Before Starting the CoC Application

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

The Collaborative Applicant is responsible for reviewing the following:

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

1A. Continuum of Care (CoC) Identification

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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1A-1. CoC Name and Number: FL-512 - St. Johns County CoC

1A-2. Collaborative Applicant Name: Flagler Hospital, Inc.

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Flagler Hospital, Inc.

1B. Continuum of Care (CoC) Engagement

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1B-1. CoC Meeting Participants.

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

Organization/Person	Participates in CoC Meetings	Votes, including selecting CoC Board Members	Participates in Coordinated Entry System
Local Government Staff/Officials	Yes	Yes	No
CDBG/HOME/ESG Entitlement Jurisdiction	Yes	Yes	No
Law Enforcement	Yes	Yes	Yes
Local Jail(s)	Yes	Yes	No
Hospital(s)	Yes	Yes	Yes
EMS/Crisis Response Team(s)	Yes	Yes	Yes
Mental Health Service Organizations	Yes	Yes	Yes
Substance Abuse Service Organizations	Yes	Yes	Yes
Affordable Housing Developer(s)	Yes	Yes	No
Disability Service Organizations	Yes	Yes	No
Disability Advocates	Yes	Yes	No
Public Housing Authorities	Not Applicable	No	No
CoC Funded Youth Homeless Organizations	Not Applicable	No	No
Non-CoC Funded Youth Homeless Organizations	Yes	Yes	Yes

Youth Advocates	Yes	Yes	No
School Administrators/Homeless Liaisons	Yes	Yes	No
CoC Funded Victim Service Providers	Yes	Yes	No
Non-CoC Funded Victim Service Providers	Yes	Yes	No
Domestic Violence Advocates	Yes	Yes	No
Street Outreach Team(s)	Yes	Yes	Yes
Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates	Yes	Yes	No
LGBT Service Organizations	Yes	Yes	No
Agencies that serve survivors of human trafficking	Yes	Yes	No
Other homeless subpopulation advocates	Yes	Yes	Yes
Homeless or Formerly Homeless Persons	Yes	Yes	No
Mental Illness Advocates	Yes	Yes	No
Substance Abuse Advocates	Yes	Yes	No
Other:(limit 50 characters)			
Not applicable	Not Applicable	No	No

1B-1a. CoC's Strategy to Solicit/Consider Opinions on Preventing/Ending Homelessness.

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

The CoC's Strategic Plan outlines several strategies for soliciting and considering opinions from varying parties interested in homelessness issues, most of which focus on connecting potential members to the CoC meetings and Committees. To accomplish this, the CoC's Membership and Outreach Committee focuses on identifying and creating partnerships with businesses, education, nonprofits, faith-based, and other organizations that have an interest in preventing or ending homelessness. The Committee invites interested organizations and individuals to attend the monthly CoC meetings, committee meetings, and other special events. The CoC general membership meetings also solicit public comment from attendees to encourage an open forum on homeless issues. Additionally, the CoC Lead Agency/Collaborative Applicant attends meetings and special events on behalf of the CoC, where CoC information including meeting times and contact information, is presented and/or distributed, typically several times a month. The CoC is also active on

social media, where we have a public Facebook page available for interested parties to learn more and ask questions regarding the CoC and homelessness initiatives.
The CoC ensures effective communication with individuals with disabilities by ensuring all documents distributed during meetings are available electronically.

1B-2. Open Invitation for New Members.

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

The CoC publicizes monthly meetings on their website, and on social media. These meetings are open to anyone interested in participating in the CoC's mission to end homelessness, and invitations are extended on an ongoing basis. CoC members are also encouraged to personally invite anyone they think may be interested to attend meetings. Additionally, The CoC has developed a brochure that provides additional information on participating with the CoC, with the Membership and Outreach committee's oversight. These brochures are given to all prospective new members and are distributed on an ongoing basis at health fairs, community events, special events, and CoC presentations. The CoC ensures effective communication with individuals with disabilities by ensuring all documents distributed during meetings are available electronically. Once a new member is identified, the Membership and Outreach Committee reaches out to ensure that the organization is listed on the membership, and to educate the new member on the CoC's opportunities, including general meetings, committees, community events, PIT Count, etc. To ensure that homeless or formerly homeless persons are represented in the CoC, the Membership and Outreach Committee also regularly works with Emergency Shelter and Transitional Housing providers to communicate with recent graduates from their programs or those experiencing homelessness currently.

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

Applicants must describe:
1. how the CoC notifies the public that it is accepting project application proposals, and that it is open to and will consider applications from organizations that have not previously received CoC Program funding, as well as the method in which proposals should be submitted;
2. the process the CoC uses to determine whether the project application will be included in the FY 2019 CoC Program Competition process;
3. the date(s) the CoC publicly announced it was open to proposal;
4. how the CoC ensures effective communication with individuals with

disabilities, including the availability of accessible electronic formats; and
5. if the CoC does not accept proposals from organizations that have not previously received CoC Program funding or did not announce it was open to proposals from non-CoC Program funded organizations, the applicant must state this fact in the response and provide the reason the CoC does not accept proposals from organizations that have not previously received CoC Program funding.
(limit 2,000 characters)

The CoC keeps the public aware of CoC program funding availability through social media, CoC membership meetings, postings on the St. Johns County CoC website, and via email. The timeline and solicitation for letters of intent was sent through email with links to the NOFA on July 31, 2019. The information was presented at a round table discussion open to the public on August 5, 2019. The links and information were posted on the CoC website on August 29, 2019. The information was shared at the CoC General Membership meeting which is open to the public on August 14, 2019. The CoC ensures effective communication with individuals with disabilities by ensuring all documents distributed during meetings are available electronically.

1C. Continuum of Care (CoC) Coordination

Instructions:

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

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

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

1C-2. CoC Consultation with ESG Program Recipients.

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

The Collaborative Applicant attends monthly conference calls with the Florida DCF Office on Homelessness (ESG recipient) and other CoC Collaborative Applicants within the state of Florida to discuss ongoing homeless issues and grants. The Collaborative Applicant also consults with the Office on Homelessness separately to discuss the unique needs of St. Johns County. DCF shares its established ESG priorities and standards with the CoC to aid in the planning and allocation of ESG funds. The HMIS Lead provides PIT and HIC data to DCF's Office on Homelessness and the St. Johns County Housing and Community Development Division for inclusion in their respective consolidated plans.

The CoC Board, along with the HMIS Lead Agency, reviews and discusses the PIT and HIC data to ensure all data is accurate and is shared with the CoC membership in a public forum and are also published in the local newspaper.

1C-2a. Providing PIT and HIC Data to Consolidated Plan Jurisdictions. **Applicants must indicate whether the CoC provided Point-in-Time (PIT) and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area.**	Yes to both
1C-2b. Providing Other Data to Consolidated Plan Jurisdictions. **Applicants must indicate whether the CoC ensured local homelessness information is communicated to Consolidated Plan Jurisdictions within its geographic area so it can be addressed in Consolidated Plan updates.**	Yes

1C-3. Addressing the Safety Needs of Domestic Violence, Dating

Violence, Sexual Assault, and Stalking Survivors.

Applicants must describe:
1. the CoC's protocols, including protocols for coordinated entry and the CoC's emergency transfer plan, that prioritize safety and incorporate trauma-informed, victim-centered services; and
2. how the CoC, through its coordinated entry, maximizes client choice for housing and services while ensuring safety and confidentiality.
(limit 2,000 characters)

The CoC has one certified domestic violence and sexual assault services provider in our county, the Betty Griffin Center. Clients experiencing domestic violence are referred directly to Betty Griffin Center, who operates a 24-hour crisis hotline and outreach services as entry points into emergency safe shelter at a confidential location, and provide services including safety planning, legal assistance in obtaining injunctions for protection, case management, economic empowerment, counseling, and other services, using trauma-informed care. All services are offered free of charge, and all Betty Griffin Center staff have a victim advocate confidentiality privilege. In the event that Betty Griffin Center is full, victims are offered confidential safe shelter in other certified domestic violence shelters within the state or are placed in a hotel until safe shelter beds are available. The CoC does not currently have an emergency transfer plan, but Betty Griffin Center and the Collaborative Applicant are in the process of drafting a plan for review and approval by the CoC.

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

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

The CoC coordinates with Betty Griffin Center to provide both general and targeted domestic violence training to CoC member agencies to address the needs of victims and their families across CoC programs. These trainings include a 30-hour core competency training, legal aspects pertaining to domestic violence, trauma-informed care, client confidentiality, and a variety of other topics. Additionally, Betty Griffin leadership and staff participate in CoC General Membership meetings and actively participate in committees and planning for the CoC, and provide suggestions for training regarding domestic violence, dating violence, sexual assault, and stalking on an ongoing basis. To address the Coordinated Entry needs of victims of domestic violence, Betty Griffin Center was awarded the DV Bonus in the 2018 NoFA cycle. Their project focuses on how to best integrate with the CoC's Coordinated Entry process, while also ensuring that the specialized and complex needs, including privacy, of domestic violence victims, are addressed. The CoC had Betty Griffin's attorney present during a legal series about domestic violence following a general membership meeting that was open to the public.

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

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

Statistics regarding domestic violence and homelessness are provided by Betty Griffin Center using the Osnium Women's Shelter Database, an HMIS comparable database, administered by the Florida Coalition Against Domestic Violence, and contracted by DCF. Statistics provided are de-identified aggregate data. Betty Griffin Leadership and Staff also actively participate in CoC General Membership meetings, committee meetings, and planning sessions to ensure that the needs of victims of domestic violence are recognized and included in CoC community planning. Additionally, statistics regarding domestic violence and those fleeing violence are collected within the local HMIS database from all participating agencies.

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

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

Public Housing Agency Name	% New Admissions into Public Housing and Housing Choice Voucher Program during FY 2018 who were experiencing homelessness at entry	PHA has General or Limited Homeless Preference	PHA has a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On
Jacksonville Housing Authority	19.00%	No	No
Housing Authority Flagler County		No	No

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

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

Currently, our CoC does not work with the PHA of our geographic area. The board intends to reach out to the Jacksonville Housing Authority to adopt a homeless admission preference.

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

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

No

1C-5. Protecting Against Discrimination.

Applicants must describe the actions the CoC has taken to address all forms of discrimination, such as discrimination based on any protected classes under the Fair Housing Act and 24 CFR 5.105(a)(2) – Equal Access to HUD-Assisted or -Insured Housing.
(limit 2,000 characters)

The CoC has provided anti-discrimination policies in their written standards, which prevents service providers from discriminating against clients based on a variety of factors. The CoC strives to educate all service providers on the written standards by distributing this information and making it readily available, as well as by providing training. One of the legal sessions provided to the public was a lawyer's presentation on the Fair Housing Act.

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

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

1. Did the CoC implement a CoC-wide anti-discrimination policy that applies to all projects regardless of funding source?	Yes
2. Did the CoC conduct annual CoC-wide training with providers on how to effectively address discrimination based on any protected class under the Fair Housing Act?	Yes
3. Did the CoC conduct annual training on how to effectively address discrimination based on any protected class under 24 CFR 5.105(a)(2) – Equal Access to HUD-Assisted or -Insured Housing?	Yes

*1C-6. Criminalization of Homelessness.

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

1. Engaged/educated local policymakers:	X
2. Engaged/educated law enforcement:	X
3. Engaged/educated local business leaders:	X
4. Implemented communitywide plans:	
5. No strategies have been implemented:	

6. Other:(limit 50 characters)	

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

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

Coordinated Entry (CE) for the St Johns County CoC is a hybrid of a decentralized (no wrong door policy), along with outreach. Initial screening can be conducted for all populations at one of the multiple access points located in various areas of the county, or via a member of the CoC's street outreach team, to ensure that the CoC's entire geographic area is covered. The street outreach team reaches those who are least likely to apply for homeless assistance. CE includes the following core components: Information so that people will know where or how to access intake for homeless prevention or housing services; screening and assessment processes and tools, including a Universal Intake and VI-SPDAT to gather and verify information about the person and his/her housing and service needs and program eligibility and priority; information about programs and agencies that can provide needed housing or services; A process and tools for referral of the person to an appropriate programs or agencies; and assistance in making program admissions decisions. While most housing and services are made available through other agencies, a variety of services may be provided on-site at the “Access Points” or by a street outreach worker. These services typically meet basic client needs and may include diversion services, crisis counseling, landlord/tenant mediation, motel vouchers, bus pass or transportation to an agency and/or access to mainstream resources. The CoC's CE system is focused on providing a continuum of care including prevention, diversion, and rapid re-housing approaches. All agencies have access to the VI-SPDAT tool, as well as VI-SPDAT training, available online. CE staff contacts clients within 24-48 hours of identification and attempts to place clients with a permanent housing provider within 30 days. Client choice is taken into account throughout the process.

1D. Continuum of Care (CoC) Discharge Planning

Instructions:

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1D-1. Discharge Planning Coordination.

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

Foster Care:	X
Health Care:	X
Mental Health Care:	X
Correctional Facilities:	X
None:	

1E. Local CoC Competition

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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*1E-1. Local CoC Competition–Announcement, Established Deadline, Applicant Notifications. Attachments Required.

Applicants must indicate whether the CoC:

1. informed project applicants in its local competition announcement about point values or other ranking criteria the CoC would use to rank projects on the CoC Project Listings for submission to HUD for the FY 2019 CoC Program Competition;	Yes
2. established a local competition deadline, and posted publicly, for project applications that was no later than 30 days before the FY 2019 CoC Program Competition Application submission deadline;	Yes
3. notified applicants that their project application(s) were being rejected or reduced, in writing along with the reason for the decision, outside of e-snaps, at least 15 days before the FY 2019 CoC Program Competition Application submission deadline; and	Did not reject or reduce any project
4. notified applicants that their project applications were accepted and ranked on the CoC Priority Listing in writing, outside of e-snaps, at least 15 days before the FY 2019 CoC Program Competition Application submission deadline.	Yes

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

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

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

1E-3. Project Review and Ranking–Severity of Needs and Vulnerabilities.

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

The CoC Scoring and Review Committee instituted a "Score Card" for reviewing and rating the project applicants. The Score Card included data elements and other criteria considered by the CoC as high priorities. Among others, the CoC considered several vulnerabilities in evaluating and scoring the projects, including: (1) that the project intends to serve those with zero income at entry, (2) intends to serve those from a place not meant for human habitation; and (3) intends to serve chronically homeless. Projects addressing the CoC's highest priorities, as well as utilizing the housing first model and participating in Coordinated Entry, scored the maximum points possible.

1E-4. Public Postings–CoC Consolidated Application. Attachment Required.

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

Public Posting of Objective Review and Ranking Process		Public Posting of CoC Consolidated Application including: CoC Application, CoC Priority Listing, Project Listings	
1. Email	X	1. Email	X
2. Mail		2. Mail	
3. Advertising in Local Newspaper(s)		3. Advertising in Local Newspaper(s)	
4. Advertising on Radio or Television		4. Advertising on Radio or Television	
5. Social Media (Twitter, Facebook, etc.)	X	5. Social Media (Twitter, Facebook, etc.)	X

6. Did Not Publicly Post Review and Ranking Process	☐	**6. Did Not Publicly Post CoC Consolidated Application**	☐

1E-5. Reallocation between FY 2015 and FY 2018.

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

Reallocation: 16%

1E-5a. Reallocation–CoC Review of Performance of Existing Projects.

Applicants must:
1. describe the CoC written process for reallocation;
2. indicate whether the CoC approved the reallocation process;
3. describe how the CoC communicated to all applicants the reallocation process;
4. describe how the CoC identified projects that were low performing or for which there is less need; and
5. describe how the CoC determined whether projects that were deemed low performing would be reallocated.
(limit 2,000 characters)

The written process for reallocation is; Agencies can either voluntary reallocate or low performing projects are reallocated. The CoC approved the reallocation process. There is an annual review by the CoC lead agency of projects to determine if there are any low performing projects. No low performing projects were identified this year. The CoC had a roundtable discussion to communicate the process to all applicants. Projects are considered low performing by a review of: returns to homelessness, exit destinations, income increases and targeting of vulnerable populations upon enrollment.

DV Bonus

Instructions

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1F-1 DV Bonus Projects.

Applicants must indicate whether the CoC is requesting DV Bonus projects which are included on the CoC Priority Listing: No

Applicant Name	DUNS Number
This list contains no items	

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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2A-1. HMIS Vendor Identification. Mediware/WellSky

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

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

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

Project Type	Total Number of Beds in 2019 HIC	Total Beds Dedicated for DV in 2019 HIC	Total Number of 2019 HIC Beds in HMIS	HMIS Bed Coverage Rate
Emergency Shelter (ES) beds	98	56	42	100.00%
Safe Haven (SH) beds	0	0	0	
Transitional Housing (TH) beds	88	14	74	100.00%
Rapid Re-Housing (RRH) beds	13	0	13	100.00%
Permanent Supportive Housing (PSH) beds	0	0	0	
Other Permanent Housing (OPH) beds	53	0	53	100.00%

2A-2a. Partial Credit for Bed Coverage Rates at or Below 84.99 for Any Project Type in Question 2A-2.

For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-2., applicants must describe:

1. steps the CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and
2. how the CoC will implement the steps described to increase bed coverage to at least 85 percent.
(limit 2,000 characters)

Not applicable

***2A-3. Longitudinal System Analysis (LSA) Submission.**

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

***2A-4. HIC HDX Submission Date.**

Applicants must enter the date the CoC submitted the 2019 Housing Inventory Count (HIC) data into the Homelessness Data Exchange (HDX). (mm/dd/yyyy)	04/30/2019

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

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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Warning! The CoC Application score could be affected if information is incomplete on this formlet.

2B-1. PIT Count Date. Applicants must enter the date the CoC conducted its 2019 PIT count (mm/dd/yyyy). 01/24/2019

2B-2. PIT Count Data–HDX Submission Date. Applicants must enter the date the CoC submitted its PIT count data in HDX (mm/dd/yyyy). 04/29/2019

2B-3. Sheltered PIT Count–Change in Implementation.

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

Not applicable

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

Applicants must select whether the CoC added or removed emergency shelter, No

transitional housing, or Safe-Haven inventory because of funding specific to a Presidentially-declared disaster, resulting in a change to the CoC's 2019 sheltered PIT count.	

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

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

Technology usage was the only change in data quality methodology. In 2019 the CoC data committee used tablets to collect data, improving the process and accuracy of data.

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

Applicants must:

Indicate whether the CoC implemented specific measures to identify youth experiencing homelessness in their 2019 PIT count.	No

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

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

Technology improvements - utilizing tablets - were implemented in the 2019 PIT count to better address individuals and families experiencing chronic homelessness, families with children and veterans experiencing homelessness.

3A. Continuum of Care (CoC) System Performance

Instructions

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*3A-1. First Time Homeless as Reported in HDX.

Applicants must:

Report the Number of First Time Homeless as Reported in HDX.	683

3A-1a. First Time Homeless Risk Factors.

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

The CoC used information gained from survey responses during the PIT Count, from universal intake applications, and from HMIS data to determine the rising risk factors for becoming homeless within our community. These main factors identified included loss of income, or some sort of crisis having taken place in their lives, such as a medical emergency, death, or other traumatic event. Current strategies in place to address risk factors are to recognize the risk factors of individuals and families during intake, and provide the appropriate referrals for concrete services such as applications for SSI/insurance, prescription assistance, assistance in obtaining identification, and other needs; as well as wrap-around case management tailored to their specific needs. The

CoC HMIS/Coordinated Entry Committee and the Lead Agency are responsible for oversight and training agencies regarding risk factors for first-time homeless.

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

Applicants must:

Report Average Length of Time Individuals and Persons in Families Remained Homeless as Reported in HDX.	76

3A-2a. Strategy to Reduce Length of Time Homeless.

Applicants must:
1. describe the CoC's strategy to reduce the length of time individuals and persons in families remain homeless;
2. describe how the CoC identifies and houses individuals and persons in families with the longest lengths of time homeless; and
3. provide the name of the organization or position title that is responsible for overseeing the CoC's strategy to reduce the length of time individuals and families remain homeless.
(limit 2,000 characters)

The average length of time individuals and families remained homeless was 76 days for those in ES and TH, and 28 days for those in ES. We are in the process of striving to reduce ES stays to 15 days or less, and TH stays to 180 days or less, to bring the overall average LOT homeless down. The CoC's Coordinated Entry process prioritizes those individuals experiencing homelessness for the longest length of time, and attempts to secure permanent housing for those individuals first. To accomplish these tasks, the CoC employs strategies such as: collaborating with homeless shelters and rapid re-housing programs, who have funding available to re-home individuals and families. The CoC has also created an Affordable Housing Taskforce to address the lack of affordable housing in the county and has also added a Housing Navigator to increase housing stock and create easier access to these affordable housing options. To identify those with the longest length of time homeless, the CoC uses a universal intake, and a VI-SPDAT, which then provide a vulnerability score for the Coordinated Entry process. The CoC Strategic Planning Committee provides oversight to the CoC on strategy, and the HMIS Lead and HMIS Committee give analysis of the data measures.

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

Applicants must:

	Percentage
1. Report the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid rehousing that exit to permanent housing destinations as reported in HDX.	36%
2. Report the percentage of individuals and persons in families in permanent housing projects, other than rapid rehousing, that retain their permanent housing or exit to permanent housing destinations as reported in HDX.	100%

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

Applicants must:
1. describe the CoC's strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations;
2. provide the organization name or position title responsible for overseeing the CoC's strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations;
3. describe the CoC's strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations; and
4. provide the organization name or position title responsible for overseeing the CoC's strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations.
(limit 2,000 characters)

The CoC's strategy to increase the rate of households exiting to permanent housing is multifaceted. One major challenge has been the lack of availability of affordable housing in the community. In 2018 the CoC initiated an Affordable Housing Taskforce, whose members have been working with the local government to address issues preventing the development of this housing locally. Additionally, the CoC began utilizing a Housing Navigator to work directly with clients to access affordable housing and build local housing stock. The CoC uses a Housing First strategy to ensure that all service providers are focused on permanent housing as a destination. Critical to strategies for both obtaining and retaining permanent housing is case management. The CoC has provided multiple training opportunities on various aspects of case management and will continue to focus efforts on ensuring that agencies providing services are also addressing the case management needs of their clients. The CoC Strategic Planning Committee provides oversight to the CoC on strategy, and the HMIS Lead and HMIS Committee give analysis of the data measures.

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

Applicants must:

	Percentage
1. Report the percentage of individuals and persons in families returning to homelessness over a 6-month period as reported in HDX.	6%
2. Report the percentage of individuals and persons in families returning to homelessness over a 12-month period as reported in HDX.	2%

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

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

Individuals and families who return to homelessness are determined by reporting from HMIS. Agencies have recently implemented diversion and prevention strategies to find other options and keep those who are at risk of losing housing to keep them in their current location and keep them from returning to homelessness. The CoC Strategic Planning Committee provides oversight to the CoC on strategy, and the HMIS Lead and HMIS Committee give analysis of the data measures.

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

Applicants must:

	Percentage
1. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their employment income from entry to exit as reported in HDX.	0%
2. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their non-employment cash income from entry to exit as reported in HDX.	0%

3A-5a. Increasing Employment Income.

Applicants must:
1. describe the CoC's strategy to increase employment income;
2. describe the CoC's strategy to increase access to employment;
3. describe how the CoC works with mainstream employment organizations to help individuals and families increase their cash income; and
4. provide the organization name or position title that is responsible for overseeing the CoC's strategy to increase jobs and income from employment.
(limit 2,000 characters)

The CoC's strategy to increase employment is to create partnerships with businesses, education, and provider agencies. NFCAA has provided training on its family self-sufficiency program and encourages agencies to utilize their services. In terms of employment, the CoC and CoC member agencies work with various employment centers including CareerSource, First Coast Technical College, Northeast Community Action Agency, Communities in Schools, Goodwill, and Labor Finders, many of whom participate in CoC meetings regularly.

3A-5b. Increasing Non-employment Cash Income.

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

The CoC's strategy to increase employment and access to mainstream benefits is to create partnerships with businesses, education, and provider agencies. NFCAA has provided training on its family self-sufficiency program and encourages agencies to utilize their services. Additionally, the County receives state funding to implement the SOAR program, which assists clients with SSI/SSDI applications. Four agencies serve as DCF community partners, providing access to public assistance services that promote self-sufficiency. The County also provides office space to DCF workers twice weekly to directly assist clients. Additionally, many CoC provider agencies have been "thinking outside the box", and offering programs in partnership with local colleges, churches, and community groups, such as sewing classes, business skills, resume writing and interviewing skills. The Lead Agency is responsible for overseeing strategy related to employment and mainstream benefits.

3A-5c. Increasing Employment. Attachment Required.

Applicants must describe how the CoC:
1. promoted partnerships and access to employment opportunities with private employers and private employment organizations, such as holding job fairs, outreach to employers, and partnering with staffing agencies; and
2. is working with public and private organizations to provide meaningful, education and training, on-the-job training, internship, and employment opportunities for residents of permanent supportive housing that further their recovery and well-being.
(limit 2,000 characters)

CoC member organizations have direct agreements with staffing agencies to hire those residing in an emergency shelter or transitional housing. In terms of employment, the CoC and CoC member agencies work with various employment centers including CareerSource, First Coast Technical College, Northeast Community Action Agency, Communities in Schools, Goodwill, and Labor Finders, many of whom participate in CoC meetings regularly.

3A-5d. Promoting Employment, Volunteerism, and Community Service.

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

1. The CoC trains provider organization staff on connecting program participants and people experiencing homelessness with education and job training opportunities.	☐

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

3A-6. System Performance Measures Data–HDX Submission Date 05/30/2019

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

3B. Continuum of Care (CoC) Performance and Strategic Planning Objectives

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions.
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3B-1. Prioritizing Households with Children.

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

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

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

Applicants must:
1. describe how the CoC currently rehouses every household of families with children within 30 days of becoming homeless that addresses both housing and service needs;
2. describe how the CoC addresses both housing and service needs to ensure families with children successfully maintain their housing once

assistance ends; and
3. provide the organization name or position title responsible for overseeing the CoC's strategy to rapidly rehouse families with children within 30 days of them becoming homeless.
(limit 2,000 characters)

Coordinated Entry data is being utilized to prioritize those individuals and families experiencing homelessness and to create a network of available services to house children and families as quickly as possible. The housing navigator assists the coordinated entry process by finding housing and linking the rapid rehousing clients. The CoC's specific strategy is to assess each individual and family seeking housing through the Coordinated Entry process and score their vulnerability for prioritization for housing. Families with children generally score higher (meaning more vulnerable), and this vulnerability moves them to the top of the list for rehousing. The CoC is focused on case management, and ensuring that families are supported as they transition to permanent housing. The CoC continues to provide ongoing training on all aspects of case management to ensure that there are still supports in place for families, even after financial assistance ends. The Coordinated Entry committee and CoC Board provide oversight for rapid re-housing strategies.

3B-1b. Antidiscrimination Policies.

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

1. CoC conducts mandatory training for all CoC- and ESG-funded housing and services providers on these topics.	X
2. CoC conducts optional training for all CoC- and ESG-funded housing and service providers on these topics.	X
3. CoC has worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients.	X
4. CoC has worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within the CoC geographic area that might be out of compliance and has taken steps to work directly with those facilities to come into compliance.	X

3B-1c. Unaccompanied Youth Experiencing Homelessness–Addressing Needs.

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

1. Unsheltered homelessness	Yes

2. Human trafficking and other forms of exploitation	Yes
3. LGBT youth homelessness	Yes
4. Exits from foster care into homelessness	Yes
5. Family reunification and community engagement	Yes
6. Positive Youth Development, Trauma Informed Care, and the use of Risk and Protective Factors in assessing youth housing and service needs	Yes

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

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

1. History of, or Vulnerability to, Victimization (e.g., domestic violence, sexual assault, childhood abuse)	X
2. Number of Previous Homeless Episodes	X
3. Unsheltered Homelessness	X
4. Criminal History	X
5. Bad Credit or Rental History	X

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

Applicants must describe how the CoC increased availability of housing and services for:
1. all youth experiencing homelessness, including creating new youth-focused projects or modifying current projects to be more youth-specific or youth-inclusive; and
2. youth experiencing unsheltered homelessness including creating new youth-focused projects or modifying current projects to be more youth-specific or youth-inclusive.
(limit 3,000 characters)

The County's only homeless shelter has continued to experience an increase in the number of younger individuals (age 18-24) in the past 4 years. An identified need within our CoC is for a dedicated full-service youth shelter, which is in the process of securing funding and additional certifications. In the meantime, this agency has opened the youth program as a day drop-in center and now has 16 beds for youth. The youth program is open 7 days a week and provides case management, meals, and other services. A targeted youth outreach team has also been working with the younger population to determine their unique needs. As part of the case management at the youth drop-in center, clients are referred to CoC housing service providers for RRH assistance and are also directed to mainstream resources and local employment agencies.

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

Applicants must:
1. provide evidence the CoC uses to measure each of the strategies in question 3B-1d. to increase the availability of housing and services for youth experiencing homelessness;
2. describe the measure(s) the CoC uses to calculate the effectiveness of both strategies in question 3B-1d.; and
3. describe why the CoC believes the measure it uses is an appropriate way to determine the effectiveness of both strategies in question 3B-1d. (limit 3,000 characters)

Youth Outreach data is collected through the HMIS system and reported in CAPER reports. Since Youth Outreach is not a performance measure actively measured by HUD with the other performance measures, the CoC is currently working with the youth outreach provider to put formal strategies and measures in place to ensure that we are meeting the needs of the homeless youth in our community. Currently, the Youth Outreach program is researching how other like programs measure their effectiveness. All efforts aimed at unaccompanied youth are grounded in Positive Youth Development and Trauma-Informed care. Once sufficient data has been gathered, additional targeted strategies will be developed to end youth homelessness in our county.

3B-1e. Collaboration–Education Services.

Applicants must describe:

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

2. how the CoC collaborates with:
a. youth education providers;
b. McKinney-Vento Local LEA or SEA; and
c. school districts.
(limit 2,000 characters)

The CoC collaborates with the local early childhood education agency to ensure that families experiencing homelessness have access to early learning resources and childcare for their children. The CoC also has an MOU in place with the school district, and the district's McKinney-Vento homeless liaison currently sits on the CoC Board, and other CoC committees, and is an active participant in the CoC. The liaison provides valuable information on homeless school children and disseminates this information both at monthly CoC Board and General Membership meetings. Additionally, the CoC works with a variety of other local youth education providers to ensure that the educational needs of families with children are met, regardless of their housing status.

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

**Applicants must describe policies and procedures the CoC adopted to inform individuals and families who become homeless of their eligibility for education services.
(limit 2,000 characters)**

The CoC has adopted Educational Assurances in its Written Standards as a requirement for all CoC-funded providers to ensure that homeless families and youth are made aware of their educational rights and eligibility for McKinney-Vento education services.

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

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

	MOU/MOA	Other Formal Agreement
Early Childhood Providers	Yes	No
Head Start	Yes	No
Early Head Start	Yes	No
Child Care and Development Fund	Yes	No
Federal Home Visiting Program	Yes	No
Healthy Start	Yes	No
Public Pre-K	Yes	No
Birth to 3 years	Yes	No
Tribal Home Visting Program	Yes	No
Other: (limit 50 characters)		

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

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

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

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

3B-2b. Housing First for Veterans.

Applicants must indicate whether the CoC No

has sufficient resources to ensure each veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach.

3B-3. Racial Disparity Assessment. Attachment Required.

Applicants must:
1. select all that apply to indicate the findings from the CoC's Racial Disparity Assessment; or
2. select 7 if the CoC did not conduct a Racial Disparity Assessment.

1. People of different races or ethnicities are more likely to receive homeless assistance.	
2. People of different races or ethnicities are less likely to receive homeless assistance.	
3. People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.	
4. People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.	
5. There are no racial or ethnic disparities in the provision or outcome of homeless assistance.	
6. The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.	
7. The CoC did not conduct a racial disparity assessment.	X

4A. Continuum of Care (CoC) Accessing Mainstream Benefits and Additional Policies

Instructions:

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4A-1. Healthcare–Enrollment/Effective Utilization

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

Type of Health Care	Assist with Enrollment	Assist with Utilization of Benefits?
Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)	Yes	Yes
Private Insurers:	Yes	Yes
Non-Profit, Philanthropic:	Yes	Yes
Other: (limit 50 characters)		

4A-1a. Mainstream Benefits.

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

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

The CoC works with a variety of mainstream resources through local service providers. St. Johns Care Connect, an organization providing resource navigation, utilizes ServicePoint (HMIS provider) as a tool to make referrals for services including housing, prescription assistance, transportation, Medicaid and insurance navigation, and other services impacting a person's social determinants of health. Additionally, the CoC state funding provides for a SOAR processor to assist clients with the SSI/SSDI application process. The CoC homeless service providers serve as DCF Access Florida Community partners, providing access to public assistance services that promote self-sufficiency, such as food stamps and TANF. County HHS also provides office space to DCF twice per week to directly assist clients with obtaining benefits. A local Legal Aid office representative attends the Monthly CoC meetings and regularly updates the CoC on the services they offer to the homeless community. The CoC Lead Agency distributes program information and related training via email and at the monthly meetings, on services that may be available. Additionally, the CoC Lead Agency provides a resource list for the community, which provides contact information for all appropriate resources, and is available to the public via the CoC website. This literature is also distributed to law enforcement, community agencies, groups, and individuals to distribute. The CoC Lead Agency is responsible for overseeing strategy related to mainstream benefits.

4A-2. Lowering Barriers to Entry Data:

Applicants must report:

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

4A-3. Street Outreach.

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

(limit 2,000 characters)

The CoC's street outreach efforts cover 100% of the catchment area. Street outreach is conducted 6 days per week by a CoC provider agency and is performed at known gathering places for persons experiencing homelessness (libraries, public parks, tourist attractions, etc). Outreach efforts are also targeted to non-public areas such as the woods, under bridges, and at the beach to seek out individuals living in unsheltered areas that are not currently seeking assistance. Street outreach is aimed at making relationships with individuals who may not be ready to seek assistance, in the hopes that once a relationship is built, the individual will make the choice to accept assistance. The street outreach program continues to research best practices and refine their program based on the changing needs of individuals experiencing homelessness.

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

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

	2018	2019	Difference
RRH beds available to serve all populations in the HIC	20	13	-7

4A-5. Rehabilitation/Construction Costs–New Projects.

No

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

4A-6. Projects Serving Homeless under Other Federal Statutes.

No

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

4B. Attachments

Instructions:

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

Document Type	Required?	Document Description	Date Attached
_FY 2019 CoC Competition Report (HDX Report)	Yes	FY19 HDX Report	09/24/2019
1C-4.PHA Administration Plan–Moving On Multifamily Assisted Housing Owners' Preference.	No		
1C-4. PHA Administrative Plan Homeless Preference.	No		
1C-7. Centralized or Coordinated Assessment System.	Yes	Coordinated Entry...	09/24/2019
1E-1.Public Posting–15-Day Notification Outside e-snaps–Projects Accepted.	Yes	Notice of Accepta...	09/25/2019
1E-1. Public Posting–15-Day Notification Outside e-snaps–Projects Rejected or Reduced.	Yes	Notice of Accepta...	09/25/2019
1E-1.Public Posting–30-Day Local Competition Deadline.	Yes	TImeline Posted	09/25/2019
1E-1. Public Posting–Local Competition Announcement.	Yes	7/5/2019 Public P...	09/24/2019
1E-4.Public Posting–CoC-Approved Consolidated Application	Yes	public posting	09/25/2019
3A. Written Agreement with Local Education or Training Organization.	No		
3A. Written Agreement with State or Local Workforce Development Board.	No		
3B-3. Summary of Racial Disparity Assessment.	Yes	Racial Disparity ...	09/26/2019
4A-7a. Project List-Homeless under Other Federal Statutes.	No		
Other	No		
Other	No		

Other	No		

Attachment Details

Document Description: FY19 HDX Report

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Coordinated Entry Policy 2018 - 2019 revisions in process of being approved

Attachment Details

Document Description: Notice of Acceptance or Rejection

Attachment Details

Document Description: Notice of Acceptance or Rejection

Attachment Details

Document Description: TImeline Posted

Attachment Details

Document Description: 7/5/2019 Public Posting

Attachment Details

Document Description: public posting

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Racial Disparity Assessment

Attachment Details

Document Description:

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Document Description:

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Document Description:

Submission Summary

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

Page	Last Updated
1A. Identification	09/16/2019
1B. Engagement	09/19/2019
1C. Coordination	09/19/2019
1D. Discharge Planning	No Input Required
1E. Local CoC Competition	09/24/2019
1F. DV Bonus	No Input Required
2A. HMIS Implementation	09/24/2019
2B. PIT Count	09/24/2019
3A. System Performance	09/20/2019
3B. Performance and Strategic Planning	09/20/2019
4A. Mainstream Benefits and Additional Policies	09/20/2019
4B. Attachments	09/26/2019

Submission Summary	No Input Required

2019 HDX Competition Report

PIT Count Data for FL-512 - St. Johns County CoC

Total Population PIT Count Data

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count	**1064**	**445**	**342**	**356**
Emergency Shelter Total	112	89	101	87
Safe Haven Total	0	0	0	0
Transitional Housing Total	143	90	77	69
Total Sheltered Count	**255**	**179**	**178**	**156**
Total Unsheltered Count	**809**	**266**	**164**	**200**

Chronically Homeless PIT Counts

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count of Chronically Homeless Persons	**35**	**42**	**65**	**14**
Sheltered Count of Chronically Homeless Persons	6	1	6	5
Unsheltered Count of Chronically Homeless Persons	29	41	59	9

2019 HDX Competition Report

PIT Count Data for FL-512 - St. Johns County CoC

Homeless Households with Children PIT Counts

	2016 PIT	2017 PIT	2018 PIT	2019 PIT
Total Sheltered and Unsheltered Count of the Number of Homeless Households with Children	**71**	**42**	**35**	**31**
Sheltered Count of Homeless Households with Children	49	38	35	27
Unsheltered Count of Homeless Households with Children	22	4	0	4

Homeless Veteran PIT Counts

	2011	2016	2017	2018	2019
Total Sheltered and Unsheltered Count of the Number of Homeless Veterans	**41**	**36**	**40**	**30**	**25**
Sheltered Count of Homeless Veterans	6	9	7	6	5
Unsheltered Count of Homeless Veterans	35	27	33	24	20

2019 HDX Competition Report

HIC Data for FL-512 - St. Johns County CoC

HMIS Bed Coverage Rate

Project Type	Total Beds in 2019 HIC	Total Beds in 2019 HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
Emergency Shelter (ES) Beds	**98**	**56**	**42**	**100.00%**
Safe Haven (SH) Beds	**0**	**0**	**0**	**NA**
Transitional Housing (TH) Beds	**88**	**14**	**74**	**100.00%**
Rapid Re-Housing (RRH) Beds	**13**	**0**	**13**	**100.00%**
Permanent Supportive Housing (PSH) Beds	**0**	**0**	**0**	**NA**
Other Permanent Housing (OPH) Beds	**53**	**0**	**53**	**100.00%**
Total Beds	252	70	182	100.00%

2019 HDX Competition Report

HIC Data for FL-512 - St. Johns County CoC

PSH Beds Dedicated to Persons Experiencing Chronic Homelessness

Chronically Homeless Bed Counts	2016 HIC	2017 HIC	2018 HIC	2019 HIC
Number of CoC Program and non-CoC Program funded PSH beds dedicated for use by chronically homeless persons identified on the HIC	0			

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

Households with Children	2016 HIC	2017 HIC	2018 HIC	2019 HIC
RRH units available to serve families on the HIC	18	1	5	3

Rapid Rehousing Beds Dedicated to All Persons

All Household Types	2016 HIC	2017 HIC	2018 HIC	2019 HIC
RRH beds available to serve all populations on the HIC	73	16	20	13

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

Summary Report for FL-512 - St. Johns County CoC

For each measure enter results in each table from the System Performance Measures report generated out of your CoCs HMIS System. There are seven performance measures. Each measure may have one or more "metrics" used to measure the system performance. Click through each tab above to enter FY2017 data for each measure and associated metrics.

RESUBMITTING FY2018 DATA: If you provided revised FY2018 data, the original FY2018 submissions will be displayed for reference on each of the following screens, but will not be retained for analysis or review by HUD.

ERRORS AND WARNINGS: If data are uploaded that creates selected fatal errors, the HDX will prevent the CoC from submitting the System Performance Measures report. The CoC will need to review and correct the original HMIS data and generate a new HMIS report for submission.

Some validation checks will result in warnings that require explanation, but will not prevent submission. Users should enter a note of explanation for each validation warning received. To enter a note of explanation, move the cursor over the data entry field and click on the note box. Enter a note of explanation and "save" before closing.

Measure 1: Length of Time Persons Remain Homeless

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

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

a. This measure is of the client's entry, exit, and bed night dates strictly as entered in the HMIS system.

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

	Universe (Persons)			Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Submitted FY 2017	Revised FY 2017	FY 2018	Submitted FY 2017	Revised FY 2017	FY 2018	Difference	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
1.1 Persons in ES and SH	533	511	721	25	28	28	0	11	12	8	-4
1.2 Persons in ES, SH, and TH	666	645	834	89	94	76	-18	25	27	12	-15

b. This measure is based on data element 3.17.

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

The construction of this measure changed, per HUD's specifications, between FY 2016 and FY 2017. HUD is aware that this may impact the change between these two years.

	Universe (Persons)			Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Submitted FY 2017	Revised FY 2017	FY 2018	Submitted FY 2017	Revised FY 2017	FY 2018	Difference	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
1.1 Persons in ES, SH, and PH (prior to "housing move in")	525	509	717	272	291	357	66	56	69	72	3
1.2 Persons in ES, SH, TH, and PH (prior to "housing move in")	669	644	834	302	312	375	63	97	113	108	-5

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness

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

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

	Total # of Persons who Exited to a Permanent Housing Destination (2 Years Prior)		Returns to Homelessness in Less than 6 Months			Returns to Homelessness from 6 to 12 Months			Returns to Homelessness from 13 to 24 Months			Number of Returns in 2 Years	
	Revised FY 2017	FY 2018	Revised FY 2017	FY 2018	% of Returns	Revised FY 2017	FY 2018	% of Returns	Revised FY 2017	FY 2018	% of Returns	FY 2018	% of Returns
Exit was from SO	0	0	0	0		0	0		0	0		0	
Exit was from ES	140	126	22	14	11%	7	7	6%	3	3	2%	24	19%
Exit was from TH	70	106	4	6	6%	2	0	0%	1	6	6%	12	11%
Exit was from SH	0	0	0	0		0	0		0	0		0	
Exit was from PH	228	80	7	0	0%	3	0	0%	1	11	14%	11	14%
TOTAL Returns to Homelessness	438	312	33	20	6%	12	7	2%	5	20	6%	47	15%

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

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

	January 2017 PIT Count	January 2018 PIT Count	Difference
Universe: Total PIT Count of sheltered and unsheltered persons	445	342	-103
Emergency Shelter Total	89	101	12
Safe Haven Total	0	0	0
Transitional Housing Total	90	77	-13
Total Sheltered Count	179	178	-1
Unsheltered Count	266	164	-102

Metric 3.2 – Change in Annual Counts

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

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Unduplicated Total sheltered homeless persons	671	648	844	196
Emergency Shelter Total	531	509	727	218
Safe Haven Total	0	0	0	0
Transitional Housing Total	159	158	137	-21

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

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

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults (system stayers)	8	11	5	-6
Number of adults with increased earned income	1	4	0	-4
Percentage of adults who increased earned income	13%	36%	0%	-36%

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

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults (system stayers)	8	11	5	-6
Number of adults with increased non-employment cash income	0	0	0	0
Percentage of adults who increased non-employment cash income	0%	0%	0%	0%

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

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults (system stayers)	8	11	5	-6
Number of adults with increased total income	1	4	0	-4
Percentage of adults who increased total income	13%	36%	0%	-36%

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

Metric 4.4 – Change in earned income for adult system leavers

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults who exited (system leavers)	18	18	1	-17
Number of adults who exited with increased earned income	2	3	0	-3
Percentage of adults who increased earned income	11%	17%	0%	-17%

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

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults who exited (system leavers)	18	18	1	-17
Number of adults who exited with increased non-employment cash income	0	0	0	0
Percentage of adults who increased non-employment cash income	0%	0%	0%	0%

Metric 4.6 – Change in total income for adult system leavers

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Number of adults who exited (system leavers)	18	18	1	-17
Number of adults who exited with increased total income	2	3	0	-3
Percentage of adults who increased total income	11%	17%	0%	-17%

2019 HDX Competition Report

FY2018 - Performance Measurement Module (Sys PM)

Measure 5: Number of persons who become homeless for the 1st time

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

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Person with entries into ES, SH or TH during the reporting period.	556	558	772	214
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	100	100	137	37
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time)	456	458	635	177

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

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	603	605	846	241
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	122	122	163	41
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)	481	483	683	200

Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD's Homeless Definition in CoC Program-funded Projects

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

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

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

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Persons who exit Street Outreach	61	112	376	264
Of persons above, those who exited to temporary & some institutional destinations	1	7	14	7
Of the persons above, those who exited to permanent housing destinations	20	20	68	48
% Successful exits	34%	24%	22%	-2%

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

2019 HDX Competition Report
FY2018 - Performance Measurement Module (Sys PM)

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	592	613	747	134
Of the persons above, those who exited to permanent housing destinations	291	297	267	-30
% Successful exits	49%	48%	36%	-12%

Metric 7b.2 – Change in exit to or retention of permanent housing

	Submitted FY 2017	Revised FY 2017	FY 2018	Difference
Universe: Persons in all PH projects except PH-RRH	14	14	14	0
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	14	14	14	0
% Successful exits/retention	100%	100%	100%	0%

2019 HDX Competition Report

FY2018 - SysPM Data Quality

FL-512 - St. Johns County CoC

This is a new tab for FY 2016 submissions only. Submission must be performed manually (data cannot be uploaded). Data coverage and quality will allow HUD to better interpret your Sys PM submissions.

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

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

2019 HDX Competition Report

FY2018 - SysPM Data Quality

	All ES, SH				All TH				All PSH, OPH				All RRH				All Street Outreach			
	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018	2014-2015	2015-2016	2016-2017	2017-2018
1. Number of non-DV Beds on HIC	40	40	40	31	159	122	80	83	96	26	34	28	110	73	16	20				
2. Number of HMIS Beds	40	40	40	31	112	108	80	83	35	0	10	28	110	6	0	20				
3. HMIS Participation Rate from HIC (%)	100.00	100.00	100.00	100.00	70.44	88.52	100.00	100.00	36.46	0.00	29.41	100.00	100.00	8.22	0.00	100.00				
4. Unduplicated Persons Served (HMIS)	619	490	514	722	196	228	158	139	0	7	15	30	321	197	8	81			15	59
5. Total Leavers (HMIS)	579	438	478	674	94	148	88	84	0	0	4	1	283	137	96	31			11	27
6. Destination of Don't Know, Refused, or Missing (HMIS)	39	67	64	0	6	12	2	0	0	0	0	0	11	5	2	0			0	0
7. Destination Error Rate (%)	6.74	15.30	13.39	0.00	6.38	8.11	2.27	0.00			0.00	0.00	3.89	3.65	2.08	0.00			0.00	0.00

2019 HDX Competition Report

Submission and Count Dates for FL-512 - St. Johns County CoC

Date of PIT Count

	Date	Received HUD Waiver
Date CoC Conducted 2019 PIT Count	1/24/2019	

Report Submission Date in HDX

	Submitted On	Met Deadline
2019 PIT Count Submittal Date	4/29/2019	Yes
2019 HIC Count Submittal Date	4/30/2019	Yes
2018 System PM Submittal Date	5/30/2019	Yes

St Johns County Continuum of Care
Written Standards of Operating Policies & Procedures
For
Coordinated Entry

St. Johns County
Continuum of Care
ENDING HOMELESSNESS TOGETHER

July 25, 2018

TABLE OF CONTENTS

ACKNOWLEDGEMENTS

In an effort to capitalize on the excellent work being done locally and nationally to improve homeless housing and service systems for individuals and families, this plan relies heavily on research and tools produced in our community and in communities across the county, especially the work of the National Alliance to End Homelessness. This plan has been influenced by several important resources including:

- The many homeless housing stakeholders of St Johns County
- The ongoing work of the Coordinated Intake and Assessment Committee ; and,
- Influenced by The Emergency Services and Homeless Coalition of Northeast Florida plan

Particular thanks are due to the members of the Coordinated Intake and Assessment Workgroup for their contributions and their time.

- Judy Dembowski- St Francis House
- Debi Redding – ESHC of St Johns County
- Brittany Coronado– HMIS, Flagler Hospital
- Jerry Cameron – Consultant
- Tracy Dillon – St Johns County Social Services
- Ellen Walden – Home Again St Johns
- Melissa Strominger – Betty Griffin Center

For additional Information please contact:

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INTRODUCTION

National research has highlighted Coordinated Entry as a key factor in the success of ending homelessness. Coordinated Entry can enhance the quality of client screening and assessment and better target program assistance where it can be most effective. As a result, the system for preventing and ending homelessness is less fragmented and scarce resources are used more efficiently.

What is Coordinated Entry?

Coordinated Entry for the St Johns County CoC is a hybrid of a decentralized (no wrong door policy), along with outreach. Initial screening can be conducted for all populations at one of the five (5) Access Points or via a mobile Outreach worker. Coordinated Entry includes the following core components:

- Information so that people will know where or how to access intake for homeless prevention or housing services;
- A screening and assessment process and tools to gather and verify information about the person and his/her housing and service needs and program eligibility and priority;
- Information about programs and agencies that can provide needed housing or services;
- A process and tools for referral of the person to an appropriate programs or agencies; and assistance in making program admissions decisions

While most housing and services are made available through other agencies, a variety of services may be provided on site at the "Access Points" or by an Outreach worker. These services typically meet basic client needs and may include diversion services, crisis counseling, landlord/tenant mediation, motel vouchers, Sunshine bus pass or transportation to an agency and/or access to mainstream resources.

KEY TERMS

A number of key terms are subject to varying interpretations and thus should be defined for purposes of this document. They are as follows:

- **Access Points –** For the purpose of this document, Access Points are designated areas located within our continuum where individuals or families can go to for intake and assessment of homeless prevention and housing services for which they may qualify.
- **Admission –** Using authority to admit a client into a program
- **Assessment –** A process that reveals the past and current details of a service seeker's strength, and needs, in order to match the client to appropriate services and housing. For the purpose of this toolkit, assessment will refer to a process (whether at primary screening and intake or at entry to a housing program) that reveals a client's eligibility, needs, barriers and strengths.
- **Chronic Homelessness-**A chronically homeless individual is someone who has experienced homelessness for a year or longer, or who has experienced at least four episodes of homelessness in the last three years and has a disability. A family with an adult member who meets this description would also be considered chronically homeless.
- **Coordinated Assessment –** For this area, this term specifically relates to the providers within our continuum that uses the same assessment tools to connect clients to services as a means for a coordinated entry system. For the purpose of this document, that tool is the VI-SPDAT (Vulnerability Index- Service Prioritization Decision Assistance Tool) and SPDAT.
- **Coordinated Entry Committee or their Designee**-Entity responsible for implementation of Coordinated Entry System and uniform decision-making across access points
- **Coordinated Entry Provider Network –** is a consortium of partners that includes homeless service providers, advocacy groups, government agencies, and homeless individuals who are working together to address the housing and support needs of the homeless in St Johns County **Coordinated Systems – Within our community, coordi**nated systems is defined as interconnected network of systems that services homeless and a**t risk households, an**d consists of coordinated intake and assessment, diversion, prevention, rapid re-housing, transitional housing, permanent supportive housing and other tailored pro**grams and services, and linkages to** ma**i**nstream resources.
- **Fiscal Agent –** For the purpose of this document, the entity that coordinates funding and provides oversight to the coordinated intake and assessment system. The fiscal agent for this community will be Flagler Hospital, Inc. This agent is also known as the "Lead Agency/Collaborative Applicant"

- **HEARTH –** The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) act of 2009 that includes Emergency Solutions Grant (ESG) and Continuum of Care (CoC) grants.
- **HMIS –** Homeless Management Information System; a centralized data base designated to create an unduplicated accounting of homelessness that includes housing and services. Bowman System /Mediware "Service Point" is the HMIS system for this CoC.
- **Homeless –** HUD definition as of January 2012; an individual or family who lacks a fixed regular, and adequate nighttime residence, which includes a primary nighttime residence of: a place not designed for or ordinarily used as a regular sleeping accommodation (including car, park, abandoned building, bus/train station, airport or camping grounds); a publicly or privately operated shelter or transitional housing, including a hotel or motel paid for by government or charitable organizations. In addition a person is considered homeless if he or she is being discharged from an institution where he or she has been a resident for 90 days or less and the person resided in shelter (but not transitional housing) or place not meant for human habitation immediately prior to entering the institution.
- **Housing First –** An Evidence-Based Practice of housing homeless individuals and families according to the provisions of a standard lease without requiring services other than case management in order to attain and retain housing.
- **Housing Ready –** A case management/housing approach that placed homeless households into permanent housing only when determined the household was ready. Until that time, households were placed into long-term shelter or transitional housing programs.
- **HUD –** The Department of Housing and Urban Development; the United States federal department that administers federal program dealing with homelessness. HUD oversees HEARTH-funded programs.
- **Information –** Specific facts about a program, such as its location, services provided, eligibility requirements, hours of operation, and contact information
- **Intake** – the general process between the client first point of contact and the initial screening for eligibility. This step involves primary assessment of needs, strengths and resources to refer households into appropriate services
- **Lead Agency –** The agency identified as the primary administrator of coordinated intake and assessment. For the purpose of this document that agency is the Flagler Hospital, Inc. or its sub-grantee who has been contracted to provide the Coordinated Intake and Assessment Services.
- **Linkage or Access to Mainstream Resources –** An approach to help people stabilize their housing for the long term by linking them to resources for which they are eligible within their community

- **Outreach Worker –** A trained intake worker whose responsibility is to provide coordinated intake and assessment for individuals or families seeking homeless prevention or housing services.
- **Outcome –** The specific result of what was provided from a specific activity or service; in relation to HUD/HEARTH, a specific result as detailed by HUD/HEARTH funding requirements.
- **Prevention –** An approach that focuses on preventing homelessness by providing assistance to households that otherwise would become homeless and end up in a shelter or on the streets.
- **Rapid Re-housing –** An approach that focuses on moving homeless individuals and families into appropriate housing as quickly as possible by providing the type, amount and duration of housing assistance needed to stabilize the household. Clients do not need to be considered "Housing Ready".
- **Referral –** Referring a client to a particular program for possible help
- **Screening –** For the purpose of this document, the process by which eligibility for housing and services is determined at the initial point of contact to a coordinated entry system. Once screening determines eligibility, the intake and referral process follows.
- **Systems Change –** For the purpose of this document, the process by which our CoC has altered the way homeless and at-risk households engage with the homeless and housing providers within our communities. The purpose of system change is to implement practices that have shown to decrease the incidence and length of time in homelessness, with a long term goal of reducing and ending homelessness.
- **Tailored Programs and Services –** An approach to case management services that matches the services to the particular individual's or family's needs rather than using a one-size-fits-all approach.
- **Targeting –** Process of determining the population to whom assistance will be directed. That is, the target population. The targeting process can occur at both the system and the program levels.
- **Unaccompanied Youth and Young Adults—**ACF defined as youth (ages 13-17) and young adults (ages 18-24) who are unaccompanied by a parent or guardian and are without shelter where appropriate care and supervision are available, whose parent or guardian is unable or unwilling to provide shelter and care, or who lack a fixed , regular and adequate nighttime residence.
- **Verification –** The gathering and review of information to substantiate the applicants/client's situation and support program eligibility and priority determination.

ENTRY SYSTEM

St Johns County is located in Northeast Florida and spans over 822 square miles of diverse geographic and demographic landscape. The largest incorporated city is St. Augustine. With this being a major tourist and retirement mecca, St. Johns County is the wealthiest county in Florida in regards to income, primarily due to concentrated high income areas such as Ponte Vedra, Northwest quadrant and the beaches. In order to meet the need of our community we will utilize a hybrid approach incorporating Access Points and Outreach workers in which all segments of our community can access housing and service supports.

Applicants and Clients :

- Clients who are in need of homeless prevention or housing services can access information and eligibility criteria through one of the Access Points. Applicants seeking assistance must be screened at one of the five Access Points or by an Outreach worker prior to being referred to an agency for assistance. Applicants not eligible for services will be referred to other appropriate community resources.

- Eligibility. Individuals and families that are **"Literally Homeless"** (meeting HUD's Category 1 definition of homelessness) or at **"Imminent Risk of Homelessness"**. For purposes of eligibility for coordinated intake and assessment, "imminent risk of homelessness" means individuals and families that are able to document that they must leave their current nighttime residence within 72 hours, and include household that;

    - Have received a court notice of eviction or foreclosure.
    - Are staying with family or friends AND can document that they must leave within 72 hours. Documentation must include a third party verification of violation. (For example, a lease that states that anyone other than occupants in the lease constitutes a lease violation.)
    - Other, as determine by a provider or by the St Johns County CoC

- Participation Requirement. All households (with the exception of households in domestic violence situations) must be assessed prior to program entry; or , in the case of households in emergency shelters that admit same day, the assessment must occur as soon as possible after entry, and before being referred to another program

- Applicants/Clients can expect :

    - To be treated with respect and dignity

- To be scheduled for an in-person, intake and assessment within two to five business days
- To be matched to an appropriate program based upon their unique needs, and referred based on their priority status to opening in a program
- To wait until the system has the capacity to assist them, and to get help from through diversion or other resource available to them.

- Responsibilities. Client must:

  - Answer all questions truthfully and to the best of their ability
  - Bring all required documentation
  - Keep their contact information current in order to be notified of available opening, and referred in a timely manner.

Providers:

- Participation Requirement.

  - All providers receiving funding through HEARTH or a HUD funded program are required to participate in the coordinated intake and assessment process.
  - Providers must be live on the HMIS system and must maintain data which is inputted no later than within 72ours of a service or outcome being achieved or rendered.
  - Providers must provide written documentation to the Coordinated Entry Committee or their Designee within 3 business days on why an applicant was denied entry into a program.
  - Providers must have an appeal process for those applicants who have been denied service or entry into a program.

Lead Agency or their Designee:

- It is the Lead Agency or their Designee responsibilities to:

  - Update and maintain information on program vacancies/opening. This must be done on a daily or weekly basis regardless of whether there are new openings to report.
  - Regularly update and make current all programs eligibility guidelines and program contact information so that Outreach workers can make the best referrals possible.

- Ensure that when a referral is made, the Outreach workers confirms within two business days whether the referral is accepted, declined by provider, declined by client, or pending, or the provider is unable to contact the client.
- Bring problems and suggestions to the monthly HMIS/Coordinated Entry meeting.
- Oversee provision of homeless diversion, prevention and housing services for eligible clients.
- Ensure that all points of entry will use the same screening and assessment tool, data collection forms, policies on eligibility verification and referral/information-sharing systems.

NOTE: *This system acknowledges that the needs of a household fleeing or attempting to flee, domestic violence, dating violence, sexual assault or stalking, may be different than the needs of non-victims. Outreach workers will be trained on sensitivity in regards to victim's assistance, and referrals will only be made to domestic violence providers. In addition, the HMIS data of victims will continue to be treated with the highest level of confidentiality and victims' data not shared with other Providers (except those designated as Domestic Violence Providers).*

ASSESSMENT TOOLS & PROTOCOLS

This system is focused on providing a continuum of care including prevention, diversion and rapid re-housing approaches. The Plan requires each Outreach worker to assess household's eligibility for services. Prevention services target people at imminent risk of homelessness, while diversion services target people as they are applying for entry into shelter, and rapid re-housing services target people who are already homeless. If the client is considered chronically homeless a full SPDAT will be conducted to determine available housing solutions.

Applicants and Clients:

- Each applicant is evaluated on a variety of criterion, including rental history, criminal history, domestic violence, mental health challenges, disabling conditions, language barriers, educational attainment, employment status, and length of homelessness. Services are then assigned based on the client level determination.
- The Assessment tool provides a procedure for determining which applicants are eligible and appropriate for the variety of housing and support services available in the community. For example, applicants for permanent supportive housing must have a disabling condition and lack the resources to obtain housing.
- Clients will be allowed to submit a survey for improvement changes and suggestions on the Coordinated Intake and Assessment process.

Providers:

- Each applicant who is referred for housing or services will be evaluated through an assessment of their current barriers to obtaining and successfully maintain permanent housing.
- The assessment is heavily focused on the applicant's immediate housing challenge and includes questions regarding household composition, current housing situation, homelessness history, evictions, criminal history and/or active warrants, physical and mental health, and domestic violence issues.
- The Assessment will be used as a guide, with the understanding that each applicant has a unique set of circumstances.
- Generally speaking, the assessment tool ensures that protocols are applied consistently throughout the county and that each Provider is engaging in responsible assessments protocol.
- VI-SPDAT Training is available to all Providers online via https://vimeo.com/126548635.

Lead Agency or their Designee:

- The Vulnerability Index- Service Prioritization Decision Assistance Tool (VI-SPDAT)
- The Service Prioritization Decision Assistance Tool (SPDAT) is the assessment tool utilized for this system.
- The SPDAT will utilize 15 dimensions to determine an acuity score that will help inform Outreach workers and Providers about the following :

    - People who will benefit most from Permanent Supportive Housing
    - People who will benefit most from Rapid Re-Housing
    - People who are most likely to end their own homelessness with little to no intervention on your part
    - Which areas of the person's life that can be the initial focus of attention in the case management relationship to improve housing stability.
    - How individuals and families are changing over time as result of case management process.
- The VI-SPDAT and SPDAT scores will be integrated into the HMIS System and the HMIS Lead Agency will ensure data is being maintained and monitored.
- The Lead Agency will provide a system of care that allows clients to give feedback on suggestions and improvements of the Intake and Assessment Process. This process will be posted in common areas of "Access Points".
- The Lead Agency will ensure that the VI-SPDAT is not used 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

PRIORITIZATION PROCEDURES & PROTOCOL

One of the main purposes of Coordinated Intake and Assessment is to ensure that people with the most severe service needs and levels of vulnerability are prioritized for housing and homeless assistance. As indicated by HUD guidelines individuals and families experiencing chronic homelessness should be prioritized for permanent supportive housing.

In addition to prioritizing chronic homelessness, Coordinated Entry will prioritize people who are more likely to need some sort form of assistance to end their homelessness or who are more vulnerable to the effects of homelessness.

HUD has released the following criteria to consider how to prioritize individuals and families for housing and homeless assistance:

- Significant health or behavioral challenges or functional impairments which require a significant level of support in order to maintain permanent housing
- High utilization of crisis or emergency services, including emergency rooms, jails, and psychiatric facilities to meet basic needs
- The extent which households, especially youth and children, are unsheltered
- Vulnerability to illness or death
- Risk of continued homelessness
- Vulnerability to victimization, including physical assault or engaging in trafficking or sex work

The St Johns County Coordinated Entry System will utilize the VI-SPDAT assessment scores to identify interventions that may be best appropriate for families seeking assistance. Assessment scores will be characterized by the following breakouts:

- Scores 10 and above will be prioritized for PSH interventions
- Scores 5-9 will be prioritized for RRH and/or TH interventions
- Scores 4 and below will be prioritized for Prevention/Diversion and other community resources

Prioritization for Permanent Supportive Housing:

In order for a household to qualify for PSH interventions they must meet the definition of chronically homeless as defined by HUD. The definition of “chronically homeless” currently in

effect for the CoC Program is that which is defined in the CoC Program interim rule at 24 CFR 578.3, which states that a chronically homeless person is:

(a) An individual who
    a. Is homeless and lives in a place not meant for habitation, a safe haven, or in an emergency shelter
    b. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last three years
    c. Currently diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability, post-traumatic stress disorder, cognitive impairments resulting from brain injury or chronic physical illness

(b) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility for fewer than 90 days and met all the criteria outlined in section (a)

(c) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all the criteria in section (a), including a family whose composition has fluctuated while the head of household has been homeless.

In accordance with HUD Notice CPD-014-12, households scoring in the permanent supportive housing range will be prioritized in the following manner:

- **First Priority- Chronically Homeless Individuals and Families with the longest history of homelessness and with the most severe service needs**
    - Household's length of time homeless will be determined by length of time as reported by homeless household during the VI-SPDAT assessment in combination with a review of their HMIS record. Households must be able to demonstrate history of homeless by producing required documentation.
    - Service needs will be identified by the acuity captured in the VI-SDPAT assessment. When applicable, portions of the SPDAT targeting the use of crisis services will be administered to the head of household if the household's needs are not accurately captured by the VI-SPDAT.

- **Second Priority- Chronically Homeless Individuals and Families with the longest history of homelessness**
    - The chronically homeless individual or head of household of a family has been homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter for at **least 12 months either continuously or on at least four separate occasions in the last 3 years, where the cumulative total length**

of the four occasions equals at least 12 months and the **CoC or CoC program recipient has NOT identified** an individual or a head of household, who meets all the criteria of the definition for chronically homeless, of the family as having severe service needs

- Household's length of time homeless will be determined by length of time as reported by homeless household during the VI-SPDAT assessment in combination with a review of their HMIS record. Households must be able to demonstrate history of homeless by producing required documentation

- **Third Priority- Chronically Homeless Individuals and Families with the most severe needs**
  - The chronically homeless individual or head of household of a family has been homeless and living or residing in a place not meant for habitation, a safe have or an emergency shelter **on at least four separate occasions in the last 3 years, where the total length of those separate occasions equals less than one year**, and the **CoC or CoC recipient has identified ta chronically homeless individual or head of household**, who meets all of the criteria of the definition for chronically homeless, of the family **as having severe service needs**.
  - Service needs will be identified by the acuity captured in the VI-SDPAT assessment. When applicable, portions of the SPDAT targeting the use of crisis services will be administered to the head of household if the household's needs are not accurately captured by the VI-SPDAT.

- **Forth Priority- All other chronically Homeless Individuals and Families**
  - The chronically homeless individual or head of house household has been homeless and living in a place not meant for human habitation, a safe haven or in an emergency shelter for at **least 12 months either continuously or on at least four separate occasions in the last 3 years where the cumulative total length of the four occasions is less than 12 months** and the CoC or CoC program recipient has **NOT identified a chronically homeless individual or head of household** who meets all the criteria of the definition for chronically homeless as having severe service needs

PREVENTION / DIVERSION

According to the National Alliance to End Homelessness many people seeking homeless assistance still have an opportunity to remain in their current housing situation, whether it's their own housing or the housing of a friend, relative, acquaintance or coworker. In light of this prevention and shelter diversion are key interventions in the fight to end homelessness. Immediate screening for these possibilities at entry is an important tactic, and can preserve emergency beds for households that truly have nowhere else to go. Access to rental subsidies and case management at entry is often enough to ensure the household successfully remain housed.

While prevention and diversion are two separate concepts, they are utilized almost interchangeably in this strategy, as they both focus on preventing homelessness. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing targets people who are already homeless.

Once household enter into the system, they should be assessed to determine what housing needs they have. To determine which households are appropriate for prevention/diversion, Outreach workers can ask applicants a series of questions during the assessment, such as those delineated below.

Client:

Clients who are being referred for prevention/diversion will:

- Be asked where did you sleep last night? *If they slept somewhere safe where they could potentially stay again, this might mean they are good candidates for diversion*
- Be asked what other options do you have for the next few days or week? *Even if there is an option outside of shelter that is only available for a very short time, it worth exploring if this housing resource can be used.*
- (If staying in someone else's housing) What issues exist with you remaining in your current housing situation? Can those issues be resolved with financial assistance, case management, etc.? *If the issues can be solved with case management, mediation, or financial assistance (or all of the above), diversion is a good option.*
- (If coming from their own unit) Is it possible/safe to stay in your current housing unit? What resources would you need to do that (financial assistance, case management, mediation, transportation, etc.)? *If the individual or family could stay in their current housing with some assistance, systems should focus on a quick prevention-oriented solution that will keep the individual or family in their unit.*

Providers:

Candidates for referrals to prevention/diversion providers will be at imminent risk of homelessness AND meet the following threshold.

- No appropriate subsequent housing options have been identified;
- The household lacks the financial resources to obtain immediate housing or remain in its existing housing; and
- The household lacks support networks needed to obtain immediate housing or remain in its existing housing

Lead Agency :

The following list includes some, but not all risk factors that may be considered when determining imminent risk of homelessness:

- Eviction within two weeks from a private dwelling (including housing provided by family or friends)
- Discharge within two weeks from an institution (including prisons, mental health institutions, hospitals);
- Residency in housing that has been condemned by housing officials and is no longer meant for human habitation;
- Sudden and significant loss of income
- Sudden and significant increase in utility cost
- Mental health and/or substance abuse issues
- Physical disabilities and other chronic health issues including HIV/AIDS
- Severe housing cost burden (greater than 50% of income for housing costs);
- Homeless in last 12 months
- Young head of household (under 25 with children or pregnant)
- Current or past involvement with child welfare, including foster care
- Pending foreclosure of rental housing
- Extremely low income (less than 30% of AMI);
- High overcrowding (the number of person exceeds health and/or safety standards for housing unit size)
- Past institutional care (prison, treatment facility, hospital)
- Recent traumatic life event, such as death of a spouse or primary care provider, or recent health crisis that prevented the household from meeting its financial responsibilities.
- Credit problems that preclude obtaining of housing or
- Significant amount of medical debt.

Some applicants may not be good candidates for diversion programs due to a lack of safe and appropriate housing alternative and require immediate admittance to shelter, e.g. client fleeing domestic violence. A client's safety should always be the top consideration when developing an individual /household referral to a program

RAPID RE-HOUSING

Generally, rapid re-housing is intended to assist eligible participants to quickly obtain and sustain stable, permanent housing. Effective rapid re-housing requires case management and financial assistance, as well as housing search and locations services. Support and duration of service are tailored to meet the needs of each household and each household has a lease in their name and is connected to mainstream resources in the community in which they reside.

Clients:

Eligible households must:

- Be literally homeless as defined by HUD

Providers:

Providers who are rapid re-housing grantees:

- Will utilize the **"Progressive Engagement"** methodology; that is, providers will determine the amount of rent and utility assistance and/or supportive services that a household will receive using the progressive engagement approach. Household will be asked to identify the minimum amount and duration of assistance needed to achieve housing stability. If it becomes clear after 90 days that the amount and duration of assistance are not enough, the household will be reassessed, and the amount and duration of assistance may be adjusted. If it becomes clear that a rapid re-housing intervention is insufficient and or inappropriate for a particular household, the provider will work with the Outreach Worker and/or other housing provider to find a more suitable program.
- Households should be housed within 30 days of acceptance into the program.
- Providers are responsible for confirming the household homeless status
- Providers are expected to remain engaged with the household from first contact to program exit.

Lead Agency :

The following process will be used to refer clients to any Rapid Re-Housing program. Providers will receive referrals from any of the following sources; provided they have been assessed by the coordinated intake worker and all eligibility and vacancy information is up to date in HMIS.

- Coordinated Access Points and/or Outreach Workers
- Shelters

- Transitional Housing Programs

All household being referred for Rapid Re-Housing must be assessed by a Intake worker. While they may be identified through other resources, e.g., shelter or transitional housing provides, McKinney-Vento Liaisons in school districts, or other services providers, they will require screening and assessment through the St Johns County Coordinated Intake and Assessment System.

- Outreach workers are responsible for gathering documentation for verification of homeless status.
- All Rapid Re-Housing clients must be entered into HMIS by the case manager once the provider has confirmed entry into the program. Information should all include all HUD required data elements.

HOUSING AND/OR MORE INTENTSIVE PROGRAM REFERRAL

Consumers unable to be served by prevention, diversion or rapid re-housing programs will most likely need more intensive housing and service interventions, such as transitional housing or permanent supportive housing. Those fleeing domestic violence that are not eligible or appropriate for prevention and rapid re-housing services may fall into this category of needing more intensive service intervention, and should be referred to a domestic violence provider prior to intake and/or HMIS data entry.

Table 1 below delineates the characteristics of Permanent Support Housing and Transitional Housing Programs.

Characteristics of Transitional Housing & Permanent Supportive Housing Programs

Programs & Characteristics	Transitional Housing	Permanent Supportive Housing
Length of Stay	Maximum stay 24 month	No time limit
Occupancy Agreement	Participant are clients , not tenants and sign an occupancy or program agreement instead of a lease	Participant have a lease
Service Requirements	Service are required	Services are optional
Eligibility	Applicant must meet HUD's definition of homeless	Applicant must meet HUD's definition of homeless and member of the household must have a disabling condition

Provider:

Transitional Housing: programs that provide transitional housing should provide housing to individuals and/or families, usually for period of six to twenty-four months along with supportive services to help them become self-sufficient. In addition to providing a place to live, transitional housing providers should help participant to increase their life management skills and resolve the problems that have contributed to their homelessness. Household who are homeless and have two or more of the following barriers are appropriate for referral to Transitional Housing:

- Domestic Violence victims (require only one barrier: being a victim of domestic violence.)
- No income
- Poor rental history
- Sporadic employment history
- No high school diploma or GED

- History of homelessness
- Poor rental history (i.e current eviction, rent/utility arrears)

Transitional housing best serves individuals and families with the potential to be self-sufficient, who may just need longer term case management to be successful.

Permanent Supportive Housing: As a minimum, candidates for Permanent Supportive Housing must meet the following basic requirements:

- Is literally homeless
- Lacks the resources to obtain housing
- Has a member of the household with a severe or significant disabling condition
- Qualifies as a high need based on the Intake and Assessment

Permanent Supportive Housing is targeted to household who need services in order to maintain housing and there is prioritization for people who have been homeless for long periods of time or have experienced repeat episodes of homelessness.

Lead Agency or their Designee:

The outreach worker needed housing navigation services, is in frequent communication with the client and serves as the primary liaison between the client and the housing provider. The Lead Agency is responsible for overseeing and ensuring that:

- Advocacy and services to collect required housing documentation are provided
- In-reach and outreach are available and provided depending on service provider's system already in place, to accomplish the task of completing the housing document checklist.
- A climate of trust is created and maintained between clients and Outreach workers.
- A housing inventory within HMIS is maintained that lists units and vouchers participating within the system.
- Clients are housed based upon a prioritization determination; that is, those who score on the VI-SPDAT as the most vulnerable should be prioritized for housing.

UNACCOMPANIED YOUTH AND YOUNG ADULTS

The Department of Health and Human Services Administration for Children, Youth and Families emphasizes that youth who run away from home are often mistakenly portrayed as juvenile delinquents. In contrast, such behaviors often reflect society's failure to develop adequate support which includes homeless services. Unaccompanied youths are one of the fastest growing and most underserved sub- populations, in our community. In addition, it is important to note that Lesbian, Gay, Bisexual, Transgendered, Questioning, and Intersexed, as well as African American youth and young adults are disproportionately impacted when compared to other groups.

Clients:

Unaccompanied Youth and Young Adults are defined as youth (ages 13-17) and young adults (ages 18-24) who are unaccompanied by a parent or guardian and are without shelter where appropriate care and supervision are available, whose parent or guardian is unable or unwilling to provide shelter and care, or who lack a fixed , regular and adequate nighttime residence. Undocumented unaccompanied youth and young adults may also be served under these provisions except where exclusions are noted

Providers:

Providers of services for unaccompanied youth and young adults should be able to provide safe and high quality housing and supportive services (scattered-site independent apartments, host homes, and shared housing) to youth and young adults experiencing homelessness that involve an integrated constellation of affordable housing, intensive strengths-based case management, self-sufficiency services, trauma informed care, and positive youth development approaches.

Lead Agency or their Designee:

All housing service referrals for unaccompanied youth and young adults must be screened and assessed at an "access point". The Lead Agency is responsible for overseeing and ensuring that:

- Unaccompanied youth and young adults willingly engage with coordinated intake for a screening and an in person comprehensive assessment.
- Whenever possible, unaccompanied youth should be re-housed within the catchment area of their school of origin.
- Low barriers of entry for this highly vulnerable population are created.
- Outreach workers consult with expert providers of this population when conducting intake to properly match clients and providers, and reduce the risk of flight for this highly vulnerable population.

PROGRAM EVALUATION

Coordinated Entry is one of many projects within our community that addresses the needs of individuals and families that are at risk or experiencing homelessness within our communities. The HMIS Data Committee will evaluate the effectiveness as well as required HEARTH Act outcomes by utilizing data from HMIS. As recommended by the National Alliance to End Homelessness, the Lead Agency will track progress in the following areas to evaluate the Coordinated Intake and Assessment process:

- Length of stay, particularly in shelter: If consumers are referred to the right interventions and those interventions have the necessary capacity, fewer individuals and families should be staying in shelter waiting to move elsewhere. Also if clients are referred immediately to the right provider, over time, clients will likely spend less time jumping from program to program looking for help, which could reduce their overall length and/or repeated episodes of homelessness.
- New entries into homelessness: If every individual and family seeking assistance is coming through the front door to receive it and the front door has prevention and diversion resources available, more people should be able to access these resources and avoid entering a program unnecessarily.
- Repeat episodes of homelessness: If clients are sent to the intervention that is the best suited to meet their needs on the first time, families are more likely to remain stably housed.

To track the outcomes summarized above, the HMIS Data Committee will analyze the following Performance Measures annually.

1) St Johns County will reduce the number of person experiencing homelessness.
    a. Reduction in the total number of person experiencing homelessness
    b. Reduction in the total number of persons experiencing first time homelessness.
2) St Johns County will reduce the length of homelessness episodes
    a. Reduction in the mean length of homelessness episode for individuals
    b. Reduction in the mean length of homelessness episode for families with children
    c. Reduction in the mean length of homelessness episode for youth
3) St Johns County will reduce the number of persons returning to homelessness.
    a. Reduction in return to homelessness within two years following exit
    b. Increase in exits to permanent housing
    c. Increase in income at exit

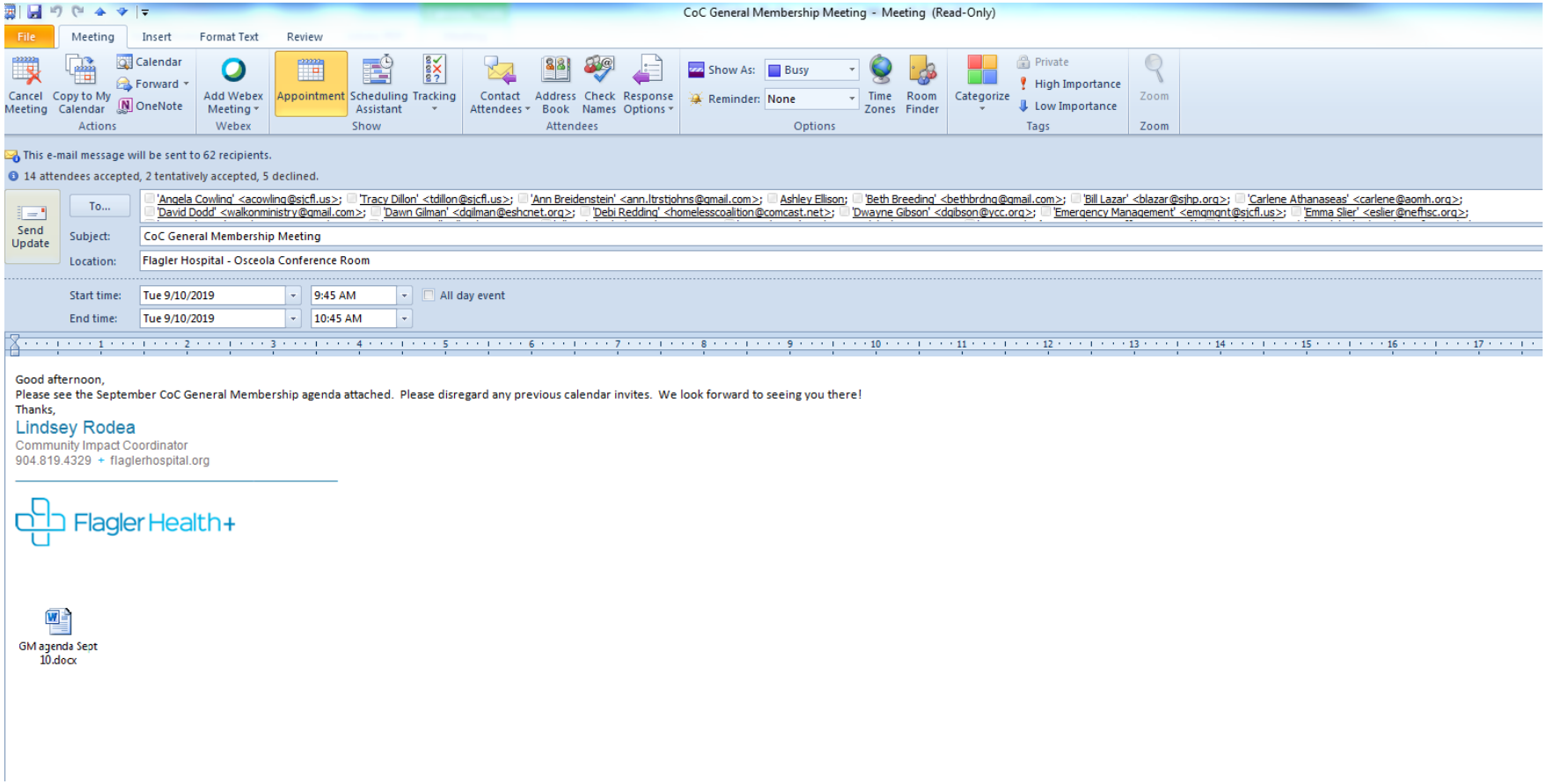
Measuring of the success of this system and transparency with the community and providers will be a key to the success of this project. The HMIS Lead Agency will summarize the data annually in conjunction with the annual Point in Time homeless census data report.

Moving forward, the HMIS Lead Agency and HMIS Data Committee or their Designee will expand the evaluation of outcomes by establishing mechanisms to monitor the quality of service through system-wide monitoring. For example, once a client enters shelter an assessment is to be completed within 48 hours. Procedures will be built into the monitoring system to determine how often this goal is met. This will allow for ongoing monitoring of the quality of services and how the program and Providers are able to follow through with this goal.

As part of the evaluation process, as recommended by the National Alliance to End Homelessness, the Lead Agency will set a goal to establish an integrated feedback loop that involves using information gained from these assessments to make any necessary adjustments to the system. For example, if families are being referred to the right program, but the program cannot serve them due to capacity issues while other program types have an increasing number of empty beds, it may be appropriate to make system-wide shifts in the types of programs and services offered. Additionally, the HMIS Lead Agency and Lead Agency will continue working to develop data tools to ensure overall system efficiency and effectiveness.

Attachment 1
VI-SPDAT TOOL
Single Adults
Families
Youth

Attachment 2
SPDAT TOOL
Single Adults
Families
Youth


CoC General Membership Meeting - Meeting (Read-Only)
File
Meeting
Insert
Format Text
Review
Cancel Meeting
Copy to My Calendar
Calendar
Forward
OneNote
Actions
Add Webex Meeting
Webex
Appointment
Scheduling Assistant
Tracking
Show
Contact Attendees
Address Book
Check Names
Response Options
Attendees
Show As:
Busy
Reminder:
None
Time Zones
Room Finder
Options
Categorize
Private
High Importance
Low Importance
Tags
Zoom
Zoom
This e-mail message will be sent to 62 recipients.
14 attendees accepted, 2 tentatively accepted, 5 declined.
Send Update
To...
'Angela Cowling' <acowling@sjcfl.us>; 'Tracy Dillon' <tdillon@sjcfl.us>; 'Ann Breidenstein' <ann.ltrstjohns@gmail.com>; Ashley Ellison; 'Beth Breeding' <bethbrdng@gmail.com>; 'Bill Lazar' <blazar@sjhp.org>; 'Carlene Athanaseas' <carlene@aomh.org>; 'David Dodd' <walkonministry@gmail.com>; 'Dawn Gilman' <dgilman@eshcnet.org>; 'Debi Redding' <homelesscoalition@comcast.net>; 'Dwayne Gibson' <dgibson@ycc.org>; 'Emergency Management' <emgmgnt@sjcfl.us>; 'Emma Slier' <eslier@nefhsc.org>;
Subject: CoC General Membership Meeting
Location: Flagler Hospital - Osceola Conference Room
Start time: Tue 9/10/2019 9:45 AM
All day event
End time: Tue 9/10/2019 10:45 AM
Good afternoon,
Please see the September CoC General Membership agenda attached. Please disregard any previous calendar invites. We look forward to seeing you there!
Thanks,
Lindsey Rodea
Community Impact Coordinator
904.819.4329 + flaglerhospital.org
Flagler Health+
GM agenda Sept 10.docx

Agenda
St. Johns County CoC General Membership Meeting
9:45 am – 10:45 am, Tuesday September 10, 2019
Flagler Hospital, 400 Health Park Blvd. St. Augustine, FL 32086
Osceola Conference Room – First Floor behind Cafeteria

I. Welcome – 9:45am – 9:55am

a. Call to Order
b. Introductions/Visitors
c. Minutes: August 14, 2019
d. Announcement of Committee Updates (*consent agenda*)

II. New Business – 9:55am – 10:15am

a. Coordinated Entry/Housing Navigation Update (Francine Avinger)
b. Housing Summit Debrief (Francine Avinger)
c. 2020 Point in Time – January 23, 2020 (Brittany Coronado)

III. Old Business – 10:15am – 10:35am

a. Built for Zero Update (Melissa Nelson)
b. Scoring and Review Report – NOFA Projects and Priority Listing (Pat O'Connell)
c. Status of subcontracts (Lindsey Rodea)
d. Spend Down Report (Lindsey Rodea)
e. Strategic Planning Session Update (Lindsey Rodea)

IV. Agency Highlights/Announcements 10:35 – 10:45

a. Agency highlights/announcements
b. Reports from funded agencies
c. CoC Board Meeting – NO OCTOBER MEETING. Next Board meeting will be Wednesday, November 13
d. CoC General Membership Meeting – Wednesday, October 9, 2019 at 9:45am

FLAGLER HOSPITAL Osceola Conference Room – 400 Health Park Blvd., St. Augustine, FL

V. Adjournment

MINUTES

St. Johns County CoC General Membership Meeting

9:45 am – 10:45 am, Tuesday, September 10, 2019
Flagler Hospital, 400 Health Park Blvd. St. Augustine, FL 32086
Osceola Conference Room – First Floor behind Cafeteria

PRESENT: John Eaton, Nancy Eisele, Malinda Everson, Melissa Witmeier, Michael Israel, Melissa Nelson, Shawna Novak, Pat O'Connell, John Spence, Ellen Walden, Brittany Coronado, Lindsey Rodea, Mary Hepler, Debi Redding, Ann McCulliss Johnson, Judy Dembowski, Karen Hensel, Benjamin Coney, Shorty Robbins, Tim Santamour, Renee Williams, Mary Ann Kriniske

I. **Welcome – 9:45am – 9:55am**
   a. **Call to Order**: 8:37
   b. **Introductions/Visitors**
   c. **Minutes: August , 2019**

Motion: Approval of July 10, 2019 minutes
Motion by: Debi Redding
Second by: Pat O'Connell
Carried

   d. **Announcement of Committee Updates** (*consent agenda*)
      i.

II. **New Business – 9:55am – 10:30am**
   a. **Coordinated Entry/Housing Navigation Update** (Francine Avinger)
      i. 1 of the top 10 most vulnerable successfully housed, 2 currently in process of arranging move in dates.
      ii. Barriers include difficulty locating housing and issues with staffing providers
      iii. All agencies are access points where unified triage and diversion assessment is conducted when seeking housing services. Now looking to stream line the prioritization better with a reduction of two organizations conducting vulnerability assessments and eliminating open interpretation.
   b. **Housing Summit Debrief** (Francine Avinger)
      i. Went to Alachua counties housing summit…
   c. **2020 Point in Time** (Brittany Coronado)
      i. Point in time is conducted each year on the last 10 days of January, the HMIS committee has motioned date, time, and methodology for approval by general membership.
      ii. Data committee presented for vote
         1. PIT Date: 1/23/2020, Time: 5:00 am – 7:00 pm;
         2. Methodology: Sheltered: Complete Census, Unsheltered: Complete coverage count, known locations, service based count

Motion: Approval of PIT Date, Time and methodology
Motion by: HMIS Data Committee
Second by: Debi Redding
Carried

III. **Old Business – 10:30am – 10:35am**
   a. **Built for Zero** (Melissa Nelson)

MINUTES

St. Johns County CoC General Membership Meeting

9:45 am – 10:45 am, Tuesday, September 10, 2019
Flagler Hospital, 400 Health Park Blvd. St. Augustine, FL 32086
Osceola Conference Room – First Floor behind Cafeteria

i. We will need 8-10 people to attend the first learning session in Denver Oct 21-23. We will send out a doodle poll to collect possible times for a conference call to discuss in-depth and send details regarding roles and responsibilities.

b. **Scoring and Review Report – NoFA Projects and Priority Listing** (Pat O'Connell)
   i. Only one organization applied for the CoC Program competition, Flagler Hospital.
   ii. Based on scoring tool, the HMIS – Expansion and Housing Navigator – Expansion projects ranked higher than the renewal projects but because of the tier 1 and tier 2 rules on reallocation and CoC Bonus funds, coc bonus funds had to be shifted to tier 2.
   iii. No projects were rejected or reduced

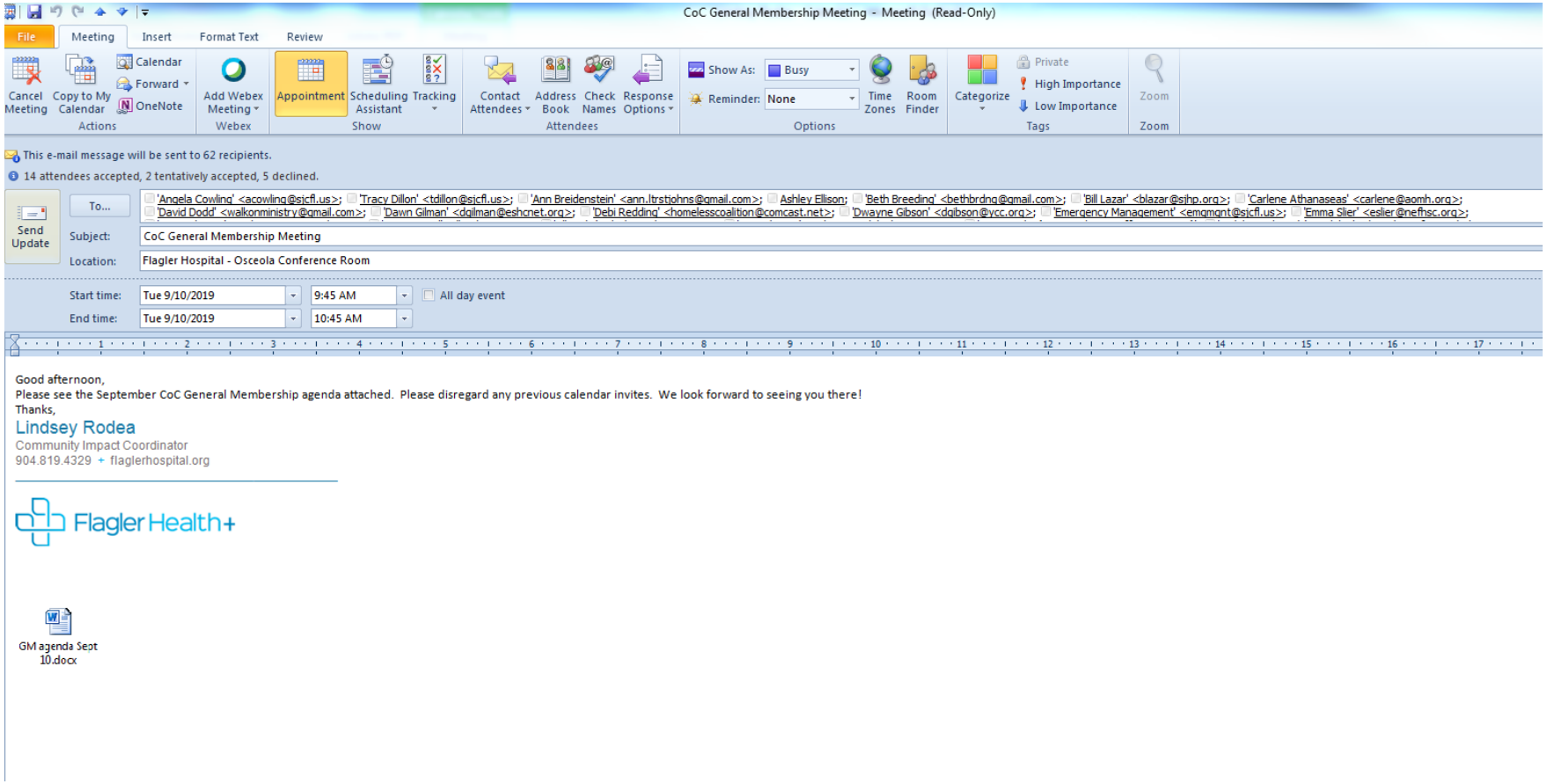
Motion: Approve ranking and tiering

c. **Status of Subcontracts (Lindsey Rodea)**
d. **Spend Down Report (Lindsey Rodea)**
e. **Strategic Planning Session Update (Lindsey Rodea**

IV. Agency Highlights/Announcements 10:35 – 10:45

a. Agency highlights/announcements
b. Reports from funded agencies
c. CoC Board Meeting – NO OCTOBER MEETING. Next board meeting will be Wednesday, November 13
d. General Membership Meeting - Wednesday, October 9, 2019 at 9:45 am (Flagler Hospital Osceola Conference Room – 400 Health Park Blvd., St. Augustine, FL

V. Adjournment: 11:02


CoC General Membership Meeting - Meeting (Read-Only)
File
Meeting
Insert
Format Text
Review
Cancel Meeting
Copy to My Calendar
Calendar
Forward
OneNote
Actions
Add Webex Meeting
Webex
Appointment
Scheduling Assistant
Tracking
Show
Contact Attendees
Address Book
Check Names
Response Options
Attendees
Show As:
Busy
Reminder:
None
Time Zones
Room Finder
Options
Categorize
Private
High Importance
Low Importance
Tags
Zoom
Zoom
This e-mail message will be sent to 62 recipients.
14 attendees accepted, 2 tentatively accepted, 5 declined.
Send Update
To...
'Angela Cowling' <acowling@sjcfl.us>; 'Tracy Dillon' <tdillon@sjcfl.us>; 'Ann Breidenstein' <ann.ltrstjohns@gmail.com>; Ashley Ellison; 'Beth Breeding' <bethbrdng@gmail.com>; 'Bill Lazar' <blazar@sjhp.org>; 'Carlene Athanaseas' <carlene@aomh.org>; 'David Dodd' <walkonministry@gmail.com>; 'Dawn Gilman' <dgilman@eshcnet.org>; 'Debi Redding' <homelesscoalition@comcast.net>; 'Dwayne Gibson' <dgibson@ycc.org>; 'Emergency Management' <emgmgnt@sjcfl.us>; 'Emma Slier' <eslier@nefhsc.org>;
Subject: CoC General Membership Meeting
Location: Flagler Hospital - Osceola Conference Room
Start time: Tue 9/10/2019 9:45 AM
All day event
End time: Tue 9/10/2019 10:45 AM
Good afternoon,
Please see the September CoC General Membership agenda attached. Please disregard any previous calendar invites. We look forward to seeing you there!
Thanks,
Lindsey Rodea
Community Impact Coordinator
904.819.4329 + flaglerhospital.org
Flagler Health+
GM agenda Sept 10.docx

Agenda
St. Johns County CoC General Membership Meeting
9:45 am – 10:45 am, Tuesday September 10, 2019
Flagler Hospital, 400 Health Park Blvd. St. Augustine, FL 32086
Osceola Conference Room – First Floor behind Cafeteria

I. Welcome – 9:45am – 9:55am

a. Call to Order
b. Introductions/Visitors
c. Minutes: August 14, 2019
d. Announcement of Committee Updates (*consent agenda*)

II. New Business – 9:55am – 10:15am

a. Coordinated Entry/Housing Navigation Update (Francine Avinger)
b. Housing Summit Debrief (Francine Avinger)
c. 2020 Point in Time – January 23, 2020 (Brittany Coronado)

III. Old Business – 10:15am – 10:35am

a. Built for Zero Update (Melissa Nelson)
b. Scoring and Review Report – NOFA Projects and Priority Listing (Pat O'Connell)
c. Status of subcontracts (Lindsey Rodea)
d. Spend Down Report (Lindsey Rodea)
e. Strategic Planning Session Update (Lindsey Rodea)

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FLAGLER HOSPITAL Osceola Conference Room – 400 Health Park Blvd., St. Augustine, FL

V. Adjournment

MINUTES

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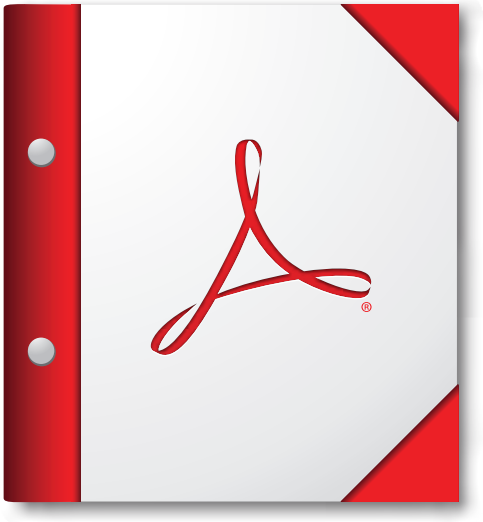

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St Johns County Racial Disparity Assessment

As shown in the CoC analysis tool, St. Johns County CoC's has minimal racial disparity when viewing the complete county census and the poverty census.

When comparing the state of Florida and St. Johns County CoC there is a major disparity in both white and black races. When assessing those experiencing homelessness there is great disparity.

Race	SJC Poverty ACS Population		State Poverty ACS Population	
	210495		**3180109**	
White	188004	89%	2049223	64%
Black	11366	5%	838187	26%
American Indian	452	0%	12518	0%
Asian/ Native Hawaiian/ Pacific Islander	4970	2%	62802	2%
Other/ Multi Race	5703	3%	217379	7%

Race	SJC Experiencing Homelessness		State Experiencing Homelessness	
	445		**32190**	
White	285	64%	18593	58%
Black	119	27%	11954	37%
American Indian	6	1%	278	1%
Asian/ Native Hawaiian/ Pacific Islander	0	0%	231	1%
Other/ Multi Race	35	8%	1134	4%

The assessment is in progress to dive into what may lead to these differences including subpopulations like veterans, youth, families and children. We will be joining the Built for Zero Collaborative this October and hope to gather more insight.

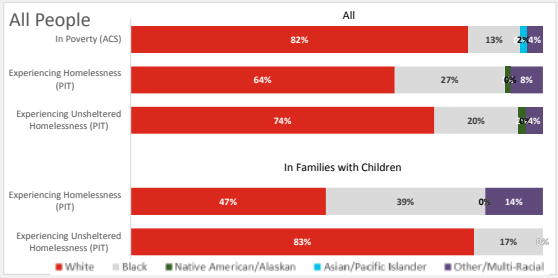
CoC Racial Equity Analysis Tool

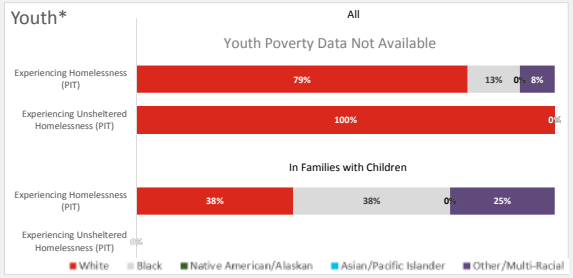
Homelessness and poverty counts at the CoC and State level

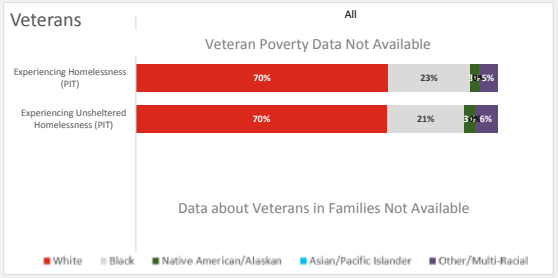
Select your CoC

FL-512 **Saint Johns County CoC**

Distribution of Race

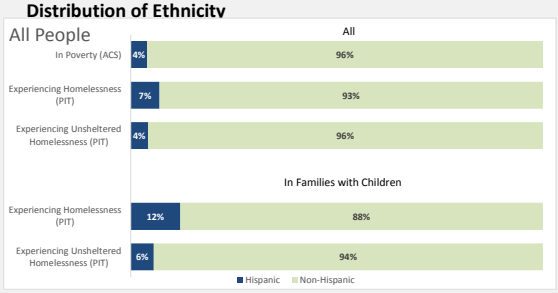


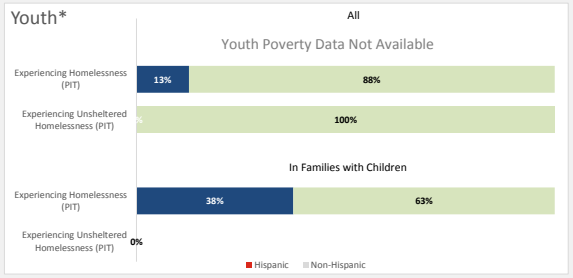


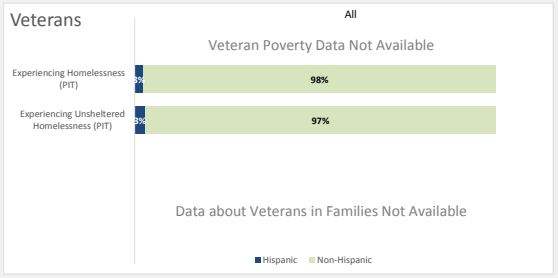


*Youth are individuals under the age of 25 who are unaccompanied or parenting.

Distribution of Ethnicity







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

CoC Data

	All (ACS)[1]				In Poverty (ACS)[1]				Experiencing Homelessness (PIT)[2]				Experiencing Sheltered Homelessness (PIT)[2]				Experiencing Unsheltered Homelessness (PIT)[2]			
	All		In Families with Children		All		In Families with Children		All		In Families with Children		All		In Families with Children		All		In Families with Children	
Race and Ethnicity	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%	#	%
All People	**210,495**		**175,219**		**19,706**		**12,360**		**445**		**150**		**179**		**132**		**266**		**18**	
Race																				
White	188,004	89%	158,159	90%	16,145	82%	10,126	82%	285	64%	71	47%	89	50%	56	42%	196	74%	15	83%
Black	11,366	5%	8,749	5%	2,472	13%	1,550	13%	119	27%	58	39%	65	36%	55	42%	54	20%	3	17%
Native	452	0%	571	0%	6	0%	0	0%	6	1%	0	0%	1	1%	0	0%	5	2%	0	0%
Asian/Pacific Islander	4,970	2%	4,448	3%	320	2%	192	2%	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Other/Multi-Racial	5,703	3%	3,292	2%	763	4%	491	4%	35	8%	21	14%	24	13%	21	16%	11	4%	0	0%
Ethnicity																				
Hispanic	12,435	6%	7,083	4%	785	4%	492	4%	31	7%	18	12%	20	11%	17	13%	11	4%	1	6%
Non-Hispanic	198,060	94%	168,136	96%	18,921	96%	11,868	96%	414	93%	132	88%	159	89%	115	87%	255	96%	17	94%
Youth <25	**63,368**		**NOT AVAILABLE**						**24**		**8**		**8**		**8**		**16**		**0**	
Race																				
White	53,778	85%	--	--	--	--	--	--	19	79%	3	38%	3	38%	3	38%	16	100%	0	0%
Black	4,585	7%	--	--	--	--	--	--	3	13%	3	38%	3	38%	3	38%	0	0%	0	0%
Native	0	0%	--	--	--	--	--	--	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Asian/Pacific Islander	1,372	2%	--	--	--	--	--	--	0	0%	0	0%	0	0%	0	0%	0	0%	0	0%
Other/Multi-Racial	3,633	6%	--	--	--	--	--	--	2	8%	2	25%	2	25%	2	25%	0	0%	0	0%
Ethnicity																				
Hispanic	4,959	8%	--	--	--	--	--	--	3	13%	3	38%	3	38%	3	38%	0	0%	0	0%
Non-Hispanic	58,409	92%	--	--	--	--	--	--	21	88%	5	63%	5	63%	5	63%	16	100%	0	0%
Veterans	**0**		**NOT AVAILABLE**						**40**		**NOT AVAILABLE**		**7**		**NOT AVAILABLE**		**33**	**100%**	**NOT AVAILABLE**	
Race																				
White	0	0%	--	--	--	--	--	--	28	70%	--	--	5	71%	--	--	23	70%	--	--
Black	0	0%	--	--	--	--	--	--	9	23%	--	--	2	29%	--	--	7	21%	--	--
Native	0	0%	--	--	--	--	--	--	1	3%	--	--	0	0%	--	--	1	3%	--	--
Asian/Pacific Islander	0	0%	--	--	--	--	--	--	0	0%	--	--	0	0%	--	--	0	0%	--	--
Other/Multi-Racial	0	0%	--	--	--	--	--	--	2	5%	--	--	0	0%	--	--	2	6%	--	--

State Data

	All (ACS)[1]				In Poverty (ACS)[1]				Experiencing Homelessness (PIT)[2]			
	All		In Families with Children		All		In Families with Children		All		In Families with Children	
Race and Ethnicity	#	%	#	%	#	%	#	%	#	%	#	%
All People	**19,611,070**		**15,827,505**		**3,180,109**		**2,309,096**		**32,190**		**9,422**	
Race												
White	14,900,000	76%	11,900,000	75%	2,049,223	64%	1,405,101	61%	18,593	58%	4,642	49%
Black	3,171,108	16%	2,603,693	16%	838,187	26%	673,170	29%	11,954	37%	4,240	45%
Native	54,569	0%	43,289	0%	12,518	0%	8,605	0%	278	1%	29	0%
Asian/Pacific Islander	509,085	3%	441,668	3%	62,802	2%	41,665	2%	231	1%	63	1%
Other/Multi-Racial	976,308	5%	838,855	5%	217,379	7%	180,555	8%	1,134	4%	448	5%
Ethnicity												
Hispanic	4,660,733	24%	4,052,437	26%	991,264	31%	808,537	35%	4,748	15%	1,854	20%
Non-Hispanic	14,950,337	76%	11,775,068	74%	2,188,845	69%	1,500,559	65%	27,442	85%	7,568	80%
Youth <25	**5,821,567**		**NOT AVAILABLE**		**1,365,206**		**NOT AVAILABLE**		**2,347**		**328**	
Race												
White	3,950,243	68%	--	--	773,167	57%	--	--	1,298	55%	124	38%
Black	1,241,761	21%	--	--	439,391	32%	--	--	924	39%	192	59%
Native	16,960	0%	--	--	4,573	0%	--	--	17	1%	0	0%
Asian/Pacific Islander	149,354	3%	--	--	24,750	2%	--	--	20	1%	1	0%
Other/Multi-Racial	463,249	8%	--	--	123,325	9%	--	--	88	4%	11	3%
Ethnicity												
Hispanic	1,658,054	28%	--	--	443,156	32%	--	--	354	15%	44	13%
Non-Hispanic	4,163,513	72%	--	--	922,050	68%	--	--	1,993	85%	284	87%
Veterans	**1,507,738**				**NOT AVAILABLE**				**2,817**		**NOT AVAILABLE**	
Race												
White	1,305,239	87%	--	--	--	--	--	--	1,871	66%	--	--
Black	153,047	10%	--	--	--	--	--	--	851	30%	--	--
Native	5,169	0%	--	--	--	--	--	--	26	1%	--	--
Asian/Pacific Islander	11,048	1%	--	--	--	--	--	--	10	0%	--	--
Other/Multi-Racial	33,235	2%	--	--	--	--	--	--	59	2%	--	--

Ethnicity																		
Hispanic	0	0%	--	--	--	--	--	--	1	3%	--	--	0	0%	--	--	1	3%	--	--
Non-Hispanic	0	0%	--	--	--	--	--	--	39	98%	--	--	7	100%	--	--	32	97%	--	--

Ethnicity										
Hispanic	110,562	7%	--	--	--	--	--	--	224	8%	--	--
Non-Hispanic	1,397,176	93%	--	--	--	--	--	--	2,593	92%	--	--

Sources:

[1] American Community Survey (ACS) 2011-2015 5-yr estimates; Veteran CoC data comes from the ACS 2015 1-yr estimates; Total youth in the American Community Survey is a rollup of race estimates of all persons under 25.

[2] Point-In-Time (PIT) 2017 data

Note: Race estimates of individuals in families with children are based on the race of the householder.