Before Starting the CoC Application

You must submit all three of the following parts in order for us to consider your Consolidated Application complete:

1. the CoC Application,
2. the CoC Priority Listing, and
3. all the CoC's project applications that were either approved and ranked, or rejected.

As the Collaborative Applicant, you are responsible for reviewing the following:

1. The FY 2021 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2021 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

Your CoC Must Approve the Consolidated Application before You Submit It

- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2021 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

Answering Multi-Part Narrative Questions

Many questions require you to address multiple elements in a single text box. Number your responses to correspond with multi-element questions using the same numbers in the question. This will help you organize your responses to ensure they are complete and help us to review and score your responses.

Attachments

Questions requiring attachments to receive points state, "You Must Upload an Attachment to the 4B. Attachments Screen." Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process. Include a cover page with the attachment name.

- Attachments must match the questions they are associated with–if we do not award points for evidence you upload and associate with the wrong question, this is not a valid reason for you to appeal HUD's funding determination.
- We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

1A. Continuum of Care (CoC) Identification

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1A-1. CoC Name and Number: MA-515 - Fall River CoC

1A-2. Collaborative Applicant Name: Fall River CoC (MA-515)

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Fall River CoC (MA-515)

1B. Coordination and Engagement–Inclusive Structure and Participation

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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1B-1.	**Inclusive Structure and Participation–Participation in Coordinated Entry.**	
	NOFO Sections VII.B.1.a.(1), VII.B.1.e., VII.B.1.n., and VII.B.1.p.	

	In the chart below for the period from May 1, 2020 to April 30, 2021:
1.	**select yes or no in the chart below if the entity listed participates in CoC meetings, voted–including selecting CoC Board members, and participated in your CoC's coordinated entry system; or**
2.	**select Nonexistent if the organization does not exist in your CoC's geographic area:**

	Organization/Person	Participated in CoC Meetings	Voted, Including Electing of CoC Board Members	Participated in CoC's Coordinated Entry System
1.	**Affordable Housing Developer(s)**	No	No	No
2.	**Agencies serving survivors of human trafficking**	Yes	Yes	Yes
3.	**CDBG/HOME/ESG Entitlement Jurisdiction**	Yes	Yes	Yes
4.	**CoC-Funded Victim Service Providers**	Yes	Yes	No
5.	**CoC-Funded Youth Homeless Organizations**	Yes	Yes	Yes
6.	**Disability Advocates**	Yes	Yes	Yes
7.	**Disability Service Organizations**	Yes	Yes	Yes
8.	**Domestic Violence Advocates**	Yes	Yes	Yes
9.	**EMS/Crisis Response Team(s)**	Yes	Yes	Yes
10.	**Homeless or Formerly Homeless Persons**	Yes	Yes	Yes
11.	**Hospital(s)**	Yes	Yes	Yes
12.	**Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)**	Nonexistent	No	No
13.	**Law Enforcement**	No	No	Yes
14.	**Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates**	Yes	Yes	Yes
15.	**LGBT Service Organizations**	No	No	No
16.	**Local Government Staff/Officials**	Yes	Yes	Yes
17.	**Local Jail(s)**	No	No	No
18.	**Mental Health Service Organizations**	Yes	Yes	Yes

19.	**Mental Illness Advocates**	Yes	Yes	Yes
20.	**Non-CoC Funded Youth Homeless Organizations**	No	No	No
21.	**Non-CoC-Funded Victim Service Providers**	Yes	Yes	No
22.	**Organizations led by and serving Black, Brown, Indigenous and other People of Color**	Yes	Yes	Yes
23.	**Organizations led by and serving LGBT persons**	Yes	Yes	Yes
24.	**Organizations led by and serving people with disabilities**	Yes	Yes	Yes
25.	**Other homeless subpopulation advocates**	Yes	Yes	Yes
26.	**Public Housing Authorities**	Yes	Yes	Yes
27.	**School Administrators/Homeless Liaisons**	No	No	No
28.	**Street Outreach Team(s)**	Yes	Yes	Yes
29.	**Substance Abuse Advocates**	Yes	Yes	Yes
30.	**Substance Abuse Service Organizations**	Yes	Yes	Yes
31.	**Youth Advocates**	Yes	Yes	Yes
32.	**Youth Service Providers**	Yes	Yes	Yes
	Other:(limit 50 characters)			
33.	Peer Outreach	Yes	Yes	Yes
34.	Veterans Housing & Services	Yes	Yes	Yes

1B-2.	**Open Invitation for New Members.**	
	NOFO Section VII.B.1.a.(2)	

	Describe in the field below how your CoC:
1.	**communicated the invitation process annually to solicit new members to join the CoC;**
2.	**ensured effective communication with individuals with disabilities, including the availability of accessible electronic formats;**
3.	**conducted outreach to ensure persons experiencing homelessness or formerly homeless persons are encouraged to join your CoC; and**
4.	**invited organizations serving culturally specific communities experiencing homelessness in the geographic area to address equity (e.g., Black, Latino, Indigenous, persons with disabilities).**

(limit 2,000 characters)

1. Membership on the Fall River CoC, through the Homeless Service Providers Coalition and Mayor's Task Force to End Homelessness, is open to any organization or person residing or doing business in Fall River with an interest in preventing and ending homelessness. Invitees are solicited annually by e-mail, phone call or in-person, particularly underrepresented populations, by subpopulations (race, disability, homelessness status) and gaps in membership/services (LGBTQ+, education, law enforcement). The invite includes an explanation HSPC's mission and goals as well as the advantages of being a part of the solution to end homelessness.
2. www.FallRiverHomeless.com provides two-way communication with providers and the public-at-large. FRCDA (CoC Lead) has TTY. Mass211 is a hotline to reach essential community services. CE can be reached by phone or walk-in and provides resources and referrals to the homeless or at risk. Information is available to be e-mailed in PDF format. Remote meetings are available.
3. The committee conducts specific outreach to ensure that certain subpopulations including homeless/formerly homeless persons are represented,

as well as sufficient representation from public and private sectors. CoC members connect with organizations that serve subpopulations that are un/under-represented to request their participation at meetings.
4. Membership on the Fall River CoC, through the Homeless Service Providers Coalition and Mayor's Task Force to End Homelessness, is open to any organization or person residing or doing business in Fall River with an interest in preventing and ending homelessness. Invitees are solicited annually by e-mail, phone call or in-person, particularly underrepresented populations, by subpopulations (race, disability, homelessness status). Family shelter programs especially work with larger populations of Black and Latino persons, and Individual shelter programs tend to serve those with disabilities. All shelter programs are represented on the CoC.

1B-3.	**CoC's Strategy to Solicit/Consider Opinions on Preventing and Ending Homelessness.**	
	NOFO Section VII.B.1.a.(3)	

	Describe in the field below how your CoC:
1.	**solicited and considered opinions from a broad array of organizations and individuals that have knowledge of homelessness, or an interest in preventing and ending homelessness;**
2.	**communicated information during public meetings or other forums your CoC uses to solicit public information; and**
3.	**took into consideration information gathered in public meetings or forums to address improvements or new approaches to preventing and ending homelessness.**

(limit 2,000 characters)

1.The CoC solicits and considers opinions from 65 members of the Homeless Service Providers Coalition (members) and 50 members of the Mayor's Task Force to End Homelessness (CoC Board). Anyone interested in homelessness issues may join the HSPC and the Mayors Task Force. The committees meet monthly to provide forums in which knowledge and resources from diverse members impact CoC planning toward ending homelessness.
2.In addition to monthly HSPC and MTF meetings, the CoC communicates information via:
•Street outreach, shelter and peer-to-peer workers who connect directly with unsheltered homeless;
•www.FallRiverHomeless.com provides two-way communication with providers and the public-at-large;
•Exit surveys for consumers and outcome forms for providers at the annual Project Homeless Connect which assist in identifying predominant subpopulations in need and gaps in services;
•The regional Veterans committee (Veterans Agents, SSVF providers, VA, shelter and housing providers, employment agencies, and CDAs), which identifies homeless veterans using a By-Name Registry and addresses their needs on a case-by-case basis. The Registry helps identify barriers to housing and services;
•Biannual Public Hearings held by FRCDA to communicate to the public and solicit public opinion regarding community needs including homelessness. Information gained from the hearings is compiled by CDA and presented to the City Administration as the City's Annual Action Plan;
•Resources are available in PDF form and can be e-mailed;
•Coordinated Entry is widely promoted;
•FRCDA (CoC Lead) has TTY.

3.The above examples demonstrate how the CoC is informed of resources in the community and the additional needs that arise among the homeless, helping to create and amend strategies to address current need.

1B-4.	Public Notification for Proposals from Organizations Not Previously Funded.	
	NOFO Section VII.B.1.a.(4)	

	Describe in the field below how your CoC notified the public:
1.	that your CoC's local competition was open and accepting project applications;
2.	that your CoC will consider project applications from organizations that have not previously received CoC Program funding;
3.	about how project applicants must submit their project applications;
4.	about how your CoC would determine which project applications it would submit to HUD for funding; and
5.	how your CoC effectively communicated with individuals with disabilities, including making information accessible in electronic formats.

(limit 2,000 characters)

1. The CoC notifies the public that it will be accepting proposals by making announcements at multiple community meetings. The CoC also sends an e-mail to a broad array of community providers and stakeholders regarding the availability of funds with information on the internal, local deadlines for Letters of Intent and the submission of the applications in e-snaps. The info is also posted on the CoC website.
2. This e-mail clearly states that the CoC will consider applications from any 501(c)(3) organization, regardless of previous funding, and provides a description of opportunities available in the federal competition and NOFA resources. Recipients are encouraged to call CDA for additional information and assistance as needed.
3. All interested organizations, whether currently receiving FRCoC funding, must submit a Letter of Intent by e-mail for what funding pool they are interested in within 10 days of the local funding announcement. When the deadline passes, projects are then opened in e-snaps to provide 2 weeks to submit a draft proposal. New projects by new or currently funded agencies are provided additional guidance to submit a reasonable draft.
4. Each project application is reviewed and ranked by an impartial committee to determine whether it will be included on the Priority Listing. The project must align with HUD priorities as well as meet a priority need in the community. The Review and Ranking Committee consists of community members including consumers who are not beneficiaries of subrecipient agencies. The Committee reviews, accepts/rejects, and ranks all projects listed in the application.
5. www.FallRiverHomeless.com provides two-way communication with providers and the public-at-large. FRCDA (CoC Lead) has TTY. Mass211 is a hotline to reach essential community services. Information is available to be e-mailed in PDF format. Remote meeting formats are usually available.

1C. Coordination and Engagement–Coordination with Federal, State, Local, Private, and Other Organiza

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
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- 24 CFR part 578

1C-1.	**Coordination with Federal, State, Local, Private, and Other Organizations.**	
	NOFO Section VII.B.1.b.	

	In the chart below:
1.	**select yes or no for entities listed that are included in your CoC's coordination, planning, and operations of projects that serve individuals, families, unaccompanied youth, persons who are fleeing domestic violence who are experiencing homelessness, or those at risk of homelessness; or**
2.	**select Nonexistent if the organization does not exist within your CoC's geographic area.**

	Entities or Organizations Your CoC Coordinates with for Planning or Operations of Projects	Coordinates with Planning or Operations of Projects
1.	**Funding Collaboratives**	No
2.	**Head Start Program**	Yes
3.	**Housing and services programs funded through Local Government**	Yes
4.	**Housing and services programs funded through other Federal Resources (non-CoC)**	Yes
5.	**Housing and services programs funded through private entities, including Foundations**	Yes
6.	**Housing and services programs funded through State Government**	Yes
7.	**Housing and services programs funded through U.S. Department of Health and Human Services (HHS)**	Yes
8.	**Housing and services programs funded through U.S. Department of Justice (DOJ)**	Yes
9.	**Housing Opportunities for Persons with AIDS (HOPWA)**	Yes
10.	**Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)**	Nonexistent
11.	**Organizations led by and serving Black, Brown, Indigenous and other People of Color**	Yes
12.	**Organizations led by and serving LGBT persons**	Yes
13.	**Organizations led by and serving people with disabilities**	Yes
14.	**Private Foundations**	No
15.	**Public Housing Authorities**	Yes
16.	**Runaway and Homeless Youth (RHY)**	Nonexistent
17.	**Temporary Assistance for Needy Families (TANF)**	Yes
	Other:(limit 50 characters)	

18.	Faith-Based Organizations	Yes

1C-2.	**CoC Consultation with ESG Program Recipients.**	
	NOFO Section VII.B.1.b.	

	Describe in the field below how your CoC:
1.	**consulted with ESG Program recipients in planning and allocating ESG and ESG-CV funds;**
2.	**participated in evaluating and reporting performance of ESG Program recipients and subrecipients;**
3.	**provided Point-in-Time (PIT) count and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area; and**
4.	**provided information to Consolidated Plan Jurisdictions within your CoC's geographic area so it could be addressed in Consolidated Plan update.**

(limit 2,000 characters)

1. FRCoC uses ESG to fund shelter services, operations, homeless prevention and rapid rehousing activities. During the pandemic, ESG-CV is used for Street Outreach and to stand up a new seasonal shelter. A CoC Committee developed ESG Written Standards, including how to allocate ESG funds for eligible activities; setting performance standards for ESG-funded activities; and establishing policies and procedures for operation and administration. The standards have been reviewed and updated by an outside consultant.
2. ESG subrecipients enter data into HMIS on a timely basis, provide monthly statistics to CDA, provide updates for the annual ConPlan, and report in the HIC, PIT Count, System Performance Measures, CAPER and AHAR/LSA annually and the state's Rehousing Data Collective warehouse quarterly. These reports are publicized and available to the CoC any time.
3. Annually on the last Wednesday of January, the CoC Lead compiles bed/unit inventories from the Fall River emergency shelter programs for the Housing Inventory Chart and the number of people using those beds for the Point-in-Time Count. The HIC is actual number of beds available. The PIT Count is derived from HMIS data collected on those using ES beds. The CoC Lead is responsible to prepare the HIC and PIT Count reports and submit them to HUDHDX.info by the HUD deadline.
4. The CoC Lead provides narratives, statistics, and CAPER reports (HMIS data reported in Sage) to CDA annually for the Consolidated Plan, Annual Action Plan, and CAPER.

1C-3.	**Ensuring Families are not Separated.**	
	NOFO Section VII.B.1.c.	

Select yes or no in the chart below to indicate how your CoC ensures emergency shelter, transitional housing, and permanent housing (PSH and RRH) do not deny admission or separate family members regardless of each family member's self-reported gender:

1.	**Conducted mandatory training for all CoC- and ESG-funded service providers to ensure families are not separated.**	No
2.	**Conducted optional training for all CoC- and ESG-funded service providers to ensure families are not separated.**	No
3.	**Worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients.**	Yes

4.	**Worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within your CoC's geographic area that might be out of compliance and took steps to work directly with those facilities to bring them into compliance.**	No
5.	**Sought assistance from HUD by submitting AAQs or requesting technical assistance to resolve noncompliance of service providers.**	No
6.	**Other. (limit 150 characters)**	
	FRCoC programs never separate families - they work to reunite if they are separated prior to program entry	Yes

1C-4.	**CoC Collaboration Related to Children and Youth–SEAs, LEAs, Local Liaisons & State Coordinators.**	
	NOFO Section VII.B.1.d.	

	Describe in the field below:
1.	**how your CoC collaborates with youth education providers;**
2.	**your CoC's formal partnerships with youth education providers;**
3.	**how your CoC collaborates with State Education Agency (SEA) and Local Education Agency (LEA);**
4.	**your CoC's formal partnerships with SEAs and LEAs;**
5.	**how your CoC collaborates with school districts; and**
6.	**your CoC's formal partnerships with school districts.**

(limit 2,000 characters)

1. The Education of Homeless Children and Youth Program under the McKinney-Vento Homeless Education Assistance Act works to ensure enrollment, attendance and the opportunity for homeless children/youth to succeed in school. State grants are available to school districts with high numbers of homeless students for tutoring, academic support, mentoring, after school and summer programming for students, professional development, and engagement of homeless parents in their children's education.
2. The partnership is dictated by law.
3. There is a state, a regional and four local liaisons (one public school district, one regional high school, one each for the 2 charter schools). The liaison's role is to ensure: procedures and outreach activities are in place to identify homeless children and youths; school staff members understand the homeless definition. The liaison ensures that homeless parents and unaccompanied youth are informed of educational protections in the law by displaying posters in schools and other locations where homeless families and youth go. They help the children and youth enroll in school and receive services, including tutoring, school supplies, and free meals. The liaison informs parents/guardians or unaccompanied youth how to appeal enrollment decisions.
4. The partnership is dictated by law.
5. Head Start and Early Head Start are free child development pre-school programs for low-income families and provide opportunities for parents to get involved to improve their own education and employment potential. People, Inc. hosts several programs for pre-school children in low-income families, and parents are encouraged to participate. The homeless liaison is on the CoC Board, provides data on homeless/at-risk students. Each year the city participates in the statewide homeless youth count.
6. Head Start and Early Head Start have formal partnerships with service providers.

1C-4a.	**CoC Collaboration Related to Children and Youth–Educational Services–Informing Individuals and Families Experiencing Homelessness about Eligibility.**	

NOFO Section VII.B.1.d.

Describe in the field below written policies and procedures your CoC adopted to inform individuals and families who become homeless of their eligibility for educational services.

(limit 2,000 characters)

Subtitle B of the McKinney-Vento Homeless Assistance Act ensures educational rights and protections for homeless students. In Massachusetts, all school districts must comply with the McKinney-Vento Act which requires the following: maintain students in school of origin; provide transportation to ensure access to school of origin; enroll homeless students immediately, even if required documentation is missing; require school districts to review and revise all local policies that may act as a barrier to retention and enrollment of homeless students; require a local homeless education liaison in all districts.

Every State has a State Coordinator for the Education for Homeless Children and Youth (EHCY) program. The State Coordinator oversees the implementation of the McKinney-Vento Act in the school districts.
For the FRCoC, there is a state, a regional and four local liaisons (one public school district, one regional high school, one each for the 2 charter schools). Liaisons ensure homeless students "enroll in, and have a full and fair opportunity to succeed in, the schools in their district." Homeless students are enrolled in school immediately to provide educational stability and avoid separation from school for any time while documents are located. Service providers contact Liaisons if they have children whose educational needs are not being met. The liaison ensures that homeless parents and unaccompanied youth are informed of educational protections in the law by displaying posters in schools and other locations where homeless families and youth go. The local homeless liaison is on the CoC Board and provides data on homeless/at-risk students.

1C-4b.	CoC Collaboration Related to Children and Youth–Educational Services–Written/Formal Agreements or Partnerships with Early Childhood Services Providers.	
	NOFO Section VII.B.1.d.	

Select yes or no in the chart below to indicate whether your CoC has written formal agreements or partnerships with the listed providers of early childhood services:

		MOU/MOA	Other Formal Agreement
1.	Birth to 3 years	No	No
2.	Child Care and Development Fund	No	No
3.	Early Childhood Providers	No	No
4.	Early Head Start	Yes	No
5.	Federal Home Visiting Program–(including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)	No	No
6.	Head Start	Yes	No
7.	Healthy Start	No	No
8.	Public Pre-K	No	No
9.	Tribal Home Visiting Program	No	No

	Other (limit 150 characters)		
10.	McKinney-Vento Board	No	Yes

1C-5.	Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Annual Training–Best Practices.	
	NOFO Section VII.B.1.e.	

	Describe in the field below how your CoC coordinates to provide training for:
1.	**Project staff that addresses safety and best practices (e.g., trauma-informed, victim-centered) on safety and planning protocols in serving survivors of domestic violence and indicate the frequency of the training in your response (e.g., monthly, semi-annually); and**
2.	**Coordinated Entry staff that addresses safety and best practices (e.g., trauma informed care) on safety and planning protocols in serving survivors of domestic violence and indicate the frequency of the training in your response (e.g., monthly, semi-annually).**

(limit 2,000 characters)

1. The FRCoC Victim Service Providers provide trauma-informed, victim-centered training on safety and planning protocols in serving survivors of domestic violence to all incoming staff pre-services. It is a 49-hour comprehensive training on domestic and sexual violence that is victim-centered, trauma- informed and includes working with victims on safety planning. Training refreshers are also provided upon request. The providers work to educate the public on recognizing signs of domestic violence and/or sexual violence, they also recommend that referrals to the VSP agencies should be made so that victims/survivors receive the special care they need.
2. Coordinated Entry leaders provide training on trauma-informed care on safety and planning protocols to ensure that victims/survivors of domestic violence, dating Violence, sexual assault, and stalking are given the proper referrals. Training is provided at orientation and upon request.
In December 2019 the Massachusetts Executive Office of Public Safety and Security, in consultation with the Assessment and Response Subcommittee of the Governor's Council to Address Sexual Assault and Domestic Violence, prepared the Recommended Best Practices for Domestic Violence High Risk Teams in Massachusetts. The guide provides instructions on establishing DV High Risk teams and promotes community awareness. It includes lethality assessment tools, and danger assessment tools for immigrants and lesbian and bi-sexual women.

1C-5a.	Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Using De-identified Aggregate Data.	
	NOFO Section VII.B.1.e.	

Describe in the field below how your CoC uses de-identified aggregate data from a comparable database to assess the special needs related to domestic violence, dating violence, sexual assault, and stalking survivors.

(limit 2,000 characters)

The Victim Service Providers domestic violence shelter uses an alternate HMIS database called EmpowerDB to collect data on its clients. This data is uploaded into Sage as an ESG or ESG-CV CAPER, and can then be viewed as de-identified aggregated data. The reports from the comparable database assure

compliance with privacy laws under HIPAA and VAWA. The data helps VSPs to assess the needs of the victims/survivors such as suitable location placement and appropriate program type, i.e., whether the individual or family needs rapid rehousing, emergency shelter, permanent housing with or without services.

1C-5b.	**Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Coordinated Assessment–Safety, Planning, and Confidentiality Protocols.**	
	NOFO Section VII.B.1.e.	

	Describe in the field below how your CoC's coordinated entry system protocols incorporate trauma-informed, victim-centered approaches while maximizing client choice for housing and services that:
1.	**prioritize safety;**
2.	**use emergency transfer plan; and**
3.	**ensure confidentiality.**

(limit 2,000 characters)

1. Through Coordinated Entry, all households are treated with client-centered, trauma-informed care. Households are assessed for safety concerns, and if they are currently in danger, they are referred to SafeLink and the local Victim Service Provider agencies for services including shelter and safety planning. If possible, Coordinated Entry staff will assist with this referral and contact SafeLink with the client when it is safe to do so. However, no one is turned away from services due to perceived concerns for safety. CE provides trainings to all CoC member agencies and other relevant organizations in the community regarding the Coordinated Entry process, including trauma informed care. The NB Women's Center has an ESG shelter at a confidential location with 5 rooms to accommodate 5 single women or families and a 24-hour DV hotline.
2. Emergency Transfer Plans are used when a homeless victim of domestic violence, dating violence, sexual assault, or stalking or a housed person at risk of homelessness because of a situation concerning DV needs relocation for safety reasons. The ability to request a transfer is available regardless of sex, gender identity, or sexual orientation. The transfer may depend on alternate housing accommodations. NBWC issues VAWA housing vouchers around the county to assist with relocation.
3. FRCoC's HMIS participating DV agency uses a comparable database called EmpowerDB that ensures aggregated is data de-identified. The reports from the comparable database assure compliance with privacy laws under HIPAA and VAWA. SSTAR's Women's Center provides therapy, legal advocacy, safety assessments, personalized safety plans, and information regarding court orders to DV victims. DTA's DV Specialist assists TAFDC workers with DV cases by providing case consultation and safety assessments; helps families advocate with DTA and other agencies; links families to proper resources; and helps with safety planning and economic self-sufficiency.

1C-6.	**Addressing the Needs of Lesbian, Gay, Bisexual, Transgender–Anti-Discrimination Policy and Training.**	
	NOFO Section VII.B.1.f.	

1.	**Did your CoC implement a written CoC-wide anti-discrimination policy ensuring that LGBT individuals and families receive supportive services, shelter, and housing free from discrimination?**	No

2.	**Did your CoC conduct annual CoC-wide training with providers on how to effectively implement the Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity (Equal Access Final Rule)?**	No
3.	**Did your CoC conduct annual CoC-wide training with providers on how to effectively implement Equal Access to Housing in HUD Programs in Accordance with an Individual's Gender Identity (Gender Identity Final Rule)?**	No

1C-7.	**Public Housing Agencies within Your CoC's Geographic Area–New Admissions–General/Limited Preference–Moving On Strategy. You Must Upload an Attachment(s) to the 4B. Attachments Screen.**	
	NOFO Section VII.B.1.g.	

Enter information in the chart below for the two largest PHAs highlighted in gray on the CoC-PHA Crosswalk Report at https://files.hudexchange.info/resources/documents/FY-2020-CoC-PHA-Crosswalk-Report.pdf or the two PHAs your CoC has a working relationship with–if there is only one PHA in your CoC's geographic area, provide information on the one:

Public Housing Agency Name	Enter the Percent of New Admissions into Public Housing and Housing Choice Voucher Program During FY 2020 who were experiencing homelessness at entry	Does the PHA have a General or Limited Homeless Preference?	Does the PHA have a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On?
Fall River Housing Authority	1%	Yes-Public Housing	No

1C-7a.	**Written Policies on Homeless Admission Preferences with PHAs.**	
	NOFO Section VII.B.1.g.	

	Describe in the field below:
1.	**steps your CoC has taken, with the two largest PHAs within your CoC's geographic area or the two PHAs your CoC has working relationships with, to adopt a homeless admission preference–if your CoC only has one PHA within its geographic area, you may respond for the one; or**
2.	**state that your CoC has not worked with the PHAs in its geographic area to adopt a homeless admission preference.**

(limit 2,000 characters)

1. Since April 2021, FRCoC has been in discussions with FRHA to establish a Limited Homeless Preference to become effective April 1, 2022. This policy is currently in development for FRHA's Annual PHA Plan for FY2023.
In the interim, FRHA is making strides to remove barriers to fair housing access, particularly as it impacts the homeless population. In a September 2021 press release, FRHA announced a 45-day public comment period to discuss significant amendment to its HUD-approved Annual PHA Plan for FY2022. Specifically, FRHA is seeking to eliminate the "rent burdened" status requirement from the highest-ranking Local Preference on its HCVP waiting list: Families residing in the City of Fall River, or have at least one adult member who works or has been hired to work in the City of Fall River and paying forty percent (40%) or more of their adjusted income for rent and utilities.
Currently, FRHA pre-screens every HCVP applicant who claims the "rent-burdened" preference. Verification of waiting list preference is carried out prior to all other screening steps in the HCVP admissions process. Applicants who cannot provide documentation to verify "rent burdened" status must return to the waiting list. Income-eligible applicants who are living in a homeless shelter or in

a PSH program and do not pay >40% of their income toward rent can never proceed beyond the pre-screening stage. The verification process for determining “rent-burdened” eligibility is an administrative burden for FRHA and precludes anyone who does not pay rent from qualifying because having verifiable housing costs as a pre-requisite for waiting list preference puts low-income families and individuals (non-rent payers) at a grave disadvantage. Income guidelines for admission should suffice for meeting threshold eligibility requirements. Using income-to-housing-cost ratio as a basis for assigning local preference is too exclusionary. Eliminating this preference will help to reduce those barriers.
2. NA

1C-7b.	Moving On Strategy with Affordable Housing Providers.	
	Not Scored–For Information Only	

Select yes or no in the chart below to indicate affordable housing providers in your CoC’s jurisdiction that your recipients use to move program participants to other subsidized housing:

1.	Multifamily assisted housing owners	Yes
2.	PHA	No
3.	Low Income Tax Credit (LIHTC) developments	No
4.	Local low-income housing programs	Yes
	Other (limit 150 characters)	
5.		

1C-7c.	Including PHA-Funded Units in Your CoC’s Coordinated Entry System.	
	NOFO Section VII.B.1.g.	

Does your CoC include PHA-funded units in the CoC’s coordinated entry process?	No

1C-7c.1.	Method for Including PHA-Funded Units in Your CoC’s Coordinated Entry System.	
	NOFO Section VII.B.1.g.	

	If you selected yes in question 1C-7c., describe in the field below:
1.	how your CoC includes the units in its Coordinated Entry process; and
2.	whether your CoC's practices are formalized in written agreements with the PHA, e.g., MOUs.

(limit 2,000 characters)

NA

1C-7d.	Submitting CoC and PHA Joint Applications for Funding for People Experiencing Homelessness.	

NOFO Section VII.B.1.g.

Did your CoC coordinate with a PHA(s) to submit a joint application(s) for funding of projects serving families experiencing homelessness (e.g., applications for mainstream vouchers, Family Unification Program (FUP), other non-federal programs)?	No

1C-7d.1.	CoC and PHA Joint Application–Experience–Benefits.	
	NOFO Section VII.B.1.g.	

	If you selected yes to question 1C-7d, describe in the field below:
1.	the type of joint project applied for;
2.	whether the application was approved; and
3.	how your CoC and families experiencing homelessness benefited from the coordination.

(limit 2,000 characters)

NA

1C-7e.	Coordinating with PHA(s) to Apply for or Implement HCV Dedicated to Homelessness Including American Rescue Plan Vouchers.	
	NOFO Section VII.B.1.g.	

Did your CoC coordinate with any PHA to apply for or implement funding provided for Housing Choice Vouchers dedicated to homelessness, including vouchers provided through the American Rescue Plan?	No

1C-7e.1.	Coordinating with PHA(s) to Administer Emergency Housing Voucher (EHV) Program–List of PHAs with MOUs.	
	Not Scored–For Information Only	

Did your CoC enter into a Memorandum of Understanding (MOU) with any PHA to administer the EHV Program?	No

If you select yes, you must use the list feature below to enter the name of every PHA your CoC has entered into a MOU with to administer the Emergency Housing Voucher Program.
PHA
This list contains no items

1C. Coordination and Engagement–Coordination with Federal, State, Local, Private, and Other Organiza

1C-8.	Discharge Planning Coordination.	
	NOFO Section VII.B.1.h.	

Select yes or no in the chart below to indicate whether your CoC actively coordinates with the systems of care listed to ensure persons who have resided in them longer than 90 days are not discharged directly to the streets, emergency shelters, or other homeless assistance programs.

1. Foster Care	Yes
2. Health Care	Yes
3. Mental Health Care	Yes
4. Correctional Facilities	Yes

1C-9.	Housing First–Lowering Barriers to Entry.	
	NOFO Section VII.B.1.i.	

1.	Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects your CoC is applying for in FY 2021 CoC Program Competition.	5
2.	Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects your CoC is applying for in FY 2021 CoC Program Competition that have adopted the Housing First approach.	5
3.	This number is a calculation of the percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects the CoC has ranked in its CoC Priority Listing in the FY 2021 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.	100%

1C-9a.	Housing First–Project Evaluation.	
	NOFO Section VII.B.1.i.	

Describe in the field below how your CoC regularly evaluates projects to ensure those that commit to using a Housing First approach are prioritizing rapid placement and stabilization in permanent housing and are not requiring service participation or preconditions of program participants.

(limit 2,000 characters)

ESG shelters are low-barrier/low-threshold shelters. Once a person/family enters shelter, they are then entered into Coordinated Entry to be evaluated for housing placement. Homeless Clients are not required to participate in any services in order to qualify for housing, but they are evaluated for referrals and

placements based on vulnerability, past history of homelessness, length of time homeless, etc.
CDA, the CoC Lead, annually monitors ESG and CoC programs for compliance. This includes reviewing client files to ensure no one is being required to complete a Service Plan, that all intentions are offers of service rather than requirements of programming.
Protocols, including working with that client to get them safe and well again without the threat of losing their housing, are in place for when someone relapses or breaks other policies that are in place for the participant's safety.

1C-9b.	**Housing First–Veterans.**	
	Not Scored–For Information Only	

Does your CoC have sufficient resources to ensure each Veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach?	Yes

1C-10.	**Street Outreach–Scope.**	
	NOFO Section VII.B.1.j.	

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

(limit 2,000 characters)

1. Using state funds and ESG-CV funds, the City, Steppingstone, St. Anne's Hospital and Eliot Community Human Services employs outreach workers, as well as community volunteers (including formerly homeless consumers) to find unsheltered homeless persons and engage with them. They provide necessities such as food/lunches, gift cards, warm clothing, hygiene items, sunscreen, first aid, transportation, tents, blankets, etc. They also provide printed resources and provider referrals. The outreach workers develop a rapport with the street homeless. Information regarding whereabouts of both the homeless and the workers is dispersed by word of mouth. Once a connection is made with an individual, they feel more secure seeking additional services.
2. Street Outreach covers the whole City including encampments, food pantries/soup kitchens, veterans drop-in centers, harsh weather day-shelters, parking lots, parks/playgrounds, bicycle/walking paths, wooded areas, laundromats, fast food restaurants, public building lobbies/sitting areas; some visits are pre-arranged. If a neighborhood resident, business owner, patron, etc. provides information about where the homeless may be, a team is called out to investigate. The teams also receive and act on word-of-mouth from other street homeless.
3. Street Outreach is performed daily. There is a more concentrated effort done leading up to, during and following the PIT Count and days leading up to and during harsh weather (snowstorms, heatwaves, hurricanes, nor'easters).
4. The street homeless are the least trusting and hardest-to-serve, mostly

staying out of public view. The outreach teams usually encounter those that only use shelter during extreme weather conditions. Many Outreach Workers were homeless persons who can relate to the difficulties the unsheltered homeless face and the needs they have. The teams provide pamphlets, advice, and information on how to access shelter and services when ready.

1C-11.	Criminalization of Homelessness.	
	NOFO Section VII.B.1.k.	

Select yes or no in the chart below to indicate strategies your CoC implemented to prevent the criminalization of homelessness in your CoC's geographic area:

1.	Engaged/educated local policymakers	Yes
2.	Engaged/educated law enforcement	Yes
3.	Engaged/educated local business leaders	Yes
4.	Implemented communitywide plans	Yes
5.	Other:(limit 500 characters)	
	Employed system with Fall River Police Department to locate missing homeless	Yes

1C-12.	Rapid Rehousing–RRH Beds as Reported in the Housing Inventory Count (HIC).	
	NOFO Section VII.B.1.l.	

	2020	2021
Enter the total number of RRH beds available to serve all populations as reported in the HIC–only enter bed data for projects that have an inventory type of "Current."	189	109

1C-13.	Mainstream Benefits and Other Assistance–Healthcare–Enrollment/Effective Utilization.	
	NOFO Section VII.B.1.m.	

Indicate in the chart below whether your CoC assists persons experiencing homelessness with enrolling in health insurance and effectively using Medicaid and other benefits.

	Type of Health Care	Assist with Enrollment?	Assist with Utilization of Benefits?
1.	Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)	Yes	Yes
2.	Private Insurers	Yes	Yes
3.	Nonprofit, Philanthropic	Yes	Yes
4.	Other (limit 150 characters)		
	SOAR-Trained Providers	Yes	Yes

1C-13a.	**Mainstream Benefits and Other Assistance–Information and Training.**	
	NOFO Section VII.B.1.m	

	Describe in the field below how your CoC provides information and training to CoC Program-funded projects by:
1.	**systemically providing up to date information on mainstream resources available for program participants (e.g., Food Stamps, SSI, TANF, substance abuse programs) within your CoC's geographic area;**
2.	**communicating information about available mainstream resources and other assistance and how often your CoC communicates this information;**
3.	**working with projects to collaborate with healthcare organizations to assist program participants with enrolling in health insurance; and**
4.	**providing assistance with the effective use of Medicaid and other benefits.**

(limit 2,000 characters)

1. Within 30 days of program entry, providers assist participants to obtain mainstream benefits. Community partners and on-line applications facilitate the application process. SNAP, WIC, cash assistance and health insurance applications can be accessed on-line. Educational materials, in-person trainings, transportation to medical appointments, and assistance with insurance enrollment are provided, as is follow up. Presentations by any agency serving the homeless are welcome at meetings of the CoC members and the CoC Board. Agencies provide calendars of events, newsletters, and mass e-mailings of events and networking opportunities. Other agencies forward notices to the CoC Lead who disseminates it to a large listserv. SOAR trainings are completed by staff of CoC agencies. The SOAR TA Center performed an electronic community assessment; a planning meeting will be held in early 2022 for more significant SOAR implementation.
2. Daily: Services pamphlet is available at www.FallRiverHomeless.com and various agencies, City Hall, soup kitchens, and food pantries; winter overflow shelter and inclement weather/overflow shelter; listserv e-mails from various state and federal depts.
Monthly: Information is circulated at HSPC and MTF meetings; Greater Fall River Addiction Help Center, Agency staff meetings.
Quarterly: SouthCoast Regional Network to End Homelessness; MBHP Behavioral and Medical Health Cluster.
Annually: Candlelight Vigil for Hunger and Homelessness Awareness Week; Project Homeless Connect; World AIDS Day; Overdose Awareness Day; Recovery Health and Wellness Day.
3. Health Insurance enrollment is available at the 2 hospitals and 3 major healthcare facilities. Homeless program staff assist with insurance applications. MBHP Cluster quarterly meetings are open to housing and service providers.
4. The CoC directs providers to presentations and webinars by state and federal depts regarding the utilization of health benefits to provide case management.

1C-14.	**Centralized or Coordinated Entry System–Assessment Tool. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.1.n.	

	Describe in the field below how your CoC's coordinated entry system:
1.	**covers 100 percent of your CoC's geographic area;**
2.	**reaches people who are least likely to apply for homeless assistance in the absence of special outreach;**
3.	**prioritizes people most in need of assistance; and**

4.	**ensures people most in need of assistance receive assistance in a timely manner.**

(limit 2,000 characters)

1. The Fall River Coordinated Entry System covers 100% of the Fall River CoC geography and is operated by Catholic Social Services, a non-profit agency. CE is promoted on the local radio station and has been part of news stories and press releases in local print and TV news, radio call-in programs, radio and TV advertisements, and social media.
2. The street homeless mostly stay out of public view, but Street Outreach workers go out to encampments, food pantries/soup kitchens, veterans drop-in centers, harsh weather day-shelters, parking lots, parks/playgrounds, bicycle/walking paths, wooded areas, laundromats, fast food restaurants, public building lobbies/sitting areas. They provide necessities such as food/lunches, gift cards, warm clothing, hygiene items, sunscreen, first aid, transportation, tents, blankets, etc. They also provide printed resources and provider referrals. The outreach teams develop a rapport with the street homeless and provide referrals to CE. CE staff reach out to housing court and FRHA staff to educate those at-risk about available resources to rapidly rehouse or keep them housed.
3. In operation since 2015, CE monitors a centralized phone line and receives e-mails at frce@cssdioc.org and through www.FallRiverHomeless.com. A SPDAT is conducted on those who are seeking housing, which is used to identify those with longest histories of homelessness as well as the barriers to accessing housing. CE is tasked with making precise assessments in order to provide the most accurate and efficient referrals and placements that suit the needs of the homeless in order to prevent returns to homelessness.
4. The CE staff researches all available programs to find the most appropriate financial resources in a timely manner to get or keep people housed. Programs are combined if necessary to cover arrears and pay future subsidies for folks to sustain the housing and avoid returns to homelessness.

1C-15.	**Promoting Racial Equity in Homelessness–Assessing Racial Disparities.**	
	NOFO Section VII.B.1.o.	

Did your CoC conduct an assessment of whether disparities in the provision or outcome of homeless assistance exists within the last 3 years?	No

1C-15a.	**Racial Disparities Assessment Results.**	
	NOFO Section VII.B.1.o.	

Select yes or no in the chart below to indicate the findings from your CoC's most recent racial disparities assessment.

1.	**People of different races or ethnicities are more likely to receive homeless assistance.**	Yes
2.	**People of different races or ethnicities are less likely to receive homeless assistance.**	No
3.	**People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.**	Yes

4.	**People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.**	No
5.	**There are no racial or ethnic disparities in the provision or outcome of homeless assistance.**	Yes
6.	**The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.**	No

1C-15b.	**Strategies to Address Racial Disparities.**	
	NOFO Section VII.B.1.o.	

Select yes or no in the chart below to indicate the strategies your CoC is using to address any racial disparities.

1.	**The CoC's board and decisionmaking bodies are representative of the population served in the CoC.**	Yes
2.	**The CoC has identified steps it will take to help the CoC board and decisionmaking bodies better reflect the population served in the CoC.**	Yes
3.	**The CoC is expanding outreach in geographic areas with higher concentrations of underrepresented groups.**	No
4.	**The CoC has communication, such as flyers, websites, or other materials, inclusive of underrepresented groups.**	Yes
5.	**The CoC is training staff working in the homeless services sector to better understand racism and the intersection of racism and homelessness.**	Yes
6.	**The CoC is establishing professional development opportunities to identify and invest in emerging leaders of different races and ethnicities in the homelessness sector.**	No
7.	**The CoC has staff, committees, or other resources charged with analyzing and addressing racial disparities related to homelessness.**	Yes
8.	**The CoC is educating organizations, stakeholders, boards of directors for local and national nonprofit organizations working on homelessness on the topic of creating greater racial and ethnic diversity.**	No
9.	**The CoC reviewed coordinated entry processes to understand their impact on people of different races and ethnicities experiencing homelessness.**	Yes
10.	**The CoC is collecting data to better understand the pattern of program use for people of different races and ethnicities in its homeless services system.**	Yes
11.	**The CoC is conducting additional research to understand the scope and needs of different races or ethnicities experiencing homelessness.**	Yes
	Other:(limit 500 characters)	
12.		

1C-15c.	**Promoting Racial Equity in Homelessness Beyond Areas Identified in Racial Disparity Assessment.**	
	NOFO Section VII.B.1.o.	

Describe in the field below the steps your CoC and homeless providers have taken to improve racial equity in the provision and outcomes of assistance beyond just those areas identified in the racial disparity assessment.

(limit 2,000 characters)

The FRCoC, after set backs on in-person meetings and other collaborations due to the pandemic, has processed the latest CoC Racial Equity Analysis Tool. The subcommittee will soon reconvene to administer a Racial Disparity Assessment that includes more than race/ethnicity of those served in order to

examine the outcomes of those served.
The Mayor of the City of Fall River has recently appointed a Diversity Working Group to address race within core elements: Community Involvement, Healthcare, Policing, Education, Employment. The group meets monthly and has held events regarding equal opportunity for the COVID-19 vaccination rollout and more recently voter registration. Although the newly established group's focus is not currently racial disparities specifically among the homeless population, the community events certainly provide cross-over opportunities to address social issues among the homeless, particularly those of color.
The FRCoC intends to invite members of the Diversity Working Group to participate in its Racial Disparity Assessment to implement improvements in racial equity and the provision of fair housing for all people of various color and ethnicity.

1C-16.	**Persons with Lived Experience–Active CoC Participation.**	
	NOFO Section VII.B.1.p.	

Enter in the chart below the number of people with lived experience who currently participate in your CoC under the five categories listed:

	Level of Active Participation	Number of People with Lived Experience Within the Last 7 Years or Current Program Participant	Number of People with Lived Experience Coming from Unsheltered Situations
1.	**Included and provide input that is incorporated in the local planning process.**	2	1
2.	**Review and recommend revisions to local policies addressing homelessness related to coordinated entry, services, and housing.**	50	50
3.	**Participate on CoC committees, subcommittees, or workgroups.**	1	1
4.	**Included in the decisionmaking processes related to addressing homelessness.**	1	1
5.	**Included in the development or revision of your CoC's local competition rating factors.**	0	0

1C-17.	**Promoting Volunteerism and Community Service.**	
	NOFO Section VII.B.1.r.	

Select yes or no in the chart below to indicate steps your CoC has taken to promote and support community engagement among people experiencing homelessness in the CoC's geographic area:

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

6.	**Other:(limit 500 characters)**	

1D. Addressing COVID-19 in the CoC's Geographic Area

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1D-1.	**Safety Protocols Implemented to Address Immediate Needs of People Experiencing Unsheltered, Congregate Emergency Shelter, Transitional Housing Homelessness.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below protocols your CoC implemented during the COVID-19 pandemic to address immediate safety needs for individuals and families living in:
1.	**unsheltered situations;**
2.	**congregate emergency shelters; and**
3.	**transitional housing.**

(limit 2,000 characters)

1. FRCoC created a new Street Outreach Program with Street Outreach Workers at CDA/FRPD and Steppingstone. The workers were provided a van, PPE, critical necessities to distribute such as food/lunches, gift cards, warm clothing, hygiene items, sunscreen, first aid, transportation, tents, blankets, etc. They also provided printed resources and provider referrals. They covered encampments, parking lots, parks/playgrounds, bicycle/walking paths, wooded areas and fast food restaurants, and as the protocols were eased they visited food pantries/soup kitchens, veterans drop-in centers, harsh weather day-shelters, laundromats, public building lobbies/sitting areas. Healthcare professionals visited encampments and met the homeless where they were to provide COVID-tests, vaccines and other healthcare. The unsheltered were advised on how to practice social distancing.
2. Congregate emergency shelters were provided with PPE for staff and guests, and the shelters were deep cleaned. Guests were tested upon entry if they didn't have appropriate proof of a negative test. Social distancing and masking were required, and bunk beds were replaced with regular beds. Hazard pay was provided to all staff. The shelter for individuals was locked down once early in the pandemic due to positive COVID cases. A new seasonal shelter was stood up and opened earlier in the season to handle the increase in guests in the cold weather. The overflow section of the shelter also opened early. EMS workers did their utmost to provide testing. Healthcare workers provided vaccines on-site. Guests and staff were educated and encouraged to receive the vaccine. Transportation to test sites was provided.
3. The only Transitional Housing program in Fall River – Local Housing Authority Transitional Housing Program – is scattered-site units. Case

management was done by phone until it was deemed safe to return to in-home visits.

1D-2.	Improving Readiness for Future Public Health Emergencies.	
	NOFO Section VII.B.1.q.	

Describe in the field below how your CoC improved readiness for future public health emergencies.

(limit 2,000 characters)

The pandemic provided an opportunity to examine the City's emergency response readiness. Without prior experience of a pandemic, over the past 20 months, municipal leaders followed protocol set by state and federal authorities. Recently the United Way convened an emergency response task force. The task force was originally formed to respond quickly when many units of housing become uninhabitable at one time (fire, condemnation), but we are in the process of defining its responsibilities and how broad a definition of emergency we want use. Invitees include the American Red Cross, the Mayor's office and other municipal employees, grassroots organizations, non-profit agencies, Salvation Army, Firefighters' Wives Association, United Way of Greater Fall River. The task force will meet quarterly and more often in urgent situations and will derive a more definitive identity over the next 6 months.

1D-3.	CoC Coordination to Distribute ESG Cares Act (ESG-CV) Funds.	
	NOFO Section VII.B.1.q	

	Describe in the field below how your CoC coordinated with ESG-CV recipients to distribute funds to address:
1.	safety measures;
2.	housing assistance;
3.	eviction prevention;
4.	healthcare supplies; and
5.	sanitary supplies.

(limit 2,000 characters)

1.FRCoC created a Street Outreach Program. Workers were provided a van, PPE, critical items to distribute such as food, gift cards, clothing, hygiene items, first aid, transportation/bus passes, tents, blankets, printed resources, etc. The unsheltered were encouraged to test for COVID and be vaccinated. Congregate emergency shelters were provided with PPE for staff and guests, shelters were deep cleaned. Guests were tested upon entry if they didn't have proof of a negative test. Social distancing and masking were required, and regular beds replaced bunk beds. Hazard pay was provided. A new seasonal shelter was stood up and opened early in the season to handle the increase in guests in the cold weather. The overflow shelter also opened early. EMS workers provided testing. Healthcare workers provided vaccines on-site. Guests and staff were educated and encouraged to be vaccinated. Transportation to test sites was provided.
2.During the eviction moratorium, the requirement to present with a court order

to qualify for HP/RRH assistance was not waived, so ESG and ESG-CV funding assistance was not an option. CE referred those at-risk or being made homeless regardless of the moratorium to state programs: RAFT, ERAP, ERMA. Interviews, meetings, inspections were virtual.
3.Catholic Social Services increased CE and emergency services staff. ESG-CV funding availability is promoted on local radio and has been part of news stories and press releases in local print and TV news, radio call-in programs, radio and TV advertisements, and social media.
4.Healthcare professionals visited encampments and met the homeless where they were to provide COVID-tests, vaccines and other healthcare. EMS workers did their utmost to provide testing. Healthcare workers provided vaccines on-site. Transportation to test sites was provided.
5.Sanitary supplies were purchased with ESG-CV funds for the shelters, street outreach workers. Shelters hired companies to provide deep cleaning.

1D-4.	**CoC Coordination with Mainstream Health.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below how your CoC coordinated with mainstream health (e.g., local and state health agencies, hospitals) during the COVID-19 pandemic to:
1.	**decrease the spread of COVID-19; and**
2.	**ensure safety measures were implemented (e.g., social distancing, hand washing/sanitizing, masks).**

(limit 2,000 characters)

1. The City Health Department disseminated daily e-mails to provide updates and protocols regarding COVID-19. EMS workers set a daily schedule to provide tests to those entering shelter. Transportation to test sites was provided. The Health Department visited the shelters to provide vaccinations on-site. Guests and staff were educated and encouraged to receive the vaccine. Healthcare professionals visited encampments and met the homeless where they were to provide COVID-tests, vaccines and other healthcare. The unsheltered were advised on how to practice social distancing in their encampments. HealthFirst Family Care Center provided vaccinations to the FRPD. The City's Health Department, HealthFirst and St. Anne's Hospital (Steward) participate in the Mayor's Task Force meetings and provide updates regarding the pandemic.
2. FRCoC created a Street Outreach Program. Workers were provided a van, PPE, critical items to distribute such as food, gift cards, clothing, PPE, hygiene items, first aid, transportation/bus passes, tents, blankets, printed resources, etc. They covered encampments, parking lots, parks/playgrounds, bicycle/walking paths, wooded areas and fast food restaurants, and as the protocols were eased they visited food pantries/soup kitchens, veterans drop-in centers, harsh weather day-shelters, laundromats, public building lobbies/sitting areas. Healthcare professionals visited encampments and met the homeless where they were to provide COVID-tests, vaccines and other healthcare. The unsheltered were advised on how to practice social distancing.
The shelters were provided with PPE including sanitizer, masks, shields, plexiglass dividers for offices and sleeping areas. Proper social distancing and masking are required. Regular beds replaced bunk beds, and soap dispensers and faucets were replaced with motion sensing ones. EMS workers set a daily schedule to provide tests to those entering shelter. Deep cleaning was provided at the shelters.

1D-5.	Communicating Information to Homeless Service Providers.	
	NOFO Section VII.B.1.q.	

	Describe in the field below how your CoC communicated information to homeless service providers during the COVID-19 pandemic on:
1.	safety measures;
2.	changing local restrictions; and
3.	vaccine implementation.

(limit 2,000 characters)

1. The CoC communicated information regarding safety measures to homeless service providers mainly by e-mail, phone and Zoom meetings. Availability of funding to make purchases of any items to keep offices and shelters safe during the pandemic was provided to the agencies that serve the homeless, including PPE (sanitizer, masks, shields, plexiglass dividers for offices and sleeping areas, regular beds rather than bunk beds), items for outreach workers to provide to the unsheltered homeless (food, gift cards, clothing, PPE, hygiene items, first aid, transportation/bus passes, tents, blankets, printed resources) and hazard pay for shelter workers.
2. Changes in local restrictions were announced by the Mayor and the City Health Department Director and through citywide e-mails. Announcements were broadcast and knowledgeable guests answered questions about the pandemic during talk shows on local radio and TV. Local print news and social media pages also covered information regarding changing restrictions.
3. Information regarding vaccination implementation was conveyed by the City Health Department Director and through citywide e-mails. Websites with vaccination sites were developed citywide and statewide. Vaccination sites were open many days of the week including weekends. Healthcare officials visited shelters to provide vaccines and education. Unsheltered homeless were met by healthcare staff providing vaccines at sites provided by street outreach workers. Other healthcare staff went door-to-door, providing vaccines to scattered-site units.

1D-6.	Identifying Eligible Persons Experiencing Homelessness for COVID-19 Vaccination.	
	NOFO Section VII.B.1.q.	

Describe in the field below how your CoC identified eligible individuals and families experiencing homelessness for COVID-19 vaccination based on local protocol.

(limit 2,000 characters)

FRCoC created a new Street Outreach Program. The workers cover the whole City including encampments, food pantries/soup kitchens, veterans drop-in centers, harsh weather day-shelters, parking lots, parks/playgrounds, bicycle/walking paths, wooded areas, laundromats, fast food restaurants, public building lobbies/sitting areas. The teams also receive and act on word-of-mouth from other street homeless. Healthcare professionals visited encampments and met the homeless where they were to provide vaccines and other healthcare. Their whereabouts was disclosed by street outreach workers.

Healthcare officials visited shelters to provide vaccines and education. Guests and staff were educated and encouraged to receive the vaccine. Other healthcare staff went door-to-door, providing vaccines to scattered-site units. Information regarding vaccination implementation was conveyed by the City Health Department Director and through citywide e-mails. Vaccination sites were open many days of the week including weekends, and this information was available on various websites. Transportation to test sites was provided.

1D-7.	**Addressing Possible Increases in Domestic Violence.**	
	NOFO Section VII.B.1.e.	

Describe in the field below how your CoC addressed possible increases in domestic violence calls for assistance due to requirements to stay at home, increased unemployment, etc. during the COVID-19 pandemic.

(limit 2,000 characters)

The Domestic Violence Unit at the Department of Transitional Housing found that were fewer referrals than usual for much of the pandemic because women stated they stayed where they were rather than go to (congregate) shelter and be exposed to more people, especially if there were minor children involved. DV calls have only increased in the last four months. Referrals to DV shelter and other DV assistance did not change.

1D-8.	**Adjusting Centralized or Coordinated Entry System.**	
	NOFO Section VII.B.1.n.	

Describe in the field below how your CoC adjusted its coordinated entry system to account for rapid changes related to the onset and continuation of the COVID-19 pandemic.

(limit 2,000 characters)

While many tasks were done remotely/virtually, Coordinated Entry staff worked in the office throughout the pandemic. There was no change in referrals. Interviews and paperwork submission was done both in-person (using social distancing and masking protocol) or remotely/virtually (e-mail, PDF, electronic signatures, virtual meetings) if it was possible for the homeless or at-risk population.

1E. Project Capacity, Review, and Ranking–Local Competition

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1E-1.	**Announcement of 30-Day Local Competition Deadline–Advance Public Notice of How Your CoC Would Review, Rank, and Select Projects. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.a. and 2.g.	

1.	**Enter the date your CoC published the 30-day submission deadline for project applications for your CoC's local competition.**	09/24/2021
2.	**Enter the date your CoC publicly posted its local scoring and rating criteria, including point values, in advance of the local review and ranking process.**	10/22/2021

1E-2.	**Project Review and Ranking Process Your CoC Used in Its Local Competition. You Must Upload an Attachment to the 4B. Attachments Screen. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria listed below.**	
	NOFO Section VII.B.2.a., 2.b., 2.c., and 2.d.	

Select yes or no in the chart below to indicate how your CoC ranked and selected project applications during your local competition:

1.	**Established total points available for each project application type.**	Yes
2.	**At least 33 percent of the total points were based on objective criteria for the project application (e.g., cost effectiveness, timely draws, utilization rate, match, leverage), performance data, type of population served (e.g., DV, youth, Veterans, chronic homelessness), or type of housing proposed (e.g., PSH, RRH).**	Yes
3.	**At least 20 percent of the total points were based on system performance criteria for the project application (e.g., exits to permanent housing destinations, retention of permanent housing, length of time homeless, returns to homelessness).**	Yes
4.	**Used data from a comparable database to score projects submitted by victim service providers.**	No
5.	**Used objective criteria to evaluate how projects submitted by victim service providers improved safety for the population they serve.**	No
6.	**Used a specific method for evaluating projects based on the CoC's analysis of rapid returns to permanent housing.**	No

1E-2a.	**Project Review and Ranking Process–Addressing Severity of Needs and Vulnerabilities.**	

	NOFO Section VII.B.2.d.

	Describe in the field below how your CoC reviewed, scored, and selected projects based on:
1.	the specific severity of needs and vulnerabilities your CoC considered when ranking and selecting projects; and
2.	considerations your CoC gave to projects that provide housing and services to the hardest to serve populations that could result in lower performance levels but are projects your CoC needs in its geographic area.

(limit 2,000 characters)

1. In order to rank the projects objectively, the Review & Ranking Committee assessed and scored the projects based on the following criteria based on HUD priorities and community needs as determined by the CoC.

Project Attributes:
Percentage of funds expended and reasonable return on investment of the project
Number of beds and number of CH beds (Dedicated or Priority)
Subpopulations the program serves (Youth, Victims of Domestic Violence, Families with Children, Veterans)
Whether the project follows a Housing First model (At entry: zero income, more than one disability, coming from a place not meant for human habitation)
System Performance Measures (remain in or exits to permanent housing, returns to homelessness within 12 months of exit, increased income)

HUD Requirements:
Participation in Coordinated Entry, the CoC and HMIS
Match requirements
Financial feasibility of the project
Financial stability of the agencies

2. The Ranking & Review Committee gave consideration to hardest to serve populations, especially those serving persons with substance use disorders including those who relapse, with no or very low income, and those serving youth. Fall River has the only PSH project for 18-24 year old persons in all of Bristol County and beyond and is operated by Catholic Social Services. Steppingstone is dedicated to provide housing and services to persons with co-occurring disorders, especially substance use and mental health.

1E-3.	Promoting Racial Equity in the Local Review and Ranking Process.	
	NOFO Section VII.B.2.e.	

	Describe in the field below how your CoC:
1.	obtained input and included persons of different races, particularly those over-represented in the local homelessness population, when determining the rating factors used to review project applications;
2.	included persons of different races, particularly those over-represented in the local homelessness population, in the review, selection, and ranking process;
3.	rated and ranked projects based on the degree to which their program participants mirror the homeless population demographics (e.g., considers how a project promotes racial equity where individuals and families of different races are over-represented).

(limit 2,000 characters)

1. This year’s rating factors used in reviewing project applications were

determined during the 2019 NOFA process. A committee needs to be reconvened to revisit the Racial Disparity Assessment process and to include more people of color and with lived experience in the complete Continuum of Care process. The Mayor of the City of Fall River has recently appointed a Diversity Working Group to address race within core elements: Community Involvement, Healthcare, Policing, Education, Employment. The FRCoC intends to invite members of the Diversity Working Group to participate in its Racial Disparity Assessment to implement improvements in racial equity and the provision of fair housing for all people of various color and ethnicity.
2. Due to concerns of the risk of COVID, many CoC members opted not to participate in the in-person meeting of the Rank & Review Committee. A remote meeting option was not available as some of the material was not readily available as a PDF. A small group of members of the Ranking & Review Committee were able to convene, of which none were persons of color.
The Mayor of the City of Fall River has recently appointed a Diversity Working Group to address race within core elements: Community Involvement, Healthcare, Policing, Education, Employment. The FRCoC intends to invite members of the Diversity Working Group to participate in its Racial Disparity Assessment to implement improvements in racial equity and the provision of fair housing for all people of various color and ethnicity.
3. The FRCoC, after set backs on in-person meetings and other collaborations due to the pandemic, has processed the latest CoC Racial Equity Analysis Tool. The subcommittee will soon reconvene to administer a Racial Disparity Assessment that includes more than race/ethnicity of those served in order to examine the outcomes of those being served. The Ranking & Review Committee will then be better informed as to if the projects are considering racial equity where those of different races are over-represented.

1E-4.	**Reallocation–Reviewing Performance of Existing Projects. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criterion below.**	
	NOFO Section VII.B.2.f.	

	Describe in the field below:
1.	**your CoC's reallocation process, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed;**
2.	**whether your CoC identified any projects through this process during your local competition this year;**
3.	**whether your CoC reallocated any low performing or less needed projects during its local competition this year;**
4.	**why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable; and**
5.	**how your CoC communicated the reallocation process to project applicants.**

(limit 2,000 characters)

1. The Reallocation Process is the result of CoC planning and the CoC's strategy to end homelessness. Local policy governing project ranking, re-allocation, and tiering involves evaluating renewal projects regarding:
•Compliance with HUD requirements;
•Preserving funds for high performing projects;
•Shifting investments from low performing projects to new projects to advance the goal of reducing homelessness.
If applicable, funds re-allocated as part of recapturing unspent funds, voluntary or involuntary, or funds from projects that are low performing are made

available for reallocation to create new projects. To date, agencies have voluntarily reallocated funds to new projects for the good of their agency or the CoC at large.
2. No projects were identified through the reallocation process this year during the local competition. The pandemic put a strain on local planning.
3. FRCoC did not reallocate any low performing or less needed projects during the local competition.
4. Applicants are fiscally responsible and reputable. Budgets are amended to fully expend funds. All projects are PSH and using the Housing First model with low barriers. The CoC has not recommended to reallocate funds in this competition. CoC-funded projects are monitored on an annual basis. Performance Measures are reviewed while preparing the APRs in Sage and when reporting SysPMs in the HUD HDX. Performance is also reviewed by the Review & Ranking Committee when assessing projects for the competition. The projects score well during the evaluations. The pandemic put a strain on local planning.
5. During the NOFO process, the Reallocation Process is discussed at various community meetings to communicate funding that may be available during the project application. The CoC Lead also has discussions with each project applicant to evaluate whether the agency has changing needs. The CoC monitoring team also has the capacity to prompt discussion regarding funding reallocation.

1E-4a.	**Reallocation Between FY 2016 and FY 2021. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criterion below.**	
	NOFO Section VII.B.2.f.	

Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2016 and FY 2021?	No

1E-5.	**Projects Rejected/Reduced–Public Posting. You Must Upload an Attachment to the 4B. Attachments Screen if You Select Yes.**	
	NOFO Section VII.B.2.g.	

1.	**Did your CoC reject or reduce any project application(s)?**	No
2.	**If you selected yes, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.**	

1E-5a.	**Projects Accepted–Public Posting. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.g.	

Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	11/01/2021

1E-6.	**Web Posting of CoC-Approved Consolidated Application. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.g.	

Enter the date your CoC's Consolidated Application was posted on the CoC's website or affiliate's website–which included: 1. the CoC Application; 2. Priority Listings; and 3. all projects accepted, ranked where required, or rejected.	

You must enter a date in question 1E-6.

2A. Homeless Management Information System (HMIS) Implementation

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

2A-1.	**HMIS Vendor.**	
	Not Scored–For Information Only	

Enter the name of the HMIS Vendor your CoC is currently using.	CaseWorthy

2A-2.	**HMIS Implementation Coverage Area.**	
	Not Scored–For Information Only	

Select from dropdown menu your CoC's HMIS coverage area.	Single CoC

2A-3.	**HIC Data Submission in HDX.**	
	NOFO Section VII.B.3.a.	

Enter the date your CoC submitted its 2021 HIC data into HDX.	05/14/2021

2A-4.	**HMIS Implementation–Comparable Database for DV.**	
	NOFO Section VII.B.3.b.	

	Describe in the field below actions your CoC and HMIS Lead have taken to ensure DV housing and service providers in your CoC:
1.	**have a comparable database that collects the same data elements required in the HUD-published 2020 HMIS Data Standards; and**
2.	**submit de-identified aggregated system performance measures data for each project in the comparable database to your CoC and HMIS lead.**

(limit 2,000 characters)

1. FRCoC's DV provider uses Empower DB as their comparable database. EMPower DB is compliant with 2020 HMIS Data Standards and is in compliance with 2022 HMIS Data Standards. The DV provider has asked the CoC/HMIS Lead to assist in exploring finding a new comparable database to assure future compliance.
2. ESG CAPER reports for the City's Annual Plans and Consolidated Plan and ESG-CV CAPER reports for quarterly reporting in Sage are downloaded and uploaded without incident. The data is de-identified and submitted by the DV provider (Our Sisters' Place of the Greater New Bedford Women's Center). The CoC/HMIS Lead never sees the identities of those served by the DV shelter.

2A-5.	**Bed Coverage Rate–Using HIC, HMIS Data–CoC Merger Bonus Points.**	
	NOFO Section VII.B.3.c. and VII.B.7.	

Enter 2021 HIC and HMIS data in the chart below by project type:

Project Type	Total Beds 2021 HIC	Total Beds in HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
1. Emergency Shelter (ES) beds	243	5	238	100.00%
2. Safe Haven (SH) beds	0	0	0	
3. Transitional Housing (TH) beds	24	0	0	0.00%
4. Rapid Re-Housing (RRH) beds	109	0	109	100.00%
5. Permanent Supportive Housing	195	0	195	100.00%
6. Other Permanent Housing (OPH)	0	0	0	

2A-5a.	**Partial Credit for Bed Coverage Rates at or Below 84.99 for Any Project Type in Question 2A-5.**	
	NOFO Section VII.B.3.c.	

	For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-5, describe:
1.	**steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and**
2.	**how your CoC will implement the steps described to increase bed coverage to at least 85 percent.**

(limit 2,000 characters)

1. The CoC/HMIS Lead has had discussions with the Fall River Housing Authority to include their Local Housing Authority Transitional Housing Program in HMIS. FRHA has agreed to participate in data entry and wants to enter their transitional housing program's participants into CaseWorthy. This will bring HMIS participating agencies that are not DV projects to 100% compliance for data entry into HMIS.
2. Over the next 4-6 months, the CoC/HMIS Lead is bringing in a consultant to assist with training in the CaseWorthy system. Once the contract with the consultant is finalized, the LHATHP staff will be trained to enter their participants into the system.

2A-5b.	**Bed Coverage Rate in Comparable Databases.**	

NOFO Section VII.B.3.c.

Enter the percentage of beds covered in comparable databases in your CoC's geographic area.	100.00%

2A-5b.1.	Partial Credit for Bed Coverage Rates at or Below 84.99 for Question 2A-5b.	
	NOFO Section VII.B.3.c.	

	If the bed coverage rate entered in question 2A-5b. is 84.99 percent or less, describe in the field below:
1.	steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent; and
2.	how your CoC will implement the steps described to increase bed coverage to at least 85 percent.

(limit 2,000 characters)

NA

2A-6.	Longitudinal System Analysis (LSA) Submission in HDX 2.0.	
	NOFO Section VII.B.3.d.	

Did your CoC submit LSA data to HUD in HDX 2.0 by January 15, 2021, 8 p.m. EST?	Yes

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

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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- 24 CFR part 578

2B-1.	**Sheltered and Unsheltered PIT Count–Commitment for Calendar Year 2022**	
	NOFO Section VII.B.4.b.	

Does your CoC commit to conducting a sheltered and unsheltered PIT count in Calendar Year 2022?	Yes

2B-2.	**Unsheltered Youth PIT Count–Commitment for Calendar Year 2022.**	
	NOFO Section VII.B.4.b.	

Does your CoC commit to implementing an unsheltered youth PIT count in Calendar Year 2022 that includes consultation and participation from youth serving organizations and youth with lived experience?	Yes

2C. System Performance

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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- 24 CFR part 578

2C-1.	**Reduction in the Number of First Time Homeless–Risk Factors.**	
	NOFO Section VII.B.5.b.	

	Describe in the field below:
1.	**how your CoC determined which risk factors your CoC uses to identify persons becoming homeless for the first time;**
2.	**how your CoC addresses individuals and families at risk of becoming homeless; and**
3.	**provide the name of the organization or position title that is responsible for overseeing your CoC's strategy to reduce the number of individuals and families experiencing homelessness for the first time or to end homelessness for individuals and families.**

(limit 2,000 characters)

1. The CoC identified the following factors to be indicative of becoming homeless for the first time through the triage and assessment intake process when the individual/family enters through the Coordinated Entry System: sudden loss of income, untreated chronic illness, substance abuse, disabling condition, domestic violence. At CE intake, the SPDAT is completed to evaluate for referrals and placements based on vulnerability, past history of homelessness, length of time homeless, etc.
2. CE staff devises creative strategies for diversion and prevention such as having them stay where they stayed the previous night or assisting them to go back to their community of support. Community Counseling of Bristol County offers short-term community support to provide intensive case management to Medicaid clients considered at risk. Catholic Social Services runs a prevention program to provide crisis intervention to avoid eviction. Peer-to-peer recovery service agencies offer support in group or independent settings to avoid behavior and actions that might make a person homeless. Tenancy Preservation Program helps disabled tenants facing eviction due to disability-related behavior by developing a plan to maintain tenancy and monitoring the case as long as needed. RAFT provides short-term, limited financial assistance to help eligible families (with a least one child under the age of 21) avoid homelessness by retaining current housing or securing new housing.
3. CE staff devises creative strategies for diversion and prevention such as having them stay where they stayed the previous night or assisting them to go back to their hometown. Catholic Social Services receives ESG funds for Homelessness Prevention from the City of Fall River and the state of Massachusetts. NeighborWorks Housing Solutions for Southeastern Massachusetts is the regional provider that operates the Residential Assistance

for Families in Transition (RAFT).

2C-2.	Length of Time Homeless–Strategy to Reduce.	
	NOFO Section VII.B.5.c.	

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

(limit 2,000 characters)

1. To reduce LOT homeless, FRCoC implemented CE in 2015. An assessment is done. The SPDAT is completed. CE staff then assesses the results to determine who receives services first. To be efficient and streamlined, CE uses a centralized waitlist and has real-time bed availability; attempts prevention and diversion first, then assesses for eligibility/suitability use of HP/RRH funds. Providers assist with mainstream benefit applications and follow-up and job training/referral.
CoC Board continues to work on the updated action steps to end homelessness:
• Identify issues around discharge planning – who the offenders are, how to decrease occurrences how to enforce Massachusetts discharge planning laws.
• Create volunteer/job opportunities – locate sponsors and a pool of funds to incentivize homeless to volunteer/work, reestablish sense of worth of those who have been out of the workforce for extensive lengths of time, provide them with work experience and a work history.
• Develop approaches to facilitate everyday tasks of the homeless – mobile showers, receipt of mail, obtaining birth certificates and identification, obtain appropriate attire for job interviews.
• Assist and support the Local Housing Authority to apply for available housing vouchers for homeless/at-risk/formerly homeless in permanent supportive housing programs in the HUD Mainstream Voucher Program. Utilize the vouchers to create a Moving On Strategy to rotate PSH units and open them up for additional clients. Supportive service agencies will provide case management to the residents who obtain vouchers.
2. The SPDAT and the System Performance Measures are used to identify and prioritize those with longest histories of homelessness.
3. The Coordinated Entry System, operated by Catholic Social Services (VI-SPDAT), and CoC Lead (SysPMs).

2C-3.	Exits to Permanent Housing Destinations/Retention of Permanent Housing.	
	NOFO Section VII.B.5.d.	

	Describe in the field below how your CoC will increase the rate that individuals and persons in families residing in:
1.	emergency shelter, safe havens, transitional housing, and rapid rehousing exit to permanent housing destinations; and
2.	permanent housing projects retain their permanent housing or exit to permanent housing destinations.

(limit 2,000 characters)

1. Strategies to increase the rate at which those in ES, SH, TH & RRH exit to permanent housing destinations include:
• FRHA is establishing a Limited Homeless Preference to become effective 4/1/2022 by eliminating the “rent burdened” preference requirement from its HCVP waiting list: Families residing or working in Fall River and paying 40% or more of their adjusted income for rent and utilities. Currently, FRHA pre-screens every HCVP applicant who claims “rent-burdened” preference. If “rent burdened” status can’t be documented, they return to the waiting list. Income-eligible applicants in shelter or PSH and not paying >40% of their income toward rent can never proceed beyond pre-screening.
• Assist and support FRHA to apply for new housing vouchers in the Mainstream Voucher Program to create a Moving On Strategy. Supportive service agencies can provide case management.
• Create volunteer/job opportunities – develop a program to incentivize homeless to volunteer/work, reestablish sense of worth for those unemployed at length, provide them with work experience and work history.
• Utilize ESG Rapid Re-Housing funds to move individuals and families from shelter to PSH and OPH.
• Encourage private landlords to adopt a homeless preference.
2. Strategies to increase the rate at which those in PSH projects, other than RRH, retain PSH or exit to permanent housing destinations include:
• Assist and support FRHA to apply for new housing vouchers in the Mainstream Voucher Program to create a Moving On Strategy. Supportive service agencies can provide case management.
• Create volunteer/job opportunities – develop a program to incentivize homeless to volunteer/work, reestablish sense of worth for those unemployed at length, provide them with work experience and work history.
• Engage the McKinney-Vento School Liaison to identify students in families who need assistance to retain housing.
• Encourage private landlords to adopt a homeless preference.

2C-4.	**Returns to Homelessness–CoC’s Strategy to Reduce Rate.**	
	NOFO Section VII.B.5.e.	

	Describe in the field below:
1.	**how your CoC identifies individuals and families who return to homelessness;**
2.	**your CoC’s strategy to reduce the rate of additional returns to homelessness; and**
3.	**provide the name of the organization or position title that is responsible for overseeing your CoC’s strategy to reduce the rate individuals and persons in families return to homelessness.**

(limit 2,000 characters)

1. The indications of Returns to Homelessness run deeper than just the problems of the individual or family who has experienced homelessness. Although mental health and addiction issues are a strong indicator that one may not be able to retain housing, there are issues beyond the control of the homeless that affect housing stability:
• The Cliff Effect refers to the notion that when low-income working families start to earn more, their public benefits are greatly reduced and/or eliminated and they cannot make ends meet without the support.
• The lack of safe, decent, sanitary, affordable housing causes low-income

families in desperate need of housing to tolerate lesser living conditions because that is all they can afford. Also, the chance that these rental properties may be condemned is highly probable and out of the renter's control.
• The lack of vouchers to make housing more affordable puts more safe, decent, sanitary, affordable housing out of reach of low-income individuals and families.
2. The CoC's strategy to reduce Returns to Homelessness:
• Utilize ESG Prevention funds to assist individuals and families retain their housing when in crisis.
• Assist and support FRHA to apply for available housing vouchers for homeless/at-risk in the HUD Mainstream Voucher Program. Utilize the vouchers to create a Moving On Strategy. Supportive service agencies will provide case management to the residents who obtain vouchers.
• Engage the McKinney-Vento School Liaison to identify students in families who may be unstable or in crisis.
• Create volunteer/job opportunities/training – develop a program to incentivize homeless to volunteer/work or attend job training, reestablish sense of worth for those unemployed at length, provide them with work with living wages.
• Research HUD-assisted private housing, and create a campaign to encourage private landlords to adopt a homeless preference.
3. CoC Board

2C-5.	**Increasing Employment Cash Income-Strategy.**	
	NOFO Section VII.B.5.f.	

	Describe in the field below:
1.	**your CoC's strategy to increase employment income;**
2.	**how your CoC works with mainstream employment organizations to help individuals and families increase their cash income; and**
3.	**provide the organization name or position title that is responsible for overseeing your CoC's strategy to increase income from employment.**

(limit 2,000 characters)

1. To increase employment income, the CoC must meet needs to assist with resume-building; obtain skills and clothing/materials for interviews; opportunities for job training or education (community college, trade schools); assistance in seeking better job openings in their field. For those who have been out of work for an extended period, or have low job skills/education levels, on-the-job support and communication with employers is key to assist employees with problem-solving and conflict-resolution. In all cases, employment stability and advancement must be promoted. The CoC Board now includes a director of a temporary employment agency as well as organizations willing to provide job/training opportunities to the homeless and formerly homeless population.
2. Job fairs are held by:
• City administration at City Hall. Transportation is provided. Veterans and recent graduates receive early admission;
• Temp agencies (Able Assoc. and Monroe Staffing);
• Public elementary schools (for parents) and the community college;
• Private businesses such as healthcare providers, supermarkets, restaurant chains.
MassHire Career Center provides job referral, development, and placement assistance.

Mass Rehab Commission helps individuals with disabilities live and work independently.
Ticket to Work program helps SSI/SSDI beneficiaries, 18-64, progress toward financial independence.
YouthBuild assists at-risk young adults, 16-24, neither in work nor school, by providing education and job opportunities.
Secure Jobs program assists adults in families in shelter and other homeless programs to obtain employment.
CoC agencies have policies that employable clients complete employment profiles and obtain job training.
3. CoC Board

2C-5a.	Increasing Employment Cash Income–Workforce Development–Education–Training.	
	NOFO Section VII.B.5.f.	

	Describe in the field below how your CoC:
1.	promoted partnerships and access to employment opportunities with private employers and private employment organizations, such as holding job fairs, outreach to employers, and partnering with staffing agencies; and
2.	is working with public and private organizations to provide meaningful education and training, on-the-job training, internships, and employment opportunities for program participants.

(limit 2,000 characters)

1. CoC promotes partnerships and employment by:
• Referring to Monroe Staffing and Able Assoc. Temp positions aren't long-term but provide skill development, work history, links with potential long-term employers.
• HealthFirst, a major healthcare provider, provides training/job opportunities to formerly homeless clients.
• Blount Fine Foods has a corporate office, processing plant, and store/restaurant in/near FRCoC. They have entry-level opportunities and will hire those in recovery.
• Secure Jobs program at SER-Jobs assists adults in families in homeless programs to obtain employment.
• Amazon Fulfillment Center offers around 1,000 varying level positions at competitive hourly rates, 401(k), medical, dental, vision.
• South Coast Market Place opened in Fall 2017 and has a movie theater, large market, 5 food establishments, retail, healthcare, and a gym.
• Job fairs are held by:
oCity administration at City Hall. Transportation is provided. Veterans receive early admission;
oTemp agencies (Able Assoc. and Monroe Staffing);
oPublic elementary schools (for parents) and the community college;
oPrivate businesses such as healthcare providers, supermarkets, restaurant chains.
2. Education, on-the-job training, internship, employment for PSH clients:
• CoC agencies have policies that employable clients complete employment profiles and obtain job training.
• The CoC Board now includes a director of a temp agency.
• CoC PSH agencies refer clients to:
oMassHire Career Center provides job referral, development, and placement assistance.
oMA Rehab Commission helps disabled individuals obtain work.

oTicket to Work program helps SSI/SSDI beneficiaries, 18-64, obtain jobs.
oYouthBuild assists at-risk young adults, 16-24, neither in work nor school, by providing education and job opportunities.
oSecure Jobs program at SER-Jobs assists adults in families in homeless programs to obtain employment.

2C-5b.	**Increasing Non-employment Cash Income.**	
	NOFO Section VII.B.5.f.	

	Describe in the field below:
1.	**your CoC's strategy to increase non-employment cash income;**
2.	**your CoC's strategy to increase access to non-employment cash sources; and**
3.	**provide the organization name or position title that is responsible for overseeing your CoC's strategy to increase non-employment cash income.**

(limit 2,000 characters)

1. The CoC's strategy to increase non-employment cash income is to have case managers assist and follow through with clients applying for mainstream unearned income benefits, such as Supplemental Security Income, Social Security Disability Income, health insurance, food assistance (SNAP, WIC, locating food pantries and soup kitchens), Emergency Aid to the Elderly, Disabled and Children.
2. Case managers are SOAR-trained to increase access to SSI/SSDI for eligible homeless or at-risk adults who have mental illness, medical impairment, and/or co-occurring substance use disorder. Having a SOAR-trained case manager reduces the chance that the client will be rejected when applying for SSI/SSDI. SOAR training consultants approached the CoC in spring of 2021 and after completing a small presentation and on-line survey, they have offered to follow through with additional education and certification to increase the number of SOAR-trained providers and to increase their ability to better navigate the application process. The training will happen in very early 2022.
Program staff can complete applications for insurance, SNAP benefits, and EAEDC benefits at www.virtualgateway.com via www.mass.gov. Insurance can be applied for at any hospital, major healthcare facility (clinic), and through for-profit and non-profit insurance companies (Neighborhood Health Plan, Inc., Boston Medical HealthNet Plan, Fallon Community Health Plan). MassHire Career Center assists with applying for unemployment benefits.
3. CoC and ESG agency staff are responsible to assist their clients to access applications to apply for non-employment cash income.

3A. Coordination with Housing and Healthcare Bonus Points

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3A-1.	**New PH-PSH/PH-RRH Project–Leveraging Housing Resources.**	
	NOFO Section VII.B.6.a.	

Is your CoC applying for a new PSH or RRH project(s) that uses housing subsidies or subsidized housing units which are not funded through the CoC or ESG Programs to help individuals and families experiencing homelessness?	No

3A-1a.	**New PH-PSH/PH-RRH Project–Leveraging Housing Commitment. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.6.a.	

Select yes or no in the chart below to indicate the organization(s) that provided the subsidies or subsidized housing units for the proposed new PH-PSH or PH-RRH project(s).

1.	**Private organizations**	No
2.	**State or local government**	No
3.	**Public Housing Agencies, including use of a set aside or limited preference**	No
4.	**Faith-based organizations**	No
5.	**Federal programs other than the CoC or ESG Programs**	No

3A-2.	**New PSH/RRH Project–Leveraging Healthcare Resources.**	
	NOFO Section VII.B.6.b.	

Is your CoC applying for a new PSH or RRH project that uses healthcare resources to help individuals and families experiencing homelessness?	No

3A-2a.	**Formal Written Agreements–Value of Commitment–Project Restrictions. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.6.b.	

1.	**Did your CoC obtain a formal written agreement that includes: (a) the project name; (b) value of the commitment; and (c) specific dates that healthcare resources will be provided (e.g., 1-year, term of grant, etc.)?**	No
2.	**Is project eligibility for program participants in the new PH-PSH or PH-RRH project based on CoC Program fair housing requirements and not restricted by the health care service provider?**	No

3A-3.	**Leveraging Housing Resources–Leveraging Healthcare Resources–List of Projects.**	
	NOFO Sections VII.B.6.a. and VII.B.6.b.	

If you selected yes to question 3A-1. or 3A-2., use the list feature icon to enter information on each project you intend for HUD to evaluate to determine if they meet the bonus points criteria.

Project Name	Project Type	Rank Number	Leverage Type
This list contains no items			

3B. New Projects With Rehabilitation/New Construction Costs

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3B-1.	**Rehabilitation/New Construction Costs–New Projects.**	
	NOFO Section VII.B.1.r.	

Is your CoC requesting funding for any new project application requesting $200,000 or more in funding for housing rehabilitation or new construction?	No

3B-2.	**Rehabilitation/New Construction Costs–New Projects.**	
	NOFO Section VII.B.1.s.	

	If you answered yes to question 3B-1, describe in the field below actions CoC Program-funded project applicants will take to comply with:
1.	**Section 3 of the Housing and Urban Development Act of 1968 (12 U.S.C. 1701u); and**
2.	**HUD's implementing rules at 24 CFR part 75 to provide employment and training opportunities for low- and very-low-income persons, as well as contracting and other economic opportunities for businesses that provide economic opportunities to low- and very-low-income persons.**

(limit 2,000 characters)

NA

3C. Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3C-1.	**Designating SSO/TH/Joint TH and PH-RRH Component Projects to Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.**	
	NOFO Section VII.C.	

Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes?	No

3C-2.	**Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.C.	

	If you answered yes to question 3C-1, describe in the field below:
1.	**how serving this population is of equal or greater priority, which means that it is equally or more cost effective in meeting the overall goals and objectives of the plan submitted under Section 427(b)(1)(B) of the Act, especially with respect to children and unaccompanied youth than serving the homeless as defined in paragraphs (1), (2), and (4) of the definition of homeless in 24 CFR 578.3; and**
2.	**how your CoC will meet requirements described in Section 427(b)(1)(F) of the Act.**

(limit 2,000 characters)

NA

4A. DV Bonus Application

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

4A-1.	**New DV Bonus Project Applications.**	
	NOFO Section II.B.11.e.	

Did your CoC submit one or more new project applications for DV Bonus Funding?	No
Applicant Name	
This list contains no items	

4B. Attachments Screen For All Application Questions

We prefer that you use PDF files, though other file types are supported. Please only use zip files if necessary.

Attachments must match the questions they are associated with.

Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process.

We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

Document Type	Required?	Document Description	Date Attached
1C-14. CE Assessment Tool	Yes	CE Assessment Tool	11/10/2021
1C-7. PHA Homeless Preference	No		
1C-7. PHA Moving On Preference	No		
1E-1. Local Competition Announcement	Yes	Local Competition...	11/09/2021
1E-2. Project Review and Selection Process	Yes	Project Review an...	11/09/2021
1E-5. Public Posting–Projects Rejected-Reduced	Yes	Public Posting-Pr...	11/09/2021
1E-5a. Public Posting–Projects Accepted	Yes	Public Posting-Pr...	11/09/2021
1E-6. Web Posting–CoC-Approved Consolidated Application	Yes		
3A-1a. Housing Leveraging Commitments	No		
3A-2a. Healthcare Formal Agreements	No		
3C-2. Project List for Other Federal Statutes	No		

Attachment Details

Document Description: CE Assessment Tool

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Local Competition Announcement & Blank Scoring Tool

Attachment Details

Document Description: Project Review and Selection Process

Attachment Details

Document Description: Public Posting-Projects Rejected or Reduced (0)

Attachment Details

Document Description: Public Posting-Projects Accepted (all)

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/20/2021
1B. Inclusive Structure	11/08/2021
1C. Coordination	11/10/2021
1C. Coordination continued	11/12/2021
1D. Addressing COVID-19	11/08/2021
1E. Project Review/Ranking	Please Complete
2A. HMIS Implementation	11/08/2021
2B. Point-in-Time (PIT) Count	10/14/2021
2C. System Performance	11/09/2021
3A. Housing/Healthcare Bonus Points	11/04/2021
3B. Rehabilitation/New Construction Costs	09/29/2021

3C. Serving Homeless Under Other Federal Statutes	11/04/2021
4A. DV Bonus Application	09/29/2021
4B. Attachments Screen	Please Complete
Submission Summary	No Input Required

Service Prioritization Decision Assistance Tool

(SPDAT)

Assessment Tool for Single Adults

VERSION 4.01

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

Welcome to the SPDAT Line of Products

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

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

VI-SPDAT Series

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

Current versions available:

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

All versions are available online at

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

SPDAT Series

The **Service Prioritization Decision Assistance Tool** (SPDAT) was developed as an assessment tool for frontline workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. It is an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

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

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

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

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

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

Current SPDAT training available:

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

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

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

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

Terms and Conditions Governing the Use of the SPDAT

SPDAT products have been developed by OrgCode Consulting, Inc. with extensive feedback from key community partners including people with lived experience. The tools are provided free of charge to communities to improve the client centered services dedicated to increasing housing stability and wellness. Training is indeed required for the administration and interpretation of these assessment tools. Use of the SPDAT products without authorized training is strictly prohibited.

By using this tool, you accept and agree to be bound by the terms of this expectation.

No sharing, reproduction, use or duplication of the information herein is permitted without the express written consent of OrgCode Consulting, Inc.

Ownership

The Service Prioritization Decision Assistance Tool ("SPDAT") and accompanying documentation is owned by OrgCode Consulting, Inc.

Training

Although the SPDAT Series is provided free of charge to communities, training by OrgCode Consulting, Inc. or a third party trainer, authorized by OrgCode, must be successfully completed. After meeting the training requirements required to administer and interpret the SPDAT Series, practitioners are permitted to implement the SPDAT in their work with clients.

Restrictions on Use

You may not use or copy the SPDAT prior to successfully completing training on its use, provided by OrgCode Consulting, Inc. or a third-party trainer authorized by OrgCode. You may not share the SPDAT with other individuals not trained on its use. You may not train others on the use of the SPDAT, unless specifically authorized by OrgCode Consulting, Inc.

Restrictions on Alteration

You may not modify the SPDAT or create any derivative work of the SPDAT or its accompanying documentation, without the express written consent of OrgCode Consulting, Inc. Derivative works include but are not limited to translations.

Disclaimer

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

A. Mental Health & Wellness & Cognitive Functioning

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

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

B. Physical Health & Wellness

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

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

C. Medication

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

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

D. Substance Use

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

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

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

E. Experience of Abuse & Trauma

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

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

F. Risk of Harm to Self or Others

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

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

G. Involvement in Higher Risk and/or Exploitive Situations

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

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

H. Interaction with Emergency Services

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

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

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

I. Legal

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

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

J. Managing Tenancy

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

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

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

K. Personal Administration & Money Management

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

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

L. Social Relationships & Networks

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

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

M. Self Care & Daily Living Skills

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

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

N. Meaningful Daily Activity

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

CLIENT SCORE:	

NOTES

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

O. History of Homelessness & Housing

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

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

Client:	Worker:	Version:	Date:

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

Client:	Worker:	Version:	Date:

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

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

Appendix A: About the SPDAT

OrgCode Consulting, Inc. is pleased to announce the release of Version 4 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

SPDAT Design

The SPDAT is designed to:

- Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
- Prioritize the sequence of clients receiving those services
- Help prioritize the time and resources of Frontline Workers
- Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
- Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team
- Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan
- Track the depth of need and service responses to clients over time

The SPDAT is NOT designed to:

- Provide a diagnosis
- Assess current risk or be a predictive index for future risk
- Take the place of other valid and reliable instruments used in clinical research and care

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, we have also created the VI-SPDAT as an initial screening tool.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client's acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services.

Version 4

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale, Camberwell Assessment of Needs, Vulnerability Index, and Transition Aged Youth Triage Tool.

In preparing SPDAT v4, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff have observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics review enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

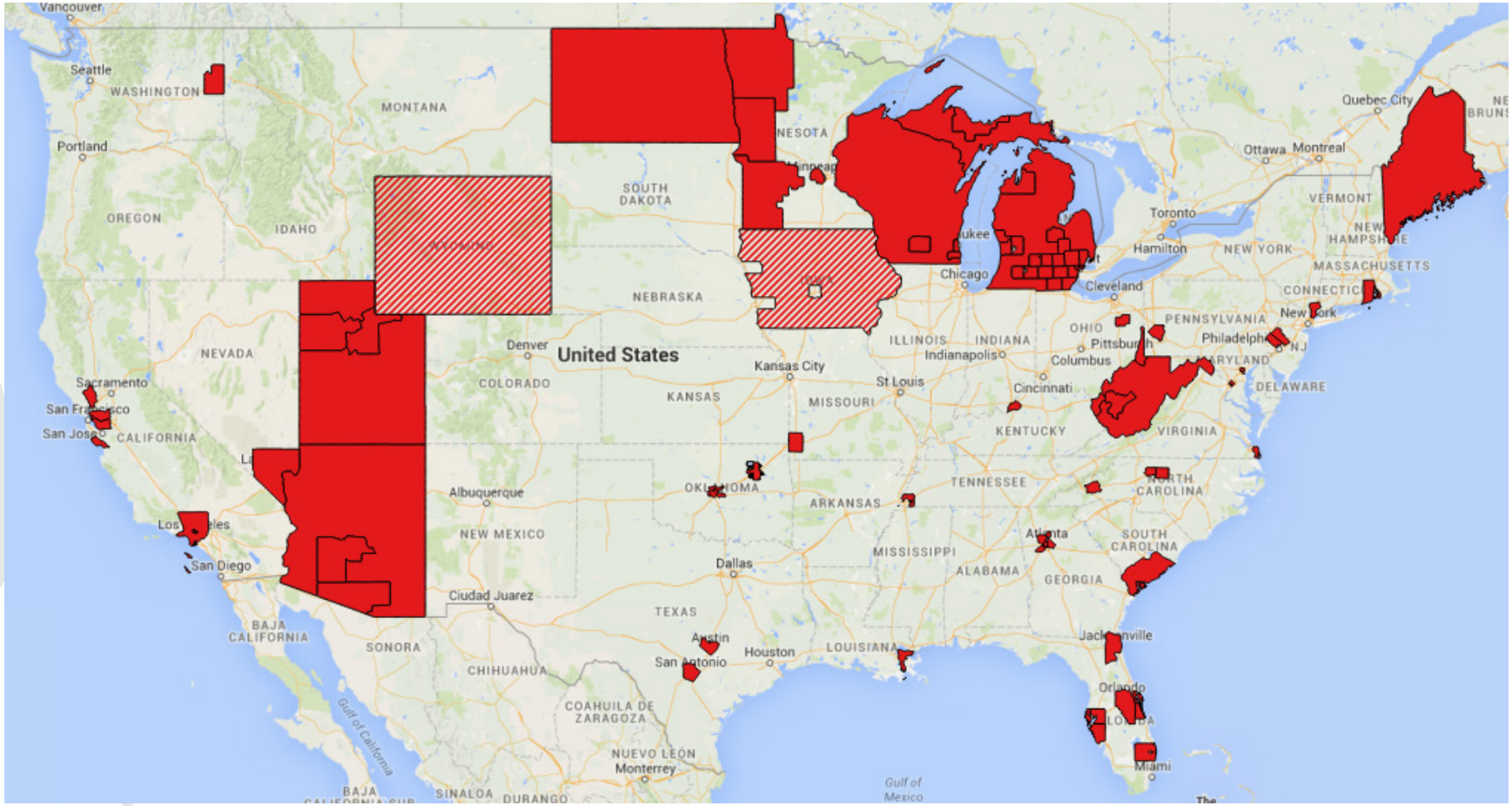
Version 4 builds upon the success of Version 3 of the SPDAT with some refinements. Starting in August 2014, a survey was launched of existing SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

The major differences from Version 3 to Version 4 include:

- The structure of the tools is the same: four domains (five for families) with components aligned to specific domains. The names of the domains and the components remain unchanged.
- The scoring of the tools is the same: 60 points for singles, and 80 points for families.
- The scoring tables used to run from 0 through to 4. They are now reversed with each table starting at 4 and working their way down to 0. This increases the speed of assessment.
- The order of the tools has changed, grouped together by domain.
- Language has been simplified.
- Days are used rather than months to provide greater clarification and alignment to how most databases capture periods of time in service.
- Greater specificity has been provided in some components such as amount of debts.

Appendix B: Where the SPDAT is being used (as of May 2015)

United States of America



Arizona
- Statewide

California
- Oakland/Alameda County CoC
- Richmond/Contra Costa County CoC
- Watsonville/Santa Cruz City & County CoC
- Napa City & County CoC
- Los Angeles City & County CoC
- Pasadena CoC
- Glendale CoC

District of Columbia
- District of Columbia CoC

Florida
- Sarasota/Bradenton/Manatee, Sarasota Counties CoC
- Tampa/Hillsborough County CoC
- St. Petersburg/Clearwater/Largo/Pinellas County CoC
- Orlando/Orange, Osceola, Seminole Counties CoC
- Jacksonville-Duval, Clay Counties CoC
- Palm Bay/Melbourne/Brevard County CoC
- West Palm Beach/Palm Beach County CoC

Georgia
- Atlanta County CoC
- Fulton County CoC
- Marietta/Cobb County CoC
- DeKalb County CoC

Iowa
- Parts of Iowa Balance of State CoC

Kentucky
- Louisville/Jefferson County CoC

Louisiana
- New Orleans/Jefferson Parish CoC

Maryland
- Baltimore City CoC

Maine
- Statewide

Michigan
- Statewide

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

Missouri
- Joplin/Jasper, Newton Counties CoC

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

North Dakota
- Statewide

Nevada
- Las Vegas/Clark County CoC

New York
- Yonkers/Mount Vernon/New Rochelle/Westchester County CoC

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

Oklahoma
- Tulsa City & County/Broken Arrow CoC
- Oklahoma City CoC

Pennsylvania
- Lower Marion/Norristown/Abington/Montgomery County CoC
- Bristol/Bensalem/Bucks County CoC
- Pittsburgh/McKeesport/Penn Hills/Allegheny County CoC

Rhode Island
- Statewide

South Carolina
- Charleston/Low Country CoC

Tennessee
- Memphis/Shelby County CoC

Texas
- San Antonio/Bexar County CoC
- Austin/Travis County CoC

Utah
- Salt Lake City & County CoC
- Utah Balance of State CoC
- Provo/Mountainland CoC

Virginia
- Virginia Beach CoC
- Arlington County CoC

Washington
- Spokane City & County CoC

Wisconsin
- Statewide

West Virginia
- Statewide

Wyoming
- Wyoming is in the process of implementing statewide

Canada

Alberta
- Province-wide

Manitoba
- City of Winnipeg

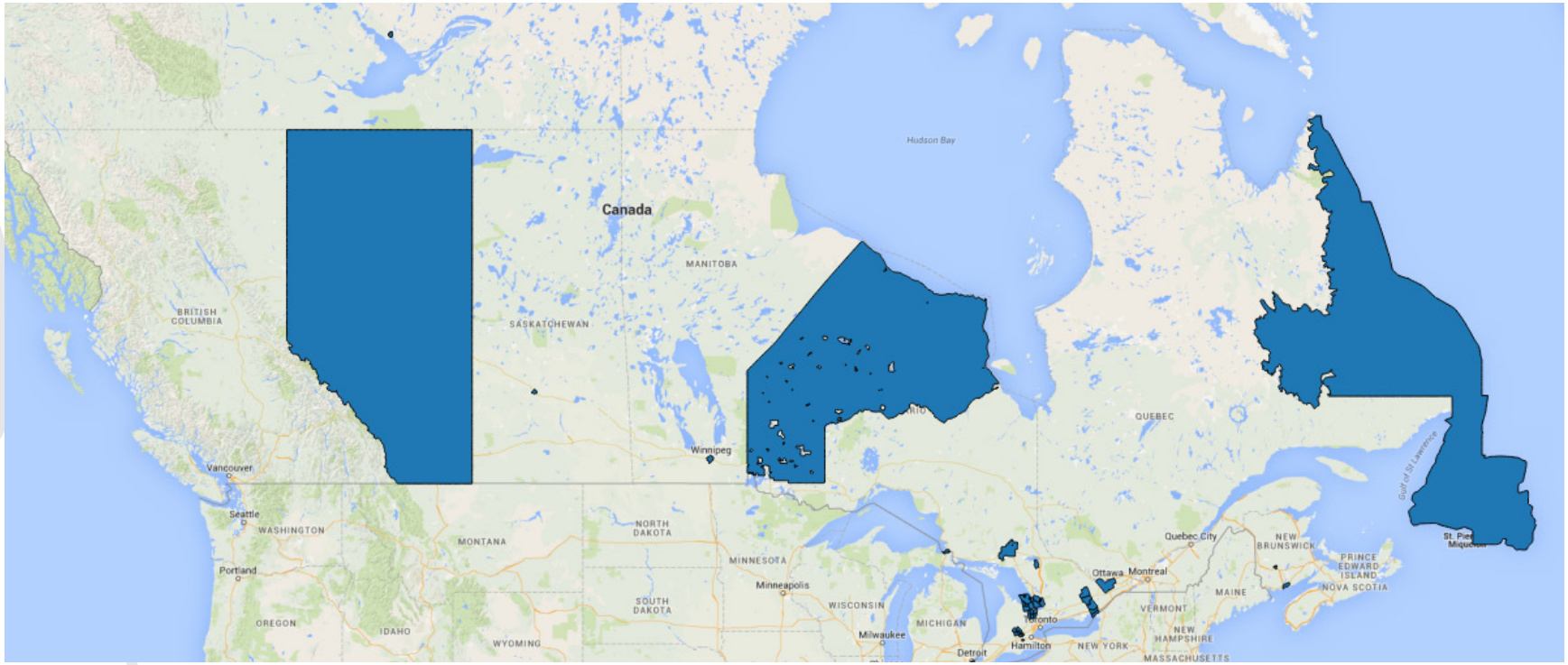
New Brunswick
- City of Fredericton
- City of Saint John

Newfoundland and Labrador
- Province-wide

Northwest Territories
- City of Yellowknife

Ontario
- City of Barrie/Simcoe County
- City of Brantford/Brant County
- City of Greater Sudbury
- City of Kingston/Frontenac County
- City of Ottawa
- City of Windsor
- District of Kenora
- District of Parry Sound
- District of Sault Ste Marie
- Regional Municipality of Waterloo
- Regional Municipality of York

Saskatchewan
- Saskatoon



Australia

Queensland
- Brisbane

- Fall River Homeless Service Pro

fallriverhomeless.com

Transitioning homeless people from instability to independence.

Fall River

Homeless Service Providers Coalition · Home · What We Do · Participating Agencies · FAQ · Contact

Welcome to Fall River Homeless Service Providers Coalition!

If you are currently homeless or at risk of becoming homeless in Fall River please call for assistance today.

Fall River Coordinated Entry System
Telephone: 774-520-2555
E-mail: frce@cssdioc.org

The Coordinated Entry System (CES) allows families and individuals to connect to resources to help resolve their housing crisis. CES works to connect the highest need, most vulnerable persons in the community to available housing and supportive services that best fit their needs

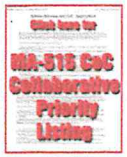
The **Fall River HSPC** seeks to provide quality of life to the formerly homeless and empower them to live as independently as possible.

The **Fall River Homeless Service Providers Coalition's** (HSPC) mission is to:

work towards eradicating homelessness in Fall River, MA

- to improve access to mainstream resources
- to assist in the transition from homelessness through the continuum of care
- to provide supportive services
- to help maintain housing
- to prevent discharge of homeless people to the streets
- and to employ a quality Homeless Management Information System (HMIS) that accurately tracks and counts the homeless.
- **Homeless Services:**
  - Shelters & Housing Services
  - Food Pantries and Soup Kitchens

RENTAL ASSISTANCE - FALL RIVER, MA
Are you in need of Rental Assistance? Are you at risk of Homelessness? Follow this link for information! >>>



Fall River HSPC News

You can help!

The Fall River Overflow Shelter is outreaching to volunteers for Fall River's Emergency Shelter Overflow that operates January 2 through mid-March. For more information visit www.fallriveroverflowshelter.com.

First Step Inn is requesting donations for the relocation of the Emergency Shelter for single men and women. The new site will eventually accommodate the overflow shelter on site, as well as provide on-site education and services to the guests. To donate or more information visit www.firststepinn.org.

Printable Pamphlets

Downloadable/printable PDF versions of our pamphlet of services for homeless families and individuals along with a list of food pantries and soup kitchens. Our By-Laws are available here on our website.

- Click here for our resources pamphlet (PDF)
- Click here for Fall River

Type here to search

10:01 AM
9/24/2021

- to prevent discharge of homeless people to the streets
- and to employ a quality Homeless Management Information System (HMIS) that accurately tracks and counts the homeless.
- **Homeless Services:**
  - Shelters & Housing Services
  - Food Pantries and Soup Kitchens

and individuals along with a list of food pantries and soup kitchens. Our By-Laws are available here on our website.

- Click here for our resources pamphlet (PDF)
- Click here for **Fall River HSPC By-Laws** (PDF)

If you or some you know is homeless or at risk for homelessness please contact us today.

Fall River
Homeless Service Providers Coalition

September 22, 2021

Dear Director:

This is to inform you that the Department of Housing and Urban Development (HUD) has released the Continuum of Care application for its competitive grants for housing and services for the homeless.

Any entity looking to apply for renewal funding of its programs must forward a **Letter of Intent**

to the Homeless Service Providers Coalition (HSPC) by **5:00 p.m., October 1, 2021.**

The organization must actively participate in the application process and may schedule time with me at my office to obtain assistance to complete the application in e-snaps, if necessary. Project applications will be due in e-snaps **October 13, 2021.**

Also attached is a description of opportunities that are available in the federal competition and may be available in the Fall River competition (local approval pending; available to any 501(c)(3) organization operating in Fall River). The opportunity to consolidate existing CoC projects is available, provided that the projects are operated by the same agency and of the same component. Please include information regarding what programs your agency is considering for consolidation in your Letter of Intent.

General information regarding the Continuum of Care Program Competition may be found at https://www.hud.gov/program_offices/comm_planning/coc/competition. (Please note: The CoC Competition information has been moved from the HUD Exchange to HUD.gov.)

Please forward your Letter of Intent by scanning your original signed letter and attaching it to an e-mail to mdcamara@fallriverma.gov by **5:00 p.m., Friday, October 1, 2021.** If you have any questions, please contact me at 508 679-0111.

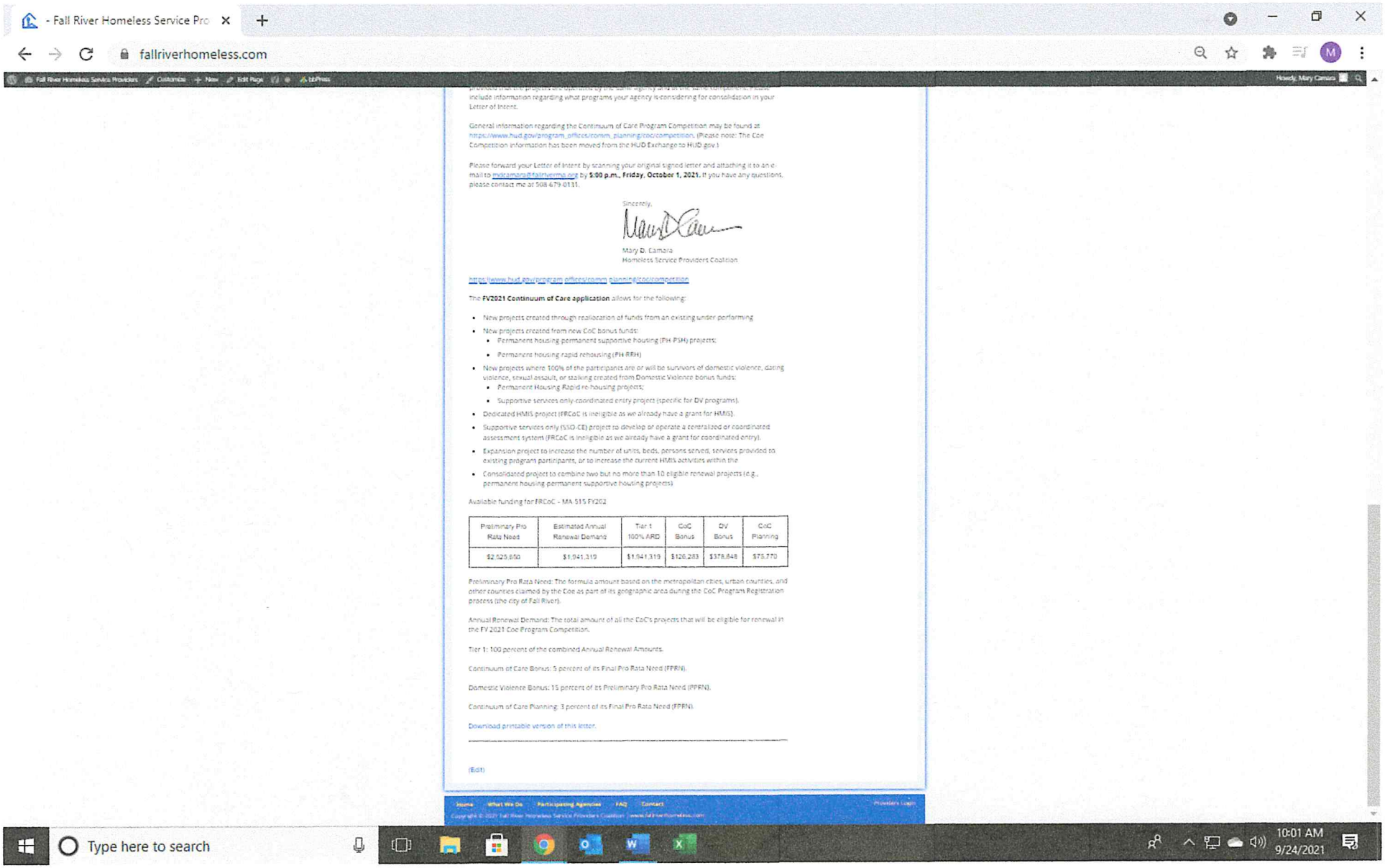
Sincerely,

Mary D. Camara
Homeless Service Providers Coalition

https://www.hud.gov/program_offices/comm_planning/coc/competition

The **FY2021 Continuum of Care application** allows for the following:

- New projects created through reallocation of funds from an existing under performing
- New projects created from new CoC bonus funds:
  - Permanent housing permanent supportive housing (PH-PSH) projects;
  - Permanent housing rapid rehousing (PH-RRH)
- New projects where 100% of the participants are or will be survivors of domestic violence, dating violence, sexual assault, or stalking created from Domestic Violence bonus funds:
  - Permanent Housing-Rapid re-housing projects;
  - Supportive services only coordinated entry project (specific for DV programs).
- Dedicated HMIS project (FRCoC is ineligible as we already have a grant for HMIS).
- Supportive services only (SSO: CE) project to develop or operate a centralized or coordinated assessment system (FRCoC is ineligible as we already have a grant for coordinated entry).
- Expansion project to increase the number of units, beds, persons served, services provided to


- Fall River Homeless Service Pro
fallriverhomeless.com
Howdy, Mary Camara
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Please forward your Letter of Intent by scanning your original signed letter and attaching it to an e-mail to mdcamara@fallriverma.org by 5:00 p.m., Friday, October 1, 2021. If you have any questions, please contact me at 508 679 0131.
Sincerely,
Mary D. Camara
Homeless Service Providers Coalition
https://www.hud.gov/program_offices/comm_planning/coc/competition
The FY2021 Continuum of Care application allows for the following:
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New projects created from new CoC bonus funds:
Permanent housing permanent supportive housing (PH PSH) projects;
Permanent housing rapid rehousing (PH RRH)
New projects where 100% of the participants are or will be survivors of domestic violence, dating violence, sexual assault, or stalking created from Domestic Violence bonus funds:
Permanent Housing Rapid re-housing projects;
Supportive services only-coordinated entry project (specific for DV programs).
Dedicated HMIS project (FRCoC is ineligible as we already have a grant for HMIS).
Supportive services only (SSO-CE) project to develop or operate a centralized or coordinated assessment system (FRCoC is ineligible as we already have a grant for coordinated entry).
Expansion project to increase the number of units, beds, persons served, services provided to existing program participants, or to increase the current HMIS activities within the
Consolidated project to combine two but no more than 10 eligible renewal projects (e.g., permanent housing permanent supportive housing projects)
Available funding for FRCoC - MA 515 FY202
Preliminary Pro Rata Need
Estimated Annual Renewal Demand
Tier 1 100% ARD
CoC Bonus
DV Bonus
CoC Planning
$2,525,650
$1,941,319
$1,941,319
$126,283
$378,848
$75,770
Preliminary Pro Rata Need: The formula amount based on the metropolitan cities, urban counties, and other counties claimed by the CoC as part of its geographic area during the CoC Program Registration process (the city of Fall River).
Annual Renewal Demand: The total amount of all the CoC's projects that will be eligible for renewal in the FY 2021 CoC Program Competition.
Tier 1: 100 percent of the combined Annual Renewal Amounts.
Continuum of Care Bonus: 5 percent of its Final Pro Rata Need (FPRN).
Domestic Violence Bonus: 15 percent of its Preliminary Pro Rata Need (PPRN).
Continuum of Care Planning: 3 percent of its Final Pro Rata Need (FPRN).
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Funding Requests

		2018 Grant Award minus CDA Admin	2018 Funds Expended	% Expended	FY2021 Request	2021 PiT # of beds	Dedicated CH	Priority CH	Youth 18-24	Youth Under 18	Veteran	Subpops	HF
Cornerstone	MA0383L1T151806	470,547.00	400,615.00	85.14%	540,465.00	64	64	0	3	0	4	Y,DV,F,V	yes
Francis House	MA0417L1T151807	95,695.00	67,590.00	70.63%	108,197.00	8	4	4	8	0	0	Y, DV	yes
Home First Consolid	MA0578L1T151802	178,176.00	182,434.00	102.39%	203,960	12	12	0	3	0	1	Y, V	yes
Next Step Home	MA0236L1T151811	451,769.00	405,234.00	89.70%	511,666	66	66	0	0	0	2	DV, F, V	yes
Stone Residence	MA0238L1T151811	386,888.00	394,896.00	102.07%	444,281	22	22	0	3	0	2	V	yes

Subpopulations: Y=Youth, DV=Victims of Domestic Violence, F=Families w/Children, V=Veterans CH = Chronically Homeless

Beds in family programs are recorded based on # of beds occupied during PiT Count.

HMIS	MA0323L1T151810	$30,526	$29,416	96%	$32,662
The CALL (SSO-CE)	MA0526L1T151500	$97,256	$53,592	55%	$100,088

Annual Renewal Demand	$1,941,319
Tier 1 (100% of ARD)	$1,941,319
Tier 2	$0
Total Funding Request	$1,941,319
Difference (Tier 2)	$0

No Bonus requests
No consolidations
No reallocations

State abbreviation	Project ID number	App Type	FO Code	CoC #	FY of App	renew
MA	0238	L	1T	15	18	11

Project Rating Tool - System Performance Measures

Exits to Permanent Housing

SPM 7b.1 & 7b.2

percent (%) remain in or move to permanent housing

CS	FH	HFC	NSHP	SR
97.50%	100.00%	80.00%	100.00%	91.00%

Minimum %	points
90	25

Returns to Homelessness

SPM 2

percent (%) of participants return to homelessness within 12 months of exit to PH

CS	FH	HFC	NSHP	SR
0.00%	0.00%	0.00%	0.00%	0.00%

Maximum %	points
15	15

New or Increased Income and Earned Income

SPM 4.1

percent (%) new or increased earned income for project stayers

CS	FH	HFC	NSHP	SR
13.00%	33.00%	0.00%	6.00%	21.00%

Minimum %	points
8	2.5

SPM 4.2

percent (%) new or increased non-employment income for project stayers

	CS	FH	HFC	NSHP	SR
	60.00%	67.00%	57.00%	71.00%	57.00%
All Stayer	67	100	57	77	64

Minimum %	points
10	2.5

SPM 4.4

percent (%) new or increased earned income for project leavers

CS	FH	HFC	NSHP	SR
0.00%	67.00%	0.00%	25.00%	0.00%

Minimum %	points
8	2.5

SPM 4.5

percent (%) new or increased non-employment income for project leavers

	CS	FH	HFC	NSHP	SR
	43.00%	33.00%	33.00%	50.00%	44.00%
All Leaver	43	100	33	75	33

Minimum %	points
10	2.5

Higher score = the project lends itself to low barrier/housing first model

Serve High Need Populations

APR - Q5a

	TOTAL CLIENTS ENTERING THE PROGRAM DURING APR TERM				
	CS	FH	HFC	NSHP	SR
Adults	46	10	12	48	30
Children	33	0	0	24	0
Total	79	10	12	72	30

APR - Q16

percent (%) of participants with zero income at entry (adults only)

	CS	FH	HFC	NSHP	SR
Adults	9	5	4	2	6
%	19.57%	50.00%	33.33%	4.17%	20.00%

Minimum %	points
80	10

APR - Q13a2

percent (%) of participants with more than one disability type at entry (all)

	CS	FH	HFC	NSHP	SR
All	29	3	12	39	28
%	36.71%	30.00%	100.00%	54.17%	93.33%

Minimum %	points
75	10

APR - Q15

percent (%) of participants entering project from place not meant for human habitation (adults only)

	CS	FH	HFC	NSHP	SR
Adults	35	9	12	40	28
%	76.09%	90.00%	100.00%	83.33%	93.33%

Minimum %	points
75	10

Coordinated Entry Participation

Housing First and/or Low Barrier Implementation

Documented, secured minimum match

Project has reasonable costs per permanent housing exit, as defined locally

Project is financially feasible

Applicant is active CoC participant

Application is complete and data are consistent

Data quality at or above 90%

Bed/unit utilization rate at or above 90%

Acceptable organizational audit/financial review

Documented organizational financial stability

October 29, 2021

To Whom It May Concern:

A subcommittee consisting of Julie Almond (HealthFirst Family Care Center), Tracy Ibbotson (Steward Healthcare System/St. Anne's Hospital), and Casey Shannon (BayCoast Bank) met on October 29, 2021, to review and rank the renewal projects that will be part of the Fall River CoC application this year.

After careful thought and consideration, the subcommittee formulated the ranking of the seven (7) programs for the CoC application that you will find below. In reaching this decision, the subcommittee took into consideration the importance of several factors: utilization of contract funds from prior years as well as a review of programmatic performance measures. Please note that the performance indicator of percent of participants with zero income entry was not factored due to all projects' performance on this being below the HUD minimum (80%).

The recommendation committee is grateful for the opportunity to be a part of the review process and appreciative of the time that representatives from all projects gave in meeting with us to explain their respective projects and answer all of our questions.

Ranking Recommendations:

Tier One	**Tier Two**
1. HMIS	[NONE]
2. The CALL (SSO-CE)	
3. Next Step Home	
4. Cornerstone	
5. Home First Consolidation	
6. Stone Residence	
7. Francis House	

Sincerely,

The members of the recommendation Committee
Julie Almond
Tracy Ibbotson
Casey Shannon

Funding Requests

			2018 Grant Award minus CDA Admin	2018 Funds Expended	% Expended	FY2021 Request	2021 PiT # of beds	Dedicated CH	Priority CH	Youth 18-24	Youth Under 18	Veteran	Subpops	HF
4	Cornerstone	MA0383L1T151806	470,547.00	400,615.00	~ 85.14%	540,465.00	64	64	0	3	0	4	Y,DV,F,V	yes
7	Francis House	MA0417L1T151807	95,695.00	67,590.00	↓ 70.63%	108,197.00	8	4	4	8	0	0	Y, DV	yes
5	Home First Consolid	MA0578L1T151802	178,176.00	182,434.00	↑ 102.39%	203,960	12	12	0	3	0	1	Y, V	yes
3	Next Step Home	MA0236L1T151811	451,769.00	405,234.00	~ 89.70%	511,666	66	66	0	0	0	2	DV, F, V	yes
6	Stone Residence	MA0238L1T151811	386,888.00	394,896.00	↑ 102.07%	444,281	22	22	0	3	0	2	V	yes

Subpopulations: Y=Youth, DV=Victims of Domestic Violence, F=Families w/Children, V=Veterans CH = Chronically Homeless

Beds in family programs are recorded based on # of beds occupied during PiT Count.

1	HMIS	MA0323L1T151810	$30,526	$29,416	96%	$32,662
2	The CALL (SSO-CE)	MA0526L1T151500	$97,256	$53,592	55%	$100,088

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Tier 1 (100% of ARD)	$1,941,319
Tier 2	$0
Total Funding Request	$1,941,319
Difference (Tier 2)	$0

No Bonus requests
No consolidations
No reallocations

State abbreviation	Project ID number	App Type	FO Code	CoC #	FY of App	renew
MA	0238	L	1T	15	18	11

	Funds exp	SIS PIT	HSG 1ST	Other
CS	1 —	4350	11	F
FH	0 ↓	45	12	
HFC	2 ↑	35	20	
NSHP	1 —	44.50	13	F
SR	2 ↑	42.50	18	

Project Rating Tool - System Performance Measures

Exits to Permanent Housing SPM 7b.1 & 7b.2

percent (%) remain in or move to permanent housing

CS	FH	HFC	NSHP	SR
97.50%	100.00%	80.00%	100.00%	91.00%
25	25	18	25	25

Minimum %	points
90	25

Returns to Homelessness SPM 2

percent (%) of participants return to homelessness within 12 months of exit to PH

CS	FH	HFC	NSHP	SR
0.00%	0.00%	0.00%	0.00%	0.00%
15	15	15	15	15

Maximum %	points
15	15

New or Increased Income and Earned Income SPM 4.1

percent (%) new or increased earned income for project stayers

CS	FH	HFC	NSHP	SR
13.00%	33.00%	0.00%	6.00%	21.00%

Minimum %	points
8	2.5

SPM 4.2

percent (%) new or increased non-employment income for project stayers

	CS	FH	HFC	NSHP	SR
	60.00%	67.00%	57.00%	71.00%	57.00%
All Stayer	67 %	100 %	57 %	77 %	64 %
	2	2.5	1	2.5	1.5

Minimum %	points
10	2.5

SPM 4.4

percent (%) new or increased earned income for project leavers

CS	FH	HFC	NSHP	SR
0.00%	67.00%	0.00%	25.00%	0.00%

Minimum %	points
8	2.5

SPM 4.5

percent (%) new or increased non-employment income for project leavers

	CS	FH	HFC	NSHP	SR
	43.00%	33.00%	33.00%	50.00%	44.00%
All Leaver	43	100	33	75	33
	1.5	2.5	1	2	1
	43.50	45.	35	44.50	42.50

Minimum %	points
10	2.5

50

Higher score = the project lends itself to low barrier/housing first model

Serve High Need Populations

APR - Q5a

	TOTAL CLIENTS ENTERING THE PROGRAM DURING APR TERM				
	CS	FH	HFC	NSHP	SR
Adults	46	10	12	48	30
Children	33	0	0	24	0
Total	79	10	12	72	30

APR - Q16

percent (%) of participants with zero income at entry (adults only)

	CS	FH	HFC	NSHP	SR
Adults	9	5	4	2	6
%	19.57%	50.00%	33.33%	4.17%	20.00%

Did Not Factor

Minimum %	points
80	10

APR - Q13a2

percent (%) of participants with more than one disability type at entry (all)

	CS	FH	HFC	NSHP	SR
All	29	3	12	39	28
%	36.71%	30.00%	100.00%	54.17%	93.33%
	4	3	10	5	9

Minimum %	points
75	10

APR - Q15

percent (%) of participants entering project from place not meant for human habitation (adults only)

	CS	FH	HFC	NSHP	SR
Adults	35	9	12	40	28
%	76.09%	90.00%	100.00%	83.33%	93.33%
	7	9	10	8	9
	11	12	20	13	18

Minimum %	points
75	10

Coordinated Entry Participation

Housing First and/or Low Barrier Implementation

Documented, secured minimum match

Project has reasonable costs per permanent housing exit, as defined locally

Project is financially feasible

Applicant is active CoC participant

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