Mission*: *Build partnerships and promote strong collaborative action to ensure all residents within the County have stable, safe, and healthy places to live.

Santa Cruz County
Housing for Health Partnership (H4HP) Policy Board
Regular Meeting Agenda
February 15, 2023; 3 pm
Aptos Village County Park Hall – 100 Aptos Creek Rd., Aptos

Call to Order/Welcome

Call-In # for Members of the Public:
+1 831-454-2222,,869583979#
Phone Conference ID: 869 583 979#

Non-Agenda Public Comment

Action Items (vote required)

1. Approval of Minutes: December 14, 2022, Regular Meeting
2. Approval of 2023 New Board Nominee from Central California Alliance for Health
3. HUD Continuum of Care (CoC) 2023 NOFO Review Committee Nominees
4. Approval of Housing for Health Partnership (H4HP) Operations Committee Coordinated Entry System (CES) Policies and Procedures

Information Items (no vote required):

5. 2023 Point in Time (PIT) Count Community Planning and Volunteer Recruitment

Report/Discussion Items (no vote required):

6. Temporary Housing Capacity and Financing Update

Board Member Announcements

Adjournment

Next Meeting: **Wednesday, April 19, 2023, 3 pm**

The County of Santa Cruz does not discriminate based on disability, and no person shall, by reason of a disability, be denied the benefit of the services, programs, or activities. This meeting is in an accessible facility. If you are a person with a disability and require special assistance to participate in the meeting, please call (831) 763-8900 (TDD/TTY- 711) at least 72 hours in advance of the meeting to make arrangements. Persons with disabilities may request a copy of the agenda in an alternative format. As a courtesy to those affected, please attend the meeting smoke and scent free.

Action Item 1: Approval of Meeting Minutes

(Action required) – Robert Ratner

Recommendation

Approve the December 14, 2022, Housing for Health Partnership Policy Board Regular Meeting minutes.

Suggested Motion

I move to approve the December 14, 2022 Housing for Health Partnership Policy Board Regular Meeting minutes.

Housing for Health Partnership Policy Board
Regular Meeting Minutes
December 14, 2022

Call to Order/Welcome
Present: Heather Rogers, JP Butler, Judy Hutchison, Larry Imwalle, Manu Koenig, Mariah Lyons, Martine Watkins, Rachel Dann, Susan True, Suzi Merriam, Tiffany Cantrell-Warren, Kate Nester, Ryan Coonerty

Absent: *Heather Rogers, Jamie Goldstein, Martine Watkins, Tamara Vides*

Additions and Deletions to the Agenda: None

Non-Agenda Public Comment
No public comment received.

Action Items (vote required):

1. Findings Authorizing Teleconference Meetings
   Motion to Approve: *Suzi Merriam*
   Motion Seconded: *Judy Hutchinson*
   Abstentions: *None*
   Board Action: *All in favor, motion passed.*

2. Approval of Minutes: *October 19, 2022,* Regular Meeting
   Motion to Approve: *Judy Hutchinson*
   Motion Seconded: *Suzi Merriam*
   Abstentions: *Rachel Dann, Kate Nester, Mariah Lyons*
   Board Action: *All in favor, motion passed.*

3. Approval of 2023 Co-Chair Nominees.
   Motion: It was moved to approve Tiffany Cantrell Williams as co-chair for 2 years and Tamara Vides as co-chair for 1 year.

   Motion to Approve: *Judy Hutchison*
   Motion Seconded: *Martine Watkins*
   Abstentions: *None*
   Board Action: *All in favor, motion passed.*

4. Adoption Approval of 2023 Regular Meeting Schedule and Location

Motion: It was moved to approve the recommended 2023 Housing for Health Partnership Policy Board meeting dates at 3:00 pm at the City of Capitola administrative building *and have as many avenues for public participation as possible.*

Motion to Approve: *Manu Koenig*
Motion Seconded: *Suzi Merriam*
Abstentions: *None*
Board Action: *All in favor, motion passed*

5. Approval of Housing for Health Partnership (H4HP) Operation Committee Coordinated Entry System Recommendations

Discussion: Monica Lippi, from the Housing for Health Division, presented the Coordinated Entry Redesign and proposed Coordinated Entry process flow. The operations committee recommended 3 action steps for this policy board to approve: (i)ending the use of the VI-SPDAT; (ii) voluntary engagement of community-based organization staff members in housing problem-solving and assessment testing using paper versions of the new Housing Needs Assessment (HNA) and Housing Action Plan (HAP) from January 2023-March 2023; (iii) the continued prioritization and matching of active participants in the Coordinated Entry Housing Queue through March 2023 using the same historical approach used to date.

Concerns about referrals based on the highest score were raised, leaving out other vulnerable populations. Staff explained that there are very few available spots in the county for referrals through the coordinated entry system process. There are different levels of resources available for different subpopulations. Referrals are made if a household meets resource specific eligibility criteria, and they are prioritized via the coordinated entry prioritization process. In any given year, HMIS data indicates that more households exit programs to permanent housing through the work of specific programs rather than through referrals to permanent housing resources made through the coordinated entry referral process. A vast majority of participants that exit programs to permanent housing do not get it through referrals but rather through services and housing problem-solving work that happens with providers in the community.

Jessica Scheiner presented a high-level overview of the Coordinated Entry process flow and how participants are matched and referred to housing. Questions were raised if there was prioritization for certain circumstances like people with unique barriers in this new version as compared to the VI-SPDAT. Staff noted the HNA provides scoring that determines prioritization on who gets on to the housing queue. Concerns were also raised about housed individuals who have their units red-tagged and will need to relocate. Staff clarified that individuals living in red-tagged buildings are considered homeless by HUD standards. Individuals that were previously homeless and lost their housing would need to restart the coordinated entry process again at the time they returned to homelessness.
Questions were asked about what people could do to access the coordinated entry system if they suddenly had a crisis. Robert Ratner shared the importance of being realistic about available resources and a shift from quantity to quality of services being provided given the lack of resources relative to

the need. Staff recommend increasing transparency about resource availability at every step in the coordinated entry process.

Tiffany Cantrell-Williams raised the issue of how equitably these resources will be available to those least able to access them. Staff indicated that connectors will be out in the field and will work on building relationships. Staff indicated the biggest barrier to helping households with significant behavioral health and other disabling health issues is the lack of housing resources dedicated to serving this population compared to the need.

Questions were raised on the scoring process to determine prioritization. Staff noted that there is a proposed scoring framework based on information gathered during the HNA. The current proposed scoring methodology provides higher scores for individuals with more barriers to securing and maintaining housing without support and to those more likely to have serious health and safety issues with continued periods of homelessness. Score thresholds will get established to determine an appropriate number of households to add to the "housing queue" so that nearly all households in the queue should expect a housing referral within a six-month period. Individuals not on the queue will not get matched to a housing resource through the coordinated entry referral process.

Concerns were raised regarding the capacity of recuperative care shelter beds in the County and the demand for these beds. Staff indicated there is currently a high anecdotal demand for recuperative care but not a system to track the number and sources of referrals for beds.
H4H is working with the Central California Alliance for Health on ways to incorporate their Medi-Cal managed care member risk stratification tool into the County's coordinated entry scoring and prioritization process.. A portion of CalAIM Housing and Homeless Incentive Program (HHIP) funding for Santa Cruz County will be utilized to support staff to develop recommendations for this process.

Inquiries were made about how the Coordinated Entry Redesign process will distinguish between rapid rehousing and permanent supportive housing interventions for people who are in the housing queue. Concerns were also raised about the number of connectors needed and the budget available to support this process. H4H staff noted that strength-based care management is being promoted as an evidenced-based practice for organizing supportive services within the Housing for Health provider network. This practice recommends a full-time care manager for every 15-20 households. H4H staff have identified an initial group of up to 15 individuals that can serve as Housing for Health connectors. H4H staff recommend working toward a goal of recruiting, training, and supporting 50 FTE of connector capacity in the county so that 750 to 1,000 households can receive in depth housing problem solving supports at a single point-in-time.

Public comment – No public comment received.

Motion – approve three action steps supported by the Operations Committee at their November 17, 2022meeting to allow H4HP to progress towards the Coordinated Entry Redesign anticipated to be launched on April 1, 2023.
Motion to Approve: Manu Koenig
Motion Seconded: Susan True
Abstentions: None
Board Action: All in favor, motion passed

Information Items (no vote required):

6. CalAIM Housing and Homeless Incentive Program (HHIP).

7. 2023 Point In Time (PIT) Count Community Planning and Volunteer Recruitment

8. City of Santa Cruz – Coral Street – Design Charette with Dahlin Group

9. Homeless Memorial – Wednesday 21st December at the Veterans memorial building, 840 Front Street, Santa Cruz at 10 am

10. H4HP Policy Board replacement nominees.
    Some policy board members changing roles. February 2023 meeting will include some proposed actions to replace some board member seats.

Report/Discussion Items (no vote required):

11. California Homeless Housing, Assistance and Prevention (HHAP) Round 3 and Round 4 Funding and Action Plan Update

In early November 2022, Governor Newsom paused all HHAP 3 funding and requested that local jurisdictions update their HHAP 3 funding applications to reflect more ambitious outcome goals. The Governor specifically requested more robust goals related to reducing unsheltered homelessness. To secure HHAP-3 funding, H4H staff were required to update their HHAP-3 unsheltered outcome goals and to agree to the implementation of several best practices. Staff shared a table analyzing changes made to the outcome goals for both HHAP round 3 and HHAP round 4 and the expected goals for Santa Cruz County & CoC moving forward.

Manu Koenig also shared his experience attending the governor's special HHAP-funding meeting on housing and homelessness for local elected leaders.

Board Member Announcements - *None*

Adjournment

Next Meeting:
Housing for Health Partnership Policy Board Wednesday, February 15, 2023, at 3 pm.

Action Item 2: Approval of 2023 New Board Nominee from Central California Alliance for Health

(Action required) – Robert Ratner

Recommendation

Approve the appointment of Kate Nester, Program Development Manager from the Central California Alliance for Health, to replace Stephanie Sonnenshine, Chief Executive Officer (CEO) from the Central California Alliance for Health, as the health care sector representative on the Housing for Health Policy Board for at least the duration of the two-year appointment term ending December 31, 2023.

Background

The current Continuum of Care (CoC) governance charter for the Housing for Health Partnership adopted on June 18, 2021, calls for the Policy Board to appointment a representative from the Health Sector to participate as a member of the Policy Board for a two-year term. The Homeless Action Partnership (HAP) CoC Board, the predecessor to the current Housing for Health Partnership Policy Board, appointed Stephanie Sonnenshine as the first health sector representative on the Board. Stephane will be resigning from her CEO role at the Alliance effective May 1, 2023.

In preparation for this transition, Stephanie recommended the current CoC Policy Board consider Kate Nester as a replacement appointment for the health care sector slot. Kate has participated as a guest in multiple CoC Policy Board meetings and continues working with CoC staff on efforts to enhance California Advancing and Innovating Medi-Cal (CalAIM) efforts related to addressing homelessness. Kate coordinated Santa Cruz County's application for CalAIM Housing and Homeless Incentive Program (HHIP) funds on behalf of the Alliance and the CoC. She continues to support data sharing, care coordination, and provider capacity development efforts to help bridge health and housing services within the County of Santa Cruz. If appointed to serve on the Board, Kate will finish out Stephanie's two-year term ending December 31, 2023, and will be eligible for subsequent two-year appointments after the end of the term.

Suggested Motion

I move to approve the appoint of Kate Nester to replace Stephanie Sonnenshine as the health sector representative on the Housing for Health Partnership Policy Board through December 31, 2023.

Action Item 3: HUD Continuum of Care (CoC) 2023 NOFO Review Committee Nominees

(Action required) – Robert Ratner, Sheryl Norteye, Tony Gardner

Recommendation

(1) Approve the nomination of 3-5 current non-conflicted Housing for Health Partnership Policy Board or other CoC members to participate in the annual review, ranking, and new proposal review process for the anticipated FY23 HUD Continuum of Care (CoC) Notice of Funding Opportunity (NOFO) and FY23 Emergency Solutions Grant (ESG) NOFO from the State of California.

(2) Authorize the nominees to participate in a review of grant recipient performance summary reports based on staff risk assessment analyses conducted on current projects receiving CoC funds.

(3) Authorize the group of nominees to make specific NOFO recommendations back to the Policy Board for consideration and action after the release of the FY 23 HUD CoC and CA ESG NOFOs.

Background

Local Continuum of Care (CoC) Boards and CoC staff are required to manage a local annual competitive application process for funding from the HUD Continuum of Care (CoC) and Emergency Solutions Grant (ESG) programs, including grant renewals and new funding opportunities. Santa Cruz County's CoC awards from federal fiscal year 2021 total $5,207,237 dollars as outlined in Figure 1.

For the FY2022 NOFO, the Policy Board nominated the following individuals to participate in an application review, ranking, and new proposal review process:

- Anthony Jordan, County of Santa Cruz, Health Services Agency, Senior Behavioral Health Manager, Director Substance Use Disorder Treatment System of Care
- Carlos Landaverry, City of Watsonville, Housing Manager, Community Development Agency
- Heather Rogers, County of Santa Cruz, Public Defender
- Judy Hutchison, Association of Faith Communities (AFC), Chair
- Karen Kern, County of Santa Cruz, Health Services Agency, Senior Behavioral Health Manager, Director Adult Mental Health Services System of Care
- Larry Imwalle, City of Santa Cruz, Homelessness Response Manager, City Manager's Office

Figure 1: CA-508 CoC FY21 Project Awards

CA-508 - Watsonville/Santa Cruz City & County CoC

801 River Street	CoC	$159,911
CA-508 CoC Planning Application FY2021	CoC	$143,649
Coordinated Entry Expansion	CoCR	$228,362
County of Santa Cruz Homeless Management Information System	CoCR	$91,699
Drop-In Center	CoC	$296,903
First Step-Scattered Site Housing for Families with Children	CoCR	$560,228
Freedom Cottages	CoCR	$15,645
Housing for Health 3	CoCR	$90,429
MATCH	CoCR	$1,028,918
New Roots Rapid Rehousing	CoC	$197,505
Santa Cruz County Shared Housing 2021 YHDP	CoC	$137,767
Shelter + Care Expansion	CoC	$150,308
Shelter+Care Consolidate	CoCR	$1,186,546
Walnut Avenue Housing & Employment Program	CoC	$154,055
Walnut Avenue Housing & Employment Program	CoCR	$112,219
Young Adults Achieving Success - YHDP RRH & TH	CoC	$263,387
Youth CES	CoC	$60,000

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State

CoC Name

Project Name	Program	Awarded Amount
Youth Homeless Response Team (YHRT) Renewal	CoC	$99,175
Youth Rapid Rehousing	CoC	$230,531
CA-508 Total :		**$5,207,237**

Recommendations from this group were utilized to approve a set of project applications in ranked order for submission to HUD as part of the FY 2022 NOFO competition. Final FY 2022 award announcements from HUD have not yet been released.

As part of the FY 2022 review process, members of the review committee recommended forming the review body sooner and spending more time understanding the performance of current grant recipients.

A review committee was not necessary for reviewing FY 2022 CA ESG applications since the limited number of applications received resulted in all applicants receiving CoC support for submission for funding. The next future ESG funding round may be more competitive and require a review committee to rate and rank proposals.

Suggested Actions

(1) Nominate and approve nominations of individuals to serve on a CoC and ESG funding review committee.
(2) Authorize the nominated group to begin work reviewing current grant recipient performance.
(3) Authorize the group to develop Policy Board recommendations related to upcoming CoC and ESG funding application cycles.

Action Item 4: Approval of H4HP Operations Committee Draft Coordinated Entry System Policies and H4H Division Staff Implementation Recommendations

(Action required) – Monica Lippi/CoC Operations Committee

Recommendation

(1) Approve the Draft Coordinated Entry System Policies supported by the H4HP Operations Committee and provide H4H Division staff with direction on incorporating additional recommendations provided by the Continuum of Care's HUD expert consultant;
(2) Approve the proposed scoring methodology for the Housing Needs Assessment (HNA);
(3) Approve the proposed implementation plan to move participants to the Housing Queue for an April 1, 2023 implementation date.

Background

The U.S. Department of Housing and Urban Development (HUD) requires Continuums of Care (CoCs) to establish and operate a "centralized or coordinated assessment system" (referred to as "coordinated entry" or "coordinated entry process") with the goal of increasing the efficiency of local crisis response systems and improving fairness and ease of access to resources, including mainstream resources. Both the CoC and ESG Program interim rules require use of the CoC's coordinated entry process, provided that it meets HUD requirements. Coordinated entry processes are intended to help communities prioritize people who are most in need of assistance. They also provide information to CoCs and other stakeholders about service needs and gaps to help communities strategically allocate their current resources and identify the need for additional resources.

Housing for Health Division staff, working with Bitfocus and Focus Strategies, has developed a proposed redesign of the coordinated entry process for the CoC. H4H staff has involved community members and people with lived experience of homelessness in the development of the proposed redesign. The proposed redesign uses a problem-solving approach to work with people experiencing homelessness in moving towards stable housing; staff providing this service are referred to as Connectors. The approach is intended to facilitate frequent and useful engagement with people experiencing homelessness, as well as more transparency for participants and service providers about who will be referred to housing programs and what the timeline is. These are particularly critical changes because the CoC does not have sufficient permanent housing available within the community to house all people experiencing homelessness who interact with the system.

Since the Policy Board approved several action steps on December 14, 2022, the H4H Division staff have continued to work toward an April 1, 2023 implementation date for the redesigned Coordinated Entry System (CES). Three issues are presented for your consideration.

Draft Coordinated Entry (CE) System Policies

During its January 2023 meeting, and through follow-up email, the H4HP Operations Committee approved the Draft CE Policies document. The Draft CE Policies were also shared with the Continuum of Care's HUD expert consultant to ensure compliance with HUD regulations and expectations. After approval from the Operations Committee, the CoC HUD expert provided comments and suggestions for the H4HP to consider for integration into the approved draft document. For the most part, the recommendations do not impact the substance or intended effects of the proposed policies, although further detailed analysis will be completed to confirm this; edits to the document and inclusion of additional information will address most issues.

One significant potential policy change identified does need discussion and input at this time. Specifically, the proposed policies are written to include support for households currently experiencing homelessness to identify the resources to alleviate their experience of homelessness. The HUD expert consultant points to the HUD requirement that "people at risk of homelessness be served and that there be a process to refer them to prevention services funded by ESG and preferably also non-ESG-funded preventions services that participate in CES."

H4H Division staff will thoroughly review all input provided by the HUD consultant and work with the Operations Committee to incorporate the changes suggested. At this time, the request of the Policy Board is to approve the Draft CE Policies document as is, understanding that updates will occur over the next two months. The Policy Board will receive an updated document at your April Board meeting.

During the April meeting, the Policy Board will also be asked to consider the extent to which the Operations Committee and H4H Division staff are able to modify and/or refine the CE Policy document. We anticipate that the CE Policies will evolve over time with changes to the H4HP priorities, local context, and other factors. The Policy Board will be asked for direction on the kinds of changes it would prefer to weigh in on versus be informed of.

Proposed Scoring Methodology for the Housing Needs Assessment (HNA)

The Housing Needs Assessment (HNA) is designed to provide Connectors and participants with the information needed to create and act together on an individualized Housing Action Plan, and to provide information for H4H coordinated entry staff to determine which participants are eligible and prioritized for H4HP-supported housing and services. Most of the HNA questions are self-reported by a participant. The questions are intended to be asked in a conversational way and Connectors will be trained to use the HNA to help meet immediate needs as well as identify longer-term strategies to assist participants. A few questions at the end of the HNA are for the Connector responses based on their interactions with and observations of the participant.

Your packet contains a document called 'HNA and Scoring". The first page of the document lists the domains covered in the HNA, the items in each domain, and whether each item is scored (Proposed

Housing Needs Assessment Items and Domains). The items included that are not indicated as contributing to the score are used for matching participants to the housing opportunities identified. The second page of the document describes the proposed scoring rubric for the scored items (Proposed Housing Needs Assessment Score Rubric).

Several things should be noted about the proposed scoring:

- The most heavily weighted domains in the HNA are Household Composition and Housing History
- Two items (highlighted in orange) are relevant only to family households, allowing the total possible score to be higher for families
- Nine items highlighted in green indicate barriers/challenges a participant may face during their efforts to find housing. Participants receive one point for each of these items, up to a total of five points. Thus, should a participant endorse all nine items, the maximum score for them will be five.
- Because of the scoring nuance associated with barriers/challenges, the total number of points across domains (29 points) is not the same as the total maximum score for families (25 points) or adults (23 points)

Using the HNA Score to Place Households on the Housing Queue

One of the primary goals of the Coordinated Entry redesign is to put households on the housing queue who have a high probability of being housed within the next six months given the availability of H4HP housing resources. To determine the number of households on the housing queue that will achieve that balance, information about the number of households completing the HNA, their scores on the HNA, and the number of H4HP housing resources becoming available for each household type is required. At the December 2022 Policy Board meeting, H4H Division staff indicated that every month, approximately one or two seniors, adults with disabilities, and transition aged youth were referred to housing, while about 9 families were referred each month. These data are currently being updated.

Regarding HNA scores and numbers of households, data will be available in March to assess an appropriate threshold score for placement on the housing queue. Connectors, who have been working with the paper HNA since January, will input data into HMIS and analysis of this data will occur.

Until specific data are available, the current proposed implementation plan for April 1, 2023 is to place no more than those scoring in the top 10% of the score range on the housing queue. Over the next two months the Operations Committee and H4H Division staff will develop a Draft Policy and specific processes for determining the threshold scores that will provide the appropriate number of family, single adult, and transition-age youth households on the housing queue at any point in time. It is anticipated that the threshold score will adjust over time as local context and housing resources shift

and the Draft Policy brought to the Board will incorporate proposed timelines and criteria under which threshold scores may change.

Suggested Motion

I move to approve three items:

(1) The Draft Coordinated Entry System Policies supported by the H4HP Operations Committee, with further incorporation and discussion of additional recommendations from the CoC's HUD expert consultant at the April 2023 Policy Board Meeting;
(2) The proposed scoring methodology for the Housing Needs Assessment (HNA);
(3) The proposed implementation plan to move participants to the Housing Queue for an April 1, 2023 implementation date.

DRAFT – HOUSING FOR HEALTH PARTNERSHIP
SANTA CRUZ COUNTY COORDINATED ENTRY POLICIES - DRAFT
February 2023

1. INTRODUCTION AND OVERVIEW

1.1 Why Coordinated Entry?

Coordinated Entry is a community's systemic approach to connecting people experiencing homelessness with available assistance in the community. The Santa Cruz County Coordinated Entry System is designed to integrate and utilize Housing for Health Partnership Connectors and Housing Problem Solving as the core approach to providing support and assistance to all persons experiencing homelessness. This approach recognizes that there isn't an immediate housing resource available for each person but understands that most persons can benefit from support, services, and partnership in problem solving to resolve homelessness.

Commented [AG1]: HUD also erequires that people at risk of homelessness be served and that there be a process to refer them to prevention services funded by ESG and preferably also non-ESG-funded preventions services that participate in CES. Probably should be some revisions accordingly in sections below (e.g., Access and Assessment).

The Santa Cruz County Coordinated Entry System is guided by the belief that homelessness is preventable and solvable. Santa Cruz County's response to homelessness is grounded in guiding principles to ensure equitable access that is culturally responsive, compassionate, and trauma informed. Linkages to permanent housing through coordinated entry will utilize a Housing First[1] approach.

The goals of Santa Cruz County's Coordinated Entry System include: (1) Facilitating connections to mainstream and community services for as many persons experiencing homelessness as local resources allow; (2) Streamlining the process for matching to limited housing resources within the Housing for Health Partnership network (CoC); and (3) Prioritizing resources to households with the most significant barriers to getting and keeping housing without support and to those with the greatest personal health and safety risks.

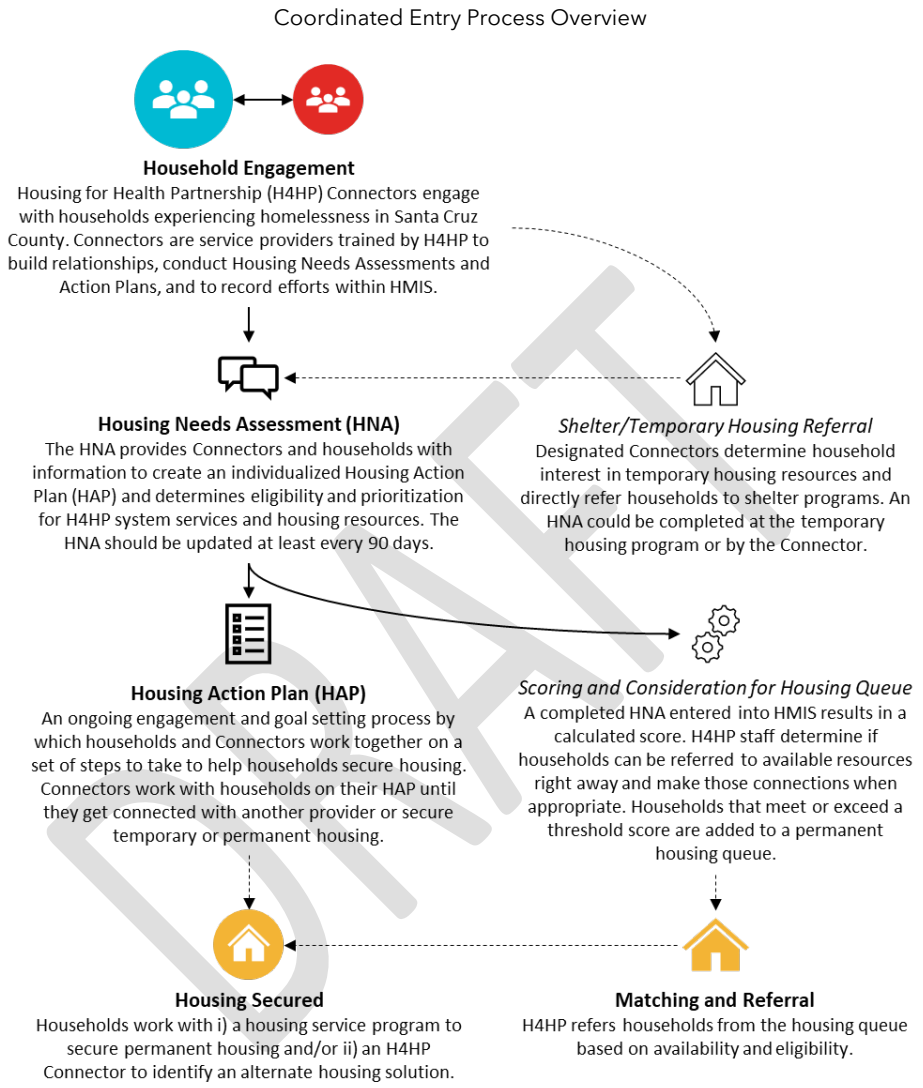
1.2 Coordinated Entry Process Overview

Santa Cruz County's Housing for Health Partnership defines Coordinated Entry as the approach to coordinate and manage the system's housing, participating shelter and supportive services resources[2] to enable providers to make equitable decisions to best connect people experiencing homelessness to interventions to end their homelessness based on available information and resources.

The Coordinated Entry *process* seeks to ensure that people experiencing homelessness have fair and equitable access to the set of resources and services for which they are eligible, regardless of where they present for assistance, and that resources designed for households

[1] Housing First is an approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements. See U.S. Department of Housing and Urban Development's (HUD) Housing First Policy Brief for additional information: https://www.hudexchange.info/resource/3892/housing-first-in-permanent-supportive-housing-brief/

[2] Housing and service resources formally linked to Santa Cruz County's Continuum of Care (Housing for Health Partnership) through funding expectations or written partnership agreements.



with highest service and housing needs are targeted to those who need them most. The process recognizes that housing resources and services are limited. Housing for Health Partnership (H4HP) Connectors, designated people specifically trained in this process, work to provide as many people as possible experiencing homelessness with support, connection to services, problem solving partnership with the goal of resolving homelessness.

The Coordinated Entry *system* refers to the whole of the public, private, and non-profit agencies and programs that participate in Coordinated Entry in any of the ways defined in and governed by these policies.

1.3 Coordinated Entry Policy Requirements

The U.S. Department of Housing and Urban Development (HUD) requires Continuums of Care (CoCs) to develop and maintain policies and procedures covering a wide variety of Coordinated Entry (CE) practices including, but not limited to, geographic coverage and access including for specific populations; the assessment, prioritization and referral process and criteria/factors used to prioritize; privacy protections, appeals, marketing, outreach, prevention, and evaluation. This Coordinated Entry Policy document, along with procedures established for specific areas of Coordinated Entry and memorialized in other policy documents referenced herein (such as the Homeless Management Information System (HMIS) Privacy and Security Policies,) constitute the required Policies and Procedures for Coordinated Entry.

1.4 Scope of Coordinated Entry

Coordinated Entry is a required process for all communities that receive funding from the U.S. Department of Housing and Urban Development.

1.4.1 Programs Required to Participate

Housing and services programs and projects that receive certain types of federal, state, or local funding are required to use the HMIS system and participate in Coordinated Entry.

Commented [AG2]: HUD expects that we clearly state that CoC and ESG programs are required to participate in CES (and HMIS for that matter).

Programs funded by other sources *may* be required to participate as part of an agreed funding structure, such as having received additional points or priority in a competitive bidding process such as a Request for Proposals (RFP) based on a commitment to participate in CE.

Required participation may vary depending on the design of the program and whether access to it depends on prior enrollment in another CE program.

1.4.2 Programs Encouraged to Participate

In order to make available the widest possible array of resources to people experiencing homelessness, other programs such as shelters and housing that do not receive any of the above funding are strongly encouraged to participate. Efforts to engage such programs will be made regularly, and non-participating programs are invited to share their rationale or concerns for not participating to allow them to be addressed, if possible.

1.4.3 Participation by Domestic Violence programs

The Federal government prohibits programs that specifically serve survivors of domestic and/or gender-based violence from entering client data into HMIS. DV providers utilize a

HMIS comparable database that is separate from the Housing for Health Partnership response system to protect the confidentiality and safety of survivors. Persons identified as seeking DV services for immediate safety needs will be referred directly to the DV system. Once their immediate safety needs have been addressed, they may participate in Coordinated Entry through the existing network of Connectors, including H4HP Coordinated Entry provisioned DV providers.

2. GOVERNANCE

2.1 Required Roles

Commented [AG3]: HUD would prefer that additional roles be listed: CES Coordinator HMIS Lead, Operations Committee, Participating Projects, Collaborative Applicants, etc.

The Coordinated Entry system and process require ongoing day-to-day management as well as community participation in design, implementation, evaluation, and improvement of the process. HUD requires that the entity charged with management of day-to-day operations and the entity charged with oversight be distinct and that both be designated by the HUD recognized Continuum of Care (CoC).

2.1.1 Policy Oversight Entity

The Policy Board of the Housing for Health Partnership (H4HP) serves as the Policy Oversight Entity which reviews policy and establishes participation expectations, performance standards, and data collection, quality and sharing protocols. The Policy Board has designated primary responsibility for this function to the System Operations, Data and Evaluation Committee (Operations Committee).

2.1.2 Management Entity

The Housing for Health division (H4H) of the County of Santa Cruz Human Services Department has been designated by the H4HP Policy Board to serve as the Coordinated Entry Management Entity to implement day-to-day workflow of the Coordinated Entry process. Management Entity responsibilities include establishing management structures, ensuring access, promoting standardized screening and assessment processes, developing, and delivering training, and conducting monitoring.

Further information about the Governance and roles and responsibilities of the Policy Oversight and Management Entity can be found in HUD's Coordinated Entry Management and Data Guide and in the Santa Cruz County Housing for Health Partnership Governance Charter.

2.2 Use of the Homeless Management Information System (HMIS)

The Homeless Management Information System (HMIS) is the data system that is used for all Coordinated Entry activities including, enrollment, Housing Needs Assessments and housing action planning, prioritization, queue management, and matching.

2.2.1 HMIS Training and licensing

All Connectors and program staff supporting CE activities must be trained and licensed to use the HMIS system and follow all requirements in the HMIS policies.

2.2.2 Privacy and Security

All staff supporting CE activities will follow HMIS protocols for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the Coordinated Entry process and providing Connection and Problem-Solving services including the development of Housing Action Plans. This includes a requirement to follow all rules regarding the capture, transmission, and storage of Personally Identifying Information (See HMIS Privacy and Security Standards).

2.2.3 Use of a Comparable Database

Victim Service Providers are prohibited from entering data into HMIS and may be required to use a comparable database to participate in CE. A comparable database is a relational database that meets all HMIS Data Standards and does so in a method that protects the safety and privacy of survivors.

2.2.4 Right to Abstain from Disclosing or Sharing Information

Coordinated Entry participants may freely abstain from disclosing and sharing information without fear of denial of services resulting from the refusal. However, participants may be unable to qualify for consideration for specific programs or services that require disclosure of specific information for purposes of establishing or documenting program eligibility.

2.3 Non-discrimination and Affirmative Marketing

2.3.1 Applicable Civil Rights and Fair Housing Law

All programs that receive referrals from CE are permitted and expected to comply with all applicable State and Federal civil rights and fair housing laws and requirements, including, but not limited to:

- Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status;
- Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance;
- Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color or national origin under any program or activity receiving Federal financial assistance; and

- Title II of the Americans with Disabilities Act prohibits public entities, which includes state and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and referral assistance. Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.
- HUD's Equal Access Rule at 24 CFR 5.105(a)(2) prohibits discriminatory eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC Program, ESG Program, and HOPWA Program. The CoC Program interim rule also contains a fair housing provision at 24 CFR 578.93. For ESG, see 24 CFR 576.407(a) and (b), and for HOPWA, see 24 CFR 574.603.

Commented [AG4]: Title 3 is also required and possibility more important since it deals with private nonprofits etch that operate public accommodations like shelters and housing programs

2.3.2 Affirmative Marketing

Housing providers participating in CE must affirmatively market their housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to apply in the absence of special outreach, and to maintain records of those marketing activities. Housing assisted with CoC funds must also be made available to individuals and families without regard to actual or perceived sexual orientation, gender identity, or marital status in accordance with 24 CFR 5.105 (a)(2).

Use of the Santa Cruz Coordinated Entry system may be considered consistent with affirmative marketing as the CE system affirmatively markets to all eligible persons as specified above. Housing providers may advertise that they participate in CE and should at a minimum ensure that this information is made available to any potentially eligible person who contacts them directly or who seeks information in publicly available ways such as a housing provider's website.

3. ACCESS

3.1 Full Coverage

Housing for Health Partnership's Coordinated Entry approach seeks to provide full coverage of the entire geography of Santa Cruz County, which is the same as the Continuum of Care boundaries, through a variety of methods which include Connection Points with designated H4HP Connectors, as well as street outreach which covers all regions of the County, and phone line access.

Commented [AG5]: HUD requires that CES cover the entire geography of the CoC, not just "seek " to.

3.2 Connection Points

Commented [AG6]: HUD would like to see an Appendix listing all access points, with details, such as type, subpop designations if any, location, hours, staffing.

Connection Points (formerly referred to as Access Points) are the virtual or physical places or programs where an individual or family experiencing homelessness or at imminent risk of homelessness seeks and receives assistance to connect to resources and services that are available through Coordinated Entry.

3.2.1 H4HP Connectors

The people who work at Connection Points and carry out the participant-directed key activities of Coordinated Entry are called Connectors. H4HP Connectors serve the system by meeting persons experiencing homelessness where they are and initiating strengths-based problem-solving conversations and conducting housing needs assessments. H4HP Connectors may work as part of an outreach team, drop-in center, multi-service center, or other program serving people experiencing or at-risk of homelessness. They work to identify persons experiencing homelessness to build rapport; conduct initial triage and safety screenings; enroll participants in HMIS programs and collect participant data; engage participants in the Housing Needs Assessment and problem-solving; support individuals and families to identify housing outside of the Housing for Health Partnership response system; create a Housing Action Plan; and make referrals that support participant goals identified in the Housing Action Plan.

3.3 Connection Points for Designated Subpopulations

To ensure that access is both convenient, comfortable, and appropriate to the range of potential persons and households needing assistance in Santa Cruz County, certain subpopulations of people experiencing homelessness may access the Coordinated Entry system through designated Connection Point providers or Connectors with specialty services designed for this population. One or more designated Connection Points may be established for:

- Families experiencing homelessness
- Transition Age Youth
- People fleeing domestic or gender-based violence

Members of subpopulations are not required to use a designated Connection Point and may seek and receive services at any Connection Point.

3.3.1 Connection for Veterans

The majority of housing resources for Veterans experiencing homelessness are managed through a parallel eligibility process administered by the Veterans Administration and their community partners. These resources are believed to be sufficient to ensure access to a housing program for every qualifying Veterans. Veterans seeking such housing and services will be referred to local Supportive Services for Veteran Families (SSVF) contractors and the

Commented [AG7]: HUD expects that Vets be served by CES, not a parallel system that is "believed to be sufficient." Best to use affirmative language, that Vets are served by CES and Vets are referred for Vet-targeted programs. Also, I would avoid saying that there are enough resources for every qualifying Vet. Not sure we know that.

Santa Cruz County Human Services Department's Veterans Services Office. SSVF will refer participants to HUD VASH services when applicable.

Veterans who do not qualify for VA services may be served through the Coordinated Entry process and may be served at any Connection Point.

3.4 Weekend and Evening Access

To ensure that persons experiencing homelessness or a housing crisis that could lead to literal homelessness can get information about how to access the system during times that Connection Points are not open and/or street outreach teams are not operating, H4H has designated the 2-1-1 line to serve as 24/7 Call Center. Crisis resources are limited. The call center will have information about resources such as any shelter beds that may be open and accepting referrals over a weekend or in the evenings and will inform callers about Connection Points for access to the Housing Needs Assessment and Connection supports, including locations, target populations (if any) and hours.

Commented [AG8]: I think HUD's expectation here is that there is more of a process to connect people to a Connection Point at the earliest time, rather than just informing them about the Connection Points.

3.5 Non-discrimination and accessibility

3.5.1 Non-discrimination

The Coordinated Entry system including all Connection Points and other participating programs may not discriminate against any populations or subpopulations in Santa Cruz County in the Coordinated Entry process. This includes people experiencing chronic homelessness, veterans, adults with children, transitional aged youth, and survivors of domestic violence, regardless of the location or method by which they access the H4HP response system.

3.5.2 Language Access

The Management Entity and Connection Points must take steps to ensure equal access for speakers of other languages. At a minimum this means that telephone interpretation in the County's threshold languages will be available via a County-sponsored language line. The Management Entity will also arrange for translation of public facing documents that are key to the CE process into Spanish. Connection Points are encouraged to hire staff who speak languages other than English, and which are widely spoken within the population and/or geography of the Connection Point.

3.5.3 Physical Accessibility

When selecting agencies to serve as physical Connection Points, the County will contract with agencies proposing locations that are physically accessible or are able to make modifications such as adding ramps or elevators for persons who require them. The County will also consider the availability of public transportation and the proximity of Connection Points to other frequently used resources such as emergency shelters, drop-in centers, free food resources, and other crisis response service locations.

Commented [AG9]: HUD expects visual and audible accessibility also be provided when requested

4. ASSESSMENT AND PRIORITIZATION

4.1 Overview of Assessment and Prioritization

The Coordinated Entry process uses a strengths-based approach to provide support to individuals and families experiencing homelessness to leverage connections to mainstream and community resources while also utilizing a housing problem solving approach. The goal is for all persons experiencing homelessness to be connected to services available such as healthcare, employment, benefits, and other resources that help meet their basic needs.

Through this approach, Connectors will conduct the Housing Needs Assessment (HNA). The HNA serves to provide Connectors and participants with the information needed to create and act together on an individualized Housing Action Plan, and to provide information to H4H to determine which participants are eligible and prioritized for H4H supported housing and services. Most of the HNA questions are self-reported by a participant. The questions are intended to be asked in a conversational way and Connectors are trained to use the HNA to help meet immediate needs as well as identify longer-term strategies to assist participants. A question is included in the HNA that records the Connector's observations based on their interactions with the participant.

4.2 Overview of Assessment and Prioritization Workflow

The workflow for the phased assessment approach is intended to only collect the information that is needed at each step and to avoid misleading expectations of certain types of assistance.

4.2.1 Steps in Workflow

The Assessment and Prioritization workflow has core steps with Housing Problem Solving occurring throughout the entire process. These steps include:

1. Triage, Assessment, and Addressing Immediate Health and Safety Issues
2. Coordinated Entry Project Enrollment
3. Housing Needs Assessment and Housing Problem Solving
4. Housing Action Plan

4.2.2 Timeframes

The steps of the Assessment and Prioritization process are independent, but many may occur simultaneously. The Housing Needs Assessment is the tool that is used to support Housing Problem Solving conversations and feeds information into the Housing Action Plan. Scoring of the Housing Needs Assessment follows its completion and matching and referral occurs as resources are available.

Commented [AG10]: HUD prefers that there be some clear timeframes for assessments, e.g., Triage immediate, Initial Assessment with 3 days, Complete Assessment with 1 week

4.3 Triage

Triage is the first step in the Coordinated Entry process. This step consists of a set of initial questions and steps to determine that the person presenting qualifies for and needs the services of Coordinated Entry. This step also screens for any health and safety needs. It includes three topics areas: urgent needs, safety planning, and eligibility.

4.3.1 Urgent needs

Prior to any other services, a Connection Point will assess whether the participant is expressing or displaying any urgent needs such as a health or behavioral health emergency. In such situations Connection Point staff will call crisis services or 911.

4.3.2 Safety Needs and Safety Planning

Questions are asked to determine if someone may be fleeing or attempting to flee domestic violence or human trafficking or is a survivor of the same. Anyone who at this point is identified as fleeing or potentially fleeing, or is a survivor who desires DV services, should be offered connection to DV resources for immediate safety needs and ongoing supports. If the person who is a survivor declines these resources and continues to the next step in the workflow, safety considerations and safety planning should be addressed in the Housing Action Plan.

Commented [AG11]: Not sure if this quite rises to what HUD expects – a safety risk assessment. Sould use those words

4.3.3 Housing Status Determination

Participants are eligible for the services and potential resources of Coordinated Entry if they are currently experiencing homelessness. Questions to determine whether the participant meets the definition of "literal homelessness" will be asked prior to proceeding with the rest of the workflow. Literal homelessness includes individuals or families living in places not meant for human habitation including on the streets, in tents, make-shift shelters, or in a vehicle. Individuals and families staying in emergency shelters, transitional housing or placed in temporary accommodations paid for by a third-party also meet the definition of literal homelessness.

Commented [AG12]: HUD requires serving people at risk of homelessness

If the above steps result in a participant being eligible for and in need of Coordinated Entry services, the H4HP Connector will start with explaining coordinated entry, review the HMIS Consumer Information Sharing Authorization, and will proceed to create or update a Client Profile in HMIS.

If the household is not eligible for Coordinated Entry services and could benefit from homelessness prevention, the H4HP Connector may provide prevention services if they have them available within their agency or refer to the 2-1-1 line or other prevention services providing agencies to determine where prevention resources are currently available.

4.4 HMIS Enrollment

All Coordinated Entry participants that proceed from triage to a Housing Needs Assessment and Problem-Solving conversation must first be enrolled in in the Coordinated Entry Program. An up-to-date enrollment allows the CoC to report as required on the operations and outcomes of Coordinated Entry.

4.4.1 Current Living Situation

Current Living Situation is a single-question assessment required by HUD that is part of the HMIS system. Upon enrollment in HMIS, regardless of the agency completing the enrollment, this assessment must be conducted.

This assessment should be updated not less frequently than every 90 days and at any time that a staff person becomes aware that a participant's situation has changed.

Commented [AG13]: Are there other required HMIS data elements, or just current living situation?

4.5 Housing Needs Assessment

Commented [AG14]: HUD expects the assessment process be "standardized," meaning all people are assessed in a "consistent manner, using the same process." The process outlined in this section may in fact be "standardized" but it is not perfectly obvious and almost give the sense that the process could be very different for different people. I would clarify this.

4.5.1 Purpose of Housing Needs Assessment

The Housing Needs Assessment (HNA) is the conversational tool used by Santa Cruz County Housing for Health (H4H) Partnership to understand participant needs, resources, and goals and to support participants with accessing housing and other resources. Information collected during this assessment helps identify potential problem-solving resolutions and helps develop a Housing Action Plan (HAP) with action steps for participants and Housing Connectors. Some questions on the HNA help establish priority and matching information for limited housing resources available through the H4HP System. Information collected helps determine the likelihood of a participant getting matched to a specific H4HP resource.

4.5.2 Scope of Housing Needs Assessment

The Housing Needs Assessment covers six domains of participant household experience and needs: Household Composition; Housing History; Income and Benefits; Social Supports; Legal and Documentation Issues; and Health. Each section includes prompts for a Connector and participant to have a wide-ranging conversation on the topic area and some specific questions that are used for either scoring and/or matching information for housing programs. The Housing Needs Assessment is designed to be used in one or multiple meetings and to feed into the Housing Action Plan.

4.5.3 Housing Needs Assessment Prioritization Factors

The Housing Needs Assessment incorporates factors from the participant profile and program enrollment as well as new questions in each of the topic domains. Certain questions are used to establish a score which indicates relative need or vulnerability in each domain. Factors used in scoring include:

- Household size and ages of household members
- Housing history, length of time homeless and housing barriers
- Income, benefits, and financial "well-being"
- Social supports
- Legal issues (e.g., criminal involvement and documentation)
- Disabilities and health related questions

Commented [AG15]: HUD requires statement that the client cannot be required or pressured to disclose disabilities and diagnoses that they don't want to disclose.

In addition, the HNA collects information about housing preferences and provides an opportunity for the Connector to make note of specific observations that may point to additional participant needs.

4.5.4 Conducting the Housing Needs Assessment

Commented [AG16]: HUD requires a written explanation of how the CES assessment will not used to screen people out of CES due to perceived barriers such as no income, substance use history, DV history, service resistance, or type of disability. Not sure this is explained anywhere in the document.

H4HP Connectors will ensure that the time and privacy needed to conduct a Housing Needs Assessment are available and that the participant is comfortable proceeding before beginning a Housing Needs Assessment. When starting the HNA, H4HP Connectors should explain the process, the purpose, and the potential outcomes, including that available housing resources are extremely limited. The HNA is designed with prompts to encourage the coverage of certain topics, but each conversation may be different and Connectors are encouraged to use the prompts as suggestions rather than required questions. The HNA may be completed in one or several settings and in any order that is comfortable for the participant and Connector.

At the bottom of each section are specific response choices that are related to scoring or matching. These need to be completed before the HNA can be considered complete and the Assessment score generated.

4.6 Generating the Housing Action Plan

Information in the Housing Needs Assessment can be used to generate a Housing Action Plan. At the end of each domain is a question about whether anything among the topics just discussed are a priority for the Connector and participant to work on. Checking that box opens a row in the Housing Action Plan and carries over the notes from that section. The Housing Action Plan includes space to identify specific goals, the strengths brought by the participant to achieve the goal, resources needed to achieve the goal, the steps that each of the Connector and participant agreed to take to address the identified need, the time frame for completion, and the status of the goal.

Housing Action Plans should focus on steps that support the participant on a path toward housing. They must be client directed and should be limited in scope to between two and five things that can be worked on at time.

Excerpt from an Example Housing Action Plan

Section 1: Household Goals						
Goal(s)	**Participant Strengths**	**Resources Needed to Achieve Goal**	**Participant Will**	**Connector Will**	**By When**	**Goal Status**
Establish childcare for child (age 3)	*Understands childcare system, has had other children in daycare*	*Financial support*	*Contact childcare referral network (include contact information)*	*Provide information and support making contact. Follow up with participant by (include date)*	*Date* _____	*In progress*

4.6.1 Housing Problem Solving

A primary purpose of the HNA/HAP process and the role of Connectors is to determine with a participant what steps can be taken to resolve their homelessness or help them establish a path to housing, in most cases without a dedicated H4HP housing resource.

Housing Problem Solving is an approach that utilizes strengths-based engagement to identify and explore options for safe housing solutions outside the Housing for Health Partnership response system. The HNA is used to help facilitate a Housing Problem Solving conversation and explore opportunities to help participants become rehoused outside the system while also identifying service needs of the participant.

If an immediate resolution is identified, such as moving in with family or friends, or quickly securing a new place to live, the Connector and participant should focus on immediate steps needed to secure this resolution. Some limited financial assistance may be available to support resolutions of this type. The Housing Problem Solving strategies and steps are reflected in the HAP.

4.6.2 Messaging after Housing Need Assessment

Although Connectors are able to see the score resulting from the completed HNA, they do not add participants to queues. After completing an HNA and associated Housing Action Plan, a Connector should reiterate to the participant that housing resources are very limited, and the participant will be notified by the Connector or someone else with whom they are working if they are added to the queue. Connectors should ensure that they have recorded in HMIS multiple ways to contact participants (phone, mail, email, alternative contacts and should set up a scheduled time to meet with the participant to engage on next steps with the Housing Action Plan. Working together on the Housing Action Plan should allow time for a determination to be made if the participant will be added to the queue. Connectors will work with participants for up to 90 days following completion of a HNA with opportunities for extensions if the participant remains homeless and in need of support.

Connectors should emphasize that they will continue to work with the participant on the Housing Action Plan and Housing Problem Solving to seek a resolution. They should also share information about other resources that may be available to them, such as getting on affordable housing waitlists, funds for move in costs, and potential flexible funding.

4.6.3 Active Time Frame of Housing Needs Assessment

A Housing Needs Assessment is considered valid and active for 90 days as long as nothing has changed. After such time, or if the participant has had a change in circumstances or housing status, the Housing Needs Assessment should be updated. The HNA expires if no updates are made after 90 days, and the participant will not be considered for referral.

4.6.4 Updating the Housing Action Plan

The Housing Action Plan is intended to be a living tool for the participant and Connector. The Housing Action Plan should be updated frequently during the time the Connector and Participant are working together to reflect current status of participant needs and the progress made on specified activities.

4.6.5 Handoff of the Housing Action Plan

While the Housing Action Plan may be generated and begun with a Connector, a participant may have the opportunity to work with another service support staff to carry out the steps. For example, a household that goes into shelter where there is case management available can and should be encouraged to work with the new case management or service support staff on the Housing Action Plan, including new or remaining steps.

5. QUEUES AND QUEUE MANAGEMENT

5.1 Overview of the Housing Queue

The Housing Queue is a list of eligible and prioritized households used to match and refer to a specific set of corresponding resources available through the Coordinated Entry process. The Queue is established and maintained in the HMIS system. A queue will not be established for access to family or adult shelter; Coordinated Entry will designate certain Outreach teams to make direct referrals to emergency shelter programs. Shelter referrals will not use the Housing Needs Assessment score for prioritization but will take into account participant willingness to consider shelter as well as other participant characteristics.

5.2 Housing Queue

Households that complete the entire HNA and score at or above a corresponding threshold will be added to the Housing Queue, which is a list of prioritized households maintained in the HMIS system. The Housing Queue pulls information from the HNA and the head of household's profile and enrollment to be used for matching and referral (see below.)

5.3 Threshold Score

Commented [AG17]: HUD will expect that the the points and criteria we spelled out clearly. The current description is very ambigious and does not make clear what it really takes to be prioritized, what the point threshold is, nor how many points there are per factor.

A Threshold Score refers to the score on the Housing Needs Assessment that qualifies a participant household to be added to the housing queue and to be considered *prioritized* for one or more of the resources available to persons on that queue.

5.3.1 Establishing threshold score

A threshold score is established by the Management Entity by reviewing the current and anticipated inventory over a specified period of time and estimates of how many referrals may be necessary to fill openings in a timely fashion while not adding participants to queues who are extremely unlikely to receive a referral.

5.3.2 Threshold variation by subpopulation

Because resources for certain subpopulations are more plentiful relative to the population group, such as families with children, threshold scores may be different or there may be no threshold score required for certain household types.

5.3.3 Adjusting threshold scores

Because thresholds scores are established based on available and anticipated inventory and on the number of referrals that are typically needed to fill an opening, H4H can and should adjust thresholds when:

1. A significant increase in inventory occurs or is anticipated that could result in resources being unused or underused if more households are not prioritized for those resources.

2. A significant decrease in inventory occurs that could result in many more households being prioritized than can be anticipated to be served.
3. The ratio at which referrals result in enrollments changes such that more or fewer households should be prioritized in order to fill openings in a timely fashion.

5.3.4 Frequency of adjusting threshold scores

The Management Entity will review all threshold scores for confirmation or adjustment not less than annually, and more frequently if warranted by one or more of the three conditions described above. However, very frequent changes in thresholds are not desirable as this may cause confusion and could result in persons with similar needs getting unequal access to resources.

5.3.5 Responsibility for Queue Management

H4H manages the Housing Queue and is the only entity that can add participants to it. H4H will add households to the queue who have expressed interest in the resources associated with the queue, completed any corresponding assessment fully and, if applicable, have received a score which meets or exceeds the threshold required to be placed on the queue.

H4H will notify Connection Point staff or other staff attached to a participant when the participant is added to the Housing Queue. Connectors will have read-only access to viewing the Housing Queue to determine if participants have been added.

5.4 Removal from the Housing Queue

5.4.1 Removal from the Housing Queue

A participant will be removed from the Housing Queue if 6 months have elapsed with no contact, or when they have been referred to a permanent housing resource within the Housing for Health Partnership CES system, or if they are connected to and enrolled in a mainstream housing resource such as a Housing Choice Voucher, even if they are still engaged in housing search.

Once on the housing queue, a participant household remains on the queue until they are removed from the queue for one of the reasons mentioned above***. A household already on the queue does not lose their place on the queue if the threshold score is changed,*** however the HNA still needs to be updated every 90 days regardless of queue placement**.** Changes in threshold score apply only to new or updated HNA's.

A participant will be exited from the Coordinated Entry program in HMIS (if enrolled) and removed from the housing queue, if not already done, when they move into any type of permanent housing including on their own without assistance, if they leave the county without the intention to return within 90 days, are in institutional care for longer than 90 days,

if they are deceased, or are no longer interested in being considered for any resource within Coordinated Entry.

5.4.2 Re-referral to a Queue

If a participant is automatically or manually removed from the queue they may be reinstated through an updating of the assessment if they meet the current threshold score when reassessed. The queue entry, however, will be updated with any new information or any change in score, and will include the date of the re-referral to the queue.

6. MATCHING

6.1 Overview of Matching

Matching and Referral are the steps used by Coordinated Entry to identify open and available resources for participant households on the Housing Queue that fit their eligibility and expressed preferences. Prior to a formal referral being made for any housing resource, one or more matches to an available opening must be identified. A match is based on the information in HMIS.

6.2 Matching for Permanent Housing Resources

Households on the Housing queue are matched to openings based on the following factors, in this order:

1. Household meets eligibility criteria for the program or opening
2. Household meets project preferences, such as geographic targeting, as stated in MOUs and/or contracts with programs
3. Household has all of the documents that are required for enrollment in the housing program (document readiness status)
4. Date of Housing Needs Assessment (oldest first)
5. Housing Assessment score (used as tiebreaker if needed)

Commented [AG18]: This may be OK with HUD, but HUD does assume people are match based on vulnerability and severity of need factors such as those in HUD's prioritization notice (e.g., CH persons with longest histories of homelessness for PSH or Fleeing DV or TAY for RRH)

If a participant is otherwise eligible but not document ready, H4H will contact their Connector or other identified party to make clear that a referral cannot be made until all documentation is complete. Connectors should upload all documents to HMIS and may inform H4H once this is done.

Households with medical necessity for an ADA unit will be prioritized for these units when available. Matching will follow the above prioritization criteria with this filter added.

If there is no participant on the queue that can be connected to the opportunity after all eligible participants have been matched, then households below the threshold score will get screened for matching in order of their score.

6.3 Document Readiness

In order to receive a referral to a housing resource, participants must be "document ready" This means that they have documentation needed to prove their identity, and their eligibility for the unit or resources available. Typically, this includes photo identification, verification of homeless status, proof of disability (if an eligibility requirement) and verification of Social Security number (if an eligibility requirement).[3]

6.3.1 Assistance with Document Readiness

Because document readiness is a factor in the order in which participants are offered access to housing resources, as well as accessing other public and private resources, assistance with getting and storing necessary documents is a critical aspect of Coordinated Entry services. H4HP Connectors should determine whether a participant desires and needs such assistance, and whether they have an existing service relationship (for example with a shelter or case manager) that can assist with this task. High priority participants without such assistance will be prioritized for Navigation services. However, if a participant is not assigned to a Navigator and does not have another source of this assistance the H4HP Connector should provide the service.

7. REFERRAL

7.1 Referral

A referral is the formal connection by Coordinated Entry of a participant who has been matched to a resource such as a shelter or housing program.

Prior to referral, H4H will ensure that participants have the needed documentation including homeless verification and disability verification where needed. Eligibility criteria will be used to pre-screen participants on the Housing Queue for potential project eligibility. H4H will use the HMIS matching feature whenever possible.

Based on the results of the housing match, H4H will make the referral in HMIS to the designated housing project staff.

7.2 Direct Referral to Shelter

Coordinated Entry will designate certain Outreach teams or specific entities to make direct referrals to family and adult emergency shelter programs within the Housing for Health Partnership. Shelter referrals will be made after taking into account a participant's willingness to consider shelter as well as other participant characteristics.

Commented [AG19]: HUD actually requires that CoC and ESG funded programs only accept referrals through CES. Maybe should state this here.

Commented [AG20]: Don't think HUD would like this. Not clear what the characteristics are and "willingness" can be punitive.

[3] H4HP Connector Document Readiness Checklist will be included in appendix when finalized.

7.2.1 Direct Referral to Family Shelter

The Coordinated Entry process refers families for placement in family shelter. Families with children who are unsheltered and who are interested in shelter may be directly referred. Prioritization of family shelter referrals is not dependent on the HNA score. Family characteristics are used to prioritize if there is more than one eligible and interested family for a given vacancy. These characteristics include:

- families with a family member who is pregnant,
- families with children under the age of 5, and
- large families (five or more members)

7.2.2 Direct Referral to Adult Shelter

Most adult shelter is accessed outside of the Coordinated Entry process. For shelters or beds that the County is able to fill, Coordinated Enty will designate certain Outreach teams or other entities to make direct referrals to emergency shelter programs. Shelter referrals are not dependent on the HNA score but use participant characteristics.

7.2.3 Number and Timing of Eligible Referrals

Shelter resources are referred to one at a time, with one eligible participant referred to each opening.

7.2.4 Confirmation of a Referral

Because it is imperative to fill shelter beds quickly and not leave available beds open, a participant or their representative must respond to the offer of a referral as quickly as possible and within 1 business day.

7.2.5 Denial of Shelter Admission

Any household referred to emergency shelter may only be denied admission for reasons including:

- The program does not have a current or upcoming vacancy.
- The participants present with more or fewer people than the shelter opening is designed for.
- The participants are not eligible under funding source or the project's written eligibility requirements for the project.
- The individual or household requires care and supervision to manage their activities of daily living and the agency lacks the resources needed to effectively or safely serve and support the referred party.
- The agency has a restraining order that prohibits admission to the facility.
- The participant presents violent or threatening behavior during an intake interview.
- The participant has a criminal record involving sex offenses, arson or violent crime that poses a current risk to the health and safety of staff and/or other participants. When

considering a participant's criminal record, shelters must include an assessment of the length of time since the crime occurred and efforts made towards rehabilitation in the evaluation of eligibility for entrance.

- The agency provides documentation that the participant has been banned due to conduct from a prior stay that puts the health and safety of staff or guests at risk per written agency policies. H4H will discuss reason for ban with agency before the referral may be declined.
- Significant safety concerns, (i.e. domestic violence history with existing participant in program).
- The referred party has an infectious disease that significantly increases the risk of harm to other participants. The County Health Services Agency should be consulted about a given health condition prior to rejecting a referral.

In addition, if shelter is denied, the shelter operator must inform the referring entity immediately so that the household may remain eligible to be referred to another available resource.

7.3 Referral to Permanent Housing Resources

When a participant is matched to a potential housing resource, H4H notifies the provider associated with their Coordinated Entry Enrollment, and/or any other service provider contact such as a Navigator, identified case manager, or someone else designated by the participant. The service provider has five (5) business days to respond.

7.3.1 Number of eligible referrals

Depending on the program type and the number of openings, H4H may provide more than one eligible referral for any given opening.

When there is a single opening within an operating site, Coordinated Entry will make one to three referrals. For a scattered site program in which the applicant will receive a voucher or rental subsidy, Coordinated Entry will typically send only one referral at a time.

Housing operators are expected to process referrals in the order referred by Coordinated Entry.

7.3.2 Confirmation of a Housing Referral

The housing operator must confirm receipt of a referral to Coordinated Entry. The agency must make an initial attempt to contact the participant(s) within three business days and a total of 3-5 separate attempts within five business days to find the participant(s) using all of the contact information provided in HMIS, contacting other service agencies that the participant(s) work with, and visiting locations that the participant(s) are known to frequent. All attempts to find the participant(s) must be documented in HMIS. Contact attempts will typically occur in coordination with the Connector.

7.3.3 Verify Eligibility

In order to confirm project eligibility, agencies will complete the project's regular eligibility and intake process. For HMIS participating agencies, the agency will enter the standard HMIS project entry information into HMIS.

7.3.4 Acceptance of the Referral and Arrangements for Move-In

If it has been determined that the referred participant(s) are eligible to participate in the project, the agency will accept the referral in HMIS. For HMIS participating agencies, the agency will enter the participant into the project in HMIS.

7.3.5 Denial of Referral

If it has been determined that the referred participant(s) are not eligible to participate in the project, the agency will decline the referral in HMIS following the guidelines below. If the agency met with the participant(s) to determine eligibility, they must be notified of a decision.

Additional reasons an agency may decline a referral:

Participating projects are expected to accept all referrals received from H4H, unless any of the following exceptions are demonstrated:

- There is no vacancy available.
- The participants present with more or fewer people than the unit or project is designed for.
- The participants are not eligible under funding source or the project's written eligibility requirements.
- Participants miss two or more mutually agreed upon intake appointments after the housing agency has provided all reasonable supports, such as transportation, reminders, and flexible scheduling to overcome barriers to attending the intake appointment. H4H Case Conferencing should occur before the housing provider may decline the referral.

Agencies may not decline referrals for reasons not included here without consulting with H4H. In particular, agencies may not decline referrals for the following reasons:

- Participants with psychiatric disabilities who refuse to participate in mental health services.
- Participants with substance use disorders who refuse to participate in treatment services.

Additional reasons a referred participant may not be placed into the project:

- Participants cannot be located: If the participant(s) ultimately cannot be located after the agency's 3-5 separate attempts within five business days, their information will be added back to the Housing Queue and a new match will be initiated for the housing agency.
- Participants are deemed ineligible for project assistance: If the participant(s) are ineligible for the project, the agency will decline the referral in HMIS and the participant(s) information will be added back to the Housing Queue according to their HNA Score. The agency must indicate the reason the referred participant(s) were not eligible for assistance. Depending on the reason for ineligibility, an appeal may be requested by the participant(s).

7.3.6 Refusal by Participant

Participants may decline a referral for any reason, including because of project requirements that are inconsistent with their needs or preferences. If the participant(s) are determined eligible but decline assistance, their information will be added back to the Housing Queue. A new referral will be initiated to the housing agency.

The following guidelines apply for participant(s) who decline offers of project assistance:

- If the participant(s) have expressed a preference not to receive services through a particular agency or project, the H4HP Connector or service provider will double check with participant(s) before referring to those projects.
- There is no limit to the number of resources participants can refuse. Participants may continue to be contacted when a resource they are likely eligible for is available; if they refuse the resource, the H4HP Connector or case manager will seek to understand why they are refusing the resource and ensure participant(s) are eligible for other resources they may be more interested in. If participants are not interested in resources available through H4H they may ask to be inactive and they will be exited from the housing queue and CES project.

Commented [AG21]: But only if they ask to be removed from the queue and CES, right. HUD would view unilateral removal as punitive.

8.TRAINING AND LEARNING COLLABORATIVE[4]

8.1 Connector Trainings

All Connectors that conduct Housing Needs Assessments, carry out Housing Problem Solving and develop and work on Housing Action Plans must be trained in the Coordinated Entry Workflow and the use of HMIS. This includes having Privacy and Security training, a valid license for use of HMIS, and participating in all introductory level trainings before performing

[4] H4HP Connector expectations and agency connector participation agreements will be added to this document's appendix when finalized.

Coordinated Entry work. As feasible, H4H will make all required training available through recordings and self-guided modules so as not to delay the start of work for new hires.

8.2 Annual Trainings and Refreshers

All Connectors are expected to participate in at least one training annually which will be made available by the Management Entity. Connection Point staff and supervisors are also expected to use the recorded trainings and accompanying materials to refresh their knowledge as needed and may be directed by H4H to review an existing training prior to proceeding with work.

8.3 Learning Collaborative

H4H will convene one or more a Learning Collaborative of Connectors and other providers engaged with Coordinated Entry. The Learning Collaborative will include:

- Training and reinforcement of training
- Resource presentations and sharing
- Housing problem solving consultations
- Networking opportunities

Connection Points must participate in the Learning Collaborative, and representatives should communicate to their staff information that is provided in the Collaborative meetings related to the appropriate delivery and recording of Coordinated Entry services.

9. DATA AND EVALUATION

9.1 Data Collection and Management Reports

The Management Entity uses information collected in the HMIS system to prepare periodic and regular CE Management reports that reflect the operations and outcomes of the CE system and its components. Reports also provide information about the process and results for participants based on race and ethnicity in order to investigate racial and ethnic disparities and therefore promote racial equity.

9.2 Evaluation

9.2.1 Annual Evaluation

HUD requires that CoCs solicit feedback at least annually from participating projects and from households that participated in Coordinated Entry during that time period. Solicitations must address the quality and effectiveness of the entire Coordinated Entry experience for both participating projects and households. This activity may be undertaken by the CoC Board, the Policy Oversight Entity or another entity designated by the CoC Board but may not be undertaken by the designated Management Entity.

The Management Entity will participate in the annual evaluation by providing information to the CoC, which may include data such as in the reports mentioned above, a self-evaluation using a tool such as the HUD Self-Evaluation format or such form as the CoC may prescribe, and other information as requested and feasible depending on time.

9.2.2 Third Party Evaluator

The CoC does not have to but may choose to engage a third-party evaluator. If such a determination is made, the CoC and the Management Entity will work together to develop a scope for outside evaluation work. The Management Entity will not have a vote in the selection process for an Evaluation Entity if one is to be selected through a competitive process but is able to participate in review and discussion. The Management Entity must provide access to a selected Third-Party Evaluation Entity as needed to conduct its work, including to Management Entity staff and materials.

10. GRIEVANCES AND COMPLAINT TRACKING[5]

10.1 Right to File a Grievance

Participants and potential participants in Coordinated Entry have the right to file a grievance, receive a response and, if they desire, appeal the determination regarding any aspect of their experience or treatment regardless of where or from what Connection Point they receive services.

Commented [AG22]: HUD requires the right to file a complaint for violation of HUD's nondiscrimination requirements. Not sure you have say "complaint" but you should refer to "nondiscrimination" violations.

The Coordinated Entry Grievance Policy includes a requirement that all Connection Points have a program or agency Grievance Policy that meets the requirements of the Policy and that they make a copy of the grievance policy and their procedure available to all participants.

10.2 Tracking and Reporting

The Management Entity requires all Connection Points track and log complaints and grievances and share the log no less than annually with the Management Entity. The Management Entity shall review the logs and the dispositions of all grievances and present a summary of the findings to the CoC as part of any annual evaluation process.

[5] Additional detail will be included when the H4HP Grievance Policy is finalized

APPENDIX A: GLOSSARY

Access: The method by which people experiencing a housing crisis learn that Coordinated Entry exists, access crisis response services, and are connected to the process to determine through *assessment* which intervention might be most appropriate to rapidly connect those people to housing.

Assessment: The use of one or more standardized assessment tool(s) to determine a household's current housing situation, housing and service needs, risk of harm, risk of future or continued homelessness, and other adverse outcomes.

Access Point: See Connection Point

Connection Point: Connection Points are the virtual or physical places or programs where an individual or family experiencing homelessness or at imminent risk of homelessness accesses the H4HP response system and may receive assistance to connect to resources that are available through Coordinated Entry.

Client: Client is a term used within the HMIS system for a participant or potential participant in Coordinated Entry that has a record in HMIS. This term may be used when specifically referring to HMIS but for Coordinated Entry the terms potential participant, participant and participant household are preferred.

Comparable Database: A comparable database is a relational database that meets all HMIS Data Standards and does so in a method that protects the safety and privacy of a survivor.

Connector: Individuals trained to conduct a Housing Needs Assessment and that assist participants in accessing resources and achieving self-identified goals that will support them in accessing housing. Connectors may work as part of an outreach team, drop-in center, or multi-service program. Connectors must participate in regular connector meetings and meet expectations of Connectors as established in the Connector Role description document.

Continuum of Care (CoC): A geographically based group of representatives that carries out the planning responsibilities of the Continuum of Care program pursuant to HUD regulations. These representatives come from organizations that provide services to the homeless or represent the interests of the homeless or formerly homeless.

Family: a family household is a household with at least one adult and one minor child.

Homeless Management Information System (HMIS): A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care (CoC) is responsible

for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

Housing Action Plan (HAP): The Housing Action Plan (HAP) is a living document that includes space to identify specific goals, the strengths brought by the participant to achieve the goal, resources needed to achieve the goal, the steps that each of the Connector and participant agreed to take to address the identified need, the time frame for completion, and the status of the goal. The HAP focuses on steps that support the participant on a path toward housing. Goals must be client directed and should be limited in scope to between two and five things that can be worked on at time

Housing Needs Assessment (HNA): The Housing Needs Assessment (HNA) is the conversational tool used by Santa Cruz County Housing for Health (H4H) Partnership to understand participant needs, resources, and goals and to support participants with accessing housing and other resources. Information collected during this assessment helps identify problem solving resolutions and/or develop a Housing Action Plan (HAP) with action steps for participants and Housing Connectors. Some questions on the HNA also help establish priority and matching information for limited housing resources available through the H4H System. The HNA is recorded in the HMIS System.

Housing for Health Partnership Response System: The set of programs, funding, activities, and coordination that is specifically intended to address the needs of people experiencing homelessness.

Housing Problem Solving: Housing Problem Solving is an engagement approach that is versatile and utilizes empowering engagement to identify and explore options through creative, strengths and resources-focused interaction. The goal is to determine options and participant action toward safe housing solutions outside of the formal H4HP response system as soon as possible and without need for ongoing support.

Housing Queue: The Housing Queue is a list of households maintained in the HMIS system that have indicated an interest in one or more types of housing resources and been assessed and prioritized for such resources. The Housing Queue contains key information about the household that is used to match clients to available and anticipated housing resources.

Housing Resources: Housing resources that clients are matched to though Coordinated Entry including Permanent Supportive Housing, Dedicated Affordable Housing, and Rapid Re-Housing (RRH) resources.

Match: Matching is the process of identifying one or more participants who are eligible for an available or anticipated resource and making a connection between them which begins the process which may lead to a referral.

Participant: A person who for themselves, or on behalf of a household experiencing homelessness, receives services from the Coordinated Entry system.

Potential Participant: A person who for themselves, or on behalf of a household experiencing homelessness, seeks services from the Coordinated Entry system.

Prioritization: The Coordinated Entry-specific process by which all persons in need of assistance who use Coordinated Entry are assessed using standard and consistent information and given a priority rank, score or status relative to other eligible persons.

Queue: A list of clients maintained in the HMIS system that have been assessed and prioritized for a resource.

Referral: The process by which persons who are prioritized for available resources within the Coordinated Entry process are connected to the resource(s) for which they are prioritized and eligible. Referral process includes eligibility screening, monitoring project availability, enrollment coordination, managing referral rejections, and tracking the status of the referral throughout the referral process.

Resource: Refers to any program opening that is filled used the Coordinated Entry process. A Housing resource is an opening in a housing-related program. A shelter resource is an opening in emergency shelter.

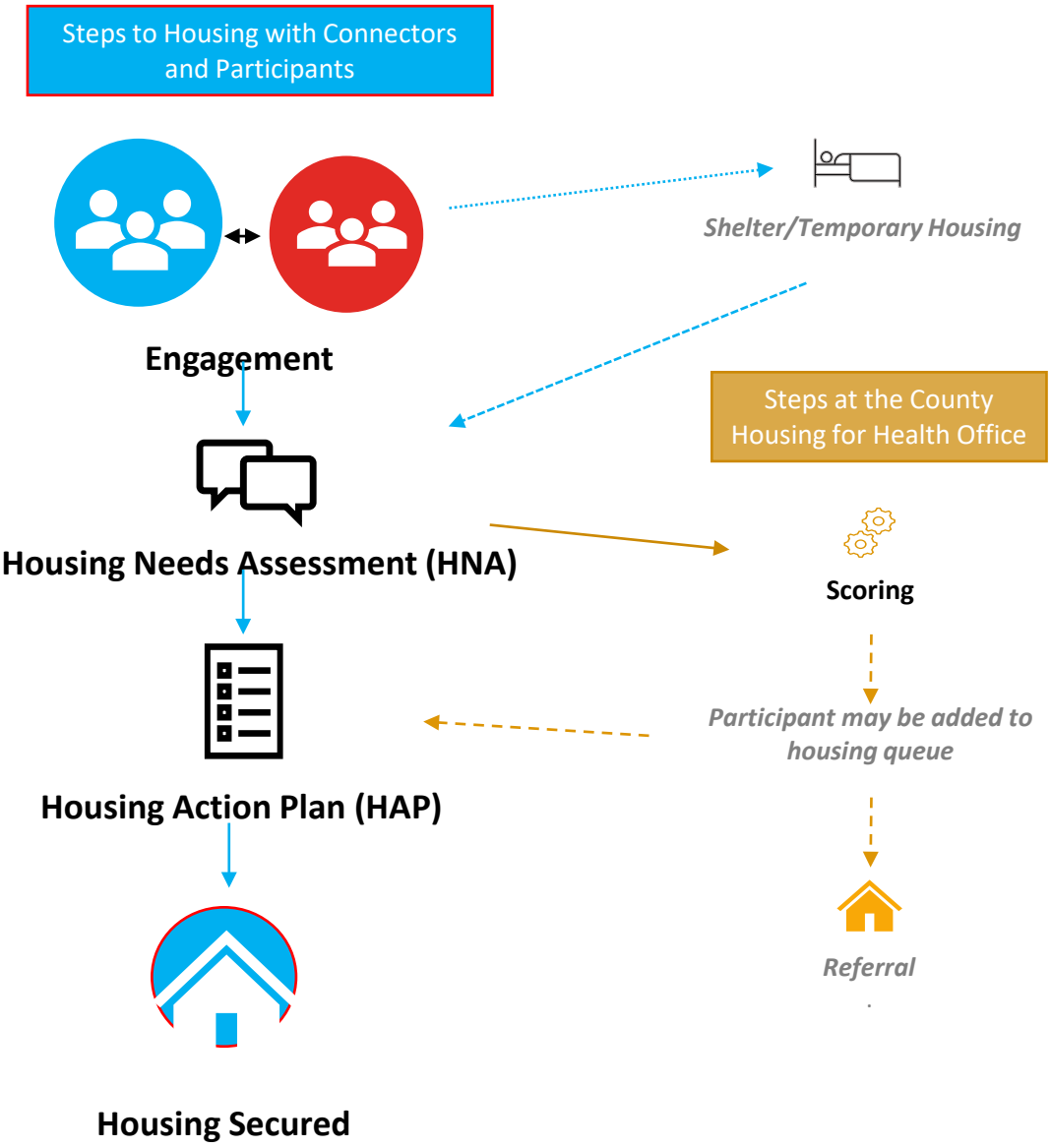
Subpopulation: A subset of people experiencing homelessness or at risk of homelessness who share certain characteristics of household type, age or status and may be served based on their membership in the subpopulation. Subpopulation categories in Coordinated Entry include Adult Only households, Family Households with Minor Children, Transition Age Youth (TAY) ages 18-24, Veterans of the U.S. Military, and Survivors of Domestic Violence.

Threshold Score: The score on an assessment needed to qualify the participant to be placed on the corresponding queue.

Victim Service Provider (VSP): A Victim Service Provider is a private nonprofit organization whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking. Providers include rape crisis centers, domestic violence shelter and transitional housing programs, and other programs.

SANTA CRUZ COUNTY
Housing for Health
PARTNERSHIP

Santa Cruz Connection:
Steps to Housing



SANTA CRUZ COUNTY
Housing for Health
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Housing Needs Assessment

The Housing Needs Assessment (HNA) is a set of questions used by the Santa Cruz County Housing for Health Partnership to help us understand your housing needs.

You and a Connector will have at least one conversation where the Connector will learn more about your housing needs. The information you share will be used to create a Housing Action Plan. Because there are not many housing resources available through our system, most of the things the Housing Action Plan will be used for is to find housing and resources outside our limited pool.

Domain	NOTES: Strengths; Desires/Aspirations, Past Resources	Key Questions
Household Composition		• Total # in household currently and desired • Ages of household members • Pregnancy among any members of household? • Household relationship safety issues? • Child welfare involvement?
Housing History		• Last permanent housing address • Last time had housing with your name on rental/ownership paperwork • # of formal evictions in last five years • Any positive housing references? • Amount of continuous time without shelter?
Financial Resources		• Current income amount and sources • Any debt or credit issues • Public benefits/insurance you have?
Social/Community Support		• Current supportive relationships
Legal Issues		• Any arrests in past five years? • Availability of driver's license, social security card, birth certificate, and paperwork • Any ongoing legal registration/reporting required?
Health Issues		• # and type of current health issues? • Health issues impacting daily living – getting up, changing clothes, etc.? • Mobility, hearing, or visual impairment?
Housing Preferences		• Type of living situation open to finding • Need place that accepts pets?

SANTA CRUZ COUNTY
Housing for Health
PARTNERSHIP

Housing Action Plan

After you complete the Housing Needs Assessment with the Connector, you and the Connector will create a Housing Action Plan. This plan will focus on your strengths and include activities for you and your connector to complete separately or together to help you find housing. You will follow up with your connector to check progress and update the Housing Action Plan regularly.

Goals will be created together with your connector and can be in one or more of the following categories:
Household Goals
Housing Goals
Income, Employment, Benefits, Health Insurance and Credit Goals
Social Support and Problem-Solving Goals
Legal Issues
Health Goals

Example Goal:

Section 1: Household Goals						
Goal(s)	**Participant Strengths**	**Resources Needed to Achieve Goal**	**Participant Will**	**Connector Will**	**By When**	**Goal Status**
Establish childcare for child (age 3)	*Understands childcare system, has had other children in daycare*	*Financial support*	*Contact childcare referral network (include contact information)*	*Provide information and support making contact. Follow up with participant by (include date)*	*Date _____*	*In progress*

SANTA CRUZ COUNTY Housing for Health PARTNERSHIP

Proposed Housing Needs Assessment Items and Domains

Domain	Scored	Item
Household Composition	X	Total # of members in the household currently (including the participant)
	X	Total # of Children in the household currently
		Total # of members in household desired (including the participant)
		If current household is different from desired household
	X	Do you have any children under 5 years old?
	X	Age of participant
		Are other adult members of your household 65 or older?
	X	Are you or any other members of your household currently pregnant?
		Due date of pregnancy
	X	Fleeing a partner violence or other unsafe or violent situation?
Housing History	X	Participant's most recent housing was in Santa Cruz County:
	X	Last time participant had a lease or owned a home in their name
	X	Number of formal evictions in the last five years
	X	The participant has a former property agent or other person that can provide a positive housing reference
	X	Total number of months homeless on the streets, in ES, or Safe Haven in the past three years
Income, Employment, Benefits, Health Insurance and Credit	X	Income status of participant
	X	Participant has problematic outstanding debt, financial, or credit issues that might show up on credit report
Social Support	X	Has relationships with others that support the participant and that they feel connected to
Legal Issues	X	Number of times in the past five years the participant has been arrested or picked up by police
	X	Participant needs help to get copies of critical documents
Health	X	Number of health conditions the participant has that they believe impact their ability to secure housing
	X	The participant needs help with activities of daily living
	X	The participant has a condition that requires housing for those with mobility, hearing, or visual impairment
	X	Administrative Data Health and Safety Risk Level **(future item)**
Housing Preferences		Types of housing participant would be willing to accept
		Places the participant would be willing to live
		Participant will only accept housing/shelter where pets are accepted
Additional Eligibility		CalWorks eligible and willing to enroll or already enrolled
		Disabled with no disability insurance (SSI, SSDI, or VA disability)
		TAY (aged 18-24) who are current or former foster youth
		Families that are child-welfare involved
		290 (sex offender) registrants
Connector Observations	X	Participant may have other health conditions (mental health, physical health, substance use issue, etc.) that could impact their ability to find or maintain housing and employment but were not discussed
		Participant may be particularly vulnerable or at high risk of suffering severe consequences from an illness or other health issue if they remain unsheltered
		Participant may be particularly vulnerable to or at high risk of violence or being taking advantage of if they remain unsheltered

SANTA CRUZ COUNTY Housing for Health PARTNERSHIP

Proposed Housing Needs Assessment Score Rubric

Domain	Maximum Domain Points	Item	Possible Points	Scoring Critera
Household Composition	8	Total # of members in the household currently (including the participant)	1	1 point if 3 or more
		Total # of Children in the household currently	1	1 point if children present
		Do you have any children under 5 years old?	1	1 point if yes
		Age of participant	2	2 points if 65+ or 18-24
		Are you or any other members of your household currently pregnant?	1	1 if yes
		Fleeing a partner violence or other unsafe or violent situation?	2	2 if yes
Housing History	8	Participant's most recent housing was in Santa Cruz County:	1	1 if yes
		Last time participant had a lease or owned a home in their name	1	included if "Never or more than 5 years ago"
		Number of formal evictions in the last five years	1	included if "Two or more rental evictions" OR "One rental eviction"
		The participant has a former property agent or other person that can provide a positive housing reference	1	included if "No"
		Total number of months homeless on the streets, in ES, or Safe Haven in the past three years	4	0 if "1 month (this is the first month)"; 1 if 2 - 5 months; 2 if 6 - 8 months; 3 if 9 - 11 months; 4 if 12 or more months
Income, Employment, Benefits, Health Insurance and Credit	3	Income status of participant	2	0 if "Some or all earned/variable income and not able to/interested in increasing" OR "Some or all earned/variable income and interested in increasing", 1 if "Fixed income and interested in increasing" OR "Fixed income and not able to/interested in increasing"; 2 if "Zero Income"
		Participant has problematic outstanding debt, financial, or credit issues that might show up on credit report	1	included if "Yes"
Social Support	1	Has relationships with others that support the participant and that they feel connected to	1	included if "No"
Legal Issues	2	Number of times in the past five years the participant has been arrested or picked up by police	1	included if "5 or more" OR "1 - 4"
		Participant needs help to get copies of critical documents	1	included if " Yes, needs help with all documents (has no documents)" OR "Yes, needs one or two key documents"
Health	5	Number of health conditions the participant has that they believe impact their ability to secure housing	3	0 if "None"; 1 if "One"; 2 if "Two"; 3 if "Three or more"
		The participant needs help with activities of daily living	1	included if "Yes"
		The participant has a condition that requires housing for those with mobility, hearing, or visual impairment	1	included if "Yes"
Connector Observations	2	Participant may have other health conditions (mental health, physical health, substance use issue, etc.) that could impact their ability to find or maintain housing and employment but were not discussed	2	0 if None, 1 if 1 checked, 2 if > 1 checked
		Participant may be particularly vulnerable or at high risk of suffering severe consequences from an illness or other health issue if they remain unsheltered		
		Participant may be particularly vulnerable to or at high risk of violence or being taking advantage of if they remain unsheltered		
		Maximum Total Score Points Single Adults	**23**	
		Maximum Total Score Points Families	**25**	

Inidicates points available only to families.

Indicates "Challenges": Items are summed to provide a single score with a maximum of five points. Each question adds one point to the score and may not exceed five points.

Information Item 5: 2023 Point in Time (PIT) Count Community Planning and Volunteer Recruitment

Housing for Health Division staff in partnership with Applied Survey Research (ASR) delayed the implementation of the 2023 PIT count from January to February 23, 2023, due to the impact of the atmospheric rainstorms on the County. HUD approved of the request to delay the Count.

A press release was issued to help with volunteer recruitment for the Count. A copy of the press release is included with this information item.

HUD requires that a comprehensive PIT count occur at least every two years and encourages local CoC's to conduct a count every year. Preliminary, high-level, PIT count data is scheduled to be shared with HUD before the end of April 2023 along with an updated Housing Inventory Chart (HIC) that captures existing housing programs in the CoC's jurisdiction, their current capacity, and the number of active participants at the time of the PIT count.

Volunteer recruitment for the count is going well. Individuals interested in volunteering can register to become a volunteer at this website link or by emailing alex@appliedsurveyresearch.org or call (877) 728-4545.

FOR IMMEDIATE RELEASE
MEDIA CONTACT
Jason Hoppin, 831-454-3401
Jason.Hoppin@santacruzcounty.us

POINT-IN-TIME COUNT SET FOR FEBRUARY 23

County conducts its annual snapshot of homeless population

The County of Santa Cruz today announced the Point-in-Time (PIT) Count will take place Thursday, February 23, 2023. The annual PIT Count is vital for funding and the development of policies that will help resolve homelessness in Santa Cruz County.

The Count will take place county-wide with the help of volunteers, including those experiencing homelessness, community members, staff from multiple city and county departments and law enforcement. Using an app-based data collection tool, volunteers will cover the entire county in one morning from 5:00 a.m. to 10:00 a.m.

Volunteers are needed for the Count. Volunteers will work in teams and are asked to lead a visual count of people who are experiencing homelessness in the County. All teams are led by a trained guide. To sign up as a volunteer, email alex@appliedsurveyresearch.org or call (877) 728-4545.

Annually, communities across the country conduct comprehensive counts of the local homeless population to measure the prevalence of homelessness in each local Continuum of Care. The data collected provides a "snapshot" of the homeless population and demographics. The Count approximates the number of people experiencing homelessness in each community and collects information on individuals and families residing in emergency shelters and transitional housing.

"The PIT Count is an important resource for our community," said Robert Ratner, Director of Housing for Health Division, Human Services Department. "The data collected influences and informs our efforts to resolve homelessness in Santa Cruz County. We look forward to conducting the Count in late February with our passionate and dedicated group of volunteers."

The Housing for Health Partnership is a collaboration of the County and each city within Santa Cruz County, along with local homelessness service providers. It acts as the federally-designated continuum of care for Santa Cruz County and helps allocate State and federal funding to address homelessness. The County of wSanta Cruz serves as lead agency for the H4H Partnership.

Attachment D:
Temporary Housing Capacity and Funding

The Housing for a Healthy Santa Cruz strategic framework established a target of 600 high-performing and low-barrier shelter and transitional housing beds countywide. The framework establishes goals for temporary housing programs to focus on assisting households to exit from homelessness to permanent homes as quickly as possible. The Framework calls for shelters to exit over 40% of participants to permanent housing within an average of 60 days and for transitional housing programs to exit 80% of participants to permanent housing within an average of 250 days.

Temporary housing or residential programs can serve purposes beyond helping with exits to permanent housing, including, but not limited to, supporting positive transitions from foster care, residential substance use treatment and recovery, supporting households impacted by natural disasters, creating alternatives to encampments, helping with recovery from illness after a hospitalization, providing warm and safe places during inclement weather. Some non-housing programs do not provide shelter but offer sanctioned safe sleeping or parking locations as alternatives to sleeping in other public places not meant for habitation.

With limited financial resources, available locations, and program operators, policy makers must make choices about the types and purposes of temporary housing or residential programs. This includes determining when investments in safe sleeping or parking are preferred to investments in programs that offer shelter. The adopted Housing for Health Framework seeks to evaluate investments based on how well they help people return to and remain in stable homes as quickly as possible.

At the time of the writing of the Framework, the County had 440 temporary housing beds, but not all the beds had exits to permanent housing as their primary focus. At the onset of the COVID-19 pandemic in early 2020, overall bed capacity was reduced to create safer temporary housing capacity. County staff members and community partners worked tirelessly to stand up additional semi-congregate and non-congregate shelters to help protect unsheltered households during the pandemic as a public health rather than a housing intervention. A Federal Emergency Management Agency (FEMA) public health emergency declaration coupled with one-time state and federal funds made it possible for the County to support the longest and largest sheltering operation in County history. In late 2021, additional state and federal resources were deployed in Santa Cruz County to convert public health shelters into housing focused shelters.

At peak capacity, the County more than doubled pre-COVID-19 community temporary housing capacity to over 1000 beds. The additional COVID shelter capacity served 1,441 people, primarily people experiencing homelessness, but also people living in overcrowded living situations with COVID exposures. The last county operated COVID sheltering site closed in June 2022. One remaining COVID shelter site, operated by contracted nonprofit partners, will close at the end of February 2023. Table 1 shows current temporary housing capacity in the County as of February 2023. The table

identifies programs that receive funding through the County Housing for Health (H4H) Division or directly from the City of Santa Cruz. The City of Santa Cruz support was made possible by a one-time $14M state grant provided directly to the City. Nearly 40% of the bed capacity in the County does not receive funding from H4H or the City of Santa Cruz. Among programs receiving public funding, the public funding generally does not cover the full cost of their program operations. The chart shows current countywide capacity falls 139 beds short of the Framework's stated 600 bed goal.

Table 1. February 2023 Temporary Housing Capacity – Santa Cruz County

	Temporary Housing Capacity		
	Family Beds	**Adult Beds**	**Total**
Currently funded at least partially through H4H or through a direct City of Santa Cruz contract	90	187	277
Does not receive H4H or City of Santa Cruz funding	150	34	184
Current Totals	**240**	**221**	**461**
Housing for Health - Goal	240	360	600
Gap	0	-139	-139

Table 2 provides an inventory of safe sleeping and parking programs in the County. These programs are not considered temporary housing, but they do provide safe places for people to sleep with access to some supportive services.

Table 2. February 2023 Safe Sleeping and Parking Capacity – Santa Cruz County

	Safe Sleeping and Parking Capacity	
	Safe Sleeping Slots	**Safe Parking Slots**
Currently funded at least partially through H4H or through a direct City of Santa Cruz contract	102	50

Table 3 outlines the geographic distribution of temporary housing, safe sleeping, and safe parking programs in the County. The table shows the percentage of the unsheltered population living in a particular jurisdiction according to the 2022 Point in Time (PIT) Count of persons experiencing homelessness within the County. A few programs rotate operational sites, so they are listed as multi-jurisdictional.

Table 3. February 2023 Geographic Distribution of Temporary Housing, Safe Sleeping, and Safe Parking Programs – Santa Cruz County

Jurisdiction	*Program Beds/Slots (% of total)*	*% Unsheltered Population in County from 2022 PIT Count Data*
City of Santa Cruz	412 (67%)	59%
City of Watsonville	132 (22%)	12%
Unincorporated Santa Cruz County	25 (4%)	22%
Multi-jurisdictional (programs rotate among multiple sites)	44 (7%)	Capitola (2%); Scotts Valley (3%)

Fluctuating levels of temporary housing capacity and program performance within the County reflect significant funding instability coupled with a lack of a sustained, collectively supported, strategic vision for establishing targeted, high-performing capacity over time. The financial resources available to support temporary housing programs within the County peaked in 2021 and has returned to winter 2019 levels in 2023. The second highest documented peak in temporary housing bed capacity in Santa Cruz County occurred in 2009 when the Point in Time (PIT) count of persons experiencing homelessness identified 729 individuals as sheltered.

The federal government has steadily reduced the resources available to support temporary housing programs since the passage of the Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH) in 2009. The HEARTH Act regulations and priorities resulted in a gradual shift of federal Housing and Urban Development (HUD) resources away from temporary housing to permanent housing interventions. These funding priority changes reflected a services and support paradigm shift away from a sequential, step-based, housing and services model to a housing first model that demonstrated significantly better outcomes in several research studies. The resources required to fully implement the researched housing first approach have not been brought to the scale necessary to implement the practice to meet national needs.

The California Homeless Emergency Aid Program (HEAP) created in 2018 represented the first statewide flexible funding source dedicated to providing resources specifically to address homelessness. HEAP funding was discontinued and replaced by the Homeless Housing, Assistance and Prevention (HHAP) program with four rounds of funding made available to date. HHAP remains a discretionary program with unpredictable funding allocations for local governments. Given the current federal and state funding landscape for temporary housing programs, local government and private sector contributions are critical for sustaining such programs.

Housing for Health Division staff estimate that higher quality temporary housing programs in Santa Cruz County currently have average operational costs of $100/bed/night. Achieving the Framework goal of 600 high-quality beds, would require an estimated $21.9M per year. Table 4 shows current known public funding sources and dollar amounts being utilized to support 277 of the 461 current shelter bed capacity

in the County. The table also indicates if the listed funding source is expected to be available in the next fiscal year.

Table 4. Current Known Public Funding Sources Supporting Temporary Housing Capacity in the County of Santa Cruz

Public Funding Revenue Sources	**Fiscal Year (FY) 22-23**	**FY23-24 Expected Availability**
City of Santa Cruz	$ 215,687	Yes
Watsonville	$ 81,614	Yes
Scotts Valley	$ 44,170	Yes
Capitola	$ 39,950	Yes
County of Santa Cruz	$ 1,127,021	Yes
Jurisdictional Contributions	*$ 1,508,442*	
HHAP-1 CoC	$ 456,041	No
HHAP-2 CoC	$ 357,170	No
HHAP-3 Combined	$ 253,094	Yes
CESH-2018	$ 237,209	No
CDBG-CV	$ 1,329,727	No
CalWorks Emergency Housing	$ 808,727	Yes
City of Santa Cruz Armory Indoor Funding (prorated estimate) - from $14M one-time state grant	$ 1,964,444	Unknown
TOTALS:	**$ 6,914,854**	

$4.3M of the FY22-23 funding sources listed in Table 4 will likely be fully utilized and unavailable in FY 23-24. Some HHAP Round 3 funding is available to cover this funding loss, but no funding has been identified to replace the City of Santa Cruz funding for the Armory shelter. This analysis does not include an analysis of the other 184 beds in the County largely supported by private funding and direct to grantee public grants. Some of these programs may also be at-risk of funding reductions or loss that may jeopardize their program operations.

Table 5 identifies known public funding sources supporting safe sleeping and safe parking programs in the County and the likelihood of current fiscal year resource availability next fiscal year. Nearly $3.2M of funding for these programs comes from the one-time $14M state grant provided to the City of Santa Cruz. These investments are likely to end in FY23-24 unless additional funding sources can be secured.

Table 5. Current Known Public Funding Sources Supporting Safe Sleeping and Safe Parking Capacity in the County of Santa Cruz

Public Funding Revenue Sources	**Fiscal Year (FY) 22-23**	**FY23-24 Expected Availability**
CORE County funds - Safe Parking	$ 104,544	Yes
CORE City of Santa Cruz funds - Safe Parking	$ 21,569	Yes
Armory City of Santa Cruz Safe Sleeping (estimate) - from $14M one-time state grant	$ 2,455,556	Unknown
Armory City of Santa Cruz Safe Parking (estimate) - from $14M one-time state grant	$ 480,000	Unknown
1220 River St. City of Santa Cruz (estimate)	$ 230,000	Unknown

H4H staff continue pursuing efforts to expand temporary housing capacity in the County through securing grants and leveraging Medi-Cal health care resources. Monterey County, with support from Santa Cruz County, the City of Watsonville, and the Pajaro River Flood Management Agency, are applying for California Encampment Resolution Funding to establish a new low-barrier shelter and rehousing program in Watsonville for individuals living in encampments along the Pajaro River. H4H and the Behavioral Health Department plan are collaborating on an effort to utilize state grants to open a behavioral health bridge housing program for individuals with serious mental health issues experiencing homelessness. The City of Santa Cruz, H4H, and Housing Matters are collaborating on efforts to strategically expand low-barrier shelter capacity on Housing Matters' current Coral St. campus. H4H and the County's Community Development and Infrastructure (CDI) Department are collaborating on an effort to secure Project Homekey Round 3 funding to establish a new transitional housing program for transition age youth in an unincorporated area of Watsonville. All four projects require securing one-time funding for capital needs and start-up costs. Sustaining the programs requires the development of the infrastructure necessary to generate Medi-Cal revenue for services provided to participants and securing a stable baseline level of funding from other local, state, and federal resources.

Without additional, ongoing, and stable financial resources, the temporary housing, safe sleeping, and safe parking capacity in the County will decline over the next 1-2 years. Ongoing financial contributions toward temporary housing from local jurisdictions in the County have remained fixed at $1.5M/year for several years. Most HUD programs to address homelessness require 25% matching funds to secure federal funding. Funding 25% of the costs of operating 600 high quality temporary housing beds in the County would require just under $5.5M/year. This represents a $4M/year increased investment from current levels. An increased investment of this scale could help leverage additional funding, expand capacity, stabilize existing programs, prevent closures, and improve housing outcomes.