Before Starting the Exhibit 1 Continuum of Care (CoC) Application

The CoC Consolidated Application has been divided into two sections and each of these two sections REQUIRE SUBMISSION in e-snaps in order for the CoC Consolidated Application to be considered complete:

- CoC Consolidated Application - CoC Project Listings

CoCs MUST ensure that both parts of this application are submitted by the submission due date to HUD as specified in the FY2012 CoC Program NOFA.

Please Note:
- Review the FY2012 CoC Program NOFA in its entirety for specific application and program requirements. - Use the CoC Application Detailed Instructions while completing the application in e-snaps. The detailed instructions are designed to assist applicants as they complete the information in e-snaps. - As a reminder, CoCs were not able to import data from the previous year due to program changes under HEARTH. All parts of the application must be fully completed.

For Detailed Instructions click here.

1A. Continuum of Care (CoC) Identification

Instructions:

The fields on this screen are read only and reference the information entered during the CoC Registration process. Updates cannot be made at this time. If the information on this screen is not correct, contact the HUD Virtual Help Desk at www.hudhre.info.

CoC Name and Number (From CoC Registration): (dropdown values will be changed)	CA-522 - Humboldt County CoC
Collaborative Applicant Name:	Humboldt County
CoC Designation:	CA

1B. Continuum of Care (CoC) Operations

Instructions:

Collaborative Applicants will provide information about the existing operations of the CoC. The first few questions ask basic information about the structure and operations: name, meeting frequency, and if the meetings have an open invitation process for new members. If there is an open invitation process for new members, the Collaborative Application will need to clearly describe the process. Additionally, the CoC should include homeless or formerly homeless persons as part of the operations process. The Collaborative Applicant will indicate if the CoC structure includes homeless or formerly homeless members and if yes, what the connection is to the homeless community.

Next, indicate if the CoC provides written agendas of the CoC meetings, includes a centralized or coordinated assessment system in the jurisdiction, and if the CoC conducts monitoring of ESG recipients and subrecipients. If the CoC does not provide any of these, explain the plans of the CoC to begin implementation within the next year. For any of the written processes that are selected, specifically describe each of the processes within the CoC.

Finally, select the processes for which the CoC has written and approved documents: establishment and operations of the CoC, code of conduct for the board, written process for board selection that is approved by the CoC membership, and governance charters in place for both the HMIS lead agency as well as participating organizations, especially those organizations that receive HUD funding. For any documents chosen, the CoC must have both written and approved documents on file.

Name of CoC Structure:	Humboldt Housing and Homelessness Coalition (HHHC)
How often does the CoC conduct open meetings?	Monthly
Are the CoC meetings open to the public?	Yes
Is there an open invitation process for new members?	Yes

If 'Yes', what is the invitation process? (limit 750 characters)

To promote an inclusive community process, announcements of CoC meetings and invitations are sent out in advance of each bimonthly meeting to a listserve encompassing a wide range of stakeholders, including local government representatives, university representatives, nonprofits, business leaders, and community members. CoC meeting announcements are also made in other community meetings. No membership is required to participate in HHHC General meetings.
The Executive Committee includes representatives of local government, nonprofits, the PHA, veterans, faith-based organizations, school systems, and the medical community. New Executive Committee members are nominated and approved by the Executive Committee and general HHHC meeting.

Are homeless or formerly homeless representatives members part of the CoC structure?	Yes
If formerly homeless, what is the connection to the community?	Agency employee

Does the CoC provide

CoC Checks	Response
Written agendas of meeting?	Yes
Centralized assessment?	No
ESG monitoring?	No

**If 'No' to any of the above what processes does the CoC plan to implement in the next year?
(limit 1000 characters)**

Centralized Assessment: The Executive Committee has begun the process of implementing a centralized assessment system. In 2012, we implemented a 211 system to connect people with services. Currently, HMIS data is not shared between agencies; to prepare for centralized assessment, the CoC is developing a protocol to share client-level data. Because our CoC has relatively few providers, coordination between agencies has always occurred on an informal level. The CoC will build on the strong relationships that already exist to develop CoC-wide standards for assessment. DHHS will take the lead in implementing the system; the ESG Committee is coordinating an ESG application to support it.
ESG Monitoring: Humboldt County does not currently receive ESG funds. However, because it is a CoC priority to build on our successful HPRP program, we will be applying for ESG through CA HCD in 2013. The ESG Committee coordinates with local stakeholders to develop local priorities & a review process.

Based on the selection made above, specifically describe each of the processes chosen
(limit 1000 characters)

Agendas of CoC meetings are sent out in advance of each meeting to a listserve encompassing a wide range of stakeholders, including local government representatives, university representatives, nonprofits, business leaders, and community members. After HHHC General Meetings, meeting minutes are posted via listserve and posted online.
Agendas are developed based on regular review of HHHC progress in achieving CoC priorities and HEARTH goals, and facilitate decision-making on new strategic directives, reviewing and adapting operating policies, approving and implementing committee recommendations, and hearing comments and concerns from all sectors.

Does the CoC have the following written and approved documents:

Type of Governance	Yes/No
CoC policies and procedures	No
Code of conduct for the Board	No
Written process for board selection	Yes
Governance charter among collaborative applicant, HMIS lead, and participating agencies.	Yes

1C. Continuum of Care (CoC) Committees

Instructions:

Provide information on up to five of the CoCs most active CoC-wide planning committees, subcommittees, and workgroups. CoCs should only include information on those groups that are directly involved in CoC-wide planning activities such as project review and selection, discharge planning, disaster planning, completion of the Exhibit 1 application, conducting the point-in-time count, LGBT homeless issues, and 10-year plan coordination. For each group, briefly describe the role and how frequently the group meets. If one of more of the groups meets less than quarterly, please explain.

Committees and Frequency:

Name of Group	Role of Group (limit 750 characters)	Meeting Frequency
Executive Committee	Coordinates outcome-oriented, community-wide process to implement a CoC system of housing and services. Plans, oversees, and implements multi-pronged CoC and 10-year strategy to prevent and eliminate homelessness among families and individuals including CH, LGBT & veterans. Coordinates committee work, sets HHHC annual work plan & meeting agendas, ensures that CoC agencies are performing, monitors outcomes, represents the Collaborative in other forums, & informs the Board of Supervisors of the CA Consolidated Plan. Establishes annual Review & Rank Committee. Coordinates discharge planning, & conducting the PIT count, & approves the Exhibit 1 & makes it available for community review. Disaster planning is w/in the EC purview.	Monthly or more
HMIS Committee	Plans to resolve issues in the countywide HMIS, obtains unduplicated counts of homeless people in the community, and analyzes data to respond to unmet needs. The group reviews HMIS bed coverage (HUD and non HUD- funded), considers best practices and program ideas for expanding coverage, and reports at each HHHC meeting. The group focuses on using HMIS for program performance review and client case management. This is a forum to consider integration of HMIS data or reports with mainstream systems. The group reviews and looks to improve HMIS data quality and compliance with technical standards, including by training. The group is exploring using HMIS for PIT counts.	Monthly or more
ESG Planning Committee	Though there are currently no ESG grantees in Humboldt County, accessing ESG funds in the future is a CoC priority. This committee was created to plan and coordinate the CoC's response to the 2013 Emergency Solutions Grants funds available through the state Dept. of Housing and Community Development (HCD). The group meets to discuss the possible uses of ESG funding, including homeless prevention, rapid rehousing, shelter, and coordinated intake; discuss CoC funding priorities for the available funds, review best practices of former HPRP program and build on its success, and coordinate the submission of the application to HCD.	Monthly or more

Discharge Planning Task Force	This workgroup was created to formalize the CoC's already robust discharge planning policy. The group creates a formal plan for discharge from local public institutions through coordination with law enforcement/probation, hospitals, the CoC's TAY Collaboration Group, mental health service providers, and other stakeholders. The group leverages existing strong relationships and informal arrangements between homeless service providers and public institutions to develop and adopt a written discharge planning policy for the CoC. This group reports to the CoC quarterly.	Monthly or more
Housing and Shelter Committee	The Housing & Shelter Cmte leads community need-based housing efforts, and works on the CoC's related action steps. Responsibilities include: 1) Working with stakeholders to ensure CoC goals are integrated in the Housing Element, Con Plan, & other community plans; 2) Creating, maintaining, & building on the community-wide inventory of housing types; 3) Identifying full spectrum of community needs for homeless housing based on the homeless population & their specific needs; 4) Determining appropriate mix of housing types with service levels based on this need determination; 5) Ensuring children who become homeless receive appropriate education assistance; 6) Improving CoC-wide participation in mainstream programs. Reports to HHHC quarterly.	Monthly or more

If any group meets less than quarterly, please explain (limit 750 characters)

N/A

1D. Continuum of Care (CoC) Member Organizations

Click on the icon to enter information for the CoC Member Organizations.

Membership Type
Public Sector
Private Sector
Individual

1D. Continuum of Care (CoC) Member Organizations Detail

Instructions:

Enter the number or public organizations, private organizations, or individuals for each of the categories below. Each section below must have at least one field completed.

Public Sectors: Enter the number of organizations that are represented in the CoC's planning process.
Enter the number of organizations that serve each of the subpopulations listed.
Enter the number of organizations that participate in each of the roles listed.

Private Sectors: Enter the number of organizations that are represented in the CoC's planning process.
Enter the number of organizations that serve each of the subpopulations listed.
Enter the number of organizations that participate in each of the roles listed.

Individuals: Enter the number of individuals that are represented in the CoC's planning process.
Enter the number of individuals that serve each of the subpopulations listed.
Enter the number of individuals who participate in each of the roles listed.

Type of Membership: Public Sector
Click Save after selection to view grids

Number of Public Sector Organizations Represented in Planning Process

	Law Enforcement/ Corrections	Local Government Agencies	Local Workforce Investment Act Boards	Public Housing Agencies	School Systems/ Universities	State Government Agencies	Other
Total Number	4	14	0	1	2	1	3

Number of Public Sector Organizations Serving Each Subpopulation

	Law Enforcement/ Corrections	Local Government Agencies	Local Workforce Investment Act Boards	Public Housing Agencies	School Systems/ Universities	State Government Agencies	Other
Subpopulations							
Seriously mentally ill	4	5	0	1	0	0	0
Substance abuse	4	2	0	1	0	0	0
Veterans	4	8	0	1	0	0	1

HIV/AIDS	4	3	0	1	0	0	0
Domestic violence	4	3	0	1	2	0	0
Children (under age 18)	4	5	0	1	2	0	0
Unaccompanied youth (ages 18 to 24)	4	3	0	1	2	0	0

Number of Public Sector Organizations Participating in Each Role

	Law Enforcement/ Corrections	Local Government Agencies	Local Workforce Investment Act Boards	Public Housing Agencies	School Systems/ Universities	State Government Agencies	Other
Roles							
Committee/Sub-committee/Work Group	4	11	0	1	2	1	0
Authoring agency for consolidated plan	0	1	0	0	0	0	0
Attend consolidated plan planning meetings during past 12 months	0	1	0	1	0	0	0
Attend consolidated plan focus groups/ public forums during past 12 months	1	2	0	1	0	0	0
Lead agency for 10-year plan	0	1	0	0	0	0	0
Attend 10-year planning meetings during past 12 months	0	13	0	1	1	0	3
Primary decision making group	1	2	0	1	0	0	0

1D. Continuum of Care (CoC) Member Organizations Detail

Instructions:

Enter the number or public organizations, private organizations, or individuals for each of the categories below. Each section below must have at least one field completed.

Public Sectors: Enter the number of organizations that are represented in the CoC's planning process.
Enter the number of organizations that serve each of the subpopulations listed.
Enter the number of organizations that participate in each of the roles listed.

Private Sectors: Enter the number of organizations that are represented in the CoC's planning process.
Enter the number of organizations that serve each of the subpopulations listed.
Enter the number of organizations that participate in each of the roles listed.

Individuals: Enter the number of individuals that are represented in the CoC's planning process.
Enter the number of individuals that serve each of the subpopulations listed.
Enter the number of individuals who participate in each of the roles listed.

Type of Membership: Private Sector
Click Save after selection to view grids

Number of Private Sector Organizations Represented in Planning Process

	Businesses	Faith-Based Organizations	Funder Advocacy Group	Hospitals/ Med Representatives	Non-Profit Organizations	Other
Total Number	1	2	2	2	13	1

Number of Private Sector Organizations Serving Each Subpopulation

	Businesses	Faith-Based Organizations	Funder Advocacy Group	Hospitals/ Med Representatives	Non-Profit Organizations	Other
Subpopulations						
Seriously mentally ill	0	0	0	2	2	0
Substance abuse	0	1	0	2	5	0
Veterans	0	0	0	2	2	0
HIV/AIDS	0	0	0	2	4	0
Domestic violence	0	2	0	2	3	0
Children (under age 18)	0	2	0	2	8	0
Unaccompanied youth (ages 18 to 24)	0	0	0	2	3	0

Number of Private Sector Organizations Participating in Each Role

	Businesses	Faith-Based Organizations	Funder Advocacy Group	Hospitals/ Med Representatives	Non-Profit Organizations	Other
Roles						
Committee/Sub-committee/Work Group	0	1	2	1	13	1
Authoring agency for consolidated plan	0	0	0	0	0	0
Attend consolidated plan planning meetings during past 12 months	0	0	0	0	1	0
Attend Consolidated Plan focus groups/ public forums during past 12 months	0	0	0	1	4	0
Lead agency for 10-year plan	0	0	0	0	0	0

Attend 10-year planning meetings during past 12 months	1	1	2	2	10	0
Primary decision making group	0	1	0	1	6	0

1D. Continuum of Care (CoC) Member Organizations Detail

Instructions:

Enter the number or public organizations, private organizations, or individuals for each of the categories below. Each section below must have at least one field completed.

Public Sectors: Enter the number of organizations that are represented in the CoC's planning process.
Enter the number of organizations that serve each of the subpopulations listed.
Enter the number of organizations that participate in each of the roles listed.

Private Sectors: Enter the number of organizations that are represented in the CoC's planning process.
Enter the number of organizations that serve each of the subpopulations listed.
Enter the number of organizations that participate in each of the roles listed.

Individuals: Enter the number of individuals that are represented in the CoC's planning process.
Enter the number of individuals that serve each of the subpopulations listed.
Enter the number of individuals who participate in each of the roles listed.

Type of Membership: Individual
Click Save after selection to view grids

Number of Individuals Represented in Planning Process

	Homeless	Formerly Homeless	Other
Total Number	0	2	15

Number of Individuals Serving Each Subpopulation

	Homeless	Formerly Homeless	Other
Subpopulations			
Seriously mentally ill	0	0	0
Substance abuse	0	0	0
Veterans	0	0	0

HIV/AIDS	0	0	0
Domestic violence	0	0	0
Children (under age 18)	0	0	0
Unaccompanied youth (ages 18 to 24)	0	0	0

Number of Individuals Participating in Each Role

	Homeless	Formerly Homeless	Other
Roles			
Committee/Sub-committee/Work Group	0	1	0
Authoring agency for consolidated plan	0	0	0
Attend consolidated plan planning meetings during past 12 months	0	1	0
Attend consolidated plan focus groups/ public forums during past 12 months	0	1	0
Lead agency for 10-year plan	0	1	0
Attend 10-year planning meetings during past 12 months	0	2	11
Primary decision making group	0	1	0

1E. Continuum of Care (CoC) Project Review and Selection Process

Instructions:

The CoC solicitation of project applications and the project application selection process should be conducted in a fair and impartial manner. For each of the following items, indicate all of the methods and processes the CoC used in the past year to assess the performance, effectiveness, and quality of all requested new and renewal project(s). Where applicable, describe how the process works.

In addition, indicate if any written complaints have been received by the CoC regarding any CoC matter in the last 12 months, and how those matters were addressed and/or resolved.

Open Solicitation Methods (select all that apply):	d. Outreach to Faith-Based Groups, c. Responsive to Public Inquiries, b. Letters/Emails to CoC Membership, f. Announcements at Other Meetings, e. Announcements at CoC Meetings
Rating and Performance Assessment Measure(s) (select all that apply):	m. Assess Provider Organization Capacity, n. Evaluate Project Presentation, i. Evaluate Project Readiness, p. Review Match, o. Review CoC Membership Involvement, r. Review HMIS participation status, q. Review All Leveraging Letters (to ensure that they meet HUD requirements), k. Assess Cost Effectiveness, l. Assess Provider Organization Experience, j. Assess Spending (fast or slow), b. Review CoC Monitoring Findings, a. CoC Rating & Review Commitee Exists, f. Review Unexecuted Grants, e. Review HUD APR for Performance Results, d. Review Independent Audit, c. Review HUD Monitoring Findings

Describe how the CoC uses the processes selected above in rating and ranking project applications.
(limit 750 characters)

To ensure that CoC projects perform well and address priority gaps/needs, the CoC recruits a committee of non-conflicted persons familiar with homelessness in the CoC to review project applications. Committee is trained on HUD regulations, CoC priorities, & how to interpret the information provided by the projects; scoring criteria and timelines are publicly available. The cmte reviews APR outcomes, agency capacity/experience including HUD, CoC, & financial audit findings & spending; HMIS participation, CoC involvement, cost effectiveness, ability to articulate achievable outcome measurements, match, & leverage. The cmte meets with & scores each project according to a CoC-approved scoring tool. Projects at risk of losing funding may appeal.

Did the CoC use the gaps/needs analysis to ensure that project applications meet the needs of the community?	Yes
Has the CoC conducted a capacity review of each project applicant to determine its ability to properly and timely manage federal funds?	Yes
Voting/Decision-Making Method(s) (select all that apply):	d. One Vote per Organization, e. Consensus (general agreement), a. Unbiased Panel/Review Commitee, f. Voting Members Abstain if Conflict of Interest
Is the CoC open to proposals from entities that have not previously received funds in the CoC process?	Yes

If 'Yes', specifically describe the steps the CoC uses to work with homeless service providers that express an interest in applying for HUD funds, including the review process and providing feedback (limit 1000 characters)

The CoC publishes an announcement of the funding opportunity to a listserve (that includes a wide range of stakeholders) and at CoC and at community meetings. Interested agencies are invited to attend a Technical Assistance workshop, through which the funding opportunity, application, and review process are explained in detail. During the application process, applicants may contact the CoC with application and review process questions. All applicants meet with the non-conflicted Review and Rank Committee, who ask questions and provide feedback about the application. After scoring, the CoC sends each applicant notice of its score, rank, and opportunity to appeal. After the application process is complete, the CoC offers each applicant the opportunity to request feedback on their application.

Were there any written complaints received by the CoC regarding any matter in the last 12 months?	No

If 'Yes', briefly describe complaint(s), how it was resolved, and the date(s) resolved (limit 1000 characters)

The CoC did not receive any written complaints in the last 12 months. However, if a complaint is filed, our CoC policy is to bring the complaint to the HHHC Executive Committee. The Executive Committee would meet with all parties to a complaint to determine appropriate corrective action.

1F. Continuum of Care (CoC) Housing Inventory Count - Change in Beds Available

Instructions:

For each housing type, indicate if there was a change (increase or reduction) in the total number of beds counted in the 2012 Housing Inventory Count (HIC) as compared to the 2011 HIC. If there was a change, describe the reason(s) in the space provided for each housing type. If the housing type does not exist in the CoC, select "Not Applicable" and indicate that in the text box for that housing type.

Indicate if any of the transitional housing projects in the CoC utilized the transition in place method; i.e., if participants in transitional housing units remained in the unit when exiting the program to permanent housing. If the units were transitioned, indicate how many.

Emergency Shelter: No

Briefly describe the reason(s) for the change in Emergency Shelter beds, if applicable
(limit 750 characters)

We had no actual change in shelter beds in 2012. On the 2011 HIC, our Winter Shelter/Motel Vouchers for GR Recipients beds were mistakenly categorized as year-round beds instead of seasonal beds. On the 2012 HIC we corrected that mistake.

HPRP Beds: Yes

Briefly describe the reason(s) for the change in HPRP beds or units, if applicable
(limit 750 characters)

Because our HPRP funding expired, we had 225 fewer HPRP beds in 2012 than in 2011. However, many of those housed through HPRP remain stably housed.

Safe Haven: Not Applicable

Briefly describe the reason(s) for the change in Safe Haven beds, if applicable
(limit 750 characters)

Not applicable; CoC has no Safe Haven beds

Transitional Housing: Yes

Briefly describe the reason(s) for the change in Transitional Housing beds, if applicable
(limit 750 characters)

There was a temporary reduction in transitional housing beds available in 2012 because Bridge House Annex Second Safe Haven was closed for renovations in January. That program has since reopened.

Did any projects within the CoC utilize transition in place; i.e., participants in transitional housing units transitioned in place to permanent housing?	No
If yes, how many transitional housing units in the CoC are considered "transition in place":	

Permanent Housing: Yes

Briefly describe the reason(s) for the change in Permanent Housing beds, if applicable
(limit 750 characters)

We had a gain of 4 PH beds in 2012. However, due to a 2011 HIC reporting error that we corrected in 2012, the HIC shows a drop in the number of PH beds from 2011 to 2012. Prior to 2012 Apartments First!, the largest PSH provider in the CoC, was operating as a single program supported by 4 McKinney-Vento grants. When that program consolidated its grants in 2012, it became clear that the 2011 HIC had mistakenly reported a total of 31 beds among the 4 grants instead of the accurate 24. Additionally, SVK House, a recent McKinney-Vento grantee, is not yet operating and should not have appeared as “current” on the 2011 HIC. We expect those 5 beds to become available in 2013. In 2012, Project HART added 4 PSH beds for CH persons with HIV/AIDS.

CoC certifies that all beds for homeless persons were included in the Housing Inventory Count (HIC) as reported on the Homelessness Data Exchange (HDX), regardless of HMIS participation and HUD funding:	Yes

1G. Continuum of Care (CoC) Housing Inventory Count - Data Sources and Methods

Instructions:

Complete the following items based on data collection methods and reporting for the Housing Inventory Count (HIC), including Unmet need determination. The information should be based on a survey conducted in a 24 hour period during the last ten days of January 2012. CoCs were expected to report HIC data on the Homelessness Data Exchange (HDX).

Did the CoC submit the HIC data in HDX by April 30, 2012?	Yes
If 'No', briefly explain why the HIC data was not submitted by April 30, 2012 (limit 750 characters)	
Indicate the type of data sources or methods used to complete the housing inventory count (select all that apply):	HMIS plus housing inventory survey
Indicate the steps taken to ensure the accuracy of the data collected and included in the housing inventory count (select all that apply):	Follow-up, Updated prior housing inventory information, Instructions, Confirmation
Must specify other:	
Indicate the type of data or method(s) used to determine unmet need (select all that apply):	National studies or data sources, Unsheltered count, HMIS data, Local studies or non-HMIS data sources, Stakeholder discussion, Housing inventory
Specify "other" data types:	
If more than one method was selected, describe how these methods were used together (limit 750 characters)	

Exec Cmte (EC) reviewed HUD unmet need guidance & started with the idea that the overall need for beds equals the number of homeless people at a point-in-time minus beds in place & under development. EC reviewed population & subpopulation PIT data & determined how many of the needed beds were for families vs individuals. Apportioning needed beds by subpopulation was done in stakeholder discussions about different groups' needs (ie, DV survivors may only need short-term shelter, while CH may only benefit from PSH) & was influenced by PIT data. In coming to a decision, EC considered all relevant objective sources (national data, Con Plan, Housing element, CA data, consumer surveys, provider reports) & subjective sources (provider opinions).

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

All CoCs are expected to have a functioning Homeless Management Information System (HMIS). An HMIS is a computerized data collection application that facilitates the collection of information on homeless individuals and families using residential or other homeless services and stores that data in an electronic format. CoCs should complete this section in conjunction with the lead agency responsible for the HMIS. All information should reflect the status of HMIS implementation as of the date of application submission.

Select the HMIS implementation coverage area:	Single CoC
Select the CoC(s) covered by the HMIS (select all that apply):	CA-522 - Humboldt County CoC
Is there a governance agreement in place with the CoC?	Yes
If yes, does the governance agreement include the most current HMIS requirements?	Yes

If the CoC does not have a governance agreement with the HMIS Lead Agency, please explain why and what steps are being taken towards creating a written agreement (limit 1000 characters)

N/A

Does the HMIS Lead Agency have the following plans in place?	Data Quality Plan, Privacy Plan, Security Plan
Has the CoC selected an HMIS software product?	Yes
If 'No', select reason:	
If 'Yes', list the name of the product:	ServicePoint
What is the name of the HMIS software company?	Bowman
Does the CoC plan to change HMIS software within the next 18 months?	No

Indicate the date on which HMIS data entry started (or will start): (format mm/dd/yyyy)	05/01/2008
Indicate the challenges and barriers impacting the HMIS implementation (select all the apply):	No or low participation by non-HUD funded providers, Inadequate resources, Inadequate staffing

If CoC indicated that there are no challenges or barriers impacting HMIS implementation, briefly describe either why CoC has no challenges or how all barriers have been overcome (limit 1000 characters)

N/A

If CoC identified one or more challenges or barriers impacting HMIS implementation, briefly describe how the CoC plans to overcome them (limit 1000 characters)

No/Low Participation by non-HUD funded providers: We are still attempting to add the Rescue Mission (non-HUD funded), the largest ES in Humboldt. The Rescue Mission continues to refuse to participate despite offers to enter data for them. Because of a recent leadership change at the Rescue Mission, HHHC has high hopes that with adequate technological and data entry support the Rescue Mission will begin participating in HMIS. The Executive Committee will continue aggressive outreach to this agency.
Inadequate Resources/Inadequate Staffing: While our HMIS administration and training is fully funded, many small agencies don't have the resources necessary to enter high-quality, timely data into HMIS. HHHC has recently provided struggling agencies with computer hardware & data entry support necessary to improve HMIS data quality & timeliness. In the next year, the CoC is planning to hire additional part-time data entry specialists who can move between agencies providing data entry support.

Does the CoC lead agency coordinate with the HMIS lead agency to ensure that HUD data standards are captured?	Yes

2B. Homeless Management Information System (HMIS): Funding Sources

In the chart below, enter the total budget for the CoC's HMIS project for the current operating year and identify the funding amount for each source:

Operating Start Month/Year	January	2013
Operating End Month/Year	December	2013

Funding Type: Federal - HUD

Funding Source	Funding Amount
SHP	$84,000
ESG	$0
CDGB	$0
HOPWA	$0
HPRP	$0
Federal - HUD - Total Amount	$84,000

Funding Type: Other Federal

Funding Source	Funding Amount
Department of Education	$0
Department of Health and Human Services	$0
Department of Labor	$0
Department of Agriculture	$0
Department of Veterans Affairs	$0
Other Federal	$0
Other Federal - Total Amount	$0

Funding Type: State and Local

Funding Source	Funding Amount
City	$0
County	$35,000
State	
State and Local - Total Amount	$35,000

Funding Type: Private

Funding Source	Funding Amount
Individual	$0
Organization	$0
Private - Total Amount	$0

Funding Type: Other

Funding Source	Funding Amount
Participation Fees	$0

Total Budget for Operating Year	$119,000

Is the funding listed above adequate to fully fund HMIS? Yes

If 'No', what steps does the CoC Lead agency, working with the HMIS Lead agency, plan to take to increase the amount of funding for HMIS? (limit 750 characters)

Our CoC's HMIS is fully funded. Our funding supports an HMIS administrator, part-time data entry staff and computer hardware for agencies with insufficient resources, regular HMIS trainings, and data quality management. However, many small agencies don't have the resources necessary to enter high-quality, timely data into HMIS. HHHC is working to supply those agencies with the computer hardware and data necessary to improve HMIS data quality and timeliness.

How was the HMIS Lead Agency selected by the CoC? Agency was Appointed

If Other, explain (limit 750 characters)

As the historical CoC Lead Agency, Humboldt County Department of Health and Human Services has an unequaled amount of institutional knowledge and experience in Humboldt County homelessness and CoC management. Because of its position as a local government agency with many staff and agency oversight, DHHS has the agency capacity to manage the community-wide HMIS.

2C. Homeless Management Information Systems (HMIS) Bed and Service Volume Coverage

Instructions:

HMIS bed coverage measures the level of provider participation in a CoC's HMIS. Participation in HMIS is defined as the collection and reporting of client level data either through direct data entry into the HMIS or into an analytical database that includes HMIS data on an at least annual basis.

HMIS bed coverage is calculated by dividing the total number of year-round beds located in HMIS-participating programs by the total number of year-round beds in the Continuum of Care (CoC), after excluding beds in domestic violence (DV) programs. HMIS bed coverage rates must be calculated separately for emergency shelters, transitional housing, and permanent supportive housing.

The 2005 Violence Against Women Act (VAWA) Reauthorization bill restricts domestic violence provider participation in HMIS unless and until HUD completes a public notice and comment process. Until the notice and comment process is completed, HUD does not require nor expect domestic violence providers to participate in HMIS. HMIS bed coverage rates are calculated excluding domestic violence provider beds from the universe of potential beds.

Indicate the HMIS bed coverage rate (%) for each housing type within the CoC. If a particular housing type does not exist anywhere within the CoC, select "Housing type does not exist in CoC" from the drop-down menu:

*** Emergency Shelter (ES) beds**	65-75%
*** HPRP beds**	86%+
*** Safe Haven (SH) beds**	Housing type does not exist in CoC
*** Transitional Housing (TH) beds**	86%+
*** Rapid Re-Housing (RRH) beds**	Housing type does not exist in CoC
*** Permanent Housing (PH) beds**	86%+

How often does the CoC review or assess its HMIS bed coverage? At least Annually

If bed coverage is 0-64%, describe the CoC's plan to increase this percentage during the next 12 months:

While our bed coverage rate for most bed types is very high, our bed coverage is 65-75% for emergency shelter beds. Humboldt County is a large, rural county that has, for the most part, responded to its homeless population through small community- and faith-based organizations that receive very little, if any, government funding. Most of the agencies in Humboldt County have very limited administrative capacity, very few staff, and no or old computers. Inter-agency HMIS coordination is made difficult by the number (25 at the last count) of small agencies. To improve data quality and timeliness of data entry, over the last two years DHHS has given several agencies computers so that they would be able to participate in HMIS. For those agencies that lack the capacity to add more administrative or technological functions to already burdened jobs, DHHS has begun offering data entry assistance to facilitate HMIS participation.
Further, HHHC HMIS planning has faced resistance from faith-based organizations who are not government-affiliated, maintain strong church-state boundaries, and are thus philosophically opposed to entering data into the HMIS. The HHHC's advocacy efforts with these agencies, in particular the Eureka Rescue Mission, have increased significantly in the last year. We will continue to offer help with every aspect of HMIS implementation, including data entry and technological assistance.
Over the next 12 months, DHHS plans to hire additional part-time data entry staff to assist small, overburdened agencies. Our advocacy efforts with the Rescue Mission will continue to increase, as we believe that a recent change of leadership at the Rescue Mission may increase the likelihood of their participation. Currently 100% of HUD-funded, non-domestic violence programs enter 100% of their beds into HMIS.

2D. Homeless Management Information System (HMIS) Data Quality

Instructions:

HMIS data quality refers to the extent that data recorded in an HMIS accurately reflects the extent of homelessness and homeless services in a local area. In order for HMIS to present accurate and consistent information on homelessness, it is critical that all HMIS have the best possible representation of reality as it relates to homeless people and the programs that serve them. Specifically, it should be a CoC's goal to record the most accurate, consistent and timely information in order to draw reasonable conclusions about the extent of homelessness and the impact of homeless services in its local area. Answer the questions below related to the steps the CoC takes to ensure the quality of its data. In addition, the CoC will indicate participation in the Annual Homelessness Assessment Report (AHAR) and Homelessness Pulse project for 2011 and 2012 as well as whether or not they plan to contribute data in 2013.

Does the CoC have a Data Quality Plan in place for HMIS? Yes

What is the HMIS service volume coverage rate for the CoC?

Types of Services	Volume coverage percentage
Outreach	5%
Rapid Re-Housing	100%
Supportive Services	50%

Indicate the length of stay homeless clients remain in the housing types in the grid below. If a housing type does not apply enter "0":

Type of Housing	Average Length of Time in Housing (Months)
Emergency Shelter	5
Transitional Housing	5
Safe Haven	0

Indicate the percentage of unduplicated client records with null or missing values on a day during the last 10 days of January 2012 for each Universal Data Element below:

Universal Data Element	Records with no values (%)	Records where value is refused or unknown (%)
Name	0%	0%
Social security number	3%	5%
Date of birth	0%	2%
Ethnicity	1%	5%

Universal Data Element	Records with no values (%)	Records where value is refused or unknown (%)
Race	1%	5%
Gender	1%	1%
Veteran status	4%	5%
Disabling condition	3%	5%
Residence prior to program entry	0%	2%
Zip Code of last permanent address	3%	5%
Housing status	0%	0%
Destination	0%	5%
Head of household	1%	5%

How frequently does the CoC review the quality of project level data, including ESG? At least Monthly

Describe the process, extent of assistance, and tools used to improve data quality for agencies participating in the HMIS (limit 750 characters)

The Administrator generates weekly data quality reports, hosts HMIS compliance trainings for all case managers & trains data entry staff on data input and report generation. The HHHC Executive and HMIS Committees have begun discussions to share client-level data between agencies, which will reduce duplication of client records. In 2013, HHHC will begin to require annual “refresher” trainings for all current HMIS users and will provide advanced reporting training to improve agencies’ ability to regularly measure data quality.

How frequently does the CoC review the quality of client level data? At least Monthly

If less than quarterly for program level data, client level data, or both, explain the reason(s) (limit 750 characters)

Our HMIS administrator reviews client-level data on a rotating program-by-program basis. Client level data for each program is reviewed twice each month. However, many small agencies don’t have the resources necessary to enter high-quality, timely data into HMIS. DHHS is working to supply those agencies with the computer hardware and data necessary to improve HMIS data quality.

Does the HMIS have existing policies and procedures in place to ensure that valid program entry and exit dates are recorded in HMIS? Yes

Indicate which reports the CoC submitted usable data (Select all that apply):	None
Indicate which reports the CoC plans to submit usable data (Select all that apply):	2013 AHAR

2E. Homeless Management Information System (HMIS) Data Usage

Instructions:

CoCs can use HMIS data for a variety of applications. These include, but are not limited to, using HMIS data to understand the characteristics and service needs of homeless people, to analyze how homeless people use services, and to evaluate program effectiveness and outcomes.

In this section, CoCs will indicate the frequency in which it engages in the following.

- Integrating or warehousing data to generate unduplicated counts
- Point-in-time count of sheltered persons
- Point-in-time count of unsheltered persons
- Measuring the performance of participating housing and service providers
- Using data for program management
- Integration of HMIS data with data from mainstream resources

Additionally, CoCs will indicate if the HMIS is able to generate program level that is used to generate information for Annual Progress Reports for: HMIS, transitional housing, permanent housing, supportive services only, outreach, rapid re-housing, emergency shelters, and prevention.

Indicate the frequency in which the CoC uses HMIS data for each of the following:

Integrating or warehousing data to generate unduplicated counts:	At least Quarterly
Point-in-time count of sheltered persons:	At least Annually
Point-in-time count of unsheltered persons:	At least Annually
Measuring the performance of participating housing and service providers:	At least Annually
Using data for program management:	At least Monthly
Integration of HMIS data with data from mainstream resources:	Never

Indicate if your HMIS software is able to generate program-level reporting:

Program Type	Response
HMIS	Yes
Transitional Housing	Yes
Permanent Housing	Yes
Supportive Services only	Yes
Outreach	Yes
Rapid Re-Housing	Yes
Emergency Shelters	Yes
Prevention	Yes

2F. Homeless Management Information Systems (HMIS) Data, Technical, and Security Standards

Instructions:

In order to enable communities across the country to collect homeless services data consistent with a baseline set of privacy and security protections, HUD has published HMIS Data and Technical Standards. The standards ensure that every HMIS captures the information necessary to fulfill HUD reporting requirements while protecting the privacy and informational security of all homeless individuals.

Each CoC is responsible for ensuring compliance with the HMIS Data and Technical Standards. CoCs may do this by completing compliance assessments on a regular basis and through the development of an HMIS Policy and Procedures manual. In the questions below, CoCs are asked to indicate the frequency in which they complete compliance assessment.

For each of the following HMIS privacy and security standards, indicate the frequency in which the CoC and/or HMIS Lead Agency complete a compliance assessment:

*** Unique user name and password**	**At least Monthly**
*** Secure location for equipment**	At least Annually
*** Locking screen savers**	At least Annually
*** Virus protection with auto update**	At least Annually
*** Individual or network firewalls**	At least Annually
*** Restrictions on access to HMIS via public forums**	At least Annually
*** Compliance with HMIS policy and procedures manual**	At least Annually
*** Validation of off-site storage of HMIS data**	At least Annually

How often does the CoC Lead Agency assess compliance with the HMIS Data and Technical Standards and other HMIS Notices? At least Semi-annually

How often does the CoC Lead Agency aggregate data to a central location (HMIS database or analytical database)? At least Monthly

Does the CoC have an HMIS Policy and Procedures Manual? Yes

If 'Yes', does the HMIS Policy and Procedures manual include governance for:

HMIS Lead Agency	X
Contributory HMIS Organizations (CHOs)	X

If 'Yes', indicate date of last review or update by CoC:	07/31/2012
If 'Yes', does the manual include a glossary of terms?	No
If 'No', indicate when development of manual will be completed (mm/dd/yyyy):	09/30/2013

2G. Homeless Management Information System (HMIS) Training

Instructions:

Providing regular training opportunities for homeless assistance providers that are participating in a local HMIS is a way that CoCs can ensure compliance with the HMIS Data and Technical Standards. In the section below, CoCs will indicate how frequently they provide certain types of training to HMIS participating providers.

Indicate the frequency in which the CoC or HMIS Lead Agency offers each of the following training activities:

*** Privacy/Ethics training**	At least Monthly
*** Data security training**	At least Monthly
*** Data quality training**	At least Monthly
*** Using data locally**	At least Monthly
*** Using HMIS data for assessing program performance**	At least Monthly
*** Basic computer skills training**	At least Monthly
*** HMIS software training**	At least Monthly
*** Policy and procedures**	At least Monthly
*** Training**	At least Monthly
*** HMIS data collection requirements**	At least Monthly

2H. Continuum of Care (CoC) Sheltered Homeless Point-in-Time (PIT) Count

Instructions:

The point-in-time count assists communities and HUD towards understanding the characteristics and number of people sleeping on the streets, including places not meant for human habitation, emergency shelters, and transitional housing. Beginning in 2012, CoCs are required to conduct a sheltered point-in-time count annually. The requirement for unsheltered point-in-time counts remains every two years; however, CoCs are strongly encouraged to conduct the unsheltered point-in-time count annually. CoCs are to indicate the date of the sheltered point-in-time count and what percentage of the community's homeless services providers participated and whether there was an increase, decrease, or no change between the 2011 and 2012 sheltered counts.

CoCs will also need to indicate the percentage of homeless service providers supplying sheltered information and determining what gaps and needs were identified.

How frequently does the CoC conduct the its sheltered point-in-time count:	annually (every year)
Indicate the date of the most recent sheltered point-in-time count (mm/dd/yyyy):	01/31/2012
If the CoC conducted the sheltered point-in-time count outside the last 10 days in January, was a waiver from HUD obtained prior to January 19, 2012?	Not Applicable
Did the CoC submit the sheltered point-in-time count data in HDX by April 30, 2012?	Yes

If 'No', briefly explain why the sheltered point-in-time data was not submitted by April 30, 2012 (limit 750 characters)

N/A

Indicate the percentage of homeless service providers supplying sheltered population and subpopulation data for the point-in-time count that was collected via survey, interview and HMIS:

Housing Type	Observation	Provider Shelter	Client Interview	HMIS
Emergency Shelters	20%	20%		60%
Transitional Housing				100%
Safe Havens				100%

Comparing the 2011 and 2012 sheltered point-in-time counts, indicate if there was an increase, decrease, or no change and describe the reason(s) for the increase, decrease, or no change (limit 750 characters)

The 2012 sheltered point-in-time count counted 14 fewer sheltered persons than in 2011. Bridge House Annex, a TH program for families with children with 27 beds, was closed for renovations in January 2012, which reduced the number of available TH beds. However, agencies in our CoC work together closely to ensure that persons in need of housing locate appropriate housing and services. Our CoC is steadily developing new PH beds, and our HPRP program has been extremely successful in swiftly housing families in need of short-term assistance. We believe that many people who would have been housed in a TH program or ES have instead been successfully housed and stabilized through HPRP over the past several years.

Based on the sheltered point-in-time information gathered, what gaps/needs were identified in the following:

Need/Gap	Identified Need/Gap (limit 750 characters)
*** Housing**	Though meeting the needs of families with children remains a community priority as we transition out of HPRP, the 2012 sheltered point-in-time count highlighted the need for increased permanent supportive housing for households without children. Permanent supportive housing for veterans in particular is a need that we are working actively to meet: in 2012, our advocacy efforts yielded 25 new HUD-VASH beds, and the North Coast Veterans Resource Center continues to be an active member of the HHHC Executive Committee.
*** Services**	Because our CoC is largely rural, it is more difficult for people experiencing homelessness in the more remote southern region of the CoC to access services. To address this problem, in 2012 our Mobile Outreach unit added case managers and clinicians to its staff, and expanded its services to the outlying areas of the CoC. As a result of new state corrections policy under AB 109, in 2012 our CoC saw an influx of persons being discharged from corrections facilities. This population in particular needs substance abuse treatment and employment services, which they access through the Community Corrections Reporting Center.
*** Mainstream Resources**	Because the size of families in shelter nearly doubled between 2011 and 2012 (2.1 persons per family in 2011 to 3.5 in 2012), mainstream resources for families and children continued to be a priority. HHHC agencies assisted families with children to apply for benefits for which they are eligible, including SSI/SSDI, SNAP, Medicaid, and child care subsidies, and offer employment training and job search assistance. Because the number of veterans in transitional housing also increased, the HHHC redoubled existing efforts to connect veterans with VA benefits and VA Medical Services.

2I. Continuum of Care (CoC) Sheltered Homeless Population & Subpopulations: Methods

Instructions:

Accuracy of the data reported in the sheltered point-in-time count is vital. Data produced from these counts must be based on reliable methods and not on "guesstimates." CoCs may use one or more method(s) to count sheltered homeless persons. This form asks CoCs to identify and describe which method(s) were used to conduct the sheltered point-in-time count. The description should demonstrate how the method(s) was used to produce an accurate count.

Indicate the method(s) used to count sheltered homeless persons during the 2012 point-in-time count (Select all that apply):

Survey providers:	X
HMIS:	X
Extrapolation:	
Other:	

If Other, specify:

N/A

Describe the methods used by the CoC, based on the selection(s) above, to collect data on the sheltered homeless population during the 2012 point-in-time count. Response should indicate how the method(s) selected were used to produce accurate data (limit 1500 characters)

For providers that participate in HMIS, which include nearly all of our emergency shelter and transitional housing programs, we informed all programs in advance about the date of the sheltered count. All programs were instructed to review their HMIS data on that date for accuracy. The HMIS administrator then constructed an HMIS report to provide data on the number of persons in emergency shelter and transitional housing on the night of the count. The HMIS administrator ran a test report, which she reviewed for potential data quality problems. Programs with data quality problems corrected their HMIS data. When the HMIS was fully accurate for the night of the count, the HMIS administer ran a final report.

For providers that do not participate in HMIS (namely the Eureka Rescue Mission, the largest emergency shelter in Humboldt County), the HHHC conducted extensive outreach to collect occupancy data for the night of the count. These providers relied on observation, knowledge of clients and case files to provide a sheltered count.

2J. Continuum of Care (CoC) Sheltered Homeless Population and Subpopulation: Data Collection

Instructions:

CoCs are required to produce data on seven subpopulations. These subpopulations are: chronically homeless, severely mentally ill, chronic substance abuse, veterans, persons with HIV/AIDS, victims of domestic violence, and unaccompanied youth (under 18). Subpopulation data is required for sheltered homeless persons. Sheltered chronically homeless persons are those living in emergency shelters only.

CoCs may use a variety of methods to collect subpopulation information on sheltered homeless persons and may utilize more than one in order to produce the most accurate data. This form asks CoCs to identify and describe which method(s) were used to gather subpopulation information for sheltered populations during the most recent point-in-time count. The description should demonstrate how the method(s) was used to produce an accurate count.

Indicate the method(s) used to gather and calculate subpopulation data on sheltered homeless persons (select all that apply):

HMIS	X
HMIS plus extrapolation:	
Sample of PIT interviews plus extrapolation:	
Sample strategy:	
Provider expertise:	X
Interviews:	
Non-HMIS client level information:	
None:	
Other:	

If Other, specify:

N/A

Describe the methods used by the CoC, based on the selection(s) above, to collect data on the sheltered homeless subpopulations during the 2012 point-in-time count. Response should indicate how the method(s) selected were used in order to produce accurate data on all of the sheltered subpopulations (limit 1500 characters)

Nearly all of our emergency shelter and transitional housing programs input data into HMIS, including chronically homeless, veteran, and disability status. HMIS data quality is checked twice monthly for all programs. All programs were instructed that all subpopulation data for the night of the count must be input promptly. The HMIS administrator reviewed the data, and data quality problems were addressed before the final count was generated.

Providers that do not participate in HMIS (in particular, the Eureka Rescue Mission) were interviewed by the HHHC, and reported subpopulation data based on case files and provider knowledge of clients.

For our 2013 count, our CoC will also use interviews and surveys to determine subpopulation data for both the sheltered and unsheltered population.

2K. Continuum of Care (CoC) Sheltered Homeless Population and Subpopulation: Data Quality

Instructions:

The data collected during point-in-time counts is vital for CoCs and HUD. Communities need accurate data to determine the size and scope of homelessness at the local level to plan services and programs that will appropriately address local needs and measure progress in addressing homelessness. HUD needs accurate data to understand the extent and nature of homelessness throughout the country and to provide Congress and OMB with information regarding services provided, gaps in service, performance, and funding decisions. It is vital that the quality of data reported accurate and of high quality. CoCs may undertake once or more actions to improve the quality of the sheltered population data.

Indicate the method(s) used to verify the data quality of sheltered homeless persons (select all that apply):

Instructions:	
Training:	
Remind/Follow-up	X
HMIS:	X
Non-HMIS de-duplication techniques:	X
None:	
Other:	

If Other, specify:

N/A

If selected, describe the non-HMIS de-duplication techniques used by the CoC to ensure the data quality of the sheltered persons count (limit 1000 characters)

Our CoC used HMIS reports for the sheltered point-in-time homeless count, because HMIS data is easily de-duplicated. To doubly ensure that no person was counted twice, after the sheltered count our HMIS administrator manually reviewed the unique identifiers assigned by HMIS for each person counted. For the Rescue Mission, which does not participate in HMIS, Rescue Mission staff knew the individuals present on the night of the count and verified that they were not duplicated.

Based on the selections above, describe the methods used by the CoC to verify the quality of data collected on the sheltered homeless population during the 2012 point-in-time count. The response must indicate how each method selected above was used in order to produce accurate data on all of the sheltered populations
(limit 1500 characters)

Remind/Follow-Up: All CoC programs were informed about the sheltered point-in-time count in advance. After the count, programs were required to review HMIS data from the night of the count for accuracy. Because most of the agencies in our CoC are very small, emergency shelter and transitional housing providers are very familiar with the individuals and families they serve, which contributes to accurate data. Our HMIS administrator followed up with programs that showed potential data quality problems to ensure accurate HMIS data.

HMIS: Our CoC uses PIT data to perform gaps analyses and inform the CoC planning process, so high-quality PIT data is essential to our community process. Our bed coverage rate for all housing types is very high, so our CoC used HMIS as a major piece of the 2012 sheltered count in order to minimize duplicate counting.

Non-HMIS De-Duplication Techniques: Our CoC used HMIS reports for the sheltered point-in-time homeless count, because HMIS data is easily de-duplicated. To doubly ensure that no person was counted twice, after the sheltered count our HMIS administrator manually reviewed the unique identifiers assigned by HMIS for each person counted.

2L. Continuum of Care (CoC) Unsheltered Homeless Point-in-Time (PIT) Count

Instructions:

The unsheltered point-in-time count assists communities and HUD towards understanding the characteristics and number of people sleeping on the streets, including places not meant for human habitation. CoCs are required to conduct an unsheltered point-in-time count every two years (biennially); however, CoCs are strongly encouraged to conduct the unsheltered point-in-time count annually. CoCs are to indicate the date of the last unsheltered point-in-time count and whether there was an increase, decrease, or no change between the last point-in-time count and the last official point-in-time count conducted in 2011.

How frequently does the CoC conduct an unsheltered point-in-time count?	biennially (every other year)
Indicate the date of the most recent unsheltered point-in-time count (mm/dd/yyyy):	01/25/2011
If the CoC conducted the unsheltered point-in-time count outside the last 10 days in January, was a waiver from HUD obtained prior to January 19, 2011 or January 19, 2012?	Not Applicable
Did the CoC submit the unsheltered point-in-time count data in HDX by April 30, 2012?	No

If 'No', briefly explain why the unsheltered point-in-time data was not submitted by April 30, 2011 (limit 750 characters)

We did not conduct an unsheltered point-in-time count in 2012. Most of the agencies in our CoC are very small and have few resources, which makes it impractical for us to conduct a labor- and resource-intensive full point-in-time count on an annual basis.

Comparing the 2011 unsheltered point-in-time count to the last unsheltered point-in-time count, indicate if there was an increase, decrease, or no change and describe the reason(s) for the increase, decrease, or no change (limit 750 characters)

We had a decrease of 397 unsheltered persons from 2009 to 2011 (we did not conduct an unsheltered PIT in 2012): 1. Many ES and voucher programs were at capacity in 2011 that were below capacity in 2009. (We did not conduct a 2010 count.)
2. In 2011 we had 234 HPRP beds that were unavailable in 2009, which contributed to the decrease in unsheltered persons. 3. The weather during our 2011 count was much sunnier than in 2009. We believe this encouraged more people to leave their camps, as we encountered a number of empty camps that were clearly inhabited most of the time. Because Humboldt is a very rural, heavily forested community, when unsheltered persons leave their camps it is very difficult to locate them.

2M. Continuum of Care (CoC) Unsheltered Homeless Population and Subpopulation: Methods

Instructions:

Accuracy of the data reported in point-in-time counts is vital. Data produced from these counts must be based on reliable methods and not on "guesstimates." CoCs may use one or more methods to count unsheltered homeless persons. This form asks CoCs to identify which method(s) they use to conduct their point-in-time counts and whether there was an increase, decrease, or no change between 2011 and the last unsheltered point-in-time count.

Indicate the method(s) used to count unsheltered homeless persons during the 2011 or 2012 point-in-time count (select all that apply):	
Public places count:	X
Public places count with interviews on the night of the count:	X
Public places count with interviews at a later date:	
Service-based count:	X
HMIS:	X
Other:	
None:	

If Other, specify:

N/A

Describe the methods used by the CoC based on the selections above to collect data on the unsheltered homeless populations and subpopulations during the most recent point-in-time count. Response should indicate how the method(s) selected above were used in order to produce accurate data on all of the unsheltered populations and subpopulations (limit 1500 characters)

Public Places Count with Interviews on the Night of the Count: Volunteers approached known homeless camps, where the majority of our unsheltered population reside, on the day of the count to count residents.
Service-Based Count: Homeless people were surveyed at soup kitchens and day centers where many unsheltered homeless people congregate during the day, as well as outdoor public areas where homeless people are known to congregate. Our survey includes the question, “Have you already filled out this survey within the last 24 hours?” to allow potentially duplicated persons to self-identify.
HMIS: After the count, we hired a consultant to analyze the data, generate reports, and compare unique identifiers, ensuring that only one survey was collected from each respondent.
Because we recognize the importance of good data for effective strategic planning and advocacy, in 2011 we hired a Point-In-Time coordinator to design our training. To ensure that our figures were not duplicated, each respondent was given a unique identifier, which consisted of the first two letters of his/her last name and the date of birth. Volunteers received training to ensure that an accurate unique identifier was assigned to each person.

2N. Continuum of Care (CoC) Unsheltered Homeless Population and Subpopulation: Level of Coverage

Instructions:

CoCs may utilize several methods when counting unsheltered homeless persons. CoCs need to determine what area(s) they will go to in order to count this population. For example, CoCs may canvas an entire area or only those locations where homeless persons are known to sleep. CoCs are to indicate the level of coverage incorporated when conducting the unsheltered count.

Indicate where the CoC located the unsheltered homeless persons (level of coverage) that were counted in the last point-in-time count:	A Combination of Locations

If Other, specify:

N/A

2O. Continuum of Care (CoC) Unsheltered Homeless Population and Subpopulation: Data Quality

Instructions:

The data collected during point-in-time counts is vital for CoCs and HUD. Communities need accurate data to determine the size and scope of homelessness at the local level to plan services and programs that will appropriately address local needs and measure progress in addressing homelessness. HUD needs accurate data to understand the extent and nature of homelessness throughout the country and to provide Congress and OMB with information regarding services provided, gaps in service, performance, and funding decisions. It is vital that the quality of data reported is accurate and of high quality. CoCs may undertake one or more actions to improve the quality of the sheltered population data.

All CoCs should engage in activities to reduce the occurrence of counting unsheltered persons more than once during the point-in-time count. The strategies are known as de-duplication techniques. De-duplication techniques should always be implemented when the point-in-time count extends beyond one night or takes place during the day at service locations used by homeless persons that may or may not use shelters. CoCs are to describe de-duplication techniques used in the point-in-time count. CoCs are also asked to describe outreach efforts to identify and engage homeless individuals and families.

Indicate the steps taken by the CoC to ensure the quality of the data collected for the unsheltered population count (select all that apply):

Training:	X
HMIS:	X
De-duplication techniques:	X
"Blitz" count:	
Unique identifier:	X
Survey question:	X
Enumerator observation:	
Other:	

If Other, specify:

N/A

Describe the techniques, as selected above, used by the CoC to reduce the occurrence of counting unsheltered homeless persons more than once during the most recent point-in-time count (limit 1500 characters)

Recognizing the importance of good data for effective strategic planning and advocacy, our 2011 PIT was very comprehensive.
Training: Volunteers received training to ensure that an accurate unique identifier was assigned to each person and that volunteers understood how to accurately collect subpopulation data.
De-duplication techniques/unique identifier: In an effort to ensure that our figures were not duplicated, each respondent was given a unique identifier, which consisted of the first two letters of his/her last name and the date of birth. After the count, we hired a consultant to analyze the data, generate reports, and compare unique identifiers, ensuring that only one survey was collected from each respondent.
Survey question: For the point-in-time unsheltered homeless count, homeless people were surveyed at soup kitchens and day centers where many unsheltered homeless people congregate during the day, as well as outdoor public areas of Eureka and Arcata where homeless people are known to congregate.

Describe the CoCs efforts to reduce the number of unsheltered homeless households with dependent children. Discussion should include the CoCs outreach plan
(limit 1500 characters)

Provide Housing: There is a CoC-wide effort to reduce the number of homeless families with children by providing a full spectrum of housing. Our first priority is to return families to PH as soon as possible, but we must also address immediate needs. In the current declining economy, we work to sustain current beds & add beds when possible. Each year, TH programs MAC & Arcata House TH serve a total of 95 families. While our HPRP program was active, it enjoyed tremendous success housing families. In 2013, HHHC is coordinating to bring in ESG dollars for rapid rehousing and homeless prevention.
Outreach: In our rural, geographically isolated CoC, outreach is essential to assisting homeless families in outlying areas. Our very active McKinney Homeless Education Liaison works with homeless families with school-aged children. We leverage strong connections between individual agencies to coordinate the best placement for families in need. County child welfare workers refer homeless families with children to services. County Social Services distributes homeless service & housing information to anyone who may need it. Open Doors Community Health Center outreach staff connect unsheltered households with basic services housing. WISH reaches out to homeless families in remote areas. The Resource Centers also act as outreach to homeless families. All of the Family Resources Centers refer clients to homeless housing & services.

Describe the CoCs efforts to identify and engage persons that routinely sleep on the streets or other places not meant for human habitation
(limit 1500 characters)

Outreach: Many service providers in the community provide outreach to homeless persons on the streets or in homeless encampments. Mobile Medical Office, Humboldt County Social Services, North Coast Veterans Resource Center, and the Arcata Night Shelter all have outreach staff who engage homeless and chronically homeless people & provide basic services & access to other services and housing. Target Specific Populations: DHHS Outreach Services program reaches out to and serves CH individuals in the remote areas of the County. One area is a college community with many homeless youth; RCAA's Raven Project reaches out to homeless street youth ages 14-21. The County AIDS program has 2 mobile outreach vans staffed by community health workers who connect homeless individuals to resources, housing, benefits, food, and health education.
Street/Encampment Outreach: New Directions is a non-adversarial, harm reduction approach to individuals living in encampments, offering resources and engaging people where they are. The Family Resource Centers, and the Veteran's Stand Down all act as outreach to persons sleeping on the streets.
Law Enforcement Support: The Eureka Police Department has hired a Homeless Liaison who reaches out to persons that are sleeping on the street, referring them to appropriate services. The Liaison has been working in homeless services for many years and is very familiar with homeless services and effective outreach models.

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 1: Create new permanent housing beds for chronically homeless persons.

Instructions:

Ending chronic homelessness continues to be a HUD priority. CoCs can do this by creating new permanent housing beds that are specifically designated for this population.

CoCs will enter the number of permanent housing beds expected to be in place in 12 months, 5 years, and 10 years. These future estimates should be based on the definition of chronically homeless.

CoCs are to describe the short-term and long-term plans for creating new permanent housing beds for chronically homeless individuals and families who meet the definition of chronically homeless. CoCs will also indicate the current number of permanent housing beds designated for chronically homeless individuals and families. This number should match the number of beds reported in the FY2012 Housing Inventory Count (HIC) and entered into the Homeless Data Exchange (HDX).

How many permanent housing beds are currently in place for chronically homeless persons?	33
In 12 months, how many permanent housing beds designated for chronically homeless persons are planned and will be available for occupancy?	38
In 5 years, how many permanent housing beds designated for chronically homeless persons are planned and will be available for occupancy?	50
In 10 years, how many permanent housing beds designated for chronically homeless persons are planned and will be available for occupancy?	70

Describe the CoC's short-term (12 month) plan to create new permanent housing beds for persons who meet HUD's definition of chronically homeless
(limit 1000 characters)

Identify CoC Needs: Exec Cmte annually reviews PIT, HIC, & HMIS data to determine the current need for CH beds.
Maximize Funding Opportunities: Each year the HHHC works through Exec Cmte to identify agencies to apply for CoC Bonus Funding for CH beds. The Exec Cmte monitors other available funding opportunities & communicates them to the CoC.
Support Housing Development: The Exec Cmte assists recipients with site control, leverage & community support at the BoS & other planning meetings. If a new proposal encounters barriers, the Exec Cmte works to address those issues or, if needed, with another HHHC member to subsume the project/grant. In 2012, the HHHC worked with Housing Humboldt, a 2010 CoC recipient, to amend their original project design to better suit CoC needs. Those 5 CH beds will become available in 2013. Additionally, Housing Humboldt & DHHS are developing 12-18 CH beds for individuals funded by the Mental Health Services Act, to become available in 2013 or early 2014.

Describe the CoC's long-term (10 year) plan to create new permanent housing beds for persons who meet HUD's definition of chronically homeless
(limit 1000 characters)

Providing PSH to prevent & end CH is a priority in our 10-Year Plan. In 2012, HHHC General Meetings included regular discussions about continuing to divert non-CoC funding away from emergency responses toward strategic development of PSH for CH persons. Action steps include:
1) Systematically identify funding: EC monitors funding availability from a variety of sources including CoC bonus/reallocated funding, THP+, MHSA, & SAMSHA.
2) Prioritize funding for CH: Scoring tool used to annually review all CoC projects gives additional points to projects serving CH persons.
3) Support housing development: EC supports development of CH beds by coordinating local approvals, finding/providing leverage, & reviewing proposals before submission. When an agency receives funding, EC provides TA to secure the project's successful operation. If a grantee is unable to operate a CH project even with CoC assistance, EC will locate another agency to subsume the grant rather than lose the CH beds.

Describe how the CoC, by increasing the number of permanent housing beds for chronically homeless, will obtain the national goal of ending chronic homelessness by the year 2015
(limit 1000 characters)

Increasing the available PSH to house CH persons is a priority in our ten-year plan. Each year the number of CH beds in our CoC increases, Our outcomes for keeping this population housed exceed HEARTH goals (PH participants in our CoC remain housed, on average, over 2 years.) As the number of CH beds rises, we will continue to keep people stable in housing long-term by providing services tailored to each individual's need and connecting participants with mainstream resources. While providing sufficient CH housing is an essential piece of ending chronic homelessness, HHHC recognizes that preventing CH in the first place is essential. Under the Housing and Shelter Committee, HHHC members connect participants in ES, TH, and PSH to mainstream resources, MH and substance abuse treatment, employment, and life skills training. The Discharge Planning Task Force coordinates with public institutions to prevent discharge into homelessness.

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 2: Increase the percentage of participants remaining in CoC funded permanent housing projects for at least six months to 80 percent or more.

Instructions:

Increasing self-sufficiency and stability of permanent housing program participants is an important outcome measurement of HUD's homeless assistance programs. Each CoC-funded permanent housing project is expected to report the percentage of participants remaining in permanent housing for more than six months on its Annual Performance Report (APR). CoCs then use this data from all of its permanent housing projects to report on the overall CoC performance on form 4C. Continuum of Care (CoC) Housing Performance.

In this section, CoCs will indicate the current percentage of participants remaining in these projects, as indicted on form 4C. as well as the expected percentage in 12 months, 5 years, and 10 years. CoCs that do not have any CoC-funded permanent housing projects for which an APR was required should indicate this by entering "0" in the numeric fields and note that this type of project does not exist in the CoC in the narratives. CoCs are then to describe short-term and long-term plans for increasing the percentage of participants remaining in all of its CoC-funded permanent housing projects (SHP-PH or S+C) to at least 80 percent.

What is the current percentage of participants remaining in CoC-funded permanent housing projects for at least six months?	86%
In 12 months, what percentage of participants will have remained in CoC-funded permanent housing projects for at least six months?	88%
In 5 years, what percentage of participants will have remained in CoC-funded permanent housing projects for at least six months?	90%
In 10 years, what percentage of participants will have remained in CoC-funded permanent housing projects for at least six months?	92%

Describe the CoCs short-term (12 month) plan to increase the percentage of participants remaining in CoC-funded permanent housing projects for at least six months to 80 percent or higher (limit 1000 characters)

Our CoC has already achieved 94% of people in PH remaining at least 6 months (3 of 35 people served had not been enrolled 6 months at APR submission). Our plan is to sustain our current success through the following strategies:
1) Invest in landlords: HHHC providers develop longstanding relationships with landlords, and intervene immediately to mitigate any potential problems.
2) Provide intensive support to participants in housing programs. Because our PH programs are small (Apartments First! is the largest, with 24 beds; Humboldt Housing offers 5 beds, and Project HART 4 beds), participants receive an extraordinary amount of one-on-one support from dedicated program staff. Apartments First! has strong partnerships with mental health and AOD service providers; as part of our integrated DHHS, Humboldt Housing and Project HART both have instant connections to the wide range of supports that the County offers.
3) Continue to explore new best practices.

Describe the CoCs long-term (10 year) plan to increase the percentage of participants remaining in CoC-funded permanent housing projects for at least six months to 80 percent or higher (limit 1000 characters)

Our CoC has surpassed HUD's goal. Apartments First!, the only PH project that has been operating for more than a year, has achieved an average length of stay of 2 years; 71% of Apartments First!'s participants have been stably housed for 2-5 years and remain in the project. Our long-term plan is to:
- Sustain our current success (see above); and
- Increase how long people remain in PH. We will achieve this goal through the following action steps: 1) Continue to invest in the Executive Committee's strong relationship with the Housing Authority (Executive Committee member) to coordinate moving CoC clients onto Sec. 8 once needs decrease; 2) connecting people to mainstream services; 3) developing resources to support an eviction prevention attorney; & 4) ensuring that PH providers focus on a client-driven service plan so that housing, income & service needs are addressed as part of a coordinated package of care, enhancing long-term housing stability, self-sufficiency, & quality of life.

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 3: Increase the percentage of participants in CoC-funded transitional housing that move into permanent housing to 65 percent or more.

Instructions:

The transitional housing objective is to help homeless individuals and families obtain permanent housing and self-sufficiency. Each transitional housing project is expected to report the percentage of participants moving to permanent housing on its Annual Performance Report h(APR). CoCs then use this data from all of the CoC-funded transitional housing projects to report on the overall CoC performance on form 4C. Continuum of Care (CoC) Housing Performance.

In this section, CoCs will indicate the current percentage of transitional housing project participants moving into permanent housing as indicated on from 4C. as well as the expected percentage in 12 months, 5 years, and 10 years. CoCs that do not have any CoC funded transitional housing projects for which an APR was required should enter "0" in the numeric fields below and note that this type of housing does not exist in the narratives. CoCs are then to describe short-term and long-term plans for increasing the percentage of participants who move from transitional housing projects into permanent housing to at least 65 percent or more.

What is the current percentage of participants in CoC-funded transitional housing projects will have moved to permanent housing?	31%
In 12 months, what percentage of participants in CoC-funded transitional housing projects will have moved to permanent housing?	65%
In 5 years, what percentage of participants in CoC-funded transitional housing projects will have moved to permanent housing?	70%
In 10 years, what percentage of participants in CoC-funded transitional housing projects will have moved to permanent housing?	75%

Describe the CoCs short-term (12 month) plan to increase the percentage of participants in CoC-funded transitional housing projects that move to permanent housing to 65 percent or more (limit 1000 characters)

Our short term plan is to:
1) Support TH programs in restructuring: During the 2012 monitoring process, the Executive Committee identified Crossroads and MAC as needing to redesign their program structure to better achieve HEARTH goals. In the past several years, Crossroads has transitioned from sending most clients to other treatment programs in its agency within 90 days to focusing on achieving housing stability and connecting people to PH. In 2013, the Exec Cmte is working with Crossroads to use AOD treatment and TH best practices to increase movement to PH. MAC, historically a easy-admission program with many participation requirements, is working with the Exec Cmte to re-examine its admissions criteria and program rules.
2) Increase client self-sufficiency: Housing and Shelter Committee will continue to work with Crossroads, MAC, and Launch Pad to improve client self-sufficiency through access to mainstream benefits, improved financial literacy, and individualized case plans.

Describe the CoCs long-term (10 year) plan to increase the percentage of participants in CoC-funded transitional housing projects that move to permanent housing to 65 percent or more
(limit 1000 characters)

Our long-term plan is to:
1) Continue to support existing TH projects to move clients to PH.
2) Implement transition-in-place: Housing and Shelter Committee, in partnership with Arcata House, is working with TH providers to implement a transition-in-place model for those clients who are able to live more independently.
3) Secure rapid rehousing funding: HHHC hopes to receive ESG funding for rapid rehousing in 2013; based on knowledge gained during the tenure of our successful HPRP program, our coordinated assessment system will divert those who need less intensive supports to rapid rehousing, and those who benefit from a longer-term, more structured environment to transitional housing.
4) Continue connecting clients with mainstream resources: The staff of the DHHS Mental Health Branch and the staff and volunteers of Hope Center will provide supportive services to these clients to help them be successful after leaving transitional housing into their own apartments.

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 4: Increase percentage of participants in all CoC-funded projects that are employed at program exit to 20 percent or more.

Instructions:

Employment is a critical step for homeless persons to achieve greater self-sufficiency, which represents an important outcome that is reflected both in participants' lives and the health of the community. Each CoC-funded project (excluding HMIS dedicated only projects) is expected to report the percentage of participants employed at exit on its Annual Performance Report (APR). CoCs then use this data from all of its non-HMIS projects to report on the overall CoC performance on form 4D. Continuum of Care (CoC) Cash Income.

In this section, CoCs will indicate the current percentage of project participants that are employed at program exit, as reported on 4D, as well as the expected percentage in 12 months, 5 years, and 10 years. CoCs that do not have any CoC-funded non-HMIS dedicated projects (permanent housing, transitional housing, or supportive services only) for which an APR was required should enter "0" in the numeric fields below and note in the narratives. CoCs are to then describe short-term and long-term plans for increasing the percentage of all CoC-funded program participants that are employed at program exit to 20 percent or more.

What is the current percentage of participants in all CoC-funded projects that are employed at program exit?	11%
In 12 months, what percentage of participants in all CoC-funded projects will be employed at program exit?	20%
In 5 years, what percentage of participants in all CoC-funded projects will be employed at program exit?	25%
In 10 years, what percentage of participants in all CoC-funded projects will be employed at program exit?	30%

Describe the CoCs short-term (12 month) plan to increase the percentage of participants in all CoC-funded projects that are employed at program exit to 20 percent or more
(limit 1000 characters)

The persistent 9.5% unemployment rate (2% higher than the national average) for the last several years has made it difficult to achieve our typical high employment outcomes. We are a largely rural CoC, geographically isolated from large population centers (the nearest large city is 277 miles away). Particularly in the rural southern area of the county, employment opportunities are scarce. Many clients must rely on reduced public transportation to reach far-away jobs.
Our short-term plan is to:
1) Improve transportation: The Exec Cmte annually advocates with local government to provide transportation and bus passes for working clients,
2) Improve childcare access: The Exec Cmte will advocate for increased childcare services available at Changing Tides and North Coast Child Services
3) Improve access to employment training: The Exec Cmte will maintain its strong relationships with the Dept. of Rehab and the Job Market to improve client access to countywide opportunities.

Describe the CoCs long-term (10 year) plan to increase the percentage of participants in all CoC-funded projects who are employed at program exit to 20 percent or more
(limit 1000 characters)

Our long term plan is to:
1) Leverage available resources: DHHS (the Collaborative Applicant) operates the Job Market, a one-stop employment services center with staff from 30 partners including the County Office of Education, the Employment Development Department of DHHS, Eureka Adult School, CalWORKs, and Experience Works. Clients in CoC-funded projects are connected with the services available through the Job Market, which include training, vocational counseling, and job search assistance.
2) Advocate for expanded childcare slots at Changing Tides and North Coast Child Services for homeless people involved in education and employment.
3) Enhance linkages between employment programs and the overall service system to increase homeless people's access to services necessary to access employment.

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 5: Increase the percentage of participants in all CoC-funded projects that obtained mainstream benefits at program exit to 20% or more.

Instructions:

Access to mainstream resources is a critical step for homeless persons to achieve greater self-sufficiency, which represents an important outcome that is reflected both in participants' lives and the health of the community. Each CoC-funded project (excluding HMIS dedicated only projects) is expected to report the percentage of participants who received mainstream resources by exit on its Annual Performance Report (APR). CoCs then use this data from all of its non-HMIS projects to report on the overall CoC performance on form 4E. Continuum of Care (CoC) Non-Cash Benefits.

In this section, CoCs will indicate the current percentage of project participants who received mainstream resources by program exit, as reported on 4E, as well as the expected percentage in 12 months, 5 years, and 10 years. CoCs that do not have any CoC-funded non-HMIS dedicated projects (permanent housing, transitional housing, or supportive services only) for which an APR was required should enter "0" in the numeric fields below and note in the narratives. CoCs are to then describe short-term and long-term plans for increasing the percentage of all CoC-funded program participants who received mainstream resources by program exit to 20 percent or more.

What is the current percentage of participants in all CoC-funded projects that receive mainstream benefits at program exit?	74%
in 12 months, what percentage of participants in all CoC-funded projects will have mainstream benefits at program exit?	75%
in 5 years, what percentage of participants in all CoC-funded projects will have mainstream benefits at program exit?	80%
in 10 years, what percentage of participants in all CoC-funded projects will have mainstream benefits at program exit?	90%

Describe the CoCs short-term (12 months) plan to increase the percentage of participants in all CoC-funded projects that receive mainstream benefits at program exit to 20% or more (limit 1000 characters)

Our CoC achieved 74% of participants receiving mainstream benefits at exit, which far exceeds HUD's goal. Our short-term plan is to sustain our current success by:
1) Supporting TH programs in restructuring: In the MAC, which accounts for 83% of the CoC's exiting participants, 84% of clients remain for less than 6 months. As part of MAC's restructuring process, participants will stay longer; program staff will focus on connecting clients with employment, SSI/SSDI, and other long-term mainstream benefits to enhance self-sufficiency.
2) Continuing to leverage the assistance of our integrated DHHS: DHHS connects people with a variety of resources upon entry to any DHHS program
3) Taking advantage of C4Yourself, our county's electronic benefits application system, which allows clients to apply for food stamps, CalWORKS, CMSP, and MediCal with a single application.
4) Using new Path 2 Health LIHP to provide healthcare for very low-income single adults who do not qualify for MediCal.

Describe the CoCs long-term (10-years month) plan to increase the percentage of participants in all CoC-funded projects that receive mainstream benefits at program exit to 20% or more (limit 1000 characters)

Because our CoC dramatically exceeds the goal of 20% of participants exiting CoC-funded projects with mainstream benefits, our long-term plan is to retain and build upon our current success. We will:
1) Monitor program performance: The Executive Committee will continue to monitor mainstream benefits access on at least an annual basis through the Review and Rank process, during which CoC programs are scored on their success connecting participants to mainstream benefits.
2) Focus on increasing access to long-term benefits, such as SSI/SSDI and employment. In 2013, the Executive Committee will consider the possibility of bringing SOAR training to our CoC to improve SSI/SSDI access. DHHS will continue to work toward removing barriers to employment by providing transportation and childcare options for homeless people engaged in employment activities and education.

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 6: Decrease the number of homeless individuals and families:

Instructions:

Ending homelessness among households with children, particularly for those households living on the streets or other places not meant for human habitation, is an important HUD priority. CoCs can accomplish this goal by creating new beds and/or providing additional supportive services for this population.

In this section, CoCs are to describe short-term and long-term plans for decreasing the number of homeless households with children, particularly those households that are living on the streets or other places not meant for human habitation. CoCs will indicate the current total number of households with children that was reported on their most recent point-in-time count. CoCs will also enter the total number of homeless households with children they expect to report on in the next 12 months, 5 years, and 10 years.

What is the current total number of homeless households with children as reported on the most recent point-in-time count?	105%
In 12 months, what will be the total number of homeless households with children?	100%
In 5 years, what will be the total number of homeless households with children?	95%
In 10 years, what will be the total number of homeless households with children?	90%

Describe the CoCs short-term (12 month) plan to decrease the number of homeless households with children (limit 1000 characters)

Homeless families are a top HHHC priority. Because of our successful HPRP program, we anticipate that the number of homeless families will decrease in the 2013 PIT. Our short-term plan is to build on current success by:
1) Securing rapid rehousing funding: ESG Committee is working to continue HPRP's success with ESG rapid rehousing funding in 2013.
2) Intervening immediately for homeless households: MAC, Apartments First!, & Launch Pad (CoC-funded programs that serve families) coordinate with our active McKinney Education Coordinator to assist homeless families with children.
3) Continuing outreach: In our geographically isolated CoC, outreach is essential to assisting homeless families in outlying areas. Open Doors Community Health Services runs a mobile unit in a converted RV, staffed with MH clinicians & case managers, which travels to remote locations and connects people with housing & services; case managers assist people to apply for public benefits electronically on site.

Describe the CoCs long-term (10 year) plan to decrease the number of homeless households with children
(limit 1000 characters)

Our long-term plan is to build on our success by
1) Enhancing long-term family stability: MAC, a TH program that serves families, will serve families for longer periods of time to increase stability, which will in turn increase access to PH at exit. MAC, Apartments First! & Launch Pad will focus on connecting families with stable, long-term sources of income, such as SSI/SSDI & employment. All HHHC agencies will continue to use our self-sufficiency calculator, which assists providers to gauge the services a family needs to avoid homelessness.
2) Investing in rapid rehousing: The ESG Cmte will build on our successful HPRP program by securing ESG funding for rapid rehousing for families & will monitor recipient performance to ensure ongoing success.
3) Increasing affordable housing stock: The Housing & Shelter Cmte will continue to work with developers to designate new affordable housing units for families and increase family access to education, job training, & job opportunities.

3A. Continuum of Care (CoC) Strategic Planning Objectives

Objective 7: Intent of the CoC to reallocate Supportive Services Only (SSO) and Transitional Housing (TH) projects to create new Permanent Housing (PH) projects.

Instructions:

CoCs have the ability to reallocate poor performing supportive services only and transitional housing projects to create new permanent supportive housing, rapid re-housing, or HMIS projects during each competition. Reallocation of poor performing projects can be in part or whole as the CoC determines.

CoCs will indicate if they intend to reallocate projects during this year's competition and if so, indicate the number of projects being reallocated (in part or whole) and if reallocation will be used as an option to create new permanent supportive housing, rapid re-housing, or HMIS projects in the next year, next two years, and next three years. If the CoC does not intend to reallocation it should enter '0' in the first section.

If the CoC does intend to reallocate projects it should clearly and specifically describe how the participants in the reallocated projects (supportive services only and/or transitional housing) will continue to receive housing and services. If the CoC does not intend to reallocate or does not need to reallocate projects to create new permanent supportive housing, rapid re-housing, or HMIS projects it should indicate the each of the narrative sections.

Indicate the current number of projects submitted on the current application for reallocation:	0
Indicate the number of projects the CoC intends to submit for reallocation on the next CoC Application (FY2013):	0
Indicate the number of projects the CoC intends to submit for reallocation in the next two years (FY2014 Competition):	1
Indicate the number of projects the CoC intends to submit for reallocation in the next three years (FY2015 Competition):	1

If the CoC is reallocating SSO projects, explain how the services provided by the reallocated SSO projects will be continued so that quality and quantity of supportive services remains in the Continuum (limit 750 characters)

Because housing in general and permanent supportive housing in particular are strong CoC priorities, our CoC has no Supportive Services Only projects. Instead, our transitional and permanent supportive housing projects work closely with the integrated Humboldt County Department of Health and Human Services, which connects people in need of services with mental health, public health, child welfare, and employment services.
Our CoC identifies potential performance problems during the annual review and rank process, during which the non-conflicted Review and Rank Committee reviews performance and capacity information from all projects. If the Review and Rank Committee identifies performance issues, the Executive Committee will provide individualized support to resolve the problem.

If the CoC is reallocating TH projects, explain how the current participants will obtain permanent housing or efforts to move participants to another transitional housing project
(limit 750 characters)

Though the CoC is not reallocating TH programs this year, our 2012 Review and Rank process placed our TH programs at the bottom of the CoC's priority list. Our TH programs are restructuring to achieve HEARTH objectives; however, in the long term, PH is our primary priority. If our CoC decides to reallocate funding from TH programs in the future, the Executive Committee will assist the project to a) seek additional funding; b) continue to serve the same number of clients with reduced funding, or c) move participants into PH before the project expires. The Executive Committee will leverage our strong provider network to locate alternative housing for program participants in market-rate housing, subsidized apartments, or another TH project.

3B. Continuum of Care (CoC) Discharge Planning: Foster Care

Instructions:

The McKinney-Vento Act requires that State and local governments have policies and protocols in place to ensure that persons being discharged from publicly-funded institutions or systems of care are not discharged immediately into homelessness. To the maximum extent practicable, Continuums of Care should demonstrate how they are coordinating with and/or assisting in State or local discharge planning efforts to ensure that discharged persons are not released directly to the streets, emergency homeless shelters, or other McKinney-Vento homeless assistance programs.

Is the discharge policy in place "State" mandated policy or "CoC" adopted policy? CoC Mandated Policy

If "Other," explain:

N/A

Describe the efforts that the CoC has taken to ensure that persons are not routinely discharged into homelessness (limit 1000 characters)

Our CoC has a policy of not discharging foster youth into homelessness. Housing: Increasing TH for former foster youth is a 10-year plan priority. RCAA & Remi-Vista contract with DHHS through THP+ to provide 14 TH services-supported beds for former foster youth. DHHS will coordinate with the PHA to designate Sec. 8 certificates for youth aging out of foster care. Under AB 12, youth can remain in foster care until age 19. RCAA & Remi-Vista own a property for which they are applying for AB 12 funding to house 5 former foster youth.
Services: ILSP offers workshops on money management, education, computer skills, life skills, employment & housing placement & retention. DHHS's TAY Division provides youth aging out of foster care with a case manager who helps youth develop a discharge plan, assists with visiting apartments, employment sites, & colleges, & connects youth with DHHS's Employment Training Dept. DHHS is expanding its TAY Division with additional case managers & peer counselors.

If the CoC does not have an implemented discharge plan for foster care, specifically describe the gap(s) in completing a comprehensive discharge plan (limit 1000 characters)

Our CoC has an implemented discharge plan for foster care.

Specifically, identify the stakeholders and/or collaborating agencies that are responsible for ensuring that persons being discharged from a system of care are not routinely discharged into homelessness (limit 1000 characters)

Our CoC maintains a TAY Collaboration Group composed of TAY service providers and TAY to ensure that the unique needs of this population are met. The Discharge Planning Task Force and the TAY Collaboration Group, which report to the Executive Committee, coordinate with the TAY service providers to ensure that youth discharged from foster care are not discharged into homelessness. The Discharge Planning Task Force coordinates with the TAY Collaboration Group, ILSP, RCAA, and Remi-Vista to formalize our current discharge plan. DHHS's (the Collaborative Applicant) TAY Division, which provides case management for every youth being discharged from foster care, is responsible for developing individualized case plans to achieve stability and success for every youth.

Specifically indicate where persons routinely go upon discharge other than HUD McKinney-Vento funded programs (limit 1000 characters)

Most youth exit foster care to market rate rental housing or shared housing. If a youth is not ready for independent living, RCAA's Youth Services Bureau and Remi-Vista both maintain non-HUD McKinney-Vento funded housing for transition-aged youth. All exiting foster youth receive case management through DHHS, and many receive support from the Independent Living Skills Program, which provides workshops designed to increase TAY self sufficiency, including money management, education, computer skills, home management, social skills, employment assistance, and housing placement and retention. Under AB 12, foster youth are currently able to remain in foster care until age 21; DHHS case managers, RCAA, Remi-Vista, and ILSP ensure that youth are aware of this option, which can provide the extra support necessary to achieve stability before emancipation.

3B. Continuum of Care (CoC) Discharge Planning: Health Care

Instructions:

The McKinney-Vento Act requires that State and local governments have policies and protocols in place to ensure that persons being discharged from publicly-funded institutions or systems of care are not discharged immediately into homelessness. To the maximum extent practicable, Continuums of Care should demonstrate how they are coordinating with and/or assisting in State or local discharge planning efforts to ensure that discharged persons are not released directly to the streets, emergency homeless shelters, or other McKinney-Vento homeless assistance programs.

Is the discharge policy in place "State" mandated policy or "CoC" adopted policy? CoC Mandated Policy

If "Other," explain:

N/A

Describe the efforts that the CoC has taken to ensure that persons are not routinely discharged into homelessness (limit 1000 characters)

Our CoC has a policy to prevent people being discharged from health care facilities into homelessness. Discharge Planning Task Force coordinates with the Policy & Advocacy Committee & local healthcare facilities to monitor discharge practices. Open Doors Community Health Center (Exec Cmte member) provides a nurse case manager to review St. Joseph's Hospital (our largest medical facility) patients' needs to determine whether a patient is in need of a St. Joseph's Hospital-funded respite bed. St. Joseph's Hospital has a Care Transition Team dedicated to working with people who are homeless; under the direction of the Care Transition Team, discharge plans are considered early in a patient's stay. There are weekly team meetings to discuss discharge options, including independent living facilities or more skilled care facilities. Our collaboration with the hospitals is currently focused on ensuring that ER staff have training & tools needed to avoid discharging patients into homelessness.

If the CoC does not have an implemented discharge plan for health care, specifically describe the gap(s) in completing a comprehensive discharge plan (limit 1000 characters)

Our CoC has an implemented discharge plan for health care.

Specifically, identify the stakeholders and/or collaborating agencies that are responsible for ensuring that persons being discharged from a system of care are not routinely discharged into homelessness (limit 1000 characters)

St. Joseph's Hospital, Redwood Memorial Hospital, Jerold Phelps, tribal services and the K'ima:w Medical Clinic all employ discharge planning staff who are responsible for ensuring that people are not discharged into homelessness. The Discharge Planning Committee is coordinating with these organizations to develop a formalized discharge planning agreement.

Specifically indicate where persons routinely go upon discharge other than HUD McKinney-Vento funded programs (limit 1000 characters)

St. Joseph's Hospital operates Ring House, a privately-funded respite home with 5 beds for homeless people being discharged from hospitals in need of further recuperation. St. Joseph's case management team advocates on behalf of these Ring House residents to help them access skilled nursing facilities, board and care housing, market rate housing, halfway houses, or return to the care of their families.

3B. Continuum of Care (CoC) Discharge Planning: Mental Health

Instructions:

The McKinney-Vento Act requires that State and local governments have policies and protocols in place to ensure that persons being discharged from publicly-funded institutions or systems of care are not discharged immediately into homelessness. To the maximum extent practicable, Continuums of Care should demonstrate how they are coordinating with and/or assisting in State or local discharge planning efforts to ensure that discharged persons are not released directly to the streets, emergency homeless shelters, or other McKinney-Vento homeless assistance programs.

Is the discharge policy in place "State" mandated policy or "CoC" adopted policy? CoC Mandated Policy

If "Other," explain:

Describe the efforts that the CoC has taken to ensure that persons are not routinely discharged into homelessness (limit 1000 characters)

Our CoC has a policy to prevent the discharge of persons from MH facilities into homelessness. Homeless persons discharged from MH institutions are routed to destinations appropriate for the level of care they need. The highest level of care is state hospitals; secondary care is Institutes for Mental Disease, Mental Health Rehabilitation Centers, & Skilled Nursing Facilities/Psychiatric Health Facilities; tertiary care is Transitional Residential Services. Persons discharged from Psychiatric Emergency Services work with hospital discharge planners to avoid discharge into homelessness. Sempervirens (Psychiatric Health Facility) works closely with the Rural Outreach Services Enterprise & Street Outreach Services to assist patients in connecting to housing prior to discharge.
Housing Humboldt & DHHS are developing 18 MHSA PSH beds for homeless persons with mental illness.
The TAY Collaboration Group recently evaluated Sempervirens on how the program can better serve TAY.

If the CoC does not have an implemented discharge plan for mental health, specifically describe the gap(s) in completing a comprehensive discharge plan (limit 1000 characters)

Our CoC has an implemented discharge plan for mental health facilities.

Specifically, identify the stakeholders and/or collaborating agencies that are responsible for ensuring that persons being discharged from a system of care are not routinely discharged into homelessness (limit 1000 characters)

Hospital psychiatric emergency services, Sempervirens, the Mental Health Rehabilitation Centers and Institutes for Mental Disease all employ discharge planning staff to ensure that homeless clients are discharged to appropriate housing and not into homelessness. Rural Outreach Services Enterprise, Street Outreach Services, and Open Doors Community Health Center (Executive Committee member) coordinate with the mental health discharge planning staff to locate appropriate housing. The Eureka Police Department employs a mental health specialist as a homeless liaison who accompanies police officers when working with people in mental health crisis. DHHS offers a week-long crisis intervention training twice each year in order to form a team of trained officers and volunteers who can work with homeless people with mental health problems. 60 law enforcement offers from all law enforcement agencies in the county have registered for the January 2013 training.

Specifically indicate where persons routinely go upon discharge other than HUD McKinney-Vento funded programs (limit 1000 characters)

Persons discharged from mental health facilities may go to market-rate housing or board-and-care facilities, or stay with friends or family. Others are discharged to Institutes for Mental Disease, Mental Health Rehabilitation Centers, & Skilled Nursing Facilities/Psychiatric Health Facilities (Sempervirens), or Transitional Residential Services.

3B. Continuum of Care (CoC) Discharge Planning: Corrections

Instructions:

The McKinney-Vento Act requires that State and local governments have policies and protocols in place to ensure that persons being discharged from publicly-funded institutions or systems of care are not discharged immediately into homelessness. To the maximum extent practicable, Continuums of Care should demonstrate how they are coordinating with and/or assisting in State or local discharge planning efforts to ensure that discharged persons are not released directly to the streets, emergency homeless shelters, or other McKinney-Vento homeless assistance programs.

Is the discharge policy in place "State" mandated policy or "CoC" adopted policy? CoC Mandated Policy

If "Other," explain:

Describe the efforts that the CoC has taken to ensure that persons are not routinely discharged into homelessness (limit 1000 characters)

AB 109 shifted responsibility for supervision of non-violent, non-sex-offender parolees from state prison to county governments. In our CoC, AB 109 funding established the Community Corrections Reporting Center, a one-stop facility for those being discharged from state prison or county jail. The Reporting Center employs a psychiatric nurse & a mental health clinician as well as case managers & employment specialists. Reporting Center case managers work with HHHC agencies to connect people with family, shelter beds, or motel vouchers. The local jail discharge planner participates in CoC activities. DHHS, SOS, Humboldt NAMI, & RCAA coordinate with jail discharge planners to ensure that housing & services are in place for parolees, & work with parolees to ensure they connect with housing & services they need. DHHS's social worker liaison to the jail works with people who may be discharged into homelessness. The focus is on non-McKinney housing & services in favor of market-rate housing.

If the CoC does not have an implemented discharge plan for corrections, specifically describe the gap(s) in completing a comprehensive discharge plan (limit 1000 characters)

The California Department of Corrections, County Sheriff, and the HHHC agreed to a discharge planning protocol and to intervene to prevent homelessness as needed for those leaving custody. The Discharge Planning Task Force coordinates with the jail discharge planner (a CoC member), the Community Connections Reporting Center, and local probations staff to ensure compliance with and effectiveness of the current discharge plan.

Specifically, identify the stakeholders and/or collaborating agencies that are responsible for ensuring that persons being discharged from a system of care are not routinely discharged into homelessness (limit 1000 characters)

The County Sherriff, jail discharge planning staff, the Community Corrections Reporting Center, and local probations work directly with people being discharged from corrections to ensure that they access housing and services. The Discharge Planning Task Force coordinates with these entities to make sure that the Corrections Discharge Plan is implemented properly. DHHS's Department of Employment Training connects the AB 109 population with job placement assistance to increase self-sufficiency and stability. The AOD Task Force and Family Violence Prevention Task Force incorporate probation staff.

Specifically Indicate where persons routinely go upon discharge other than HUD McKinney-Vento funded programs (limit 1000 characters)

Most people are discharged to market rate housing or housing with family or friends; the Community Corrections Reporting Center assists with transportation costs when family is not local. Some persons, through the assistance of the Community Corrections Reporting Center, obtain HOPWA funding and are connected with an apartment. Some are discharged to residential substance abuse facilities. Others are connected with shelter beds (particularly at the Eureka Rescue Mission) or motel vouchers while Community Corrections Reporting Center case managers seek permanent housing solutions.

3C. Continuum of Care (CoC) Coordination

Instructions:

A CoC should regularly assess its local homeless assistance system and identify gaps and unmet needs. CoCs can improve their communities through long-term strategic planning. CoCs are encouraged to establish specific goals and implement short-term action steps. Because of the complexity of existing homeless systems and the need to coordinate multiple funding sources and priorities, there are often multiple long-term strategic planning groups. It is imperative for CoCs to coordinate, as appropriate, with each of these existing strategic planning groups to meet local needs.

Does the Consolidated Plan for the jurisdiction(s) that make up the CoC include the CoC strategic plan goals for addressing homelessness?	Yes
If 'Yes', list the goals in the CoC strategic plan that are included in the Consolidated Plan:	CA State Consolidated Plan: 1) Prevention of homelessness must begin at the earliest possible age and at the earliest moment that a person or family is assessed as being at risk. 2) Housing is the linchpin to holding together a prevention and intervention plan. 3) It is important to identify the major barriers, issues, and needs impacting alcohol and other drug (AOD) clients who are homeless

Now that the Homeless Prevention and Rapid Re-housing Program (HPRP) program(s) in the CoC have ended, describe how the CoC is working with service providers to continue to address the population types served by the HPRP program(s)
(limit 1000 characters)

Thanks in large part to our successful HPRP program, the number of homeless families identified in the 2011 PIT count decreased from 224 in 2009 to 105 in 2011. (We did not conduct an unsheltered PIT in 2012.) Though HPRP has ended, HHHC is eager to build on our success with new rapid rehousing and prevention funding. The ESG Committee is coordinating with service providers to apply for Emergency Solutions Grant rapid rehousing funding in 2013. In the meantime, MAC, our largest family TH program which served 75 families with children last year) is re-evaluating its program model to better suit the needs of the population it serves. MAC plans to create a continuum of housing models depending on the needs of individual families: families with fewer needs will be rehoused permanently quickly, while higher-need families will enroll in the program for a longer period.

Describe how the CoC is participating in or coordinating with any of the following: HUD-VASH, HOPWA, Neighborhood Stabilization Programs, Community Development Block Grants, and ESG?
(limit 2500 characters)

DHHS, in its role as Collaborative Applicant, and the Executive Committee remain abreast of all new funding sources available to our CoC and disseminate notices to local providers via listerves and meeting announcements. DHHS assists agencies to apply for available funding.
1) Humboldt County was not initially allocated any HUD-VASH vouchers. However, North Coast Veteran's Resource Center (NCVRC), an HHHC Executive Committee member, worked with the regional VA office to secure our current 50 HUD-VASH vouchers. The Housing Authority, a member of the Executive Committee, works with NCVRC to identify chronically homeless veterans who might be eligible for the available vouchers.
2) DHHS (the Collaborative Applicant) was granted $165,009 in HOPWA funding over 3 years to provide Short-Term Rent Mortgage Utility Assistance and supportive services, including case management, meals, nutrition, and transportation.
3) Humboldt County is a small, rural community that was not eligible for NSP funds.
4) In 2012 The City of Eureka received $1,100,000 in CDBG funding for homeownership assistance, housing rehabilitation, planning and technical assistance; the City of Arcata received $600,000 in funding for public services; and the County of Humboldt received $700,000 in funding for homeownership assistance and planning and technical assistance.
5) Humboldt County does not currently receive any Emergency Solutions Grant funding. However, the ESG Committee is coordinating with local service providers (RCAA, WISH, Arcata House, North Coast Veterans Resource Center, and Crossroads) to submit a strong application in 2013 for ESG funds through the California Department of Housing and Community Development.

Indicate if the CoC has established policies that require homeless assistance providers to ensure all children are enrolled in school and connected to appropriate services within the community?	Yes

If 'Yes', describe the established policies that are in currently in place:	Housing and service providers across the entire CoC are required to post notice of students' rights under the McKinney-Vento Act. They must also explain those rights to families and youth upon intake, and assist families and students in exercising those rights. Agencies are encouraged to keep track of the enrollment and attendance of students in their care. Agencies are encouraged to collaborate with local schools. For families with students who have Independent Education Plans, which are designed for special education students, agencies coordinate with the school to ensure the student has adequate support. Organizations that serve youth are encouraged to gather students' report cards and grading information, truancy and suspension notices, and other communications with school staff. Service providers are encouraged to aid parents by helping them obtain school records, health records, and other documentation.

Specifically describe the steps the CoC, working with homeless services providers, has taken to collaborate with local education authorities to ensure individuals and families who become or remain homeless are informed of their eligibility for McKinney-Vento educational services (limit 1500 characters)

Our McKinney Education Liaison is a very active in CoC activities, and is involved in developing educational policies within the CoC. Schools in Humboldt County have Family Resource Centers located on-site; Family Resource Center staff regularly meet with school administrators and the Education Liaison to identify homeless or at-risk families. When teachers or educational staff identify homeless and at-risk households, those families are referred directly to the MAC (a HUD McKinney-Vento transitional housing provider) for connection with housing and services. All HUD-funded providers who work with families maintain designated staff to coordinate with the Education Liaison, the Family Resource Centers, teachers, the County Office of Education, housing and benefits counselors, and other appropriate stakeholders. Providers report that in-school AOD education is an effective venue for identifying children who need assistance. During our most recent PIT Count, we conducted extensive outreach to local schools to ensure that our community’s homeless youth (10 counted in PIT) are identified and connected with resources.

Specifically describe how the CoC collaborates, or will collaborate, with emergency shelters, transitional housing, and permanent housing to ensure families with children under the age of 18 are not denied admission or separated when entering shelter or housing (limit 1500 characters)

Humboldt County's Ten-Year Plan prioritizes access to housing and services for families with children. The Housing and Shelter Committee continues to work with its housing providers to ensure that families are admitted and housed in appropriate settings that allow families to remain together with all of their children under age 18; families are not subject to inquiries regarding sexual orientation, gender identity, and marital status; and that these (whether perceived or actual) are not factors in eligibility for program admission. As we acquire funding to continue our successful HPRP program, families will ideally bypass the shelter system and facility-based housing system entirely, which will prevent any possible separation. Our CoC is beginning its plans for implementing Coordinated Assessment, which will divert families in need to available rapid rehousing or prevention services before they enter the shelter system, or identify their housing needs immediately and make referrals to the most appropriate available intervention.

Describe the CoC's current efforts to combat homelessness among veterans. Narrative should identify organizations that are currently serving this population, how this effort is consistent with CoC strategic plan goals, and how the CoC plans to address this issue in the future (limit 1500 characters)

Our CoC is in alignment with the Opening Doors goal of ending veteran homelessness by 2015. Veteran housing and services and best practices for working with veterans appear regularly on Executive Committee and HHHC General meeting agendas. The North Coast Veteran's Resource Center (NCVRC) is the primary agency targeting homeless veterans in Humboldt County. NCVRC sits on the HHHC Executive Committee ensuring that the needs of vets are addressed in all aspects of CoC planning. In 2011, NCVRC worked with the local VA office to bring Humboldt County its first 25 HUD-VASH vouchers; in 2012, our CoC gained 25 additional vouchers, for a total of 50 HUD-VASH beds. In partnership with the CoC, NCVRC organizes an annual Stand Down event that all CoC agencies support with staff and resources. NCVRC was recently awarded a highly competitive SSVF grant for services to keep veterans housed. NCVRC has recently completed a new 38-bed transitional housing program specifically for homeless vets, which is centrally located in the County, and provides much-needed beds for female veterans. NCVRC has fully implemented HMIS for all of its services, allowing the CoC to more fully track the needs of veterans in our community and progress toward ending veteran homelessness. DHHS, the Collaborative Applicant, is a PATH grantee which targets resources to vets.

Describe the CoC's current efforts to address the youth homeless population. Narrative should identify organizations that are currently serving this population, how this effort is consistent with the CoC strategic plan goals, and the plans to continue to address this issue in the future
(limit 1500 characters)

Under our TYP, advancing health & housing stability for TAY is a CoC priority. Action steps to achieve that goal include increasing the TH available for TAY & leveraging our strong relationship with the Housing Authority to use FUP & Section 8 voucher to serve TAY who need long-term housing support. The TAY Collaboration Group presents at HHHC meetings on tailoring services to youth. Recently, the TAY Collaboration Group evaluated Sempervirens, a MH service provider, from a youth perspective. RCAA (Exec Cmte member) is recognized as a state leader in serving homeless youth. RCAA operates 4 youth programs: Launch Pad (CoC-funded TH); Raven (peer-based supportive services); Our House (youth crisis shelter); & THP+ (TH for former foster youth). We use AB 12 (state legislation extending the age at which youth age out of foster care to 21) to ensure that our CoC meets TAY needs. Foster youth are systematically informed about their right to remain in foster care, which allows TAY to become more self-sufficient before emancipation. RCAA & Remi-Vista own a property for which they are applying for AB 12 funding to house 5 former foster youth. ILSP offers workshops that prepare youth for emancipation: money management, education, computer skills, life skills, employment assistance, & housing placement/retention. DHHS provides county-funded case managers to all youth aging out of foster care to help them develop individual discharge plans & connects them with housing & services.

Has the CoC established a centralized or coordinated assessment system? No

If 'Yes', describe based on ESG rule 576.400 (limit 1000 characters)

Our CoC has not yet established a coordinated assessment system, but in order to comply with HEARTH regulations the Executive Committee, HMIS Committee, and ESG Committee have begun planning and preparation work to implement the system by fall 2014, which DHHS will take the lead in implementing and operating. The ESG Committee is working to apply for coordinated assessment funding through ESG in 2013. The ESG Committee, in partnership with the Executive Committee, will develop written policies and procedures for evaluating eligibility, admission, diversion, referral, and discharge for all CoC agencies. Because our CoC is small, HHHC agencies already coordinate on an informal basis to direct clients to the housing most appropriate for their needs. The ESG and Executive Committees' work will formalize this existing collaboration. All agencies participating in the 2013 ESG application already fully participate in HMIS.

Describe how the CoC consults with the ESG jurisdiction(s) to determine how ESG funds are allocated each program year (limit 1000 characters)

Our CoC does not yet receive Emergency Solutions Grant funding. However, the ESG Committee of the HHHC is the entity responsible for coordinating the 2013 ESG application to the California Department of Housing and Community Development (HCD). Executive Committee members have coordinated with HCD during ESG outreach sessions. The ESG Committee, in partnership with the Executive Committee is working with all HHHC agencies interested in applying for ESG funds (RCAA, Arcata House, North Coast Veterans Resource Center, Crossroads, and WISH) to determine funding priorities. The ESG Committee will work with the Executive Committee to develop written policies and procedures for evaluating eligibility, admission, diversion, referral, and discharge for all CoC agencies.

Describe the procedures used to market housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, age, familial status, or disability who are least likely to request housing or services in the absence of special outreach
(limit 1000 characters)

The Housing and Shelter Committee works to ensure that all eligible persons, regardless of race, color, national origin, religion, sex, age, familial status, or disability are aware of the housing and services available and feel comfortable accessing them. We are currently translating our housing brochures into Spanish. All staff regularly attend trainings, including trainings on LGBT issues, to improve cultural competency. In 2013, the Housing and Shelter Committee will work to identify potentially underserved populations least likely to apply for housing and services without special outreach, which may include LGBTQ and those with limited English proficiency; evaluate the CoC's success in marketing available housing and services to them, and report these results to the Executive Committee.

3D. Continuum of Care (CoC) Strategic Planning Coordination

Instructions:

CoCs should be actively involved in creating strategic plans and collaborating within the jurisdiction towards ending homelessness. CoCs should clearly and specifically respond to the following questions as they apply to coordination and implantation within the CoC, planning, review, and updates to the local 10-Year plan that includes incorporating the Federal Strategic Plan, "Opening Doors," and coordination with Emergency Solutions Grants within the CoC jurisdiction.

Has the CoC developed a strategic plan? Yes

Does the CoC coordinate the implementation of a housing and service system that meets the needs of homeless individuals and families? (limit 1000 characters)

Because our CoC is geographically isolated, it is essential that we have a well-developed continuum of housing and services available locally. Our CoC is comprised of a wide range of active stakeholders, including local government, nonprofits, law enforcement, university representatives, and community members, who work closely together through bi-monthly general meetings (and more frequent subcommittee meetings) to address gaps in housing and services. To ensure that our housing and services system meets the needs of the homeless individuals and families in our community, each year the HHHC reviews PIT and HIC data to improve our knowledge about the populations we serve, and approves an update to the 10-Year Plan. The HHHC develops funding priorities each year and has begun a long-term movement away from emergency shelter and toward rapid rehousing and permanent supportive housing.

Describe how the CoC provides information required to complete the Consolidated Plan(s) within the CoC's geographic area (limit 1000 characters)

The Humboldt Consolidated Plan is administered by the City of Eureka. During plan development, the City of Eureka consulted many core HHHC members, including DHHS (the Collaborative Applicant), the Housing Authority, and many providers, including Arcata House, RCAA, and North Coast Substance Abuse Council, and North Coast Veterans Resource Center (all HHHC Executive Committee members). The Executive Committee reviews the Consolidated Plan on an annual basis and provides relevant information to the City of Eureka. The Consolidated Plan is annually presented to the HHHC General Meeting for comments.

Describe how often the CoC and jurisdictional partner(s) review and update the CoC's 10-Year Plan (limit 1000 characters)

Humboldt County's ten-year plan goals include increasing the stock of available permanent housing, providing affordable housing to those who are homeless or at-risk, and increasing economic security. Humboldt County's ten-year plan was adopted in 2008 and is updated annually to evaluate progress on action steps. DHHS drafts each annual update, which is reviewed and edited by the HHHC Executive Committee. Once the Executive Committee has approved the draft, it is presented to the county Board of Supervisors and the general HHHC meeting for review. The Executive Committee uses each annual update to inform the focus of Executive Committee and General HHHC meetings for the next year. In 2013, as part of our work to implement the new HEARTH regulations, the Executive Committee, Housing and Shelter Committee, and ESG Committee will work with local stakeholders to align the TYP with federal and local priorities.

Specifically describe how the CoC incorporates the Federal Strategic Plan, "Opening Doors" goals in the CoC's jurisdiction(s) (limit 1000 characters)

End Chronic Homelessness by 2015: The HHHC has determined that permanent supportive housing for CH persons is a top CoC priority. Each year, we bring new CH beds online through the CoC Program, and since 2010 have added 50 HUD-VASH beds for chronically homeless veterans.

End Veteran Homelessness by 2015: Over the past 2 years, North Coast Veterans Resource Center (HHHC Executive Committee member) has successfully worked with the local VA office to secure 50 HUD-VASH vouchers for chronically homeless veterans, 25 of which vouchers are new in 2012.

End Family, Child, and Youth Homelessness by 2020: We are building on the tremendous success of our HPRP program to develop long-term rapid rehousing projects to quickly and stably house homeless families. Our CoC maintains a TAY collaboration group to ensure that we are meeting the needs of this population, and Redwood Community Action Agency (HHHC Executive Committee member) operates a successful transitional housing program for TAY.

Select the activities in which the CoC coordinates with the local Emergency Solutions Grant(ESG): None

Based on the selections above, describe how the CoC coordinates with the local ESG funding (limit 1000 characters)

Humboldt County does not currently receive Emergency Solutions Grant funding, but the ESG Committee is coordinating with local stakeholders to develop a strong application to the California Department of Housing and Community Development for 2013. The ESG and Executive Committees are drafting policies and procedures and a rank and review process to evaluate ESG. All providers applying for ESG funding in 2013 (RCAA, Arcata House, North Coast Veterans Resource Center, Crossroads, and WISH) have fully implemented HMIS in their agencies, and several (RCAA, Arcata House, and Crossroads) are already recipients of CoC funding. As the Executive Committee and the HMIS Committee develop our new coordinated assessment system, they will consult with the ESG Committee to develop written policies and procedures and acquire coordinated assessment funding.

Does the CoC intend to use HUD funds to serve families with children and youth defined as homeless under other Federal statutes? No

If 'Yes', has the CoC discussed this with the local HUD CPD field office and received approval?

If 'Yes', specifically describe how the funds will be used to prevent homelessness among families with children and youth who are at the highest risk of becoming homeless (limit 1500 characters)

N/A

If 'Yes', specifically describe how the funds will be used to assist families with children and youth achieve independent living (limit 1500 characters)

N/A

3E. Reallocation

Instructions:

Reallocation is a process whereby a CoC may reallocate funds in whole or in part from renewal projects to create one or more new permanent housing, rapid re-housing, or dedicated HMIS projects. The Reallocation process allows CoCs to fund new permanent housing, rapid re-housing, or dedicated HMIS projects by transferring all or part of funds from existing grants that are eligible for renewal in FY2012 into a new project.

Does the CoC plan to reallocate funds from one or more expiring grant(s) into one or more new permanent housing, rapid re-housing, or dedicated HMIS project(s) or one new SSO specifically designated for a centralized or coordinated assessment system?	No

4A. Continuum of Care (CoC) FY2011 Achievements

Instructions:

In the FY2011 CoC application, CoCs were asked to propose numeric achievements for each of HUD's five national objectives related to ending chronic homelessness and moving individuals and families to permanent housing and self-sufficiency through employment. CoCs will report on their actual accomplishments since FY2011 versus the proposed accomplishments.

In the column labeled FY2011 Proposed Numeric Achievement enter the number of beds, percentage, or number of households that were entered in the FY2011 application for the applicable objective. In the column labeled Actual Numeric Achievement enter the actual number of beds, percentage, or number of households that the CoC reached to date for each objective.

CoCs will also indicate if they submitted an Exhibit 1 (now called CoC Consolidated Application) in FY2011. If a CoC did not submit an Exhibit 1 in FY2011, enter "No" to the question. CoCs that did not fully meet the proposed numeric achievement for any of the objectives should indicate the reason in the narrative section.

Additionally, CoCs must indicate if there are any unexecuted grants. The CoC will also indicate how project performance is monitored, how projects are assisted to reach the HUD-established goals, and how poor performing projects are assisted to increase capacity that will result in the CoC reach and maintain HUD goals.

CoCs are to provide information regarding the efforts in the CoC to address average length of time persons remain homeless, the steps to track additional spells of homelessness and describe outreach procedures to engage homeless persons. CoCs will also provide specific steps that are being taken to prevent homelessness with its geography as outlined in the jurisdiction(s) plan.

Finally, if the CoC requested and was approved by HUD to serve persons under other Federal statutes, the CoC will need to describe how the funds were used to prevent homelessness and how the funds were used to assist families with children and youth achieve independent living.

Objective	FY2011 Proposed Numeric Achievement		FY2011 Actual Numeric Achievement	
Create new permanent housing beds for the chronically homeless	45	**Beds**	33	**Beds**
Increase the percentage of homeless persons staying in permanent housing over 6 months to at least 77%	95	**%**	86	**%**
Increase the percentage of homeless persons moving from transitional housing to permanent housing to at least 65%	65	**%**	31	**%**
Increase the percentage of homeless persons employed at exit to at least 20%	23	**%**	10	**%**
Decrease the number of homeless households with children	105	**Households**	105	**Households**

Did the CoC submit an Exhibit 1 application in FY2011? Yes

If the CoC was unable to reach its FY2011 proposed numeric achievement for any of the national objectives, provide a detailed explanation (limit 1500 characters)

We set ambitious goals in 2012, but as an isolated rural CoC in a declining economy, were unable to meet 4 of those goals.
We added 4 CH beds in 2012. However, due to a reporting error that we corrected in 2012, the 2011 HIC reported more CH beds than we have (see 1F). Because of the error we set our 2011 target number too high.
Our PH programs achieved 91% remaining in PH for 6 months (3 persons had not yet been enrolled 6 months at APR). Because our outcomes are so strong, it is difficult to exceed the high rate we have already achieved.
Our TH programs moved 31% of participants to PH. Crossroads was originally structured so that clients stay for 90 days & transition to other AOD treatment in the agency, which reduces their percentage exiting to PH. The project has gradually been restructuring to achieve stronger outcomes. MAC, which has a very short average length of stay and consequently does not meet HUD's goals, is also restructuring. One TH program serves youth under age 18, who do not traditionally move immediately to PH at 18.
Because of our typically strong employment outcomes, we targeted 23% employed at exit. However, the current economy, our geographic isolation (the nearest large city is 277 miles away) & high unemployment made that goal impossible this year. Plans for 2013 include securing transportation to far-away jobs, increasing childcare & strengthening partnerships between providers & county programs to ensure access to countywide opportunities.

How does the CoC monitor recipients' performance? (limit 750 characters)

The annual review and rank process is the primary means by which the CoC monitors recipients' performance. Projects submit APR outcome measurements, financial, CoC and HUD audits, drawdown history, and other information for review by an impartial panel trained in HUD's requirements and CoC priorities. After review is complete, the HHHC Executive reviews the results to identify low-performing projects. Throughout the year, the CoC (through the Collaborative Applicant) reviews HMIS reports to monitor ongoing performance. The CoC also identifies low-performing projects through consumer complaints and periodic site visits.

How does the CoC assist project applicants to reach HUD-established performance goals? (limit 750 characters)

Projects identified as low-performing during the annual review and rank process receive special attention from the CoC Collaborative Applicant to improve outcomes. In 2012, two transitional housing programs (Crossroads and the MAC) were identified as having program structures not well-suited to HUD's performance goals. Those programs have entered into a restructuring process with the CoC. In partnership with the CoC Collaborative Applicant, MAC is re-examining its admissions criteria to ensure that it is serving the most appropriate population for the housing and services it offers. Crossroads is using substance abuse treatment best practices and HUD guidance to realign its structure with HUD's performance goals.

How does the CoC assist poor performers to increase capacity? (limit 750 characters)

During the annual review and rank process, the non-conflicted Review and Rank Committee reviews performance information for each CoC-funded project. The Committee meets with each applicant for an in-depth conversation about the projects and voices any concerns about/suggestions for improving agency capacity. In 2012, all of our agencies had sufficient capacity to manage their CoC grants; any performance issues were related to project structure (which agencies are already taking steps to amend), rather than agency capacity. If a project performs poorly, the Executive Committee will assist them to improve. In the past, the Executive Committee has provided funding for HMIS data entry staff for a program struggling with HMIS participation.

Does the CoC have any unexecuted grants awarded prior to FY2011? Yes

If 'Yes', list the grants with awarded amount:

Project Awarded	Competition Year the Grant was Awarded	Awarded Amount
Humboldt Bay Housing	2010	$53,903
	Total	$53,903

What steps has the CoC taken to track the length of time individuals and families remain homeless? (limit 1000 characters)

To comply with HEARTH performance measurements regarding length of homelessness, our CoC has begun implementing a number of protocols. At intake, providers ask all households entering the system about how long they have been homeless. Nearly all of our providers contribute to HMIS; HMIS-participating agencies have been trained in the importance of collecting accurate data and updating exit date and destination at exit. Because of our high HMIS bed coverage, we are able to track many individuals and families through our system. Our HMIS has the capacity to generate reports tracking average length of homelessness.

What steps has the CoC taken to track the additional spells of homelessness of individuals and families in the CoC's geography? (limit 1000 characters)

To track recidivism, at program entry providers ask all households about previous episodes of homelessness. Because our CoC has a small population and relationships between homeless housing and service providers are unusually vibrant, in many cases people experiencing additional spells of homelessness are already known to our providers. However, to formalize our recidivism tracking, our HMIS administrator is designing an HMIS recidivism report that will track additional spells of homelessness for all households entered into HMIS. Though HMIS data prior to 2010 is not reliable enough to develop a comprehensive longitudinal study at present, we are continually working to improve data quality moving forward. In 2013, our CoC plans to run monthly recidivism reports through HMIS and present them at Executive Committee meetings.

What specific outreach procedures has the CoC developed to assist homeless service providers in the outreach efforts to engage homeless individuals and families? (limit 1500 characters)

Our very rural CoC has many areas that are isolated from our small population centers. One settlement in particular is not accessible for part of the year because the roads are impassible. Because of our geography, outreach is crucial to connect people to necessary housing and services. We have developed the following responses: DHHS Mobile Outreach runs a mobile unit in a converted RV, staffed with MH professionals and case managers, which travels to remote locations and connects people with housing and services; case managers assist people to apply for public benefits electronically on site. The Arcata Night Shelter runs a mobile food truck through the Arcata area that connects people with the Arcata Night Shelter. The County AIDS program has 2 mobile outreach vans staffed with community health workers. WISH, Open Doors Community Health Center, Resource Centers, DHHS, and NCVRC also provide outreach to homeless persons.

What are the specific steps the CoC has incorporated to prevent homelessness within the CoC geography and how are these steps outlined in the jurisdiction(s) plans? (limit 1500 characters)

Our HPRP program was designed in part to prevent homelessness among at-risk households. Though HPRP has ceased operations, our ESG Committee is coordinating with local stakeholders to determine what role ESG prevention funding should play in CoC activities. Our CoC has begun the process to implement a coordinated assessment system, which will incorporate guidelines for serving households at risk of homelessness and assist providers to intervene before people become homeless. Our Collaborative Applicant, DHHS, is an integrated agency encompassing Public Health, Mental Health, and Social Services, which serves both homeless and housed individuals and families. DHHS integration allows any household entering a DHHS any program to be connected automatically to services in physical health, mental health, child welfare, alcohol and drug abuse, and public benefits, which improves housing stability. We will continue to build upon these successes in the future.

Did the CoC exercise its authority and receive approval from HUD to serve families with children and youth defined as homeless under other Federal statutes? No

If 'Yes', specifically describe how the funds were used to prevent homelessness among families with children and youth who are at the highest risk of becoming homeless (limit 1500 characters)

N/A

If 'Yes', specifically describe how the funds were used to assist families with children and youth achieve independent living (limit 1500 characters)

N/A

4B. Continuum of Care (CoC) Chronic Homeless Progress

Instructions:

HUD tracks each CoCs progress toward ending chronic homelessness.

CoCs are to track changes from one year to the next in the number of chronically homeless persons as well as the number of beds available for this population. CoCs will complete this section using data reported for the FY2010, FY2011, and FY2012 (if applicable) point-in-time counts as well as the data collected and reported on the Housing Inventory Counts (HIC) for those same years. For each year, indicate the total unduplicated point-in-time count of chronically homeless as reported in that year. For FY2010 and FY2011, this number should match the number indicated on form 2J of the respective years Exhibit 1. For FY2012, this number should match the number entered on the Homeless Data Exchange (HDX). CoCs should include beds designated for this population from all funding sources.

Additionally, CoCs will specifically describe how chronic homeless eligible is determined within the CoC and how the data is collected.

Indicate the total number of chronically homeless persons and total number of permanent housing beds designated for the chronically homeless persons in the CoC for FY2010, FY2011, and FY2012:

Year	Number of CH Persons	Number of PH beds for the CH
2010	427	35
2011	306	41
2012	306	33

What methods does the CoC used to determine chronic homeless eligibility and how is data collected for this population (limit 1000 characters)

All HMIS users and intake workers receive thorough training in the definition of chronically homeless and necessary eligibility documentation under HEARTH. All individuals and families seeking housing or services are asked questions at intake or during outreach engagements about the person's homelessness experience, when they first became homeless, and how many times they have been homeless in the last three years. This data is then input in HMIS. Because of our relatively small population, DHHS Street Outreach Services and Arcata Night Shelter outreach teams are familiar with many of the chronically homeless persons in our CoC and work to connect them with the appropriate housing.

Indicate the number of new permanent housing beds in place and made available for occupancy for the chronically homeless between February 1, 2011 and January 31, 2012: 4

**If the number of chronically homeless persons increased or if the number of permanent beds designated for the chronically homeless decreased, please explain
(limit 750 characters)**

Because we did not conduct an 2012 unsheltered PIT, the 2012 PIT does not accurately capture the number of CH persons in our CoC. Therefore, we have chosen to refer to the 2011 count of CH persons. We gained 4 CH beds in 2012. However, due to a 2011 HIC error that we corrected in 2012, the HIC shows a drop in the number of PH beds from 2011 to 2012. Prior to 2012 Apartments First! operated as one program supported by 4 CoC grants. When the program consolidated it became clear that the 2011 HIC had mistakenly reported 31 beds instead of the accurate 24. Also, SVK House is not yet operating & should not have appeared as “current” on the 2011 HIC. We expect those 5 beds to become available in 2013. In 2012, Project HART added 4 CH beds.

Identify the amount of funds from each funding source for the development and operations costs of the new permanent housing beds designated for the chronically homeless, that were created between February 1, 2011 and January 31, 2012:

Cost Type	HUD McKinney-Vento	Other Federal	State	Local	Private
Development					
Operations	$41,701			$13,556	
Total	$41,701	$0	$0	$13,556	$0

4C. Continuum of Care (CoC) Housing Performance

Instructions:

HUD will assess CoC performance of participants remaining in permanent housing for 6 months or longer. To demonstrate performance, CoCs must use data on all permanent housing projects that should have submitted an APR for the most recent operating year. Projects that did not submit an APR on time must also be included in this calculation.

Complete the table below using cumulative data on the most recent APRs submitted by all permanent housing projects within the CoC that should have submitted one. Once amounts have been entered click "Save" which will auto-calculate the percentage. CoCs that do not have CoC-funded permanent housing projects for which an APR was required should select "No" to the question below. This only applies to CoCs that do not have any CoC-funded permanent housing projects currently operating within their CoC that should have submitted an APR.

Does the CoC have any permanent housing projects for which an APR was required to be submitted? Yes

Participants in Permanent Housing (PH)	
a. Number of participants who exited permanent housing project(s)	4
b. Number of participants who did not leave the project(s)	31
c. Number of participants who exited after staying 6 months or longer	4
d. Number of participants who did not exit after staying 6 months or longer	26
e. Number of participants who did not exit and were enrolled for less than 6 months	3
TOTAL PH (%)	86

Instructions:

HUD will assess CoC performance in moving participants from transitional housing programs into permanent housing. To demonstrate performance, CoCs must use data on all transitional housing projects that should have submitted an APR for the most recent operating year. Projects that did not submit an APR on time must also be included in this calculation.

Complete the table below using cumulative data on the most recent APRs submitted by all transitional housing projects within the CoC that should have submitted one. Once amounts have been entered click "Save" which will auto-calculate the percentage. CoCs that do not have CoC-funded transitional housing projects for which an APR was required should select "No" to the question below. This only applies to CoCs that do not have any CoC-funded transitional housing projects currently operating within their CoC that should have submitted an APR.

Does the CoC have any transitional housing projects for which an APR was required to be submitted? Yes

Participants in Transitional Housing (TH)	
a. Number of participants who exited TH project(s), including unknown destination	235
b. Number of SHP transitional housing participants that moved to permanent housing upon exit	73
TOTAL TH (%)	31

4D. Continuum of Care (CoC) Cash Income Information

Instructions:

HUD will assess CoC performance in assisting program participants with accessing cash income sources. To demonstrate performance, CoCs must use data on all non-HMIS projects that should have submitted an APR in e-snaps for the most recent operating year. Projects that did not submit an APR on time must also include the data in this calculation.

Complete the table below using cumulative data as reported on the most recent submitted HUD APR in e-snaps for all non-HMIS projects within the CoC that should have submitted one. The CoC will first indicate the total number of exiting adults. Next, enter the total number of adults who exited CoC non-HMIS projects with each source of cash income. Once the total number of exiting adults has been entered, select "Save" and the percentages will auto-calculate. CoCs that do not have any non-HMIS projects for which an APR was required should select "No" to the question below. This only applies to CoCs that do not have any CoC-funded non-HMIS projects currently operating within the CoC that should have submitted an APR.

Total Number of Exiting Adults: 239

Total Number of Exiting Adults

Cash Income Sources (Q25a1.)	Number of Exiting Adults	Exit Percentage (Auto-Calculated)
Earned income	24	10%
Unemployment insurance	4	2%
SSI	9	4%
SSDI	1	0%
Veteran's disability	0	0%
Private disability insurance	0	0%
Worker's compensation	0	0%
TANF or equivalent	65	27%
General assistance	6	3%
Retirement (Social Security)	0	0%
Veteran's pension	0	0%
Pension from former job	0	0%
Child support	8	3%
Alimony (Spousal support)	0	0%
Other source	8	3%
No sources (from Q25a2.)	146	61%

The percentage values will be calculated by the system when you click the "save" button.

Does the CoC have any non-HMIS projects for which an APR was required to be submitted? Yes

4E. Continuum of Care (CoC) Non-Cash Benefits

Instructions:

HUD will assess CoC performance in assisting program participants with accessing non-cash benefit sources to improve economic outcomes of homeless persons. To demonstrate performance, CoCs must use data on all non-HMIS that should have submitted an APR in e-snaps for the most recent operating year. Projects that did not submit an APR on time must also include the data in this calculation.

Complete the table below using cumulative data from the most recent submitted HUD APR in e-snaps for all non-HMIS projects within the CoC that should have submitted one. The CoC will first indicate the total number of exiting adults. Next, enter the total number of adults who exited CoC non-HMIS projects with each source of non-cash benefits. Once the total number of exiting adults has been entered, select "Save" and the percentages will auto-calculate. CoCs that do not have any non-HMIS projects for which an APR was required should select "No" to the question below. This only applies to CoCs that do not have any CoC-funded non-HMIS projects currently operating within the CoC that should have submitted an APR.

Total Number of Exiting Adults: 239

Total Number of Exiting Adults:

Non-Cash Benefit Sources (Q26a1.)	Number of Exiting Adults	Exit Percentage (Auto-Calculated)
Supplemental nutritional assistance program	88	37%
MEDICAID health insurance	147	62%
MEDICARE health insurance	6	3%
State children's health insurance	0	0%
WIC	25	10%
VA medical services	0	0%
TANF child care services	18	8%
TANF transportation services	19	8%
Other TANF-funded services	0	0%
Temporary rental assistance	0	0%
Section 8, public housing, rental assistance	2	1%
Other source	24	10%
No sources (from Q26a2.)	61	26%

The percentage values will be calculated by the system when you click the "save" button.

Does the CoC have any non-HMIS projects for which an APR was required to be submitted? Yes

4F. Continuum of Care (CoC) Participation in Energy Star and Section 3 Employment Policy

Instructions:

HUD promotes energy-efficient housing. All McKinney-Vento funded projects are encouraged to purchase and use Energy Star labeled products. For information on the Energy Star Initiative go to: www.energystar.gov .

A "Section 3 business concern" is one in which: 51% or more of the owners are Section 3 residents of the area of services; or at least 30% of its permanent full-time employees are currently Section 3 residents of the area of services; or within three years of their date of hire with the business concern were Section 3 residents; or evidence of a commitment to subcontract greater than 25% of the dollar award of all subcontracts to businesses that meet the qualifications in the above categories is provided. The Section 3 clause can be found at 24 CFR Part 135.

Has the CoC notified its members of the Energy Star Initiative?	Yes
Are any projects within the CoC requesting funds for housing rehabilitation or new construction?	No

If 'Yes' to above question, click save to provide activities

If yes, are the projects requesting $200,000 or more?	

4G. Continuum of Care (CoC) Enrollment and Participation in Mainstream Programs

It is fundamental that each CoC systematically help homeless persons to identify, apply for, and follow-up to receive benefits under SSI, SSDI, TANF, Medicaid, Food Stamps, SCHIP, WIA, and Veterans Health Care as well as any other State or Local program that may be applicable.

Does the CoC systematically analyze its projects APRs in order to improve access to mainstream programs? Yes

If 'Yes', describe the process and the frequency that it occurs:

During the annual review and rank process, an impartial panel of reviewers analyze APR data on access to mainstream resources and report their findings and recommendations to the Executive Committee. The Executive Committee identifies any gaps in access to services. Based on these findings, the Executive Committee arranges for informational session at HHHC general meetings during the next year. Additionally, the Collaborative Applicant gives special attention to any agency struggling to connect clients with mainstream resources. For the past several years, HHHC has continued to build upon the success of the C4Yourself, an electronic system that allows households to apply for 4 benefits at once online.

Does the CoC have an active planning committee that meets at least 3 times per year to improve CoC-wide participation in mainstream programs? Yes

If 'Yes', indicate all meeting dates in the past 12 months:

HHHC Executive Committee: January 18, 2012; February 15, 2012; March 21, 2012; April 18, 2012; May 16, 2012; June 20, 2012; July 18, 2012; July 18, 2012; August 15, 2012; September 19, 2012; October 17, 2012; November 14, 2012; December 19, 2012.

Does the CoC coordinate with the State Interagency Council on Homelessness to reduce or remove barriers to accessing mainstream services? Yes

Does the CoC and/or its providers have specialized staff whose primary responsibility is to identify, enroll, and follow-up with homeless persons on participation in mainstream programs?	Yes
If 'Yes', identify these staff members:	Both
Does the CoC systematically provide training on how to identify eligibility and program changes for mainstream programs to provider staff:	Yes
If 'Yes', specify the frequency of the training:	quarterly (once each quarter)
Does the CoC use HMIS as a way to screen for mainstream benefit eligibility?	No

If 'Yes', indicate for which mainstream programs HMIS completes screening:

N/A

Has the CoC participated in SOAR training?	No

If 'Yes', indicate training date(s):

N/A

4H. Homeless Assistance Providers Enrollment and Participation in Mainstream Programs

Indicate the percentage of homeless assistance providers that are implementing the following activities:

Activity	Percentage
1. Case managers systematically assist clients in completing applications for mainstream benefits.	82%
1a. Describe how service is generally provided:	
Staff at each agency in the continuum complete an intake form on new clients. This intake asks the client for information regarding all of the mainstream benefits that they may already be receiving in as well as those benefits for which they may be eligible. Many agencies use the Self-Sufficiency Calculator which, by using a simple question-and-answer interface, can estimate a working family's eligibility and benefit amount for twelve state and federal work supports and tax burdens. After this assessment, staff then assist clients in applying for any mainstream benefits that the individual/family may be entitled to but is not yet receiving. Agency staff use C4Yourself, an electronic system that allows households to apply for SNAP, CalWorks, CMSP, and Medical with a single application. Staff may also call the mainstream benefit office to set up an appointment and follow up after, provide the client with transportation and reminders for appointments, accompany the client to the appointments, and support homeless persons in completing applications.	
2. Homeless assistance providers supply transportation assistance to clients to attend mainstream benefit appointments, employment training, or jobs:	73%
3. Homeless assistance providers use a single application form for four or more mainstream programs:	100%
3.a Indicate for which mainstream programs the form applies:	
Food stamps, CalWorks, CMSP, MediCal	
4. Homeless assistance providers have staff systematically follow-up to ensure mainstream benefits are received:	45%
4a. Describe the follow-up process:	
Agency staff follow up with clients and mainstream benefits offices through weekly case conferences, individual weekly supervision, and a variety of program-specific tracking forms. If a client has not received benefits, the case manager may then directly contact the mainstream agency to advocate on the client's behalf, write letters, or take the client to meetings with the mainstream agency staff. In 2012, DHHS implemented Service Center/Call Center so that clients and advocates can call a single phone number a determine the status of their application for health benefits or CalFresh. Service Center/Call Center operates on a "one and done" philosophy, according to which the operator is able to handle any question during the first phone call.	

4I. Unified Funding Agency

Instructions

CoCs that were approved for UFA designation during the FY2011 CoC Registration process must complete all of the questions below in full.

Is the collaborative applicant able to apply to HUD for funding for all of the projects within the geographic area and enter into a grant agreement with HUD for the entire geographic area?

Is the collaborative applicant able to enter into legal binding agreements with subrecipients and receive and distribute funds to subrecipients for all projects with the geographic area?

What experience does the CoC have with managing federal funding, excluding HMIS experience?
(limit 1500 characters)

Indicate the financial management system that has been established by the UFA applicant to ensure grant funds are executed timely with subrecipients, spent appropriately, and draws are monitored. (limit 1500 characters)

Indicate the process for monitoring subrecipients to ensure compliance with HUD regulations and the NOFA. (limit 1500 characters)

What is the CoC's process for issuing concerns and/or findings to HUD-funded projects?
(limit 1500 characters)

Specifically describe the process the CoC will use to obtain approval for any proposed grant agreement amendments prior to submitting the request for amendment to HUD.
(limit 1500 characters)

Attachments

Document Type	Required?	Document Description	Date Attached
Certification of Consistency with the Consolidated Plan	Yes	Humboldt County C...	01/17/2013
CoC-HMIS Governance Agreement	No		
Other	No		
Other	No		
Other	No		
Other	No		
Other	No		
Other	No		

Attachment Details

Document Description: Humboldt County CoC CA-522 Certification of Consistency with the Consolidated Plan

Attachment Details

Document Description:

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Submission Summary

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1A. Identification	No Input Required
1B. CoC Operations	01/17/2013
1C. Committees	01/15/2013
1D. Member Organizations	01/15/2013
1E. Project Review and Selection	01/15/2013
1F. e-HIC Change in Beds	01/15/2013
1G. e-HIC Sources and Methods	01/15/2013
2A. HMIS Implementation	01/17/2013
2B. HMIS Funding Sources	01/10/2013
2C. HMIS Bed Coverage	01/10/2013
2D. HMIS Data Quality	01/17/2013
2E. HMIS Data Usage	01/15/2013
2F. HMIS Data and Technical Standards	01/17/2013
2G. HMIS Training	01/10/2013
2H. Sheltered PIT	01/17/2013
2I. Sheltered Data - Methods	01/15/2013
2J. Sheltered Data - Collections	01/10/2013
2K. Sheltered Data - Quality	01/15/2013
2L. Unsheltered PIT	01/17/2013
2M. Unsheltered Data - Methods	01/15/2013
2N. Unsheltered Data - Coverage	01/10/2013
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3B. Discharge Planning: Foster Care	01/17/2013
3B. CoC Discharge Planning: Health Care	01/16/2013
3B. CoC Discharge Planning: Mental Health	01/17/2013
3B. CoC Discharge Planning: Corrections	01/16/2013
3C. CoC Coordination	01/17/2013
3D. CoC Strategic Planning Coordination	01/16/2013
3E. Reallocation	01/12/2013
4A. FY2011 CoC Achievements	01/17/2013
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4C. Housing Performance	01/11/2013
4D. CoC Cash Income Information	01/12/2013
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4F. Section 3 Employment Policy Detail	01/12/2013
4G. CoC Enrollment and Participation in Mainstream Programs	01/16/2013
4H. Homeless Assistance Providers Enrollment and Participation in Mainstream Programs	01/17/2013
4I. Unified Funding Agency	No Input Required
Attachments	01/17/2013
Submission Summary	No Input Required

Certification of Consistenc with the Consolidated Plan

U.S. Department of Housing and Urban Development

I certify that the proposed activities/projects in the application are consistent with the jurisdiction's current, approved Con solidated Plan.

(Type or clearly print the following information:)

Applicant Name: Humboldt Housing and Homeless Coalition

Project Name: Multiple projects - see attached

Location of the Project: Scattered sites

Name of the Federal Program to which the applicant is applying: HUD McKinney-Vento CoC Program

Name of Certifying Jurisdiction: City of Eureka

Certifying Official of the Jurisdiction Name: William Panos

Title: City Manager

Signature:

Date: 1/17/2013