



**Alameda County Continuum of Care/
EveryOne Home Governance Charter**

Approved by the EveryOne Home Leadership Board and
Membership in October 2017

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I. Overview and Purpose

EveryOne Home is a collective impact initiative founded in 2007 to facilitate the implementation of Alameda County, California's plan to end homelessness, known as the *EveryOne Home Plan*. The Plan calls for ending homelessness in Alameda County by 2020, noting the need for engagement of stakeholders well beyond the homeless and housing service delivery system. To that end, the Plan has been adopted by the Alameda County Board of Supervisors, all 14 cities in the county, and over 70 non-profit homeless and housing providers.

The Everyone Home Plan envisions a system of care in Alameda County that ensures that all extremely low-income residents have a safe, supportive and permanent place to call home with services available to help them stay housed and improve the quality of their lives. The vision is ambitious, and possible. We are building a future in which there are sufficient resources, political leadership, and community involvement to erase homelessness as a permanent fixture in our social landscape. The vision focuses on quick access to permanent housing, strength-based consumer relationships, coordination and collaboration with mainstream partners, policy and resource advocacy, and comprehensive community education. We will have arrived when our community has no unsheltered or chronically homeless people, and we are returning as many people to permanent homes each month as lose them. The Plan charges us with achieving this vision by 2020.

This Governance Charter memorializes how stakeholders will govern the collective impact initiative to end homelessness, meet the federally-defined responsibilities of operating a HUD Continuum of Care as found in the Continuum of Care Program Rule at 24 CFR Part 578, direct the work of the backbone organization, and promote partnership and accountability among the various leadership bodies. This Governance Charter replaces two documents previously adopted by the EveryOne Home Leadership Board: first, the "*Leadership Board Governance Policies*" adopted December 4, 2008, and second, the "*Alameda County Continuum of Care Interim Governance Charter*" adopted on August 28, 2014. An organizational chart depicting the relationships amongst the various leadership bodies in the collective impact initiative may be found in **Appendix A**.

II. Definition of Terms

NOTE: Some of the terms used in this Governance Charter are from The Homeless Emergency Assistance and Rapid Transition to Housing Continuum of Care Program Interim Final Rule at 24 CFR Part 578 (the "Interim Rule"). Those terms are denoted with an asterisk (*). Definitions in the Interim Rule can be found at §578.3. *Subpart B-Establishing and Operating a Continuum of*

Care of the Interim Rule are may be found in **Appendix B**. The full Interim Rule may be found at [HUD CoC Interim Rule](#).

Additional terms used in this Charter are also noted below.

As used in this Governance Charter:

Backbone Organization means the separate organization and staff that manages the collective impact initiative through ongoing facilitation, technology and communications support, data collection and reporting, and handling the myriad logistical and administrative details needed for the initiative to function smoothly. EveryOne Home, the organization, is the backbone organization for Alameda County's initiative to end homelessness. It is also the *Continuum of Care Lead* (defined below).

Centralized or coordinated assessment system means a centralized and/or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized and/or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool.

Collaborative applicant means the eligible applicant that has been designated by the Continuum of Care to apply for a grant for Continuum of Care planning funds on behalf of the Continuum.

Collective impact means the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem. Unlike most collaborations, collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants. EveryOne Home is the name of the collective impact initiative to end homelessness in Alameda County. Additional information may be found in **Appendix C**.

Continuum of Care and Continuum (CoC) means the group organized to carry out the responsibilities required under Interim Rule. In Alameda County the CoC is part of a collective impact effort to end homelessness. It is composed of representatives of organizations including nonprofit homeless providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, organizations that serve homeless and formerly homeless veterans, and homeless and formerly

homeless persons to the extent these groups are represented within the geographic area and are available to participate. The CoC can delegate its responsibilities to a board/council, and organizations including the CoC Lead, the Collaborative Applicant, and the HMIS Lead to act on its behalf in fulfilling these responsibilities. (*text partially from §578.3.)

Continuum of Care Lead (CoC Lead) is the entity designated by the CoC to coordinate its operations and planning functions, including the submission of the CoC funding application. EveryOne Home, the organization, is both the CoC Lead and the backbone organization (as defined above).

Continuum of Care Members are persons who have joined in the collective impact initiative to end homelessness in Alameda County. They are members of EveryOne Home.

Eligible applicant means a private nonprofit organization, State, local government, or instrumentality of State and local government.

Geographic Area identifies the region(s) within a Continuum of Care. Alameda County's CoC encompasses all 14 cities and the unincorporated County.

Homeless Management Information System (HMIS) means the information system designated by the Continuum of Care to comply with the HMIS requirements prescribed by HUD.

HMIS Lead means the entity designated by the Continuum of Care in accordance with the Interim Rule to operate the Continuum's HMIS on its behalf.

HUD Continuum of Care Committee (HUD CoC Committee) is the name given to the board which the Interim Rule requires the CoC establish to act on its behalf. The Continuum of Care Committee of EveryOne Home is a part of the collective impact effort to end homelessness in Alameda County.

Interim Rule means the Continuum of Care Program Rule 24 CFR 578, published July 31, 2012, which details the requirements for establishing and operating a Continuum of Care. Where needed, this Governance Charter provides citations from the Interim Rule.

Leadership Board means the body leading the EveryOne Home collective impact initiative.

Program participant means an individual (including an unaccompanied youth) or family who is assisted with Continuum of Care program funds.

Project means a group of eligible activities, such as HMIS costs, identified as a project in an application to HUD for Continuum of Care funds and includes a structure (or structures) that is (are) acquired, rehabilitated, constructed, or leased with assistance provided under [the Interim Rule] or with respect to which HUD provides rental assistance or annual payments for operating costs, or supportive services under [the Interim Rule].

Recipient means an applicant that signs a grant agreement with HUD.

Subrecipient means a private nonprofit organization, State, local government, or instrumentality of State or local government that receives a subgrant from the recipient to carry out a project.

III. Continuum of Care Membership/Collective Impact Initiative

Summary: Continuum of Care members are persons who have joined in the collective impact initiative to end homelessness in Alameda County. They are members of EveryOne Home and provide input and vote as individuals, not as representatives of a particular organization, geography or constituency. Membership meetings and activities are staffed by EveryOne Home organizational staff.

A. Continuum of Care Membership Roles and Responsibilities

The Governance Charter assigns the following roles and responsibilities to the Continuum of Care Membership:

1. Hold a minimum of two meetings per year of the full membership, one of which will be the Annual Meeting.
2. Extend an open public invitation for new members to join. Ensure that an updated membership roster is maintained.
3. Adopt and follow the written process for selecting one (1) member to the EveryOne Home Leadership Board.
4. Adopt and follow the written process for selecting three (3) members of the HUD CoC Committee, who will act on behalf of the Continuum as outlined by this Governance Charter.
5. Hold annual elections to fill vacant seats on the Leadership Board and on the HUD CoC Committee.
6. Update the Leadership Board and HUD CoC Committee selection policies no less than every five years.

7. Ratify the initial Governance Charter and approve the annual updates as developed and recommended by the HUD Continuum of Care Committee and approved by the Leadership Board.
8. Utilize the Governance Charter to delegate certain responsibilities (detailed below) for operating the Continuum of Care, designating and operating an HMIS, and Continuum of Care planning to the HUD Continuum of Care Committee, its sub-committees and workgroups, the Continuum of Care Lead Agency (EveryOne Home), the HMIS Lead and the collaborative applicant.
9. Generate ideas and provide strategic input to Leadership Board, HUD Continuum of Care Committee, other committees, workgroups and staff for the annual work plan; systems changes and improvements to be explored, designed or implemented; and updates needed to the Governance Charter.

B. Continuum of Care Membership

Membership will be open to any individual interested in and committed to ending homelessness in Alameda County, California. Persons will join, provide input, and vote as individuals, not as representatives of a particular organization, geography or constituency. Persons can attend meetings and provide input, but must become members to vote.

To become a member an individual will complete a brief application (available on-line or on paper) with contact information and the opportunity to indicate their experience/relationship to the collective impact initiative's work (i.e. person with lived experience, advocate, non-profit or local government employee, geographic area of the county, type of organization, local government, etc.). This information will be collected by the Continuum of Care Lead to understand who is joining the Initiative/CoC and where more outreach can be done to ensure all stakeholders have the opportunity to engage.

EveryOne Home, the backbone organization, will maintain and update the roster on an annual basis.

C. Continuum of Care Membership Meetings

The Continuum of Care will host no less than two community meetings for the full membership. One will serve as the Annual Meeting and the second will serve to update the membership on work plan implementation, system change initiatives and system performance. Additional meetings may be convened as needed throughout the year.

During the Annual Meeting, the following actions will be taken:

1. Invite new members to join the Continuum.
2. Hold elections to fill one (1) CoC membership representative seat on the EveryOne Home Leadership Board.
3. Hold elections to fill open CoC membership representative seats on the HUD CoC Committee. Initially elections will be held for all three seats and then staggered so that one seat per year is up for election. If a representative leaves before the end of his/her term that seat will also be filled through election at the annual meeting.
4. Vote on recommended changes to the Governance Charter.
5. Generate ideas and provide strategic input for the Leadership Board and the CoC Committee.

Members who do not attend the annual meeting (described below) will be contacted and asked if they wish to maintain their membership. Persons who do not respond, as well as those members who wish to discontinue their membership, will be removed from the roster. Persons can join or rejoin at any time by filling out the membership form.

D. Membership Voting

Decisions will be passed by the majority present at a meeting.

E. Continuum of Care Membership Committees

Committees and workgroups can be established as needed. Membership and selection process will be determined at the time a workgroup is established.

F. Procedure for Selection of Members to the EveryOne Home Leadership Board and the HUD CoC Committee

Elections for seats on the EveryOne Home Leadership Board and the HUD CoC Committee will be held at the Annual Meeting.

Nominations will be invited through a public notice at least thirty (30) days prior to the Annual Meeting. Candidates for the elected seats (one to the Leadership Board and one of the three to the HUD CoC Committee) can be nominated by other CoC members, board members or themselves. Nominees will complete a brief application from which the EveryOne Home staff will produce a ballot of all nominees. Candidates can be nominated from the floor of the Annual Meeting and the ballot will include a space for write-in candidates. If not already a CoC member at the time of nomination, nominees must join the CoC to be elected to the Leadership Board and the HUD CoC Committee.

Open elected seats will be filled by the top vote getters and results will be tabulated at the Annual Meeting. In the case of a tie, the membership will vote again to determine the electee.

IV. Leadership Board

Summary: The body leading the EveryOne Home collective impact initiative. It is staffed by EveryOne Home organizational staff.

A. Leadership Board Roles and Responsibilities

The Governance Charter assigns the following responsibilities to the Leadership Board and/or its committees and work groups.

1. Determine desired population results; adopt and promote broad strategies to end homelessness in Alameda County.
2. Adopt population indicators and system performance measures and benchmarks.
3. Adopt standards of care and guiding principles.
4. Adopt an annual work plan informed by a turn the curve analysis of population results and program performance.
5. Collaborate to find resources and expand partnerships to achieve results.
6. Establish guidelines and resource recommendations for a coordinated housing crisis resolution system that meets HUD CES expectations and ensure it is contributing to desired results.
7. Seek strategic input and ongoing involvement from the EveryOne Home membership.
8. Adopt communications strategies to inform and engage stakeholders on collective impact efforts.
9. Adopt Governance Charter changes for ratification by EveryOne Home membership.
10. Recruit and approve committee members with set membership; members proposed by ad-hoc nominating committee.

B. Leadership Board Membership

The Leadership Board will include high-level staff members (e.g. agency or department heads or organizational directors) who are also members of the larger Continuum of Care Membership. The Leadership Board will have a range of 17 to 25 members; three (3) appointed by the HUD CoC Committee, one (1) elected directly by the CoC Membership annually, and the remaining members appointed/recruited by the Leadership Board itself.

In addition to the four seats representing the Continuum of Care general membership and the HUD CoC Committee, the Leadership Board will have representation from organizations as identified in the Interim Final Rule as well as consumers. The Leadership will designate a

nominating committee responsible for recruiting remaining open positions. There will be active recruitment if there are gaps needing to be filled.

The Leadership Board will invite the following entities to appoint representatives to serve:

1. Alameda County Community Development Agency (appointed seat)
2. Alameda County Health Care Services Agency (appointed seat)
3. Alameda County Social Services Agency (appointed seat)
4. City of Berkeley (appointed seat)
5. City of Oakland (appointed seat)
6. Veterans Affairs (appointed seat)

The appointed representatives can select a single alternate to attend meetings and vote in their place. Multiple delegates are not allowed.

The nominating committee will recruit members broadly from, but not limited to, the following stakeholder groups.

- Jurisdictions within Alameda County
- School districts
- Law enforcement
- Housing Authorities
- Persons with lived experience of homelessness
- University or other researcher
- Provider organizations
- Housing developers
- Business, philanthropic and faith leaders

The membership of the Leadership Board is intended to represent the geographic, programmatic, and cultural diversity of the continuum.

It is anticipated that different levels of leadership from the same stakeholder groups will want to participate in the collective impact initiative. Therefore an entity can have representatives participate on separate bodies; for example, an agency may have one person serving as a Leadership Board member while another from that same agency could serve on a committee such as the HUD CoC Committee or the Advocacy Committee.

C. Leadership Board Terms

Terms shall be three years and will be staggered such that approximately one-third the seats shall be filled each year. There are no term limits. In order to establish this system, in calendar year 2016, one-third of the board members will serve a twelve-month term (January-December 2016), one-third will serve a twenty four-month term (January 2016-December 2017), and the remaining third will serve a full three-year term (January 2016-December 2018).

D. Leadership Board Officers

The Leadership Board will have two Co-Chairs to serve as its officers. They will be elected by Board members and serve for a term of one year. They are responsible for facilitating the Leadership Board meetings. At least one Chair will serve as Chair of the Organizational Health Committee and one as the convener of the full membership meetings.

E. Leadership Board Meetings

Board meetings will happen no fewer than six times per year and will be open to the CoC members should they wish to observe. Only board members can vote at board meetings with the exception of alternates described under Leadership Board membership. EveryOne Home staff will provide public notice of meeting times and locations.

A quorum is established when at least 50% +1 of the membership attends a Board meeting. Members must attend 75% percent of the meetings annually to be considered members in good standing, which shall be verified by EveryOne Home staff.

F. Leadership Board Voting

For voting matters at the Leadership Board meetings, decisions will be passed by a majority of the members present (50% plus 1).

G. Leadership Board Committees

Committees and workgroups to the Leadership Board will be established as needed. Each committee will develop its own set of annual activities for implementing the broad strategic work plan. Each committee will select a chair(s) to facilitate meeting and ensure progress is reported to the Leadership Board. Membership and selection process will be determined at the time a workgroup is established. Committees will determine whether they will be led by a single Chair or Co-chairs. Committee quorums will be established as follows unless otherwise specified in committee's charter: decisions will be passed by the majority present at a meeting when the membership is open otherwise vote carries at 50% + 1 at meetings with selected memberships. In addition:

- Each committee will develop its own set of annual activities for implementing the broad strategic work plan
- Each committee will select a chair to facilitate meeting and ensure progress is reported to the Leadership Board

Vacancies of selected membership committees will be filled, upon recommendation of a qualified candidate by the Committee Chair(s) and/or Executive Director, and by the affirmative vote of the majority of that committee. A Committee member elected to fill the vacancy shall be elected for the unexpired term of his/her predecessor in office.

A brief description of each committee is below.

Committees with selected memberships, meaning they are seated through election or appointment

1. Backbone Organization Advisory Committee-oversees the budget staffing and operations of EveryOne Home, the CoC lead agency. Manage the health of EveryOne Home the organization. Provide resource development strategies for the organization. Conduct performance review of the Executive Director. Provide succession planning for the organization. Coordinate and support the priority activities of EveryOne Home in terms of resources and staffing.
2. HUD Continuum of Care Committee- functions as the Continuum of Care Board required by the Interim Rule to act on behalf of the membership to ensure the CoC responsibilities are fulfilled. Those include; operating a Continuum of Care, operating and HMIS, Continuum of Care planning, and preparing an application for Continuum of Care funds (Interim Rule §578.7 and §578.9)
3. Funders Collaborative Committee- collaborate on strategies to effectively secure, distribute and sustain resources for the approved coordinated entry system design and the housing crises resolution system envisioned in Alameda County's plan to end homelessness. Includes braiding funding, coordinating requests for proposals, aligning deliverables and performance benchmarks for system components, i.e. outreach, interim housing, rapid rehousing, housing navigation, etc. when possible.
4. System Coordination Committee- Oversee the implementation, operations, compliance and quality improvement of the Coordinated Entry System. Includes developing/revising policies practices and tools; convening stakeholders as a learning community for operating an effective system; establishing subcommittees/work groups focused on a sub-population or system component as needed (examples include Operation Vets Home for vets or Outreach Roundtable for street outreach workers).

Committees with open membership, meaning interested persons can join at any time.

5. Advocacy/Policy Committee- develop, comment on and advocate for public policies at state federal and local levels that enhance the initiative's ability to end homelessness, particularly by adding funding resources to the effort.

V. Backbone Organization Advisory Committee

Summary: EveryOne Home is a project of Tides, which serves as EveryOne Home's fiscal agent. Per Tides' requirements, EveryOne Home is required to have an Advisory Board that interfaces with Tides on behalf of the organization.

A. Backbone Organization Advisory Committee Roles and Responsibilities

1. Approve the EveryOne Home staff activities that support the collective impact work plan including ensuring adequate funding and staffing to implement annual work plan established by the Leadership Board.
2. Ensure EveryOne Home the organization meets its contractual and financial obligations.
3. Monitor the fiscal health and operations of EveryOne Home the organization.
4. Serve as Advisory Board for Tides Center.
5. Determine resource development strategies for EveryOne Home the organization.
6. Conduct performance reviews of the Executive Director and succession planning.

B. Backbone Organization Advisory Committee Membership

Summary: The committee is small in size (3-5 members); at least 50% of the members would serve on the Leadership Board to encourage cross-representation from this body to the Leadership Board, but all members of this committee do not necessarily need to serve on the Leadership Board. Individuals who bring some experience and interest in organizational management, financial planning, legal, human resources, etc. would be encouraged to participate. At least one of Leadership Board Co-Chairs will serve on the Backbone Organization Advisory Committee.

C. Backbone Organization Advisory Committee Terms

Members of the committee shall be elected annually by the Leadership Board per the recommendation of the nominating committee. Terms shall be for one (1) year and there are no term limits.

VI. HUD Continuum of Care Committee

Summary: This committee functions as the Continuum of Care Board required by the Interim Rule to act on behalf of the membership to ensure the CoC responsibilities are fulfilled. Those include; operating a Continuum of Care, operating and HMIS, Continuum of Care planning, and preparing an application for Continuum of Care funds (Interim Rule §578.7 and §578.9)HUD Continuum of Care Committee Roles and Responsibilities.

I. HUD Continuum of Care Committee Roles and Responsibilities

The Governance Charter assigns the following responsibilities to the HUD Continuum of Care Committee:

1. Acts on behalf of the membership to ensure compliance with HUD CoC regulations.
2. Appoint committee / sub-committees or working groups under its purview.
3. Determine costs of complying with HUD mandates.
4. Designate and operate an HMIS system; ensures it meets system performance needs.
5. Facilitates CoC planning to meet regulatory obligations.
6. Recommend annual updates to the Governance Charter.
7. Recommend guiding principles and strategic direction to CoC NOFA Committee based on HUD NOFA guidelines.
8. Design, operate and follow a collaborative process for submitting the CoC application to HUD.
9. Monitor, evaluate, and take action to improve poor performance of CoC funded projects.
10. Evaluate outcomes of ESG and CoC projects and report to HUD.
11. Consult with local government recipients on allocations of ESG funds.
12. Adopt written standards for CoC assistance and ensure compliance.
13. Direct Homeless Count; approve methodology; submit results.
14. Direct an annual gaps analysis.
15. Ensure CoC lead provides information to jurisdictions that submit Con Plans.

The HUD Continuum of Care Committee will delegate a number of these responsibilities to Committees and Workgroups as specified in Section V.D. below.

The HUD Continuum of Care Committee will seek and utilize input from the CoC membership to:

1. Develop and recommend annual updates to the Governance Charter when needed.

2. Generate ideas and provide strategic input for the implementation of an annual work plan.
3. Conduct an annual gaps analysis.
4. Set priorities for funding projects with Continuum of Care funds.

II. HUD Continuum of Care Committee Membership

The HUD CoC Committee is a sub-committee of the Leadership Board, not a standalone group. This group meets the definition of the board required to be established per the Interim Rule at §578.5(b); and must follow conflict of interest policies outlined in the Interim Rule at §578.95(b). This group could have crossover with the Leadership Board in terms of agencies represented, but may be different levels of organizational staff. It is staffed by EveryOne Home and supported by HMIS staff as needed.

The HUD CoC Committee will have nine (9) members including six (6) appointed/recruited positions and three (3) elected by the CoC membership.

- The Leadership Board will seat the six members who are not elected by the CoC membership. Interested parties will be invited to submit a written statement indicating their interest in being considered for the Committee; this shall be considered by the Nominating Committee first, then approved by the Leadership Board.
- The CoC membership will seat the three remaining positions on the Committee pursuant to the written policy noted in Section III.C above.
- Once the nine-member committee is established it will designate three of its members to serve on the Leadership Board for a term of 1 year.

The 9 seats will represent the following entities:

1. Two representatives from Alameda County Departments
2. Two representatives from Cities.
3. Two representatives from homeless assistance providers.
4. Two persons with lived experience.
5. One at-large representative.

III. HUD CoC Committee Terms

Terms shall be for three (3) years. There are no term limits. In order to establish this system in calendar year 2016, one-third of the committee members will serve a twelve-month term (January-December 2016), one-third will serve a twenty four-month term (January 2016-December 2017), and the remaining third will serve a full three-year term (January 2016-December 2018). Members of the committee shall be selected annually by the Leadership Board per the recommendation of the nominating committee.

D. Subcommittees to the HUD CoC Committee

Sub-committees and workgroups will be established as needed. Membership and selection process will be determined at the time a workgroup is established. Committee quorums will be established as follows unless otherwise specified in committee's charter: decisions will be passed by the majority present at a meeting when the membership is open otherwise vote carries at 50% + 1 at meetings with appointed memberships.

1. NOFA Sub-Committee conducts the local rating and ranking process. Integrates funding priorities and strategic direction from HUD CoC. Approves projects for submission to NOFA. Members cannot be employed by or related to someone who is employed by a non-profit or government department who is a recipient of CoC or Emergency Solutions Grants (ESG) funds. Members are selected through an application process and approved by the HUD CoC Committee.
2. HUD CoC NOFA Appeals Panel reviews appeals made by CoC Project applicants to the local competition's rating and ranking list. Appeals submitted to EveryOne Home are reviewed by a non-conflicted panel consisting of members from each of the following three bodies: Leadership Board, HUD CoC Committee, and NOFA Sub-Committee. Panel members are seated for each NOFA round. Panel decisions on appeals are final.
3. HMIS Oversight Sub-committee directs the operations of HMIS, including selection of software and administrator. Ensures compliance with federal requirements. Reviews and adopts updates to Policies and Procedures Manual. Supports and protects the rights and privacy of service users. Reviews data quality reports. Ensures production of HMIS generated dashboards and reports.

VII. System Coordination Committee

Summary: This committee monitors the operations and performance of the Alameda County housing crisis response system and recommends changes and improvements.

A. System Coordination Committee Roles and Responsibilities

1. Review the operations and performance of the coordinated system to determine:
 - a. Consistency with approved design, standards, policies and procedures
 - b. Fairness and transparency
 - c. Compliance with funding regulations
 - d. Meeting performance benchmarks
2. Develop, review and recommend standards, policies, procedures and tools for operating the coordinated system.
 - a. System Manual:
 - i. Review the System Manual and recommend substantive changes, especially any changes related to prioritization, to the Leadership Board annually, at minimum.
 - b. Prioritization Tool:
 - i. Review reports from System Analyst that summarize testing and monitoring of the prioritization tool and recommend adjustments to the Leadership Board.
 - ii. Recommend ad adjustments that impact prioritization to the Leadership Board.
3. Establish and convene Sub-committees, Implementation and Learning Communities (ILC), and Working Groups for launch, operation and on-going improvement of the coordinated system.

B. System Coordination Committee Membership and Selection

Membership will include 8-12 seats with appropriate representation from users of the coordinated system, Continuum of Care Committee, County and City departments, non-profit service providers, community-wide partners of the coordinated system, and experts in housing crisis systems or related expertise.

C. System Coordination Committee Terms

Members of the committee shall be selected annually by the Leadership Board per the recommendation of the nominating committee. Terms shall be for three (3) years. There are no term limits. In order to establish this system in calendar year 2018, one-third of the committee members will serve a twelve-month term (January-December 2018), one-third will serve a twenty four-month term (January 2018-December 2019), and the remaining third will serve a full three-year term (January 2018-December 2020).

D. Subcommittees to the System Coordination Committee

Sub-committees, ILCs, and Working Groups will be established as needed. Membership and selection process will be determined at the time a group is established. Active groups include: Home Stretch, Operation Vets Home, ILC-Ops, and Communications Working Group.

VIII. Results Based Accountability Committee

A. Results Based Accountability Committee Roles and Responsibilities

1. Review system performance by tracking and reporting of population indicators and performance measures
2. Recommend initial and updated performance measures and benchmarks
3. Recommend dashboard design to Leadership Board
4. Ensure publication of dashboard and other published performance reports
5. Work to integrate data from mainstream systems of care

B. Results Based Accountability Committee Membership

This committee has an open membership. Interested stakeholders can join at any time. An invitation to join the committee will be issued a minimum of once per year at the annual meeting.

C. Results Based Accountability Committee Terms

The committee does not have terms or term limits.

IX. Advocacy Committee

Summary: This committee is open to any interested stakeholders. It develops, comments on and advocates for public policies at state federal and local levels that enhance the initiative's ability to end homelessness, particularly by adding funding resources to the effort.

A. Advocacy Committee Roles and Responsibilities

1. Develop an annual advocacy work plan for the Leadership to adopt, including policy development and public education at the local, state and federal levels.

2. Review requests to EveryOne Home to endorse or oppose policies and legislation. Ensure the endorsement policy is followed with regard to items that can be resolved at the Committee level and those requiring a Leadership Board decision.
3. Craft and implement advocacy campaign strategies including outreach to EveryOne Home Stakeholders

B. Advocacy Committee Membership

This committee has an open membership. Interested stakeholders can join at any time. An invitation to join the committee will be issued a minimum of once per year at the annual meeting.

C. Advocacy Committee Terms

The committee does not have terms or term limits.

X. Funders Collaborative

A. Funders Collaborative Roles and Responsibilities

1. Recommend ways to align local RFPs and contracts with adopted systems standards of care, performance measures and benchmarks
2. Recommend ways to braid funding for common activities in joint or coordinated RFPs
3. Implement joint monitoring protocols
4. Implement joint training/TA for providers
5. Recommend ways to expand available resources to implement strategies

B. Funders Collaborative Membership

This committee has representation from each county department that funds housing and homelessness services. Also all direct ESG grantees and other cities that fund homeless services.

C. Funders Collaborative Terms

There are no terms for this committee.

XI. Standards for Providing Continuum of Care Assistance

A. General Eligibility and Prioritization

This CoC operates using a Housing First approach to delivering services and screening for eligibility. Programs prioritize rapid placement and stabilization in permanent housing. They do not have clinical or income thresholds for entry into their programs.

The CoC has prioritized services for those who are “literally homeless”, which includes those living in emergency shelters, on the streets and other places not meant for human habitation, exiting an institution where they resided for up to 90 days, and were homeless immediately prior to entering that institution, and those who are fleeing or attempting to flee domestic violence, etc. The HUD definition of homelessness is included in **Appendix D**, Categories 1 and 4, Page 50 below.

In accordance with HUD requirements that Continuums of Care operate a coordinated entry system to assess, prioritize and match people experiencing homelessness to resources available to assist them (24 CFR Part 578.7(a)(8) and HUD Notice CPD-17-01 dated 1/23/17), the Leadership Board adopted operating standards and policies in August 2017. They are a section of Alameda County’s Housing Crisis Response System Manual. The full section is included as **Appendix I**. Policies related to eligibility and prioritization are included herein.

The fundamental goals of the Alameda County Coordinated Entry System are:

- Ensure that all homeless people in the county access services in a consistent and fair manner, regardless of their geographic location, housing barriers, or other factors;
- Prioritize for assistance those households with the most acute needs; and
- Prevent as many people as possible from entering the homeless system by connecting them to Housing Problem Solving support and other emergency solutions that can resolve a housing crisis before it becomes homelessness.

Alameda County has organized our Coordinated Entry process around five regional Housing Resource Centers (HRCs) that together provide full coverage of the County’s geography. Each HRC serves as a hub from which housing resources and assistance are deployed, and the administrative home of key Coordinated Entry staff, including outreach teams and trained Assessors.

All programs funded with Federal Continuum of Care (CoC), and with State and Local Emergency Solution Grants (ESG) are required to participate in Coordinated Entry. In addition, most programs specifically designated for people experiencing homelessness that are funded

by the Whole Person Care Pilot—Alameda Care Connect, Mental Health services Act (MHSA), Department of veterans Affairs (VA), County General Funds, and City General Funds are also required to participate in Coordinated Entry.

The performance of the County’s Coordinated Entry process – and all of the programs associated with it – will be carefully measured, reviewed on a regular basis, and subject to continual adjustment and improvement.

The purpose of Prioritization is to assign each household a level of priority for receiving limited housing resources, since housing resources are not yet to scale and all households cannot be served immediately. The households being matched to housing resources at any time are those who are most vulnerable and have the greatest barriers to housing.

All households are assessed with the same tool, which was designed to address factors across household types and subpopulations.

Factors that are weighted to form the score are listed in the following table:

Prioritization Tool Factors	
Household Characteristics	<ul style="list-style-type: none"> ● Children aged 5 or under ● Seniors ● Larger households ● Pregnant household member ● Youth head of household aged 18-24
Homeless History	<ul style="list-style-type: none"> ● Unsheltered ● In emergency shelter ● Episodes of homelessness ● Length of time homeless
Housing Barriers	<ul style="list-style-type: none"> ● Time since last held a lease ● History of eviction ● History of incarceration/law enforcement involvement ● Income
Vulnerability	<ul style="list-style-type: none"> ● Emergency service utilization ● Functional impairment/disability ● Life-threatening illnesses or acute medical conditions ● Unsafe or risky survival strategies ● Households whose members have run away from home ● Chronic homelessness

The tool is designed to weight these characteristics so that people with the greatest number of vulnerabilities and barriers receive the highest scores. Histories of homelessness and significant housing barriers are strongly weighted. The tool has been tested to ensure that it creates a

normal distribution, and that scores are not biased based on race, ethnicity, gender, age, or other protected classes.

People with disabilities are never denied access to resources because of their disabling conditions. Rather, people with disabilities are prioritized for resources. The Assessment process does not require disclosure of a specific disability or diagnosis. Such information can only be obtained for the purposes of determining program eligibility and making appropriate matches.

B. Policies for Determining Eligibility and Prioritizing which Households Receive Various Types of Assistance

Housing resources are mostly prioritized regionally through the Housing Resource Centers, although there are the following exceptions:

- Any vacancy in a Permanent Supportive Housing program is matched countywide, to the highest priority household, in accordance with any applicable eligibility restrictions associated with the funding source and is subject to terms of operations of HCSA/Home Stretch MOU. (Appendix H)
- Winter/inclement weather shelter beds and drop in center services are not subject to the Prioritization process.

The following table summarizes how different housing resources are prioritized for allocation.

	Year-Round Shelter Beds	Transitional Housing	Rapid Rehousing	Permanent Supportive Housing/ Home Stretch
Assessment Score	Full score, highest priority	Full Score, highest priority	Full Score, highest priority	Full Score, highest priority
Eligibility (All eligibility and program criteria must be submitted and approved by EOH and funder/contracting agency. Through that process, programs will be required to explain any additional eligibility or program criteria.)	Literally Homeless (Category 1 or 4); Meet household type for shelter	Literally Homeless (Category 1 or 4); Meet household type for program	Literally Homeless (Category 1 or 4); Meet household type for program; Informed consent to work on housing stability services	Literally homeless (Category 1 or 4); Disabled

Other	HRCs supported by Outreach to fill beds	Client choice to enter TH rather than RRH	The household must also provide informed consent, confirming that the resource is “realistic” prior to enrollment. Overwrites former policy of at least 1/3 of beds not dedicated to specific populations must be allocated to chronically homeless	High priority non-VA eligible Vets will get priority
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Implementation will be monitored and adjusted to ensure it is having the intended results.

c. Policies for Individuals and Families Fleeing Domestic Violence

In order to ensure safety, confidentiality and access to well-trained DV services, Alameda County’s Coordinated Entry process offers any household fleeing domestic violence the option to connect immediately to the appropriate regional domestic violence provider. Each regional DV hotline is available on a 24-7 basis.

Once a household’s immediate safety and DV-related needs are met, it is the responsibility of the DV provider to conduct the remaining steps of the Coordinated Entry process, including the Housing Crisis Screening, Housing Problem Solving, Assessment, and connection to DV shelter or DV-specific transitional housing. If there are no DV housing resources available in a region in which a household fleeing DV is seeking services, the regional DV providers will coordinate to connect that household to available resources in another region and/or back to the HRC if safe for the client and with her/his consent.

Consistent with the Violence Against Women Act, client level data for people fleeing domestic violence is not entered into the HMIS system. It is the responsibility of the DV provider to ensure that any household fleeing domestic violence is also given the option to access the non-DV-specific services offered at the HRC if they prefer, and to inform the household that non-DV-specific programs do not have the same prohibitions on collecting HMIS data.

D. Determining Rent Amounts Eligible Households Receiving Rapid Rehousing Assistance Must Pay

These standards for rent amounts were adopted for Rapid Rehousing funded by Emergency Solutions Grant funding. They were adopted in 2013. Additional funding sources have since become available, and policies are being updated to integrate these sources.

1. For rental assistance payments, households with any income are expected to contribute either 50% of their income, or 50% of the rent, whichever is lower. An exception to this rule may be made for persons with disabilities who are anticipated to receive a permanent subsidy within six months of their ESG program enrollment.
2. With supervisor approval, households may be permitted to contribute less toward the rent for a brief period to cover other extraordinary costs. The program may pay the entire rent on behalf of households that have no income.

E. Other Standards for Providing Assistance

1. Families seeking emergency shelter, transitional housing, and permanent housing from the Continuum will not be denied admission to services or required to separate any from other members based on age, sex or gender when entering shelter or housing.
2. All school aged children residing in Continuum programs will be required to register for school within 5 business days during the school year.
3. All individuals, families, and youth exiting from Continuum programs to permanent housing, with or without ongoing services, will be encouraged by the current provider to contact them and/or the regional Rapid Rehousing provider should the household's housing become at risk in order to avoid future episodes of homelessness.
4. Continuum of providers will screen service users for all mainstream benefits to which they may be entitled and assist them in applying for and securing such benefits, including but not limited to health care, income supports and food assistance.
5. Providers shall not discriminate based upon actual or perceived sexual orientation, actual or perceived gender identity, or marital status. Programs must determine eligibility for housing regardless of an individual sexual orientation or gender identity, grant equal access to programs or facilities consistent with a person's gender identity, and not require anatomical, documentary, physical, or medical evidence of gender identity. In addition, all HUD-funded Homeless Assistance Programs must take non-discriminatory steps to address privacy concerns based on actual or perceived LGBT status.

XII. Homeless Management Information System (HMIS)

A. Designated HMIS

The Alameda County Continuum of Care will establish and maintain database system that collects and reports on and the universal data elements as required by HUD. The HMIS facilitates effective and streamlined services to individuals-served as well as creating information that communities can use to determine the use and effectiveness of services.

HMIS is designed and intended to benefit multiple stakeholders, including persons using homeless and/or at-risk of homelessness-targeted services, provider agencies, jurisdictions, other systems of care, funders and the community. Improved knowledge gained from HMIS about various communities with special needs and their service usage aides with providing a more effective and efficient service delivery system. By community partner agreement, the HMIS database operates as a shared system: permission granted by an individual-served allows for all HMIS-entering Covered Homeless Organizations (CHOs) to have viewership of client level data (excluding Case Management tasks).

B. Designated HMIS Lead

The Alameda County Continuum of Care designates the Alameda County Department of Housing and Community Development (HCD) as its HMIS Lead. It administers the HMIS funds provided by Continuum of Care funding as well as the local match.

The Continuum delegates the following responsibilities to the HMIS Lead:

1. Enter into written HMIS Participation Agreements with each Contributing HMIS Organization (CHO) requiring the CHO to comply with federal regulations regarding HMIS and imposing sanctions for failure to comply; and maintain documentation of these agreements.
2. In collaboration with the the HUD COC Committee and the Continuum of Care Lead Agency, EveryOne Home will
 - a. Review, revise and approve the policies and plans required by federal regulation;
 - b. Create and update the Data Quality Plan;
 - c. Coordinate and submit Housing Inventory Chart, and Annual Homeless Assessment Reports; and
 - d. Adopt written policies and procedures for the operation of the HMIS that apply to the HMIS Lead, its CHOs, and the Continuum of Care.
3. Oversee the day-to-day operation of HMIS.
4. Provide staffing for HMIS.

5. Provide technical support to participating agencies.
6. Provide training on privacy, and software related issues.
7. Regularly review data quality (monthly) take necessary actions to maintain input of high-quality data from all HMIS-utilizing agencies.
8. In conjunction with EveryOne Home, coordinate and submit the Point in Time Count and CoC funding application.
9. Submit a security plan, an updated data quality plan, and a privacy policy to the Leadership Board for approval within 6 months after the effective date of the HUD final rule establishing the requirements of these plans. The HMIS Lead must review and update the plans and policy at least annually. During this process, the HMIS Lead must seek and incorporate feedback from the Continuum membership and the Leadership Board and applicable entities. The HMIS Lead must implement the plans and policy within 6 months of the date of approval by the Leadership Board.
10. Solicits HMIS User feedback – including operational milestones, system functionality and ease of use, and progress. Feedback will come from the following groups that are open to all CHOs:

The HMIS User Group--will work with the HMIS Lead to:

1. Provide recommendations on use of software and software enhancements.
2. Trouble-shoot frequent data quality errors.
3. Recommend modifications to HMIS staff created reports.

XIII. Process for responding to the Continuum of Care Notice of Funding Availability

A. The Collaborative Applicant

The Continuum of Care designates Alameda County Department of Housing and Community Development (HCD) as the Collaborative Applicant for Continuum of Care funding. The Collaborative Applicant will:

1. Review, verify and submit the Grants Inventory Worksheet.
2. Register the Continuum of Care.
3. Review the budgets and narratives of all Project Applications and facilitate the submission of all Project Applications after they have been rated, ranked and approved by the NOFA Committee.
4. Work with EveryOne Home to complete the Continuum of Care application, formerly known as Exhibit 1.

5. Approve and assist projects with making amendments to their project budgets and other assistance they may need in working with the local HUD field office.
6. Consult the Continuum of Care Lead Agency regarding negotiations with HUD on behalf of projects.

B. The Continuum of Care Lead Agency

EveryOne Home serves as the Continuum of Care Lead Agency and will:

1. Provide staff support to the NOFA Committee and the local rating, ranking and prioritization process for Continuum of Care funds.
2. Facilitate the input of the Continuum membership into establishing priorities and giving feedback on scoring criteria and the application process.
3. In partnership with the Collaborative Applicant complete the Continuum of Care application.
4. Approve all requests for amendments and/or changes to CoC projects that occur outside of the annual renewal process.
5. Staff the HUD Continuum of Care Committee and its sub-committees.

C. HUD CoC Committee

This Committee, as stated above, functions as the Continuum of Care Board required by the Interim Rule to act on behalf of the membership to ensure the CoC responsibilities are fulfilled, including preparing an application for Continuum of Care funds (Interim Rule §578.7 and §578.9). Under its Roles and Responsibilities, this Committee will:

1. Recommend guiding principles and strategic direction to CoC NOFA Committee based on HUD NOFA guidelines.
2. Design, operate and follow a collaborative process for submitting the CoC application to HUD.

The HUD Continuum of Care Committee will delegate some of these responsibilities to Committees and Workgroups as specified in Section D. and E. below.

D. The Continuum of Care NOFA Committee

As noted above, the NOFA Committee will oversee the local rating and ranking process and approve the projects applications to be submitted for funding. The Committee will:

1. Integrate funding priorities and strategic direction from HUD CoC Committee.
2. Develop a local application and scoring criteria in compliance with the requirements of the NOFA.
3. Read and score proposals.

4. Approve the final priority list of projects to be included in the CoC application package.

E. The Appeals Panel

New in 2017, the Appeals Panel reviews appeals made by CoC Project applicants to the local competition's rating and ranking list. Panel members are seated for each NOFA round. Panel decisions on appeals are final.

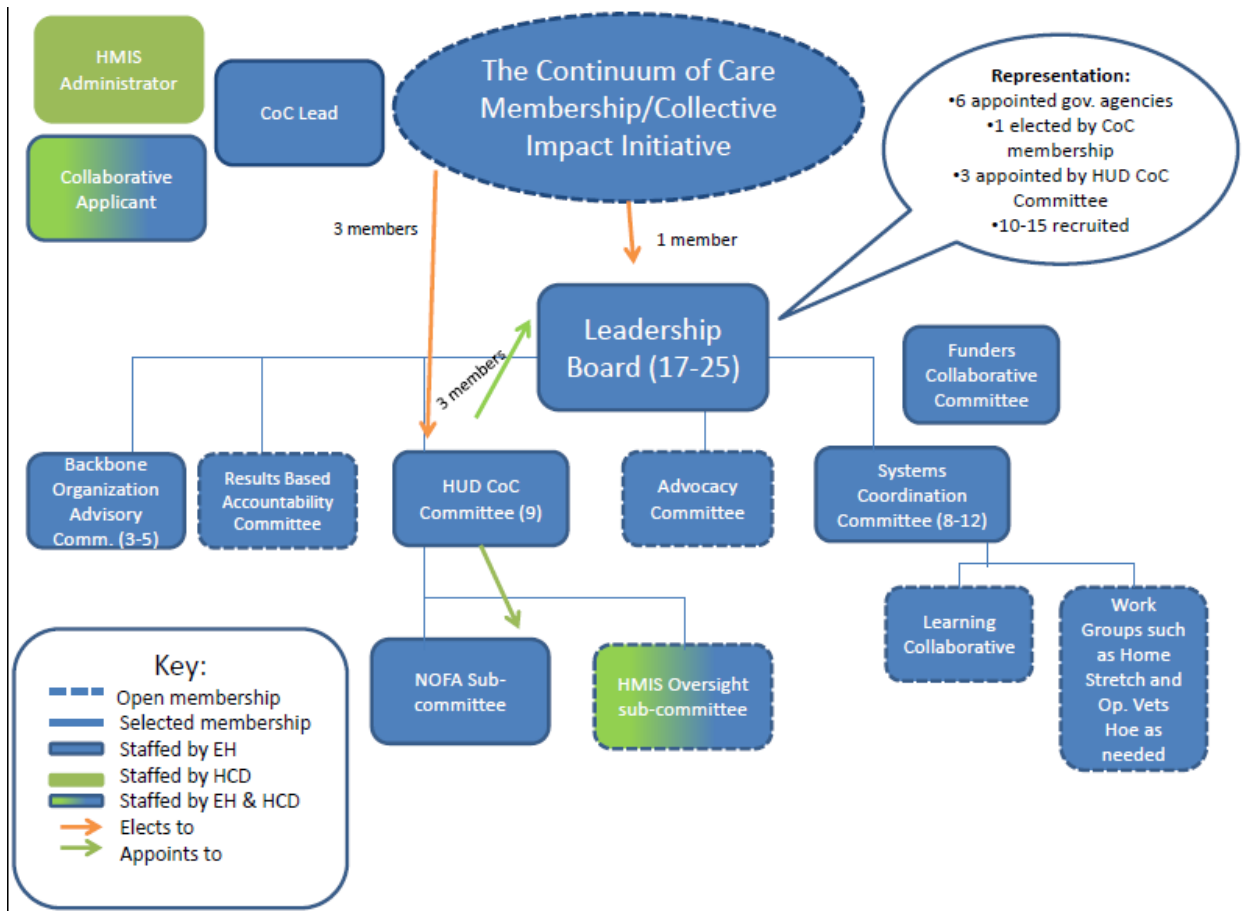
XIV. Conflict of Interest Requirements

All Continuum, Leadership Board, and Committee members will abide by §578.95 (Conflicts of Interest) in the Interim Rule. Members of the Organizational Health Committee, Leadership Board and all Selected membership committees will be required annually to sign the Tides Conflict of Interest form. General Continuum Membership, Leadership Board, and all Committee members (both selected and open membership) will disclose potential conflicts when the topics of funding awards or other financial benefits that could be gained or lost by an organization which they represent as an employee, agent, consultant or board member or their spouse represents are under consideration by the group in which they are participating. If a conflict of interest exists, the member(s) will recuse themselves from the discussion and any related votes that take place.

The Continuum desires that it, and those entities to which it has delegated authority, make informed as well as non-conflicted decisions. The annual gaps analysis, eligibility criteria for who gets served by what resources in the Continuum, prioritization of who gets served, performance targets, etc. are best developed and refined with broad stakeholder input. Funded projects and jurisdictions will not be deemed conflicted in discussions on these topics nor in providing input on local priorities for Continuum of Care Funding and refinements the scoring criteria for projects or the application process. The NOFA Committee will evaluate the merits of the input and will make the final determination on the scoring criteria and application process.

As noted above members of the NOFA Committee cannot be an employee, agent and consultant or board member of or married to someone who is, any non-profit or government department that is a recipient or sub-recipient of Continuum of Care Funding. The same restriction applies to the any involvement the CoC

APPENDIX A – Organizational Chart





FEDERAL REGISTER

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Part II

Department of Housing and Urban Development

24 CFR Part 578
Homeless Emergency Assistance and Rapid Transition to Housing:
Continuum of Care Program; Interim Final Rule

§ 578.5

or annual payments for operating costs, or supportive services under this subtitle.

Recipient means an applicant that signs a grant agreement with HUD.

Safe haven means, for the purpose of defining chronically homeless, supportive housing that meets the following:

(1) Serves hard to reach homeless persons with severe mental illness who came from the streets and have been unwilling or unable to participate in supportive services;

(2) Provides 24-hour residence for eligible persons for an unspecified period;

(3) Has an overnight capacity limited to 25 or fewer persons; and

(4) Provides low-demand services and referrals for the residents.

State means each of the 50 States, the District of Columbia, the Commonwealth of Puerto Rico, American Samoa, Guam, the Commonwealth of the Northern Marianas, and the Virgin Islands.

Subrecipient means a private nonprofit organization, State, local government, or instrumentality of State or local government that receives a subgrant from the recipient to carry out a project.

Transitional housing means housing, where all program participants have signed a lease or occupancy agreement, the purpose of which is to facilitate the movement of homeless individuals and families into permanent housing within 24 months or such longer period as HUD determines necessary. The program participant must have a lease or occupancy agreement for a term of at least one month that ends in 24 months and cannot be extended.

Unified Funding Agency (UFA) means an eligible applicant selected by the Continuum of Care to apply for a grant for the entire Continuum, which has the capacity to carry out the duties in § 578.11(b), which is approved by HUD and to which HUD awards a grant.

Victim service provider means a private nonprofit organization whose primary mission is to provide services to victims of domestic violence, dating violence, sexual assault, or stalking. This term includes rape crisis centers, battered women's shelters, domestic vio-

24 CFR Ch. V (4-1-13 Edition)

lence transitional housing programs, and other programs.

Subpart B—Establishing and Operating a Continuum of Care

§ 578.5 Establishing the Continuum of Care.

(a) *The Continuum of Care.* Representatives from relevant organizations within a geographic area shall establish a Continuum of Care for the geographic area to carry out the duties of this part. Relevant organizations include nonprofit homeless assistance providers, victim service providers, faith-based organizations, governments, businesses, advocates, public housing agencies, school districts, social service providers, mental health agencies, hospitals, universities, affordable housing developers, law enforcement, and organizations that serve veterans and homeless and formerly homeless individuals.

(b) *The board.* The Continuum of Care must establish a board to act on behalf of the Continuum using the process established as a requirement by § 578.7(a)(3) and must comply with the conflict-of-interest requirements at § 578.95(b). The board must:

(1) Be representative of the relevant organizations and of projects serving homeless subpopulations; and

(2) Include at least one homeless or formerly homeless individual.

(c) *Transition.* Continuums of Care shall have 2 years after August 30, 2012 to comply with the requirements of paragraph (b) of this section.

§ 578.7 Responsibilities of the Continuum of Care.

(a) *Operate the Continuum of Care.* The Continuum of Care must:

(1) Hold meetings of the full membership, with published agendas, at least semi-annually;

(2) Make an invitation for new members to join publicly available within the geographic area at least annually;

(3) Adopt and follow a written process to select a board to act on behalf of the Continuum of Care. The process must be reviewed, updated, and approved by the Continuum at least once every 5 years;

(4) Appoint additional committees, subcommittees, or workgroups;

(5) In consultation with the collaborative applicant and the HMIS Lead, develop, follow, and update annually a governance charter, which will include all procedures and policies needed to comply with subpart B of this part and with HMIS requirements as prescribed by HUD; and a code of conduct and recusal process for the board, its chair(s), and any person acting on behalf of the board;

(6) Consult with recipients and subrecipients to establish performance targets appropriate for population and program type, monitor recipient and subrecipient performance, evaluate outcomes, and take action against poor performers;

(7) Evaluate outcomes of projects funded under the Emergency Solutions Grants program and the Continuum of Care program, and report to HUD;

(8) In consultation with recipients of Emergency Solutions Grants program funds within the geographic area, establish and operate either a centralized or coordinated assessment system that provides an initial, comprehensive assessment of the needs of individuals and families for housing and services. The Continuum must develop a specific policy to guide the operation of the centralized or coordinated assessment system on how its system will address the needs of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, or stalking, but who are seeking shelter or services from non-victim service providers. This system must comply with any requirements established by HUD by Notice.

(9) In consultation with recipients of Emergency Solutions Grants program funds within the geographic area, establish and consistently follow written standards for providing Continuum of Care assistance. At a minimum, these written standards must include:

(1) Policies and procedures for evaluating individuals' and families' eligibility for assistance under this part;

(11) Policies and procedures for determining and prioritizing which eligible individuals and families will receive transitional housing assistance;

(11) Policies and procedures for determining and prioritizing which eligible individuals and families will receive rapid rehousing assistance;

(1v) Standards for determining what percentage or amount of rent each program participant must pay while receiving rapid rehousing assistance;

(v) Policies and procedures for determining and prioritizing which eligible individuals and families will receive permanent supportive housing assistance; and

(vi) Where the Continuum is designated a high-performing community, as described in subpart G of this part, policies and procedures set forth in 24 CFR 576.400(e)(3)(vi), (e)(3)(vii), (e)(3)(viii), and (e)(3)(ix).

(b) *Designating and operating an HMIS.* The Continuum of Care must:

(1) Designate a single Homeless Management Information System (HMIS) for the geographic area;

(2) Designate an eligible applicant to manage the Continuum's HMIS, which will be known as the HMIS Lead;

(3) Review, revise, and approve a privacy plan, security plan, and data quality plan for the HMIS.

(4) Ensure consistent participation of recipients and subrecipients in the HMIS; and

(5) Ensure the HMIS is administered in compliance with requirements prescribed by HUD.

(c) *Continuum of Care planning.* The Continuum must develop a plan that includes:

(1) Coordinating the implementation of a housing and service system within its geographic area that meets the needs of the homeless individuals (including unaccompanied youth) and families. At a minimum, such system encompasses the following:

(1) Outreach, engagement, and assessment;

(11) Shelter, housing, and supportive services;

(11) Prevention strategies.

(2) Planning for and conducting, at least biennially, a point-in-time count of homeless persons within the geographic area that meets the following requirements:

(1) Homeless persons who are living in a place not designed or ordinarily

used as a regular sleeping accommodation for humans must be counted as unsheltered homeless persons.

(11) Persons living in emergency shelters and transitional housing projects must be counted as sheltered homeless persons.

(11) Other requirements established by HUD by Notice.

(3) Conducting an annual gaps analysis of the homeless needs and services available within the geographic area;

(4) Providing information required to complete the Consolidated Plan(s) within the Continuum's geographic area;

(5) Consulting with State and local government Emergency Solutions Grants program recipients within the Continuum's geographic area on the plan for allocating Emergency Solutions Grants program funds and reporting on and evaluating the performance of Emergency Solutions Grants program recipients and subrecipients.

§ 578.9 Preparing an application for funds.

(a) The Continuum must:

(1) Design, operate, and follow a collaborative process for the development of applications and approve the submission of applications in response to a NOFA published by HUD under § 578.19 of this subpart;

(2) Establish priorities for funding projects in the geographic area;

(3) Determine if one application for funding will be submitted for all projects within the geographic area or if more than one application will be submitted for the projects within the geographic area;

(1) If more than one application will be submitted, designate an eligible applicant to be the collaborative applicant that will collect and combine the required application information from all applicants and for all projects within the geographic area that the Continuum has selected funding. The collaborative applicant will also apply for Continuum of Care planning activities. If the Continuum is an eligible applicant, it may designate itself;

(11) If only one application will be submitted, that applicant will be the collaborative applicant and will collect and combine the required application

information from all projects within the geographic area that the Continuum has selected for funding and apply for Continuum of Care planning activities;

(b) The Continuum retains all of its responsibilities, even if it designates one or more eligible applicants other than itself to apply for funds on behalf of the Continuum. This includes approving the Continuum of Care application.

§ 578.11 Unified Funding Agency.

(a) *Becoming a Unified Funding Agency.* To become designated as the Unified Funding Agency (UFA) for a Continuum, a collaborative applicant must be selected by the Continuum to apply to HUD to be designated as the UFA for the Continuum.

(b) *Criteria for designating a UFA.* HUD will consider these criteria when deciding whether to designate a collaborative applicant a UFA:

(1) The Continuum of Care it represents meets the requirements in § 578.7;

(2) The collaborative applicant has financial management systems that meet the standards set forth in 24 CFR 84.21 (for nonprofit organizations) and 24 CFR 85.20 (for States);

(3) The collaborative applicant demonstrates the ability to monitor subrecipients; and

(4) Such other criteria as HUD may establish by NOFA.

(c) *Requirements.* HUD-designated UFAs shall:

(1) Apply to HUD for funding for all of the projects within the geographic area and enter into a grant agreement with HUD for the entire geographic area.

(2) Enter into legally binding agreements with subrecipients, and receive and distribute funds to subrecipients for all projects within the geographic area.

(3) Require subrecipients to establish fiscal control and accounting procedures as necessary to assure the proper disbursement of and accounting for federal funds in accordance with the requirements of 24 CFR parts 84 and 85 and corresponding OMB circulars.

(4) Obtain approval of any proposed grant agreement amendments by the

Continuum of Care before submitting a request for an amendment to HUD.

§ 578.13 Remedial action.

(a) If HUD finds that the Continuum of Care for a geographic area does not meet the requirements of the Act or its implementing regulations, or that there is no Continuum for a geographic area, HUD may take remedial action to ensure fair distribution of grant funds within the geographic area. Such measures may include:

(1) Designating a replacement Continuum of Care for the geographic area;

(2) Designating a replacement collaborative applicant for the Continuum's geographic area; and

(3) Accepting applications from other eligible applicants within the Continuum's geographic area.

(b) HUD must provide a 30-day prior written notice to the Continuum and its collaborative applicant and give them an opportunity to respond.

Subpart C—Application and Grant Award Process

§ 578.15 Eligible applicants.

(a) *Who may apply.* Nonprofit organizations, States, local governments, and instrumentalities of State or local governments are eligible to apply for grants.

(b) *Designation by the Continuum of Care.* Eligible applicant(s) must have been designated by the Continuum of Care to submit an application for grant funds under this part. The designation must state whether the Continuum is designating more than one applicant to apply for funds and, if it is, which applicant is being designated as the collaborative applicant. If the Continuum is designating only one applicant to apply for funds, the Continuum must designate that applicant to be the collaborative applicant.

(c) *Exclusion.* For-profit entities are not eligible to apply for grants or to be subrecipients of grant funds.

§ 578.17 Overview of application and grant award process.

(a) *Formula.* (1) After enactment of the annual appropriations act for each fiscal year, and issuance of the NOFA, HUD will publish, on its Web site, the

Preliminary Pro Rata Need (PPRN) assigned to metropolitan cities, urban counties, and all other counties.

(2) HUD will apply the formula used to determine PPRN established in paragraph (a)(3) of this section, to the amount of funds being made available under the NOFA. That amount is calculated by:

(1) Determining the total amount for the Continuum of Care competition in accordance with section 413 of the Act or as otherwise directed by the annual appropriations act;

(11) From the amount in paragraph (a)(2)(1) of this section, deducting the amount published in the NOFA as being set aside to provide a bonus to geographic areas for activities that have proven to be effective in reducing homelessness generally or for specific subpopulations listed in the NOFA or achieving homeless prevention and independent living goals established in the NOFA and to meet policy priorities set in the NOFA; and

(111) Deducting the amount of funding necessary for Continuum of Care planning activities and UFA costs.

(3) PPRN is calculated on the amount determined under paragraph (a)(2) of this section by using the following formula:

(1) Two percent will be allocated among the four insular areas (American Samoa, Guam, the Commonwealth of the Northern Marianas, and the Virgin Islands) on the basis of the ratio of the population of each insular area to the population of all insular areas.

(11) Seventy-five percent of the remaining amount will be allocated, using the Community Development Block Grant (CDBG) formula, to metropolitan cities and urban counties that have been funded under either the Emergency Shelter Grants or Emergency Solutions Grants programs in any one year since 2004.

(111) The amount remaining after the allocation under paragraphs (a)(1) and (2) of this section will be allocated, using the CDBG formula, to metropolitan cities and urban counties that have not been funded under the Emergency Solutions Grants program in any year since 2004 and all other counties in the United States and Puerto Rico.

APPENDIX C—Collective Impact Background

Stanford SOCIAL
INNOVATION REVIEW

Collective Impact
By John Kania & Mark Kramer

Stanford Social Innovation Review
Winter 2011

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Stanford Social Innovation Review
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Collective Impact

Large-scale social change requires broad cross-sector coordination, yet the social sector remains focused on the isolated intervention of individual organizations.

The scale and complexity of the U.S. public [education](#) system has thwarted attempted reforms for decades. Major funders, such as the Annenberg Foundation, [Ford Foundation](#), and [Pew Charitable Trusts](#) have abandoned many of their efforts in frustration after acknowledging their lack of progress. Once the global leader—after World War II the United States had the highest high school graduation rate in the world—the country now ranks 18th among the top 24 industrialized nations, with more than 1 million secondary school students dropping out every year. The heroic efforts of countless teachers, administrators, and [nonprofits](#), together with billions of dollars in charitable contributions, may have led to important improvements in individual schools and classrooms, yet system-wide progress has seemed virtually unobtainable.

Against these daunting odds, a remarkable exception seems to be emerging in Cincinnati. Strive, a nonprofit subsidiary of KnowledgeWorks, has brought together local leaders to tackle the student achievement crisis and improve education throughout greater Cincinnati and northern Kentucky. In the four years since the group was launched, Strive partners have improved student success in dozens of key areas across three large public school districts. Despite the recession and budget cuts, 34 of the 53 success indicators that Strive tracks have shown positive trends, including high school graduation rates, fourth-grade reading and math scores, and the number of preschool children prepared for kindergarten.

Why has Strive made progress when so many other efforts have failed? It is because a core group of community leaders decided to abandon their individual agendas in favor of a collective approach to improving student achievement. More than 300 leaders of local organizations agreed to participate, including the heads of influential private and corporate foundations, city government officials, school district representatives, the presidents of eight universities and community colleges, and the executive directors of hundreds of education-related nonprofit and advocacy groups.

These leaders realized that fixing one point on the educational continuum—such as better after-school programs—wouldn't make much difference unless all parts of the continuum improved at the same time. No single organization, however innovative or powerful, could accomplish this alone. Instead, their ambitious mission became to coordinate improvements at *every* stage of a young person's life, from "cradle to career."

Strive didn't try to create a new educational program or attempt to convince donors to spend more money. Instead, through a carefully structured process, Strive focused the entire educational community on a single set of goals, measured in the same way. Participating organizations are grouped into 15 different Student Success Networks (SSNs) by type of activity, such as early childhood education or tutoring. Each SSN has been meeting with coaches and facilitators for two hours every two weeks for the past three years, developing shared performance indicators, discussing their progress, and most important, learning from each other and aligning their efforts to support each other.

Strive, both the organization and the process it helps facilitate, is an example of *collective impact*, the commitment of a group of important actors from different sectors to a common agenda for solving a specific social problem. Collaboration is nothing new. The social sector is filled with examples of partnerships, networks, and other types of joint efforts. But collective impact initiatives are distinctly different. Unlike most collaborations, collective impact initiatives involve a centralized infrastructure, a dedicated staff, and a structured process that leads to a common agenda, shared measurement, continuous communication, and mutually reinforcing activities among all participants.

Although rare, other successful examples of collective impact are addressing social issues that, like education, require many different players to change their behavior in order to solve a complex problem. In 1993, Marjorie Mayfield Jackson helped found the Elizabeth River Project with a mission of cleaning up the Elizabeth River in southeastern Virginia, which for decades had been a dumping ground for industrial waste. They engaged more than 100 stakeholders, including the city governments of Chesapeake, Norfolk, Portsmouth, and Virginia Beach, Va., the Virginia Department of Environmental Quality, the U.S. Environmental Protection Agency (EPA), the U.S. Navy, and dozens of local businesses, schools, community groups, environmental organizations, and universities, in developing an 18-point plan to restore the watershed. Fifteen years later, more than 1,000 acres of watershed land have been conserved or restored, pollution has been reduced by more than 215 million pounds, concentrations of the most severe carcinogen have been cut sixfold, and water quality has significantly improved. Much remains to be done before the river is fully restored, but already 27 species of fish and oysters are thriving in the restored wetlands, and bald eagles have returned to nest on the shores.

Or consider Shape up Somerville, a citywide effort to reduce and prevent childhood obesity in elementary school children in Somerville, Mass. Led by Christina Economos, an associate

professor at Tufts University's Gerald J. and Dorothy R. Friedman School of Nutrition Science and Policy, and funded by the Centers for Disease Control and Prevention, the Robert Wood Johnson Foundation, Blue Cross Blue Shield of Massachusetts, and United Way of Massachusetts Bay and Merrimack Valley, the program engaged government officials, educators, businesses, nonprofits, and citizens in collectively defining wellness and weight gain prevention practices. Schools agreed to offer healthier foods, teach nutrition, and promote physical activity. Local restaurants received a certification if they served low-fat, high nutritional food. The city organized a farmers' market and provided healthy lifestyle incentives such as reduced-price gym memberships for city employees. Even sidewalks were modified and crosswalks repainted to encourage more children to walk to school. The result was a statistically significant decrease in body mass index among the community's young children between 2002 and 2005.

Even companies are beginning to explore collective impact to tackle social problems. Mars, a manufacturer of chocolate brands such as M&M's, Snickers, and Dove, is working with NGOs, local governments, and even direct competitors to improve the lives of more than 500,000 impoverished cocoa farmers in Cote d'Ivoire, where Mars sources a large portion of its cocoa. Research suggests that better farming practices and improved plant stocks could triple the yield per hectare, dramatically increasing farmer incomes and improving the sustainability of Mars's supply chain. To accomplish this, Mars must enlist the coordinated efforts of multiple organizations: the Cote d'Ivoire government needs to provide more agricultural extension workers, the World Bank needs to finance new roads, and bilateral donors need to support NGOs in improving health care, nutrition, and education in cocoa growing communities. And Mars must find ways to work with its direct competitors on pre-competitive issues to reach farmers outside its supply chain.

These varied examples all have a common theme: that large-scale social change comes from better cross-sector coordination rather than from the isolated intervention of individual organizations. Evidence of the effectiveness of this approach is still limited, but these examples suggest that substantially greater progress could be made in alleviating many of our most serious and complex social problems if nonprofits, governments, businesses, and the public were brought together around a common agenda to create collective impact. It doesn't happen often, not because it is impossible, but because it is so rarely attempted. Funders and nonprofits alike overlook the potential for collective impact because they are used to focusing on independent action as the primary vehicle for social change.

ISOLATED IMPACT

Most funders, faced with the task of choosing a few grantees from many applicants, try to ascertain which organizations make the greatest contribution toward solving a social problem. Grantees, in turn, compete to be chosen by emphasizing how their individual activities produce the greatest effect. Each organization is judged on its own potential to achieve impact, independent of the numerous other organizations that may also influence the issue. And when a grantee is asked to evaluate the impact of its work, every attempt is made to isolate that grantee's individual influence from all other variables.

In short, the nonprofit sector most frequently operates using an approach that we call *isolated impact*. It is an approach oriented toward finding and funding a solution embodied within a single organization, combined with the hope that the most effective organizations will grow or replicate to extend their impact more widely. Funders search for more effective interventions as if there were a cure for failing schools that only needs to be discovered, in the way that medical cures are discovered in laboratories. As a result of this process, nearly 1.4 million nonprofits try to invent independent solutions to major social problems, often working at odds with each other and exponentially increasing the perceived resources required to make meaningful progress. Recent trends have only reinforced this perspective. The growing interest in venture [philanthropy](#) and [social entrepreneurship](#), for example, has greatly benefited the social sector by identifying and accelerating the growth of many high-performing nonprofits, yet it has also accentuated an emphasis on scaling up a few select organizations as the key to social progress.

Despite the dominance of this approach, there is scant evidence that isolated initiatives are the best way to solve many social problems in today's complex and interdependent world. No single organization is responsible for any major social problem, nor can any single organization cure it. In the field of education, even the most highly respected nonprofits—such as the Harlem Children's Zone, Teach for America, and the Knowledge Is Power Program (KIPP)—have taken decades to reach tens of thousands of children, a remarkable achievement that deserves praise, but one that is three orders of magnitude short of the tens of millions of U.S. children that need help.

The problem with relying on the isolated impact of individual organizations is further compounded by the isolation of the nonprofit sector. Social problems arise from the interplay of governmental and commercial activities, not only from the behavior of social sector organizations. As a result, complex problems can be solved only by cross-sector coalitions that engage those outside the nonprofit sector.

We don't want to imply that all social problems require collective impact. In fact, some problems are best solved by individual organizations. In "Leading Boldly," an article we wrote with Ron Heifetz for the winter 2004 issue of the *Stanford Social Innovation Review*, we described the difference between *technical problems* and *adaptive problems*. Some social problems are technical in that the problem is well defined, the answer is known in advance, and one or a few organizations have the ability to implement the solution. Examples include funding college scholarships, building a hospital, or installing inventory controls in a food bank. Adaptive problems, by contrast, are complex, the answer is not known, and even if it were, no single entity has the resources or authority to bring about the necessary change. Reforming public education, restoring wetland environments, and improving community health are all adaptive problems. In these cases, reaching an effective solution requires learning by the stakeholders involved in the problem, who must then change their own behavior in order to create a solution.

Shifting from isolated impact to collective impact is not merely a matter of encouraging more collaboration or public-private partnerships. It requires a systemic approach to social impact that focuses on the relationships between organizations and the progress toward shared objectives. And it requires the creation of a new set of [nonprofit management](#) organizations that have the skills and resources to assemble and coordinate the specific elements necessary for collective action to succeed.

THE FIVE CONDITIONS OF COLLECTIVE SUCCESS

Our research shows that successful collective impact initiatives typically have five conditions that together produce true alignment and lead to powerful results: a common agenda, shared measurement systems, mutually reinforcing activities, continuous communication, and backbone support organizations.

Common Agenda Collective impact requires all participants to have a shared vision for change, one that includes a common understanding of the problem and a joint approach to solving it through agreed upon actions. Take a close look at any group of funders and nonprofits that believe they are working on the same social issue, and you quickly find that it is often not the same issue at all. Each organization often has a slightly different definition of the problem and the ultimate goal. These differences are easily ignored when organizations work independently on isolated initiatives, yet these differences splinter the efforts and undermine the impact of the field as a whole. Collective impact requires that these differences be discussed and resolved. Every participant need not agree with every other participant on all dimensions of the

problem. In fact, disagreements continue to divide participants in all of our examples of collective impact. All participants must agree, however, on the primary goals for the collective impact initiative as a whole. The Elizabeth River Project, for example, had to find common ground among the different objectives of corporations, governments, community groups, and local citizens in order to establish workable cross-sector initiatives.

Funders can play an important role in getting organizations to act in concert. In the case of Strive, rather than fueling hundreds of strategies and nonprofits, many funders have aligned to support Strive's central goals. The Greater Cincinnati Foundation realigned its education goals to be more compatible with Strive, adopting Strive's annual report card as the foundation's own measures for progress in education. Every time an organization applied to Duke Energy for a grant, Duke asked, "Are you part of the [Strive] network?" And when a new funder, the Carol Ann and Ralph V. Haile Jr./U.S. Bank Foundation, expressed interest in education, they were encouraged by virtually every major education leader in Cincinnati to join Strive if they wanted to have an impact in local education.¹

Shared Measurement Systems Developing a shared measurement system is essential to collective impact. Agreement on a common agenda is illusory without agreement on the ways success will be measured and reported. Collecting data and measuring results consistently on a short list of indicators at the community level and across all participating organizations not only ensures that all efforts remain aligned, it also enables the participants to hold each other accountable and learn from each other's successes and failures.

It may seem impossible to evaluate hundreds of different organizations on the same set of measures. Yet recent advances in Web-based technologies have enabled common systems for reporting performance and measuring outcomes. These systems increase efficiency and reduce cost. They can also improve the quality and credibility of the data collected, increase effectiveness by enabling grantees to learn from each other's performance, and document the progress of the field as a whole.²

All of the preschool programs in Strive, for example, have agreed to measure their results on the same criteria and use only evidence-based decision making. Each type of activity requires a different set of measures, but all organizations engaged in the same type of activity report on the same measures. Looking at results across multiple organizations enables the participants to spot patterns, find solutions, and implement them rapidly. The preschool programs discovered that children regress during the summer break before kindergarten. By launching an innovative "summer bridge" session, a technique more often used in middle school, and implementing it simultaneously in all preschool programs, they increased the average kindergarten readiness scores throughout the region by an average of 10 percent in a single year.³

Mutually Reinforcing Activities Collective impact initiatives depend on a diverse group of stakeholders working together, not by requiring that all participants do the same thing, but by encouraging each participant to undertake the specific set of activities at which it excels in a way that supports and is coordinated with the actions of others.

The power of collective action comes not from the sheer number of participants or the uniformity of their efforts, but from the coordination of their differentiated activities through a mutually reinforcing plan of action. Each stakeholder's efforts must fit into an overarching plan if their combined efforts are to succeed. The multiple causes of social problems, and the components of their solutions, are interdependent. They cannot be addressed by uncoordinated actions among isolated organizations.

All participants in the Elizabeth River Project, for example, agreed on the 18-point watershed restoration plan, but each is playing a different role based on its particular capabilities. One group of organizations works on creating grassroots support and engagement among citizens, a second provides peer review and recruitment for industrial participants who voluntarily reduce pollution, and a third coordinates and reviews scientific research.

The 15 SSNs in Strive each undertake different types of activities at different stages of the educational continuum. Strive does not prescribe what practices each of the 300 participating organizations should pursue. Each organization and network is free to chart its own course consistent with the common agenda, and informed by the shared measurement of results.

Continuous Communication Developing trust among nonprofits, corporations, and government agencies is a monumental challenge. Participants need several years of regular meetings to build up enough experience with each other to recognize and appreciate the common motivation behind their different efforts. They need time to see that their own interests will be treated fairly, and that decisions will be made on the basis of objective evidence and the best possible solution to the problem, not to favor the priorities of one organization over another.

Even the process of creating a common vocabulary takes time, and it is an essential prerequisite to developing shared measurement systems. All the collective impact initiatives we have studied held monthly or even biweekly in-person meetings among the organizations' CEO-level leaders. Skipping meetings or sending lower-level delegates was not acceptable. Most of the meetings were supported by external facilitators and followed a structured agenda.

The Strive networks, for example, have been meeting regularly for more than three years. Communication happens between meetings too: Strive uses Web-based tools, such as Google Groups, to keep communication flowing among and within the networks. At first, many of the leaders showed up because they hoped that their participation would bring their organizations additional funding, but they soon learned that was not the meetings' purpose. What they discovered instead were the rewards of learning and solving problems together with others who shared their same deep knowledge and passion about the issue.

Backbone Support Organizations Creating and managing collective impact requires a separate organization and staff with a very specific set of skills to serve as the backbone for the entire initiative. Coordination takes time, and none of the participating organizations has any to spare. The expectation that collaboration can occur without a supporting infrastructure is one of the most frequent reasons why it fails.

The backbone organization requires a dedicated staff separate from the participating organizations who can plan, manage, and support the initiative through ongoing facilitation, technology and communications support, data collection and reporting, and handling the myriad logistical and administrative details needed for the initiative to function smoothly. Strive has simplified the initial staffing requirements for a backbone organization to three roles: project manager, data manager, and facilitator.

Collective impact also requires a highly structured process that leads to effective decision making. In the case of Strive, staff worked with General Electric (GE) to adapt for the social sector the Six Sigma process that GE uses for its own continuous quality improvement. The Strive Six Sigma process includes training, tools, and resources that each SSN uses to define its common agenda, shared measures, and plan of action, supported by Strive facilitators to guide the process.

In the best of circumstances, these backbone organizations embody the principles of adaptive leadership: the ability to focus people's attention and create a sense of urgency, the skill to apply pressure to stakeholders without overwhelming them, the competence to frame issues in a way that presents opportunities as well as difficulties, and the strength to mediate conflict among stakeholders.

FUNDING COLLECTIVE IMPACT

Creating a successful collective impact initiative requires a significant financial investment: the time participating organizations must dedicate to the work, the development and monitoring of

shared measurement systems, and the staff of the backbone organization needed to lead and support the initiative's ongoing work.

As successful as Strive has been, it has struggled to raise money, confronting funders' reluctance to pay for infrastructure and preference for short-term solutions. Collective impact requires instead that funders support a long-term process of social change without identifying any particular solution in advance. They must be willing to let grantees steer the work and have the patience to stay with an initiative for years, recognizing that social change can come from the gradual improvement of an entire system over time, not just from a single breakthrough by an individual organization.

This requires a fundamental change in how funders see their role, from funding organizations to leading a long-term process of social change. It is no longer enough to fund an innovative solution created by a single nonprofit or to build that organization's capacity. Instead, funders must help create and sustain the collective processes, measurement reporting systems, and community leadership that enable cross-sector coalitions to arise and thrive.

This is a shift that we foreshadowed in both "Leading Boldly" and our more recent article, "Catalytic Philanthropy," in the fall 2009 issue of the *Stanford Social Innovation Review*. In the former, we suggested that the most powerful role for funders to play in addressing adaptive problems is to focus attention on the issue and help to create a process that mobilizes the organizations involved to find a solution themselves. In "Catalytic Philanthropy," we wrote: "Mobilizing and coordinating stakeholders is far messier and slower work than funding a compelling grant request from a single organization. Systemic change, however, ultimately depends on a sustained campaign to increase the capacity and coordination of an entire field." We recommended that funders who want to create large-scale change follow four practices: take responsibility for assembling the elements of a solution; create a movement for change; include solutions from outside the nonprofit sector; and use actionable knowledge to influence behavior and improve performance.

These same four principles are embodied in collective impact initiatives. The organizers of Strive abandoned the conventional approach of funding specific programs at education nonprofits and took responsibility for advancing education reform themselves. They built a movement, engaging hundreds of organizations in a drive toward shared goals. They used tools outside the nonprofit sector, adapting GE's Six Sigma planning process for the social sector. And through the community report card and the biweekly meetings of the SSNs they created

actionable knowledge that motivated the community and improved performance among the participants.

Funding collective impact initiatives costs money, but it can be a highly leveraged investment. A backbone organization with a modest annual budget can support a collective impact initiative of several hundred organizations, magnifying the impact of millions or even billions of dollars in existing funding. Strive, for example, has a \$1.5 million annual budget but is coordinating the efforts and increasing the effectiveness of organizations with combined budgets of \$7 billion. The social sector, however, has not yet changed its funding practices to enable the shift to collective impact. Until funders are willing to embrace this new approach and invest sufficient resources in the necessary facilitation, coordination, and measurement that enable organizations to work in concert, the requisite infrastructure will not evolve.

FUTURE SHOCK

What might social change look like if funders, nonprofits, government officials, civic leaders, and business executives embraced collective impact? Recent events at Strive provide an exciting indication of what might be possible.

Strive has begun to codify what it has learned so that other communities can achieve collective impact more rapidly. The organization is working with nine other communities to establish similar cradle to career initiatives.⁴ Importantly, although Strive is broadening its impact to a national level, the organization is not scaling up its own operations by opening branches in other cities. Instead, Strive is promulgating a flexible process for change, offering each community a set of tools for collective impact, drawn from Strive's experience but adaptable to the community's own needs and resources. As a result, the new communities take true ownership of their own collective impact initiatives, but they don't need to start the process from scratch. Activities such as developing a collective educational reform mission and vision or creating specific community-level educational indicators are expedited through the use of Strive materials and assistance from Strive staff. Processes that took Strive several years to develop are being adapted and modified by other communities in significantly less time.

These nine communities plus Cincinnati have formed a community of practice in which representatives from each effort connect regularly to share what they are learning. Because of the number and diversity of the communities, Strive and its partners can quickly determine what processes are universal and which require adaptation to a local context. As learning accumulates, Strive staff will incorporate new findings into an Internet-based knowledge portal

that will be available to any community wishing to create a collective impact initiative based on Strive's model.

This exciting evolution of the Strive collective impact initiative is far removed from the isolated impact approach that now dominates the social sector and that inhibits any major effort at comprehensive, large-scale change. If successful, it presages the spread of a new approach that will enable us to solve today's most serious social problems with the resources we already have at our disposal. It would be a shock to the system. But it's a form of shock therapy that's badly needed.

APPENDIX D – HUD Definition of Homeless

and creates the Rural Housing Stability program to replace the Rural Homelessness Grant program. The HEARTH Act also codifies in law the Continuum of Care planning process, long a part of HUD's application process to assist homeless persons by providing greater coordination in responding to their needs.

This final rule integrates the regulation for the definition of "homeless," and the corresponding recordkeeping requirements, for the Shelter Plus Care program, and the Supportive Housing Program. This final rule also establishes the regulation for the definition "developmental disability" and the definition and recordkeeping requirements for "homeless individual with a disability" for the Shelter Plus Care program and the Supportive Housing Program.

DATES: *Effective Date:* January 4, 2012.
FOR FURTHER INFORMATION CONTACT: Ann Marie Oliva, Director, Office of Special Needs Assistance Programs, Office of Community Planning and Development, Department of Housing and Urban Development, 451 7th Street SW., Washington, DC 20410-7000; telephone number (202) 708-4300 (this is not a toll-free number). Hearing- and speech-impaired persons may access this number through TTY by calling the Federal Relay Service at (800) 877-8339 (this is a toll-free number).

SUPPLEMENTARY INFORMATION:

I. Background—HEARTH Act

An Act to Prevent Mortgage Foreclosures and Enhance Mortgage Credit Availability was signed into law on May 20, 2009 (Pub. L. 111-22). This new law implements a variety of measures directed toward keeping individuals and families from losing their homes. Division B of this new law is the Homeless Emergency Assistance and Rapid Transition to Housing Act of 2009 (HEARTH Act). The HEARTH Act consolidates and amends three separate homeless assistance programs carried out under title IV of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11371 *et seq.*) (McKinney-Vento Act) into a single grant program that is designed to improve administrative efficiency and enhance response coordination and effectiveness in addressing the needs of homeless persons. The single Continuum of Care program established by the HEARTH Act consolidates the following programs: The Supportive Housing Program, the Shelter Plus Care program, and the Moderate Rehabilitation/Single Room Occupancy program. The former Emergency Shelter Grant program is

renamed the Emergency Solutions Grant program and revised to broaden existing emergency shelter and homelessness prevention activities and to add rapid rehousing activities. The new Rural Housing Stability program replaces the Rural Homelessness Grant program. The HEARTH Act also codifies in law and enhances the Continuum of Care planning process, the coordinated response to addressing the needs of homelessness established administratively by HUD in 1995. HUD has commenced rulemaking to implement these new and revised programs, and this final rule is central to all of the HEARTH Act rules.

II. The April 2010 Proposed Rule

On April 20, 2010, HUD published a proposed rule (75 FR 20541) to commence HUD's implementation of the HEARTH Act. The proposed rule provided necessary clarification on terms within the statutory definitions of "homeless," "homeless individual," "homeless person," and "homeless individual with a disability." In addition, the proposed rule contained proposed recordkeeping requirements designed to assist communities appropriately document an individual or family's homeless status in the case file.

Through the proposed rule, HUD solicited public comment and suggestions on the proposed clarifications. The public comment period closed on June 21, 2010.

A more detailed discussion of HUD's April 20, 2010, proposed rule can be found at 75 CFR 20541 through 20546, of the April 20, 2010, edition of the *Federal Register*, and the discussion of public comments submitted on the proposed rule and HUD's responses to the comments are addressed later in this preamble.

This final rule is being published contemporaneously with the interim rule for the Emergency Solutions Grants (ESG) program, which establishes the regulations for the ESG program in 24 CFR part 576 and makes corresponding amendments to HUD's Consolidated Plan regulations in 24 CFR part 91. To complement the ESG interim rule, this final rule revises the definition of "homeless" in both 24 CFR parts 91 and adds recordkeeping requirements to part 576. While the proposed rule also included definitions for "developmental disability" and "homeless individual with a disability," those definitions are not being adopted by this final rule. Part 576 does not use those terms, and the Consolidated Plan regulations in 24 CFR part 91 covers more than HUD's homeless assistance programs.

The definitions of "developmental disability" and "homeless individual with a disability" will be addressed in the final rule for the Continuum of Care program, which will replace the Shelter Plus Care program and the Supportive Housing Program, and in the rule for the new Rural Housing Stability Assistance program. The rulemaking for the Continuum of Care program and the Rural Housing Stability Assistance program have not yet commenced, and therefore, this final rule integrates these new definitions into the current regulations for the Shelter Plus Care program and Supportive Housing Program at 24 CFR parts 582 and 583, respectively.

III. Overview of the Final Rule—Key Clarifications

The proposed rule, submitted for public comment, provided four possible categories under which individuals and families may qualify as homeless, corresponding to the broad categories established by the statutory language of the definition in section 103 of the McKinney-Vento Act, as amended by the HEARTH Act. The final rule maintains these four categories. The categories are: (1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided; (2) individuals and families who will imminently lose their primary nighttime residence; (3) unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; and (4) individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member. Throughout this preamble, all references to a number "category of homeless" refer to this list.

After reviewing issues raised by the commenters, discussed in Section IV of this preamble, and upon HUD's further consideration of issues related to this final rule, the following highlights the changes that are made by this final rule.

"Shelter" includes "Emergency Shelter" but not "Transitional Housing." The HEARTH Act defines an individual or family who resided in shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily

¹ HUD Rules and Regulations: [Changes in the HUD definition of "Homeless"](#) (2012)

Alameda County Priority Home Partnership



Emergency Solutions Grant Rapid Rehousing and Prevention Assistance Policies and Procedures Manual

Version 1
February 2013

Budget and Housing Stability Plan

The purpose of ESG Prevention and/or Rapid Rehousing assistance is to provide the support necessary to help the household retain or gain housing in the shortest period of time possible. Critical to being able to retain the housing is a budget and a housing plan. The budget is also needed to determine the amount of financial assistance to be provided.

The Housing Stability Plan should be updated as frequently as necessary to reflect changing situations. Once a participant has moved into housing, the housing specialist and participant should prepare a new Housing Stability Plan that emphasizes those steps or actions needed to retain housing.



A [Sample Budgeting Worksheet](#) and a sample [Housing Stability Plan](#) format can be found in the Appendix of Forms. *ESG-funded programs may use another version of these forms if approved by the recipient.* Be sure to make a copy of the Budget and Housing Plan for the participant and insert a signed copy in the participant's file.

3: Financial Assistance for Housing

Eligible Financial Assistance Expenses

The ESG program has the ability to provide temporary financial assistance to participants on a short or medium-term basis. This assistance may include:

Security Deposits: The housing agency may provide a maximum of two times the monthly rent for a unit as a security deposit to assist a participant to secure housing. At such time as the participant may leave the unit and the landlord return all or part of the deposit to the participant, the participant may retain any balance to use toward a new housing situation.

Utility Deposits: If, in order to begin utility service, the household must provide a deposit to a utility company, the program may assist with this deposit.

Rental Assistance payments: If the participant cannot currently afford to rent a unit in the community but is reasonably anticipated to have sufficient income, either through employment or benefits, within approximately six months the program may provide a rental subsidy for the participant. Such subsidies will be as low as possible:

- If the participant has an income he/she is expected to contribute at least 50% of his/her income toward the rent, unless the participant is expect to receive a permanent housing subsidy within approximately six months, in which case the participant may pay only 30% of their income. Documentation of the expectation of a permanent subsidy should be included in the file.
- If the participant has no income, the program may subsidize the entire rent for the first three months.

Rental assistance may be conditioned on the participant fulfilling his or her agreements as part of the Housing Stability Plan and is never offered for more than three months at a time. To continue rental assistance after three months, the program must recertify the participant. See Section [6: Three Month Reassessment of Eligibility](#)

Past due rent arrears: If in order for a household to retain their housing they must pay past due rent the program will cover up to three months of rent arrears not to exceed \$3,000

Past due utility arrears: In rare cases, the ESG program will provide funding for past due utilities. The program will only provide such funding for prevention clients if failure to do so will result in the loss of utilities and under the terms of the participants lease this would be grounds for eviction. The program will only provide utility arrears assistance to rapid rehousing clients if utility arrears mean that then household will be unable to establish utility service in their new housing.

In addition, ESG funds may be used to cover the costs of rental applications provided this is a fee that is charge by the owner to all applicants.

Determining the Amount of Financial Assistance

The amount of financial assistance is determined by the amount needed to secure the housing and by the amount of contribution the household is able to make toward the housing costs.

For one-time costs, such as security deposits, and rent and utility arrears, the program will pay the entire amount if the household will have less than 50% of income available after paying rent, the household's budget does not contain any disposable income, and the household assets are less than \$500.00. If the household has assets greater than \$500, and/or the household budget indicates income is available to make a portion of the payment, the household should be required to provide a portion of the deposit and/or arrears. The household's payment may be made through a payment plan with the landlord or utility company if that is possible.

For rental assistance payments, households with any income are expected to contribute either 50% of their income, or 50% of the rent, whichever is lower. An exception to this rule may be made for

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persons with disabilities who are anticipated to receive a permanent subsidy within six months of their ESG program enrollment.

With supervisor approval, households may be permitted to contribute less toward the rent for a brief period to cover other extraordinary costs. The program may pay the entire rent on behalf of households that have no income.



The [ESG Financial Assistance Calculation Form](#) can be found in the appendix. The program should complete the form with the participant and the participant should sign it. This calculation needs to be prepared every three months for households receiving medium-term rental assistance.

4: Supportive Services and Connection to Mainstream Resources

Whether covered by ESG funds or other sources, ESG programs are expected to assist clients with housing stability case management and with housing search and placement services as needed.

Housing stability case management includes:

- conducting the official evaluation of eligibility and need, including verifying and documenting eligibility
- counseling
- developing, securing, and coordinating services and assistance in obtaining Federal, state and local benefits
- monitoring and evaluating participant progress;
- providing information and referral to other providers;
- developing an individualized housing plan to permanent housing stability; and
- conducting reevaluations.

These services *may not exceed* 30 days during the period the program participant is seeking permanent housing, and may be provided for up to a total of 24 months within a 36 month period.

While providing prevention or rapid rehousing financial assistance, the program must ensure that the participant meets with a case manager not less than once per month to assist the participant in ensuring long-term housing stability. Case management should be provided more frequently if needed.

Housing search assistance are those services intended to assist program participants in locating, obtaining, and retaining suitable permanent housing, and are expected to be offered to all participants receiving rapid rehousing assistance or prevention assistance that includes moving to another unit. These include:

- assessment of housing barriers, needs, and preferences;
- development of a plan for locating housing;
- housing search;
- outreach and negotiations with landlords; and
- assistance with submitting rental applications and understanding leases.

APPENDIX F--Applications for Membership to Continuum; Leadership Board; HUD CoC Committee

Application for Leadership Board/Selected Membership Committees

Name _____

Phone 1 _____ Phone 2 _____

Address _____

Email _____

Committee(s) you are interested in joining (includes Leadership Board, HUD CoC Committee, Organizational Health Committee, and HUD NOFA Committee) _____

Relevant Experience and/or Employment (may attach a resume) _____

Why are you interested in EveryOne Home? _____

Area of expertise/contribution you feel you can make? _____

Other volunteer commitments _____

Can be completed and returned by email to Elaine de Coligny at info@everyonehome.org or by fax (510) 670-6378.

Project Conflict of Interest Policy

For Tides Center project directors, project senior staff, and project advisory board members

The 2001 Enron scandal brought about a decline of public trust in accounting and reporting practices. In response, the federal government passed the Sarbanes-Oxley Act to curb corporate abuses; several of the Act's stipulations also pertain to nonprofits. Following the passage of Sarbanes-Oxley, California enacted the Nonprofit Integrity Act, which, among many requirements, mandates signed conflict of interest statements from key employees and board members. Versions of California's act are being considered by a majority of states across the country.

In 2005, Tides Center's auditors' report to management recommended that each of Tides Center's project directors, key management staff, and advisory board members fill out and sign conflict of interest forms annually. Tides Center adheres to this policy to continue our history of transparency and compliance with government regulations, and to help ensure the protection of all projects.

Conflicts of interest arise whenever the personal or professional interests of a project director or an advisory board member are potentially at odds with the best interests of a nonprofit. These conflicts are common, for example, when a board member performs paid, professional services for an organization, or proposes that a relative or friend be considered for a staff position. Such situations are generally acceptable if the transactions benefit the organization and if the advisory board approves the decisions in an objective and informed manner. Even if they do not meet these standards, such transactions are usually not illegal. They are, however, vulnerable to legal challenges, and to public misunderstanding. Loss of public confidence and a damaged reputation are the most likely results of a poorly managed conflict of interest. Advisory boards should take steps to avoid even the appearance of impropriety.

More difficult conflicts can arise when an advisory board member sits on the board or works for a competing or similarly-focused organization. The advisory board member's organization may apply for funding from the same sources as the project. The "duty of loyalty" for board service requires project advisory board members to place loyalty to the project above other conflicting loyalties. If a project advisory board member works for an organization that is a competitor in some way with the project, this member may not use information gained through that project advisory board role to aid his/her employer. Conflict of interest situations can be difficult to manage, so it is recommended that projects keep this in mind when selecting advisory board members.

Potential conflicts can occur when advisory board members have a direct personal financial interest in a business or economic transaction with a project. Examples include situations where advisory board members:

- buy or sell goods and services to or from the project
- lease property and equipment to or from the project
- receive a gift, grant or other financial benefit from the project
- purchase or sell real estate, securities, or other property to or from the project
- borrow money from the project or receive advances of money

- are board members or employees of a competing or affinity organization of the project
- are primary donors or others supporting the project

Conflicts can also occur when the board member has an indirect relationship to an economic or business transaction, as outlined above. The same transactions as are outlined above fall within this policy if the transaction involves the friends, family members or employees of the advisory board member, or if the advisory board member has a material financial interest in an entity which is involved in the transaction.

Tides Center requires each of our project advisory board members and project directors to agree to the following Conflict of Interest Policy:

- Each project director and advisory board member will complete annually a Conflict of Interest Disclosure Statement annually, and provide updated information whenever a conflict arises, and agree to fully disclose potential conflicts to the Advisory Board and to the Tides Project Advisor when they occur so that advisory board members who are voting on an issue are aware that another member's interests may be affected.
- Advisory board members will be required to withdraw—meaning they should not be part of the discussion nor vote—on decisions that present a potential conflict for him or her.
- The advisory board will establish procedures, such as competitive bids, comparability surveys, or similar due diligence to ensure that the project and Tides Center are receiving fair value in a transaction.
- The advisory board in consultation with Tides Governance Advisor and Project Advisor will determine whether a conflict exists and is material, and in the presence of an existing material conflict, determine whether the contemplated transaction may be authorized as just, fair, and reasonable to the project.
- The advisory board will record in their meeting minutes the potential conflict of interest, and will document that in making a decision they have used the procedures and criteria provided in this policy, and they will forward a copy of the minutes to Tides Center.

Project Name:

Tides Center Project Conflict of Interest Disclosure Statement

Please check one box:

- Advisory Board Member
- Project Staff

Please check only one box (and please add the Project name):

I have no Conflicts of Interest as defined in the Project Conflict of Interest Policy to report regarding

Project Name
(Check the box, sign and date this statement.)

APPENDIX H--HOME STRECH MOU

MEMORANDUM OF UNDERSTANDING FOR HUD CONTINUUM OF CARE-FUNDED ORGANIZATIONS PARTICIPATING IN HOME STRETCH

By signing this Memorandum of Understanding, _____
("Provider") agrees to participate in Home Stretch as a Permanent Supportive Housing Provider and as described in the corresponding Exhibit (see page 5).

Provider agrees to work collaboratively with Home Stretch to ensure clarity in roles and responsibilities in the service of meeting client needs and ending homelessness for people with disabilities.

I. Home Stretch Overview

The U.S. Department of Housing and Urban Development (HUD) requires that communities receiving Federal Continuum of Care (CoC) or Emergency Solutions Grant funding to address homelessness establish Coordinated Entry (CE). The purpose of CE is to ensure that all persons experiencing homelessness are assessed and prioritized for assistance using a fair, consistent, and coordinated process. The Alameda County HUD Continuum of Care (HUD CoC) Committee, in accordance with guidance from HUD's Office of Community Planning and Development (Notices [CPD-14-012](#) and [CPD-16-11](#)), has established prioritization criteria for access to permanent supportive housing (PSH) opportunities within Alameda County. The prioritization criteria were developed through a community input process, and have been approved by both the HUD CoC Committee and the EveryOne Home Leadership Board. Home Stretch represents Alameda County's implementation of coordinated entry and prioritization into PSH.

Home Stretch is a program of Alameda County Health Care Services Agency (HCSA), EveryOne Home, government, nonprofit, and community partners. The HUD CoC Committee of EveryOne Home has designated HCSA (also "Home Stretch Administrator") to administer Home Stretch. For the purposes of this MOU, "Home Stretch" refers to the registry and its management as well as to the Home Stretch Administrator.

The purpose of Home Stretch is to ensure that people with long histories of homelessness, a high level of vulnerability, and multiple barriers to housing are identified and matched with appropriate supportive services and permanent housing as quickly as possible. Specifically, Home Stretch works to:

- Create a countywide prioritized registry of people who are homeless and disabled, and therefore eligible for PSH;

- Ensure that persons prioritized to receive PSH have service providers helping them to obtain and maintain housing; and
- Make PSH openings available to people in the Home Stretch registry in order of priority, consistent with applicable eligibility and preference criteria for a given opening.

Home Stretch is informed by a commitment to each client’s right to self-determination, the importance of protecting a client’s personal information, and the need for collaboration between Home Stretch and partnering providers.

By signing this MOU, Provider agrees to carry out its identified role in coordination with Home Stretch to ensure that individuals prioritized for PSH through Home Stretch are matched to appropriate resources as they become available. Provider understands that the design of Home Stretch may be revised over time with the participation of partnering organizations and in alignment with the overall Coordinated Entry (CE) process in Alameda County.

Provider’s activities are central to the effective functioning of Home Stretch, and the Home Stretch Administrator will rely on Provider to perform the functions described in this MOU. For its part, Provider can expect the Home Stretch Administrator to work in a supportive and flexible way to enable Provider to carry out these functions efficiently and effectively. Benefits to Provider from participating in Home Stretch include helping to make possible a more integrated and effective system of care. Through partnership with Home Stretch, Provider may enjoy efficiencies and cost savings as a result of transitioning from a de-centralized system of matching clients with resources to a more centralized and streamlined process.

II. Record Keeping and Reporting

Provider agrees to participate in required local and national data collection and evaluation of Home Stretch. As appropriate to its role(s), Provider agrees to participate in a HUD-approved Homeless Management Information System (HMIS) data collection system adopted by the County to the extent required by applicable County and federal regulations and requirements. Provider acknowledges the importance of confidentiality and agrees to adhere to policies and procedures that safeguard client information.

III. Indemnity

To the fullest extent permitted by law, Provider shall hold harmless, defend and indemnify the County, its Board of Supervisors, officers, employees and agents (collectively “Indemnitees”) from and against any and all claims, losses, damages, liabilities or expenses, including reasonable attorney fees, incurred in the defense thereof, for the death or injury to any person or persons (including employees of Provider or County) or damage of any property (including property of Provider or County) which arises out of or is in any way connected with the

performance of this agreement (collectively “Liabilities”) except where such Liabilities are proximately caused solely by the negligence or willful misconduct of any Indemnitee.

IV. Term and Termination

This MOU becomes effective when signed on _____ and covers a twelve month period ending _____, with automatic annual renewal unless a written notice not to renew by either party is received sixty (60) days prior to expiration of the MOU. If Provider ends its participation in Home Stretch, Provider agrees to work with Home Stretch as feasible to ensure continuity of care for Home Stretch clients.

IN WITNESS WHEREOF, the parties hereto have caused this Agreement to be executed.

COUNTY OF ALAMEDA

Alameda County Health Care Services Agency, Home Stretch Administrator

Printed Name: Robert Ratner

Title: Housing Services Director

Signature

Date: _____

ALAMEDA COUNTY CONTINUUM OF CARE

Organization: EveryOne Home

Printed Name: Elaine de Coligny

Title: Executive Director

Signature

Date: _____

PROVIDER

Organization:

Printed Name:

Title:

Signature

Date: _____

Approved as to form:

_____, County Counsel

Date: _____

EXHIBIT 1 – PERMANENT SUPPORTIVE HOUSING PROVIDER: ROLES AND RESPONSIBILITIES

Permanent Supportive Housing (PSH) providers operate housing units and/or housing subsidies offered to and utilized by clients referred through Home Stretch. Provider agrees to the following with respect to the units and/or vouchers identified within the Properties and Projects listed in Exhibit 2 (the “Projects”).

I. Tenant Selection

A. Eligibility and Prioritization

Through the Alameda County HUD Continuum of Care (HUD CoC) Committee, Home Stretch has established eligibility and prioritization criteria which define the types and priority of clients to be referred to Provider. Using these criteria, Home Stretch will coordinate the initial screening of individuals and families that may be eligible for PSH. Subject to the limitations described below, Provider agrees to fill vacancies at the Projects with persons referred by Home Stretch.

Some Projects, or slots within the Projects, may be subject to additional criteria not established by Home Stretch, such as criteria established by grant agreements and regulatory restrictions. Provider agrees to inform Home Stretch about such grant agreements and restrictions governing any slots within the Projects. Home Stretch agrees to use its best efforts to ensure that its referrals meet all project-specific eligibility criteria. Home Stretch and Provider are committed to a collaborative process to ensure that the CoC priorities are met in a manner that complies with Provider’s funding restrictions.

Provider agrees to complete Exhibit 2 (“PSH Project Worksheet”), including housing slot eligibility, preferences, and key contact people for all Projects included in this Agreement. Provider agrees to provide the Home Stretch Administrator with all required Project specific housing application paperwork. Provider agrees to update the worksheet and application paperwork within 60 days of any significant changes to the information contained in the worksheet or application materials.

Home Stretch and Provider agree to the principle or philosophy of ‘Housing First.’ This means providing housing with low barriers and few to no programmatic conditions to housing entry; and low barrier admission policies that do not reject individuals or families with active substance use disorders, unstable tenancy histories, lack of strong credit history, criminal convictions, or other factors in compliance with HUD Housing First Principles. Supportive services are offered to maximize housing stability and prevent returns to homelessness as opposed to addressing predetermined treatment goals prior to permanent housing entry. The principles of Housing First shall also be reflected in Provider’s House Rules and Shared Living Agreements.

B. Existing Wait Lists

If Provider currently maintains any waitlists for the Projects, Provider agrees that they will notify all current households on their Project-specific waiting list of the Home Stretch Registry and that future vacancies will be filled from the Home Stretch registry rather than the Project-specific waiting list. Individuals from the Project-specific waiting list wishing to remain under consideration for future openings in this Project, and for other PSH opportunities throughout the continuum, need to be assessed and referred to the Home Stretch registry. They will have their original application date for the Project recorded as their Home Stretch referral date for purposes of prioritization for the Project and other housing opportunities. Provider agrees that within one month of executing this agreement, Provider will fill 100% of vacancies in these units from referrals received from Home Stretch.

C. Vacancies and Referrals

As soon as an opportunity within the Project is identified for an upcoming vacancy, Provider will communicate to Home Stretch specific information regarding the unit, including the unit's availability date, location, features, and accessibility to persons with disabilities, as well as any eligibility criteria specific to that unit (see Exhibit 3, 'Notification of Permanent Supportive Housing Opening'). Provider shall also send to Home Stretch a copy of the housing application and a list of any additional documentation required from the client.

Upon notification by Provider of an upcoming vacancy, Home Stretch will send Provider three or fewer referrals (Provider requests the number of referrals to be made via the 'Notification of Permanent Supportive Housing Opening') within 3 business days from notification. The Project to which the household(s) was matched is responsible for confirming receipt of the match.

Once the referrals have been provided to the Project, Home Stretch will continue working to notify the client and their service provider, and will require that referred clients gather final housing documentation to submit to Home Stretch within 14 days. Once the Project receives final documentation they shall also attempt to contact household, and if, after making 4 attempts over 14 days, the household cannot be reached by the Project, or a household declines the PSH opportunity or has changes in eligibility so that they no longer meet eligibility requirements for the opening, the Project must update the 'Notification of Permanent Supportive Housing Opening' and submit to Home Stretch for additional referral(s).

Referrals from Home Stretch will be sent in priority order. Provider agrees to make best efforts to fill the vacancy in this priority order. Home Stretch will respond promptly to Provider's requests for additional referrals if persons already referred do not meet eligibility criteria or if Provider has denied these applications for any of the reasons outlined in section D below.

If the ongoing service needs of the potential tenant are expected to be met by an outside agency and not by Provider, Home Stretch will also identify the PSH service provider that will provide these support services.

D. Denials

Provider may deny the application of a person referred by Home Stretch for the reasons below. However, Provider should consider mitigating circumstances, outlined in Section E, which demonstrate that any of these factors are unlikely to result in an unsuccessful tenancy. In addition, many applicants will need reasonable accommodations to successfully complete the housing application process including reasonable flexibility regarding scheduled appointments, support to complete paperwork, etc. Both Home Stretch and Provider will affirmatively offer reasonable accommodations throughout the process and document any accommodations requested.

- Failure to meet project eligibility requirements made known to Home Stretch
- Failure to provide required documentation
- Failure to keep scheduled appointments during the screening process
Appointments canceled for documented good cause must be re-scheduled
- Disruptive behavior, defined as threatening, abusive, or violent behavior, during the screening or orientation process
- Falsification of information by the applicant during the screening process
- Criminal convictions that make applicants categorically ineligible for a particular resource based on funding agency standards
- Where a housing opportunity offering accessibility features is available and there are other tenants or applicants who could benefit from these features, an applicant whose household does not require the accessibility features may be denied the housing opportunity.

E. Mitigating Circumstances

Applicants with problematic histories or other factors whose applications might otherwise be denied may request that their applications be approved based on reasonable accommodation for a disability and/or mitigating circumstances. Mitigating circumstances are verifiable facts that overcome or outweigh information gathered during the resident selection process because they demonstrate that the reason for the applicant's otherwise disqualifying circumstance is no longer operative or likely to interfere with occupancy.

Either before or after a Provider has decided to deny an application, an applicant may request a meeting with Provider or with a consideration committee made up of property management and a resident services representative. Applicant's housing navigator or other service provider(s) may attend this meeting.

During the meeting, an applicant may explain the circumstances which indicate that the barrier to housing is not likely to impede a successful tenancy. Provider will seek to make a decision based on its assessment of the applicant's current capacity to comply with the lease and other conditions of housing.

F. Notice of Denial; Appeals

Where Provider denies an application, Provider shall communicate in writing to the applicant the denial decision, the reason(s) for the denial, and a notice providing applicant 14 days to appeal the decision via a written request. A client's appeal may assert that legal requirements were not met or that eligibility criteria were misapplied, or may request that Provider waive nonessential policies or practices or determine whether mitigating circumstances or reasonable accommodations would make it possible to house the applicant. Provider agrees to respond in writing to the applicant within four days of receiving the applicant's appeal or request for review of reasonable accommodation or mitigating circumstances.

Where Provider denies an application initially or on appeal, Provider must notify Home Stretch within three (3) business days, including providing a copy of the denial letter and appeal response, if any. Provider agrees to retain the following for at least three years for each denied applicant:

- Application;
- Denial;
- Applicant reply or appeal and Provider's final response, if any; and
- Documentation of interview or other information upon which the denial was based.

Provider may fill a vacancy as soon as the appeal process is closed, but must keep the vacancy open while the appeal is under consideration. A backup applicant may be considered during this period so that an applicant is ready for move-in pending final outcome of the appeal.

G. Acceptance

If an applicant is eligible and qualified for a housing opportunity and still interested after receiving an orientation or interview, Provider shall send an approval letter to the applicant describing next steps. The letter shall also confirm that Provider will contact the applicant when the unit is ready for occupancy and move-in.

II. Move-In Procedures

A. Housing Slot Availability Letter

When the housing slot becomes available, Provider shall inform the approved applicant in writing of:

- The unit's address and physical location;
- Move-in date and time;
- Rent (both prorated rent due on move-in day and regular monthly amount);
- Security deposit amount;
- Contact information for move-in assistance resources; and
- Information regarding move-in procedures.

B. Additional Requirements of Occupancy

Provider may establish any of the following as requirements of occupancy, and as included in the lease agreement and subsidy agreement (where applicable) between Provider and tenant:

- Agreement to maintain premises in a safe and sanitary condition;
- Agreement to abide by House Rules;
- Agreement to a Shared Living Agreement, if applicable;
- Annual unit inspection;
- Annual income recertification, if a condition of eligibility, and requirement to immediately report to Provider changes in household income;
- Provision that falsifying income information is grounds for collecting back-rent and/or eviction; and
- If a tenant is occupying a unit modified for the physically disabled and the tenant does not need these modifications, Provider, with 30 days' notice, may move the tenant to a comparable unit within the property should a physically disabled tenant or applicant need a unit with such modifications.

C. Prior to Move-In

Provider shall establish procedures which include the following steps below. Applicant's housing navigator or other service provider(s) may be present during any or all of the pre-move-in procedures.

- Applicant signs lease, House Rules and related documents;
- Applicant and Provider inspect the unit and both sign the move-in inspection form;
- Applicant or responsible payee pays any security deposit;
- Applicant or responsible payee pays first month's rent;
- Acceptance of security deposit and first month's rent by personal check, cashier's check, or money order;
- At or after the orientation, which may be at the same time as the screening, Provider provides Applicant with a summary of the lease requirements, House Rules,

and any other information needed to assure that the new tenant will be comfortable and welcome in his or her new residence; and

- Applicant is provided with a copy of the lease, Move-In Inspection Form, House Rules, 50059 "Tenants Rights and Responsibilities Brochure," and other documents, including a receipt for the security deposit and first month's rent.

D. At Move-In

At the agreed upon date and time for move-in, Provider shall issue keys to the applicant. If the applicant does not show up on the confirmed move-in date, Provider agrees to send applicant a letter with a copy to Home Stretch and the client's housing navigator (or other identified service provider) stating that the applicant has 72 hours to contact Provider to reschedule the move-in. If the applicant does not contact Provider within 72 hours, Provider will send the applicant a denial letter. Regardless of circumstances, an applicant who has requested and been granted an extension for move-in must complete the move-in process within 14 days of a scheduled move-in date. If the applicant is not able to complete the process within this time, Provider may send the applicant a denial letter.

III. Notifications

Provider agrees to provide the following notifications to Home Stretch within three (3) business days, so that Home Stretch may ensure that applicants receive the supports they need to transition successfully into housing and to allow Home Stretch to monitor the effectiveness of its work.

- When an interview with an applicant has been scheduled;
- If an applicant is appealing a decision and when and how the appeal will be heard;
- The final outcome of an application (offer and acceptance, denial, or offer and decline);
- When a move-in date is set;
- Confirmation that applicant has moved in; and
- Notification of potential move-out or eviction.

IV. Fair Housing

Home Stretch and Provider agree to comply with all federal, state, and local fair housing, civil rights, and equal opportunity laws and requirements in connection with unit marketing, rent-up, and ongoing operations. Specifically, Home Stretch and Provider agree to observe the requirements of Title VI of the Civil Rights Act of 1964, Title VIII and Section 3 of the Civil Rights Act of 1968 (as amended by the Community Project Act of 1974), Executive Order 11063, Section 504 of the Rehabilitation Act of 1973, the Age Discrimination Act of 1975, Fair Housing

Amendments of 1988, and legislation which may subsequently be enacted protecting the rights of tenants, applicants, and staff.

Provider agrees not to discriminate against prospective tenants on the basis of the fact or perception of their race, religion, creed, national origin, color, age (with the exception that the applicant must be 18 years or older, as required by the specific property), sex, blindness, or other physical or mental disability, marital status, domestic partner status, ancestry, sexual orientation, gender identity, HIV/AIDS, medical condition, height, weight, political affiliation or other consideration made unlawful by federal, state, or local laws.

Provider further agrees not to discriminate against prospective tenants on the basis of their receipt of or eligibility for housing assistance under any federal, state, or local housing assistance program or on the basis that prospective tenants have minor children. While Provider will not discriminate against those using Section 8 certificates or vouchers or other rental assistance, applicants with such rental assistance must meet all eligibility requirements.

Provider will work with legal counsel and regulatory agencies as needed throughout the marketing, outreach, and application process to ensure compliance with applicable requirements.

Provider agrees that rental advertisements for the Properties will bear the Fair Housing logo and slogan. Provider also agrees to display a Fair Housing poster conspicuously in the rental office and where initial rent-up will occur. Any information sheets about units that are accessible to persons with disabilities will indicate the presence of these accessibility features.

Provider will also provide information on its website and in its marketing materials to encourage prospective applicants to contact Home Stretch if they are interested in applying for permanent supportive housing.

EXHIBIT 2- PSH Project Worksheet

_____ (“Provider”) agrees that the following properties/projects are subject to this MOU with Home Stretch (the “Projects”).

Instructions: Provider must fill out one worksheet per project. Please create a separate row for each unit type included in the Project.

Provider Organization: _____ **Name of Project:** _____

Single Site-Based Project:

Scattered Site Rental Assistance

Project:

Project Contact Name: _____ **Project Contact Number & Email:** _____

Unique Unit Addresses: Site-Based Projects Only (list the addresses for each unique unit type)	Funding Source (i.e. HOPWA, HUD-VASH, etc.)	# Units Included at this Address	Unit Sizes & Description	Unit Occupancy Standards for Each Unit Size	Eligibility Criteria as documented by funding source (requirements vs. preferences shall be documented in detail in the table below)	Tenant Services Provided (if yes, indicate services on-site assigned to the sub)
1)						
2)						
3)						
4)						
5)						

Instructions: For each type of unique unit identified in the Project (for each row completed in the table above), please select ‘Must Be’, ‘Can Be’, ‘Can’t Be’, or ‘Preference’ for each of the following.

Unique Unit Address/Corresponding Row # from the table above:

Eligibility Criteria	Must Be	Can Be	Can't Be	Preference (please specify)
Area Median Income (AMI) Extremely Low				
Citizenship Residency				
Arson				
On Parole				
Eviction				
City (of Project) Residence				
County Residence				
Chronically Homeless				
Legal Residency				
Serious Mental Illness				
Substance Use				
AIDS or related diseases				
Eligible for VA Healthcare				
Life-Time Sex Offender Status				
Meth Production Conviction				
Veteran				
Age 18-24				
Survivor of Domestic Violence				
History of Police Interaction				

Families with Children				
Seniors (specify min. age requirement)				

Exhibit 3- Notification of Permanent Supportive Housing Opening

(see separate attachment for sample form to be used when notifying Home Stretch of a PSH opening)

APPENDIX I—Systems Manual: Coordinated Entry Chapter of Alameda County’s Housing Crisis Response System Manual

1. Introduction to Coordinated Entry

2. Guiding Principles [Note: This section is being re-written and will be proposed as a set of principles to guide the policies, procedures, and operation of the Alameda County housing crisis response system in its entirety. This section, as written, will be removed from the Coordinated Entry Chapter and the new version will be proposed to the Leadership Board. Once adopted, it will be placed as an introductory section of the pending System Manual. The principles will be based on and preserve the intention of the Guiding Principles for System Design outlined in the Coordinated Entry Housing Resource Centers and Initial Design Report of June 2016 and currently included in this chapter.]

3. The Steps of Coordinated Entry: Screening, Assessment, Prioritization and Matching

- A. Initial Screening
- B. Housing Problem Solving
- C. Assessment
- D. Additional Considerations for Screening and Assessment
- E. Prioritization
- F. Matching
- G. Additional Considerations for Prioritization and Matching

4. Structure and Components of Coordinated Entry

- A. Countywide Call Center
- B. Outreach
- C. Housing Resource Centers

5. Ensuring Universal Access to CE System

- A. Affirmative Marketing
- B. Geographic Coverage
- C. Nondiscrimination

- D. Serving Vulnerable Populations
- E. Cultural and Linguistic Barriers
- F. People with Disabilities
- G. Other Special Populations
- H. Grievances and Appeals

6. Data Protocols and Privacy

- A. Privacy, confidentiality, and informed consent
- B. Data Protocols
- C. Data Protection

7. Coordinated Entry Oversight and Management

Appendices

- A. Core CE Staffing

NOTE:

Other chapters in the larger System Manual (written standards) will include: Oversight and Management, which will cover funders, system oversight, performance measures, etc.) and System Resources (which will cover emergency shelter, rapid rehousing, outreach, housing navigation, permanent supportive housing, and other housing-related services (e.g. landlord liaison and Subsidy management services, housing counseling, etc.). The System Resources section will describe, at a minimum: eligibility criteria for each type of resource; scope or range of assistance; standards for determining what percentage or amount of rent program participants must pay; transfer policies within and between Rapid Rehousing and Permanent Supportive Housing; and other expectations and accountabilities for each project type.

1. Introduction to Coordinated Entry

Coordinated Entry is a standardized process for connecting people experiencing homelessness to the resources available in a community. The U.S. Department of Housing and Urban Development (HUD) requires that every community implement Coordinated Entry in order to assess and prioritize people for programs and assistance within the region, including emergency shelter, transitional housing, permanent supportive housing, rapid rehousing, and other interventions.

The fundamental goals of the Alameda County Coordinated Entry System are:

- Ensure that all homeless people in the county access services in a consistent and fair manner, regardless of their geographic location, housing barriers, or other factors;
- Prioritize for assistance those households with the most acute needs; and
- Prevent as many people as possible from entering the homeless system by connecting them to Housing Problem Solving support and other emergency solutions that can resolve a housing crisis before it becomes homelessness.

Screening, Assessment, and Prioritization

Alameda County's Coordinated Entry system serves as a response system for County residents experiencing a housing crisis. Through Coordinated Entry, anyone who is homeless – or at risk of homelessness – can easily seek assistance, by phone or in person, without having to make multiple appointments, seek assistance at various sites, or complete numerous and repetitive questions and assessments. Any household that is literally homeless will be assessed to determine their level of need, and connected to a regional Housing Resource Center (HRC) for a range of housing-related supports. Homeless households who are most vulnerable and facing the most barriers to housing will be prioritized for housing resources. However, everyone seeking services – including those who are not literally homeless – will be connected to other mainstream assistance, including (but not limited to): housing workshops; food pantries and SNAP assistance; income and benefits advocacy; primary care and mental health services; and other services. For more information about how households are screened, assessed, and prioritized for services, please refer to Section 4C: *Housing Resource Centers*.

Housing Resource Centers

Alameda County has organized our Coordinated Entry process around five regional Housing Resource Centers (HRCs) that together provide full coverage of the County's geography. Each HRC serves as a hub from which housing resources and assistance are deployed, and the administrative home of key Coordinated Entry staff, including outreach teams and trained Assessors. Although some HRCs have limited walk-in capacity, they are not designed as drop-in service centers. Rather, HRC staff are tasked

with “bringing the front door to the clients” by conducting extensive street-level outreach and offering field- and phone-based Screening, Assessment, Prioritization, and referral to a broad range of housing-related and other mainstream services, including (but not limited to): primary and behavioral health care, income and benefits support, SNAP and food pantries, children’s/family services, legal assistance, housing counseling and workshops, and more. For more information about the HRCs, refer to Section 4C: *Housing Resource Centers*.

Target Populations and Eligibility

Designed to be a seamless experience for people seeking assistance, the Coordinated Entry process is collaboratively funded and operated with a variety of resources, including Alameda County General funds (Boomerang), HUD Continuum of Care funds, and Alameda County Care Connect (Whole Person Care). These resources are matched with a range of additional local funds and private resources to support the coordinated entry process and associated services. Some of these funds come with funding and eligibility restrictions. More specifically:

- HRC services are targeted to people who are living in Alameda County and who are literally homeless or fleeing domestic violence.
- There are limited Boomerang resources available for people who are “at imminent risk of homelessness” according to HUD’s definition.
- Individuals matched to AC Care Connect services and resources must be enrolled (or eligible for) Medi-Cal; willing to enroll in AC Care Connect; chronically homeless and high-priority (for housing navigation); and/or homeless and disabled (for tenancy-sustaining services).

Participating Programs

All programs funded with Federal Continuum of Care (CoC), and with State and Local Emergency Solution Grants (ESG) are required to participate in Coordinated Entry. In addition, most programs specifically designated for people experiencing homelessness that are funded by the Whole Person Care Pilot – Alameda County Care Connect, Mental Health Services Act (MHSA), Department of Veterans Affairs (VA), County Boomerang (general funds), SAMHSA, non-Boomerang County General Funds, and City General Funds are also required to participate in Coordinated Entry.

A list of programs participating in Coordinated Entry is available on EveryOne Home’s website (www.everyonehome.org). The programs include, but are not limited to, shelter, transitional housing, outreach, housing navigation, rapid rehousing, and permanent supportive housing. All of these resources are distributed regionally through the HRCs, with the exception of permanent supportive housing, which is distributed County-wide. The list of participating programs is updated at least annually by HRC leads in collaboration with EveryOne Home.

Performance Measurement and Results-Based Accountability (RBA)

The performance of the County’s Coordinated Entry process – and all of the programs associated with it – will be carefully measured, reviewed on a regular basis, and subject to continual adjustment and improvement. The service providers and operators of the Coordinated Entry process will be responsible for attaining the key outputs, outcomes, deliverables, and other contractual obligations that are included in their funding contracts, as well as any other performance expectations agreed upon by the Results-Based Accountability Committee and adopted by the Leadership Board of EveryOne Home. The core deliverables will likely include metrics such as service volume, timely completion of process steps, successful referrals/transfers, and housing outcomes, and will also be subject to ongoing review and adjustment by funders and the RBA Committee as appropriate.

2. Guiding Principles for Systems Design [Note: This section is being re-written and will be proposed as a set of principles to guide the policies, procedures, and operation of the Alameda County housing crisis response system in its entirety. This section, as written, will be removed from the Coordinated Entry Chapter and the new version will be proposed to the Leadership Board. Once adopted, it will be placed as an introductory section of the pending System Manual. The principles will be based on and preserve the intention of the Guiding Principles for System Design outlined in the Coordinated Entry Housing Resource Centers and Initial Design Report of June 2016 and currently included in this chapter.]

~~In 2015-2016, EveryOne Home convened a broad-based committee of service providers, government agencies, and people who have experienced homelessness, to guide the design of Alameda County's coordinated entry process. The committee developed and proposed the following set of guiding principles, which were used throughout the design process. These guiding principles, along with the initial coordinated entry design, were adopted by EveryOne Home's Leadership Board in June 2016 and can be found at <http://everyonehome.org/wp-content/uploads/2016/02/AC-CE-Initial-Design-final.pdf>~~

~~Housing First and Low Barrier: The CE system and all programs within it will use a housing first, low barrier approach focused on ending homelessness for each household as quickly as possible.~~

Access:

- ~~• CES will be easily accessible throughout the county, with multiple entry points: potentially will include in person, phone, internet or app, etc.~~
- ~~• CES will include outreach so people least likely to seek services independently have access to the resources of the system.~~

~~Standardized Process: Every CE point will screen, assess, and refer clients with standardized protocols using standardized tools and processes.~~

Respect for Clients and Confidentiality

- ~~• Information will be collected in a respectful, strengths-based and trauma-informed manner.~~
- ~~• The number of times people have to repeat their stories will be limited as much as possible.
 - ~~○ Tools and decision/referral processes will require only as much information as is needed to assist or refer clients at that point.~~
 - ~~○ With client consent, information will be shared within the system.~~~~

- Client choice and the client's service and personal network will inform options for services, housing, and referrals.

Referral Processes

- Referrals will be based on meeting the clients' housing and service needs, in addition to ensuring efficient utilization of available resources.
- Clear referral and handoff protocols support both the service providers making and receiving the referral.
- Programs will only take individuals or families into their program through CE under established eligibility criteria, and not from alternate sources (except in specific, defined circumstances).
- As much as possible, waitlists will be avoided.

Services for those who are Literally Homeless (or would be that night)

- Entry into services and housing intended for those who are homeless will go first to people sleeping in places not meant for human habitation and those with no safe indoor place to stay that night. No one should have to sleep outside first to become eligible for initial housing support services.
- For those who are literally homeless, resources that are more intensive or of longer duration will be targeted to those with the highest needs.
- Programs will follow a progressive approach to service delivery, matching the level of service intervention to the level of client need to resolve their housing crisis. Assessment is ongoing and more intensive services will be offered as needed. Clients can opt for less intensive support than what is offered.

Housing Problem Solving (Prevention) for those Not Yet Homeless: People not yet homeless will be provided support and problem solving services to avoid becoming literally homeless whenever safe.

Links to Domestic Violence Services: Throughout the system, safety Screening and links to domestic violence services will be integrated.

CE Management, Oversight, & Evaluation

- Resources will be allocated to ensure the coordinated entry system is managed, well-coordinated, and continually improving. Data will be used to assess the impacts and outcomes of the system to inform changes.
- Stakeholders — including service providers, funders, and people with lived experience of homelessness — will have an ongoing role in the oversight and refinement of the Coordinated Entry System.

3. The Steps of Coordinated Entry: Screening, Assessment, Prioritization, and Matching

At the heart of Coordinated Entry is a standardized process and shared set of tools for Screening, Assessment and Prioritization. Each of these steps plays a critical role in connecting clients to the assistance needed to address their housing crisis. More specifically:

- An immediate Health and Safety Screening identifies any crisis health or safety needs and, if there is a health or safety emergency, ensures an immediate connection to the appropriate emergency response (e.g. police, hospital, DV services, etc.)
- A brief Housing Crisis Screening confirms that the household lives in Alameda County, and whether they are literally homeless² (and should be referred for full Assessment and additional assistance Housing Resource Centers), or if they are not literally homeless (and should be offered Housing Problem Solving and referred to other mainstream and prevention services outside the HRC).
- A Housing Problem Solving (HPS) conversation seeks to help all households (literally homeless or not) to identify and facilitate access to any alternatives to entering shelter or seeking homeless services.
- A full Assessment of homeless households, which allows Assessors to make an initial determination of a household's level of need.
- Prioritization, an automated process that generates a list of homeless households seeking assistance, ranked in order of priority for housing assistance.
- The Matching process, through which any available housing resources are offered to eligible households in order of highest priority.

These steps are progressive in nature, such that not all households will complete all the steps if they are not eligible to receive services or if housing alternatives are identified through problem-solving. However, the steps are continuous, such that – for any client that consents to share their information - the information gathered in one step informs the next and does not have to be repeated.

Alameda County's Coordinated Entry process is designed to facilitate immediate and easy access for the County's most vulnerable residents, and to meet them "where they're at." Thus, a client can access the system through various means, including:

- A 24-7 Call Center;

² "Literally homeless" refers to Categories 1 and 4 of the definition of homelessness used by the U.S. Department of Housing and Urban Development, in which Category 1 includes people living on the streets, in emergency shelter or transitional housing, in a place not meant for human habitation, or in an institution where they have resided for fewer than 90 days and before which they were literally homeless, and Category 4 refers to people who are fleeing domestic violence.

- Street-level outreach teams; and
- Walk-in services at some regional Housing Resource Centers, on a limited basis.

Regardless of where a client is screened and assessed, the process by which that person is screened, assessed, prioritized, and matched to available housing resources is the same. This section of the manual focuses in on how each of these key Coordinated Entry Process steps happens.

The next section (4: The Structure and Components of Coordinated Entry) maps out where these services happen, focusing specifically on the specific roles that the Call Center, the Outreach Teams, and the Housing Resource Centers play to ensure that the County’s highest need homeless residents can access the housing and services that they need. These access points are summarized in the table below. For additional information on the structure and geography of the Coordinated Entry process, refer to Section 4.

ACCESS POINTS	Health and Safety Screening	Housing Crisis Screening	Housing Problem Solving	Assessment	Prioritization and Matching
Call Center	X	X	X		
Outreach	X	X	X	X	
HRC	X	X	X	X	X

3A. Initial Screening

The initial Screening, sometimes referred to as “triage,” consists of two important steps:

- A Health and Safety Screening that identifies if someone needs emergency medical care, domestic violence services, or assistance from law enforcement; and
- A Housing Crisis Screening that determines if someone is living in Alameda County and if they are literally homeless or not.

Health/Safety Screening: Anyone seeking housing assistance is screened immediately for health and safety needs. This Screening can be conducted on the phone (by trained Call Center Operators) or in person (by Outreach Workers or, if an HRC is allowing walk-in visits, an HRC Assessor).

Any staff person conducting the Health and Safety Screening must:

- Explain the Screening process to the individual or household;
- Determine through a scripted set of questions if the person needs immediate medical attention or the assistance of law enforcement and, if so, connect them immediately through to 9-1-1. Inform the client that they can seek housing assistance once their immediate crisis is resolved.
- Determine through a scripted set of questions if the person is fleeing domestic violence or seeking services for domestic violence, dating violence, sexual assault, stalking, or other related dangerous conditions, like human trafficking (referred to throughout as “DV services”). If so, inform the client that Coordinated Entry offers the the option to seek housing assistance through the housing crisis response system as well as through the DV services system, depending on their choice. If the client chooses to access services through the DV system, connect them immediately to the appropriate regional DV hotline and inform the client that they can seek housing assistance again through the housing crisis system at their discretion. If the client chooses to continue accessing services through the housing crisis system, special attention should be paid to inform the client of the risks, benefits, and protection policies for sharing their private information and protecting their safety.
- For clients that choose to access services through the DV system, DV-specific providers will conduct the rest of the Assessment and Prioritization process and assist with safely connecting the client back to the housing system if they are matched to housing resources. For more information about the DV-specific Screening, Assessment and Prioritization process, please refer to Sections 3D: *Special Considerations in Screening and Assessment* and 3G: *Special Considerations in Prioritization and Matching* at the end of this section.
- If the client is not in immediate danger and chooses to access services through housing crisis system, proceed to the Housing Crisis Screening.
- If the Health and Safety Screening is conducted through the Call-Center, track the volume and disposition of all calls for evaluation purposes.

Housing Crisis Screening: Anyone seeking housing assistance who does not need immediate medical care, police assistance, or DV services will proceed to the Housing Crisis Screening. This Screening can be conducted on the phone (by trained Call Center Operators) or in person (by Outreach Workers or, if an HRC is allowing walk-in visits, an HRC Assessor).

Any staff person conducting an Initial Screening must:

- Explain the Screening process to the individual or household;
- Obtain Release of Information (verbal if via phone or written if in person) to collect and enter data;
- Confirm that the client is residing in Alameda County. If not, refer them to the 2-1-1 or Coordinated Entry in the County in which they reside.

- Confirm, to the greatest degree possible, that the person is literally homeless by asking a set of scripted questions that speak specifically to the homeless definition.
- If the client is not homeless, initiate the Housing Problem Solving conversation (described below) and refer the client to other resources available to them, such as eviction prevention services, housing workshops, legal assistance, income/benefits advocacy, food programs, and other mainstream services.
- If the client is homeless, refer them to mainstream resources and to the appropriate regional HRC for Housing Problem Solving, Assessment, and connection to other mainstream resources.
- Complete the Screening Form in HMIS, indicating the outcome of the Screening and, if applicable, the HRC to which the client was referred.

3B. Housing Problem Solving

Anyone seeking housing assistance via the Coordinated Entry process – whether or not they are literally homeless – will receive Housing Problem Solving assistance. Housing Problem Solving is a strength-based approach, with the goal of supporting households who might be able to solve their housing crises more quickly by using their own support networks and/or other mainstream resources rather than having to wait for shelter or other homeless services. Housing Problem Solving is not intended to screen homeless people out, but to identify and pursue any and all opportunities to resolve their current housing crisis as quickly as possible, and to maximize the number of people who can be served with limited homeless resources.

Housing Problem Solving conversations can be conducted on the phone (by Call Center Operators) or in person (by Outreach Workers or an HRC Assessor). All staff members conducting Housing Problem Solving will have undergone thorough training to ensure consistency of approach, familiarity with the HPS conversation guide, and the ability to identify creative and flexible options for crisis resolution.

All staff members conducting Housing Problem Solving conversations will use a structured conversation guide, which includes suggested questions and themes to explore, such as:

- What type of assistance the household is seeking,
- Where they are currently staying and why they have to leave,
- Whether there are other safe places for them to stay and what those other places are,
- What it would take to remain where they are currently staying or have stayed in the past,
- Whether they have sufficient financial resources to stay where they are, and/or
- What they plan to do if they do not receive additional assistance.

This intervention is intended to explore all possible avenues for getting or remaining housed, encourage problem-solving and conflict resolution whenever possible, and offer support with respect to any options or solutions that arise from the conversation. However, this step is not intended to delay assessment or assistance, and those living on the street may engage in this conversation rapidly and move quickly to the Assessment.

Staff conducting problem solving will offer support with family/friends and/or landlords if the potential to preserve a current situation or renew a previous one is deemed possible, including referral to mediation services.

In some cases, and only if such resources are available, the staff person may be able to offer modest financial means to support a potential solution, such as grocery gift cards that will resolve a roommate conflict or payment of utility arrears that are preventing someone from moving into a new unit.

Upon completion of the Housing Problem Solving conversation by the Call Center if the housing crisis was not resolved or averted, and the client remains or has become homeless, the client is referred to the closest HRC for an Assessment. If Outreach has a HPS that does not resolve the situation, that worker can proceed with an Assessment.

All HPS conversations conducted by Call Center Operators, Outreach, or HRC Assessors are tracked in HMIS as notes, in which the person guiding the conversation provides a brief description of the content and result of the conversation. Housing Problem Solving may be revisited periodically or after the Assessment. There is no limit to the number of times a client can receive Housing Problem Solving conversations, however there may be a limit on funds available to support a client or household.

3C. Assessment

The purpose of Assessment is to determine the extent of a household's need for assistance and the types of services that they might need, and to begin to gather basic eligibility information for matching. Assessments are conducted in person or by phone, by Assessors at each HRC and Outreach Workers in the field. Ideally, Assessments are conducted in locations that are safe, private, and confidential to allow for clients to discuss sensitive information, but it is understood that some field-based Assessments will take place in locations that may be public (e.g. parks, libraries, coffee shops, etc.). In these cases, it is the responsibility of the Assessor to ensure confidentiality and privacy to the greatest degree possible. All questions and instructions are designed to work for people of various developmental capacities.

To complete an Assessment, Assessors take the following steps:

- Explain the Assessment process to the client, including the types of questions asked, the approximate length of the Assessment, the factors that inform Prioritization, and what happens after the Assessment.
- Conduct a search in HMIS for the client's record, import information already gathered from the Screening, and initiate the Assessment process.
- Guide the client through the Assessment questions and ensure that the Assessment Form is completed and entered into HMIS.
- When the Assessment is complete, HMIS will generate a Prioritization script to be discussed with the client. The script is intended to inform the household of housing resources that are immediately or imminently available to the client and, if none are immediately available, to connect the household with other needed services.
- Ensure that the client provides at least one means of contacting him/her in the event that s/he is matched to a housing resource.
- Refer the client to services that s/he can access immediately, such as housing workshops, income/benefits advocacy, food programs, and other mainstream resources.
- If possible, complete a homelessness verification to expedite enrollment into other programs.

Neither the Assessor nor the client is provided with the numerical score to which their Prioritization correlates. The score is deliberately obscured in order to ensure that the Assessment is administered and the questions are answered in as objective and unbiased a manner as possible.³

Updating Client Records and Score Adjustments: At any time during the Assessment, or any time thereafter, a client or any provider licensed to update client records is expected to update information that may affect the assessment score. For example, information about duration of homelessness or previous episodes of homelessness may change the score and thus qualify a participant who did not self-report those things. If third party supplemental information is provided, the scores from the supplemental information are recorded and any additional points added to create a new score.

If at any time while being assisted, a client experiences or discloses domestic violence, sexual assault, stalking or trafficking, Coordinated Entry staff will inform the client of their option to seek housing and DV services through the DV system and assist them to evaluate what changes, if any, are needed to

³ It has been demonstrated with other similar Assessment processes that people being assessed and/or people conducting Assessments ask and answer questions in a biased fashion once they learn that certain answers correlate to specific scores and, by extension, particular outcomes or benefits. Removing the numerical score reduces the level to which such bias is introduced into the Assessment process.

protect their safety and confidentiality within the housing crisis system. This procedure will be governed by the Coordinated Entry Release Of Information, and will include options to de-identifying or remove their HMIS record. Consent to share a client's information, can be rescinded at any time by the client.

Ensuring Access and Fairness in the Assessment Process: The Assessment process is designed to ensure universal access and fairness for all households seeking assistance, including people living with disabilities; people facing linguistic or cultural barriers to assistance; and vulnerable populations. All people undergoing the Assessment should be treated equally and proceed through the same process, regardless of where they seek services, and irrespective of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual identity, or gender identity. The only exceptions to the Assessment process are made as reasonable accommodations for people living with disabilities, to overcome any barriers associated with those disabilities. For additional information about the measures taken to ensure fairness in the Assessment process, and universal access to the CES more broadly, please refer to Section 5: *Ensuring Universal Access to Coordinated Entry*.

Appealing the Assessment: All clients have the right to appeal their Assessment score if they believe that the process was unfair or that they were not assessed properly due to missing or erroneous information. As part of that process, participants are welcome to bring an advocate or supportive person with them, the Assessment is re-administered, and clarification of the participant's responses to the Assessment may be offered. For more detail about Appeals, please refer to the Section 5H: *Grievances and Appeals*.

3D: Additional Considerations for Screening and Assessment

In some cases the process of Screening and Assessment is conducted slightly differently, in order to ensure the safety, privacy, and/or preferences among certain populations with barriers to housing. Those situations are described below.

Screening and Assessment for People Fleeing DV

In order to ensure safety, confidentiality and access to well-trained DV services, Alameda County's Coordinated Entry process offers any household fleeing domestic violence the option to connect immediately to the appropriate regional domestic violence provider. Each regional DV hotline is available on a 24-7 basis.

Once a household's immediate safety and DV-related needs are met, it is the responsibility of the DV provider to conduct the remaining steps of the Coordinated Entry process described above, including the Housing Crisis Screening, Housing Problem Solving, Assessment, and connection to DV shelter or DV-specific transitional housing. If there are no DV housing resources available in a region in which a household fleeing DV is seeking services, the regional DV providers will coordinate to connect that household to available resources in another region and/or back to the HRC if safe for the client and with her/his consent.

Consistent with the Violence Against Women Act, client level data for people fleeing domestic violence is not entered into the HMIS system. It is the responsibility of the DV provider to ensure that any household fleeing domestic violence is also given the option to access the non-DV-specific services offered at the HRC if they prefer, and to inform the household that non-DV-specific programs do not have the same prohibitions on collecting HMIS data.

Screening and Assessment for Veterans

Veterans in Alameda County can access the Coordinated Entry process through the same channels as any other household, and there is no "separate door" for veterans. However, because Alameda County has a range of veteran-specific providers and a coordinated initiative (Operation Veterans Home) to house homeless veterans, the County's Coordinated Entry process leverages those veteran-specific resources to maximize the ability of veterans to access services. More specifically, the OVH outreach team (like other outreach teams) is trained to perform Screening, Housing Problem Solving and Assessment for any veterans that they contact through their outreach. Any veterans engaged through this means are screened and assessed with the same tools as non-veterans, and prioritized and matched according to the same County priorities. Veterans are not required to access Coordinated Entry through the OVH team, and can work with other outreach workers as preferred, or utilize the Call Center.

Screening and Assessment for Young People

Homeless young adults are screened and assessed in accordance with the standard process described above. In Oakland, age-appropriate Assessors will conduct these steps for any young person who prefers to work with youth-specific providers, but the tools and process are the same. In other HRCs, a recommended best practice would be to hire staff representative of the population including the diversity of culture, gender, and age.

3E. Prioritization

The purpose of Prioritization is to assign each household a level of priority for receiving limited housing resources, since housing resources are not yet to scale and all households cannot be served immediately. The households being matched to housing resources at any time are those who are most vulnerable and have the greatest barriers to housing.

People are not matched only to specific resources based on a score or prediction of what intervention will meet their needs. Consistent with the practice of dynamic and continuous prioritization, the highest-scoring households at any given time are prioritized for available housing resources. All homeless households regardless of priority are able to access basic housing services including housing workshops and housing problem solving.

All households are assessed with the same tool, which was designed to address factors across household types and subpopulations.

Factors that are weighted to form the score are listed in the following table:

Prioritization Tool Factors	
Household Characteristics	<ul style="list-style-type: none"> ● Children aged 5 or under ● Seniors ● Larger households ● Pregnant household member ● Youth head of household aged 18-24
Homeless History	<ul style="list-style-type: none"> ● Unsheltered ● In emergency shelter ● Episodes of homelessness ● Length of time homeless
Housing Barriers	<ul style="list-style-type: none"> ● Time since last held a lease ● History of eviction ● History of incarceration/law enforcement involvement ● Income
Vulnerability	<ul style="list-style-type: none"> ● Emergency service utilization ● Functional impairment/disability ● Life-threatening illnesses or acute medical conditions ● Unsafe or risky survival strategies ● Households whose members have run away from home ● Chronic homelessness

The tool is designed to weight these characteristics so that people with the greatest number of vulnerabilities and barriers receive the highest scores. Histories of homelessness and significant housing barriers are strongly weighted. The tool has been tested to ensure that it creates a normal distribution, and that scores are not biased based on race, ethnicity, gender, age, or other protected classes.

People with disabilities are never denied access to resources because of their disabling conditions. Rather, people with disabilities are prioritized for resources. The Assessment process does not require disclosure of a specific disability or diagnosis. Such information can only be obtained for the purposes of determining program eligibility and making appropriate matches.

Information about the specific weights associated with factors is generally not distributed to ensure accuracy and eliminate any false expectations among clients or service providers about what resources a household might be eligible to receive. Evaluation of and adjustments to the relative weights of scoring factors may be proposed by the ILCs and System Coordination Committee at least annually and adopted

by the Leadership Board to ensure an appropriate distribution and/or more appropriate matches to the system’s resources.

Housing resources are mostly prioritized regionally through the Housing Resource Centers, although there are the following exceptions, each of which is described in greater detail at the end of this section.

- Permanent Supportive Housing is allocated to the highest-need homeless people on a county-wide basis through Home Stretch.
- Transitional housing for transition-aged youth (TAY) is allocated on a county-wide basis with regional preferences.
- Winter/inclement weather shelter beds and drop in center services are not subject to the Prioritization process.

The following table summarizes how different housing resources are prioritized for allocation.

	Year-Round Shelter Beds	Transitional Housing	Rapid Rehousing	Permanent Supportive Housing/ Home Stretch
Assessment Score	Full score, highest priority	Full Score, highest priority	Full Score, highest priority	Full Score, highest priority
Eligibility (All eligibility and program criteria must be submitted and approved by EOH and funder/contracting agency. Through that process, programs will be required to explain any additional eligibility or program criteria.	Literally Homeless (Category 1 or 4); Meet household type for shelter	Literally Homeless (Category 1 or 4); Meet household type for program	Literally Homeless (Category 1 or 4); Meet household type for program; Informed consent to work on housing stability services	Literally homeless (Category 1 or 4); Disabled
Other	HRCs supported by Outreach to fill beds	Client choice to enter TH rather than RRH	The household must also provide informed consent, confirming that the resource is “realistic” prior to enrollment. Overwrites former policy of at least 1/3 of beds not dedicated to specific populations must be allocated to	High priority non-VA eligible Vets will get priority

			chronically homeless	
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Implementation will be monitored and adjusted to ensure it is having the intended results.

3F: Matching

As housing resources become available, the households at the top of the list as high priority are evaluated for eligibility and matched to those available resources in order of priority, and the resources are offered to the households. The process for Matching will vary slightly for each housing resource (shelter, housing navigation, transitional housing, rapid rehousing, and permanent supportive housing) however, each will follow to the same basic approach:

- HRCs, Home Stretch, and all receiving programs will identify an efficient process by which vacancies are identified and filled. This step may eventually occur in HMIS but, until the HMIS is capable of this, sharing information on vacancies will happen through as much of a “real-time” process as is possible.
- Upon notification of an actual or pending available resource, the HRC or Home Stretch is instructed to identify an eligible household for Matching, using a by-name list of homeless households in prioritized order and sorted by housing resource.
- The HRC or Home Stretch filters the list according to eligibility criteria and other restrictions, and identifies the first household that can be matched to the resource.
- If more than one household is eligible for and prioritized equally for the resource, HRCs or Home Stretch will offer the resource first to the person whose Assessment date is the oldest or use information from its regular case conferences to determine which household should be prioritized.
- HRCs, Outreach, and Home Stretch will work together to contact a household and to offer them the resource according to the specific protocol for the housing resource available. HRCs, Outreach, and Home Stretch staff will record in HMIS each attempted contact.
- If the household cannot be contacted, HRCs and Home Stretch will offer the resource to the next highest prioritized household, according the specific time-frames and protocols determined for each housing resource. For example, HRCs and Outreach are expected to fill shelter beds on the same day, while Home Stretch will use a different time-frame to fill permanent supportive housing.
- If the household can be reached, the HRC Assessors will explain the resource that is available and what the program may expect of them, answering any questions that the household has, confirming that the household’s homeless status has not changed, and offers them the resource. If the household declines, the Assessor enters that information into HMIS and proceeds with the next prioritized household.

- If the household accepts, the Assessor must make their best attempt at verifying the household's homelessness at this time.
- The household is then matched directly to the housing/service provider whose program has a vacancy/open slot according to the specific protocols for the housing resource available. It is the shared responsibility of the HRC and the receiving program to achieve a successful match and enrollment, and "real-time" communication to the greatest extent possible is expected.
- Staff of the program to which the household was matched must document in HMIS or the alternative interim system the reason for refusing a match made by the HRC. Refusing a match must be rare and generally limited to reasons such as: the household was not homeless; household could not produce eligibility documentation in a reasonable timeframe; household exceeded income maximums; or household size could not be accommodated/was different from what was shared with the HRC.

3G: Additional Considerations for Prioritization and Matching

In certain cases, the processes of Prioritization and Matching is conducted slightly differently, either to ensure access for a population with specific barriers to housing, or to ensure equitable distribution of certain unique resources. Those processes are described below.

Prioritization and Matching for People Fleeing DV

Similar to the process of Screening and assessing, the process of Prioritization and Matching housing resources for DV survivors may occur through the regional DV hotlines and providers, not the regional HRC. If there are no DV resources available in a region in which a household fleeing DV is seeking services, the regional DV providers will coordinate to connect that household to available shelter or transitional housing in another region.

Consistent with the Violence Against Women Act, client level data for people fleeing domestic violence is not entered into the HMIS system but is entered into a comparable data system.

Survivors of domestic violence are entitled to access any of the non-DV-specific resources for which they are eligible at the HRC, and it is the responsibility of the DV provider to ensure that any household fleeing domestic violence is also given the option to access the services offered at the HRC if they prefer. It is also the responsibility to inform the household that non-DV-specific programs do not have the same prohibitions on collecting HMIS data.

If at any time while being assisted in non-dv services or housing, a client experiences or discloses domestic violence, sexual assault, stalking or trafficking service providers will refer them to DV services, and help them to evaluate what changes if any are needed to protect their safety and confidentiality including deidentifying or removing their HMIS record and relocating housing or services.

Prioritization and Matching for Permanent Supportive Housing (Home Stretch)

Subject to the terms of operation of HCSA/Home Stretch MOU

Prioritization and Matching for Rapid Re-Housing

Any vacancy in a Rapid Re-housing program is matched regionally, to the highest-priority household, and in accordance with any applicable eligibility restrictions associated with the funding source.

This Prioritization policy was crafted with the County's commitment to prioritizing the most vulnerable households for housing resources. However, it is acknowledged that there is a risk associated with Matching high-need households with limited-term resources like Rapid Re-Housing. The following measures are designed to mitigate this risk:

- Any client or household referred to Rapid Re-housing must be willing to create a housing plan and take reasonable steps toward accomplishing goals in the plan. The household must also provide informed consent, confirming that the resource is "realistic" prior to enrollment. Any provider that enrolls a client who matched to a Rapid Re-housing resource must confirm that this informed consent as part of the enrollment process.
- Providers must identify and execute a support services strategy for achieving the goals in the housing plan.
- Households who are matched to Rapid Re-housing are not guaranteed placement in Permanent Supportive Housing upon exit from Rapid Re-housing, but any high-priority client who is enrolled in Rapid Re-housing retains priority and his/her place in the Home Stretch queue. If, upon reassessment at the 6-9 month mark, a household enrolled in Rapid Re-Housing does not seem likely to successfully transition off the subsidies and likely requires PSH, the provider can initiate the process of connecting them to PSH.

Prioritization and Matching for Housing Navigation

Among the resources to which clients will be matched is Housing Navigation, which is also prioritized for the highest-need households. When a household is matched to Housing Navigation services through the

Prioritization and Matching process, they will be assigned a Housing Navigator. Housing Navigation funded by Alameda County Care Connect requires additional verification of eligibility. The Housing Navigator is responsible for helping clients to locate and secure housing, and providing advocacy, guidance, and support throughout the process.

Prioritization and Matching for Transition-Aged Youth (TAY)

The County's Prioritization tool has been designed and tested to ensure that vulnerable young people can access the housing and services available to them, including both TAY-specific resources as well as resources for adults and family. As such, the process for prioritizing TAY does not differ substantially from that for non-TAY populations, except that (unlike other transitional housing) transitional housing for TAY is allocated County-wide with a regional preference, such that a TAY-specific transitional housing bed will be offered first eligible young person in the region where the TH bed is located or which HRC the young person is affiliated, and then to eligible young people countywide.

In addition, transition-aged youth are not prevented from accessing services that are not TAY-specific. For instance, if there is a vacancy in a rapid re-housing program and, in the process of Matching to that vacancy, the highest priority match is a young person, s/he must be offered that resource even if it is not TAY-specific. In that case, it is the responsibility of the Assessor to explain that the match offered is not TAY-specific, and that the young person is entitled to decline the resource in favor of one that is TAY-specific, but that a TAY-specific match may not be readily available.

Prioritization and Matching for Year-Round Shelter Beds

The County's process for prioritizing and matching year-round shelter beds is designed to both ensure that these beds are available to the highest priority, most vulnerable homeless residents and that they do not sit vacant excessively if the highest priority households cannot be located. The process for matching year-round shelter is as follows:

- Year-round emergency shelter beds are allocated regionally to the highest-need homeless people.
- Each working morning, HRCs determine how many shelter beds are available within the region.
- HRC's fill open shelter beds using a by-name list of assessed and prioritized individuals and families.
-

- If beds are available, the HRC attempts to locate the highest-priority people on that list, working their way down , to offer as many of the beds as possible to the highest priority households.
- If needed and available, outreach staff will support HRCs to identify, contact, locate, engage, and transport clients.
- Anyone who accepts a year-round shelter bed will be allowed to stay in that bed until they are housed provided they are working on their housing plan per a monthly review.

Prioritization and Matching for Seasonal Beds: The County’s seasonal shelter beds (i.e., winter shelter beds or those open during inclement weather) are offered to anyone seeking a bed on the nights that they are available and subject to the terms of their operation.

Prioritization and Matching for BHCS Shelter Beds: [Section Pending: TBD, subject to the terms of operation of BHCS agreement]

Prioritization and Matching for Medical Respite Beds: [Section Pending: TBD, subject of the terms of operation of Medical Respite agreement]

Short-Term Transitional Housing Matching: [Transitional Housing beds will be filled by high priority literally homeless persons. The mechanics of matching prioritized households to openings is to dependent of discussion in ILCs and collection of eligibility and program criteria]

4. Structure and Components of Coordinated Entry

The County’s Coordinated Entry process has been designed to ensure that the County’s most vulnerable homeless residents can be connected to available housing resources and that, when seeking assistance, they encounter as few barriers as possible. This section describes the steps that someone seeking assistance will take – and the steps that Coordinated Entry staff will take to engage them – in order to connect to the resources they need.

County residents experiencing a housing crisis can access the Coordinated Entry system through three channels:

- By phone, through the Countywide Call Center;
- In the field, by engaging with one of the regional Outreach teams; or
- In person, if and when walk-in services are offered at a regional HRC.

[INSERT SMALL/SIMPLIFIED VERSION OF FLOW CHART TO SHOW ACCESS TO SYSTEM]

4A. Countywide Call Center

Many people seeking assistance will contact the Call Center as a first step. The Call Center will be staffed with operators trained to conduct Screening and Housing Problem Solving with callers, and to refer callers to appropriate Housing Resource Centers, mainstream providers, and other emergency and non-emergency services that they need. The Call Center provides 24/7 availability, technology for handling a high volume of calls, and significant language capacity.

Core functions of the Call Center include:

- **Safety/Emergency Referrals:** The first step for Call Center Operators is to screen for health and safety and, for any caller in immediate danger, to make an immediate connection to the appropriate emergency assistance. Callers fleeing DV are referred to the regional DV hotline for immediate assistance, and callers experiencing a medical emergency or other safety threat will be referred to 9-1-1. If there is an imminent threat to the client or to others, the Operator may call the police.
- **Initial Screening:** If there is no health or safety concern, the Operator conducts a brief Initial Screening to determine whether the caller lives in Alameda County and is literally homeless. Residents of other counties are referred to that County's 2-1-1 or Coordinated Entry. All Alameda County residents who are not literally homeless receive Housing Problem Solving assistance and are referred to prevention and mainstream services. Those who are homeless are referred to the regional HRC. A more detailed description of the Initial Screening is included in Section 3A: *Initial Screening*.
- **Housing Problem Solving:** For all callers who live in Alameda County, operators conduct a Housing Problem Solving conversation to explore any options and or avenues that might resolve someone's housing crisis more quickly than the Coordinated Entry process. A more detailed description of Housing Problem Solving is included in Section 3B: *Housing Problem Solving*.
- **Warm Hand-Offs to Housing Resource Centers:** If a caller is homeless, the Operator transfers the caller to the appropriate HRC for a full Assessment. Whenever possible, this transfer should be a "warm hand off" in which the Operator makes a live transfer to one of the regional HRCs. The ability to make a "warm hand off" will be determined by call volume and HRC staffing levels, the intention is for the Call Center to at least make the attempt

while they have the caller. Determination of which HRC is appropriate is based on a series of brief questions about the person's current whereabouts, any employment, education or service connections, and any specific needs to NOT be referred to specific areas.

- **Data Entry:** Call Center Operators are responsible for tracking the volume and disposition of all calls that they receive. For any calls that move past the Safety Screening, they are also responsible for completing the Housing Crisis Screening Forms in HMIS on a live-time basis, to create an initial HMIS record that will enable tracking.
- **24-7 Coverage:** Call Center Operators are available on a 24-7 basis to conduct the Screening process and provide and emergency/safety referrals to callers.

Furthermore, a sample of calls will be recorded for quality assurance and reviewed annually by Implementation and Learning Communities or System Coordination Committee, and a sample of callers will have the opportunity to respond to caller surveys and other means of expressing satisfaction and providing feedback about their experiences using the Call Center.

4B. Outreach

Outreach services are a critical tool for engaging the most vulnerable homeless people into Coordinated Entry and the larger system of care. Focused primarily on unsheltered individuals who are living in places not meant for human habitation, outreach workers seek to establish trust, build rapport, and cultivate relationships with people who have multiple barriers to services to work in partnership to rehouse them. Our outreach teams are trained to “bring the front door” to homeless people who need additional support in receiving care, and to perform all of the key Coordinated Entry functions (Screening, Housing Problem Solving, Assessment, and Prioritization) in the field, rather than requiring clients to travel to a service site.

Outreach services are primarily field-based. In small teams that typically consist of 2-3 people, outreach workers approach people experiencing homelessness in encampments, parks, vehicles, and other places not meant for human habitation. Outreach is conducted on a varying schedule that includes early mornings, weekends, and evenings and is otherwise not limited to standard business hours. Outreach workers focus initially on meeting the immediate needs expressed by the individuals encountered, which may include food, hygiene supplies, clothing, medical care or other items, as well as offering information about available services. The larger goal is to gradually establish sufficient trust through regular outreach encounters to engage clients into the Coordinated Entry process so that they can be connected to housing and care. The standard is to have sufficient countywide geographic coverage with teams that are closely tied to the HRCs and not population-specific.

Core Outreach services include:

- Building trusting relationships and rapport with participants through regular, consistent, nonjudgmental and compassionate contact;
- Relying upon harm reduction and motivational interviewing to help participants establish priorities and start to think about steps that they feel ready to take;
- Conducting field-based Screening, Housing Problem Solving, and full Assessments for access to the CE process;
- Conducting targeted outreach to individuals prioritized for engagement who are highest on any given list;
- Reaching out to and engaging clients who, after Assessment and Prioritization, are matched with a housing resource but could not be initially contacted by HRC staff and, via warm hand-off, connecting them directly to either the HRC and/or the program offering the match to begin enrollment;
- Offering immediate and emergency support for participants' most pressing needs, including food, clothing, transportation, medical care, etc.;
- Providing crisis intervention support for participants who have experienced violence on the streets; when there is a death or other traumatic event; when encampments are swept or destroyed; and when they need support with criminal justice matters;
- Connecting participants to public benefits, mainstream resources, health care, legal assistance, and other services that they may need;

Outreach teams support clients with whatever it takes to access housing assistance, including conducting regular follow-up as the client waits for a housing opportunity post-Assessment, connecting them to emergency shelter when appropriate, engaging with HRC staff to explore short-term housing options, and/or, when the time comes and a housing opportunity is available, working in partnership with the HRC to notify and engage the participant and make a warm hand-off to the service provider(s) associated with the housing opportunity.

Although the outreach teams affiliated with different HRC's may vary in terms of schedule, staff composition and other factors, outreach services are closely coordinated across HRC's to ensure that services are consistent, the system has full geographic coverage, and that outreach workers are providing equitable access to the HRC for all county residents. Outreach services affiliated with the HRCs will be coordinated with other County outreach teams through formal coordination meetings.

5C. Housing Resource Centers

The County's Coordinated Entry process is organized around five regional Housing Resource Centers (HRCs) that together provide full coverage of the County's geography. Each HRC serves as a hub from which housing resources and assistance are deployed, and the as the administrative home of key Coordinated Entry staff, including outreach teams and trained Assessors. Although some HRCs have limited walk-in capacity, they are not designed as drop-in service centers. Rather, HRC staff are tasked with "bringing the front door to the clients" by conducting extensive street-level outreach and offering field- and phone-based Screening, Assessment, Prioritization, and referral services.

Consistent with the goal of serving the County's most vulnerable residents, the HRC's are intended to serve only those households who are literally homeless or are fleeing domestic violence. Because most people who are not literally homeless will access Coordinated Entry through the Call Center, it is expected that they will be screened and referred to homelessness prevention, housing workshops, and other mainstream resources rather than to the HRC. If a household that is not literally homeless happens to drop-in at one of the HRCs, an HRC staff person will direct them to the Call Center, where they will be connected to the appropriate prevention and mainstream resources.

Geographic Coverage: The Housing Resource Centers are listed below by region and, together, provide coverage for the entirety of Alameda County.

- North County/Berkeley: Provides coverage for adult-only households in Berkeley, Albany, and Emeryville.
- North County/Oakland: Provides coverage for adult-only households in Oakland and Piedmont, and (through the North County Family Center) families in Oakland, Berkeley, Emeryville, Piedmont, and Albany.
- Mid-County: Provides coverage for Hayward, Alameda, Castro Valley, San Leandro, San Lorenzo and other western unincorporated areas.
- South County: Provides coverage for Fremont, Newark, Union City, and southern unincorporated county.
- East County: Provides coverage for Livermore, Pleasanton, Dublin and eastern unincorporated county.

The HRC's are organized regionally to ensure accessibility by all County residents, as Alameda County is both large and geographically diverse. Rather than requiring households needing services to travel to an HRC site to engage in services, the HRC's are designed to reach out to clients, both by deploying outreach teams to locate and engage unsheltered people and by sending Assessors out to meet with homeless clients referred from the Call Center. Some of the HRC's will have limited drop-in capacity, but they are intended to serve primarily as the administrative base for staff whose work takes place primarily in the field. Some of the HRCs will have satellite locations with specific days/hours of operation.

Some of services provided by staff based at the HRC include:

Assessment: When someone is referred to a regional HRC for Assessment (as described in Section 3C: *Assessment*), they are connected immediately to an Assessor. At that time, the client can make an appointment for an in-person Assessment, or opt to complete the Assessment over the phone.

Housing Problem Solving: It is expected that many of the homeless households referred to the HRC may be determined eligible to receive shelter and/or housing assistance, but there may not be any slots immediately available. In those cases, Assessors are expected to engage in additional Housing Problem

Solving to identify any possible interim and short-term options that the household could explore until Matching to another housing resource.

Connection to Mainstream Services: Each HRC is responsible for connecting clients to appropriate mainstream resources within the region (or outside of the region, as needed), to help to address other service needs. It is the County's goal that no one will seek assistance from Coordinated Entry without receiving some immediate problem-solving assistance or access to services, even if they cannot be immediately matched to housing.

The mainstream services to which clients are referred will vary, depending on the needs identified and direct referral relationships or co-located services offered by each HRC. It is the responsibility of each HRC to maintain solid and collaborative relationships with providers of essential mainstream services and to clearly identify which services are Coordinated Entry services and which are referral or co-located services, which may include (but are not limited to):

- Mental and physical health providers;
- Alcohol and substance abuse treatment;
- SNAP benefits and food pantry services;
- Housing and tenancy workshops;
- Benefits advocacy;
- Adult education;
- Childcare and children's services;
- Eviction prevention and related legal services;
- Financial literacy and credit counseling; and
- Employment/Vocational programs including job training and job placement.

Prioritization and Matching: One of the primary responsibilities of the HRC's is to match clients to available resources when there are openings. Described in greater detail in Sections 3E: *Prioritization*, 3F: *Matching* and 3G: *Additional Considerations in Prioritization and Matching*, this process involves a designated HRC staff person generating the list of highest priority households when a housing resource becomes available; "Matching" the housing resource to the first eligible household on the list; then actively facilitating the connection between the high-priority household and the program to which they have been matched. If necessary, HRC staff can engage the assistance of HRC outreach workers to locate and engage a client that cannot be reached immediately.

Connection to Shelter: In accordance with the Prioritization and Matching process described in Section 3, HRC staff coordinate closely with regional outreach teams to connect high-priority households to emergency shelter beds.

Although the HRC's will operate primarily during standard business hours, any homeless households that contact the Call Center or engage with outreach workers outside of standard business hours will receive Screening, Housing Problem Solving assistance, referrals to other mainstream services, and the opportunity to make an appointment with an Assessor as early as the next business day and no more than 3 days later.

Movement between HRC's: All homeless clients will be assigned to one of the HRC's. This assignment will be based on where the client is experiencing homelessness or their housing crisis, as well as based on community connections identified by the client and/or locations that the client can or cannot safely live. Clients may not work simultaneously with more than one HRC. Outreach workers HRC's will look clients up in HMIS before referring them to or enrolling them at an HRC. [Section Pending: ILCs will develop and propose a transfer policy that is fair, consistent and preserves client choice]

Housing Education and Counseling: Each HRC can connect households experiencing or at risk of homelessness to Housing Education and Counseling services to which are focused on cultivating some of the skills needed to access and maintain stable housing. These services are intended primarily for people who need housing assistance but whose Assessment scores are not high enough to necessitate connection to a Housing Navigator or other more intensive housing supports. The HRC can support clients with making an appointment for housing counseling, hosting workshops, and otherwise facilitating that connection for clients.

Consisting of one-on-one assistance for housing seekers as well as regularly scheduled workshops and training modules, these services orient clients on how to search for appropriate housing options, low- and no-cost services available to reduce spending (such as PG&E Care Assistance), and how to advocate for themselves with landlords and property managers and with respect to their rights under the Fair Housing Act, the Americans with Disabilities Act, and other Federal, State, and local statutes.

Workshop and counseling sessions cover topics like:

- Online housing search assistance;
- How to complete housing applications;
- Housing Problem Solving;
- Tenancy skills and being a good neighbor;
- Fair housing and nondiscrimination basics;
- Renter rights and responsibilities; and

- Other topics as appropriate.

Participants in the workshops receive practical tools that can be applied to their housing search, such as sample rental applications, resume/cover-letter templates, budget forms, and updated lists of community resources. Counseling services providers will also offer these services periodically at emergency shelter and other programs. A sign-in sheet is used at every workshop to track attendance.

Housing Legal Services: Each HRC will offer referral to Housing Legal Services, which consist of training, workshops and one-on-one assistance. The workshops and trainings will cover a range of topics, such as:

- Tenant Rights and Responsibilities
- Understanding a Lease
- Addressing Housing Barriers
- Addressing Consumer Barriers
- Disabilities and Reasonable Accommodation

The workshops will be developed and offered in close partnership with the HRC Housing Education and Counseling services, and will be customized to address legal issues that pertain directly to the experiences of HRC participants. Limited one-on-one legal assistance may be available in some cases, to assist clients with resolving inappropriate denials of service; addressing violations of Fair Credit Reporting, Fair Housing, the ADA, or other discrimination laws; eviction defense; and other related issues.

5. Ensuring Universal Access to Coordinated Entry

Alameda County's Coordinated Entry process ensures universal access through a variety of measures, including:

- Affirmative marketing of the housing and services available to all eligible persons, including those who are least likely to access those services in the absence of outreach and support;
- Offering comprehensive geographic coverage for all parts of the County;
- Ensuring nondiscrimination in all aspects of Screening, Assessment, Prioritization, Matching, program operations, and service delivery;
- Ensuring and enhancing the ability of all service providers to effectively serve people living with disabilities and adhere fully to the Americans with Disabilities Act;
- Ensuring and enhancing the ability of all service providers to serve people with multiple barriers to services, including cultural and linguistic barriers, as well as other vulnerable populations;
- Maintaining a fair and transparent process by which clients can appeal provider decisions and/or file grievances that ensure that such concerns will be heard, considered, and resolved in a fair and timely manner.

Each of these means of ensuring universal access is described in greater detail below.

5A. Affirmative Marketing

The Coordinated Entry process – and the housing and services that can be accessed through that process – are affirmatively marketed to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identity, or marital status. More specifically, marketing will build on the networked model of the HRCS, and:

- The CES process and associated housing and services will be well-advertised through non-English and community-based newspapers and radio stations, by posting flyers at local businesses, community/neighborhood centers, faith-based institutions, and other places that serve communities in which English is not the primary language.
- Representatives of HRC staff, the Call Center, EveryOne Home and other stakeholders will make presentations at meetings of community and neighborhood groups, service providers, LGBTQ community groups, disability and other advocacy organizations, and other entities that work closely with a diverse group of members and clientele.
- Information about Coordinated Entry will be posted on the EveryOne Home website, offered to 2-1-1 callers, and posted on other community and provider websites and forums.

The Coordinated Entry process, and the housing and services associated with it, are affirmatively marketed to vulnerable subpopulations throughout the geography of the county, including people experiencing chronic homelessness, veterans, families with children, youth, and survivors of domestic violence, to ensure that they have fair and equal access. More specifically:

- Street-level outreach will be conducted throughout the County to engage people living in encampments, vehicles, and other places not meant for human habitation and conduct Screening and Assessments in the field.
- Representatives of HRC staff, the Call Center, EveryOne Home and other stakeholders will conduct outreach to and make presentations for organizations and institutions that specifically serve veterans, youth, survivors of domestic violence, including school districts throughout the County, all of the regional VA offices, the County Social Services Agency, Child Welfare offices, and other stakeholders who serve people experiencing housing crises.
- The Countywide Call Center will be widely advertised, with a focus on locations and formats most likely to reach vulnerable subpopulations, including service providers, community centers, faith-based institutions, food pantries, and other sites.
- Information about accessing Coordinated Entry will be readily available on the EveryOne Home website and with links on websites at other homeless-serving agency, local government websites, and legal assistance providers.

5B. Geographic Coverage

The CES is designed to serve the geographic entirety of the county, and to ensure that access to services is consistent and equitable, regardless of one's geographic location or the access point through which one seeks services. Some of the measures that the County has taken – and will continue to take, as appropriate – to ensure this access include:

- The County has adopted a “Networked Housing Resource Center” model that ensures full and consistent coverage across five regions.
- The process by which someone is screened, assessed, and prioritized for services is the same at all entry points, and there are standardized protocols for each step.
- All HRCs are well-served by public transportation, located near other useful amenities and service providers, and offer sufficient parking to facilitate access.
- HRC staff undergo rigorous training on an ongoing basis to ensure that Screening, Assessment, Prioritization, and access to services is consistent and equitable across all five of the HRCs.
- Monitoring and data quality reviews will be completed to assess geographic coverage and equitable access.

5C. Nondiscrimination

Coordinated Entry is designed to ensure universal and equitable access to all homeless people living in the County, irrespective of race, color, national origin, religion, sex, age, familial status, disability, actual

or perceived sexual identity, or gender identity. Some of the measures that the County has taken – and will continue to take, as appropriate – to ensure this access include:

- The CES process and Housing Resource Centers adhere to all applicable Federal, State and local nondiscrimination laws, including the Fair Housing Act; Sections 503 and 504 of the Rehabilitation Act; Titles VI, VII, and VIII of the Civil Rights Act of 1964; Title IX of the Education Amendments of 1972; and the Age Discrimination Act of 1975; the Drug Abuse Office and Treatment Act of 1972; the Comprehensive Alcohol Abuse and Alcoholism Prevention, Treatment, and Rehabilitation Act of 1970; Sections 523 and 527 of the Public Health Service Act of 1912; Titles II and III of the Americans with Disabilities Act; and any other nondiscrimination laws that may apply.
- None of the data collected during the Assessment process is used to discriminate or prioritize households for housing and services on a protected basis, except to the degree that program enrollment is allowed by Federal statute to limit enrollment (e.g. HOPWA programs can only serve people living with HIV/AIDS).
- Clients are not “steered” toward particular programs or neighborhoods based upon their race, color, national origin, religion, sex, disability, or the presence of children.
- The providers selected through the competitive bid process demonstrated full adherence to all applicable nondiscrimination laws.
- The County has a process by which anyone who believes that they were discriminated against or otherwise treated unfairly can file a nondiscrimination complaint or an appeal, as appropriate. For more information, please see the Section 5H: *Grievances and Appeals*.

5D. Serving Vulnerable Populations

Consistent with County priorities, CES services are affirmatively marketed and prioritized for people with other barriers to services who are less likely to be able to access services through other channels. More specifically, in order to ensure that the CES is accessible to people who are vulnerable or otherwise disconnected from care, the following measures have been taken:

- People do not need to navigate a complex process or jump through hoops to receive assistance. They can seek assistance in numerous low-barrier ways without preconditions: by calling the Call Center; by working with an outreach worker; and, when drop-in services are available, by visiting an HRC.
- The process is designed to prioritize for services those people with the greatest barriers to housing, the longest histories of homelessness, and the highest level of vulnerability. As such, prospective clients are not screened out or de-prioritized based upon perceived barriers related to housing or services, such as too little income, a history of or active substance use, a history of domestic violence, resistance to receiving services, extent of disability-related services needed, history of eviction, a criminal record, or other similar circumstances.
- All services provided throughout the Coordinated Entry process rely upon trauma-informed techniques to ensure that clients are not re-traumatized as part of seeking assistance. CE

staff receive thorough and ongoing training about providing trauma-informed care, domestic violence, stigma, and other topics that ensure that they can effectively serve vulnerable populations.

5E. Cultural and Linguistic Barriers

To connect people with linguistic or cultural barriers to services, these measures have been taken:

- Key written materials, including marketing materials, consent forms, Releases of Information, and others are available in multiple languages, including Spanish. Translation services make the information available in other languages such as Vietnamese, Tagalog, Cantonese, Mandarin, and others.
- The HRC's and affiliated providers will actively recruit multi-lingual staff when hiring for HRC positions.
- In the event that someone seeking services has limited English proficiency and there is no Assessor or other staff person who is able to communicate with them, the HRC will seek the services of a phone-based translation line to ensure that they are not denied services due to a linguistic barrier.
- All HRC staff will receive cultural and linguistic humility training as part of their larger training curriculum to cultivate greater sensitivity to, awareness of, and skills related to serving the diversity of life experiences presented by the people seeking services.

5F. People with Disabilities

Many of the people seeking assistance through the Coordinated Entry process will be living with physical and/or mental health disabilities. To ensure that people with disabilities have full access to the housing and services offered through Coordinated Entry, these measures have been taken:

- All of the sites of service provision associated with the Coordinated Entry process are fully ADA-compliant and accessible to people with mobility impairments.
- People with other disabilities seeking services are connected with the auxiliary aids and services needed to ensure clear and effective communication including, but not limited to, materials available in Braille, large type printed materials, assistive listening devices, sign language interpreters, and other tools.
- The Assessment process does not require disclosure of specific disability or diagnosis. Such information can only be obtained for the purposes of determining specific program eligibility and making appropriate referrals and matches.
- HRC staff are trained to provide reasonable accommodations as needed to better serve people with disabilities. Such accommodations could include, but are not limited to, actions like: enabling someone with a mobility impairment to complete an Assessment at a location that is easier to access than the regional HRC; allowing someone with a mental health disability to be assessed in multiple phases if they become overwhelmed; scheduling

appointments at a time of day that will prevent an extended wait; and/or allowing a client to bring someone with them to an appointment for support.

- HRC staff are also trained specifically to support people with mental health disabilities, such that behaviors associated with their disabilities do not lead to unnecessary or inappropriate termination from services. These supports can include tasks like allowing for frequent appointment rescheduling, providing extra reminders, and allowing extra time to complete paperwork.

5G. Other Special Populations

Some of the County's homeless residents have unique needs with respect to accessing housing assistance. To ensure that they have equitable access to Coordinated Entry in the face of these needs, there are some elements of the process that have been modified. These modifications are summarized below and described in greater detail in other parts of the manual.

- Age-appropriate Assessors are available to work with young people, in order to build trust and allow young people to feel more comfortable during the Assessment process.
- Veterans can receive services from any outreach team or regional HRC, but are also targeted by a veteran-specific outreach team whose shared experiences are designed to build trust.
- Individuals and families who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking or human trafficking have equitable access to the services offered through Coordinated Entry but, in order to ensure their safety and connect them to DV-related emergency services, they can select to go through the entire Coordinated Entry process with a DV-specific provider and network of services.

An individual or household who is included in more than one of the populations for which an access point is dedicated can be served at any of the access points for which they qualify. For instance, an unaccompanied youth who is fleeing domestic violence can be matched to DV-specific services, youth-specific services, and services that are not population-specific, and will be offered any of those matched resources if they arise.

5H. Grievance Process

Coordinated Entry seeks to provide a fair and transparent way of connecting clients to housing and services. If a client is unsatisfied with any element of the Coordinated Entry process, s/he has the right to file a General Grievance, Assessment Appeal, Non-Discrimination Complaint, and/or a Grievance Review. Standardized forms will be provided by EveryOne Home [Pending development with ILC]. If requested, clients will be provided with a written copy of the Grievance Process and Standardized Forms or directed to the EveryOne Home website where the forms will be available. More specifically:

- If a client feels that they received unsatisfactory services or poor treatment during the CE process, they can file a General Grievance. Each provider participating in Coordinated Entry is expected to have an internal protocol for informing clients of their right to file a grievance, for accepting grievances, and for attempting to resolve any grievances related to any part of CE process. Providers must document all attempts to resolve a General Grievance.
- If a client feels that they were not assessed fairly, they have the right to an Assessment Appeal. Assessment Appeals will be considered if the Assessment was conducted improperly and/or information that would have an impact upon the score was omitted or not considered. An Assessment Appeal will not be considered if the Assessment was done properly and with full information, but the client is unsatisfied with the results of the Prioritization. As part of Assessment Appeal, participants are welcome to bring an advocate or supportive person with them, the Assessment is re-administered, and clarification of the participant's responses to the Assessment may be offered.
- If a client feels that they were discriminated against at any phase of the Coordinated Entry process, they have the right to file a Nondiscrimination Complaint. Examples of nondiscrimination complaints could include: if a client feels as though their request for a reasonable accommodation was unfairly denied, or if a client did not feel that services were accessible due to linguistic or cultural barriers.
- If the client does not feel that his/her Grievance was appropriately resolved by the responsible provider, s/he can file a Grievance Review with EveryOne Home who will seek to mediate and resolve the conflict. Grievance Review will be signed off by EveryOne Home and, if appropriate, any funder of the service in question.

6. Data Protocols and Privacy

Data privacy shall be safeguarded in accordance with applicable privacy laws and regulations. Alameda County Homeless Management Information System (HMIS), InHOUSE, currently serves as the primary database for storage of client-level information. The CE activities described in this manual will be entered and tracked in HMIS. Data collection, storage, and protection protocols are governed by the HUD Data and Technical Standards, the Continuum of Care's HMIS Policies and Procedures Manual, and the HMIS Release of Information (ROI) Form, and all rules and requirements for the collection, storage and utilization of data set forth there apply.

6A. [Pending: Section that clearly describes the new integrated ROI and the approach to privacy, confidentiality, and informed consent to be developed with HCSA/HCD privacy and data and legal teams]

6B. Data Protocols

Data quality, completeness, and accuracy are critical components of operating the CE and, are also essential for ongoing analysis and system improvement. As detailed in the HMIS Policies and Procedures manual, the following key reminders about data quality are essential for maintaining accurate and useable data.

- The CE Call Center and HRCs will use HMIS real-time with on-line entry of Screening, intake, and Assessment forms, ensuring a complete record for each caller/head of household.
- Each agency and program is responsible for ensuring a complete data record with no null values.
- Each agency and program will run weekly data quality reports and make corrections in a timely manner, including having all data entry corrections done by the 5th of the following month for the prior month.
- Once the HMIS is set up for this purpose, all vacancy information will be kept in HMIS for Emergency Shelter, Transitional Housing, Rapid Re-Housing, Housing Navigation, and other services.
- Initial Prioritization of households to match to openings will occur through the HMIS.
- Over time, HMIS technology will be built out to support the use of technology to assist with eligibility and Matching.
- Programs will receive matches through HMIS and record any other information about those matches, including (but not limited to) program intakes, reasons not eligible, etc.

6C. Data Protection

The CES requires thorough privacy protections for participant information, including the following measures.

- Prior to collecting any data that will be entered into HMIS, all of the participating providers must obtain an HMIS Release of Information (ROI) in which the client authorizes them to store their data in the HMIS and to share that data with the providers identified on the ROI for a limited period of time. Any client that refuses to sign the ROI cannot be denied services, unless Federal statute requires the collection, use, storage, and reporting of a client's personally identifiable information as a condition of program participation. However, if a client refuses to sign the ROI, s/he may have to answer many of the initial Assessment/Intake questions again if they are referred to another program.
- Clients are free to decide upon what information they provide during the Assessment process, and may refuse to answer questions.
- If a client refuses to share certain types of information, they cannot be refused services, unless that information is needed to establish or document program eligibility and Prioritization.

All staff are trained in privacy standards prior to handling any personal information intended for or generated by the HMIS system.

- Computer hardware and software also meet HUD Security measures to protect personally identifying information.
- Special data entry instruction exists for survivors of domestic violence and others who do not wish to have their name shared in the data system.
- Victim services programs funded by the Violence Against Women's Act are prohibited from entering client information into a third-party data base and must enter client information into a comparable database and only provide de-identified and/or aggregate information to funders.

Breaches of confidentiality are addressed to the agency whose staff conducted the alleged breach activity and has consequences up to and including termination of employment.

Other specific HMIS protocols can be found in the HMIS Policy and Procedures Manual at:

http://www.acgov.org/cda/hcd/documents/HMIS_PoliciesandProcedures.pdf

7. Coordinated Entry Oversight and Management

The U.S. Department of Housing and Urban Development (HUD) requires that communities receiving Federal Continuum of Care (CoC) or Emergency Solutions Grant funding to address homelessness establish Coordinated Entry (CE), the purpose of which is to ensure that all persons experiencing homelessness are assessed and prioritized for assistance using a fair, consistent, and coordinated process, and follows the requirements of the CoC Interim Rule 24 CFR 578 and all applicable notices; including Notice [CPD-17-01](#), [CPD-14-012](#) and [CPD-16-11](#).

The County of Alameda has endorsed and supports the creation and operation of Alameda County Coordinated Entry that serves the entire County, includes multiple entry points, uses a standard assessment process and approach, matches eligible homeless people to a range of housing and service options.

Alameda County Coordinated Entry is funded in part by a grant from the U.S. Department of Housing and Urban Development and is included and approved in the annual Continuum of Care application submitted to HUD. No additional approvals or certifications are required from HUD at this time.

The entity responsible for the operations and oversight of the Coordinated Entry is the EveryOne Home Leadership Board, which includes representatives of the County, cities within the county, housing and service providers within the county, the Alameda County HUD CoC Committee, and other Stakeholders, and which designs, oversees, approves and evaluates the operations of Coordinated Entry and ensures its compliance with all Federal requirements.

Home Stretch is a program of Alameda County Health Care Services Agency (HCSA), EveryOne Home, government, nonprofit, and community partners. The EveryOne Home Leadership Board and the HUD CoC Committee has designated HCSA to administer Home Stretch and is the entity responsible for managing the operations of matching to PSH within the Coordinated Entry.

The EveryOne Home Leadership Board will annually review the performance, fairness, and compliance of Coordinated Entry.

APPENDIX A: Key Coordinated Entry Staffing and Roles

Call Center Operators: Call Center Operators are responsible for responding to calls that come into the Countywide Call Center for housing assistance. They are responsible for conducting the brief initial Screening for each household; conducting Housing Problem Solving conversations to prevent people from entering the homeless system; connecting households to their closest Housing Resource Center; making referrals to other services as appropriate; and prescribed data entry about the caller and the interactions and disposition of the services.

Outreach Workers: Outreach Workers conduct regular street-level outreach, engagement activities, and Coordinated Entry processes designed to identify people who are experiencing homelessness but are largely disconnected from housing and services. By visiting people who are living in encampments, vehicles, and other places not meant for human habitation and offering them nonjudgmental services and supplies that meet their basic needs, Outreach Workers build the trust and rapport needed to connect clients to the services available at the HRCs and elsewhere to end their homelessness. Outreach workers have a key role in locating people if they are matched to resources.

Assessors: Assessors are responsible for conducting initial Screenings, Housing Problem Solving and full Intake and Assessment process needed to access housing opportunities and other services. Assessors are trained to conduct standard Assessments in a client-centered, consistent, and fair manner, to ensure that the households seeking assistance have the same experience as they seek services, and that their needs and experiences are prioritized fairly when “matched” with available resources. When conducting problem solving, Assessors ask questions that might generate solutions to a housing crisis or otherwise enable a household to remain where they are currently staying and, when appropriate and possible, possibly offering modest financial assistance to pursue those options.

One specialized role for certain Assessors is to conduct the Matching processes on a regular basis, in which high-priority households who match to eligibility in available program vacancies are contacted and supported to enroll into those programs.

Staff Recruitment and Hiring

In order to ensure universal access to Coordinated Entry all participating providers are strongly encouraged to fill staff positions with employees whose identities or life experiences enable them to better understand and provide services to the individuals and families seeking assistance. More

specifically, each HRC should have employees who speak languages other than English, including Spanish, and Vietnamese, as well as employees who represent a diverse array of backgrounds, including representatives of the LGBTQ community, people of diverse ethnic/racial backgrounds, and immigrants. In addition, it is highly recommended that HRC operators recruit employees with lived experiences with homelessness, mental health or other disabilities, substance use, foster care, or other circumstances commonly faced by people experiencing or at risk of homelessness. For a more detailed description of the specific steps needed to ensure universal access, please refer to Section 4: *Ensuring Universal Access to Coordinated Entry*.

Staff Training [Pending: Standardized training program in development]

All Coordinated Entry staff are trained to ensure fidelity to the model, consistency and fairness in Assessment and resource Matching, uniform decision-making, the provision of high-quality services, and the ability to serve people with multiple barriers to housing. The specific trainings required vary by position, and required training topics are listed in the table on the following page.

<p>Required Staff Training By Position [This will be refined to identify sequencing, required trainings for on-boarding, and annual training requirements.]</p>	<p>Outreach Worker</p>	<p>Call Center Operator</p>	<p>Assessor/ Housing Problem Solver</p>	<p>Housing Navigator</p>	<p>Housing Care Manager</p>
Introduction to Coordinated Entry	x	x	x	x	x
Housing First Principles	x	x	x	x	x
Trauma-Informed Care	x	x	x	x	x
Harm Reduction	x	x	x	x	x
Understanding Mental Health Disabilities	x	x	x	x	x
ADA and Reasonable Accommodation	x	x	x	x	x
Grievances, Complaints, and Appeals	x	x	x	x	x
Cultural and Linguistic Humility	x	x	x	x	x
Crisis Intervention, Conflict Resolution and De-escalation	x	x	x	x	x
Domestic Violence Overview	x	x	x	x	x
Mandated Reporting	x	x	x	x	x
HMIS and CE Data Protocols	x	x	x	x	x
HMIS Data Privacy and Security	x	x	x	x	x
Motivational Interviewing	x	x	x	x	x
Critical Time Intervention	x		x	x	x
Landlord/Tenant Basics			x	x	x
Fair Housing Overview			x	x	x
Screening and Housing Problem Solving	x	x	x	x	
Conducting CE Assessments	x		x		
Outreach Safety	x				
Mental Health First Aid	x				
Safety Planning	x	x	x	x	

