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-508 - East St. Louis, Belleville/St. Clair County CoC

1A-2. Collaborative Applicant Name: St. Clair County

1A-3. CoC Designation: CA

1A-4. HMIS Lead: St. Clair County
**1B. Continuum of Care (CoC) Engagement**

**Instructions:**
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**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>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Local Jail(s)</td>
<td>No</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Hospital(s)</td>
<td>Yes</td>
<td>No</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>No</td>
<td>No</td>
</tr>
<tr>
<td>Disability Service Organizations</td>
<td>Yes</td>
<td>No</td>
<td>Yes</td>
</tr>
<tr>
<td>Disability Advocates</td>
<td>Yes</td>
<td>No</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>Not Applicable</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Non-CoC Funded Youth Homeless Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

Applicant: East Saint Louis/Belleville/Saint Clair County COC  
Project: IL-508 CoC Registration FY2019  
COC_REG_2019_170617
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.

1. The Homeless Action Council (IL-508 CoC entity) has a robust strategy for soliciting and considering opinions of those who have an interest in preventing or ending homelessness. The CoC seeks members who represent a range of expertise in homelessness/housing, including DV, youth advocates, and Veterans. Each year, the CoC evaluates the current makeup of the Board, committees/workgroups, and identifies gaps. The Executive Board then solicits membership that can provide missing insight. The Rank and Review committee has non-CoC funded reps to provide objective input and recommendations.

2. The Homeless Action Council holds numerous focus groups and committee meetings, drawing in outside agencies and individuals with expertise and knowledge in a variety of issues that affect our homeless population to improve the delivery of homeless prevention services. These issues include addressing mental health challenges from hospital discharge through permanent housing
placement; serving LGBT individuals/families; improving employment and non-
employment income; and youth homelessness.

3. During our monthly open meetings, we discuss community homelessness
issues and solicit feedback from all present. Based on feedback, the Homeless
Action Council designated this year homeless youth as a priority population.
After each meeting, we encourage opinions from the dozens of groups and
persons to whom we send the meeting minutes. These specific focus groups
and committee meetings have led to feedback on improvement of services and
suggestions for new approaches, including an employment boot camp for
homeless individuals, resulting in several hires.

4. The CoC provides related materials and forms through accessible electronic
formats. Also, the CoC has access to interpreters, including sign language
interpreters to assist those with disabilities, or that speak a language other than
English.

1B-2. Open Invitation for New Members.

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

1. The CoC solicits Board and committee membership annually via a public
announcement to the CoC listserv, posting info through social media and the
CoC’s website; and concentrated outreach to faith-based organizations,
churches, non-CoC agencies, and government groups to invite their
participation.

2. We communicate the invitation process publicly via the CoC listserv, posting
on the CoC’s social media accounts, and direct outreach to organizations or
individuals who represent specific expertise in needed areas. We issue
invitations to become general CoC members verbally in local meetings on an
on-going basis throughout the year.

3. The CoC ensures effective communication with individuals with disabilities by
having CoC materials available in accessible electronic formats and through
partnerships with local disability agencies. This ensures that the CoC addresses
homelessness across a variety of subpopulations and provides resources that
can easily be ascertained by individuals with disabilities.

4. The CoC Governance Charter states that we issue an annual public invitation
to solicit new members via the news media, but we have a year-round
continuous process for engaging new groups and soliciting members into the
CoC with formal new member recommendations made quarterly with the Homeless Action Council officially voting the agency/individual into the Council.

5. The CoC reaches out to local providers to seek assistance identifying interested homeless or formerly homeless individuals within their projects and encouraging them to participate, including helping them apply for CoC Board membership.

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 solicited new project proposal via a request for proposals (RFP) that was open to all nonprofits regardless of current CoC grantee status. We provided information at monthly CoC meetings to encourage attending non-CoC agencies to apply and to share with other agencies interested in applying. CoC staff shared the RFP for FY2019 CoC Competition on 07/22/2019 by posting it on the St. Clair County, Illinois website. Renewal projects were required to apply via esnaps. New project applicants were required to submit a proposal via email. CoC staff and consultants worked with new applicants to understand HUD grant requirements and assist with completing applications within esnaps system.

2. The CoC required all renewal and new applicants to submit a Letter of Intent to apply. The primary factors considered in project selection were community need, use of Housing First practices, and prioritizing those with the greatest need. The Ranking and Review committee made recommendations to the CoC Board regarding priority list of ranked projects. All projects notified of decisions via email outside of esnaps on 09/03/2019.

3. This year, the CoC publicly announced it was open to proposals through website posting (07/22/19), email (07/24/19) and announcements at community meetings. The CoC vigorously encouraged all agencies to consider applying for CoC funds, particularly those agencies which do not currently receive CoC funding.
4. The CoC provides application and announcements in accessible electronic formats to ensure that individuals with disabilities can participate in the grant application process. If additional support is needed to accommodate a disability, community disability advocates assist the CoC in providing needed resources/services.

5. The CoC encourages and gladly accepts proposals from non-CoC agencies.
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>
</tr>
<tr>
<td>Head Start Program</td>
<td>Yes</td>
</tr>
<tr>
<td>Funding Collaboratives</td>
<td>No</td>
</tr>
<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>No</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>
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. Our continuum is in the Illinois Balance of State jurisdiction for ESG purposes. We worked closely with the Illinois Department of Human Services (IDHS), the Balance of State ESG recipient, to develop performance standards and help ensure that all ESG funded projects comply with performance goals. The CoC provided IDHS with HMIS data and ESG subrecipient information. CoC staff solicited feedback from the CoC Board and agency providers regarding the ESG providers addressing the homeless population needs in our community.

2. The CoC’s Prevention Committee developed performance standards for all ESG projects, which were adopted and implemented in project monitoring. The CoC evaluates outcomes of ESG projects on a quarterly basis throughout the year.

3. CoC staff communicates with our county Community Development office, which is our Consolidated Plan jurisdiction, throughout the year and participates in the planning process. This communication allows the Community Development staff to relay the CoC’s ideas and concerns regarding the local homelessness challenges and to ensure relevant input is included in the Consolidated Plan updates.

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

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.

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. The coordinated entry (CE) center immediately connects all individuals and families who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, trafficking, or stalking to the Violence Prevention Center hotline. We conduct this warm handoff by calling the hotline directly from the CE center immediately upon receiving permission from the person to do so. By making this connection, we assure that such persons have safe and confidential access to emergency services such as domestic violence counseling, advocacy, and shelter, as well as a comparable CE process.

Coordinated entry staff and VPC staff collaborate on best practices that prioritize the safety of clients through the coordinated entry process and identifying housing options. VPC provides training on safety planning and other best practices for working with victims of DV. Additional CoC training for non-domestic violence homeless providers includes trauma-informed care and motivational interviewing.

2. To maximize client choice and ensure safety, the CoC partners with VPC to review data collection practices and trauma-informed care in conducting coordinated entry assessment (VI-SPDAT). Also, all personal data on DV victims are shared in a confidential manner between VPC and other providers when making referrals. We never enter personal data into our HMIS system. VPC and the Housing Resource Center work together to find appropriate housing based on client choice and their safety plan.

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

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

1. Annually, the CoC partners with the Violence Prevention Center (VPC) to provide training for all project staff in best practices in serving DV survivors and safety planning. We share training announcements via the CoC listserv. We
mandate attendance for CoC and ESG project staff, and we encourage all nonfunded homeless services providers to attend. In addition to this training, Chestnut Health Systems provided a separate training session for providers covering trauma-informed care and motivational interviewing.

2. The CoC requires all coordinated entry staff to receive 40 hours of training from the Violence Prevention Center. Topics include Court Advocacy; Detecting Domestic Abuse; Counseling Persons Fleeing; and Intensive Case Management. VPC staff provides an annual training review for coordinated entry staff.

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

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

The CoC’s domestic violence provider, the Violence Prevention Center (VPC), utilizes a comparable database to the Coordinated Entry’s HMIS database. VPC submits monthly utilization reports as well as statistics and relevant data related to domestic violence, dating violence, sexual assault, and stalking to help the CoC assess the community needs related to domestic violence. CoC staff review the data to evaluate project implementation and performance and for any changes in numbers served or in demand. The CoC also collects info about DV experience in the PIT count, and reports aggregate data to the full CoC during a monthly Homeless Action Council meeting.

**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>East Saint Louis Housing Authority</td>
<td>0.00%</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>St. Clair County Housing Authority</td>
<td>0.00%</td>
<td>No</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)

2. The CoC does not currently work with the two local PHAs on adopting a homeless admission preference policy. The Strategic Planning Committee has identified the need to build a relationship with the PHAs, and in the next few months, we will advocate for a homeless admission preference policy.

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.

No

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 addresses all forms of discrimination in the following ways:

1. Our CoC Written Standards require all homeless assistance projects to make all services and housing available to individual and families “without regard to actual or perceived sex, sexual orientation, or gender identity.” The program standards prohibit all projects from denying admission to individuals and families based on age, sex, gender, LGBT status, marital status, or disability.

2. In 2019, we provided training in cultural diversity, LGBT needs, and the Equal Access Rule to all CoC projects. We reinforce this training annually.

3. Coordinated entry staff works consistently with projects, clients, and housing providers on an individual basis to guide them as they put the rule into practice.

*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>Answer</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>Yes</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>Yes</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 5.105(a)(2) – Equal Access to HUD-Assisted or -Insured Housing?</td>
<td>Yes</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.

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

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

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

1. The CoC’s coordinated entry system covers 100% of the St. Clair County geographic area. Our outreach efforts extend to all homeless service providers, police departments, community churches, and township offices.

2. The persons least likely to apply for assistance are unsheltered homeless, especially those with multiple barriers. Coordinated entry staff work with local agencies providing outreach efforts to unsheltered homeless and our outreach teams reach out to homeless individuals who have multiple barriers. Most of these individuals are chronically homeless and have mental health or substance abuse issues. The coordinated entry staff, in tandem with crucial outreach workers, develop and maintain a by-name list of these individuals and discuss the progress of outreach staff in encouraging the individual to engage with the CoC and accept housing.
3. The coordinated entry assessment process prioritizes those most in need of assistance. We use the VI-SPDAT score, an individual's length of homelessness, and the date of first engagement to create priority lists for each housing type. Coordinated entry staff does a follow-up with participants to ensure services have been received in a timely manner by contacting clients and agencies within 30 days of the referral acceptance or denial in the HMIS system and within 30 days of participants' housing move-in dates.
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:
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1D-1. Discharge Planning Coordination.

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

<table>
<thead>
<tr>
<th>System of Care</th>
<th>Selection</th>
</tr>
</thead>
<tbody>
<tr>
<td>Foster Care:</td>
<td>x</td>
</tr>
<tr>
<td>Health Care:</td>
<td>x</td>
</tr>
<tr>
<td>Mental Health Care:</td>
<td>x</td>
</tr>
<tr>
<td>Correctional Facilities:</td>
<td>x</td>
</tr>
<tr>
<td>None:</td>
<td></td>
</tr>
</tbody>
</table>
## 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:
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### *1E-1. Local CoC Competition–Announcement, Established Deadline, Applicant Notifications. Attachments Required.

Applicants must indicate whether the CoC:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>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;</td>
<td>Yes</td>
</tr>
<tr>
<td>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;</td>
<td>Yes</td>
</tr>
<tr>
<td>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</td>
<td>Did not reject or reduce any project</td>
</tr>
<tr>
<td>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.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

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

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Indicator</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Used objective criteria to review and rank projects for funding (e.g., cost effectiveness of the project, performance data, type of population served);</td>
<td>Yes</td>
</tr>
<tr>
<td>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</td>
<td>Yes</td>
</tr>
<tr>
<td>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.</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

1. The CoC evaluated all renewal CoC projects and used the resulting scores to rank projects for the CoC project listing. We considered the following factors related to the severity of need and vulnerabilities: (1) actual percentage of chronic homeless served, which includes significant physical and mental disabilities; (2) multiple barriers in current population: mental illness, chronic health conditions, physical disabilities, HIV/AIDS, developmental disabilities, and substance use disorders; and (3) acceptance of persons with low or no income, criminal records, current or past substance usage, and high utilization of emergency systems.

2. The CoC’s neutral panel gave special consideration to projects serving a higher number of vulnerable participants, based on the three criteria mentioned above, through the ranking, review, and selection process. Together, these three factors accounted for 15 of 55 points, or 27% of the total score.


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

<table>
<thead>
<tr>
<th>Public Posting of Objective Review and Ranking Process</th>
<th>Public Posting of CoC Consolidated Application including: CoC Application, CoC Priority Listing, Project Listings</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Email</td>
<td>1. Email</td>
</tr>
<tr>
<td>2. Mail</td>
<td>2. Mail</td>
</tr>
<tr>
<td>3. Advertising in Local Newspaper(s)</td>
<td>3. Advertising in Local Newspaper(s)</td>
</tr>
</tbody>
</table>

Public Posting of CoC Application
1E-5. Reallocation between FY 2015 and FY 2018.

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

Reallocation: 0%


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. Per the CoC’s reallocation policy, the Ranking and Review Committee determines if a project is subject to an involuntary reallocation of funds. To be subject to reallocation a project must be either low performing under the System Performance Measures or be low performing under at least two of the following: data quality, participation in mandatory CoC training, HAC participation, and adherence to HAC policy and procedures.

Based on the severity of the issue and whether the project took corrective actions in improving in low performing areas, the Ranking and Review Committee submits a recommendation to the Executive Board for either a partial or a full reallocation of the project’s funding. A majority vote is needed to approve the reallocation by the Executive Board members eligible to vote who are not affiliated with a CoC or ESG currently funded organization or an organization which has applied for CoC or ESG funding.

2. The 15-member Homeless Action Council Board has approved the reallocation policy.

3. The CoC made all applicants were made aware of the criteria for reallocation when it disseminated the ranking and scoring process to them.

4. During the FY2019 grant application process, the Ranking and Review
Committee did not identify any projects that were low performing or for which there was less of a need.

5. The Ranking and Review Committee did not deem any projects low performing, and therefore the CoC did not reallocate any grant funds this year.
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/

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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.

1F-1  DV Bonus Projects.

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

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

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

Applicants must click “Save” after checking SSO Coordinated Entry to view questions 1F-3 and 1F-3a.

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

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

| Need Housing or Services | 1,700.00 |

FY2019 CoC Application Page 20 09/23/2019
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)

1. The CoC calculated the number of DV survivors needing housing or service through the Violence Prevention Center’s intake assessment and InfoNet’s reports. The CoC collected additional data through the CoC’s HMIS records for DV survivors served by non-DV providers.

2. The data source is the Violence Prevention Center’s comparable database, Infonet. The agency provides a monthly report to the Housing Resource Center, identifying the number of clients residing in their shelter.

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>Violence Preventi...</td>
<td>174171496</td>
</tr>
</tbody>
</table>
1F-4. PH-RRH and Joint TH and PH-RRH Project

Applicant Capacity

<table>
<thead>
<tr>
<th>DUNS Number:</th>
<th>174171496</th>
</tr>
</thead>
<tbody>
<tr>
<td>Applicant Name:</td>
<td>Violence Prevention Center</td>
</tr>
<tr>
<td>Rate of Housing Placement of DV Survivors–Percentage:</td>
<td>60.00%</td>
</tr>
<tr>
<td>Rate of Housing Retention of DV Survivors–Percentage:</td>
<td>92.00%</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)

1. We calculated the housing placement rate by dividing the total number of exits from the domestic violence shelter by the number of exits to permanent housing (either moving into housing of their own or moving in permanently with relatives). We calculated the retention rate by dividing the number of permanent housing exits by those who later returned to the DV shelter.

2. The data source is Illinois Infonet, a comparable database maintained by the Violence Prevention Center.

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)

The Violence Prevention Center (VPC) assists survivors in moving as quickly as possible into permanent housing. When persons fleeing from domestic violence enter our domestic violence emergency shelter, we immediately assign a case manager to work with them in identifying and addressing their needs to prepare them for permanent housing.

We have an array of approaches to increase clients’ income so they can afford safe and decent housing. We make employment referrals to job placement specialists at the Illinois State Employment Service, Goodwill Industries, Urban League Employment Center, and the St. Clair County WIOA program. We provide transportation to and from work and for personal business matters. Case managers assist participants in applying for SNAP benefits, state ID cards, social security cards, TANF cash assistance, Medicaid, disability, and general assistance. VPC partners with banks, who offer financial literacy classes to assist clients with understanding budgeting, savings accounts, and money management. VPC also owns a Shelter Shop, which provides clothing and household needs for participants to better prepare them for permanent
housing and maintaining their home

Simultaneously, while all the case management pieces identified are being addressed, a VPC Housing Specialist assists in locating permanent housing, utilizing our established partnerships with reputable landlords.

Once a client identifies permanent housing, we assist with related needs such as utility deposits, food, childcare, moving assistance, rental deposits, transportation, and ongoing DV counseling and legal advocacy.

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. The Violence Prevention Center (VPC) has extensive experience in ensuring safety for survivors of domestic violence.

   a. Safety Planning. We require every staff member to complete training on developing safety plans. This is integrated into a 40-hour domestic violence training curriculum that is mandatory prior to working with clients. Our staff also conducts lethality assessments, which identify specific and unique circumstances that need to be addressed in the safety plan.

   b. Intake Space. Every Case Manager and Housing Specialist has a private office in the VPC building. These offices provide confidential, safe places for intake interviews, service planning, and supportive counseling.

   c. Separate Intakes. Every intake interview is private and individual. We do not work with couples, only with victims and their children.

   d. Safe Housing. The lethality assessment helps identify what type of rental assistance and housing is needed. A Housing Specialist works closely with the client in determining the safest resource for permanent housing.

   e. Congregate Spaces. Our shelter has been designed to maximize safety for our residents. The shelter can only be accessed through electronically locked doors and has an intercom and camera system to ensure the safety of the residents and staff.

   f. Confidential Location. Our shelter is in a confidential location. We use a post
office box for the mailing address.

2. We measure our effectiveness at ensuring safety by obtaining regular feedback from clients. We provide victims with basic domestic violence education to assist them in recognizing the cycle of violence in order to recognize key warning signs before abuse happens. We help them develop individualized safety plans, and we inform them of their options so they can make informed decisions. At every step, we ask for feedback. These conversations help us ensure the safety of the victim during a time of crisis.

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

Applicants must describe:
1. project applicant’s experience in utilizing trauma-informed, victim-centered approaches to meet needs of DV survivors; and
2. how, if funded, the project will utilize trauma-informed, victim-centered approaches to meet needs of DV survivors by:
   (a) prioritizing participant choice and rapid placement and stabilization in permanent housing consistent with participants’ preferences;
   (b) establishing and maintaining an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures program participant staff interactions are based on equality and minimize power differentials;
   (c) providing program participants access to information on trauma, e.g., training staff on providing program participant with information on trauma;
   (d) placing emphasis on the participant’s strengths, strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans include assessments of program participants strengths and works towards goals and aspirations;
   (e) centering on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;
   (f) delivering opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and
   (g) offering support for parenting, e.g., parenting classes, childcare. (limit 4,000 characters)

1. The Violence Prevention Center (VPC) is a trauma-informed agency. We implemented trauma-informed principles years ago, and we view domestic violence through the lens of trauma. We have adapted the understanding of trauma to guide us. Each client’s need is individualized, and we use victim-centered approaches. Gaining knowledge of the impact of trauma helps staff better understand triggers and the unique vulnerabilities of survivors. It also helps us tailor services to account for the impact of violence and trauma.

As advocates, our first concern is for physical safety. Our staff knows that traumatic reactions are “normal” reactions to “abnormal” events. They have learned that symptoms that in the past were quickly referred to as mental health symptoms or uncooperative and negative behaviors may actually be traumatic reactions to abuse.

2. We use a trauma-informed approach that focuses on resilience and strengths as well as psychological harm. Our victim-centered philosophy is expressed
throughout our program. We assess victims utilizing the Domestic Violence Survivor’s Assessment. This tool is designed specifically for those who have experienced domestic violence and who seek a violence-free life. Following the assessment, the staff and the survivors together develop and review service plans that are the basis for interventions and supports responding to individual circumstances, needs, and preferences.

a. Housing Choice. We develop service plans jointly with clients, who identify their own goals with the guidance and support of the Housing Specialist.

b. Mutual Respect. The trauma-informed approach is sensitive and respectful. We provide support with intent, and we never re-traumatize. We do not use punitive interventions.

c. Access to Information. We assist clients in understanding how their exposure to abuse and violence can affect their ability to regulate emotions, process information, and attend to their surroundings. We help them understand that “symptoms” may be survival strategies and assist them in developing new survival strategies. We design services and support to prevent re-traumatization and promote healing and recovery.

d. Strength-Based Approach. Our intake protocol includes a comprehensive, individualized, strength-based, culturally responsive assessment. It identifies strengths and personal assets along with needs and risk factors. We tailor assessments according to the strengths and needs of the specific individuals.

e. Cultural Sensitivity. Cultural sensitivity is a vital component of our service delivery approach. We train all staff on an ongoing basis on cultural sensitivity and awareness. Cultural, religious, or familial beliefs that abuse is an accepted part of a culture or family history are often barriers. Educating clients about options and providing access to culturally appropriate support is crucial in addressing these barriers. For example, we have a staff position to address clients’ spiritual needs.

f. Connections. VPC’s counseling program offers domestic violence groups, mentorships, and peer to peer connections. These groups are led by our licensed therapists. Groups are available for adults and children. All groups are voluntary and free.

g. Parenting Support. VPC staff provides supportive counseling and guidance in the area of parenting as well as connecting clients to parenting classes and childcare.

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)

Child Custody. The VPC Legal Advocates and attorneys with the Land of Lincoln Legal Assistance Foundation work with clients to help gain custody of children.

Legal Services. VPC Legal Advocates obtain orders of protection, educate clients concerning their rights, assist with victim’s compensation application, and link clients to attorneys with the Land of Lincoln Legal Assistance Foundation.

Criminal History. Our Housing Specialist works with clients to expunge criminal histories or vacate criminal convictions when possible and appropriate.

Credit History. Our Housing Specialist works with clients to cure poor credit histories, and our financial literacy curriculum helps avoid future credit problems.

Education. If the client is interested in returning to school, the Housing Specialist assists with obtaining funding and well as filling out applications.

Job Training. The Housing Specialist assists in job searches and resume writing, and we connect clients with mainstream training programs.

Employment. We connect clients with the Illinois State Employment Service, Goodwill Industries, Urban League Employment Center, and the St. Clair County WIOA program. We provide transportation to and from work

Physical/Mental Healthcare. We have working relationships with physical and behavioral health care providers, including two CoC-funded providers, Chestnut Health Systems and Comprehensive Behavioral Health Care.

Drug and Alcohol Treatment. We have a working relationship with a licensed substance abuse treatment provider, Chestnut Health Systems.

Childcare. We host groups for children. A Licensed Therapist and/or Art Therapist conducts behavioral and art assessments for children who receive services.
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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Warning! The CoC Application score could be affected if information is incomplete on this formlet.

2A-1. HMIS Vendor Identification.
MISI
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>44</td>
<td>10</td>
<td>34</td>
<td>100.00%</td>
</tr>
<tr>
<td>Safe Haven (SH) beds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Transitional Housing (TH) beds</td>
<td>138</td>
<td>0</td>
<td>113</td>
<td>81.88%</td>
</tr>
<tr>
<td>Rapid Re-Housing (RRH) beds</td>
<td>72</td>
<td>0</td>
<td>72</td>
<td>100.00%</td>
</tr>
<tr>
<td>Permanent Supportive Housing (PSH) beds</td>
<td>274</td>
<td>0</td>
<td>274</td>
<td>100.00%</td>
</tr>
<tr>
<td>Other Permanent Housing (OPH) beds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</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)

1. Our transitional housing (TH) bed coverage was slightly under 85%, at 82%. This was due entirely to the fact that two agencies, Caritas and Community Stabilization Center, do not report their TH beds through HMIS. The steps the CoC will take over the next 12 months to increase the bed coverage rate to at least 85% for TH projects will be: (a) increased communication with the two agencies; and (b) offering the CoC’s coordinated entry to enter the agencies’ TH into HMIS.

2. To achieve an increase in Transitional Housing bed coverage, the CoC has identified the following specific steps. First, the Housing Resource Center staff will provide education on the HMIS system to two agencies not currently using the system. Second, the Housing Resource Center staff will work with the staff of these agencies either to obtain the HMIS system or to find an appropriate method of reporting to the Housing Resource Center the number and use of the transitional housing beds to allow input into the system. Since January 2019, the Housing Resource Center staff have been able to connect the Community Stabilization Center to utilize the HMIS system.


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). 04/30/2019

(mm/dd/yyyy)
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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The FY 2019 CoC Program Competition Notice of Funding Availability at:

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2B-1. PIT Count Date. 01/31/2019
Applicants must enter the date the CoC conducted its 2019 PIT count (mm/dd/yyyy).

2B-2. PIT Count Data–HDX Submission Date. 04/30/2019
Applicants must enter the date the CoC submitted its PIT count data in HDX (mm/dd/yyyy).

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

*2B-4. Sheltered PIT Count–Changes Due to Presidentially-declared Disaster.
Applicants must select whether the CoC added or removed emergency shelter, No
transitional housing, or Safe-Haven inventory because of funding specific to a
Presidentially-declared disaster, resulting in a change to the CoC’s 2019 sheltered PIT count.

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

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

Not Applicable

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

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

Yes

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

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

1. The CoC took engaged stakeholders who serve youth in planning for the 2019 PIT count. We worked with a collaborative team of community partners where the CoC provided training on HUD PIT requirements, identifying additional volunteers, and implementing new strategies for reaching the homeless youth. Representatives from youth service agencies and stakeholders such as Children’s Home + Aid and school liaisons for homeless youth actively participated in the planning process and identified other stakeholders.

2. Community stakeholders who serve youth identified potential new locations for homeless youth. They suggested locations where we might find homeless youth, and they conducted street outreach to these locations during the PIT count.

3. We did not have any youth involved in the planning process or assisting during the PIT count. They were represented by advocates and stakeholders.
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)

The CoC uses PIT Survey tools based on the HUD sample tool to ensure that survey questions elicit information that accurately reflects chronic homelessness, household composition, and Veteran status. Also, the CoC conducts a service-based count as a vital piece of the overall PIT effort to identify individuals and families not captured in the unsheltered census.

1. To reach individuals and families experiencing chronic homelessness, we worked with outreach teams to identify homeless encampments. These familiar staff members participated in the survey team. We improved training for staff and volunteers who administered the survey.

2. For families with children, we included questions about children allowing us to get a better understanding of how many families were living separately. These questions also helped us prevent the family from being separated when being admitted to shelters or other homeless facilities.

3. For veterans, our PIT team coordinated with the Veteran Affairs office and SSVF, allowing increased outreach to homeless encampments and other locations where we found Veterans experiencing homelessness.
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. 483


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)

Regrettably, our CoC experienced an increase in first-time homeless from 416 in FY 2018 to 483 in FY 2019.

1. To address this outcome, we focused on identifying specific risk factors. We accomplished this through an analysis of coordinated entry intake and assessment data. The risk factors we identified were prior homelessness; disability; low or no income; the number of people in the household; the amount of rent; support system of family or friends in the area; and a score on the VI-SPDAT of 8 or higher.
2. Our strategies revolve around directly addressing these risk factors. When risk factors are noted, coordinated entry staff enroll or refer individuals to appropriate resources and benefits such as subsidized housing, and mainstream benefits such as Social Security.

3. The organization responsible for overseeing the CoC’s strategy on reducing or ending the number of first-time homelessness is the Homeless Action Council Planning 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. 150


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)

We increased the length of time of homelessness from FY 2018 to FY 2019, with the average bed-nights for all persons increasing from 140 to 150, and the median from 78 to 81.

1. The CoC’s strategy to reduce the length of time individuals and persons in families remain homeless is to encourage all providers to identify the resources the participants need to obtain permanent housing, starting on the day of admission to transitional housing or emergency shelter, and then to immediately connect the participants to those resources.

2. To identify and house individuals and families with the longest length-of-time homeless, we utilize HMIS to track the number of bed-nights spent in transitional housing or emergency shelter. The Housing Resource Center Coordinator works with the transitional housing providers and emergency shelters to review their progress in moving these individuals into permanent housing.

3. The Transitional Housing Committee is responsible for overseeing the CoC’s strategy to reduce length-of-time homeless.

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

<table>
<thead>
<tr>
<th>Percentage</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>69%</td>
</tr>
<tr>
<td>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.</td>
<td>93%</td>
</tr>
</tbody>
</table>

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. Successful placements into permanent housing from shelters and transitional housing increased from 62% to 69%. The CoC has implemented three strategies to increase the rate of exits to permanent housing destinations: 1) planned for PH placement upon entry a transitional housing project or emergency shelter; (2) intensified case management in permanent housing; and (3) identified and encouraged participation in medication management, health services, and supportive services such as AA/NA and counseling.

2. The Planning Committee is 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. Successful retention in permanent housing decreased from 96% to 93%. The CoC’s strategies to increase the rate at which individuals and persons in families in permanent housing projects retain their permanent housing or exit to permanent housing destinations are to train project staff on successful intensive case management and to identify and encourage participation in life-skills education and improving daily living.

4. The Planning Committee is responsible for overseeing the CoC’s strategy to increase the rate of individuals and persons in families in permanent housing...
projects to retain or exit to permanent housing.

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

Applicants must:

<table>
<thead>
<tr>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Report the percentage of individuals and persons in families returning to homelessness over a 6-month period as reported in HDX.</td>
</tr>
<tr>
<td>2. Report the percentage of individuals and persons in families returning to homelessness over a 12-month period as reported in HDX.</td>
</tr>
</tbody>
</table>

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. Our strategy to identify individuals and families who return to homelessness is by using HMIS data and analyzing entry intake and VI-SPDAT assessment from the coordinated entry center.

2. Our strategy to reduce the number of individuals and families returning to homelessness over the next 12 months is three-fold. First, all housing providers fully embrace the Housing First approach. Second, permanent supportive housing providers have stopped discharging persons for minor offenses or failure to maintain sobriety. Third, tenants requiring ongoing intensive support services are placed in projects with on-site mental health and/or substance use treatment services.

3. The position responsible for overseeing our efforts to reduce returns to homelessness is the planning Committee.

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

Applicants must:

<table>
<thead>
<tr>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
</tr>
<tr>
<td>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.</td>
</tr>
</tbody>
</table>

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. To increase employment income, we work to build participants’ skills to equip them for jobs that pay well. The CoC has held several project-specific employment boot camps for the project participants. These boot camps are a collaboration of project staff, employment agencies, and employers. Program-funded projects work with a variety of agencies to help clients increase their income, such as Workforce Development Group of St. Clair County.

2. Our strategy to increase access to employment include the Project Homeless Employment event, which addressed challenges in gaining employment. Several individuals secured jobs at the event. The event also helped individuals with needed paperwork and obtaining ID’s and social security cards. Other strategies utilized by the CoC includes reviewing current employment opportunities at every monthly HAC meeting, and partnering with the state employment service agencies, and resume writing, interviewing, and job searches.

3. The CoC works with several mainstream employment organizations, including WIOA. Our CoC Collaborative Applicant is the county WIOA administrator. Several mainstream employment organizations are members of our monthly HAC meetings. Each month they inform project staff of employment opportunities for participants. This partnership has led to several referrals to employment organizations and has increased skill-building and job readiness for several clients.

4. The CoC Project Employment Committee is responsible for oversight of this strategy.


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

1. The CoC’s primary strategy to increase non-employment cash income is to provide updated resources available through our email listserv and during our monthly HAC meetings. Our second strategy is to encourage projects to
increase the number of staff that are trained in SOAR and in enrolling participants in other mainstream benefits.

2. Our strategy to increase access to non-employment cash sources is to make referrals to the local townships, TANF, and other resources. CoC-funded projects provide transportation for participants to agencies for mainstream benefits. These agencies also participate in our annual Project Homeless Connect, where they can accept applications for benefit programs on the spot.

3. The Community Resource Committee is responsible for overseeing the CoC’s strategy to increase non-employment cash income.


 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. Working with employers and employment organizations, the CoC sponsored Project Homeless Employment event, which addressed challenges in gaining employment. Several individuals secured jobs at the event. The event also helped individuals with needed paperwork and obtaining ID’s and social security cards.

  The CoC promoted partnerships with several employment agencies as well as the Illinois Department of Rehabilitation Services to increase access to employment opportunities, increase outreach to employers and to host small job fairs for participants. These partnerships among agencies and providers help identify participants’ strengths and challenges when applying for employment opportunities. The individualized skill-building that the employment agencies have created for participants impacted their efforts to find employment.

 2. The CoC works with employment organizations and providers to create and foster supportive employment opportunities for those permanent supportive housing residents who have more challenges in employment settings due to barriers and disabilities.


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

### 3A-6. System Performance Measures

**Data–HDX Submission Date**

Applicants must enter the date the CoCs submitted its FY 2018 System Performance Measures data in HDX. (mm/dd/yyyy)

**05/28/2019**
3B. Continuum of Care (CoC) Performance and Strategic Planning Objectives

Instructions

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

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

3B-1. Prioritizing Households with Children.

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

<table>
<thead>
<tr>
<th>Factor</th>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of or Vulnerability to Victimization (e.g. domestic violence, sexual assault, childhood abuse)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Number of previous homeless episodes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. Unsheltered homelessness</td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Criminal History</td>
<td></td>
<td></td>
</tr>
<tr>
<td>5. Bad credit or rental history</td>
<td></td>
<td></td>
</tr>
<tr>
<td>6. Head of Household with Mental/Physical Disability</td>
<td></td>
<td></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 current CoC strategy for rapidly rehousing households with children is to interview and approve these households within 48 hours after the initial referral. Our current timeframe is that we typically rehouse households within 15-20 days of becoming homeless. This short timeframe offers clear evidence of the effectiveness of our approach.

However, we face two challenges in rapidly rehousing these households. In terms of housing needs, we have a shortage of appropriate housing. In terms of service needs, many participants have poor credit histories which limit their ability to obtain leases. In these cases, our coordinated entry center works to find temporary housing through hotel vouchers and shelters. Project staff work with clients to find appropriate and affordable housing by assisting them in advocating and educating landlords on project goals and supportive services available to the client while in the housing unit. By project staff developing a strong relationship with local landlords, more housing options become available for clients.

2. Providers work with participants on their housing needs by helping to advocate for them with local landlords and by providing housing rental assistance. Once participants are housed, case managers identify community resources that will allow the participant to achieve housing stability.

3. The position which oversees the CoC’s rapid rehousing strategy is the Planning Committee.

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 |
| 4. CoC has worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within the CoC geographic area that might be out of compliance and has taken steps to work directly with those facilities to come into compliance. | 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>Requirement</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Unsheltered homelessness</td>
<td>No</td>
</tr>
<tr>
<td>2. Human trafficking and other forms of exploitation</td>
<td>No</td>
</tr>
<tr>
<td>3. LGBT youth homelessness</td>
<td>No</td>
</tr>
<tr>
<td>4. Exits from foster care into homelessness</td>
<td>No</td>
</tr>
<tr>
<td>5. Family reunification and community engagement</td>
<td>No</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>No</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>Priority Factor</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of, or Vulnerability to, Victimization (e.g., domestic violence, sexual assault, childhood abuse)</td>
<td>X</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></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. The CoC’s coordinated entry center is the primary source of contact for all youth facing homelessness. Our geographic area is severely deficient in housing resources for youth. Our primary strategy is to coordinate housing
availability through the coordinated entry center in order to stretch the limited number of units as far as possible and assure that housing is allocated to those most in need.

2. In order to address unsheltered youth homelessness, the CoC’s created a Homeless Youth Committee to develop bridges between current CoC-funded agencies and as other community youth agencies and youth advocates. This has improved the CoC’s efforts to assist youth in experiencing unsheltered homelessness in St. Clair County.

The Homeless Youth Committee works with community agencies to identify and secure new funding sources to increase housing and services. The agencies the CoC partners with include Caritas Family Solutions and Children’s Home and Aid. Both agencies are now seeking funds to increase housing options for unsheltered homeless youth and to increase resources and support services. In addition, Children’s Home and Aid is considering providing a dedicated homeless youth coordinated entry portal in conjunction with the CoC’s coordinated entry office.

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. To determine the effectiveness of the two strategies in item 3B-1d, our CoC looks at two types of factors. For the first strategy, which concerns overall youth homelessness, we examine past and current practices to see if the limited housing resources are being directed to those most in need. The evidence for this is found in Coordinated Entry HMIS records.

For the second strategy, which focuses on unsheltered youth homelessness, we track three factors: (1) the number of providers serving young persons experiencing homelessness; (2) the number of beds and units available to young persons experiencing homelessness; and (3) the types of housing options available. The evidence for the first two factors located in HMIS and the annual HIC; the evidence for the third factor is located in the minutes of the Homeless Youth Committee.

2. To measure the first strategy, we review VI-SPDAT scores for young persons and track subsequent housing referrals to determine if those with higher risks and needs are being referred to housing. To measure the second strategy, we review HMIS and HIC data to determine the number of housing providers and the number of beds and units available; next, we review committee minutes to determine what types of housing options are available.
3. We believe these are the most effective and direct measures possible to determine the effectiveness of our strategies. Regarding the first strategy, because housing resources are so minimal, it is imperative to serve those most in need, and the VI-SPDAT is the standard tool used by the vast majority of CoCs to measure the level of need. We can compare HMIS records of housing referrals with VI-SPDAT scores to see if those with the highest needs and risks are most likely to receive housing referrals.

Regarding the second strategy of increasing the availability and range of housing options for youth, using HMIS and HIC data is the most accurate measure.

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)

1a. Our formal partnerships with youth education providers are arranged through the local Regional Office of Education (ROE), which is the SEA agency for our area. Our formal partnership with the ROE states that the ROE conducts outreach to youth education providers to identify at-risk youth. Similarly, youth education referrals to the CoC go through the ROE.

1b. Based on our formal agreements, the Associate Regional Superintendent of the ROE is the designated McKinney-Vento liaison for the SEA. He is an active member of the CoC Board and serves on several committees.

1c. Likewise, our formal partnerships with individual school districts are coordinated through the local ROE. Referrals to the CoC from these providers are made through this office.

2a. Per the above agreements, youth education providers collaborate with the CoC through the Regional Office of Education (ROE), which is the SEA agency. On a practical basis, this means that all referrals between education providers and the CoC are channeled through the ROE, which enhances coordination and communication while avoiding duplication.

2b. As stated above, the Associate Superintendent for the ROE is the McKinney-Vento liaison for the SEA agency. His office oversees all collaboration among the CoC, SEA, and LEAs. His staff assures that referral flow freely among these entities, and that every child has access to the full range of educational services. CoC projects make referrals directly to the REO, and from there to the McKinney-Vento liaisons in local districts. The ROE refers
families experiencing homeless to the CoC’s coordinated entry system for intake, assessment, prioritization, and housing referrals.

2c. Through the above arrangement, the CoC ensures that all children are enrolled in early childhood programs or school and are connected to appropriate education-related services.

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)

All funded providers inform homeless families of eligibility for McKinney-Vento education services. Whenever the coordinated entry center encounters a family experiencing homeless under either HUD or DOE standards, we contact the McKinney-Vento liaison for the Regional Office of Education (ROE), who then works directly with the appropriate school district.

For example, when a family with school-aged children enters a transitional housing program, the program notifies the Regional Office of Education (ROE), which arranges for the children to receive specialized assistance, including transportation to and from their home school, enrollment in classes and extracurricular activities, Special Education, and early childhood education, as needed.

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

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

<table>
<thead>
<tr>
<th>Early Childhood Providers</th>
<th>MOU/MOA</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>No</td>
<td>No</td>
</tr>
<tr>
<td>Federal Home Visiting Program</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Healthy Start</td>
<td>No</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>No</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>No</td>
<td>No</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.

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.

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.


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.

<table>
<thead>
<tr>
<th>Finding</th>
<th>Yes/No</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. People of different races or ethnicities are more likely to receive homeless assistance.</td>
<td></td>
</tr>
<tr>
<td>2. People of different races or ethnicities are less likely to receive homeless assistance.</td>
<td></td>
</tr>
<tr>
<td>3. People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.</td>
<td></td>
</tr>
<tr>
<td>4. People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.</td>
<td></td>
</tr>
<tr>
<td>5. There are no racial or ethnic disparities in the provision or outcome of homeless assistance.</td>
<td>X</td>
</tr>
<tr>
<td>6. The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.</td>
<td></td>
</tr>
<tr>
<td>7. The CoC did not conduct a racial disparity assessment.</td>
<td></td>
</tr>
</tbody>
</table>

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:

<p>| | |</p>
<table>
<thead>
<tr>
<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. The CoC is ensuring that staff at the project level are representative of the persons accessing homeless services in the CoC.</td>
<td>X</td>
</tr>
<tr>
<td>2. The CoC has identified the cause(s) of racial disparities in their homeless system.</td>
<td>X</td>
</tr>
<tr>
<td>3. The CoC has identified strategies to reduce disparities in their homeless system.</td>
<td>X</td>
</tr>
<tr>
<td>4. The CoC has implemented strategies to reduce disparities in their homeless system.</td>
<td>X</td>
</tr>
<tr>
<td>5. The CoC has identified resources available to reduce disparities in their homeless system.</td>
<td>X</td>
</tr>
<tr>
<td>6. The CoC did not conduct a racial disparity assessment.</td>
<td></td>
</tr>
</tbody>
</table>
4A. Continuum of Care (CoC) Accessing Mainstream Benefits and Additional Policies

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

4A-1. Healthcare–Enrollment/Effective Utilization

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

<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...
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. We update providers on mainstream resources for homeless program participants through our monthly CoC meetings and email updates.

2. The CoC disseminates information on the availability of mainstream resources and other assistance information to projects during our monthly meetings and through email updates.

3. The CoC collaborates with healthcare organizations through partnerships with health insurance organizations such as Molina Healthcare, and with health insurance agencies such as Southern Illinois Healthcare Foundation. We refer individuals age 60+ to AgeWise, the local Area Agency on Aging, and it enrolls them in Medicare programs at no cost.

4. Our Collaborative Applicant supplements CoC program funds to help participants apply for Medicaid and other mainstream benefits. St. Clair County provides $10,000 in cash to our coordinated entry center for this purpose. These are public resources. CoC providers work with individuals and families to apply for mainstream benefits. If the CoC providers cannot assist them in applying online, they refer them to agency partners who have designated SOAR counselors to apply for benefits.

5. The person/agency responsible for overseeing the CoC’s strategy for mainstream benefits is the Community Resource Committee.

4A-2. Lowering Barriers to Entry Data:

Applicants must report:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Value</th>
</tr>
</thead>
<tbody>
<tr>
<td>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.</td>
<td>17</td>
</tr>
<tr>
<td>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.</td>
<td>17</td>
</tr>
<tr>
<td>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.</td>
<td>100%</td>
</tr>
</tbody>
</table>


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 four agencies that conduct street outreach. These three agencies – St. Vincent de Paul, SSVF, and Comprehensive Behavioral Health Center – provide street outreach three days per week. Also, one agency offers a free meal daily as an outreach activity.

2. Outreach staff covers 100% of the geographic area of St. Clair County.

3. The outreach team provides street outreach three days per week. Outreach workers go to locations where people can be found. For people whose first language is not English, we have brochures and print material in Spanish, and the Latino Roundtable joins in outreach. We have translators on call for several non-English languages and interpreters for persons with hearing impairments. For the persons with sight impairments, we have large-print publications. The coordinated entry center is fully accessible for persons with disabilities.

4. We customize these activities to reach those who are unlikely to request help. Our Outreach Committee has trained in Transtheoretical Models of Change, so outreach workers are aware of levels of engagement for individuals who are least likely to ask for assistance. The training allows the outreach staff to adjust their approach when they go to homeless encampments.

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>0</td>
<td>72</td>
<td>72</td>
</tr>
</tbody>
</table>


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.

No


Applicants must indicate whether the CoC is requesting to designate one or more of its

No
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>FY 2019 CoC Compe...</td>
<td>09/10/2019</td>
</tr>
<tr>
<td>1C-4. PHA Administration Plan—Moving On Multifamily Assisted Housing Owners’ Preference.</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1C-4. PHA Administrative Plan Homeless Preference.</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1C-7. Centralized or Coordinated Assessment System.</td>
<td>Yes</td>
<td>CE Assessment Tool</td>
<td>09/10/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting—15-Day Notification Outside e-snaps—Projects Accepted.</td>
<td>Yes</td>
<td>Projects Accepted...</td>
<td>09/10/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting—15-Day Notification Outside e-snaps—Projects Rejected or Reduced.</td>
<td>Yes</td>
<td>Projects Rejected...</td>
<td>09/10/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting—30-Day Local Competition Deadline.</td>
<td>Yes</td>
<td>Local Competition...</td>
<td>09/10/2019</td>
</tr>
<tr>
<td>1E-1. Public Posting—Local Competition Announcement.</td>
<td>Yes</td>
<td>Local Competition...</td>
<td>09/10/2019</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>09/23/2019</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>09/23/2019</td>
</tr>
<tr>
<td>3B-3. Summary of Racial Disparity Assessment.</td>
<td>Yes</td>
<td>Racial Disparity ...</td>
<td>09/10/2019</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>
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<tr>
<td>Other</td>
<td>No</td>
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<td></td>
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<td>Other</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>-------</td>
<td>----</td>
<td>---</td>
<td></td>
</tr>
</tbody>
</table>

Applicant: East Saint Louis/Belleville/Saint Clair County COC
Project: IL-508 CoC Registration FY2019

COC_REG_2019_170617
Attachment Details

Document Description: FY 2019 CoC Competition Report

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: CE Assessment Tool

Attachment Details

Document Description: Projects Accepted Notification

Attachment Details

Document Description: Projects Rejected/Reduced Notification
Attachment Details

Document Description: Local Competition Deadline

Attachment Details

Document Description: Local Competition Public Announcement

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>09/18/2019</td>
</tr>
<tr>
<td>1B. Engagement</td>
<td>09/18/2019</td>
</tr>
<tr>
<td>1C. Coordination</td>
<td>09/19/2019</td>
</tr>
<tr>
<td>1D. Discharge Planning</td>
<td>No Input Required</td>
</tr>
<tr>
<td>1E. Local CoC Competition</td>
<td>09/18/2019</td>
</tr>
<tr>
<td>1F. DV Bonus</td>
<td>09/19/2019</td>
</tr>
<tr>
<td>2A. HMIS Implementation</td>
<td>09/19/2019</td>
</tr>
<tr>
<td>2B. PIT Count</td>
<td>09/18/2019</td>
</tr>
<tr>
<td>3A. System Performance</td>
<td>09/19/2019</td>
</tr>
<tr>
<td>3B. Performance and Strategic Planning</td>
<td>09/19/2019</td>
</tr>
<tr>
<td>4A. Mainstream Benefits and Additional Policies</td>
<td>09/19/2019</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>
2019 CoC Consolidated Application Attachment:
FY 2019 CoC Competition Report
St. Clair County CoC
IL-508
# 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>240</td>
<td>300</td>
<td>250</td>
<td>247</td>
</tr>
<tr>
<td>Emergency Shelter Total</td>
<td>48</td>
<td>26</td>
<td>55</td>
<td>42</td>
</tr>
<tr>
<td>Safe Haven Total</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transitional Housing Total</td>
<td>109</td>
<td>128</td>
<td>105</td>
<td>111</td>
</tr>
<tr>
<td>Total Sheltered Count</td>
<td>157</td>
<td>154</td>
<td>160</td>
<td>153</td>
</tr>
<tr>
<td>Total Unsheltered Count</td>
<td>83</td>
<td>146</td>
<td>90</td>
<td>94</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>41</td>
<td>21</td>
<td>26</td>
<td>31</td>
</tr>
<tr>
<td>Sheltered Count of Chronically Homeless Persons</td>
<td>15</td>
<td>0</td>
<td>10</td>
<td>0</td>
</tr>
<tr>
<td>Unsheltered Count of Chronically Homeless Persons</td>
<td>26</td>
<td>21</td>
<td>16</td>
<td>31</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>Total Sheltered and Unsheltered Count of the Number of Homeless Households with Children</td>
<td>37</td>
<td>42</td>
<td>40</td>
<td>40</td>
</tr>
<tr>
<td>Sheltered Count of Homeless Households with Children</td>
<td>32</td>
<td>33</td>
<td>34</td>
<td>31</td>
</tr>
<tr>
<td>Unsheltered Count of Homeless Households with Children</td>
<td>5</td>
<td>9</td>
<td>6</td>
<td>9</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>Total Sheltered and Unsheltered Count of the Number of Homeless Veterans</td>
<td>31</td>
<td>34</td>
<td>36</td>
<td>29</td>
<td>27</td>
</tr>
<tr>
<td>Sheltered Count of Homeless Veterans</td>
<td>18</td>
<td>29</td>
<td>24</td>
<td>24</td>
<td>20</td>
</tr>
<tr>
<td>Unsheltered Count of Homeless Veterans</td>
<td>13</td>
<td>5</td>
<td>12</td>
<td>5</td>
<td>7</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>44</td>
<td>10</td>
<td>34</td>
<td>100.00%</td>
</tr>
<tr>
<td>Safe Haven (SH) Beds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Transitional Housing (TH) Beds</td>
<td>138</td>
<td>0</td>
<td>113</td>
<td>81.88%</td>
</tr>
<tr>
<td>Rapid Re-Housing (RRH) Beds</td>
<td>72</td>
<td>0</td>
<td>72</td>
<td>100.00%</td>
</tr>
<tr>
<td>Permanent Supportive Housing (PSH) Beds</td>
<td>274</td>
<td>0</td>
<td>274</td>
<td>100.00%</td>
</tr>
<tr>
<td>Other Permanent Housing (OPH) Beds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>NA</td>
</tr>
<tr>
<td>Total Beds</td>
<td>528</td>
<td>10</td>
<td>493</td>
<td>95.17%</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>34</td>
<td>34</td>
<td>34</td>
<td>76</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>7</td>
<td>14</td>
<td>36</td>
<td></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>19</td>
<td>36</td>
<td>72</td>
<td></td>
</tr>
</tbody>
</table>
Measure 1: Length of Time Persons Remain Homeless

This measure 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.

<table>
<thead>
<tr>
<th></th>
<th>Universe (Persons)</th>
<th>Average LOT Homeless (bed nights)</th>
<th>Median LOT Homeless (bed nights)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Submitted FY 2017</td>
<td>FY 2018</td>
<td>Submitted FY 2017</td>
</tr>
<tr>
<td>1.1 Persons in ES and SH</td>
<td>115</td>
<td>206</td>
<td>41</td>
</tr>
<tr>
<td></td>
<td>FY 2017</td>
<td>FY 2018</td>
<td>FY 2018</td>
</tr>
<tr>
<td></td>
<td></td>
<td>76</td>
<td>35</td>
</tr>
<tr>
<td></td>
<td>Difference</td>
<td></td>
<td>Submitted FY 2017</td>
</tr>
<tr>
<td></td>
<td>Difference</td>
<td></td>
<td>FY 2018</td>
</tr>
<tr>
<td></td>
<td>-9</td>
<td>33</td>
<td>24</td>
</tr>
<tr>
<td>1.2 Persons in ES, SH, and TH</td>
<td>378</td>
<td>421</td>
<td>140</td>
</tr>
<tr>
<td></td>
<td>FY 2017</td>
<td>FY 2018</td>
<td>FY 2018</td>
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<tr>
<td></td>
<td></td>
<td>150</td>
<td>10</td>
</tr>
<tr>
<td></td>
<td>Difference</td>
<td></td>
<td>Submitted FY 2017</td>
</tr>
<tr>
<td></td>
<td>Difference</td>
<td></td>
<td>FY 2018</td>
</tr>
<tr>
<td></td>
<td>3</td>
<td>78</td>
<td>81</td>
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<tr>
<td></td>
<td></td>
<td></td>
<td></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.
## FY2018 - Performance Measurement Module (Sys PM)

<table>
<thead>
<tr>
<th></th>
<th>Universe (Persons)</th>
<th>Average LOT Homeless (bed nights)</th>
<th>Median LOT Homeless (bed nights)</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Submitted FY 2017</td>
<td>FY 2018</td>
<td>Submitted FY 2017</td>
</tr>
<tr>
<td>1.1 Persons in ES, SH, and PH (prior to &quot;housing move in&quot;)</td>
<td>115</td>
<td>199</td>
<td>51</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>152</td>
</tr>
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<td>36</td>
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<td></td>
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<td>51</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>15</td>
</tr>
<tr>
<td>1.2 Persons in ES, SH, TH, and PH (prior to &quot;housing move in&quot;)</td>
<td>378</td>
<td>410</td>
<td>184</td>
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<tr>
<td></td>
<td></td>
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<td>223</td>
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<td></td>
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<td>132</td>
</tr>
<tr>
<td></td>
<td></td>
<td></td>
<td>30</td>
</tr>
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</table>
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>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>Exit was from SO</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Exit was from ES</td>
<td>32</td>
<td>0</td>
<td>0%</td>
<td>3</td>
</tr>
<tr>
<td>Exit was from TH</td>
<td>109</td>
<td>0</td>
<td>0%</td>
<td>1</td>
</tr>
<tr>
<td>Exit was from SH</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Exit was from PH</td>
<td>127</td>
<td>1</td>
<td>1%</td>
<td>2</td>
</tr>
<tr>
<td>TOTAL Returns to Homelessness</td>
<td>268</td>
<td>1</td>
<td>0%</td>
<td>6</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)**

**January 2017 PIT Count** | **January 2018 PIT Count** | **Difference**
--- | --- | ---
Universe: Total PIT Count of sheltered and unsheltered persons | 300 | 250 | -50
Emergency Shelter Total | 26 | 55 | 29
Safe Haven Total | 0 | 0 | 0
Transitional Housing Total | 128 | 105 | -23
Total Sheltered Count | 154 | 160 | 6
Unsheltered Count | 146 | 90 | -56

**Metric 3.2 – Change in Annual Counts**

<table>
<thead>
<tr>
<th>FY2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Submitted FY 2017</strong></td>
<td><strong>FY 2018</strong></td>
<td><strong>Difference</strong></td>
</tr>
<tr>
<td>Universe: Unduplicated Total sheltered homeless persons</td>
<td>379</td>
<td>432</td>
</tr>
<tr>
<td>Emergency Shelter Total</td>
<td>116</td>
<td>203</td>
</tr>
<tr>
<td>Safe Haven Total</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Transitional Housing Total</td>
<td>274</td>
<td>255</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>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults (system stayers)</td>
<td>131</td>
<td>178</td>
<td>47</td>
</tr>
<tr>
<td>Number of adults with increased earned income</td>
<td>6</td>
<td>14</td>
<td>8</td>
</tr>
<tr>
<td>Percentage of adults who increased earned income</td>
<td>5%</td>
<td>8%</td>
<td>3%</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>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults (system stayers)</td>
<td>131</td>
<td>178</td>
<td>47</td>
</tr>
<tr>
<td>Number of adults with increased non-employment cash income</td>
<td>26</td>
<td>46</td>
<td>20</td>
</tr>
<tr>
<td>Percentage of adults who increased non-employment cash income</td>
<td>20%</td>
<td>26%</td>
<td>6%</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>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Number of adults (system stayers)</td>
<td>131</td>
<td>178</td>
<td>47</td>
</tr>
<tr>
<td>Number of adults with increased total income</td>
<td>30</td>
<td>52</td>
<td>22</td>
</tr>
<tr>
<td>Percentage of adults who increased total income</td>
<td>23%</td>
<td>29%</td>
<td>6%</td>
</tr>
</tbody>
</table>
Metric 4.4 – Change in earned income for adult system leavers

<table>
<thead>
<tr>
<th>Universe: Number of adults who exited (system leavers)</th>
<th>Submitted FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>61</td>
<td>83</td>
<td>22</td>
</tr>
<tr>
<td>Number of adults who exited with increased earned income</td>
<td>9</td>
<td>19</td>
<td>10</td>
</tr>
<tr>
<td>Percentage of adults who increased earned income</td>
<td>15%</td>
<td>23%</td>
<td>8%</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>Universe: Number of adults who exited (system leavers)</th>
<th>Submitted FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>61</td>
<td>83</td>
<td>22</td>
</tr>
<tr>
<td>Number of adults who exited with increased non-employment cash income</td>
<td>11</td>
<td>20</td>
<td>9</td>
</tr>
<tr>
<td>Percentage of adults who increased non-employment cash income</td>
<td>18%</td>
<td>24%</td>
<td>6%</td>
</tr>
</tbody>
</table>

Metric 4.6 – Change in total income for adult system leavers

<table>
<thead>
<tr>
<th>Universe: Number of adults who exited (system leavers)</th>
<th>Submitted FY 2017</th>
<th>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>61</td>
<td>83</td>
<td>22</td>
</tr>
<tr>
<td>Number of adults who exited with increased total income</td>
<td>19</td>
<td>36</td>
<td>17</td>
</tr>
<tr>
<td>Percentage of adults who increased total income</td>
<td>31%</td>
<td>43%</td>
<td>12%</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>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>301</td>
<td>322</td>
<td>21</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>17</td>
<td>24</td>
<td>7</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>284</td>
<td>298</td>
<td>14</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>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>473</td>
<td>568</td>
<td>95</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>57</td>
<td>85</td>
<td>28</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>416</td>
<td>483</td>
<td>67</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>FY 2018</th>
<th>Difference</th>
</tr>
</thead>
<tbody>
<tr>
<td>Universe: Persons who exit Street Outreach</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Of persons above, those who exited to temporary &amp; some institutional destinations</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>Of the persons above, those who exited to permanent housing destinations</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>% Successful exits</td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Metric 7b.1 – Change in exits to permanent housing destinations
2019 HDX Competition Report

**FY2018 - Performance Measurement Module (Sys PM)**

<table>
<thead>
<tr>
<th>Metric 7b.2 – Change in exit to or retention of permanent housing</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Universe:</strong> Persons in all PH projects except PH-RRH</td>
</tr>
<tr>
<td><strong>Submitted FY 2017</strong></td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>286</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Submitted FY 2017</strong></td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>275</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th><strong>% Successful exits/retention</strong></th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Submitted FY 2017</strong></td>
</tr>
<tr>
<td>-----------------------</td>
</tr>
<tr>
<td>96%</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.
<table>
<thead>
<tr>
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<th></th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Number of non-DV Beds on HIC</td>
<td>29</td>
<td>32</td>
<td>16</td>
<td>26</td>
<td>135</td>
<td>135</td>
<td>135</td>
<td>129</td>
<td>248</td>
<td>270</td>
<td>287</td>
<td>304</td>
<td>19</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>2. Number of HMIS Beds</td>
<td>25</td>
<td>26</td>
<td>16</td>
<td>22</td>
<td>135</td>
<td>135</td>
<td>135</td>
<td>129</td>
<td>220</td>
<td>242</td>
<td>287</td>
<td>304</td>
<td>19</td>
<td>36</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>3. HMIS Participation Rate from HIC ( % )</td>
<td>86.21</td>
<td>78.13</td>
<td>100.00</td>
<td>84.62</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>88.71</td>
<td>89.63</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td>100.00</td>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>4. Unduplicated Persons Served (HMIS)</td>
<td>27</td>
<td>53</td>
<td>107</td>
<td>282</td>
<td>254</td>
<td>276</td>
<td>274</td>
<td>253</td>
<td>334</td>
<td>334</td>
<td>312</td>
<td>311</td>
<td>0</td>
<td>125</td>
<td>86</td>
<td>367</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>5. Total Leavers (HMIS)</td>
<td>7</td>
<td>35</td>
<td>97</td>
<td>237</td>
<td>159</td>
<td>182</td>
<td>175</td>
<td>161</td>
<td>46</td>
<td>48</td>
<td>27</td>
<td>43</td>
<td>0</td>
<td>51</td>
<td>15</td>
<td>149</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>6. Destination of Don't Know, Refused, or Missing (HMIS)</td>
<td>3</td>
<td>15</td>
<td>0</td>
<td>87</td>
<td>5</td>
<td>3</td>
<td>6</td>
<td>5</td>
<td>8</td>
<td>2</td>
<td>6</td>
<td>6</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>9</td>
<td>0</td>
<td>0</td>
<td>0</td>
</tr>
<tr>
<td>7. Destination Error Rate (%)</td>
<td>42.86</td>
<td>42.86</td>
<td>0.00</td>
<td>36.71</td>
<td>3.14</td>
<td>1.65</td>
<td>3.43</td>
<td>3.11</td>
<td>17.39</td>
<td>4.17</td>
<td>22.22</td>
<td>13.95</td>
<td>0.00</td>
<td>0.00</td>
<td>6.04</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
<td>0.00</td>
</tr>
</tbody>
</table>
## 2019 HDX Competition Report

### Submission and Count Dates for IL-508 - East St. Louis, Belleville/St. Clair County CoC

#### Date of PIT Count

| Date CoC Conducted 2019 PIT Count | 1/31/2019 |

#### 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>4/30/2019</td>
</tr>
<tr>
<td>2019 HIC Count Submittal Date</td>
<td>4/30/2019</td>
</tr>
<tr>
<td>2018 System PM Submittal Date</td>
<td>5/28/2019</td>
</tr>
</tbody>
</table>
Vulnerability Index - Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen Triage Tool for Families

AMERICAN VERSION 2.0

©2015 OrgCode Consulting Inc. and Community Solutions. All rights reserved. 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 2.0 for Youth

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

SPDAT Series

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

Current versions available:
• SPDAT V 4.0 for Individuals
• SPDAT V 4.0 for Families
• SPDAT V 4.0 for Youth

Information about all versions is available online at
www.orgcode.com/products/spdat/
SPDAT Training Series
To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

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

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

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

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

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

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

<table>
<thead>
<tr>
<th>Interviewer’s Name</th>
<th>Agency</th>
<th>Team</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td>Staff</td>
</tr>
<tr>
<td></td>
<td></td>
<td>Volunteer</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Survey Date</th>
<th>Survey Time</th>
<th>Survey Location</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD/MM/YYYY</td>
<td><em><strong>/</strong></em>/____</td>
<td>___ : ___</td>
</tr>
</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 that clarification can be provided
- the importance of relaying accurate information to the assessor and not feeling that there is a correct or preferred answer that they need to provide, nor information they need to conceal

Basic Information

| PARENT 1 | | | |
|----------|---------|--------|
| First Name | Nickname | Last Name |
| In what language do you feel best able to express yourself? | 

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Age</th>
<th>Social Security Number</th>
<th>Consent to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD/MM/YYYY</td>
<td><em><strong>/</strong></em>/____</td>
<td>___</td>
<td>______________________</td>
</tr>
</tbody>
</table>

- No second parent currently part of the household

| PARENT 2 | | | |
|----------|---------|--------|
| First Name | Nickname | Last Name |
| In what language do you feel best able to express yourself? | 

<table>
<thead>
<tr>
<th>Date of Birth</th>
<th>Age</th>
<th>Social Security Number</th>
<th>Consent to participate</th>
</tr>
</thead>
<tbody>
<tr>
<td>DD/MM/YYYY</td>
<td><em><strong>/</strong></em>/____</td>
<td>___</td>
<td>______________________</td>
</tr>
</tbody>
</table>

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

<table>
<thead>
<tr>
<th>First Name</th>
<th>Last Name</th>
<th>Age</th>
<th>Date of Birth</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
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</tr>
</tbody>
</table>

**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

**SCORE:** 0

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

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

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

**SCORE:** 0
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:** 0

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:** 0

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:** 0

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:** 0

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:** 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. ◊ 0

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. ◊ 0

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. ◊ 0

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. ◊ 0
Scoring Summary

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<td></td>
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<tr>
<td>A. HISTORY OF HOUSING &amp; HOMELESSNESS</td>
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<td></td>
</tr>
<tr>
<td>B. RISKS</td>
<td>0 /4</td>
<td></td>
</tr>
<tr>
<td>C. SOCIALIZATION &amp; DAILY FUNCTIONS</td>
<td>0 /4</td>
<td></td>
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<tr>
<td>D. WELLNESS</td>
<td>0 /6</td>
<td></td>
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<tr>
<td>E. FAMILY UNIT</td>
<td>0 /4</td>
<td></td>
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<td>GRAND TOTAL:</td>
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</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 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
- age/ing 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.
VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

FAMILIES

A partial list of continuas of care (CoCs) in the US where we know the VI-SPDAT is being used includes:

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

**Arizona**
- Statewide

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

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

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

**District of Columbia**
- District of Columbia

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

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

**Hawaii**
- Honolulu

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

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

**Kansas**
- Kansas City/Wyandotte County

**Kentucky**
- Louisville/Jefferson County

**Louisiana**
- Lafayette/Acadiana
- Shreveport/Rossier/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/Lees Summit/Jackson County
- Parts of Missouri Balance of State

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

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

**North Dakota**
- Statewide

**Nebraska**
- Statewide

**New Mexico**
- Statewide

**Nevada**
- Las Vegas/Clark County

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

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

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

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

**Rhode Island**
- Statewide

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

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

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

**Utah**
- Statewide

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

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

**Wisconsin**
- Statewide

**West Virginia**
- Statewide

**Wyoming**
- Wyoming Statewide is in the process of implementing
Vulnerability Index -
Service Prioritization Decision Assistance Tool
(VI-SPDAT)

Prescreen Triage Tool for Single Adults

AMERICAN VERSION 2.01

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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 frontline 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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<td><em><strong>/</strong></em>/____</td>
<td>___ ___ ___</td>
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</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 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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<th>Last Name</th>
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In what language do you feel best able to express yourself? ______________________________

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<th>Date of Birth</th>
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<th>Social Security Number</th>
<th>Consent to participate</th>
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<td>DD/MM/YYYY</td>
<td>___</td>
<td>___</td>
<td>○Yes ○No</td>
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IF THE PERSON IS 60 YEARS OF AGE OR OLDER, THEN SCORE 1.

SCORE: 0
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: 0

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

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

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

SCORE: 0

B. Risks

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

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

SCORE: 0

5. Have you been attacked or beaten up since you’ve become homeless?
   □ Y  □ N  □ Refused

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

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

SCORE: 0
## VULNERABILITY INDEX - SERVICE PRIORITIZATION DECISION ASSISTANCE TOOL (VI-SPDAT)

**SINGLE ADULTS**

### 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:** 0

#### 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:** 0

#### 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:** 0

#### 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:** 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?  
YNRefused

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

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?  
YNRefused

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?  
YNRefused

19. When you are sick or not feeling well, do you avoid getting help?  
YNRefused

20. FOR FEMALE RESPONDENTS ONLY: Are you currently pregnant?  
YNNA or Refused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR PHYSICAL HEALTH.  
SCORE: 0

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?  
YNRefused

22. Will drinking or drug use make it difficult for you to stay housed or afford your housing?  
YNRefused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR SUBSTANCE USE.  
SCORE: 0

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?  
YNRefused
   b) A past head injury?  
YNRefused
   c) A learning disability, developmental disability, or other impairment?  
YNRefused

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?  
YNRefused

IF “YES” TO ANY OF THE ABOVE, THEN SCORE 1 FOR MENTAL HEALTH.  
SCORE: 0

IF THE RESPONDENT SCORED 1 FOR PHYSICAL HEALTH AND 1 FOR SUBSTANCE USE AND 1 FOR MENTAL HEALTH, SCORE 1 FOR TRI-MORBIDITY.  
SCORE: 0
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: 0

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: 0

Scoring Summary

<table>
<thead>
<tr>
<th>DOMAIN</th>
<th>SUBTOTAL</th>
<th>RESULTS</th>
</tr>
</thead>
<tbody>
<tr>
<td>PRE-SURVEY</td>
<td>0 /1</td>
<td>Score: Recommendation:</td>
</tr>
<tr>
<td>A. HISTORY OF HOUSING &amp; HOMELESSNESS</td>
<td>0 /2</td>
<td>0-3: no housing intervention</td>
</tr>
<tr>
<td>B. RISKS</td>
<td>0 /4</td>
<td>4-7: an assessment for Rapid Re-Housing</td>
</tr>
<tr>
<td>C. SOCIALIZATION &amp; DAILY FUNCTIONS</td>
<td>0 /4</td>
<td>8+: an assessment for Permanent Supportive Housing/Housing First</td>
</tr>
<tr>
<td>D. WELLNESS</td>
<td>0 /6</td>
<td></td>
</tr>
<tr>
<td>GRAND TOTAL:</td>
<td>0 /17</td>
<td></td>
</tr>
</tbody>
</table>

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 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.
The process of implementing the Wyoming Sheltered in the Wyoming Statewide Homeless Initiative.

A partial list of continuums of care (CoCs) in the US where

• City of Lexington, Kentucky
• Joplin/Jasper, Newton County, Missouri
• Charleston/Low Country, South Carolina
• South Carolina/Tuscaloosa County
• West Virginia/Monongalia County
• Louisiana/Baton Rouge
• South Carolina/Horry County
• South Carolina/Charleston

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

American Version 2.0

Single Adults
2019 CoC Consolidated Application Attachment:
Projects Accepted Notification
St. Clair County CoC
IL-508
Hi, everyone

Please see the letter from HAC's Board ChairPresident posted below regarding this year’s projects approved for inclusion into the FY19 CoC application for HUD. Attached to this email are the project priority ranking and an updated ranking process guide. During the process of ranking the projects, the committee determined that three ranking factors did not have sufficient data documentation to be effective in ranking projects this year. These three factors included the spending percentage of projects; referral rejection rates; and attendance at HAC meetings. In addition, the ranking committee approved a project to apply past the deadline after the project first indicated it did not want to renew. Due to the late application entry, this project was ranked last in the renewal projects regardless of rank scoring.

September 4, 2019

The Rank and Review Committee has met and made its final ranking selection for inclusion in the FY19 COC application to HUD. This is the formal notification to inform applicants that no projects were rejected and no projects were reduced in monetary numbers. This notification is sent to comply with HUD requirements. The project ranking selection is as follows:
1. Saint Clair County HMIS
2. Saint Clair County Housing Resource Center
3. CDBG Operations Corporation Beacon Place
4. CDBG Operations Corporation Family Living Center
5. CDBG Operations Corporation New Beginnings
6. Violence Prevention Center Domestic Violence RRH
7. St. Clair County Next Step Up
8. St. Clair County Journey Home
9. St. Clair County Road Home
10. Bethany Place New Horizons
11. Chestnut Health Systems Fairview Heights
12. Call for Help, Inc SUTI II
13. Chestnut Health Systems St. Clair Connections
14. Bethany Place Permanent Housing
15. Call for Help, Inc Jobe Center
16. St. Clair County Home at Last
17. East St. Louis Housing Authority Lighthouse Rental Project
18. Violence Prevention Center VPC RRH
19. St. Clair County At Home

Thank you for all that you do to address St. Clair County’s homeless population. I look forward to seeing what we can accomplish together.

James Kellerman, President
Homeless Action Council IL 508

–

Kate Baker
St. Clair County CoC Liaison
618-246-3269
2019 CoC Consolidated Application Attachment:
Projects Rejected/Reduced Notification
St. Clair County CoC
IL-508
Hi, everyone

Please see the letter from HAC’s Board Chair/President posted below regarding this year’s projects approved for inclusion into the FY19 CoC application for HUD. Attached to this email are the project priority ranking and an updated ranking process guide.

During the process of ranking the projects, the committee determined that three ranking factors did not have sufficient data documentation to be effective in ranking projects this year. These three factors included the spending percentage of projects; referral rejection rates; and attendance at HAC meetings. In addition, the ranking committee approved a project to apply past the deadline after the project first indicated it did not want to renew. Due to the late application entry, this project was ranked last in the renewal projects regardless of rank scoring.

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8. St. Clair County Journey Home
9. St. Clair County Road Home
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11. Chestnut Health Systems Fairview Heights
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13. Chestnut Health Systems St. Clair Connections
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Thank you for all that you do to address St. Clair County’s homeless population. I look forward to seeing what we can accomplish together.

James Kellerman, President
Homeless Action Council IL SOB

--

Kate Baker
St. Clair County CoC Liaison
618-246-3269
2019 CoC Consolidated Application Attachment:
Local Competition Deadline
St. Clair County CoC
IL-508
Notification and Solicitation - Availability of Grants for Homelessness

The St. Clair County Homeless Action Council Continuum of Care (CoC) announces the availability of grants to prevent and end homelessness through the United States Department of Housing and Urban Development's "Notice of Funding Availability (NOFA) for the Fiscal Year 2019 Continuum of Care Competition." More Information Here

Bridge Weight Restriction

Please be advised that Trimple Lakes Road over Prairie Du Pont Creek in Cahokia has a Single Vehicle Weight Limit Restriction of 30 TONS & a Combination Vehicle Weight Limit Restriction of 34 TONS.

Employment Opportunities

Current employment openings are available on our Employment Site.
Notification and Solicitation - Availability of Grants for Homelessness

Date: July 19, 2019

The St. Clair County Homeless Action Council Continuum of Care (CoC) announces the availability of grants to prevent and end homelessness through the United States Department of Housing and Urban Development’s “Notice of Funding Availability (NOFA) for the Fiscal Year 2019 Continuum of Care Competition.” The CoC is open to, and it will accept and consider proposals from organizations that have not previously received CoC Program Grants. Organizations that have not received CoC funding in the past are encouraged to apply.

NEW PROJECTS

- Three basic types of new projects are eligible: Rapid Rehousing; Permanent Supportive Housing for persons with disabilities who experience long-term or repeated homelessness; and Joint Transitional Housing and Permanent Housing/Rapid Rehousing. The NOFA provides details on each of these. The maximum amount for these projects is $164,057, plus any amount made available through reallocation.
- Under a separate Domestic Violence Bonus, organizations may apply for targeted projects serving victims of domestic violence, sexual assault, stalking, and/or trafficking. These projects may be: Rapid Rehousing; Joint Transitional Housing and Permanent Housing/Rapid Rehousing; and specialized Coordinated Entry. The minimum amount for a housing project is $25,000, and the maximum amount for all projects is $227,844. Organizations with track records of serving victims of domestic violence are especially urged to consider applying for Domestic Violence Bonus funds.

Applicants for all new projects must submit a letter of intent including the project type and estimated amount of request to km bakerconsulting@gmail.com by July 31, 2019. The CoC Representative will respond to all letters of intent to instruct on next steps in the application process. All interested organizations are urged to contact the CoC and read the NOFA in its entirety before submitting a letter of intent. Select NOFA FY 19 to download the NOFA and select Instruct to access critical instructions and guidance from the HUD website.

New project applicants must complete applications in HUD’s e-snap’s electronic grants systems by August 16, 2019.

RENEWAL PROJECTS

Applicants for renewal projects must indicate their intent to renew and any plans for voluntary reallocation by July 26, 2019 to km bakerconsulting@gmail.com. Renewal projects must complete e-snap’s applications by August 9, 2019.

ALL PROJECTS

The CoC will notify all applicants of acceptance, rejection, or modification of their projects no later than August 23, 2019.

Please understand that HUD has specific requirements for applicants including:

- The Continuum of Care will carefully review the qualifications of the applicant and the proposed project to assure that they meet HUD’s threshold requirements.
- Projects that (1) are eligible; (2) that meet HUD’s threshold requirements; and (3) that demonstrate need; and (4) that demonstrate organizational capacity, will be accepted and ranked in priority order using an objective process. The ranking process will be posted on the St. Clair County website after August 23, 2019. Select this link to access.
- Individuals, for-profit organizations, and unincorporated entities are not eligible to apply.
- Applicant organizations must use the e-snap’s system to submit their proposals. If interested, you are strongly urged to create an “Applicant Profile” in e-snap’s immediately. Select this link to access the log-in page for e-snap’s. If you do not have an e-snap’s user account, select “Create a Profile” from the e-snap’s login page. The CoC will provide assistance with this step upon request.

Contact Kate Baker at km bakerconsulting@gmail.com for more information.
2019 CoC Consolidated Application Attachment:
Local Competition Public Announcement
St. Clair County CoC
IL-508
Introduction

CoC IL-508 utilized a well-defined set of objective criteria to review, score, and rank projects in the FY2019 CoC Competition.

The criteria are balanced, using four major factors for a maximum score of 55:

- **Project Management Criteria (12 maximum points, 22% of score)**
  - APR submission (3 points)
  - Spending (5)-Not ranked FY19
  - HMIS data quality (2)
  - Utilization (5)
  - PIT/HIC participation (2)

- **Priority Population Criteria (10 maximum points, 18% of score)**
  - Number of chronically homeless served (5)
  - Percentage of participants with 2 or more barriers (5)

- **Participant Outcome Criteria (15 maximum points, 27% of score)**
  - Retention in, or exits to permanent housing (5)
  - Increases in cash income from employment (5)
  - Increases in cash income from non-employment (5)
  - Project Referral Rejections for non-viable reasons (5)-Not ranked FY19

- **Best Practice Criteria (18 maximum points, 33% of score)**
  - Project type (5)
  - Housing First compliance (5)
  - Participation and attendance at CoC’s Homeless Action Council monthly meetings (5)-Not ranked FY19
  - Active Participation and compliance with quarterly project evaluation and monitoring (5)
  - SOAR training (3)

**Three factors were not ranked as previously indicated due to insufficient data documentation. The Ranking and Review Committee made the decision to not measure this factors at its meeting 08/22/2019.**

To assure fairness, the committee used data from HMIS that were custom generated in SAGE format for the same 12-month period for all projects. We used the period from April 1, 2018 to March 31, 2019.
## Project Ranking Scorecard

<table>
<thead>
<tr>
<th>Factor</th>
<th>Project Management</th>
<th>Priority Pop</th>
<th>Outcomes</th>
<th>Best Practices</th>
<th>TOTAL SCORE</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>APR submission</td>
<td>Spending: non-rent/lease funds</td>
<td>HMIS data quality</td>
<td>Utilization</td>
<td>PT/PHC participation</td>
</tr>
</tbody>
</table>

### Maximum Score

<table>
<thead>
<tr>
<th>Project</th>
<th>Max Score</th>
</tr>
</thead>
<tbody>
<tr>
<td>Bethany Place</td>
<td>3</td>
</tr>
<tr>
<td>New Horizon</td>
<td>5</td>
</tr>
<tr>
<td>Call For Help</td>
<td>2</td>
</tr>
<tr>
<td>Jobe Center</td>
<td>5</td>
</tr>
<tr>
<td>Step Up to Independence II</td>
<td>2</td>
</tr>
<tr>
<td>Beacon Place</td>
<td>5</td>
</tr>
<tr>
<td>Family Living Center</td>
<td>5</td>
</tr>
<tr>
<td>New Beginnings</td>
<td>5</td>
</tr>
<tr>
<td>Chestnut Connections - St. Clair</td>
<td>0</td>
</tr>
<tr>
<td>Fairview Heights</td>
<td>0</td>
</tr>
<tr>
<td>Lighthouse</td>
<td>0</td>
</tr>
<tr>
<td>Home at Last</td>
<td>0</td>
</tr>
<tr>
<td>Journey Home</td>
<td>0</td>
</tr>
<tr>
<td>Next Step Up</td>
<td>0</td>
</tr>
<tr>
<td>Road Home</td>
<td>0</td>
</tr>
<tr>
<td>Domestic Violence TH/RRH</td>
<td>0</td>
</tr>
</tbody>
</table>
Factors and Scoring Scales

**PROJECT MANAGEMENT CRITERIA**

- **3 points – APR Submission**

  *How scored:* This measures the timeliness of submission. Projects which submitted their most recent APR within 90 days of their project ending dates were awarded 3 points. Projects which filed late but received extensions from HUD were also awarded 3 points. All other projects received 0 points.

  *Data source:* Project questionnaire; documentation of submission and extensions.

- **5 points – Spending Not ranked FY19**

  *How scored:* This measures the extent to which projects spent their non-housing money. The Ranking and Review Committee looked at the percentage of total budget expended in the most recent project year for three line items: Operations, Supportive Services, and Administration.

  We did not include Rental Assistance and Leasing, as they can be affected by participant contributions to rent, which should not count against projects. We listed all 15 projects in order, with the highest percentage of expended funds at the top of the list.

  - The four projects with the highest percentage (1-4) received 5 points.
  - The four with the next highest percentage (5-8) received 4 points.
  - Projects 9-12 received 3 points.
  - Projects 13-14 received 2 points.
  - Projects 15 received 1 point.

  *Data source:* Project questionnaire.

- **2 points – HMIS Data Quality**

  *How scored:* This measures the completeness of client-level HMIS data. The committee looked at the percentage of unduplicated client records with null or missing values and the percentage of "Client Doesn't Know" or "Client Refused" during the 12-month period. We listed all 15 projects in order, with the lowest percentage of null, missing, "doesn’t know", and refused at the top of the list.

  - Projects with 0-5% received 2 points.
  - Projects with 6-10% received 1 point.
  - Projects with more than 10% received 0 point.

  *Data source:* SAGE items 6a, 6b, and 6c.
5 points – Utilization

How scored: This measures how efficiently projects use their housing assets. The Review and Ranking Committee used a customized HMIS report that divides the average number of households by the number of units. We listed all 15 projects in order, with the highest percentage of utilized units at the top of the list.

- The four projects with the highest percentage (1-4) received 5 points.
- The four with the next highest percentage (5-8) received 4 points.
- Projects 9-11 received 3 points.
- Projects 12-14 received 2 points.
- Projects 15 received 1 point.

Data source: SAGE #8b (average number of households served), divided by number of units reported in HUD application.

2 points – PIT/PHC Participation

How scored: This measures whether projects participated in the Point-in-Time count and Project Homeless Connect in January 2018. PIT participation includes planning, providing PIT volunteers, and canvassing for unsheltered. Project Homeless Connect participation includes planning for the event or volunteering, but it does not include staffing your vendor booth at the event.

- Projects that participated in PIT and PHC received 2 points.
- Projects that participated only in PIT or only in PHC received 1 point.
- Projects that participated in neither PIT nor PHC received 0 points.

Data source: Project questionnaire. [NOTE: In future years, the accuracy and timeliness of HIC data may be scored].
PRIORITY POPULATION CRITERIA

- **5 points – Chronic Homelessness**
  
  *How scored:* This rewards projects that serve high numbers of persons experiencing chronic homelessness. The Review and Ranking Committee examined the number of persons served during the 12-month period who were chronically homeless when they entered the project. We listed all 15 projects in order, with the projects serving the highest number of chronically homeless at the top.
  
  - The four projects with the highest number of CH participants (1-4) received 5 points.
  - The four with the next highest number (5-8) received 4 points.
  - Projects 9-11 received 3 points.
  - Projects 12-14 received 2 points.
  - Projects 15 received 1 point.

  *Data source:* SAGE item 5a(11).

- **5 points – Multiple Barriers**
  
  *How scored:* This measures the extent to which project serve persons with significant barriers. The committee looked at the percentage of participants who had two or more barriers at the time of project entry. We listed all 16 projects in order, with the highest percentage of multiple barrier participants at the top of the list.
  
  - The four projects with the highest percentage (1-4) received 5 points.
  - The four with the next highest percentage (5-8) received 4 points.
  - Projects 9-11 received 3 points.
  - Projects 12-14 received 2 points.
  - Projects 15 received 1 point.

  *Data source:* SAGE item 13a2 (2 conditions and 3+ conditions), divided by total number of adults served in SAGE item 5a(2).
PARTICIPANT OUTCOME CRITERIA

• 5 points – Exits to / Retention of Permanent Housing

How scored: This measures housing stability. For transitional housing projects, the Review and Ranking Committee obtained the percentage of all exits that were to permanent housing. For permanent housing projects including RRH, the committee obtained the number of adults who retained housing plus those who exited to other permanent housing, and computed the total as a percentage of all adult participants. We listed all 16 projects in order, with the highest percentage at the top of the list.

- The four projects with the highest percentage (1-4) received 5 points.
- The four with the next highest percentage (5-8) received 4 points.
- Projects 9-11 received 3 points.
- Projects 12-14 received 2 points.
- Projects 15 received 1 point.

Data source: For transitional housing, the total persons who exited to positive housing destinations in SAGE items 23a and 23b, divided by number of leavers in item 5a(5).

For permanent housing including RRH, the total stayers from SAGE item 5a(8), plus the total persons who exited to positive housing destinations in SAGE items 23a and 23b; all divided by the total number of persons served in item 5a(1).

• 5 points – Increases in Cash Income from Employment

How scored: This measures increased resources. The committee looked at the percentage of adult participants who increased their income from employment during the 12-month period, including those who started with no employment income and gained some. We listed all 16 projects in order, with the highest percentage of adults gaining employment income at the top of the list.

- The four projects with the highest percentage (1-4) received 5 points.
- The four with the next highest percentage (5-8) received 4 points.
- Projects 9-11 received 3 points.
- Projects 12-14 received 2 points.
- Projects 15 received 1 point.

Data source: SAGE item 19a, line 1 (earned income) columns 4 and 5 (retained and increased, and no income and gained); divided by total adults in item 5a(2).
• **5 points – Increases in Cash Income from Non-Employment Sources**

*How scored:* This also measures resources. The committee looked at the percentage of adult participants who increased their income from non-employment sources during the 12-month period, including those who started with no non-employment income and gained some. We listed all 16 projects in order, with the highest percentage of adults gaining non-employment income at the top of the list.

- The four projects with the highest percentage (1-4) received 5 points.
- The four with the next highest percentage (5-8) received 4 points.
- Projects 9-11 received 3 points.
- Projects 12-14 received 2 points.
- Projects 15 received 1 point.

*Data source:* SAGE item 19a, line 3 (other income) columns 4 and 5 (retained and increased, and no income and gained); divided by total adults in item 5a(2).

• **5 points – Project referral rejection % based on non-viable reasons** *Not ranked FY19*

*How scored:* This measures the extent to which people exiting homeless remained housed. The committee wanted to look at the percentage of former participants who returned to homelessness within 24 months of exiting each project.

*Data source:* Project-level reports from Housing Resource Center.

**BEST PRACTICE CRITERIA**

• **5 points – Project Type**

*How scored:* This rewards the types of projects that have been shown to be highly effective. The committee awarded points based on the type of project based on the following scale:

- Permanent Supportive Housing – 5 points
- Rapid Re-Housing – 4 points
- Transitional Housing – 3 points

*Data source:* Project Application
• **5 points – Housing First Compliance**

*How scored:* This rewards projects that following evidence-based Housing First practices. The committee has requested all projects complete the HUD Housing First Self-Assessment form.

Projects percentage utilization of Housing First Standards will determine scoring
Projects with 100% - 5 points
Projects with 95-99% - 4 points
Projects with 90-94% - 3 points
Projects with 85-89% - 2 points
Projects with 80-84% - 1 point
Projects with less than 80% - 0 points

*Data source:* HUD Housing First Self-Assessment.

• **5 points - Participation and Attendance at monthly Homeless Action Council meetings. Not Ranked in FY19**

*How scored:* This rewards projects that have staff attending monthly Homeless Action Council meetings 80% or higher during the 12-month period.

*Data Source:* Homeless Action Council monthly meeting minutes.

• **5 points - Active Participation and Compliance with quarterly project evaluation and monitoring.**

*Data Source:* Quarterly monthly monitoring form signed by monitoring staff and project staff noting any issues or non-compliance areas.

• **3 points – SOAR training**

*How scored:* This rewards projects that have staff qualified to assist persons in received mainstream benefits. The committee asked for the names of staff persons or referral agents providing assistance and advocacy with Social Security applications and the date of their most recent SOAR training.

- All projects with at least one person with SOAR training in the past 24 months received 3 points.
- All other projects received 0 points

*Data source:* Project questionnaire.
Notes

**DEADLINE**
Projects were given a project questionnaire to be completed for the ranking and review process. A deadline for completion was set for August 2, 2019. Any project that did not meet this deadline would receive 0 points for project ranking. *The Rank and Review Committee made an exception for one project that had indicated an intent for non-renewal. The project reversed their decision and requested the committee to allow them to renew. The committee granted the late renewal, but the project will be ranked last of all renewal projects regardless of ranking score as a consequence of late renewal.*

**TIEBREAKERS**
Ties were broken by project’s number of beds with the project with the highest number having priority. If after utilizing the first tie breaker created a secondary tie breaker then bed utilization was used to break the tie.

**UNRANKABLE PROJECTS**
HMIS and SSO projects cannot be ranked using the same criteria as housing projects. They are essential to the functioning of the entire system. The Ranking and Review Committee placed these projects at the bottom of Tier One to protect their renewal funding.

**NEW PROJECTS**
All new projects were reviewed for compliance with HUD eligibility standards and HUD threshold requirements. Projects that did not meet wither HUD eligibility or threshold were not ranked. For projects that cleared this review, the Ranking and Review Committee reserved the right to place them appropriately based on HUD priorities and local needs.

**APPEAL PROCESS**
Project applicants may appeal rankings to the Appeals Committee. The Appeals Committee will consider all appeals based on their merit. The Appeals Committee is comprised of active Homeless Action Council (HAC) members that have non-HUD funding projects.
2019 CoC Consolidated Application Attachment:
Local Education or Training Organization Agreement
St. Clair County CoC
IL-508
This Agreement is between The Illinois Continuum of Care 508 (CoC) and Southern Illinois University Edwardsville (SIUE).
The CoC and its participating projects agree to refer persons experiencing homelessness to SIUE for their job skills training program.
SIUE agrees to prioritize access to these services for persons referred by the CoC and its participating projects.

Signed: 

Jerry B. Weinberg

SIUE

By (Print name): Jerry B. Weinberg
(Title): Associate Provost for Research and Dean of the Graduate School

Date

9/20/19

James Kellerman

By (Print name): James Kellerman
(Title): Chairman

Date

9/20/19
2019 CoC Consolidated Application Attachment:
State or Local Workforce Agreement
St. Clair County CoC
IL-508
This Agreement is between The Illinois Continuum of Care 508 (CoC) and the St. Clair County Intergovernmental Grants Department as administrators of Workforce Innovation and Opportunity Act (WIOA) services for St. Clair County. The CoC and its participating projects agree to refer persons experiencing homelessness to the St. Clair County Intergovernmental Grants Department for their job skills training program. St. Clair County Intergovernmental Grants Department agrees to prioritize access to these services for persons referred by the CoC and its participating projects.

Signed:

[Signature]
St. Clair County Intergovernmental Grants Department 9/19/19
By (Print name): Richard Stubblefield
(Title): Executive Director

[Signature]
Illinois Continuum of Care 508 9-19-19
By (Print name): James Kellerman
(Title): President
2019 CoC Consolidated Application Attachment:
Racial Disparity Assessment Summary
St. Clair County CoC
IL-508
Background
In compliance with guidance from the United States Department of Housing and Urban Development (HUD), the St. Clair County Continuum of Care conducted this FY2019 assessment of racial and ethnic disparities in the provision of housing and services to those experiencing homelessness.

This summary reports our analyses of racial or ethnic disparities in the following two factors:

- Likelihood of receiving homeless assistance.
- Likelihood of obtaining positive outcomes.

HUD did not offer a specific numerical definition of disparity. In the absence of such parameters, this report used the “80% rule.” This rule is used by the U.S. Equal Employment Opportunity Commission to determine if an employment practice results in a disparate outcome. This rule states that the selection rate of a protected group should be at least 80% of the selection rate of the non-protected group. Differences of less than 20% are not sufficient to demonstrate disparity.

Key Question #1: Are persons of differing races or ethnicities more or less likely to receive homeless assistance?
To assess this issue, we conducted two comparisons. First, we compared the population below the federal poverty line within the entire CoC geographic coverage area with the population of those experiencing homelessness, using data provided by HUD’s Racial Equity Analysis Tool (see chart on page 3). The source for poverty data is the U.S. Census, and the source for homelessness data is the annual Point-in-Time count (PIT).

This is not a perfect methodology, as it assumes that all persons in poverty are equally likely to experience homelessness regardless of income levels. It seems far more likely that extreme poverty (e.g., 10% or 20% AMI) would be more associated with homelessness than poverty alone. However, we did not have data on extreme poverty.

Second and more to the point, we compared the proportion of each group experiencing homelessness with the proportion of the same group receiving assistance (as measured by enrollment in all HMIS projects). The following findings emerged:

- St. Clair County was more black and less Hispanic than Illinois as a whole, with 29% of the county African American (versus 14% statewide), and only 2% of the county Hispanic (versus 16% statewide). See data highlighted in blue in the CoC Data Chart.
- The number of Hispanic/Latino persons experiencing homelessness was very low (only 2 persons), and therefore this group could not be analyzed statistically.
• Although African Americans represented 61% of those living at or below the poverty limits, they represented 76% of the homeless population. See data highlighted in green in the CoC Data Chart.

• Looking more closely at families with children, African Americans represented 61% of those living at or below the poverty limits and 85% of the homeless population. See data highlighted in rose in the CoC Data Chart.

• According to HMIS records, African Americans made up 76% of the homeless population, and they constituted 77% of those served by the CoC. Whites made up 23% of the homeless population, and they constituted 20% of those served by the CoC. Thus, the CoC provided homeless assistance to both racial groups in proportion almost exactly identical to their presence in the homeless population.¹

Based on the above, we conclude that there are no racial disparities in the likelihood of receiving homeless assistance.

¹ See Outcomes chart on page 4 for the percentages of racial groups receiving homeless assistance from the CoC.
### CoC Racial Equity Analysis Tool

#### Distribution of Race

<table>
<thead>
<tr>
<th>Race</th>
<th>All People</th>
<th>In Poverty (ACS)</th>
<th>Experiencing Homelessness (PIT)</th>
<th>Experiencing Unsheltered Homelessness (PIT)</th>
<th>In Families with Children</th>
</tr>
</thead>
<tbody>
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<td>63%</td>
<td>65%</td>
<td>58%</td>
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<tr>
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<tr>
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<tr>
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<td>1%</td>
</tr>
<tr>
<td>Native American/Alaskan</td>
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<td>1%</td>
</tr>
<tr>
<td>All (ACS)</td>
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| Data about Veterans in Families Not Available

#### Distribution of Ethnicity

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<th>Experiencing Homelessness (PIT)</th>
<th>Experiencing Unsheltered Homelessness (PIT)</th>
<th>In Families with Children</th>
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</table>
| Data about Veterans in Families Not Available

#### CoC Data

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<th>Race and Ethnicity</th>
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<th>In Poverty (ACS)</th>
<th>Experiencing Homelessness (PIT)</th>
<th>Experiencing Unsheltered Homelessness (PIT)</th>
<th>In Families with Children</th>
</tr>
</thead>
<tbody>
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<td>White</td>
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<td>100%</td>
<td>100%</td>
<td>100%</td>
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<tr>
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<tr>
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<tr>
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</table>

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

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**Sources:**
- American Community Survey (ACS) 2013-2015 5-yr estimates
- Veteran CoC data comes from the AIS 2011-5 yr estimates
- Total youth in the American Community Survey is a lookup of race estimates of all persons under 25
- Panel Size (PIT) 2017 Final
Key Question #2: Are persons of differing races or ethnicities more or less likely to achieve positive outcomes?

To assess this issue, we compared housing placements and returns to homelessness. Data is from local HMIS customized reports and the Stella Performance function (demographic tab) in HDX 2.0. Stella did not provide a “clean” breakout of ethnicity, instead including all Hispanic/Latino persons in the “White, Hispanic/Latino” category. This failed to account for persons of Hispanic ethnicity who do not identify racially as white. This limited us to comparisons by race. We were not able to compare ethnicity. This had minimal impact because the population of persons of Hispanic ethnicity is very small in this CoC.

The chart below shows outcomes. The first line shows the racial breakdown of all persons receiving assistance. It is based on the CoC’s local HMIS records. The next four lines show outcomes by race:

- Placement in Emergency Shelters and Transitional Housing projects, from Stella.
- Placement in Rapid Re-Housing projects, from Stella.
- Placement in Permanent Supportive Housing projects, from Stella.
- Returns to homelessness, from local HMIS records.

The only indicator where there is a concern is Returns to Homelessness. Data in that area suggests that whites were far more likely than blacks to return to homeless status within two years after obtaining permanent housing. However, the numbers in that area were very small, with only 12 persons returning to homelessness in the prior 24 months. The data on Returns to Homelessness is not sufficient to draw a conclusion.

Data for the other three indicators were all very close to mirroring the racial breakdown of all persons receiving services (+/- 9%), well within the EEOC 20% rule.

Based on the above, we conclude that there are no racial disparities in the outcome of homeless assistance.