Before Starting the CoC Application

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

The Collaborative Applicant is responsible for reviewing the following:

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

Instructions:

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

Resources:
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1A-1. CoC Name and Number: IL-511 - Cook County CoC

1A-2. Collaborative Applicant Name: Alliance to End Homelessness in Suburban Cook County

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Alliance to End Homelessness in Suburban Cook County
1B. Continuum of Care (CoC) Engagement

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

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

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

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

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

Applicant: Cook County Continuum of Care
Project: IL-511 CoC Registration FY2019

FY2019 CoC Application Page 3 09/26/2019
1B-1a. CoC’s Strategy to Solicit/Consider Opinions on Preventing/Ending Homelessness.

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

1) The CoC does targeted outreach to organizations and systems that impact homelessness such as housing, health care, justice, education, child welfare, and people with lived experience of homelessness and recruits them to join the board and participate in CoC committees. The CoC regularly updates our strategic plan, which involves focus groups and surveys targeting a wide range of community stakeholders. The CoC has regional councils and numerous committees and working groups open to the public that meet monthly.

2) The Alliance communicates and solicits feedback through our website, email, targeted outreach, committees, working groups, and community meetings. For example, the Alliance convenes councils in each of the three geographic regions of suburban Cook County. The councils meet monthly and include homeless service providers, local educational liaisons, landlords, township officials, faith-based organizations, mental health advocates, Veteran groups,
government officials, and people with the lived experience of homelessness. A calendar of meetings, minutes, and agendas are posted to the website and shared via email.

3) Information gathered through meetings, focus groups, and surveys directly informs our approach to preventing and ending homelessness. For example, participation from a diverse group of stakeholders informed our strategic plan, influence the content of CoC-wide policies, and determines the strategies tested through initiatives like Built for Zero and the 100-day challenge to end youth homelessness.

4) Our community strives to ensure our communication is accessible to people with disabilities. We create and share our meeting materials electronically through Word or PDFs in a format that can be interpreted by a document reader. In addition, we have meetings in accessible locations, and offer call-in options for people who have difficulty getting to meetings.

1B-2. Open Invitation for New Members.

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

(limit 2,000 characters)

1 & 2) The Alliance invites new members to the annual continuum orientation, held on 5/30/19. The orientation introduces new members to the CoC, ways to get involved, and how to apply for funding through the NOFA. Invitations are sent by email, mail, and posted to the website. Alliance staff, regional councils, and the nominating and governance committee review the CoC’s membership and do targeted outreach throughout the year to stakeholders who are needed to implement a plan to prevent and end homelessness. At any point during the year, someone can join the CoC by filling out a membership form. The CoC regularly invites participants at monthly committee and council meetings to join. All CoC meetings are open to the public and posted on the website calendar.

3) Our community strives to ensure our communication is accessible to people with disabilities. We create and share our meeting materials electronically through Word or PDFs in a format that can be interpreted by a document reader. In addition, we have meetings in accessible locations, and offer call-in options for people who have difficulty getting to meetings.

4) CoC workgroups and committees actively recruit members at monthly meetings throughout the year with a focus in the summer months prior to the NOFA and the start of the board year. In addition, the CoC does targeted outreach to solicit new members based on the initiatives we are working on, such as the 100-day challenge to end youth homelessness.
5) Engagement of people who have experienced homelessness is particularly important to our CoC. The nominating committee and homeless service providers reach out directly to individuals who have experienced homelessness to become members and board representatives. Stipends and transportation assistance is provided to people with lived experience of homelessness to encourage participation in meetings. In addition, we created a Youth Action Board to help guide our work to end youth homelessness.

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

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

1) The CoC invites new project applications, including from agencies that have not received prior funding, through email to 526 recipients on 5/7/19 and 6/3/19, mail to 469 recipients on 5/26, the CoC's website on 5/7/19 and 6/3/19, the annual CoC orientation on 5/30/19, and meeting announcements. New applicants are instructed to complete an application which is submitted to the Alliance by email.

2) All new applicants are invited to submit an application by email for consideration and ranking by the Project Review Panel. All applicants that submitted an application by the publicly posted due date of 7/2/19 at 5pm, were included in the FY 2019 CoC program competition process. Applicants must meet basic threshold criteria set through the HUD NOFA, which was listed in the CoC application, shared in a training for applicants, email, and the CoC’s website.

3) On May 7, 2019, the Alliance announced via the website, mail, and email our annual CoC orientation on 5/30/19, where we described the application process, timeline, and invited new applicants. On 6/3/19, a public announcement was made available via the Alliance website and email to formally invite organizations to apply for new bonus projects, new reallocation projects, and renewal projects. In addition, the announcement included information on new project funding opportunities and training and technical support, such as a new and renewal project application training held 6/14/19.
4) Our community strives to ensure our communication is accessible to people with disabilities. We create and share our meeting materials electronically through Word or PDFs in a format that can be interpreted by a document reader. In addition, we have meetings in accessible locations, and offer call-in options for people who have difficulty getting to meetings.

5) The CoC accepts and encourages proposals from non-CoC program funded organizations.
1C. Continuum of Care (CoC) Coordination

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

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

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

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

Applicant: Cook County Continuum of Care
Project: IL-511 CoC Registration FY2019
1C-2. CoC Consultation with ESG Program Recipients.

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

1) The Alliance advises on funding allocation, planning, policies, and performance measurement for the 5 jurisdictions that administer Emergency Solutions Grants (ESG). The Alliance consults with the Cook County Department of Planning and Development to help plan the distribution of the largest source of ESG in our community. In the last year, the County was awarded supplemental ESG. The CoC and County worked together to identify priorities for the funding, which included funding for a diversion pilot and rapid re-housing (RRH). Similarly, the Alliance advises the State of Illinois ESG on unmet need and community priorities and designates the ESG subrecipients and award amounts. In addition, we consulted with the state and county on the application process. In the end, our community decided more Rapid Rehousing (RRH) was the top funding priority. The Alliance partners with 3 additional entitlement communities receiving ESG within our geography to set policies and priorities, advise them on an allocation plan, establish benchmarks, and evaluate outcomes.

2) The Alliance works closely with each jurisdiction to set performance benchmarks, evaluate, and report the performance of ESG program recipients and subrecipients. For example, our CE lead agency worked closely with the County to develop performance benchmarks for ESG-funded street outreach programs. In addition, the CoC will provide project monitoring visits to state-funded ESG programs within our CoC this fiscal year.

3) The CoC ensures data on homelessness is accurately portrayed and taken into consideration during the development of the Consolidated Plan and contributes to the narrative and reviews the draft plan for each of 14 Entitlement Community jurisdictions within the CoC. The CoC shared our 2019-2022 strategic plan with ESG recipients and regularly shares reports that highlight need such as the HIC/PIT.

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

Applicants must indicate whether the CoC provided Point-in-Time (PIT) and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area. Yes to both
1C-2b. Providing Other Data to Consolidated Plan Jurisdictions.

Yes

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

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

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

(limit 2,000 characters)

1) Trauma-informed and victim-centered safety planning protocols are incorporated throughout the CoC’s intake and Coordinated Entry (CE) assessment process. The CE pre-screen tool includes an initial safety screening & protocols for immediate safety planning. If a victim indicates that safety is their top concern, CoC staff are trained to connect them with victim service providers first and then work on their permanent housing solution after their safety is established. CoC providers must complete all required CE trainings annually, including mandatory training on how best to identify, screen, and serve DV survivors using a victim-centered and trauma-informed approach. If a client is currently in CoC housing and becomes a victim of DV, the tenant is eligible for an emergency transfer to another housing unit as soon as one becomes available. The housing provider ensures that the request of an emergency transfer is kept confidential. Victims are encouraged to contact the 24-hour DV hotline or connect with a local DV provider to assist with safety planning and get connected to additional resources.

2) After safety needs are met, participants complete an assessment to determine ongoing housing/service needs through DV programs, funded by DOJ's OVW and DHHS's Family Violence Prevention & Service, and CoC grants. CE also has a DV screening tool that identifies the level of danger a victim is in. Victims scoring high are moved to the top of our prioritized list for CoC housing. Although DV providers cannot enter data into HMIS, DV partners, the CE lead, and the CoC have developed mechanisms to match DV survivors to housing while maintaining confidentiality. DV clients are given the choice of other non-CoC housing and services that are available. Finally, in addition to the trainings mentioned above, CoC program staff are trained on how to maintain confidentiality when working with DV survivors.

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

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

(1) and (2) CoC project staff and Coordinated Entry (CE) staff have a robust array of mandatory and suggested trainings offered multiple times a year and conducted by the CE lead team, victim service providers, and other experts in the field. This includes the CE Basic training, required by all providers and coordinated entry staff annually, covering best practices in serving survivors of domestic violence (DV). The training covers trauma-informed care, establishing a safety plan, & ensuring privacy is maintained. In addition, there is a mandatory Screening and Safety Planning for DV, Sexual Assault, and Trafficking training offered several times a year, covering how to recognize survivors of DV, sexual assault, and trafficking, and how to make plans to ensure their safety, healing, and access to care using a trauma-informed, victim-centered approach. Finally, there is a required training on trauma and its impact and trauma-informed care offered at least once a year. Curriculum for the trainings was developed by victim service providers in the community and is conducted by certified trainers. In addition, regional councils have hosted trainings on trafficking and sexual assault conducted by experts in the field. CE established a DV workgroup comprised of victim service providers and CoC staff to discuss issues both sides experience when trying to refer clients between the two systems. These conversations inform the CE referral process and HMIS procedures designed for our CoC and help inform the training curriculum.

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

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

(1) and (2) CoC project staff and Coordinated Entry (CE) staff have a robust array of mandatory and suggested trainings offered multiple times a year and conducted by the CE lead team, victim service providers, and other experts in the field. This includes the CE Basic training, required by all providers and coordinated entry staff annually, covering best practices in serving survivors of domestic violence (DV). The training covers trauma-informed care, establishing a safety plan, & ensuring privacy is maintained. In addition, there is a mandatory Screening and Safety Planning for DV, Sexual Assault, and Trafficking training offered several times a year, covering how to recognize survivors of DV, sexual assault, and trafficking, and how to make plans to ensure their safety, healing, and access to care using a trauma-informed, victim-centered approach. Finally, there is a required training on trauma and its impact and trauma-informed care offered at least once a year. Curriculum for the trainings was developed by victim service providers in the community and is conducted by certified trainers. In addition, regional councils have hosted trainings on trafficking and sexual assault conducted by experts in the field. CE established a DV workgroup comprised of victim service providers and CoC staff to discuss issues both sides experience when trying to refer clients between the two systems. These conversations inform the CE referral process and HMIS procedures designed for our CoC and help inform the training curriculum.

The CoC uses multiple sources to assess the scope of community needs related to victims of DV, dating violence, sexual assault, and stalking. First, the primary source of data is from the HMIS-comparable database called InfoNet, which is used by all victim service providers in Illinois. The CoC works with the administrator of the database to request de-identified, aggregate reports detailing the housing and services needs of victims and to identify gaps. For example, using this data, the CoC was able to determine that 1,459 households were turned away from DV shelter in our CoC due to lack of available beds last year. Of all DV households not turned away, 705 indicated needing housing, yet our CoC was only able to provide permanent housing to 56 households fleeing violence in the same time period. To ensure InfoNet captures the data needed by the CoC and HUD, a working group was formed between the local CoCs, DV providers, and the administrator of the comparable database. The CoC also reviews data from HMIS to identify the numbers of people served annually in projects who indicated a history of DV or fleeing DV and collects data to identify the number of victims served by the CoC during the annual Point-in-Time count.
In addition, the CoC refers to recent studies done by local universities on the needs of victims of Domestic Violence in the area, such as a 2016 study prepared by the Loyola University Chicago Center for Urban Research and Learning on domestic violence outcome measures. This research is used to identify needs of victims and gaps that the CoC can help address. Finally, the Alliance relies on qualitative and quantitative data collected by DV providers in the community through surveys and a CE DV working group comprised of victim service providers, CoC staff, and CE staff.

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

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

<table>
<thead>
<tr>
<th>Public Housing Agency Name</th>
<th>% New Admissions into Public Housing and Housing Choice Voucher Program during FY 2018 who were experiencing homelessness at entry</th>
<th>PHA has General or Limited Homeless Preference</th>
<th>PHA has a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Authority of Cook County</td>
<td>8.00%</td>
<td>Yes-Both</td>
<td>Yes-Both</td>
</tr>
<tr>
<td>Housing Authority of Cook County</td>
<td>0.00%</td>
<td>Yes-HCV</td>
<td>No</td>
</tr>
</tbody>
</table>

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

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

Four of the five largest PHAs within the CoC geography have a homeless preference. These 4 PHAs represent over 97% of the assisted units in our geography. The Housing Authority of Cook County (HACC), the largest PHA serving our CoC, has created a written summary of its multifaceted efforts to address homelessness, including a homeless preference, a moving-on program, a partnership with school districts to house homeless families, VASH, CoC-funded permanent supportive housing, FUP, and the Mainstream Voucher program. The CoC has made all PHAs within its geography aware of HUD Notice PIH 2013-15 that encourages PHAs to adopt a homeless preference. The CoC has done targeted outreach to the one PHA that does not have a homeless preference, including inviting the PHA to partner on a Mainstream Voucher program application and Family Unification Program (FUP) application. The CoC reached out to all PHAs to partner on Mainstream and FUP applications in 2018. HACC was awarded mainstream vouchers, which added 45 beds of PSH for people who are homeless in our community, and FUP, which serves youth who are homeless and aged out of care in our community. The CoC reached out to PHAs for the next round of mainstream vouchers in
2019 and HACC and the Oak Park Housing Authority submitted applications for projects to serve people who are homeless and provide move-on assistance to households in PSH and RRH. The Alliance executive director has presented at statewide conferences on homeless preferences and other innovative PHA/CoC partnership strategies.

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

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

Yes

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

(limit 1,000 characters)

The largest public housing authority in the CoC, the Housing Authority of Cook County (HACC), operates a Moving-On program with the CoC. In this year's round of mainstream vouchers, the CoC applied for more Move On vouchers for Permanent Supportive Housing and Rapid Re-Housing in partnership with HACC and the Oak Park Housing Authority.

1C-5. Protecting Against Discrimination.

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

(limit 2,000 characters)

The CoC has taken several actions to further fair housing, ensure equal access to housing, and protect against discrimination. First, CE and CoC providers market housing and services to households online, through events, community meetings, and community outreach. Second, the CoC has a policy and process to address any fair housing issues or discrimination our clients experience. Third, CoC programs inform households of their fair housing rights at program entry and throughout their time in the program. The CoC offers annual training on fair housing and how to address discrimination annually to ensure that fair housing standards are upheld across the CoC. The CoC also helped lead an initiative that passed County legislation making it harder for landlords to discriminate against people with a criminal record. To ensure equal access to services to people with limited English proficiency, our community's coordinated entry call center can provide services in over 200 languages as well as TTY accessibility. CoC providers have access to translation services when needed. As CE implementation is rolled out, materials in Braille and large print will also be available. The CoC has adopted a CE anti-discrimination policy that ensures fair housing standards are implemented across the CoC. CoC program staff are trained in best practices for engaging people with disabilities. For example, the CE lead organizes a two-day mental health first aid training, to help outreach, housing, and shelter staff know how to recognize signs of mental illness and
how to intervene in productive ways. The CoC conducts annual training to improve competency when working with populations that may face discrimination including the LGBTQ population.

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

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

<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Did the CoC implement a CoC-wide anti-discrimination policy that applies to all projects regardless of funding source?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Did the CoC conduct annual CoC-wide training with providers on how to effectively address discrimination based on any protected class under the Fair Housing Act?</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Did the CoC conduct annual training on how to effectively address discrimination based on any protected class under 24 CFR 5.109(a)(2) – Equal Access to HUD-Assisted or -Insured Housing?</td>
<td>X</td>
<td></td>
</tr>
</tbody>
</table>

*1C-6. Criminalization of Homelessness.

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

<table>
<thead>
<tr>
<th>Strategy</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Engaged/educated local policymakers:</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>2. Engaged/educated law enforcement:</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>3. Engaged/educated local business leaders:</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>4. Implemented communitywide plans:</td>
<td>X</td>
<td></td>
</tr>
<tr>
<td>5. No strategies have been implemented:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Other:(limit 50 characters)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

(limit 2,000 characters)

1 and 2) Entry Point, the Coordinated Entry System for our CoC, is accessible across all suburban Cook County. In order to reach people across the County, including people who are least likely to seek out assistance, the system has multiple access points. First, anyone seeking help can call our call center M-F from 8:30-4:30pm or go to one of four walk-in centers dispersed throughout our CoC. In addition, outreach staff covering the entire geography are trained assessors who engage people who do not seek out services, regardless of their location. Other CoC programs, such as shelter and daytime support centers, have staff trained in the assessment as well. We have trained staff strategically located to be assessors so that individuals can be assessed in multiple venues and locations across the region. We have also developed a partnership with the Cook County Health and Hospital System to allow Care Coordinators to assess high utilizers of the health and mental health care systems. The CoC is working on developing similar partnerships with other non-CoC stakeholders that interact with people who are homeless. Finally, we have been marketing our CE system to stakeholders that interact with people who are homeless frequently such as police, libraries, hospitals, and townships.

3) Our community uses the VI-SPDAT, a tool developed to identify people most in need of assistance based on vulnerability. People who have been assessed are placed on our community’s “by-name list” and prioritized for housing accordingly. Our CE team has weekly case conferencing calls and a monthly meeting to help coordinate services to identify and house people as quickly as possible. The CE system also operates a prevention and diversion program to reduce entries into homelessness.
1D. Continuum of Care (CoC) Discharge Planning

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

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

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

1D-1. Discharge Planning Coordination.

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

| Foster Care: | X |
| Health Care: | X |
| Mental Health Care: | X |
| Correctional Facilities: | X |
| None: | |
1E. Local CoC Competition

Instructions

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

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

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

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

Applicants must indicate whether the CoC:

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


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

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

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

1) Projects that serve vulnerable populations are given additional points when ranking projects. These populations include: chronic homelessness, survivors of DV, veterans, families with children, and youth. In addition, projects are ranked according to how well it participates in and takes referrals from coordinated entry. The CE system uses the VI-SPDAT to identify and prioritize housing to people with the most severe needs and vulnerability based on factors such as medical service utilization, health, mental health, substance abuse, and justice involvement. Finally, regional needs are considered when ranking projects, specifically the need for more permanent supportive housing resources in the southern portion of our CoC, and more rapid rehousing in the northern and western regions.

2) Projects that prioritize these populations and regions and participate effectively in CE get extra points for their projects on our ranking tool. In addition, consideration is given to projects that provide housing and services to the hardest to serve populations that could result in lower performance levels. For example, PSH vacancies are filled with the most vulnerable and hardest to serve people, who sometimes take longer to house. As a result, lower occupancy rates did not cause these projects to rank poorly. In addition, performance targets are set by looking across similar projects that serve similar populations to maintain equity in ranking across project types. For example, housing retention ranking is set for PSH by looking at what is considered good for a PSH project serving people who are chronically homeless locally and nationally.


Applicants must:
1. indicate how the CoC made public the review and ranking process the CoC used for all project applications; or
2. check 6 if the CoC did not make public the review and ranking process; and
3. indicate how the CoC made public the CoC Consolidated Application— including: CoC Application, CoC Priority Listing, Project Listings that includes all project applications accepted and ranked or rejected—which HUD required CoCs to post to their websites, or partners websites, at least 2 days before the FY 2019 CoC Program Competition application submission deadline; or
4. check 6 if the CoC did not make public the CoC Consolidated Application.
1E-5. Reallocation between FY 2015 and FY 2018.

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

Reallocation: 17%


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

(limit 2,000 characters)

1) Each year, the CoC board approves a reallocation plan and process that involves setting a reallocation target to help ensure new projects can be created. The target is reached by: a) encouraging voluntary reallocation of renewal projects that are consistently underspending or can improve performance by converting to a different project type b) evaluating a project’s history of recapture and cutting average recapture c) reallocating funding from projects that choose not to renew and d) cutting additional resources from low performing projects. This year the CoC board approved a reallocation target of $260,000.

2) The reallocation process was communicated at the June 2019 CoC board meeting, through email to applicants, the CoC website, and through a written reallocation plan.

3) The CoC uses the project ranking tool as one means of determining which
projects are low performing. Projects that are low performing are at risk of a percentage-based cut. Projects that consistently score low in the annual competition and through project site visits are evaluated to determine if the project can be improved or if reallocation is needed. The CoC board makes the determination whether a low performing project should be reallocated. The CoC’s strategic plan uses data to inform the community on what types of projects are needed for which populations.

4) This year, the project review panel and CoC board approved a 1.8% cut to projects that were identified as low performers on the ranking tool, which is the bottom half of the ranked list. With the support of the Alliance, a TH project that serves veterans voluntarily decided to change the program type to TH-RRH and broaden the population served to include non-veterans to improve the program.
**DV Bonus**

**Instructions**

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

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

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

1F-1  DV Bonus Projects.

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

Yes

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

<table>
<thead>
<tr>
<th>Type of Project</th>
<th>YES</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. PH-RRH</td>
<td></td>
</tr>
<tr>
<td>2. Joint TH/RRH</td>
<td>X</td>
</tr>
<tr>
<td>3. SSO Coordinated Entry</td>
<td>X</td>
</tr>
</tbody>
</table>

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

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

- Need Housing or Services: 2,164.00
- the CoC is Currently Serving: 895.00

Applicant: Cook County Continuum of Care
Project: IL-511 CoC Registration FY2019

FY2019 CoC Application | Page 21 | 09/26/2019
1F-2a. Local Need for DV Projects.

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

According to the HMIS comparable database, 1,459 households were turned away from DV shelter in our CoC due to lack of available beds last year. Of all DV households not turned away, 705 indicated needing housing.

1,459+705=2,164 households needing housing or services. Last year the CoC served 895 DV households in all programs that report in HMIS and comparable databases, 251 of which indicated currently fleeing DV. A fraction of survivors fleeing, 56, received permanent housing (RRH, PSH).

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

<table>
<thead>
<tr>
<th>DUNS Number</th>
<th>798229725</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant Name</td>
<td>Housing Forward</td>
</tr>
</tbody>
</table>

1F-3a. Addressing Coordinated Entry Inadequacy.

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

There are two challenges to integrating DV services into our CE process. First, homeless and DV services use separate databases. We need a data solution to refer individuals anonymously between the two systems. Second, staff at homeless agencies, particularly shelters, which are managed primarily by volunteers, have limited capacity to navigate DV services and address safety concerns. Staff at DV agencies struggle to provide immediate safe shelter and long-term housing through the CoC. We need additional staff capacity so DV survivors entering one system but needing support from the other are safely and effectively connected to the services needed. The CoC was awarded DV Bonus funds in 2018 to implement a DV CE SSO project. However, the original budget for the project was reduced by $100K during 2018 CoC project review process so that the community could maximize resources for 2 additional DV housing projects applying for DV Bonus Funds. Fully funding this project will allow our community to allocate additional resources to each DV partner to support competitive, full-time, rather than part-time, salaries to hire staff with appropriate education and experience. Additional funding for the CE Lead Team will help support data requirements that ensure safe and efficient data management for DV households seeking housing assistance. This project enhances the assessment and outreach capacity at 5 DV agencies by adding cross-trained DV/CE assessors located at victim service agencies, in the field at
hospitals, court houses, CE Walk-In Centers, and shelters/day time support centers. The DV/CE assessors will provide DV expertise to ensure victim-centered housing assessments that prioritize safety-informed choices and safeguard against re-traumatization. They will improve access to DV services for households entering through CoC agencies. Additionally, households assessed will be entered anonymously into the CE system to connect households to permanent housing solutions.

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

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

<table>
<thead>
<tr>
<th>Applicant Name</th>
<th>DUNS Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Forward</td>
<td>798229725</td>
</tr>
<tr>
<td>Connections for t...</td>
<td>607213295</td>
</tr>
</tbody>
</table>
1F-4. PH-RRH and Joint TH and PH-RRH Project

Applicant Capacity

| DUNS Number: | 798229725 |
| Applicant Name: | Housing Forward |
| Rate of Housing Placement of DV Survivors–Percentage: | 30.00% |
| Rate of Housing Retention of DV Survivors–Percentage: | 86.00% |

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

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

1. and 2. The project applicant calculated housing placement rate using data from HMIS for the 2018 calendar year for clients that indicated a history of DV in the homeless shelter, outreach, drop-in center, prevention, and transitional housing programs. 37 exits to permanent destinations/124 clients exits=.3 x100=30%. HMIS was used to calculate housing retention for the 44 DV survivors housed in PSH. 37 remained housed, 7 exited in 2018, 1 to a positive destination for retention rate of 86%.

1F-4b. DV Survivor Housing.

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

Housing Forward, a homeless services agency, encounters DV survivors in programs such as the homeless shelter, street outreach, and homeless drop-in center. When someone discloses a history of DV or fleeing DV, staff records it in their initial assessment and vulnerability assessment. All Housing Forward staff are trained to screen for those whose safety is at imminent risk, and those households are prioritized and connected to resources through partnering DV agencies such as Sarah’s Inn, a partner on the grant. Once safety and needs are assessed, Housing Forward works to quickly connect DV survivors with resources. If housing is a top priority and essential to their safety, Housing Forward works within Coordinated Entry (CE) to quickly locate housing. The proposed partnership with Housing Forward and Sarah’s Inn will help coordinate our efforts in housing this vulnerable population, as well as close a gap in services in west Cook County. Housing Forward uses a low-barrier, Housing First model for all housing programs, meaning there are no preconditions to housing in any of our programs, including the proposed Safe Bridge Housing Program for victims of domestic violence. We believe homelessness is a crisis that can be addressed by providing safe, affordable housing and that all those experiencing homelessness can achieve housing.
stability. When we address the immediate, basic survival need of shelter first and foremost, all other conditions, such as sobriety, economic status, mental or physical health, can be addressed with supportive services or linkage to other resources. Additionally, Housing Forward’s Housing Navigator maintains relationships with local landlords, which is important to help overcome barriers to housing such as previous evictions. These established, working relationships in the community position Housing Forward to successfully house DV victims in west suburban Cook County.

1F-4c. DV Survivor Safety.

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

1. Sarah’s Inn, a DV agency and partner on the application, a) have staff that are certified DV professionals by the state of Illinois, and certified trainers who trained over 6,000 individuals in the region on best practices for working with DV survivors. b) Sarah’s Inn operates a 24-hour crisis line, which provides safety planning, counseling, legal support and connects DV survivors to shelter and other resources. Staff ensures callers maintain privacy on the call and erase call history. Clients served at the office have a private meeting space. c) Sarah’s Inn conducts separate interviews with each member of a couple and offers programing for perpetrators. d) When housing assistance is offered, safety planning, client choice, and location of the units is a primary consideration. e) and f) Sarah’s Inn does not operate a shelter or have dedicated units, but the location of the building where services are provided is kept confidential and has safety precautions in place like appropriate lighting and cameras. 1. a) Housing Forward (HF) intake staff are trained to recognize signs of DV and conduct DV safety assessments. b) Screenings are conducted in private spaces and c) separate interviews of couples are conducted when domestic violence is suspected or disclosed. DV survivors are referred to DV-specific services and shelter. d) Client choice and safety is a top priority when searching for permanent housing. e and f) HF homeless shelters are not DV specific. All clients fleeing DV are referred to DV-specific shelter and resources that provide safe and confidential locations. HF shelter doors are locked at night.

2. Sarah’s Inn uses a client survey to determine the client’s overall feeling of safety after receiving services and 95% of clients served in FY19 report feeling safer and having more resources in order to remain safe.
1F-4d. Trauma-Informed, Victim-Centered Approaches.

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

1. Sarah’s Inn and Housing Forward have ample experience utilizing trauma-informed, victim-centered approaches to meet the needs of DV survivors. Sarah’s Inn has been providing services to DV survivors for 38 years, is a certified trainer on best practices for serving this population, including trauma-informed care, and has DV trained and certified professionals working with over 1,000 clients a year. Sarah’s Inn uses a trauma informed intake process that includes a safety plan, service plan, and needs assessment. Intake policies ensure clients do not continually have to retell their story to avoid re-traumatization. Short and long-term goals are individualized, and client directed. Advocates and counselors explore with victims ways to find safety, utilize their legal rights through protections under the law, explore benefit and financial options, provide accompaniment to various community resources (i.e. DHS, immigration programs), effectively process the trauma of their experience, and establish a violence free and sustainable life for themselves and their children. Sarah’s Inn’s Intervention Program provides services for families affected by domestic violence in order to safely navigate crisis, effectively process trauma and ensure self-sufficiency. Services include: emergency assistance through a 24-hour crisis line; emergency shelter referrals, emergency hotel stays, transportation, and housing assistance; individual and group advocacy and counseling; legal advocacy; partner abuse intervention program for perpetrators of violence; and children and teens group services and individual counseling. Housing Forward homeless shelter and street outreach staff are trained in trauma-informed care and safety planning. Services are strengths-based and prioritize safety, choice, and collaboration.

2. If funded, Sarah’s Inn and Housing Forward will use over 65 years of combined experience working with people who are homeless and DV survivors.
to ensure the TH-RRH project provides trauma-informed victim centered services. a) Housing Forward has a long history of operating a RRH and PSH program that prioritizes participant choice when determining where to live. Identifying a place that the household feels safe is a top priority. Housing Forward has ample landlord relationships, which gives participants multiple housing options and shortens the timeframe to house participants. b) Sarah’s Inn and Housing Forward have skilled staff trained in best practices like housing first, harm reduction, motivational interviewing, and strengths-based case management. These philosophies ensure that services are low-barrier, client-centered, and based on equitable relationships, not punitive interventions. c) Sarah’s Inn are experts on trauma-informed care and train providers across the region. Staff are equipped to provide trauma-informed care and process trauma with survivors. d) Housing Forward and Sarah’s Inn have staff trained to create client-driven strengths-based case plans. e) All CoC front-line staff are required to attend cultural competency training, with specialized training for various populations such as LGBTQ, families, and youth. In addition, basic training contains information on equal access and non-discrimination. f) Both agencies offer connection for participants. Specifically, Sarah’s Inn offers group advocacy and counseling and children and ten group services. g) Both agencies provide case management support to help parenting participants connect to child care resources and parenting support.

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

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

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

(limit 2,000 characters)

Sarah’s Inn and Housing Forward have over 65 years of combined experience serving DV survivors and people who are homeless. As a housing and homeless services provider, Housing Forward has experience quickly housing participants in RRH and PSH. The organization has strong relationships with landlords that are willing to accept participants who have a criminal history and bad credit. In the last year, there were 44 PSH residents with a history of DV. Housing Forward has its own job training and employment program and strong connections to organizations that provide healthcare, drug treatment, and child care. Sarah’s Inn provides services at no cost, which are available in English and Spanish, and confidential. Every client is assigned to a certified DV trained advocate or counselor and is provided with safety planning for them and their
children, needs assessments, emotional support, trauma informed counseling, information on legal rights under the IDVA (including information on orders of protection), and advocacy within systems such as Department of Human Services, schools, and other social service programs. Together with staff, the client develops a service plan that includes assessing their safety and case management needs, domestic violence education, and other goals the client has expressed as a priority. If needed clients are referred to our Legal Advocacy Program which will assist them in obtaining an order of protection and linking them to further legal services pertaining to divorce, parenting time, and child support enforcement. Progress on service plans are reviewed at least monthly and documented on the plan itself along with case notes. The assigned staff will also provide on-going case management and when necessary have a client sign a release of information in order to advocate and/or collaborate with other systems in order to ensure improved outcomes.

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

Applicant Capacity

<table>
<thead>
<tr>
<th>DUNS Number:</th>
<th>607213295</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant Name:</td>
<td>Connections for the Homelessness</td>
</tr>
<tr>
<td>Rate of Housing Placement of DV Survivors–Percentage:</td>
<td>49.00%</td>
</tr>
<tr>
<td>Rate of Housing Retention of DV Survivors–Percentage:</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

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

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

YWCA’s DV shelter had (117 exits from July 1, 2018 – June 30, 2019)/57 to a permanent destination=.49x100=49%. This information came from InfoNet, a statewide HMIS comparable database. Connections operates a permanent housing program that supports 20 families that uses HMIS. 6 of the families served from July 1, 2018 – June 30, 2019 fled domestic violence, all 6 remained housed and 0 exited the program for a 100% housing retention rate.

1F-4b. DV Survivor Housing.

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

Since 1981, YWCA has operated a 32-bed emergency shelter specifically designed to meet the immediate safety and housing needs of survivors and their children fleeing domestic violence. Throughout the shelter’s history, safety
has remained a top priority. Each situation is unique, and YWCA works with the household to develop a safety plan and discuss safety measures to ensure a safe transition to permanent housing.

Given the YWCA’s long tenure providing emergency shelter and trauma-informed services to DV survivors and their children, the agency has extensive partnerships and expertise to produce the best housing outcomes for the people they serve. YWCA utilizes harm-reduction and housing first philosophies that focus on safety, quality of life, and personal decision making. Participants can access comprehensive supportive services to ensure DV survivors have the tools and resources they need to overcome their homelessness. During the last year, nearly half of the people served by the emergency shelter program exited to permanent housing.

Connections also has a history of providing housing and services to survivors of domestic violence. Through the agency’s robust outreach efforts, Connections engages with more than 1,500 people each year who are homeless or housing insecure. When the agency encounters people fleeing domestic violence, Connections partners with YWCA Evanston/North Shore and other domestic violence service providers to ensure their immediate housing and safety needs are met. The agency also operates housing programs and utilizes harm-reduction and housing first philosophies. People are accepted into the housing program as they are, regardless of income, sobriety, or mental or physical health. Through this approach, the agency quickly moves people into permanent housing. Of the 20 families currently served in a HUD-funded PSH project, 6 families fled domestic violence. 5 of the 6 families have maintained permanent housing for 2 or more years.

1F-4c. DV Survivor Safety.

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

1. Safety is a primary concern when working with DV survivors. This involves calling the police, assisting with criminal charges or an Order of Protection, helping make an emergency exit plan, etc. When working with someone in crisis, safety planning is a key element of services we provide. a) YWCA staff are certified DV professionals by the state. Future staff will also complete the 40-hour DV training program. Connections staff are trained by the CoC on safety-planning and trauma-informed care. b) Both agencies have private spaces to conduct intakes and mechanisms to conduct separate interviews with
couples. c) When couples present at the Connections walk-in center or homeless shelter, separate intakes are conducted with each member of the family. d) Staff at both agencies immediately develop a safety plan with DV survivors. This includes identifying what is safe for them and whether living in scatter-site or location-based housing is appropriate. Our safety and security procedures address client physical safety from the moment they arrive at the shelter, TH, or RRH unit, until they leave the program. e) The YWCA DV shelter creates a safe environment for its residents. This includes proper lighting, security cameras, and meeting participants at the YWCA’s main building and escorting them to the shelter’s secured entrance. f) To protect the safety of survivors and staff, the address of the shelter and scattered-site housing is not shared with the public, nor are the locations of scatter-site RRH. We support participants to gain a sense of normalcy with family and friends while in our programs by helping them determine what level of disclosure is appropriate. If participants ever feel their safety is compromised, we help them find another shelter or RRH unit where they would feel safe, if that is their desire.

2. YWCA uses participant surveys to assess safety and well-being. In FY19, 93% of shelter residents reported feeling safer as a result of services provided.

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

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

1. This new joint effort by Connections and YWCA will utilize best-practices to provide trauma-informed DV and housing services to help survivors and their children move forward with safe, permanent housing. Both projects have trained and skilled staff who are trauma-informed and empower participants to take control and make choices to live a violence-free future. YWCA has operated since 1931 and provides trauma-informed shelter and services to over 700 DV survivors every year. Services are designed to avoid revictimization by creating
a safe and welcoming environment and an approach that respects a woman’s choices and control over her recovery, emphasize strengths, and focuses on trust, safety, and collaboration.

2. a) and b) People we connect to this project through the coordinated entry process will enter as they are. Together, we will ensure that people are not screened out or prevented from accessing a housing unit because of substance use, mental health, physical disability, or no income. Our spaces are safe and welcoming to encourage healing and mutual respect. Participant preference and safety are top priorities when locating permanent housing options. c) and e) Staff at both agencies will participate in trainings and receive ongoing support and supervision about cultural competence, equal access, trauma-informed care, harm reduction, and equity. The CoC offers multiple trainings a year on these topics for its members, and the YWCA is an expert and trainer on many of these topics as well. d) Both organizations have staff trained to provide strengths-based case management and to develop participant-driven goals. Our staff will ensure participants have access to a broad range of services to achieve their goals. f) and g) This includes access to advocates and children’s counselors for individual and group counseling, parent/child workshops, and specialized workshops such as health education, job readiness, and financial literacy. It also includes access to physical health services, benefits assistance, and groups and mentorship programs. We seek to strengthen community connections, whenever appropriate and safe, to help build a strong safety net of support.

YWCA and Connections will also partner to enable survivors to secure the economic resources and longer-term supports to achieve stable and sustainable futures. This includes: Trauma-informed counseling for survivors; Workforce training and employment assistance; Financial education and legal assistance; Early-intervention and trauma-informed therapies for children; and Health care.

Together, we utilize best-practices to provide trauma-informed DV and housing services to help survivors and their children move forward with safe, permanent housing.

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

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

- Child Custody
- Legal Services
- Criminal History
- Bad Credit History
- Education
- Job Training
- Employment
- Physical/Mental Healthcare
- Drug and Alcohol Treatment
- Childcare
Supportive services are offered on an ongoing basis as long as needed to ensure DV survivors and their children can maintain housing for good. With housing in place and safety established, we can begin to make more progress to enable survivors to secure the economic resources and supports to achieve sustainable futures. We help them connect to benefits they are eligible for and provide support throughout the application process. Participants also have access to financial assistance to pay for education expenses, including tuition and school fees. YWCA has a full-time Economic Empowerment Specialist who provides one-on-one job search, resume development, and interview support. YWCA also has a Culinary Job Training program open to interested participants. Connections will leverage relationships with local employers and help to facilitate participants in accessing job opportunities.

Households will also have access to DV specific services like safety planning and legal advocacy, and one-on-one counseling, case management, health services, food, clothing, education support, psychiatric support, workforce development and employment preparation, benefits and transportation assistance, and advocacy services. Whenever needed, we will help households connect to services we don’t directly provide, including child care, substance use treatment, and specific legal support beyond legal advocacy. As partners, we will provide a range of services to help DV survivors and their children live a violence free future.
2A. Homeless Management Information System (HMIS) Implementation

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

Resources:
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https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources
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2A-1. HMIS Vendor Identification.
WellSky, formerly known as Mediware Information Systems

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

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

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

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Total Number of Beds in 2019 HIC</th>
<th>Total Beds Dedicated for DV in 2019 HIC</th>
<th>Total Number of 2019 HIC Beds in HMIS</th>
<th>HMIS Bed Coverage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shelter (ES) beds</td>
<td>185</td>
<td>121</td>
<td>64</td>
<td>100.00%</td>
</tr>
<tr>
<td>Safe Haven (SH) beds</td>
<td>29</td>
<td>0</td>
<td>29</td>
<td>100.00%</td>
</tr>
<tr>
<td>Transitional Housing (TH) beds</td>
<td>253</td>
<td>51</td>
<td>202</td>
<td>100.00%</td>
</tr>
<tr>
<td>Rapid Re-Housing (RRH) beds</td>
<td>318</td>
<td>0</td>
<td>318</td>
<td>100.00%</td>
</tr>
<tr>
<td>Permanent Supportive Housing (PSH) beds</td>
<td>1,494</td>
<td>25</td>
<td>1,469</td>
<td>100.00%</td>
</tr>
<tr>
<td>Other Permanent Housing (OPH) beds</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

2A-2a. Partial Credit for Bed Coverage Rates at or Below 84.99 for Any Project Type in Question 2A-2.
For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-2., applicants must describe:
1. steps the CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and
2. how the CoC will implement the steps described to increase bed coverage to at least 85 percent.
(limit 2,000 characters)
NA


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

*2A-4. HIC HDX Submission Date.
Applicants must enter the date the CoC submitted the 2019 Housing Inventory Count (HIC) data into the Homelessness Data Exchange (HDX).
04/29/2019
2B. Continuum of Care (CoC) Point-in-Time Count

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

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2B-1. PIT Count Date.
Applicants must enter the date the CoC conducted its 2019 PIT count (mm/dd/yyyy).

02/06/2019

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

04/29/2019


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

N/A

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

Applicants must select whether the CoC added or removed emergency shelter,

No
transitional housing, or Safe-Haven inventory because of funding specific to a Presidentially-declared disaster, resulting in a change to the CoC’s 2019 sheltered PIT count.

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

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

There were several changes to the implementation of the unsheltered count that ultimately helped our CoC get a more accurate count of people who are homeless. First, based on feedback from providers, the start time for the unsheltered count was adjusted and extended to better reach people who are easier to find earlier and later in the evening. Second, the regions were divided to be smaller and more manageable for teams to cover. Third, we did a more comprehensive mapping of “hotspots” with people with lived experience and outreach workers to identify 24-hour locations, known locations of people who are homeless, police stations, and hospitals for teams to visit. In addition, we did more targeted outreach to places to complete the site survey in the days following the count. All of these changes resulted in a more accurate count of people who are homeless in the region.

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

Applicants must:

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

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

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

The CoC implemented several measures to better count youth in the 2019 PIT count. The CoC worked with the Youth Action Board (YAB), composed of young adults who have experienced homelessness, to help identify youth-specific hotspots and participate in the count. On the night of the PIT, a team was
dedicated to finding youth. The team included several YAB members and a caseworker from a youth organization. The team had access to a vehicle that could drive youth to a shelter on the night of the count allowing for post-PIT service engagement. The CoC also engaged all CoC and non-CoC-funded youth providers to get the most accurate count of youth who are homeless in various youth programs across the CoC for the sheltered and unsheltered count. This included outreach to Runaway and Homeless Youth-funded providers. The CoC conducted a service site survey that McKinney-Vento liaisons and other youth-serving organizations could complete to capture homeless youth not found on the night of the Count. After the PIT, the Alliance gathered feedback from the youth service community to continue to improve how we find youth in the PIT.

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

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

1. To better count individuals and families experiencing chronic homelessness, the CoC and outreach workers identified known locations where people who are homeless sleep, 24-hour locations, and other hotspots in the community. These locations were added to a google map and shared with PIT count volunteers and leaders. In addition, site surveys were mailed to locations that may interact with people who are homeless including police stations, libraries, day centers, hospitals, and parks. Focus groups were held at shelters with individuals who are homeless to also help identify hotspots. Finally, the time PIT volunteers were deployed and the length of time they canvassed an area was extended to ensure adequate coverage and time to identify people

2. To better count families, programs that serve families were provided the support to participate in the count, including DV providers. Local area schools, head start, and child care providers were included in the site survey mailer as well as other programs that serve families.

3. To better count veterans, the CoC collaborated with key stakeholders at the Hines VA to identify hotspots and ensure someone from the VA was on call to work with vets identified during the count. Outreach workers from the VA also volunteered for the count.
3A. Continuum of Care (CoC) System Performance

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

Resources:
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*3A-1. First Time Homeless as Reported in HDX.
Applicants must:

Report the Number of First Time Homeless as Reported in HDX. 1,583

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

1) Using HMIS data from our CoC and research on homelessness locally and from other communities, the CoC has identified the following risk factors for becoming homeless: job loss, medical/ unforeseen expenses, no or low income, frequent moves for economic reasons (2 times within 60 days), past evictions or homeless episodes, pregnancy, children under age 2, head of household under age 24, previously in foster care, criminal history, child welfare involvement, sexual orientation-related discrimination, and disabling conditions including substance abuse.

2) The CoC is undertaking several strategies to prevent homelessness and
divert people from homelessness. First, we have ensured that prevention and diversion resources are easily accessible through a call center and walk-in sites. Our CoC created a Short-Term Stability Services program, initially funded by Cook County as a pilot. Now CE funds 7 FTE STSS Case Managers throughout the county who work with individuals who are not eligible for homeless prevention but might instead resolve their housing crisis through short term stability focused case management and connection to mainstream resources. Our community piloted a new screening tool to better target scarce prevention resources for individuals and families most likely to become homeless. In addition, we launched a pilot to divert homeless individuals and families from shelter. Diversion services stabilize a household to prevent homelessness and include landlord or family mediation, connections to mainstream resources and legal services, and financial assistance. Finally, the CoC is working with the child welfare, justice, and health care system to identify improved strategies to reduce the risk of homelessness for households exiting those systems.

3) The CoC Program Director is responsible for overseeing these strategies with the support of the Prevention/Diversion committee.

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

Applicants must:

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

102


Applicants must:

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

(limit 2,000 characters)

1) The CoC utilizes several strategies to reduce LOTH. First, we use our CE system to identify, prioritize, and house the most vulnerable people and longest stayers. Weekly case conferencing and proactive outreach helps to coordinate and accelerate the housing process for permanent supportive housing, rapid rehousing and other permanent housing options. CE policy ensures that certain vulnerable populations like youth and families are assessed for housing immediately so they can be connected to resources like RRH as quickly as possible. In addition, we used data to track our progress and guide our work. For example, we have created HMIS reports to help providers prioritize engaging their longest stayers. In addition, we use data to track our progress toward ending veteran and chronic homelessness in Built for Zero, a national effort to end homelessness. We have begun targeting resources like rapid rehousing to people who might not need the intensive services offered through
PSH but have long histories of homelessness. We are implementing a pilot to divert households from entering shelter if they came from a housed situation and to rapidly exit new entries to shelter by leveraging a household’s support network.

2) The CoC identifies and houses the most vulnerable and longest stayers through CE. There are numerous CE access points as well as outreach across the community to target people with the longest stays. The CoC uses HMIS to determine LOTH and has a uniform CH documentation form across all CoC programs to improve data quality on LOTH. The CE vulnerability assessment and LOTH are used to prioritize long stayers for CoC resources. The CoC is also prioritizing some long stayers who might not need intensive services to RRH, and exploring non-CoC resources to house long stayers, such as subsidized senior housing.

3) The CE project team at Housing Forward oversees these strategies.

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

Applicants must:

<table>
<thead>
<tr>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>33%</td>
</tr>
<tr>
<td>98%</td>
</tr>
</tbody>
</table>

1. Report the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid rehousing that exit to permanent housing destinations as reported in HDX.

2. Report the percentage of individuals and persons in families in permanent housing projects, other than rapid rehousing, that retain their permanent housing or exit to permanent housing destinations as reported in HDX.

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

Applicants must:

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

(limit 2,000 characters)

1) We are implementing a diversion pilot to identify and divert families that are
entering shelter from housed situations, and rapidly exit new entries to shelter. The CE team oversees housing matching to ensure that PH placement is quick, efficient, and client-centered. Weekly case conferencing helps to improve coordination and accelerate the housing process. Participation in initiatives like Built for Zero help our community to identify and address barriers to housing people quickly and to track our progress using data. Our community is exploring non-CoC resources to help exit people from homelessness. For example, in partnership with the PHA, we were awarded Mainstream Program and Family Unification Program vouchers, and we applied for more mainstream vouchers this year. Several CoC providers have created new PH options using non-CoC funding sources, and we have a Move On program through our PHA that helps free up PSH. To increase the rate clients exit RRH, our CoC has created a RRH learning collaborative to train providers on best practices such as progressive engagement and standards for program exit.

2) The CoC Program Director is responsible for this strategy.

3) In order to increase housing retention, our CE team provides training on best practices for working with clients such as motivational interviewing, nonviolent crisis intervention, housing first, harm reduction, and trauma-informed care. Another strategy we use to increase retention is case conferencing, which offers the opportunity for providers to troubleshoot challenges with clients who are at risk of losing their housing. Our providers also leverage partnerships with community resources to better support clients in housing. Finally, in July 2019, the CoC adopted a termination policy, which ensures that all housing projects follow best practices like housing first, and that termination from projects is rare.

4) The Housing Forward CE team and the Alliance is responsible for this strategy.

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

**Applicants must:**

1. Report the percentage of individuals and persons in families returning to homelessness over a 6-month period as reported in HDX. **10%**

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

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

**Applicants must:**

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

1) The CoC uses a tracking tool in HMIS that allows providers to see if a client was previously housed in the system before the current episode of
homelessness, and the CoC can view returns to homelessness at a systems level. Our CE call center and access points have developed diversion and prevention screening questions to identify households that are at-risk of homelessness or are seeking shelter but could potentially be diverted. This includes questions that identify past episodes of homelessness. Shelter, outreach, and support centers ask universal intake questions that identify whether a household had previous episodes of homelessness.

2) The CoC utilizes several strategies to reduce returns to homelessness. First, the CoC used HMIS data and research to identify common factors among households who return to homelessness to inform our prevention and diversion screening questions. These questions help prioritize prevention and diversion resources to people most at risk of becoming homeless, including people with past episodes of homelessness. Second, the CoC adopted a system-wide termination policy to ensure that all housing programs use best practices like housing first to ensure program termination is rare. Potential terminations are referred to the CE team for housing stability case conferencing. The CoC trains housing providers on best practices to ensure housing stability on topics such as housing first, harm reduction, trauma-informed care, and motivational interviewing, and organizes a RRH learning collaborative to help improve program performance. CoC providers are trained to have a strong program exit process, which includes connecting clients to community resources and information on whom to contact if they experience a housing crisis in the future. Finally, providers also follow up with households after they have exited the project to assess stability and provide support if needed.

3) The CoC Program Director and CE team oversee these strategies.

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

Applicants must:

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

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


Applicants must:

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

(limit 2,000 characters)

1 and 2) The CoC utilizes multiple strategies to increase employment income
and access to employment. First, the CoC has established an MOU with the local workforce investment board to meet regularly to plan cross-training between employment and homeless service organizations, to develop a standard referral and collaboration process, and to consistently share employment and training opportunities with programs (e.g., job fairs, apprenticeship programs, internships, training programs). Second, the CoC incentivizes providers to increase employment income by including measures on this in the ranking tool. Third, the CoC shares information about employment opportunities and job fairs with its members in meetings and by email. To further increase access to employment, CoC providers offer transportation assistance to and from employment and training programs. In addition, providers look for housing near a client’s employment, close to public transportation, and where job opportunities are more readily available. For example, the CoC encourages mainstream voucher program participants to locate to an opportunity zone and the local PHA offers housing search assistance and financial assistance for the security deposit to do so. 3) The CoC and providers also proactively build relationships with employment and mainstream service providers that will serve people who are homeless. For example, the CoC has an MOU with the local workforce investment board to better connect clients to employment and training resources. The majority (97%) of CoC projects offer their own employment programs, vocational training programs, and/or have relationships with regional American Job Centers (one-stops). The CoC regional councils often invite local resources to meetings to share information about employment and training opportunities.

4) The Alliance’s Program Coordinator oversees these strategies.


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

1 and 2) The CoC utilizes multiple tactics to increase non-employment cash income and access to non-employment cash income. To increase successful SSI/SSDI applications, the CoC encourages all programs to have at least one staff trained in SSI/SSDI Outreach, Access, and Recovery (SOAR). All CoC-funded housing provides have SOAR trained staff. The CoC also encourages providers to utilize a standard screening tool and application for public benefits (i.e. Medicaid, TANF, SNAP, etc.). All CoC-funded providers use the online Illinois Consolidated Application for Benefits to apply for public benefits with clients. The CoC also serves as a clearinghouse for mainstream resources. The CoC regularly receives and shares info on mainstream resources on a listserv and in monthly regional council meetings to ensure providers are educated on the resources available in the community. The CoC incentivizes increasing non-employment cash income on the project ranking tool. Finally, CoC providers accompany clients to mainstream benefit appointments and provide transportation assistance to help clients obtain benefits.

3) The CoC Program Coordinator is responsible for overseeing this strategy.

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

(limit 2,000 characters)

1) The CoC promotes partnerships with employers and employment organizations in multiple ways. First, the CoC and members share info on job fairs and employment opportunities with programs by email and in meetings. Second, the CoC incentivizes programs to connect clients to employment in the project ranking tool. The CoC also has a formal agreement with the workforce investment board to conduct cross training between job training programs and homeless service providers and to share information about job opportunities. Many CoC programs have employment specialists that identify job opportunities for clients, host job fairs, and coordinate with American Jobs Centers.

2) The CoC encourages meaningful education, training, internship, and employment opportunities for PSH residents in multiple ways. First, the CoC recruits and supports PSH residents to participate on the board and at committee meetings. Participants receive a stipend, contribute to the work to end homelessness, and gain valuable skills. The CoC also invites PSH residents to join local speaker’s bureaus and participate in local training targeting people who have experienced homelessness to share their story and learn to be effective advocates. Residents are invited to meetings with elected officials and advocacy days. The CoC encourages providers to support PSH residents’ participation in meaningful activities including employment through annual training conducted by our coordinated entry team. CoC programs offer various employment support to PSH clients, including supported employment and Individual Placement and Support (IPS), which targets people with a mental illness living in PSH. The CoC also promotes a culture of recovery in PSH by hosting events for PSH residents and their case managers to advertise FLOW, a Move-on program, to encourage participants to set goals that will help them eventually move on from PSH.


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

1. The CoC trains provider organization staff on connecting program participants and people experiencing homelessness with education and job training opportunities.
2. The CoC trains provider organization staff on facilitating informal employment opportunities for program participants and people experiencing homelessness (e.g., babysitting, housekeeping, food delivery).
3. The CoC trains provider organization staff on connecting program participants with formal employment opportunities.
4. The CoC trains provider organization staff on volunteer opportunities for program participants and people experiencing homelessness.

5. The CoC works with organizations to create volunteer opportunities for program participants.

6. The CoC works with community organizations to create opportunities for civic participation for people experiencing homelessness (e.g., townhall forums, meeting with public officials).

7. Provider organizations within the CoC have incentives for employment.

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

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

Applicants must enter the date the CoCs submitted its FY 2018 System Performance Measures data in HDX. (mm/dd/yyyy)
3B. Continuum of Care (CoC) Performance and Strategic Planning Objectives

Instructions

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

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3B-1. Prioritizing Households with Children.

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

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

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

Applicants must:
1. describe how the CoC currently rehouses every household of families with children within 30 days of becoming homeless that addresses both housing and service needs;
2. describe how the CoC addresses both housing and service needs to ensure families with children successfully maintain their housing once
assistance ends; and
3. provide the organization name or position title responsible for overseeing the CoC’s strategy to rapidly rehouse families with children within 30 days of them becoming homeless.
(limit 2,000 characters)

1) The CoC strategy to rehouse households with children within 30 days of becoming homeless starts with identifying household type in the initial section of the CE phased assessment. Families are immediately assessed at the time of intake with the family VI-SPDAT. Housing is then offered based on need, availability, and participant preference. To increase availability of PH for families, the CoC provided technical assistance to projects seeking to convert from TH to RRH resulting in over an increase in RRH available to families from 2014 to the present. In addition, the CoC worked with ESG recipients like Cook County and the State to increase the amount of ESG used for RRH. The CoC launched a homeless diversion and rapid exit pilot, which engages families and individuals who are entering shelter from a housed situation to divert or rapidly exit the client from shelter using case management, conflict resolution, and financial assistance.

2) The CoC works to ensure families successfully maintain housing once their assistance ends by connecting families to mainstream and community resources prior to program exit, following up with clients after program exit to assess stability and provide support if needed, and informing clients whom to contact if they face another housing crisis. Last fall, RRH providers began participating in a learning collaborative to improve practices across our CoC, including good exit planning. RRH providers also offer case management and housing location support to help clients find units that are affordable after the program subsidy ends. In addition, providers work to help clients increase income, develop savings, and improve financial literacy to ensure families maintain housing once assistance ends.

3) The Housing Forward CE project team oversees the strategy to reduce family homelessness.

3B-1b. Antidiscrimination Policies.

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

1. CoC conducts mandatory training for all CoC- and ESG-funded housing and services providers on these topics. X
2. CoC conducts optional training for all CoC- and ESG-funded housing and service providers on these topics. [ ]
3. CoC has worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients. X
3B-1c. Unaccompanied Youth Experiencing Homelessness–Addressing Needs.

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

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

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

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

<table>
<thead>
<tr>
<th>Category</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of, or Vulnerability to, Victimization (e.g., domestic violence, sexual assault, childhood abuse)</td>
<td></td>
</tr>
<tr>
<td>2. Number of Previous Homeless Episodes</td>
<td></td>
</tr>
<tr>
<td>3. Unsheltered Homelessness</td>
<td></td>
</tr>
<tr>
<td>4. Criminal History</td>
<td></td>
</tr>
<tr>
<td>5. Bad Credit or Rental History</td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

(limit 3,000 characters)
1) and 2) The CoC is utilizing multiple strategies to more effectively serve all
youth experiencing homelessness, including unsheltered youth. Last fall, during
the 100-day challenge to jumpstart efforts to prevent and end youth
homelessness, our community identified several strategies to improve
identification of youth in need of services and to increase the number of youth
housed during that time period. Our strategies included improving outreach to
identify youth, changing prioritization for CoC and ESG housing programs to
give youth access to these resources, completing a backlog of youth
assessments for housing, training our existing “adult” providers to be better
equipped to work with youth, partnering with schools, and collaborating with
other systems like child welfare. Our Youth Action Board (YAB), composed of
youth with lived experience of homelessness, reported that they did not
consider themselves homeless or know where to go to get help. In order to
better reach youth and connect them to housing and support through our
coordinated entry system, the YAB helped our community design marketing
materials and conduct outreach to sites that may encounter youth such as
schools, libraries, benefit offices, community centers, and police stations. Not
long before the 100-day challenge, there were few CoC resources specifically
dedicated to youth so there was little incentive for youth providers to assess
young people for housing interventions. However, to increase resources for
youth, the CoC developed new prioritization protocol to ensure that a portion of
our RRH resources go to TAY and prioritize PSH to chronically homeless youth
when appropriate. As part of the 100-day challenge, our community set a goal
to assess all youth currently active in our system newly prioritized CoC
resources and other housing resources like the Family Unification Program
(FUP). Our community also provided support to exiting projects to be more
youth-specific by requiring training on working with youth and the LGBTQ
population. The CoC also did outreach to dozens of K-12 schools to educate
them on how to connect homeless students to services through the CoC and to
implement state legislation that our community helped pass allowing school
districts to use transportation funding for housing homeless students. Finally,
the CoC has developed formal partnerships with key stakeholders needed to
more effectively prevent and end youth homelessness including the juvenile
justice system, welfare system, education system, and workforce development
system. For example, the CoC worked with our local PHA and welfare agency
to apply for Family Unification Program vouchers in 2018. Our community was
awarded vouchers and is now working closely with the child welfare agency and
member agencies to identify youth for the program. As a YHDP community, our
community will build on these strategies to create new projects and improved
systems to better prevent and end youth homelessness.

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

Applicants must:
1. provide evidence the CoC uses to measure each of the strategies in
question 3B-1d. to increase the availability of housing and services for
youth experiencing homelessness;
2. describe the measure(s) the CoC uses to calculate the effectiveness of
both strategies in question 3B-1d.; and
3. describe why the CoC believes the measure it uses is an appropriate
way to determine the effectiveness of both strategies in question 3B-1d.
(limit 3,000 characters)
1) and 2) There are several measures that illustrate the success of the previously mentioned strategies to increase housing and services for youth, particularly for the strategies pursued during the 100-day challenge. We measured the success of outreach to better identify youth by marketing to over 100 new stakeholders and increasing the number of youth identified in our system by approximately 20%. During the 100-day challenge, we also set an ambitious goal to connect 75 youth with safe and stable housing. We tracked weekly housing placement rates and exits to permanent destinations and housed 79 TAY households during that time frame. We also set out to assess youth for housing resources through the CoC and for the Family Unification Program and assessed 95% of the youth in our system. We engaged dozens of school districts to educate them on how to better identify youth who are homeless, connect students to housing resources, and implement state legislation to house homeless students with transportation funding. Two school districts implemented the new legislation and housed 3 students during the 100 days. During the application process for the Youth Homeless Demonstration Program grant, we developed 17 formal partnerships with various systems including child welfare, juvenile justice, education, RHY providers, and the public housing authority to work together to prevent and end youth homelessness. Due to collaboration between our local PHA and welfare agency, we applied for and were awarded 89 FUP vouchers with a percentage dedicated to youth. During the 100-days we conducted training for CoC providers on best practices for working with youth and a training on best practices for working with the LGBTQ population. These measures were tracked during the 100-day challenge and we continue to track progress on these efforts. Additional measures that determine the effectiveness of the strategies include trends in the number of youth who were homeless over the course of the month and year that are active in HMIS, identified during the PIT count, and by homeless liaisons in schools. In addition, our system performance measures help us measure the effectiveness of youth providers in several domains including housing and employment. As a YHDP community, we are working to establish metrics that include all USICH core outcomes for ending youth homelessness including: achieving stable housing, building permanent connections, achieving education and employment goals, and developing social-emotional well-being

3) The CoC chose these measures because they will help us track the extent to which our housing and services for youth increase and the impact of those increases on our overall youth homelessness numbers and program outcomes. Our CoC, youth committee, and Youth Action Board will continue to examine our progress towards ending youth homelessness and how we most effectively measure it.

**3B-1e. Collaboration–Education Services.**

Applicants must describe:

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

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

(limit 2,000 characters)

1. and 2. A formal partnership was formed between the 3 regional McKinney-Vento Educational Liaisons and the CoC to support the work to end youth homelessness, to better identify students who are homeless, to conduct cross-training for both systems, and to implement state legislation to use transportation funding to house homeless students and their families within the school district. These regional liaisons provide oversight over every school district within the CoC service area. As part of an effort to implement this new legislation, CoC staff have attended meetings with dozens of school districts across the CoC to educate schools on homelessness and the legislation. The target audience for the sessions included homeless liaisons, school social workers, and district leadership. The CoC made a formal partnership with School District 63 to house homeless students using resources from the new legislation and to educate other school districts on how to partner with local CoC providers to implement the new law. As part of the effort to spread the use of the new legislation, the CoC, District 63, the regional McKinney-Vento Liaisons, and a CoC program are presenting to providers at a state-wide conference this October and sharing a toolkit the CoC created to help school districts implement the law. The 3 McKinney-Vento regional liaisons are also active participants in CoC meetings and committees, including the youth committee and regional councils.

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

Applicants must describe policies and procedures the CoC adopted to inform individuals and families who become homeless of their eligibility for education services.

(limit 2,000 characters)

The CoC has established policies and procedures in our coordinated entry system to ensure that family with children that enter a CoC program are immediately assessed to identify housing needs and what education and early childhood services families are eligible for. If the children are school-age, the CoC provider works jointly with the school homeless liaisons to ensure children can attend their school of origin without disruption if they choose to do so or transfer to the district in which they are temporarily staying. If the children are not school-age, providers and liaisons work to determine if children qualify for early childhood services. In addition, CoC providers and school homeless liaisons educate the family on their rights and other services they are eligible for, such as transportation assistance, free meals, and the waiving of school fees. Regional McKinney-Vento Liaisons come regularly to CoC meetings to educate CoC and ESG providers on the rights of homeless students and the resources available through the school system, and to better understand CoC and ESG resources. With the passage of state legislation that allow schools to use transportation funding to help house homeless students near their school of origin, school districts, CoC providers, and homeless liaisons are developing protocols to take advantage of this new resource.
3B-1e.2. Written/Formal Agreements or Partnerships with Early Childhood Services Providers.

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

<table>
<thead>
<tr>
<th>Early Childhood Providers</th>
<th>MOU/OA</th>
<th>Other Formal Agreement</th>
</tr>
</thead>
<tbody>
<tr>
<td>Head Start</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Early Head Start</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Child Care and Development Fund</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Federal Home Visiting Program</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Healthy Start</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Public Pre-K</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Birth to 3 years</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Tribal Home Visiting Program</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Other: (limit 50 characters)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

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

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

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

3B-2b. Housing First for Veterans.

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


Applicants must:
1. select all that apply to indicate the findings from the CoC’s Racial Disparity Assessment; or
2. select 7 if the CoC did not conduct a Racial Disparity Assessment.
1. People of different races or ethnicities are more likely to receive homeless assistance.  
   
2. People of different races or ethnicities are less likely to receive homeless assistance.  

3. People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.  

4. People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.  

5. There are no racial or ethnic disparities in the provision or outcome of homeless assistance.  

6. The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.  

7. The CoC did not conduct a racial disparity assessment.  

3B-3a. Addressing Racial Disparities.

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

1. The CoC is ensuring that staff at the project level are representative of the persons accessing homeless services in the CoC.  

2. The CoC has identified the cause(s) of racial disparities in their homeless system.  

3. The CoC has identified strategies to reduce disparities in their homeless system.  

4. The CoC has implemented strategies to reduce disparities in their homeless system.  

5. The CoC has identified resources available to reduce disparities in their homeless system.  

6. The CoC did not conduct a racial disparity assessment.
4A. Continuum of Care (CoC) Accessing Mainstream Benefits and Additional Policies

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

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

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

4A-1. Healthcare–Enrollment/Effective Utilization

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

<table>
<thead>
<tr>
<th>Type of Health Care</th>
<th>Assist with Enrollment</th>
<th>Assist with Utilization of Benefits?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Private Insurers:</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Non-Profit, Philanthropic:</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other: (limit 50 characters)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


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

Applicant: Cook County Continuum of Care
Project: IL-511 CoC Registration FY2019

COC_REG_2019_170654
health insurance;
4. describe how the CoC provides assistance with the effective utilization of Medicaid and other benefits; and
5. provide the name of the organization or position title that is responsible for overseeing the CoC’s strategy for mainstream benefits.
(limit 2,000 characters)

1) The CoC keeps providers up-to-date on resources by organizing trainings on benefit programs and best practices. For example, our CoC Program Specialist is the SOAR coordinator for our region, which means she provides support to ensure our program staff get trained in SOAR to improve access to SSI/SSDI. The CoC regional councils invite mainstream providers to their meetings to improve collaboration. The CoC shares info on mainstream resources via email and at CoC meetings. The CoC incentivizes partners to work with mainstream organizations by assigning points to these activities in our project ranking tools. As a result, most organizations have benefit specialists on staff that help clients apply for mainstream programs. All CoC-funded providers use the Illinois Consolidated Application for Benefits, a standard screening tool at intake for mainstream benefits, including SNAP, TANF, and Medicaid. Finally, the CoC uses HMIS data to monitor program performance in this area.

2) The CoC disseminates the availability of mainstream resources via email, at monthly CoC meetings, and training several times a year.

3) The CoC partners with healthcare organizations to improve connections to health insurance. For example, County Care, the largest Managed Care Organization (MCO) in our region, came to a CoC meeting to train providers on how to enroll clients in health insurance and collaborate with MCO care coordinators.

4) The CoC uses a standard intake form to identify the benefits a client needs to apply for, including Medicaid. A required field in HMIS is health insurance, including the name of the Medicaid provider, which helps the CoC track benefits obtained. Certain housing is targeted to clients with Medicaid from the largest MCO in the region, so our CE team is regularly checking to ensure people are being enrolled.

5) The CoC Program Coordinator oversees these strategies.

4A-2. Lowering Barriers to Entry Data:

Applicants must report:

| 1. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition. | 33 |
| 2. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing. | 33 |
| Percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects the CoC has ranked in its CoC Priority Listing in the FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing. | 100% |

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

(limit 2,000 characters)

1) The CoC’s outreach team consists of 3 VA staff and 8 provider staff. In addition, we have 1 CE staff that leads the outreach committee to develop and implement a community outreach plan and train providers on best practices. To expand the outreach team reach, the outreach committee plans events quarterly to engage community stakeholders (libraries, police, hospitals, parks, etc.) to educate stakeholders on how to connect people who are homeless to outreach and the coordinated entry system. All outreach staff are trained assessors for the CE system.

2) Our team covers 100% of our geography.

3) Currently, outreach is conducted 5 days a week with pending plans to expand beyond business hours.

4) Outreach staff reach persons least likely to request assistance in several ways. First, outreach workers are assigned unsheltered persons from the By Name List and visit other hotspots like libraries, parks & underpasses to engage new participants. Outreach staff inform community stakeholders of what outreach staff is assigned to that area. In addition, teams have access to translation services & written materials in several languages. Several outreach staff speak Spanish. Outreach staff are trained in mental health first aid & de-escalation to meet the needs of people experiencing a mental health crisis. Outreach workers meet the needs of people with transportation barriers by meeting with them in the field. Although our outreach covers 100% of our geography, we have a massive area to cover. In the last year, we have mapped the areas that our outreach workers go to, and areas that we do not reach frequently due to capacity issues. To hit these locations, outreach providers have teamed up to do outreach blitzes targeting people who are homeless and sharing information with places people who are homeless often go (libraries, police stations, hospitals, etc.).

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

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

<table>
<thead>
<tr>
<th>RRH beds available to serve all populations in the HIC</th>
<th>2018</th>
<th>2019</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>250</td>
<td>318</td>
<td>68</td>
</tr>
</tbody>
</table>

Applicant: Cook County Continuum of Care
Project: IL-511 CoC Registration FY2019
4A-5. Rehabilitation/Construction Costs–New Projects. No

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

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

Applicants must indicate whether the CoC is requesting to designate one or more of its SSO or TH projects to serve families with children or youth defined as homeless under other federal statutes.
4B. Attachments

**Instructions:**

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

<table>
<thead>
<tr>
<th>Document Type</th>
<th>Required?</th>
<th>Document Description</th>
<th>Date Attached</th>
</tr>
</thead>
<tbody>
<tr>
<td>FY 2019 CoC Competition Report (HDX Report)</td>
<td>Yes</td>
<td>FY2019 CoC Compet...</td>
<td>07/30/2019</td>
</tr>
<tr>
<td>1C-4. PHA Administration Plan–Moving On Multifamily Assisted Housing Owners’ Preference.</td>
<td>No</td>
<td>Moving on Multifa...</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>1C-4. PHA Administrative Plan Homeless Preference.</td>
<td>No</td>
<td>PHA Administratio...</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>1C-7. Centralized or Coordinated Assessment System.</td>
<td>Yes</td>
<td>CE Assessment Tool</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting–15-Day Notification Outside e-snaps–Projects Accepted.</td>
<td>Yes</td>
<td>Project Accepted ...</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting–15-Day Notification Outside e-snaps–Projects Rejected or Reduced.</td>
<td>Yes</td>
<td>Project Rejected/...</td>
<td>09/26/2019</td>
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<tr>
<td>1E-1. Public Posting–30-Day Local Competition Deadline.</td>
<td>Yes</td>
<td>Local Competition...</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting–Local Competition Announcement.</td>
<td>Yes</td>
<td>Local Competition...</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>1E-4. Public Posting–CoC-Approved Consolidated Application</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A. Written Agreement with Local Education or Training Organization.</td>
<td>No</td>
<td>Local Education o...</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>3A. Written Agreement with State or Local Workforce Development Board.</td>
<td>No</td>
<td>State or Local Wo...</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>3B-3. Summary of Racial Disparity Assessment.</td>
<td>Yes</td>
<td>Racial Disparity ...</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>4A-7a. Project List-Homeless under Other Federal Statutes.</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Other</td>
<td>No</td>
<td></td>
<td></td>
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<tr>
<td>-------</td>
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<td>---</td>
</tr>
</tbody>
</table>
Attachment Details

**Document Description:** FY2019 CoC Competition Report

Attachment Details

**Document Description:** Moving on Multifamily Preference

Attachment Details

**Document Description:** PHA Administration Plan Preference

Attachment Details

**Document Description:** CE Assessment Tool

Attachment Details

**Document Description:** Project Accepted Notification

Attachment Details

**Document Description:** Project Rejected/Reduced Notification
Attachment Details

Document Description: Local Competition Deadline

Attachment Details

Document Description: Local Competition Public Announcement

Attachment Details

Document Description:

Attachment Details

Document Description: Local Education or Training Organization Agreement

Attachment Details

Document Description: State or Local Workforce Agreement
Document Description: Racial Disparity Assessment Summary

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:
Submission Summary

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

<table>
<thead>
<tr>
<th>Page</th>
<th>Last Updated</th>
</tr>
</thead>
<tbody>
<tr>
<td>1A. Identification</td>
<td>09/15/2019</td>
</tr>
<tr>
<td>1B. Engagement</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>1C. Coordination</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>1D. Discharge Planning</td>
<td>No Input Required</td>
</tr>
<tr>
<td>1E. Local CoC Competition</td>
<td>09/25/2019</td>
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<tr>
<td>1F. DV Bonus</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>2A. HMIS Implementation</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>2B. PIT Count</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>3A. System Performance</td>
<td>09/26/2019</td>
</tr>
<tr>
<td>3B. Performance and Strategic Planning</td>
<td>09/25/2019</td>
</tr>
<tr>
<td>4A. Mainstream Benefits and Additional Policies</td>
<td>09/25/2019</td>
</tr>
<tr>
<td>4B. Attachments</td>
<td>Please Complete</td>
</tr>
<tr>
<td>Submission Summary</td>
<td>No Input Required</td>
</tr>
</tbody>
</table>

Applicant: Cook County Continuum of Care  
Project: IL-511 CoC Registration FY2019
### Total Population PIT Count Data

<table>
<thead>
<tr>
<th></th>
<th>2016 PIT</th>
<th>2017 PIT</th>
<th>2018 PIT</th>
<th>2019 PIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sheltered and Unsheltered Count</td>
<td>952</td>
<td>780</td>
<td>873</td>
<td>897</td>
</tr>
<tr>
<td>Emergency Shelter Total</td>
<td>449</td>
<td>443</td>
<td>511</td>
<td>533</td>
</tr>
<tr>
<td>Safe Haven Total</td>
<td>23</td>
<td>23</td>
<td>24</td>
<td>21</td>
</tr>
<tr>
<td>Transitional Housing Total</td>
<td>370</td>
<td>222</td>
<td>246</td>
<td>238</td>
</tr>
<tr>
<td>Total Sheltered Count</td>
<td>842</td>
<td>688</td>
<td>781</td>
<td>792</td>
</tr>
<tr>
<td>Total Unsheltered Count</td>
<td>110</td>
<td>92</td>
<td>92</td>
<td>105</td>
</tr>
</tbody>
</table>

### Chronically Homeless PIT Counts

<table>
<thead>
<tr>
<th></th>
<th>2016 PIT</th>
<th>2017 PIT</th>
<th>2018 PIT</th>
<th>2019 PIT</th>
</tr>
</thead>
<tbody>
<tr>
<td>Total Sheltered and Unsheltered Count of Chronically Homeless Persons</td>
<td>128</td>
<td>107</td>
<td>134</td>
<td>142</td>
</tr>
<tr>
<td>Sheltered Count of Chronically Homeless Persons</td>
<td>103</td>
<td>84</td>
<td>111</td>
<td>121</td>
</tr>
<tr>
<td>Unsheltered Count of Chronically Homeless Persons</td>
<td>25</td>
<td>23</td>
<td>23</td>
<td>21</td>
</tr>
</tbody>
</table>
## Homeless Households with Children PIT Counts

<table>
<thead>
<tr>
<th></th>
<th>2016 PIT</th>
<th>2017 PIT</th>
<th>2018 PIT</th>
<th>2019 PIT</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Sheltered and Unsheltered Count of the Number of Homeless Households with Children</strong></td>
<td>136</td>
<td>93</td>
<td>105</td>
<td>113</td>
</tr>
<tr>
<td><strong>Sheltered Count of Homeless Households with Children</strong></td>
<td>136</td>
<td>92</td>
<td>104</td>
<td>113</td>
</tr>
<tr>
<td><strong>Unsheltered Count of Homeless Households with Children</strong></td>
<td>0</td>
<td>1</td>
<td>1</td>
<td>0</td>
</tr>
</tbody>
</table>

## Homeless Veteran PIT Counts

<table>
<thead>
<tr>
<th></th>
<th>2011</th>
<th>2016</th>
<th>2017</th>
<th>2018</th>
<th>2019</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Total Sheltered and Unsheltered Count of the Number of Homeless Veterans</strong></td>
<td>118</td>
<td>81</td>
<td>53</td>
<td>50</td>
<td>43</td>
</tr>
<tr>
<td><strong>Sheltered Count of Homeless Veterans</strong></td>
<td>91</td>
<td>74</td>
<td>50</td>
<td>47</td>
<td>38</td>
</tr>
<tr>
<td><strong>Unsheltered Count of Homeless Veterans</strong></td>
<td>27</td>
<td>7</td>
<td>3</td>
<td>3</td>
<td>5</td>
</tr>
</tbody>
</table>
# HMIS Bed Coverage Rate

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Total Beds in 2019 HIC</th>
<th>Total Beds in 2019 HIC Dedicated for DV</th>
<th>Total Beds in HMIS</th>
<th>HMIS Bed Coverage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shelter (ES) Beds</td>
<td>185</td>
<td>121</td>
<td>64</td>
<td>100.00%</td>
</tr>
<tr>
<td>Safe Haven (SH) Beds</td>
<td>29</td>
<td>0</td>
<td>29</td>
<td>100.00%</td>
</tr>
<tr>
<td>Transitional Housing (TH) Beds</td>
<td>253</td>
<td>51</td>
<td>202</td>
<td>100.00%</td>
</tr>
<tr>
<td>Rapid Re-Housing (RRH) Beds</td>
<td>318</td>
<td>0</td>
<td>318</td>
<td>100.00%</td>
</tr>
<tr>
<td>Permanent Supportive Housing (PSH) Beds</td>
<td>1494</td>
<td>25</td>
<td>1469</td>
<td>100.00%</td>
</tr>
<tr>
<td>Other Permanent Housing (OPH) Beds</td>
<td>10</td>
<td>0</td>
<td>10</td>
<td>100.00%</td>
</tr>
<tr>
<td><strong>Total Beds</strong></td>
<td><strong>2,289</strong></td>
<td><strong>197</strong></td>
<td><strong>2092</strong></td>
<td><strong>100.00%</strong></td>
</tr>
</tbody>
</table>
PSH Beds Dedicated to Persons Experiencing Chronic Homelessness

<table>
<thead>
<tr>
<th>Chronically Homeless Bed Counts</th>
<th>2016 HIC</th>
<th>2017 HIC</th>
<th>2018 HIC</th>
<th>2019 HIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Number of CoC Program and non-CoC Program funded PSH beds dedicated for use by chronically homeless persons identified on the HIC</td>
<td>525</td>
<td>589</td>
<td>616</td>
<td>286</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Households with Children</th>
<th>2016 HIC</th>
<th>2017 HIC</th>
<th>2018 HIC</th>
<th>2019 HIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRH units available to serve families on the HIC</td>
<td>60</td>
<td>55</td>
<td>54</td>
<td>73</td>
</tr>
</tbody>
</table>

Rapid Rehousing Beds Dedicated to All Persons

<table>
<thead>
<tr>
<th>All Household Types</th>
<th>2016 HIC</th>
<th>2017 HIC</th>
<th>2018 HIC</th>
<th>2019 HIC</th>
</tr>
</thead>
<tbody>
<tr>
<td>RRH beds available to serve all populations on the HIC</td>
<td>309</td>
<td>284</td>
<td>250</td>
<td>318</td>
</tr>
</tbody>
</table>
Measure 1: Length of Time Persons Remain Homeless

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

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

a. This measure is of the client’s entry, exit, and bed night dates strictly as entered in the HMIS system.
2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

<table>
<thead>
<tr>
<th>Universe (Persons)</th>
<th>Average LOT Homeless (bed nights)</th>
<th>Median LOT Homeless (bed nights)</th>
</tr>
</thead>
<tbody>
<tr>
<td>1.1 Persons in ES and SH</td>
<td>2262</td>
<td>2085</td>
</tr>
<tr>
<td>1.2 Persons in ES, SH, and TH</td>
<td>2704</td>
<td>2515</td>
</tr>
</tbody>
</table>

b. This measure is based on data element 3.17.

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

The construction of this measure changed, per HUD’s specifications, between FY 2016 and FY 2017. HUD is aware that this may impact the change between these two years.
Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness

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

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

<table>
<thead>
<tr>
<th>Exit Type</th>
<th>Total # of Persons who Exited to a Permanent Housing Destination (2 Years Prior)</th>
<th>Returns to Homelessness in Less than 6 Months</th>
<th>Returns to Homelessness from 6 to 12 Months</th>
<th>Returns to Homelessness from 13 to 24 Months</th>
<th>Number of Returns in 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Revised FY 2017 FY 2018 Revised FY 2017 FY 2018 % of Returns</td>
<td>Revised FY 2017 FY 2018 % of Returns</td>
<td>Revised FY 2017 FY 2018 % of Returns</td>
<td>Revised FY 2017 FY 2018 % of Returns</td>
<td>Revised FY 2017 FY 2018 % of Returns</td>
</tr>
<tr>
<td>Exit was from SO</td>
<td>63 57 15 13 23%</td>
<td>3 0 0%</td>
<td>1 2 4%</td>
<td>15 26%</td>
<td></td>
</tr>
<tr>
<td>Exit was from ES</td>
<td>181 265 52 82 31%</td>
<td>15 26 10%</td>
<td>13 9 3%</td>
<td>117 44%</td>
<td></td>
</tr>
<tr>
<td>Exit was from TH</td>
<td>316 320 14 15 5%</td>
<td>4 8 3%</td>
<td>9 11 3%</td>
<td>34 11%</td>
<td></td>
</tr>
<tr>
<td>Exit was from SH</td>
<td>17 21 0 1 5%</td>
<td>0 0 0%</td>
<td>1 0 0%</td>
<td>1 5%</td>
<td></td>
</tr>
<tr>
<td>Exit was from PH</td>
<td>385 578 14 10 2%</td>
<td>10 18 3%</td>
<td>7 9 2%</td>
<td>37 6%</td>
<td></td>
</tr>
<tr>
<td>TOTAL Returns to Homelessness</td>
<td>962 1241 95 121 10%</td>
<td>32 52 4%</td>
<td>31 31 2%</td>
<td>204 16%</td>
<td></td>
</tr>
</tbody>
</table>

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts
2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

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

<table>
<thead>
<tr>
<th></th>
<th>January 2017 PIT Count</th>
<th>January 2018 PIT Count</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Total PIT Count of sheltered and unsheltered persons</td>
<td>780</td>
<td>873</td>
<td>93</td>
</tr>
<tr>
<td>Emergency Shelter Total</td>
<td>443</td>
<td>511</td>
<td>68</td>
</tr>
<tr>
<td>Safe Haven Total</td>
<td>23</td>
<td>24</td>
<td>1</td>
</tr>
<tr>
<td>Transitional Housing Total</td>
<td>222</td>
<td>246</td>
<td>24</td>
</tr>
<tr>
<td>Total Sheltered Count</td>
<td>688</td>
<td>781</td>
<td>93</td>
</tr>
<tr>
<td>Unsheltered Count</td>
<td>92</td>
<td>92</td>
<td>0</td>
</tr>
</tbody>
</table>

Metric 3.2 – Change in Annual Counts

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Unduplicated Total sheltered homeless persons</td>
<td>2735</td>
<td>2562</td>
<td>2284</td>
<td>-278</td>
</tr>
<tr>
<td>Emergency Shelter Total</td>
<td>2225</td>
<td>2066</td>
<td>1890</td>
<td>-176</td>
</tr>
<tr>
<td>Safe Haven Total</td>
<td>73</td>
<td>72</td>
<td>75</td>
<td>3</td>
</tr>
<tr>
<td>Transitional Housing Total</td>
<td>492</td>
<td>477</td>
<td>372</td>
<td>-105</td>
</tr>
</tbody>
</table>
Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults (system stayers)</td>
<td>392</td>
<td>445</td>
<td>414</td>
<td>-31</td>
</tr>
<tr>
<td>Number of adults with increased earned income</td>
<td>22</td>
<td>52</td>
<td>53</td>
<td>1</td>
</tr>
<tr>
<td>Percentage of adults who increased earned income</td>
<td>6%</td>
<td>12%</td>
<td>13%</td>
<td>1%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults (system stayers)</td>
<td>392</td>
<td>445</td>
<td>414</td>
<td>-31</td>
</tr>
<tr>
<td>Number of adults with increased non-employment cash income</td>
<td>99</td>
<td>87</td>
<td>126</td>
<td>39</td>
</tr>
<tr>
<td>Percentage of adults who increased non-employment cash income</td>
<td>25%</td>
<td>20%</td>
<td>30%</td>
<td>10%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults (system stayers)</td>
<td>392</td>
<td>445</td>
<td>414</td>
<td>-31</td>
</tr>
<tr>
<td>Number of adults with increased total income</td>
<td>112</td>
<td>102</td>
<td>150</td>
<td>48</td>
</tr>
<tr>
<td>Percentage of adults who increased total income</td>
<td>29%</td>
<td>23%</td>
<td>36%</td>
<td>13%</td>
</tr>
</tbody>
</table>
2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

Metric 4.4 – Change in earned income for adult system leavers

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults</td>
<td>236</td>
<td>234</td>
<td>162</td>
<td>-72</td>
</tr>
<tr>
<td>who exited (system leavers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of adults who exited</td>
<td>59</td>
<td>60</td>
<td>28</td>
<td>-32</td>
</tr>
<tr>
<td>with increased earned income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of adults who</td>
<td>25%</td>
<td>26%</td>
<td>17%</td>
<td>-9%</td>
</tr>
<tr>
<td>increased earned income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults</td>
<td>236</td>
<td>234</td>
<td>162</td>
<td>-72</td>
</tr>
<tr>
<td>who exited (system leavers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of adults who exited</td>
<td>28</td>
<td>29</td>
<td>30</td>
<td>1</td>
</tr>
<tr>
<td>with increased non-employment</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>cash income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of adults who</td>
<td>12%</td>
<td>12%</td>
<td>19%</td>
<td>7%</td>
</tr>
<tr>
<td>increased non-employment cash</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Metric 4.6 – Change in total income for adult system leavers

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults</td>
<td>236</td>
<td>234</td>
<td>162</td>
<td>-72</td>
</tr>
<tr>
<td>who exited (system leavers)</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Number of adults who exited</td>
<td>79</td>
<td>80</td>
<td>54</td>
<td>-26</td>
</tr>
<tr>
<td>with increased total income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Percentage of adults who</td>
<td>33%</td>
<td>34%</td>
<td>33%</td>
<td>-1%</td>
</tr>
<tr>
<td>increased total income</td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
# Measure 5: Number of persons who become homeless for the 1st time

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Person with entries into ES, SH or TH during the reporting period.</td>
<td>2470</td>
<td>2341</td>
<td>2076</td>
<td>-265</td>
</tr>
<tr>
<td>Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.</td>
<td>769</td>
<td>743</td>
<td>769</td>
<td>26</td>
</tr>
<tr>
<td>Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time)</td>
<td>1701</td>
<td>1598</td>
<td>1307</td>
<td>-291</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Person with entries into ES, SH, TH or PH during the reporting period.</td>
<td>3065</td>
<td>2909</td>
<td>2492</td>
<td>-417</td>
</tr>
<tr>
<td>Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.</td>
<td>857</td>
<td>833</td>
<td>909</td>
<td>76</td>
</tr>
<tr>
<td>Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)</td>
<td>2208</td>
<td>2076</td>
<td>1583</td>
<td>-493</td>
</tr>
</tbody>
</table>
Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD’s Homeless Definition in CoC Program-funded Projects

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

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

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

<table>
<thead>
<tr>
<th></th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Persons who exit Street Outreach</td>
<td>269</td>
<td>305</td>
<td>381</td>
<td>76</td>
</tr>
<tr>
<td>Of persons above, those who exited to temporary &amp; some institutional destinations</td>
<td>24</td>
<td>28</td>
<td>90</td>
<td>62</td>
</tr>
<tr>
<td>Of the persons above, those who exited to permanent housing destinations</td>
<td>56</td>
<td>68</td>
<td>104</td>
<td>36</td>
</tr>
<tr>
<td>% Successful exits</td>
<td>30%</td>
<td>31%</td>
<td>51%</td>
<td>20%</td>
</tr>
</tbody>
</table>

Metric 7b.1 – Change in exits to permanent housing destinations
### Metric 7b.2 – Change in exit to or retention of permanent housing

<table>
<thead>
<tr>
<th>Metric</th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing</td>
<td>2543</td>
<td>2347</td>
<td>1969</td>
<td>-378</td>
</tr>
<tr>
<td>Of the persons above, those who exited to permanent housing destinations</td>
<td>928</td>
<td>800</td>
<td>644</td>
<td>-156</td>
</tr>
<tr>
<td>% Successful exits</td>
<td>36%</td>
<td>34%</td>
<td>33%</td>
<td>-1%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Metric</th>
<th>Submitted FY 2017</th>
<th>Revised FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Persons in all PH projects except PH-RRH</td>
<td>1273</td>
<td>1232</td>
<td>1220</td>
<td>-12</td>
</tr>
<tr>
<td>Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations</td>
<td>1222</td>
<td>1190</td>
<td>1190</td>
<td>0</td>
</tr>
<tr>
<td>% Successful exits/retention</td>
<td>96%</td>
<td>97%</td>
<td>98%</td>
<td>1%</td>
</tr>
</tbody>
</table>
This is a new tab for FY 2016 submissions only. Submission must be performed manually (data cannot be uploaded). Data coverage and quality will allow HUD to better interpret your Sys PM submissions.

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

You may enter a note about any field if you wish to provide an explanation about your data quality results. This is not required.
2019 HDX Competition Report

FY2018 - SysPM Data Quality

<table>
<thead>
<tr>
<th></th>
<th>All ES, SH</th>
<th>All TH</th>
<th>All PSH, OPH</th>
<th>All RRH</th>
<th>All Street Outreach</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of non-DV Beds on HIC</td>
<td>91</td>
<td>111</td>
<td>72</td>
<td>94</td>
<td>401</td>
</tr>
<tr>
<td>2. Number of HMIS Beds</td>
<td>77</td>
<td>105</td>
<td>72</td>
<td>94</td>
<td>392</td>
</tr>
<tr>
<td>3. HMIS Participation Rate from HIC ( % )</td>
<td>84.62</td>
<td>94.59</td>
<td>100.00</td>
<td>100.00</td>
<td>97.76</td>
</tr>
<tr>
<td>4. Unduplicated Persons Served (HMIS)</td>
<td>1825</td>
<td>1915</td>
<td>2699</td>
<td>2637</td>
<td>26381</td>
</tr>
<tr>
<td>5. Total Leavers (HMIS)</td>
<td>1633</td>
<td>1718</td>
<td>2472</td>
<td>2331</td>
<td>455</td>
</tr>
<tr>
<td>6. Destination of Don't Know, Refused, or Missing (HMIS)</td>
<td>224</td>
<td>991</td>
<td>1293</td>
<td>831</td>
<td>12</td>
</tr>
<tr>
<td>7. Destination Error Rate (%)</td>
<td>13.72</td>
<td>57.68</td>
<td>52.31</td>
<td>35.65</td>
<td>2.64</td>
</tr>
</tbody>
</table>

7/22/2019 5:25:30 PM
2019 HDX Competition Report  
Submission and Count Dates for IL-511 - Cook County CoC

### Date of PIT Count

| Date CoC Conducted 2019 PIT Count | 2/6/2019 | Yes |

### Report Submission Date in HDX

<table>
<thead>
<tr>
<th>Submitted On</th>
<th>Met Deadline</th>
</tr>
</thead>
<tbody>
<tr>
<td>2019 PIT Count Submittal Date</td>
<td>4/29/2019</td>
</tr>
<tr>
<td>2019 HIC Count Submittal Date</td>
<td>4/29/2019</td>
</tr>
<tr>
<td>2018 System PM Submittal Date</td>
<td>5/31/2019</td>
</tr>
</tbody>
</table>
Chapter 4 – Applications, Waiting List, and Tenant Selection

4-III.B. SELECTION AND HCV FUNDING SOURCES

Special Admissions [24 CFR 982.203]

HUD may award funding for specifically-named families living in specified types of units (e.g., a family that is displaced by demolition of public housing; a non-purchasing family residing in HOPE 1 or 2 projects). In these cases, the HACC may admit families that are not on the waiting list, or without considering the family’s position on the waiting list. The HACC must maintain records showing that such families were admitted with special program funding.

Targeted Funding [24 CFR 982.204(e)]

HUD may award the HACC funding for a specified category of families on the waiting list. The HACC must use this funding only to assist the families within the specified category. Within this category of families, the order in which such families are assisted is determined according to the policies provided in Section 4-III.C.

Regular HCV Funding

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

Special Initiative Program Funding

Funding for any of the HACC’s special initiative programs, such as FLOW, Family First Pilot Program, and the Re-entry Program comes from the regular HCV funding.

The FLOW Program provides vouchers to formerly homeless people residing in permanent supportive housing (PSH) who no longer need the services of the housing, but are unable to pay full market rent without a housing subsidy. The HACC works with the Continuum of Care to administer this program and has allocated 150 vouchers to support this initiative. This enables other chronically homeless people to become housed in the PSH units.

The Family First Pilot Program provides vouchers to 25 homeless families with school age children, at least one under the age of 13, who are experiencing homelessness or at risk of becoming homeless. Eligible families must have had an economic hardship that caused the homelessness or places them at risk of homelessness and must have been self-sufficient prior to the economic hardship. The families must be able to return to self-sufficiency within 24 months. The HACC works with the South Cook Intermediate Service Center to administer this program.

The Re-entry Pilot Program provides vouchers to 25 formerly incarcerated people who have turned their lives around, but are in need of affordable housing. Eligible participants come through our admissions process who may not technically qualify based on our criminal screening criteria, but have completed an appropriate recovery program for their criminal activity.
Public Housing Authority
Administrative Plan Excerpts
Attachments to IL-511 CoC Application

1. Housing Authority of Cook County (pages 2-5)
2. Oak Park Housing Authority (pages 6-9)
Chapter 4 – Applications, Waiting List, and Tenant Selection

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4-III.C. SELECTION METHOD

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

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

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

Admissions Preferences

The HACC has established a system of preferences for the selection of families admitted to the Program. Preferences will be applied cumulatively and must be verified. The following are the preferences the HACC has established:

- Homelessness (see below for definition) – 4 points
- Veterans and veterans’ families – 3 points
- Working families and those unable to work due to age or disability – 2 points
- Victims of domestic violence (VAWA) – 1 point

To meet the preference definition of homelessness, an applicant must qualify as follows: An individual who lacks a fixed, regular and adequate nighttime residence and whose primary nighttime residence is a supervised publicly or privately operated shelter designed to provide temporary living accommodations; OR an institution that provides a temporary residence for individuals intended to be institutionalized; OR a public or private place not designed for, or ordinarily used as, a regular sleeping accommodation for human beings.

The HACC will use these same preferences in its project-based voucher (PBV) program, but may apply them in a different order. Additionally, additional preferences may apply to the PBV program based on the type of housing receiving assistance. Chapter 17 describes the preferences as they apply to PBV projects.

Project Based Vouchers – Chapter 17

17-VI.C. ORGANIZATION OF THE WAITING LIST

The HACC will establish and manage separate waiting lists for individual projects or buildings that are receiving PBV assistance [24 CFR 983.251(c)]. The HACC will offer to place applicants who are on the tenant-based waiting list on the waiting list for PBV assistance. The HACC may also merge the PBV waiting list with a waiting list for other assisted housing programs offered by the HACC. While not an actual merger of the wait lists, applicants who are currently on one of the HACC’s LIPH wait lists are also eligible for placement on a PBV wait list.
Excerpts from the Housing Authority of Cook County’s Administrative Plan

The HACC has PBV developments that are designated to serve the homeless. The HACC has site based wait lists for those properties, but often has difficulty filling the units quickly due to the homeless status of the applicants. Many of the homeless do not have mailing addresses or phone numbers, making it difficult to locate them when their names come to the top of the wait list. The HACC participates in suburban Cook County’s Continuum of Care, which has a commitment to end homelessness. The CoC uses Coordinated Entry as its system to house the homeless in any housing resources that are available. The Coordinated Entry system increases efficiency to accessing resources to help house the homeless. The Coordinated Entry system helps prioritize people who are most in need. Coordinated Entry can make quick referrals to housing for the homeless. The HACC will accept referrals for the waiting list from Coordinated Entry at any time for the PBV housing designated to serve the homeless. This will help ensure those most in need are housed as quickly as possible and reduce the length of time any units are vacant.

Preferences [24 CFR 983.251(d)]

The HACC may use the same selection preferences that are used for the tenant-based voucher program, establish selection criteria or preferences for the PBV program as a whole or for occupancy of particular PBV developments or units. In addition to the preferences used in the tenant-based HCV Program, the HACC may also implement preferences for specific developments based on the population served. The preferences will still be applied cumulatively, but the priority of the preferences may change from PBV development to PBV development. The HACC must provide an absolute selection preference for eligible in-place families as described in Section 17-VI.B. above.

Although the HACC is prohibited from granting preferences to persons with a specific disability, the HACC may give preference to disabled families who need services offered at a particular project or site if the preference is limited to families (including individuals):

- With disabilities that significantly interfere with their ability to obtain and maintain themselves in housing;
- Who, without appropriate supportive services, will not be able to obtain or maintain themselves in housing; and
- For whom such services cannot be provided in a non-segregated setting.

In advertising such a project, the owner may advertise the project as offering services for a particular type of disability; however, the project must be open to all otherwise eligible disabled persons who may benefit from services provided in the project. In these projects, disabled residents may not be required to accept the particular services offered as a condition of occupancy.

If the HACC has buildings with more than 25 percent of the units receiving project-based assistance because those buildings include “excepted units” (units specifically made available for elderly families or families receiving supportive services), the HACC must give preference to such families when referring families to these units [24 CFR 983.261(b)].
Excerpts from the Housing Authority of Cook County’s Administrative Plan

The HACC will provide a selection preference when required by the regulation (e.g., eligible in-place families, qualifying families for “excepted units,” mobility impaired persons for accessible units). The HACC will also provide a preference for families meeting the definition of a targeted population at special housing types, such as housing for the homeless, victims of domestic violence, and supportive housing.
The OPHA will announce the closing of the waiting list by public notice in the same way as opening the waiting list.

4. Reopening the Waiting List

Any time that there are not enough applicants, the OPHA may reopen the waiting list. The open period shall be long enough to achieve a waiting list adequate to cover projected turnover and new allocations over the next 24 months. The OPHA will give at least five days notice prior to closing the list. When the period for accepting pre-applications is over, the OPHA will add the new applicants to the waiting list by separating the new applicants into groups based on preferences and ranking applicants within each group by date and time of application.

C. PREFERENCES AND INCOME TARGETING

1. Residency Preference [24 CFR 982.207]

The OPHA will not apply a system of preferences, but has established only one local preference ---residency in the OPHA jurisdiction: preference for families who live, work for 30 hours or more, or have been hired to work for 30 hours or more, in the Village of Oak Park.

An applicant will not be granted any preference if any member of the family has been evicted from any housing assistance under a 1937 Housing Act Program during the past three years because of drug-related criminal activity. The OPHA will grant an exception to a family if:

a. The responsible member has successfully completed a rehabilitation program.

b. The evicted person clearly did not participate in or know about the drug related activity.

If an applicant makes a false statement in order to qualify for a preference, the OPHA may deny admission to the program for the family.

2. Initial Determination of Local Preference Qualification [24 CFR 982.207]

At the time of pre-application, an applicant's entitlement to a local preference may be made on the following basis.

An applicant's certification that they qualify for a preference will be accepted without verification at the pre-application. When the family is selected from the waiting list for the pre-determination and full application of eligibility, the preference will be verified.
If the preference verification indicates that an applicant does not qualify for the preference, the applicant will be returned to the waiting list without the local preference and given an opportunity for a meeting.

If the OPHA utilizes the Exception to Waiting List Guidelines as outlined in this chapter and the preference verification indicates that an applicant did not qualify for the preference at the time the pre-application was submitted, the applicant will be denied admission to the program and offered an opportunity for an Informal Review.

3. Treatment of Single Applicants

Single applicants will be treated as any other eligible family on the waiting list.

4. Income Targeting

In accordance with the Quality Housing and Work Responsibility Act of 1998, each fiscal year the OPHA will reserve a minimum of seventy-five percent of its HCV new admissions for families whose income does not exceed 30 percent of the area median income. HUD refers to these families as “extremely low-income families.” The OPHA will admit families who qualify under the Extremely Low Income limit to meet the income targeting requirement.

5. Change in Circumstances

Changes in an applicant's circumstances while on the waiting list may affect the family’s entitlement to a preference. Applicants are required to notify the OPHA in writing when their circumstances change.

When an applicant claims a local preference, s/he will be placed on the waiting list in the appropriate order determined by the newly-claimed preference.

If the family’s initial and verified annual income, at pre-determination and full application eligibility determination, does not fall under the Extremely Low Income limit and the family was selected for income targeting purposes before family(ies) with a higher preference, the family will be returned to the waiting list.

6. Exceptions for Special Admissions [24CFR 982.203, 982.54(d)(3)]

If HUD has awarded or awards program funding that is targeted for specifically named families, the OPHA will admit these families under a Special Admission procedure.

Special admissions families will be admitted outside of the regular waiting list process. They do not have to qualify for any preferences, nor are they required to be on the program waiting list. OPHA maintains separate records of these admissions.
The following are examples of types of program funding that may be designated by HUD for families living in a specified unit:

a. A family displaced because of demolition or disposition of a public or Indian housing project;

b. A family residing in a multifamily rental housing project when HUD sells, forecloses or demolishes the project;

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

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

e. A non-purchasing family residing in a HOPE 1 or HOPE 2 project.

The OPHA will admit families under Special Admission procedures who are applying for its **Mainstream Housing Opportunity for Person with Disabilities Program who are chronically homeless (maximum of 5)** and to its Non-Elderly Persons with Disabilities (NED) Program (maximum of 15). The OPHA may receive referrals from **Housing Forward (formally known as PADS, Public Action to Deliver Shelter) or its affiliate** and the State of Illinois’ Department of Healthcare and Family Services or its affiliate to fill vacancies in these programs.

**7. Targeted Funding** [24CFR 982.203]

When HUD awards special funding for certain family types, families who qualify are placed on the regular waiting list. When a specific type of funding becomes available, the waiting list is searched for the first available family meeting the targeted funding criteria.

**8. Other Housing Assistance** [24 CFR 982.205(b)]

Other housing assistance means a federal, State or local housing subsidy, as determined by HUD, including public housing.

The OPHA may not take any of the following actions because an applicant has applied for, received, or refused other housing:

a. Refuse to list the applicant on the OPHA waiting list for tenant-based assistance;

b. Deny any admission preference for which the applicant is currently qualified;
c. Change the applicant’s place on the waiting list based on preference, date and time of application, or other factors affecting selection under the OPHA selection policy; or

d. Remove the applicant from the waiting list.

D. PRE-APPLICATION PROCESS [24 CFR 982.204 (b)]

1. Information to be Obtained

The OPHA may utilize a preliminary application form (pre-application). The information is to be filled out by the applicant whenever possible.

The purpose of the pre-application is to permit assessment of family eligibility or ineligibility and to determine placement on the waiting list. The pre-application may contain questions to obtain the following information:

* Names of adult members and age of all members
* Family unit size
* Sex and relationship of all members
* Street address and telephone numbers
* Amount(s) and source(s) of income received by household members
* Information regarding disabilities relating to program requirements (i.e., deductions)
* Information related to qualification for residency preference
* Social Security Numbers
* Race/ethnicity
* Citizenship/eligible immigration status
* Arrests/and/or Convictions for Drug Related or Violent Criminal Activity
* Request for Specific Accommodation needed to fully utilize program and services
* Previous address
IC-7, IL-511 Centralized or Coordinated Assessment Tool Cover Page

Attachments include:

1) Single adults VI-SPDAT version 2.0
2) Family VI-SPDAT version 2.0
3) TAY VI-SPDAT version 1.0
Vulnerability Index -
Service Prioritization Decision Assistance Tool
(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.0

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1 (800) 355-0420   info@orgcode.com   www.orgcode.com
Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:

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

All versions are available online at

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

SPDAT Series

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

Current versions available:

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

Information about all versions is available online at

www.orgcode.com/products/spdat/
SPDAT Training Series

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

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

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

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

Other related training available:
- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at [http://www.orgcode.com/product-category/training/spdat/](http://www.orgcode.com/product-category/training/spdat/)
Administration

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<th>☐ Team</th>
<th>☐ Staff</th>
<th>☐ Volunteer</th>
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<td>__ __ : __ AM/PM</td>
<td>__________________</td>
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</tbody>
</table>

Opening Script

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

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

Basic Information

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

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A. History of Housing and Homelessness

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


SCORE:

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

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

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

SCORE:

B. Risks

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

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

SCORE:

5. Have you been attacked or beaten up since you’ve become homeless?

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

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

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

**SCORE:**

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

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

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

**SCORE:**

---

**C. Socialization & Daily Functioning**

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

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

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

**SCORE:**

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

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

**SCORE:**

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

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

**SCORE:**

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

**IF “YES,” THEN SCORE 1 FOR SOCIAL RELATIONSHIPS.**

**SCORE:**
VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)
SINGLE ADULTS AMERICAN VERSION 2.0

D. Wellness

15. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? □ Y □ N □ Refused

16. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? □ Y □ N □ Refused

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

18. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you’d need help? □ Y □ N □ Refused

19. When you are sick or not feeling well, do you avoid getting help? □ Y □ N □ Refused

20. FOR FEMALE RESPONDENTS ONLY: Are you currently pregnant? □ Y □ N □ N/A or Refused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR PHYSICAL HEALTH.

21. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? □ Y □ N □ Refused

22. Will drinking or drug use make it difficult for you to stay housed or afford your housing? □ Y □ N □ Refused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR SUBSTANCE USE.

23. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
   a) A mental health issue or concern? □ Y □ N □ Refused
   b) A past head injury? □ Y □ N □ Refused
   c) A learning disability, developmental disability, or other impairment? □ Y □ N □ Refused

24. Do you have any mental health or brain issues that would make it hard for you to live independently because you’d need help? □ Y □ N □ Refused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR MENTAL HEALTH.

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

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

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

IF “YES” TO ANY OF THE ABOVE, SCORE 1 FOR MEDICATIONS.  
SCORE:

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

IF “YES”, SCORE 1 FOR ABUSE AND TRAUMA.  
SCORE:

Scoring Summary

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<tr>
<td>B. RISKS</td>
<td>/4</td>
<td>4-7: an assessment for Rapid</td>
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<tr>
<td>C. SOCIALIZATION &amp; DAILY FUNCTIONS</td>
<td>/4</td>
<td>Re-Housing</td>
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<td>D. WELLNESS</td>
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<td>GRAND TOTAL:</td>
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Follow-Up Questions

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

time: ____ : _____ or Morning/Afternoon/Evening/Night

Is there a phone number and/or email where someone can safely get in touch with you or leave you a message?  
phone: (____) _____ - _____________

email: ___________________________________________

Ok, now I’d like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?  
☐ Yes  ☐ No  ☐ Refused

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

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

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

The VI-SPDAT

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

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

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

Version 2

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

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

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

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

**Alabama**
- Parts of Alabama Balance of State

**Arizona**
- Statewide

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

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

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

**District of Columbia**
- District of Columbia

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

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

**Hawaii**
- Honolulu

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

**Iowa**
- Parts of Iowa Balance of State

**Kansas**
- Kansas City/Wyandotte County
- Topeka
- Lawrence

**Kentucky**
- Louisville/Jefferson County
- Northumberland

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

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

**Maryland**
- Baltimore City
- Montgomery County

**Maine**
- Statewide

**Michigan**
- Statewide

**Minnesota**
- Minneapolis/Hennepin County
- Northwest Minnesota
- Moorhead/West Central Minnesota
- Southwestern Minnesota

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

**Mississippi**
- Jackson/Rankin, Madison Counties
- Gulfport/Gulf Coast Regional

**North Carolina**
- Winston Salem/Forsyth County
- Asheville/Buncombe County
- Greensboro/High Point

**North Dakota**
- Statewide

**Nebraska**
- Statewide

**New Mexico**
- Statewide

**Nevada**
- Las Vegas/Clark County

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

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

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

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

**Rhode Island**
- Statewide

**South Carolina**
- Charleston/Low Country
- Columbia/Midlands

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

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

**Utah**
- Statewide

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

**Washington**
- Seattle/King County
- Spokane City & County

**Wisconsin**
- Statewide

**West Virginia**
- Statewide

**Wyoming**
- Wyoming Statewide is in the process of implementing
Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:
- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

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

SPDAT Series

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

Current versions available:
- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/
SPDAT Training Series

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

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

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

**Current SPDAT training available:**
- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

**Other related training available:**
- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at [http://www.orgcode.com/product-category/training/spdat/](http://www.orgcode.com/product-category/training/spdat/)
Administration

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Opening Script

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

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

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

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☐ No second parent currently part of the household

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

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

FAMILIES

AMERICAN VERSION 2.0

Children

1. How many children under the age of 18 are currently with you? _______ □ Refused

2. How many children under the age of 18 are not currently with your family, but you have reason to believe they will be joining you when you get housed? _______ □ Refused

3. **IF HOUSEHOLD INCLUDES A FEMALE:** Is any member of the family currently pregnant? □ Y □ N □ Refused

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

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

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

A. History of Housing and Homelessness

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

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

6. How long has it been since you and your family lived in permanent stable housing? _______ □ Refused

7. In the last three years, how many times have you and your family been homeless? _______ □ Refused

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

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

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

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

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

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

IF “YES,” THEN SCORE 1 FOR LEGAL ISSUES.

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

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF EXPLOITATION.
C. Socialization & Daily Functioning

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

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

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

SCORE:

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

IF “NO,” THEN SCORE 1 FOR MEANINGFUL DAILY ACTIVITY.

SCORE:

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

IF “NO,” THEN SCORE 1 FOR SELF-CARE.

SCORE:

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

IF “YES,” THEN SCORE 1 FOR SOCIAL RELATIONSHIPS.

SCORE:

D. Wellness

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

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

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

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

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

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR PHYSICAL HEALTH.

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

**Families - American Version 2.0**

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

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

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

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

   a) A mental health issue or concern?
   - [ ] Y
   - [ ] N
   - [ ] Refused

   b) A past head injury?
   - [ ] Y
   - [ ] N
   - [ ] Refused

   c) A learning disability, developmental disability, or other impairment?
   - [ ] Y
   - [ ] N
   - [ ] Refused

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

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

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

**IF “YES”, SCORE 1 FOR TRI-MORBIDITY.**

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

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

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

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

**IF “YES”, SCORE 1 FOR ABUSE AND TRAUMA.**
E. Family Unit

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

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

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

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

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

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

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

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

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

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

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

40. After school, or on weekends or days when there isn’t school, is the total time children spend each day where there is no interaction with you or another responsible adult...
   a) 3 or more hours per day for children aged 13 or older? □ Y □ N □ Refused
   b) 2 or more hours per day for children aged 12 or younger? □ Y □ N □ Refused

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

IF “NO” TO QUESTION 39, OR “YES” TO ANY OF QUESTIONS 40 OR 41, SCORE 1 FOR PARENTAL ENGAGEMENT.
Scoring Summary

<table>
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<tr>
<td>A. HISTORY OF HOUSING &amp; HOMELESSNESS</td>
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<td>B. RISKS</td>
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<td>C. SOCIALIZATION &amp; DAILY FUNCTIONS</td>
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<td>D. WELLNESS</td>
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<tr>
<td>E. FAMILY UNIT</td>
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<tr>
<td><strong>GRAND TOTAL:</strong></td>
<td>/22</td>
<td></td>
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</tbody>
</table>

**Score:**

**Recommendation:**

0-3 no housing intervention

4-8 an assessment for Rapid Re-Housing

9+ an assessment for Permanent Supportive Housing/Housing First

Follow-Up Questions

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

place: ____________________________

time: ___:___ or Morning/Afternoon/Evening/Night

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

phone: (____) _____ - _____________

e-mail: ____________________________

**Ok, now I’d like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so?**

☐ Yes ☐ No ☐ Refused

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

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

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

The VI-SPDAT

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

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

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

Version 2

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

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

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

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

**Alabama**
- Parts of Alabama Balance of State

**Arizona**
- Statewide

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

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

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

**District of Columbia**
- District of Columbia

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

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

**Hawaii**
- Honolulu

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

**Iowa**
- Parts of Iowa Balance of State

**Kansas**
- Kansas City/Wyandotte County

**Kentucky**
- Louisville/Jefferson County

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

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

**Maryland**
- Baltimore City
- Montgomery County

**Maine**
- Statewide

**Michigan**
- Statewide

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

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

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

**North Carolina**
- Winston Salem/Forsyth County
- Asheville/Buncombe County
- Greensboro/High Point

**North Dakota**
- Statewide

**Nebraska**
- Statewide

**New Mexico**
- Statewide

**Nevada**
- Las Vegas/Clark County

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

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

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

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

**Rhode Island**
- Statewide

**South Carolina**
- Charleston/Low Country
- Columbia/Midlands

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

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

**Utah**
- Statewide

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

**Washington**
- Seattle/King County
- Spokane City & County

**Wisconsin**
- Statewide

**West Virginia**
- Statewide

**Wyoming**
- Wyoming Statewide is in the process of implementing
Transition Age Youth -
Vulnerability Index -
Service Prioritization Decision Assistance Tool

(TAY-VI-SPDAT)

“Next Step Tool for Homeless Youth”
Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:
- VI-SPDAT V 2.0
- Family VI-SPDAT V 2.0
- Next Step Tool for Homeless Youth V 1.0

All versions are available online at www.orgcode.com/products/vi-spdat/

SPDAT Series

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

Current versions available:
- SPDAT V 4.0 for Individuals
- F-SPDAT V 2.0 for Families
- Y-SPDAT V 1.0 for Youth

Information about all versions is available online at www.orgcode.com/products/spdat/
SPDAT Training Series

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

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

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

Current SPDAT training available:
• Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
• Level 1 SPDAT Training: SPDAT for Frontline Workers
• Level 2 SPDAT Training: SPDAT for Supervisors
• Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:
• Excellence in Housing-Based Case Management
• Coordinated Access & Common Assessment
• Motivational Interviewing
• Objective-Based Interactions

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

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

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

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

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<th>Agency</th>
<th>□ Team</th>
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<tr>
<td></td>
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<td>□ Staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>□ Volunteer</td>
</tr>
</tbody>
</table>

Survey Date: DD/MM/YYYY   /       / Survey Time: ___ : ___ AM/PM

Survey Location: ______________________

Opening Script

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

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

Basic Information

First Name: ________________________

Nickname: ________________________

Last Name: ________________________

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

Date of Birth: DD/MM/YYYY   /       / Age: ___ Social Security Number: ________________

Consent to participate: □ Yes   □ No

IF THE PERSON IS 17 YEARS OF AGE OR LESS, THEN SCORE 1.
A. History of Housing and Homelessness

1. Where do you sleep most frequently? (check one)
   - Shelters
   - Transitional Housing
   - Safe Haven
   - Couch surfing
   - Outdoors
   - Other (specify):


   SCORE:

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

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

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

   SCORE:

B. Risks

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

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

   SCORE:

5. Have you been attacked or beaten up since you’ve become homeless?

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

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

   SCORE:
NEXT STEP TOOL FOR HOMELESS YOUTH

SINGLE YOUTH AMERICAN VERSION 1.0

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

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

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR LEGAL ISSUES.

SCORE: 

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

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

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR RISK OF EXPLOITATION.

SCORE: 

C. Socialization & Daily Functioning

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

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

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

SCORE: 

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

IF “NO,” THEN SCORE 1 FOR MEANINGFUL DAILY ACTIVITY.

SCORE: 

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

IF “NO,” THEN SCORE 1 FOR SELF-CARE.

SCORE:
15. Is your current lack of stable housing...
   a) Because you ran away from your family home, a group home or a foster home? □ Y □ N □ Refused
   b) Because of a difference in religious or cultural beliefs from your parents, guardians or caregivers? □ Y □ N □ Refused
   c) Because your family or friends caused you to become homeless? □ Y □ N □ Refused
   d) Because of conflicts around gender identity or sexual orientation? □ Y □ N □ Refused
   
   IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR SOCIAL RELATIONSHIPS.

   e) Because of violence at home between family members? □ Y □ N □ Refused
   f) Because of an unhealthy or abusive relationship, either at home or elsewhere? □ Y □ N □ Refused
   
   IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR ABUSE/TRAUMA.

D. Wellness

16. Have you ever had to leave an apartment, shelter program, or other place you were staying because of your physical health? □ Y □ N □ Refused
17. Do you have any chronic health issues with your liver, kidneys, stomach, lungs or heart? □ Y □ N □ Refused
18. If there was space available in a program that specifically assists people that live with HIV or AIDS, would that be of interest to you? □ Y □ N □ Refused
19. Do you have any physical disabilities that would limit the type of housing you could access, or would make it hard to live independently because you’d need help? □ Y □ N □ Refused
20. When you are sick or not feeling well, do you avoid getting medical help? □ Y □ N □ Refused
21. Are you currently pregnant, have you ever been pregnant, or have you ever gotten someone pregnant? □ Y □ N □ Refused
   
   IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR PHYSICAL HEALTH.
22. Has your drinking or drug use led you to being kicked out of an apartment or program where you were staying in the past? □ Y □ N □ Refused
23. Will drinking or drug use make it difficult for you to stay housed or afford your housing? □ Y □ N □ Refused
24. If you’ve ever used marijuana, did you ever try it at age 12 or younger? □ Y □ N □ Refused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR SUBSTANCE USE.

25. Have you ever had trouble maintaining your housing, or been kicked out of an apartment, shelter program or other place you were staying, because of:
   a) A mental health issue or concern? □ Y □ N □ Refused
   b) A past head injury? □ Y □ N □ Refused
   c) A learning disability, developmental disability, or other impairment? □ Y □ N □ Refused

26. Do you have any mental health or brain issues that would make it hard for you to live independently because you’d need help? □ Y □ N □ Refused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR MENTAL HEALTH.

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

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

IF “YES” TO ANY OF THE ABOVE, SCORE 1 FOR MEDICATIONS.

Scoring Summary

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Score: Recommendation:
- 0-3: no moderate or high intensity services be provided at this time
- 4-7: assessment for time-limited supports with moderate intensity
- 8+: assessment for long-term housing with high service intensity
Follow-Up Questions

| On a regular day, where is it easiest to find you and what time of day is easiest to do so? | place: ________________________________ | time: ___ : ___ or Morning/Afternoon/Evening/Night |
| Is there a phone number and/or email where someone can get in touch with you or leave you a message? | phone: (____) _____ - ___________ | email: ________________________________ |
| Ok, now I’d like to take your picture so that it is easier to find you and confirm your identity in the future. May I do so? | ☐ Yes ☐ No ☐ Refused |

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

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

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

The VI-SPDAT

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

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

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

The Youth – Transition Age Youth Tool from CSH

Released in May 2013, the Corporation for Supportive Housing (CSH) partnered with Dr. Eric Rice, Assistant Professor at the University of Southern California (USC) School of Social Work, to develop a triage tool that targets homeless Transition Age Youth (TAY) for permanent supportive housing. It consists of six items associated with long-term homelessness (five or more years) among transition-aged youth (age 18-24).

Version 2 of the VI-SPDAT

Version 2 builds upon the success of Version 1 of the VI-SPDAT with some refinements. Starting in August 2014, a survey was launched of existing VI-SPDAT users to get their input on what should be amended, improved, or maintained in the tool.

Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.
The TAY-VI-SPDAT – The Next Step Tool for Homeless Youth

One piece of feedback was the growing concern that youth tended to score lower on the VI-SPDAT, since the Vulnerability Index assesses risk of mortality which is less prevalent among younger populations. So, in version 2 of the VI-SPDAT, OrgCode Consulting, Inc. and Community Solutions joined forces with CSH to combine the best parts of the TAY, the VI, and the SPDAT to create one streamlined triage tool designed specifically for youth aged 24 or younger.

If you are familiar with the VI-SPDAT, you will notice some differences in the TAY-VI-SPDAT compared to VI-SPDAT version 1. Namely:

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

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

**Alabama**
- Parts of Alabama Balance of State

**Arizona**
- Statewide

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

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

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

**District of Columbia**
- District of Columbia

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

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

**Hawaii**
- Honolulu

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

**Iowa**
- Parts of Iowa Balance of State

**Kansas**
- Kansas City/Wyandotte County

**Kentucky**
- Louisville/Jefferson County

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

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

**Maryland**
- Baltimore City
- Montgomery County

**Maine**
- Statewide

**Michigan**
- Statewide

**Minnesota**
- Minneapolis/Hennepin County
- North/West Minnesota
- Moorhead/West Central Minnesota
- Southwest Minnesota

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

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

**North Dakota**
- Statewide

**Nebraska**
- Statewide

**New Mexico**
- Statewide

**Nevada**
- Las Vegas/Clark County

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

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

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

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

**Rhode Island**
- Statewide

**South Carolina**
- Charleston/Low Country
- Columbia/Midlands

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

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

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

**Washington**
- Seattle/King County
- Spokane City & County

**Wisconsin**
- Statewide

**West Virginia**
- Statewide

**Wyoming**
- Wyoming Statewide is in the process of implementing
1E-1 Public Posting 15-day Notification – Project accepted notifications Cover page for IL-511 CoC

This attachment contains:

- The notification of projects that were accepted posted to the CoC website, pages 2-3
  - The website link, date, and the link to the ranked list (which includes the dollar amounts projects were reduced) are highlighted in the document. **Note that all projects were accepted.**
- The notification of projects that were accepted emailed 7/29/19 to all applicants, pages 4-5
  - The link to the ranked list, which includes the approved dollar amounts for projects, is highlighted.
- The local ranked list with approved amounts for each project, including how much projects were reduced, pages 6-7
On Friday, July 26, the board of directors of the Alliance to End Homelessness in Suburban Cook County voted to accept the Project Review Panel's ranked list of new and renewal projects, distributed in draft form on July 19th.

All projects were accepted and ranked, and some projects were reduced. Projects should consult the “Approved Amount” column in preparing their e-snaps applications.

An applicant may appeal a project review decision by submitting an appeal letter by email to Jennifer Hill, Executive Director, at jennifer@suburbancook.org, by Thursday August 1st at 12pm. The executive committee will decide the appeals, and you will be notified of their decision in advance of the August 15th E-snaps application due date.

E-snaps reminder

Project Applications for new and renewal projects are available in e-snaps.

Organizations that have already submitted an Alliance new or renewal project application by the existing deadlines will be required to complete a Project Application in e-snaps and email the pdf copy of the application to nofa@suburbancook.org by Thursday, August 15th, at 5pm.

The NOFA timeline has been updated to reflect the e-snaps application deadline and the date that the CoC application and CoC priority listing will be emailed and posted online at www.suburbancook.org/nofa. All other due dates for the local competition remain the same.

For more information on how to complete the Project Application in e-snaps, please visit:

- FY 2019 Renewal Project Application Detailed Instructions and Navigational Guide, OR
FY 2019 New Project Application Detailed Instructions and Navigational Guide

For questions about the e-snaps application or the NOFA process, please contact Kurt Runge at kurt@suburbancook.org or Kathryn Primas at Kathryn@suburbancook.org.

For updates and more info, visit www.suburbancook.org/nofa.
Ranked list and appeals process

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kurt@suburbancook.org or Kathryn Primas at Kathryn@suburbancook.org.

For updates and more info, visit www.suburbancook.org/nofa.

Kurt Runge
Continuum of Care Program Director
Alliance to End Homelessness in Suburban Cook County
4415 Harrison St., Suite 228 | Hillside, IL 60162
Email: kurt@suburbancook.org
Office: 708-236-3261 x8# | Fax: 708-236-3299
Cell: 708-384-9020
www.suburbancook.org
## Project Review Panel - Ranking List Recommendation
### Alliance to End Homelessness in Suburban Cook County
#### July 17, 2019

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**Running Total:** $8,694,044
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Orange: new project application (non-DV)  
Purple: new project application (Domestic Violence)  
Yellow: highlighting the columns showing rank & approved amounts  
Green: new project scoring shown at bottom; renewal project scoring shown in top header
This attachment contains:

- The notification of projects that were reduced posted to the CoC website, pages 2-3
  - The website link, date, and the link to the ranked list (which includes the dollar amounts projects were reduced) are highlighted in the document. Note that no projects were rejected.
- The notification of projects that were reduced emailed 7/29/19 to all applicants, pages 4-5
  - The link to the ranked list, which includes the dollar amounts projects were reduced, is highlighted in the document.
- The local ranked list with approved amounts for each project, including how much projects were reduced, pages 6-7
Ranked List and Appeals Process

July 29, 2019

Ranked list and appeals process

On Friday, July 26, the board of directors of the Alliance to End Homelessness in Suburban Cook County voted to accept the Project Review Panel's ranked list of new and renewal projects, distributed in draft form on July 19th.

All projects were accepted and ranked, and some projects were reduced. Projects should consult the "Approved Amount" column in preparing their e-snaps applications.

An applicant may appeal a project review decision by submitting an appeal letter by email to Jennifer Hill, Executive Director, at jennifer@suburbancook.org, by Thursday August 1st at 12pm. The executive committee will decide the appeals, and you will be notified of their decision in advance of the August 15th E-snaps application due date.

E-snaps reminder

Project Applications for new and renewal projects are available in e-snaps.

Organizations that have already submitted an Alliance new or renewal project application by the existing deadlines will be required to complete a Project Application in e-snaps and email the pdf copy of the application to nofa@suburbancook.org by Thursday, August 15th, at 5pm.

The NOFA timeline has been updated to reflect the e-snaps application deadline and the date that the CoC application and CoC priority listing will be emailed and posted online at www.suburbancook.org/nofa. All other due dates for the local competition remain the same.

For more information on how to complete the Project Application in e-snaps, please visit:

- FY 2019 Renewal Project Application Detailed Instructions and Navigational Guide, OR
FY 2019 New Project Application Detailed Instructions and Navigational Guide

For questions about the e-snaps application or the NOFA process, please contact Kurt Runge at kurt@suburbancook.org or Kathryn Primas at Kathryn@suburbancook.org.

For updates and more info, visit www.suburbancook.org/nofa.
Ranked list and appeals process
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kurt@suburbancook.org or Kathryn Primas at Kathryn@suburbancook.org.

For updates and more info, visit www.suburbancook.org/nofa.

Kurt Runge
Continuum of Care Program Director
Alliance to End Homelessness in Suburban Cook County
4415 Harrison St., Suite 228 | Hillside, IL 60162
Email: kurt@suburbancook.org
Office: 708-236-3261 x8# | Fax: 708-236-3299
Cell: 708-384-9020
www.suburbancook.org
## Project Review Panel - Ranking List Recommendation

**Alliance to End Homelessness in Suburban Cook County**  
**July 17, 2019**

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<td>13</td>
<td>8</td>
<td>13</td>
<td>11</td>
<td>6</td>
<td>0</td>
<td>51</td>
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<td>19</td>
<td>$ 475,634</td>
<td>$ 475,634</td>
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<tr>
<td>Housing Forward</td>
<td>WIN Plus</td>
<td>PH</td>
<td>13</td>
<td>8</td>
<td>13</td>
<td>12</td>
<td>4</td>
<td>1</td>
<td>51</td>
<td>2.844</td>
<td>20</td>
<td>$1,059,577</td>
<td>$1,059,577</td>
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<tr>
<td>Catholic Charities of the Archdiocese of Chicago</td>
<td>New Hope Apartments PSH NW</td>
<td>PH</td>
<td>12</td>
<td>8</td>
<td>13</td>
<td>14</td>
<td>4</td>
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<td>21</td>
<td>$ 346,487</td>
<td>$ 346,487</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Aunt Martha’s Health and Wellness</td>
<td>Independence Place</td>
<td>TH</td>
<td>13</td>
<td>8</td>
<td>11.5</td>
<td>10</td>
<td>8</td>
<td>0</td>
<td>50.5</td>
<td>0.366</td>
<td>22</td>
<td>$ 199,988</td>
<td>$ 199,988</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Housing Options d.b.a. Impact Behavioral Health Partners</td>
<td>Claire Ganey</td>
<td>PH</td>
<td>14</td>
<td>8</td>
<td>12</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>50</td>
<td>1.692</td>
<td>23</td>
<td>$ 95,152</td>
<td>$ 95,152</td>
<td>1.87% cut</td>
<td>$ 93,373</td>
</tr>
</tbody>
</table>

**Running Total:** $6,229,637

**Notes:**
- 1.87% cut 10,471,990
- 1.87% cut 10,275,742
- 1.87% cut 9,929,255
- 1.87% cut 10,471,990
<table>
<thead>
<tr>
<th>Applicant Name</th>
<th>Project Name</th>
<th>Project Component</th>
<th>Sec. I (out of 15)</th>
<th>Sec. II (out of 8)</th>
<th>Sec. III (out of 13)</th>
<th>Sec. IV (out of 16)</th>
<th>Sec. V (out of 10)</th>
<th>Bonus (0 or 1)</th>
<th>Score</th>
<th>Tiebreaker H:S Ratio</th>
<th>Rank</th>
<th>2019 Request amt</th>
<th>Cuts by Review Panel</th>
<th>Approved Amount</th>
<th>Notes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Catholic Charities of the Archdiocese of Chicago</td>
<td>NHA-Family PSH</td>
<td>PH</td>
<td>13</td>
<td>8</td>
<td>13</td>
<td>12</td>
<td>4</td>
<td>0</td>
<td>50</td>
<td>1.277</td>
<td>24</td>
<td>$221,021</td>
<td>$4,133</td>
<td>$216,888</td>
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<tr>
<td>NORTHWEST COMPASS, INC.</td>
<td>Community Family Homes Initiative IV</td>
<td>PH</td>
<td>13</td>
<td>8</td>
<td>13</td>
<td>8</td>
<td>7</td>
<td>0</td>
<td>49</td>
<td>2.245</td>
<td>25</td>
<td>$164,780</td>
<td>$3,081</td>
<td>$161,699</td>
<td>1.87% cut</td>
</tr>
<tr>
<td>South Suburban PADS</td>
<td>Project WISH</td>
<td>RRH</td>
<td>11</td>
<td>8</td>
<td>12.5</td>
<td>13</td>
<td>4</td>
<td>0</td>
<td>48.5</td>
<td>1.690</td>
<td>26</td>
<td>$265,620</td>
<td>$4,967</td>
<td>$260,653</td>
<td>1.87% cut</td>
</tr>
<tr>
<td>Respond Now</td>
<td>Responding with Care</td>
<td>PH</td>
<td>12</td>
<td>8</td>
<td>11.5</td>
<td>11</td>
<td>6</td>
<td>0</td>
<td>48.5</td>
<td>1.587</td>
<td>27</td>
<td>$191,230</td>
<td>$3,576</td>
<td>$187,654</td>
<td>1.87% cut</td>
</tr>
<tr>
<td>Heartland Health Outreach, Inc.</td>
<td>HAH Shelter Plus Care</td>
<td>PH</td>
<td>13</td>
<td>5</td>
<td>13</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>48</td>
<td>99.000</td>
<td>28</td>
<td>$206,910</td>
<td>$3,869</td>
<td>$203,041</td>
<td>1.87%; ranked 16th last yr</td>
</tr>
<tr>
<td>Housing Options d.b.a. Impact Behavioral Health Partners</td>
<td>Pathways</td>
<td>PH</td>
<td>12</td>
<td>8</td>
<td>12</td>
<td>12</td>
<td>3</td>
<td>1</td>
<td>48</td>
<td>3.636</td>
<td>29</td>
<td>$488,968</td>
<td>$9,144</td>
<td>$479,824</td>
<td>1.87%; ranked 6th last yr</td>
</tr>
<tr>
<td>South Suburban PADS</td>
<td>Country Club Hills Wellness Center</td>
<td>PH</td>
<td>12</td>
<td>8</td>
<td>11.5</td>
<td>11</td>
<td>4</td>
<td>0</td>
<td>46.5</td>
<td>3.545</td>
<td>30</td>
<td>$406,439</td>
<td>$7,600</td>
<td>$398,839</td>
<td>1.87%; ranked 9th last yr</td>
</tr>
<tr>
<td>Community and Economic Development Association of Cook County, Inc. (CEDA)</td>
<td>CEDA SSHIP TH/RRH</td>
<td>TH</td>
<td>10</td>
<td>5</td>
<td>27</td>
<td>14.0</td>
<td>56</td>
<td>99.000</td>
<td>31</td>
<td>$325,617</td>
<td></td>
<td>$218,806</td>
<td>6 TH/6 RRH units</td>
<td>$12,692,767</td>
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</tr>
<tr>
<td>Connections for the Homeless Inc.</td>
<td>Connections New Permanent Housing Project</td>
<td>PSH</td>
<td>10</td>
<td>5</td>
<td>34</td>
<td>15.5</td>
<td>64.5</td>
<td>2.557</td>
<td>32</td>
<td>$227,488</td>
<td></td>
<td>$227,488</td>
<td>8 PSH units/15 beds</td>
<td>$12,920,255</td>
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</tr>
<tr>
<td>NORTHWEST COMPASS, INC.</td>
<td>New Way Housing</td>
<td>TH/RRH</td>
<td>13</td>
<td>5</td>
<td>32</td>
<td>14.2</td>
<td>64.2</td>
<td>1.902</td>
<td>33</td>
<td>$235,580</td>
<td></td>
<td>$235,580</td>
<td>3 TH/6 RRH units</td>
<td>$13,155,835</td>
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<tr>
<td>Housing Forward</td>
<td>SSO for Coordinated Entry for Domestic Violence</td>
<td>SSO</td>
<td>10</td>
<td>5</td>
<td>27</td>
<td>14.0</td>
<td>56</td>
<td>0.000</td>
<td>34</td>
<td>$75,000</td>
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<td>$130,000</td>
<td>expansion</td>
<td>$13,285,835</td>
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</tr>
<tr>
<td>Connections for the Homeless Inc.</td>
<td>Connections - YWCA DV RRH</td>
<td>TH/RRH</td>
<td>13</td>
<td>5</td>
<td>30</td>
<td>14.7</td>
<td>62.7</td>
<td>1.170</td>
<td>35</td>
<td>$225,004</td>
<td></td>
<td>$466,012</td>
<td>4 TH/20 RRH units</td>
<td>$13,751,847</td>
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</tr>
<tr>
<td>BEDS Plus Care</td>
<td>Southwest Seniors Permanent Supportive Housing</td>
<td>PSH</td>
<td>13</td>
<td>5</td>
<td>29</td>
<td>15.0</td>
<td>62</td>
<td>5.969</td>
<td>36</td>
<td>$383,280</td>
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<td>$215,554</td>
<td>~13 units/20 beds</td>
<td>$13,967,401</td>
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<tr>
<td>Housing Forward</td>
<td>Safe Bridge Housing DV</td>
<td>TH/RRH</td>
<td>13</td>
<td>5</td>
<td>29</td>
<td>14.5</td>
<td>61.5</td>
<td>1.932</td>
<td>37</td>
<td>$470,326</td>
<td></td>
<td>$570,326</td>
<td>6 TH/17 RRH units</td>
<td>$14,537,727</td>
<td></td>
</tr>
</tbody>
</table>

**Oranges:** new project application (non-DV)  
**Purples:** new project application (Domestic Violence)  
**Yellows:** highlighting the columns showing rank & approved amounts  
**Greens:** new project scoring shown at bottom; renewal project scoring shown in top header

---

Orange: new project application (non-DV)  
Purple: new project application (Domestic Violence)  
Yellow: highlighting the columns showing rank & approved amounts  
Green: new project scoring shown at bottom; renewal project scoring shown in top header

IL-511 CoC Planning Grant: $382,040
This attachment contains:

- The local competition deadline posted to the CoC website 7/11/19, pages 2-3
  - The date posted, deadline for the e-snaps application, link to our local competition timeline, and website address are highlighted.

- The local competition deadline emailed 7/15/19 to 538 recipients, pages 4-7
  - The date emailed, number of recipients, deadline for the e-snaps application, and link to our local competition timeline are highlighted.

- The local competition timeline, which is a linked to in the website and email, page 8
The Notice of Funding Availability (NOFA) for Fiscal Year 2019 Continuum of Care (CoC) Program Competition has been posted on the HUD exchange and Project Applications for new and renewal projects are also available in e-snaps.

Organizations that have already submitted an Alliance new or renewal project application by the existing deadlines will be required to complete a Project Application in e-snaps and email the pdf copy of the application to nofa@suburbancook.org by Thursday, August 15th, at 5pm.

The NOFA timeline has been updated to reflect the e-snaps application deadline and the date that the CoC application and CoC priority listing will be emailed and posted online at www.suburbancook.org/nofa. All other due dates for the local competition remain the same.

For more information on how to complete the Project Application in e-snaps, please visit:

- FY 2019 Renewal Project Application Detailed Instructions and Navigational Guide, OR
- FY 2019 New Project Application Detailed Instructions and Navigational Guide

For questions about the e-snaps application or the NOFA process, please contact Kurt Runge at kurt@suburbancook.org or Kathryn Primas at Kathryn@suburbancook.org.

For updates and more info, visit www.suburbancook.org/nofa.

Thank you!
hud releases the NOFA and e-snaps is avail

 HUD Releases the NOFA
SENT on Mon, Jul 15, 2019 at 11:59 am CDT

Lists    Members

From Name  Sharon King
From Address  sharon@suburbancook.org
Reply-to Address  sharon@suburbancook.org
Email Link  https://conta.cc/2Sns2GE

EMAIL STATS

Open Rate  24.7%

Desktop  89%  Mobile  11%
SOCIAL

Expand your reach with a Facebook Lead Ad
Capture the attention of future fans by creating a Facebook Lead Ad.

Create an Ad

Share this campaign on social media
Share your email newsletter with your fans and followers across all your social networks.

Schedule Posts
When your contacts click a link in your email, we’ll show you the stats here.

<table>
<thead>
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<th>Distribution</th>
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<td>9</td>
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</tr>
<tr>
<td><a href="https://www.hudexchange.info/resource/2909/coc-project-application-instructions-for-new-projects/">https://www.hudexchange.info/resource/2909/coc-project-application-instructions-for-new-projects/</a></td>
<td>8</td>
<td>22.9%</td>
</tr>
<tr>
<td><a href="https://www.hudexchange.info/resource/2910/coc-project-application-instructions-for-renewal-projects/">https://www.hudexchange.info/resource/2910/coc-project-application-instructions-for-renewal-projects/</a></td>
<td>7</td>
<td>20%</td>
</tr>
<tr>
<td><a href="https://esnaps.hud.gov/">https://esnaps.hud.gov/</a></td>
<td>5</td>
<td>14.3%</td>
</tr>
<tr>
<td><a href="https://www.hudexchange.info/resource/5842/fy-2019-coc-program-nofa/">https://www.hudexchange.info/resource/5842/fy-2019-coc-program-nofa/</a></td>
<td>5</td>
<td>14.3%</td>
</tr>
<tr>
<td><a href="http://www.suburbancook.org/nofa">http://www.suburbancook.org/nofa</a></td>
<td>1</td>
<td>2.9%</td>
</tr>
<tr>
<td><strong>Total Click-throughs</strong></td>
<td><strong>35</strong></td>
<td><strong>100%</strong></td>
</tr>
</tbody>
</table>
HUD releases the NOFA and e-snaps is available

The Notice of Funding Availability (NOFA) for Fiscal Year 2019 Continuum of Care (CoC) Program Competition has been posted on the HUD exchange and Project Applications for new and renewal projects are also available in e-snaps.

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- FY 2019 New Project Application Detailed Instructions and Navigational Guide

For questions about the e-snaps application or the NOFA process, please contact Kurt Runge at kurt@suburbancook.org or Kathryn Primas at Kathryn@suburbancook.org.

For updates and more info, visit www.suburbancook.org/nofa.

Thank you!
## 2019 Continuum of Care Process for Suburban Cook County

**TIMELINE – last revised 7/15/2019**

Check for updates and important details on the Alliance’s NOFA page: [http://suburbancook.org/nofa](http://suburbancook.org/nofa)

<table>
<thead>
<tr>
<th>Event</th>
<th>Date/Time</th>
<th>Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>Continuum of Care NOFA released by HUD</td>
<td>TBD</td>
<td></td>
</tr>
<tr>
<td>Continuum of Care Orientation and Annual Meeting</td>
<td>May 30, 9:00-12:00</td>
<td>Catholic Char’s, 721 N LaSalle</td>
</tr>
<tr>
<td>Training on CoC and Other Resources</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance Application Forms released for new and renewal projects</td>
<td>May 30</td>
<td></td>
</tr>
<tr>
<td>– see Alliance website</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Application and ESnaps Training: New and renewal project</td>
<td>June 14, 10:00-12:00</td>
<td>Alliance Offices Conf Rm 306</td>
</tr>
<tr>
<td>applicants encouraged to attend for important info – RSVP to</td>
<td></td>
<td></td>
</tr>
<tr>
<td><a href="mailto:sharon@suburbancook.org">sharon@suburbancook.org</a></td>
<td></td>
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</tr>
<tr>
<td>Applicants provide budgets with recapture amounts: Submit</td>
<td>June 17</td>
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</tr>
<tr>
<td>budget form to <a href="mailto:nofa@suburbancook.org">nofa@suburbancook.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renewals: Alliance application submitted</td>
<td>June 24, 5pm</td>
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</tr>
<tr>
<td>– Alliance app and most recent APR emailed to <a href="mailto:nofa@suburbancook.org">nofa@suburbancook.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Project Review Panel: receive materials/instructions for RENEWAL</td>
<td>July 1, 10-12</td>
<td>Alliance Offices Conf Rm 306</td>
</tr>
<tr>
<td>projects (Session 1)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Projects: Alliance application submitted</td>
<td>July 2, 5pm</td>
<td></td>
</tr>
<tr>
<td>– Alliance app and all other attachments emailed to <a href="mailto:nofa@suburbancook.org">nofa@suburbancook.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance staff completes threshold review of project applications</td>
<td>In the 3 days following the Alliance deadlines</td>
<td></td>
</tr>
<tr>
<td>Project Review Panel: Renewal Review Day – meeting to score</td>
<td>July 9, 10-12:30pm</td>
<td>Alliance Offices Conf Rm 306</td>
</tr>
<tr>
<td>and rank renewal projects (Session 2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Project Review Panel: receive materials/instructions</td>
<td>July 9, 12:30-1:30</td>
<td>Alliance Offices Conf Rm 306</td>
</tr>
<tr>
<td>(Session 2)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>New Project Review Day: all-day meeting to score; project</td>
<td>July 17, 9:00-5:00</td>
<td>Alliance Offices Conf Rm 306</td>
</tr>
<tr>
<td>presentations (mandatory for New Projects to present)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>(Session 3)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Written Notice of Review Panel Recommendations: the ranked order of</td>
<td>July 19, 5pm</td>
<td><a href="http://www.suburbancook.org/nofa">www.suburbancook.org/nofa</a></td>
</tr>
<tr>
<td>new and renewal projects, including recommended dollar amounts, to</td>
<td></td>
<td></td>
</tr>
<tr>
<td>be posted on Alliance website</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Alliance Board of Directors approves Project List</td>
<td>July 26, 10am-12pm</td>
<td>Board Mtg</td>
</tr>
<tr>
<td>Project applicants notified in writing – whether project was accepted</td>
<td>July 29</td>
<td></td>
</tr>
<tr>
<td>or rejected, notice delivered via email</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Rejected/reduced projects: appeal deadline August 1</td>
<td>August 1, 12pm</td>
<td></td>
</tr>
<tr>
<td>Executive Cmte call to make final decision on any written appeals,</td>
<td>August 5, 1:30pm</td>
<td></td>
</tr>
<tr>
<td>if applicable</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Renewal and New Projects: ESnaps application – ESnaps</td>
<td>August 15th, 5pm</td>
<td></td>
</tr>
<tr>
<td>application submitted and emailed to <a href="mailto:nofa@suburbancook.org">nofa@suburbancook.org</a></td>
<td></td>
<td></td>
</tr>
<tr>
<td>CoC Application and CoC Priority Listing posted to</td>
<td>September 26, 2019</td>
<td></td>
</tr>
<tr>
<td><a href="http://www.suburbancook.org">www.suburbancook.org</a>; Stakeholders notified via email</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Combined application submitted by the Alliance to HUD – in time for</td>
<td>September 30, 2019</td>
<td></td>
</tr>
<tr>
<td>HUD’s deadline</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>
1E-1 Local Competition Public Announcement Cover page for IL-511 CoC

This attachment contains:

- The local competition public announcement posted to the CoC website 6/3/19, pages 2-5
  - The date posted, description of how projects are ranked, and the links to the ranking tools for new and renewal applications are highlighted
- The local competition public announcement emailed 6/3/19 to 529 recipients, pages 6-12
  - The date emailed, description of how projects are ranked, links to the ranking tools for new and renewal applications, and number of recipients are highlighted
The Alliance to End Homelessness in Suburban Cook County invites new bonus and reallocation Project Applications, Domestic Violence Bonus applications, and Renewal Project Applications in advance of the 2019 Continuum of Care competition.

Alliance applications are available here:

- **Alliance Renewal Project Application**
- **Alliance New Project Application** (Bonus, DV Bonus, Reallocation)

Alliance Applications are completed in an Adobe PDF form where you can save your work and come back to the form before submitting it. These Alliance Applications are submitted by email to nofa@suburbancook.org with attachments as described in the instructions on the last page of the forms.

**Key dates:**

- The training for new and renewal project applications will be held on **Friday, June 14, 10:00-12:00 pm** at the Alliance offices, 4415 Harrison Street, Suite 306, Hillside.
- Renewal application **project reallocation budgets** are due **Monday, June 17th**.
- Alliance renewal applications are due **Monday, June 24th at 5:00 pm**.
- Alliance new project applications (bonus or reallocation) are due **Tuesday, July 2nd at 5:00 pm**.
- New projects will be required to do an oral presentation on **July 17th**. The Alliance will contact to schedule a time for the presentation.
- These and other dates and times are included on the updated **Timeline**.

Projects will also complete the HUD Project Application within e-snaps by a deadline that the Alliance will set after HUD releases the Continuum of Care Notice of Funding Availability (NOFA). **The deadline may be on the**
same date as the deadline for the Alliance Application or later. Applicants should check the Alliance NOFA web page for updates once the NOFA is released.

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HUD may allow suburban Cook County to request bonus project or reallocation funding to support applications for:

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All projects will be required to fill units through the Alliance’s Coordinated Entry system.

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Multiple providers can be awarded separate grants, but we can only rank one project of each category above. For example, HUD may fund both a RRH project and a RRH/TH joint project, but it will not fund 2 RRH projects.

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Transition grant applicants need to complete the Alliance New Project Application form and the HUD project application within esnaps. Last year's renewal application/s need to be attached to the project application within esnaps.

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All applicants are strongly encouraged to read more about the Continuum of Care competition at HUD’s Continuum of Care Program website.
Alliance releases applications for CoC Funding

SENT on Mon, Jun 3, 2019 at 3:30 pm CDT

Lists    Members
From Name    Sharon King
From Address    sharon@suburbancook.org
Reply-to Address    sharon@suburbancook.org
Email Link    https://conta.cc/2KxaFkT

Open Rate
30.2%
Desktop 84.8%  Mobile 15.2%
SOCIAL

Expand your reach with a Facebook Lead Ad
Capture the attention of future fans by creating a Facebook Lead Ad.

Create an Ad

Share this campaign on social media
Share your email newsletter with your fans and followers across all your social networks.

Schedule Posts
When your contacts click a link in your email, we'll show you the stats here.

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**Total Click-throughs**: 89 (100%)
The Alliance to End Homelessness in Suburban Cook County invites new bonus and reallocation Project Applications, Domestic Violence Bonus applications, and Renewal Project Applications in advance of the 2019 Continuum of Care competition. Alliance applications are available here:

- Alliance Renewal Project Application
- Alliance New Project Application (Bonus, DV Bonus, Reallocation)

Alliance Applications are completed in an Adobe PDF form where you can save your work and come back to the form before submitting it. These Alliance Applications are submitted by email to nofa@suburbancook.org with attachments as described in the instructions on the last page of the forms.

**Key dates:**
- The training for new and renewal project applications will be held on **Friday, June 14, 10:00-12:00 pm** at the Alliance offices, 4415 Harrison Street, Suite 306, Hillside.
- Renewal application project reallocation budgets are due **Monday, June 17th**.
- Alliance renewal applications are due **Monday, June 24th at 5:00 pm**.
- Alliance new project applications (bonus or reallocation) are due **Tuesday, July 2nd at 5:00 pm**.
- New projects will be required to do an oral presentation on **July 17th**. The Alliance will contact to schedule a time for the presentation.
- These and other dates and times are included on the updated [Timeline](#).

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April 22, 2019

Contact Name
Youth Job Center
1114 Church Street, Evanston, IL 60201

RE: Youth Job Center, Inc. and The Alliance to End Homelessness in Suburban Cook County (Alliance) Letter of Agreement.

This Letter constitutes an agreement between Youth Job Center and the Alliance. This letter's objective is to identify areas of collaboration and participation of both entities for the development of a Coordinated Community Plan to end and prevent youth homelessness in suburban Cook County.

The Youth Job Center (YJC) assists young adults to make strides toward, secure, and maintain living-wage employment in positions that meet their individual needs and interests and provide advancement opportunities.

YJC's service delivery model starts with enrollment and assessment, and includes job-readiness training, career advising, referrals for social service support, job placement, retention coaching, and ongoing career planning.

The CoC organizes services to prevent and end homelessness, including youth homelessness

As a partner with the Alliance, we believe our missions are complementary and wish to continue working together in the identified areas of collaboration:

- Supporting the development of a coordinated community plan to prevent and end youth homelessness.
- Supporting the implementation of the plan.
- Supporting the plan by providing job readiness training, career advising, placement services, retention coaching, and ongoing career planning for referrals made through the CoC.

As a partner with the Alliance, we share their commitment to end and prevent youth homelessness, and we look forward to collaborating with the Alliance on this effort.

Principal Contacts

The Principal Contacts for each one of the organizations is:

[PARTNER]: Youth Job Center, Inc.
[NAME OF PRINCIPAL CONTACT] Eileen Hallstrom
[TITLE] Director of Strategic Initiatives
[ADDRESS] 1114 Church Street, Evanston, IL 60201
[TELEPHONE] 847.864.5627

The Alliance to End Homelessness in Suburban Cook County (IL-511)
Kurt Runge
CoC Program Director
4415 Harrison St., Ste 228, Hillside, IL 60162
708-236-3261 ext. 08
The Alliance to End Homelessness
Name]

Kurt Runge
Director of CoC Programs

Date: 4/22/19

To Expire: 

[Agency

NAME: Eileen Hallstrom
TITLE: Director of Strategic Initiatives

Date: 4/22/2019
April 16, 2019

Al Saulys
Business and Career Services, Inc.
North Suburban Cook County American Job Center
723 W. Algonquin Road
Arlington Heights, IL 60005

RE: Business and Career Services, Inc. and the Alliance to End Homelessness in Suburban Cook County (CoC IL-511) Letter of Agreement

This letter constitutes an agreement between Business and Career Services, Inc. at the North Suburban Cook County American Job Center and the Alliance to End Homelessness in Suburban Cook County. This letter’s objective is to identify areas of collaboration and participation of both entities for the development of a coordinated community plan to end and prevent youth homelessness in suburban Cook County.

Business and Career Services, Inc. is a non-profit agency that implements comprehensive workforce development initiatives that address the occupational training and career placement needs of adults, dislocated workers, youth and businesses. BCS has served as the management entity and operator for the North Suburban Cook County American Job Center for more than 15 years. It also operates affiliate locations in Hanover Park and Robbins.

As a partner with the Alliance, we believe our missions are complementary and wish to continue working together in the identified areas of collaboration:

- Supporting the development of a coordinated community plan to prevent and end youth homelessness
- Supporting the implementation of the plan
- Additional collaboration to support YHDP: including receiving training to participate in coordinated entry system, engaging in outreach efforts targeted at youth experiencing homelessness and providing supportive services.

As a partner with the Alliance, we share their commitment to end and prevent youth homelessness, and we look forward to collaborating with them on this effort.

Principal Contacts
The Principal Contacts for each one of the organizations is:

Business and Career Services, Inc.
Al Saulys
Executive Director
723 W. Algonquin Road, Arlington Heights
847.437.9395

Alliance to End Homelessness in Suburban Cook County (IL-511)
Kurt Runge
CoC Program Director
Alliance to End Homelessness (CoC IL-511)

Kurt Runge
CoC Program Director

Date: 4/25/19

Business and Career Services, Inc.

Al Saulys
Executive Director

Date: 4-16-2019
MEMORANDUM OF UNDERSTANDING

BETWEEN

ALLIANCE TO END HOMELESSNESS IN SUBURBAN COOK COUNTY

AND

THE CHICAGO COOK WORKFORCE PARTNERSHIP

This Memorandum of Understanding, hereafter referred to as ("MOU") by and between the Chicago Cook Workforce Partnership ("The Partnership") and the Alliance To End Homelessness in Suburban Cook County is an agreement to collaborate designed to leverage resources and relationships to advance both organizations’ common goals and missions in relations to the U.S. Department of Housing and Urban Development funding opportunity. All parties hereto agree to abide by the terms and provisions of this MOU throughout the duration of the Agreement.

Part I

Purpose of Agreement

This MOU is to establish a formal partnership between the Alliance To End Homelessness in Suburban Cook County and The Partnership for the purposes of:

- Coordinating social, economic, educational, and other benefits and services for individuals experiencing homelessness;
- Establishing and improving cross-sector relationships and collaboration
- Increasing cross-sector knowledge;
- Streamlining and increasing cross-sector referrals; and
- Identifying opportunities to engage in joint efforts to improve outcomes for individuals experiencing homelessness.

Part II

The Partners’ Responsibilities

The following entities ("partners") agree to participate in the activities articulated in this MOU:

i. Alliance to End Homelessness in Suburban Cook County is a non-profit organization which strives for the elimination of homelessness in suburban
Cook County through the coordination and maximization of available resources to assist homeless individuals and families. The Alliance to End Homelessness coordinates the Cook County Continuum of Care, which encompasses homeless assistance efforts throughout all of Cook County except for the City of Chicago. The Alliance serves as a convener for the collaborative, community-based endeavors of homeless service providers, affordable housing developers, local governments, foundations, and the private sector.

II. The Chicago Cook Workforce Partnership ("The Partnership") is an Illinois non-profit organization with offices located at 69 West Washington, Suite 2860, Chicago, Illinois. The Partnership convenes the Chicago Cook Workforce Investment Board pursuant to the Workforce Innovation and Opportunity Act of 2014. Ms. Karin M. Norington-Reaves is the Chief Executive Officer and was appointed by Mayor Rahm Emanuel and Cook County President Toni Preckwinkle.

Additional partners may be added at any time. Partners may terminate their participation at any time.

Part III

The Partnership and Alliance to End Homelessness in Suburban Cook County

i. Alliance to End Homelessness in Suburban Cook County’s Responsibilities
   - Plan quarterly meetings with partners at rotating locations;
   - Identify meeting co-chairs responsible for disseminating meeting agendas and notes;
   - Provide training for core partners on Cook County’s Continuum of Care and how to refer persons needing assistance; and
   - Maintain strong communication with program staff and staff at the community-based agencies to stay informed of program goals, and outcomes.

ii. The Partnership’s Responsibilities:
   - Attend quarterly meetings with partners to identify goals, share information and strengthen communication;
   - Identify existing training and technical assistance resources that can be made available to other stakeholder groups and share that information with other partners;
   - Regularly share WIOA program orientation information and employment opportunities.
Part IV
Responsibilities of All Parties

All Agree to:

Training and technical assistance
- Each partner will identify existing training and technical assistance resources that can be made available to other stakeholder groups and share that information with other partners.
- Partners will develop and conduct a survey for each sector to identify training and technical assistance needs across sectors.
- Partners will collaboratively plan at least one cross-training for employment specialists and homeless services stakeholders in suburban Cook County on an annual basis.
- Partners will be responsive to requests for technical assistance from other partners, up to two hours per month.
- Partners will collaboratively develop written resources that will be publicly available, as appropriate. The written resources will be reviewed and updated annually, as appropriate. Resources will include:
  - Brief overview of each service system;
  - List of key partners and resources within each sector; and
  - Materials posted on partner websites

Standard referral and collaboration processes
Partners will collaboratively develop standard referral and general collaboration processes that may include the following activities:
  a. Establishing designated Points of Contact at program sites;
  b. Developing a standardized referral form and release of information process/form; and
  c. Ensuring accessibility to the Continuum of Care’s Coordinated Entry System and/or access to homeless prevention resources.

Part V
General Contract Provisions

Amendment Provisions
This Agreement may be amended at any time through consensus of both parties and must be in writing. Such amendments will require the signature of all parties affected by such amendment. Assignment of responsibilities under this MOU by any of the parties shall be effective upon written notice to the other parties.

Consistency with Authorizing Laws and Regulations
Both parties agree to provide services consistent with federal, state, and local laws and regulations.
Administrative and Operational Procedures
Both parties consent to share confidential information pursuant to any Partnership and Alliance policies concerning personal identifiable information (PII) between the parties as relating to this Agreement that will be helpful in job creation and procedures set forth in this Agreement.

Mutual Indemnification/No Agency Relationship
The collaborating parties agree to indemnify, defend, armless, each other and their officers, agents, and employee from any, and all claims, actions or proceedings arising solely out of the acts or omissions of the indemnifying party of this Memorandum of Understanding. The collaborating parties agree that each is acting in and independent capacity and not as officers, employee or agents of the other party.

No funding Obligations
Nothing in this MOU shall obligate either The Partnership or Alliance to End Homelessness in Suburban Cook County to transfer or pay any funds to each other. Any agreement that involves payment from one party to the other requires execution of a separate agreement and will be contingent upon funding availability. Such activities must be independent and appropriately authorized and negotiated, executed and administered separately and independent of this MOU.

Duration of Agreement (Term)
Partners will review and revise the MOU annually to ensure it meets current needs across sectors. The MOU shall be established from September 30, 2019 – August 31, 2020.

This MOU is at-will and may be modified by mutual consent of authorized officials from The Partnership and Alliance to End Homelessness in Suburban Cook County. This MOU shall become effective upon signature by the authorized officials from The Partnership and Alliance to End Homelessness in Suburban Cook County and will remain in effect until the end of the relevant grant period.

The Term of this MOU is coincidental and coterminous to the requested grant funding and will take effect upon the date of the grant award. In the event there is no grant award for this specific program, this MOU will be immediately null and void.

Entire Agreement
This Agreement sets forth the entire understanding of both parties with respect to the transactions contemplated hereby and supersedes all previous arrangements and understanding relating to the subject matter hereof.

VII
Authority and Signatures
The individual signing below has the authority to commit the party they represent to the terms of this MOU and do so commit by signing below.
Alliance to End Homelessness in Suburban Cook County

By: Kurt Runge

Its: Community of Care Program Director

Date: 9/25/19

Chicago Cook Workforce Partnership

By: Karin M. Norington-Reaves

Its: Chief Executive Officer

Date: 9/25/19
Race and Homelessness

An Assessment of Racial disparities in the suburban Cook County Continuum of Care

IL-511

8/26/19
Summary of Racial Disparity Assessment

Methodology

- The CoC used US Census 2010-2014 American Community Survey 5-year estimates and data from the CoC-Analysis Tool for IL-511 to identify population and poverty rates for the region by race and ethnicity.

- 2019 PIT, entries to shelter, entries to Coordinated Entry, exits to permanent destinations, length of time homeless (LOTH), and returns to homelessness were pulled from HMIS from Oct 1 2017 to Sept 30, 2018. These measures were compared based on race and ethnicity to identify possible disparities in the homeless services system.
Summary of Racial Disparity Assessment

Entries to system

- African Americans have a greater chance of becoming homeless than white households
- African Americans are over represented in shelter compared to other races (16% of population, 41% in poverty, 54% of shelter entries over a fiscal year, 66% of homeless population in 2019 PIT)
- Latinos represent a smaller share of the homeless population than expected (20% of population, 20% in poverty, 10% of shelter entries over a fiscal year, 19% of homeless population in 2019 PIT)
- A slightly smaller percentage of African Americans were assessed through CE (50%) than were in shelter over the course of a year (54%). This could suggest a slight bias towards assessing African Americans.
- A slightly higher percentage of whites were assessed through CE (47%) than were in shelter over the course of the year (41%). This could suggest a slight bias towards assessing white households.
Summary of Racial Disparity Assessment

Outcomes

- African Americans enter PSH (56%) at an almost equal proportion to African Americans in shelter (54%), with a greater proportion entering RRH (70%), indicating that African Americans have equal or greater access to CoC housing resources.
- African Americans are over represented in the homeless services system but have lower returns to homelessness compared to whites (13% compared to 22%)
- African Americans have a slightly lower average Length of Time Homeless (LOTH) in shelter and safe haven (50 days) compared to whites (60 days).
- Hispanic/Latino have the lowest LOTH in shelter and safe have (42 days)
Summary of Racial Disparity Assessment

Conclusions

- **People of different races or ethnicities are more or less likely to receive homeless assistance.**
  - African Americans are over-represented in homeless shelter (16% of population, 41% in poverty, 54% of shelter entries over a fiscal year, 66% of homeless population in 2019 PIT).
  - Latino households are underrepresented in shelters (20% of population, 20% in poverty, 10% of shelter entries over a fiscal year, 19% of homeless population in 2019 PIT).
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- **People of different races or ethnicities are more or less likely to receive a positive outcome from homeless assistance.**
  - African Americans are over represented in the homeless services system but have lower returns to homelessness compared to whites (13% compared to 22%).
  - African Americans have a slightly lower average Length of Time Homeless (LOTH) in shelter and safe haven (50 days) compared to whites (60 days).
  - Hispanic/Latino have the lowest LOTH in shelter and safe have (42 days).
Racial Disparity Assessment Results

Distribution of population and poverty in suburban Cook County

Source: US Census 2010-2014 American Community Survey 5-year estimates
Distribution of Race and ethnicity in suburban Cook County

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<tr>
<td>Experiencing Unsheltered Homelessness (PIT)</td>
<td>66%</td>
<td>66%</td>
<td>66%</td>
<td>66%</td>
</tr>
</tbody>
</table>

In Families with Children:
- Experiencing Homelessness (PIT): 5.8%
- Experiencing Unsheltered Homelessness (PIT): 3.2%

### Distribution of Ethnicity

<table>
<thead>
<tr>
<th>Category</th>
<th>All People</th>
<th>In Poverty (ACS)</th>
<th>Experiencing Homelessness (PIT)</th>
<th>Experiencing Unsheltered Homelessness (PIT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>All People</td>
<td>69%</td>
<td>31%</td>
<td>9%</td>
<td>11%</td>
</tr>
<tr>
<td>Experiencing Homelessness (PIT)</td>
<td>91%</td>
<td>91%</td>
<td>91%</td>
<td>91%</td>
</tr>
<tr>
<td>Experiencing Unsheltered Homelessness (PIT)</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
<td>89%</td>
</tr>
</tbody>
</table>

In Families with Children:
- Experiencing Homelessness (PIT): 87%
- Experiencing Unsheltered Homelessness (PIT): 87%

Source: CoC-Analysis Tool IL-511
## Racial Disparity Assessment Results

### Entries to shelter by race in suburban Cook

#### Entries between Oct 1, 2016 and Sept 30, 2017

<table>
<thead>
<tr>
<th>Race (HUD)</th>
<th>% of total entries</th>
<th>% low-income</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native (HUD)</td>
<td>30</td>
<td>1.15%</td>
</tr>
<tr>
<td>Asian (HUD)</td>
<td>27</td>
<td>1.04%</td>
</tr>
<tr>
<td>Black or African American (HUD)</td>
<td>1410</td>
<td>54.25%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander (HUD)</td>
<td>8</td>
<td>0.31%</td>
</tr>
<tr>
<td>White (HUD)</td>
<td>1066</td>
<td>41.02%</td>
</tr>
</tbody>
</table>

#### Entries between Oct 1, 2017 and Sept 30, 2018

<table>
<thead>
<tr>
<th>Race (HUD)</th>
<th>% of total entries</th>
<th>% low-income</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native (HUD)</td>
<td>25</td>
<td>1.13%</td>
</tr>
<tr>
<td>Asian (HUD)</td>
<td>26</td>
<td>1.18%</td>
</tr>
<tr>
<td>Black or African American (HUD)</td>
<td>1194</td>
<td>54.13%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander (HUD)</td>
<td>8</td>
<td>0.36%</td>
</tr>
<tr>
<td>White (HUD)</td>
<td>904</td>
<td>40.98%</td>
</tr>
</tbody>
</table>

*This is an estimate resulting from a combination of white non-Hispanic and Hispanic % low-income.*
### Entries to shelter by ethnicity in suburban Cook

<table>
<thead>
<tr>
<th>Ethnicity (896)</th>
<th>Count Client</th>
<th>% total entries</th>
<th>% low income population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino (HUD)</td>
<td>256</td>
<td>9.87%</td>
<td>32%</td>
</tr>
<tr>
<td>Non-Hispanic/Non-Latino (HUD)</td>
<td>2268</td>
<td>87.43%</td>
<td>68%</td>
</tr>
</tbody>
</table>

#### 2018

<table>
<thead>
<tr>
<th>Ethnicity (896)</th>
<th>Count Client</th>
<th>% total entries</th>
<th>% low income population</th>
</tr>
</thead>
<tbody>
<tr>
<td>Hispanic/Latino (HUD)</td>
<td>224</td>
<td>10.18%</td>
<td>31%</td>
</tr>
<tr>
<td>Non-Hispanic/Non-Latino (HUD)</td>
<td>1909</td>
<td>86.77%</td>
<td>69%</td>
</tr>
</tbody>
</table>

#### 2019
### 2019 PIT Data

#### Ethnicity (adults and children)

<table>
<thead>
<tr>
<th>Ethnicity / Shelter Type</th>
<th>Emergency</th>
<th>Transitional</th>
<th>Total</th>
<th>% Total (2019)</th>
<th>% Total (2018)</th>
</tr>
</thead>
<tbody>
<tr>
<td>Non-Hispanic/Non-Latino</td>
<td>125</td>
<td>136</td>
<td>261</td>
<td>78%</td>
<td>81%</td>
</tr>
<tr>
<td>Hispanic/Latino</td>
<td>27</td>
<td>36</td>
<td>63</td>
<td>22%</td>
<td>19%</td>
</tr>
</tbody>
</table>

#### Race (adults and children)

<table>
<thead>
<tr>
<th>Race / Shelter Type</th>
<th>Emergency</th>
<th>Transitional</th>
<th>Total</th>
<th>% Total</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>32</td>
<td>57</td>
<td>89</td>
<td>30%</td>
</tr>
<tr>
<td>Black or African-American</td>
<td>109</td>
<td>105</td>
<td>214</td>
<td>66%</td>
</tr>
<tr>
<td>Asian</td>
<td>40</td>
<td>4</td>
<td>8</td>
<td>1%</td>
</tr>
<tr>
<td>American Indian or Alaska Native</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Multiple Races</td>
<td>7</td>
<td>6</td>
<td>13</td>
<td>3%</td>
</tr>
</tbody>
</table>
## Coordinated Assessment (HUD)

### Entries between Oct 1, 2016 and Sept 30, 2017

<table>
<thead>
<tr>
<th>Primary Race (895)</th>
<th>Count</th>
<th>Client Unique ID</th>
<th>% entries in CE</th>
<th>% entries to shelter</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native (HUD)</td>
<td>7</td>
<td></td>
<td>1.23%</td>
<td>1.15%</td>
</tr>
<tr>
<td>Asian (HUD)</td>
<td>5</td>
<td></td>
<td>0.88%</td>
<td>1.04%</td>
</tr>
<tr>
<td>Black or African American (HUD)</td>
<td>263</td>
<td></td>
<td>46.06%</td>
<td>54.25%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander (HUD)</td>
<td>1</td>
<td></td>
<td>0.18%</td>
<td>0.31%</td>
</tr>
<tr>
<td>White (HUD)</td>
<td>282</td>
<td></td>
<td>49.39%</td>
<td>41.02%</td>
</tr>
</tbody>
</table>

### 2018

## Coordinated Assessment (HUD)

### Entries between Oct 1, 2017 and Sept 30, 2018

<table>
<thead>
<tr>
<th>Primary Race (895)</th>
<th>Count</th>
<th>Client Unique ID</th>
<th>% entries in CE</th>
<th>% entries to shelter</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native (HUD)</td>
<td>4</td>
<td></td>
<td>0.75%</td>
<td>1.13%</td>
</tr>
<tr>
<td>Asian (HUD)</td>
<td>7</td>
<td></td>
<td>1.31%</td>
<td>1.18%</td>
</tr>
<tr>
<td>Black or African American (HUD)</td>
<td>265</td>
<td></td>
<td>49.53%</td>
<td>54.13%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander (HUD)</td>
<td>1</td>
<td></td>
<td>0.19%</td>
<td>0.36%</td>
</tr>
<tr>
<td>White (HUD)</td>
<td>254</td>
<td></td>
<td>47.48%</td>
<td>40.98%</td>
</tr>
</tbody>
</table>

### 2019
# Outcomes: Entries to housing by race

<table>
<thead>
<tr>
<th>Primary Race (HUD)</th>
<th>2018 Percentage</th>
<th>2019 Percentage</th>
<th>2020 Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native (HUD)</td>
<td>1.15%</td>
<td>0.46%</td>
<td>0.49%</td>
</tr>
<tr>
<td>Asian (HUD)</td>
<td>1.04%</td>
<td>1.84%</td>
<td>0.98%</td>
</tr>
<tr>
<td>Black or African American (HUD)</td>
<td>54.27%</td>
<td>56.22%</td>
<td>69.59%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander (HUD)</td>
<td>0.31%</td>
<td>0.92%</td>
<td>0.33%</td>
</tr>
<tr>
<td>White (HUD)</td>
<td>40.99%</td>
<td>39.63%</td>
<td>27.64%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Primary Race (HUD)</th>
<th>2018 Percentage</th>
<th>2019 Percentage</th>
<th>2020 Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>American Indian or Alaska Native (HUD)</td>
<td>1.13%</td>
<td>0.0%</td>
<td>1.07%</td>
</tr>
<tr>
<td>Asian (HUD)</td>
<td>1.18%</td>
<td>1.40%</td>
<td>0.85%</td>
</tr>
<tr>
<td>Black or African American (HUD)</td>
<td>54.13%</td>
<td>48.37%</td>
<td>70.94%</td>
</tr>
<tr>
<td>Native Hawaiian or Other Pacific Islander (HUD)</td>
<td>0.36%</td>
<td>1.86%</td>
<td>0.21%</td>
</tr>
<tr>
<td>White (HUD)</td>
<td>40.98%</td>
<td>47.44%</td>
<td>26.07%</td>
</tr>
</tbody>
</table>
Outcomes: Return to homelessness

<table>
<thead>
<tr>
<th>Black or African American</th>
<th>Percentage of Returns in 2 Years</th>
<th>White</th>
<th>Percentage of Returns in 2 Years</th>
<th>ALL</th>
<th>Percentage of Returns in 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exits from SO</td>
<td>34.48%</td>
<td>Exits from SO</td>
<td>30.56%</td>
<td>Exits from SO</td>
<td>31.82%</td>
</tr>
<tr>
<td>Exits from ES</td>
<td>38.89%</td>
<td>Exits from ES</td>
<td>46.85%</td>
<td>Exits from ES</td>
<td>43.27%</td>
</tr>
<tr>
<td>Exits from TH</td>
<td>9.27%</td>
<td>Exits from TH</td>
<td>7.69%</td>
<td>Exits from TH</td>
<td>8.33%</td>
</tr>
<tr>
<td>Exits from SH</td>
<td>10.00%</td>
<td>Exits from SH</td>
<td>0.00%</td>
<td>Exits from SH</td>
<td>5.56%</td>
</tr>
<tr>
<td>Exits from All PH</td>
<td>7.42%</td>
<td>Exits from All PH</td>
<td>8.33%</td>
<td>Exits from All PH</td>
<td>7.53%</td>
</tr>
<tr>
<td>TOTAL Returns</td>
<td>13.66%</td>
<td>TOTAL Returns</td>
<td>21.43%</td>
<td>TOTAL Returns</td>
<td>16.32%</td>
</tr>
</tbody>
</table>

**2018**

<table>
<thead>
<tr>
<th>Black or African American</th>
<th>Percentage of Returns in 2 Years</th>
<th>White</th>
<th>Percentage of Returns in 2 Years</th>
<th>ALL</th>
<th>Percentage of Returns in 2 Years</th>
</tr>
</thead>
<tbody>
<tr>
<td>Exits from SO</td>
<td>18.42%</td>
<td>Exits from SO</td>
<td>42.86%</td>
<td>Exits from SO</td>
<td>27.12%</td>
</tr>
<tr>
<td>Exits from ES</td>
<td>40.52%</td>
<td>Exits from ES</td>
<td>47.85%</td>
<td>Exits from ES</td>
<td>43.06%</td>
</tr>
<tr>
<td>Exits from TH</td>
<td>11.85%</td>
<td>Exits from TH</td>
<td>10.43%</td>
<td>Exits from TH</td>
<td>11.78%</td>
</tr>
<tr>
<td>Exits from SH</td>
<td>12.50%</td>
<td>Exits from SH</td>
<td>0.00%</td>
<td>Exits from SH</td>
<td>4.17%</td>
</tr>
<tr>
<td>Exits from All PH</td>
<td>6.89%</td>
<td>Exits from All PH</td>
<td>9.58%</td>
<td>Exits from All PH</td>
<td>7.40%</td>
</tr>
<tr>
<td>TOTAL Returns</td>
<td>13.49%</td>
<td>TOTAL Returns</td>
<td>22.37%</td>
<td>TOTAL Returns</td>
<td>16.84%</td>
</tr>
</tbody>
</table>

**2019**
<table>
<thead>
<tr>
<th>Black or African American</th>
<th>Avg LOTH</th>
<th>Median LOT</th>
<th>White</th>
<th>Avg LOTH</th>
<th>Median LOT</th>
<th>Hispanic/Latino</th>
<th>Avg LOT</th>
<th>Median LOT</th>
<th>ALL</th>
<th>Avg LOT</th>
<th>Median LOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES and SH</td>
<td>33</td>
<td>11</td>
<td></td>
<td>49</td>
<td>19</td>
<td></td>
<td>27</td>
<td>10</td>
<td></td>
<td>39</td>
<td>13</td>
</tr>
<tr>
<td>ES, SH, and TH</td>
<td>92</td>
<td>23</td>
<td></td>
<td>77</td>
<td>24</td>
<td></td>
<td>73</td>
<td>16</td>
<td></td>
<td>84</td>
<td>23</td>
</tr>
</tbody>
</table>

2018

<table>
<thead>
<tr>
<th>Black or African American</th>
<th>Avg LOTH</th>
<th>Median LOT</th>
<th>White</th>
<th>Avg LOTH</th>
<th>Median LOT</th>
<th>Hispanic/Latino</th>
<th>Avg LOT</th>
<th>Median LOT</th>
<th>ALL</th>
<th>Avg LOT</th>
<th>Median LOT</th>
</tr>
</thead>
<tbody>
<tr>
<td>ES and SH</td>
<td>50</td>
<td>16</td>
<td></td>
<td>60</td>
<td>19</td>
<td></td>
<td>43</td>
<td>17</td>
<td></td>
<td>54</td>
<td>17</td>
</tr>
<tr>
<td>ES, SH, and TH</td>
<td>103</td>
<td>31</td>
<td></td>
<td>86</td>
<td>25</td>
<td></td>
<td>104</td>
<td>37</td>
<td></td>
<td>95</td>
<td>29</td>
</tr>
</tbody>
</table>

2019