To: Leadership Board

From: Roles & Responsibilities Workgroup

Re: Conflict of Interest policies and forms

Date: June 8, 2023

You will find attached a draft Conflict of Interest Policy (and Conflict of Interest form) for your consideration. A summary of what is included and the approach behind the policy follows.

EveryoneHome, the Oakland and Berkeley/Alameda County Continuum of Care (CoC) needs policies for conflicts of interest that are clear and transparent. The procedures need to be understandable, easy to implement, and objectively applied. To that end, we have developed a draft that does the following:

- **Defines a conflict of interest** (Section 2, a-h);
- Requires that CoC board members, staff, consultants, volunteers, funding recipients or subrecipients, and members of a committee with governing board delegated powers **disclose any conflict of interest** they may have (Section 3a);
- **Identifies the procedures** for what to do when a conflict of interest exists (Section 3e, i-vi);
- Clarifies that **not all conflicts require recusal or non-participation**, i.e., the policy delineates considerations for when a CoC may opt to allow someone with a conflict of interest to participate in decisions (Section 3e(i)); and
- Spells out the **procedures for when the policy is violated**.

There are two key components of the policy: 1. Everyone discloses when they have a conflict, both annually when they complete the conflict of interest form (Sections 3b and 3g) or in real-time when a conflict arises (Section 3b); 2. The CoC has a process in place that regularly identifies conflicts of interest and can then determine if the interests of the CoC allow for the person to participate in discussions/decisions even if they have a conflict (3e).

A conflict does not inherently mean that a person is conflicted out and unable to participate in a decision. What is most important is that a conflict is disclosed and the Leadership Board or appropriate committee can collectively make a determination whether the person needs to recuse themselves from the decision making process.

Many individuals working within the CoC will have conflicts of interest. People on the Leadership Board and the committees, subcommittees, and workgroups often work or volunteer for other organizations seeking funding from the CoC. Housing partners run programs that provide homeless prevention assistance to residents. Rather than have every individual participant be conflicted out of participation, the policy seeks **disclosure** and a **process** for the CoC to determine when conflicts of interest are permissible.

Under the policy, the Leadership Board or the appropriate committee has authority to allow people with conflicts of interest to participate in decision making. The criteria includes:

1. The proposed transaction is fair and reasonable to the CoC;
2. The CoC proposes to engage in this transaction for its own purposes and benefits and not for the benefit of such person; and
3. The proposed transaction is the most beneficial arrangement which the CoC could obtain in the circumstances with reasonable efforts.

(Section 3e(i)).

The policy requires appropriate documentation of how the Board or committee addressed a conflict of interest.

We recognize that all onboarding procedures for members, staff, and others will need to incorporate robust training on conflict of interest standards and will incorporate them into the developing onboarding process.

THE OAKLAND, BERKELEY/ALAMEDA COUNTY COC

Conflict of Interest Policy

May 2023

1. Purpose

The purpose of the Conflict of Interest policy is to protect Everyone Home, the Oakland, Berkeley/Alameda County Continuum of Care (CoC), when it contemplates entering into a transaction or arrangement that might benefit the private interests of CoC board members, staff, consultants, volunteers, funding recipients or subrecipients, or members of a committee with governing board delegated powers, which might result in a possible excess benefit transaction. The Conflict of Interest policy is intended to supplement but not replace any applicable state and federal laws governing conflict of interest applicable to nonprofit and charitable organizations.

The Department of Housing and Urban Development (HUD) requires non-Federal entities that receive Federal assistance awards, excluding States, to develop and maintain written standards/codes of conduct covering conflicts of interest and governing the actions of interested parties engaged in the selection, award, and administration of contracts.

Continuum of Care Boards are covered by Federal and state regulations and 24 C.F.R. §578.95 (b-d) and 24 C.F.R. §576.404 (a-b), which define conflicts of interest and the required actions to avoid conflicts of interest. CoCs are required to have a code of conduct that covers conflict of interest in compliance with 2 C.F.R. §200.3189(c)(1).

CoC board members, staff, consultants, volunteers, funding recipients or subrecipients, or members of a committee with governing board delegated powers are expected to use good judgment, to adhere to high ethical standards and to conduct their affairs in such a manner as to avoid any actual or potential conflict between the personal interests and those of the CoC. A conflict of interest exists when the loyalties or actions are divided between the interests of the CoC and the interest of the board members, staff, consultants, volunteers, funding recipients or subrecipients, or members of a committee with governing board delegated powers. Both the fact and the appearance of a conflict of interest should be avoided.

1. Definitions

For purposes of this policy, the following terms have the specific meanings:

a. Conflict of Interest

HUD's CoC Interim Rule Section §578.95 identifies four types of conflicts of interest:

i. Individual conflicts of interest regarding provision of services, which occur when interested parties indirectly benefit financially or otherwise by the activities carried out using CoC grant funds. This includes any decision or activity made by a recipient or subrecipient that gives the appearance of impropriety;
ii. Organizational conflicts of interest regarding provision of services, which occur when interested parties are unable, or potentially unable, to render impartial assistance or perform objectively;
iii. Conflicts of interest related to the procurement process, which occur when interested parties violate the code of conduct or conflict of interest rules of 2 C.F.R. §200.112 during the procurement of goods, supplies, equipment, or services; and
iv. Conflicts of interest related to CoC Board decision-making, which occur when CoC Board members or officers participate in or influence discussions or decisions concerning the award of a grant or other financial benefits to organizations that the member or officer represents.

Such conflicts are presumed to exist in those circumstances in which CoC board members, staff, consultants, volunteers, funding recipients or subrecipient, or committee member's actions may have a preferential impact upon the agency or entity employing the CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers. Such actions are presumed to include, but are not limited to, the development of policies in which a self-serving bias may be present, as well as in decisions affecting the allocation of resources.

A CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers must take certain affirmative steps to prevent, address, and/or manage conflicts of interest.

b. Interested Person

Any CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers, who has a direct or indirect financial interest, as defined below, is an interested person.

c. Financial Interest

A person has a financial interest if the person has, directly or indirectly, through business, investment, or family:

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i. An ownership or investment interest in any entity with which the CoC has a transaction or arrangement;
ii. A compensation arrangement with the CoC or with any entity or individual with which the CoC has a transaction or arrangement; and / or
iii. A potential ownership or investment interest in, or compensation arrangement with, any entity or individual with which the CoC is negotiating a transaction or arrangement.

A financial interest is not necessarily a conflict of interest. A person who has a financial interest may have a conflict of interest only if the appropriate governing board or committee decides that a conflict of interest exists. Compensation for persons with lived experience or for staff is not a conflict of interest.

d. Compensation

Includes direct and indirect remuneration as well as gifts or favors that are not insubstantial. Gifts or gratuities by anyone for someone's personal benefit are not insubstantial if they are in excess of $20/$25.

Commented [JS1]: Leadership Board: We need to propose a certain amount that is considered "in excess of minimal" - $20? $25?

2. Activities that Constitute a Conflict of Interest

A conflict of interest occurs when CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers takes an action which results, or has the appearance of resulting in personal, organizational, or professional gain.

No CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers may participate in or influence discussions and/or decisions concerning the award of a grant or other financial benefit(s) to the CoC that the member represents or to the member individually. All interested persons must identify actual or perceived conflicts of interest as they arise and comply with this policy. Disclosure should occur at the earliest possible time and, if possible, prior to the discussion of any such issue. Individuals with a conflict of interest should abstain from discussing and voting on any issue in which they may have a conflict.

Conflicts of interest include the following:

a. When a CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers participates in or influences decisions concerning the award of a grant or other financial benefit to the organization that the member, staff, recipient or sub-recipient represents (including as a staff, board member, or volunteer).

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A board member is considered to represent an organization if that person is an employee, agent, consultant, volunteer, board member/officer, or elected or appointed official of the organization.

b. When a CoC board member, staff, consultant, volunteer, funding recipient or subrecipient member of a committee with governing board delegated powers participates in or influences decisions concerning grant awards or other financial benefits to organizations with whom they have immediate family or business ties, during their tenure or during the one-year period following their tenure.

c. When a CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers participates in making rent reasonableness determinations and housing inspections on units that the board member, staff, volunteer, funding recipient, subrecipient, or related entity owns.

d. When a CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers may condition an individual's or family's acceptance of emergency shelter or housing owned by the recipient, subrecipient, or parent or subsidiary of the subrecipient, as a condition of assistance.

e. When a funding recipient or subrecipient provides an individual or family with any type of Homelessness Prevention (HP) assistance when the participant is living in housing owned by the recipient, subrecipient, or parent or subsidiary of the subrecipient.

f. When a funding recipient or subrecipient carries out the initial evaluation for rapid rehousing (RRH) or HP assistance for an individual or family when the participant is living in housing owned by the recipient, subrecipient, or parent or subsidiary of the subrecipient.

g. When a voting member of the governing board who receives compensation, directly or indirectly, from the CoC for services votes on matters pertaining to that member's compensation.

h. When a voting member of any committee whose jurisdiction includes compensation matters and who receives compensation, directly or indirectly, from the CoC for services votes on matters pertaining to that member's compensation.

3. Conflict of Interest Procedures

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a. Duty to Disclose

Each CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers has a duty to disclose any actual, possible, or perceived conflict of interest. They must disclose the existence of a financial interest and be given the opportunity to disclose all material facts to the board and / or members of committees that the board has delegated powers considering a proposed transaction or arrangement.

Participation on the Review and Rank process for the CoC local program annual funding will require an additional conflict of interest form specific to the Review and Rank process.

b. Disclosure

Annual Disclosure: Continuum of Care board members, staff, consultants, volunteers, funding recipients or subrecipients, or members of a committee with governing board delegated powers shall complete and sign an annual conflict of interest statement, disclosing issues with any possible relationships or areas of influence. The forms shall be returned to the Collaborative Applicant and remain on file with the Collaborative Applicant and/or their designee for at least 5 years.

The annual disclosure shall affirm such person:

i. Has received a copy of the conflicts of interest policy,
ii. Has read and understands the policy, and
iii. Has agreed to comply with the policy.

Verbal Disclosure Continuum of Care board members, staff, consultants, volunteers, funding recipients or subrecipients, or members of a committee with governing board delegated powers shall verbally disclose potential conflicts of interest prior to participating in discussions that may result in decisions that may confer financial benefit on themselves, family members, spouse or partner, or organization in which they in any official capacity.

c. Recusal

Any CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers has a duty to recuse themselves, including stating a reason, at any time from involvement in any decision or discussion in which they believe they have or may have a conflict of interest, without going through the process for determining whether a conflict of interest exists.

d. Determining Whether a Conflict of Interest Exists

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After disclosure of the financial interest and all material facts, and after any discussion with the CoC board or delegated committees, an interested person shall leave the Board or committee meeting while the determination of a conflict of interest is discussed and voted upon. The remaining Board or committee members shall decide if a conflict of interest exists.

e. Addressing the Conflict of Interest

- **i.** The CoC Leadership Board and/or relevant committees shall review the material facts of the conflict of interest. The transaction may be approved only if a majority of the directors or committee members, not counting the vote of such person, concludes that:
  1. The proposed transaction is fair and reasonable to the CoC;
  2. The CoC proposes to engage in this transaction for its own purposes and benefits and not for the benefit of such person; and
  3. The proposed transaction is the most beneficial arrangement which the CoC could obtain in the circumstances with reasonable efforts.
- **ii.** The minutes of any meeting at which such a decision is taken shall record the nature of the affiliation and the material facts disclosed by such person and reviewed by the Chair of the board.
- **iii.** After exercising due diligence, the governing board or committee shall determine whether the CoC can obtain, with reasonable efforts, a more advantageous transaction or arrangement from a person or entity that would not give rise to a conflict of interest.
- **iv.** If a more advantageous transaction or arrangement is not reasonably possible under circumstances not producing a conflict of interest, the governing board or committee shall determine by a majority vote of the disinterested directors whether the transaction or arrangement is in the CoC's best interest, for its own benefit, and whether it is fair and reasonable. In conformity with the above determination, it shall make its decision as to whether to enter into the transaction or arrangement.
- **v.** When real or perceived or possible conflicts of interest arise, CoC board members, staff, consultants, volunteers, funding recipients or subrecipients, or members of a committee with governing board delegated powers must disclose the conflict to those present. The disclosure and the member's recusal from any discussion / vote related to the topic must be recorded in the meeting minutes.
- **vi.** The recusal process must be described in the CoC Governance Charter.

Commented [JS2]: Leadership Board - this is required to be in the Governance Charter under HUD Interim Rule - but it is not in there now. There is a reference to the conflict of interest policy, however.

f. Obligations of the Collaborative Applicant

The CoC's Collaborative Applicant will verify that all recipients and sub-recipients, current or proposed, have a Code of Conduct statement on file as part of the threshold requirements for inclusion in the annual CoC NOFO application.

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g. Annual Conflict of Interest Requirements
Each year, CoC board members, staff, consultants, volunteers, funding recipients or subrecipients, or members of a committee with governing board delegated powers will be required to review and sign a conflict of interest form.

4. Violations of the Conflict of Interest Policy

a. If the governing board or committee has reasonable cause to believe a CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers has failed to disclose actual or possible conflicts of interest, it shall inform them of the basis for such belief and afford them an opportunity to explain the alleged failure to disclose.

b. If, after hearing the CoC board member, staff, consultant, volunteer, funding recipient or subrecipient, or member of a committee with governing board delegated powers respond and after making further investigation as warranted by the circumstances, the governing board or committee determines the CoC board member, staff, consultant, volunteer, funding recipient or subrecipient , or member of a committee with governing board delegated powers has failed to disclose an actual or possible conflict of interest, it shall take appropriate disciplinary and corrective action.

5. **Records of Proceedings**

The minutes of the CoC board and all committees with board delegated powers shall contain:

a. The names of the persons who disclosed or otherwise were found to have a financial interest in connection with an actual or possible conflict of interest, the nature of the financial interest, any action taken to determine whether a conflict of interest was present, and the CoC board's or committee's decision as to whether a conflict of interest in fact existed.

b. The names of the persons who were present for discussions and votes relating to the transaction or arrangement, the content of the discussion, including any alternatives to the proposed transaction or arrangement, and a record of any votes taken in connection with the proceedings.

6. Exceptions and Changes to Policy

The CoC reserves the right to make an exception to this policy and procedures based on communication from HUD that impact the CoC's ability to carry out the policy and procedures as described above. The CoC also reserves the right to amend this policy on an annual basis.

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THE OAKLAND, BERKELEY/ALAMEDA COUNTY COC

Personal Conflict of Interest Form

I, __________, am a *board member / staff / consultant / volunteer / funding recipient / ESG subrecipient / member of a committee with governing board delegated powers* (*circle one*) of the Oakland, Berkeley/Alameda County Continuum of Care (CoC). In that position, I have read and understand the Conflict of Interest Policy of the CoC and I agree to uphold these standards and good conduct and to avoid real or apparent conflicts of interest.

- I will not participate in or influence decisions concerning the selection or award of a grant or other financial benefit to an organization that I have a financial or other interest in or represent, except for the CoC board itself.

  Organizations that I or a close relative or family member have a financial or other interest in are:

  ____

  ____

  If and when such discussions or decisions occur, I will inform the CoC board of my conflict and excuse myself from the meeting or deliberations during those discussions.

- I will not solicit and/or accept gifts or gratuities by anyone for my personal benefit in excess of minimal value, as identified in the CoC's policies and procedures; and
- I will not engage in any behavior demonstrating an actual conflict of interest or giving the appearance of any such conflict.

I understand that any failure by me to comply with this conflict of interest policy could result in disciplinary action, which may include termination of my position from the CoC and civil and/or criminal penalties.

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Signed: ____

Dated: ____

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Home Together 2026
Year One Progress Update

Home Together 2026

Goals + Strategies

- Center Racial Equity in every activity
- Use Needs Analysis data to inform pathways
- Ensure system works to end homelessness

1 Prevent homelessness for our residents

1. Address racial disparities in mainstream/upstream systems to prevent racially disproportionate inflow into homelessness
2. Focus resources for prevention on people most likely to lose their homes
3. Rapidly resolve episodes of homelessness through Housing Problem Solving
4. Prevent racially disproportionate returns to homelessness

2 Connect people to shelter and needed resources

1. Expand access in key neighborhoods and continue improvements to Coordinated Entry
2. Lower programmatic barriers to crisis services such as prevention, problem solving, and shelter
3. Prevent discharge from mainstream systems to homelessness
4. Significantly increase the availability of shelter, especially non-congregate models, to serve vulnerable adults and families with children and to reduce unsheltered homelessness
5. Provide accessible behavioral health services to people with serious mental illness or substance use needs and who are unsheltered, in shelter, or in supportive housing programs

3 Increase housing solutions

1. Add units and subsidies for supportive housing, including new models for frail/older adults
2. Create dedicated affordable housing subsidies for people who do not need intensive services
3. Create shallow subsidies for those who can exit or avoid homelessness with more limited assistance
4. Add new slots of rapid rehousing for those who can pay full rent over time
5. Ensure new housing funding is distributed across the county according to need
6. Reduce entry barriers to housing and ensure racial equity in referrals and placements

4 Strengthen coordination, communication and capacity

1. Use data to improve outcomes and track racial equity impacts
2. Improve messaging and information availability
3. Build infrastructure to support and monitor new and expanded programs

Our Key Informants

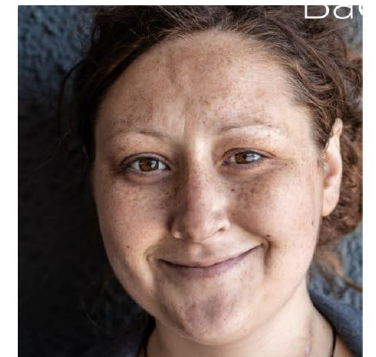
Without addressing the impact of racism in our society, homelessness will continue to disproportionately impact African Americans and other people of color. Creating a mix of housing and services in order to reduce these enormous racial disparities is a major focus of this Plan.

"I am still looking [for housing] and two years into it.... Antioch and other places are miles away. I built a life here for myself and want to stay here. I want to be close to my son and grandsons. Nothing has come up in Oakland.

— Participant 30, Black woman, aged 65+

"I first became homeless when I was 59. I had a bad heart attack and couldn't work. I had savings, then the money ran out and I had no place to go."

— CRE Focus Group Participant, Black man, aged 50-64

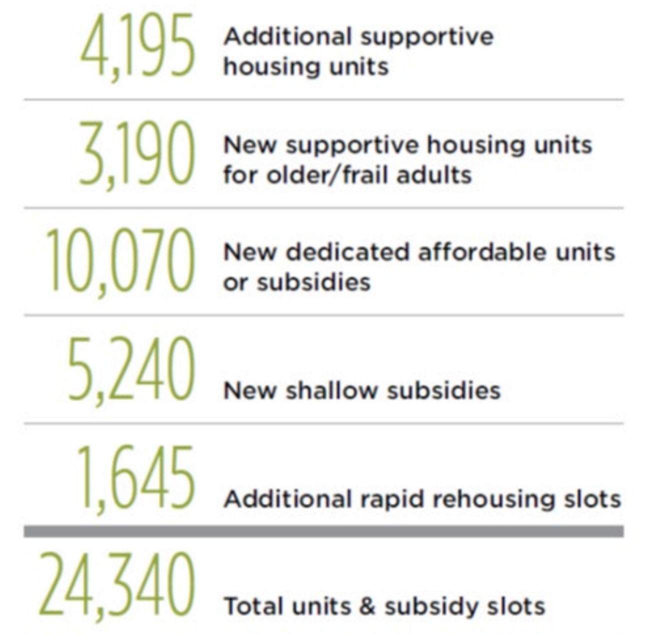


Home Together 2026: System Needs

- In order to drastically reduce homelessness and racial inequities, the 5-year Home Together 2026 Community Plan calls for the **addition of more than 24,000 housing resources** in a variety of programs.
- The total estimated **cost of operating this inventory over 5-years is $2.5 billion**. This cost **does *not* include** capital development or the cost of additional operations such as prevention, street outreach, or administrative activities.

The total cost of scaling up shelter and housing inventory over 5-years to fully meet system needs is **$2.5 billion**.

- $430 million for additional shelter
- $1.68 billion for permanent housing
- $388 million for prevention, rapid re-housing and shallow subsidies.



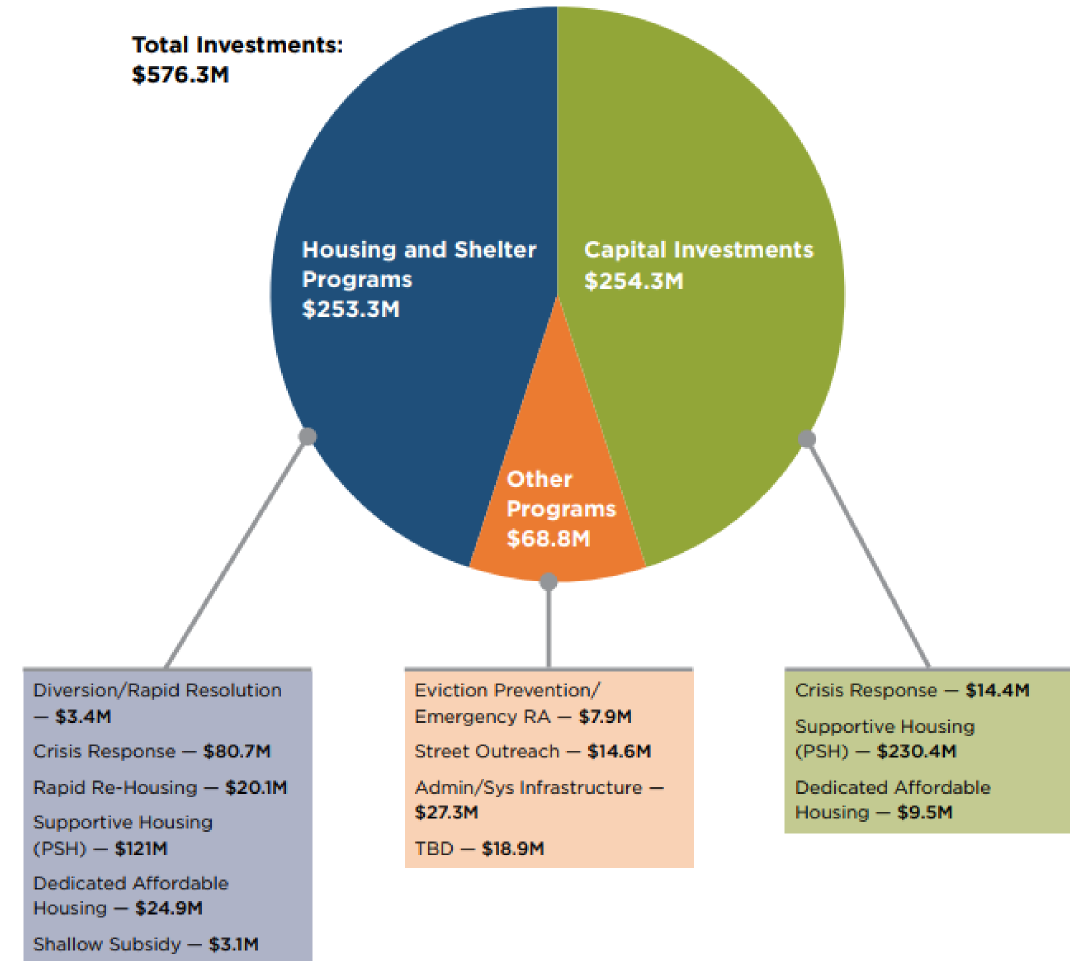
Home Together 2026 : Tracking Progress

- Home Together progress update tracking period: July 1, 2021 – June 30, 2022
- Data Sources:
  - HMIS
  - Point in Time Count
  - Alameda County Agencies
  - Cities
  - Service Providers

Home Together 2026: Key Takeaways from Year 1

Takeaway #1. System Capacity has Expanded.

The homelessness response system served 25% more people during FY21-22 compared to FY20-21; $576 million was allocated towards system inventory and operations, and close to 1,900 permanent housing opportunities and 1,500+ crisis response units were added to the system.



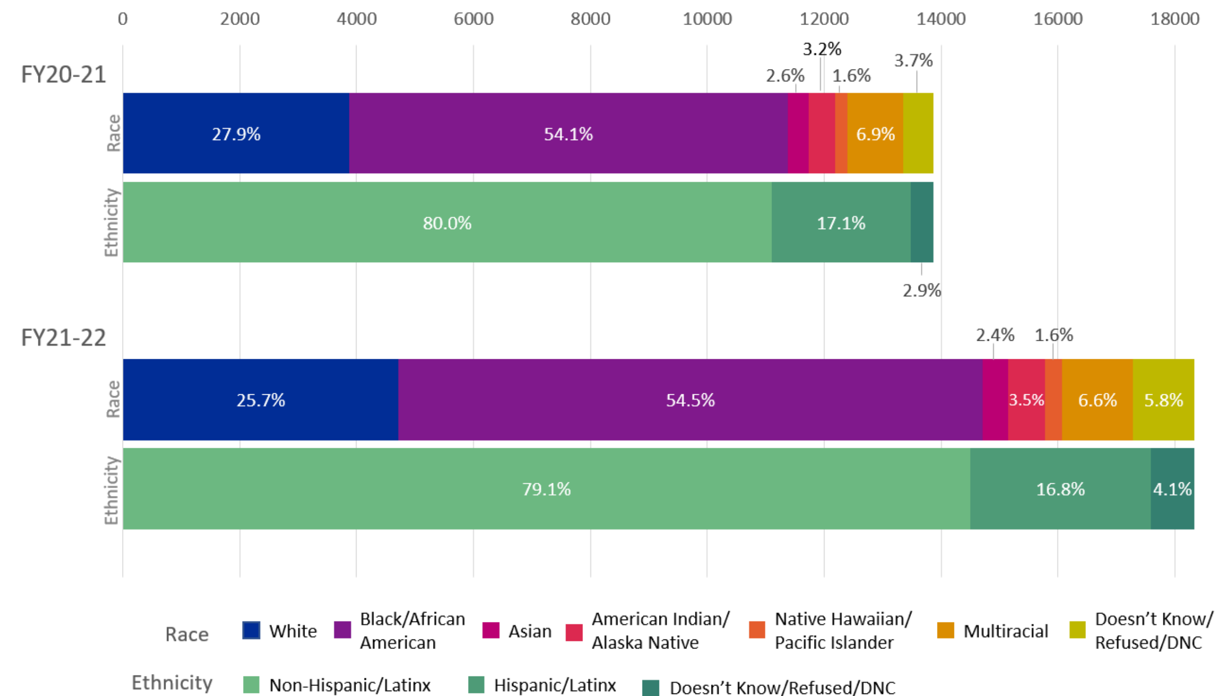
Home Together 2026: Key Takeaways from Year 1

Takeaway #2. New Homelessness Outpaces Housing Placement Rates.

4,033 newly homeless people entered the system in FY21-22 while 3,010 people moved from homelessness into housing.

Takeaway #3. Racial Disparities Persist.

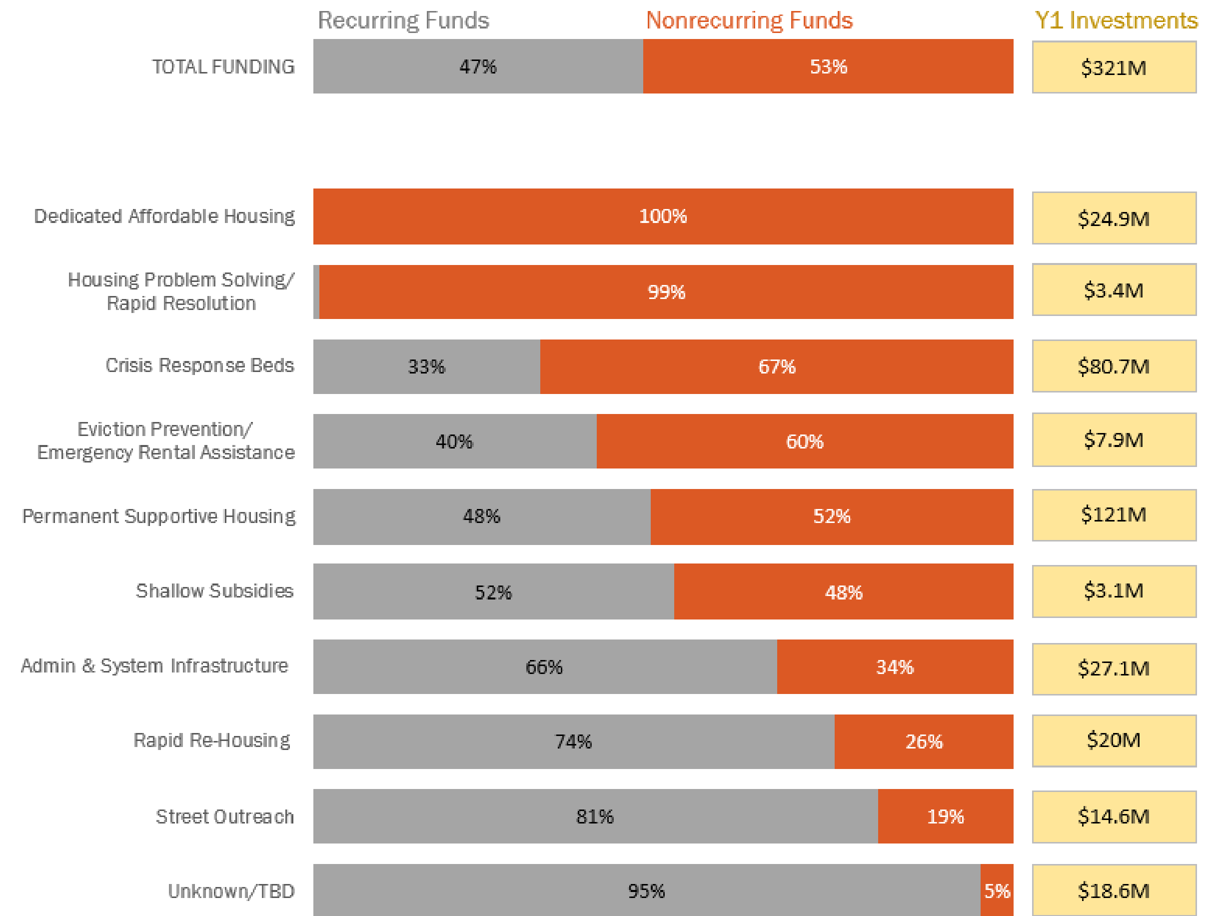
Homelessness continues to disproportionately impact people of color, especially Black/ African Americans.



Home Together 2026: Key Takeaways from Year 1

Takeaway #4. Lack of Funding is Stalling Key Activities. A lack of funding stalled activities that are critical to addressing racial inequities, including adding subsidies for people with fixed incomes, and expansion of dedicated affordable housing for people who do not need intensive services.

Takeaway #5. Sustainable Resources are Needed. More than half of the system's funding for key programs is *nonrecurring*. Reliable funding is needed to maintain the existing inventory and to significantly grow inventory over time.

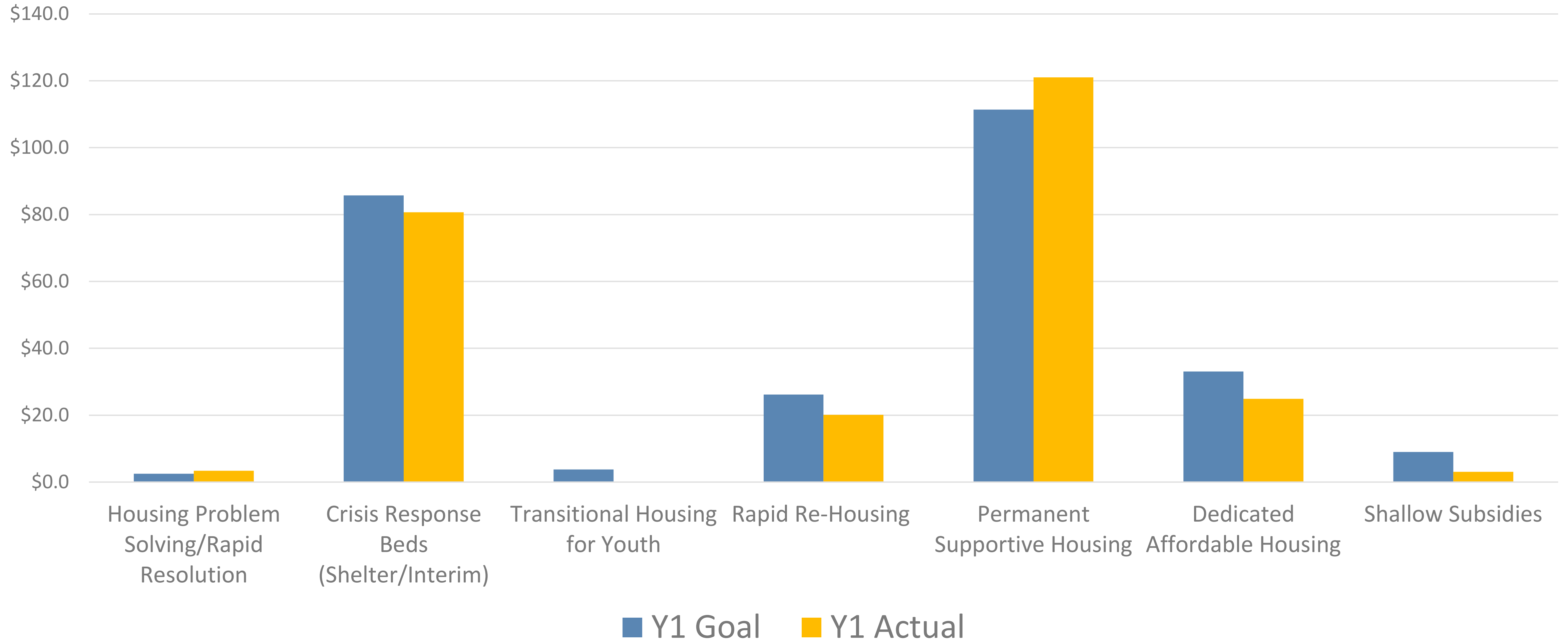


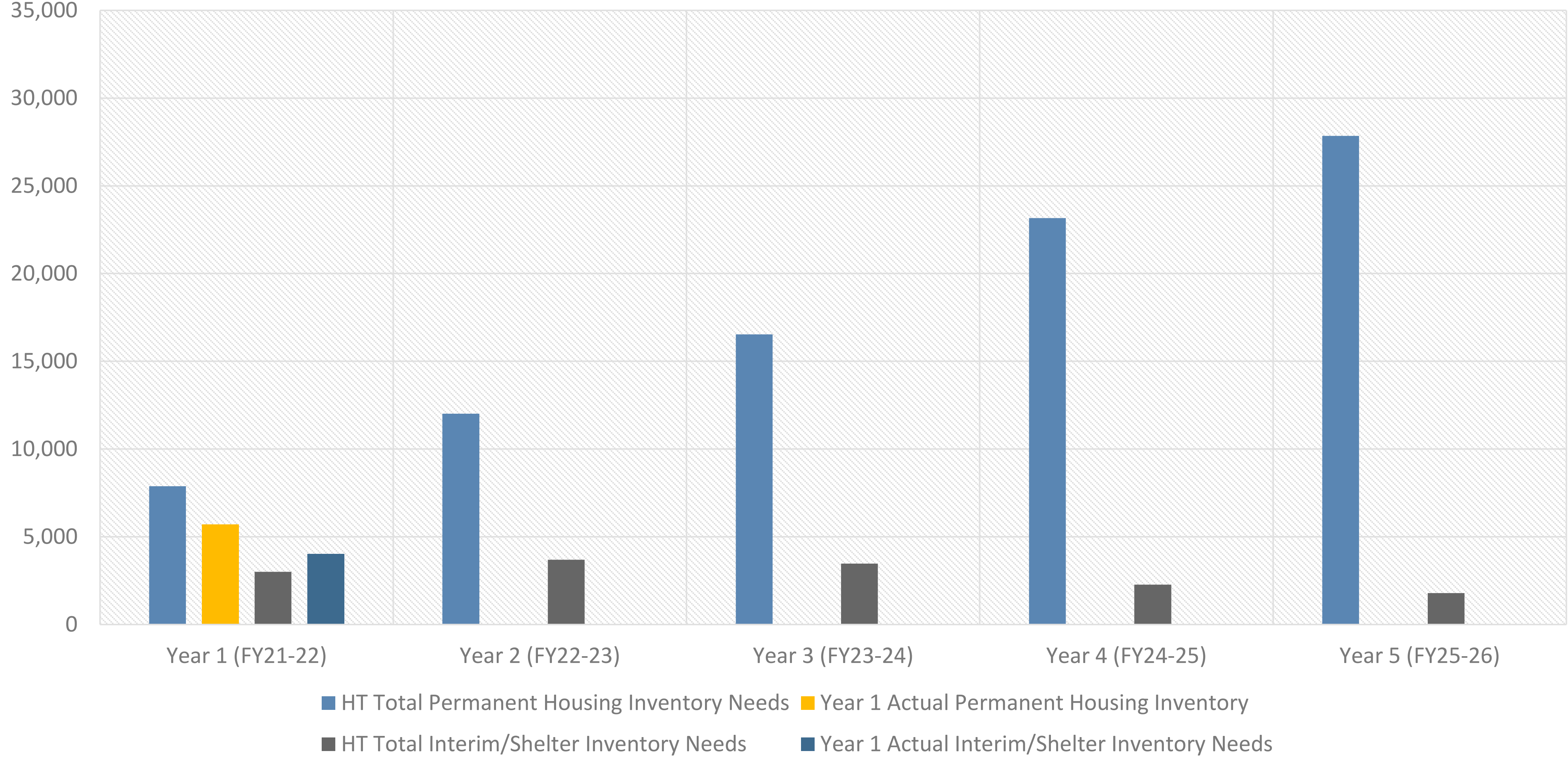
Progress Toward Goals

Inventory Type/ Program Model	Home Together Target FY21-22	Actual Investments FY21-22	% of Target Achieved FY21-22
Rapid Resolution	$2.5M	$3.4M	136%
Crisis Response (shelter/ interim)	$85.7M	$80.7M	94%
Transitional Housing for Youth	$3.8M	N/A	N/A
Rapid Re-Housing	$26.2M	$20M	76%
Supportive Housing (PSH)	$111.4M	$121M	109%
Dedicated Affordable Housing	$33.1M	$24.9M	75%
Shallow Subsidies	$9M	$3.1M	34%
TOTAL	**$271.7M**	**$253.1M**	**93%**

a) Includes $15.1M in RRH rental assistance subsidies and $4.8M in RRH supportive services.
b) Nonrecurring amounts include $5.0M for RRH rental assistance subsidies and $0.05M in RRH supportive services.
c) Includes $38.3M in PSH tenant-based rental subsidies; $62M in project-based operating costs, and $20.7M in PSH case management/supportive services.
d) $24.9M represents the award through the Federal American Rescue Plan Act (ARPA) for 875 Emergency Housing Vouchers to five Public Housing Authorities in Alameda County.

FY21-22 Home Together Funding: Y1 Goal and Y1 Actual Investments

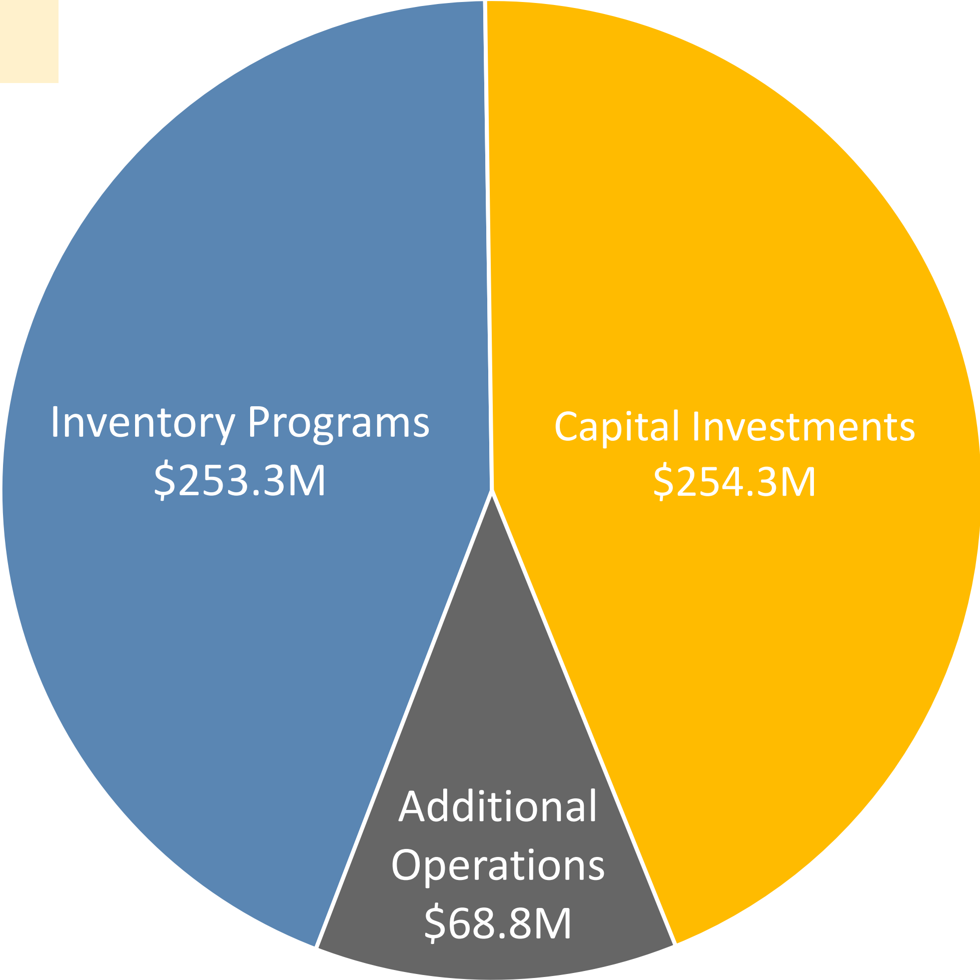



Home Together System Inventory Needs
35,000
30,000
25,000
20,000
15,000
10,000
5,000
0
Year 1 (FY21-22)
Year 2 (FY22-23)
Year 3 (FY23-24)
Year 4 (FY24-25)
Year 5 (FY25-26)
HT Total Permanent Housing Inventory Needs
Year 1 Actual Permanent Housing Inventory
HT Total Interim/Shelter Inventory Needs
Year 1 Actual Interim/Shelter Inventory Needs

FY21-22 Home Together Funding: Investments

Total Investments in FY21-22: $576.3M

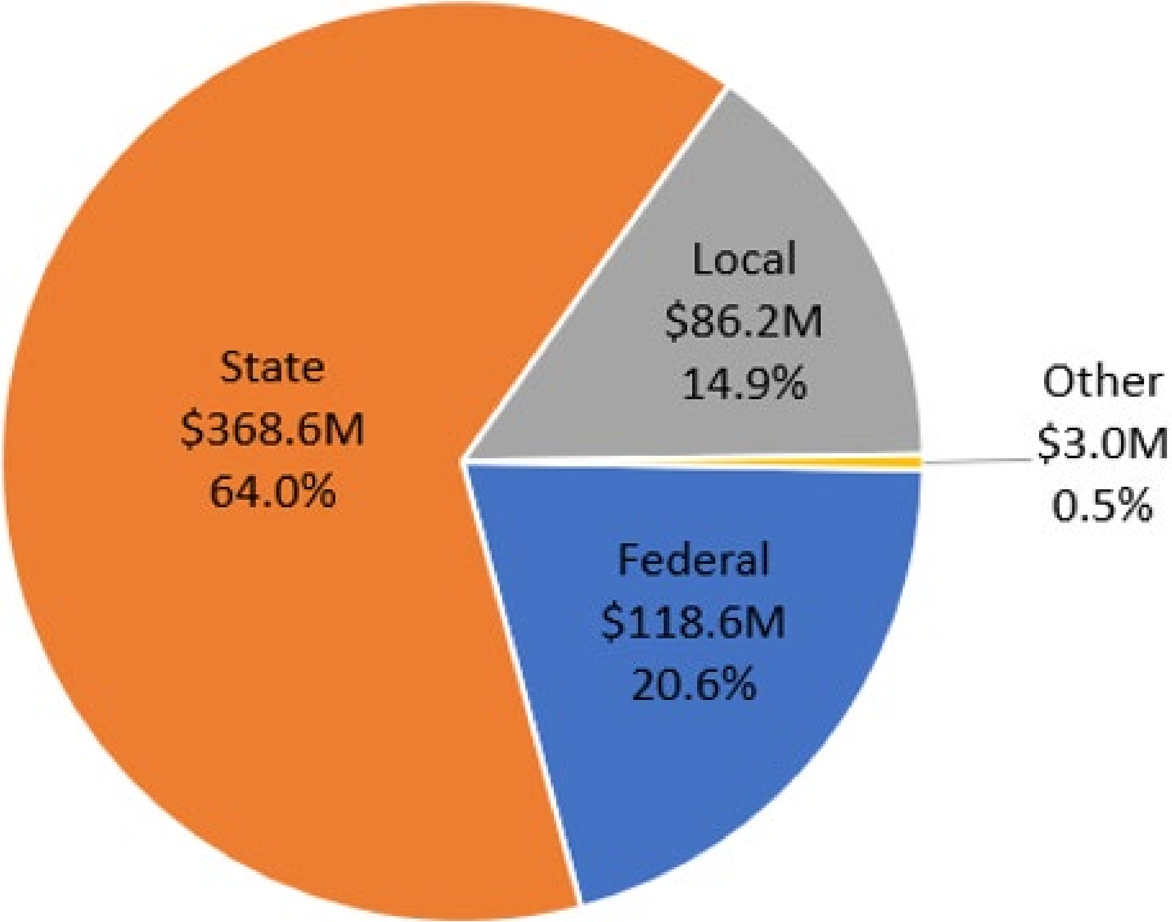
Diversion/Rapid Resolution - $3.4M
Crisis Response – $80.7M
Rapid Re-housing - $20.1M
Supportive Housing (PSH) - $121M
Dedicated Affordable Housing - $24.9M
Shallow Subsidy - $3.1M



Crisis Response - $14.4M
Dedicated Affordable Housing - $9.5M
Supportive Housing (PSH) - $230.4M

Eviction Prevention/
Emergency RA - $7.9M
Street Outreach - $14.6M
Admin/Sys Infrastructure - $27.3M
TBD - $18.9M

FY21-22 Home Together Funding: by Source



FY21-22 Home Together: Ongoing/Launched & Stalled Activities

Highlights of Launched/Ongoing Activities in Cities:

- Eviction prevention and rental assistance programs in Berkeley, Oakland, Fremont, Livermore, San Leandro, Dublin, Alameda and Pleasanton.
- Shallow subsidy programs in Berkeley, Oakland and Hayward.
- Guaranteed Income Pilot program focused on low-income residents in Alameda.
- Dedicated funding for PSH in Berkeley, Oakland, Livermore, Newark, Hayward and Fremont.
- Rapid re-housing programs in Pleasanton and Fremont.

Examples of Activities Pending Funding:

- Flex funds to support subsidies for people with fixed or limited income to reduce the risk of becoming homeless.
- Eviction Prevention services and funding to fill in needs as eviction moratorium ends.
- Capacity building for service providers.
- Increased behavioral and support services to help people maintain permanent housing.
- Crisis response and support accessible to unsheltered people.
- Expansion of dedicated affordable housing inventory.

Year 2 Preview

- New CoC Committees to focus on Racial Equity, Housing Capacity, Homelessness Prevention
- Recently launched Homelessness Prevention Strategy Team and framework development
- Refined reporting and analysis methods in place
- City participation in tracking
- Higher HMIS participation results in more comprehensive data
- CoC Unsheltered NOFO Implementation

Questions or Comments?

HOME TOGETHER 2026

COMMUNITY PLAN

YEAR 1 PROGRESS UPDATE

July 1, 2021 – June 30, 2022

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Without addressing the impact of racism in our society, homelessness will continue to disproportionately impact African Americans and other people of color. Creating a mix of housing and services in order to reduce these enormous racial disparities is a major focus of the Home Together Plan.

All of the photographs of people and of housing featured in this Plan were generously provided by photographer Steven Texeira or by providers in our community. Every person and building featured is from Alameda County and individuals pictured provided their permission for the photograph to be used.

In May 2022 the Home Together 2026 Community Plan for Alameda County was released. This five-year plan was adopted by the Board of Supervisors, the Oakland, Berkeley/ Alameda County Continuum of Care and mayors and city councils throughout the county.

Building an Effective Response

The **Home Together 2026 Community Plan** ("the Plan") relies on an extensive needs analysis (system modeling[1]) to predict changes in homelessness over time, and calls for significant increases in housing, shelter and direct services over five years to meet the needs of people experiencing or at risk of homelessness in Alameda County. Building from the Centering Racial Equity in Homeless System Design report (released in 2021), the Plan calls for promoting racial equity through focused work to reduce the racial disparities that shape homelessness in Alameda County, including adding housing resources that more equitably address the conditions leading to higher rates of homelessness among Black, Indigenous, and other people of color (BIPOC).

Within the Plan is a commitment to report back to the community annually on progress. For each year of the Plan, data will be collected in the following areas to analyze progress towards the Home Together goals and to inform strategic planning for Alameda County's homelessness response system:

- **Funding and investments**
- **System inventory**
- **Home Together strategies and activities**
- **Key service and outcome measures**

Overall, progress during the first year of the Plan[2] was nearly on track with what was projected as needed in terms of investments and inventory growth. Growth was particularly strong in interim programs such as shelter, which grew at 121% of the targeted inventory. Permanent housing inventory came close to the projected number needed (95%), and new housing programs typically take more time to develop. However, the simultaneous growth in new homelessness, and a lack of sustainable resources (rather than one-time funding) makes the prospect of continued progress uncertain and leaves several key strategies awaiting funding to launch or expand to the level needed.

The affordable housing crisis will not be resolved overnight, but these data suggest that with stable and sufficient resources, the homelessness response system can convert investments into tangible outcomes.

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1 System modeling is a structured, data-informed process used to estimate the investments needed to build a system that can provide resources to meet the current and future needs of those experiencing homelessness in Alameda County. For the Home Together 2026 Community Plan, system modeling was used to generate projections of the amount and different types of housing opportunities (or inventory) necessary to meet current and future need.

2 Progress reported in Year 1 of the Plan includes data from County Fiscal Year 2021–2022 or "FY21–22" (July 1, 2021 to June 30, 2022).

FY21–22 Key Takeaways

HOME TOGETHER YEAR 1 PROGRESS UPDATE

TAKEAWAY #1

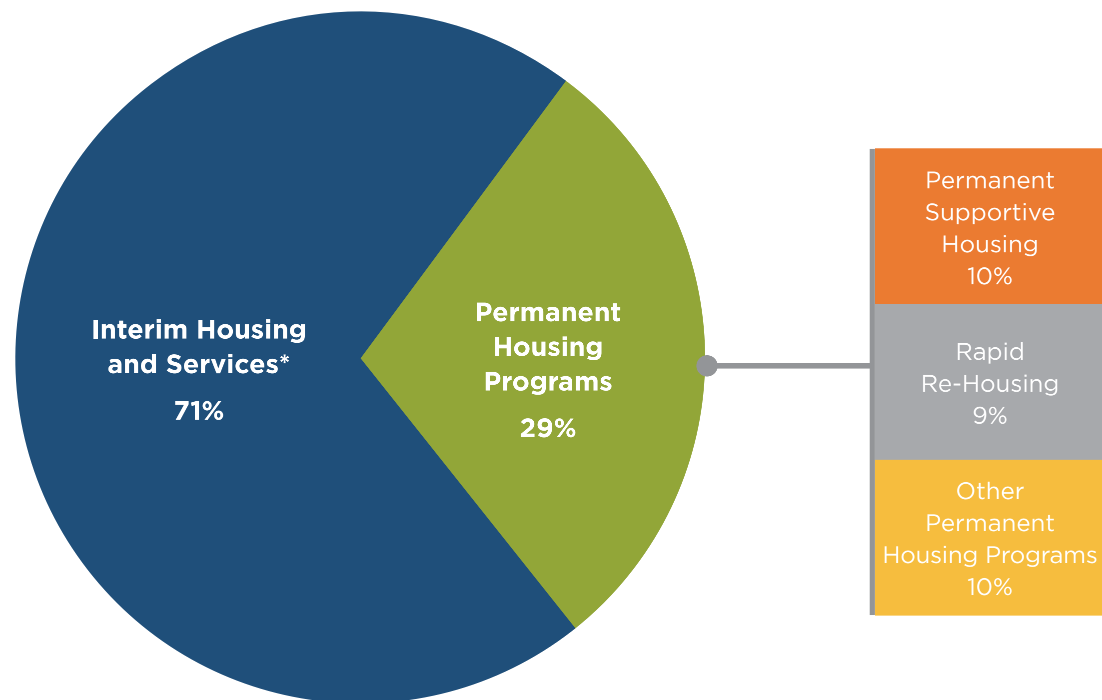
System Capacity has Expanded

In the first year of the Plan, Alameda County's homelessness response system expanded capacity to serve people experiencing homelessness.

Over $576 million was allocated towards system inventory and operations, more than 1,900 permanent housing opportunities were deployed along with more than 1,500 crisis response units and other resources to help resolve people's homelessness. Many activities related to each of the Home Together goals were launched in FY21–22. The homelessness response system was able to serve 25% more people during FY21–22 compared to FY20–21.

The growing population served by the homelessness response system in FY21–22 includes people newly experiencing homelessness, people served in housing programs, and people already homeless who were not previously connected to the services system.

Persons Served by Alameda County's Homelessness Response System, FY21–22



* Interim Housing and Services include Coordinated Entry, Emergency Shelter, Homeless Prevention, Safe Haven, Services Only, Street Outreach, and Transitional Housing.

TAKEAWAY #2

New Homelessness Outpaces Housing Placement Rates

While homelessness response providers are working tirelessly to help people experiencing homelessness exit to housing of their own, the rate at which people in Alameda County are newly becoming homeless outpaces the rate at which people are moving to housing.

In FY21–22, 3,010 people exited to housing but more than 4,000 people entered the system.[3] Homelessness is typically a "lagging indicator" of broader economic distress, so it is possible that the full impact of the pandemic and resulting recession on the number of people who will become homeless may not be evident for another year or two. The only way to reduce homelessness in the community is to simultaneously slow the rate of inflow into homelessness through prevention while accelerating the housing rate. This will take an ongoing, comprehensive, well-coordinated, well-funded strategy across the entire community.

3 The reference to more than 4,000 persons includes 3,623 persons experiencing homelessness for the first time as well as 420 persons who returned to homelessness.

TAKEAWAY #3

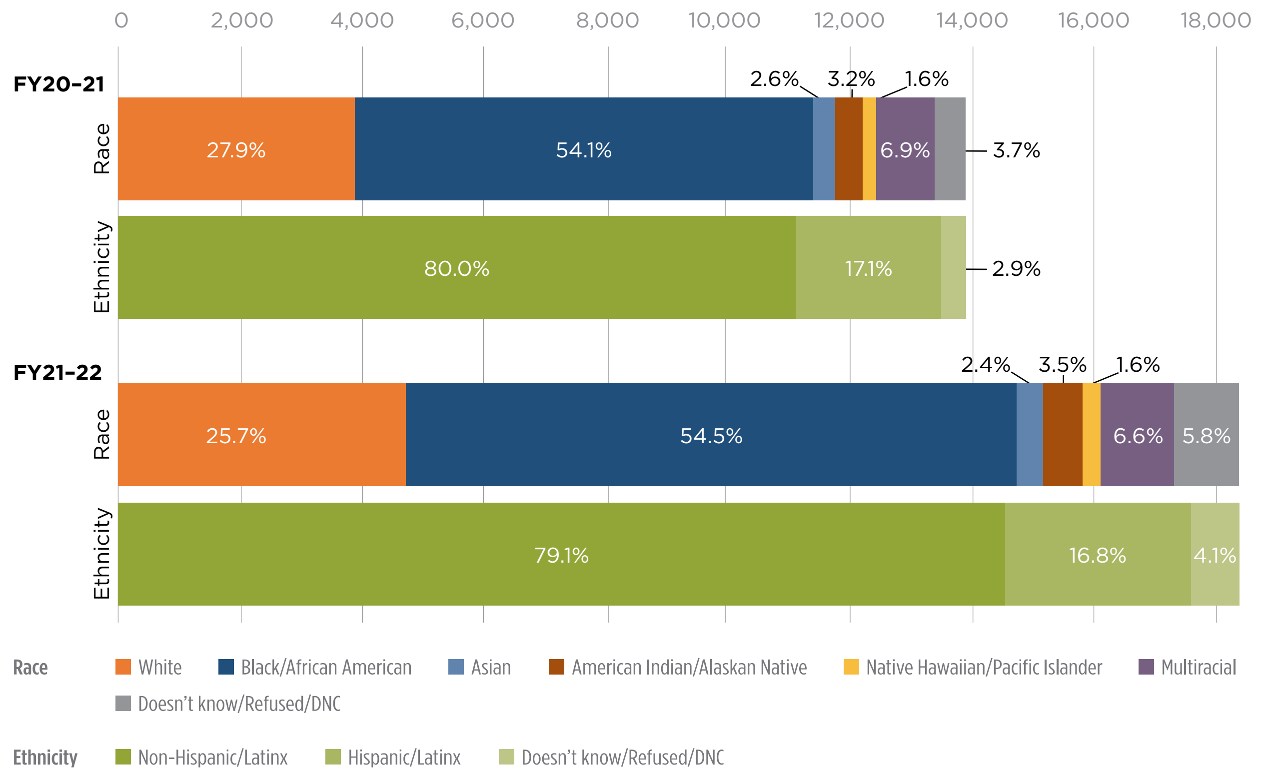
Racial Disparities Persist

As highlighted in the Home Together Plan, homelessness disproportionately impacts people of color in Alameda County, especially Black/African Americans.

While Black/African American people comprise just 10% of Alameda County's general population,[4] they make up over 54% of the people served in Alameda County's homelessness response system, and 43% of the homeless population counted in the 2022 Point-in-Time (PIT) Count.[5] Black/African Americans continue to be vastly overrepresented among the population becoming homeless each year, highlighting the ongoing need for targeted homelessness prevention resources.

A lack of funding for new program models identified as priorities in the Home Together Plan — specifically to expand targeted prevention programs, dedicated affordable housing and shallow subsidies — jeopardizes our ability to effectively address racial inequities in the community. County partners will continue to work towards serving populations of all races and ethnicities with housing resources at a rate that will eliminate any overrepresentation in homelessness.

Homeless Program Participants by Race and Ethnicity, FY20-21 and FY21-22 (HMIS)



4 U.S. Census Bureau. (2020). American Community Survey 2020 5-Year Estimates.

5 HMIS FY21-22. 2022 Alameda County Homeless Count and Survey Report, Applied Survey Research.

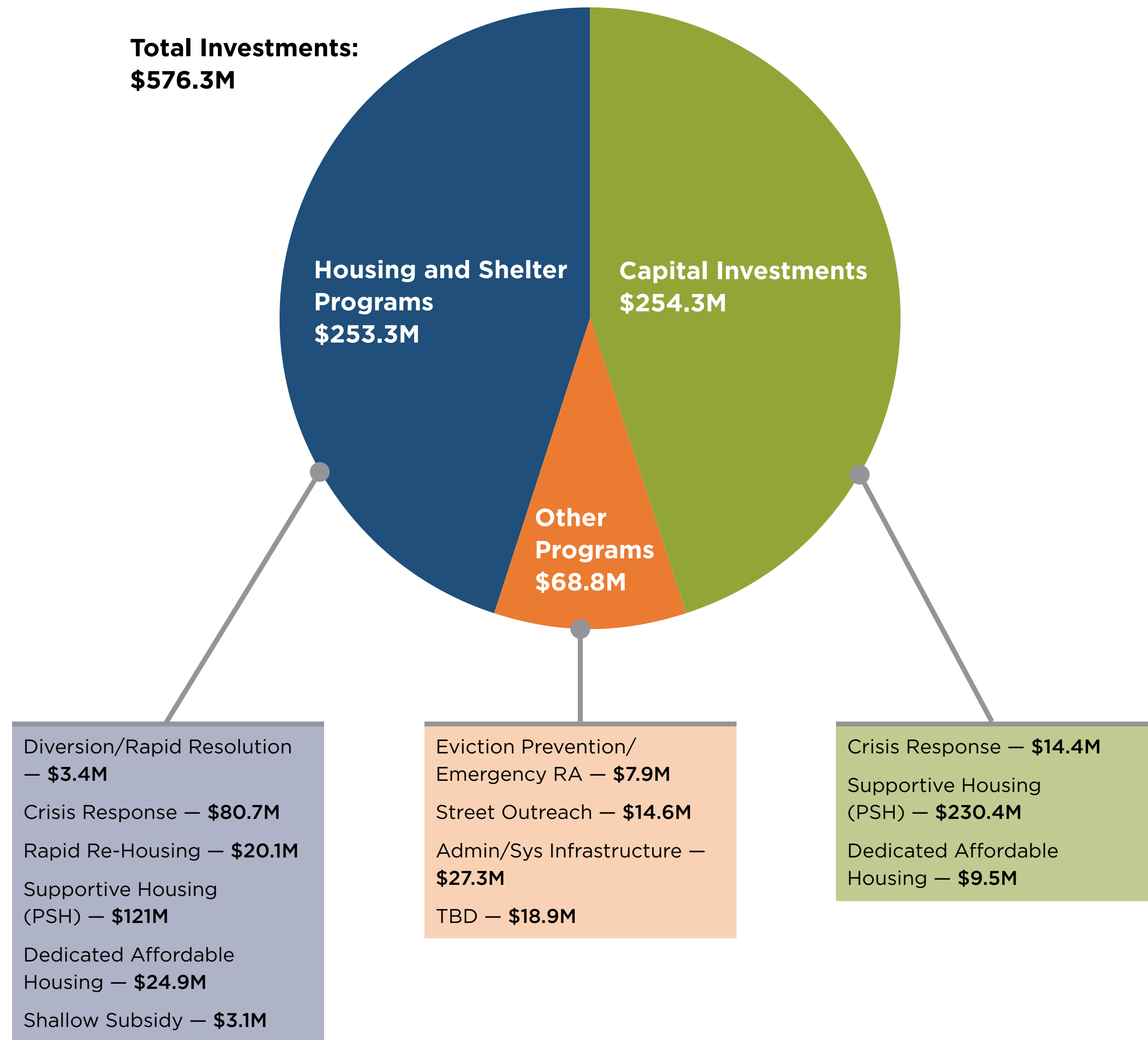
TAKEAWAY #4

Lack of Funding is Stalling Key Activities

An impressive number of activities to support Home Together goals were launched throughout Alameda County during the first year of the Plan.

However, lack of funding has stalled several activities that are critical to addressing racial inequities in the community, including adding subsidies for people with fixed or limited incomes, expanding dedicated affordable housing subsidies for people who do not need intensive services, and increasing capacity-building support for service providers. The addition of homeless units in deeply affordable housing is particularly critical to ending homelessness for Black/African American and Native American adults, who continue to be vastly over-represented among those who experience homelessness, encounter the greatest barriers to housing, and disproportionately return to homelessness once housed.

FY21–22 Home Together Funding: Total Investments by Program Type



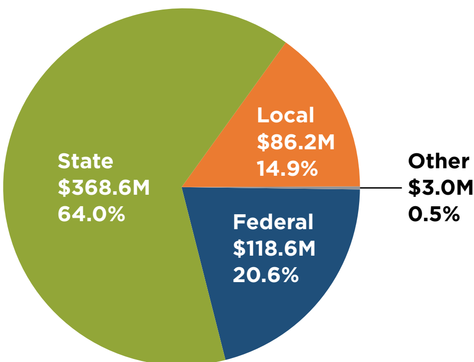
TAKEAWAY #5

Sustainable Resources are Needed

While some data from the first year of the Plan suggest that investments are beginning to slow the rate of increase in homelessness, results can only be maintained and accelerated with adequate funding.

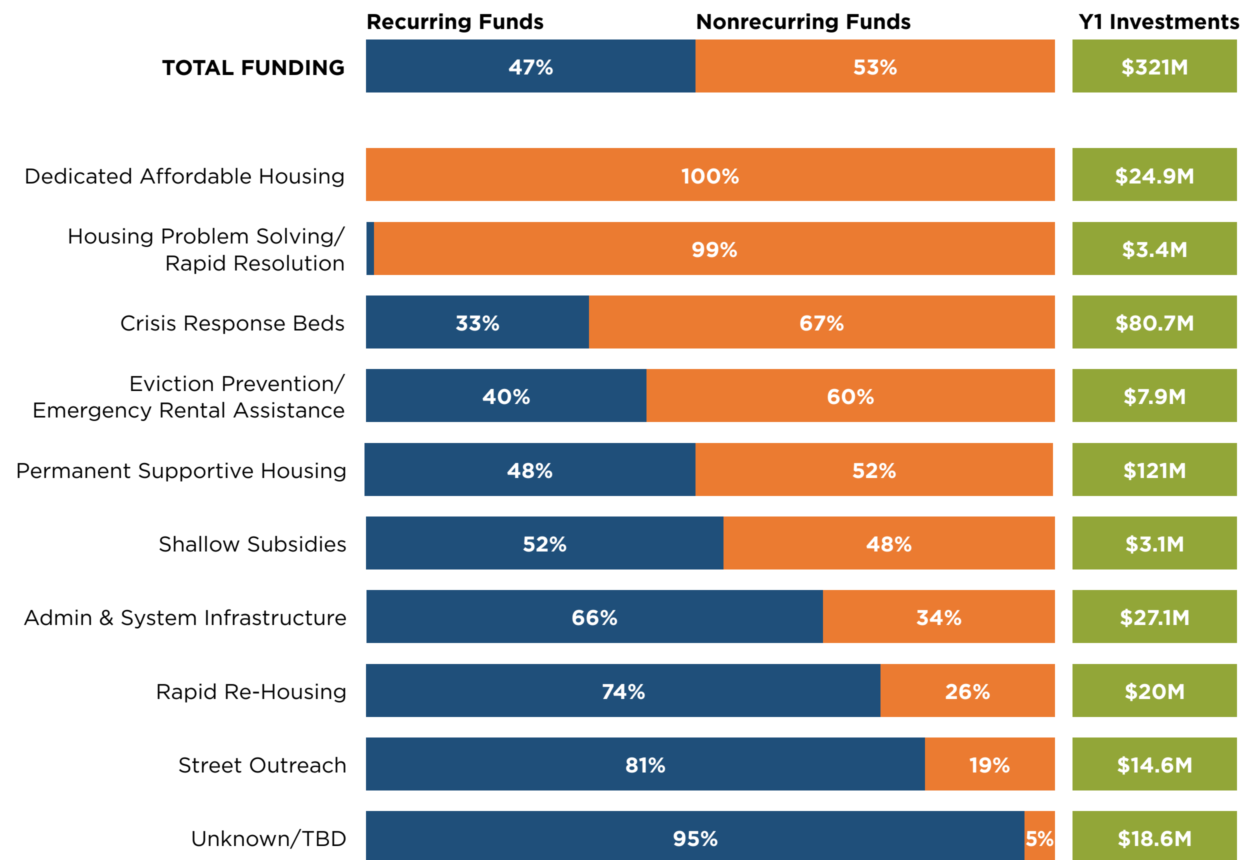
As the funding analysis for this progress update revealed, more than half of system funding is nonrecurring, meaning it is either one-time or short-term with no guarantee of continuation or renewal. Ongoing funding is needed to both maintain existing housing and services inventory (much of which is used to assist people housed in prior years), and to significantly grow the inventory over time to meet current and future need. This can only be achieved with year-over-year increases of recurring investments.

FY21–22 Funding, by Source



The state of homelessness funding also impacts the community's ability to plan and execute effective programs. The community is currently patching together more than 50 separate federal, state, local, and private funding sources — all of which have different rules, requirements, and timelines. Because over half of the homelessness response system's funding resources are nonrecurring, service providers face a difficult cycle of scaling programs up and down, hiring and downsizing, repurposing and transitioning. Increasing the community's programmatic inventory at the rate needed in future years cannot be done in one-year cycles.

Recurring vs. Nonrecurring Funds for Key System Programs, FY21–22



Progress Towards Home Together Goals

YEAR 1 PROGRESS TOWARDS

GOAL 1

Prevent Homelessness

Progress: Although the number of people losing their housing may have been higher without the pandemic-related eviction moratoriums[6], the number of people estimated to have become homeless in FY21–22 (4,033 people) still outpaced the rate at which people moved from homelessness to housing (3,010).

Reduce racial disparities in new and repeated homelessness: Black/African American, American Indian and Native Hawaiian people are all disproportionately represented among people becoming newly homelessness. Lack of new funding to expand program models identified as most likely to reduce disparities — such as targeted homelessness prevention, additional shallow subsidies and dedicated affordable housing—has impacted efforts to address racial inequities in the community.

6 Eviction moratoriums were adopted by the State of CA, County of Alameda and many cities in response to the COVID-19 pandemic and its economic disruptions. Some of these moratoriums have expired, and others will be lifted at a future date.

GOAL 1

Ongoing/Launched Activities, FY21–22

- County initiatives: Opportunity Accelerator initiative to pilot homelessness prevention services for Black/African American households in reentry; new Housing Problem Solving resources and training.
- Implementation of CalAIM housing navigation and tenancy sustaining services, serving more than 1,800 people in 2022.
- City-specific eviction prevention and rental assistance programs in Berkeley, Oakland, Fremont, Livermore, San Leandro, Dublin, Alameda and Pleasanton.
- Cities of Berkeley, Oakland and Hayward have launched shallow subsidy programs.
- City of Alameda launching a Guaranteed Income Pilot program focused on low-income residents.

Activities Pending Funding, FY21–22

- Flexible funds are needed to support subsidies for people with fixed or limited income with housing insecurity to relieve rent burden and reduce the risk of becoming homeless.
- Eviction prevention services and funding to fill in needs as eviction moratoriums end.
- Capacity building for service providers so that programs and services are well supported.

YEAR 1 PROGRESS TOWARDS

GOAL 2

Connect People to Shelter and Needed Resources

Progress: Alameda County's homelessness response system served 25% more people during FY21–22 compared to FY20–21. People served annually include those new to homelessness, those returning to homelessness and those still awaiting a housing resource, as well as people served in housing projects. Countywide, more than 1,500 crisis response units were added in FY21–22.[7]

CalAIM: In January of 2022, Alameda County launched its new Housing Community Supports programs in collaboration with managed care plans. Throughout the year, the Health Care Services Agency added housing navigation or tenancy sustaining services for more than 1,800 people, acting as an administrator over 14 direct service providers.

Coordinated Entry: Access Point and Housing Resource Center services were expanded significantly in FY21–22, adding several sites to serve people in target neighborhoods with the most significant racial disparities, and creating a new access point for Transition Aged Youth (18–24 years).

7 Crisis response programs provide temporary places for people to stay (whether it is a cabin, RV, safe parking site, emergency shelter bed, etc.) while they access other services and seek housing solutions.

GOAL 2

Ongoing/Launched Activities, FY21–22

- Adding Coordinated Entry Access Points for Survivors of Domestic Violence and Youth.
- Newly launched services in Santa Rita Jail, developing a care coordination re-entry team.
- Connecting former foster youth to dedicated rapid and supportive housing.
- Expanding access to shelter and needed resources throughout the county through HRC's, new tiny homes, drop-in centers and Street Outreach.

Activities Pending Funding, FY21–22

- Additional (and more flexible) resources and capacity to expand housing navigation and Access Points (for Veterans, Reentry, and additional access in encampments and priority neighborhoods).
- Increase behavioral and support services to help people in permanent housing to maintain their housing.
- Crisis response and support that is accessible for unsheltered people, and mental health and harm reduction services available for homeless people in shelters and other programs.

YEAR 1 PROGRESS TOWARDS

GOAL 3

Increase Housing Solutions

Progress: During the first year of the Plan, partners in Alameda County added close to 1,900 housing opportunities. Inventory added during FY21–22 includes 1,558 crisis response units, 577 slots of Rapid Re-Housing, and 813 new permanent housing units or subsidies, 495 slots of dedicated affordable housing[8] and 57 shallow subsidies. This increase represents 89% of the total inventory goal set for the first year of the Home Together Plan. An additional 1,800+ housing units are anticipated to become available in the next two years of the Plan.

Some innovative housing solutions recommended in the Home Together Plan, such as subsidies for people with fixed or limited incomes and accelerated expansion of dedicated affordable housing for people experiencing homelessness who do not need intensive services, could not be fully launched without an influx of flexible funding.

8 Includes 488 Emergency Housing Vouchers (awarded to local Public Housing Authorities) which are not able to be reissued or transferred once out of use by the original recipient.

GOAL 3

Ongoing/Launched Activities, FY21–22

- Developed new housing subsidies for homeless housing units.
- Housed more than 1,700 people from Project Roomkey into permanent housing.
- Opened new PSH and Homekey projects throughout the county.
- Made more than 800 referrals for Emergency Housing Vouchers.
- Cities of Berkeley, Oakland, Livermore, Newark and Fremont dedicated funding towards PSH, including units targeted for frail/ older adults.
- New PSH for medically frail and elderly awarded in Hayward. Cities of Pleasanton and Fremont are funding Rapid Re-Housing programs.

Activities Pending Funding, FY21–22

- Expand the supply of PSH subsidies and units to scale.
- Create dedicated affordable housing for people who do not need intensive services to scale.
- Add new slots of Rapid Re-Housing for those who can pay full rent over time.

YEAR 1 PROGRESS TOWARDS

GOAL 4

Build Coordination, Communication and Capacity

Progress: In the first year of the Plan, Alameda County's homelessness response system expanded capacity to serve those experiencing homelessness, added resources to help resolve people's homelessness, and launched numerous activities related to each of the Home Together goals, though the impacts of many of these efforts will likely be seen in FY22–23 and future years.

People with lived experience: During the first year of the Plan, two cohorts of the Emerging Leaders Program helped to bring people with lived experience into key roles in our Continuum of Care (CoC), helping shape our governance structure and participate on the CoC Board and related committees. The program provides in-depth skill-building and leadership development tailored to the issue of ending and preventing homelessness in Alameda County. Program participants are also building a robust network of alumni, peers and mentors who share their commitment to ending homelessness.

DATA: The development of this reporting process marks the community's opportunity to implement new tools and processes to collect, track and analyze system data to measure progress towards the Home Together goals. As such, a number of strategies have emerged, including: efforts to improve data collection; deeper or revised outcome analysis; timelines and procedures to better align with reporting needs; and tackling constraints facing partner agencies. These efforts will help to ensure that the most timely and accurate understanding of priorities, needs, gaps and trends in Alameda County's homelessness response system can inform strategic decision making among elected leaders and community stakeholders.

GOAL 4

Ongoing/Launched Activities, FY21–22

- Two cohorts of Emerging Leaders bringing people with lived experience to CoC governance and beyond.
- Improving Homelessness Management Information System (HMIS) functionality and regularly reviewing system and program outcome data disaggregated by race.
- Using Social Health Information Exchange to support smaller providers with billing Medi-Cal through OHCC.
- Improved data collection to track data for youth and young adults and by race and ethnicity.
- Capacity building for service provider organizations serving the homeless population.

Activities Pending Funding, FY21–22

- Funding needed to improve HMIS coverage and confidence in HMIS to be the primary method for future data tracking, particularly for special populations highlighted in the Home Together Plan.
- Additional career and financial support for people with lived experience of homelessness.
- Support to providers in recruiting and retaining staff.

Conclusion

A year of action on the Home Together 2026 Community Plan has resulted in significant expansion of programs and resources, but for a growing population.

Community partners have made extraordinary efforts to expand the homelessness response system using every available resource, but the rate of growth in homelessness, the challenges associated with piecing together funding and the lack of reliability of those sources continues to pose major roadblocks to achieving the vision of Home Together.

Priorities for the coming years of implementation of the Home Together 2026 Community Plan will continue to focus on programs and activities that reduce racial inequities, decrease both first time homelessness and returns to homelessness, accelerate the process of people resolving homelessness and gaining housing, expand housing availability, improve the quality of data about people being served by the homelessness response system, and expand crisis response inventory to reduce unsheltered homelessness.

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Office of Homeless Care and Coordination

Alameda County Coordinated Entry Policies

First approved	*February 22, 2022*
Last reviewed/Last revised	*March 31, 2023*
Author of policy/ policy revision	*Office of Homeless Care and Coordination*
Approved by	*System Coordination Committee*
Effective date	*February 22, 2022*
Next review required by	*March 31, 2024*

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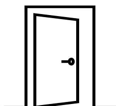
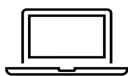
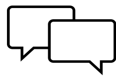
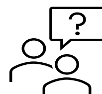
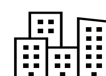







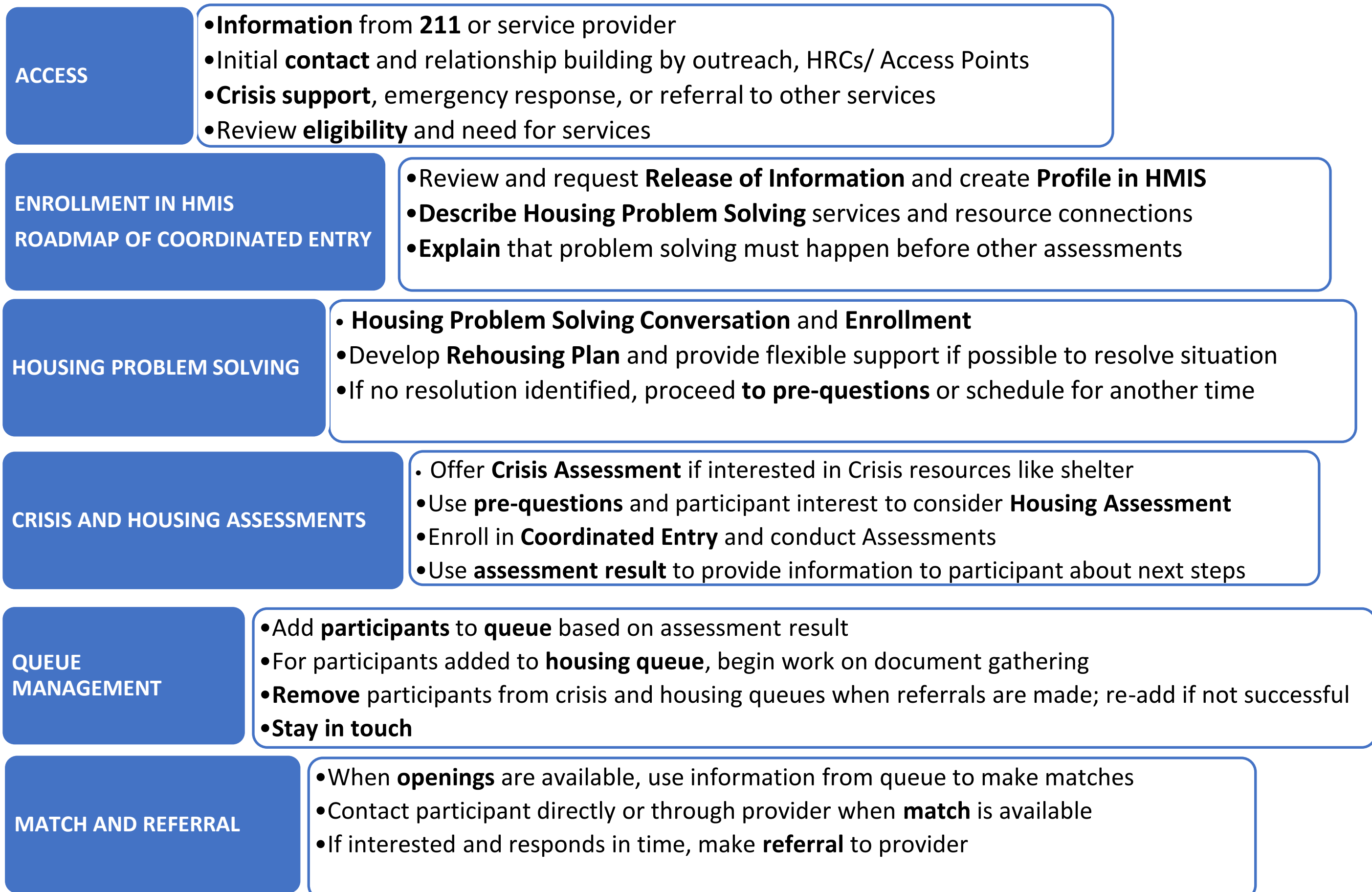
1. Introduction and Overview

Why Coordinated Entry?

At its best, coordinated entry allows our community to match people who are homeless quickly to the best pathway to housing that will meet their needs. It allows us to ensure that decisions and referrals will uphold our commitment to racial equity and to serving our most vulnerable county residents. We aspire to making coordinated entry all about access that is open, clear, and useful.

Alameda County's Coordinated Entry has the following key elements:

Coordinated Entry Process Overview



1.1 Purpose of Coordinated Entry

Alameda County defines Coordinated Entry as the approach to coordinate and manage the Housing Crisis Response System's resources to enable providers to make equity-consistent decisions to best connect people experiencing homelessness to interventions to end their homelessness based on available information and resources.

The Coordinated Entry *process* serves to ensure that all persons experiencing homelessness have fair and equal access to the same set of resources and services regardless of where they present for assistance, and that resources for households with greater service and housing needs are targeted to those who need them most.

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

1.2 Coordinated Entry Policy Requirements

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

1.3 Scope of Coordinated Entry

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

1.3.1 Programs Required to Participate

Programs and projects that receive funding from the HUD CoC and ESG programs, from the State Homekey programs, and from County of Alameda homelessness-specific funding (including but not limited to general fund, HHAP, MHSA, CDBG and EHV and some programs funded by HOPWA targeted for people experiencing homelessness and living with HIV) including shelters and dedicated homeless housing units or resources, must use the HMIS system and participate in Coordinated Entry.

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

Required participation may look differently depending on the design of the program and whether access to it depends on prior enrollment in another CE program. For example, a

CoC-funded Rapid Rehousing program serving specific target populations and people staying in specific shelters does not have to be filled using the CE Housing Queue, *if* the initial match to shelter was a result of use of the Crisis Queue, and if the program maintains clear, standard, and objective criteria for subsequent enrollment.

1.3.2 Programs Encouraged to Participate

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

1.3.3 Participation by Domestic Violence programs

The Federal government prohibits programs that specifically serve survivors of domestic and/or gender-based violence from entering client data into HMIS. Such programs in Alameda County will use a comparable database and will participate in Coordinated Entry through one or more dedicated Access Points, utilizing separate and non-shared data collection and the use of unique identifiers that protect participant privacy while allowing survivors enrolled in domestic violence (DV) programs access to the resources managed by Coordinated Entry.

1.4 Guiding Principles

The following guiding principles reflect key values and features of the current CE design and a commitment to implement and evaluate the system in alignment with these principles.

1. Coordinated Entry will embody in all steps of the process a commitment and practice of direct communication and transparency with participants about the process, limitations on resources and the likelihood of and timing of any assistance.
2. The Coordinated Entry system will operate similarly in each place the services are offered so that participants have equal access to support and resources regardless of where they seek assistance or their circumstances.
3. Historic and current racial inequalities will be considered in the design, implementation and evaluation of the CE process and system, and accountability for reducing disparities and increasing equity within the housing crisis response system will be part of the required results.
4. The CE process will be trauma-informed and personal information will be collected from participants only as needed and when relevant to a determination or decision needed to help meet the participant's self-reported needs. Efforts will be made to ensure that participants do not need to repeat information.
5. The Coordinated Entry system and the programs to which it refers will be low barrier and operate consistent with the core practices of harm reduction and Housing First.

6. Participants are experts in their own lives and will make choices about what is right for them. Such choices may be constrained by the availability of resources but will not prevent the participant from being served.
7. The reality of limited resources means that participants may not receive the most desirable or appropriate resources for their needs. All participants will retain the ability to engage continuously with the system and seek and receive support for a self-directed resolution.
8. Training, monitoring, and evaluation will be consistent with the above principles.

1.5 Governance

1.5.1 Required Roles

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

1.5.1.1 Policy Oversight Entity

The CoC serves as the Policy Oversight Entity which reviews policy and establishes participation expectations, and data collection, quality and sharing protocols. The CoC has designated primary responsibility for this function to the System Coordination Committee.

1.5.1.2 Management Entity

The Alameda County Office of Homeless Care and Coordination (OHCC) is the Management Entity designated by the CoC to implement day-to-day workflow of the Coordinated Entry process. Management Entity responsibilities include establishing day-to-day management structures, promoting standardized screening and assessment processes, developing and delivering training, and conducting monitoring.

Further information about the Governance and roles and responsibilities of the Policy Oversight and Management Entity can be found in HUD's Coordinated Entry Management and Data Guide and in the Memorandum of Understanding between the CoC and the Office of Homeless Care and Coordination.

1.6 Use of HMIS

The County-wide Homeless Management Information System (HMIS) is the data system that is used for all Coordinated Entry activities including Housing Problem Solving, enrollment, assessment, prioritization, queue management, posting openings in shelter programs, and matching. The Management Entity maintains a separate database for tracking and matching to housing openings.

1.6.1 HMIS Training and licensing

All Access Point staff and all receiving entities for referrals must be trained and licensed to use the HMIS system and follow all requirements in the HMIS policies.

1.6.2 Privacy and Security

All Access Points will follow HMIS protocols for obtaining participant consent to share and store participant information for purposes of assessing and referring participants through the Coordinated Entry process. This includes all rules regarding the capture, transmission, and storage of Personally Identifying Information.

1.6.3 Comparable Database

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

1.6.4 Right to Abstain from Disclosing or Sharing Information

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

1.7 Non-discrimination and Affirmative Marketing

1.7.1 Applicable Civil Rights and Fair Housing Law

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

- Fair Housing Act prohibits discriminatory housing practices based on race, color, religion, sex, national origin, disability, or familial status;
- Section 504 of the Rehabilitation Act prohibits discrimination on the basis of disability under any program or activity receiving Federal financial assistance;
- Title VI of the Civil Rights Act prohibits discrimination on the basis of race, color or national origin under any program or activity receiving Federal financial assistance; and
- Title II of the Americans with Disabilities Act prohibits public entities, which includes state and local governments, and special purpose districts, from discriminating against individuals with disabilities in all their services, programs, and activities, which include housing, and housing-related services such as housing search and

referral assistance. Title III of the Americans with Disabilities Act prohibits private entities that own, lease, and operate places of public accommodation, which include shelters, social service establishments, and other public accommodations providing housing, from discriminating on the basis of disability.

- HUD's Equal Access Rule at 24 CFR 5.105(a)(2) prohibits discriminatory eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC Program, ESG Program, and HOPWA Program. The CoC Program interim rule also contains a fair housing provision at 24 CFR 578.93. For ESG, see 24 CFR 576.407(a) and (b), and for HOPWA, see 24 CFR 574.603.

1.7.2 Affirmative Marketing

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

2. ACCESS

2.1 Full Coverage

Alameda County's Coordinated Entry approach provides full coverage of the entire geography of the County, which is the same as the Continuum of Care boundaries, through a variety of methods which include physical Open Access Points known as Housing Resource Centers (HRCs) distributed across the county, as well as street outreach which covers all regions of the County, and phone line access.

2.2 Access Points

Access Points are the virtual or physical places or programs where an individual or family experiencing homelessness or at imminent risk of homelessness seeks and receives assistance to connect to resources from the Housing Crisis Response System that are available through Coordinated Entry. An Access Point may be Open or Limited.

2.2.1 Open Access Points

An Open Access Point provides all of the services associated with CE to any eligible person in its target population group(s) regardless of whether they receive any other services from the Access Point provider.

2.2.2 Housing Resource Centers (HRC)

Housing Resource Centers are Open Access Points at physical sites located across the County offering in-person and virtual services. Housing Resource Centers must offer the full range of Coordinated Entry activities including outreach, triage, Housing Problem Solving,

assessment and matching to regional resources. HRCs may be targeted to specific populations and geography but must be open to all eligible persons.

2.2.3 24/7 Call Center

Alameda County Coordinated Entry will also utilize a 24/7 Call Center to connect potential participants with HRCs and/or outreach teams and to refer to other resources including prevention and crisis resources. The Call Center will act as an Open Access Point conducting initial screening (Triage), provide referrals to other resources outside of the CE system and carry out warm transfers to HRCs during business hours. Outside of business hours the Call Center will refer to crisis resources and provide households seeking CE services with information about where to access these services and/or when to expect to hear from an HRC.

2.2.4 Limited Access Points

Limited Access Points provide CE services to eligible participants with whom they have an existing service relationship or who must meet additional criteria in order to receive services. Examples of Limited Access Points may include mental health clinics, schools, hospitals, or other settings and certain outreach teams. Limited Access Points must be trained, provide the entire range of CE services, and must use HMIS (unless provider is a Victim Service Provider). Limited Access Points that do not receive funding from a CE-dedicated source will sign an MOU with the Management Entity.

2.2.5 Access through Outreach Teams

Trained and designated outreach teams may serve as either Open or Limited Access Points. Such teams include the County's Street Health teams, which serves as a Limited Access Point serving designated encampments and outdoor locations by region and provides CE services to eligible and enrolled clients.

An outreach team that does not provide the full range of Coordinated Entry activities may refer a participant to an HRC or another outreach team that is able to provide full CE services but must ensure that such connections are easily made and do not delay or deny service to any eligible participant. Examples of such a link may be an outreach team that performs all functions of CE including Housing Problem Solving but refers to an HRC for flexible financial assistance to support an identified problem-solving resolution.

2.3 Access Points for Designated Subpopulations

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

1. Transition Age Youth
2. People fleeing domestic or gender-based violence

3. Veterans of the U.S. Military *(proposed)*

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

2.4 Weekend and Evening Access

2.4.1 Access to Emergency Resources

To ensure that persons experiencing a housing crisis or homelessness can be served during times that HRCs are not open and/or street outreach teams are not operating, the CoC has designated the 2-1-1 line to serve as 24/7 Call Center. The call center will have information about resources such as shelter beds that may be open and accepting referrals over a weekend or in the evenings.

2.4.2 Access to Coordinated Entry process

The 2-1-1 call center provides a portion of the Coordinated Entry workflow and can conduct Triage, make referrals to crisis resources, and refer to HRCs for additional services and to conduct assessments. HRCs must make an effort to respond to such a referral within 24 hours if during the work week, or up to 72 hours over a weekend or holiday period. CE Assessments are not required for short-term referrals to crisis resources during times that HRCs and street outreach teams are not operating.

2.5 Non-discrimination and accessibility

2.5.1 Non-discrimination

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

2.5.2 Language Access

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

2.5.3 Physical Accessibility

When selecting HRC's the County will contract with agencies proposing locations that are physically accessible or are able to make modifications such as adding ramps or elevators for persons who require them. The County will also consider the availability of public

transportation and the proximity of Access Points to other frequently used resources such as local emergency shelters, drop-in centers, free food resources, and other crisis response service locations.

3. Assessment and Prioritization

3.1 Overview of Assessment and Prioritization

The Coordinated Entry process uses specific Assessments to obtain information about both the immediate and long-term needs of persons and households seeking services. Portions of these assessments are weighted and assigned points leading to a score which is used, along with eligibility information, for placing participants on to prioritized queues for referral to crisis and housing resources.

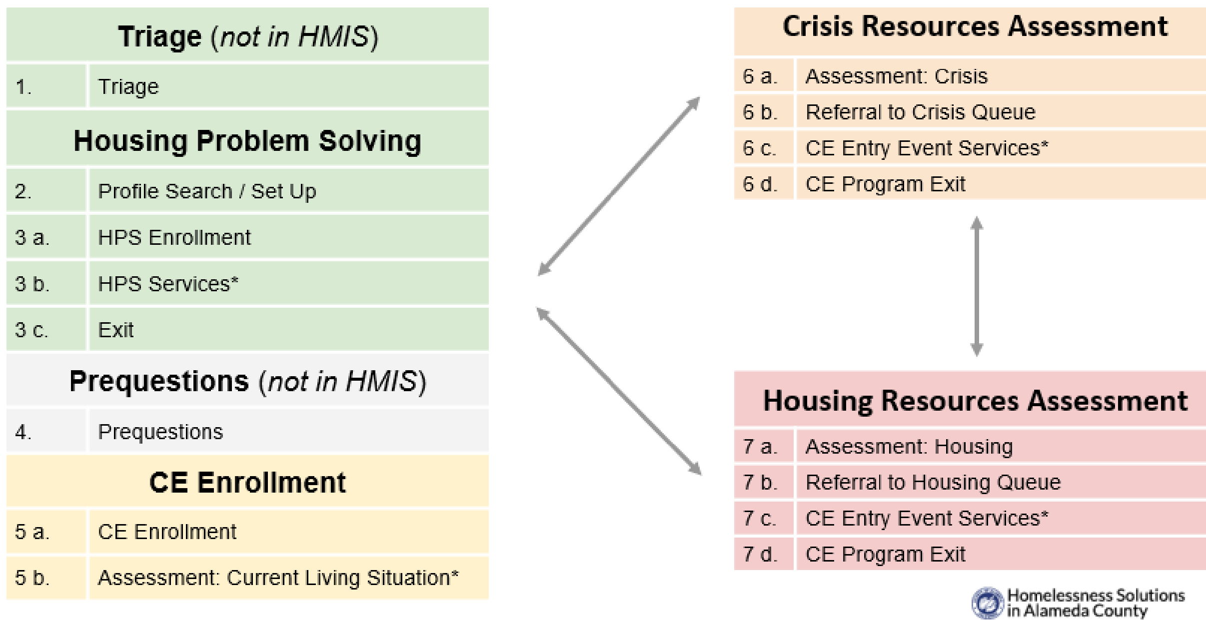
3.2 Overview of Assessment and Prioritization Workflow

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

3.2.1 Steps in Workflow

The Assessment and Prioritization workflow has seven steps. These steps include:

1. Triage
2. Client Profile
3. Conduct Housing Problem Solving
4. Assessment pre-questions
5. Enrollment in Coordinated Entry
6. Crisis Assessment
7. Housing Assessment



3.2.2 Timeframes

While the seven steps of the Assessment and Prioritization process must occur in the order listed above, not all steps must occur at the same time. Access Point staff will determine with a participant whether there is time and interest in proceeding through the steps in one interaction or whether to schedule additional time to complete a step or move on to another step in the process.

3.2.3 Requirement to Follow Workflow

All Access Points must follow the order of the Workflow for the smooth and fair functioning of the Coordinated Entry process. Skipping steps in the workflow may result in some households getting access to resources ahead of others who are eligible and prioritized. It may also result in Housing Problem Solving resolutions that could meet a participant's needs being overlooked or lost.

Access Points or specific Access Point staff which repeatedly fail to follow the workflow may lose their ability to conduct assessments or their access to the Coordinated Entry agency in HMIS.

3.3 Triage

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

3.3.1 Urgent needs

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

3.3.2 Safety Needs and Safety Planning

Questions designed to determine if someone may be a fleeing or attempting to flee domestic violence or human trafficking or is a survivor of the same. Anyone who at this point is identified as a survivor should be offered DV resources. If the person who is a survivor declines these resources, and continues to the next step in the workflow, a Housing Problem Solving conversation, safety considerations and any safety planning should be addressed in the resolution plan.

3.3.3 Housing Status Determination

Participants will be eligible for the services and potential resources of Coordinated Entry if they are currently experiencing homelessness. Questions to determine whether the participant meets the definition of "literal homelessness" will be asked prior to proceeding with the rest of the workflow

3.3.3.1 If the above steps result in a participant being eligible for and in need of Coordinated Entry services, the Access Point will proceed to create or update a Client Profile in HMIS

3.3.3.2 If the household is not eligible for Coordinated Entry services and could benefit from homelessness prevention, the Access Point will refer to the 2-1-1 line to determine where prevention resources are currently available or may refer the household directly to a homelessness prevention program.

3.3.3.3 When prevention resources are available in HRCs and Access Points they are prioritized for people who are at imminent risk of homelessness and/or have previous homelessness, especially those who are completing a rapid re-housing program and remain at high risk for returning to homelessness.

3.4 Housing Problem Solving

3.4.1 Definition of Housing Problem Solving

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

3.4.2 Key components of Housing Problem Solving

Housing Problem Solving consists of three key components: an effective HPS conversation, a Housing Resolution Plan if a resolution is identified, and connections to other services and supports which may include:

1. Referrals to other programs and resources
2. Conflict resolution and mediation support
3. Housing search and housing location assistance
4. Flexible funds to help secure a temporary or permanent housing resolution

3.4.3 Continuous Availability of Housing Problem Solving

All Coordinated Entry participants will be offered Housing Problem Solving prior to any Assessment. Housing Problem Solving is also continuously available to anyone who qualifies for services from the Coordinated Entry System. Based on available inventory and whether a household is added to one or more queues, Housing Problem Solving may be the primary service that a person or household is offered.

3.4.4 Housing Problem Solving Policies

Access Points and other programs that offer Housing Problem Solving services as part of the Coordinated Entry process must follow the Housing Problem Solving Policies adopted by the CoC.

3.5 Assessment Pre-Questions

Consistent with the principle that participants should not be asked unnecessary questions or misled as to the likelihood of receiving assistance, pre-questions are used to know if the next steps (enrollment and assessment) are necessary due to the participant's desired services and their likelihood to be prioritized for a resource. These questions will be different depending on the subpopulation to which the participant belongs and the assistance they are seeking, given that anticipated available resources vary by subpopulation.

Pre-questions may change from time to time based on eligibility and prioritization criteria for resources and changes in resource inventory

Pre-questions are not in or recorded in the HMIS system. Access Points will be furnished with the pre-questions and notified if the questions change.

3.6 Coordinated Entry Enrollment

All Coordinated Entry participants that proceed from Housing Problem Solving to an Assessment must first be enrolled in the Coordinated Entry program in HMIS. An enrollment in the CE program allows the CoC to report as required on the operations and outcomes of Coordinated Entry.

3.6.1 Current Living Situation

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

In general, this assessment should be updated at every encounter as current living situation may change frequently. However, for programs that may see participants daily, such as street outreach and drop-in programs, a current living situation assessment must be done not less frequently than once per calendar month and at any time that a staff person becomes aware that a participant's living situation has changed.

3.6.2 Disenrollment

A participant is disenrolled from Coordinated Entry if:

1. They are referred to and enroll in another resource, or
2. They have no Coordinated Entry "events" (an HMIS term for any contact with Coordinated Entry) over a six-month period.

Participants who are disenrolled from Coordinated Entry may be reenrolled at any time but must go through the prior steps on the workflow to determine that they remain in need of and eligible for Coordinated Entry services. Disenrollment from Coordinated Entry is a separate step from removal from a queue which is covered below.

3.7 Crisis Assessment

3.7.1 Purpose of Crisis Assessment

The purpose of the Crisis Assessment is to ascertain the household's interest in emergency shelter, transitional housing, or safe parking and to determine the household's relative priority for crisis resources which are currently or anticipated to become available.

3.7.2 Brevity

The Crisis Assessment will be brief and rely primarily on information that can be quickly determined and is of a minimally personal nature.

3.7.3 Crisis Assessment Prioritization Factors

The Crisis Assessment incorporates factors from the participant profile and the Coordinated Entry enrollment, as well as additional questions for determining relative priority. Questions associated with the following factors are used to establish a Crisis Assessment score.

- Prior Living Situation
- Household Information – number and ages of members of the household
- Income – combined household income
- Health – whether one or more members of the household has a condition, disability (including HIV+) or health need that increases their priority for crisis resources

3.7.4 Conducting the Assessment

Access Points will ensure that the time and privacy needed to conduct a Crisis Assessment are available and that the participant is comfortable proceeding before beginning a Crisis Assessment. Access Point staff should explain the process and purpose and the potential outcomes before beginning, though the questions in the assessment should be asked as written.

3.7.5 Active Timeframe for a Crisis Assessment

A Crisis Assessment is considered valid and active for 90 days, *if* nothing in the participant's situation changes. After such time, or if the participant has had a change in circumstances or housing status, the Assessment should be updated.

3.7.6 Messaging after Crisis Assessment

After completing a Crisis Assessment, an Access Point worker can immediately see the participant's score in HMIS. The Access Point worker will refer to the relevant Crisis Assessment Threshold Score for the population group of the participant, if any, in use at the time and will inform the household whether they are being added to the Crisis Queue and what they can anticipate as next steps. The Access Point worker should utilize guidance regarding scores most likely to get matched to a crisis resource to discuss the likelihood and

likely wait time for the desired resource. Guidance will be included in trainings and made available to Access Points.

3.8 Housing Assessment

3.8.1 Purpose of Housing Assessment

The purpose of the Housing Assessment is to ascertain the participant household's interest in and eligibility for time-limited housing subsidies (such as Rapid Rehousing) or permanently subsidized housing and the participant's relative priority for permanent housing that is currently or anticipated to become available.

3.8.2 Scope of Housing Assessment

The Housing Assessment is a more in-depth assessment than the Crisis Assessment. It contains additional questions and questions that are considered to be more personal or sensitive in nature. For this reason, and to avoid creating expectations that are misleading regarding the likelihood of receiving a housing referral, Access Points will seek to minimize the number of persons assessed with the Housing Assessment who, based on the pre-questions, are unlikely to achieve the Threshold Score.

3.8.3 Housing Assessment Prioritization Factors

The Housing Assessment incorporates factors from the participant profile and the Coordinated Entry enrollment, the Crisis Assessment questions, if completed, as well as some additional questions. Questions associated with these factors are used to establish a score.

- Crisis Assessment questions including household size and ages, length of time homeless, disabilities (including HIV+) and health related questions
- Additional questions about health conditions and wellbeing
- Questions regarding housing history and housing barriers
- Questions regarding exposure to violence and risk of violence

3.8.4 Conducting the Housing Assessment

Access Points will ensure that the time and privacy needed to conduct a Housing Assessment are available and that the participant is comfortable proceeding before beginning a Housing Assessment. Access Point staff should explain the process and purpose and the potential outcomes before beginning, though the questions in the assessment should be asked as written.

If the participant has previously completed the Crisis Assessment the Access Point staff will review the recorded responses to these questions as part of the Housing Assessment.

3.8.5 Active Time Frame of Housing Assessment

A Housing Assessment is considered valid and active for 180 days as long as nothing has changed. After such time, or if the participant has had a change in circumstances or housing status, the Housing Assessment should be updated.

3.8.6 Messaging after Housing Assessment

After completing a Housing Assessment, an Access Point worker can immediately see the participant's score. The Access Point worker will refer to the Housing Assessment Threshold Score for all household types and subpopulations that the household is included in and will inform the household whether they are being added to the Housing Queue, what they can anticipate and what they should do as a next step, such as gathering identifying documents and staying in touch.

If the participant is not being added to the Housing Queue the Access Point worker should make clear that it is not likely there will be a long-term housing resource available for the participant and that they may continue to engage with Housing Problem Solving to seek a resolution. They should also share information about other resources that may be available to them, such as getting on affordable housing waitlists, funds for move in costs and potential flexible funding. The participant may remain on the Crisis Queue if they have completed the Crisis Assessment.

4. Queues and Queue Management

4.1 Overview of Queues

Queues are ordered lists of eligible and prioritized households used to match and refer to a specific set of corresponding resources available through the Coordinated Entry process. Queues are established and maintained in the HMIS system.

4.2 Crisis Queue

The Crisis Queue is a list of households that have indicated an interest in crisis resources including shelter, transitional housing, and safe parking, and that have been assessed using the Crisis Assessment and prioritized for such resources. The Crisis Queue contains key information about the household that is used to match clients to available crisis resources.

4.3 Housing Queue

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

4.4 Threshold Scores

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

4.4.1 Establishing threshold scores

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

4.4.2 Threshold variation by subpopulation

Because resources for certain subpopulations are more plentiful relative to the population group, such as families with children, Veterans and people living with HIV/AIDS, threshold scores may be different or there may be no threshold score required for certain household types. Information about how to apply thresholds scores will be made available to Access Points through frequent communication and training and will be updated as needed to reflect changes in inventory.

4.4.3 Adjusting threshold scores

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

1. A significant increase in inventory occurs or is anticipated that could result in resources being unused or underused if more households are not prioritized for those resources.
2. A significant decrease in inventory occurs that could result in many more households being prioritized than can be anticipated to be served.
3. The ratio at which referrals result in enrollments changes such that more or fewer households should be prioritized in order to fill openings in a timely fashion.

4.4.4 Frequency of adjusting threshold scores

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

4.5 Responsibility for Queue Management

4.5.1 Authorized Access Point staff have the ability to add participants to queues. Access Points may only add someone to a queue who has expressed interest in that queue, completed the corresponding assessment fully and received a score which meets or exceeds the threshold required to be placed on that queue.

4.5.2 Access Points may view in HMIS whether a participant on the queue has been assessed and whether they received the Threshold Score. Access Points are expected to review the queues frequently to ensure that they are not adding participants to queues prematurely or inappropriately.

4.5.3 Access Points or specific Access Point staff who repeatedly add participants to queues that do not qualify to be on that queue may lose their ability to conduct assessments.

4.6 Removal from a Queue

4.6.1 Removal from the Crisis Queue

A participant that has received and accepted a referral to a long-term stay shelter, transitional housing program or safe parking site should be removed from the Crisis Queue. Participants who indicate they are no longer interested in a crisis resource should be removed from the Crisis Queue. Participants in a night-to-night shelter or in a respite care shelter bed can be placed on the Crisis Queue if not already on it and may remain on the queue if on it already.

Participants who are removed from the Crisis Queue may and should remain on the Housing Queue unless referred to a program that includes a connected and guaranteed housing resources (such as a TH to RRH program).

4.6.2 Removal from the Housing Queue

A participant should be removed from the Housing Queue when they have been referred to a permanent housing resource within the crisis response system or if they are connected to and enrolled in a mainstream housing resource such as a Housing Choice Voucher, even if they are still engaged in housing search. Participants with a housing referral may remain on the Crisis Queue until they move into housing if they continue to want crisis housing.

4.6.3 Removal from All Queues

A participant should be exited from the Coordinated Entry program in HMIS and removed from all queues, if not already done, when they move into any type of permanent housing including on their own without assistance, if they leave the county without the intention to return within 90 days, are in institutional care for longer than 90 days, if they are deceased, or are no longer interested in being considered for any resource within Coordinated Entry.

4.6.4 Re-referral to Queue

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

5. MATCHING

5.1 Overview of Matching

Matching and Referral are the steps used by Coordinated Entry to identify open and available resources for participant households on the Crisis or Housing Queues that fit their eligibility and expressed preferences.

5.1.1 Regional Matching

Regional matching is the process of matching participant households to available or anticipated resources based on the region in which they have sought services. Regional matching is used for Crisis resources and for most Rapid Rehousing and is conducted by Housing Resource Centers. Some Rapid Rehousing programs may be matched to by Alameda County Health Care Services Agency (HCSA) staff in conjunction with HRCs.

5.1.2 County-wide Matching

County-wide matching is the process of matching participant households to available or anticipated resources anywhere in the County based on their eligibility and preferences. County-wide matching is primarily used for non-time limited permanent housing resources such as Permanent Supportive Housing and Dedicated Affordable Housing and is conducted by the Management Entity.

5.2 Matching for Crisis Resources

Participants seeking crisis resources consisting of Emergency Shelter, Transitional Housing and Safe Parking are matched from the Crisis Queue by Housing Resource Centers. Housing Resource Centers generally will match participants on the Crisis Queue from their region to programs within their region. An HRC may match clients from other regions to a crisis resource if there is not an eligible and interested participant from the region, or if another HRC has communicated that a client in their region has a critical need for a placement in another region because that need cannot be met within the region (i.e. safety, proximity to critical care, unusual family size, or need for specific accessibility).

Households are matched and referred to Crisis resources using the following criteria (in this order):

1. Meets the eligibility criteria for the program or opening
2. Meets specific project preferences, such as geographic targeting, as stated in MOUs and/or contracts
3. Score on the Crisis Queue
4. Date of referral to queue

Programs such as TH to RRH programs which combine crisis and housing resources in a single program may, in consultation with the Management Entity, elect to use the Housing Queue to fill the TH slots in lieu of the Crisis Queue (see below).

5.2.1 Denial of Shelter Admission

Any household matched to year-round emergency shelter or transitional housing program through Coordinated Entry can only be denied admission for reasons outlined in the Emergency Shelter Standards for Year-Round Shelters. In addition, if shelter is denied, the shelter operator must inform the referring HRC immediately, so that the household may remain eligible to be matched to another available resource.

5.3 Matching for Rapid Rehousing

Rapid rehousing is matched from the Housing Queue and considers prioritization, participant interest and the likelihood of a household being able to successfully resolve their homelessness with a rapid rehousing intervention (i.e., ability to pay rent independently after the temporary subsidy ends, which is covered by unscored questions in the pre-question phase). Most rapid rehousing resources are regional and are matched at a regional level by HCSA staff in coordination with Housing Resource Centers or directly by Housing Resource Center staff who coordinated closely with HCSA staff.

Some Rapid Rehousing is connected to other programs such as CoC-funded TH to RRH programs which begin with a transitional housing stay and then connect households in the TH program to RRH subsidy and services. In these cases, the RRH portion of the programs do not have to be filled using the CE Housing Queue, *if* the prior enrolling program was matched using either the Housing or Crisis Queue, and if the program maintains clear and objective criteria for enrollment in the RRH portion if such enrollment is not offered to all participants in the connected program.

5.4 Matching for Permanent Housing

Non-time limited permanent housing resources including Permanent Supportive Housing (PSH) and Dedicated Affordable Housing are matched county-wide by dedicated staff at the Management Entity. Countywide matching does not mean that a program or an individual may not have stated geographic preferences.

5.4.1 PSH Pool

The Housing Queue is used for matching to PSH, by focusing on a band of the highest scoring households on the Housing Queue. This group is considered to be in the PSH Pool.

The size of the PSH Pool is determined by:

1. Estimating the number of PSH vacancies in the upcoming year, including from turnover and from new projects leasing up, and
2. Determining a threshold score which targets a number of households that is roughly two times the anticipated PSH vacancies in the next 12 months.

Once a household is in the PSH pool their order or score on the queue is no longer primarily used for matching or for order of referral. Instead, any household in the pool may be matched to an available resource based on the Matching Factors.

5.4.2 Matching Factors for PSH

Households in the PSH Pool are matched to PSH based on the following factors, in this order:

1. Households meets eligibility criteria for the program or opening
2. Household meets PSH project preferences, as stated in regulatory agreements, MOUs and/or contracts
3. Households has all of the documents that are required for enrollment in the housing program (document readiness status)
4. Date of Housing Assessment
5. Participant preferences such as location or housing type
6. Housing Assessment score (used as tiebreaker if needed)

If there is not a household in the PSH Pool that can be connected to the opportunity after all eligible PSH pool participants have been matched, then households below the threshold score will get screened for matching in order of their score.

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

5.5 Document Readiness

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

5.5.1 Assistance with Document Readiness

Because document readiness is a factor in the order in which participants are offered access to housing resources, assistance with getting and storing necessary documents is a critical aspect of Coordinated Entry services. HRC's should determine whether a participant desires and needs such assistance, and whether they have an existing service relationship (for example with a shelter or street health case manager) that can assist with this task. High priority participants without such assistance will be prioritized for Navigation (see below). However, if a participant is not assigned to a Navigator and does not have another source of this assistance the Housing Resource Center or the Limited Access Point provider should provide this service.

5.6 Matching to Other Permanent Housing

Other Permanent Housing such as Dedicated Affordable Housing will be matched from the Housing Queue based on a modified version of the PSH matching process, with consideration to the following factors:

1. Households meets eligibility criteria for the program or opening
2. Household meets project preferences, such as geographic targeting, as stated in MOUs and/or contracts
3. Housing Assessment information
4. Participant preferences such as location or housing type

5.7 Matching for Navigation services

Navigation services provide persons who are either matched to a housing resource or likely to be matched to a housing resource by virtue of their placement on the queue with assistance gathering documents, applying, searching for housing, and moving in. They also provide support with referrals and service connections for other needs of the participant. When ample resources are available, Navigation will be offered to any prioritized participant when placed on the Housing Queue that wants these services and does not have a relationship with a service provider able to perform the navigation function.

As Navigation resources are not currently adequate to meet the need, Navigation is matched to and provided in two ways

1) Based on availability it is offered to participants in the PSH Pool based on time on the queue
2) If not previously matched to a Navigator, Navigation services may be offered when referred to a specific housing resource (such as EHV) that has dedicated Navigation attached to that pathway.

6. Referral

6.1 Referral

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

6.2 Match

Prior to a formal referral being made for any resource, one or more matches may be identified. A match is based on the information in HMIS, if a participant meets the criteria for an opening and they have been prioritized highly enough that they are either going to be referred to an opening directly upon confirmation of interest (such as for shelter) or they are being asked to submit documents for that program.

A match is the first step toward a referral but does not guarantee that a participant will be referred, or if referred that they will be accepted to the program. Typically, with housing programs multiple participants are matched for each opening.

6.3 Matching and Referral for Crisis Resources

When a participant is matched to an open crisis resource, the HRC will attempt to notify the participant, if reachable, and any service provider that is associated with their Coordinated Entry enrollment and/or any other service provider contact such as a Navigator, identified case manager or someone else designated by that participant. Once the participant is reached and confirms interest a referral may be made.

6.3.1 Number and timing of eligible referrals

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

6.3.2 Confirmation of a Referral

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

6.3.3 Acceptance of the Referral and Arrangements for Move in

If a referral is accepted by the participant, the crisis bed operator will notify the HRC. The crisis resource provider will support the participant to prepare for occupying the unit or bed as quickly as possible.

6.3.4 Denial of Referral

If an applicant is denied by the program to which they have been referred, they are eligible to be re-referred to the queue.

6.3.5 Refusal by Participant

In order to allow for participants to exercise choice, a participant may refuse a referral to a crisis resource up to three times before being removed from the Crisis Queue.

6.4 Matching and Referral to Permanent Housing Resources

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

6.4.1 Number of eligible referrals

Depending on the program type and the number of openings, the Management Entity may provide more than one eligible referral.

When an entire building or portion of a building is first leasing up, Coordinated Entry will send 1.5 referrals for each opening.

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

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

6.4.2 Confirmation of a Housing Referral

The housing operator must confirm receipt of a referral to OHCC. If the applicant appears eligible, the housing operator must contact the applicant and/or their service provider within 10 business days to arrange for any further steps such as an application review or interview. Initial acceptance of the referral may be one step in the process and does not mean that the person has been confirmed as eligible by the housing provider or will be approved for the housing opportunity.

6.4.3 Acceptance of the Referral and Arrangements for Move in

If a referral is accepted the housing operator will notify the service provider, the participant and OHCC. The service provider will support the participant to prepare for move in, including applying for funds for move in costs when applicable. The existing service provider may begin to coordinate a warm hand off to services associated with the housing program or may continue to provide services temporarily or long term if there are not identified services associated with the housing program.

6.4.4 Denial of Referral

If the housing operator reviews the initial referral and the applicant appears ineligible, they will notify OHCC.

Denials after an accepted referral will be communicated to OHCC, the applicant, and their service provider. If an applicant is denied the housing operator will provide documentation of the denial, along with information about how to appeal, to the participant, the service provider and OHCC. If the participant choses to appeal and their appeal is denied the service provider will support the individual to be re-referred to the Housing Queue if still eligible. The participant may choose not to appeal, in which case the service provider will support the participant to be re-referred to the Housing Queue if still eligible.

6.4.5 Refusal by Participant

A participant may refuse a referral or may, after accepting a referral, determine not to accept the housing unit or resource offered. To allow for participant choice, a participant may refuse two referrals or offers of housing. Upon refusal of a third offer for which they qualify they may be removed from the Housing Queue. For some resources this policy may be changed to reduce the number of offers to two.

6.4.6 Expiration of a Match or a Referral

If a period to respond to a match (5 days) or a referral (10 days) has expired, a participant may still be considered if there are still available units or slots in the program. The participant's service provider should reach out to OHCC to determine whether they can still submit documents.

7. TRAINING

7.1 Access Point Trainings

All Access Point staff that conduct assessments and carry out Housing Problem Solving must be trained in the Coordinated Entry Workflow and the use of HMIS. This includes having had Privacy and Security training and a valid license for use of HMIS and participating in all introductory level trainings before performing Coordinated Entry work.

All Access Point staff including front line staff and managers must participant in the overview training. Staff conducing Housing Problem Solving and Assessments must participate in all modules related to the participant-facing and queue management work flow, while matchers are provided with training related specially to matches and referrals.

The following chart indicates the training modules and for whom they are suggested or required.

Who takes this course?

CE 2.0 Training by Roles Chart:

ROLE / COURSE	1: Overview	2A-B: System Entry & HPS	3A-B: Prequestions & Enrollment	4: Crisis Assessment & Queue	5: Housing Assessment & Queue	6A-C: Matching & After	7: HMIS Reports	8: Q & A
HRC/Access Points: direct service staff including outreach	Req	Req	Req	Req	Req			Req
HRC/Access Points: Program Manager, Supervisor, HMIS Liaison, QA staff	Req	Req	Req	Req	Req		Req	Req
Shelter, Outreach, Housing Navigators, Other non-HRC/Access Points staff	Req	Req	Req (3A)			Req (6A, 6C)		Sug
HRC staff that does matching	Req			Sug	Sug	Req (6A, 6B, 6C)		Sug

Req = Required. Sug = Suggested

Homelessness Solutions in Alameda County 3

7.2 Annual Trainings and Refreshers

The Management Entity will make all required training available through recordings and self-guided modules so as not to delay the start of work for new hires. All Access Point staff are expected to participate in at least one training annually which will be made available by the Management Entity. Access Point staff and supervisors are also expected to use the recorded

trainings and accompanying materials to refresh their knowledge as needed and may be directed by the Management Entity to review an existing training prior to proceeding with work.

7.3 Learning Collaborative

The Management Entity will convene one or more Learning Collaboratives of HRC's and other organizations engaged with Coordinated Entry. Learning Collaboratives will include training and reinforcement of training. Access Points must participate in the Learning Collaborative, and representatives should communicate to their staff information that is provided in the Collaborative meetings related to the appropriate delivery and recording of Coordinated Entry services.

8. DATA AND EVALUATION

8.1 Data Collection and Management Reports

The Management Entity uses information collected in the HMIS system to prepare periodic and regular CE Management reports that reflect on the operations and outcomes of the CE system and its components.

8.1.1 Report content

The set of management reports will be determined in conjunction with the CoC. Such reports will contain data available and considered to be reliable about

- number of calls received by the call center seeking housing assistance and number of callers referred by the call center to an HRC
- numbers and characteristics of participants in Housing Problem Solving, services delivered, financial assistance expended, and outcomes achieved
- type and number of assessments administered, and the numbers and characteristics of participants placed on queues
- matches and referrals made including numbers and characteristics of those matched and referred and the success rates of such referrals
- data about the time elapsed between various steps in the Coordinated Entry process such as HPS, Assessment, match, referral and successful program entry.

All Coordinated Entry reports, to the extent feasible, will provide information about the functioning of system as a whole and about the process and results for participants based on race and ethnicity to fully be able to analyze and address racial and ethnic disparities and create racial equity.

8.1.2 Reporting Frequency

Management reports will be provided according to a calendar agreed to by the Management Entity and the CoC.

8.2 Evaluation

8.2.1 Annual Evaluation

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

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

8.2.2 Third Party Evaluator

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

9. Grievances and Complaint Tracking

9.1 Right to File a Grievance

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

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

9.2 Tracking and Reporting

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

APPENDIX A: GLOSSARY

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

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

Access Point: Access Points are the virtual or physical places or programs where an individual or family experiencing homelessness or at imminent risk of homelessness seeks and receives assistance to connect to resources from the Housing Crisis Response System that are available through Coordinated Entry. An Access Point may be Open or Limited.

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

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

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

Countywide Matching: The process of matching eligible participants to available or anticipated openings across the entire County.

Crisis Assessment: The Crisis Assessment is a short set of questions recorded in HMIS which are used is to ascertain the participant's eligibility for and interest in emergency shelter, transitional housing or safe parking and the household's relative priority for crisis resources currently or anticipated to be available. It is used to determine whether a participant is placed on the Crisis Queue.

Crisis Queue: The Crisis Queue is a list of households that have indicated an interest in crisis resources including shelter, transitional housing and safe parking, and that have been assessed using the Crisis Assessment and prioritized for such resources. The Crisis Queue contains key information about the household that is used to match clients to available crisis resources.

Homeless Management Information System (HMIS): A Homeless Management Information System (HMIS) is a local information technology system used to collect client-level data and data on the provision of housing and services to homeless individuals and families and persons at risk of homelessness. Each Continuum of Care (CoC) is responsible for selecting an HMIS software solution that complies with HUD's data collection, management, and reporting standards.

Housing Assessment: The Housing Assessment is a set of questions recorded in HMIS which are used is to ascertain the participant's eligibility for and interest in emergency shelter, transitional housing or safe

parking and the household's relative priority for crisis resources currently or anticipated to be available. It is used to determine whether a participant is placed on the Crisis Queue.

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

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

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

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

Limited Access Point: Limited Access Points provide CE services to eligible participants with whom they have an existing service relationship or who must meet additional criteria to those for CE in order to receive services.

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

Open Access Point: An Open Access Point provides all of the services associated with CE to any eligible person in its target population group(s) regardless of whether they receive any other services from the Access Point provider.

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

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

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

Queue: A list of clients that have been assessed and prioritized for a resource.

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

Regional Matching: The process of matching eligible participants to available or anticipated openings within a specific region.

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

Subpopulation: A subset of people experiencing homelessness or at risk of homelessness who share certain characteristics of household type, age or status and may be served based on their membership in the subpopulation. Subpopulation categories in Coordinated Entry include Adult Only households, Family Households with Minor Children, Transition Age Youth (TAY) ages 18-24, Seniors ages 62 and older, Veterans of the U.S. Military, People living with HIV or AIDS, and Survivors of Domestic Violence.

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

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

CoC System Coordination Committee

Medically Frail Beds Program Presentation

March 8, 2023

Agenda

1. History
2. Proposed Prioritization Policy
3. Discussion

History

Need Identified Through Project Roomkey

- In response to COVID-19 Public Health Emergency, the County created 1235 non-congregate shelter rooms (primarily in hotels)
- People with risk factors associated with COVID-19 were prioritized
- More than 2,600 people were served through Project Roomkey: Safer Ground
  - April 2020- December 2022
- Program Roomkey participants were offered long-term housing options when they exited
- A need was identified for people with complex medical conditions (not all of whom were highly prioritized on the housing queue)

Pilot Program for Medically Frail Individuals: OakDays

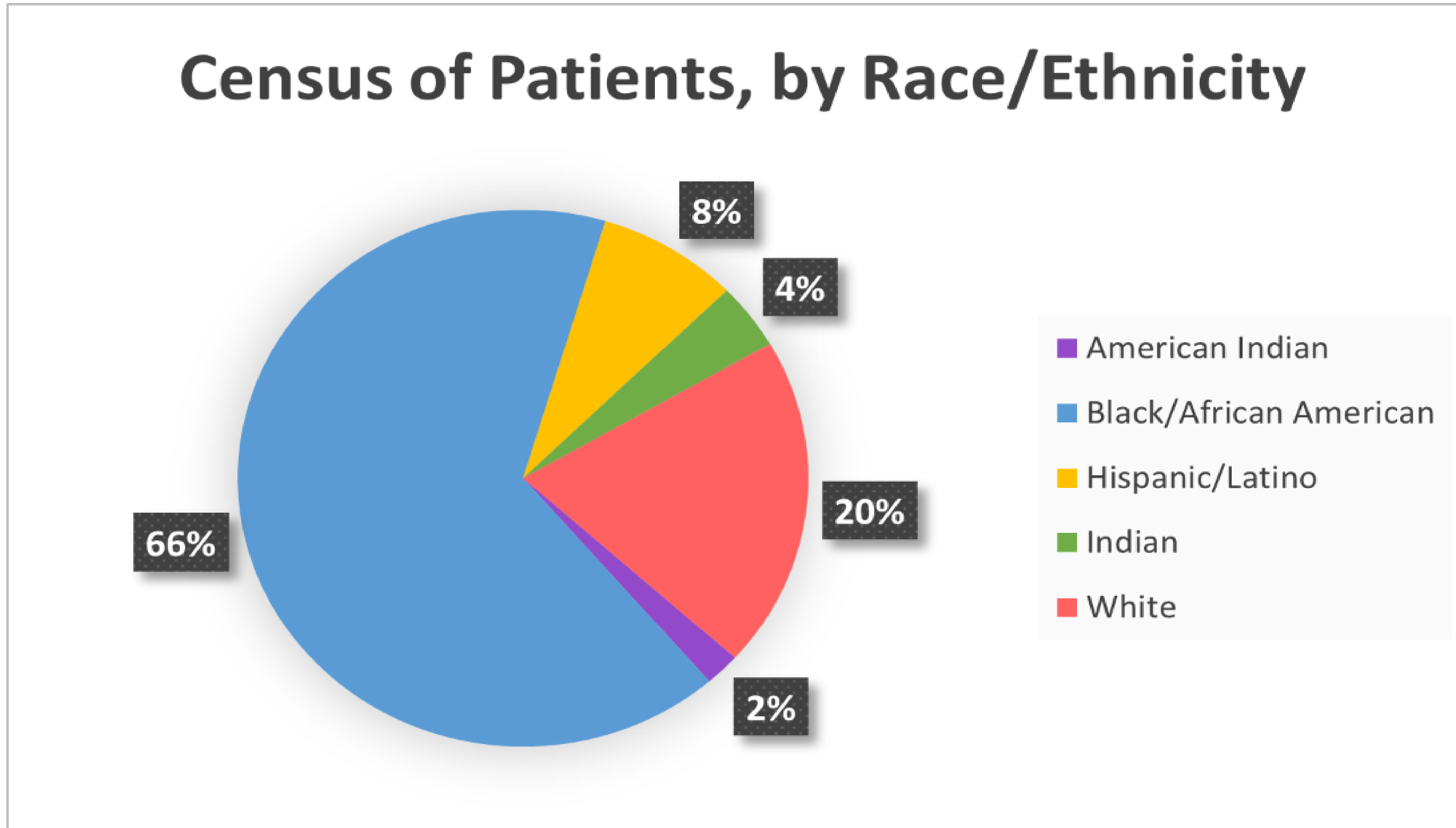
1. **Additional nursing and caregiver services**
   - OakDays is one of the Homekey sites- a hotel that started as shelter through Project Roomkey purchased to convert to long-term housing through Homekey
   - In addition to existing services, nursing and caregiver services were added
2. **Set-aside of Rooms**
   - Initially 30, now 60, of the 138 rooms at site were set-aside for people meeting “medically frail” criteria
   - Criteria included: utilization, functional limitations, and medical complexity
   - Prioritization followed COVID-19 prioritization protocol
3. **Funding**
   - County funds on-going operating cost of the housing
   - County provided one-time start-up funding for added Nursing and Caregiver services, maintained through Home and Community Based Alternative (HCBA) waiver. (For more info on the HCBA Waiver visit: Home and Community Based (HCB) Alternatives Waiver (ca.gov))

OakDays Results

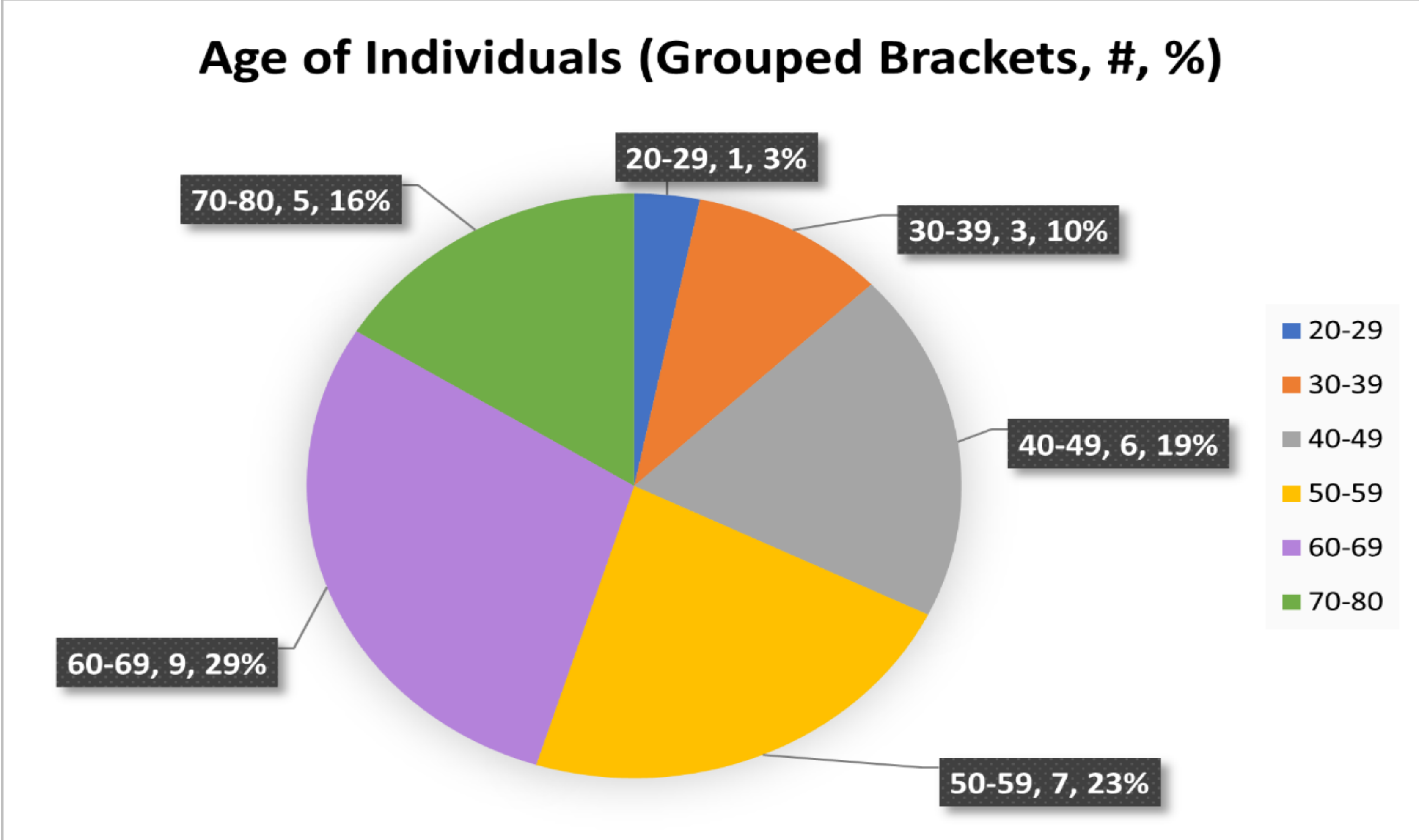
1. **Reduction in ED visits.**
   - OakDays residence was associated with a substantial reduction in ED visits (psychiatric and medical), skilled nursing facility admissions and inpatient admissions among individuals who were housed for 180 days or more
2. **Reduction in health care spending.**
   - $3,539,060 reduction in healthcare spending for OakDays residents over a 180-day period
   - $8,477,217* projected savings for all OakDays residents since project inception

*Assumptions: 1) Association between OakDays residence and healthcare utilization for residents who lived at OakDays for <6 mos is equivalent to association for PRK residents who remained housed for >6 mos, 2) 1000 residents, 425 bed days per since PRK inception

Clients Served to Date in Medially Fragile Beds



Clients Served to Date in Medially Fragile Beds



Current Status

1. **Expansion Goal**
   - Based on OakDays outcomes and need, there is a goal to expand the number of Medically Frail beds through a combination of interim housing and permanent housing options
   - Estimated county-wide need is 250-300 beds for unsheltered population (additional beds needed to address people in SNFs who could be discharged)
2. **Long-term Referral and Prioritization Policy**
   - Initial prioritization was under COVID policy
   - Current goal to establish long-term referral and prioritization policy as part of coordinated entry

Proposed Prioritization Policy

Eligibility and Prioritization Policy

- Would currently apply to OakDays and Comfort Medically Frail beds
- Would apply to any new Medically Frail beds with county capital or operations funding involved
  - Medically Frail beds can be either interim OR permanent housing

Proposed Policy: “Medically Frail” Definition

Referrals must meet **both** of the following program eligibility criteria to be considered:

1) **Homeless:** individual or family who lacks a fixed, regular and adequate nighttime residence. The individual’s or household’s primary nighttime residence is: 1) a public or private place not meant for human habitation in Alameda County, OR 2) the individual or family is living in a shelter or is exiting an institution (jail, hospital, skilled nursing facility) and would be homeless at the time of discharge in Alameda County.

2) **Qualifying health condition that meets:**
    - **a) Frequent utilization of (or unmet need for) Healthcare services, AND**
    - **b) Significant functional limitations, AND**
    - **c) Medical Complexity/Complex Chronic Illness.**

Referrals that meet the criteria will be prioritized for available resources based primarily on **severity of medical condition** and **within a tier of medical need Coordinated Entry Housing Queue score will be use**.

Proposed Policy: Medically Frail Referral Process

- **Identify Eligible Population**
  - Referral form
  - SHIE report
- **Eligibility Confirmed by County Staff**
- **County Staff Prioritizes and Refers to Resource**

Differences Between Medically Frail Interim and Permanent Housing

	Interim Housing	Permanent Housing
HMIS Assessments	Must have a completed crisis assessment in HMIS (within 90 days) prior to arrival or within 24 hours of arrival. If no housing assessment is complete, onsite staff will assist with completion after arrival.	Completed Housing needs assessment completed or updated within 180 days.
Prioritization	HCH staff can prioritize based on acuity with priority for emergencies	See slide 15
Length of Stay	No maximum stay, however if acuity level decreases, client will be required to move to a non-Medically Frail interim housing bed as soon as one becomes available.	Permanent lease

Proposed Policy: Medically Frail Prioritization

Tier One:	• Individuals enrolled in hospice services, or eligible for hospice services (prognosis under 6 months), OR • Individuals considered to be at imminent and continuous risk for violence or victimization in an unsheltered setting due to disability or inability to care for oneself, OR • Referral is unable to access necessities such as food or water, OR lifesaving treatment due to unhoused status.
Tier Two:	• Individuals that require treatment or access to durable medical equipment that cannot be reliably provided in an unsheltered setting including continuous oxygen, dialysis, chemotherapy/radiation treatment, infusion services, cardiac support devices, or ongoing care for complex wounds, OR • Conditions that carry avoidable risk of progression to permanent disability if inadequately treated (loss of extremity, sight, or mobility), OR • Undergoing treatment that requires consistent access to toileting/hygiene facilities.
Tier Three:	• Individuals who have multiple chronic conditions that would benefit from ongoing support from clinical team for maintenance/prevention of acute destabilization, OR • Individuals that have severe mental illness as the underlying source of medical destabilization.

Coordinated entry assessment score will be used to prioritize within each tier.

Discussion

Appendix: Medical Frail Definition of Elements

Medical Complexity: Defined as a serious illness (or multiple illnesses) requiring ongoing medical care, which are likely to get worse if the client does not have access to shelter and medical support such as nurses and caregivers, Examples include *(but are not limited to*) end stage organ failure (like liver failure, heart failure, or kidney disease requiring dialysis), active cancer, dementia, advanced lung/heart disease that requires oxygen or other support devices, insulin dependent diabetes with a history of complications, or history of stroke or trauma with resulting disability.

Functional Status: Eligible if the client is unable to manage activities of daily living (ADLs) independently such as walking, feeding oneself, dressing and grooming, toileting, bathing, or transferring from the bed to chair, or if applicant requires a walker or wheelchair for ambulation (walking), or is bed bound. This includes clients who are not able to complete ADLs independent due to severe mental illness, traumatic brain injury or other cognitive disability. The short-term use of a temporary assistive device, after a surgery for example, would not meet this eligibility requirement.

Utilization: Defined as 8 or more hospital ER visits, or 2 or more inpatient admissions in the prior 12 months. Note that if applicant needed Emergency Room, inpatient, or Skilled Nursing Facility care but declined services, was not connected to care, or needed services were inaccessible, please make note of that in box below so it can be considered for the purposes of utilization assessment

Office of Homeless Care and Coordination

Health and Safety Transfer Policy

First approved/Last revised	Month XX, 202X
Author of policy/ policy revision	Colleen Budenholzer, Coordinated Entry Program Director
Approved by	CoC System Coordination Committee
Effective date	Month XX, 202X
Next review required by	Month XX, 202X

1. Introduction

From time to time, formerly homeless residents of permanent housing may need to move between units or programs for health or safety reasons. This policy identifies when tenants of covered permanent housing programs are eligible to request a health or safety transfer, the documentation needed to request such a transfer when it requires changing housing programs, how such a transfer should occur, and additional guidance related to protecting tenants' safety and security.

2. Definitions

Coordinated Entry – The Coordinated Entry process is an approach to coordination and management of the crisis response system's resources that allows users to make equity consistent decisions from available information to connect people efficiently and effectively to interventions that will end their homelessness. Coordinated Entry consists of four components: access, assessment, prioritization, and referral.

Covered housing program: A permanent housing program which houses formerly homeless individuals or households which receives referral to its units and/or program slots from the Alameda County Coordinated Entry process and is covered by the Coordinated Entry policies.

Emergency transfer: A transfer that is needed to safeguard the life or physical safety of a tenant in a covered housing program and needs to occur immediately.

Intra-program Transfer: An approved move for reasons covered under this policy from one unit or subsidized rental location within a covered housing program to another operated by the same agency and approved by the provider agency.

Inter-program Transfer: An approved move for reasons covered under this policy from one unit or subsidized rental location within a covered housing program to another unit or building in a different covered housing program, and authorized by the Office of Homeless Care and Coordination

Service Provider: A provider of supportive services that is associated with a particular tenant or group of tenants in a covered housing program.

Transfer Pool: The list of tenants in covered housing programs approved for an inter-program transfer and awaiting a referral.

Household Member: Any person who is living with the head of household and is on the lease or a minor child living in the current unit. For the purposes of this policy, household members must intend to move together.

VAWA: The federal Violence Against Women Act which provides a range of rights and protections for survivors of domestic violence, dating violence, sexual assault, or stalking.

3. Policy Scope

This policy covers the handling of health and safety transfer requests for tenants of all covered housing programs for which referrals are made through the Alameda County Coordinated Entry process. Covered housing organizations may keep their own internal transfer policies for other types of transfers.

4. Policy Language

Tenants of covered permanent housing programs may request, and if approved based on this policy, receive a health or safety transfer from their unit or program to another unit or program.

Health or safety transfers may be requested if:

1) The tenant or any member of the household is a survivor of domestic violence, dating violence, sexual assault, or stalking covered under VAWA and the tenant reasonably believes that there is a threat of imminent harm from further violence if the tenant remains within the same unit. If the tenant is a survivor of sexual assault, the tenant is also eligible to request a transfer if the sexual assault occurred on the premises within the 90 days preceding the request for transfer; or
2) A tenant or any member of the household reasonably believes that there is threat of imminent harm from violence, including sexual violence, if they remain in their unit but the situation does not fit category 1; or
3) Family composition increases such that the household exceeds allowable occupancy standards and there is not the ability to move to a larger unit within the program; or
4) A tenant or any member of the tenant's household is in danger due to a severe medical condition that cannot be addressed in their current unit or is exacerbated by where they are living. Examples include, but are not limited to, moving from a building without an elevator to one with an elevator or moving to a more accessible unit.

Covered housing providers may not discriminate on the basis of any protected characteristic, including race, national origin, religion, sex, gender identity, sexual orientation, familial status, disability, or age. The ability to request a VAWA transfer is available regardless of sex, gender identity or sexual orientation.

5. Procedures

A. Process for Requesting an Intra-Program Transfer:

1. In the event of the need for a health or safety transfer, if a move within the same property or within the same program could resolve the need for transfer, covered housing programs must support the tenant to request an intra-program transfer, following the property or program's policies and procedures. Health and safety requests

for transfer must be prioritized over other types of transfer requests. Home Stretch should be notified of the transfer by securely e-mailing homestretch@acgov.org with "Inter-Program Transfer" in the subject line. The e-mail should include the name of the tenant, the unit they are transferring from and the unit they are transferring to. Home Stretch does not need to approve the transfer in this case and the notification is for tracking purposes.

2. Emergency intra-program transfers should be considered and executed as quickly as possible with the safety and wellbeing of the tenant in mind.
3. If no intra-program transfer is possible or anticipated to be available within a reasonable period of time, or an intra-program transfer cannot resolve the health or safety need, the covered housing program or designated service provider associated with the tenant should assist the tenant to apply for an inter-program transfer.

If a participant is eligible under VAWA for a transfer, they have the choice to request an inter-program transfer immediately without first requesting an intra-program transfer**.** If a tenant eligible under VAWA is pursuing both options it is important that the service provider keep the program and Home Stretch aware of updates and status at all times. In the case of a VAWA transfer, if the current provider does not work for an agency that specializes in serving survivors the current provider must offer a referral to a survivor-serving organization (victim service provider) as they may be able to offer practical assistance to help the person or household stay safe. See list of potential organizations in Section 3.

B. Process for Requesting an Inter-Program Transfer

1. If an intra-program transfer is not possible or would not resolve the need for transfer, or if a VAWA-covered tenant is requesting an inter-program transfer, the tenant's designated service provider should support the tenant to apply for an inter-program transfer. The service provider and the tenant will jointly complete the Tenant Inter-Program Transfer Request form (Appendix A) and submit the form to Alameda County's Office of Homeless Care and Coordination (OHCC) by e-mailing HomeStretch@acgov.org using secure e-mail with "Health or Safety Transfer Request" in the subject line and attach the form. Please include URGENT in the subject line if there is a need for an emergency transfer. Service providers are expected to act as the liaison between OHCC and the tenant. See information about confidentiality below. Potential transfer needs and questions may be discussed at Regional Housing Coordination Meetings if appropriate or needed to explore potential resolution, however a request form will be required following the conversation to proceed and ensure that all required information to complete the transfer is received. Such discussions must be treated as confidential and should only provide the minimum information necessary to seek an appropriate resolution.
    - Requests for a VAWA Transfer must include a VAWA transfer request form or third-party verification per HUD Form 5383 (Appendix B) in addition to the Tenant Inter-Program Transfer Request form.
    - Requests based on medical need must include a letter from a medical provider in addition to the Tenant Inter-Program Transfer Request form (see Appendix C for template).

2. OHCC will review the request as quickly as possible once received. If the documentation provided is insufficient or the application lacks sufficient information for OHCC to decide, OHCC will advise the service provider of the missing information within 5 business days of receipt of the request, and as quickly as possible (not to exceed 2 business days) for emergency requests. Requests that are incomplete or lacking sufficient information cannot be approved until the missing information is provided.
3. OHCC will approve or deny the request as quickly as possible and within not more than 10 business days from when all necessary documentation was submitted. OHCC will inform the service provider of the determination. When an emergency transfer is needed OHCC will attempt to review the documentation as quickly as possible and provide a decision no more than 3 business days from when all necessary documentation was submitted. OHCC's review will consider the urgency of the situation and what, if any, other alternatives to a transfer could resolve the issue or be put in place in the interim. OHCC may come back with a suggestion or requirement to try a different resolution.

C. Process Once Transfer Request is Approved:

1. Approval of a transfer request places the tenant in the Transfer Pool of potential transfer applicants pending availability of an appropriate unit. OHCC does not guarantee transfers to a specific site or program; potential applicants are matched to available units or programs based on need and the amenities and location. Transfer requests will be prioritized based on severity of need.
2. Tenants in the Transfer Pool facing immediate risk if they remain in their current unit or eligible for a VAWA transfer will be prioritized for transfers and offered the next available unit that meets their needs and for which they are eligible.
3. OHCC staff will notify the service provider when a potential unit or program becomes available that is perceived to resolve the need for transfer and that the tenant is likely to be eligible for. At this time OHCC will communicate what documentation is needed to be referred to the program or property. Service providers are expected to support the tenant to submit all required documentation within 5 business days of the request.
4. Whenever possible eligibility documentation submitted at the time of initial placement (such as homeless status verification and disability verification) will be accepted as qualifying for the new housing provider and do not need to be redocumented.
5. OHCC will notify the service provider once a referral has been made.
6. Service providers are expected to act as the liaison between the tenant, OHCC, and the new covered housing program. Housing programs may require additional documentation after referral and may have required timeframes for appointments and/or documentation as stipulated in their Resident Selection Criteria, though in cases of great urgency they will be encouraged to waive or delay the need for these steps or documents.
7. Failure to respond to communications and requests for updated information (or failure to transfer to the available unit or program) may result in the unit or program being offered to another person or household.

8. If a tenant refuses, or does not complete the required steps for two transfer offers for which they are eligible and would resolve the reason for the transfer request, the request to transfer will be considered closed and the tenant will no longer be considered part of the Transfer Pool. Additional offers may be made under extenuating circumstances.
9. Refusal of a viable offer may significantly increase the length of time before receiving another offer.
10. OHCC cannot guarantee that a transfer request will be approved or how long it will take for a new unit or program to be identified. OHCC will, however, act as quickly as possible to offer a tenant who is not safe in their current unit the opportunity to apply for another unit or program subject to availability and safety of the alternative unit or program. If a tenant reasonably believes a proposed transfer would not be safe, the tenant may request a transfer to a different unit. If a unit is available, the transferred tenant must agree to abide by the terms and conditions that govern occupancy in the unit to which the tenant has been transferred. OHCC may be unable refer a tenant to a particular unit if the tenant has not or cannot establish eligibility for that unit.

D. Completing the Transfer

1. A tenant approved for an inter-program transfer may choose to remain in their current unit until the new unit or program is identified, provided they continue to abide by all program rules and regulations.
2. The service provider supporting the transfer is responsible for a ensuring the tenant is able to move successfully and that there is warm hand-off to a new service provider if there will be a change in service provider. They are also responsible for supporting the tenant through all aspects of the transfer process including things like arranging for interviews, property tours etc. as required and based on the tenant's direction (i.e. if the tenant would like to see the property first, even if it means it may take longer to complete the process).
3. The tenant must relinquish their current unit within 7 days of the lease start date for their new unit. Extensions required to accommodate a disability may be granted if a request for reasonable accommodation is made and approved, not to exceed an additional 2 weeks. Requests must be sent to homestretch@acgov.og prior to the 7 days expiring.
4. Following the inter-program transfer, HMIS must be updated by the appropriate service provider or by the housing operator indicating an exit from one program and new entry into another.

E. Additional information related to VAWA Transfers

1. **Confidentiality:** OHCC will keep confidential any information that a tenant submits in requesting a VAWA transfer, and information about the transfer, unless the tenant gives OHCC written permission to release the information on a time limited basis, or disclosure of the information is required by law or required for use in an eviction proceeding or hearing regarding termination of assistance from the covered program. This includes keeping confidential the new location of the dwelling unit of the tenant, if

one is provided, from the person(s) that committed an act(s) of domestic violence, dating violence, sexual assault, or stalking against the tenant. See the Notice of Occupancy Rights under the Violence Against Women Act For All Tenants (Appendix D) for more information about OHCC's responsibility to maintain the confidentiality of information related to incidents of domestic violence, dating violence, sexual assault, or stalking.

2. **Alternative Arrangements:** If OHCC has no safe and available units for which a tenant who needs an emergency transfer is eligible, the service provider should assist the tenant in identifying other housing providers who may have safe and available units to which the tenant could move, or establishing temporary accommodations. At the tenant's request, service providers will also assist tenants in contacting the local organizations offering assistance to victims of domestic violence, dating violence, sexual assault, or stalking.

3. **Safety and Security of Tenants:** Pending processing of the transfer and the actual move, if it is approved, the tenant is urged to take all reasonable precautions to be safe.

    a. Tenants who are or have been victims of domestic violence are encouraged to contact the National Domestic Violence Hotline at 1-800-799-7233, or a local domestic violence shelter, for assistance in creating a safety plan. For persons with hearing impairments, that hotline can be accessed by calling 1-800-787-3224 (TTY).

       Local Crisis Lines:

       - A Safe Place: 510-536-7233
       - Building Futures with Women and Children: 1-866-292-9688
       - Crisis Support Services of the East Bay: 1-800-309-2131
       - Ruby's Place: 888-339-7233
       - Tri-Valley Haven: 1-800-884-8119 or 925-449-5842
       - Center for Domestic Peace: 415-924-6616; 415-924-3456 (Español)
       - WOMAN, Inc. – referrals (SF): 415-864-4722; 877-384-3578 (Español)
       - Next Door: 408-279-2962
       - Family Violence Law Center Mobile Response Team: 1-800-947-8301
       - Queer Asian Women and Transgender Hotline: 877-751-0880
       - Bay Area Women Against Rape: 510-845-7273
       - Safe Alternatives to Violent Environments (SAVE): 510-794-6055
       - Domestic Violence Resource Guide for Alameda County: https://acphd-web-media.s3-us-west-2.amazonaws.com/media/resource-guides/docs/domestic-violence.pdf

    b. Tenants who have been victims of sexual assault may call the Rape, Abuse & Incest National Network's National Sexual Assault Hotline at 800-656-HOPE, or visit the online hotline at https://ohl.rainn.org/online/.

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c. Tenants who are or have been victims of stalking seeking help may visit the National Center for Victims of Crime's Stalking Resource Center at https://www.victimsofcrime.org/our-programs/stalking-resource-center.

Tenants can also call Alameda County's 2-1-1 (2-1-1 or 888-886-9660) to learn more about local resources and availability. Resources can also be found on their webpage at http://211alamedacounty.org/2-1-1-alameda-county-resource-finder/.

6. Policy Location

This Policy is under the oversight of OHCC as the Coordinated Entry Management Entity. It will be maintained along with other Coordinated Entry Policies and posted to the OHCC website.

7. References, Related Resources, or Appendices

- Additional information on VAWA and multi-family housing: https://www.hud.gov/program_offices/housing/mfh/violence_against_women_act
- Appendix A: Tenant Inter-Program Transfer Request form
- Appendix B: HUD Form 5383
- Appendix C: Template for Medical Verification for Health and Safety Transfer
- Appendix D: Notice of Occupancy Rights under the Violence Against Women Act for All Tenants

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Proposed Policy: “Medically Frail” Definition

Referrals must meet **both** of the following program eligibility criteria to be considered:

1) **Homeless:** individual or family who lacks a fixed, regular and adequate nighttime residence. The individual’s or household’s primary nighttime residence is: 1) a public or private place not meant for human habitation in Alameda County, OR 2) the individual or family is living in a shelter or is exiting an institution (jail, hospital, skilled nursing facility) and would be homeless at the time of discharge in Alameda County.

2) **Qualifying health condition that meets:**
   a) Frequent utilization of (or unmet need for) Healthcare services, AND
   b) Significant functional limitations, AND
   c) Medical Complexity/Complex Chronic Illness.

Referrals that meet the criteria will be prioritized for available resources based primarily on **severity of medical condition** and **within a tier of medical need Coordinated Entry Housing Queue score will be use**.

Proposed Policy: Medically Frail Referral Process

- **Identify Eligible Population**
  - Referral form
  - SHIE report
- **Eligibility Confirmed by County Staff**
- **County Staff Prioritizes and Refers to Resource**

Differences Between Medically Frail Interim and Permanent Housing

	Interim Housing	Permanent Housing
HMIS Assessments	Must have a completed crisis assessment in HMIS (within 90 days) prior to arrival or within 24 hours of arrival. If no housing assessment is complete, onsite staff will assist with completion after arrival.	Completed Housing needs assessment completed or updated within 180 days.
Prioritization	HCH staff can prioritize based on acuity with priority for emergencies	See slide 15
Length of Stay	No maximum stay, however if acuity level decreases, client will be required to move to a non-Medically Frail interim housing bed as soon as one becomes available.	Permanent lease

Proposed Policy: Medically Frail Prioritization

Tier One:	• Individuals enrolled in hospice services, or eligible for hospice services (prognosis under 6 months), OR • Individuals considered to be at imminent and continuous risk for violence or victimization in an unsheltered setting due to disability or inability to care for oneself, OR • Referral is unable to access necessities such as food or water, OR lifesaving treatment due to unhoused status.
Tier Two:	• Individuals that require treatment or access to durable medical equipment that cannot be reliably provided in an unsheltered setting including continuous oxygen, dialysis, chemotherapy/radiation treatment, infusion services, cardiac support devices, or ongoing care for complex wounds, OR • Conditions that carry avoidable risk of progression to permanent disability if inadequately treated (loss of extremity, sight, or mobility), OR • Undergoing treatment that requires consistent access to toileting/hygiene facilities.
Tier Three:	• Individuals who have multiple chronic conditions that would benefit from ongoing support from clinical team for maintenance/prevention of acute destabilization, OR • Individuals that have severe mental illness as the underlying source of medical destabilization.

Coordinated entry assessment score will be used to prioritize within each tier.

Coordinated Entry Policies Annual Review

- No substantive changes suggested.
- Only a few very minor readability/clarifying updates were made but nothing that would constitute a policy change.

Health and Safety Transfer Policy

- Under VAWA, it is required by HUD that recipients of CoC and ESG grants have an emergency transfer plan for people who meet the following requirement:
  - The tenant or any member of the household is a survivor of domestic violence, dating violence, sexual assault, or stalking covered under VAWA and the tenant reasonably believes that there is a threat of imminent harm from further violence if the tenant remains within the same unit. If the tenant is a survivor of sexual assault, the tenant is also eligible to request a transfer if the sexual assault occurred on the premises within the 90 days preceding the request for transfer
- OHCC, as the Coordinated Entry Management Entity, recommended to SCC a Health and Safety Transfer Policy that allows for people who meet one of the following criteria to request a transfer as well:
  - A tenant or any member of the household reasonably believes that there is threat of imminent harm from violence, including sexual violence, if they remain in their unit but the situation does not fit category 1; or
  - Family composition increases such that the household exceeds allowable occupancy standards and there is not the ability to move to a larger unit within the program; or
  - A tenant or any member of the tenant's household is in danger due to a severe medical condition that cannot be addressed in their current unit or is exacerbated by where they are living. Examples include, but are not limited to, moving from a building without an elevator to one with an elevator or moving to a more accessible unit.

Project:
Project Reclamation – Alameda County Scattered Site Homekey Round 3 Application

Purpose:
Proposed Prioritization, Tenant Selection, and Housemate Matching Process

Action:
For Outreach, Access, and Coordination Committee consideration and approval as alternative to existing Coordinated Entry Policy for matching to Scattered Site Co-Living Deeply Affordable Housing

Context:
Homekey Application
BACS, the City of Hayward, and Union City are preparing to submit a Homekey Round 3 application that involves rebooting our previous Alameda County multi-jurisdictional scattered site app, which was not awarded in Round 2 based on the unfortunate changes in the NOFA requirements between Round 1 to 2 that added site control requirements for all applications. In Round 2, HCD included single family home scattered site projects as an eligible and targeted project type in the NOFA. However, the department's interpretation of the eligibility criteria categorically prevented scattered site single family housing projects from meeting threshold requirements for appraisal and site control, which were not feasible for single family homes as a project type. Unlike hotel, other conversion, or new construction project types, single family home market offers require short contingency periods and little or no financing requirements in order to compete for single family home acquisitions. As such, single family home projects were rendered functionally impossible.

In response to this unfortunate and unintended preclusion, BACS, the participating cities, and other local elected officials prepared a coordinated advocacy campaign that resulted in HCD modifying the NOFA for Round 3 to include a dedicated discretionary reserve of $40M specifically for scattered site projects. At the time of our Round 2 submission, BACS and the cities suggested an alternate process: conditional ("up to") awards, contingent on properties meeting criteria within specific timeframes (appraisals and site control within 60 days; physical needs assessments or relevant inspections within 90 days). Surprisingly, while disqualified as ineligible last round, HCD has now adopted our exact proposed alternative process as the official process for the Round 3 scattered site discretionary reserve and plan to award up to four projects at up to $10M per project. Based on this updated NOFA process and the state's expressed interest in supporting this innovative model across the state, BACS and the cities are confident that a re-application of our proposed project in Round 3 is very likely to be awarded and bring more that 30 units of scattered site, deeply affordable housing for those experiencing homelessness in Alameda County.

Tenant Selection
In addition to this change, the Round 3 NOFA also modified the tenant selection requirements that enables applicants to structure selection plans either in accordance with local Coordinate Entry system protocols "or another comparable prioritization system" provided that these alternate referral protocols are developed in collaboration with the local CoC. In conjunction with these modifications and the unique context of shared living, BACS is proposing the below tenant selection plan and referral process as an alternative to the existing 'one to a unit,' individual score based matching system our current CE protocol is understandably predicated upon.

Justification:
Current CE processes and policies were not designed with explicit consideration for co-living and the relevant best practices for self-selection into shared living environments. To have a truly client-centered approach where tenants are supported to be successful and thrive and have a degree of agency in identifying who and how they live in their shared space, an alternate *housemate matching* based system is necessary.

As BACS learned during the Homekey Round 1 matching and referral process for the BACS and City of Oakland scattered site project, co-living is often unsuccessful when the process does not include deep person-to-person coordination and housemate matching. Housemate matching for shared living requires screening residents not just for their individual eligibility (confirmed homelessness, vulnerability, etc.), but also to identify their lifestyle, schedule, and preferences in housemates and living environments, among other things. As all the local[1] and national research[2] and technical assistance resources on shared housing best practices[3] and BACS' own experience doing this work for over four decades has identified, these coordinated and collaborative matching processes are essential for successful shared housing models.

On June 1, 2023, BACS and the City of Hayward met with HCD Homekey leadership for a pre-application consultation meeting where we previewed the details of the tenant selection plan and they expressed unanimous support for the proposed plan and its conformity with the NOFA regulations.

Eligibility Criteria:
The Project Reclamation team proposes the following eligibility criteria for an alternative tenant selection process

- Single adults experiencing literal homelessness (according to 24 CFR 91.5) in Alameda County
- Extremely Low Income (0-30% AMI)
- Willingness to enter into shared housemate agreements (collaboratively developed)
- Coordinated Entry program enrollment (in HMIS) with completed Housing Assessment

Matching Protocol:
BACS will manage the inflow of interested applicants throughout the County, sharing the availability of the resource, marketing materials, eligibility criteria, and other relevant information equitably and widely (to providers, HRCs, in partnership with the Homekey jurisdictions, etc.), screening interested parties for eligibility and to gather relevant matching information.

Initial screening will include the following:
- Documentation of eligibility
- Confirmation of interest in scattered site co-living based on a detailed program description
- Clinical safety assessment to determine that no severe health or safety risks relevant to shared living contexts are present

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[1] Shared Housing – The Chronic Homelessness Initiative White Paper (2020). The Tipping Point Community. Retrieved from http://chi.tippingpoint.org/wp-content/uploads/2020/09/TPC-Shared-Housing-SF-White-Paper.pdf
[2] Shared Housing: Challenges, Best Practices, and Outcomes (2019). Homelessness Policy Research Institute. Retrieved from https://socialinnovation.usc.edu/wp-content/uploads/2019/06/Shared-Housing-Literature-Review-Final.pdf
[3] The Shared housing Institute (2023). https://www.sharedhousinginstitute.com/

SAMHSA published the following Matching Principle Best Practices[4] as a helpful summary which serves to guide the below process and protocol for tenant selection and matching:

Matching Principles:

- ➢*Person-centered process:* Get to get to know the home seeker's preferences and areas where they can compromise
- ➢*Client choice*: Support the ability to choose to enter into or leave shared housing arrangement.
- ➢*Maintain existing relationships*: Support clients existing relationships who then become roommates, building on existing peer networks when possible
- ➢*Take Time:* Don't rush to match or match just based on

After the initial screening, BACS will support interested eligible parties and any existing service teams or natural supports in completing a formal application and to begin the housemate matching process. For the housemate matching process, BACS will prioritize client choice in identifying which home/unit/co-living environment within the available stock is most suitable to each individual. BACS will reserve the right to identify when a co-living unit may be more suitable to client success based on housemate matching information gathered, expressed lifestyle preferences, existing collaboratively designed housemate agreements among tenants at a given property, or other relevant information. BACS will make the final placement determination in close collaboration with each individual to ensure their preferences are centered and a successful match is identified to the best extent possible.

In cases where multiple eligible applicants express interest together as potential housemates, BACS will work to support their co-living together where possible, provided that sufficient existing units within preferred homes are available and any existing tenants and housemate agreements are mutually agreeable to all parties. With an eye toward best practices and the continued success of each tenant, BACS will work to prioritize this process of "naturally occurring" housemate matching, making shared housing available to those with existing natural supports and positive relationships (provided that all parties are eligible under the above criteria).

In situations where individual applicants do not have existing relationships with other eligible and interested applicants looking to be housemates together, BACS will manage the housemate and home matching process using screening forms, one-to-one and small group introductions, housemate mixer events, and home visits to support individuals in identifying if and where a suitable co-living environment might best meet there needs.

Where needed and in alignment with best practices, BACS will utilize existing resources developed in conjunction with the Shared Housing Institute, such as a housemate resource booklet and housemate pairing tools (e.g., pairing and conversation cards) to support each individual's identification of the unit best suited to match their needs and lifestyle. However, given the variables and contingencies around available units at a given time, lifestyles preferences among existing and potential housemates, and the willingness to commit to collaboratively drafted housemate agreements, BACS cannot guarantee a

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[4] Shared Housing – Alternative Housing Review (2019). SAMHSA. Retrieved from https://www.cceh.org/wp-content/uploads/2019/02/SAMHSA-Shared-Housing-Alt-Housing-PPT-7-23-18-FinalPDF.pdf

successful match and placement to all applicants, but will work diligently to ensure each of those interested are matching to available units that meet their needs and preferences quickly and efficiently.

In an effort manage applicant interest and inflow efficiently and without producing protracted waitlists and delays, BACS will open and receive referrals in rounds, targeting to receive sufficient eligible and interest applicants in smaller batches (10-15 applicants per round) until units are filled. We project a total unit count somewhere between 28 and 32 for this project and thus two to three rounds of rounds of referrals.

Homekey Round 3

Coordinated Entry System Participation and Continuum of Care Coordination Form

The Eligible Applicant's Continuum of Care (CoC) must complete this form and it must be uploaded with the Homekey Application.

1. **The CoC acknowledges the below Homekey Project details, type, and Target Population:**

Project Name:	
Project Address:	

Project Type (please check all that apply):

☐ Permanent Housing
☐ Interim Housing
(See additional requirements for Interim Housing in NOFA Section 301).

Please check the box below to acknowledge that Homekey Applicants will utilize the Homeless Management Information System (HMIS) for data entry:

☐ This applicant will enter Homekey resident data into HMIS as required per Homekey NOFA Round 3, Section 503. Please click here for more information on this requirement per state law AB 977 (Chapter 397, Statutes of 2021). Please check box to confirm planned HMIS use.

Unit mix:

Please enter the Target Population(s) for the eligible Project and the number of Assisted Units serving the Target Population below (information on Target Populations can be found in NOFA Section 502).

Population served	Subpopulation* *(if needed, i.e. Seniors)*	Number of Assisted Units	Project Type (Interim or Perm)
Chronically Homeless			
Homeless			
At-risk of Homelessness			
Homeless Youth or Youth At-risk of Homelessness			
Manager's Unit			
Total Number of Assisted Units in Homekey Project:			

* If the Project shows a subpopulation, please note that Qualified Homekey Target Populations must be met in addition to this Target Population i.e., Seniors at-risk of homelessness, Chronically Homeless Veterans, etc.

2. Coordinated Entry Participation or similar referral system

NOFA Section 502 States:

"Referrals to Homekey Assisted Units shall be made through the local Coordinated Entry System (CES) or another comparable prioritization system based on greatest need. All referral protocols for Homekey Assisted Units must be developed in collaboration with the local CoC and implemented consistent with the requirements set forth in this NOFA. CoC collaboration in Project and Supportive Services design is also strongly encouraged to help target and serve greatest need populations. If referrals will be made using a prioritization system other than CES, the Applicant must describe the plan for tenant and participant selection, and it shall be reasonably detailed and comprehensive, as determined by the Department in its sole and absolute discretion."

Please check whether the project will utilize CES:

☐The Homekey project **will use CES** to for referrals into Homekey Assisted Units.

☐ The project has an alternate prioritization system and **will not use CES** (*Please attach or describe below the housing first compliant prioritization and referral method that will be utilized instead*.) Please also describe the planned efforts for CES use in the future and how the Project will coordinate with the CoC. Please mention which agency is responsible for managing this prioritization and referral method (e.g., Health and Human Services) and the official name of the prioritization tool.

3. **Other CoC support to the Project**

Other activities the CoC intends to support the Homekey Project with include:

☐ Trainings or presentations related to the Target Population for the local agency (lead applicant), development team, property management, and/or service providers.
☐ Provide Homekey Project information on the CoC's website
☐ Staffing support
☐ Operating subsidies or other funding (*Please explain below*)
☐ Other (Please explain below):

The Continuum of Care (CoC) has reviewed the information on this form and, to the extent possible, is committed to supporting the project. The request and information above have been reviewed and verified by the *following* representative of the CoC:

Signature

Name:

Title:

CoC Name