Before Starting the CoC Application

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

The Collaborative Applicant is responsible for reviewing the following:

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

Instructions:
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

1A-1. CoC Name and Number: CO-504 - Colorado Springs/El Paso County CoC

1A-2. Collaborative Applicant Name: Community Health Partnership

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Community Health Partnership
1B. Continuum of Care (CoC) Engagement

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

1B-1. CoC Meeting Participants.

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

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

Applicant: Colorado Springs/El Paso County CoC
Project: CO-504 CoC Registration FY 2019

FY2019 CoC Application  Page 3  09/25/2019
<table>
<thead>
<tr>
<th>Role</th>
<th>Yes</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>Youth Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>School Administrators/Homeless Liaisons</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>CoC Funded Victim Service Providers</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Non-CoC Funded Victim Service Providers</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Domestic Violence Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Street Outreach Team(s)</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>LGBT Service Organizations</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Agencies that serve survivors of human trafficking</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Other homeless subpopulation advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Homeless or Formerly Homeless Persons</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Mental Illness Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Substance Abuse Advocates</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other:(limit 50 characters)</td>
<td></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Faith Community</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Funders</td>
<td>Yes</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>Department of Local Affairs, DOH</td>
<td>Yes</td>
<td>Yes</td>
<td>Yes</td>
</tr>
</tbody>
</table>

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

Applicants must describe how the CoC:

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

The Pikes Peak Continuum of Care (PPCoC) welcomes any community member or organization that is interested in reducing/ending homelessness to participate in bi-annual general membership meetings. Members are encouraged to participate in the monthly Coalition of Homeless Advocates & Providers (CHAP) Meetings. CHAP is an open and flexible forum for service providers and citizens working together to identify needs and priorities related to coordination of services for people at risk of/ experiencing homelessness in El Paso County. 40-50 people regularly attend CHAP monthly meetings and provide input/feedback on current CoC issues and learn about available services in the community. The PPCoC uses listservs to share general information related to homelessness, announce meetings, distribute reports, and solicit participation in PPCoC activities. In addition, the PPCoC participates in listening sessions with the City and County when input is sought from the public about homelessness and affordable housing.
To ensure that individuals with disabilities are aware of, and can access information about upcoming CoC meetings, information is printed and posted, handed out by organization representatives to clients and staff, sent out electronically to a listserv of 450 people, posted on the City’s website and the CHP website.

1B-2. Open Invitation for New Members.

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

(limit 2,000 characters)

Per the Pikes Peak Continuum of Care (PPCoC) Governance Charter, membership in the PPCoC is open to all stakeholders in El Paso County including and not limited to nonprofit homeless assistance providers, victim service providers, faith-based organizations, governments, businesses, and advocates. The application to join is open year-round and available on the CHP website. At a minimum, once per year a formal invitation to apply goes into the community using an email distribution list which currently consists of 453 members. Membership solicitation also occurs at monthly CHAP meetings, as appropriate when networking occurs, and at the two annual CoC membership meetings. Meetings are advertised and hosted at Marian House Soup Kitchen. Attendees at CHAP consist of persons experiencing homelessness as well as formerly homeless persons, and these individuals are encouraged to apply to become PPCoC members. The PPCoC believes in being inclusive of individuals of all types of abilities and are willing to assist anyone who may need assistance in applying. The PPCoC welcomes and encourages all individuals to come forward with circumstances which would require accessibility or removal of barriers due to disability.

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

Applicants must describe:
1. how the CoC notifies the public that it is accepting project application proposals, and that it is open to and will consider applications from organizations that have not previously received CoC Program funding, as well as the method in which proposals should be submitted;
2. the process the CoC uses to determine whether the project application will be included in the FY 2019 CoC Program Competition process;
3. the date(s) the CoC publicly announced it was open to proposal;
4. how the CoC ensures effective communication with individuals with disabilities, including the availability of accessible electronic formats; and
5. if the CoC does not accept proposals from organizations that have not previously received CoC Program funding or did not announce it was open to proposals from non-CoC Program funded organizations, the applicant must state this fact in the response and provide the reason the CoC does not accept proposals from organizations that have not previously received CoC Program funding. (limit 2,000 characters)

The Pikes Peak Continuum of Care (PPCoC) posts on the website, uses meetings and uses an up-to-date email distribution list to make announcements regarding CoC NOFA funding. The email distribution list contains contact information of local service providers, government entities, and community members who all take an interest in ending homelessness in El Paso County. In each of the formats used to announce CoC Program Competition information, the PPCoC encouraged new applicants to apply. On July 8, 2019, the PPCoC announced that the FY2019 CoC program competition was opened on July 3, 2019. On July 10, 2019, the PPCoC released the Request for Letters of Interest (LOI) for new applications. LOIs were due by July 22, 2019. Each LOI was sent to the Ranking and Prioritization committee with a checklist on whether the proposed project met thresholds. Any project which met threshold was formally invited to apply. All projects which were already receiving CoC funds were also formally invited to apply. The PPCoC welcomes and encourages all individuals to come forward with circumstances which would require accessibility or removal of barriers in applying for CoC funding due to disability.
1C. Continuum of Care (CoC) Coordination

Instructions:
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
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The FY 2019 CoC Program Competition Notice of Funding Availability at:

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

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

<table>
<thead>
<tr>
<th>Entities or Organizations the CoC coordinates planning and operation of projects</th>
<th>Coordinates with Planning and Operation of Projects</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Opportunities for Persons with AIDS (HOPWA)</td>
<td>Yes</td>
</tr>
<tr>
<td>Temporary Assistance for Needy Families (TANF)</td>
<td>Yes</td>
</tr>
<tr>
<td>Runaway and Homeless Youth (RHY)</td>
<td>Yes</td>
</tr>
<tr>
<td>Head Start Program</td>
<td>Yes</td>
</tr>
<tr>
<td>Funding Collaboratives</td>
<td>Yes</td>
</tr>
<tr>
<td>Private Foundations</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and services programs funded through U.S. Department of Justice (DOJ) Funded Housing and Service Programs</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and services programs funded through U.S. Health and Human Services (HHS) Funded Housing and Service Programs</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and service programs funded through other Federal resources</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and services programs funded through State Government</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and services programs funded through Local Government</td>
<td>Yes</td>
</tr>
<tr>
<td>Housing and service programs funded through private entities, including foundations</td>
<td>Yes</td>
</tr>
<tr>
<td>Other:(limit 50 characters)</td>
<td></td>
</tr>
<tr>
<td>Public Library System</td>
<td>Yes</td>
</tr>
</tbody>
</table>
1C-2. CoC Consultation with ESG Program Recipients.

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

The Pikes Peak Continuum of Care (PPCoC) works closely with the City of Colorado Springs and ESG staff on housing and homeless issues. The PPCoC’s two ex-officio board members from the City consult with the CoC Board and the Coalition of Homeless Advocates & Providers (CHAP), to align ESG & CDBG funding priorities. Every fall, the City and the PPCoC host a consultation with the City’s Community Development Division, the Homeless Prevention and Response Coordinator, PPCoC Staff and Board members, and recipient agencies of ESG, CBDG, and CoC funds to better understand the needs and gaps of organizations serving people who are homeless. If an organization is under-performing, their challenges are addressed during the consultation and solutions are suggested in a non-threatening, peer driven format. The City and the PPCoC utilize the information and feedback given during the fall consultation to determine funding priorities and strategic plans. PPCoC staff works closely with ESG staff on monitoring performance of funding recipients.

1C-2a. Providing PIT and HIC Data to Consolidated Plan Jurisdictions.

Applicants must indicate whether the CoC provided Point-in-Time (PIT) and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area.

1C-2b. Providing Other Data to Consolidated Plan Jurisdictions.

Applicants must indicate whether the CoC ensured local homelessness information is communicated to Consolidated Plan Jurisdictions within its geographic area so it can be addressed in Consolidated Plan updates.

1C-3. Addressing the Safety Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors.
Applicants must describe:
1. the CoC’s protocols, including protocols for coordinated entry and the CoC’s emergency transfer plan, that prioritize safety and incorporate trauma-informed, victim-centered services; and
2. how the CoC, through its coordinated entry, maximizes client choice for housing and services while ensuring safety and confidentiality.

(limit 2,000 characters)

Per the written guidelines in the Pikes Peak Continuum of Care (PPCoC) Coordinated Entry (CE) Policies Implementations and Procedures (PIP) Manual, PPCoC Coordinated Entry process requires that individuals or families are not denied access to the CE process if experiencing or fleeing from domestic violence, dating violence, sexual assault, and/or stalking (HUD Category 4 Homeless Definition).

The PPCoC has a No Wrong Door Policy (documented in the CE PIP manual) at all access points, regardless of whether the agency serves all individuals. This means that any individual presenting at an access point will be provided help to access an emergency shelter (domestic violence or other shelter) or medical facility when they present with an emergency need. Help in emergency situations is available 24/7, and clients will be referred/helped by staff to manage the emergency in best way possible.

DV survivors served by HMIS participating agencies have a choice to remain anonymous/private in HMIS as well as whether to identify as a victim. Homeless and victim services providers have trauma-informed care training. Information is shared as directed/approved by clients through releases. When a client presents at a homeless services provider, their full range of needs are evaluated, case plans are created, and referrals are provided to needed resources, including TESSA for victim services. Each access point makes every effort to protect DV survivors’ privacy and safety and ensure that established housing is never endangered by reports of DV or re-victimization.

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

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

(limit 2,000 characters)

TESSA, the region’s largest domestic violence agency, provides emergency assistance to clients in imminent danger as a result of domestic violence. TESSA provides comprehensive Victim Advocacy confidentiality training 3 times year and other training as requested. Member agency and Coordinated Entry staff are required to attend at least one DV training annually. PPCoC staff coordinated a Domestic Violence/Sexual Assault Awareness class taught by an organization representative from TESSA which occurred on September 17, 2019. The training provided local service providers (including organizations
which participate in Coordinated Entry) with trauma-informed, victim-centered information and how to develop safety plans with victims. The training also provided resources for providers to give to any participant who is experiencing Domestic Violence. Additional topics of training provided by TESSA include: Dynamics of DVSA, recognizing trauma, trauma-informed care, best practices for working with victims, and identifying high lethality.

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

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

TESSA, the largest domestic violence agency in the Pikes Peak Continuum of Care (PPCoC) has just begun the process of implementing a comparable database. HUD provided a waiver for their 2019 APR so that they could submit de-identified aggregate data to meet their HUD CoC reporting requirements. TESSA then provided this data to the PPCoC for review and inclusion in DV data that was accessed from HMIS. The information from non-DV providers in HMIS, TESSA, and the PIT, inform decisions and discussions with the PPCoC Board in regard to funding priorities for the 2019 NOFA and strategic planning efforts.

Additional data provided by TESSA and local law enforcement agencies indicates that only 25% of domestic violence and sexual assault victims are reporting the crimes. Based on this information, the PPCoC recognizes that services and resource needs for DV/SA survivors are likely much greater than currently indicated.

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

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

<table>
<thead>
<tr>
<th>Public Housing Agency Name</th>
<th>% New Admissions into Public Housing and Housing Choice Voucher Program during FY 2018 who were experiencing homelessness at entry</th>
<th>PHA has General or Limited Homeless Preference</th>
<th>PHA has a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On</th>
</tr>
</thead>
<tbody>
<tr>
<td>Housing Authority, City of Colorado Springs</td>
<td></td>
<td>No</td>
<td>No</td>
</tr>
</tbody>
</table>

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

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

The El Paso County Housing Authority (EPCHA) is a non-traditional housing authority and does not provide any type of housing vouchers or programs, therefore, they do not have a written policy for homeless admission preference. The Executive Director of the El Paso County Housing Authority and Economic Development Division is an ex-officio member of the PPCoC Board of Directors. Including this position on the PPCoC Board ensures that the EPCHA is aware of available resources and challenges impacting people experiencing homelessness in El Paso County, creates buy-in and understanding of CoC needs, and also helps to inform the County’s Consolidated Plan.

The Colorado Springs Housing Authority (CSHA) has not adopted a homeless admission preference. Efforts have been made to meet with CSHA Board Members to explain the importance of adopting a homeless admission preference, but all requests have been declined to date. A Housing Authority Specialist from the CSHA has been regularly attending Coordinated Entry. In August 2019, CSHA brought non-CoC funded housing resources through CE for the first time in over two years.

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

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

Yes

If “Yes” is selected above, describe the type of provider, for example, multifamily assisted housing owners, PHAs, Low Income Tax Credit (LIHTC) developments, or local low-income housing programs. (limit 1,000 characters)

Greenway Flats, a 65-unit Permanent Supportive Housing facility, opened in July this year with 30 units of project-based Housing Choice Vouchers from the Department of Local Affairs, Housing Division. All 30 of these units were filled through Coordinated Entry, housing some of the community’s most vulnerable, chronic and disabled population. After one year of occupancy with the project based vouchers, tenants will have the option to convert these vouchers to tenant-based vouchers and relocate to another location in Colorado that accepts their voucher.

1C-5. Protecting Against Discrimination.

Applicants must describe the actions the CoC has taken to address all forms of discrimination, such as discrimination based on any protected classes under the Fair Housing Act and 24 CFR 5.105(a)(2) – Equal Access to HUD-Assisted or -Insured Housing. (limit 2,000 characters)
The Pikes Peak Continuum of Care (PPCoC) verifies that all CoC funded project recipients ensure that their housing and services are available to all who are eligible regardless of race, color, national origin, religion, sexual orientation, gender identity, age, familial status, disability, marital status, etc.

Individuals or families who fall into multiple populations for which an access point is dedicated (i.e. a parent accompanying a youth who is fleeing domestic violence) can be served at all access points for which they qualify. The same assessment approach is used.

In addition, all physical access points are accessible to individuals and families with disabilities. All points of entry have ADA accessible facilities. Other services available in facilities to individuals include translation, interpretation, and services for vision and hearing impaired. For those individuals and families who are least likely to seek out homeless assistance, street outreach is provided.

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

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

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

*1C-6. Criminalization of Homelessness.

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

<table>
<thead>
<tr>
<th>Strategy</th>
<th>X</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Engaged/educated local policymakers:</td>
<td></td>
</tr>
<tr>
<td>2. Engaged/educated law enforcement:</td>
<td></td>
</tr>
<tr>
<td>3. Engaged/educated local business leaders:</td>
<td></td>
</tr>
<tr>
<td>4. Implemented communitywide plans:</td>
<td></td>
</tr>
<tr>
<td>5. No strategies have been implemented:</td>
<td></td>
</tr>
<tr>
<td>6. Other:(limit 50 characters)</td>
<td></td>
</tr>
<tr>
<td>Provided Community Education</td>
<td></td>
</tr>
</tbody>
</table>

Applicant: Colorado Springs/El Paso County CoC
Project: CO-504 CoC Registration FY 2019

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

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

The Pikes Peak Continuum of Care (CoC) Coordinated Entry (CE) system ensures fair and equal opportunities for homeless individuals, youths, and families, to be assessed throughout the CoC geographic region of Colorado Springs/El Paso County, Colorado. CE is advertised through a variety of outlets to support the CoC's, "No Wrong Door" policy throughout the community. Advertisement techniques include: Street outreach, 24-hour a day sign postage, web advertisement through the Community Health Partnership and City of Colorado Springs websites, and 15 distinct locations for homeless service providers throughout El Paso County to conduct the housing vulnerability assessment for housing placement.

The CoC has partnered with both housing agencies & homeless supportive services agencies. This includes partnering with the local low-barrier emergency shelter for homeless adults, youths, & families, to assist in identifying higher needs clients to assign to available housing resources. This partnership emphasizes the most frequently serviced locations for homeless individuals, youth, & families seeking to connect to food, healthcare, emergency shelter, & other community resources. Supportive services providers offer street outreach to assess the housing vulnerability assessment in the community.

Coordinated Entry utilizes the VI-SPDAT, TAY-VI-SPDAT, and FAMILY-VI-SPDAT housing vulnerability assessment to assess all clients, adult individuals, youth, and families, experiencing homelessness seeking housing placement through the CoC. These housing assessment surveys allow for a fair & equal opportunity for individuals, youths, & families experiencing homelessness to be ranked & prioritized based on vulnerability & housing need on the Coordinated Entry, By Name List. CE meets on a weekly basis to review the By Name List and ensure timely & efficient housing assignment & placement based on clients' vulnerabilities and level of supportive need.
1D. Continuum of Care (CoC) Discharge Planning

Instructions:
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at:
https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources
The FY 2019 CoC Program Competition Notice of Funding Availability at:

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

1D-1. Discharge Planning Coordination.

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

<table>
<thead>
<tr>
<th>Foster Care:</th>
<th></th>
</tr>
</thead>
<tbody>
<tr>
<td>Health Care:</td>
<td>X</td>
</tr>
<tr>
<td>Mental Health Care:</td>
<td>X</td>
</tr>
<tr>
<td>Correctional Facilities:</td>
<td>X</td>
</tr>
<tr>
<td>None:</td>
<td></td>
</tr>
</tbody>
</table>
1E. Local CoC Competition

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at:
https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources
The FY 2019 CoC Program Competition Notice of Funding Availability at:

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

*1E-1. Local CoC Competition—Announcement, Established Deadline, Applicant Notifications. Attachments Required.

Applicants must indicate whether the CoC:

<table>
<thead>
<tr>
<th>Requirement</th>
<th>Response</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. informed project applicants in its local competition announcement about point values or other ranking criteria the CoC would use to rank projects on the CoC Project Listings for submission to HUD for the FY 2019 CoC Program Competition;</td>
<td>Yes</td>
</tr>
<tr>
<td>2. established a local competition deadline, and posted publicly, for project applications that was no later than 30 days before the FY 2019 CoC Program Competition Application submission deadline;</td>
<td>Yes</td>
</tr>
<tr>
<td>3. notified applicants that their project application(s) were being rejected or reduced, in writing along with the reason for the decision, outside of e-snaps, at least 15 days before the FY 2019 CoC Program Competition Application submission deadline; and</td>
<td>Yes</td>
</tr>
<tr>
<td>4. notified applicants that their project applications were accepted and ranked on the CoC Priority Listing in writing, outside of e-snaps, at least 15 days before the FY 2019 CoC Program Competition Application submission deadline.</td>
<td>Yes</td>
</tr>
</tbody>
</table>


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

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

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

The Pikes Peak Continuum of Care (PPCoC) is committed to considering the specific needs and vulnerabilities in the community. The PPCoC Ranking and Prioritization (R&P) Committee put emphasis on awarding 10 points to project applications which utilize Coordinated Entry as the method of bringing project participants into their project. This requirement is important since the VI-SPDAT is required for placement. The VI-SPDAT prioritizes an individual’s vulnerability and access to housing. The scoring rubric allowed the R&P committee to award points based off additional criteria that are of importance in the community from a vulnerability and capacity perspective. These criteria include how quickly organizations are housing participants, whether participants are returning to homelessness after project participation, whether the program uses a Housing First approach, and examples of supportive services that are provided to project participants. The R&P committee is also committed to supporting projects which will support Domestic Violence victims in the community. In consideration of these needs, the scoring rubric served in awarding points to projects who are appropriately meeting objectives and capacity for the community. Two new Domestic Violence projects were able to be ranked in Tier 1 alongside other projects that are serving the community well.


Applicants must:
1. indicate how the CoC made public the review and ranking process the CoC used for all project applications; or
2. check 6 if the CoC did not make public the review and ranking process; and
3. indicate how the CoC made public the CoC Consolidated Application—including the CoC Application and CoC Priority Listing that includes all project applications accepted and ranked or rejected—which HUD required CoCs to post to their websites, or partners websites, at least 2 days before the FY 2019 CoC Program Competition application submission deadline; or
4. check 6 if the CoC did not make public the CoC Consolidated Application.
1E-5. Reallocation between FY 2015 and FY 2018.

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

Reallocation: 5%


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

(limit 2,000 characters)

Per the documented Process for Ranking and Prioritization, the Pikes Peak Continuum of Care (PPCoC) has the following guidelines regarding reallocation: The PPCoC may use the reallocation process to shift funds in whole, or part, from existing renewal projects to new project applications without decreasing the CoC’s annual renewal demand. Reallocation can be partially or fully applied to agencies which are not performing well or who choose to not renew their projects. The CoC approves all reallocation recommendations made by the Ranking and Prioritization Committee. During the Spring Technical Assistance training as well as the Summer Technical Assistance training provided by the PPCoC on May 8, 2019 and August 9, 2019 respectively, applicants were notified of the reallocation process. In the FY2019 competition, Partners in Housing notified the PPCoC of their decision to not submit a renewal application in the full amount of $67,747. The Ranking and Prioritization Committee was notified that this amount was eligible for reallocation. For the FY2019 competition, points were awarded to individual projects using the scoring rubric. The HUD ranking and rating tool was utilized to generate the Priority Listing. Due to the ARD and Partners in Housing funds available, there was not a need to reduce the requested funding in any project other than the one project ranked in Tier 2 to match the amount of funding available for Tier 2. If there was a need to reduce funding, the Ranking and Prioritization Committee would reduce
funding from low scoring projects as well as projects who were consistently returning money at the end of their grant terms.
DV Bonus

Instructions
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

1F-1 DV Bonus Projects.

Applicants must indicate whether the CoC is requesting DV Bonus projects which are included on the CoC Priority Listing:

1F-1a. Applicants must indicate the type(s) of project(s) included in the CoC Priority Listing.

<table>
<thead>
<tr>
<th>1. PH-RRH</th>
<th></th>
<th>2. Joint TH/RRH</th>
<th></th>
<th>3. SSO Coordinated Entry</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td></td>
<td></td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

Applicants must click “Save” after checking SSO Coordinated Entry to view questions 1F-3 and 1F-3a.

*1F-2. Number of Domestic Violence Survivors in CoC’s Geographic Area.

Applicants must report the number of DV survivors in the CoC’s geographic area that:

<table>
<thead>
<tr>
<th>Need Housing or Services</th>
<th>202.00</th>
</tr>
</thead>
</table>
1F-2a. Local Need for DV Projects.

Applicants must describe:
1. how the CoC calculated the number of DV survivors needing housing or service in question 1F-2; and
2. the data source (e.g., HMIS, comparable database, other administrative data, external data source).
(limit 500 characters)

Data reported by non-DV Providers (9/1/2018 – 8/30/2019) indicated that of the 11,044 individuals input into HMIS, 513 individuals indicated that they were fleeing domestic violence. In the January 2019 annual PIT Survey, 118 out of 1,562 people surveyed indicated that they were fleeing domestic violence. Data reported from TESSA’s RRH program (1/1/18 -12/31/18) indicated that 102 people (38 adults, 64 children) were fleeing domestic violence.

1F-4. PH-RRH and Joint TH and PH-RRH Project Applicant Capacity.

Applicants must provide information for each unique project applicant applying for PH-RRH and Joint TH and PH-RRH DV Bonus projects which the CoC is including in its CoC Priority Listing—using the list feature below.

<table>
<thead>
<tr>
<th>Applicant Name</th>
<th>DUNS Number</th>
</tr>
</thead>
<tbody>
<tr>
<td>TESSA</td>
<td>196369599</td>
</tr>
<tr>
<td>Red Wind</td>
<td>612840830</td>
</tr>
</tbody>
</table>
1F-4a. Rate of Housing Placement and Housing Retention.

Applicants must describe:
1. how the project applicant calculated the rate of housing placement and rate of housing retention reported in the chart above; and
2. the data source (e.g., HMIS, comparable database, other administrative data, external data source). (limit 500 characters)

The rate of housing placement was calculated using the number receiving housing placement services divided by the number requesting services. TESSA has resources to house approximately 60. 12,562 survivors seek services annually. There is significantly greater need. The rate of housing retention was calculated using the number of clients placed in housing who are still housed when they exit from the program. Data source is a comparable database to HMIS to keep confidentiality.

1F-4b. DV Survivor Housing.

Applicants must describe how project applicant ensured DV survivors experiencing homelessness were assisted to quickly move into permanent housing. (limit 2,000 characters)

TESSA offers Safehousing (DV Shelter) for clients in imminent danger until permanent housing can be found. Other clients that have housing are offered support to maintain the housing once the abuser has left. Advocacy is provided to all clients enrolled in the Housing First Program. In addition, TESSA advocates coordinate with area landlords to help clients obtain long-term housing solutions.

1F-4c. DV Survivor Safety.

Applicants must describe how project applicant:
1. ensured the safety of DV survivors experiencing homelessness by:
   (a) training staff on safety planning;
   (b) adjusting intake space to better ensure a private conversation;
   (c) conducting separate interviews/intake with each member of a couple;
   (d) working with survivors to have them identify what is safe for them as it relates to scattered site units and/or rental assistance;
   (e) maintaining bars on windows, fixing lights in the hallways, etc. for
congregate living spaces operated by the applicant;
(f) keeping the location confidential for dedicated units and/or congregate living spaces set-aside solely for use by survivors; and
2. measured its ability to ensure the safety of DV survivors the project served.
(limit 2,000 characters)

All TESSA staff, interns, and volunteers must attend 48 hours of Confidential Victim Advocate training pursuant to Colorado Statute. This training includes detailed information on legal and advocate definitions of domestic violence, sexual assault, and stalking, trauma informed care, safety planning, and confidentiality.

TESSA advocates have their own individual offices and there are designated individual spaces for overflow as needed. Clients have the opportunity to meet with advocates on a 1:1 basis and information is only shared with the permission of a client which is verified with a written Release of Information.

TESSA provides services to victims of Domestic and Sexual violence. They do not offer offender services, but they do partner with and refer to, Stand-up Colorado, an organization that works with abusers and offenders to help them break the cycle of domestic violence.

Through a trauma-informed care approach, clients take the lead in prioritizing their housing needs and preferences. If safe, permanent housing is not available to someone in imminent danger, TESSA will offer Safehouse, a domestic violence emergency shelter, as an option until the client feels safe or their preferred housing option becomes available.

TESSA does not operate rental units, scattered site units, or congregate living spaces with HUD funding.

TESSA Confidential Victim Advocates are bound to VAWA, VOCA, CRS 13-90-107 (K) (I) (k) (I), etc. All TESSA staff, volunteers, and interns are required to attend Confidential Victim Advocate training. TESSA advocates understand and practice confidentiality throughout all phases of programming. Clients can meet with advocates on a 1:1 basis. Their information is only shared with their permission, which is verified with a written Release of Information.

1F-4d. Trauma-Informed, Victim-Centered Approaches.

Applicants must describe:
1. project applicant’s experience in utilizing trauma-informed, victim-centered approaches to meet needs of DV survivors; and
2. how, if funded, the project will utilize trauma-informed, victim-centered approaches to meet needs of DV survivors by:
(a) prioritizing participant choice and rapid placement and stabilization in permanent housing consistent with participants’ preferences;
(b) establishing and maintaining an environment of agency and mutual respect, e.g., the project does not use punitive interventions, ensures program participant staff interactions are based on equality and minimize power differentials;
(c) providing program participants access to information on trauma, e.g.,
training staff on providing program participant with information on trauma;
(d) placing emphasis on the participant’s strengths, strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans include assessments of program participants strengths and works towards goals and aspirations;
(e) centering on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;
(f) delivering opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and
(g) offering support for parenting, e.g., parenting classes, childcare.

(limit 4,000 characters)

Trauma-informed care takes a collaborative approach, with healing led by the client and supported by TESSA staff. Clients take the lead role in the planning, design, implementation and monitoring of their healing. When a client seeks assistance through TESSA, whether it’s counseling, safe shelter, or other resources, the client ultimately determines her/his own goals and chooses which services and resources to utilize in the process. This approach allows direct-service staff to employ methods and support geared specifically to the individual, based on that victim’s unique experience and trauma as well as their inherent response to that trauma as informed by their background, culture, gender, etc.

Through a trauma-informed care approach, clients take the lead in prioritizing their housing preferences. If safe permanent housing is not available to someone in imminent danger, TESSA will offer Safehouse, a domestic violence shelter, until the client feels safe or their preferred housing option become available.

The project is especially needed considering the barriers domestic violence survivors often face as they pursue housing. Barriers include: Lack of references, criminal records, or simply lacking the income for deposits and rent on alternative housing because of financial abuse. Other barriers include lack of transportation, moving expenses and basic living necessities, crucial to establishing stability and independence.

A cornerstone element of the Counseling Program is TESSA’s DoVE (Domestic Violence Education) psychoeducational support groups. Group counseling encompasses a 16-week curriculum utilizing relaxation techniques, skills and activities that help process the client’s lived experiences.

TESSA’s approach to evaluating the impact of programs focuses on both output metrics and client outcomes information. Assessment includes formative and summative evaluation processes that utilize both quantitative and qualitative data collection methods.

TESSA promotes the values of inclusivity amongst all levels of the agency. They embrace an anti-oppression ideology to understand and integrate culturally inclusive principles into policy and practice and provide services to victims of DVSA without regard to race, religion, national origin, sexual orientation, gender, gender expression, physical or mental handicap, marital status, language, or age. They conduct ongoing training around the ideas/issues of oppression, racism, sexism, heterosexism, ableism, and classism. Their non-discrimination policy applies to serving clients, hiring practices, internal promotions, training, terminations, use of outside vendors, use of contractors and consultants, relationships with donors, and the general public. Because of the confidentiality provided at TESSA, many traditionally ‘underserved’ populations who would hesitate to seek services due to
immigration status, LGBTQ affiliation, military relationship or other potential
dangers do not face those same fears at TESSA. Additionally, multi-lingual
advocates and translation services are provided for those clients with language
barriers.
TESSA has created curriculum to provide schools and youth-serving
organizations information about ongoing parenting classes that TESSA will offer
to parents and soon-to-be parents who may be either adult or teens.

1F-4e. Meeting Service Needs of DV Survivors.

Applicants must describe how the project applicant met services needs
and ensured DV survivors experiencing homelessness were assisted to
quickly move into permanent housing while addressing their safety
needs, including:

- Child Custody
- Legal Services
- Criminal History
- Bad Credit History
- Education
- Job Training
- Employment
- Physical/Mental Healthcare
- Drug and Alcohol Treatment
- Childcare

(limit 2,000 characters)

TESSA has a long history of providing comprehensive, trauma-informed
services to domestic and sexual violence victims that include a 32-bed shelter
(one of Colorado’s largest domestic violence shelters); a Children’s Program for
residential and non-residential children; and a Safety and Support Program with
six satellite offices for case management.
Shelter systems include assessment and eligibility, intake process, client
orientation, facility safety measures, and transition to sustainable, safe housing.
By assisting participants with the following, TESSA is able to assist DV
survivors quickly into moving into permanent housing:
Child Custody/Legal Services: TESSA helps victims navigate the criminal
justice system and provide legal assistance. Examples include helping to
identify options, acquire information and referrals and receive assistance with
Temporary Protection Orders (TPOs) and Permanent Protection Orders
(PPOs).
Criminal History: TESSA provides participants with legal assistance and
advocacy in securing basic needs.
Bad Credit History: TESSA provides advocacy in securing needs for
participants.
Education: TESSA provides resources to locate adult educational options.
Job Training: TESSA helps program participants get resources for Job Training.
Employment: TESSA helps program participants find employment.
Physical/Mental Healthcare: TESSA assists victims in finding medical care
when needed and has a Counseling Program for adults and children which
includes individual therapy as well as specialized support groups.
Drug and Alcohol Treatment: TESSA will assist program participants in getting

Applicant: Colorado Springs/El Paso County CoC
Project: CO-504 CoC Registration FY 2019
access to drug and alcohol treatment options.
Childcare: Tessa offers a children’s program for residential as well as nonresidential children.

1F-4. PH-RRH and Joint TH and PH-RRH Project

Applicant Capacity

| DUNS Number: | 612840830 |
| Applicant Name: | Red Wind |
| Rate of Housing Placement of DV Survivors–Percentage: | 90.00% |
| Rate of Housing Retention of DV Survivors–Percentage: | 75.00% |

1F-4a. Rate of Housing Placement and Housing Retention.

Applicants must describe:
1. how the project applicant calculated the rate of housing placement and rate of housing retention reported in the chart above; and
2. the data source (e.g., HMIS, comparable database, other administrative data, external data source). (limit 500 characters)

Red Wind calculated the rate of housing placement and retention by averaging the rate of placement and the rate of retention over the past two years in their transitional housing program. The data is currently kept in an internal database.

1F-4b. DV Survivor Housing.

Applicants must describe how project applicant ensured DV survivors experiencing homelessness were assisted to quickly move into permanent housing.
(limit 2,000 characters)

Red Wind is building landlord relationships to help facilitate moving participants into housing quickly. Advocates are becoming familiar with housing resources in the community, through their work with survivors, they learn about the barriers that each survivor might have to be able to help them choose housing that fits their needs while also being low barrier to accessing.

1F-4c. DV Survivor Safety.

Applicants must describe how project applicant:
1. ensured the safety of DV survivors experiencing homelessness by:
   (a) training staff on safety planning;
   (b) adjusting intake space to better ensure a private conversation;
   (c) conducting separate interviews/intake with each member of a couple;
   (d) working with survivors to have them identify what is safe for them as
it relates to scattered site units and/or rental assistance;
(e) maintaining bars on windows, fixing lights in the hallways, etc. for
congregate living spaces operated by the applicant;
(f) keeping the location confidential for dedicated units and/or congregate
living spaces set-aside solely for use by survivors; and
2. measured its ability to ensure the safety of DV survivors the project
served.
(limit 2,000 characters)

Red Wind staff receive a minimum of 40 hours of domestic violence advocacy
training each year. Within that, they receive an estimated 4 hours of training
each year on safety planning.

Red Wind's intake space is a private room called our "soft room" where staff
members meet with all survivors one-to-one to ensure privacy. There is a sound
machine to help muffle sounds to further ensure privacy. The soft room is set up
with a couch and 2 chairs with an intent of moving away from meeting with
survivors from behind a desk.

Red Wind's program does not work with couples as they are working with
survivors of domestic violence, meaning that one partner is not within the
household due to their perpetration of violence.

Advocates work with survivors through a process that facilitates dialogue, a free
exchange of thoughts and ideas. Each DV participant is asked about the kind of
housing they would like to live in, the things they are concerned about for
safety, and advocates offer information about safety as well to ensure
participants understand the pros and cons of different options enabling them to
make an informed decision about their own safety needs.

Red Wind will not be operating any properties/living spaces.

Red Wind has strict confidentiality policies it operates with to ensure safety for
survivors; only advocates know the locations of units the survivors secure. Red
Wind's finance department operates within strict guidance provided by the
Office on Violence against Women that does not allow them to have survivor
confidential information to perform their duties. Red Wind has adopted a coding
process that is assigned to DV survivors at intake and that information is the
only information passed to finance department.

1F-4d. Trauma-Informed, Victim-Centered Approaches.

Applicants must describe:
1. project applicant’s experience in utilizing trauma-informed, victim-
centered approaches to meet needs of DV survivors; and
2. how, if funded, the project will utilize trauma-informed, victim-centered
approaches to meet needs of DV survivors by:
(a) prioritizing participant choice and rapid placement and stabilization in
permanent housing consistent with participants’ preferences;
(b) establishing and maintaining an environment of agency and mutual
respect, e.g., the project does not use punitive interventions, ensures
program participant staff interactions are based on equality and minimize
power differentials;
(c) providing program participants access to information on trauma, e.g., training staff on providing program participant with information on trauma;
(d) placing emphasis on the participant’s strengths, strength-based coaching, questionnaires and assessment tools include strength-based measures, case plans include assessments of program participants strengths and works towards goals and aspirations;
(e) centering on cultural responsiveness and inclusivity, e.g., training on equal access, cultural competence, nondiscrimination;
(f) delivering opportunities for connection for program participants, e.g., groups, mentorships, peer-to-peer, spiritual needs; and
(g) offering support for parenting, e.g., parenting classes, childcare.

Red Wind was formed in 2005 as a national tribal technical assistance provider working through a cooperative agreement with the Office on Violence Against Women. The staff at Red Wind are highly trained in trauma informed and victim-centered approaches. Red Wind’s advocates work with survivors through an understanding of the impact of trauma on domestic violence victims, how that may look different for different individuals, and have a depth of experiencing providing culturally informed responses to survivors. Additionally, Red Wind has coined the term “creating sister space” in its work with tribes and it carries into our work. This work recognizes our sister relationship with victims and that their needs are central in our work.

Red Wind is experienced in recognizing and supporting survivor autonomy. This means that the survivor has personal sovereignty, control over their decisions and their choices guide the advocates direction in their work.

Each staff recognizes their role as an advocate has positional power and since our program is culturally centered, honoring survivor autonomy and sovereignty, building advocate-participant relationships is critical to working successfully with the survivor, and offering voluntary services helps to minimize the power differential. Participants are not mandated to participate in program activities and are not provided consequences if they choose to not participate in services.

Participants can participate in Red Wind’s education groups and cultural activities. As part of that work, topics such as dynamics and impacts of domestic violence, multigenerational trauma and their continued impacts, options for healing, and indigenous-based cultural supports are offered to participants. Advocates also engage in one-to-one conversations with survivors on these topics. We also provide handouts on trauma, selfcare, dynamics of domestic violence, and offer a community resource directory that includes options for healing.

Red Wind advocates conduct their work with an indigenous centered approach that helps survivors reflect on who they are as indigenous peoples, what those strengths are that developed resiliency and how to build on that. Red Wind has a tool that it uses for housing participants that covers short term, intermediary, and long-term goals. Each participant takes time with their advocate periodically to discuss goals and develop milestones to help accomplish them. Goals are reviewed periodically and modified and refined as new ideas and directions emerge and old ideas no longer fit or have been completed.
Red Wind is an indigenous based program, working intertribally across the many tribes that reside in El Paso County. Advocates are experienced in working across different tribes and respecting individual tribal identity. Additionally, as an urban native organization, we do not discriminate. We uphold the civil rights laws of non-discrimination. Staff have been trained to work across multiple racial and ethnic cultures, work with LGBTQ and 2 Spirit populations. Additionally, staff have been trained to work with male victims and elder victims.

Red Wind provides women’s education groups, community events and activities to enable participants to build supports with their peers and community members while protecting their confidentiality. Red Wind operates an indigenous healing garden for groups, gatherings, and indigenous spiritual activities.

Red Wind advocates are certified facilitators for teaching indigenous parenting classes and offer topics for participants in education groups; and provide childcare stipends to support survivor participation.

1F-4e. Meeting Service Needs of DV Survivors.

Applicants must describe how the project applicant met services needs and ensured DV survivors experiencing homelessness were assisted to quickly move into permanent housing while addressing their safety needs, including:

- Child Custody
- Legal Services
- Criminal History
- Bad Credit History
- Education
- Job Training
- Employment
- Physical/Mental Healthcare
- Drug and Alcohol Treatment
- Childcare

(limit 2,000 characters)

Child Custody – Identified & secured pro bono legal services to assist with civil matters. Red Wind advocates assist with providing support & accompaniment. Legal Services – Identified legal services available to clients in El Paso County, as well has provided information about pro se legal clinics when they are available. Advocates can accompany survivors if needed. Criminal History – Helped survivors get their record expunged & identified landlords that provide felon friendly accommodation within their housing. Bad Credit History – Provide financial literacy education & assist participants with accessing & reviewing their credit histories to engage in credit repair. Education – Work with Denver Indian Center to provide onsite monthly sessions on education & job readiness education. Job Training – Work with Denver Indian Center to provide onsite monthly sessions on job readiness education. Employment – Assist participants with identifying & securing employment,
including, helping them get clothing for their jobs & providing support as they take their early steps forward.

Physical/Mental Healthcare – Assist participants with addressing physical, mental, & emotional trauma from the violence. This occurs through helping them get medical coverage, finding a medical practitioner, identifying a therapist or counselor, & engage in indigenous healing & spiritual options available to them.

Drug & Alcohol Treatment – Assist participants with exploring alcoholics anonymous & other options for treatment if they chose.

Childcare – Assist participants by providing childcare subsidies to participant in a range of activities. They have also helped participants identify childcare options for their needs while employed or as a student.
2A. Homeless Management Information System (HMIS) Implementation

Instructions:
Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

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2A-1. HMIS Vendor Identification. Bitfocus Clarity

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

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

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

<table>
<thead>
<tr>
<th>Project Type</th>
<th>Total Number of Beds in 2019 HIC</th>
<th>Total Beds Dedicated for DV in 2019 HIC</th>
<th>Total Number of 2019 HIC Beds in HMIS</th>
<th>HMIS Bed Coverage Rate</th>
</tr>
</thead>
<tbody>
<tr>
<td>Emergency Shelter (ES) beds</td>
<td>840</td>
<td>36</td>
<td>787</td>
<td>97.89%</td>
</tr>
<tr>
<td>Safe Haven (SH) beds</td>
<td>0</td>
<td>0</td>
<td>0</td>
<td>0%</td>
</tr>
<tr>
<td>Transitional Housing (TH) beds</td>
<td>451</td>
<td>0</td>
<td>229</td>
<td>50.78%</td>
</tr>
<tr>
<td>Rapid Re-Housing (RRH) beds</td>
<td>97</td>
<td>0</td>
<td>97</td>
<td>100.00%</td>
</tr>
<tr>
<td>Permanent Supportive Housing (PSH) beds</td>
<td>626</td>
<td>0</td>
<td>626</td>
<td>100.00%</td>
</tr>
<tr>
<td>Other Permanent Housing (OPH) beds</td>
<td>31</td>
<td>0</td>
<td>31</td>
<td>100.00%</td>
</tr>
</tbody>
</table>

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

For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-2., applicants must describe:
1. steps the CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and
2. how the CoC will implement the steps described to increase bed coverage to at least 85 percent.
(limit 2,000 characters)

Transitional housing (TH) is at 50.58% coverage rate vs. 100% in 2018. This is due to the fact the the largest TH provider decided to stop using HMIS because they no longer wish to bring resources through Coordinated Entry. This provider has not followed a Housing First Model for these units for the past two years. To ensure a high success rate, they hand select candidates that meet a number of requirements to enter their housing program.

PPCoC members and board members have tried for the last 18 months to discuss different strategies with this TH provider and they are simply not willing to continue participating in HMIS. This provider does have a high success rate (95%) in keeping people in housing and a 90% success rate of people remaining housed once leaving their program.

Because TH is no longer a HUD funding priority and the organization is successfully housing people at this time, there is currently not a strategy in place to increase bed coverage to 85% in HMIS, because there is technically a much higher TH bed coverage rate in the community.


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

*2A-4. HIC HDX Submission Date.

Applicants must enter the date the CoC submitted the 2019 Housing Inventory Count (HIC) data into the Homelessness Data Exchange (HDX). (mm/dd/yyyy) 04/29/2019
2B. Continuum of Care (CoC) Point-in-Time Count

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

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2B-1. PIT Count Date. 01/27/2019
Applicants must enter the date the CoC conducted its 2019 PIT count (mm/dd/yyyy).

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


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

The implementation and methodology for the 2019 PIT was unchanged from the 2018 PIT.

The following was a recommendation from the 2019 PIT, which will be a goal of upcoming PIT Counts: Increase the number of providers that participate in the PIT Count. Many housing programs are not required to participate in HMIS and choose not to participate, which prevents communities from understanding the true nature and extent of homelessness in their jurisdictions and from fully participating in the aggregation of data to better inform homeless policy at the
federal and state levels. Finding strategies to encourage robust participation in this system will help improve the quality of interventions.

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

Applicants must select whether the CoC added or removed emergency shelter, transitional housing, or Safe-Haven inventory because of funding specific to a Presidentially-declared disaster, resulting in a change to the CoC’s 2019 sheltered PIT count. No

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

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

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

Applicants must:

Indicate whether the CoC implemented specific measures to identify youth experiencing homelessness in their 2019 PIT count. Yes

2B-6a. PIT Count–Involving Youth in Implementation.

Applicants must describe how the CoC engaged stakeholders serving youth experiencing homelessness to:
1. plan the 2019 PIT count;
2. select locations where youth experiencing homelessness are most likely to be identified; and
3. involve youth in counting during the 2019 PIT count.
(limit 2,000 characters)
The Urban Peak Colorado Springs (UPCS) street outreach team engaged youth in reviewing supplemental questions for the PIT. During the 2019 PIT, the Pikes Peak Continuum of Care (PPCoC) supported the statewide effort to conduct a youth specific count simultaneously with the PPCoC’s PIT Count. The youth’s specific effort included a Youth Supplemental Survey (YSS) that incorporated
questions about life experiences of the youth. All questions were specifically created to ensure the data would be useful in making recommendations about systems change or identifying areas where programs need to expand services. The YSS asked questions about: Where the youth slept the night of the survey; if they had been in foster care; if they were homeless with their parents; if they were involved in the juvenile justice system; if they were responsible for youth under 18; if they were currently enrolled in school HLN experience; if HLN was a response to their gender identity or sexual orientation; and lastly, if they had a stable adult they could count on for help. The goal of these questions was to identify additional life experiences beyond homelessness. The Colorado Office of Homeless Youth Services collected all surveys and used the data collected to create a YSS report. The report included a detailed break out of the data for the state and compared it to each CoC. The report also made specific recommendations about major finding. For example the YSS data showed that Latino youth were significantly underrepresented in the workforce and that many of the youth who were not currently in school had completed a basic level of education (high school graduation or GED), busting the common myth that homeless youth are high school dropouts. During the 2018 and 2019 PIT Count, UPCS dedicated staff to helping with the count to ensure youth hotspots were accessed and that youth specific staff with skills and experience in working with youth were administering surveys.

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

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

The Pikes Peak Continuum of Care (PPCoC) utilized PIT surveys that included questions to identify families experiencing chronic homelessness, families with children experiencing homelessness, and veterans experiencing homelessness. In addition, agencies that serve these populations were involved in the PIT outreach planning process. These agencies were instrumental in mapping locations where these individuals congregate or set up encampments. These same agencies insured that their staff received PIT training and participated in the PIT count either at their agency or canvassing areas that were identified where large numbers of people experiencing homelessness stay.
3A. Continuum of Care (CoC) System Performance

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

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

Applicants must:

<table>
<thead>
<tr>
<th>Applicant: Colorado Springs/El Paso County CoC</th>
</tr>
</thead>
<tbody>
<tr>
<td>Project: CO-504 CoC Registration FY 2019</td>
</tr>
</tbody>
</table>

Report the Number of First Time Homeless as Reported in HDX. 3,636


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

In April 2019, Rocky Mountain Human Services (RMHS), Homes for all Veterans (HAV) program was awarded a Rapid Resolution grant from the Veterans Administration (VA). Since April, the VA, Salvation Army, Community Health Partnership, Peak Vista Community Health Centers, VOA, Mt. Carmel, Pikes Peak Workforce Center, Catholic Charities, Peak Military Care Network, The City of Colorado Springs, Family Promise, and Homeward Pikes Peak have been meeting to define goals and create policies and procedures for the Rapid Resolution program that will be implemented beginning October 1, 2019. The Rapid Resolution Program is a system-wide homelessness prevention intervention that can be used for all populations, not just Veterans. All persons
and households presenting for housing assistance will have a conversation with trained case workers to better understand if positive rapid resolutions exist to avoid entry into the shelter system/homelessness, and if none do, the conversation then acts as a starting point for longer-term housing plans and assessments. RMHS will begin implementation of this program in October 2019 and will determine what challenges or gaps in the system may exist. In January, RMHS and VOA will be providing community wide training in Trauma-Informed Care, Motivational Interviewing, Conflict Resolution, Vicarious Trauma, and Rapid Resolution procedures to all case workers at client access points within the Continuum. Coordinated Entry will be incorporating homelessness prevention and rapid resolution policies in the CE Policies and Procedures update in January 2020 to ensure that all providers within the continuum follow a consistent process. Rocky Mountain Human Services has been identified as the agency responsible for overseeing the CoC’s strategy to reduce the number of Veterans experiencing homelessness for the first time.

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

Applicants must:

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


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

(limit 2,000 characters)

Coordinated Entry (CE) through the Pikes Peak Continuum of Care (PPCoC) ranks and prioritizes individuals, youth, and families based on a variety of risk factors including length of time homelessness. The CE policies and procedures prioritize length of time homeless and numbers of time homeless in a three-year period as the second and third factors, respectively, when determining the community ranking in the CE By Name List, which is proceeded only by the vulnerability index housing assessment score produced in the PPCoC community housing assessment tool, the VI-SPDAT.

The PPCoC has expanded involvement with emergency shelter service providers in reducing length-of-time individuals and persons in families remain homeless. This collaboration allows for chronic homeless individuals, youth, and families to be assigned a resource navigator to assist with case management, documentation readiness, and referrals to community resources.

To ensure that length-of-time homeless is being shortened, the PPCoC
monitors performance data by housing type and by individual grantee to determine if individual projects or the collective system is reducing the length of time homeless for families and individuals. This information is reviewed monthly during the Coordinated Entry Advisory/Planning meeting. In addition, the PPCoC is working to increase HMIS use for non-CoC funded housing providers so that system-wide data around length of time homeless is more accurate; sending data quality reports with suggested improvements to each CoC funded grantee monthly; and providing system wide data to key stakeholders on a quarterly basis to ensure the continuum is aware of progress in reducing length of time homeless.

Community Health Partnership (CHP) is responsible for overseeing the PPCoC’s strategy to reduce the length of time individuals and families remain homeless.

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

Applicants must:

<table>
<thead>
<tr>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Report the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid rehousing that exit to permanent housing destinations as reported in HDX.</td>
</tr>
<tr>
<td>2. Report the percentage of individuals and persons in families in permanent housing projects, other than rapid rehousing, that retain their permanent housing or exit to permanent housing destinations as reported in HDX.</td>
</tr>
</tbody>
</table>

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

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

(limit 2,000 characters)

The CoC’s strategy in increasing the permanent housing rate for individuals and persons in families in emergency shelters, transitional housing, and rapid rehousing is a two-pronged approach. First, supportive case management
services are provided within ES, TH, and RRH programs to empower individuals and persons in families to seek financial independence through job placement and access to federal and state aid programs. Supporting individuals and persons in families also requires offering a diversity of assistance programs such as available access and choice for physical health, mental health, and substance use services. Many homeless individuals and persons in families struggling to maintain financial independence have been forced into homeless housing service programs due to major life events such as addictions or illnesses, which need to be addressed and treated before individuals and persons in families can successfully take advantage of permanent housing opportunities. The second goal of improving the CoC permanent housing rate is through improving landlord engagement and housing navigation to connect individuals and persons in families capable of maintaining permanent housing independently. The CoC actively engages with the Southern Colorado Apartment Association to improve landlord relationships and educate landlords around housing voucher and assistance programs. The CoC also directs support to individuals and persons in families in permanent housing projects by maintaining relationships with the local Housing Authority, who oversee permanent housing projects, with a goal to connect the Housing Authority to local supportive service agencies.

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

Applicants must:

| Percentage |
|---|---|
| 1. Report the percentage of individuals and persons in families returning to homelessness over a 6-month period as reported in HDX. | 10% |
| 2. Report the percentage of individuals and persons in families returning to homelessness over a 12-month period as reported in HDX. | 17% |

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

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

The CoC uses performance data from the Homeless Management Information System (HMIS) to analyze program success rates in individuals and persons in families retaining permanent housing. This allows the CoC to identify common factors at a program specific level for individuals and persons in families who return to homelessness from permanent housing. The CoC can then assess and evaluate programmatic performance success by scoring housing agencies on housing retention based on outcome-based measures.
The CoC encourages housing and service providers to adopt, use, and refine evidence-based practices, within HUD guidelines, to reduce the rate of additional returns to homelessness. The CoC can then provide oversight and support for agencies seeking to improve their practices by conducting annual site reviews visits or monthly education and re-training opportunities of housing best practices through Coordinated Entry. Reducing returns to homelessness is currently tracked at each individual program level. The PPCoC uses program specific reporting to look at returns to homelessness. This information is reviewed by the Ranking and Prioritization Committee when reviewing renewing program applications for the annual CoC NOFA competition.

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

Applicants must:

<table>
<thead>
<tr>
<th>Percentage</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their employment income from entry to exit as reported in HDX.</td>
</tr>
<tr>
<td>2. Report the percentage of individuals and persons in families in CoC Program-funded Safe Haven, transitional housing, rapid rehousing, and permanent supportive housing projects that increased their non-employment cash income from entry to exit as reported in HDX.</td>
</tr>
</tbody>
</table>


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

The CoC supports job assistance programs and SOAR case management programs to increase access to cash sources. The PPCoC has partnered with job assistance programs such as the local Workforce Center to provide vocational training programs, job fairs, and job preparedness programs such as classes for resume building and improving job interviewing skills. The PPCoC works with supportive service agencies with SOAR case managers who assist disabled individuals to access social security benefits and disability programs. The PPCoC has collaborated with pro-bono legal representatives to oversee social security disability cases for homeless individuals and persons in families. The PPCoC promotes employment organizations by offering community forums for employment organizations to educate and advertise current and upcoming job fairs and funding opportunities for job placement. Service providers also offer bus passes and transportation options for individuals and families seeking job placement.

There is currently not an organization responsible for overseeing the PPCoC’s
strategy to increase job and income growth from employment. The newly hired (4/18) Coordinated Entry Administrator has begun discussions with the Pikes Peak Workforce Center to create a partnership with the PPCoC.


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

The Department of Human Services (DHS) provides access to SNAP, TANF, Medicaid and WIC at a number of different locations throughout El Paso County in an effort to reach as many families in need as possible. In addition, organisations within the CoC have become certified to provide assistance with benefits such as SNAP to ensure their clients have access to all of the non-cash benefits that they qualify for.

DHS is the agency responsible for overseeing the CoC’s strategy to increase non cash employment income.


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

The PPCoC works with a number of organizations in the community that are providing access to employment opportunities, hosting job fairs and providing work opportunities. The PPCoC promotes these different opportunities to the CHAP list whenever possible.


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

1. The CoC trains provider organization staff on connecting program participants and people experiencing homelessness with education and job training opportunities.
2. The CoC trains provider organization staff on facilitating informal employment opportunities for program participants and people experiencing homelessness (e.g., babysitting, housekeeping, food delivery).
3. The CoC trains provider organization staff on connecting program participants with formal employment opportunities.

4. The CoC trains provider organization staff on volunteer opportunities for program participants and people experiencing homelessness.

5. The CoC works with organizations to create volunteer opportunities for program participants.

6. The CoC works with community organizations to create opportunities for civic participation for people experiencing homelessness (e.g., townhall forums, meeting with public officials).

7. Provider organizations within the CoC have incentives for employment.

8. The CoC trains provider organization staff on helping program participants budget and maximize their income to maintain stability in permanent housing.

3A-6. System Performance Measures Data–HDX Submission Date

Applicants must enter the date the CoCs submitted its FY 2018 System Performance Measures data in HDX. (mm/dd/yyyy)
3B. Continuum of Care (CoC) Performance and Strategic Planning Objectives

Instructions

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

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The FY 2019 CoC Program Competition Notice of Funding Availability at:

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3B-1. Prioritizing Households with Children.

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

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

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

Applicants must:
1. describe how the CoC currently rehouses every household of families with children within 30 days of becoming homeless that addresses both housing and service needs;
2. describe how the CoC addresses both housing and service needs to ensure families with children successfully maintain their housing once
assistance ends; and
3. provide the organization name or position title responsible for overseeing the CoC’s strategy to rapidly rehouse families with children within 30 days of them becoming homeless.
(limit 2,000 characters)

The Pikes Peak Continuum of Care (PPCoC) Strategic Plan (Goal #3) is to “Build a durable and unified system focused on performance, coordination, and sustainability.” The PPCoC focuses on ensuring families are housed quickly. Relationships with landlords ensure families with evictions, bad credit & poor rental history have housing choices. All housing (CoC & ESG) comes through CE, prioritizing families with children for housing resources. Catholic Charities Day center is a portal to shelter and housing for families. Crisis services and case management are a bridge for families awaiting RRH and other housing options. The Catholic Charities Day center offers opportunities for VI-SPDATs to be administered onsite & then linked to crisis & stable housing via HMIS. Catholic Charities Family Connections works with law enforcement to get motel vouchers to families. Another family motel voucher program & outreach services at Pikes Peak Library District (PPLD) are effective outreach tools, connecting families to assessment, housing & services. Weekly CE meetings facilitate case management & triage/coordinate housing solutions to minimize disruption of families & prevent or reduce unsheltered periods.

3B-1b. Antidiscrimination Policies.

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

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

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

Applicants must indicate whether the CoC’s strategy to address the unique needs of unaccompanied youth experiencing homelessness who are 24 years of age and younger includes the following:
3B-1c.1. Unaccompanied Youth Experiencing Homelessness—Prioritization Based on Needs.

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

<table>
<thead>
<tr>
<th>Priority Factor</th>
<th>Yes</th>
</tr>
</thead>
<tbody>
<tr>
<td>1. History of, or Vulnerability to, Victimization (e.g., domestic violence, sexual assault, childhood abuse)</td>
<td>X</td>
</tr>
<tr>
<td>2. Number of Previous Homeless Episodes</td>
<td>X</td>
</tr>
<tr>
<td>3. Unsheltered Homelessness</td>
<td>X</td>
</tr>
<tr>
<td>4. Criminal History</td>
<td></td>
</tr>
<tr>
<td>5. Bad Credit or Rental History</td>
<td></td>
</tr>
</tbody>
</table>

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

Applicants must describe how the CoC increased availability of housing and services for:

1. all youth experiencing homelessness, including creating new youth-focused projects or modifying current projects to be more youth-specific or youth-inclusive; and
2. youth experiencing unsheltered homelessness including creating new youth-focused projects or modifying current projects to be more youth-specific or youth-inclusive.

(limit 3,000 characters)

The Pikes Peak Continuum of Care has made concerted efforts with community partners supporting youth services to expand outreach and housing opportunities for homeless youth in the region. One of these factors included adding a Youth Supplemental Survey (YSS) to the annual Point in Time Count. The YSS was administered in conjunction with the annual Point in Time count to increase outreach and identification of youth experiencing or at imminent risk of experiencing homelessness. All questions were specifically created to ensure the data would be useful in making recommendations about systems change or identifying areas where programs need to expand services. Some findings specific to the YSS include: a higher percentage of youth identified a non-binary gender (5.39% vs. 3.71) when compared to the Colorado state averages.
suggesting more intention being placed on service providers receiving more training on how to work with youth who identify as non-binary and to ensure safety and appropriate service policies around emergency services. YSS also had higher instances of youth with corrections experience when compared to the state average (64.58% vs. 53.59%), identifying a possible need for extra effort on connecting youth to legal services, creating specific relationships with landlord who may be more flexible with background checks, and including justice staff in ongoing meetings regarding youth experiencing homelessness. Lastly, less youth reported earning money in YSS when compared to the state average (42.86% vs. 55.30%), indicating a need to build partnerships and connect to employment services or increased programs to grow job skills. The additional data helped expand youth referrals to non-traditional youth housing programs such as the CoC’s first Project-Based Housing Project (Greenway Flats) and a new criminal justice rapid re-housing project (COR3). Since the introduction of these two new projects in 2019, the CoC has housed an additional 7 youth-aged households, which is 20% of the population housed through the Greenway Flats or the COR3 projects.

The CoC partners with the primary youth-service provider in the region, Urban Peak, who offers emergency shelter, case management, street outreach, and several different housing projects funded through the CoC and RHY programs, among other private and local governmental funders. Urban Peak conducts daily street outreach to identify unsheltered youth experiencing homelessness throughout the CoC region. In 2019, Urban Peak has even begun to educate local community partners with their street outreach efforts to work with a variety of health and services agencies such as the Colorado Springs Police and Fire Department, Homeward Pikes Peak, and Rocky Mountain Human Services. Urban Peak remains the community leader in street outreach by addressing unsheltered youth homelessness in illegal encampments and places not meant for human habitation including homeless households living in vehicles.

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

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

The Pikes Peak Continuum of Care (PPCoC) utilizes the Homeless Management Information System (HMIS) and the Coordinated Entry System (CES) to collect youth housing data and supportive services. The PPCoC and the local youth-service provider, Urban Peak, participate in the Coordinated Entry Learning Collaborative (CELC) sponsored by Youth Collaboratory. Through the CELC, the PPCoC collects monthly data for the A Way Home America (AWHA) Community Dashboard to measure progress on effectively ending youth homelessness. The CoC has collected monthly data for the AWHA Dashboard since June 2017. The measures collected for the AWHA
Dashboard include: total active youth (continuing active, new, and returning youth), housing assessment scores broken down by vulnerability, most frequent sleeping locations, and exit destinations. The AWHA Dashboard is additionally broken down by gender identity, race, and ethnicity to explore how vulnerable subpopulations of homeless youth are entering and exiting the homelessness system. Some interesting trends between July 2018 to June 2019 in the PPCoC data compared to the national average of CoCs participating in the AWHA Dashboard includes: the percentage of youth staying in emergency shelters was significantly higher in PPCoC compared to the national average of youth (44% of staying most frequently vs. 29% nationally). PPCoC is also doing a better job of exiting youth from the CES By Name List to permanent or transitional housed destinations than the CELC national average (67% positive outcomes vs. 41% nationally). This measurement is best observed when looking at youth exiting to unknown or inactive exit destinations from the CES By Name List for PPCoC versus the national average (25% unknown or inactive exits vs. 54% nationally).

The PPCoC measures effectiveness for housing resources and services based on the CELC data collection for the AWHA Dashboard. The measurement provided by the AWHA Dashboard allow the PPCoC and youth-based service providers, such as Urban Peak, to allocate resources in the most effective ways possible to produce positive housing destination outcomes for youth. These measurements align with the U.S. Interagency Council on Homelessness (USICH) Criteria and Benchmarks.

The PPCoC believes that these measurement strategies are effective because of technical support offered by the Youth Collaboratory community, who developed their strategies for the CELC with support from HUD, U.S. Health and Human Services, USICH, and the Melville Charitable Trust. The CELC has also significantly shaped the national conversation. Common challenges and promising solutions identified through the CELC have contributed to numerous practical tools for communities, providers, and other national initiatives. Furthermore, key questions prioritized by the CELC have spurred the development of new data dashboards and analysis of homeless youth data.

3B-1e. Collaboration–Education Services.

Applicants must describe:

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

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

(limit 2,000 characters)

No formal partnerships currently exist with youth education providers, McKinney-Vento LEA or SEA, or school districts. The Pikes Peak Continuum of Care (PPCoC), has identified a number organizations that MOUs need to be
established with and has worked on building relationships with these organizations in 2019. In 2020, the goal is to draft and establish official MOU’s with these organizations.

The PPCoC coordinates services with public schools’ McKinney-Vento Homeless Liaisons & State Coordinator for Education of Homeless Children and Youth. PPCoC agencies connect youth, children & families experiencing homelessness with school district liaisons. A local high school, Mitchell High School added a case manager funded by Catholic Charities to assist the McKinney Vento social worker to support homeless youth. The PPCoC ensures that youth experiencing homelessness have access to educational resources & services and attempt to remove barriers for youth by doing the following: Ensuring immediate enrollment into programming, providing transportation to enrolled schools and coordinating with school liaisons to help youth stay current with school work.

Local schools conduct a survey at the start of the school year to identify homeless or at-risk families and provide info to students and parents regarding available services. Teachers are trained to identify homeless children & work with coordinators to ensure students have access to services. Liaisons attend a monthly meeting with the PPCoC to ensure coordination and knowledge of available resources. The PPCoC has worked closely with the MV Liaisons the last two years to increase the number of families participating in the point in time count.

As the primary provider to unaccompanied homeless youth, Urban Peak Colorado Springs (UPCS) provides young people with a GED practice testing site, volunteer tutors, and access to on-line classes at it's computer lab in the shelter.

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

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

The Pikes Peak Continuum of Care (PPCoC) does not have formal policies and procedures regarding Subtitle VII-B of the McKinney-Vento Act. However, McKinney-Vento Homeless Liaisons from several local school districts participate regularly in case conferencing through Coordinated Entry to ensure they have an understanding of the help that is available to children and youth experiencing homelessness. This allows them to refer eligible students to housing agencies for needed services, thus facilitating the provision of the broadest array of supports to these vulnerable students. Conversely, when children and youth experiencing homelessness are identified through partner agencies, referrals can be made to the McKinney-Vento liaisons to ensure that the children and youth are informed of their rights to receive education services.

3B-1e.2. Written/Formal Agreements or Partnerships with Early Childhood Services Providers.
Applicant must indicate whether the CoC has an MOU/MOA or other types of agreements with listed providers of early childhood services and supports and may add other providers not listed.

<table>
<thead>
<tr>
<th>Provider</th>
<th>MOU/MOA</th>
<th>Other Formal Agreement</th>
</tr>
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<tr>
<td>Early Childhood Providers</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Head Start</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Early Head Start</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Child Care and Development Fund</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Federal Home Visiting Program</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Healthy Start</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Public Pre-K</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Birth to 3 years</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Tribal Home Visiting Program</td>
<td>No</td>
<td>No</td>
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<tr>
<td>Other: (limit 50 characters)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>

3B-2. Active List of Veterans Experiencing Homelessness.
Applicant must indicate whether the CoC uses an active list or by-name list to identify all veterans experiencing homelessness in the CoC.

Yes

3B-2a. VA Coordination–Ending Veterans Homelessness.
Applicants must indicate whether the CoC is actively working with the U.S. Department of Veterans Affairs (VA) and VA-funded programs to achieve the benchmarks and criteria for ending veteran homelessness.

Yes

3B-2b. Housing First for Veterans.
Applicants must indicate whether the CoC has sufficient resources to ensure each veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach.

Yes

Applicants must:
1. select all that apply to indicate the findings from the CoC’s Racial Disparity Assessment; or
2. select 7 if the CoC did not conduct a Racial Disparity Assessment.
1. **People of different races or ethnicities are more likely to receive homeless assistance.**

2. **People of different races or ethnicities are less likely to receive homeless assistance.**

3. **People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.**

4. **People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.**

5. There are no racial or ethnic disparities in the provision or outcome of homeless assistance.

6. **The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.**

7. The CoC did not conduct a racial disparity assessment.

### 3B-3a. Addressing Racial Disparities.

Applicants must select all that apply to indicate the CoC’s strategy to address any racial disparities identified in its Racial Disparities Assessment:

1. The CoC is ensuring that staff at the project level are representative of the persons accessing homeless services in the CoC.

2. The CoC has identified the cause(s) of racial disparities in their homeless system.

3. The CoC has identified strategies to reduce disparities in their homeless system.

4. The CoC has implemented strategies to reduce disparities in their homeless system.

5. The CoC has identified resources available to reduce disparities in their homeless system.

6. The CoC did not conduct a racial disparity assessment.
4A. Continuum of Care (CoC) Accessing Mainstream Benefits and Additional Policies

Instructions:

Guidance for completing the application can be found in the FY 2019 CoC Program Competition Notice of Funding Availability and in the FY 2019 CoC Application Detailed Instructions. Please submit technical questions to the HUD Exchange Ask-A-Question at https://www.hudexchange.info/program-support/my-question/

Resources:
The FY 2019 CoC Application Detailed Instruction can be found at: https://www.hudexchange.info/e-snaps/guides/coc-program-competition-resources

Warning! The CoC Application score could be affected if information is incomplete on this formlet.

4A-1. Healthcare—Enrollment/Effective Utilization

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

<table>
<thead>
<tr>
<th>Type of Health Care</th>
<th>Assist with Enrollment</th>
<th>Assist with Utilization of Benefits?</th>
</tr>
</thead>
<tbody>
<tr>
<td>Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Private Insurers:</td>
<td>No</td>
<td>No</td>
</tr>
<tr>
<td>Non-Profit, Philanthropic:</td>
<td>Yes</td>
<td>Yes</td>
</tr>
<tr>
<td>Other: (limit 50 characters)</td>
<td></td>
<td></td>
</tr>
</tbody>
</table>


Applicants must:
1. describe how the CoC systematically keeps program staff up to date regarding mainstream resources available for program participants (e.g., Food Stamps, SSI, TANF, substance abuse programs) within the geographic area;
2. describe how the CoC disseminates the availability of mainstream resources and other assistance information to projects and how often;
3. describe how the CoC works with projects to collaborate with healthcare organizations to assist program participants with enrolling in...
4A-2. Lowering Barriers to Entry Data:

Applicants must report:

<table>
<thead>
<tr>
<th></th>
<th>1. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition.</th>
<th>12</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>2. Total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.</td>
<td>2</td>
</tr>
<tr>
<td>---</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
<td>----</td>
</tr>
<tr>
<td></td>
<td>Percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects the CoC has ranked in its CoC Priority Listing in the FY 2019 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.</td>
<td>17%</td>
</tr>
</tbody>
</table>


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

The PPCoC recognizes that Street Outreach is an essential strategy to ending homelessness. There are 3 agencies in the PPCoC’s geographic area that are conducting Street Outreach. Blackbird Outreach and the Colorado Springs Police Department’s Homeless Outreach Team (HOT) conduct regular outreach and primarily interact with unsheltered individuals experiencing homelessness.
These two outreach teams have been able to establish trust among those least likely to seek assistance and as a result, connect these individuals to a variety of resources that they might not otherwise been able to access. Urban Peak also conducts street outreach and is focused on youth ages 18 -24. Urban Peak’s outreach efforts have resulted in a better understanding of why youth become homeless and the realization that there are more homeless youth in the community than previously thought. UP’s efforts have helped to identify more of these youth and connect them with resources. Although street outreach does not reach the entire geographic area in the PPCoC, significant efforts have been made to identify where homeless individuals and families are staying to ensure they are aware of available resources.

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

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

<table>
<thead>
<tr>
<th></th>
<th>2018</th>
<th>2019</th>
<th>Difference</th>
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<tr>
<td>RRH beds available to serve all populations in the HIC</td>
<td>106</td>
<td>97</td>
<td>-9</td>
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</table>

4A-5. Rehabilitation/Construction Costs–New Projects.  No

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

4A-6. Projects Serving Homeless under Other Federal Statutes. No

Applicants must indicate whether the CoC is requesting to designate one or more of its SSO or TH projects to serve families with children or youth defined as homeless under other federal statutes.
4B. Attachments

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

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<th>Required?</th>
<th>Document Description</th>
<th>Date Attached</th>
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<tr>
<td>FY 2019 CoC Competition Report (HDX Report)</td>
<td>Yes</td>
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<tr>
<td>1C-4.PHA Administration Plan—Moving On Multifamily Assisted Housing Owners' Preference.</td>
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<td></td>
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<tr>
<td>1C-4. PHA Administrative Plan Homeless Preference.</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>1C-7. Centralized or Coordinated Assessment System.</td>
<td>Yes</td>
<td>Coordinated Entry...</td>
<td>09/25/2019</td>
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<tr>
<td>1E-1.Public Posting–15-Day Notification Outside e-snaps–Projects Accepted.</td>
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<td></td>
<td></td>
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<tr>
<td>1E-1. Public Posting–15-Day Notification Outside e-snaps–Projects Rejected or Reduced.</td>
<td>Yes</td>
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<td>1E-1.Public Posting–30-Day Local Competition Deadline.</td>
<td>Yes</td>
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<tr>
<td>1E-1. Public Posting–Local Competition Announcement.</td>
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<tr>
<td>1E-4.Public Posting–CoC-Approved Consolidated Application</td>
<td>Yes</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A. Written Agreement with Local Education or Training Organization.</td>
<td>No</td>
<td></td>
<td></td>
</tr>
<tr>
<td>3A. Written Agreement with State or Local Workforce Development Board.</td>
<td>No</td>
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<tr>
<td>3B-3. Summary of Racial Disparity Assessment.</td>
<td>Yes</td>
<td>PPCoC Racial Disp...</td>
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<td>4A-7a. Project List-Homeless under Other Federal Statutes.</td>
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Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Coordinated Entry Policy Implementation Procedure

Attachment Details

Document Description:
Document Description: PPCoC Racial Disparity Tool

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

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

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<td>09/24/2019</td>
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<tr>
<td>1C. Coordination</td>
<td>09/24/2019</td>
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<tr>
<td>1D. Discharge Planning</td>
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<td>1E. Local CoC Competition</td>
<td>09/24/2019</td>
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<td>1F. DV Bonus</td>
<td>09/25/2019</td>
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<td>09/24/2019</td>
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<td>09/25/2019</td>
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<tr>
<td>3B. Performance and Strategic Planning</td>
<td>09/24/2019</td>
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<tr>
<td>4A. Mainstream Benefits and Additional Policies</td>
<td>09/25/2019</td>
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</tr>
<tr>
<td>Submission Summary</td>
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**Applicant:** Colorado Springs/El Paso County CoC

**Project:** CO-504 CoC Registration FY 2019
Pikes Peak Continuum of Care

Coordinated Entry
Policy, Implementation, and Procedures

Approved 1.23.2018
Revised version approved February 23, 2018
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<td>23-37</td>
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<td>Housing Vacancy Form</td>
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<td>VI-SPDAT/CE Agreement</td>
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<td>MIC-Authorization to Participate in Housing Eligibility Survey</td>
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<td>Document Ready Form</td>
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<td>Client Information Sheet Handout</td>
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<td>Anonymous Process Form Authorization</td>
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<tr>
<td>Coordinated Entry Grievance Form</td>
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</table>
**Policy**

The Pikes Peak Continuum of Care (PPCoC) will use the Coordinated Entry Process to promote client choice and to demonstrate openness, inclusiveness, and transparency in homeless assistance. The PPCoC Coordinated Entry process will operate within the requirements of [HUD Notice CPD-17-01](https://www.hud.gov) under the authority of [HUD 24 CFR 578.7(a)(8)](https://www.hud.gov), which mandates the coordinated entry process, be developed to ensure that all people experiencing a housing crisis have fair and equal access and are quickly identified, assessed for, referred, and connected to housing and assistance based on their individual strengths and needs.

The PPCoC adheres to [HUD Notice CPD-016-11](https://www.hud.gov) prioritizing persons experiencing chronic homelessness in permanent supportive housing and requiring chronic homeless status documentation records. This policy is in fulfillment of Key Goal 3 of the [PPCoC’s Strategic Plan](https://www.hud.gov).

**Overview**

**Coordinated Entry Purpose:**

The Coordinated Entry process establishes a common tool for assessing individuals’ housing needs and a single system for matching clients to available supportive housing. The common assessment tools are the Vulnerability Index & Service Prioritization Decision Assistance Tool and the Transitional Age Youth Service Prioritization Decision Assistance Tool, ([VI-SPDAT version 2.0](https://www.hud.gov), [F-VI-SPDAT version 2.0](https://www.hud.gov) and [TAY-VISPDAT version 1.0](https://www.hud.gov)), which examines and scores individual or family vulnerability. Individuals/families are prioritized for housing opportunities according to this score and other criteria from these assessments. HUD CoC funded housing programs and ESG funded housing programs are now required to use Coordinated Entry for placing clients into housing resources.

**Vision:**

The PPCoC Coordinated Entry (CE) Process will implement the PPCoC’s vision to “have a durable system of places and programs to ensure that all people facing homelessness have access to housing and supportive services to sustain their quality of life.” This process will provide timely access to appropriate resources through a centralized, equitable, person-centered process that preserves choice, dignity, and transparency.

**Guiding Principles:**

1. Our Continuum of Care, encompassing the entirety of El Paso County, supports a client-centered, low-barrier approach to housing, ensuring the needs and well-being of those experiencing homelessness are paramount while fostering self-determination for the client.

2. Our process will operationalize a shared community vision with clear priorities and community ownership.
3. We will use real-time key performance indicator data to inform decisions, goal setting, and resource allocation.

4. The process is transparent, with expectations and outcomes communicated regularly to all stakeholders, including housing service providers and clients.

5. The process is accessible to all and able to prioritize those most in need within different populations for available and appropriate services based on a common assessment tool.

6. Through coordination, our process targets appropriate resources by ensuring every individual, family and youth assessed is linked to the most relevant housing intervention.

7. Our collaborative effort focuses on long-term outcomes, including sustainability and support for both providers and clients in housing retention.

**Process Components and Key Performance Indicators:**

**Identification:** Through outreach and communications efforts, we will identify who needs help and who can provide help in our community. This information will be maintained and managed in the form of a “by-name” list and a list or database of housing programs.

- **Key Performance Indicator:** Number of individuals/families added to the By-Name List.
- **Key Performance Indicator:** Number of housing programs participating.

**Assessment:** In order to prioritize those most vulnerable and in need of help, we will use the VI-SPDAT version 2.0, F-VI-SPDAT and TAY-VISPDAT version 1.0 tools developed by OrgCode and Community Solutions. These tools will provide a starting point for case conferencing as a community. Other resources and information will be used in the process to prioritize individuals and families.

- **Key Performance Indicator:** Number of individuals and families with VI-SPDAT/f-VI-SPDAT/TAY-VISPDAT completed referred to resources.

**Assistance:** Community service providers will help individuals move toward housing solutions. This includes obtaining documents (see Document Ready Form, Attachment VI), development of client referral program application packet, developing a housing plan and providing case management.

- **Key Performance Indicator:** Number of individuals/families assisted with program application
- **Key Performance Indicator:** Number of individuals/families assisted with document readiness
- **Key Performance Indicator:** Number of individuals/families assisted with housing plans
- **Key Performance Indicator:** Number of individuals/families assisted with case management beyond the initial assessment.

If an individual does not score high enough to be matched to a housing resource, they will still receive assistance by being contacted by 211. Weekly the list of clients entered onto the By-Name List whose calculated score is low enough for “no housing resource”, are compiled and sent to 211 for follow up. The 211 staff will initiate a call to these clients and ask them what
other types of assistance they might need and then give them ways to connect with people/agencies that can assist them. This is an important part of our service to the community.

- **Key Performance Indicator:** Number of individuals/families referred to 211.

**Assignment:** Service providers will meet for case conferencing and match (see Match Initiation Form, Attachment I) individuals with the appropriate housing resource or program.

- **Key Performance Indicator:** Number of individuals/families identified in case conferencing (PSH, SSVF, VASH, RRH, TH, etc.)
- **Key Performance Indicator:** Number of individuals/families accepted into a housing solution program (PSH, SSVF, VASH, RRH, TH, etc.)
- **Key Performance Indicator:** Number of individuals/families receiving rental assistance $\$\$, leasing assistance $\$\$, alternate funding for a housing solution program (PSH, SSVF, VASH, RRH, TH, etc.)
- **Key Performance Indicator:** Number of housing vacancies (See Housing Vacancy Form attachment II) brought to CE (PSH, SSVF, VASH, RRH, TH, etc.)
- **Key Performance Indicator:** Number of case conferencing meetings held to refer individual/family into a housing solution program (PSH, SSVF, VASH, RRH, TH, etc.)

**Housing:** Service providers will connect individuals with permanent housing units to move into and provide follow up services to ensure sustainability.

- **Key Performance Indicator:** Numbers of “move in”
- **Key Performance Indicator:** Length of time from reception of “referral acceptance” to “move in”
- **Key Performance Indicator:** Numbers of “referral acceptances” received that did not result in “move in”

**Sustainability:** Six months after “move-in” date, programs will follow up with individuals to determine success of program.

- **Key Performance Indicator:** Percentage of individuals still in housing

**Roles and Responsibilities:**

**Requirement**

The CE Process requires participation and support from agencies with resources committed to helping clients to attain housing and to retain housing.

**Implementation**

This will be accomplished through support of participating agencies and through centralized resources, as and when funding is secured. The following sections identify specific roles, responsibilities of these types of resources, including but not limited to: community coordination, housing navigation, and case management.

**Community Coordinator** (to be hired when funding is secured)

- Coordinate community efforts to follow the agreed upon CE Process and continue improvement initiatives
- Ensure assessment of individuals/families and work with agency case management staff to gather necessary documents
- Ensure individuals/families are added to the By-Name List
- Work with agency staff to coordinate initial client meetings and discuss program expectations
- Report numbers of individuals/families assessed, assigned, and placed monthly to the CE committee
- Coordinate outreach
- Coordinate community outreach efforts to reduce duplication and ensure comprehensive assessment of all individuals experiencing homelessness in El Paso County
- Lead outreach coordination meetings and facilitate communication between agency outreach efforts
- Identify outreach gaps and develop an annual plan to reduce the gaps
- Report monthly on community outreach performance
- Create training curricula for tools and processes used in CE with the support of the CoC.
- Supervise Housing Navigator Coordinator

**Housing Navigator** *(to be hired when funding is secured)*

The CE requires participation and support from resources committed to helping clients to attain and to retain housing. This will be accomplished through support of participating agencies and through centralized resources, as and when funding is secured.

- Coordinate community housing navigators to consolidate housing resources and engagement efforts
- Create and maintain housing resource list for inclusion in the CE Process
- Lead landlord engagement efforts
- Train and organize community housing navigators on community plan to coordinate and maintain housing placement portion of the CE Process
- Report the number of individuals housed each month to the CE Committee

**Case Manager** *(applicable only in programs where the program has case management services in existence and client is assigned to case management)*

- **Upon Program Entry (Case Assignment):**
  - Conduct an Assessment and Housing Stability Plan within seven calendar days
  - Assist with action planning in accordance with agency procedures
  - Assist with collection of any additional documents necessary for housing
  - Coordinate with housing navigator for housing match
- **Upon Lease-Up: (Housing Stabilization Model)**
  - Coordinate bed delivery
  - Coordinate furniture delivery
  - Provide access to treatment groups, therapy, and vocational services (if applicable)
Training

Requirement

PPCoC will provide training opportunities at least once annually to organizations and/or staff person(s) that serve as access points or administer assessments. The purpose of the training is to provide all staff administering assessments with access to materials that clearly describe the methods by which assessments are to be conducted (HUD Coordinated Entry notice: Section II.B.4). All street outreach staff are trained and required to use the same standardized process as if they were site based.

Implementation

Training in the Coordinated Assessment process and procedures is important for effective community coordination and standardization. CE Process training will cover, at a minimum, the following topics:

- Messaging. (the common community language used to introduce and clarify questions).
  All messaging complies with “Harm Reduction” philosophy.
- How to administer the VI-SPDAT
- Processes and procedures for submitting/entering the VI-SPDAT into CE system.

The CE System training and guiding materials will be approved by the CE Advisory Committee. All participating agency staff and volunteers will be trained using the approved CE System training prior to administering the VI-SPDAT and entering individuals into the CE System. The CE Advisory committee is the approval authority for suggested changes or improvements to training materials, the assessment tool, the referral process, and other components of the CE process. The CE Community Coordinator is responsible for implementation.
Access

Requirement
The Coordinated Entry Process is available to all who are eligible regardless of race, color, national origin, religion, sexual orientation, gender identity, age, familial status, disability, marital status, etc.

Individuals or families who fall into multiple populations for which an access point is dedicated (i.e. a parent accompanying a youth who is fleeing domestic violence) can be served at all access points for which they qualify. The same assessment approach is used. All physical access points are accessible to individuals and families with disabilities. For those individuals and families who are least likely to seek out homeless assistance, street outreach is provided. Information is available regarding where to access coordinated entry by internet through [https://www.ppcp.org/](https://www.ppcp.org/) or in person by visiting one of the participating agencies. PPCoC requires all staff and volunteers participating in CE sign the VI-SPDAT and CE agreement (see Attachment III.)

Implementation
PPCoC is currently working with the Colorado School for the Deaf and Blind for available resources for ocular and/or auditory challenges. All points of entry have ADA accessible facilities. The VI-SPDAT (Housing Survey) has been translated into Spanish. For other languages, we have several local translation organizations that will provide interpreters to any access point.

- **Marketing:** All participating agencies have prominently posted notices/posters announcing points of entry information (address, phone and hours doing surveys). This information is updated any time there is a change. The Community Coordinator inspects sites to be sure posted notices are prominent.

Identify

Requirement
The initial step into the CE Process is the identification of persons experiencing homelessness. All agencies funded within the Pikes Peak Continuum of Care (PPCoC) must also participate in the outreach and identification of any people experiencing homelessness.

Implementation
There will be “no wrong door” for people in the Pike’s Peak Region to enter the CE Process. This means that at all entry points (shelters, walk-in agencies, street outreach, etc.) staff and volunteers will be informed of this process and use the following steps to enter individuals into the system with the goal of leveraging community resources to most effectively make homelessness in the Pike’s Peak region rare, brief, and non-recurring.

Procedure
An outreach/identification primary point of contact (POC) will be identified for each agency.
CE trained outreach workers are formal access points just as if the clients walked into an agency. The outreach worker will administer a Housing Survey wherever they find a client. This process ensures entrance into the CE process. The outreach/identification POC will agree to participate in the community coordinated outreach effort. The PPCoC will hire a community outreach coordinator to develop a coordinated community process of outreach to reduce redundancy and synergize efforts. Outreach POCs will be trained in the CE process and in administering the VI-SPDAT.

- **Key Performance Indicator:** The community outreach coordinator will report the number of individuals newly identified over the past month. This number will be based on the number of individuals added to the By-Name List\(^1\) from various sources. This number will be compared to the number housed in the last month to determine community-housing capacity in the system.

**Diversion and Prevention**

**Requirement**

A process must be documented for persons seeking access to homelessness prevention services funded with ESG program funds through the Coordinated Entry process.

**Implementation**

All Emergency Solutions Grants funded programs or other homelessness prevention programs shall bring their resources to CE case conferencing for assignment of clients at highest risk (most vulnerable). PPCoC’s intention is to prevent as many clients as possible from becoming homeless, to assign clients to the most appropriate housing resource (housing program: PSH, RRH, TH) when we first identify them, and to honor client choice in the process. This reduces the repeat numbers of homeless. Our CoC area currently has no ESG prevention funded programs. We continue to encourage agencies to apply for this funding. Applications from agencies have been submitted for homeless prevention services in the current year’s ESG cycle. This diversion and prevention process will be developed and integrated into the Coordinated Entry process once funding is secured. Currently, clients identified as seeking homeless prevention are referred to 211 and are responsible for reaching out and connecting with 211.

**Assess**

**Requirement**

Before being assessed with the VI-SPDAT, the client must sign the CE Process Release of Information (Assessment Screening and Match Initiation Consent/MIC) form (see Attachment IV).

**Implementation**

The purpose of this release is to facilitate referrals for housing, treatment, case management, treatment planning, coordination of medical care, and other services. By signing, the client agrees that his or her VI-SPDAT responses can be exchanged among the organizations

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\(^1\) By-Name-List=VI-SPDAT list and exceptions to the process list.
participating in the CE Process. Only the minimum amount of information necessary at any point in time to assist either in the prioritization or referral process is disclosed. Specific diagnosis or disability information can only be obtained/shared for purposes of determining program eligibility to make an appropriate referral. Signing the MIC is not required for services within the PPCoC; however, it is required to participate in the routine weekly CE process described below. Without a signed MIC, the client’s paperwork will be processed through the Alternate Placement Process described later in this document.

**Procedure**

Agencies will identify persons experiencing homelessness through outreach or walk-in requests for assistance. Once identified, the trained agency staff will complete the CE MIC, HMIS Central Intake Basic Information sheet, and appropriate VI-SPDAT with the client. The CE MIC which is available at [https://www.ppchp.org/](https://www.ppchp.org/) must be uploaded into clients HMIS file and kept on file at the agency conducting the initial intake for seven years (electronic or hard copy, in accordance with agency procedures). If an individual refuses to sign the MIC, the staff member or volunteer should explain the benefits of being in the CE process. Staff members/volunteers should also refer to the “Alternate Placement Process”, described later in this document, which recognizes that some of the most vulnerable in our community may not be willing to participate in a community-coordinated process.

The agency-trained staff with access to the HMIS CE Program module will enter the client into HMIS Central Intake (if not already completed). Once in central intake, the staff member will enter the VI-SPDAT Assessment in the HMIS. Ideally, the Document Ready Form (see Attachment V) which is available at [https://www.ppchp.org/](https://www.ppchp.org/), will also be filled out so readiness can be better assessed when a housing resource becomes available.

After assessing an individual, he or she is provided the Client Housing Information Sheet hand-out (see Attachment VI) that lays out the next steps in their CE journey. Additionally, the client is reminded verbally that if they have received no contact regarding a housing resource in three months it is their responsibility to check in and be re-assessed to remain on the coordinated entry By-Name List. If no re-assessment takes place, the client is moved to inactive status.

By-Name Lists are pulled weekly so that all those in case conferencing can see who is most vulnerable. This ensures placement of the most vulnerable and coincides with a no waiting list approach. Clients who are identified but refuse a resource or who cannot be found are not removed from the list so that they still have a future opportunity. By-Name Lists are shredded following each case conferencing to preserve confidentiality of all whose names appear on list. Case conferencing is a transparent inner-agency forum that ensures proper identification of vulnerable clients into appropriate resources.

**Denial of Referrals**

Both PPCoC providers and program clients may deny or reject referrals. Service denials by providers may only occur within their requirements/policies. The specific allowable criteria for denying a referral must be established by the PPCoC, must be shared with each project and client, and reviewed annually. All participating projects must provide the reason for
service denial and the reason will be documented in HMIS. Denials outside of this must be brought to CE case conferencing for unanimous approval. Program clients may deny referrals for any reason and will remain on list for future referrals.

**Criteria established for denial:**
- Client refused further participation (or client moved out of PPCoC area)
- Client does not meet required criteria for program eligibility
- Client unresponsive to multiple communication attempts
- Client resolved crisis without assistance
- Client safety concerns, client’s health or well-being or the safety of current program clients would be negatively impacted due to staffing, location, or other program issues
- Client needs cannot be addressed by the program
- Property management denial
- Conflict of interest

- **Key Performance Indicator:** Number of persons with newly completed VI-SPDAT scores and entered into the VI-SPDAT module in HMIS. (This should also be the same as the number of individuals newly “IDENTIFIED” within the last month.)

**Alternate Placement Process:**

**Requirement**

Together with the CE System, there is an alternate process for housing placement to ensure equal access for those individuals whose needs may not be fully addressed by the CE Process\(^2\).

**Implementation**

This alternate process must be accessible to community members advocating for clients who fall into at least one of the following categories:

- Individuals who are unable because of mental health concerns to complete the VI-SPDAT
- The VI-SPDAT score seems incongruent with the actual vulnerability of the person assessed. Are there special circumstances not captured by the screening tool that could be generating additional vulnerabilities for this person?
- Duplicate VI-SPDATs have been completed by different community providers and the variance in scores is greater than 5 OR the scoring difference crosses a threshold of housing interventions (i.e., one score indicates rapid re-housing and one score permanent supportive housing) or vulnerability
- A housing resource comes available that necessitates out-of-the-ordinary qualifications (for example, only available for 90 days so quick expedition necessary-may have to take someone already document ready). Even in these

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\(^2\) All information obtained is under adequate privacy protection per the HMIS Data and Technical Standards HUD24 CFR 578.7(a) (8).
out-of-the ordinary qualifications, our referral process ensures clients are not steered toward a facility or neighborhood because of race, color, national origin, religion, sex, disability, or the presence of children

- Client is unwilling to sign MIC and must be conferenced anonymously (Share Anonymously form, see Attachment VII)-with no identifying information shared
- Client is using a victim service provider

For any individual/family in the above categories, agency representatives must bring these high priority individual/family cases to case conferencing meetings. Since there may not be a release of information, these situations must be referenced without revealing personal information in the community forum; however, such details as mental health diagnosis, physical health vulnerability, age, family status, criminal record, and financial resources must be discussed without association to a particular name. When first identified, the case conferencing facilitator will assign a reference number based on the agency associated such as SRM001 or RMHS002, etc. The case conference facilitator will add this number to the By-Name List and the committee will assign an objective assessment score to prioritize this individual/family in the list for future reference. The associated agency will maintain a “private” list which associates the “list” reference number to the actual name of the individual.

Grievance

Requirement

All individual’s or family’s concerns and grievances must be resolved promptly and fairly, in the most appropriate manner.

Implementation

Providers inform individuals and families of the process for filing a grievance. Each agency provides instructions for a grievance on a form given to client on completion of Housing Survey. The grievance form (see attachment VIII) and instructions are also provided on the Community Health Partnership website.

Procedure

Fair Housing Grievances should be made directly to:
PPCoC has no further involvement in these particular grievances.

Agency Grievances: The agency completing the screening should address any complaints by clients as best as they can in the moment. Complaints that should be addressed directly by agency staff are agency conditions and/or violation of confidentiality agreements. Any other complaint should refer to process below. Any complaints filed by a client should note their name and contact information so the CE Community Coordinator can contact him/her to discuss the issues.
• Level 1: If client has a grievance regarding a particular agency or representative of that agency (general grievances such as customer service or services offered), they should follow that agency’s grievance procedure. Agency grievance form is included with intake packet. If both the client and the agency come to a mutual resolution, the process ends and the resolution is implemented. If the client or the agency disagree on resolution, the grievance must be advanced to the next level by complainant. The process to advance grievance is found on Community Health Partnership’s website (https://www.ppchp.org/).

• Level 2: The CE Community Coordinator is the first person to review the grievance and will gather relevant information about the situation, including but not limited to, communicating with the client and the agency in question. The CE Community Coordinator will inform the client and the agency in question of the resolution reached. If both the client and the agency mutually agree to the resolution, the process ends and the resolution is implemented. If the client or the agency disagree on resolution, the CE Community Coordinator will advance the grievance to the next level.

• Level 3: The PPCoC Governing Board Chair reviews the grievance or designates one or more Board members to review the grievance. After gathering relevant information, the Board Chair or designated Board member(s) will inform all parties of the resolution reached. This is the final step in the process, and the decision of the Governing Board of Directors is final.

Coordinated Entry Grievance: If the grievance is with the Coordinated Entry Process, the CE grievance form is provided on Community Health Partnership’s website. The Coordinated Entry Grievance process begins at Level 2.

**Emergency**

**Requirement**

PPCoC CE process will allow services, including all domestic violence and emergency services hotlines, drop-in service programs, and emergency shelters to operate with as few barriers to entry as possible.

**Implementation**

PPCoC has a No Wrong Door Policy at all access points, regardless of whether that agency serves all individuals. This means that any individual presenting at an access point will be provided help to access a shelter (domestic violence or other shelter) or medical facility when they present with an emergency need outside of during business hours. Although Housing Surveys are not conducted 24 hours a day, all access points have staff available or posted notices directing to an emergency service to assist anyone presenting with an emergency. Individuals presenting outside of Housing Survey hours will then be offered the Housing Survey during Housing Survey hours. The Housing Survey hours are as robust as possible within staff limitations of each agency. Help in emergency situations; however, is always available, and clients will be referred/helped by staff to manage the emergency in best way available at the time. PPCoC only uses the standardized assessment tool for prioritizing PSH, TH, and RRH match and referral. Shelter services are not prioritized through CE. As hours
and locations for the Housing Survey administration vary and change frequently, the current VI-SPDAT schedule of locations and hours where the Housing Survey is being conducted is located on the Community Health Partnership website:

**Safety Planning**

**Domestic Violence:**

*Requirement*

Individuals or families may not be denied access to the CE process if experiencing or fleeing from domestic violence, dating violence, sexual assault, and/or stalking (HUD Category 4 Homeless Definition). Victim service providers funded by the CoC and ESG program funds are not required to use CoC’s coordinated entry process, but victim service providers are allowed to do so. Victim service providers may use an alternative coordinated entry process for victims of domestic violence, dating violence, sexual assault, and/or stalking.

*Implementation*

Individuals that present to any agency experiencing domestic violence, dating violence, sexual assault, and/or stalking will be referred to the CoC’s Domestic Violence agency TESSA. TESSA will use their own coordinated entry process regarding RRH and other supportive services that are managed by TESSA. Individuals or families that present to TESSA needing community TH or PSH will be included in CoC case conferencing when the following is provided: VI-SPDAT completed by TESSA staff by Monday, but not entered into CO504; email sent to CE Community Coordinator stating that a new individual or family will be presented at case conferencing (email should include the following data: created reference ID#, age, gender, veteran status, household size, monthly income, date assessed, raw score, and # of children if any. DV names will not be presented, the only information that will be given is: created reference ID#, age, gender, veteran status, household size, monthly income, date assessed, raw score, and # of children if any). A TESSA case manager will need to be present at case conferencing to vet initial eligibility match for candidates.

*Assist*

*Requirement*

The core of the CE Process is a community effort to assist our neighbors experiencing homelessness. PPCoC requires that all CoC and ESG program recipients and sub-recipients use the coordinated entry process established by the CoC as the ONLY referral source to consider filling vacancies in the housing and/or services funded by CoC and ESG programs.

*Implementation*
The case conference process will organize the assistance phase. The next step is to assign the individual/family to an appropriate housing resource (housing program: PSH, RRH, TH). Individuals or families will not be steered toward any particular housing facility based on race, color, national origin, religion, sexual orientation, gender identity, disability, or the presence of children. Next, we will assist with developing and completing a plan with goals and action steps as well as gathering and storing required documentation. We will strive to keep client document requirements as low barrier as possible, recognizing the need for providers to have complete records for their programs and any audits that may ensue, along with the landlord’s requirements for leasing. We recognize that there are different documentation requirements for different programs, but remain committed to achieving as much consistency as possible, while working toward a low barrier process.

**Procedure**

At least monthly, the community will have a CE Advisory/Planning meeting. The meetings are open and attended by stakeholders in the community interested in the work. The purpose of the meeting is to support case coordination, advancement of CE work, and problem-solving among service providers. The PPCoC will determine the CE Advisory/Planning meeting facilitator, participants and frequency, but will consist of no fewer than two stakeholders and no less frequent than once per month. The goals of the CE Advisory/Planning meeting are:

- To ensure holistic, coordinated, and integrated assistance across providers for all experiencing homelessness in the community.
- To review progress and barriers related to housing goals.
- To identify and track systemic barriers and strategize solutions across multiple providers.
- To clarify roles and responsibilities and reduce duplication of services.

At least weekly, the community will have a CE case conferencing meeting. These meetings are confidential and only participating agencies currently listed on the MIC (most current MIC with participating agency list located on Community Health Partnership website) are invited to attend. Staff who intersect with the clients at their respective agency are who generally attend case conferencing. The purpose of the meeting is to identify and match the most vulnerable (per the By-Names List) to available housing resources via the process detailed in this document. Participating Agency attendance is expected at every meeting per HUD 24 CFR 578.7. Agencies required to attend are those receiving HUD COC NOFA and HUD ESG funding. Meeting attendance will be recorded and could be a factor for future funding.

At a minimum, the CE case conferencing meeting agenda will include the following items:

- Update of Progress with case conferencing since last meeting
- Discussion of prioritization of most vulnerable clients-In addition to the VI-SPDAT score, length of time homeless, and number of times homeless in last three years the following priorities are considered if scores are equal:
  - Families with Children
Youth (ages 16-24) Currently unaccompanied youth under the age of 16 are not prioritized for housing resources as we do not have the means to house them independently.

Veterans

Tri-morbidity

- Review of housing resources available
- Match of most vulnerable clients to resources available
- Case Coordination/Action Assignments
- Report out of Key Performance Indicators
- Specifically. The case conferencing meeting will be held weekly as long as there is a housing resource available. The priority of this meeting is to allocate housing and service resources as effectively and timely as possible. Assistance is prioritized based upon vulnerability. Currently the VI-SPDAT, F-SPDAT and TAY-SPDAT scores are categorized to fit PSH, TH, RRH and (No Housing) Services Referral only.

The metric currently used to match clients into available housing categories for Permanent Supportive Housing (PSH), Transitional Housing (TH), Rapid Re-Housing (RH) and Service Referral Only based upon their raw score from the VI-SPDAT is:

- PSH= Individuals/TAY score of 8+, Families score of 9+. All compute to category 4.
- TH = Individuals/TAY score of 6-7, Families score of 7-8. All compute to category 3.
- RRH = Individuals/TAY score of 4-5, Families score of 4-6. All compute to category 2.
- Services Referral Only = Individuals/TAY/Families score of 0-3. All compute to category 1.

The deadline to have an agency’s newly VI-SPDAT assessed client(s) appear on the active list to be discussed at that week’s case conferencing meeting is Monday. If clients VI-SPDAT are not entered by Monday, they will be discussed the following week at case conferencing (unless using Alternate Placement Process, and in those cases names should not be shared…see Alternate Placement Process as described in this document).

Participation at case conferencing meetings are limited to staff from participating agencies as denoted on the current MIC. Confidentiality is a huge part of case conferencing and meetings must be secure with those attending. A confidential sign in sheet is used expressing the confidentiality of the meeting. Currently, technology is not in place to conduct these meetings with the degree of confidentiality needed for call ins and webinars, so attendance is in person. The Coordinated Entry meeting schedule is as follows:

- 1st Wednesday of the month: Housing first hour Case Conferencing second hour
- 2nd Wednesday of the month: Case Conferencing two hours
- 3rd Wednesday of the month: Planning first hour Case Conferencing second hour
- 4th Wednesday of the month: Case Conferencing two hours
- 5th Wednesday of the month: Case Conferencing two hours
The facilitator will prepare for each meeting by organizing and updating the By-Name List and determining which clients will be discussed at the upcoming meeting. The facilitator will also organize the By-Name List, sort the list by VI-SPDAT score, then length of time homeless. The facilitator prepares and sends out the agenda for the conference.

The following is a list of documents considered important to housing:

- Colorado ID/Driver’s License, or having proof that one has been ordered*
- Birth Certificate, or proof that one has been ordered*
- Social Security Card, or proof that one has been obtained*
- Proof of Income (within last 60 days)
- Proof of disability
- Documentation of chronic homelessness
- DD-214 (for Veterans*)

*must be scanned into HMIS at “organization” level to protect the high level of confidentiality of document

No documents are required to be in hand to be matched to a housing program; however, individuals/families will receive assistance to obtain these documents as quickly as possible since most housing resources will require them prior to move in.

Once an individual/family has been identified through case conferencing as the most vulnerable in the community for the housing resource available, the representative from the agency who conducted the VI-SPDAT/TAY-SPDAT, or a representative from one of the other agencies that is in touch with this individual, will be charged with locating the individual/family and making sure the Document Ready Form (see Attachment V) is completed. Those being sought are not guaranteed a housing resource, it means that we are trying to see if they are a match for the available housing resource. If a client has not been contacted regarding a housing resource in three months, the client is responsible for going to a participating agency to be assessed again. On initial assessment the client will receive the PPCoC Client information sheet with the date they need to be re-assessed. If client cannot be found and there are no leads on where they may be located after two weeks, the client will be moved back to active By-Name List. Once the client is found, if there is no update on client within 30 days, the identified client would be moved back to the active By-Name List, and another client would be identified to be found. Once client is found, they will then be given until the next case conference to accept or decline referral. If the client accepts the resource, initial eligibility is confirmed to determine a match with the available housing resource. Then client will be referred to the housing resource program for intake. In the event that two or more households within the same area are identically prioritized and eligible for the next available unit, the PPCoC selects the household that presented first.

When the accepted resource is a Rapid Re-Housing (RRH) resource, the client will be provided with the percentage (amount of rent) they will be responsible for while receiving RRH assistance. For RRH placements, clients will contribute 30% of their income to rent while receiving RRH assistance.

Assign
**Requirement**

The purpose of the CE Process is to allocate housing and service resources as effectively as possible in a manner that is easily accessible.

**Implementation**

Assistance is prioritized based on vulnerability and severity of service needs to ensure that people who need assistance the most can receive it in a timely manner. Under no circumstances should an individual/family be screened out of the CE process based on perceived barriers, such as: too little or no income, active or history of substance abuse, domestic violence history, resistance to receiving services, criminal record, lease violations or history of not being a lease holder etc. Exceptions are a.) conviction for manufacturing Methamphetamine, b.) registered sex offender or c.) eviction from federally funded housing for drug – related criminal activity in the past 3 years. Individuals that have criminal records must be reviewed on a case-by-case basis.

**Procedure**

By-Name List

- **Creating the Active List:**
  - The By-Name List should be created from the CE Report in HMIS. This report should not be printed and shared with anyone, and confidential information on the By-Name active list should not be discussed outside of the Case Conference meeting. All confidential information should be secured at all times.

- **Updating the Active List:**
  - Print report from HMIS-CE program
  - Include any names from the Alternate Placement Process
  - Individuals will be removed from the Active By-Name”list by another designated person through the following process:
    - Run an HMIS report to list the individuals housed since the last time the list was updated
    - Change the “List Status” to “Exit” and add in the Move-In date for anyone on the “housed” list from HMIS
    - Sort the Active By-Name List by “Last Contact” and choose any dates 90 days or prior from current date.
    - If “Last Contact” is longer than 90 days, unless they are currently working with an agency case manager for a housing resource, client is moved off active list to inactive list status.

**Housing Placement:**

**Requirement**

All Continuum of Care grantee providers and ESG funded programs are required to fill vacancies using CE Process. In addition, providers outside the PPCoC funding stream are encouraged to use CE Process to identify candidates for housing vacancies.

**Implementation**
The PPCoC will ensure that applicants entering through CE shall not be denied admission to housing, nor will any family members be separated from other members of their family, based on age, sex, gender, gender identity or sexual orientation when entering housing.

In order to meet HUD’s Continuum of Care Notice of Funding Availability grant requirements on turnover units and vouchers each time a PPCoC-funded supportive housing project has an opening, a Housing Vacancy Update form (see Attachment X) available on the Community Health Partnership website, needs to be completed to inform the PPCoC of each opening.

The Community Coordinator will create a list with submitted housing vacancies. The list will be brought to case conferencing where participating agency staff will match vacancies with vulnerability needs of individuals/families from the El Paso County area who meet the project’s criteria. An Action List is generated, assigning agencies to help find identified clients. Once found, the client is connected to the agency with the open housing resource for eligibility confirmation. If eligible, a referral is made from Coordinated Entry to the open housing resource. The agency with the open housing resource assists with program application and acceptance of referral. Once referral is accepted, housing search commences. This ensures communication between the housing providers, the potential client and the person helping that client (Housing Navigator) to make a final determination on housing.

Evaluation

Requirement
PPCoC consults with participating projects and project staff at least annually to evaluate the intake assessment and referral processes associated with CE. Feedback must address the following for both participating projects and staff: quality of coordinated entry process for intake/includes posted signage, effectiveness of coordinated entry process for referrals, and Planning Committee evaluation meeting to inform changes.

Implementation
PPCoC technical/training staff do an annual site visit to evaluate the following:

- Security of client information
- Correct use of training procedures
- Utilization and consistency of CE for every individual, youth, or family
- Data quality

Staff then address concerns or issues agencies may have and provide feedback based on CE successes or concerns. Staff provides an annual report to the PPCoC Governing Board regarding KPI results.
Glossary

**By-Name List**-The weekly list of clients in PPCoC desiring housing, sorted by vulnerability.

**CE**- Coordinated Entry

**CH**-Chronic Homelessness

**CHP**-Community Health Partnership

**DV**- Domestic Violence

**ESG**-Emergency Solutions Grant

**Extension**-Term used when asking for an adjustment to a deadline. Most often associated with expiration of a resource (voucher).

**HMIS**- Homeless Management Information System

**Homeless definition-HUD**-Chart of HUD’s homelessness definitions click [here](#)

**Housing Survey**-Community name for VI-SPDAT

**HUD**- Housing and Urban Development

**KPI**-Key Performance Indicator—Data that measures achievement as related to objectives.

**MIC**- VI-SPDAT Assessment Screening and Match Initiation Consent Form

**POC**-Point of Contact

**PPCoC**- Pikes Peak Continuum of Care

**Prioritization List**: A list kept, of sorting by vulnerability. After each use of list, the list is updated, re-pulled, and re-sorted thus always having those with the most vulnerabilities serviced first.

**Progress List**-The weekly progress list of clients that our agencies are actively working on housing.

**PSH**-Permanent Supportive Housing

**RA**-Reasonable Accommodation. A change, exception, or adjustment to a rule, policy, practice, or service to allow a person with disabilities to fully access the HUD programs or services.

**RRH**-Rapid Re-Housing

**SSVF**-Supportive Services for Veterans’ Families

**TESSA**-The only confidential assistance agency for victims of domestic violence and/or sexual assault in El Paso and Teller counties

**TH**-Transitional Housing

**VASH**-Veterans’ Administration Supportive Housing
Glossary continued

**VI-SPDAT**- Vulnerability Index- Service Prioritization Decision Assistance Tool. Common assessment tool used in Coordinated Entry process. Commonly referred to in community as the “Housing Survey”.

**Wait List:** A list that is kept by first come first serve basis. Once a client’s name is placed on the list, the client keeps their position and are advanced as openings occur.
Coordinated Entry Client Assess flowchart

1. Client Presents
   - Direct help to needed emergency services
   - Is client in crisis?
     - Yes: Direct help to needed emergency services
     - No: Is client literally homeless?
   - Yes: Enter client in Housing Survey
   - No: Refer to 211 for services
2. Is client literally homeless?
   - Yes: Enter client in Housing Survey
   - No: Referred to 211 for services
3. Admission: Consent form, Client intake, and Housing Survey (VI-SPOAT)
4. Take photo and upload any documentation client has
5. Enter data in HHIS Coordinated Entry by Monday for Case Conferencing on Wednesday.
Coordinated Entry Case
Conferencing flow 12.2017

Case Conferencing

- By Name List created and sorted weekly
- Available Housing Resources identified

- Identify most vulnerable to find
- Place on standby name from list as backup if client identified is not eligible for housing

- Client is identified for CE housing resource
- Action List created from Case Conferencing regarding who is helping who

- Is client housed within two weeks?
- Eligibility for potential housing resource verified

- By Name Active List or exit if housed

- Available Housing Resources identified
- Newly Available Resources

- Using By Name List identify most vulnerable for available housing resource
- Agency program packet application is filled out and submitted to agency with housing resource
- Agency intake successful?

- Update Progress List
- Begin Housing Search

- Voucher/coupon issued
- Document reason
- Does client accept offer of resources?

- Found Housing
- Lease Up/Move in

- Exit from CE

Option
Attachment I
Pikes Peak Continuum of Care Match Initiation Form

This Match Initiation Form includes questions that will assist with making a match to a unit of Supportive Housing in your community. These questions will assess for basic eligibility requirements of these resources, making it possible to prioritize housing placements for those with the highest acuity as determined by the VI-SPDAT Screener. This form will also document client preference relative to where he/she would like to live in housing, making the unit match possible for their community of origin (where they are currently homeless) or their top two community preferences. The VI-SPDAT Survey, Family VI-SPDAT Survey, or TAY VI-SPDAT Survey must be filled out before this form, either administered at the same time as the Survey, or sometime thereafter. Scan completed form into the documents tab. * denotes required questions.

3. *First Name of Point of Contact (POC) working on housing this Client: POC will be the person contacted to match this client with permanent supportive housing. In most cases, the POC will be the client’s Navigator.

4. *Last Name of Point of Contact (POC) working on housing this Client:

5. *Agency the POC is affiliated with:

6. *Phone number of POC:

7. *Email of POC:

8. *Has Client signed a Release of Information? If not, the client must sign a release before the Housing Matching Process can begin. YES NO

BACKGROUND INFORMATION

QUESTIONS TO ASSIST WITH HOUSING MATCH

9. *If a family unit is needed, how many children (under 18) for whom you have full legal custody will be living with you? Not Applicable 1 child 2 children 3 children 4 children 5 children 6 children 7 children 8 children

10. *If a family unit is needed, are there any adults (18+) who will be living in the unit? Not Applicable Yes No

11. Who in addition to you will be living in the unit, please list each adult and his/her relation to you.
12. *If a family unit is needed, how many bedrooms are required?__Not Applicable-I need an individual unit.  
   __1 bedroom __2 bedroom  __3 bedroom  
   __4 bedroom  __5 or more bedrooms

13. *Do you need shared housing? Two or more unrelated people share a 2 or more bedroom unit. 

14. Do you need access to public transportation? __Yes  No

15. Do you live in El Paso County? __Yes  No

16. *Which of the following areas would be your FIRST choice for housing?__Anywhere in El Paso County. (Wherever I will be placed into housing most quickly)  
   __Downtown/Central Colorado Springs  
   __North Colorado Springs/Monument  
   __South Colorado Springs/Fountain  
   __East Colorado Springs  
   __West Colorado Springs/Manitou Springs

17. Which of the following areas would be your SECOND choice for housing?__Anywhere in El Paso County. (Wherever I will be placed into housing most quickly)  
   __Downtown/Central Colorado Springs  
   __North Colorado Springs/Monument  
   __South Colorado Springs/Fountain  
   __East Colorado Springs  
   __West Colorado Springs/Manitou Springs

**FINAL QUESTIONS TO ASSIST WITH HOUSING MATCH**

18. Which of the following documents do you have with you or have easily accessible?  
   __Colorado-Issued ID Card or Driver’s License (or receipt of application)  
   __Social Security Card (or receipt of application)  
   __Birth Certificate

19. *What are your sources of income right now? Select all that apply. Note: If Client refuses to answer, Housing Match cannot begin. If "other" is chosen for source of income please specify what the other source(s) are.  
   __Refused to Answer  
   __No Income  
   __General Relief (GR)  
   __SSA  
   __SSI/SSDI  
   __VA
20. *How much income do you receive in total each month?  
*Answer can be rounded to the nearest $10 and should NOT include the value of Food Stamps. Please write without the “$” sign or commas.*  

| None | Medicaid | Medicare | Colorado Indigent Care Program (CICP) | Veterans Administration (VA) | Medical Services | Private Insurance | State Health Insurance for Adults | COBRA Employer-Provided Health Insurance | Other: |

21. What kind(s) of health insurance do you have, if any?  

| None | Medicaid | Medicare | Colorado Indigent Care Program (CICP) | Veterans Administration (VA) | Medical Services | Private Insurance | State Health Insurance for Adults | COBRA Employer-Provided Health Insurance | Other: |

22. *Are you already receiving supportive services that can/will follow you into supportive housing?*  

| Yes | No |

23. If yes, what agency provides those supportive services?  

24. Have you ever been a patient at any of the following Hospitals and/or at an El Paso County Health Clinic? If other, please state the name of the specific health facility.  

| No |
| Memorial Hospital |
| Penrose Hospital |
| Evans Hospital |
| Peak Vista |

25. Are you currently or have you ever received treatment for mental health issues?  

| Yes | No |

26. If you selected “Yes” in question 26, what are the names of all clinics, hospitals and/or agencies that you are currently receiving treatment from?  

27. What is your citizenship status?  

<p>| Citizen |
| Permanent Legal Resident |
| Asylee, Refugee, or other Eligible Immigrant |
| Ineligible Immigrant (including Undocumented) |</p>
<table>
<thead>
<tr>
<th>Question</th>
<th>Yes</th>
<th>No</th>
</tr>
</thead>
<tbody>
<tr>
<td>28. Do you have a permanent physical disability that limits your mobility?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>29. If yes, please describe the limits to your mobility:</td>
<td></td>
<td></td>
</tr>
<tr>
<td>30. *Have you ever been evicted from housing or abandoned a unit, of which your name was on the lease?</td>
<td>__Yes</td>
<td>No</td>
</tr>
<tr>
<td>31. If yes, approximate month and year of last eviction: If you are unsure of the day, please write in “1” to indicate the first day of the month.</td>
<td>Month: / Day: / Year:</td>
<td></td>
</tr>
<tr>
<td>32. *Were any of the evictions from Public Housing Authority units?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>33. If you’ve been evicted from a PHA unit, was it due to fraud?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>34. If yes, approximate month and year of the last eviction due to fraud: If you are unsure of the day, please write in “1” to indicate the first day of the month.</td>
<td>Month: / Day: / Year:</td>
<td></td>
</tr>
<tr>
<td>35. If you’ve been evicted from a PHA unit, was it due to unit damage?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>36. If yes, approximate month and year of the last eviction due to unit damage: If you are unsure of the day, please write in “1” to indicate the first day of the month.</td>
<td>Month: / Day: / Year:</td>
<td></td>
</tr>
<tr>
<td>37. *If you’ve been evicted from a PHA unit, do you owe money?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>38. *If you selected “Yes” in question 38, do you have a payment plan in place?</td>
<td>__Yes</td>
<td>No</td>
</tr>
<tr>
<td>39. *Have you ever been convicted of a felony?</td>
<td>__Yes</td>
<td>No</td>
</tr>
<tr>
<td>40. If yes, please describe all felonies for which you have been convicted?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>41. If yes, when was the month and year of your last conviction? If you are unsure of the day, please write in “1” to indicate the first day of the month.</td>
<td>Month: / Day: / Year:</td>
<td></td>
</tr>
<tr>
<td>42. If you've been convicted, were any of the felonies considered violent?</td>
<td></td>
<td></td>
</tr>
<tr>
<td>43. If yes, when was the month and year of your last violent felony conviction?</td>
<td>Month: / Day: / Year:</td>
<td></td>
</tr>
<tr>
<td>44. *Have you ever been convicted of manufacturing or producing methamphetamine?</td>
<td>__Yes</td>
<td>No</td>
</tr>
<tr>
<td>45. Do you have a history of drug or alcohol use?</td>
<td>__Yes</td>
<td>No</td>
</tr>
<tr>
<td>46. Do you currently use alcohol or drugs?</td>
<td>__Yes</td>
<td>No</td>
</tr>
<tr>
<td>47. If yes, please list what you are using.</td>
<td>__Yes</td>
<td>No</td>
</tr>
<tr>
<td>48. Are you interested in sober living?</td>
<td>__Yes</td>
<td>No</td>
</tr>
<tr>
<td>49. *Have you ever been convicted of arson?</td>
<td>__Yes</td>
<td>No</td>
</tr>
<tr>
<td>50. *Are you a registered sex offender?</td>
<td>__Yes</td>
<td>No</td>
</tr>
<tr>
<td>Question</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>-------------------------------------------------------------------------</td>
<td>-----</td>
<td>----</td>
</tr>
<tr>
<td>51. If no; Have you ever been accused or charged with any sexual offense?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>52. *Are you currently, or have you in the past two years, been on parole, probation or in a diversion program?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>53. When a background check is run will anything show up that hasn’t been covered by these questions?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>54. If you are receiving disability benefits (Social Security, VA, or other), what is/are the disabilng condition(s) for which you receive payments?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>55. *Do you need a smoking or non-smoking apartment?</td>
<td>Smoking</td>
<td>Non-smoking</td>
</tr>
<tr>
<td>56. *Do you use an accompaniment (service) animal? Please only specify “Yes” if the animal is required rather than just nice to have.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>57. If yes, what is the animal trained to do?</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>58. *Do you have a pet? Please only specify “yes” if this is a non-required pet.</td>
<td>Yes</td>
<td>No</td>
</tr>
<tr>
<td>59. If yes, what type of pet is it?</td>
<td>ADA accessible</td>
<td></td>
</tr>
<tr>
<td>60. Are there other requirements or requests around permanent housing that we need to be aware of (ADA compliant/Reasonable Accomodations)? If so, please list them. Please include here details not covered elsewhere (e.g. needs ground-floor unit, has a dog/pet, etc.) to help ensure that the housing match meets the client's needs.</td>
<td>Walk-in</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Grab bars</td>
<td></td>
</tr>
<tr>
<td></td>
<td>No stairs</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Limited stairs</td>
<td></td>
</tr>
</tbody>
</table>

62. Date this Match Initiation Form is being submitted: Month: / Day: / Year:
### Parameters for Dwelling Resource Listing

<table>
<thead>
<tr>
<th>Resource Name</th>
<th>Status</th>
<th>Available Date</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th># Bedrooms</th>
<th>#People</th>
<th># People</th>
</tr>
</thead>
</table>

<table>
<thead>
<tr>
<th>Unit Size</th>
<th>Maximum</th>
<th>Minimum</th>
</tr>
</thead>
</table>

#### Unit Description:

General Description of dwelling: type (house, condo, apt.), bedrooms, bathrooms, amenities etc.

School District _________

Blocks from Bus stop _ ___________

Walkability: Proximity to grocery, medical, client services

ADA Accessibility ________________

Rent Cap ________________

Program eligibility requirements:
Attachment III

VI-SPDAT/CE Agreement

I__________________________ acknowledge that I attended training and received instruction on how to administer the Vulnerability Index – Standardized Prioritization Decision Assistance Tool (VI-SPDAT). To ensure compliance with HUD’s notice CPD-17-01, I understand I will be held accountable for the following HUD requirements:

_______ I will not discriminate against: age, race, color, ethnicity, national origin, disability, sexual orientation, gender identity, marital status, etc.

_______ I will not steer any individual or family towards a particular housing facility based on: age, race, color, ethnicity, national origin, disability, sexual orientation, gender identity, marital status, etc.

_______ I understand that all information obtained during VI-SPDAT administration is confidential.

_______ I will keep all confidential information obtained secure. This security includes but is not limited to immediate shredding/destruction of paper copies once no longer needed, storage of records in locked filing cabinets, removal of any personal information that is not necessary to support prioritization or referral processes of a household, etc.

I understand that if I am found in breach of this agreement, I will no longer be permitted to administer the VI-SPDAT, obtain documents or information regarding coordinated entry.

_________________________________________________________________________/__________

Signature                                      Date

__________________________________________________________________________

Print Name

__________________________________________________________________________

Agency

__________________________________________________________________________

Email
Attachment IV
Pikes Peak Continuum of Care
Regional Coordinated Entry System

VI-SPDAT Assessment Screening and Match Initiation Consent Form Authorization to Participate in Housing Eligibility Survey

<table>
<thead>
<tr>
<th>Participant Last Name:</th>
<th>Participant First Name:</th>
<th>DOB (mm/dd/yyyy):</th>
</tr>
</thead>
</table>

HMIS Client ID Number (If Social Security Number: applicable):

We are here today to talk to you about your housing and service needs. If you give us permission, we will ask you questions about your health and housing for about 20-30 minutes. Participation in the VI-SPDAT Assessment and Match Initiation is completely voluntary. If you feel uncomfortable or upset during the interview, you may ask the interviewer to take a break, skip any of the questions, or stop the survey.

No one will be upset or angry if you decide not to be interviewed today. You will not be denied access to necessary services based on your refusal to participate in the assessment interview.

Please initial below if you agree with the following statements:

_____ I agree to allow my responses to VI-SPDAT Assessment and Match Initiation to be disclosed and received by the organizations that participate in the Pikes Peak Continuum of Care Coordinated Entry System and to be used to determine if I am eligible for participating housing, service and related programs. These organizations include but are not limited to:

- Ascending To Health
- AspenPointe
- Partners In Housing
- Coalition for Compassion and Action
- Colorado Springs Housing Authority
- Colorado Division of Housing
- Community Health Partnership
- The Salvation Army
- Springs Rescue Mission
- Tri-Lakes Cares
- Homeward Pikes Peak
- Catholic Charities
- Greccio Housing
- Peak Vista Health Clinic
- Pikes Peak United Way
- Rocky Mountain Human Services
- CSPD Homeless Outreach Team
- Ecumenical Social Ministries
- Family Promise
- Veterans Administration

A complete list of participating agencies is provided online at https://www.pppchp.org/

_____ I understand that the information from this survey will be entered into Pikes Peak Continuum of Care Regional Coordinated Entry database. My personal information will be kept
in accordance with all federal, state and local laws and regulations related to protecting personal information.

I understand that the Pikes Peak Continuum of Care Regional Coordinated Entry databases operate over the Internet and use many security protections to ensure confidentiality. The information collected may either be kept in separate databases or in a joint HMIS database, and may remain in the database or databases past the expiration of this consent or after consent is withdrawn.

I understand that the following information can be shared with participating agencies in the Pikes Peak Continuum of Care Region and other agencies as needed to help me find appropriate housing and/or services:

- Birth date
- Gender
- Scanned copies of vital documents to assist with housing application requirements
- History of medical treatments
- History of mental health treatment
- Housing and homeless history
- Income
- Contact information
- Additional information used for matching me with suitable housing and/or services
- Alcohol and Drug Use History
- HIV/AIDS Status (only for targeted housing programs)

I allow my case manager or outreach worker to enter my personal information to the interview questions into a secure database. My signature below signifies my permission.

I, or my outreach worker/case manager, may be contacted about my survey.

I understand that participating in the Pikes Peak Continuum of Care Regional Coordinated Entry System does not guarantee that I will be eligible for, or admitted into, a housing program.

I understand that the Pikes Peak Continuum of Care Regional Coordinated Entry System will act as the agency that matches my information against eligibility requirements of housing that becomes available and that I may be eligible for.

Important Rights and Other Required Statements You Should Know

• You may revoke this authorization at any time. To do so, please contact the Pikes Peak Continuum of Care Regional Coordinated Entry at Community Health Partnership at 719-632-5094.

• All participating organizations of the Pikes Peak Continuum of Care Regional Coordinated Entry System agree to use information provided for the sole purpose of linking clients with housing or supportive service options.
• This authorization will expire one year after the date it is signed by you.
• This authorization is completely voluntary, and you do not have to agree to authorize any use or disclosure.
• You have a right to a copy of this authorization once you have signed it. To obtain a copy, please contact the

Pikes Peak Continuum of Care Coordinated Entry System 719-632-5094

SIGN BELOW IF AGREEING TO BE INTERVIEWED

Your signature (or mark) below indicates that you have read (or been read) the information provided above, have received answers to your questions, and have freely chosen to be interviewed. By agreeing to be interviewed, you are not giving up any of your legal rights.

__________________________________________  _________________________________
Date                                                Signature (or Mark) of Participant

______________________________________________
Printed Name of Participant

__________________________________________  _________________________________
Date                                                Signature (or Mark) of Guardian

______________________________________________
Printed Name of Guardian

updated 4/2018
Attachment V
Pikes Peak Continuum of Care
PSH Document Ready Form for Coordinated Entry

Client Name____________________________________

Please mark the appropriate box(es) for all documentation you can affirm the client has in their possession. Use the comment section for conveying additional pertinent information.

Photo ID, --State of Issue: _______________  
___Original (In Hand)  
___Copy (In Hand)  
___Applied For (With Receipt)  
___No

Birth Certificate  
___Original (In Hand)  
___Copy (In Hand)  
___Applied For (With Receipt)  
___No

Social Security Card  
___Original (In Hand)  
___Copy (In Hand)  
___Applied For (With Receipt)  
___No

DD214  
___Original (In Hand)  
___Copy (In Hand)  
___Applied For (With Receipt)  
___No

Proof of Income (Within Last 2 Months)  
___Yes  
___No  
___N/A

Homeless Verification (HUD Definition)  
___Yes  
___No  
___N/A

Comments:__________________________________________________________________________
PPCoC Housing Client Information Sheet

El Paso County does not use waitlists. “First come first served” does not exist. If you are experiencing homelessness and seeking housing, you must complete the “housing survey”, and be placed on the prioritization list. The VI-SPDAT is the “housing survey” used in El Paso County. In no way does taking, the “housing survey” guarantee you will receive housing.

IMPORTANT: You must check in every 3 months to remain on list for housing. If you have not been contacted regarding housing. It is your responsibility to check in by this

Date: _______________, to be reassessed and remain on the housing list.

It is important that you keep any and all contact information current!

Important Information:

Agency where I was assessed: ________________________________

__________________________________________

Person who assessed me: __________________________________________

Client Name: _______________________________

Agency Address:

Today’s Date: _______________  __________________

VI-SPDAT (Circle One):   Individual   TAY    Family         ____________________________________

Below are the steps to being housed in El Paso County, with The Pikes Peak Continuum of Care.

1. Take the “Housing Survey” also called the VI-SPDAT; you only have to take it at one location.
2. Answers given on the “housing survey” are entered into the system and used to identify people for housing.
3. Weekly a new list is pulled with all “housing surveys” entered into the system. If your score does not qualify you for housing assistance, you will receive a phone call from 211 offering you other potential resources.
4. Weekly open housing slots are submitted
5. Weekly case conferencing occurs. Eligible person(s) are identified and matched to appropriate open housing slot.
6. Once identified for an opening, the identified person(s) will be looked for. If not found in 2 weeks the person is returned to the list. It is very important to keep your contact information up to date!!!
7. Once a person is found, the place where the “housing survey” was taken will verify your eligibility, and help you gather documents.

Documents needed are:
- Disability paperwork (if disabled)  - Birth Certificate
- Veteran Paperwork (DD214)  - Colorado ID
- Proof of length of time homeless  - Proof of Income
- Social Security Card

8. Once all your documents are obtained, and it is verified that you are an eligible match for the open housing slot you will be referred to the program with the open housing slot.
9. If you have not been contacted about housing within 3 months, it is your responsibility to go and take a new “housing survey”. See date written on the top of this sheet.
10. If you have a grievance pursuant to fair housing, contact the Dept. of Housing and Urban Development directly

https://portal.hud.gov/hudportal/HUD?src=/program/offices/fair_housing_equal_opp/online-complaint. If you have a grievance with the agency you worked with-see the agency grievance procedure information form given to you upon completion of the housing survey. If you have a grievance with the coordinated entry process, you can access the grievance procedure and form on the Community Health Partnership website - https://www.ppchp.org/

Please call Community Health Partnership at 719-632-5094 for any other resources you may want information about.

On the reverse of this form is a schedule/locator where you can update your housing survey.
**Attachment VII**

Pikes Peak Continuum of Care  
Regional Coordinated Entry System  
Authorization to Share VI-SPDAT Information Anonymously

<table>
<thead>
<tr>
<th>Participant Last Name:</th>
<th>Participant First Name:</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>DOB:</strong></td>
<td><strong>HMIS ID #:</strong></td>
</tr>
</tbody>
</table>

I have participated in the VI-SPDAT Assessment and Match Survey. I did not agree to allow my identification to be connected to my Survey. Rather, I am choosing to have my information shared anonymously through a representative.

**Please initial below if you agree with the following statements:**

___ I agree to allow my responses to VI-SPDAT Assessment and Match Initiation to be disclosed anonymously only to organizations that participate in the Pikes Peak Continuum of Care Coordinated Entry System and to be used to determine if I am eligible for participating housing, service and related programs. These organizations include but are not limited to:

- Ascending To Health
- AspenPointe
- Catholic Charities
- Coalition for Compassion and Action
- Colo. Springs Housing Authority
- Colorado Division of Housing
- Ecumenical Social Ministries
- Family Promise
- Greccio Housing
- CSPD Homeless Outreach Team
- Homeward Pikes Peak
- Partners in Housing
- Peak Vista
- Pikes Peak United Way
- Rocky Mountain Human Services
- The Salvation Army
- Springs Rescue Mission
- Tri-Lakes Care
- Veterans Administration
- Urban Peak, Colo. Springs
- Community Health Partnership

A complete list of participating agencies is provided online at [https://www.ppchp.org/](https://www.ppchp.org/)

___ This agency (listed below) may represent me at Coordinated Entry Case Conferencing and contact me about my survey and possible housing.

The Name of Agency that did my survey: ____________________________________________

Contact/Location: ________________________________________________________________

______________________________________________________________________________

I am best reached at the following address, phone number, and/or e-mail:

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________

______________________________________________________________________________
Attachment VIII
Pikes Peak Continuum of Care
Coordinated Entry Grievance Form

This form is to be filled out if you have a grievance with the Coordinated Entry Process, those grievances would include, any complaint against the Coordinated Entry policies and/or procedures. This form is also used if you have filed a grievance against one of the CE participating agencies, and the grievance needs to be escalated.

<table>
<thead>
<tr>
<th>Name</th>
<th>Today’s Date</th>
</tr>
</thead>
</table>

Phone#: ________________________
Email: ________________________
Current Address: ________________________

Brief Description of Grievance / Attached Copy of Agency Grievance Form

For Coordinated Entry Use Only,
Coordinated Entry Director Resolution

<table>
<thead>
<tr>
<th>Coordinated Entry Director Signature</th>
<th>Date</th>
</tr>
</thead>
</table>

Client Signature: ________________________

<table>
<thead>
<tr>
<th>Agree to Resolution</th>
<th>Please Escalate to Next Level</th>
</tr>
</thead>
</table>

Updated 6/5/2017
**Distribution of Race**

<table>
<thead>
<tr>
<th>In Families with Children</th>
<th>All</th>
<th>Experiencing Homelessness (PIT)</th>
<th>Experiencing Sheltered Homelessness (PIT)</th>
<th>Experiencing Unsheltered Homelessness (PIT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>66%</td>
<td>68%</td>
<td>93%</td>
<td>91%</td>
</tr>
<tr>
<td>Black</td>
<td>16%</td>
<td>15%</td>
<td>4%</td>
<td>6%</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>10%</td>
<td>8%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Native</td>
<td>7%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other/Multi-Racial</td>
<td>7%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Youth</th>
<th>All</th>
<th>Experiencing Homelessness (PIT)</th>
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</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>72%</td>
<td>68%</td>
<td>93%</td>
<td>91%</td>
</tr>
<tr>
<td>Black</td>
<td>16%</td>
<td>15%</td>
<td>4%</td>
<td>6%</td>
</tr>
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<td>0%</td>
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<td>0%</td>
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<tr>
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<td>2%</td>
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**Distribution of Ethnicity**

<table>
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<tr>
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<td>8%</td>
<td>0%</td>
<td>2%</td>
</tr>
<tr>
<td>Native</td>
<td>7%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other/Multi-Racial</td>
<td>7%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
</tr>
</tbody>
</table>

<table>
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<tr>
<th>Youth</th>
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</tr>
<tr>
<td>Native</td>
<td>7%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
</tr>
<tr>
<td>Other/Multi-Racial</td>
<td>7%</td>
<td>2%</td>
<td>0%</td>
<td>0%</td>
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</tbody>
</table>

**CoC Data**

<table>
<thead>
<tr>
<th>Race and Ethnicity</th>
<th>All (ACS)</th>
<th>In Families with Children</th>
<th>Experiencing Homelessness (PIT)</th>
<th>Experiencing Sheltered Homelessness (PIT)</th>
<th>Experiencing Unsheltered Homelessness (PIT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>65,024</td>
<td>54,657</td>
<td>7,350</td>
<td>1,644</td>
<td>483</td>
</tr>
<tr>
<td>Black</td>
<td>39,158</td>
<td>32,401</td>
<td>7,519</td>
<td>1,334</td>
<td>229</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>4,185</td>
<td>3,778</td>
<td>1,994</td>
<td>177</td>
<td>44</td>
</tr>
<tr>
<td>Native</td>
<td>6,185</td>
<td>5,007</td>
<td>1,608</td>
<td>201</td>
<td>41</td>
</tr>
<tr>
<td>Other/Multi-Racial</td>
<td>6,257</td>
<td>5,143</td>
<td>1,303</td>
<td>129</td>
<td>41</td>
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</tbody>
</table>

**State Data**

<table>
<thead>
<tr>
<th>Race and Ethnicity</th>
<th>All (ACS)</th>
<th>In Families with Children</th>
<th>Experiencing Homelessness (PIT)</th>
<th>Experiencing Sheltered Homelessness (PIT)</th>
<th>Experiencing Unsheltered Homelessness (PIT)</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>5,278,006</td>
<td>4,192,558</td>
<td>60,960</td>
<td>438,480</td>
<td>16,940</td>
</tr>
<tr>
<td>Black</td>
<td>2,222,065</td>
<td>1,505,045</td>
<td>111,473</td>
<td>781,473</td>
<td>27,788</td>
</tr>
<tr>
<td>Asian/Pacific Islander</td>
<td>15,408</td>
<td>11,316</td>
<td>140,613</td>
<td>404,569</td>
<td>13,186</td>
</tr>
<tr>
<td>Native</td>
<td>50,988</td>
<td>39,807</td>
<td>51,645</td>
<td>8,648</td>
<td>2,566</td>
</tr>
<tr>
<td>Other/Multi-Racial</td>
<td>415,549</td>
<td>305,530</td>
<td>117,198</td>
<td>310,196</td>
<td>7,752</td>
</tr>
</tbody>
</table>

**Youth**

<table>
<thead>
<tr>
<th>Experiencing Homelessness (PIT)</th>
<th>Experiencing Sheltered Homelessness (PIT)</th>
<th>Experiencing Unsheltered Homelessness (PIT)</th>
</tr>
</thead>
<tbody>
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<td>2%</td>
</tr>
<tr>
<td>Other/Multi-Racial</td>
<td>7%</td>
<td>2%</td>
</tr>
</tbody>
</table>

**Veterans**

<table>
<thead>
<tr>
<th>Experiencing Homelessness (PIT)</th>
<th>Veteran Poverty Data Not Available</th>
</tr>
</thead>
<tbody>
<tr>
<td>White</td>
<td>81%</td>
</tr>
</tbody>
</table>

**Youth Experiencing Homelessness**

Youth experiencing homelessness is limited to unaccompanied and parenting youth persons under 18.

**Veterans Experiencing Homelessness**

Veteran Poverty Data Not Available
<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Hispanic</th>
<th>Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>14,415</td>
<td>141,840</td>
</tr>
<tr>
<td></td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td>In Poverty</td>
<td>18</td>
<td>180</td>
</tr>
<tr>
<td>All Homeless</td>
<td>9%</td>
<td>91%</td>
</tr>
<tr>
<td>Unsheltered Homeless</td>
<td>11</td>
<td>115</td>
</tr>
<tr>
<td></td>
<td>7</td>
<td>65</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>90%</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Ethnicity</th>
<th>Hispanic</th>
<th>Non-Hispanic</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>38,840</td>
<td>312,845</td>
</tr>
<tr>
<td></td>
<td>10%</td>
<td>90%</td>
</tr>
<tr>
<td>In Poverty</td>
<td>134</td>
<td>944</td>
</tr>
<tr>
<td>All Homeless</td>
<td>12%</td>
<td>88%</td>
</tr>
<tr>
<td>Unsheltered Homeless</td>
<td>115</td>
<td>91%</td>
</tr>
</tbody>
</table>

Sources:
1. American Community Survey (ACS) 2011-2015 5-yr estimates; Veteran CoC data comes from the ACS 2015 1-yr estimates; Total youth in the American Community Survey is a rollup of race estimates of all persons under 25.
2. Point-In-Time (PIT) 2017 data

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