the previous point-in-time count (2008 or 2007), describe any factors that may have resulted in an increase, decline, or no change in the unsheltered population data (limit 1500 characters):

The numbers between the 2007 and 2009 unsheltered counts were quite similar. There was a decrease in total unsheltered persons by 12 people (7%). We noted slight decreases within the unsheltered subpopulations of Severe Mental Illness, Chronic Substance Abuse and Veterans, with a corresponding significant increase in these subpopulations within the sheltered count. So even though our capacity to serve these subpopulations increased, only slight differences resulted in those unsheltered subpopulations, indicating there are more people in need of those services overall.

We took substantial steps forward in our count methodology in 2009, seeking outside technical assistance from Abt Associates, nearly doubling our volunteer base, incorporating more consumer participation in count design and implementation, and expanding our service-based methodology with a mailing to over 3000 churches, schools, libraries, food pantries and other service sites. The service site survey asked where the identified homeless person or family slept on the night of the count and enough identifying information to de-duplicate. The numbers for 2009 are therefore that much more complete and statistically reliable.

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 1: Create new permanent housing beds for chronically homeless individuals.

Instructions:

Ending chronic homelessness is a HUD priority. CoCs can work towards accomplishing this by creating new beds for the chronically homeless. Describe the CoCs short-term and long-term plan for creating new permanent housing beds for the chronically homeless. For additional instructions, refer to the detailed instructions available on the left menu bar.

In the next 12-months, what steps will the CoC take to create new permanent housing beds for the chronically homeless (limit 1000 characters)?

- Implementation of the 2008 and 2009 bonus projects will create 38 PH beds for chronically homeless individuals, 13 by Catholic Charities and 25 by Pillars, within 2010.
- The Project Review and Prioritization Committee will continue to weight project rankings in favor of those that serve chronically homeless individuals.
- We will connect Alliance members to the Corporation for Supportive Housing (CSH)-sponsored Supportive Housing Institute for permanent supportive housing development training and technical assistance. Five Alliance-affiliated teams have completed this training. Two project concepts represented by recently graduated teams include: PSH for homeless individuals and families in the south suburbs (100 units) and PSH for adults with mental illness in the northwest suburbs (15 units).

Describe the CoC plan for creating new permanent housing beds for the chronically homeless over the next ten years (limit 1000 characters)?

- Our Community Plan to End Homelessness in Suburban Cook County plans creation of 20 PH beds for chronically homeless individuals per year for the next five years. Twenty-nine (29) of the 164 PSH beds we expect to create in suburban Cook County within 2009 will be targeted to chronically homeless individuals, with at least 15 more to be created in early 2010. We calculate an unmet need for 100 CH beds out of the 467 needed additional PH beds. Twenty (20) CH beds annually for the next five years will meet this need.
- The Alliance and its partners will use the Neighborhood Stabilization Program (NSP) to expand PSH by redeveloping foreclosed housing. Two Alliance-affiliated projects will receive nearly \$10 million in state NSP funding and \$1.5 million in Cook County NSP funding to develop 20-35 units of rental housing to come online in 2011, including 6-10 units of PH for chronically homeless.

How many permanent housing beds do you currently have in place for chronically homeless persons? 61

How many permanent housing beds do you plan to create in the next 12-months? 20

How many permanent housing beds do you plan to create in the next 5-years? 100

How many permanent housing beds do you plan to create in the next 10-years? 150

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 2: Increase percentage of homeless persons staying in permanent housing over 6 months to at least 77 percent.

Instructions:

Increasing the self-sufficiency and stability of homeless participants is an important outcome measurement of HUD's homeless assistance programs. Describe the CoCs short-term and long-term plan for increasing the percentage of homeless persons staying in permanent housing over 6 months to at least 77 percent. For additional instructions, refer to the detailed instructions available on the left menu bar.

In the next 12-months, what steps will the CoC take to increase the percentage of homeless persons remaining in permanent housing for at least six months to at least 77 percent? If the CoC has already reached this threshold, describe how it will be exceeded or maintained (limit 1000 characters)?

- The Alliance will continue to coordinate training about Housing First, harm reduction, motivational interviewing, tenant leadership, and other evidence-based practices to people with serious mental illness and co-occurring disorders in an effort to sustain our PH housing tenure at over 77 percent. The 2009 Outcome Evaluation Committee final report recommends and commits to assist in convening four of these best practice trainings in the next 12 months.
- This year the Outcome Evaluation Tool will be formally incorporated into the Project Review and Prioritization process to ensure more inclusive eligibility criteria for admission to PSH.
- We will continue to weight project rankings in favor of achieving longer tenure in permanent supportive housing.

Describe the CoC's long-term plan to increase the percentage of homeless persons remaining in permanent housing for at least six months to at least 77 percent? CoCs response should include how it will continue to work towards meeting and exceeding this objective (limit 1000 characters).

- The Alliance values and rewards a Housing First approach where projects do not screen out more difficult-to-house homeless individuals and families. We will make use of the HMIS self-sufficiency matrix capabilities to monitor projects' emphasis on client progress while in permanent supportive housing.
- The Alliance will use the Outcome Evaluation and HMIS data it collected in 2008 and 2009 to educate member agencies on their housing tenure and other program outcome results and how they compare to best-practice standards. The Outcome Evaluation tool will reward highly inclusive eligibility criteria over restrictive eligibility criteria.
- The Alliance will continue its work with Illinois' Supportive Housing Providers Association to advocate for a higher state funding appropriation for supportive services in PSH.

What percentage of homeless persons in permanent housing have remained for at least six months? 81

- In 12-months, what percentage of homeless persons in permanent housing will have remained for at least six months?** 81
- In 5-years, what percentage of homeless persons in permanent housing will have remained for at least six months?** 83
- In 10-years, what percentage of homeless persons in permanent housing will have remained for at least six months?** 85

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 3: Increase percentage of homeless persons moving from transitional housing to permanent housing to at least 65 percent.

Instructions:

The ultimate objective of homeless assistance is to achieve the outcome of helping homeless families and individuals obtain permanent housing and self-sufficiency. Describe the CoC's short-term and long-term plan to increase the percentage of homeless persons moving from transitional housing to permanent housing to at least 65 percent. For additional instructions, refer to the detailed instructions available on the left menu bar.

In the next 12-months, what steps will the CoC take to increase the percentage of homeless persons moving from transitional housing to permanent housing to at least 65 percent? If the CoC has already reached this threshold, describe how it will be exceeded or maintained (limit 1000 characters)?

- The Alliance will continue efforts to increase the stock of affordable housing for persons earning 30% area median income or below through deeper income targeting within the HOME, tax credit, and state housing trust fund programs in an effort to sustain our regional percentage of persons moving from transitional housing to PH at over 65 percent.
- The Alliance will promote training (such as SOARS) about increasing non-employment income supports that TH residents need to transition successfully into permanent housing. Training topics will include improving access to food stamps, Medicaid, utility assistance and rebates, and childcare assistance.
- The Alliance will promote the use of two new housing search tools, ILhousingsearch.org and direct2housing.org, which both emphasize affordable and supportive housing listings.
- Our Outcome Evaluation tool will incentivize projects to conduct assertive follow-up with transitional housing graduates for at least six months.

Describe the CoC's long-term plan to increase the percentage of homeless persons moving from transitional housing to permanent housing to at least 65 percent? CoCs response should include how it will continue to work towards meeting and exceeding this objective (limit 1000 characters).

- The Alliance will continue to coordinate training about Housing First, harm reduction, motivational interviewing, tenant leadership, and other evidence-based practices in an effort to sustain our regional percentage of transitional housing residents moving to PH at over 65 percent.
- The Alliance will use the Outcome Evaluation and HMIS data it collected in 2008 and 2009 to educate member agencies on their program outcome results and how they compare to best-practice standards.
- The Alliance values and rewards a Housing First approach where projects do not screen out more difficult-to-house homeless people. We will make use of the HMIS self-sufficiency matrix capabilities to monitor projects' emphasis on client progress while in transitional housing.
- In conjunction with Illinois advocacy groups, Alliance members will call for more affordable housing, deeper income targeting of affordable housing, and better funding of services within housing in Illinois.

What percentage of homeless persons in transitional housing have moved to permanent housing? 72

In 12-months, what percentage of homeless persons in transitional housing will have moved to permanent housing? 73

In 5-years, what percentage of homeless persons in transitional housing will have moved to permanent housing? 75

In 10-years, what percentage of homeless persons in transitional housing will have moved to permanent housing? 77

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 4: Increase percentage of persons employed at program exit to at least 20 percent.

Instructions:

Employment is a critical step for homeless persons to achieve greater self-sufficiency, which represents an important outcome that is reflected both in participants' lives and the health of the community. Describe the CoCs short-term and long-term plans for increasing the percentage of persons employed at program exit to at least 20 percent. For additional instructions, refer to the detailed instructions available on the left menu bar.

In the next 12-months, what steps will the CoC take to increase the percentage of persons employed at program exit to at least 20 percent? If the CoC has already reached this threshold, describe how it will be exceeded or maintained (limit 1000 characters)?

- The Alliance will continue to connect its member agencies to the Cook County workforce boards and One-Stop Centers, the Career Advancement Network, the Chicago Jobs Council 5-week training for job developers and supported employment program implementation, and other resources to enhance the employment options for project residents and sustain our regional percentage of homeless persons employed at over 20 percent.
- Transportation to jobs can be a significant barrier in suburban Cook County, and so we will continue to connect member agencies to resources like the PACE (the suburban transit agency) program to offer decommissioned vans to get program residents to jobs, the Illinois Department of Transportation (IDOT) vehicle donation program, and other vehicle and transportation services.

Describe the CoC's long-term plan to increase the percentage of persons employed at program exit to at least 20 percent. CoCs response should include how it will continue to work towards meeting and exceeding this objective (limit 1000 characters).

- We expect that with the difficult economy, employment outcomes may worsen before getting better. The Alliance will connect its member agencies to vocational training resources to prepare program residents to perform work that will be viable in the coming economy.
- The Alliance will continue to coordinate training about Housing First, harm reduction, motivational interviewing, tenant leadership, and other evidence-based practices in an effort to sustain our regional percentage of homeless persons employed at exit at 20 percent or higher.
- The Alliance values and rewards a Housing First approach where projects do not screen out more difficult-to-house and employ homeless individuals and families. We will make use of the HMIS self-sufficiency matrix capabilities to monitor projects' emphasis on client progress while in supportive housing. We will weight project rankings in favor of highly inclusive eligibility criteria over restrictive eligibility criteria.

What percentage of persons are employed at program exit? 24

- In 12-months, what percentage of persons will be employed at program exit?** 20
- In 5-years, what percentage of persons will be employed at program exit?** 24
- In 10-years, what percentage of persons will be employed at program exit?** 28

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 5: Decrease the number of homeless households with children.

Instructions:

Ending homelessness among households with children is a HUD priority. CoCs can work towards accomplishing this by creating beds and/or increasing supportive services for this population. Describe the CoCs short-term and long-term plans for decreasing the number of homeless households with children. For additional instructions, refer to the detailed instructions available on the left menu bar.

In the next 12-months, what steps will the CoC take to decrease the number of homeless households with children (limit 1000 characters)?

- The Alliance will continue to provide technical assistance to Family TH programs that seek to convert to PH. Two TH family programs made this conversion in 2009, representing 9 new units and 35 beds of Family PH.
- We will continue to incentivize the creation of permanent supportive housing for families through reallocation within the NOFA. Two new Family PH programs were created in 2009 through reallocation, creating 10 new units and 34 beds of Family PH.
- We will use action steps related to employment and non-employment supports that are detailed in the previous sections, as well as promote the available resources to connect families to childcare assistance, including Head Start and the state's Childcare Initiative. The Illinois Department of Human Services (IDHS) offers a calculator online for low-income workers to determine their eligibility for this program. TANF recipients who participate in WorkFirst are automatically signed up for the Childcare Initiative.

Describe the CoC's long-term plan to decrease the number of homeless households with children (limit 1000 characters)?

- Our Community Plan to End Homelessness includes creation of one new permanent supportive housing program annually (20 beds each) for families for each of the next five years, through new development or through the conversion of existing transitional programs to permanent supportive housing. We calculate the current unmet need for permanent supportive housing for families to be an additional 52 units and 156 beds, which at a pace of 20 beds per year can be attained in eight (8) years.
- In conjunction with Illinois advocacy groups, Alliance members will continue to call for reinstatement of Illinois' \$11 million homelessness prevention program, which was substantially cut in 2009 due to the state fiscal crisis.
- We will continue to coordinate the Homelessness Prevention and Rapid Re-Housing Program (HPRP) to target the funding effectively to families and individuals who will benefit most from the program.

What is the current number of homeless households with children, as indicated on the Homeless Populations section (2I)? 186

In 12-months, what will be the total number of homeless households with children? 175

**In 5-years, what will be the total number of
homeless households with children?** 150

**In 10-years, what will be the total number of
homeless households with children?** 120

3B. Continuum of Care (CoC) Discharge Planning

Instructions:

The McKinney-Vento Act requires that State and local governments have policies and protocols developed to ensure that persons being discharged from a publicly- funded institution or system of care are not discharged immediately into homelessness. To the maximum extent practicable, Continuums of Care should similarly have in place or be developing policies and protocols to ensure that discharged persons are not released directly onto the streets or into CoC funded homeless assistance programs. In the space provided, provide information on the policies and/or protocols that the CoC either has in place or is developing for each system of care, to ensure that persons are not routinely discharged into homelessness (this includes homeless shelters, the streets, or other homeless assistance housing programs). Response should address the following:

- ¿ What? Describe the policies that have been developed or are in the process of being developed.
- ¿ Where? Indicate where persons routinely go upon discharge from a publicly funded institution or system of care.
- ¿ Who? Identify the stakeholders or collaborating agencies.

Failure to respond to each of these questions will be considered unresponsive.

For each of the systems of care identified below, describe any policies and/or protocols that the CoC either has in place or is developing for each system of care, to ensure that persons are not routinely discharged into homelessness (this includes homeless shelters, the streets, or other homeless assistance housing programs) (limit 1500 characters).

Foster Care:

The Youth Housing Assistance Program of the Illinois Department of Children and Family Services (DCFS) provides housing advocacy and cash assistance to young people ages 18 to 21 emancipated from foster care. These youth have received services to prepare them for transitioning to adulthood. Therefore, the program attempts to discharge them to their own housing in the community they choose. Up to six months before emancipation, the youth applies to the program and is assigned a Housing Advocate who helps to find housing, create a budget, and link to other services. The program offers cash assistance for security deposit and move-in expenses up to \$800 (\$1,200 if parenting, pregnant or disabled) and a rental subsidy up to \$250 per month. Being homeless or at risk of homelessness is one of the program's eligibility factors. This formal protocol is understood and agreed to by the Alliance to End Homelessness in Suburban Cook County, youth service providers, and the DCFS Local Area Networks (LAN's) and Housing Advocates.

Health Care:

The Alliance co-convened the Countywide Discharge Planning Forum in July 2008 with 200 participants. The healthcare workgroup initiated at this forum identified two major priorities, (A) creating more respite beds for people leaving hospitals who might otherwise be homeless, and (B) advocating to ensure housing is added as an element of discharge planning for JCAHO accreditation. The Alliance has researched the JCAHO accreditation procedures, which address discharge planning protocols in general but do not address housing placement specifically as a part of discharge planning. Most homeless patients go to a shelter or a family or friend's house. Key members of the healthcare workgroup include representatives from private and public hospitals, representatives from housing, community health, and respite care providers, and representatives from the area CoCs.

In 2009, workgroup members collected existing discharge planning policies from both public and private hospitals in Cook County for discussion, and they reviewed hospital accreditation and memoranda of understanding that hospitals have established with social service agencies pertaining to discharge planning. The workgroup is working on a resource guide and model protocols to follow when a patient is homeless. Alliance members also work locally with hospital representatives to provide improved housing referral information for patients being discharged.

Mental Health:

The Illinois Department of Human Services, Division of Mental Health (IDHS/DMH), implements a "Continuity of Care Agreement" between State-Funded Inpatient Psychiatric Services (SFIPS) sites and community providers. The agreement cites the best practice not to discharge into homelessness; that SFIPS sites and provider agencies will work together to find appropriate housing that the individual is willing to accept; that if it is reasonably anticipated that housing will shortly be in place a SFIPS site may delay discharge to prevent homelessness; and if an individual is not housed at discharge, the clinical record must document the reasons. IDHS/DMH discharges persons to DMH-funded supportive housing, nursing and intermediate care facilities, board and care, Institutes for Mental Disease, and private residences. No person is discharged to McKinney-Vento funded programs.

This formal discharge protocol is understood and agreed to by the Alliance to End Homelessness in Suburban Cook County, mental health providers and local mental health institutions. Stakeholders include: DMH funded agencies, other social service agencies, family advocacy groups (NAMI), consumers, and the Alliance.

In the protocol, Sec. III talks of the responsibility to identify a provider for homeless persons; Sec. VII.A.5 says application for benefits is to be done; Sec. VIII.A.5 says discharge into homelessness is to be avoided.

Corrections:

The Placement Resource Unit (PRU) of the Illinois Department of Corrections (IDoC) provides caseworkers to identify services needed by detainees upon re-entry, including housing placement. Two PRU caseworkers and their supervisor are active participants in our Alliance.

The Illinois legislature passed a bill this year to reinstate Medicaid benefits upon release for all corrections detainees who had benefits at entry. The bill, to be enacted in 2012, will provide for staffing to assist detainees with Medicaid applications, and it will waive the state identification fee. IDoC is implementing an agreement with SSA to expedite Social Security Cards and SSI/SSDI benefit applications prior to release.

The Cook County Jail is upgrading its information system to track homelessness upon entry. The jail participates in research on the effectiveness of PSH for frequent jail and mental health users. The Sheriff's Re-entry Council studies ways to better integrate community agencies into the jail. This year, the jail hosted two resource fairs for the first time, bringing outside vendors into the jail to meet directly with selected detainees.

As required by the Federal Second Chance Act, IDoC, City of Chicago, and Cook County formed a statewide re-entry planning council which meets quarterly around four core re-entry issues. One product so far has been a statewide resource website at www.reentryillinois.net.

No person is discharged into McKinney-Vento funded programs.

3C. Continuum of Care (CoC) Coordination

Instructions:

A CoC should regularly assess the local homeless system and identify shortcomings and unmet needs. One of the keys to improving a CoC is to use long-term strategic planning to establish specific goals and then implement short-term/medium-term action steps. Because of the complexity of existing homeless systems and the need to coordinate multiple funding sources, there are often multiple long-term strategic planning groups. It is imperative for CoCs to coordinate, as appropriate, with each of these existing strategic planning groups to meet the local CoC shortcomings and unmet needs.

New in 2009, CoCs are expected to describe the CoC's level of involvement and coordination with HUD's American Recovery and Reinvestment Act of 2009 programs, such as the Homelessness Prevention and Rapid Re-housing Program (HPRP), the Community Development Block Grant-Recovery (CDBG-R), the Tax Credit Assistance Program and the Neighborhood Stabilization Program (NSP1 or NSP2). Finally, CoCs with jurisdictions that are receiving funds through the HUD-VASH initiative should describe coordination with this program as well. CoCs that include no jurisdictions receiving funds from any one of these programs, should indicate such in the text box provided.

Does the Consolidated Plan for the jurisdiction(s) that make up the CoC include the CoC strategic plan goals for addressing homelessness? Yes

If yes, list the goals in the CoC strategic plan that are included in the Consolidated Plan:

Cook County Consolidated Plan 2005-2009, Objective 2: End Homelessness in Suburban Cook County.
- Strategy 2A: Increase the Supply of Affordable Permanent Supportive Housing (Output: 20 new beds per year)
- Strategy 2B: Support the Shelter and Transitional Housing Systems and Encourage the Development of a Year-round Shelter System. (Output: 3,000 shelter nights per year)
- Strategy 2C: Increase the Effectiveness of Homeless Prevention Activities. (Output: 120 households assisted per year)
- Strategy 2D: Improve the Effectiveness of Continuum-wide Planning and Coordination. (Output: Continuum of Care serving 1,200 homeless persons)

Describe how the CoC is participating in or coordinating with the local Homeless Prevention and Rapid re-housing Program (HPRP) initiative, as indicated in the substantial amendment to the Consolidated Plan 2008 Action Plan (1500 character limit):

Four jurisdictions within our Continuum of Care geography received direct HPRP allocations: Cook County, Oak Park, Berwyn and Cicero. As proposed in its Substantial Amendment, Cook County completed a Request for Proposals and subsequently made direct allocations to the Alliance for Rapid Re-Housing and Data Collection and to 15 other organizations for Homelessness Prevention and related services. Cook County and the Alliance have jointly developed local targeting criteria and levels of assistance based on risk of homelessness. Oak Park, Berwyn and Cicero (three west suburban HPRP jurisdictions which are adjacent to each other) have worked together and with the Alliance to identify one nonprofit subgrantee per community to lead HPRP efforts for their respective communities. The Alliance is the lead HMIS agency for our Continuum of Care. Alliance staff is working with the HPRP jurisdictions and all nonprofit HPRP partners to complete customized HMIS data entry screens and reports for HPRP.

Describe how the CoC is participating in or coordinating with the local Neighborhood Stabilization Program (NSP) initiative, HUD VASH, and/or any HUD managed American Reinvestment and Recovery Act programs (2500 character limit)?

NSP: Two local NSP partnerships developed including Alliance member agencies seeking to create more permanent supportive housing for homeless people. The two partnerships have garnered \$10 million in state NSP and \$1.5 million in Cook County NSP and will bring 20-35 units of rental housing online in 2011, including 6-10 units for the chronically homeless.

VASH: Hines VA Hospital and the Housing Authority of the County of Cook (both active Alliance members) are implementing VASH vouchers together. The 70 Round 1 vouchers already in use have housed 15 families and 55 individuals, including 25 chronically homeless. Round 2 will add 35 more vouchers.

CDBG-R: In its CDBG-R Substantial Amendment, Cook County included \$50,000 for Homeless Facility Improvements to improve a shelter operated by an Alliance member agency.

TCAP: The Tax Credit Assistance Program and Tax Credit Exchange Program, to be administered by the Illinois Housing Development Authority (IHDA), were profiled in a recent statewide affordable housing conference, and our members that are working on tax credit project proposals are investigating the opportunity.

CSBG-ARRA: The Community Economic Development Association of Cook County (CEDA) is gearing up to administer the ARRA allocation of Community Services Block Grants (CSBG). These funds will support financial assistance and services to prevent homelessness. The Alliance and CEDA are comparing the geographic coverage of CSBG with HPRP to minimize gaps.

4A. Continuum of Care (CoC) 2008 Achievements

Instructions:

For the five HUD national objectives in the 2009 CoC application, enter the 12-month numeric achievements that you provided in Exhibit 1, Part 3A of the 2008 electronic CoC application. Enter this number in the first column, "Proposed 12-Month Achievement". Under "Actual 12-Month Achievement" enter the actual numeric achievement that your CoC attained within the past 12 months that is directly related to the national objective. CoCs that did not submit an Exhibit 1 application in 2008 should answer no to the question, "Did CoC submit an Exhibit 1 application in 2008?"

Objective	Proposed 12-Month Achievement (number of beds or percentage)		Actual 12-Month Achievement (number of beds or percentage)	
Create new permanent housing beds for the chronically homeless.	77	Beds	61	B e d s
Increase the percentage of homeless persons staying in permanent housing over 6 months to at least 71.5%.	80	%	81	%
Increase the percentage of homeless persons moving from transitional housing to permanent housing to at least 63.5%.	70	%	72	%
Increase percentage of homeless persons employed at exit to at least 19%	23	%	24	%
Decrease the number of homeless households with children.	300	Households	186	H o u s e h o l d s

Did CoC submit an Exhibit 1 application in 2008? Yes

For any of the HUD national objectives where the CoC did not meet the proposed 12-month achievement as indicated in 2008 Exhibit 1, provide explanation for obstacles or other challenges that prevented the CoC from meeting its goal:

The Alliance surpassed each of its goals except for the number of permanent housing beds for chronically homeless individuals. We planned to create 20 CH beds, which would have increased the total from 57 to 77 CH beds, but instead we increased the total to 61 beds at the time of the January 22, 2009 homeless count. When the Alliance learned we were not awarded a 2007 NOFA bonus project which would have come online in 2008, we redoubled our efforts to create more permanent supportive housing through project conversions and reallocation strategies. Since that time, two family projects have converted from transitional to permanent supportive housing, five new PSH projects were created through reallocation, and 70 VASH vouchers were implemented. We were awarded two bonus projects in the 2008 NOFA competition, and one of those projects is scheduled to come online in January 2010.

All told, 116 new PSH beds came online between the January 2009 count date and September 30, 2009, with 48 more expected to come online before December 31, for a total of 164 PH beds in 2009. Of the 164 beds created within 2009, 29 will be targeted to chronically homeless individuals. Another 21 PH beds (including 15 chronic homeless beds) are scheduled to open in January or February 2010. So despite not reaching last year's goal of adding 20 CH beds in time for the January count, Alliance members have created 29 CH beds since that time, with 15 more coming soon.

4B. Continuum of Care (CoC) Chronic Homeless Progress

Instructions:

HUD must track each CoCs progress toward ending chronic homelessness. A chronically homeless person is defined as an unaccompanied homeless individual with a disabling condition who has either been continuously homeless for a year or more OR has had at least four episodes of homelessness in the past three years. To be considered chronically homeless, persons must have been sleeping in a place not meant for human habitation (e.g., living on the streets) and/or in an emergency shelter during that time. An episode is a separate, distinct, and sustained stay on the streets and/or in an emergency homeless shelter.

This section asks each CoC to track changes in the number of chronically homeless persons as well the number of beds available for this population. For each year, indicate the total unduplicated point-in-time count of the chronically homeless. For 2006 and 2007, this number should come from Chart K in that that year's Exhibit 1. The 2008 and 2009 data has automatically been pulled forward from the respective years 2I. Next, enter the total number of existing and new permanent housing beds, from all funding sources, that were/are readily available and targeted to house the chronically homeless for each year listed.

CoCs must also identify the cost of new permanent housing beds for the chronically homeless. The information in this section can come from point-in-time data and the CoCs housing inventory.

Indicate the total number of chronically homeless persons and total number of permanent housing beds designated for the chronically homeless persons in the CoC for 2007, 2008, and 2009.

Year	Number of CH Persons	Number of PH beds for the CH
2007	198	49
2008	198	57
2009	226	61

Indicate the number of new permanent housing beds in place and made available for occupancy for the chronically homeless between February 1, 2008 and January 31, 2009. 4

Identify the amount of funds from each funding source for the development and operations costs of the new permanent housing beds designated for the chronically homeless, that were created between February 1, 2008 and January 31, 2009.

Cost Type	HUD McKinney-Vento	Other Federal	State	Local	Private
Development	\$0	\$0	\$0	\$0	\$0
Operations	\$63,926	\$0	\$6,104	\$0	\$0
Total	\$63,926	\$0	\$6,104	\$0	\$0

If the number of chronically homeless persons increased or if the number of permanent beds designated for the chronically homeless decreased, please explain (limit 750 characters):

There was a 14% increase in the number of Chronically Homeless individuals between the January 2007 count and the January 2009 count. This increase of 28 individuals can be largely attributed to the severe economic recession and lack of jobs. The increase is consistent with increases seen in chronic homelessness in some of the neighboring suburban Continua of Care, like in Evanston (26%) and DuPage County (17%). We expect that the 29 additional CH beds projected to be added by December 31, 2009 (plus 15 more by February, 2010) will make a significant impact in decreasing chronic homelessness in 2009.

4C. Continuum of Care (CoC) Housing Performance

Instructions:

In this section, CoCs will provide information from the recently submitted APR for all projects within the CoC, not just those being renewed in 2009.

HUD will be assessing the percentage of all participants who remain in S+C or SHP permanent housing (PH) for more than six months. SHP permanent housing projects include only those projects designated as SH-PH. Safe Havens are not considered permanent housing. Complete the following table using data based on the most recently submitted APR for Question 12(a) and 12(b) for all permanent housing projects within the CoC.

Does CoC have permanent housing projects for which an APR should have been submitted? Yes

Participants in Permanent Housing (PH)	
a. Number of participants who exited permanent housing project(s)	23
b. Number of participants who did not leave the project(s)	138
c. Number of participants who exited after staying 6 months or longer	15
d. Number of participants who did not exit after staying 6 months or longer	115
e. Number of participants who did not exit and were enrolled for less than 6 months	6
TOTAL PH (%)	81

Instructions:

HUD will be assessing the percentage of all transitional housing (TH) participants who moved to a PH situation. TH projects only include those projects identified as SH-TH. Safe Havens are not considered transitional housing. Complete the following table using data based on the most recently submitted APR for Question 14 for all transitional housing projects within the CoC.

Does CoC have any transitional housing programs for which an APR should have been submitted? Yes

Participants in Transitional Housing (TH)	
a. Number of participants who exited TH project(s), including unknown destination	186
b. Number of participants who moved to PH	133
TOTAL TH (%)	72

4D. Continuum of Care (CoC) Enrollment in Mainstream Programs and Employment Information

Instructions:

HUD will be assessing the percentage of clients in all of your existing projects who gained access to mainstream services, especially those who gained employment. This includes all S+C renewals and all SHP renewals, excluding HMIS projects. Complete the following charts based on responses to APR Question 11 for all projects within the CoC.

Total Number of Exiting Adults: 597

Mainstream Program	Number of Exiting Adults	Exit Percentage (Auto-calculated)	
SSI	65	11	%
SSDI	33	6	%
Social Security	12	2	%
General Public Assistance	3	1	%
TANF	7	1	%
SCHIP	17	3	%
Veterans Benefits	22	4	%
Employment Income	142	24	%
Unemployment Benefits	11	2	%
Veterans Health Care	6	1	%
Medicaid	115	19	%
Food Stamps	154	26	%
Other (Please specify below)	68	11	%
Child Support, Pension/Retirement Funds, Worker's Compensation, Trust, Fin Aid 1-Military			
No Financial Resources	217	36	%

The percentage values will be calculated by the system when you click the "save" button.

Does CoC have projects for which an APR should have been submitted? Yes

4E. Continuum of Care (CoC) Participation in Energy Star and Section 3 Employment Policy

Instructions:

HUD promotes energy-efficient housing. All McKinney-Vento funded projects are encouraged to purchase and use Energy Star labeled products. For information on Energy Star initiative go to: <http://www.energystar.gov>

A "Section 3 business concern" is one in which: 51% or more of the owners are section 3 residents of the area of service; or at least 30% of its permanent full-time employees are currently section 3 residents of the area of service, or within three years of their date of hire with the business concern were section 3 residents; or evidence of a commitment to subcontract greater than 25% of the dollar award of all subcontracts to businesses that meet the qualifications in the above categories is provided. The "Section 3 clause" can be found at 24 CFR Part 135.

Has the CoC notified its members of the Energy Star Initiative? Yes

Are any projects within the CoC requesting funds for housing rehabilitation or new construction? No

4F. Continuum of Care (CoC) Enrollment and Participation in Mainstream Programs

It is fundamental that each CoC systematically help homeless persons to identify, apply for, and follow-up to receive benefits under SSI, SSDI, TANF, Medicaid, Food Stamps, SCHIP, WIA, and Veterans Health Care as well as any other State or Local program that may be applicable.

Does the CoC systematically analyze its projects APRs in order to improve access to mainstream programs? Yes

If 'Yes', describe the process and the frequency that it occurs.

The Alliance requires submission of a copy of the last submitted APR in order for a renewal to be considered for continued funding. Annually, we analyze length of stay, destination upon exit, and income and benefits at exit. An Outcome Evaluation Committee is in the process of setting benchmarks for participant eligibility criteria, program capacity and utilization, and progress in accessing mainstream benefits.

Does the CoC have an active planning committee that meets at least 3 times per year to improve CoC-wide participation in mainstream programs? No

If "Yes", indicate all meeting dates in the past 12 months.

Does the CoC coordinate with the State Interagency Council on Homelessness to reduce or remove barriers to accessing mainstream services? No

Does the CoC and/or its providers have specialized staff whose primary responsibility is to identify, enroll, and follow-up with homeless persons on participation in mainstream programs? Yes

If yes, identify these staff members Provider Staff

Does the CoC systematically provide training on how to identify eligibility and program changes for mainstream programs to provider staff. Yes

If "Yes", specify the frequency of the training. Semi-annually

Does the CoC use HMIS as a way to screen for mainstream benefit eligibility? No

If "Yes", indicate for which mainstream programs HMIS completes screening.

NA

Has the CoC participated in SOAR training? Yes

If "Yes", indicate training date(s).

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4G: Homeless Assistance Providers Enrollment and Participation in Mainstream Programs

Indicate the percentage of homeless assistance providers that are implementing the following activities:

Activity	Percentage
1. Case managers systematically assist clients in completing applications for mainstream benefits. 1a. Describe how service is generally provided:	94%
Case managers identify mainstream benefits that clients may qualify for, assist them in completing paperwork and obtaining documentation needed to apply, and finally advocate with mainstream benefits agency personnel in securing benefits.	
2. Homeless assistance providers supply transportation assistance to clients to attend mainstream benefit appointments, employment training, or jobs.	89%
3. Homeless assistance providers use a single application form for four or more mainstream programs: 3.a Indicate for which mainstream programs the form applies:	44%
Medicare, Medicaid, SSI, SSDI, Social Security, Food Stamps, General Assistance, Veteran's Health, Unemployment, Worker's Comp, WIC, TANF, All Kids, Link Card (Food Stamps)	
4. Homeless assistance providers have staff systematically follow-up to ensure mainstream benefits are received.	100%
4a. Describe the follow-up process:	
Case managers have direct follow up with clients throughout the process of receiving benefits. Select agencies list mainstream benefits as goals that are written into the client's service plan. Case managers then review this set of goals with their clients on a regular basis and help identify and remove barriers. In addition, select agencies have an attorney available who assists with cases of denial of some mainstream benefits.	

Part A - Questionnaire for HUD's Initiative on Removal of Regulatory Barriers

Part A. Local Jurisdictions. Counties Exercising Land Use and Building Regulatory Authority and Other Applicants Applying for Projects Located in such Jurisdictions or Counties [Collectively, Jurisdiction]

<p>*1. Does your jurisdiction's comprehensive plan (or in the case of a tribe or TDHE, a local Indian Housing Plan) include a "housing element"?</p> <p>A local comprehensive plan means the adopted official statement of a legislative body of a local government that sets forth (in words, maps, illustrations, and/or tables) goals, policies, and guidelines intended to direct the present and future physical, social, and economic development that occurs within its planning jurisdiction and that includes a unified physical plan for the public development of land and water. If your jurisdiction does not have a local comprehensive plan with a housing element, please select No. If you select No, skip to question # 4.</p>	<p>Yes</p>
<p>2. If your jurisdiction has a comprehensive plan with a housing element, does the plan provide estimates of current and anticipated housing needs, taking into account the anticipated growth of the region, for existing and future residents, including low, moderate and middle income families, for at least the next five years?</p>	<p>Yes</p>
<p>3. Does your zoning ordinance and map, development and subdivision regulations or other land use controls conform to the jurisdiction's comprehensive plan regarding housing needs by providing: a) sufficient land use and density categories (multi-family housing, duplexes, small lot homes and other similar elements); and, b) sufficient land zoned or mapped "as of right" in these categories, that can permit the building of affordable housing addressing the needs identified in the plan?</p> <p>(For purposes of this notice, "as-of-right" as applied to zoning, means uses and development standards that are determined in advance and specifically authorized by the zoning ordinance. The ordinance is largely self-enforcing because little or no discretion occurs in its administration). If the jurisdiction has chosen not to have either zoning, or other development controls that have varying standards based upon districts or zones, the applicant may also enter yes.</p>	<p>Yes</p>
<p>4. Does your jurisdiction's zoning ordinance set minimum building size requirements that exceed the local housing or health code or that are otherwise not based upon explicit health standards?</p>	<p>Yes</p>
<p>*5. If your jurisdiction has development impact fees, are the fees specified and calculated under local or state statutory criteria?</p> <p>If no, skip to question #7. Alternatively, if your jurisdiction does not have impact fees, you may select Yes.</p>	<p>Yes</p>
<p>6. If yes to question #5, does the statute provide criteria that sets standards for the allowable type of capital investments that have a direct relationship between the fee and the development (nexus), and a method for fee calculation?</p>	<p>Yes</p>

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<p>*7. If your jurisdiction has impact or other significant fees, does the jurisdiction provide waivers of these fees for affordable housing?</p>	<p>No</p>
<p>*8. Has your jurisdiction adopted specific building code language regarding housing rehabilitation that encourages such rehabilitation through gradated regulatory requirements applicable as different levels of work are performed in existing buildings?</p> <p>Such code language increases regulatory requirements (the additional improvements required as a matter of regulatory policy) in proportion to the extent of rehabilitation that an owner/developer chooses to do on a voluntary basis. For further information see HUD publication: Smart Codes in Your Community: A Guide to Building Rehabilitation Codes (http://www.huduser.org/publications/destech/smartcodes.html.)</p>	<p>Yes</p>
<p>*9. Does your jurisdiction use a recent version (i.e. published within the last 5 years or, if no recent version has been published, the last version published) of one of the nationally recognized model building codes (i.e. the International Code Council (ICC), the Building Officials and Code Administrators International (BOCA), the Southern Building Code Congress International (SBCI), the International Conference of Building Officials (ICBO), the National Fire Protection Association (NFPA)) without significant technical amendment or modification.</p> <p>In the case of a tribe or TDHE, has a recent version of one of the model building codes as described above been adopted or, alternatively, has the tribe or TDHE adopted a building code that is substantially equivalent to one or more of the recognized model building codes?</p>	<p>Yes</p>
<p>Alternatively, if a significant technical amendment has been made to the above model codes, can the jurisdiction supply supporting data that the amendments do not negatively impact affordability.</p>	
<p>*10. Does your jurisdiction's zoning ordinance or land use regulations permit manufactured (HUD-Code) housing "as of right" in all residential districts and zoning classifications in which similar site-built housing is permitted, subject to design, density, building size, foundation requirements, and other similar requirements applicable to other housing that will be deemed realty, irrespective of the method of production?</p>	<p>Yes</p>
<p>*11. Within the past five years, has a jurisdiction official (i.e., chief executive, mayor, county chairman, city manager, administrator, or a tribally recognized official, etc.), the local legislative body, or planning commission, directly, or in partnership with major private or public stakeholders, convened or funded comprehensive studies, commissions, or hearings, or has the jurisdiction established a formal ongoing process, to review the rules, regulations, development standards, and processes of the jurisdiction to assess their impact on the supply of affordable housing?</p>	<p>No</p>
<p>*12. Within the past five years, has the jurisdiction initiated major regulatory reforms either as a result of the above study or as a result of information identified in the barrier component of the jurisdiction's "HUD Consolidated Plan?" If yes, briefly describe. (Limit 2,000 characters.)</p>	<p>No</p>
<p>*13. Within the past five years has your jurisdiction modified infrastructure standards and/or authorized the use of new infrastructure technologies (e.g. water, sewer, street width) to significantly reduce the cost of housing?</p>	<p>No</p>

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<p>*14. Does your jurisdiction give "as-of-right" density bonuses sufficient to offset the cost of building below market units as an incentive for any market rate residential development that includes a portion of affordable housing?</p> <p>(As applied to density bonuses, "as of right" means a density bonus granted for a fixed percentage or number of additional market rate dwelling units in exchange for the provision of a fixed number or percentage of affordable dwelling units and without the use of discretion in determining the number of additional market rate units.)</p>	No
<p>*15. Has your jurisdiction established a single, consolidated permit application process for housing development that includes building, zoning, engineering, environmental, and related permits?</p> <p>Alternatively, does your jurisdiction conduct concurrent, not sequential, reviews for all required permits and approvals?</p>	Yes
<p>*16. Does your jurisdiction provide for expedited or "fast track" permitting and approvals for all affordable housing projects in your community?</p>	Yes
<p>*17. Has your jurisdiction established time limits for government review and approval or disapproval of development permits in which failure to act, after the application is deemed complete, by the government within the designated time period, results in automatic approval?</p>	No
<p>*18. Does your jurisdiction allow "accessory apartments" either as: a) a special exception or conditional use in all single-family residential zones or, b) "as of right" in a majority of residential districts otherwise zoned for single-family housing?</p>	Yes
<p>*19. Does your jurisdiction have an explicit policy that adjusts or waives existing parking requirements for all affordable housing developments?</p>	No
<p>*20. Does your jurisdiction require affordable housing projects to undergo public review or special hearings when the project is otherwise in full compliance with the zoning ordinance and other development regulations?</p>	No

Continuum of Care (CoC) Project Listing

Instructions:

To upload all Exhibit 2 applications that have been submitted to this CoC, click on the "Update List" button. This process may take several hours depending on the size of the CoC, however the CoC can either work on other parts of Exhibit 1 or it can log out of e-snaps and come back later to view the updated list. To rank a project, click on the icon next to each project to view project details.

For additional instructions, refer to the 2008 Project Listing Instructions on the left-hand menu bar.

EX1_Project_List_Status_field List Updated Successfully

Project Name	Date Submitted	Grant Term	Applicant Name	Budget Amount	Proj Type	Prog Type	Comp Type	Rank
N/NW CC ACMH Part...	2009-10-23 17:54:...	1 Year	Catholic Charities	140,000	Renewal Project	SHP	PH	F
Esperanza	2009-10-13 19:12:...	1 Year	New Foundation Ce...	277,596	Renewal Project	SHP	PH	F
Permanent Housing...	2009-10-30 11:48:...	1 Year	Housing Opportuni..	47,392	Renewal Project	SHP	PH	F
Palatine House	2009-10-16 13:02:...	1 Year	WINGS PROGRAM, INC.	43,402	Renewal Project	SHP	TH	F
Hope III	2009-10-28 09:58:...	1 Year	YMCA of Metropoli...	468,552	Renewal Project	SHP	TH	F
South Suburban Ho...	2009-10-27 16:52:...	1 Year	CEDA Bloom-Rich	231,678	Renewal Project	SHP	TH	F
West Suburban Saf...	2009-10-20 16:29:...	1 Year	Thresholds Inc	403,199	Renewal Project	SHP	SH	F
Project WCHIP Exp...	2009-10-14 19:30:...	1 Year	Pillars Community...	110,000	Renewal Project	SHP	PH	F
Homeless Day Center	2009-10-16 10:42:...	1 Year	PADS to HOPE, Inc.	183,666	Renewal Project	SHP	SSO	F
New Hope Apartmen..	2009-10-16 16:38:...	1 Year	Catholic Charities	731,105	Renewal Project	SHP	TH	F
Genesis Place	2009-10-08 17:26:...	1 Year	Interdependent Li...	156,964	Renewal Project	SHP	PH	F
COMMUNITY FAMILY ...	2009-10-16 11:14:...	1 Year	CEDA Northwest Se...	144,873	Renewal Project	SHP	TH	F

Skokie House	2009-10-16 14:47:...	1 Year	WINGS PROGRAM, INC.	89,874	Renewal Project	SHP	TH	F
Shelter Plus Care	2009-10-16 17:10:...	1 Year	Housing Authority...	152,712	Renewal Project	S+C	SRA	U
Families First	2009-10-28 15:04:...	1 Year	Together We Cope	190,517	Renewal Project	SHP	TH	F
Project WCHIP Exp...	2009-10-14 18:40:...	1 Year	Pillars Community...	24,115	Renewal Project	SHP	PH	F
Family Housing North	2009-10-19 14:56:...	1 Year	Connections for t...	94,535	Renewal Project	SHP	PH	F
Project Success	2009-10-16 14:29:...	1 Year	Pillars Community...	31,177	Renewal Project	SHP	TH	F
Project WCHANCE (...)	2009-10-29 14:00:...	2 Years	Pillars Community...	731,504	New Project	SHP	PH	P1
Project WISH	2009-10-15 14:09:...	1 Year	South Suburban PADS	284,574	Renewal Project	SHP	TH	F
NHA - Family PSH	2009-11-04 09:48:...	1 Year	Catholic Charities	194,713	Renewal Project	SHP	PH	F
Permanent Housing...	2009-10-16 13:31:...	1 Year	WINGS PROGRAM, INC.	84,968	Renewal Project	SHP	PH	F
Suburban Cook Cou...	2009-11-19 16:33:...	1 Year	Alliance to End H...	252,725	Renewal Project	SHP	HMIS	F
Supportive Housin...	2009-10-20 17:17:...	1 Year	The Center of Con...	130,534	Renewal Project	SHP	TH	F
HUD 6 Transitiona ...	2009-10-16 12:33:...	1 Year	WINGS PROGRAM, INC.	124,554	Renewal Project	SHP	TH	F
Page One Transiti...	2009-10-22 12:02:...	1 Year	Bethel Human Reso...	184,231	Renewal Project	SHP	TH	F
Shelter Plus Care	2009-10-23 17:35:...	1 Year	Housing Authority...	450,504	Renewal Project	S+C	SRA	U
Project West Cook...	2009-10-14 19:47:...	1 Year	Pillars Community...	521,332	Renewal Project	SHP	PH	F
The Sanctuary	2009-10-14 20:46:...	1 Year	South Suburban Fa...	281,957	Renewal Project	SHP	TH	F

Cooke's Manor Hines	2009-10-23 16:49:...	1 Year	Catholic Charities	89,379	Renewal Project	SHP	TH	F
CEDA West Suburba...	2009-10-23 14:24:...	1 Year	CEDA, Inc.	265,875	Renewal Project	SHP	TH	F
Project W.I.N. (W...	2009-10-14 16:27:...	1 Year	Pillars Communit y...	477,060	Renewal Project	SHP	SSO	F
COMMUNITY FAMILY ...	2009-10-16 11:52:...	1 Year	CEDA Northwest Se...	162,947	Renewal Project	SHP	TH	F
Suburban Project	2009-10-16 17:30:...	2 Years	Single Room Housi...	731,000	New Project	SHP	PH	X
Schaumburg House	2009-10-16 14:07:...	1 Year	WINGS PROGRAM, INC.	44,693	Renewal Project	SHP	TH	F
Hope IV	2009-10-16 16:13:...	1 Year	YMCA of Metropoli...	36,313	Renewal Project	SHP	PH	F
Families First Pe...	2009-11-03 10:14:...	1 Year	Together We Cope	124,837	Renewal Project	SHP	PH	F
WINGS/HC Transit...	2009-10-16 15:25:...	1 Year	WINGS PROGRAM, INC.	100,120	Renewal Project	SHP	TH	F
Independence Place	2009-10-16 16:00:...	1 Year	YMCA of Metropoli...	225,546	Renewal Project	SHP	TH	F
Salubrity House	2009-10-13 19:10:...	1 Year	New Foundation Ce...	205,204	Renewal Project	SHP	PH	F

Budget Summary

FPRN	\$7,160,207
Permanent Housing Bonus	\$731,504
SPC Renewal	\$603,216
Rejected	\$731,000

Attachments

Document Type	Required?	Document Description	Date Attached
Certification of Consistency with the Consolidated Plan	Yes	Cook County Con P...	11/22/2009

Attachment Details

Document Description: Cook County Con Plan Certification