Santa Cruz County Continuum of Care

Smart Path to Housing and Health: *Coordinated Assessment and Referral System*

Policies & Procedures Manual Approved on December 13, 2017

Contents

1. Background

a) What is a Coordinated Entry System?

A coordinated entry system, also known as coordinated assessment, is an emerging best practice for conducting assessments and referrals that provides a "no wrong door" approach to addressing homelessness. This community-wide system seeks to effectively and efficiently match people experiencing homelessness to available housing and services that best fit their specific needs and situation. In a coordinated entry system, individuals and families (referred to hereafter as "participants") who experience homelessness are assessed with the same tool regardless of where the assessment occurs. Assessment results are used to prioritize participants for scarce resources based on vulnerability and need. Participating projects agree to accept referrals from the system when they have project vacancies, reducing the need for participants to traverse the county seeking assistance from each agency separately. A countywide list of participants experiencing homelessness is retained and prioritized by need and vulnerability for quick referral when agencies have project vacancies.

In Santa Cruz County, the local coordinated entry system, Smart Path to Housing and Health: Coordinated Assessment and Referral System (referred to hereafter as Smart Path), is the responsibility of the Homeless Action Partnership (HAP), which serves as the countywide Continuum of Care (CoC).

b) Federal Department of Housing and Urban Development Requirement

Under the U.S. Department of Housing and Urban Development's (HUD) interim rule[1] 24 CFR 578.7(a)(8), each CoC must establish and operate a centralized or coordinated assessment system. HUD defines a centralized or coordinated assessment system as "a centralized or coordinated process designed to coordinate program participant intake assessment and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by individuals and families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool" (24 CFR 578.3).

To be eligible for HUD CoC and Emergency Solutions Grant (ESG) funds, communities must participate in a coordinated entry system.

In addition, developing a robust coordinated entry system is one of the primary recommendations of the countywide plan to address homelessness, *All In-Toward a Home for Every County Resident*[2].

c) Community Vision

[1] https://www.hudexchange.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf
[2] http://smartsolutionstohomelessness.org/wp-content/uploads/2012/08/HSP-FullReport-FINAL-Small.pdf

The Santa Cruz County community holds firmly to the vision that everyone should have access to stable housing. The vision is to move beyond the current fragmented approach to serving persons experiencing or at-risk of homelessness to one that effectively prevents people from becoming homeless and quickly stabilizes people who are already experiencing homelessness.

d) Guiding Principles

Underlying Santa Cruz County's Coordinated Entry System is the conviction that homelessness is preventable and solvable. The system is guided by the following principles:

- Equitable access: Coordinated entry access will be available to all people in all areas of the county
- Compassionate, caring service: All people will be treated with dignity and respect throughout the process
- Cultural responsiveness: Coordinated entry will provide services that are linguistically and culturally appropriate throughout the process
- Trauma-informed services: Coordinated entry will utilize trauma-informed practices while engaging, assessing, and referring participants
- Housing First[3]: Coordinated entry will provide permanent housing as quickly as possible with low to no barriers

e) System Goals

The goals of Santa Cruz County's Coordinated Entry System include:

- Create an organized system to improve access to all housing and service types to ensure the experience of homelessness is rare, brief, and nonrecurring
- Improve and streamline the referral process
- Create better linkages across projects, including but not limited to establishing warm hand-off referrals to non-housing services and developing coordinated entry committees to regularly discuss strengths and challenges of the project

[3] See Section 13. Definitions, "Housing First"

- Improve the experience for people to easily and quickly get the assistance they need without having to contact each agency separately

- Prioritize projects and services for participants who are most in need, utilizing a common assessment tool and community prioritization plan

- Quickly assess a household's needs and most appropriate intervention, including tailored resources that provide the level of support needed to attain and retain housing

- Ensure that all people who complete an initial screening are referred to appropriate available resources for immediate needs

- Diverting those whose housing crisis can be resolved with relatively minimal resources so that they do not require the homeless services system

- Coordinate outreach countywide to ensure everyone has the same opportunities to receive housing and services regardless of their location

- Better coordinate emergency shelter referral and placement, and connect participants in shelters to permanent housing opportunities

- Incorporate data-driven metrics to evaluate and strategically develop homeless services and housing resources

- Develop and implement improved, consistent, and shared training for service agencies in evidence-based practices, for example Trauma-Informed Care and Housing First

f) Benefits of Coordinated Entry

Benefits of Coordinated Entry to Santa Cruz County include:

- Effective targeting of existing resources by connecting the most vulnerable people to the available housing and resources that best fit their situation.

- Streamlined assessment and application process for all participants, ensuring everyone who completes a Smart Path assessment is included in the pool of participants considered for openings at participating agencies

- Development of comprehensive data on the number of participants experiencing homelessness and their needs. This data will inform programmatic and policy decisions and support advocacy efforts to leverage additional resources.

2. Smart Path Overview

Ultimately, Smart Path will assist anyone with a housing crisis, including those who are literally homeless[4], at imminent risk of losing housing, or lack adequate or stable housing. Using a decentralized structure, Smart Path will include all agencies and projects that provide assistance, services, and housing to participants who are homeless or at risk of homelessness. Completed Smart Path Assessments will be used to develop a pool of prioritized participants from which participating projects will fill their vacancies. Participating agencies will accept referrals from Smart Path to fill all project vacancies from the pool of eligible participants who completed a Smart Path Assessment. Referrals will be prioritized based on the household's VI-SPDAT score, with participants with the highest VI-SPDAT score (i.e., the greatest vulnerability) receiving first priority.

Participants will be able to access the following resources through Smart Path:

- Phase 1: Transitional Housing, Rapid Rehousing, Permanent Supportive Housing, Specialized Housing Choice Vouchers that include case management (e.g., Disabled Medically Vulnerable (DMV) Vouchers), and shelter diversion projects
- Phase 2: Shelter beds and eviction prevention (rental assistance) projects, in addition to the above

Smart Path will be able to provide immediate information and connections to the following agencies and services:

- Services unrelated to housing or shelter, such as food and showers
- Health care agencies
- Government services such as mainstream benefits programs
- School-based programs such as those funded through the McKinney-Vento Homeless Assistance Act
- Faith-based programs

3. Administrative Structure

a) System Oversight and Roles

Oversight of the coordinated entry system, including implementation of the Assessment, Participant List, prioritization and referral matching processes, will be provided by the Homeless Action Partnership (HAP). The HAP serves as the Santa Cruz County CoC's collaborative applicant and staffs the CoC Board and the CoC Smart Path/Coordinated Entry Steering Committee. The CoC Board delegated authority to the HAP, as the collaborative applicant, to approve and implement operational policies for coordinated assessment (See Delegation of Authority Table approved in April 2015). The Smart Path/Coordinated Entry Steering Committee, a committee of the HAP, will lead implementation of coordinated entry and report back on progress to the HAP.

[4] See Section 13. Definitions, "Literally Homeless"

There are two work groups of the Smart Path/Coordinated Entry Steering Committee: the Metrics and Improvement Work Group, which evaluates coordinated entry system metrics and monitors participant and agency feedback; and the Coordinated Entry and Housing Work Group, which provides case conferencing support for Smart Path. The Coordinated Entry and Housing Work Group is comprised of representatives from all Smart Path participating agencies and meets twice a month to coordinate efforts around outreach and referrals.

The Homeless Services Center (HSC) is the Lead Agency for the first phase of implementing coordinated entry. As the Lead Agency HSC is responsible for supervising Smart Path staff, interns, and volunteers including ensuring appropriate performance and addressing issues as needed. Smart Path staff includes the Smart Path System Manager, who is responsible for leading the implementation of coordinated entry throughout the county, and the Smart Path Referral Specialist, who is responsible for managing the Smart Path Participant List and referrals to housing projects as described in the sections below.

b) Grievance Procedures

Any person participating in the coordinated entry process has the right to file a grievance. Resolution of grievances related to a particular service agency (for example, a grievance related to how an assessment was conducted at a particular agency) should be attempted first through that agency's grievance procedure. Grievances specific to the coordinated entry system (for example, a grievance related to the match making process), should be forwarded to the Smart Path Referral Specialist using the Smart Path Grievance Form (see Appendix A). Within five business days, the Referral Specialist will draft an initial recommendation on how to address the grievance, which will be forwarded to the Smart Path System Manager for review and a final determination. The decision will be communicated to the participant within thirty days. Should the participant seek a different resolution, they may appeal the decision by contacting the HAP staff, who will respond within an additional thirty days.

c) Revisions to Policies and Procedures

The Policies and Procedures Manual will be reviewed and, if necessary, updated at least annually by the Smart Path/Coordinated Entry Steering Committee and HAP staff. Operational changes may be approved by the Smart Path/Coordinated Entry Steering Committee, and any significant policy changes must be approved by the HAP.

d) Participating Agencies:

All CoC and ESG funded service agencies must participate in the Coordinated Entry System. The CoC strongly encourages all other housing agencies with housing dedicated to people who are homeless to participate, as well.

4. Smart Path Access Points

Smart Path Access Points refer to any location which participants experiencing or at imminent risk of homelessness can complete the Smart Path Assessment, as described further below. Initial Access Points will include all HMIS partner agencies, with the goal of incorporating additional projects in the future from throughout the County as appropriate and available. Specific Access Point locations and operating hours will be posted and regularly updated on the Smart Path website at www.SmartPathSCC.org.

Access Points are located at convenient locations throughout the county and are accessible by public transportation. Access Points are required to be accessible to individuals with disabilities, and participants with a mobility impairment may request a reasonable accommodation in order to complete the Smart Path Assessment at a different location.

The following types of locations will either serve as Smart Path Access Points or have the ability to assist persons in immediately connecting to Access Points:

- Street outreach: mobile case managers/outreach workers
- Homeless service locations: shelters, homeless service and housing agencies, day services projects (such as meals and showers)
- Institutions: schools, hospitals, jails
- Public service agencies: clinics, government service agencies, libraries
- Emergency and crisis support agencies: 911, police, first responders, mental health agencies, projects that serve survivors of domestic violence
- Events: such as Santa Cruz Connect and Watsonville Connect, the local Project Homeless Connect events
- Virtual locations/phone lines such as 211
- Faith-based organizations

5. Outreach and Marketing

Outreach and marketing practices ensure that persons throughout Santa Cruz County who are either experiencing or at risk of homelessness are aware of and able to access Smart Path. Initial targets for distributing information about Smart Path include all of the Access Points described above, as well as:

- Public websites: such as County and City websites
- Informational flyers at public locations, such as bus stops, laundromats
- Information to the general public, such as public service announcements on the radio and in the newspaper

Smart Path outreach materials will be available in English and Spanish throughout the county, and Access Points with Spanish-speaking Assessment Specialists will be indicated on all Access Point lists. For participants who need additional language translation services, including sign language, interpreters can be made available in-person or via telephone with at least a one day advance request.

The HAP will affirmatively market housing and supportive services to eligible persons who are least likely to apply in the absence of special outreach, including those who may not realize they are eligible to participate, have recently become homeless, are resistant to receiving services, youth and young adults, location-bound due to physical disabilities, and monolingual Spanish-speaking participants. The outreach methods described above are used to connect people unlikely to access Smart Path on their own.

The marketing campaign will be designed to ensure that people in different populations and subpopulations in the CoC's geographic area, including people experiencing chronic homelessness, veterans, families with children, youth, survivors of domestic violence, and any other protected classes under federal and state law, have fair and equal access to Smart Path.

Similarly, the marketing campaign will be designed to ensure that the Smart Path process is available to all eligible persons regardless of race, color, national origin, religion, sex, age, familial status, disability, actual or perceived sexual orientation, gender identify, or marital status.

All physical Access Points must be accessible to individuals with disabilities, including participants who use wheelchairs. Smart Path Assessments can be completed on mobile devices and therefore completed in any accessible area of the Access Point. In addition, Access Points must ensure effective communication with participants, including providing appropriate auxiliary aids and other services necessary to ensure effective communication. Marketing materials will clearly convey that the access sites are accessible to all sub-populations.

6. Non-Discrimination

The HAP does not tolerate discrimination on the basis of any protected class (including actual or perceived race, color, religion, national origin, sex, age, familial status, disability, sexual orientation, gender identity, or marital status) during any phase of the Smart Path process. All agencies participating in Smart Path must comply with applicable equal access and nondiscrimination provisions of federal and state civil rights laws.

Some projects may be forced to limit enrollment based on requirements imposed by their funding sources and/or state or federal law. For example, a HOPWA-funded project might be required to serve only participants who have HIV/AIDS. All such programs will avoid discrimination to the maximum extent allowed by their funding sources and their authorizing legislation.

All aspects of the Coordinated Entry System will comply with all Federal, State, and local Fair Housing laws and regulations. Participants will not be "steered" toward any particular housing facility or neighborhood because of race, color, national origin, ancestry, religion, sex, age, familial status, presence of children, disability, actual or perceived sexual orientation, gender identity or expression, marital status, source of income, genetic information, or other arbitrary reasons.

All locations where participants are likely to access or attempt to access Smart Path will include signs or brochures displayed in prominent locations informing participants of their right to file a non-discrimination complaint and containing the contact information needed to file a non-discrimination complaint. The requirements associated with filing a non-discrimination complaint, if any, will be included on the signs or brochures.

See Appendix B for the Homeless Action Partnership Non-Discrimination Policy.

7. Assessments

a) The Smart Path Assessment

Smart Path prohibits screening participants out of the coordinated entry process due to perceived barriers to housing or services, including, but not limited to, too little or no income, active or a history of substance abuse, domestic violence history, resistance to receiving services, the type or extent of disability-related services or supports that are needed, history of evictions or poor credit, lease violations or history of not being a leaseholder, or criminal record.

Prior to conducting Smart Path Assessments, Assessment Specialists will have discussions with persons experiencing or at-risk of homelessness regarding diversion opportunities such as natural supports and potential housing options. If no diversion opportunities are identified, the participant will be invited to complete the common assessment which identifies immediate health and safety needs, potential project eligibility, medical vulnerability, and housing assistance needs. The current Smart Path Assessment utilizes the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) and additional questions to determine participants' immediate needs and project

eligibility. Disclosure of specific disabilities or diagnoses is not required to receive assistance or participate in Coordinated Entry. However, specific diagnosis or disability information may be obtained for the purposes of determining program eligibility to make appropriate referrals.

Based on demographic information, one of three population-specific VI-SPDAT tools will be used:

- "Single VI-SPDAT" for single adults 25 years old and over and for each individual adult in a couple without minor children
- "Family VI-SPDAT" for one or two adults 18 years old and over with minor children in custody
- "TAY VI-SPDAT" for transition-age youth and young adults (18-24 years old).

See Appendix C for the current Smart Path Assessment tools.

b) Training and Authorization for Conducting the Smart Path Assessment

The Smart Path Assessment can be conducted only by persons who successfully complete the Smart Path Assessment training and are subsequently authorized by the HAP to serve as trained Smart Path Assessment Specialists (Assessment Specialists). The training will be offered at least twice annually and will provide information on conducting the Assessment including the VI-SPDATs, explaining to others about how the coordinated entry system works, assessing diversion opportunities, and assisting people in crisis. Training protocols will be updated and distributed to participating agencies annually, clearly describing the methods by which assessments are to be conducted in adherence to these policies and procedures.

The HAP and Smart Path staff will monitor the quality and consistency of completed Assessments and provide training and adjustments to policies and procedures as necessary. The HAP may revoke the right of any individual or agency to complete Smart Path Assessments if they violate the signed Memorandum of Understanding (MOU) or the policies and procedures described in this document. Please see Appendix D for the current MOU agreement.

c) Confidentiality and Release of Information

The HAP, Smart Path, and its partner agencies recognize the importance of client confidentiality and will inform participants about how, with whom, and for what period of time their information will be shared. Multiple security protections are used to ensure confidentiality of information. The HAP extends the same HMIS data privacy and security protections prescribed by HUD for HMIS practices in the HMIS Data and Technical Standards with respect to Smart Path Assessments and the Participant List, including maintaining a local HMIS security plan. A participant's refusal to consent to share their information does not disqualify the participant for assistance or participation in Smart Path.

The Smart Path Assessment (including the VI-SPDAT) is covered under the standard HMIS Release of Information (ROI). The ROI authorizes Smart Path partner agencies to conduct the HMIS intake and

the Smart Path Assessment, enter the information in HMIS, and share the participant's information with other participating agencies in order to facilitate the provision of housing and services. The ROI must be completed and uploaded into HMIS before any other information, including the Smart Path Assessment, can be entered into HMIS. Please see Appendix E for the current Release of Information agreement.

If a participant declines to sign the ROI, the first course of action is to seek to understand the participant's concerns and further explain the purpose of the data sharing. If the participant continues to decline, the Assessment Specialist may ask the participant to provide an alias of their choice and enter the participant's non-identifying information into HMIS (omitting their Social Security number or birth date). The Assessment Specialist may also enter the participant by "Adding Anonymous Client". The agency should keep record of the participant's alias or anonymous HMIS ID number on file if possible and also provide it to the Smart Path Referral Specialist.

If a participant declines to sign the ROI and does not consent to having their information entered into HMIS, the Assessment Specialist will ask the participant if they are willing to complete the Smart Path Assessment on paper which will be shared with the Referral Specialist. The Referral Specialist will maintain a separate Participant List outside of HMIS for these participants. No participant data will be entered into HMIS, in order to maintain confidentiality and adhere to the participant's request. When there is an opening in a Permanent Supportive Housing, Rapid Rehousing, or Transitional Housing project, the Referral Specialist will reference both the HMIS Participant List and Participant List outside of HMIS to determine the most highly prioritized eligible participant.

d) Conducting the Smart Path Assessment

The Smart Path Assessment may be directly entered into HMIS or completed on paper and then entered into HMIS by an authorized user.

The Assessment should be conducted in a setting that promotes privacy and confidentiality. The Assessment must be completed in accordance with the Smart Path guidelines. See Appendix F for the Smart Path Assessment Process Guide.

During Phase 1, the Assessment must be conducted in person and the completed Release of Information entered into HMIS.

Participants may decide what information they provide during the Assessment process, to refuse to answer Assessment questions and to refuse housing and service options without retribution or limiting their access to other forms of assistance. However, projects may require participants to provide certain information to determine project eligibility when the applicable project regulation requires the information to establish or document eligibility.

After completing the Assessment, the Assessment Specialist must provide the participant with resource information and assist in direct service connections to meet immediate needs, including emergency shelter, as outlined in the Smart Path Assessment Process Guide.

Connection to available emergency services such as emergency shelter services are not contingent upon Smart Path Access Point assessment operating hours. Emergency service providers will have the information necessary to connect participants to Smart Path as soon as the assessment processes are operating. At minimum, emergency service providers will provide participants with details about the location and operating hours of the nearest Access Point. If possible given staff capacity, providers may call and arrange for the Assessment to take place and/or provide transportation if needed.

e) Updates to Assessments

As long as they are experiencing homelessness, participants should complete the Assessment on an annual basis. Participants or their designee should contact the Referral Specialist to update the participant's contact or household information when changes occur. In addition, any Assessment Specialist will have the capability to update participants' contact and household information. Participants or their designee may also contact the Referral Specialist to report any significant changes in their circumstances; the Referral Specialist will bring these updates to the Coordinated Entry and Housing Work Group to determine whether another Assessment should take place.

8. Participant List and Prioritization

a) Smart Path Participant List

Smart Path will maintain a comprehensive list in HMIS of all participants who have completed an Assessment at any Access Point. VI-SPDAT assessments that have been completed prior to Smart Path implementation will be transferred into the Smart Path Participant List (Participant List). Participants whom are considered "active" will be included in the Participant List and considered for available housing openings based on the prioritization policies described below. Participants whom have not had contact with a Smart Path participating agency within nine months will be considered "inactive" until such contact is recorded in HMIS.

b) Resource Prioritization

In Santa Cruz County there is a significant gap between the availability of housing and the need. To best utilize the area's limited housing resources, Smart Path uses the VI-SPDAT to assist with prioritization and determination of the type of assistance that best meets the needs of each individual or household. See Appendix G for the HAP Local CoC/ESG Written Standards.

Prioritization Criteria for Referral to Permanent Supportive Housing[5]:
Smart Path will prioritize active participants who meet the HUD definition of chronically homeless and have the highest VI-SPDAT score for referral to available Permanent Supportive Housing (PSH) program openings. For participants who completed a Single or Transition-Aged-Youth (TAY) VI-SPDAT, the score range for consideration for a PSH referral is 8-17. For the Family VI-SPDAT, it is 9-22.

If multiple participants have the same score and project eligibility, the participant who has the longest history of homelessness will be prioritized for referral to Permanent Supportive Housing project openings. If both the score and the length of homelessness are the same, then participants will be prioritized based on the order they completed the assessment, with participants completing the assessment first receiving priority.

Prioritization Criteria for Referral to Rapid Rehousing Projects[6] and Transitional Housing[7]:
Rapid Rehousing (RRH) and Transitional Housing (TH) projects typically serve individuals and families who are considered to need only short-term support in order to end their homelessness. Smart Path will prioritize participants with the highest VI-SPDAT score within the Rapid Rehousing range for referral to RRH and TH project openings. For participants who completed a Single or Transition-Aged-Youth (TAY) VI-SPDAT, the score range for consideration for a RRH referral is 4-7. For the Family VI-SPDAT, it is 4-8.

Participants with the same rapid rehousing score will be prioritized based on their length of time homeless, with participants experiencing homelessness the longest receiving priority. If both the score and the length of homelessness are the same, then participants will be prioritized based on the order they completed the assessment, with participants completing the assessment first receiving priority.

Other Assistance:
Participants identified as having low VI-SPDAT scores of 0-3 (and who therefore are placed lower on the community's prioritization list) may be able to resolve their homelessness with limited assistance. Smart Path participating agencies will, as appropriate, connect participants to services such as deposit assistance, eviction prevention assistance, mainstream benefits, or other community services as applicable. Eviction prevention services will be included in Phase 2 of Smart Path's implementation. Non-housing resources (such as those specified in this paragraph), prevention, and emergency shelter are not prioritized through Coordinated Entry.

9. Referrals

a) Matches to Housing Opportunities

[5] See Section 13. Definitions, "Permanent Supportive Housing"
[6] See Section 13. Definitions, "Rapid Rehousing"
[7] See Section 13. Definitions, "Transitional Housing"

During Phase 1 of Smart Path, participant housing matches will be made for (a) agency-operated Permanent Supportive Housing and/or Transitional Housing units and (b) case management and housing navigation projects for Permanent Supportive Housing vouchers and Rapid Rehousing subsidies. Participating agencies will include their project housing and service inventory and basic eligibility criteria in HMIS. The eligibility criteria will be used to pre-screen participants on the Participant List for potential project eligibility. Agencies will update availability of agency-operated housing units and openings in case management/housing navigation projects into HMIS two weeks prior to the assistance becoming available or as soon as possible, and no later than one business day after it becomes available. Upon notification of the available resource, the Smart Path Referral Specialist will use the HMIS housing match feature along with non-HMIS participant lists to prioritize participants from the Participant List for referral to the project by:

1. Filtering the Participant List based on the type of available housing assistance, so that it pulls a list of only those participants who have VI-SPDAT scores in the appropriate range as described above;

2. Filtering the Participant List based on the specific eligibility criteria of the available housing project; and

3. Prioritizing the Participant List based on the prioritization methodology for the applicable housing type as described above

Based on the results of the housing match, the Referral Specialist will make the referral in HMIS to the designated housing project staff.

Matches are facilitated by the Referral Specialist with the support of the Coordinated Entry and Housing Work Group as needed. The Referral Specialist will manage referrals based upon the prioritization and match-making methodology laid out in this document.

In order to increase the likelihood that a referred participant will be able to be contacted by the receiving agency, the Referral Specialist will take action to verify the contact information for the top five participants who would be referred next to each housing project type by demographic. For example, RRH for veterans and TH for families.

b) Receiving Agency Responsibilities

The following steps will be taken when an agency receives a Smart Path referral:

1. **Contact the participant(s) being referred for assistance**: The agency must make an initial attempt to contact the participant(s) within three business days and a total of 3-5 separate attempts within five business days to find the participant(s) using all of the contact

information provided in HMIS, contacting other service agencies that the participant(s) work with, and visiting locations that the participant(s) are known to frequent. All attempts to find the participant(s) must be documented in HMIS.

2. **Verify eligibility:** In order to confirm project eligibility, agencies will complete the project's regular eligibility and intake process. For HMIS participating agencies, the agency will enter the standard HMIS project entry information into HMIS.

3. **Accept Referral:** If it has been determined that the referred participant(s) are eligible to participate in the project, the agency will accept the referral in HMIS. For HMIS participating agencies, the agency will enter the participant into the project in HMIS.

4. **Decline Referral:** If it has been determined that the referred participant(s) are **not** eligible to participate in the project, the agency will decline the referral in HMIS following the guidelines below. If the agency met with the participant(s) to determine eligibility, they must be notified of the decision.

Additional reasons an agency may decline a referral:
Participating projects are expected to accept all referrals received from Smart Path, unless any of the following exceptions are demonstrated:

- There is no vacancy available
- The participants present with more or fewer people than the unit or project service is designed for
- The participants are not eligible under funding source or the project's written eligibility requirements for the project
- The agency provides documentation that it lacks the resources needed to effectively or safely serve and support the individual or family in question
- For Transitional Housing projects only: if the participant has already graduated from a Transitional Housing project within the previous two years
- The participants miss two or more mutually agreed upon initial eligibility intake appointments after the agency has provided all reasonable supports, such as transportation, reminders, and flexible scheduling, to overcome barriers to attend the appointment. Before the agency could decline the referral, the Referral Specialist would bring the case to the Coordinated Entry and Housing Work Group for case conferencing.
- There is a conflict of interest as defined in writing by the receiving agency, e.g., where the participant is related to a staff or Board member of the receiving agency
- The agency provides documentation that the participant has been banned indefinitely from the project per written agency policies. Before the agency could decline the referral, the Referral Specialist would discuss the reason for the ban with the agency.
- Significant safety concerns, i.e. domestic violence history with existing participant

Agencies may not decline referrals for reasons not enumerated here without seeking permission from the Smart Path/Coordinated Entry Steering Committee. In particular, agencies may not decline for referrals for the following reasons:

- Participants with psychiatric disabilities refuse to participate in mental health services
- Participants with substance use disorder refuse to participate in substance use treatment services

Additional Reasons a Referred Participant May Not be Placed in the Project:

- Participant(s) cannot be located:
  If the participant(s) ultimately cannot be located after the agency's 3-5 separate attempts within five business days, their information will be added back to the Participant List and the Referral Specialist will initiate a new match for the agency.

- Participant (s) are determined ineligible for project assistance:
  If the participant(s) are ineligible for the project, the agency will decline the referral in HMIS and the participant(s)' information will be added back to the Participant List according to their current Assessment score. The agency must indicate the reason the referred participant(s) were not eligible for project assistance. Depending on the ineligibility reason, agency staff may review the participant(s)' information for accuracy and request the participant(s) complete the Assessment again. The Referral Specialist will receive notification of the declined referral and will assess how to best assist the participant. The Referral Specialist will determine whether to initiate a new match for the agency or continue to seek to engage the previous participant as appropriate.

- Participant(s) decline project assistance:
  Participant(s) may decline a referral for any reason, including because of project requirements that are inconsistent with their needs or preferences.
  If the participant(s) are determined eligible for the referred project but decline assistance, their information will be added back to the Participant List according to their current Assessment score and the Referral Specialist will initiate a new match for the vacancy. Smart Path participants may decline any offers of project assistance. The following guidelines apply for participants who decline offers of project assistance:
  1) If the participant(s) have expressed a preference not to receive services through particular agencies or projects, the Referral Specialist will double check with the participant(s) before referring them to those projects.
  2) There is no limit to the number of resources participants can refuse. Participants may continue to be contacted when a resource they are likely eligible for is available; if they refuse the resource, the Referral Specialist will seek to understand why they are refusing the resource and ensure that the participant(s) are eligible for other resources that they may be more interested in. If the participant(s) are not interested in resources available through Smart Path they may ask to be inactive.

The HAP and Smart Path staff will monitor the quality and appropriateness of housing match referrals as outlined in the signed Memorandum of Understanding (MOU) and the policies and procedures described in this document. The HAP and Smart Path staff may provide additional training to participating agencies and adjustments to policies and procedures as necessary.

10. Confidential Process for Domestic Violence Survivors

All individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking who seek shelter or services from non-domestic violence service agencies participating in Smart Path will receive a warm hand-off referral to local domestic violence service agencies with the household's permission.

Smart Path has a separate, confidential process for individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking who are receiving services from designated domestic violence service agencies. This process provides for the confidentiality and safety of participants, while ensuring they receive the same opportunities for accessing housing opportunities as other Smart Path participants.

a) Assessment

When a participating domestic violence agency is working with project clients who are experiencing homelessness or at risk of homelessness, the agency will explain Smart Path and ask them if they would like to complete the Assessment.

If appropriate and available, a trained Smart Path Assessment Specialist from the Smart Path Lead Agency will meet with the project client to complete the Assessment in HMIS, which will only be visible to the Smart Path Lead Agency and the Smart Path Referral Specialist. The project client will determine whether their identifying information will be included in HMIS or not. If not, the Assessment Specialist will "Add Anonymous Client" and keep a record of the participant's anonymous HMIS ID number on file by providing it to the Referral Specialist.

If the project client does not consent to the Smart Path Lead Agency entering their information into HMIS, or this process is otherwise not appropriate or available, then the participating domestic violence agency will conduct a modified Smart Path Assessment form in hard copy format to conform to regulations that prohibit domestic violence service agencies from entering information on survivors of domestic violence into HMIS. The modified assessment form will include only the minimum information necessary to determine eligibility and prioritization and it will specifically exclude personally identifying information, including: name, date of birth, Social Security number, and last permanent address. The domestic violence service agency completing the form will include the name of the agency, two staff contacts, and an internally generated identification number to be used for all communications regarding the client. The domestic violence service agency will submit the modified assessment form to the Smart Path Referral Specialist. In order to maintain the client's

safety and confidentiality, all communication related to the Smart Path assessment and referrals will be conducted through the domestic violence service agency. The Referral Specialist will use the identification number to identify the client when communicating with the service agency.

b) Participant List

The Referral Specialist will maintain a separate DV Participant List outside of HMIS for survivors referred by domestic violence agencies using the modified Assessment forms. No client data will be entered into HMIS, in order to maintain confidentiality and safety for survivors and compliance with federal law. Whenever there is an opening in a Permanent Supportive Housing, Rapid Rehousing, or Transitional Housing project, the Referral Specialist will reference both the Smart Path Participant List in HMIS and the DV Participant List outside of HMIS to determine the most highly prioritized eligible participant.

c) Housing Support Project Referrals

If the most highly prioritized eligible participant is from the DV Participant List, then the Referral Specialist will provide the referral to the receiving agency via email or phone by providing the participant's identification number and the DV agency's contact information. Smart Path participating agencies that receive referrals for participants with identification numbers instead of names will contact the appropriate domestic violence service agency. The domestic violence service agency will be expected to contact the participant and connect them with the applicable project.

11. Other Special Populations

a) Unaccompanied Youth

Santa Cruz County is one of ten communities that was awarded the Youth Homelessness Demonstration Program (YHDP) grant by HUD in 2017. Smart Path is working closely with the YHDP Youth Advisory Board (YAB) to develop a youth coordinated entry system. This includes designing Access Points to increase easy access for unaccompanied youth and young adults, such as secondary schools, colleges, as well as developing a street outreach team to connect with youth frequenting downtown corridors, parks, libraries, and other locations as applicable.

Santa Cruz County currently lacks youth-specific housing resources for persons without a history or current involvement in the Foster Care System. However, youth and young adults will be considered for all available housing support programs utilizing the same eligibility criteria and prioritization policies as all populations, which includes vulnerability as indicated by the VI-SPDAT, and in this case the TAY-VI- SPDAT. As youth-specific housing resources are created, the YAB will assist with the development of any specific prioritization policies, taking into account HUD prioritization guidance as well as data gathered from the first phase of coordinated entry.

If available resources are available, unaccompanied minors that are identified through Smart Path will be provided transportation to the Bill Wilson Center's Crisis Residential Center in Santa Clara, which serves youth ages 11-17.

b) Veterans

Participants who are currently or at-risk of becoming homeless who have served in the military will be able to access Smart Path through any of the Access Points. In addition, veteran services agencies will serve as Access Points to increase access to Smart Path for all populations. All participants completing an Assessment will be asked if they have served in the military, and if so, they will be connected to veteran services agencies to ensure they are connected with non-housing services they may be eligible for.

12. Evaluation Process

The Metrics and Improvement Work Group, a work group of the Smart Path/Coordinated Entry Steering Committee, and the HAP are responsible for oversight of the coordinated entry system evaluation.

A Participant Survey was conducted countywide in May 2017 to gain an understanding of participants' experience with the current homeless services system prior to implementation of the Coordinated Entry System (see Appendix H). The survey focused on ease of access to project locations, experience of safety and respect at project locations, understanding of the various application processes, and linkage to community resources. The results of the pre-implementation survey indicate areas for improvement and have informed the planning of Access Points, resource linkage, and other Smart Path policies and procedures.

A post-implementation Participant Survey will be conducted six months after the initial launch of Smart Path, and annually thereafter to solicit feedback on the quality and effectiveness of the entire coordinated entry experience, including the assessment and referral processes associated with coordinated entry (see Appendix I). Similar to the pre-implementation survey, respondents will be selected randomly based on willingness to participate. The survey results will be analyzed by the Smart Path/Coordinated Entry Steering Committee and the HAP to assess the effectiveness of Smart Path and develop recommendations for improvements.

In addition, each participating agency will be consulted at least annually regarding the assessment and referral process associated with coordinated entry.

In addition, system metrics will be evaluated every six months. Data to evaluate these metrics will be generated through the HMIS. The results will be analyzed by the Smart Path/Coordinated Entry Steering Committee and the HAP to assess the effectiveness of Smart Path and develop recommendations for improvements. All participant information collected and used in the evaluation process will be utilized in accordance with privacy and confidentiality protections.

13. Definitions

The definitions below are included for the purposes of better understanding the Policies and Procedures Manual. Some definitions are simplified versions of HUD definitions and are not intended to suggest that the CoC uses definitions that differ from HUD's.

Access Point – Any location where people can complete the Smart Path Assessment to participate in coordinated entry.

Chronically Homeless – A ''chronically homeless'' individual is defined to mean a homeless individual with a disability who lives in a place not meant for human habitation, a safe haven, an emergency shelter, or in an institutional care facility if the individual has been living in the facility for fewer than 90 days and had been living in a place not meant for human habitation, a safe haven, or in an emergency shelter immediately before entering the institutional care facility. In order to meet the ''chronically homeless'' definition, the individual also must have been living as described above continuously for at least 12 months, or on at least four separate occasions in the last 3 years, where the combined occasions total a length of time of at least 12 months. Each period separating the occasions must include at least 7 nights of living in a situation other than a place not meant for human habitation, in an emergency shelter, or in a safe haven.

Chronically homeless families are families with adult heads of household who meet the definition of a chronically homeless.

Collaborative Applicant – The Collaborative Applicant is the eligible applicant (State, unit of local government, private, nonprofit organization, or public housing agency) designated by the CoC to:

1. Collect and submit the required CoC Application information for all projects the CoC has selected for funding, and
2. Apply for CoC planning funds on behalf of the CoC.

The CoC may assign additional responsibilities to the Collaborative Applicant so long as these responsibilities are documented in the CoC's governance charter.

Continuum of Care (CoC) – A program of the U.S. Department of Housing and Urban Development (HUD) (regulations at 24 CFR 578) with the expressed goals of promoting communitywide commitment to end homelessness; providing funding for efforts by nonprofit providers, and State and local governments to quickly rehouse homeless individuals and families; promoting access to and effecting utilization of mainstream programs by homeless individuals and families; and optimizing self-sufficiency among individuals and families experiencing homelessness. The program funds five types of projects: Permanent Housing, Transitional Housing, Supportive Services Only, Homeless Management Information System (HMIS), and Rapid Re-housing (RRH).

In Santa Cruz County, the Continuum of Care, or Homeless Action Partnership (HAP), comprises a broad group of stakeholders dedicated to ending and preventing homelessness in Santa Cruz County. CoC membership is open to all interested parties, and includes representatives from community

members, organizations, and jurisdictions within Santa Cruz County. Projects funded by this HUD program are required to participate in the Coordinated Entry System.

Emergency Solutions Grant (ESG) – ESG is a grant program of the U.S. Department of Housing and Urban Development (HUD) that funds emergency assistance for people who are homeless or at-risk of homelessness. ESG funds may be used for street outreach, emergency shelter, homelessness prevention, Rapid Re-housing, and HMIS. ESG grantees are required to participate in the Coordinated Entry System.

Homeless – HUD's definition of homelessness (24 CFR 578.3) has four categories:

o Category 1 – "Literally homeless" individuals/families (see definition)

o Category 2 – Individuals/families who will imminently lose their primary nighttime residence with no subsequent residence, resources, or support networks.

o Category 3 – Unaccompanied youth or families with children/youth who meet the homeless definition under another federal statute.

o Category 4 – Individuals/families fleeing or attempting to flee domestic violence.

Homeless Action Partnership (HAP) –Santa Cruz County's Continuum of Care (see definition, above), responsible for implementing and overseeing Coordinated Entry. The HAP also is responsible for communitywide planning and strategic use of resources to address homelessness; improving coordination and integration with mainstream resources and other programs targeted to people experiencing homelessness; and improving data collection and performance measurement

Homeless Management Information System (HMIS) – A local information technology system used to collect data on the provision of housing and services to homeless individuals and families.

Housing First- An approach to quickly and successfully connect individuals and families experiencing homelessness to permanent housing without preconditions and barriers to entry, such as sobriety, treatment or service participation requirements.

HUD – The United States Department of Housing and Urban Development, which funds and administers the Continuum of Care Program nationwide.

Literally Homeless – Lacking a fixed, regular, and adequate nighttime residence. Includes having a primary nighttime residence that is a public or private place not meant for human habitation; living in a publicly or privately operated shelter designated to provide temporary living arrangements (including hotels and motels paid for by charitable organizations or federal, state, or local government programs); or staying in an institution for 90 days or less and having stayed in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Participant List – A list, primarily within HMIS, of people who have completed a Smart Path Assessment and are homeless. The list is used to ensure that individuals and families with the greatest need receive priority for referral to housing and related services.

Permanent Supportive Housing (PSH) – Permanent housing with indefinite leasing or rental assistance paired with supportive services to assist homeless persons with a disability or families with an adult or child member with a disability to achieve housing stability.

Project- Those projects identified by the CoC as part of its service system, whose primary purpose is to meet the specific needs of people who are experiencing a housing crisis including both 'homeless assistance' and 'homelessness prevention' projects. The term "project" is used here to distinguish an individual agency's project from HUD "programs". A project may or may not be funded by a HUD program.

Rapid Rehousing (RRH) – A HUD Permanent Housing program that provides housing search and relocation services and short- and medium-term rental assistance to move homeless persons and families (with or without a disability) as rapidly as possible into permanent housing.

Release of Information (ROI) – The consent form that participants complete and sign to grant consent for their personal information to be entered into HMIS and used for Coordinated Entry. Signing the release of information is not required to participate in coordinated entry and receive referrals for housing; however, it is required in order to enter a participants' information into HMIS.

Service Prioritization Decision Assistance Tool (SPDAT) – an assessment tool developed by OrgCode Consulting, Inc., that is designed to help guide case management and improve housing stability outcomes.

Transition Age Youth (TAY) – Young adults ages 18 – 24 years old.

Transitional Housing (TH) - A project that has as its purpose facilitating the movement of homeless individuals and families to permanent housing within a reasonable amount of time (usually 24 months). Transitional housing includes housing primarily designed to serve deinstitutionalized homeless individuals and other homeless individuals with mental or physical disabilities and homeless families with children.

Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT) – a questionnaire designed by OrgCode Consulting, Inc. and Community Solutions that can be administered to quickly assess a person's health status and level of risk.

Appendix A: Grievance Form

Smart Path to Housing and Health
Coordinated Assessment and Referral System
Santa Cruz County

Grievance/Complaint Form
Version 12/9/17

Date _____
Your Name _____
Telephone _____
Address _____
_____

People who we can contact to reach you:
Name _____
Telephone _____
Address _____
_____

Name _____
Telephone _____
Address _____
_____

Our intention is to provide accessible, respectful service to assist people in getting connected with programs and services to end their homelessness. We are sorry that you have an unresolved complaint. If your complaint is related to a particular service agency (for example, a complaint related to how a particular agency handled your assessment), please follow the agency's grievance/complaint procedure before completing and submitting this form. If your complaint is related to the Smart Path process including the assessment and housing referral, you will need to put your complaint in writing. You can give your written complaint to any Smart Path Access Point, or you can mail this form to **Homeless Services Center, 115B Coral Street, Santa Cruz, 95060 c/o Smart Path Referral Specialist.**

Once your written complaint is received, it will be reviewed by the Smart Path Referral Specialist and the Smart Path System Manager. The Referral Specialist will respond in writing to your complaint at the address you listed above, or through a contact person you listed above, within 30 days and will contact you by phone to let you know that the written response has been sent.

You may write your complaint in your own way, or use the other side of this form. If you are unable to complete the written complaint you may ask for assistance from the Smart Path initial assessment specialist or you can have a friend or relative help you complete the complaint.

What is the outcome you want?

_____
_____
_____
_____

Please describe your complaint about Smart Path in your own words.

_____
_____
_____

What action or communication have you already taken to resolve your complaint?

What was the result of the action or communication you took?

Signature _____ **Date** _____

Appendix B: Homeless Action Partnership Non-Discrimination Policy

(Insert upon completion)

Appendix C: Assessment Tools

(Insert upon completion. Single Adult, Family, TAY VI-SPDATS plus all additional questions.

Appendix D: Memorandum of Understanding Agreement

Memorandum of Understanding (MOU) Between

Agencies Participating in Smart Path to Housing and Health (Smart Path)
and the Santa Cruz County Homeless Action Partnership (HAP)
Version 12/9/17

Santa Cruz County's vision is to address homelessness using a unified set of efficient interventions that effectively prevent people from becoming homeless and quickly stabilize people who are already experiencing homelessness. This vision can be achieved by better assessing people's needs and barriers, and quickly and seamlessly matching them to the services and housing that they need, regardless of the provider agency or program to which they originally reached out. This is the vision that Smart Path embodies and that agencies signing this MOU support.

Agencies signing this MOU agree to participate in the Smart Path to Housing and Health (Smart Path) Coordinated Assessment and Referral System, comply with the Smart Path Policies and Procedures, and:

- Ensure that participants seeking assistance have prompt access to screenings and assessments as agreed upon in a safe and welcoming environment, including collaborating with other Smart Path partners
- Maintain knowledge of community resources in order to provide every participant who completes the Smart Path assessment with assistance in meeting their immediate needs
- Ensure clients sign a release of information prior to any information being included in the Smart Path/HMIS database and otherwise shared
- Ensure agency representation at Smart Path meetings, including the Smart Path/Coordinated Entry Steering Committee, the Coordinated Entry and Housing Work Group, and ad-hoc meetings as needed
- Ensure that staff conducting assessments attend a minimum of one Smart Path Assessment training a year, with additional trainings as needed, to maintain consistent adherence to the Smart Path principles and procedures
- Ensure that only persons trained and authorized to use the Smart Path/HMIS database and the assessment do so
- Commit to maintaining current agency information in the countywide 211 system

Agencies that have agreed to conduct Smart Path assessments further agree to maintain at least one staff person trained and authorized to perform the assessments, including using the Smart Path/HMIS database.

Agencies that have agreed to receive Smart Path referrals further agree to accept and act promptly on all client referrals, as outlined in the Smart Path Policies and Procedures.

In signing this MOU, agencies agree to collaboratively address issues with Smart Path, participants, and other agencies as appropriate to support the success of Smart Path.

I agree to all of the above:

Name: _____

Title: _____

Agency: _____

Date: _____

Appendix E: Release of Information Agreement

(Insert upon completion)

Appendix F: Assessment Process Guide

(Insert upon completion)

Appendix G: Local CoC/ESG Written Standards

SANTA CRUZ COUNTY HOMELESS ACTION PARTNERSHIP

Local CoC/ESG Written Standards

For CA-508 Watsonville/Santa Cruz City and County Continuum of Care

The Homeless Action Partnership (HAP) has developed the following standards for the Santa Cruz County Continuum of Care (CoC). They are intended to guide Emergency Solutions Grant (ESG) and CoC funded project within the CoC. Each project may have its own program rules or focus, but they must all align with these standards.

1. **Standard policies and procedures for evaluating individuals' and families' eligibility for assistance under ESG and CoC. The policies and procedures must be consistent with the recording keeping requirements and definitions for "homeless" and "at-risk of homelessness," as applicable, in the federal ESG and CoC regulations at 24.CFR 576.2 and 24 CFR 576.500 (b-e),**

Agencies receiving ESG funds will ensure that all prospective participants are homeless or at-risk of homelessness under the required definitions and that all participants' total family income is less than 30% of the area median income. All agencies receiving ESG Funds will follow state and federal documentation guidelines to prove homeless, at-risk and income eligibility. Agencies will either develop internal documentation forms, or utilize ESG mandated forms as available and appropriate. Agencies will ensure that participant documentation of eligibility is recorded and maintained in accordance with state and federal guidelines.

To qualify as "homeless" or "at-risk of homeless" households will meet one of the following definitions:

HOMELESS:

A. An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

1. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground;
2. An individual or family living in a supervised publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or general purpose local government programs for low-income individuals); or
3. An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

B. An individual or family who will imminently lose their primary nighttime residence, provided that: 1. The primary nighttime residence will be lost within 14 days of the date of Application for homeless assistance; 2. No subsequent residence has been identified; and 3. The individual or family lacks the resources or support networks, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing;

C. Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

1. Are defined as homeless under Section 387 of the Runaway and Homeless Youth Act (42 U.S.C. 5732a), Section 637 of the Head Start Act (42 U.S.C. 9832), Section 41403 of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2), Section 330(h) of the Public Health Service Act (42 U.S.C. 254b(h)), Section 3 of the Food and Nutrition Act of 2008 (7 U.S.C. 2012), Section 17(b) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)), or Section 725 of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a).
2. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of Application for homeless assistance;

3. Have experienced persistent instability as measured by two moves or more during the 60-day period immediately preceding the date of applying for homeless assistance; and
4. Can be expected to continue in such status for an extended period of time because of chronic disabilities, chronic physical health or mental health conditions, substance addiction, histories of domestic violence or childhood abuse (including neglect), the presence of a child or youth with a disability, or two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment; or

D. Any individual or family who:

1. Is fleeing, or is attempting to flee, domestic violence, dating violence sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;
2. Has no other residence; and
3. Lacks the resources or support networks, e.g., family, friends, faith based or other social networks, to obtain other permanent housing

AT RISK OF HOMELESSNESS

A. An individual or family who:

1. Has an annual income below 30 percent of median family income for the area, as determined by HUD;
2. Does not have sufficient resources or support networks, e.g., family, friends, faith-based or other social networks, immediately available to prevent them from moving to an emergency shelter or another place described in paragraph (1) of the Homeless definition in this Section; and
3. Meets one of the following conditions:
    a. Has moved because of economic reasons two or more times during the 60 days immediately preceding the Application for homelessness prevention assistance;
    b. Is living in the home of another because of economic hardship;
    a. Has been notified in writing that their right to occupy their current housing or living situation will be terminated within 21 days after the date of Application for assistance;
    b. Lives in a hotel or motel and the cost of the hotel or motel stay is not paid by charitable organizations or by Federal, State, or general purpose local government programs for low-income individuals;
    c. Lives in a single-room occupancy or efficiency apartment unit in which there reside more than two persons or lives in a larger housing unit in which there reside more than 1.5
    people per room, as defined by the U.S. Census Bureau; 34
    d. Is exiting a publicly funded institution, or system of care (such as a health-care facility, a mental health facility, foster care or other youth facility, or correction program or institution); or
    e. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved consolidated plan;

B. A child or youth who does not qualify as homeless under this Section, but qualifies as homeless under Section 387(3) of the Runaway and Homeless Youth Act (42 U.S.C. 5732a(3)), Section 637(11) of the Head Start Act (42 U.S.C. 9832(11)), Section 41403(6) of the Violence Against Women Act of 1994 (42 U.S.C. 14043e–2(6)), Section 330(h)(5)(A) of the Public Health Service Act (42 U.S.C. 254b(h)(5)(A)), Section 3(m) of the Food and Nutrition Act of 2008 (7 U.S.C. 2012(m)), or Section 17(b)(15) of the Child Nutrition Act of 1966 (42 U.S.C. 1786(b)(15)); or

C. A child or youth who does not qualify under this section, but qualifies as homeless under Section 725(2) of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11434a(2)), and the parent(s) or guardian(s) of that child or youth if living with her or him.

It is the intent of these standards for each ESG-funded agency to be aware of and comply with any changes or updates made to the above definitions. The latest HUD information on these definitions is available at: https://www.hudexchange.info/programs/esg/.

INCOME
Only households who have an income below 30% of area median income will be eligible for services under ESG funding. Current income limits can be found at: http://www.huduser.org/portal/datasets/. Income eligibility will be documented through the collection of pay stubs, benefit statements and third party statements whenever possible. All agencies will follow guidance from federal and state regulations in the development, implementation and monitoring of ESG income eligibility documentation requirements. Agencies will utilize internal, state and/or federal forms for record keeping as available and appropriate.

GENERAL RECORDKEEPING GUIDELINES
Documentation of participants' homelessness situation and income is an important aspect of ESG project management. ESG recipients are required to maintain adequate documentation of homelessness status and income to determine the eligibility of persons served by ESG. The documentation must meet current HUD standards for documentation as updated from time-to-time, and is typically obtained from the participant or a third party at the time of referral, entry, intake or orientation to the ESG-funded project. A copy of the documentation should be maintained in the client file. Specific documentation requirements provided by ESG should be followed closely by the agency. For the latest HUD Guidance, see: https://www.hudexchange.info/programs/coc/toolkit/determining-and-documenting-homelessness/.

2. Standards for targeting and providing essential services related to street outreach.

Any agency seeking ESG funds for outreach will be asked to develop a written standard for the HAP's review. The agency must design an outreach plan that contains targeting strategies built around both a general outreach plan and one targeted to the unique niches that the partners fill. This plan will include:

1. A listing of the target groups
2. How you have determined that this target group contains eligible participants
3. How you will outreach to this target group
4. What are the challenges of reaching each target group
5. What minimal information that will be provided including information and referral for housing related needs

3. Policies and procedures for admission, diversion, referral, and discharge by emergency shelters assisted under ESG, including standards regarding length of stay, if any, and safeguards to meet the safety and shelter needs of special populations, e.g., victims of domestic violence, dating violence, sexual assault, and stalking; and individuals and families who have the highest barriers to housing and are likely to be homeless longest.

Admission to emergency shelter facilities will be limited to those who meet the Federal definition of "homeless," inclusive of the homeless categories listed below:

(1) Individuals and families who lack a fixed, regular, and adequate nighttime residence and includes a subset for an individual who resided in an emergency shelter or a place not meant for human habitation and who is exiting an institution where he or she temporarily resided; (2) individuals and families who will imminently lose their primary nighttime residence; (3) unaccompanied youth and families with children and youth who are defined as homeless under other federal statutes who do not otherwise qualify as homeless under this definition; and (4) individuals and families who are fleeing, or are attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member.

Upon initial contact with the point-of-entry, homeless persons will be screened by intake staff to determine appropriate diversion tactics. Diversion tactics may range from immediate case management assistance in determining available and unutilized resources, to referrals for existing homelessness prevention and/or rapid re-housing programs.

If diversion is not possible and emergency shelter is necessary, the maximum length of stay will be no longer than 6 months. No person or persons who are facing or suspect they may face a threat of violence will be discharged into an unsafe condition. Emergency shelter workers will work in collaboration with functional needs support service providers to arrange safe accommodations for those who are or may be facing a threat of violence. Those who are in danger of a violent crime or feel they may be will be entered into a secure database system that is comparable to HMIS. All other emergency shelter admissions will be entered into HMIS.

All persons discharged from emergency shelters will have their exit status entered into either HMIS or a comparable database, and will be provided discharge paperwork as applicable or upon request.

Under the coordinated entry process, homeless persons who are determined through assessment to have the highest barriers to housing – due to a myriad of factors including tri-morbidity, history of chronic homelessness, etc. – will be prioritized for existing housing resources and paired with existing supportive services to increase the likelihood of staying successfully housed.

4. Policies and procedures regarding participation in the CoC coordinated entry system and compliance with ESG program core practices

Coordinated Entry

All ESG-funded programs are required to participate in the CoC's coordinated entry system and comply with all federal and ESG coordinated entry requirements. In addition, all ESG-funded programs are required to comply with State of ESG Core Practices, available at 25 CCR 8409.

The CoC's coordinated entry system will be designed to be easy to navigate, to ensure immediate access to assistance, and to provide comprehensive and coordinated access to assistance regardless of where the person is located in the CoC. In addition it prioritizes access to assistance for people with the most urgent and severe needs, including, but not limited to:

- Survivors of domestic violence;
- Persons who are unsheltered and living in places not designed for human habitation, such as cars, parks, bus stations, and abandoned buildings;
- Persons who have experienced the longest amount of time homeless;
- Persons who have multiple and severe service needs that inhibit their ability to quickly identify and secure housing on their own; and
- For Homelessness prevention activities, people who are at greatest risk of becoming literally homeless without an intervention and are at greatest risk of experiencing a longer time in shelter or on the street should they become homeless.

Emphasis on Housing First

All ESG-funded will use Housing First (and progressive engagement practices), including the following:

- Ensuring low-barrier, easily accessible assistance to all people, including, but not limited to, people with no income or income history, and people with active substance abuse or mental health issues;
- Helping participants quickly identify and resolve barriers to obtaining and maintaining housing;
- Seeking to quickly resolve the housing crisis before focusing on other non-housing related services;
- Allowing participants to choose the services and housing that meets their need, as practical;
- Connecting participants to services available in the community that foster long-term housing stability;
- Offering financial assistance and supportive services in a manner that offers a minimum amount of assistance initially, adding more assistance over time if needed to quickly resolve the housing crisis. The type, duration, and

amount of assistance offered shall be based on an individual assessment of the household, and the availability of other resources or support systems to resolve their housing crisis.

5. Policies and procedures for assessing, prioritizing, and reassessing individuals' and families' needs for essential services related to emergency shelter: coordinated entry and ESG program core practices

Under the CoC's coordinated entry system, the VI-SPDAT is the standardized assessment tool that will be used by all ESG-funded programs to assess, prioritize, and reassess participants needs for essential services related to emergency shelter, as well as for referral to the most appropriate housing and service interventions.

The first tier of assessment occurs as they access our service area's 2-1-1 program, where qualified advocates will assist those seeking services. In keeping with Federal guidelines, our service area is committed to prioritizing those who are experiencing chronic homelessness, homeless veterans, and families with children who are experiencing a homeless condition.

Upon determination of the appropriate program for referral, the next tier of assessment will involve more complex case management services to be performed by representatives of the program to which the persons were referred.

Under coordinated entry, VI-SPDAT re-assessment will be at least once per year for participants who remain homeless that long. In addition, program participants will meet with case managers throughout their participation in the program, and will have regular progress assessments or evaluations. Participants will also be given the opportunity to provide assessment and feedback of programs as well. Each organization receiving ESG funding will be required to have a provable system of program evaluation. Additionally, participating agencies in our service area's Continuum of Care will share their experiences providing clients services, and refine service delivery based on feedback from service providers as well as participants.

6. Policies and procedures for coordination among emergency shelter providers, essential services providers, homelessness prevention, and rapid re-housing assistance providers; other homeless assistance providers; and mainstream service and housing providers. The required coordination may be done over an area covered by the Continuum of Care or a larger area.

Any ESG applicant and/or grantee will be expected to participate in our service area's CoC, known as the Homeless Action Partnership (HAP), and will work collaboratively to coordinate funding that addresses the needs of the entire CoC. To meet these goals, the CoC requires that all ESG applicants and/or grantees:

1) Participate in the CoCs coordinated entry system. Coordinated entry provides a standardized means for clients to access emergency shelter (including essential services), prevention, and rapid re-housing programs; a common assessment tool – the VI-SPDAT – for client information related to identification, needs, barriers, and risks; and a process for referral or clients to other needed homeless assistance, mainstream, and housing providers.

2) Ensure that staff members coordinate as needed regarding referrals and service delivery with staff members from other CoC agencies in order to ensure that services are not duplicated and clients can easily and efficiency access the services they need.

3) Ensure that staff members participate in any CoC trainings related to improving coordination among continuum members and relating to implementation of the coordinated entry system.

7. Policies and procedures for determining and prioritizing which eligible families and individuals will receive homelessness prevention assistance and which eligible families and individuals will receive rapid re-housing

assistance. For homeless prevention, include the risk factors used to determine who would be most in need of this assistance to avoid becoming homeless

ESG-funded agencies will prioritize eligible individuals and families based on need.

A key component of the coordinated entry system is screening and assessment (using the VI-SPDAT) to determine if basic eligibility criteria for homelessness / at risk of homelessness and income are met and to thoroughly explore each family or individual's situation and pinpoint their unique housing and service needs. Based upon this assessment, each family or individual is referred to and provided with the housing intervention and services most appropriate for their needs and situation.

Households who are deemed eligible based on basic eligibility criteria may receive either rapid re-housing services or homeless prevention services based on housing status at time of initial intake. Not all agencies will necessarily provide all types of ESG services, or have a particular funded service immediately available. If appropriate, individual agencies will refer potential eligible households to other ESG participating agencies, or alternate resources, if they are unable to provide services.

Households that are assessed to be homeless, and that meet the income standards, are eligible for rapid rehousing services. Housing receiving a moderate acuity score on the VI-SPDAT assessment are prioritized for rapid rehousing.

Households that are assessed to be at risk of homelessness, and that meet the income standards, are eligible for homelessness prevention services. Additional risk factors for prioritizing limited assistance include: Seniors, families with dependent children, former foster youth, chronically homeless, veterans, victims of domestic violence, and medically vulnerable individuals.

Each ESG Agency will be responsible for serving potential participants that are referred through the coordinated entry system in order of referral, with provisions for priority service for eligible households prioritized through coordinated entry by the CoC.

Homeless Prevention Households will be re-certified for continued eligibility every 3 months. Rapid Re-Housing Households will be re-certified annually.

8. Standards for determining what percentage or amount, (if any), of rent and utilities costs each program participant must pay while receiving homelessness prevention or rapid re-housing assistance.

Each ESG-funded agency will be responsible for determining income as a basis of eligibility for services. As part of this income determination the relevant staff person will ascertain the amount that the household is able to contribute towards rental payments. Factors to consider may include: Potential upcoming income increases / decreases, family size, availability of other resources to meet costs and other factors as determined by the agency staff in consultation with the household.

Due to the great variety of circumstances among homeless and at risk families and individuals in Santa Cruz County, the CoC has determined that each individual prevention or rapid rehousing program may (within ESG or other funder requirements) decide internally if they will charge participants a set percentage of income, a set percentage of actual rent, or a set dollar amount while receiving ESG services, or if they will provide a phased payment plan dependent on individual household circumstances. Individual agencies may also decide to not have participants pay any rental costs while receiving services. In keeping with the State ESG core practices, the program should use a progressive engagement and assistance approach.

Each participant and landlord will receive written verification of the amount and duration of assistance provided by the agency and rent to be paid by the participant. Income to be calculated includes: wages of adults in household, cash

benefits, child support and self-employment income. Employment income of children, non-cash benefits and sporadic gifts will not be counted as available income in determining rental payments.

As the overall goal of ESG funding is to ensure that households are able to maintain housing independently it is important that each Agency properly assess potential households to ensure that they are a good match for the program, and to refer them to more extensive supports as available if the household is not likely to be able to maintain housing costs independently.

9. Standards for determining how long a particular program participant will be provided with rental assistance and whether and how the amount of that assistance will be adjusted over time. One-year lease required for project-based assistance. Annual participant evaluations required with rapid rehousing assistance; 3-month evaluations required with homeless prevention assistance. Individual assistance cannot exceed 24 months in a 3-year period.

Again, due to the great variety of circumstances among homeless and at risk families and individuals in Santa Cruz County, the CoC has determined that each individual prevention or rapid rehousing program may set a maximum number of months that a Program Participant may receive rental assistance, or a maximum number of times that a Program participant may receive rental assistance. In keeping with the State ESG core practices, the program should use a progressive engagement and assistance approach.
The total period for which any participant may receive services must not exceed 24 months in three years. However, no family may receive more than a cumulative total of eighteen months of rental assistance, including any rental assistance paid in arrears.

Short-term and medium-term rental assistance must follow requirements as listed in 24 CFR, section 576.106.

Each agency will perform initial screening to determine the number of months that a client will initially receive a commitment of rent assistance including payments in arrears. This initial commitment will be in writing and verified by the agency representative and the participant. Factors to take into consideration during the initial commitment are the participant's ability to pay rent in the immediate month and subsequent months such as anticipated change in income, time necessary to recover from unexpected expenses, etc.

Short-term rental assistance may begin as soon as an applicant and a unit have been approved.

As the program participant is nearing the end of their initial commitment of assistance, the caseworker will contact the household to assess their need for continued assistance. After a review of the participant's continued eligibility, the caseworker will make a recommendation regarding the receipt of additional rental assistance, and this recommendation will be forwarded to the supervisor for review and approval. In addition to this analysis of additional assistance requirements, each participant will need to recertify each three month period providing the required, completed sections of the application forms and back-up verification documents.

Over the course of program participation, the caseworker will continue to meet with the household on an as needed basis, and will re-determine the eligibility of the household at least every three months. In the event that a program participant reaches 12 months of rental assistance, their unit will be re-inspected for continued compliance with rent reasonableness and habitability standards.

Rent may be paid in arrears as long as it allows the client to remain in their unit or move to another unit. Rental months paid in arrears are included in the maximum number of assistance months.

10. Standards for determining the type, amount, and duration of housing stabilization and/or relation services to provide to a program participant, including the limits, if any, on the homelessness prevention or rapid rehousing assistance that each program participant may receive, such as the maximum amount of assistance, maximum number of months the program participant receive assistance; or the maximum number of times the program participant may

receive assistance. Note: ESG regulations limit this assistance to no more than 24 months in a 3-year period. Housing stability case management is limited as specific on pp. 75979-80 of the federal regulations.

Each agency will perform initial screening to determine the number of months that a client will initially receive a commitment of assistance including direct assistance payments and stabilization services. This initial commitment will be in writing and verified by the agency representative and the participant. Factors to take into consideration during the initial commitment are the participant's ability to pay rent or obtain housing in the immediate month and subsequent months, such as anticipated change in income, time necessary to recover from unexpected expenses, etc.

Consistent with program limits in 24 CFR 576.105 (c), ESG-funded programs may determine the type, maximum amount and duration of housing stabilization and relocation services for individuals and families who are in need of homelessness prevention or rapid re-housing assistance through the initial evaluation, re-evaluation and ongoing case management processes. In keeping with the State ESG core practices, the program should use a progressive engagement and assistance approach.

As the program participant is nearing the end of their initial commitment of assistance, the caseworker will contact the household to assess their need for continued assistance. After a review of the participant's continued eligibility, the caseworker will make a recommendation regarding the receipt of additional rental assistance, and this recommendation will be forwarded to the supervisor for review and approval. In addition to this analysis of additional assistance requirements, each participant will need to recertify each three month period providing the required, completed sections of the application forms and back-up verification documents.

Additional requirements:
a. Household(s) must have an annual income below 30 percent of median family income for the geographic area.

b. Program Participants must meet with a case manager at least once a month for the duration of assistance, except where funding under Violence Against Women Act (VAWA) or Family Violence Prevention and Services Act (FVSP) prohibits the sub-recipient from making shelter or housing conditional upon the receipt of

c. Program Participants must be assisted, as needed, in obtaining appropriate supportive services, like mediation or mental health treatment or services essential for independent living; and mainstream benefits like Medicaid, SSI, or TANF.

d. Except for housing stability case management, the total period for which any Program Participant may receive service costs must not exceed 24 months during any three-year period. The limits on the assistance under this section apply to the total assistance an individual receives, either as an individual or as part of a family. (24 CFR, Section 576.105).

e. Homelessness Prevention must be provided in accordance with the housing relocation and stabilization services requirements in 24 CFR, section 576.105, the short-term and medium-term rental assistance requirements in 24 CFR Section 576.106, and the written standards and procedures established under 24 CFR Section 574.400.

f. Security Deposits: ESG funds may pay for a security deposit that is equal to no more than two months' rent. (24 CFR, Section 576.105(a)(2)).

g. Last Month's Rent: If necessary to obtain housing for a Program Participant, the last month's rent may be paid from ESG funds to the owner of that housing at the time the owner is paid the security deposit and the first month's rent. This assistance must not exceed one month's rent and must be included in calculating the Program Participant's total rental assistance, which cannot exceed 24 months during any three-year period. (24 CFR, Section 576.105(a)(3)).

h. Utility Payments: ESG funds may pay for up to 24 months of utility payments per Program Participant, per service, including up to six months of utility payments in arrears, per service. A partial payment of a utility bill counts as one

month. This assistance may only be provided if the Program Participant or a member of the same household has an account in his or her name with a utility company or proof of responsibility to make utility payments. Eligible utility services are gas, electric, water, and sewage. No Program Participant shall receive more than 24 months of utility assistance within any three-year period. (24 CFR, Section, 576.105(a)(5)).

i. Housing Stability Case Management: ESG funds may be used to pay cost of assessing, arranging, coordinating, and monitoring the delivery of individualized services to facilitate housing stability for a Program Participant who resides in permanent housing or to assist a Program Participant in overcoming immediate barriers to obtaining housing. This assistance cannot exceed thirty days during the period the Program Participant is seeking permanent housing and cannot exceed 24 months during the period the
Program Participant is living in permanent housing. (24 CFR, Section, 576.105(b)(2)).

j. Maximum Amounts and Periods of Assistance: The recipient may set a maximum dollar amount that a Program Participant may receive for each type of financial assistance under 24 CFR, Section, 576.105, paragraph (a). The sub-recipient may also set a maximum period for which a Program Participant may receive any of the types of assistance or services under this section. However, except for housing stability case management, the total period for which any Program Participant may receive the services under paragraph (b) of this section must not exceed 24 months during any three-year period. The limits on the assistance under this section apply to the total assistance an individual receives, either as an individual or as part of a family. (24 CFR, Section, 576.105(c)). The agency may set a maximum number of months that a Program Participant may receive rental assistance, or a maximum number of times that a Program participant may receive rental assistance. The total period for which any participant may receive services must not exceed 24 months in three years. However, no family may receive more than a cumulative total of eighteen months of rental assistance, including any rental assistance paid in arrears.

Short-term and medium-term rental assistance must follow requirements as listed in 24 CFR, section 576.106.

The following eligibility requirements must be followed.

Short and Medium-Term Rental Assistance:
a. Compliance with Fair Market Rent (FMR) Limits and Rent Reasonableness: Rental assistance is prohibited from being provided for a housing unit, unless the total rent for the unit does not exceed the fair market rent established by HUD, as provided under 24 CFR Part 888, and complies with HUD's standard of rent reasonableness, as established under 24 CFR Section 982.507. These rent restrictions are intended to make sure that Program Participants can remain in their housing after their ESG assistance ends.

b. Compliance with Minimum Habitability Standards: The revised habitability standards (shelter and housing standards) incorporate lead-based paint remediation and disclosure requirements. The revised standards for emergency shelters require all shelters to meet minimum habitability standards. Shelters renovated with ESG funds are also required to meet state or local government safety and sanitation standards, as applicable, include energy efficient appliances and materials. If ESG funds are used to help a Program Participant remain in or move into permanent housing, that housing must meet habitability standards.

c. Rental Assistance Agreement and Lease Standards: The rental assistance agreement must set forth the terms under which rental assistance will be provided.

d. Each Program Participant receiving rental assistance must have a legally binding, written lease (between Program Participant and the owner) for the rental unit, unless the assistance is solely for rental arrears.

e. Project-based rental assistance leases must have an initial term of one year.

f. No rental assistance can be provided to a household receiving rental assistance from another public source for same time period (except 6 months of arrears).

g. Rental assistance may not be provided to Program Participants who are currently receiving replacement-housing payments under the Uniform Relocation Assistance (URA).

h. The rental assistance agreement held by sub-recipients must contain the same payment due date, grace period, and late payment penalty requirements as the Program Participant's lease.

i. The sub-recipient must make timely payments to the owners in accordance with the rental assistance agreement.

j. The sub-recipient is solely responsible for paying (with non-ESG funds) late payment penalties that it incurs.

k. Under Homelessness Prevention, the total period for which any sub-recipient may receive services must not exceed 24 months during any three-year period.

l. Under the Short-Term and Medium-Term Rental Assistance, the agencies may set a maximum amount or percentage of rental assistance that a Program Participant may receive, a maximum number of months that a Program Participant may receive rental assistance, or a maximum number of times that a Program Participant may receive rental assistance. The sub-recipient may also require Program Participants to share in the costs of rent.

m. Short-Term and Medium-Term Rental Assistance Use with Other Subsidies: Except for a one-time payment of rental arrears on the tenant's portion of the rental payment, rental assistance cannot be provided to a Program Participant who is receiving tenant-based rental assistance, or living in a housing unit receiving project-based rental assistance or operating assistance through other public sources.

n. Short-Term and Medium-Term Rental Assistance may not be provided to a Program Participant who has been provided with replacement housing payments under the URA during the period of time covered by the URA payments.

o. Short-Term and Medium-Term Rental Assistance: Rental assistance cannot be provided unless the rent does not exceed the Fair Market Rent established by HUD, as provided under 24 CFR part 888, and complies with HUD's standard of rent reasonableness, as established under 24 CFR Section 982.507.

p. Short-Term and Medium-Term Rental Assistance Lease: Each Program Participant receiving rental assistance must have a legally binding, written lease for the rental unit, unless the assistance is solely for rental arrears. The lease must be between the Program Participant and the owner. Where the assistance is solely for rental arrears, an oral agreement may be accepted in place of a written lease if the agreement gives the Program Participant an enforceable leasehold interest, under state law, and the agreement and rent owed are sufficiently documented by the owner's financial records, rent ledgers, or canceled checks.

11. Participation in HMIS.

Any agency seeking ESG funding will be required to agree to participate in the Santa Cruz County Homeless Management Information System by collecting and entering required data on all clients to be served in its ESG-funded program(s). Each agency receiving ESG funds will ensure that data on all persons served and all activities assisted under ESG are entered into the Santa Cruz County HMIS, in accordance with HUD's standards on participation, data collection, and reporting, and in accordance with locally approved HMIS policies and procedures. Such agencies must also participate in CoC HMIS Technology Committee meetings.

If the ESG funding recipient is a domestic violence agency, or other Victim Services Provider as defined in VAWA and related federal law, the recipient is prohibiting from entering client data into HMIS, but must instead entered such data into a comparable data system as defined in applicable HUD guidance.

Appendix H: Pre-Implementation Participant Survey

Smart Path Consumer Pre-Launch Survey
Version: 5/8/17

Date: _____

Location: _____

Name of Survey Administrator: _____

1. What is your age?_____

2. Are you:
   - Single adult
   - Family with children
   - Veteran
   - Foster youth

3. Which racial group do you identify with most?
   - White
   - Black or African American
   - American Indian or Alaska Native
   - Native Hawaiian or Pacific Islander
   - Asian
   - Other: _____

4. Which ethnicity do you identify with most?
   - Hispanic or Latino
   - Not Hispanic or Latino

5. Where do you sleep most frequently (check one)?
   - Shelters
   - Transitional Housing
   - Permanent Housing
   - Outdoors
   - Vehicle
   - Other: _____

6. Have you done the VI-SPDAT or VI or 180 survey? Yes / No
   If Yes, How did you find out about doing the VI-SPDAT or VI or 180 survey?
   - Referred by someone:
     - Friend/someone I know
     - Another service provider
     - Other: _____
   - Advertisement
   - 2-1-1
   - Other: _____

7. Have you received services or applied for services at homeless services or housing programs? Yes / No

If Yes, how did you hear about the programs? (you can mark more than one)

Referred by someone:

Friend/someone I know

Another service provider

Other: _____

Advertisement

2-1-1

Other: _____

8. Was it easy to know where to go to apply for homeless services and housing programs you might be eligible for? Yes / No

9. Were there any challenges in reaching places to apply for homeless services and housing programs? Yes / No

If Yes, what where they:

Transportation

Hours of operation

Location

Other: _____

If Yes, how can we make it easier for you? _____

10. Did you know what to expect from the process when you were first referred to do the VI-SDAT survey or other homeless services and housing programs? Yes / No

11. Was the process clearly explained to you when you met with program staff? Yes / No

12. In your interactions with program staff, did you usually feel welcomed, safe, and put at ease?

Yes / No

If Yes, what made you feel welcome?_____

_____

If No, how could we make you feel more welcome?_____

_____

13. Were you able to get services in your primary language?

Yes / No

If No, what is your primary language? _____

14. As you were searching for services, did you feel your wishes were respected and that you were treated with dignity?

Yes / No

If No, what can we do to improve?_____

_____

15. As you were searching for services, did you feel like all the things about you (like your culture, ethnicity, age, sexual orientation, gender) were respected and treated with dignity?

Yes / No

If No, what can we do to improve?_____

_____

16. Since applying for homeless services and/or housing programs, have you attempted to contact program staff for information? Yes / No

    If Yes, was it easy to access? Yes / No

    If No, what can we do to improve?_____

    _____

    Did you get the information you were looking for? Yes / No

    If No, what can we do to improve?_____

    _____

17. As you were searching for services, did staff at any of the programs connect you to resources that were helpful to you?

    Yes / No

    If Yes, which ones were most helpful?

    Showers? Yes / No / Didn't need
    Meals? Yes / No / Didn't need
    CalFresh (Food Stamps)? Yes / No / Didn't need
    County Benefits (GA, SSI, CalWorks)? Yes / No / Didn't need
    Health care services? Yes / No / Didn't need
    Shelter? Yes / No / Didn't need
    Other: _____

    If No, why weren't those resources helpful?

    I already tried the resource, not for me
    It took too long to get
    I wasn't interested
    I wasn't eligible
    Other: _____

16. Did program staff connect you to resources that you didn't know about before? Yes / No

17. Did program staff connect you to resources that you knew about but had trouble accessing? Yes / No

18. What other resources do you need that you wish you could get?

    _____

    _____

    _____

    _____

19. Is there anything else you would like us to know about your experience?

    _____

    _____

    _____

    _____

THANK YOU FOR COMPLETING THE SURVEY!

Appendix I: Post-Implementation Participant Survey

Smart Path Consumer Post-Launch Survey
Version: 5/8/17

Date: _____

Location: _____

Name of Survey Administrator: _____

1. What is your age? _____

2. Are you:
   - Single adult
   - Family with children
   - Veteran
   - Foster youth

3. Which racial group do you identify with most?
   - White
   - Black or African American
   - American Indian or Alaska Native
   - Native Hawaiian or Pacific Islander
   - Asian
   - Other: _____

4. Which ethnicity do you identify with most?
   - Hispanic or Latino
   - Not Hispanic or Latino

5. Where do you sleep most frequently (check one)?
   - Shelters
   - Transitional Housing
   - Permanent Housing
   - Outdoors
   - Vehicle
   - Other: _____

6. Have you done a Smart Path Initial Assessment? Yes / No
   If Yes, How did you find out about Smart Path?
   - Referred by someone:
     - Friend/someone I know
     - Another service provider
     - Other: _____
   - Advertisement
   - 2-1-1
   - Other: _____

7. Was it easy to know where to go for Smart Path? Yes / No

8. Were there any challenges in reaching a Smart Path location? Yes / No
   If Yes, what where they:
   Transportation
   Hours of operation
   Location
   Other: _____
   If Yes, how can we make it easier for you?_____

9. Did you know what to expect from the process when you were first referred to Smart Path? Yes / No

10. Was the Smart Path process clearly explained to you when you met with staff? Yes / No

11. In your interactions with the staff you met with for the Smart Path Initial Assessment, did you usually feel welcomed, safe, and put at ease?
    Yes / No
    If Yes, what made you feel welcome?_____
    _____
    If No, how could we make you feel more welcome?_____
    _____

12. Were you able to get services in your primary language?
    Yes / No
    If No, what is your primary language? _____

13. In your interactions with the staff you met with for the Smart Path Initial Assessment, did you feel your wishes were respected and that you were treated with dignity?
    Yes / No
    If No, what can we do to improve?_____
    _____

14. In your interactions with the staff you met with for the Smart Path Initial Assessment, did you feel like all the things
    about you (like your culture, ethnicity, age, sexual orientation,
    gender) were respected and treated with dignity?
    Yes / No
    If No, what can we do to improve?_____
    _____

15. Since doing the Initial Assessment, have you attempted to contact Smart Path for information? Yes / No
    If Yes, was it easy to access? Yes / No
    If No, what can we do to improve?_____
    _____
    Did you get the information you were looking for? Yes / No
    If No, what can we do to improve?_____
    _____

16. Did Smart Path connect you to resources that were helpful to you?
    Yes / No
    If Yes, which ones were most helpful?
    Showers? Yes / No / Didn't need

Meals? Yes / No / Didn't need
CalFresh (Food Stamps)? Yes / No / Didn't need
County Benefits (GA, SSI, CalWorks)? Yes / No / Didn't need
Health care services? Yes / No / Didn't need
Shelter? Yes / No / Didn't need
Other:_____

If No, why weren't those resources helpful?
I already tried the resource, not for me
It took too long to get
I wasn't interested
I wasn't eligible
Other:_____

17. Did Smart Path connect you to resources that you didn't know about before? Yes / No

18. Did Smart Path connect you to resources that you knew about but had trouble accessing? Yes / No

19. What other resources do you need that you wish you could get?

_____
_____
_____
_____

20. If there is one thing you would like to be improved with Smart Path, what would it be?

_____
_____
_____
_____

THANK YOU FOR COMPLETING THE SURVEY!