Before Starting the CoC Application

You must submit all three of the following parts in order for us to consider your Consolidated Application complete:

1. the CoC Application,
2. the CoC Priority Listing, and
3. all the CoC's project applications that were either approved and ranked, or rejected.

As the Collaborative Applicant, you are responsible for reviewing the following:

1. The FY 2021 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2021 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

Your CoC Must Approve the Consolidated Application before You Submit It

- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2021 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

Answering Multi-Part Narrative Questions

Many questions require you to address multiple elements in a single text box. Number your responses to correspond with multi-element questions using the same numbers in the question. This will help you organize your responses to ensure they are complete and help us to review and score your responses.

Attachments

Questions requiring attachments to receive points state, "You Must Upload an Attachment to the 4B. Attachments Screen." Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process. Include a cover page with the attachment name.

- Attachments must match the questions they are associated with–if we do not award points for evidence you upload and associate with the wrong question, this is not a valid reason for you to appeal HUD's funding determination.
- We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

1A. Continuum of Care (CoC) Identification

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1A-1. CoC Name and Number: MA-505 - New Bedford CoC

1A-2. Collaborative Applicant Name: City of New Bedford

1A-3. CoC Designation: CA

1A-4. HMIS Lead: City of New Bedford

1B. Coordination and Engagement–Inclusive Structure and Participation

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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1B-1.	**Inclusive Structure and Participation–Participation in Coordinated Entry.**	
	NOFO Sections VII.B.1.a.(1), VII.B.1.e., VII.B.1.n., and VII.B.1.p.	

	In the chart below for the period from May 1, 2020 to April 30, 2021:
1.	**select yes or no in the chart below if the entity listed participates in CoC meetings, voted–including selecting CoC Board members, and participated in your CoC's coordinated entry system; or**
2.	**select Nonexistent if the organization does not exist in your CoC's geographic area:**

	Organization/Person	Participated in CoC Meetings	Voted, Including Electing of CoC Board Members	Participated in CoC's Coordinated Entry System
1.	**Affordable Housing Developer(s)**	Yes	Yes	Yes
2.	**Agencies serving survivors of human trafficking**	Yes	Yes	Yes
3.	**CDBG/HOME/ESG Entitlement Jurisdiction**	Yes	Yes	Yes
4.	**CoC-Funded Victim Service Providers**	Nonexistent	No	No
5.	**CoC-Funded Youth Homeless Organizations**	Nonexistent	No	No
6.	**Disability Advocates**	Yes	Yes	Yes
7.	**Disability Service Organizations**	Yes	Yes	Yes
8.	**Domestic Violence Advocates**	Yes	Yes	Yes
9.	**EMS/Crisis Response Team(s)**	Yes	Yes	Yes
10.	**Homeless or Formerly Homeless Persons**	Yes	Yes	Yes
11.	**Hospital(s)**	Yes	Yes	Yes
12.	**Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)**	Nonexistent	No	No
13.	**Law Enforcement**	Yes	Yes	Yes
14.	**Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates**	Yes	Yes	Yes
15.	**LGBT Service Organizations**	Yes	Yes	Yes
16.	**Local Government Staff/Officials**	Yes	Yes	Yes
17.	**Local Jail(s)**	Yes	No	No
18.	**Mental Health Service Organizations**	Yes	Yes	Yes

19.	**Mental Illness Advocates**	Yes	Yes	Yes
20.	**Non-CoC Funded Youth Homeless Organizations**	Yes	Yes	Yes
21.	**Non-CoC-Funded Victim Service Providers**	Yes	Yes	Yes
22.	**Organizations led by and serving Black, Brown, Indigenous and other People of Color**	Yes	Yes	Yes
23.	**Organizations led by and serving LGBT persons**	Yes	Yes	Yes
24.	**Organizations led by and serving people with disabilities**	Yes	Yes	Yes
25.	**Other homeless subpopulation advocates**	Yes	Yes	Yes
26.	**Public Housing Authorities**	Yes	Yes	Yes
27.	**School Administrators/Homeless Liaisons**	Yes	Yes	Yes
28.	**Street Outreach Team(s)**	Yes	Yes	Yes
29.	**Substance Abuse Advocates**	Yes	Yes	Yes
30.	**Substance Abuse Service Organizations**	Yes	Yes	Yes
31.	**Youth Advocates**	Yes	Yes	Yes
32.	**Youth Service Providers**	Yes	Yes	Yes
	Other:(limit 50 characters)			
33.	FAITH COMMUNITY	Yes	Yes	Yes
34.	UNITED WAY	Yes	Yes	Yes

1B-2.	**Open Invitation for New Members.**	
	NOFO Section VII.B.1.a.(2)	

	Describe in the field below how your CoC:
1.	**communicated the invitation process annually to solicit new members to join the CoC;**
2.	**ensured effective communication with individuals with disabilities, including the availability of accessible electronic formats;**
3.	**conducted outreach to ensure persons experiencing homelessness or formerly homeless persons are encouraged to join your CoC; and**
4.	**invited organizations serving culturally specific communities experiencing homelessness in the geographic area to address equity (e.g., Black, Latino, Indigenous, persons with disabilities).**

(limit 2,000 characters)

1.The invitation process is communicated through an annual email blast sent via different listserve groups identifying the HSPN/its work/its website/its goal of ending/preventing homelessness. Estimated reach of this effort is 1,000+ recipients. Additional invitations are made through social media. The CoC solicits new members annually and follows a calendar year for the mbr term. CoC members are asked to bring someone new to CoC meetings to ensure inclusion of a broad, diverse and expanding membership. 2.The CoC relies on its relationship with local disability providers (eg SouthCoast Independent Living) in ensuring effective communication with individuals with disabilities. Additionally, all materials published online and as part of CoC mailings, outreach and administration is made available in electronic formats, specifically PDFs. 3.Direct outreach is made on an ongoing basis to agency representatives, housing advocates, homeless advocates, street outreach teams and emergency shelters requesting their assistance year-round in inviting folks they serve/know to join the HSPN to ensure those with lived experience are well-represented. 4.Invitations to organizations serving culturally specific communities experiencing homelessness in this CoC are regularly made

through direct contact. Given the small size of the CoC, it is fortunate that the primary organizations serving such populations in this geographic area—including Immigrants Assistance Center and the CEDC—are long term members of this CoC.

1B-3.	CoC's Strategy to Solicit/Consider Opinions on Preventing and Ending Homelessness.	
	NOFO Section VII.B.1.a.(3)	

	Describe in the field below how your CoC:
1.	solicited and considered opinions from a broad array of organizations and individuals that have knowledge of homelessness, or an interest in preventing and ending homelessness;
2.	communicated information during public meetings or other forums your CoC uses to solicit public information; and
3.	took into consideration information gathered in public meetings or forums to address improvements or new approaches to preventing and ending homelessness.

(limit 2,000 characters)

1.The small size of MA-505 CoC and its geographic area has the advantage of enjoying tight connections within the community. This has helped facilitate a deep familiarity between those invested in/engaged with, preventing/ending homelessness resulting in the CoC being approached by those interested in participating. Despite this practice and historical strength of such connections, the CoC recognizes the value/importance of also culling wide diversity in its approaches to ending homelessness and actively solicit/engage/rely on opinions from across the community on an ongoing basis. Solicitations made via email blasts, website, social media postings and regular participation in ancillary community efforts ensures the inclusion of homelessness in broader local discussions while engaging others to share insights with the CoC. Such efforts are routinely made to ensure/strengthen those relationships/perspectives/voices. Whether it's folks currently living on our streets who come to a monthly CoC meeting, a businessperson who commits personal, financial and human capital to ending homelessness or so many others, the CoC's meetings and its org model have always been rooted in the breadth of its collective voice. All are welcomed to meetings. 2.The CoC communicates info during public meetings to better understand public ideas and concerns. Examples include the annual Action Plan process where the collaborative applicant reviews information about upcoming ESG/CoC funding opportunities. These forums always involve public participation including brainstorming and public speaking, all of which is aired on cable to ensure wider community reach. Similarly, CoC events like the public kick-off of the annual Point In Time Count and speaking engagements on local radio where callers raise concerns and questions have dramatically helped inform the local process. 3.The CoC uses and relies on information it gathers in all forums, recognizing all ideas are potential great ideas.

1B-4.	Public Notification for Proposals from Organizations Not Previously Funded.	
	NOFO Section VII.B.1.a.(4)	

Describe in the field below how your CoC notified the public:

1.	**that your CoC's local competition was open and accepting project applications;**
2.	**that your CoC will consider project applications from organizations that have not previously received CoC Program funding;**
3.	**about how project applicants must submit their project applications;**
4.	**about how your CoC would determine which project applications it would submit to HUD for funding; and**
5.	**how your CoC effectively communicated with individuals with disabilities, including making information accessible in electronic formats.**

(limit 2,000 characters)

1.The CoC announced the opening of the local NOFO competition, availability of its RFP and its acceptance of project proposals on 9.10.2021 through the CoC administrative lead's (City of New Bedford Office of Housing & Community Development—OHCD) website, the CoC's own website (www.nbhspn.com), through emailing to the entire CoC mailing list as well as additional in-house mailing lists of non-profits, agencies and community stakeholders. Social media postings were also used to notify the public via two different Facebook sites and twitter and specifically noted new applicants not previously funded were encouraged to apply. 2.The CoC's notices included language indicating proposals from organizations that had not previously received CoC program funding would be accepted. In its public posting the RFP advertising includes the following language: "This competition is open to all eligible applicants; one need not have previously applied to participate and submit an application." Inquiries from new potential applicants were made this year and encouraged to apply but no new projects were received in competition. 3.Information about how project applicants must submit their project applications was included throughout the RFP including specific information regarding project applications within the Application Requirements section. Once ranked, project applicants were individually provided with specific guidance and instruction as to submission of their project information via esnaps. 4.Information about how the CoC determined which project applications it would submit to HUD was provided throughout the RFP including specific information within the RFP's Appendix B "CoC Application Selection Process, Scoring, Ranking and Reallocation Process 2021." 5.The CoC ensured effective communication with individuals with disabilities through the RFP process by placing the RFP on the City's website which is ADA compliant and is screen-reader compatible.

1C. Coordination and Engagement–Coordination with Federal, State, Local, Private, and Other Organiza

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1C-1.	**Coordination with Federal, State, Local, Private, and Other Organizations.**	
	NOFO Section VII.B.1.b.	

	In the chart below:
1.	**select yes or no for entities listed that are included in your CoC's coordination, planning, and operations of projects that serve individuals, families, unaccompanied youth, persons who are fleeing domestic violence who are experiencing homelessness, or those at risk of homelessness; or**
2.	**select Nonexistent if the organization does not exist within your CoC's geographic area.**

	Entities or Organizations Your CoC Coordinates with for Planning or Operations of Projects	Coordinates with Planning or Operations of Projects
1.	**Funding Collaboratives**	Yes
2.	**Head Start Program**	Yes
3.	**Housing and services programs funded through Local Government**	Yes
4.	**Housing and services programs funded through other Federal Resources (non-CoC)**	Yes
5.	**Housing and services programs funded through private entities, including Foundations**	Yes
6.	**Housing and services programs funded through State Government**	Yes
7.	**Housing and services programs funded through U.S. Department of Health and Human Services (HHS)**	Yes
8.	**Housing and services programs funded through U.S. Department of Justice (DOJ)**	Nonexistent
9.	**Housing Opportunities for Persons with AIDS (HOPWA)**	Nonexistent
10.	**Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)**	Nonexistent
11.	**Organizations led by and serving Black, Brown, Indigenous and other People of Color**	Yes
12.	**Organizations led by and serving LGBT persons**	Yes
13.	**Organizations led by and serving people with disabilities**	Yes
14.	**Private Foundations**	Yes
15.	**Public Housing Authorities**	Yes
16.	**Runaway and Homeless Youth (RHY)**	Nonexistent
17.	**Temporary Assistance for Needy Families (TANF)**	Yes
	Other:(limit 50 characters)	

18.	UNITED WAY	Yes

1C-2.	**CoC Consultation with ESG Program Recipients.**	
	NOFO Section VII.B.1.b.	

	Describe in the field below how your CoC:
1.	**consulted with ESG Program recipients in planning and allocating ESG and ESG-CV funds;**
2.	**participated in evaluating and reporting performance of ESG Program recipients and subrecipients;**
3.	**provided Point-in-Time (PIT) count and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area; and**
4.	**provided information to Consolidated Plan Jurisdictions within your CoC's geographic area so it could be addressed in Consolidated Plan update.**

(limit 2,000 characters)

1.The NB CoC connects with ESG subrecipts on an ongoing basis through the CoC's lead/collaborative applicant, the city's OHCD that's responsible for ESG/ESG-CV funding for the City. OHCD staff is responsible for CoC and ESG/ESG-CV ensuring clarity/communication btwn decision-makers and project personnel. The CoC Performance Review Committee(PRC) is engaged in planning/allocating funds. Because it's a small CoC, each agency receiving funds also sits as a mbr of the CoC and the majority of ESG/ESG-CV program directors serve on the CoC's Exec Board. The CoC Strategic Plan includes strategies related to the allocation of ESG/ESG-CV funding (initiatives focused on homeless prevention/rapid rehousing/street outreach/shelter). In this way there's a connection btwn the CoC, ESG subs and the CoC's planning/allocation of funds. 2.The CoC participates qtrly in evaluating/reporting ESG subrecipient perform. through its PRC(whose mbrs aren't part of orgs receiving any CoC/ESG $). All ESG decisions are reviewed/apprvd/recmnded by the PRC; all ESG programs are monitored by the OHCD. The efficacy of these progs, evidenced through data reports presented to the CoC during mbr meetings is valuable in ensuring a collective understanding re importance each ESG program plays as a contributor to the CoC's system-based performance. 3.OHCD staff who oversee PIT/HIC efforts from organizing to collecting/processing data/entering into HDX are the same staff who oversee/develop Action Plans and ConPlan for NB so there's no delivery gap/issue in ensuring all CoC data is wholly and expeditiously provided to the ConPlan jurisdiction.4.OHCD staff prepares draft and final versions of all planning docs for the ConPlan jurisdiction including Consolidated Plans, (most recent being 2020-2024). From conducting focus groups/engaging providers to conducting public mtgs/writing the ConPlan, OHCD staff are on the forefront of ensuring seamless integration of accurate/timely CoC data into the ConPlan.

1C-3.	**Ensuring Families are not Separated.**	
	NOFO Section VII.B.1.c.	

Select yes or no in the chart below to indicate how your CoC ensures emergency shelter, transitional housing, and permanent housing (PSH and RRH) do not deny admission or separate family members regardless of each family member's self-reported gender:

1.	**Conducted mandatory training for all CoC- and ESG-funded service providers to ensure families are not separated.**	No
2.	**Conducted optional training for all CoC- and ESG-funded service providers to ensure families are not separated.**	Yes
3.	**Worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients.**	Yes
4.	**Worked with ESG recipient(s) to identify both CoC- and ESG-funded facilities within your CoC's geographic area that might be out of compliance and took steps to work directly with those facilities to bring them into compliance.**	Yes
5.	**Sought assistance from HUD by submitting AAQs or requesting technical assistance to resolve noncompliance of service providers.**	Yes
6.	**Other. (limit 150 characters)**	

1C-4.	**CoC Collaboration Related to Children and Youth–SEAs, LEAs, Local Liaisons & State Coordinators.**	
	NOFO Section VII.B.1.d.	

	Describe in the field below:
1.	**how your CoC collaborates with youth education providers;**
2.	**your CoC's formal partnerships with youth education providers;**
3.	**how your CoC collaborates with State Education Agency (SEA) and Local Education Agency (LEA);**
4.	**your CoC's formal partnerships with SEAs and LEAs;**
5.	**how your CoC collaborates with school districts; and**
6.	**your CoC's formal partnerships with school districts.**

(limit 2,000 characters)

1.The CoC collaborates directly with youth education providers including the McKinney Vento Local Education Agency and local school district. Specifically: (a) multiple youth education providers are active CoC members and (b)the LEA/McKinney Vento Liaison is elected by the CoC membership to the CoC's Exec Com and provides written and verbal reporting to the CoC each month and (c) with the New Bedford Public Schools (NBPS) District.
2.CoC formerly partners with (a)two local colleges to ensure access/outreach to those experiencing homelessness or on the precipice of homelessness (particularly true for colleges during the months leading up to the PIT Count/MA state PIT, (b)McKinney-Vento Local Liaison/LEA through the NBPS System and (c)NB Public Schools' Family Resource Ctr who provides assistance to families experiencing homelessness. 3.The CoC collaborates with the SEA through the LEA/NBPS School Registrar who serves as the CoC Vice-Chair. 4.The CoC formerly partners with the LEAs through a signed agreement on an annual basis. 5.The CoC actively participates in Southeastern Regional McKinney Vento Partnership meetings conducted by the NBPS as well as broader area regional McKinney Vento meetings which bring together all MB liaisons from surrounding schools/districts adjoining the geography of the CoC and other CoC leadership have presented at regional mtgs; the CoC regularly contributes printed materials/other resources to these mtgs and participates in them. 6.The CoC Chair is a publicly elected member of the NB School Committee. The NBPS School Registrar and LEA is vice-chair of the CoC and presents statistical information and trending analysis of students being connected with MB supports/services.

1C-4a.	CoC Collaboration Related to Children and Youth–Educational Services–Informing Individuals and Families Experiencing Homelessness about Eligibility.	
	NOFO Section VII.B.1.d.	

Describe in the field below written policies and procedures your CoC adopted to inform individuals and families who become homeless of their eligibility for educational services.

(limit 2,000 characters)

The NB CoC, acting through its lead (City's OHCD), requires that all ESG and CoC project applicants be able to clearly demonstrate that they are informing all families/youth experiencing homelessness as to their eligibility for McKinney-Vento education services. CoC applicants must demonstrate that they are considering the educational needs of children when families are placed in emergency (or any TH) shelter and, to the maximum extent practicable, demonstrate they are placing families with children as close as possible to their schools of origin so as not to disrupt the children's education. All project applicants must be able to demonstrate that their programs are establishing policies and practices that are consistent with, and do not restrict the exercise of, rights provided by the education subtitle of the McKinney-Vento Act, and other laws relating to the provision of educational and related services to individuals and families experiencing homelessness. Project applicants funded through ESG or CoC must be able to demonstrate that they have designated a staff person to ensure that children are enrolled in school and connected to the appropriate services within the community, including early childhood programs such as Head Start, Part C of the Individuals with Disabilities Education Act and McKinney-Vento education services. The OHCD serves as the grantee for both ESG and CoC funding; as such, it compels agencies to abide by these policies/protocols and reinforces them through subrecipient agreements and monitoring of projects.

1C-4b.	CoC Collaboration Related to Children and Youth–Educational Services–Written/Formal Agreements or Partnerships with Early Childhood Services Providers.	
	NOFO Section VII.B.1.d.	

Select yes or no in the chart below to indicate whether your CoC has written formal agreements or partnerships with the listed providers of early childhood services:

		MOU/MOA	Other Formal Agreement
1.	Birth to 3 years	No	Yes
2.	Child Care and Development Fund	No	Yes
3.	Early Childhood Providers	Yes	No
4.	Early Head Start	Yes	No
5.	Federal Home Visiting Program–(including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)	No	Yes
6.	Head Start	Yes	No
7.	Healthy Start	No	Yes
8.	Public Pre-K	No	Yes
9.	Tribal Home Visiting Program	No	No
	Other (limit 150 characters)		

10.			

1C-5.	**Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Annual Training–Best Practices.**	
	NOFO Section VII.B.1.e.	

	Describe in the field below how your CoC coordinates to provide training for:
1.	**Project staff that addresses safety and best practices (e.g., trauma-informed, victim-centered) on safety and planning protocols in serving survivors of domestic violence and indicate the frequency of the training in your response (e.g., monthly, semi-annually); and**
2.	**Coordinated Entry staff that addresses safety and best practices (e.g., trauma informed care) on safety and planning protocols in serving survivors of domestic violence and indicate the frequency of the training in your response (e.g., monthly, semi-annually).**

(limit 2,000 characters)

1.1.The local certified provider of domestic violence services (Women's Center) provides an annual training about DV related resources available within the community during/following a regular CoC meeting so non-victim service providers and all CoC area project staff are updated on all relevant Fed/State/Local laws. Additionally, best practice trainings on domestic violence, dating violence, stalking and sexual assault for CoC providers (outside of regular CoC meetings) are offered on an ongoing basis to community stakeholders/CoC providers. In addition, individual CoC housing and/or supportive service providers conduct agency specific trainings (in-service trainings) to provide robust, periodic training around serving survivors, trafficking victims, etc. 2.Procedure/protocols for working with survivors of domestic violence, dating violence, stalking, trafficking, and sexual assault are all a part of the CoC's triage/intake process used in the New Bedford CoC's Coordinated Entry System (CES). Specifically, Catholic Social Services, the agency providing the CoC's CES offers training to the CES team focusing on best practices in working with folks who may be survivors of domestic violence/sexual predation in a trauma-informed manner while ensuring they are able to access the appropriate resources for safety planning. The CES has frequent contact with the local domestic violence service provider (GNB Women's Center) to maintain open communication and ask specific questions as to how to increase best practices for CES and interaction with survivors presenting to the CES team. Additionally, the CoC's Coordinated Entry staff are mandated to participate in the annual trainings offered by the WC and are provided ongoing technical assistance and supervision that addresses survivor protocols through the coordinated entry/assessment process.

1C-5a.	**Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Using De-identified Aggregate Data.**	
	NOFO Section VII.B.1.e.	

Describe in the field below how your CoC uses de-identified aggregate data from a comparable database to assess the special needs related to domestic violence, dating violence, sexual assault, and stalking survivors.

(limit 2,000 characters)

The New Bedford CoC has, since January of 2019, transitioned to a new HMIS

vendor (CaseWorthy). In so doing, the CoC (through its administrative arm, the City's Office of Housing and Community Development—OHCD) at that time reviewed the means by which it had been collecting data from domestic violence/dating violence/sexual assault/stalking and trafficking providers and challenges that had resulted. With the CaseWorthy system, the OHCD is now able to take de-identified aggregate .csv files from domestic violence providers and import it directly into the HMIS system. In this way the aggregated data now more cleanly aligns with HMIS data thereby providing greater comprehensive and ongoing representation of the domestic violence survivor cohort ensuring strategically placed initiatives can be developed. In addition, other data is collected and used to inform and assess needs related to these cohorts including: data collected from a CDBG funded DV advocate embedded within the NB Police Dept, anecdotal data from providers of domestic violence services, police and court, folks that work within multiple systems on behalf of their clients who identify as part of this cohort, other human service providers, those trained to work with survivors in general but not at the more intensive level typically associated with victim service providers (VSPs), other persons not falling into the aforementioned groups, those who may find themselves in a position of being confided in or turned to for advice/referrals (such has been the case with a university staff member), data from community gatherings, public forums, outreach through surveys, data collected by community services throughout the city/CoC, coordinated entry data, PIT/HIC Count annual data collections and LGBTQ+ Allies' data.

1C-5b.	**Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Coordinated Assessment–Safety, Planning, and Confidentiality Protocols.**	
	NOFO Section VII.B.1.e.	

	Describe in the field below how your CoC's coordinated entry system protocols incorporate trauma-informed, victim-centered approaches while maximizing client choice for housing and services that:
1.	**prioritize safety;**
2.	**use emergency transfer plan; and**
3.	**ensure confidentiality.**

(limit 2,000 characters)

1.The CoC's coord entry system (CES) protocols & CoC written standards ensure those seeking services for DV/Dating Violence/Sexual Assault/ Trafficking/Stalking receive immediate assistance to ensure safety during their housing crisis. CES ensures clients who identify as being in danger because of any form of sexual predation—one of the first questions asked of callers—are offered rapid safety planning assistance. Those identified as victims/fleeing are considered vulnerable and given the highest priority within the CoC's prioritization protocol.2.The CoC's emergency transfer plan involves frequent communication btwn CES staff and the CoC's sole DV shelter/VSP—the NB Women's Center (WC) ensuring a smooth/safe transition for those seeking services. The WC partners with the CES providing assessment/action related to individs/families presenting as fleeing DV or those later found to be in danger post-intake/whose safety is otherwise compromised; they're immed. referred to the WC for emerg. transfer and/or safety planning where a trauma-informed, victim centered model is used prioritizing safety/confidentiality/client choice to id appropriate housing/supports for DV survivors. The WC team follows a supportive, non-judgmental approach to ensure survivors aren't re-traumatized

and offers training to CES and project providers to ensure protocols for survivor safety/choice are met. 3.CES and the WC require written releases to facilitate sharing of any info with the client's permission within strict time limits. Clients are offered choice in next steps+given the info they need to make an informed decision about what's best for them/what will afford them the greatest safety/peace of mind. While it's often necessary to place a hhld in an undisclosed location due to safety concerns, the CoC strives to ensure the hhld has control/choices/options when selecting a safety plan.

1C-6.	**Addressing the Needs of Lesbian, Gay, Bisexual, Transgender–Anti-Discrimination Policy and Training.**	
	NOFO Section VII.B.1.f.	

1.	**Did your CoC implement a written CoC-wide anti-discrimination policy ensuring that LGBT individuals and families receive supportive services, shelter, and housing free from discrimination?**	Yes
2.	**Did your CoC conduct annual CoC-wide training with providers on how to effectively implement the Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity (Equal Access Final Rule)?**	Yes
3.	**Did your CoC conduct annual CoC-wide training with providers on how to effectively implement Equal Access to Housing in HUD Programs in Accordance with an Individual's Gender Identity (Gender Identity Final Rule)?**	Yes

1C-7.	**Public Housing Agencies within Your CoC's Geographic Area–New Admissions–General/Limited Preference–Moving On Strategy. You Must Upload an Attachment(s) to the 4B. Attachments Screen.**	
	NOFO Section VII.B.1.g.	

Enter information in the chart below for the two largest PHAs highlighted in gray on the CoC-PHA Crosswalk Report at https://files.hudexchange.info/resources/documents/FY-2020-CoC-PHA-Crosswalk-Report.pdf or the two PHAs your CoC has a working relationship with–if there is only one PHA in your CoC's geographic area, provide information on the one:

Public Housing Agency Name	Enter the Percent of New Admissions into Public Housing and Housing Choice Voucher Program During FY 2020 who were experiencing homelessness at entry	Does the PHA have a General or Limited Homeless Preference?	Does the PHA have a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On?
New Bedford Housing Authority	92%	Yes-Both	No

1C-7a.	**Written Policies on Homeless Admission Preferences with PHAs.**	
	NOFO Section VII.B.1.g.	

	Describe in the field below:
1.	**steps your CoC has taken, with the two largest PHAs within your CoC's geographic area or the two PHAs your CoC has working relationships with, to adopt a homeless admission preference–if your CoC only has one PHA within its geographic area, you may respond for the one; or**
2.	**state that your CoC has not worked with the PHAs in its geographic area to adopt a homeless admission preference.**

(limit 2,000 characters)

1.The New Bedford's CoC is not only privileged to have an excellent working relationship with the New Bedford Housing Authority (NBHA) but it is additionally fortunate that the NBHA understands the importance of having an established homeless admission preference, ensuring that it consistently exercises that preference by committing the highest quality services in ensuring safe, stable housing for those coming out of homelessness. To this end, the NBHA has adopted a homeless admission preference in both its Public Housing and its HCV programs. The NBHA annually places large numbers of individuals and families experiencing homelessness into housing through its own housing authority properties and through its Section 8 voucher program (Housing Choice Vouchers-HCV). 2.Because the CoC does work with the one PHA within its geographic area as noted under (1), this question is not applicable.

1C-7b.	**Moving On Strategy with Affordable Housing Providers.**	
	Not Scored–For Information Only	

Select yes or no in the chart below to indicate affordable housing providers in your CoC's jurisdiction that your recipients use to move program participants to other subsidized housing:

1.	**Multifamily assisted housing owners**	Yes
2.	**PHA**	Yes
3.	**Low Income Tax Credit (LIHTC) developments**	Yes
4.	**Local low-income housing programs**	Yes
	Other (limit 150 characters)	
5.		

1C-7c.	**Including PHA-Funded Units in Your CoC's Coordinated Entry System.**	
	NOFO Section VII.B.1.g.	

Does your CoC include PHA-funded units in the CoC's coordinated entry process?	No

1C-7c.1.	**Method for Including PHA-Funded Units in Your CoC's Coordinated Entry System.**	
	NOFO Section VII.B.1.g.	

	If you selected yes in question 1C-7c., describe in the field below:
1.	**how your CoC includes the units in its Coordinated Entry process; and**
2.	**whether your CoC's practices are formalized in written agreements with the PHA, e.g., MOUs.**

(limit 2,000 characters)

1C-7d.	Submitting CoC and PHA Joint Applications for Funding for People Experiencing Homelessness.	
	NOFO Section VII.B.1.g.	

Did your CoC coordinate with a PHA(s) to submit a joint application(s) for funding of projects serving families experiencing homelessness (e.g., applications for mainstream vouchers, Family Unification Program (FUP), other non-federal programs)?	No

1C-7d.1.	CoC and PHA Joint Application–Experience–Benefits.	
	NOFO Section VII.B.1.g.	

	If you selected yes to question 1C-7d, describe in the field below:
1.	the type of joint project applied for;
2.	whether the application was approved; and
3.	how your CoC and families experiencing homelessness benefited from the coordination.

(limit 2,000 characters)

1C-7e.	Coordinating with PHA(s) to Apply for or Implement HCV Dedicated to Homelessness Including American Rescue Plan Vouchers.	
	NOFO Section VII.B.1.g.	

Did your CoC coordinate with any PHA to apply for or implement funding provided for Housing Choice Vouchers dedicated to homelessness, including vouchers provided through the American Rescue Plan?	Yes

1C-7e.1.	Coordinating with PHA(s) to Administer Emergency Housing Voucher (EHV) Program–List of PHAs with MOUs.	
	Not Scored–For Information Only	

Did your CoC enter into a Memorandum of Understanding (MOU) with any PHA to administer the EHV Program?	Yes

If you select yes, you must use the list feature below to enter the name of every PHA your CoC has entered into a MOU with to administer the Emergency Housing Voucher Program.

PHA
New Bedford Housi...
MA Dept of Housin...

1C-7e.1. List of PHAs with MOUs

Name of PHA: New Bedford Housing Authority

1C-7e.1. List of PHAs with MOUs

Name of PHA: MA Dept of Housing & Community Development

1C. Coordination and Engagement–Coordination with Federal, State, Local, Private, and Other Organiza

1C-8.	Discharge Planning Coordination.	
	NOFO Section VII.B.1.h.	

Select yes or no in the chart below to indicate whether your CoC actively coordinates with the systems of care listed to ensure persons who have resided in them longer than 90 days are not discharged directly to the streets, emergency shelters, or other homeless assistance programs.

1. Foster Care	Yes
2. Health Care	Yes
3. Mental Health Care	Yes
4. Correctional Facilities	Yes

1C-9.	Housing First–Lowering Barriers to Entry.	
	NOFO Section VII.B.1.i.	

1.	**Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects your CoC is applying for in FY 2021 CoC Program Competition.**	8
2.	**Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects your CoC is applying for in FY 2021 CoC Program Competition that have adopted the Housing First approach.**	8
3.	**This number is a calculation of the percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects the CoC has ranked in its CoC Priority Listing in the FY 2021 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.**	100%

1C-9a.	Housing First–Project Evaluation.	
	NOFO Section VII.B.1.i.	

Describe in the field below how your CoC regularly evaluates projects to ensure those that commit to using a Housing First approach are prioritizing rapid placement and stabilization in permanent housing and are not requiring service participation or preconditions of program participants.

(limit 2,000 characters)

The City of New Bedford's Office of Housing & Community Development (OHCD) serves not only as the collaborative applicant and lead for the MA-505 CoC, but it is also the recipient of all ESG and CoC funding and administering entity that oversees subrecipient agencies who operate such projects. In this

capacity, the OHCD is responsible for monitoring all projects on an ongoing basis and in so doing, conducts ongoing monitoring of all projects who have committed to using a Housing First approach. This is largely accomplished on three fronts: (a)In the course of its monitoring, the OHCD requires quarterly reporting of all subrecipients that includes both statistical performance data as well as narrative documentation where the subrecipient has an opportunity to demonstrate/discuss the extent to which they have been working to prioritize client stabilization and rapid movement into permanent housing. Performance metrics, themselves are reviewed in these quarterly reports to ensure the projects are successfully ensuring rapid sustainability so as to increase the likelihood of success in quickly moving to permanent settings. (b)On an annual basis, risk monitoring is performed by the OHCD and on-site monitoring visits that include the review of client files and agency/program operational details are conducted. During these visits OHCD monitoring staff look for evidence that projects are, in fact, appropriately reflecting the approach of the housing first model. (c)The NB CoC also sets forth in its Written Standards the importance and primacy of the Housing First approach and sets that as a baseline expectation for all relevant projects. Failure to follow this model are reflected in monitoring concerns.

1C-9b.	**Housing First–Veterans.**	
	Not Scored–For Information Only	

Does your CoC have sufficient resources to ensure each Veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach?	Yes

1C-10.	**Street Outreach–Scope.**	
	NOFO Section VII.B.1.j.	

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

(limit 2,000 characters)

1.The NB CoC's outreach strategy is a public/private effort following protocols established in 2017 by a coalition of city government and CoC members including key partners from the faith community. The resulting Homeless Emergency Assistance Resource Team (HEART) protocols ensure a compassionate, consistent and comprehensive outreach approach to effectively address encampments and instances of unsheltered individuals/ families living throughout the CoC. The HEART outreach protocols include four strategies—immediate response, ongoing outreach, supportive program capacity building and best practices/innovative approaches—and outreach is conducted on an ongoing basis. In addition to the Mobile Ministries food truck and shelter staff's own outreach efforts, the City allocates funding through its ESG for a Street Outreach position.2.The CoC's outreach covers 100% of the

CoC's entire geographic area. 3.Street outreach is conducted weekly or more often as needed. Findings, issues and concerns reporting is provided every month at each CoC member meeting. 4.New Bedford's HEART outreach is rooted in building trust and forming relationships to further that trust. CoC members Mobile Ministries and shelter/street outreach staff from Steppingstone, Inc. along with other CoC members constituting the HEART team work diligently to provide an empathetic response to those living in unsheltered conditions including providing food, medical attention, resources—both immediate and long-term—and rehousing alternatives. The CoC uses this approach to connect with those least likely to "come in" and least likely to request or accept any assistance. In this regard the outreach strategy includes monthly triage at CoC meetings and the Community Crisis Intervention Team meetings; additionally, the Sr.Rose Soup Kitchen partners with the local hospital to connect hard to reach individuals with pressing med. needs in a confidential safe setting.

1C-11.	**Criminalization of Homelessness.**	
	NOFO Section VII.B.1.k.	

Select yes or no in the chart below to indicate strategies your CoC implemented to prevent the criminalization of homelessness in your CoC's geographic area:

1.	**Engaged/educated local policymakers**	Yes
2.	**Engaged/educated law enforcement**	Yes
3.	**Engaged/educated local business leaders**	Yes
4.	**Implemented communitywide plans**	Yes
5.	**Other:(limit 500 characters)**	
	LEAD (COMMUNITY DIVERSION/COMMTY POLICING PROGRAM), RISE UP FOR HOMES	Yes

1C-12.	**Rapid Rehousing–RRH Beds as Reported in the Housing Inventory Count (HIC).**	
	NOFO Section VII.B.1.l.	

	2020	**2021**
Enter the total number of RRH beds available to serve all populations as reported in the HIC–only enter bed data for projects that have an inventory type of "Current."	38	41

1C-13.	**Mainstream Benefits and Other Assistance–Healthcare–Enrollment/Effective Utilization.**	
	NOFO Section VII.B.1.m.	

Indicate in the chart below whether your CoC assists persons experiencing homelessness with enrolling in health insurance and effectively using Medicaid and other benefits.

	Type of Health Care	Assist with Enrollment?	Assist with Utilization of Benefits?
1.	**Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)**	Yes	Yes
2.	**Private Insurers**	Yes	Yes
3.	**Nonprofit, Philanthropic**	Yes	Yes
4.	**Other (limit 150 characters)**		
	SOAR CERTIFIED PROVIDERS	Yes	Yes

1C-13a.	**Mainstream Benefits and Other Assistance–Information and Training.**	
	NOFO Section VII.B.1.m	

	Describe in the field below how your CoC provides information and training to CoC Program-funded projects by:
1.	**systemically providing up to date information on mainstream resources available for program participants (e.g., Food Stamps, SSI, TANF, substance abuse programs) within your CoC's geographic area;**
2.	**communicating information about available mainstream resources and other assistance and how often your CoC communicates this information;**
3.	**working with projects to collaborate with healthcare organizations to assist program participants with enrolling in health insurance; and**
4.	**providing assistance with the effective use of Medicaid and other benefits.**

(limit 2,000 characters)

1.The CoC regularly updates mbrs on mainstream resource availability by providing trainings in CoC meetings and sending out HUD/other resource updates including updates from MEDICAID, MA Health, SAMSHA, HHS, Benefits.gov, the VA, etc; this is most frequently done through a large email listserve with hundreds of recipients. Each CoC meeting includes mainstream resource discussion and/or distribution of available resources, training to access resources, etc. These particular methods have proven quite successful because multiple government agencies attend/participate in the CoC's monthly meetings. The CoC lead as HUD grantee also provides regular tech assistance to all providers (CoC, ESG, etc.) ensuring they are apprised of state and federal mainstream updates, trainings and benefit changes. Finally, population-specific training is offered during monthly family and individual service meetings. 2.Info is disseminated via email blasts to the entire CoC membership whenever HUD releases new information or state/private vendors share new info-generally sent twice monthly. Additional/more detailed information is also provided through annual trainings and two annual tech workshops. 3.The local health care system is well represented within the CoC: the largest hospital/health system's rep sits on the CoC Exec Committee and the local health clinic participates in every single CoC meeting. Because of this contact, projects have great access on a regular basis to health systems. Additionally, specialized staff working with the elderly has also presented to/works with the CoC on educating folks as to how to connect clients with MassHealth. 4.The CoC provides assistance with effective utilization of Medicaid etc by ensuring its projects have access to training materials and are connected with locally based resources that provide support and training.

1C-14.	**Centralized or Coordinated Entry System–Assessment Tool. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.1.n.	

	Describe in the field below how your CoC's coordinated entry system:
1.	covers 100 percent of your CoC's geographic area;
2.	reaches people who are least likely to apply for homeless assistance in the absence of special outreach;
3.	prioritizes people most in need of assistance; and
4.	ensures people most in need of assistance receive assistance in a timely manner.

(limit 2,000 characters)

1.The New Bedford Coordinated Entry System (NBCES) covers the entire CoC geographic area, which is the City of New Bedford. 2.The NBCES reaches those least likely to apply for homeless assistance in several ways: (a) The NBCES may be reached by phone or TTY. (b) The NBCES relies on targeted diversion strategies evidenced by SPMs that reveal a continued reduction of first-time homelessness for those entering emergency/ transitional housing in the New Bedford CoC. (c)The NBCES directly markets to the NB school system, senior centers, housing court, NB Connect (resource) event and agencies providing mental health and substance use services. 3.The assessment process begins with inquiries as to safety as relates to domestic violence, etc. and then looks to strategic diversion practices to prevent homelessness. If diversion doesn't work, the NBCES' operation continues to reflect the CoC's "Order of Priorities" as articulated in the continuum's written standards. Although MA is a right-to-shelter state necessitating all family emergency shelter needs go through the state, not the local CoC, individuals seeking emergency shelter in the NB CoC contact shelters directly. There are no waiting lists for individual emergency shelter in the NB CoC, and therefore no assessment is undertaken for admission to individual shelter. The NBCES prioritization is rooted in the SPDAT (families, individuals, youth) for placement on the waiting list permanent housing within the CoC, thus assuring that those households with the greatest need are prioritized. 4.To ensure that those with the greatest need are served in a timely fashion the NB CoC strives to provide barrier free and low-barrier access to services. Individuals seeking emergency shelter access are referred directly to shelter and not assessed by NBCES. Households in need of ESG HP or RRH services are provided a referral to an ESG provider within 24 hours of assessment.

1C-15.	Promoting Racial Equity in Homelessness–Assessing Racial Disparities.	
	NOFO Section VII.B.1.o.	

Did your CoC conduct an assessment of whether disparities in the provision or outcome of homeless assistance exists within the last 3 years?	Yes

1C-15a.	Racial Disparities Assessment Results.	
	NOFO Section VII.B.1.o.	

Select yes or no in the chart below to indicate the findings from your CoC's most recent racial disparities assessment.

1.	**People of different races or ethnicities are more likely to receive homeless assistance.**	Yes
2.	**People of different races or ethnicities are less likely to receive homeless assistance.**	No
3.	**People of different races or ethnicities are more likely to receive a positive outcome from homeless assistance.**	No
4.	**People of different races or ethnicities are less likely to receive a positive outcome from homeless assistance.**	Yes
5.	**There are no racial or ethnic disparities in the provision or outcome of homeless assistance.**	No
6.	**The results are inconclusive for racial or ethnic disparities in the provision or outcome of homeless assistance.**	No

1C-15b.	**Strategies to Address Racial Disparities.**	
	NOFO Section VII.B.1.o.	

Select yes or no in the chart below to indicate the strategies your CoC is using to address any racial disparities.

1.	**The CoC's board and decisionmaking bodies are representative of the population served in the CoC.**	Yes
2.	**The CoC has identified steps it will take to help the CoC board and decisionmaking bodies better reflect the population served in the CoC.**	Yes
3.	**The CoC is expanding outreach in geographic areas with higher concentrations of underrepresented groups.**	Yes
4.	**The CoC has communication, such as flyers, websites, or other materials, inclusive of underrepresented groups.**	Yes
5.	**The CoC is training staff working in the homeless services sector to better understand racism and the intersection of racism and homelessness.**	Yes
6.	**The CoC is establishing professional development opportunities to identify and invest in emerging leaders of different races and ethnicities in the homelessness sector.**	Yes
7.	**The CoC has staff, committees, or other resources charged with analyzing and addressing racial disparities related to homelessness.**	Yes
8.	**The CoC is educating organizations, stakeholders, boards of directors for local and national nonprofit organizations working on homelessness on the topic of creating greater racial and ethnic diversity.**	Yes
9.	**The CoC reviewed coordinated entry processes to understand their impact on people of different races and ethnicities experiencing homelessness.**	Yes
10.	**The CoC is collecting data to better understand the pattern of program use for people of different races and ethnicities in its homeless services system.**	Yes
11.	**The CoC is conducting additional research to understand the scope and needs of different races or ethnicities experiencing homelessness.**	Yes
	Other:(limit 500 characters)	
12.	THE COC IS PRODUCING ITS OWN RACIAL DISPARITY REPORT EACH YEAR RE: SERVICES TO THOSE EXPERIENCING HOMELESSNESS.	Yes

1C-15c.	**Promoting Racial Equity in Homelessness Beyond Areas Identified in Racial Disparity Assessment.**	
	NOFO Section VII.B.1.o.	

Describe in the field below the steps your CoC and homeless providers have taken to improve racial equity in the provision and outcomes of assistance beyond just those areas identified in the racial disparity assessment.

(limit 2,000 characters)

The MA-505 CoC and its providers have taken multiple steps toward improving racial equity in the provision and outcomes of assistance beyond those areas identified in the racial disparity assessment. (a)The CoC created its first-ever Racial Equity Committee (REC) whose key role includes developing constructive dialogue, analysis and proposed actions to affect more positive outcomes for minorities disproportionately impacted by conditions leading to homelessness. The REC's responsibilities include assisting CoC member agencies in creating more leadership opportunities for BIPOC and marginalized communities and helping the CoC move toward greater inclusivity. (b)An analysis of local data is used to produce an annual Racial Disparity Study each year to help the CoC align its actions toward improving equity performance. (c)The CoC, through its REC, is actively working with organizations to help build capacity and support continuum participant growth and demystification of systemic and institutionalized equity issues in their respective organizations and programs. To this end the REC sponsored a conversation with the CoC regarding Racial Equity led by the City of New Bedford Health Director in the midst of COVID. (d)Monthly emails to the CoC listserve are being sent out focusing on Racial Equity information. (e)Upon analysis of local data, the CoC acknowledged that racial and linguistic disparities do exist in the service provision of those experiencing homelessness. As a result the REC has both, begun the process of convening a focus group of Spanish-speaking people personally impacted by homelessness and are distributing the CoC's "StreetSheet" translated into Spanish to key stakeholders that interface with the Spanish-speaking population including the faith community and business community that support the Latino community.

1C-16.	**Persons with Lived Experience–Active CoC Participation.**	
	NOFO Section VII.B.1.p.	

Enter in the chart below the number of people with lived experience who currently participate in your CoC under the five categories listed:

	Level of Active Participation	Number of People with Lived Experience Within the Last 7 Years or Current Program Participant	Number of People with Lived Experience Coming from Unsheltered Situations
1.	**Included and provide input that is incorporated in the local planning process.**	0	3
2.	**Review and recommend revisions to local policies addressing homelessness related to coordinated entry, services, and housing.**	0	3
3.	**Participate on CoC committees, subcommittees, or workgroups.**	0	3
4.	**Included in the decisionmaking processes related to addressing homelessness.**	0	3
5.	**Included in the development or revision of your CoC's local competition rating factors.**	0	1

1C-17.	**Promoting Volunteerism and Community Service.**	
	NOFO Section VII.B.1.r.	

Select yes or no in the chart below to indicate steps your CoC has taken to promote and support community engagement among people experiencing homelessness in the CoC's geographic area:

1.	**The CoC trains provider organization staff on connecting program participants and people experiencing homelessness with education and job training opportunities.**	Yes
2.	**The CoC trains provider organization staff on facilitating informal employment opportunities for program participants and people experiencing homelessness (e.g., babysitting, housekeeping, food delivery, data entry).**	Yes
3.	**The CoC works with organizations to create volunteer opportunities for program participants.**	Yes
4.	**The CoC works with community organizations to create opportunities for civic participation for people experiencing homelessness (e.g., townhall forums, meeting with public officials).**	Yes
5.	**Provider organizations within the CoC have incentives for employment and/or volunteerism.**	Yes
6.	**Other:(limit 500 characters)**	
		Yes

1D. Addressing COVID-19 in the CoC's Geographic Area

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1D-1.	**Safety Protocols Implemented to Address Immediate Needs of People Experiencing Unsheltered, Congregate Emergency Shelter, Transitional Housing Homelessness.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below protocols your CoC implemented during the COVID-19 pandemic to address immediate safety needs for individuals and families living in:
1.	**unsheltered situations;**
2.	**congregate emergency shelters; and**
3.	**transitional housing.**

(limit 2,000 characters)

1.Unsheltered protocols: On 3.16.2020 a group of 40 orgs launched a daily ZOOM to address emerging needs of clients within the CoC focusing on those unsheltered/most vulnerable. Calls utilized a crowdsource approach to problem-solving addressing hygiene, food insecurity, access to medical and psychological care, reinforcement and support in getting the unsheltered out of unsafe situations into stabilized housing, issues of the CoC's congregate shelters and a host of other basic needs not being addressed with the shutdown of the community including. The group (Southcoast Response Corps—SCRC) is still operating on a daily basis to this day. 2.Congregate shelter protocols: (a)The CoC's shelter system was taxed because of reduced occupancy levels due to COVID distancing requirements. Alternative options and mitigation efforts created by the CoC/SCRC addressed unmet needs such as access to restrooms, showers, tent shelters, food distribution and hot meals. (b)Emergency outreach centers were established in 4 locations of the city to reach those displaced because of the pandemic. (c)With winter months quickly approaching, state disaster resources were leveraged to provide cold weather emergency shelter at a local motel to capture congregate overflow. Hotel rooms for 124 unique individuals were provided from Nov 2020 to Apr 2021. The program provided transport and food services for the participants. There were 37avg served each frigid night. (d)The SCRC/CoC responded quickly/efficiently utilizing its network to meet the needs of more than 70 people displaced by multiple fires during that time, diverting them from congregate shelter and facilitating other resources to prevent homelessness. 3.Transitional Housing protocols: Largest provider of TH undertook strict safety and hygiene measures to ensure the facility's self-sufficiency, limited public exposure and persistently

successful social distancing that has, to date, resulted in no COVID cases.

1D-2.	Improving Readiness for Future Public Health Emergencies.	
	NOFO Section VII.B.1.q.	

Describe in the field below how your CoC improved readiness for future public health emergencies.

(limit 2,000 characters)

Efforts have improved the MA-505 CoC's readiness for future public health emergencies: (a)The SouthCoast Response Corps (SCRC) estb March 2020 continues to meet daily as a community network and has evolved over the past 18-months with a proactive mission that's led to creation of special focus groups. These SCRC focus groups include Housing, COVID Response, Youth/Education and a growing Food Insecurity spin-off group. The SCRC has allowed the community to more nimbly respond to emergency needs beyond pandemic-related issues where previously no such mechanism was in place. Examples of the CoC's resulting improved readiness because of the SCRC includes coalescing resources to support fire victims, hosting care giver support training and linking w/govt officials so they can hear from those with "boots on the ground." The SCRC has also provided a community space for discussion, innovation and collaboration on outreach events and connectivity vital in securing outside funding opportunities. SCRC members secured a $400k grant to provide COVID outreach and support services to vulnerable populations (homeless, mental health, immigrants, etc.). The CoC's improved readiness in responding to future public health emergencies has proactively begun with the SCRC's ability to coalesce once divergent community efforts, engendering interagency trust building new partnerships—attributable largely because folks regularly tune in at 11am for 30 minutes for updates/strategy discussions. As much of the pandemic response has become more manageable, the SCRC is focused on new challenges including a huge wave of evictions in the CoC, a diminished housing inventory and an emerging methamphetamine/Fentanyl crisis. (b)The City of New Bedford (constituting 100% of the New Bedford CoC) has developed a City Resiliency Plan that includes specific public health and safety vision that articulates actionable steps to mitigate vulnerabilities to future and chronic stressors and conditions.

1D-3.	CoC Coordination to Distribute ESG Cares Act (ESG-CV) Funds.	
	NOFO Section VII.B.1.q	

	Describe in the field below how your CoC coordinated with ESG-CV recipients to distribute funds to address:
1.	safety measures;
2.	housing assistance;
3.	eviction prevention;
4.	healthcare supplies; and
5.	sanitary supplies.

(limit 2,000 characters)

The availability of two different rounds of ESG-CV funding was widely advertised at the time of availability and both focus groups and surveys were conducted by the City's OHCD to ensure robust public participation. As the OHCD serves as both recipient of ESG-CV funding and lead agency/collaborative applicant for the CoC, collaboration was a natural fit in both outreach, program development and oversight of execution. Specifically: 1.Safety: Arising from the CoC's collective understanding of critical safety issues developing as the pandemic began, funding was awarded to the Women's Center for DV services and measures were taken to ensure protection of shelter staff including the use of ESG-CV funding for hazard pay + PPEs. 2.Housing: Projects were funded with ESG-CV dollars whose purpose was to prevent homelessness and/or rapidly re-house those experiencing homelessness esp. those affected by COVID-19. These projects include wrap-around resources to tenants to prevent eviction and homelessness in the wake of the end of the state and federal eviction moratoria. Financial assistance in order to ensure continued tenancies was similarly funded along with legal services in support of tenancy preservation. 3.Eviction Prevention: ESG-CV funding was used in support of South Coastal Counties Legal Services' (SCCLS) efforts at staving off evictions. The SCCLS, an active member of the CoC and part of the Exec Board, partnered with a lead agency receiving ESG-CV funding for HP and RRH efforts. 4.Healthcare Supplies: ESG-CV funding enabled shelters to ensure adequate healthcare supplies for those being served in their facilities; such needs were first articulated in daily COVID calls amongst a CoC led response effort. 5.Sanitary Supplies: Funding from ESG-CV specifically provided much needed supplies to the CoC's congregate shelters without which they would be unable to provide the ongoing cleaning and decontamination needed to ensure safety for clients and staff alike.

1D-4.	**CoC Coordination with Mainstream Health.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below how your CoC coordinated with mainstream health (e.g., local and state health agencies, hospitals) during the COVID-19 pandemic to:
1.	**decrease the spread of COVID-19; and**
2.	**ensure safety measures were implemented (e.g., social distancing, hand washing/sanitizing, masks).**

(limit 2,000 characters)

1.The Southcoast Response Corps (SCRC), a group of CoC agency providers formed during, and in response to, COVID-19, continues to meet daily since March of 2020 to share materials, resources and strategies for decreasing the spread of COVID-19. Among its accomplishments has been: ensuring adequate/ongoing supplies of masks, sanitizer and other PPE; working with the health department to establish mobile clinics in underserved neighborhoods; securing grant funding from the State to provide Navigation for underserved populations such as homeless, SUD, MH affected individuals; providing outdoor and socially distanced support services such as food distribution at large sites throughout the community, providing home deliveries for people that were shut in or struggling with COVID disease and coordinating weekly clinics for testing and vaccinations with the GNB Community Health Center and Seven Hills who also provide ongoing support, guidance and testing to residents of local emergency shelters. 2.The SCRC created distribution networks among CoC members for various supplies that were at times scarce. Additionally, the

SCRC has provided training on best practice safety guidance and support services such as Help & Hope Campaign that provide mental health support to workers and clients, community rest areas were created for unsheltered/displaced residents who were in need of bathroom facilities during the shutdown; the SCRC worked closely with the Department of Health Director and staff to provide outreach/support to people living on streets during this time, coordinated with state entities to expand shelter options that maintained distancing and COVID protocols. Of not has been the phenomenal collaboration between agencies in the CoC whose collective effort was reflected in the excellence of the response.

1D-5.	**Communicating Information to Homeless Service Providers.**	
	NOFO Section VII.B.1.q.	

	Describe in the field below how your CoC communicated information to homeless service providers during the COVID-19 pandemic on:
1.	**safety measures;**
2.	**changing local restrictions; and**
3.	**vaccine implementation.**

(limit 2,000 characters)

1.Safety Measures - The SCRC hosted a daily call where updates on restrictions and safety measures were covered. A daily notification alert email detailing updates and resources was also sent to our network of more than 200 human services providers. These communications included updates on everything from food insecurity to COVID response to mental health resources and all basic needs. The calls were also used as an opportunity to address special needs for emergent challenges such as fire response, mobile testing/vaccination sites and new food distribution sites. 2.Changing Restrictions – The daily call provided regular opportunity to make adjustments and address changing local restrictions and updates to quarantine policy. Similarly the call facilitated sharing of the latest updates on the rate and clusters of infection and was able to mobilize outreach and resources to hard hit areas. The CoC, itself, actively communicated with its entire listserve on a weekly basis providing regular updates, COVID-based resources, local opportunities for agencies/staff and clients, guidance and HUD notifications. 3.Vaccine Implementation: Members of the COC and SCRC collaborated to outreach to underserved communities such as Spanish speaking immigrants, BIPOC and people suffering from mental health, substance use disorder and those experiencing homelessness. The network brought together key partners that specialize in connecting these hard-to-reach populations with vaccination assistance navigators (24 trained individuals). The Navigators' primary role was/continues to be to engage these identified populations with access to vaccine, the latest information, protocols and any other support they need to remain safe. The teams have been on the streets throughout the pandemic hosting weekly outreach events, going door-to-door and meeting people wherever they may be with a message of hope and resources to ensure safety.

1D-6.	**Identifying Eligible Persons Experiencing Homelessness for COVID-19 Vaccination.**	

NOFO Section VII.B.1.q.

Describe in the field below how your CoC identified eligible individuals and families experiencing homelessness for COVID-19 vaccination based on local protocol.

(limit 2,000 characters)

CoC Identification Protocol: The leadership of the CoC met regularly (at least weekly) with community medical leaders such as the Department of Health and Local Hospitals to discuss rates of infections, community strategy to testing and mass vaccinations. All the COVID response work of the CoC has been directed in concert with Health Department leadership and guidance. From the outset of the pandemic there has consistently been a great deal of attention given to the operation of congregate emergency shelters to ensure their safety. As a result, there was a very low COVID transmission rate in these facilities.Testing clinics were of key importance early in the pandemic so testing sites were developed in key underserved areas of the community with CoC/SCRC member assistance. There were upwards of 300 plus tests administered per day at the high point of the pandemic.

As vaccines came online, the focus has shifted from testing to mass vaccination sites which have been very successful. However it is important to note that it has been the establishment of targeted, smaller neighborhood based sites and mobile outreach implemented to reach disenfranchised populations is largely credited with the reason vaccination rates are as high as they are in this CoC. For example, CoC member Seven Hills' presence at the main (SRTA) bus terminal each week ensures the most vulnerable are given easy access to the vaccine in a non-threatening manner. Pop-up vaccination clinics were held outdoors throughout the community and at outreach events such as NB Connect Resource Event in September 2020 and 2021. Sister Rose (individual congregate shelter) conducted several vaccine clinics on site bringing the vaccines directly to the shelter through a partnership with CoC member Greater New Bedford Community Health Center. Ongoing mobile clinics and outreach continue to this day affording access is operated throughout the city by Seven Hills and the Vaccination Connect network.

1D-7.	Addressing Possible Increases in Domestic Violence.	
	NOFO Section VII.B.1.e.	

Describe in the field below how your CoC addressed possible increases in domestic violence calls for assistance due to requirements to stay at home, increased unemployment, etc. during the COVID-19 pandemic.

(limit 2,000 characters)

During the pandemic the MA-505 CoC did see an increase in domestic violence calls. In response, the CoC took four major steps:
(a)ESG-funded victim service provider (VSP) (the New Bedford Women's Center) kept all three of its shelters open/fully operational throughout the pandemic. Funding for hotel rooms was also made available to serve victims of violence who were awaiting shelter placement. During the height of the pandemic, additional shelter families were housed in Safehome space. Housing was supplemented with community-based services and individual/group

counseling was provided virtually and in-person. By instituting careful infection prevention protocols, including requiring vaccines, weekly testing and mask-wearing for staff, this housing and supports were consistently available within the CoC. (b)Outreach efforts including ongoing radio ads and widely placed in four languages advertising resources assured that local victims/survivors were aware that help was available to them. (c)In March of 2020, a board member of the VSP, a doctor at the local community health center, visited all three DV shelters to talk to staff and residents about COVID-19. Her sobering presentation of the number of victims of the virus that could be expected within the CoC and the reality of the limited number of hospital beds available to serve them caused staff and residents alike to limit their own activities in the community to emergency medical appointments, only, for many months. During the worst months, DV shelter staff traveled from home to work & work to home with no stops to avoid the spread of the virus both to the shelters and into their homes (d)The SouthCoast Response Corps-a collaborative group from the HSPN—met/continues to meet virtually every morning to facilitate referrals between partners. Such collaboration and ongoing work on each of these fronts will continue until the crisis is past.

1D-8.	**Adjusting Centralized or Coordinated Entry System.**	
	NOFO Section VII.B.1.n.	

Describe in the field below how your CoC adjusted its coordinated entry system to account for rapid changes related to the onset and continuation of the COVID-19 pandemic.

(limit 2,000 characters)

During the COVID-19 pandemic, the NBCES remained open and active to respond to households in the area experiencing a housing crisis. Utilizing HUD guidance provided at the onset of the pandemic, the CoC evaluated its policies and procedures to ensure that vulnerable subpopulations at the highest risk for contracting and spreading COVID-19 (including both sheltered and unsheltered homeless) were prioritized for placement during the declared public health crisis. CoC leadership attending weekly HUD virtual office hours to keep current with CDC and HUD guidance, protocols, and emerging best practices to keep homeless households, as well as those working in the field as safe as possible. Weekly updates were then provided to all CoC providers to disseminate any new or changing CDC and HUD guidance. As the NB CoC is located in an area still identified as moderate to high risk of COVID transmission, CoC leadership continues to monitor and adapt the NBCES to reflect current HUD and CDC guidance regarding COVID-19 and households experiencing a housing crisis.

1E. Project Capacity, Review, and Ranking–Local Competition

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

1E-1.	**Announcement of 30-Day Local Competition Deadline–Advance Public Notice of How Your CoC Would Review, Rank, and Select Projects. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.a. and 2.g.	

1.	**Enter the date your CoC published the 30-day submission deadline for project applications for your CoC's local competition.**	09/10/2021
2.	**Enter the date your CoC publicly posted its local scoring and rating criteria, including point values, in advance of the local review and ranking process.**	09/10/2021

1E-2.	**Project Review and Ranking Process Your CoC Used in Its Local Competition. You Must Upload an Attachment to the 4B. Attachments Screen. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria listed below.**	
	NOFO Section VII.B.2.a., 2.b., 2.c., and 2.d.	

Select yes or no in the chart below to indicate how your CoC ranked and selected project applications during your local competition:

1.	**Established total points available for each project application type.**	Yes
2.	**At least 33 percent of the total points were based on objective criteria for the project application (e.g., cost effectiveness, timely draws, utilization rate, match, leverage), performance data, type of population served (e.g., DV, youth, Veterans, chronic homelessness), or type of housing proposed (e.g., PSH, RRH).**	Yes
3.	**At least 20 percent of the total points were based on system performance criteria for the project application (e.g., exits to permanent housing destinations, retention of permanent housing, length of time homeless, returns to homelessness).**	Yes
4.	**Used data from a comparable database to score projects submitted by victim service providers.**	Yes
5.	**Used objective criteria to evaluate how projects submitted by victim service providers improved safety for the population they serve.**	Yes
6.	**Used a specific method for evaluating projects based on the CoC's analysis of rapid returns to permanent housing.**	Yes

1E-2a.	**Project Review and Ranking Process–Addressing Severity of Needs and Vulnerabilities.**	

	NOFO Section VII.B.2.d.

	Describe in the field below how your CoC reviewed, scored, and selected projects based on:
1.	the specific severity of needs and vulnerabilities your CoC considered when ranking and selecting projects; and
2.	considerations your CoC gave to projects that provide housing and services to the hardest to serve populations that could result in lower performance levels but are projects your CoC needs in its geographic area.

(limit 2,000 characters)

1.The CoC's evaluation and scoring criteria for permanent housing projects includes consideration of severity of needs and vulnerabilities. Specifically, the CoC prioritizes projects that serve individuals and families who are chronically homeless with the longest histories of homelessness, disabilities and most severe service needs. Of these, survivors of domestic violence/sexual assault/trafficking and/or stalking, along with veterans, families and unaccompanied youth have the highest priority. Individuals and families with higher barriers to housing and higher service needs who are waiting to obtain another permanent housing subsidy are prioritized over others in considering rapid rehousing projects for those at risk of homelessness. Given these priorities, such aspects always factor into the selection and ranking of projects.
2.The CoC's Performance Review Committee (PRC) reviews and scores all applications and ranks the projects, new and renewals alike, then provides its recommended ranking to the full CoC membership. The PRC does not simply meet on an annual basis to carry out these responsibilities but instead meets quarterly to review ESG and CoC quarterly reporting and data reports. In this way, the PRC has cultivated a working understanding of the rigors and challenges faced by each project and project type within the CoC. It is because of this that the PRC is able to appropriately consider how those populations hardest to serve fare within the CoC and within different program types. These individual and collective understanding/s are appropriated during all scoring criteria reviews, monitoring discussions and considerations of competitive review.

1E-3.	Promoting Racial Equity in the Local Review and Ranking Process.	
	NOFO Section VII.B.2.e.	

	Describe in the field below how your CoC:
1.	obtained input and included persons of different races, particularly those over-represented in the local homelessness population, when determining the rating factors used to review project applications;
2.	included persons of different races, particularly those over-represented in the local homelessness population, in the review, selection, and ranking process;
3.	rated and ranked projects based on the degree to which their program participants mirror the homeless population demographics (e.g., considers how a project promotes racial equity where individuals and families of different races are over-represented).

(limit 2,000 characters)

1.In establishing rating factors, the CoC solicited input from diverse individuals within the CoC, doing so thru the year as it established performance evaluation standards for projects against which the CoC's Performance Review Committee measures ongoing achievement. The CoC mbrshp. voting to adopt these standards/ corresponding rating factors included a significant number of individuals self-identifying as Black and others as Latinx. These two cohorts

account for those experiencing a disparate number of incidences of homelessness and were well-represented in both discussions preceding the establishment of rating factors as well as the vote that established them/perform stds. 2.Persons over-represented in the CoC's population experiencing or threatened with homelessness within the CoC were significant contributors in the review/selection/ranking process. In particular, the Performance Review Committee (PRC) of 5 who reviews applications and produces a draft slate of ranked projects included the Chair of the HSPN Racial Equity Committee who self identifies as Latina is directly involved with the scoring, ranking and selection of projects. The complete membership of the HSPN responsible for the final vote of the selection and ranking of projects reflects the population diversity experiencing homelessness. 3.Scoring of both new and renewal applications includes points specific to the degree to which racial equity was made a part of their programming. All Project Applications asked if the agency, specific to the proposed new project, intentionally/ effectively instituted racial equity initiatives and/or equity initiatives including efforts to obtain input/include historically marginalized pops when identifying barriers to participation faced by such persons. Follow up questions dependent on initial responses further sought information to better understand barriers, specific plans, etc.

1E-4.	**Reallocation–Reviewing Performance of Existing Projects. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criterion below.**	
	NOFO Section VII.B.2.f.	

	Describe in the field below:
1.	**your CoC's reallocation process, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed;**
2.	**whether your CoC identified any projects through this process during your local competition this year;**
3.	**whether your CoC reallocated any low performing or less needed projects during its local competition this year;**
4.	**why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable; and**
5.	**how your CoC communicated the reallocation process to project applicants.**

(limit 2,000 characters)

1.The CoC has a written reallocation process to determine whether an existing project has performed well and if it should be considered for reallocation. The HSPN develops annual performance standards for all programs and the review of performance through quarterly and annual performance reports is integral to the evaluation process. The OHCD staff monitors all programs and assists the HSPN Performance Review Committee (PRC) comprehensively assess agency capacity and ability to implement performance measure goals and objectives. Those demonstrating poor performance against these standards are considered for reallocation. 2.The CoC identified one project this year that experienced persistent poor performance, both through quarterly reporting and annual reporting. 3.There was one project identified in 2021 for reallocation in its entirety. 4.Not applicable as a project was identified for reallocation to higher performing projects. 5.The Reallocation process and the CoC's Reallocation Plan.2021 is a printed document posted on the continuum's website and discussed with the continuum membership. The subrecipient whose project was being reallocated had been working with the Office of Housing & Community Development (OHCD) staff for over a year because of continued programmatic

challenges they had been experiencing. Despite significant technical assistance, the program could not perform at an acceptable level and the project sponsor agency conceded that the project should be reallocated to a higher performing project in order to strengthen and better serve the continuum.

1E-4a.	**Reallocation Between FY 2016 and FY 2021. We use the response to this question as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criterion below.**	
	NOFO Section VII.B.2.f.	

Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2016 and FY 2021?	No

1E-5.	**Projects Rejected/Reduced–Public Posting. You Must Upload an Attachment to the 4B. Attachments Screen if You Select Yes.**	
	NOFO Section VII.B.2.g.	

1.	**Did your CoC reject or reduce any project application(s)?**	No
2.	**If you selected yes, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps.**	

1E-5a.	**Projects Accepted–Public Posting. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.g.	

Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps.	10/21/2021

1E-6.	**Web Posting of CoC-Approved Consolidated Application. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.2.g.	

Enter the date your CoC's Consolidated Application was posted on the CoC's website or affiliate's website–which included: 1. the CoC Application; 2. Priority Listings; and 3. all projects accepted, ranked where required, or rejected.	11/05/2021

2A. Homeless Management Information System (HMIS) Implementation

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

2A-1.	**HMIS Vendor.**	
	Not Scored–For Information Only	

Enter the name of the HMIS Vendor your CoC is currently using.	CASEWORTHY

2A-2.	**HMIS Implementation Coverage Area.**	
	Not Scored–For Information Only	

Select from dropdown menu your CoC's HMIS coverage area.	Single CoC

2A-3.	**HIC Data Submission in HDX.**	
	NOFO Section VII.B.3.a.	

Enter the date your CoC submitted its 2021 HIC data into HDX.	05/10/2021

2A-4.	**HMIS Implementation–Comparable Database for DV.**	
	NOFO Section VII.B.3.b.	

	Describe in the field below actions your CoC and HMIS Lead have taken to ensure DV housing and service providers in your CoC:
1.	**have a comparable database that collects the same data elements required in the HUD-published 2020 HMIS Data Standards; and**
2.	**submit de-identified aggregated system performance measures data for each project in the comparable database to your CoC and HMIS lead.**

(limit 2,000 characters)

The New Bedford Women's Center is the city's only domestic violence housing and service provider within the CoC and operates two shelters for survivors. As an Emergency Shelter Grant subrecipient and Victims Service Provider, the agency is required to report program performance using a HUD Approved HMIS-comparable database reflecting the latest HMIS data elements or standards and able to produce a CSV file for reporting purposes. All clients served at the two domestic violence shelters are entered into a secure HMIS-comparable system that is only used by the two DV shelters in order to maintain client confidentiality. The agency is able to enter client data into the HMIS system on a real-time basis and provide a HUD-required CSV excel file that is used for aggregated annual reporting, system performance and other required HUD reporting purposes without personally identifying information (PII). The SAGE CAPER report submitted by the agency meets all the required HMIS data elements including a de-identified aggregate report for SAGE. Currently, the agency is in the process of selecting a new HMIS data vendor who will satisfy all HUD requirements. The existing HMIS vendor has agreed to continue maintaining the system according to the most recently released 2020 data element or standards until a new vendor is selected.

2A-5.	**Bed Coverage Rate–Using HIC, HMIS Data–CoC Merger Bonus Points.**	
	NOFO Section VII.B.3.c. and VII.B.7.	

Enter 2021 HIC and HMIS data in the chart below by project type:

Project Type	Total Beds 2021 HIC	Total Beds in HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
1. Emergency Shelter (ES) beds	294	38	247	96.48%
2. Safe Haven (SH) beds	19	0	19	100.00%
3. Transitional Housing (TH) beds	89	17	72	100.00%
4. Rapid Re-Housing (RRH) beds	115	0	83	72.17%
5. Permanent Supportive Housing	297	0	242	81.48%
6. Other Permanent Housing (OPH)	0	0	0	

2A-5a.	**Partial Credit for Bed Coverage Rates at or Below 84.99 for Any Project Type in Question 2A-5.**	
	NOFO Section VII.B.3.c.	

	For each project type with a bed coverage rate that is at or below 84.99 percent in question 2A-5, describe:
1.	**steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent for that project type; and**
2.	**how your CoC will implement the steps described to increase bed coverage to at least 85 percent.**

(limit 2,000 characters)

1.STEPS: RRH Beds. The CoC has recently discovered that HomeBase RRH units administered by the Commonwealth of Massachusetts but provided locally within the CoC have not been consistently entered into the local MA-505 CoC's HMIS (despite being entered into the state HMIS). This has caused the figure to be incorrect and fall below the 85% threshold in this category. A meeting has

been set up between the HMIS lead, administering subrecipient agency and state RRH project grantee to review existing protocols and correct data entry issues to ensure all RRH beds are entered into the local HMIS going forward. PSH Beds. Of the projects providing PSH beds within this CoC, only one PSH does not currently participate in HMIS: Providence VA's HUD VASH vouchers. The VA has advised that this is something they are working toward. 2.IMPLEMENTATION: RRH Beds. Going forward the CoC's HMIS lead will review RRH beds being entered into the local HMIS to ensure all RRH beds are being accounted for and reflected within HMIS. PSH Beds: The CoC is working with the VA to create a workable solution to its participation in the HMIS going forward. It's first step will be to orient and train VA staff on how the CoC's HMIS works and will benefit their operation The timeliness of doing so over the past year has been hindered by COVID.

2A-5b.	**Bed Coverage Rate in Comparable Databases.**	
	NOFO Section VII.B.3.c.	

Enter the percentage of beds covered in comparable databases in your CoC's geographic area.	100.00%

2A-5b.1.	**Partial Credit for Bed Coverage Rates at or Below 84.99 for Question 2A-5b.**	
	NOFO Section VII.B.3.c.	

	If the bed coverage rate entered in question 2A-5b. is 84.99 percent or less, describe in the field below:
1.	**steps your CoC will take over the next 12 months to increase the bed coverage rate to at least 85 percent; and**
2.	**how your CoC will implement the steps described to increase bed coverage to at least 85 percent.**

(limit 2,000 characters)

2A-6.	**Longitudinal System Analysis (LSA) Submission in HDX 2.0.**	
	NOFO Section VII.B.3.d.	

Did your CoC submit LSA data to HUD in HDX 2.0 by January 15, 2021, 8 p.m. EST?	Yes

2B. Continuum of Care (CoC) Point-in-Time (PIT) Count

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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- 24 CFR part 578

2B-1.	**Sheltered and Unsheltered PIT Count–Commitment for Calendar Year 2022**	
	NOFO Section VII.B.4.b.	

Does your CoC commit to conducting a sheltered and unsheltered PIT count in Calendar Year 2022?	Yes

2B-2.	**Unsheltered Youth PIT Count–Commitment for Calendar Year 2022.**	
	NOFO Section VII.B.4.b.	

Does your CoC commit to implementing an unsheltered youth PIT count in Calendar Year 2022 that includes consultation and participation from youth serving organizations and youth with lived experience?	Yes

2C. System Performance

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
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2C-1.	**Reduction in the Number of First Time Homeless–Risk Factors.**	
	NOFO Section VII.B.5.b.	

	Describe in the field below:
1.	**how your CoC determined which risk factors your CoC uses to identify persons becoming homeless for the first time;**
2.	**how your CoC addresses individuals and families at risk of becoming homeless; and**
3.	**provide the name of the organization or position title that is responsible for overseeing your CoC's strategy to reduce the number of individuals and families experiencing homelessness for the first time or to end homelessness for individuals and families.**

(limit 2,000 characters)

1.The CoC's process in identifying risk factors begins with the CoC's By-Name Committees and its Street Outreach team; each are charged with reviewing actual circumstances these differing cohorts are experiencing prior to and when becoming homeless for the first time. The process includes evaluating PIT risk factors that have historically revealed a prevalence of mental health and/or substance use disorders among those becoming homeless for the first time. The CoC also uses ongoing monitoring of ESG/CoC projects by the City's OHCD for important insight into personal challenges (mental health, sub. abuse, etc.) and broader issues like those resulting from barriers to housing (landlords not allowing those with poor credit, etc). The CoC's HMIS has improved the ability to gather better data including demographics and vulnerability information from the CoC's CES. This reveals greater detail as to what folks are experiencing, the nature of their crisis and what they need to avoid homelessness. Additionally, if someone has experienced homelessness elsewhere in the county, data from one of two other CoC's sharing the HMIS database with this CoC can provide important information about how and why people are becoming homeless locally. 2.The CoC's strategy begins with dynamic targeting of prevention efforts. Other strategies include a Homeless Emergency Assistance Response (HEART) providing immediate response/innovation in addressing encampments, a community hospital Account Care Org (ACO)team of health workers engaging/supporting "high utilizers" of hospital ER services, most often those at risk of homelessness, active participation in the Community Crisis Intervention Team and the CoC's annual NB Connect resource event, providing housing, services, etc. 3.The OHCD/collaborative applicant is responsible for overseeing the CoC's strategy to reduce numbers of those becoming homeless for the first time.

2C-2.	Length of Time Homeless–Strategy to Reduce.	
	NOFO Section VII.B.5.c.	

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

(limit 2,000 characters)

1.The CoC's strategy to reduce the length of time individs/persons in families remain homeless continues to be rooted in the understanding that barriers presented by a stagnant shelter/housing pipeline result in longer experiences in homelessness. Given this, (a)EHVs have been prioritized to those in RRH/PSH ready to move on; (b)prevention is seen as critical so efforts to prevent homelessness (HP) are offered via several ESG, CDBG-CV and ESG-CV projects and diversion through the CoC's Coordinated Entry System (CES); (c)CoC RRH and ESG RRH projects both exist within the CoC and help to move folks interested in moving and requiring less supports to get quickly into PH-something supported by the CoC's Move On Strategy; (d)the CoC continues to pursue strategies like increasing the #units in private housing dedicated to persons transitioning from homelessness; (e)agencies w/PSH projects are actively working with private landlords and looking at development of a property owner engagement initiative and a possible property owner mitigation fund; (f)ongoing guidance and training to ensure program efficiencies continue. 2.The CoC relies on its CES to identify those experiencing homelessness for the longest lengths of time. Use of the SPDAT and careful assessment of chronic homelessness are two ways the CoC ensures those with the longest periods in crisis are prioritized for housing as quickly as possible. The lack of readily available housing stock and longer tenancies for those who are in PSH programs have challenged the CoC in keeping pace with increasing demand. 3.The OHCD is responsible for overseeing the CoC's strategy to reduce the length of time homeless for all.

2C-3.	Exits to Permanent Housing Destinations/Retention of Permanent Housing.	
	NOFO Section VII.B.5.d.	

	Describe in the field below how your CoC will increase the rate that individuals and persons in families residing in:
1.	emergency shelter, safe havens, transitional housing, and rapid rehousing exit to permanent housing destinations; and
2.	permanent housing projects retain their permanent housing or exit to permanent housing destinations.

(limit 2,000 characters)

1.The NB CoC strategy to increase the rate at which individs/families in ES/SH/TH/RRH exit to PH destinations is fourfold: (a) Effective use of the CoC's coordinated entry system—the CoC will continue to ensure all ES/SH/TH/RRH have staff fully trained on completing the SPDAT and referring participants to coordinated entry to gain entry to permanent supportive housing

programs. (b)Leveraging mainstream supportive services for those exiting to independent permanent housing. (c)Technical support to review data and examine trends/patterns including quarterly reporting to detect issues as they come about. (d)Active partnership with the local PHA in ensuring move-on opportunities and use of Emergency Housing Vouchers. 2.Permanent supportive housing projects are monitored by the OHCD and CoC to ensure services being provided focus on stability, retention and self-sufficiency in multiple ways. (a)The CoC partners with local educational/vocational resources providing participants with long term strategies for success in permanent housing. (b)Both formal and informal employment opportunities are cultivated to ensure sustainable earned income. (c)SOAR and similar trainings for staff are used to assist participants with increasing cash benefit income. (d)Partnerships with local agencies provide community case management services & recovery coaching to support participants exiting to permanent housing. (e)CoC Committee focusing on landlord relationships to enhance communication to increase retention in PH and prevent eviction.

2C-4.	**Returns to Homelessness–CoC's Strategy to Reduce Rate.**	
	NOFO Section VII.B.5.e.	

	Describe in the field below:
1.	**how your CoC identifies individuals and families who return to homelessness;**
2.	**your CoC's strategy to reduce the rate of additional returns to homelessness; and**
3.	**provide the name of the organization or position title that is responsible for overseeing your CoC's strategy to reduce the rate individuals and persons in families return to homelessness.**

(limit 2,000 characters)

1.The CoC's strategy to identify individuals/persons in families who return to homelessness begins first with the CoC's historic emphasis on stability in permanent housing. Additionally, identifying who is returning and arises from its coordinated entry and homeless management information systems. Despite being a right-to-shelter state for families experiencing homelessness, families who have lived in permanent supportive housing within the CoC typically contact the CoC's local coordinated entry for assistance thereby triggering their previous information within HMIS. For individuals experiencing homelessness, whether that person has been in permanent housing or sheltered within the CoC, their name/information similarly shows up on HMIS during that initial contact with coordinated entry. Those returning to homelessness are again assessed and placed in housing as rapidly as possible, ensuring that conditions that precipitated the return to homelessness are mitigated to the greatest extent possible to ensure long term, sustainable success in their permanent housing tenancy going forward. 2.As a proactive measure toward reducing the rate of additional returns to homelessness, the CoC strategically works to increase focus on prevention and enhances training opportunities around housing first best practices for case management and housing staff so that those they serve are better equipped to stay in their housing for the long term. Additionally, the CoC has found that the limited supply of affordable rental units has the unintended effect of program participants remaining in their PH units longer for fear of losing a housing option in the CoC, altogether. 3.With the ongoing administrative support of the city's Office of Housing and Community Development (OHCD), the CoC's Executive Committee has responsibility for overseeing the implementation of the CoC's strategy for overseeing the way in

which the CoC reduces the rate of indivds/fams' returns to homelessness.

2C-5.	**Increasing Employment Cash Income-Strategy.**	
	NOFO Section VII.B.5.f.	

	Describe in the field below:
1.	**your CoC's strategy to increase employment income;**
2.	**how your CoC works with mainstream employment organizations to help individuals and families increase their cash income; and**
3.	**provide the organization name or position title that is responsible for overseeing your CoC's strategy to increase income from employment.**

(limit 2,000 characters)

1.This year's metric of 23% of adults who increased their earned income is a favorable increase over the 18% reported in the previous year. The CoC's strategy to ensure this continued trend includes providing PSH/WIB connectivity, guidance to CoC programs that communicates the importance of increasing employment income in order to sustain housing over the long term, tech assist. to case managers to help them reinforce job skills, employment acumen and their program participant's value as an employee and providing clarity/connection to local educational/training resources—including disability/vocational assistance—to help improve worker skills. 2.The NB CoC recognizes the value of collaboration between itself and local workforce systems and maintains a well-established relationship with the local WIB (MassHire) whose Exec Dir was a mbr of the CoC's Executive Committee and who actively participates in the CoC including presentations to the CoC membership. The October 2021 meeting featured a MassHire staff presentation on employment in a post-pandemic environment. Such relationships are valued as an important aspect of the CoC's ability to connect those experiencing homelessness with the local employment network. In addition, New Bedford CoC's leadership is also directly connected with private employment including a bank president and chamber members. 3.The CoC's Supportive Services Committee has responsibility for ensuring the CoC's strategy for increasing jobs and income from employment and is developing a dashboard of key indicator that the CoC's data collection system has been enhanced.

2C-5a.	**Increasing Employment Cash Income–Workforce Development–Education–Training.**	
	NOFO Section VII.B.5.f.	

	Describe in the field below how your CoC:
1.	**promoted partnerships and access to employment opportunities with private employers and private employment organizations, such as holding job fairs, outreach to employers, and partnering with staffing agencies; and**
2.	**is working with public and private organizations to provide meaningful education and training, on-the-job training, internships, and employment opportunities for program participants.**

(limit 2,000 characters)

1.Employment and self-sufficiency have been key values of the NB CoC since its inception in 1997. The CoC continues to coordinate with workforce and educational institutions as part of its continuum of services, maintaining close

working relationships and collaborative efforts. The MassHire Greater New Bedford Career Center (GNBCC)—an active CoC member—closely collaborates with the CoC and prioritizes referrals from NB CoC providers registered in their system. The GNBCC provides access to multiple job fairs throughout the year, drop-in access for job search and career development activities. A program funded by the Dept of Labor/SAMHSA is the Access to Recovery program which has provided numerous paid training and work experience opportunities for many of the CoC's population experiencing homelessness. 2.The CoC is working with public and private organizations to provide meaningful outcomes for those in its PSH and RRH projects. Provider agencies within the Continuum have also partnered to create employment opportunities for those experiencing homelessness in RRH and PSH programs for over 20 years. One such example has been the creative partnerships between Step-Up (PSH) and the High Point Treatment Center to fill housekeeping, maintenance and transportation services. The positions provide entry-level work experience for people returning to the workforce from homelessness, often leading to advancement within the employment system as participant's education and skill levels increase. This program has provided more than 1,500 opportunities for people since its inception in 2000. Another example would be raising funds and creating opportunities to connect people with securing their IDs through the MA Registry of Motor Vehicles-something critically important in securing cash-income based employment.

2C-5b.	**Increasing Non-employment Cash Income.**	
	NOFO Section VII.B.5.f.	

	Describe in the field below:
1.	**your CoC's strategy to increase non-employment cash income;**
2.	**your CoC's strategy to increase access to non-employment cash sources; and**
3.	**provide the organization name or position title that is responsible for overseeing your CoC's strategy to increase non-employment cash income.**

(limit 2,000 characters)

1.This year's metric of 33% of adults who increased their non-employment cash income is a favorable increase over the 25% of adults reported in the previous year. The CoC's strategy stems from 3 primary barriers, consistent with HUD's "Strategies for Improving Homeless People's Access to Mainstream Benefits and Services" publication. (a)The CoC recognizes mainstream structural barriers like the absence of private transportation and lmtd public transit within the area and in response holds the "NB Connect" event each year. This is a large one-day resource-based event that connects sheltered/unsheltered persons directly with multiple mainstream resources all under one roof. (b) Capacity barriers arise as a result of inadequate local resources. To address this, the CoC actively works with local and state agencies (such as the MA Executive Office of Elder Affairs) to provide education and training about access to mainstream resources (eg MA Health). (c)Eligibility barriers in this CoC have given rise to a 3rd strategy example, that being challenges around many experiencing homelessness who have no ID. Securing IDs, working with the MA Registry of Motor Vehicles (RMV), raising funds to pay for the IDs and provide connective access to the RMV so that IDs can be secured has become an important strategy that paves the way for someone to successfully access/increase their non-employment cash income. 2.The CoC's strategy to

increase access to non-employment cash sources is part of each PSH's onboarding process and woven into its strategies to increase income. Increasing access through the estab of events, education, communication, connection w/outside resources, fundraising for a broader reach and direct services on a client-by-client basis each play an important role in the overall CoC strategy to access such resources. 3.The CoC's CE-Case Conferencing Committee is responsible for ensuring the CoC's strategy for increasing non-employment cash-income.

3A. Coordination with Housing and Healthcare Bonus Points

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3A-1.	**New PH-PSH/PH-RRH Project–Leveraging Housing Resources.**	
	NOFO Section VII.B.6.a.	

Is your CoC applying for a new PSH or RRH project(s) that uses housing subsidies or subsidized housing units which are not funded through the CoC or ESG Programs to help individuals and families experiencing homelessness?	No

3A-1a.	**New PH-PSH/PH-RRH Project–Leveraging Housing Commitment. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.6.a.	

Select yes or no in the chart below to indicate the organization(s) that provided the subsidies or subsidized housing units for the proposed new PH-PSH or PH-RRH project(s).

1.	**Private organizations**	No
2.	**State or local government**	No
3.	**Public Housing Agencies, including use of a set aside or limited preference**	No
4.	**Faith-based organizations**	No
5.	**Federal programs other than the CoC or ESG Programs**	No

3A-2.	**New PSH/RRH Project–Leveraging Healthcare Resources.**	
	NOFO Section VII.B.6.b.	

Is your CoC applying for a new PSH or RRH project that uses healthcare resources to help individuals and families experiencing homelessness?	Yes

3A-2a.	**Formal Written Agreements–Value of Commitment–Project Restrictions. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.B.6.b.	

1.	**Did your CoC obtain a formal written agreement that includes: (a) the project name; (b) value of the commitment; and (c) specific dates that healthcare resources will be provided (e.g., 1-year, term of grant, etc.)?**	Yes
2.	**Is project eligibility for program participants in the new PH-PSH or PH-RRH project based on CoC Program fair housing requirements and not restricted by the health care service provider?**	Yes

3A-3.	**Leveraging Housing Resources–Leveraging Healthcare Resources–List of Projects.**	
	NOFO Sections VII.B.6.a. and VII.B.6.b.	

If you selected yes to question 3A-1. or 3A-2., use the list feature icon to enter information on each project you intend for HUD to evaluate to determine if they meet the bonus points criteria.

Project Name	Project Type	Rank Number	Leverage Type
Welcome Home (Exp...	PSH	8	Healthcare
Family Preservati...	PSH	9	Healthcare
Green Light	PSH	10	Healthcare

3A-3. List of Projects.

1. What is the name of the new project? Welcome Home (Expansion)

2. Select the new project type: PSH

3. Enter the rank number of the project on your CoC's Priority Listing: 8

4. Select the type of leverage: Healthcare

3A-3. List of Projects.

1. What is the name of the new project? Family Preservation Program (Expansion)

2. Select the new project type: PSH

3. Enter the rank number of the project on your CoC's Priority Listing: 9

4. Select the type of leverage: Healthcare

3A-3. List of Projects.

1. What is the name of the new project? Green Light

2. Select the new project type: PSH

3. Enter the rank number of the project on your CoC's Priority Listing: 10

4. Select the type of leverage: Healthcare

3B. New Projects With Rehabilitation/New Construction Costs

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3B-1.	**Rehabilitation/New Construction Costs–New Projects.**	
	NOFO Section VII.B.1.r.	

Is your CoC requesting funding for any new project application requesting $200,000 or more in funding for housing rehabilitation or new construction?	No

3B-2.	**Rehabilitation/New Construction Costs–New Projects.**	
	NOFO Section VII.B.1.s.	

	If you answered yes to question 3B-1, describe in the field below actions CoC Program-funded project applicants will take to comply with:
1.	**Section 3 of the Housing and Urban Development Act of 1968 (12 U.S.C. 1701u); and**
2.	**HUD's implementing rules at 24 CFR part 75 to provide employment and training opportunities for low- and very-low-income persons, as well as contracting and other economic opportunities for businesses that provide economic opportunities to low- and very-low-income persons.**

(limit 2,000 characters)

3C. Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

3C-1.	**Designating SSO/TH/Joint TH and PH-RRH Component Projects to Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.**	
	NOFO Section VII.C.	

Is your CoC requesting to designate one or more of its SSO, TH, or Joint TH and PH-RRH component projects to serve families with children or youth experiencing homelessness as defined by other Federal statutes?	No

3C-2.	**Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes. You Must Upload an Attachment to the 4B. Attachments Screen.**	
	NOFO Section VII.C.	

	If you answered yes to question 3C-1, describe in the field below:
1.	**how serving this population is of equal or greater priority, which means that it is equally or more cost effective in meeting the overall goals and objectives of the plan submitted under Section 427(b)(1)(B) of the Act, especially with respect to children and unaccompanied youth than serving the homeless as defined in paragraphs (1), (2), and (4) of the definition of homeless in 24 CFR 578.3; and**
2.	**how your CoC will meet requirements described in Section 427(b)(1)(F) of the Act.**

(limit 2,000 characters)

4A. DV Bonus Application

To help you complete the CoC Application, HUD published resources at https://www.hud.gov/program_offices/comm_planning/coc/competition, including:
- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2021 Continuum of Care Program Competition
- FY 2021 CoC Application Detailed Instructions–essential in helping you maximize your CoC Application score by giving specific guidance on how to respond to many questions and providing specific information about attachments you must upload
- 24 CFR part 578

4A-1.	**New DV Bonus Project Applications.**	
	NOFO Section II.B.11.e.	

Did your CoC submit one or more new project applications for DV Bonus Funding?	No

Applicant Name
This list contains no items

4B. Attachments Screen For All Application Questions

We prefer that you use PDF files, though other file types are supported. Please only use zip files if necessary.

Attachments must match the questions they are associated with.

Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process.

We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).

Document Type	Required?	Document Description	Date Attached
1C-7. PHA Homeless Preference	No	1C-7 PHA HOMELESS...	11/01/2021
1C-7. PHA Moving On Preference	No	1C-7 PHA MOVING O...	11/01/2021
1C-14. CE Assessment Tool	Yes	1C-14 CE ASSESSME...	11/01/2021
1E-1. Local Competition Announcement	Yes	1E-1 LOCAL COMPET...	11/09/2021
1E-2. Project Review and Selection Process	Yes	1E-2 PROJECT REVI...	11/09/2021
1E-5. Public Posting–Projects Rejected-Reduced	Yes	1E-5 PUBLIC POSTI...	11/09/2021
1E-5a. Public Posting–Projects Accepted	Yes	1E-5a PUBLIC POST...	11/01/2021
1E-6. Web Posting–CoC-Approved Consolidated Application	Yes	1E-6 WEB POSTING-...	11/05/2021
3A-1a. Housing Leveraging Commitments	No	3A-1a HOUSING LEV...	11/01/2021
3A-2a. Healthcare Formal Agreements	No	3A-2a HEALTHCARE ...	11/01/2021
3C-2. Project List for Other Federal Statutes	No	3C-2 PROJECT LIST...	11/01/2021

Attachment Details

Document Description: 1C-7 PHA HOMELESS PREFERENCE

Attachment Details

Document Description: 1C-7 PHA MOVING ON PREFERENCE

Attachment Details

Document Description: 1C-14 CE ASSESSMENT TOOL

Attachment Details

Document Description: 1E-1 LOCAL COMPETITION ANNOUNCEMENT

Attachment Details

Document Description: 1E-2 PROJECT REVIEW AND SELECTION PROCESS

Attachment Details

Document Description: 1E-5 PUBLIC POSTING-PROJECTS REJECTED-REDUCED

Attachment Details

Document Description: 1E-5a PUBLIC POSTING-PROJECTS ACCEPTED

Attachment Details

Document Description: 1E-6 WEB POSTING-CoC APPROVED CONSOLIDATED APPLICATION

Attachment Details

Document Description: 3A-1a HOUSING LEVERAGING COMMITMENTS

Attachment Details

Document Description: 3A-2a HEALTHCARE FORMAL AGREEMENTS

Attachment Details

Document Description: 3C-2 PROJECT LIST FOR OTHER FEDERAL STATUTES

Submission Summary

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

Page	Last Updated
1A. CoC Identification	10/21/2021
1B. Inclusive Structure	11/09/2021
1C. Coordination	10/22/2021
1C. Coordination continued	11/09/2021
1D. Addressing COVID-19	11/09/2021
1E. Project Review/Ranking	11/09/2021
2A. HMIS Implementation	11/09/2021
2B. Point-in-Time (PIT) Count	10/21/2021
2C. System Performance	11/09/2021
3A. Housing/Healthcare Bonus Points	11/09/2021
3B. Rehabilitation/New Construction Costs	10/22/2021

3C. Serving Homeless Under Other Federal Statutes	10/22/2021
4A. DV Bonus Application	10/22/2021
4B. Attachments Screen	11/09/2021
Submission Summary	No Input Required

Attachment 1C-7

New Bedford Continuum of Care
MA-505

PHA Homeless Preference

NEW BEDFORD HOUSING AUTHORITY

Post Office Box 2081
New Bedford, Massachusetts 02741

Steven A. Beauregard
Executive Director

CENTRAL OFFICE:
128 UNION STREET
SUITE 400
TEL. :508-997-4829
FAX: 508-997-4808
TDD: 508-997-4874

October 26, 2021

Jennifer Clarke AICP
Deputy Director, Community Development
City of New Bedford
133 William St.
New Bedford, MA 02740

Re: Continuum of Care

Dear Ms. Clarke,

The New Bedford Housing Authority (NBHA) is pleased to assist the City of New Bedford's Continuum of Care (COC) in the development of its annual application for COC funding and offers this letter as a means of memorializing both the preferences employed by the NBHA and its effect in ensuring housing for the homeless over the past fiscal year, as well as the ongoing relationship between our two entities.

The NBHA is committed to providing the highest quality service in order to ensure safe, stable housing for those coming out of homelessness. Annually this Housing Authority Places many individuals and families coming out of homelessness into housing though its preferences as follows:

*Family Preferences for the Section 8 Voucher Choice Program vouchers:
- Priority 1 = (a)Displacement due to disaster such as flood, fire or natural disaster.
(b) Court ordered no-fault eviction
(c) Displacement by Domestic Violence
(d) Avoidance of reprisal/witness protection
(e) Victim of hate crime
(f) Condemnation of Home
(g) Inaccessibility of dwelling unit (Disabled ONLY)
(h) Homelessness

These preferences were changed to try to help those most in need. What the Housing Authority has discovered is that the people that are most in need are either unwilling or unable to comply with the verification requirements to determine their eligibility for these priorities or that their circumstances changed and no longer qualify for these priorities when their name came up on the list. In addition, many of the applicants are unable to pass the CORI check and screening requirements of the program, which then disqualifies them. During the past year only 66 vouchers were utilized by homeless individuals or families, which was 100% of the those leased were in one of the Priority 1 categories.

Recently, due to the low number of people able to prove their priority to receive a Section 8 Voucher, we added back the priority of paying over 50% of income for rent and utilities. Another reason for this is due to the ever-increasing rental prices in the city which is literally pricing out those on a fixed income such as elderly and disabled individuals and families, where the increased rents are more than what the family receives in income. To avoid homelessness for these clients, this priority has now been reinstated effective immediately. The NBHA currently has 3,822 applicants waiting for a Section 8 Housing Choice Voucher.

For State-aided public housing the following Priorities and preferences have remained the same:

1) Homeless and displaced by Natural forces such as fire, flood, hurricane.
2) Homeless and displaced by Public Action, such as urban renewal or eminent domain.
3) Homeless and displaced by enforcement of Minimum Housing Standards
4) Emergency Case plan which includes domestic violence, medical emergencies and those without housing due to no fault of their own.
   a) Local Preference
   b) Veteran Preference

The NBHA is required to place resident using the state's CHAMP system. Due to the pandemic, he waitlist has grown from 5, 551 applicants in 2019 to almost 20,000 applicants today from all over the state and some across the country. Out of the 77 State housing placements the NBHA made from 8-1-20 to 8-1-21, 92.3% were for those that were homeless due to one of the above conditions, including 5 homeless veterans. These priorities and preferences help those in greatest need first.

Finally, the NBHA celebrates the long history of collaboration between NBHA and the City's Office of Housing & Community Development (OHCD) in its role as lead administrative agent for the City's COC. The NBHA continues to commit to this relationship in order to ensure a strong relationship with shared goals which actively ensure consistency, transparency and success in housing the homeless in the City of New Bedford.

If you need any other information, please don't hesitate to contact me.

Sincerely,

Cheryl Souza
Policy Administrator
New Bedford Housing Authority

Attachment 1C-7

New Bedford Continuum of Care
MA-505

PHA Moving On Preference

NOTE:

The New Bedford CoC has memorialized those elements of its own Moving On Strategy germane to its work and strategic vision. The resulting document, approved by a vote of the CoC membership in 2019 remains in effect and is provided here.

Separate from this Moving On document is the priority list developed in concert with the roll out of Emergency Housing Vouchers. The resulting prioritization list for EHVs further reinforces the CoC's coordinated work with the local Housing Authority in moving people on. That document is similarly included within this attachment.

Homeless Service Provider Network :: HSPN
New Bedford Continuum of Care

Moving On Strategy

The New Bedford Continuum of Care (CoC), acting through the Homeless Service Provider Network (HSPN), hereby establishes and memorializes its Moving On Strategy.

Purpose.

Affordability, availability of suitable housing and a combination thereof have been identified by the CoC as a primary issue preventing current supportive housing tenants who are no longer in need of intensive services from moving out of their permanent supportive housing units (PSH) and into either a public housing authority (PHA) unit or other affordable housing unit independent of supportive services.

This strategy exists for the purpose of providing guidance as to how CoC projects can move current CoC Program participants who no longer require intensive services, from CoC Program funded-PSH beds to other housing assistance programs (including, but not limited to, Housing Choice Vouchers and Public Housing) in order to free up CoC Program funded-PSH beds to be used for persons experiencing homelessness.

Public Housing Authorities

As described by the Corporation for Supportive Housing's CSH Moving On Toolkit, "Under PIH Notice 2013-15 (HA), PHAs may create set-asides of units and/or vouchers for either people exiting homelessness or people referred by providers as being ready to move on from supportive housing. Through this mechanism, the CoC and its supportive housing providers may partner with the New Bedford Public Housing Authority (NBHA) to make public housing units and tenant-based Housing Choice Vouchers (HCV, or Section 8) available through the use of preferences in their local administrative plans for people who have achieved stability in supportive housing and no longer require the same level of support.

Affordable Housing Owners

In addition to the NBHA, "HUD also funds a variety of deeply subsidized units through the Multi-family division, which can be owned and operated by either PHAs or private owners. These include primarily the Project Based Section 8 (general population), Section 202 (elderly—such as the Coastline project, "Carriage House at Acushnet Heights"), and Section 811 (persons with disabilities) programs and combinations of Sections 202/811 projects (as is the case with Melville Towers). Such units frequently offer some level of services and are experienced in dealing with special needs tenants. Multifamily owners can create set-asides of units for either people exiting homelessness or people referred by providers as being ready to move on from supportive housing. As vouchers and public housing units are usually a scarce resource, programs may also look to the largest current production program for new affordable units - Low Income Housing Tax Credits (LIHTC) – to create Moving On units. LIHTC developments must typically meet stringent quality and location requirements to obtain competitive funding, so they may be appealing from a tenant choice perspective. Prioritization of LIHTC resources is accomplished through the state Qualified Allocation plan, which accepts public comment on a regular basis.

In order to ensure that those individuals and families who previously experienced homelessness and who have successfully lived in CoC PSH projects but no longer require intensive supportive services have viable

alternatives to where they can move on from PSH into permanent housing, the HSPN seeks to actively collaborate with housing providers so noted here.

Strategic Steps

In its efforts to enact its CoC-wide Move On Strategy, the CoC will, to the best of its ability through its PSH programs:

- Identify households in permanent supportive housing (PSH) that no longer require intensive supportive services and demonstrate the ability to live stably and maintain housing.
- Ask such households if they are willing to move on (the household must retain choice and must be willing to move on; this is voluntary).
- Confirm that willing households meet any housing screening criteria in order to move on.
- Ensure that willing households in need rental subsidies move into housing with a rental subsidy available to them.
- Continue supporting the New Bedford Housing Authority's homeless preference for households to increase the possibility of willing households receiving a rental subsidy through housing choice vouchers;
- Work collaboratively with mainstream affordable housing resources including those financed with LIHTC.
- Provide flexible financial assistance to cover costs related to moving expenses, security deposits, first/last month's rent, etc. as may be needed to ensure tenancy.
- Work to develop a source of landlord mitigation funds (by individual agency and/or collaboratively as a CoC) to offset potential problems including excessive damage to units or unpaid rent.
- Provide case management to assist clients who have moved on with income re-certifications and/or application paperwork to support continued housing stability.
- Offer home-based case management for three months to help ensure a successful transition out of PSH into permanent housing.

This strategy may be amended or revised at any time by a vote of the HSPN Executive Committee. This document was reviewed and accepted by a vote of the HSPN Executive Committee on September 19, 2019.

New Bedford Emergency Housing Voucher Prioritization Plan

July 26.2021

The New Bedford Continuum of Care (MA-505) is a U.S. Department of Housing & Urban Development (HUD) recognized Continuum of Care (CoC) that wholly encompasses the City of New Bedford, Massachusetts. Within this CoC exists 7 Emergency Solutions Grant projects as well as multiple CoC-funded programs that include five permanent supportive housing projects, one rapid re-housing project and coordinated entry. Combined, these programs provide critical housing and supportive services for New Bedford families and individuals experiencing homelessness or who are at risk of homelessness.

Although these programs continued operations throughout the duration of the COVID-19 pandemic, the need for housing and support for the most vulnerable of New Bedford's population, whether for rental subsidies alone or combined with supportive services, continued to increase, not unlike the increasing demand seen across the nation. Concurrent with this has been a renewed recognition of the persistent disparities that exist across the country in providing such resources to marginalized people including black, indigenous, people of color (BIPOC) populations, those who are of Hispanic descent and those within the LGBTQ+ community. As a result of the confluence of these factors, the federal American Rescue Plan of 2021 included funding and provisions for an Emergency Housing Voucher (EHV) program that necessitates the collaborative efforts and operation of the local housing authorities and continuums of care.

> "…the need for housing and support for the most vulnerable of New Bedford's population, whether for rental subsidies alone or combined with supportive services, continued to increase, not unlike the increasing demand seen across the nation."

An allocation of 25 EHVs was made to the New Bedford Housing Authority as part of this action and an additional 34 vouchers has been awarded through the MA Department of Housing & Community Development (MA DHCD) for a total of 59 EHVs in New Bedford. Having received vouchers through both a local and state housing authority, the New Bedford CoC is positioned to prioritize both sets of vouchers in order to reflect the unique needs of the New Bedford community, specifically.

Prior to developing its prioritization strategy, New Bedford first considered factors explicitly affecting the movement of persons in crisis through its continuum and beyond. Although its permanent supportive housing (PSH) units provide 231 units of housing for individuals and families, the continuum recognized that the high

utilization rate of 104%[1]--one which reveals a system exceeding its capacity—means that there is little to no opportunity to move others in crisis into permanent stable housing. Moreover the continuum acknowledged that in moving increasingly stable persons out of PSH program units and into other subsidized housing, the CoC potentially increases its supply of available PSH units for others with heightened vulnerabilities and needs.

Because PSH units are intended to serve those most vulnerable, it is considered beneficial to the CoC system to assist in creating opportunities for clients to move on to less "supportive" housing as they are willing and able. Likewise, as it was anecdotally understood that many of those in PSH programs struggle with stable income to sustain a market rate unit they effectively remain in PSH only for the benefit of the rental subsidy, the availability of a housing voucher could provide the impetus needed to "unclog" the CoC housing pipeline and free up additional units for occupancy.

Given this, the continuum acknowledged that whenever the opportunity presents itself for a PSH household to "move on" to other stable permanent housing thereby freeing up the unit for a new household coming out of crisis, this opportunity should be acted upon as appropriate and possible. In so doing, the household moving out of PSH can benefit from a rental subsidy and a more vulnerable household with higher needs can benefit from the PSH unit. EHVs have been embraced as an important tool toward this end.

Adjacent to the need for increased housing and rental assistance and arising from a national reawakening as to disparities experienced by historically marginalized populations, the New Bedford CoC examined its own data to better understand the presence of racial disparities in its homeless housing and support system.

"…arising from a national reawakening as to disparities experienced by historically marginalized populations, the New Bedford CoC examined its own data to better understand the presence of racial disparities in its homeless housing and support system."

Using the CoC Racial Equity Analysis Tool[2] it becomes clear that there may be an unconscious bias in serving Black, Indigenous and people of color (BIPOC) households experiencing homelessness as well and those identifying as LGBTQ+. By way of example, although just 6% of those in the general New Bedford population identify as Black, those identifying as Black experience homelessness at a rate of 27% (individuals) and 35% (families). Similarly, while just 20% of the general population in the city is represented by those who are Hispanic, 40% of families

[1] The 104% utilization rate was measured during the 2021 Point In Time Count in January 2021 at which time 241 persons were counted in housing that typically provides 231 beds.

[2] Version 2.1 downloadable spreadsheet for MA-505 (New Bedford CoC) at: https://www.hudexchange.info/resource/5787/coc-analysis-tool-race-and-ethnicity/.

experiencing homelessness in the city are Hispanic. These simple statistics immediately reveal a significant and disproportionate ratio between general population and those experiencing homelessness by race and ethnicity in New Bedford.[3]

From this data, the CoC is concerned with the extent to which it is disproportionally housing those who identify as white over those who identify as BIPOC and/or Hispanic as well as those identifying as LGBTQ+. While this is not seen as intentional it necessitates action to ensure the disparity is diminished and eliminated.

In light of its finding as to the need for additional housing and mitigation of any systemic or institutionalized barriers in serving marginalized populations, and given the availability of new Emergency Housing Vouchers (EHVs), the New Bedford CoC will prioritize the following households (providing they otherwise meet qualifying eligibility) for use of the EHVs:

Priority	Cohort
1	Those New Bedford residents identifying as part of a BIPOC and/or LGBTQ+ community who are ready/willing/able to successfully move on from PSH or HomeBASE (exiting the program) but who continue to need a housing subsidy to remain stably housed.
2	Those New Bedford residents who are ready/willing/able to successfully move on from PSH or HomeBASE (by exiting the program) but who continue to need a housing subsidy to remain stably housed.
3	Those New Bedford residents identifying as part of a BIPOC and/or LGBTQ+ community and currently receiving Rapid Rehousing funds (either through ESG or CoC sources) and can show they need a voucher to maintain housing.
4	Those New Bedford residents who are receiving Rapid Rehousing funds (either through ESG or CoC sources) and can show they need a voucher to maintain housing.
5	Those New Bedford residents who identify as BIPOC and/or LGBTQ+ in the community, are currently in a housing crisis and can show they need a voucher to maintain housing.

Priority list continues on the following page.

> “…the CoC is concerned with the extent to which it is disproportionately housing those who identify as white over those who identify as BIPOC and/or Hispanic as well as those identifying as LGBTQ+…”

[3] While national statistics show that over 5% of the population identifies as LGBTQ+ and .6% of the population identifies as transgender, the CoC has not asked this question throughout any measurable intake either in outreach or placement. Both of these populations are underserved throughout the continuum and are significantly more affected by housing crisis, which, during the recent pandemic, has been magnified as these households are at greater risk and therefore at a heightened risk of COVID-19.

Priority	Cohort
6	Those either recently released from a correctional institution or who have a history of incarceration and only need a voucher to maintain housing.
7	Those New Bedford residents on the existing Coordinated Entry waiting list.
8	All other qualifying and eligible households.

Prepared by the Office of Housing & Community Development,
Patrick J. Sullivan, Director
on behalf of the
City of New Bedford's Continuum of Care,
Homeless Service Provider Network (HSPN)

Attachment 1C-14

New Bedford Continuum of Care
MA-505

CE Assessment Tool

NOTE:

The New Bedford CoC uses <u>two</u> standard assessment tools, one for single adults and one for families.
The Assessment Tool for Single Adults appears first in the attachment followed by the Assessment Tool for Families.

Service Prioritization Decision Assistance Tool (SPDAT)

Assessment Tool for Single Adults

VERSION 4.01

1 (800) 355-0420 info@orgcode.com www.orgcode.com

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or service delivery contexts. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The **Vulnerability Index – Service Prioritization Decision Assistance Tool** (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and may not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The **Service Prioritization Decision Assistance Tool** (SPDAT) was developed as an assessment tool for frontline workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. It is an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

Terms and Conditions Governing the Use of the SPDAT

SPDAT products have been developed by OrgCode Consulting, Inc. with extensive feedback from key community partners including people with lived experience. The tools are provided free of charge to communities to improve the client centered services dedicated to increasing housing stability and wellness. Training is indeed required for the administration and interpretation of these assessment tools. Use of the SPDAT products without authorized training is strictly prohibited.

By using this tool, you accept and agree to be bound by the terms of this expectation.

No sharing, reproduction, use or duplication of the information herein is permitted without the express written consent of OrgCode Consulting, Inc.

Ownership

The Service Prioritization Decision Assistance Tool ("SPDAT") and accompanying documentation is owned by OrgCode Consulting, Inc.

Training

Although the SPDAT Series is provided free of charge to communities, training by OrgCode Consulting, Inc. or a third party trainer, authorized by OrgCode, must be successfully completed. After meeting the training requirements required to administer and interpret the SPDAT Series, practitioners are permitted to implement the SPDAT in their work with clients.

Restrictions on Use

You may not use or copy the SPDAT prior to successfully completing training on its use, provided by OrgCode Consulting, Inc. or a third-party trainer authorized by OrgCode. You may not share the SPDAT with other individuals not trained on its use. You may not train others on the use of the SPDAT, unless specifically authorized by OrgCode Consulting, Inc.

Restrictions on Alteration

You may not modify the SPDAT or create any derivative work of the SPDAT or its accompanying documentation, without the express written consent of OrgCode Consulting, Inc. Derivative works include but are not limited to translations.

Disclaimer

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

1 (800) 355-0420 info@orgcode.com www.orgcode.com

A. Mental Health & Wellness & Cognitive Functioning

PROMPTS	CLIENT SCORE:
• *Have you ever received any help with your mental wellness?* • *Do you feel you are getting all the help you need for your mental health or stress?* • *Has a doctor ever prescribed you pills for nerves, anxiety, depression or anything like that?* • *Have you ever gone to an emergency room or stayed in a hospital because you weren't feeling 100% emotionally?* • *Do you have trouble learning or paying attention?* • *Have you ever had testing done to identify learning disabilities?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby?* • *Have you ever hurt your brain or head?* • *Do you have any documents or papers about your mental health or brain functioning?* • *Are there other professionals we could speak with that have knowledge of your mental health?*	NOTES

SCORING	
4	**Any** of the following: ☐¨Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐¨Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
	Any of the following: ☐¨Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐¨Diminished ability to perform tasks and functions of daily living or communicating intent☐because of a brain injury, learning disability or developmental disability
	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐¨No major concerns about safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐¨No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐¨No compelling reason for screening by an expert in mental health or cognitive functioning prior to housing to fully understand capacity
	☐¨In a heightened state of recovery, has a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** is engaged with mental health supports as necessary.
	☐¨No mental health or cognitive functioning issues disclosed, suspected or observed.

B. Physical Health & Wellness

PROMPTS	CLIENT SCORE:
• *How is your health?* • *Are you getting any help with your health? How often?* • *Do you feel you are getting all the care you need for your health?* • *Any illness like diabetes, HIV, Hep C or anything like that going on?* • *Ever had a doctor tell you that you have problems with blood pressure or heart or lungs or anything like that?* • *When was the last time you saw a doctor? What was that for?* • *Do you have a clinic or doctor that you usually go to?* • *Anything going on right now with your health that you think would prevent you from living a full, healthy, happy life?* • *Are there other professionals we could speak with that have knowledge of your health?* • *Do you have any documents or papers about your health or past stays in hospital because of your health?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Pallative health condition
3	Presence of a health issue with **any** of the following: ☐ Not connected with professional resources to assist with a real or perceived serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) ☐ Unable to follow the treatment plan as a direct result of homeless status
2	☐ Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements.
0	☐ No serious or chronic health condition disclosed, observed, or suspected ☐ If any minor health condition, they are managed appropriately

C. Medication

PROMPTS	CLIENT SCORE:
• *Have you recently been prescribed any medications by a health care professional?* • *Do you take any medications prescribed to you by a doctor?* • *Have you ever sold some or all of your prescription?* • *Have you ever had a doctor prescribe you medication that you didn't have filled at a pharmacy or didn't take?* • *Were any of your medications changed in the last month? If yes: How did that make you feel?* • *Do other people ever steal your medications?* • *Do you ever share your medications with other people?* • *How do you store your medications and make sure you take the right medication at the right time each day?* • *What do you do if you realize you've forgotten to take your medications?* • *Do you have any papers or documents about the medications you take?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason
3	**Any** of the following: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

D. Substance Use

PROMPTS	CLIENT SCORE:
• *When was the last time you had a drink or used drugs?* • *Is there anything we should keep in mind related to drugs or alcohol?* • *[If they disclose use of drugs and/or alcohol] How frequently would you say you use [specific substance] in a week?* • *Ever have a doctor tell you that your health may be at risk because you drink or use drugs?* • *Have you engaged with anyone professionally related to your substance use that we could speak with?* • *Ever get into fights, fall down and bang your head, or pass out when drinking or using other drugs?* • *Have you ever used alcohol or other drugs in a way that may be considered less than safe?* • *Do you ever end up doing things you later regret after you have gotten really hammered?* • *Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?*	**NOTES**

Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

SCORING

☐ In a life-threatening health situation as a direct result of substance use,**or**, In the past 30 days, **any** of the following are true...
- ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation,
- ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times
- ☐ Substance use resulting in passing out 2+ times

☐ Experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or**, In the past 30 days, **any** of the following are true...
- ☐ Drug use reached the point of complete inebriation 12+ times
- ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation
- ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times

In the past 30 days, **any** of the following are true...
- ☐ Drug use reached the point of complete inebriation fewer than 12 times
- ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times

☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or**,
☐ If making claims to sobriety, no substance use in the past 30 days

☐ In the past 365 days, no substance use

E. Experience of Abuse & Trauma

PROMPTS	CLIENT SCORE:
To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported. • *"I don't need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?"* • *"Are you currently or have you ever received professional assistance to address that abuse?"* • *"Does the experience of abuse or trauma impact your day to day living in any way?"* • *"Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?"* • *"Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?"* • *"Have you ever become homeless as a direct result of experiencing abuse or trauma?"*	**NOTES**

SCORING	
4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☐ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

F. Risk of Harm to Self or Others

PROMPTS	CLIENT SCORE:
• *Do you have thoughts about hurting yourself or anyone else? Have you ever acted on these thoughts? When was the last time?* • *What was occurring when you had these feelings or took these actions?* • *Have you ever received professional help – including maybe a stay at hospital – as a result of thinking about or attempting to hurt yourself or others? How long ago was that? Does that happen often?* • *Have you recently left a situation you felt was abusive or unsafe? How long ago was that?* • *Have you been in any fights recently - whether you started it or someone else did? How long ago was that? How often do you get into fights?*	**NOTES**

SCORING	
4	**Any** of the following: □¨In the past 90 days, left an abusive situation □¨In the past 30 days, attempted, threatened, or actually harmed self or others□ □¨In the past 30 days, involved in a physical altercation (instigator or participant)
3	**Any** of the following: □¨In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days □¨Most recently attempted, threatened, or actually harmed self or others in the past 180 days,□but not in the past 30 days □¨In the past 365 days, involved in a physical altercation (instigator or participant), but not in□the past 30 days
2	**Any** of the following: □¨In the past 365 days, left an abusive situation, but no exposure to abuse in the past 180 days □¨Most recently attempted, threatened, or actually harmed self or others in the past 365 days,□but not in the past 180 days □¨366+ days ago, 4+ involvements in physical alterations
1	□¨366+ days ago, 1-3 involvements in physical alterations
0	□¨Reports no instance of harming self, being harmed, or harming others

G. Involvement in Higher Risk and/or Exploitive Situations

PROMPTS	CLIENT SCORE:
• *[Observe, don't ask] Any abcesses or track marks from injection substance use?* • *Does anybody force or trick you to do something that you don't want to do?* • *Do you ever do stuff that could be considered dangerous like drinking until you pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* • *Do you ever find yourself in situations that may be considered at a high risk for violence?* • *Do you ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?*	NOTES

SCORING	
4	**Any** of the following: ☐¨In the past 180 days, engaged in 10+ higher risk and/or exploitive events ☐¨In the past 90 days, left an abusive situation
3	**Any** of the following: ☐¨In the past 180 days, engaged in 4-9 higher risk and/or exploitive events ☐¨In the past 180 days, left an abusive situation, but not in the past 90 days
2	**Any** of the following: ☐¨In the past 180 days, engaged in 1-3 higher risk and/or exploitive events ☐¨181+ days ago, left an abusive situation
1	☐¨Any involvement in higher risk and/or exploitive situations occurred more than 180 days ago but less than 365 days ago
0	☐¨In the past 365 days, no involvement in higher risk and/or exploitive events

H. Interaction with Emergency Services

PROMPTS	CLIENT SCORE:
• *How often do you go to emergency rooms?* • *How many times have you had the police speak to you over the past 180 days?* • *Have you used an ambulance or needed the fire department at any time in the past 180 days?* • *How many times have you called or visited a crisis team or a crisis counselor in the last 180 days?* • *How many times have you been admitted to hospital in the last 180 days? How long did you stay?*	NOTES

Note: Emergency service use includes: admittance to emergency room/department; hospitalizations; trips to a hospital in an ambulance; crisis service, distress centers, suicide prevention service, sexual assault crisis service, sex worker crisis service, or similar service; interactions with police for the purpose of law enforcement; interactions with fire service in emergency situations.

SCORING	
4	☐ In the past 180 days, cumulative total of 10+ interactions with emergency services
3	☐ In the past 180 days, cumulative total of 4-9 interactions with emergency services
2	☐ In the past 180 days, cumulative total of 1-3 interactions with emergency services
1	☐ Any interaction with emergency services occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no interaction with emergency services

I. Legal

PROMPTS	CLIENT SCORE:
• *Do you have any "legal stuff" going on?* • *Have you had a lawyer assigned to you by a court?* • *Do you have any upcoming court dates? Do you think there's a chance you will do time?* • *Any involvement with family court or child custody matters?* • *Any outstanding fines?* • *Have you paid any fines in the last 12 months for anything?* • *Have you done any community service in the last 12 months?* • *Is anybody expecting you to do community service for anything right now?* • *Did you have any legal stuff in the last year that got dismissed?* • *Is your housing at risk in any way right now because of legal issues?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand
3	**Any** of the following: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand
2	**Any** of the following: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)
1	☐ There are no current legal issues, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration
0	☐ No legal issues within the past 365 days, **and** currently no conditions of release

J. Managing Tenancy

PROMPTS	CLIENT SCORE:
• *Are you currently homeless?* • *[If the person is housed] Do you have an eviction notice?* • *[If the person is housed] Do you think that your housing is at risk?* • *How is your relationship with your neighbors?* • *How do you normally get along with landlords?* • *How have you been doing with taking care of your place?*	NOTES

Note: Housing matters include: conflict with landlord and/or neighbors, damages to the unit, payment of rent on time and in full. Payment of rent through a third party is <u>not</u> considered to be a short-coming or deficiency in the ability to pay rent.

SCORING	
4	**Any** of the following: ☐¨Currently homeless ☐¨In the next 30 days, will be re-housed or return to homelessness ☐¨In the past 365 days, was re-housed 6+ times ☐¨In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters
3	**Any** of the following: ☐¨In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days ☐¨In the past 365 days, was re-housed 3-5 times ☐¨In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters
2	**Any** of the following: ☐¨In the past 365 days, was re-housed 2 times ☐¨In the past 180 days, was re-housed 1+ times, but not in the past 60 days ☐¨Continuously housed for at least 90 days but not more than 180 days ☐¨In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters
1	**Any** of the following: ☐¨In the past 365 days, was re-housed 1 time ☐¨Continuously housed, with no assistance on housing matters, for at least 180 days but not more than 365 days
0	☐¨Continuously housed, with no assistance on housing matters, for at least 365 days

K. Personal Administration & Money Management

PROMPTS	CLIENT SCORE:
• *How are you with taking care of money?* • *How are you with paying bills on time and taking care of other financial stuff?* • *Do you have any street debts?* • *Do you have any drug or gambling debts?* • *Is there anybody that thinks you owe them money?* • *Do you budget every single month for every single thing you need? Including cigarettes? Booze? Drugs?* • *Do you try to pay your rent before paying for anything else?* • *Are you behind in any payments like child support or student loans or anything like that?*	NOTES

SCORING	
4	**Any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Does not have an income (including formal and informal sources) ☐ Not aware of the full amount spent on substances, if they use substances ☐ Substantial real or perceived debts of $1,000+, past due or requiring monthly payments
3	**Any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use, if they are a substance user ☐ Real or perceived debts of $999 or less, past due or requiring monthly payments
2	**Any** of the following: ☐ In the past 365 days, source of income has changed 2+ times ☐ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) ☐ Has been self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ Has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ Has been self-managing financial resources and taking care of associated acministrative tasks for at least 180 days

L. Social Relationships & Networks

PROMPTS	CLIENT SCORE:
• *Tell me about your friends, family or other people in your life.* • *How often do you get together or chat?* • *When you go to doctor's appointments or meet with other professionals like that, what is that like?* • *Are there any people in your life that you feel are just using you?* • *Are there any of your closer friends that you feel are always asking you for money, smokes, drugs, food or anything like that?* • *Have you ever had people crash at your place that you did not want staying there?* • *Have you ever been threatened with an eviction or lost a place because of something that friends or family did in your apartment?* • *Have you ever been concerned about not following your lease agreement because of your friends or family?*	**NOTES**

SCORING	
4	**Any** of the following: ☐¨In the past 90 days, left an exploitive, abusive or dependent relationship ☐¨Friends, family or other people are placing security of housing at imminent risk, **or** impacting life, wellness, or safety ☐¨No friends or family and demonstrates no ability to follow social norms ☐¨Currently homeless and would classify most of friends and family as homeless
3	**Any** of the following: ☐¨In the past 90-180 days, left an exploitive, abusive or dependent relationship ☐¨Friends, family or other people are having some negative consequences on wellness or housing stability ☐¨No friends or family but demonstrating ability to follow social norms ☐¨Meeting new people with an intention of forming friendships ☐¨Reconnecting with previous friends or family members, but experiencing difficulty advancing the relationship ☐¨Currently homeless, and would classify some of friends and family as being housed, while others are homeless
2	**Any** of the following: ☐¨More than 180 days ago, left an exploitive, abusive or dependent relationship ☐¨Developing relationships with new people but not yet fully trusting them ☐¨Currently homeless, and would classify friends and family as being housed
1	☐¨Has been housed for less than 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability
0	☐¨Has been housed for at least 180 days, **and** is engaged with friends or family, who are having no negative consequences on the individual's housing stability

M. Self Care & Daily Living Skills

PROMPTS	CLIENT SCORE:
• *Do you have any worries about taking care of yourself?* • *Do you have any concerns about cooking, cleaning, laundry or anything like that?* • *Do you ever need reminders to do things like shower or clean up?* • *Describe your last apartment.* • *Do you know how to shop for nutritious food on a budget?* • *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* • *Do you tend to keep all of your clothes clean?* • *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* • *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?*	**NOTES**

	SCORING
4	**Any** of the following: ☐ No insight into how to care for themselves, their apartment or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life
3	**Any** of the following: ☐ Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life
2	**Any** of the following: ☐ Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, accessed community resources 4 or fewer times, **and** is fully taking care of all their daily needs
0	☐ For the past 365+ days, fully taking care of all their daily needs independently

N. Meaningful Daily Activity

PROMPTS	CLIENT SCORE:
• *How do you spend your day?* • *How do you spend your free time?* • *Does that make you feel happy/fulfilled?* • *How many days a week would you say you have things to do that make you feel happy/fulfilled?* • *How much time in a week would you say you are totally bored?* • *When you wake up in the morning, do you tend to have an idea of what you plan to do that day?* • *How much time in a week would you say you spend doing stuff to fill up the time rather than doing things that you love?* • *Are there any things that get in the way of you doing the sorts of activities you would like to be doing?*	NOTES

SCORING	
4	☐ No planned, legal activities described as providing fulfillment or happiness
3	☐ Discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness
2	☐ Attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment or happiness, **or** the individual is not fully committed to continuing the activities.
1	☐ Has planned, legal activities described as providing fulfillment or happiness 1-3 days per week
0	☐ Has planned, legal activities described as providing fulfillment or happiness 4+ days per week

O. History of Homelessness & Housing

PROMPTS	CLIENT SCORE:
• *How long have you been homeless?* • *How many times have you been homeless in your life other than this most recent time?* • *Have you spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your permanent address?* • *Have you ever spent time sleeping in a car or alleyway or garage or barn or bus shelter or anything like that?* • *Have you ever spent time sleeping in an abandoned building?* • *Were you ever in hospital or jail for a period of time when you didn't have a permanent address to go to when you got out?*	NOTES

SCORING	
4	☐ ¨Over the past 10 years, cumulative total of 5+ years of homelessness
3	☐ ¨Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of homelessness
2	☐ ¨Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of homelessness
1	☐ ¨Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of homelessness
0	☐ ¨Over the past 4 years, cumulative total of 7 or fewer days of homelessness

E ADULTS

VERSION 4.01

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
MENTAL HEALTH & ELLNESS AND COGNITIVE FUNCTIONING	)	
PHYSICAL HEALTH & WELLNESS	)	
MEDICATION	)	
SUBSTANCE USE	)	
PERIENCE OF ABUSE AND/ OR TRAUMA	)	
SK OF HARM TO SELF OR OTHERS	)	
VOLVEMENT IN HIGHER SK AND/OR EXPLOITIVE SITUATIONS	)	
INTERACTION WITH EMERGENCY SERVICES	)	

Ξ ADULTS

VERSION 4.01

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
LEGAL INVOLVEMENT	0	
MANAGING TENANCY	0	
SONAL ADMINISTRATION MONEY MANAGEMENT	0	
CIAL RELATIONSHIPS & NETWORKS	0	
LF-CARE & DAILY LIVING SKILLS	0	
MEANINGFUL DAILY ACTIVITIES	0	
ISTORY OF HOUSING & HOMELESSNESS	0	
TOTAL		**No housing intervention**

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Appendix A: About the SPDAT

OrgCode Consulting, Inc. is pleased to announce the release of Version 4 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including: discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

SPDAT Design

The SPDAT is designed to:

- Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
- Prioritize the sequence of clients receiving those services
- Help prioritize the time and resources of Frontline Workers
- Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
- Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team
- Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan
- Track the depth of need and service responses to clients over time

The SPDAT is NOT designed to:

- Provide a diagnosis
- Assess current risk or be a predictive index for future risk
- Take the place of other valid and reliable instruments used in clinical research and care

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, we have also created the VI-SPDAT as an initial screening tool.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client's acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services.

Version 4

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale, Camberwell Assessment of Needs, Vulnerability Index, and Transition Aged Youth Triage Tool.

In preparing SPDAT v4, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff have observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics review enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

Version 4 builds upon the success of Version 3 of the SPDAT with some refinements. Starting in August 2014, a survey was launched of existing SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

The major differences from Version 3 to Version 4 include:

- The structure of the tools is the same: four domains (five for families) with components aligned to specific domains. The names of the domains and the components remain unchanged.
- The scoring of the tools is the same: 60 points for singles, and 80 points for families.
- The scoring tables used to run from 0 through to 4. They are now reversed with each table starting at 4 and working their way down to 0. This increases the speed of assessment.
- The order of the tools has changed, grouped together by domain.
- Language has been simplified.
- Days are used rather than months to provide greater clarification and alignment to how most databases capture periods of time in service.
- Greater specificity has been provided in some components such as amount of debts.

Family Service Prioritization Decision Assistance Tool (F-SPDAT)

Assessment Tool for Families

VERSION 2.01

1 (800) 355-0420 info@orgcode.com www.orgcode.com

Welcome to the SPDAT Line of Products

The Service Prioritization Decision Assistance Tool (SPDAT) has been around in various incarnations for over a decade, before being released to the public in 2010. Since its initial release, the use of the SPDAT has been expanding exponentially and is now used in over one thousand communities across the United States, Canada, and Australia.

More communities using the tool means there is an unprecedented demand for versions of the SPDAT, customized for specific client groups or service delivery contexts. With the release of SPDAT V4, there have been more current versions of SPDAT products than ever before.

VI-SPDAT Series

The **Vulnerability Index – Service Prioritization Decision Assistance Tool** (VI-SPDAT) was developed as a pre-screening tool for communities that are very busy and may not have the resources to conduct a full SPDAT assessment for every client. It was made in collaboration with Community Solutions, creators of the Vulnerability Index, as a brief survey that can be conducted to quickly determine whether a client has high, moderate, or low acuity. The use of this survey can help prioritize which clients should be given a full SPDAT assessment first. Because it is a self-reported survey, no special training is required to use the VI-SPDAT.

Current versions available:

- VI-SPDAT V 2.0 for Individuals
- VI-SPDAT V 2.0 for Families
- VI-SPDAT V 1.0 for Youth

All versions are available online at

www.orgcode.com/products/vi-spdat/

SPDAT Series

The **Service Prioritization Decision Assistance Tool** (SPDAT) was developed as an assessment tool for frontline workers at agencies that work with homeless clients to prioritize which of those clients should receive assistance first. It is an in-depth assessment that relies on the assessor's ability to interpret responses and corroborate those with evidence. As a result, this tool may only be used by those who have received proper, up-to-date training provided by OrgCode Consulting, Inc. or an OrgCode certified trainer.

Current versions available:

- SPDAT V 4.0 for Individuals
- SPDAT V 2.0 for Families
- SPDAT V 1.0 for Youth

Information about all versions is available online at

www.orgcode.com/products/spdat/

1 (800) 355-0420 info@orgcode.com www.orgcode.com

SPDAT Training Series

To use the SPDAT, training by OrgCode or an OrgCode certified trainer is required. We provide training on a wide variety of topics over a variety of mediums.

The full-day in-person SPDAT Level 1 training provides you the opportunity to bring together as many people as you want to be trained for one low fee. The webinar training allows for a maximum of 15 different computers to be logged into the training at one time. We also offer online courses for individuals that you can do at your own speed.

The training gives you the manual, case studies, application to current practice, a review of each component of the tool, conversation guidance with prospective clients – and more!

Current SPDAT training available:

- Level 0 SPDAT Training: VI-SPDAT for Frontline Workers
- Level 1 SPDAT Training: SPDAT for Frontline Workers
- Level 2 SPDAT Training: SPDAT for Supervisors
- Level 3 SPDAT Training: SPDAT for Trainers

Other related training available:

- Excellence in Housing-Based Case Management
- Coordinated Access & Common Assessment
- Motivational Interviewing
- Objective-Based Interactions

More information about SPDAT training, including pricing, is available online at

http://www.orgcode.com/product-category/training/spdat/

Terms and Conditions Governing the Use of the SPDAT

SPDAT products have been developed by OrgCode Consulting, Inc. with extensive feedback from key community partners including people with lived experience. The tools are provided free of charge to communities to improve the client centered services dedicated to increasing housing stability and wellness. Training is indeed required for the administration and interpretation of these assessment tools. Use of the SPDAT products without authorized training is strictly prohibited.

By using this tool, you accept and agree to be bound by the terms of this expectation.

No sharing, reproduction, use or duplication of the information herein is permitted without the express written consent of OrgCode Consulting, Inc.

Ownership

The Service Prioritization Decision Assistance Tool ("SPDAT") and accompanying documentation is owned by OrgCode Consulting, Inc.

Training

Although the SPDAT Series is provided free of charge to communities, training by OrgCode Consulting, Inc. or a third party trainer, authorized by OrgCode, must be successfully completed. After meeting the training requirements required to administer and interpret the SPDAT Series, practitioners are permitted to implement the SPDAT in their work with clients.

Restrictions on Use

You may not use or copy the SPDAT prior to successfully completing training on its use, provided by OrgCode Consulting, Inc. or a third-party trainer authorized by OrgCode. You may not share the SPDAT with other individuals not trained on its use. You may not train others on the use of the SPDAT, unless specifically authorized by OrgCode Consulting, Inc.

Restrictions on Alteration

You may not modify the SPDAT or create any derivative work of the SPDAT or its accompanying documentation, without the express written consent of OrgCode Consulting, Inc. Derivative works include but are not limited to translations.

Disclaimer

The management and staff of OrgCode Consulting, Inc. (OrgCode) do not control the way in which the Service Prioritization Decision Assistance Tool (SPDAT) will be used, applied or integrated into related client processes by communities, agency management or frontline workers. OrgCode assumes no legal responsibility or liability for the misuse of the SPDAT, decisions that are made or services that are received in conjunction with the assessment tool.

A. Mental Health & Wellness & Cognitive Functioning

PROMPTS	CLIENT SCORE:
• *Has anyone in your family ever received any help with their mental wellness?* • *Do you feel that every member in your family is getting all the help they need for their mental health or stress?* • *Has a doctor ever prescribed anyone in your family pills for nerves, anxiety, depression or anything like that?* • *Has anyone in your family ever gone to an emergency room or stayed in a hospital because they weren't feeling 100% emotionally?* • *Does anyone in your family have trouble learning or paying attention, or been tested for learning disabilities?* • *Do you know if, when pregnant with you, your mother did anything that we now know can have negative effects on the baby? What about when you were pregnant?* • *Has anyone in your family ever hurt their brain or head?* • *Do you have any documents or papers about your family's mental health or brain functioning?* • *Are there other professionals we could speak with that have knowledge of your family's mental health?*	**NOTES**

SCORING	
4	**Any** of the following among any family member: ☐ Serious and persistent mental illness (2+ hospitalizations in a mental health facility or psychiatric ward in the past 2 years) **and** not in a heightened state of recovery currently ☐ Major barriers to performing tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
3	**Any** of the following among any family member: ☐ Heightened concerns about state of mental health, but fewer than 2 hospitalizations, and/or without knowledge of presence of a diagnosable mental health condition ☐ Diminished ability to perform tasks and functions of daily living or communicating intent because of a brain injury, learning disability or developmental disability
2	While there may be concern for overall mental health or mild impairments to performing tasks and functions of daily living or communicating intent, **all** of the following are true: ☐ No major concerns about the family's safety or ability to be housed without intensive supports to assist with mental health or cognitive functioning ☐ No major concerns for the health and safety of others because of mental health or cognitive functioning ability ☐ No compelling reason for any member of the family to be screened by an expert in mental health or cognitive functioning prior to housing to fully understand capacity
1	☐ All members of the family are in a heightened state of recovery, have a Wellness Recovery Action Plan (WRAP) or similar plan for promoting wellness, understands symptoms and strategies for coping with them, **and** are engaged with mental health supports as necessary.
0	☐ No mental health or cognitive functioning issues disclosed, suspected or observed.

B. Physical Health & Wellness

PROMPTS	CLIENT SCORE:
- *How is your family's health?* - *Are you getting any help with your health? How often?* - *Do you feel you are getting all the care you need for your family's health?* - *Any illnesses like diabetes, HIV, Hep C or anything like that going on in any member of your family?* - *Ever had a doctor tell anyone in your family that they have problems with blood pressure or heart or lungs or anything like that?* - *When was the last time anyone in your family saw a doctor? What was that for?* - *Do you have a clinic or doctor that you usually go to?* - *Anything going on right now with your family's health that you think would prevent them from living a full, healthy, happy life?* - *Are there other professionals we could speak with that have knowledge of your family's health?* - *Do you have any documents or papers about your family's health or past stays in hospital because of your health?*	**NOTES**

SCORING	
4	**Any** of the following for any member of the family: ☐ Co-occurring chronic health conditions ☐ Attempting a treatment protocol for a chronic health condition, but the treatment is not improving health ☐ Palliative health condition
3	Presence of a health issue among any family member with **any** of the following: ☐ Not connected with professional resources to assist with a real or perceived serious health issue, by choice ☐ Single chronic or serious health concern but does not connect with professional resources because of insufficient community resources (e.g. lack of availability or affordability) ☐ Unable to follow the treatment plan as a direct result of homeless status
2	☐ Presence of a relatively minor physical health issue, which is managed and/or cared for with appropriate professional resources or through informed self-care ☐ Presence of a physical health issue, for which appropriate treatment protocols are followed, but there is still a moderate impact on their daily living
1	Single chronic or serious health condition in a family member, but **all** of the following are true: ☐ Able to manage the health issue and live a relatively active and healthy life ☐ Connected to appropriate health supports ☐ Educated and informed on how to manage the health issue, take medication as necessary related to the condition, and consistently follow these requirements.
0	☐ No serious or chronic health condition ☐ If any minor health condition, they are managed appropriately

C. Medication

PROMPTS	CLIENT SCORE:
• *Has anyone in your family recently been prescribed any medications by a health care professional?* • *Does anyone in your family take any medication, prescribed to them by a doctor?* • *Has anyone in your family ever had a doctor prescribe them a medication that wasn't filled or they didn't take?* • *Were any of your family's medications changed in the last month? Whose? How did that make them feel?* • *Do other people ever steal your family's medications?* • *Does anyone in your family ever sell or share their medications with other people it wasn't prescribed to?* • *How does your family store their medication and make sure they take the right medication at the right time each day?* • *What do you do if you realize someone has forgotten to take their medications?* • *Do you have any papers or documents about the medications your family takes?*	**NOTES**

SCORING	
4	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which **is** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **less** than is sold or shared ☐ Regularly misuses medication (e.g. frequently forgets; often takes the wrong dosage; uses some or all of medication to get high) ☐ Has had a medication prescribed in the last 90 days that remains unfilled, for any reason
3	**Any** of the following for any family member: ☐ In the past 30 days, started taking a prescription which is **not** having any negative impact on day to day living, socialization or mood ☐ Shares or sells prescription, but keeps **more** than is sold or shared ☐ Requires intensive assistance to manage or take medication (e.g., assistance organizing in a pillbox; working with pharmacist to blister-pack; adapting the living environment to be more conducive to taking medications at the right time for the right purpose, like keeping nighttime medications on the bedside table and morning medications by the coffeemaker) ☐ Medications are stored and distributed by a third-party
2	**Any** of the following for any family member: ☐ Fails to take medication at the appropriate time or appropriate dosage, 1-2 times per week ☐ Self-manages medications except for requiring reminders or assistance for refills ☐ Successfully self-managing medication for fewer than 30 consecutive days
1	☐ Successfully self-managing medications for more than 30, but less than 180, consecutive days
0	**Any** of the following is true for **every** family member: ☐ No medication prescribed to them ☐ Successfully self-managing medication for 181+ consecutive days

D. Substance Use

PROMPTS	CLIENT SCORE:
- *When was the last time you had a drink or used drugs? What about the other members of your family?* - *Anything we should keep in mind related to drugs/alcohol?* - *How often would you say you use [substance] in a week?* - *Ever have a doctor tell you that your health may be at risk because you drink or use drugs?* - *Have you engaged with anyone professionally related to your substance use that we could speak with?* - *Ever get into fights, fall down and bang your head, do things you regret later, or pass out when drinking or using other drugs?* - *Have you ever used alcohol or other drugs in a way that may be considered less than safe?* - *Do you ever drink mouthwash or cooking wine or hand sanitizer or anything like that?*	**NOTES**

Note: Consumption thresholds: 2 drinks per day or 14 total drinks in any one week period for men; 2 drinks per day or 9 total drinks in any one week period for women.

SCORING	
4	☐ An adult is in a life-threatening health situation as a direct result of substance use, **or,** ☐ Any family member is under the legal age but over 15 and would score a 3+, **or,** ☐ Any family member is under 15 and would score a 2+, **or** who first used drugs prior to age 12, **or,** In the past 30 days, **any** of the following are true for any adult in the family... ☐ Substance use is almost daily (21+ times) **and** often to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use 4+ times ☐ Substance use resulting in passing out 2+ times
3	☐ An adult is experiencing serious health impacts as a direct result of substance use, though not (yet) in a life-threatening position as a result, **or,** ☐ Any family member is under the legal age but over 15 and would score a 2, **or,** ☐ Any family member is under 15 and would score a 1, **or** who first used drugs at age 13-15, **or,** In the past 30 days, **any** of the following are true for any adult in the family... ☐ Drug use reached the point of complete inebriation 12+ times ☐ Alcohol use usually exceeded the consumption thresholds (at least 5+ times), but usually not to the point of complete inebriation ☐ Binge drinking, non-beverage alcohol use, or inhalant use occurred 1-3 times
2	☐ Any family member is under the legal age but over 15 and would otherwise score 1, **or,** In the past 30 days, **any** of the following are true for any adult in the family... ☐ Drug use reached the point of complete inebriation fewer than 12 times ☐ Alcohol use exceeded the consumption thresholds fewer than 5 times
1	☐ In the past 365 days, no alcohol use beyond consumption thresholds, **or,** ☐ If making claims to sobriety, no substance use in the past 30 days
0	☐ In the past 365 days, no substance use

E. Experience of Abuse & Trauma of Parents

PROMPTS	CLIENT SCORE:
To avoid re-traumatizing the individual, ask selected approved questions as written. Do not probe for details of the trauma/abuse. This section is entirely self-reported. ***Because this section is self-reported, if there are more than one parent present, they should each be asked individually.*** - *"I don't need you to go into any details, but has there been any point in your life where you experienced emotional, physical, sexual or psychological abuse?"* - *"Are you currently or have you ever received professional assistance to address that abuse?"* - *"Does the experience of abuse or trauma impact your day to day living in any way?"* - *"Does the experience of abuse or trauma impact your ability to hold down a job, maintain housing or engage in meaningful relationships with friends or family?"* - *"Have you ever found yourself feeling or acting in a certain way that you think is caused by a history of abuse or trauma?"* - *"Have you ever become homeless as a direct result of experiencing abuse or trauma?"*	**NOTES**

SCORING	
4	☐ A reported experience of abuse or trauma, believed to be a direct cause of their homelessness
3	☐ The experience of abuse or trauma is **not** believed to be a direct cause of homelessness, but abuse or trauma (experienced before, during, or after homelessness) **is** impacting daily functioning and/or ability to get out of homelessness
2	**Any** of the following: ☐ A reported experience of abuse or trauma, but is not believed to impact daily functioning and/or ability to get out of homelessness ☐ Engaged in therapeutic attempts at recovery, but does not consider self to be recovered
1	☐ A reported experience of abuse or trauma, and considers self to be recovered
0	☐ No reported experience of abuse or trauma

F. Risk of Harm to Self or Others

PROMPTS	CLIENT SCORE:
- *Does anyone in your family have thoughts about hurting themselves or anyone else? Have they ever acted on these thoughts? When was the last time? What was occurring when that happened?* - *Has anyone in your family ever received professional help – including maybe a stay at hospital – as a result of thinking about or attempting to hurt themself or others? How long ago was that? Does that happen often?* - *Has anyone in your family recently left a situation you felt was abusive or unsafe? How long ago was that?* - *Has anyone in your family been in any fights recently – whether they started it or someone else did? How long ago was that? How often do they get into fights?*	**NOTES**

SCORING	
4	**Any** of the following for any family member: ☐ In the past 90 days, left an abusive situation ☐ In the past 30 days, attempted, threatened, or actually harmed self or others ☐ In the past 30 days, involved in a physical altercation (instigator or participant)
3	**Any** of the following for any family member: ☐ In the past 180 days, left an abusive situation, but no exposure to abuse in the past 90 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 180 days, but not in the past 30 days ☐ In the past 365 days, involved in a physical altercation (instigator or participant), but not in the past 30 days
2	**Any** of the following for any family member: ☐ In the past 365 days, left an abusive situation, but no exposure to abuse in the past 180 days ☐ Most recently attempted, threatened, or actually harmed self or others in the past 365 days, but not in the past 180 days ☐ 366+ days ago, 4+ involvements in physical alterations
1	☐ 366+ days ago, a family member had 1-3 involvements in physical alterations
0	☐ Whole family reports no instance of harming self, being harmed, or harming others

G. Involvement in Higher Risk and/or Exploitive Situations

PROMPTS	CLIENT SCORE:
• *(Observe, don't ask) Any abcesses or track marks from injection substance use?* • *Does anybody force or trick people in your family to do things that they don't want to do?* • *Do you or anyone in your family ever do stuff that could be considered dangerous like drinking until they pass out outside, or delivering drugs for someone, having sex without a condom with a casual partner, or anything like that?* • *Does anyone in your family ever find themselves in situations that may be considered at a high risk for violence?* • *Does your family ever sleep outside? How do you dress and prepare for that? Where do you tend to sleep?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 10+ higher risk and/or exploitive events ☐ In the past 90 days, any member of the family left an abusive situation
3	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 4-9 higher risk and/or exploitive events ☐ In the past 180 days, any member of the family left an abusive situation, but not in the past 90 days
2	**Any** of the following: ☐ In the past 180 days, family engaged in a total of 1-3 higher risk and/or exploitive events ☐ 181+ days ago, any member of the family left an abusive situation
1	☐ Any involvement in higher risk and/or exploitive situations by any member of the family occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no involvement by any family member in higher risk and/or exploitive events

H. Interaction with Emergency Services

PROMPTS	CLIENT SCORE:
• How often does your family go to emergency rooms? • How many times have you had the police speak to members of your family over the past 180 days? • Has anyone in your family used an ambulance or needed the fire department at any time in the past 180 days? • How many times have members of your family called or visited a crisis team or a crisis counselor in the last 180 days? • How many times have you or anyone in your family been admitted to hospital in the last 180 days? How long did they stay?	NOTES

Note: Emergency service use includes: admittance to emergency room/department; hospitalizations; trips to a hospital in an ambulance; crisis service, distress centers, suicide prevention service, sexual assault crisis service, sex worker crisis service, or similar service; interactions with police for the purpose of law enforcement; interactions with fire service in emergency situations.

SCORING	
4	☐ In the past 180 days, cumulative family total of 10+ interactions with emergency services
3	☐ In the past 180 days, cumulative family total of 4-9 interactions with emergency services
2	☐ In the past 180 days, cumulative family total of 1-3 interactions with emergency services
1	☐ Any interaction with emergency services by family members occurred more than 180 days ago but less than 365 days ago
0	☐ In the past 365 days, no interaction with emergency services

I. Legal

PROMPTS	CLIENT SCORE:
• *Does your family have any "legal stuff" going on?* • *Has anyone in your family had a lawyer assigned to them by a court?* • *Does anyone in your family have any upcoming court dates? Do you think there's a chance someone in your family will do time?* • *Any outstanding fines?* • *Has anyone in your family paid any fines in the last 12 months for anything?* • *Has anyone in your family done any community service in the last 12 months?* • *Is anybody expecting someone in your family to do community service for anything right now?* • *Did your family have any legal stuff in the last year that got dismissed?* • *Is your family's housing at risk in any way right now because of legal issues?*	**NOTES**

SCORING	
4	**Any** of the following among any family member: ☐ Current outstanding legal issue(s), likely to result in fines of $500+ ☐ Current outstanding legal issue(s), likely to result in incarceration of 3+ months (cumulatively), inclusive of any time held on remand
3	**Any** of the following among any family member: ☐ Current outstanding legal issue(s), likely to result in fines less than $500 ☐ Current outstanding legal issue(s), likely to result in incarceration of less than 90 days (cumulatively), inclusive of any time held on remand
2	**Any** of the following among any family member: ☐ In the past 365 days, relatively minor legal issue has occurred and was resolved through community service or payment of fine(s) ☐ Currently outstanding relatively minor legal issue that is unlikely to result in incarceration (but may result in community service)
1	☐ There are no current legal issues among family members, **and** any legal issues that have historically occurred have been resolved without community service, payment of fine, or incarceration
0	☐ No family member has had any legal issues within the past 365 days, **and** currently no conditions of release

J. Managing Tenancy

PROMPTS	CLIENT SCORE:
• *Is your family currently homeless?* • *[If the family is housed] Does your family have an eviction notice?* • *[If the family is housed] Do you think that your family's housing is at risk?* • *How is your family's relationship with your neighbors?* • *How does your family normally get along with landlords?* • *How has your family been doing with taking care of your place?*	**NOTES**

Note: Housing matters include: conflict with landlord and/or neighbors, damages to the unit, payment of rent on time and in full. Payment of rent through a third party is not considered to be a short-coming or deficiency in the ability to pay rent.

SCORING	
4	**Any** of the following: ☐ Currently homeless ☐ In the next 30 days, will be re-housed or return to homelessness ☐ In the past 365 days, was re-housed 6+ times ☐ In the past 90 days, support worker(s) have been cumulatively involved 10+ times with housing matters
3	**Any** of the following: ☐ In the next 60 days, will be re-housed or return to homelessness, but not in next 30 days ☐ In the past 365 days, was re-housed 3-5 times ☐ In the past 90 days, support worker(s) have been cumulatively involved 4-9 times with housing matters
2	**Any** of the following: ☐ In the past 365 days, was re-housed 2 times ☐ In the past 180 days, was re-housed 1+ times, but not in the past 60 days ☐ Continuously housed for at least 90 days but not more than 180 days ☐ In the past 90 days, support worker(s) have been cumulatively involved 1-3 times with housing matters
1	**Any** of the following: ☐ In the past 365 days, was re-housed 1 time ☐ Continuously housed, with no assistance on housing matters, for at least 180 days but not more than 365 days
0	☐ Continuously housed, with no assistance on housing matters, for at least 365 days

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K. Personal Administration & Money Management

PROMPTS	CLIENT SCORE:
- *How are you and your family with taking care of money?* - *How are you and your family with paying bills on time and taking care of other financial stuff?* - *Does anyone in your family have any street debts or drug or gambling debts?* - *Is there anybody that thinks anyone in your family owes them money?* - *Do you budget every single month for every single thing your family needs? Including cigarettes? Booze? Drugs?* - *Does your family try to pay your rent before paying for anything else?* - *Is anyone in your family behind in any payments like child support or student loans or anything like that?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ No family income (including formal and informal sources) ☐ Substantial real or perceived debts of $1,000+, past due or requiring monthly payments **Or**, for the person who normally handles the household's finances, **any** of the following: ☐ Cannot create or follow a budget, regardless of supports provided ☐ Does not comprehend financial obligations ☐ Not aware of the full amount spent on substances, if the household includes a substance user
3	☐ Real or perceived debts of $999 or less, past due or requiring monthly payments, **or** For the person who normally handles the household's finances, **any** of the following: ☐ Requires intensive assistance to create and manage a budget (including any legally mandated guardian/trustee that provides assistance or manages access to money) ☐ Only understands their financial obligations with the assistance of a 3rd party ☐ Not budgeting for substance use, if the household includes a substance user
2	☐ In the past 365 days, source of family income has changed 2+ times, **or** For the person who normally handles the household's finances, **any** of the following: ☐ Budgeting to the best of ability (including formal and informal sources), but still short of money every month for essential needs ☐ Voluntarily receives assistance creating and managing a budget or restricts access to their own money (e.g. guardian/trusteeship) ☐ Self-managing financial resources and taking care of associated administrative tasks for less than 90 days
1	☐ The person who normally handles the household's finances has been self-managing financial resources and taking care of associated administrative tasks for at least 90 days, but for less than 180 days
0	☐ The person who normally handles the household's finances has been self-managing financial resources and taking care of associated administrative tasks for at least 180 days

L. Social Relationships & Networks

PROMPTS	CLIENT SCORE:
- *Tell me about your family's friends, extended family or other people in your life.* - *How often do you get together or chat with family friends?* - *When your family goes to doctor's appointments or meet with other professionals like that, what is that like?* - *Are there any people in your life that you feel are just using you, or someone else in your family?* - *Are there any of your family's closer friends that you feel are always asking you for money, smokes, drugs, food or anything like that?* - *Have you ever had people crash at your place that you did not want staying there?* - *Have you ever been threatened with an eviction or lost a place because of something that friends or extended family did in your apartment?* - *Have you ever been concerned about not following your lease agreement because of friends or extended family?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ Currently homeless and would classify most of friends and family as homeless ☐ Friends, family or other people are placing security of housing at imminent risk, **or** impacting life, wellness, or safety ☐ In the past 90 days, left an exploitive, abusive or dependent relationship ☐ No friends or family and any family member demonstrates an inability to follow social norms
3	**Any** of the following: ☐ Currently homeless, and would classify some of friends as housed, while some are homeless ☐ In the past 90-180 days, left an exploitive, abusive or dependent relationship ☐ Friends, family or other people are having some negative consequences on wellness or housing stability ☐ No friends or family but all family members demonstrate ability to follow social norms ☐ Any family member is meeting new people with an intention of forming friendships ☐ Any family member is reconnecting with previous friends or family members, but experiencing difficulty advancing the relationship
2	**Any** of the following: ☐ Currently homeless, and would classify friends and family as being housed ☐ More than 180 days ago, left an exploitive, abusive or dependent relationship ☐ Any family member is developing relationships with new people but not yet fully trusting them
1	☐ Has been housed for less than 180 days, **and** family is engaged with friends or family, who are having no negative consequences on the individual's housing stability
0	☐ Has been housed for at least 180 days, **and** family is engaged with friends or family, who are having no negative consequences on the individual's housing stability

M. Self Care & Daily Living Skills of Family Head

PROMPTS	CLIENT SCORE:
• *Do you have any worries about taking care of yourself or your family?* • *Do you have any concerns about cooking, cleaning, laundry or anything like that?* • *Does anyone in your family ever need reminders to do things like shower or clean up?* • *Describe your family's last apartment.* • *Do you know how to shop for nutritious food on a budget?* • *Do you know how to make low cost meals that can result in leftovers to freeze or save for another day?* • *Do you tend to keep all of your family's clothes clean?* • *Have you ever had a problem with mice or other bugs like cockroaches as a result of a dirty apartment?* • *When you have had a place where you have made a meal, do you tend to clean up dishes and the like before they get crusty?*	**NOTES**

SCORING	
4	**Any** of the following for head(s) of household: ☐ No insight into how to care for themselves, their apartment or their surroundings ☐ Currently homeless and relies upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing) on an almost daily basis ☐ Engaged in hoarding or collecting behavior and is not aware that it is an issue in her/his life
3	**Any** of the following for head(s) of household: ☐ Has insight into some areas of how to care for themselves, their apartment or their surroundings, but misses other areas because of lack of insight ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), 14+ days in any 30-day period ☐ Engaged in hoarding or collecting behavior and is aware that it is an issue in her/his life
2	**Any** of the following for head(s) of household: ☐ Fully aware and has insight in all that is required to take care of themselves, their apartment and their surroundings, but has not yet mastered the skills or time management to fully execute this on a regular basis ☐ In the past 180 days, relied upon others to meet basic needs (e.g. access to shelter, showers, toilet, laundry, food, and/or clothing), fewer than 14 days in every 30-day period
1	☐ In the past 365 days, family accessed community resources 4 or fewer times, **and** head of household is fully taking care of all the family's daily needs
0	☐ For the past 365+ days, fully taking care of all the family's daily needs independently

N. Meaningful Daily Activity

PROMPTS	CLIENT SCORE:
• How does your family spend their days? • How does your family spend their free time? • Do these things make your family feel happy/fulfilled? • How many days a week would you say members of your family have things to do that make them feel happy/fulfilled? • How much time in a week would you or members of your family say they are totally bored? • When people in your family wake up in the morning, do they tend to have an idea of what they plan to do that day? • How much time in a week would you say members of your family spend doing stuff to fill up the time rather than doing things that they love? • Are there any things that get in the way of your family doing the sorts of activities they would like to be doing?	NOTES

SCORING	
4	☐ Any member of the family has no planned, legal activities described as providing fulfillment or happiness
3	☐ Any member of the family is discussing, exploring, signing up for and/or preparing for new activities or to re-engage with planned, legal activities that used to provide fulfillment or happiness
2	☐ Some members of the family are attempting new or re-engaging with planned, legal activities that used to provide fulfillment or happiness, but uncertain that activities selected are currently providing fulfillment or happiness, **or** they are not fully committed to continuing the activities.
1	☐ Each family member has planned, legal activities described as providing fulfillment or happiness 1-3 days per week
0	☐ Each family member has planned, legal activities described as providing fulfillment or happiness 4+ days per week

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D. History of Homelessness & Housing

PROMPTS	CLIENT SCORE:
- How long has your family been homeless? - How many times has your family experienced homelessness other than this most recent time? - Has your family spent any time sleeping on a friend's couch or floor? And if so, during those times did you consider that to be your family's permanent address? - Has your family ever spent time sleeping in a car, alleyway, garage, barn, bus shelter, or anything like that? - Has your family ever spent time sleeping in an abandoned building? - Was anyone in your family ever been in hospital or jail for a period of time when they didn't have a permanent address to go to when they got out?	NOTES

SCORING	
4	☐ Over the past 10 years, cumulative total of 5+ years of family homelessness
3	☐ Over the past 10 years, cumulative total of 2+ years but fewer than 5 years of family homelessness
2	☐ Over the past 4 years, cumulative total of 30+ days but fewer than 2 years of family homelessness
1	☐ Over the past 4 years, cumulative total of 7+ days but fewer than 30 days of family homelessness
0	☐ Over the past 4 years, cumulative total of 7 or fewer days of family homelessness

P. Parental Engagement

PROMPTS	CLIENT SCORE:
- *Walk me through a typical evening after school in your family.* - *Tell me about what role, if any, the older kids have with the younger kids. Do they babysit? Walk them to school? Bathe or put the younger kids to bed?* - *Does your family have play time together? What kinds of things do you do and how often do you do it?* - *Let's pick a day like a Saturday...do you know where your kids are the entire day and whom they are out with all day?*	**NOTES**

Note: In this section, a child is considered "supervised" when the parent has knowledge of the child's whereabouts, the child is in an age-appropriate environment, and the child is engaged with the parent or another responsible adult. "Caretaking tasks" are tasks that may be expected by a parent/caregiver such as getting children to/from school, preparing meals, bathing children, putting children to bed, etc.

SCORING	
4	☐ No sense of parental attachment and responsibility ☐ No meaningful family time together ☐ Children 12 and younger are unsupervised 3+ hours each day ☐ Children 13 and older are unsupervised 4+ hours each day ☐ In families with 2+ children, the older child performs caretaking tasks 5+ days/week
3	☐ Weak sense of parental attachment and responsibility ☐ Meaningful family activities occur 1-4 times in a month ☐ Children 12 and younger are unsupervised 1-3 hours each day ☐ Children 13 and older are unsupervised 2-4 hours each day ☐ In families with 2+ children, the older child performs caretaking tasks 3-4 days/week
2	☐ Sense of parental attachment and responsibility, but not consistently applied ☐ Meaningful family activities occur 1-2 days per week ☐ Children 12 and younger are unsupervised fewer than 1 hour each day ☐ Children 13 and older are unsupervised 1-2 hours each day ☐ In families with 2+ children, the older child performs caretaking tasks fewer than 2 days/week
1	☐ Strong sense of parental attachment and responsibility towards their children ☐ Meaningful family activities occur 3-6 days of the week ☐ Children 12 and younger are never unsupervised ☐ Children 13 and older are unsupervised no more than an hour each day
0	☐ Strong sense of attachment and responsibility towards their children ☐ Meaningful family activities occur daily ☐ Children are never unsupervised

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Q. Stability/Resiliency of the Family Unit

PROMPTS	CLIENT SCORE:
- *Over the past year have there been any different adults staying with the family like a family friend, grandparent, aunt or that sort of thing? If so, can you tell me when and for how long and the changes that have occurred?* - *Other than kids being taken into care, have there been any instances where any child has gone to stay with another family member or family friend for any length of time? Can you tell me how many times, when and for how long that happened?*	**NOTES**

SCORING	
4	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relative within the family have changed 4+ times ☐ Children have left or returned to the family 4+ times
3	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 3 times ☐ Children have left or returned to the family 3 times
2	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 2 times ☐ Children have left or returned to the family 2 times
1	In the past 365 days, **any** of the following have occurred: ☐ Parental arrangements and/or other adult relatives within the family have changed 1 time ☐ Children have left or returned to the family 1 time
0	In the past 365 days, **any** of the following have occurred: ☐ No change in parental arrangements and/or other adult relatives within the family ☐ Children have not left or returned to the family

R. Needs of Children

PROMPTS	CLIENT SCORE:
- *Please tell me about the attendance at school of your school-aged children.* - *Any health issues with your children?* - *Any times of separation between your children and parents?* - *Without going into detail, have any of your children experienced or witnessed emotional, physical, sexual or psychological abuse?* - *Have your children ever accessed professional assistance to address that abuse?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 15+ days in any month ☐ School-aged children are not currently enrolled in school ☐ Any member of the family, including children, is currently escaping an abusive situation ☐ The family is homeless
3	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 7-14 days in any month ☐ School-aged children typically miss 3+ days of school per week for reasons other than illness ☐ In the last 180 days, any child(ren) in the family has experienced an abusive situation that has since ended
2	**Any** of the following: ☐ In the last 90 days, children needed to live with friends or family for 1-6 days in any month ☐ School-aged children typically miss 2 days of school per week for reasons other than illness ☐ In the past 365 days, any child(ren) in the family has experienced an abusive situation that has ended more than 180 days ago
1	**Any** of the following: ☐ In the last 365 days, children needed to live with friends or family for 7+ days in any month, but not in the last 90 days ☐ School-aged children typically miss 1 day of school per week for reasons other than illness
0	**All** of the following: ☐ In the last 365 days, children needed to live with friends or family for fewer than 7 days in every month ☐ School-aged children maintain consistent attendance at school ☐ There is no evidence of children in the home having experienced or witnessed abuse ☐ The family is housed

S. Size of Family Unit

PROMPTS	CLIENT SCORE:
- *I just want to make sure I understand how many kids there are, the gender of each and their age. Can you take me through that again?* - *Is anyone in the family currently pregnant?*	NOTES

SCORING	FOR ONE-PARENT FAMILIES:	FOR TWO-PARENT FAMILIES:
4	**Any** of the following: ☐ A pregnancy in the family ☐ At least one child aged 0-6 ☐ Three or more children of any age	**Any** of the following: ☐ A pregnancy in the family ☐ Four or more children of any age
3	**Any** of the following: ☐ At least one child aged 7-11 ☐ Two children of any age	**Any** of the following: ☐ At least one child aged 0-6 ☐ Three children of any age
2	☐ At least one child aged 12-15.	**Any** of the following: ☐ At least one child aged 7-11 ☐ Two children of any age
1	☐ At least one child aged 16 or older.	☐ At least one child aged 12 or older
0	☐ Children have been permanently removed from the family and the household is transitioning to services for singles or couples without children	

T. Interaction with Child Protective Services and/or Family Court

PROMPTS	CLIENT SCORE:
- *Any matters being considered by a judge right now as it pertains to any member of your family?* - *Have any of your children spent time in care? When was that? For how long were they in care? When did you get them back?* - *Has there ever been an investigation by someone in child welfare into the matters of your family?*	**NOTES**

SCORING	
4	**Any** of the following: ☐ In the past 90 days, interactions with child protective services have occurred ☐ In the past 365 days, one or more children have been removed from parent's custody that have **not** been reunited with the family at least four days per week ☐ There are issues still be decided or considered within family court
3	In the past 180 days, **any** of the following have occurred: ☐ Interactions with child protective services have occurred, but not within the past 90 days ☐ One or more children have been removed from parent's custody through child protective services (non-voluntary) **and** the child(ren) has been reunited with the family four or more days per week; ☐ Issues have been resolved in family court
2	☐ In the past 365 days, interactions with child protective services have occurred, but not within the past 180 days, and there are no active issues, concerns or investigations
1	☐ No interactions with child protective services have occurred, within the past 365 days, and there are no active issues, concerns or investigations.
0	☐ There have been no serious interactions with child protective services because of parenting concerns

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
MENTAL HEALTH & WELLNESS AND COGNITIVE FUNCTIONING	0	
PHYSICAL HEALTH & WELLNESS	0	
MEDICATION	0	
SUBSTANCE USE	0	
EXPERIENCE OF ABUSE AND/ OR TRAUMA	0	
RISK OF HARM TO SELF OR OTHERS	0	
INVOLVEMENT IN HIGHER RISK AND/OR EXPLOITIVE SITUATIONS	0	
INTERACTION WITH EMERGENCY SERVICES	0	

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Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
LEGAL INVOLVEMENT	0	
MANAGING TENANCY	0	
PERSONAL ADMINISTRATION & MONEY MANAGEMENT	0	
SOCIAL RELATIONSHIPS & NETWORKS	0	
SELF-CARE & DAILY LIVING SKILLS	0	
MEANINGFUL DAILY ACTIVITIES	0	
HISTORY OF HOUSING & HOMELESSNESS	0	

Client:	Worker:	Version:	Date:

COMPONENT	SCORE	COMMENTS
PARENTAL ENGAGEMENT	0	
STABILITY/ RESILIENCY OF THE FAMILY UNIT	0	
NEEDS OF CHILDREN	0	
SIZE OF FAMILY	0	
INTERACTION WITH CHILD PROTECTIVE SERVICES AND/ OR FAMILY COURT	0	
TOTAL	0	No housing intervention

Appendix A: About the SPDAT

OrgCode Consulting, Inc. is pleased to announce the release of Version 4 of the Service Prioritization Decision Assistance Tool (SPDAT). Since its release in 2010, the SPDAT has been used with over 10,000 unique individuals in over 100 communities across North America and in select locations around the world.

Originally designed as a tool to help prioritize housing services for homeless individuals based upon their acuity, the SPDAT has been successfully adapted to other fields of practice, including discharge planning from hospitals, work with youth, survivors of domestic violence, health research, planning supports for consumer survivors of psychiatric care systems, and in work supporting people with fetal alcohol spectrum disorders. We are encouraged that so many service providers and communities are expanding the use of this tool, and OrgCode will continue to support the innovative use of the SPDAT to meet local needs.

SPDAT Design

The SPDAT is designed to:

- Help prioritize which clients should receive what type of housing assistance intervention, and assist in determining the intensity of case management services
- Prioritize the sequence of clients receiving those services
- Help prioritize the time and resources of Frontline Workers
- Allow Team Leaders and program supervisors to better match client needs to the strengths of specific Frontline Workers on their team
- Assist Team Leaders and program supervisors to support Frontline Workers and establish service priorities across their team
- Provide assistance with case planning and encourage reflection on the prioritization of different elements within a case plan
- Track the depth of need and service responses to clients over time

The SPDAT is NOT designed to:

- Provide a diagnosis
- Assess current risk or be a predictive index for future risk
- Take the place of other valid and reliable instruments used in clinical research and care

The SPDAT is only used with those clients who meet program eligibility criteria. For example, if there is an eligibility criterion that requires prospective clients to be homeless at time of intake to be eligible for Housing First, then the pre-condition must be met before pursuing the application of the SPDAT. For that reason, we have also created the VI-SPDAT as an initial screening tool.

The SPDAT is not intended to replace clinical expertise or clinical assessment tools. The tool complements existing clinical approaches by incorporating a wide array of components that provide both a global and detailed picture of a client's acuity. Certain components of the SPDAT relate to clinical concerns, and it is expected that intake professionals and clinicians will work together to ensure the accurate assessment of these issues. In fact, many organizations and communities have found the SPDAT to be a useful method for bridging the gap between housing, social services and clinical services.

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Family SPDAT

Upon the release of SPDAT Version 3, a special version was released - the Family SPDAT Version 1. This tool introduced five new components that specifically address the unique challenges to housing stability faced by homeless families. In addition, the tool has a focus on households throughout.

SPDAT Version 4/Family SPDAT Version 2

The SPDAT has been influenced by the experience of practitioners in its use, persons with lived experience that have had the SPDAT implemented with them, as well as a number of other excellent tools such as (but not limited to) the Outcome Star, Health of the Nation Outcome Scale, Denver Acuity Scale, Camberwell Assessment of Needs, Vulnerability Index, and Transition Aged Youth Triage Tool.

In preparing SPDAT v4 and F-SPDAT v2, we have adopted a comprehensive and collaborative approach to changing and improving the SPDAT. Communities that have used the tool for three months or more have provided us with their feedback. OrgCode staff have observed the tool in operation to better understand its implementation in the field. An independent committee composed of service practitioners and academics review enhancements to the SPDAT. Furthermore, we continue to test the validity of SPDAT results through the use of control groups. Overall, we consistently see that groups assessed with the SPDAT have better long-term housing and life stability outcomes than those assessed with other tools, or no tools at all.

OrgCode intends to continue working with communities and persons with lived experience to make future versions of the SPDAT even better. We hope all those communities and agencies that choose to use this tool will remain committed to collaborating with us to make those improvements over time.

The new versions build upon the success of previous versions of the SPDAT products with some refinements. Starting in August 2014, a survey was launched of existing SPDAT and F-SPDAT users to get their input on what should be amended, improved, or maintained in the tool. Analysis was completed across all of these responses. Further research was conducted. Questions were tested and refined over several months, again including the direct voice of persons with lived experience and frontline practitioners. Input was also gathered from senior government officials that create policy and programs to help ensure alignment with guidelines and funding requirements.

The major differences from F-SPDAT Version 1 to Version 2 include:

- The structure of the tools is the same: four domains (five for families) with components aligned to specific domains. The names of the domains and the components remain unchanged.
- The scoring of the tools is the same: 60 points for singles, and 80 points for families.
- The scoring tables used to run from 0 through to 4. They are now reversed with each table starting at 4 and working their way down to 0. This increases the speed of assessment.
- The order of the tools has changed, grouped together by domain.
- Language has been simplified.
- Days are used rather than months to provide greater clarification and alignment to how most databases capture periods of time in service.
- Greater specificity has been provided in some components such as amount of debts.

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Attachment 1E-1

New Bedford Continuum of Care
MA-505

Local Competition Announcement

NOTE:

The New Bedford CoC publicly announced the local competition through an RFP whose availability was advertised through the CoC's website, its Facebook page and its twitter account.

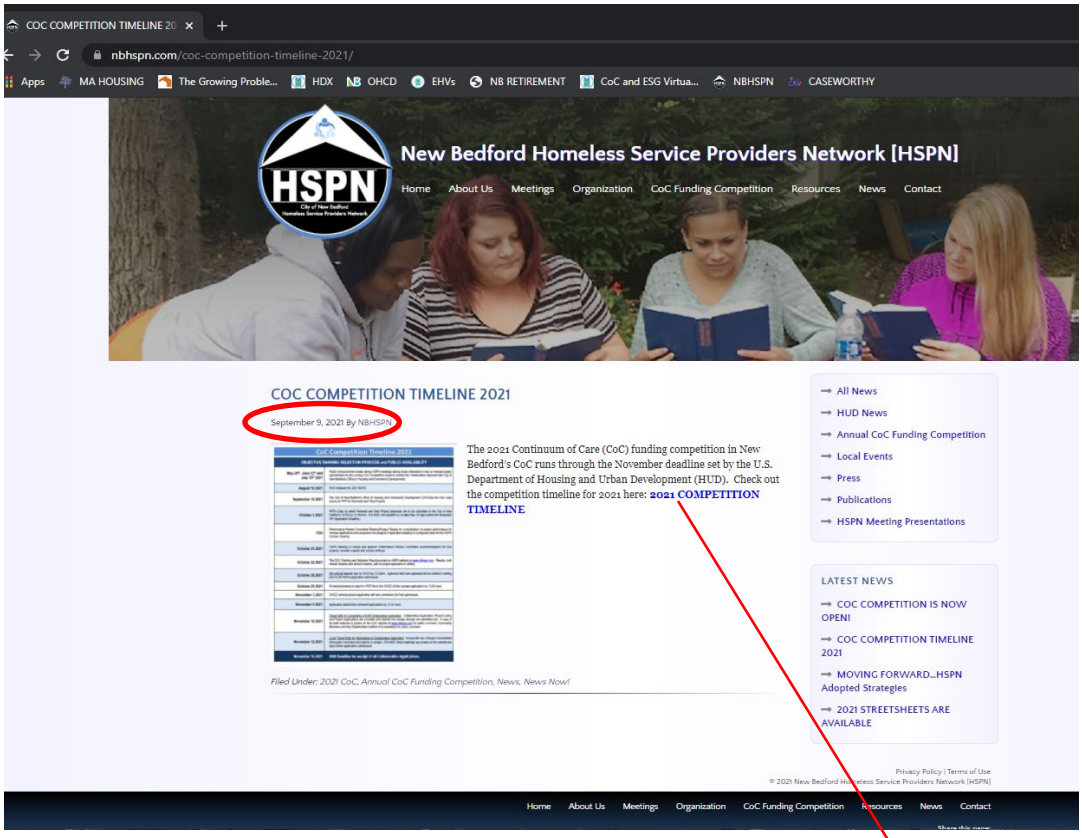
Additionally, the RFP issued September 10, 2021 included information advising potential applicants of the ranking criteria that would be used in project evaluation.

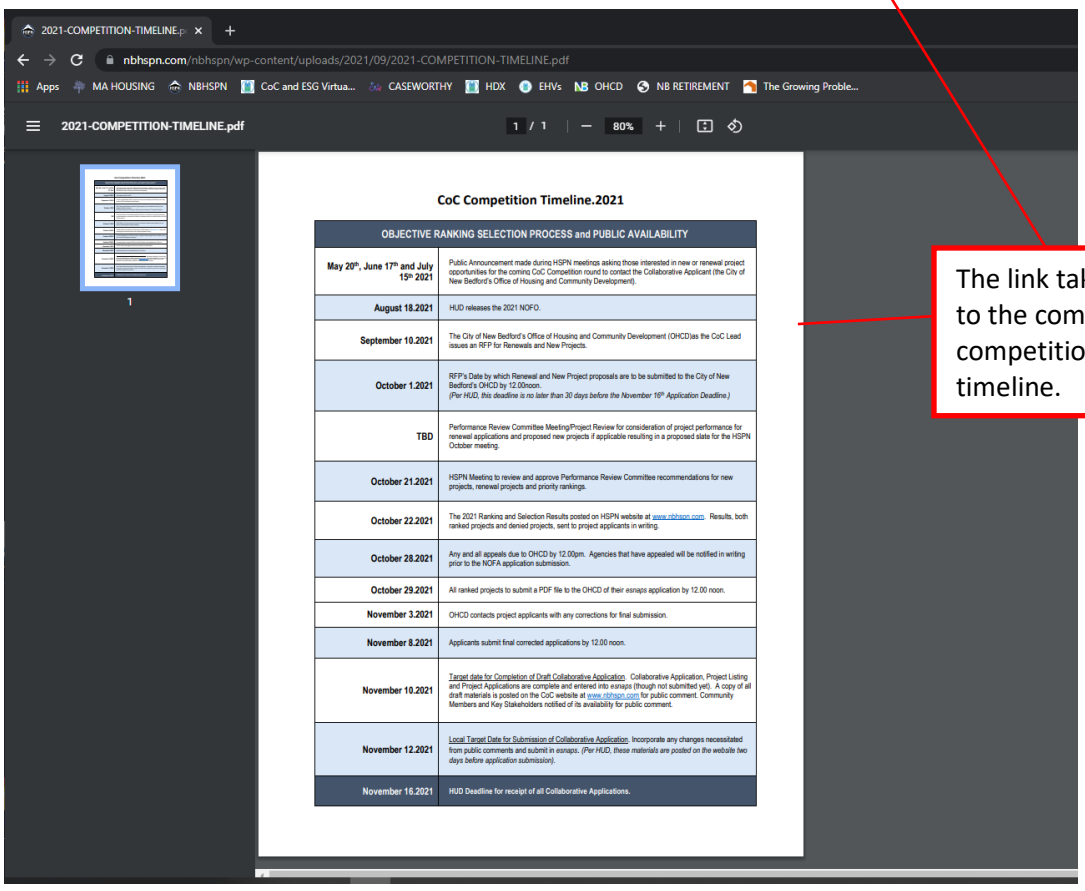
This attachment includes both (1) evidence of publicly posting the RFP through those three sources and (2) includes the RFP, itself. Although the RFP has a significant amount of information, one may wish to note in particular--the CoC Application Selection Process, Scoring and Ranking (criteria) in the RFP's Appendix B beginning on page 19 of this attachment.

1. Evidence of Posting

Website posting showing local competition timeframe

Posted September 9, 2021 at https://www.nbhspn.com/coc-competition-timeline-2021/

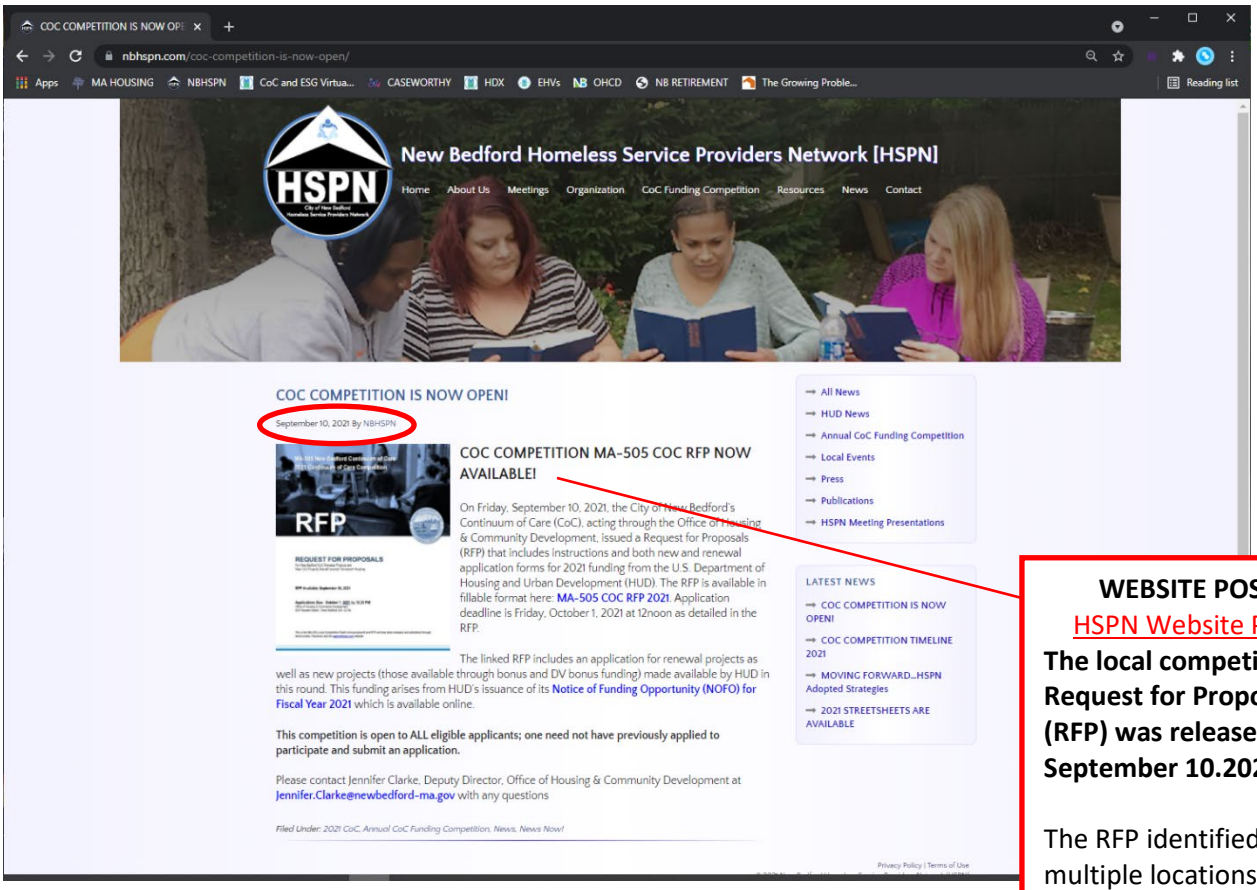




The link takes one to the complete competition timeline.

Website posting showing release of local competition material (RFP)

Posted September 10, 2021 at https://www.nbhspn.com/coc-competition-is-now-open/



WEBSITE POST

HSPN Website Post

The local competition Request for Proposals (RFP) was released on September 10.2021.

The RFP identified in multiple locations (including on the cover of the document) that the local competition deadline was October 1, 2021 at 12.00PM.

Facebook posting showing September 10, 2021 release of local competition material (RFP)

Homeless Service Provider's Network- HSPN

September 10 ·

COC COMPETITION NOW UNDERWAY!
https://www.nbhspn.com/open-competition-2021-coc-competition-is-open/

OVERVIEW
The City of New Bedford's Continuum of Care (MA-505 CoC), its, "Homeless Service Provider's Network" (HSPN), acting through the City's Office of Housing & Community Development (OHCD) has released its 2021 Request for Proposals (RFP) that includes both instructions and an application for funding from the U.S. Department of Housing & Urban Development (HUD). The link to the RFP is provided here and can be accessed through the HSPN website at www.nbhspn.com. Deadline is October 1, 2021 at noon.

This is an OPEN competition; this unding is available to both new (eligible) applicants who have not previously received CoC funding and those seeking to renew a project.

FUNDING
The New Bedford CoC expects to be awarded an estimated $1,889,575 in this funding round in addition to funding for new "bonus" projects. Available funding anticipated consists of renewal projects, new projects through a permanent housing bonus and/or reallocation, and new projects through a Domestic Violence bonus. Additional funds may also be available through the reallocation process as determined by the CoC's Performance Review Committee/HSPN. The CoC Bonus is $118,994 and DV Bonus is $356,983 for this competition. The RFP is available online at https://www.nbhspn.com/open-competition-2021-coc-competition-is-open/. Questions concerning this notice may be directed to Jennifer Clarke, AICP Deputy Director, OHCD via email at Jennifer.Clarke@newbedford-ma.gov.

NBHSPN.COM
New Bedford Homeless Service Providers Network [HSPN]

FACEBOOK POST
HSPN Facebook Page
The local competition Request for Proposals (RFP) was released on September 10, 2021.

The RFP cover included the October 1, 2021 deadline information.

Twitter posting September 11, 2021 showing the release of local competition material (RFP)

TWITTER POST
HSPN Twitter Account
The local competition Request for Proposals (RFP) was posted on the HSPN Twitter Account on September 11.2021.

The tweet referenced the RFP, provided a link and identified the October 1.2021 deadline information.

MA-505 New Bedford Continuum of Care
2021 Continuum of Care Competition

RFP

REQUEST FOR PROPOSALS

For New Bedford CoC Renewal Projects and
New CoC Projects that will provide Permanent Housing

RFP Available: September 10, 2021

Applications Due: October 1, 2021 by 12.00 PM
Office of Housing & Community Development
608 Pleasant Street | New Bedford, MA 02740

This is the MA-505 Local Competition Public Announcement and RFP and has been released and advertised through direct emails, Facebook and the www.nbhspn.com website.

Request for Proposals

New Bedford Continuum of Care Renewal Projects *and* New Projects that will provide Permanent Housing

Introduction

The U.S. Department of Housing and Urban Development (HUD) annually releases a Notice of Funding Opportunity (NOFO) for the Continuum of Care Homeless Assistance Program. Following that release, the City of New Bedford's Office of Housing and Community Development (OHCD), acting on behalf of the Homeless Service Provider Network (HSPN) Continuum of Care, is now issuing this Request for Proposals (RFP) to allow adequate time for the local review and decision-making process and will be accepting proposals for Continuum of Care funding for both renewal and new projects.

A single, consolidated submission of all selected projects in New Bedford Continuum of Care will be submitted to HUD by the OHCD as the Collaborative Applicant representing the HSPN. Funding will be derived from a Federal Fiscal Year 2021 allocation of HUD funding and is subject to funding availability under the NOFO. The OHCD reserves the right to request that applicant organizations submit adjusted project budgets based on the amount of funding made available by HUD.

The NOFO was published on August 18, 2021 including:

HUD 2021 NOFO:
https://www.hud.gov/sites/dfiles/SPM/documents/FY21_Continuum_of_Care_Competition.pdf

HUD *esnaps* CoC Program Applications and Grants Management System:
https://www.hudexchange.info/programs/e-snaps/

The OHCD reserves the right to publish additional information subject to NOFO guidelines and additional HUD guidance and further reserves the right to modify, correct or amend this RFP in order to ensure consistency with HUD regulations.

The HUD NOFO sets up the procedure by which a CoC, through its Collaborative Applicant, submits a single collaborative application to fund the CoC and eligible projects that advance the CoC's goals. The Collaborative Applicant for the New Bedford CoC (HSPN) is the City of New Bedford through its Office of Housing & Community Development (OHCD). The OHCD serves as grantee and administers the CoC and all grants awarded to the CoC.

The consolidated application that will be submitted by the OHCD for the FY2021 CoC Program Competition will include eligible new projects and renewal projects from prior competitions. The CoC is specifically seeking proposals from New Bedford providers of services and housing for renewal projects, new Permanent Housing-Supportive Housing (PH-PSH) projects and new Permanent Housing-Rapid Rehousing projects (PH-RRH) as well as the following projects under the DV Bonus specifically dedicated to serving survivors of domestic violence, dating violence, sexual assault or stalking who are defined as homeless (24 CFR 578.3): new PH-RRH, new Joint Transitional Housing (TH) and PH-RRH projects and new Supportive Service-Only (SSO) Coordinated Entry projects. The highest need is for new permanent housing.

Please review the HUD website materials for technical assistance. If questions remain after doing so, please contact the Office of Housing & Community Development at 508.979.1500.

Ranked/selected applications must be submitted in HUD's electronic grant application system, *esnaps*. The City of New Bedford will provide applicants access to *esnaps* and technical assistance regarding the use of the system. An explanation of the process that will be used for selection of projects, including the scoring criteria, is attached as Appendix B.

The New Bedford CoC's Performance Review Committee (PRC) will recommend new projects to be put forward with the New Bedford CoC FY21 Collaborative Application to HUD. Any new projects, together with renewal projects, will go through the PRC ranking process (Appendix B) and be subject to the final approval by the governing board of the CoC, it's Homeless Service Provider Network (HSPN).

That final ranking, along with final project applications to be submitted through HUD's *esnaps* system, will, along with the project priority listing, be paired with the CoC's collaborative application and will constitute the CoC's 2021 Consolidated Application to HUD. HUD will make final decisions regarding awards via a national competition.

The deadline for submission of the application is Friday, October 1, 2021 by 12.00 PM.

Eligible Applicants

Eligible applicants include non-profits, local and state government, and housing authorities.

All recipients/subrecipients of HUD CoC funds must comply with HUD and New Bedford CoC Conflict of Interest requirements, including:

- Projects cannot use leasing funds in buildings owned by the recipient, subrecipient, their parent organization(s), a staff or board member, relative or business associate;
- The owner of a unit or his/her subordinate may not conduct the Housing Quality Standard, Rent Reasonableness or lead-based paint visual inspection; and
- Staff, persons with whom staff has immediate family or business ties and board members are prohibited from accruing any financial interest/benefit from CoC assisted activities during their tenure with the organization and for one year following tenure.

Funding Availability

The New Bedford Continuum of Care expects to be awarded an estimated $1,889,575 this funding round and may receive additional funding for bonus projects. Available funding anticipated consists of:

- **Renewal Projects.** The total amount of funding estimated to be available for Renewal Projects (see Eligible Projects) from HUD is $1,889,575; this amount is based on the amount of currently funded projects eligible for renewal funding; this is also referred to as the Annual Renewal Demand (ARD) as determined by HUD. Annual grant amounts for existing permanent housing programs range from approximately $123,296 to $672,667; the average permanent housing grant size is roughly $294,175.

- **New Projects** can be funded through reallocation from existing projects or through a bonus funding process, as described in this RFP. New project activities are limited by HUD to permanent supportive housing, rapid re-housing, joint transitional/rapid re-housing and coordinated entry SSO projects specifically related to domestic violence as detailed in the NOFO. HUD strictly limits the type of projects for which reallocated or bonus funds may be used.
  - **New Project through a CoC Bonus.** It is anticipated that the total amount of funding to be available through the CoC bonus will be $118,994.
  - **New Project through a DV Bonus.** It is anticipated that the total amount of funding which the New Bedford CoC may apply for under this bonus will be $356,983.

Additional funds may also be available through the reallocation process as determined by the New Bedford CoC's Performance Review Committee (PRC).

Tier 1 will be equal to 100% of the CoC's Annual Renewal Demand (ARD) or $1,889,575; Tier 2 is the difference between Tier 1 and the maximum amount of renewal, reallocation and CoC Bonus funds that the CoC can apply for (exclusive of CoC planning projects or projects selected with DV Bonus funds). For New Bedford's CoC, it is estimated that Tier 2 will be roughly $118,994.

NOTE: The OHCD reserves the right to adjust proposals and funding amounts based on final allocations published by HUD.

Eligible Projects

The following types of projects are eligible for funding in this competition:

- **Renewal Projects**
  Projects currently funded as CoC Permanent Supportive Housing (PSH) or Permanent Housing Rapid ReHousing (PH-RRH) are eligible for renewal for FY 2021 funds if they have a subrecipient agreement that expires in Calendar Year 2022. Projects may renew as is, or they may be part of transition, expansion or consolidated projects as further described in this section:

  - "Transition Grants:" This year, HUD is permitting HUD transition grants that will allow renewal projects to "transition" from one CoC program component to another during the CoC Program Competition. Transition Grants are *not* an additional source of funding but rather, would be part of the existing Annual Renewal Demand (ARD) amount for the CoC. No more than 50% of each transition grant may be used for costs of eligible activities of the program component originally funded, transition grants in this competition are eligible for renewal in subsequent fiscal years for eligible activities of the new program component and eligibility to receive a transition grant requires renewal project applicants to have the consent of the CoC and meet all other criteria and standards in the NOFO. *See Section III.B.2.z. of the HUD NOFO for further details.*

  - "Expansion Projects:" Projects currently funded under the CoC Supportive Housing Program (SHP) may apply to expand an existing renewal project in accordance with the NOFO. *See Section V.4.a.(6) of the HUD NOFO for further details*.

  - "Consolidated Projects:" Eligible renewal project applicants can consolidate two or more eligible renewal projects into one project application during the application process. This means that a CoC Program subrecipient no longer must wait for a grant agreement amendment to be executed to consolidate two or more grants before it can apply for a single consolidated project in the CoC Competition. Consultation with the OHCD prior to undertaking this opportunity is required as HUD must confirm eligibility to consolidate projects. *See Sections II.B.6 and V.4.a.(7) of the HUD NOFO for further details.*

- **New Projects**
  Projects not currently funded in the MA-505 and that propose to provide new CoC Permanent Supportive Housing (PSH) are eligible for FY2021 funds provided they meet all requirements of the NOFO and this RFP including aspects further described in this section:

  - Permanent Supportive Housing (PSH) for Chronically Homeless Individuals or Families (CoC Bonus Projects) New permanent supportive housing projects that will serve 100% chronically homeless individuals or families, or, persons who meet the definition of DedicatedPLUS (*See Section III.B.2.g of the HUD NOFO for further details*) are eligible to apply in this competition in accordance with the NOFO. Permanent housing is community-based housing, the purpose of which is to provide housing without a designated length of stay. Grant funds may be used for leasing, rental assistance, operating costs and supportive services; definitions and guidance for each of these items is at 24 CFR 578.49 - 24 CFR 578.63. "Chronically homeless" is defined in Appendix A of this RFP.

  a. New PH-RRH, Joint TH and PH-RRH and SSO Coordinated Entry Projects providing eligible activities that the Secretary of HUD determines are critical in order to assist persons fleeing/attempting to flee domestic violence (DV Bonus Projects) New projects that are dedicated to survivors of domestic violence, dating violence, sexual assault, or stalking as defined at 24 CFR 578.3 Definition for Homeless, paragraph (4) are eligible to apply for funding in this competition. The following project types are permitted to apply for a DV Bonus consistent with, and further defined within, the NOFO:

     - Permanent Housing Rapid Re-housing (PH-RRH) projects dedicated to serving survivors of domestic violence, dating violence, sexual assault or stalking that are defined as homeless (24 CFR 578.3) and that follow a housing first approach.
     - Joint TH and PH-RRH component projects defined in Section III.B.2.q. of this NOFO dedicated to serving survivors of domestic violence, dating violence, sexual assault or stalking that are defined as homeless (24 CFR 578.3) and that follow a housing first approach.
       - SSO Projects for Coordinated Entry (SSO-CE) to implement policies, procedures, and practices that equip the CoC's coordinated entry to better meet the needs of survivors of domestic violence, dating violence, sexual assault, or stalking (e.g., to implement policies and procedures that are trauma-informed, client-centered or to better coordinate referrals

between the CoC's coordinated entry and the victim service providers coordinated entry system where they are different).

Additional information germane to these projects:

- PSH projects cannot combine the following types of assistance in a single structure or housing unit:
  - Leasing and acquisition, rehabilitation or new construction;
  - Tenant-based rental assistance and acquisition, rehabilitation, or new construction;
  - Short or medium-term rental assistance and acquisition, rehabilitation or new construction;
  - Rental assistance and leasing, and
  - Rental assistance and operating
- All projects must follow the written policies and procedures established by the CoC for determining and prioritizing which eligible families and individuals will receive rapid rehousing assistance, as well as the amount or percentage of rent that each program participant must pay.
- All projects 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, and/or a maximum number of times that a program participant may receive rental assistance. The recipient or subrecipient may also require program participants to share in the costs of rent.
- Rental assistance, where applicable, must be limited to no more than 24 months to a household.
- All projects may provide supportive services for no longer than 6 months after rental assistance stops.
- All projects must re-evaluate, not less than once annually, that the program participant lacks sufficient resources and support networks necessary to retain housing without Continuum of Care assistance and the types and amounts of assistance that the program participant needs to retain housing. The recipient or subrecipient may require each program participant receiving assistance to notify the recipient or subrecipient of changes in the program participant's income or other circumstances (e.g., changes in household composition) that affect the program participant's need for assistance. When notified of a relevant change, the recipient or subrecipient must reevaluate the program participant's eligibility and the amount/types of assistance that the program participant needs.
- All projects must require the program participant to meet with a case manager not less than once per month to assist the program participant in ensuring long-term housing stability. (The project is exempt from this requirement if the Violence Against Women Act of 1994 (42 U.S.C. 13925 *et seq.*) or the Family Violence Prevention and Services Act (42 U.S.C. 10401 *et seq.*) prohibits the recipient carrying out the project from making its housing conditional on the participant's acceptance of services.)
- All projects must meet the threshold criteria shown in the application package in Appendix D.
- New projects may only be funded through reallocation of funds from existing projects or through the permanent housing bonus process. HUD strictly limits the type of projects for which reallocated or bonus funds may be used.
- All projects will be limited to requests for one year of assistance, unless a different term is required by HUD. Upon expiration, projects may be renewed subject to HUD requirements, local priorities, satisfactory performance, and availability of funds.

Eligible Populations

Populations who may be served by each of the project types are, as follow:

1. **Permanent Supportive Housing (PSH)**
   - All PSH projects must dedicate 100% of the units to chronically homeless individuals and/or chronically homeless families as defined by HUD. (See Appendix A).

- Project applicants must demonstrate that they will first serve the chronically homeless according to the order of priority established in Notice CPD-14-012: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons.
- Disabilities: All PSH projects must serve exclusively disabled households as defined by HUD.
- PSH projects may serve survivors of domestic violence, dating violence, sexual assault, or stalking as defined at 24 CFR 578.3 Definition of Homeless, paragraph (4).

2. **PH Rapid Re-Housing (PH-RRH)**
   - All projects must serve 100% literally homeless families and/or single adults coming from emergency shelters and/or unsheltered locations or meeting the criteria of paragraph (4) of the HUD definition of homeless including survivors of domestic violence, dating violence, sexual assault, or stalking as defined under homeless, paragraph (4) at 24 CFR 578.3.
   - Persons in transitional housing are not eligible for either project type, even if they met the criteria described above prior to entering the Transitional Housing (TH) Program, unless they meet the criteria of category (4) definition of homelessness at 24 CFR 578.3 (survivors of domestic violence, dating violence, sexual assault, or stalking as defined). A household would meet category 4 of the definition of homelessness if they are fleeting or attempting to flee from domestic violence and meet all other requirements, regardless of where they are residing.

3. **Joint Transitional Housing (TH) and Rapid Re-Housing (PH-RRH) Component Projects**
   - Individuals and families experiencing homelessness including those survivors of domestic violence ,dating violence, sexual assault or stalking as defined in paragraph (4) at 24 CFR 578.3.
   - Combines the TH and PH RRH components into a single project.
   - Joint TH and RRH projects must provide low-barrier, temporary housing while individuals and families quickly move to permanent housing with a seamless program design. Projects must have the capacity to provide both kinds of assistance to each participant.

4. **SSO Projects for Coordinated Entry (SSO-CE) Component Projects**
   - Individuals and families who are survivors of domestic violence, dating violence, sexual assault or stalking.

Eligible Costs

The following guidance indicates the costs that may be included in program budgets, to be paid for by the CoC grant or by matching funds.

Rental Assistance
Rental assistance for homeless individuals and families, including tenant-based rental assistance. Grant funds may be used for security deposits in an amount not to exceed two months of rent, as well as last month's rent.

Leasing
The costs of leasing scattered site units to provide housing to homeless persons.

Leasing: Limits on rent costs. Rents paid must be reasonable in relation to comparable space or units and may not be more than the owner charges others for comparable units. Rents for residential units cannot exceed the HUD Fair Market Rent (FMR).

Utilities. Utilities are not a leasing line item. If utilities are not provided by the landlord, utility costs are an operating cost.

Security deposits and first and last month's rent. Grant funds may be used to pay security deposits, in an amount not to exceed two months of actual rent, as well as last month's rent.

Supportive Services
The eligible costs of supportive services that address the special needs of the program participants.

Supportive Services in PSH and RRH Programs Must Relate to Housing Stability.

Supportive services must be necessary to assist program participants obtain and maintain housing and agencies must conduct an annual assessment of the service needs of the program participants and adjust services accordingly to achieve those ends.

Eligible supportive services costs:

- Reasonable one-time moving costs
- Case management
- Food—meals or groceries for program participants
- Housing search and counseling services
- Life skills training
- Outreach services
- Transportation
- Utility deposits (one-time fee, paid to utility companies)
- Direct provision of services: 1) costs of labor, supplies, and materials; and 2) salary and benefit packages of service delivery staff.

Ineligible costs: Any cost that is not described as an eligible cost is not an eligible cost.

Operating Costs
Grant funds may be used to pay the costs of the day-to-day operation of permanent supportive housing in a single structure or individual housing units.

Eligible operating costs:

- Maintenance and repair of housing
- Property taxes and insurance
- Building security for a structure where more than 50 percent of the units or area is paid for with grant funds
- Electricity, gas, and water
- Furniture
- Equipment.

Ineligible costs Program funds may not be used for rental assistance and operating costs in the same project. Program funds may not be used for the maintenance and repair of housing where the costs of maintaining and repairing the housing are included in the lease.

Project Administration
All renewal subgrantees are required to allocate the maximum 10% of their full grant amount to administration. The subgrantee may use up to 50% of the HUD-allowed administrative funds associated with the project; the remaining 50% of the allowed administrative funds are retained by the City of New Bedford (grantee). Administrative costs for renewal programs are set by HUD. The HUD-allowed administrative costs allowable for new grants are 7% of the full grant amount.

Matching Funds

The subgrantee must match all funds, except for leasing funds, with no less than 25% of funds or in-kind contributions from other sources. Guidance regarding cash and in-kind match is at 24 CFR 578.73. Cash match must be used for the costs of activities that are eligible CoC Program costs. Appendix C provides information required to document match.

Homeless Management Information System

All successful project applicants—with the exception of entities that are victim service providers—must participate in the CoC's Homeless Management Information System (HMIS).

Coordinated Entry/Assessment System

All successful applicants must participate in the CoC's coordinated entry/assessment system.

Grant Term

Renewal projects may only apply for one year grant terms. New projects may request funds for a grant term of 1.

Please note: any new project application that includes leasing–either leasing alone or leasing costs plus other costs (e.g. supportive services, HMIS, etc.)–may only request up to a 1-year grant term.

HUD Requirements & Resources

While this document summarizes key components of the CoC Program, more information is available from the NOFO, itself and HUD.

Continuum of Care Program information is available at the HUD exchange website here:	https://www.hudexchange.info/programs/coc/
A copy of the NOFO 2021 is available here:	https://www.hud.gov/sites/dfiles/SPM/documents/FY21_Continuum_of_Care_Competition.pdf
HUD Resource page on the Continuum of Care Program Competition 2021	https://www.hud.gov/program_offices/comm_planning/coc/competition
If selected, it is recommended that all renewal applicants under this RFP also review information from HUD published here:	https://www.hud.gov/sites/dfiles/CPD/documents/FY-2021-Renewal-Project-Application-Detailed-Instructions.pdf
If selected, it is recommended that all new applicants under this RFP also review information from HUD published here:	https://www.hud.gov/sites/dfiles/CPD/documents/FY-2021-New-Project-Application-Navigational-Guide.pdf
HUD e-snaps Training and Resources Page,	http://www.hudhre.info/esnaps/

If there are any conflicts between guidance in this document and HUD guidance, the HUD guidance takes priority and is what should be relied upon.

All parties intending to apply for funding are strongly encouraged to review the program regulations, both new and renewal applicants.

The RFP Continues on the following page.

Timeline

CoC Competition Timeline.2021

OBJECTIVE RANKING SELECTION PROCESS and PUBLIC AVAILABILITY	
May 20th, June 17th and July 15th 2021	Public Announcement made during HSPN meetings asking those interested in new or renewal project opportunities for the coming CoC Competition round to contact the Collaborative Applicant (the City of New Bedford's Office of Housing and Community Development).
August 18.2021	HUD releases the 2021 NOFO.
September 10.2021	The City of New Bedford's Office of Housing and Community Development (OHCD)as the CoC Lead issues an RFP for Renewals and New Projects.
October 1.2021	RFP's Date by which Renewal and New Project proposals are to be submitted to the City of New Bedford's OHCD by 12.00noon. *(Per HUD, this deadline is no later than 30 days before the November 16th Application Deadline.)*
TBD	Performance Review Committee Meeting/Project Review for consideration of project performance for renewal applications and proposed new projects if applicable resulting in a proposed slate for the HSPN October meeting.
October 21.2021	HSPN Meeting to review and approve Performance Review Committee recommendations for new projects, renewal projects and priority rankings.
October 22.2021	The 2021 Ranking and Selection Results posted on HSPN website at www.nbhspn.com. Results, both ranked projects and denied projects, sent to project applicants in writing.
October 28.2021	Any and all appeals due to OHCD by 12.00pm. Agencies that have appealed will be notified in writing prior to the NOFA application submission.
October 29.2021	All ranked projects to submit a PDF file to the OHCD of their *esnaps* application by 12.00 noon.
November 3.2021	OHCD contacts project applicants with any corrections for final submission.
November 8.2021	Applicants submit final corrected applications by 12.00 noon.
November 10.2021	Target date for Completion of Draft Collaborative Application. Collaborative Application, Project Listing and Project Applications are complete and entered into *esnaps* (though not submitted yet). A copy of all draft materials is posted on the CoC website at www.nbhspn.com for public comment. Community Members and Key Stakeholders notified of its availability for public comment.
November 12.2021	Local Target Date for Submission of Collaborative Application. Incorporate any changes necessitated from public comments and submit in *esnaps*. *(Per HUD, these materials are posted on the website two days before application submission).*
November 16.2021	**HUD Deadline for receipt of all Collaborative Applications.**

Threshold Requirements & Competitive Review

Threshold Requirements.

To be eligible for consideration as an applicant for funding described in the NOFO and this RFP, all projects must first successfully pass a review of threshold requirements. The OHCD will perform a threshold review of all submitted projects. Each project must meet the eligibility requirements for applicants of HUD grant programs stipulated in the NOFO (*See Section 5.B.1 of the NOFO for details*) as well as the project eligibility threshold requirements and project quality threshold requirements stipulated in the NOFO (*See Section V.C.3.b and c. of the NOFO for details)* and the following minimum standards in order to be considered for scoring; those projects not meeting the threshold criteria as determined by the OHCD will not be scored or considered for funding:

Threshold Criteria
new projects:
▪ Evidence that the project will improve the CoC's system performance.
▪ Demonstrated financial and management capacity and experience to carry out the project including documentation of having served HUD-eligible individuals/families experiencing homelessness during the previous calendar year.
▪ Proposal for an eligible activity for eligible homeless population pursuant to HUD requirements
▪ Eligibility as contractor for federal funds per https://www.sam.gov/, current tax-exempt status as verified by IRS 501(c)3 designation letter and must not owe overdue tax debts as documented on IRS 990 submission to the IRS.
▪ Must not propose to use HUD funds to supplant current funding
▪ Must identify matching funds prior to application submission
▪ Must agree to participate in the CoCs HMIS (or comparable data base if DV project) and coordinated entry
▪ Must provide copy of Code of Conduct
▪ Must provide a complete application by the deadline including submission of all required certifications specified
renewal projects:
▪ Must be meeting plans and goals established in the initial application,
▪ Must demonstrate all timeliness standards, including standards for the expenditure of grant funds,
▪ Demonstration of positive performance in assisting program participants to achieve and maintain independent living and records of success.
▪ Must be a current and active participant in the CoC's HMIS and its coordinated entry system
▪ Must provide a complete application by the deadline including submission of all required certifications specified
all projects:
▪ If for housing, project proposes to serve 100% Chronically Homeless individuals and families;
▪ Application demonstrates a plan for rapid implementation/seamless continuation of the program.
▪ Evidence of coordination with housing and healthcare consistent with the NOFO (*see VII B.6 in NOFO for details*)
▪ Evidence of racial equity and the promotion of meaningful involvement of those with lived experience in program administration.

Competitive Review

All applications that meet the threshold requirements will be forwarded to the CoC's Performance Review Committee for evaluation, selection and ranking. Appendix B explains the process that will be used for the competitive review.

Similar to past years, all applications for funding will be vetted, evaluated and ranked by the CoC – Homeless Service Provider Network (HSPN) Performance Review Committee (PRC), ratified by the HSPN membership and eventually submitted to HUD via the E-SNAPS system. The City of New Bedford's OHCD will act as the Collaborative Applicant and submit an application for funds on behalf of the New Bedford Continuum of Care for renewal projects and any new projects identified through the Request for Proposal (RFP).

IMPORTANT! When considering renewal projects for award, HUD—and by extension the New Bedford CoC through both the OHCD and the PRC--will review information in the Line of Credit Control System (LOCCS), Annual Performance Reports (APRs), information provided from/for the local HUD/CPD Field Office that includes monitoring reports and audit reports as applicable, performance achievements on prior grants, and will also assess projects on the following criteria using a pass/fail basis:

1. The project applicant's performance against plans and goals established in the initial application as amended;
2. Project applicants must demonstrate all timeliness standards for grants being renewed, including that standards for the expenditure of grant funds have been met;
3. The project applicant's performance in assisting program participants to achieve and maintain independent living and record of success, except HMIS dedicated projects are not required to meet this standard; and
4. Evidence that a project applicant has been unwilling to accept technical assistance, has a history of inadequate financial accounting practices, has indications of project mismanagement, has a drastic reduction in the population served, has made program changes without prior OHCD/HUD approval, or has lost a project site. These conditions may result in the rejection of an application from the competition.

HUD/New Bedford CoC reserves the right to reduce or reject a funding request from the project applicant for the following reasons:

1. Outstanding obligation to HUD in arrears or for which a payment schedule has not been agreed upon;
2. Audit finding(s) for which a response is overdue or unsatisfactory;
3. History of inadequate financial management accounting practices;
4. Evidence of untimely expenditures on prior award;
5. History of other major capacity issues that have significantly impacted the operation of the project and its performance;
6. Timeliness in reimbursing subrecipients for eligible costs. HUD will consider a project applicant as meeting this standard if it has drawn down grant funds at least once per month; and
7. History of serving ineligible persons, expending funds on ineligible costs, or failing to expend funds within statutorily established timeframes.

HUD requires the CoC to rank all projects applying for grant funds in E-SNAPS. To ensure that the CoC has the opportunity to prioritize its projects locally in the event that HUD is not able to fund all renewals, it is anticipated that HUD will be requiring CoCs to rank projects within 2 tiers, similar to NOFAs issued over the past two years.

See Appendix B for the scoring criteria used for the competitive review of new and renewal projects.

Application Requirements

This RFP was released on August 18, 2021 and is subject to change. A one-page application for RENEWAL projects as well as a multi-page application for NEW projects are both located within Appendix D.

Deadline
Agencies desiring to submit renewal and/or new projects must submit a completed application packet including required attachments to the City by 12:00pm on Friday, October 1.2021. **Late applications will not be accepted**.

Submission
All documents must be submitted in PDF electronic format (only email will be accepted) to Jennifer Clarke, Deputy Director, via e-mail to Jennifer.Clarke@newbedford-ma.gov. No extensions will be granted. NOTE: Successful applicants will, at a later date to be determined, be required to complete an electronic application in HUD's *esnaps* system at the direction of the OHCD according to the timeline provided in this RFP.

Project Requirements & Priorities
All applications must propose eligible activities/projects and serve eligible populations as further described within this RFP and within the published NOFO. All CoC Program funded projects must comply in full with New Bedford's Written Standards as well as all HUD regulations and NOFO requirements. HUD regulations that govern the CoC Program may be found at:
https://www.hudexchange.info/resources/documents/CoCProgramInterimRule.pdf

CoC Program funded projects may also be subject to additional criteria as set forth in annual competitive application processes administered by the New Bedford CoC in conjunction with HUD's annual CoC program competitions. All applicants are responsible for reviewing the New Bedford CoC's Written Standards in their entirety.

Additional Resources & Information

HUD Homelessness Resource Exchange, http://www.hudhre.info/
HUD Supportive Housing Program Desk Guide, http://www.hudhre.info/index.cfm?do=viewShpDeskguide

Appendices

Appendix A

Definition of Homeless and Chronically Homeless

"Homeless" is defined as:

1. 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 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.

2. An individual or family who will imminently lose their primary nighttime residence, provided that:
   (1) The primary nighttime resident 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;
3. (not applicable)
4. 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 resident 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) needed to obtain other permanent housing.

"Chronically homeless" is defined as:

(1) A "homeless individual with a disability," as defined in section 401(9)of the McKinney-Vento Homeless Assistance Act (42 U.S.C. 11360(9)), who: (i) Lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and (ii) Has been homeless and living as described in paragraph (1)(i) of this definition continuously for at least 12 months or on at least 4 separate occasions in the last 3 years, as long as the combined occasions equal at least 12 months and each break in homelessness separating the occasions included at least 7 consecutive nights of not living as described in paragraph (1)(i). Stays in institutional care facilities for fewer than 90 days will not constitute as a break in homelessness, but rather such stays are included in the 12-month total, as long as the individual was living or residing in a place not meant for human habitation, a safe haven, or an emergency shelter immediately before entering the institutional care facility;

(2) An individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90 days and met all of the criteria in paragraph (1) of this definition, before entering that facility; or

(3) A family with an adult head of household (or if there is no adult in the family, a minor head of household) who meets all of the criteria in paragraph (1) or (2) of this definition, including a family whose composition has fluctuated while the head of household has been homeless.

Appendix B

CoC Application Selection Process, Scoring, Ranking, and Reallocation Process 2021

Selection Process

The process for considering projects includes a threshold review requirement, project scoring and responses to any requests for explanations or requests for more information from the Performance Review Committee (PRC). The process ends with the PRC presenting its recommended ranking to the Homeless Service Provider's Network (HSPN) and the membership votes in the final selection step.

- **Threshold Review.** The City of New Bedford's Office of Housing & Community Development (OHCD) will complete the threshold review for all submitted applications. The OHCD will then provide all information necessary for scoring each application meeting the threshold requirements to the PRC.

  Agencies that do not meet the threshold score or who are not recommended for funding may appeal and address the members of the COC PRC based only on the guidelines within this Appendix B (agencies recommended or only partially funded are *not* eligible to request an appeal).

- **Scoring.** The PRC of the HSPN will complete the review, scoring and evaluation process using the scoring rubrics provided in this Appendix.

  In the case of renewal applications, the scoring rubric evaluates past performance. In the case of new applications and renewal applications, the scoring rubric evaluates practices that will improve the New Bedford CoC's system response to homelessness and align this response with national policies and best practices. These include, but are not limited to:

  - Commitment to a Housing First low-demand service model, and
  - Projects that use low-barrier standards.

  The City of New Bedford's OHCD and/or the PRC reserve the right to request additional and/or clarifying information in order to inform its review of a project.

  Scores will determine each project's rank in the CoC's application to HUD and rank will be the primary determinant of placement into Tier 1 and Tier 2. Scores may also be used to reject applications or to reduce budgets for low-scoring projects or over-funded projects.

- **Final Selection.** After scoring the application, the PRC will present its resulting ranking recommendation (as discussed elsewhere in this Appendix) for funding approval to the HSPN at the HSPN member meeting.

  If the project is not selected for funding, the applicant has the right to appeal, provided that the appeal is based upon violations of program regulations. For example, reviewing members did not consistently follow the scoring criteria and process or if there was a conflict of interest that prevented a fair review of the proposal. No appeals will be heard on the basis of funding level.

Scoring

New Projects

Consideration for funding of new projects funded out of the CoC Bonus and/or including those created as a result of reallocation, will be based on the following performance objectives:

- Agency Experience and Capacity (20 point maximum)
- Project Quality (40 point maximum)

- Match Resources (20 point maximum)
- Fiscal Management (20 point maximum)

New projects may score up to 100 points maximum based on information provided in the application including attachments of required materials. Specific scoring criteria for new projects is as follows:

Scoring Criteria :: New Projects	
STANDARDS AND SCORING	**MAX POINTS**
Agency Experience and Capacity. Applicants demonstrating extensive experience in administering HUD or other federal funds and providing the proposed service and/or serving the proposed population will receive 20 points.	**20**
Project Quality. Each application will be scored on the overall quality of the project, and the extent to which the applicant can clearly demonstrate the following: ▪ Housing First (10 points): Applicants may receive up to 10 points based on the extent to which the new Bonus project will follow a Housing First model/low barrier approach. ▪ Chronic Homeless (8 points) Projects serving at least 100% of beds dedicated to chronic homeless will receive 10 points. ▪ Severity of Barriers (3 points): For those projects where at least 70% of its participants are identified as having substance use disorders and/or mental health issues will receive 3 points. ▪ Mainstream Services (4 points): Applicants may receive up to 4 points based on the extent to which the project is fully leveraging mainstream resources for supportive services. ▪ Low Barrier (5 points): Projects demonstrating low barriers to program admission and flexible participation policies designed to retain program participants will receive 5 points. ▪ Homeless Lived Experience (5 points): Applicants may receive up to 5 points based on the extent to which the agency authentically incorporates those currently experiencing homelessness or with lived experience into decision-making. ▪ Racial Equity (5 points): Projects demonstrating initiatives consistent with racial equity and the equity of those historically marginalized may receive up to 5 points.	**40**
Match Resources. Projects demonstrating ability to match the required HUD 25% match will receive 20 points.	**20**
Fiscal Management. To receive maximum points, applicants must demonstrate history of financial stability, including prompt expenditure of program funds, and no outstanding audit or HUD monitoring findings.	**20**
TOTAL POSSIBLE POINTS *for* NEW PROJECTS	**100**

Renewal Projects

Consideration for funding of renewal projects, including those created as a result of reallocation, will be based on the submitted application, previous APR reporting, HMIS, the HUD LOCCS system and any other monitoring conducted by the OHCD and/or HUD using the following performance objectives:

- Performance (70 point maximum)
- Data Quality (10 point maximum)
- Fiscal Management (10 point maximum)
- Narrative Responses #3-6 (10 point maximum)

In addition to these scored elements, all renewal projects will be expected to satisfy additional evaluation criteria noted within this section. Renewal projects may score up to 100 points maximum based on information provided in the application including attachments of required materials. Specific scoring criteria for renewal projects is as follows:

Scoring Criteria :: Renewal Projects

GOALS	PERFORMANCE STANDARD	SCORING	MAX POINTS
1. Housing Stability *Persons residing in permanent housing exited to another form of a permanent housing destination.* ***Goal 85%***	Based on APR Q1 & Q23c *The % of persons who exited to permanent housing destinations as of the end of the operating year.*	≥85%=20 80%-84%= 15 65%-79%= 10 55%-64%= 5 ≤54%= 0	**10**
2. Returns to Homelessness *Persons exiting permanent housing will not return to homelessness (Including Transitional Housing)* ***Goal <10%***	Based on APR Q1 & Q23c *The % of persons in the PSH program returning to homelessness shall be less than 10%.*	<0% - <2%= 10 <3% - <5% = 7 <6% - <8% = 4 <9% =2 <10%= 0	**10**
3. Earned Income – Stayers *Adult stayers will increase earned income (employment income).* ***Goal 10%***	Based on APR Q19a1 – Adults with Earned Income *The % of persons ages 18 or older staying in the program who increased their income (employment income) as of the latest annual assessment.*	≥10%= 5 9%-7%= 4 6%-4%= 3 3%-2%= 2 ≤1%= 0	**5**
4. Non-Employment Cash Income – Stayers *Adult stayers will increase non-employment cash income (mainstream resources).* ***Goal 40%***	Based on APR Q19a1 – Adults with Other Income *The % of persons ages 18 or older staying in the program who increased their non-employment cash income (mainstream resources) as of the latest annual assessment*	≥40%= 5 39%-30%= 4 29%-20%= 3 19%-10%= 2 ≤9%= 0	**5**
5. Earned Income – Leavers *Adult leavers will increase earned income (employment income).* ***Goal 20%***	Based on APR Q19a2 – Adults with Earned Income *The % of persons ages 18 or older leaving the program who increased their income (employment income) by program exit.*	≥20%= 5 14%-19%= 4 7%-13%= 3 2%-6%= 2 ≤1%= 0	**5**
6. Non-Employment Cash Income – leavers *Adult leavers will increase non-employment cash income (mainstream resources).* ***Goal 50%***	Based on APR Q19a2 – Adults with Other Income *The % of persons ages 18 or older leaving the program who increased their non-employment cash income (mainstream resources) by program exit.*	≥50%= 5 49%-40%= 4 39%-30%= 3 30%-20%= 2 ≤19%= 0	**5**
7. Utilization Rate - Beds *Program operates at full capacity, with low vacancy rate, and quickly fill vacancies.* ***Goal 90%***	Based on APR Q8b *Average quarterly utilization rate during the operating year.*	≥90%= 15 70%-89%= 10 51%-69%= 5 ≤50%= 0	**15**
8. Date Quality *Agency's thoroughness in ensuring all data is collected and entered into HMIS.* ***Goal = No Omissions***	Based on APR Q2, Q3, Q4, Q5	0 oms= 10 1%-10%= 6 11%-20%= 4 21%>= 0	**10**
9. Chronic Homeless - Persons *Persons who are chronically homeless by household* ***Goal 100%***	Based on APR Q26b *The # of chronically homeless persons divided by the total number of persons served.*	Prorated up to 15 points for 100% of CH Beds.	**15**
10.Fiscal Management *Complete and timely drawdown of funds.* ***Goal = 100% Drawndown***	Based on HUD LOCS	0%=10 1%-5%= 8 6%-10%= 5 10%>= 0	**10**
11.Narrative Responses. Applicant responses to narrative responses #3, #4, #5 and #6 will each be scored with a cumulative total of 10 points possible.		Up to 2.5 points per question possible	**10**
		TOTAL POSSIBLE POINTS	**100**

Additional Evaluation Criteria

Renewal projects will also be evaluated based on the following baseline criteria. Subrecipients that fail that meet these required criteria will lose points.

Additional Evaluation Criteria
Agency Experience and Capacity. ▪ Administration : Applicants demonstrating extensive experience in administering HUD or other federal funds, and providing the proposed service and/or serving.
Fiscal Management. ▪ Applicants must demonstrate history of financial stability, including prompt expenditure of program funds, and no outstanding audit or HUD monitoring findings.
Project Quality. ▪ Housing First: Applicants will be evaluated to the extent to which the Permanent Supportive Housing Bonus project will follow a Housing First model/low barrier approach. ▪ Mainstream Services: Applicants will be evaluated to the extent to which the project is fully leveraging mainstream resources for supportive services. ▪ Low Barrier: Projects must demonstrate low barriers to program admission and flexible participation policies designed to retain program participants. ▪ Consistency of Program: Applicants will be evaluated to the extent to which the project's performance is consistent against plans and goals established in the application.

Ranking

HUD requires that all CoCs list all projects that they approved to submit project applications to HUD, in the order of priority as determined by the CoC. CoCs should place all new and renewal project applications that the CoC determines are high priority, high performing, and meet the needs and gaps as identified by the CoC in Tier 1. HUD will select projects in Tier 1 as described in the NOFO. HUD will select all projects in Tier 1 before selecting any projects in Tier 2. Then, HUD will select projects in Tier 2 as described in the NOFO. Lower ranked projects may be selected for funding above higher ranked projects, consistent with HUD's selection priorities.

The CoC renewal application components and narratives serve to:

- Confirm the capacity of agencies to provide CoC funded programs;
- Provide information on program delivery in order to evaluate performance and meeting HUD priorities for scoring and ranking of projects by the PRC; and
- Provide project level narrative to be utilized in the CoC Collaborative Application. HUD will limit renewal grants to one (1) year of funding. Renewal Project Applications that request multiple years of funding will be reduced to one (1) year grant amounts.

Renewal projects must meet minimum project eligibility, capacity, timeliness, and performance standards. HUD will review information in the LOCCS; Annual Performance Reports (APRs); and information provided from the HUD local /CPD Field Office, including monitoring reports and Part 200 audit reports as applicable, as well as performance standards on prior grants, and assess a project on the following criteria using a pass/fail basis:

- Applicant's performance against plans and goals;
- Timeliness standards;
- Applicant's performance in assisting program participants to achieve and maintain independent living and record of success;
- Financial management accounting practices;
- Timely expenditures;
- Capacity;
- Timeliness; and
- Eligible activities.

The final ranking for this competition will be posted online at www.nbhspn.com after the CoC ranking vote is taken at a date to be determined.

Reallocation Process

The U.S. Department of Housing and Urban Development (HUD) requires that CoCs careful evaluate and review all renewal projects and to develop a reallocation process for projects funded with CoC funds. Reallocating funds is an important tool used by CoCs to make strategic improvements to their homelessness system. Through reallocation, the CoC can create new projects that are aligned with HUD's goals, by eliminating projects that are underperforming or are more appropriately funded from other sources. Reallocation is particularly important when new resources are not available.

The New Bedford CoC relies on this reallocation process in determining funding to ensure highest performing projects and those that can positively effect system performance throughout the continuum receive reallocated funding from lower-performing projects.

A copy of the New Bedford CoC's Reallocation Process is available online at www.nbhspn.com.

Appendix C

Match for the Continuum of Care Program

Match Guidance:

- Per the HEARTH Interim Rule (24 CFR 578.73), match must equal at least **25 percent of the total grant request including admin costs but excluding leasing costs** (i.e., any funds identified for Leased Units and Leased Structures). For example, if the 'total assistance requested' is $100,000, and the project applicant did not request costs for Leased Units or Leased Structures, then the project applicant must secure commitments for match funds equal to no less than $25,000. For example, if the 'total assistance requested' is $100,000, of which $50,000 is for Leased Units or Leased Structures, then the project applicant must secure commitments for match funds equal to no less than $12,500 (i.e. , ($100,000 Total Assistance - $50,000 Leasing)*.25).

- HUD expects that the full match amount committed in the application is met and would monitor based on that amount. Match that exceeds the minimum requirement should be used to meet the leverage requirements described below.

- The total match requirement can be met through **cash, in-kind, or a combination** of the two.

- Match must be used for **eligible costs** for the program component you are applying for, as set forth in the HEARTH Interim Rule (Subpart D of 24 CFR part 578).

- **Cash sources.** A recipient or subrecipient may use funds from any source, including any other federal sources (excluding Continuum of Care program funds), as well as State, local, and private sources, provided that funds from the source are not statutorily prohibited to be used as a match. The recipient must ensure that any funds used to satisfy the matching requirements of this section are eligible under the laws governing the funds in order to be used as matching funds for a grant awarded under this program.

- The recipient may use the value of any real property, equipment, goods, or services contributed to the project as match, provided that if the recipient had to pay for them with grant funds, the costs would have been eligible. Any such value previously used as match, may not be used again.

- If match is provided through **in-kind sources** from a third party, it must be documented by an **MOU** between the recipient or subrecipient and the third party that will provide the services. Services provided by individuals must be **valued at rates consistent** with those ordinarily paid for similar work in the recipient's or subrecipient's organization. If the recipient or subrecipient does not have employees performing similar work, the rates must be consistent with those ordinarily paid by other employers for similar work in the same labor market. The MOU must establish the **unconditional commitment**, except for selection to receive a grant, by the third party to provide the services, the **specific service** to be provided, the **profession** of the persons providing the service, and the **hourly cost** of the service to be provided. Subrecipients using staff time as an in-kind match must provide job descriptions for each position.

- During the term of the grant, the recipient or subrecipient must keep and make available, for inspection, **records documenting the service hours provided**.

- **To qualify as match, funds must come to and be disbursed by the grantee.** If benefits are paid directly to program participants, the funding is not going through the agency's books and it cannot be counted as match.

- Tenant rent payments or public benefits participants receive **may not be used as match**. When the rents are paid directly to the sponsor agency, it is considered to be 'program income' and program income cannot be used as match. Similarly, rent paid directly to a private landlord does not come to the grantee and so cannot qualify as match. Benefits received by tenants such as SSI, do not go to the grantee and cannot be used as match.

Appendix D
Applications

The 2021 CoC competition is open to renewal and eligible new projects, all of which will be scored competitively. The highest scoring projects will be included in the CoC Consolidated Application submitted to HUD. Each project requires its own complete application.

All applicants must complete the paper application in accordance with this RFP. Those projects selected for funding by a vote of the HSPN membership will then be expected to complete an online *esnaps* renewal or new application (as applicable) according to guidance to be provided through the city's Office of Housing & Community Development (OHCD).

For RENEWAL project applications (only)…

Applicants submitting a **renewal** project application must also include the following:

- ☐ Completed CoC Renewal Application *(begins on the following page)*
- ☐ 2021 (or most recent) Form 990 for Applicant (Subrecipient)
- ☐ Most recent audited financial statement (Required only if $750,000 in aggregate federal funds expended)
- ☐ A copy of the last "e-snaps" application for the project submitted to HUD (likely 2019). Applicant must review it and provide a marked-up copy with any changes to the city as part of complete application submission. (Please note that changes to the budget should be noted on the attached budget).
- ☐ A copy of the most recently completed Annual Performance Report (APR) for the most recent grant year. Please note: data for other time periods may be used by the city in developing performance scores for ranking of projects, subject to information in the HUD Notice of Funding Availability.

For NEW project applications (only)…

Applicants submitting a **new** project application must also include the following:

- ☐ Completed CoC New Project Application *(begins after the Renewal Application)*
- ☐ 2021 (or most recent) Form 990 for Applicant
- ☐ Most recent audited financial statement (Required only if $750,000 in aggregate federal funds expended)
- ☐ Evidence of eligibility as contractor for federal funds per https://www.sam.gov,
- ☐ Current tax-exempt status verified by IRS 501(c)3 letter
- ☐ Copy of Code of Conduct for Applicant Agency

IMPORTANT!
Failure to include the materials noted for your application type
means that your application is incomplete and will not meet the requirements of this RFP.

The deadline for submission of this application is Friday, October 1, 2021 by 12.00 pm.

2021 COC
RENEWAL APPLICATION

For New Bedford CoC Renewal Projects that will provide
Permanent Supportive Housing (PSH) or Permanent Housing Rapid Rehousing (PH-RRH)

The deadline for submission of this application is Friday, October 1, 2021 by 12.00 pm.

Applicants must submit a complete application including all additional materials referenced in the RFP to be considered.

I. AGENCY AND PROJECT INFORMATION

Name of Applicant Agency:			
Project Name:			
Project Location: *(Physical address of the project; if project is scattered site, write "scattered site.")*			
Check Only if Applicable:	☐ Transition Grant	☐ Expansion Project	☐ Consolidated Project
Check HUD Component Type:	☐ Permanent Housing	☐ Rapid Re-Housing	
Renewal Amount *(Same as current budget total):*			
Agency DUNS Number:		**Tax ID or EIN** *(format: 12-3456789)*	

Project Contact Person:			
Job Title of Contact Person:			
Agency Mailing Address:			
Contact Phone Number:		**Fax number:**	
Email Address:			

# of Units Proposed:		**# of Beds Proposed:**	

If you checked either Transition Grant, Expansion Project or Consolidated Project in the section above, please detail the exact nature of what is being proposed through the use of one of these options as relates to the renewal of your project. Please be sure that your understanding and application of these terms is consistent with the NOFO and this RFP. *If none of these were checked, please mark this as Not Applicable and proceed to the narratives on the following page.*

II. PROJECT NARRATIVES

1. Does the project have 100% dedicated beds for chronically homeless individuals and/or families?	☐ Yes ☐ No
If YES: Briefly demonstrate that the proposed renewal does and will continue to first serve the chronically homeless according to the order of priority established in the CoC Written Standards and in Section III.A. of Notice CPD-14-012. To receive full points, the applicant must clearly describe the system it currently uses to determine severity of need for the chronically homeless, its process for prioritizing persons with the most severe needs, and the outreach process used to engage chronically homeless persons living on the streets and in shelter. **If NO:** Please describe what prioritization is followed and why chronic homelessness is not prioritized.	
2. If funded, does the applicant anticipate a seamless continuation of the program?	☐ Yes ☐ No
If NO, please briefly describe challenges or barriers you face in ensuring seamless continuation.	
3. Has the proposed renewal project maximized the use of mainstream and other community-based resources, specifically including this program's coordination with public and private healthcare organizations consistent with the NOFO?	☐ Yes ☐ No
If YES: Briefly identify with whom such coordination has been undertaken, how long it has existed or when it is anticipated to start and provide a description of the nature of the healthcare collaboration and the extent to which it benefits program participants. **If NO:** Briefly describe what barriers may be faced in so doing and what future plans the program has for mitigating those barriers toward collaboration with a healthcare partner.	
4. Has the agency, specific to the proposed renewal project, intentionally and effectively instituted racial equity and/or equity initiatives including efforts to obtain input and include historically marginalized populations when identifying any barriers to participation faced by such persons?	☐ Yes ☐ No
If YES: Briefly describe what the agency has done, the breadth of its efforts and its relatedness to the proposed renewal project. Please discuss whether this is agency-wide, program-specific, related to staff and/or related to service delivery, barriers, etc.. **If NO:** Briefly describe what barriers may be faced in so doing and what future plans the program has for mitigating those barriers in order to ensure racial equity and equity for historically marginalized populations.	

5. Has the agency, specific to the proposed renewal project, intentionally and effectively engaged with those with current or recent-past lived experiences of homelessness?	☐ Yes ☐ No
If YES: Briefly identify the level of involvement those with lived experience have in shaping policy and program administration. **If NO:** Briefly describe what barriers may be faced in so doing and what future plans the program has for mitigating those barriers toward empowering those with lived experience within the proposed renewal project and authentically listening and acting upon their suggestions.	
6. Does the proposed renewal project actively operate following the Housing First model?	☐ Yes ☐ No
If YES: Briefly identify if there are any circumstances which would lead to your tenant's removal from the program (*e.g. failure to participate in supportive services, failure to make progress on a service plan, loss of income or failure to improve income, being a victim of domestic violence or other activity not covered in a typical lease agreement*). **If NO:** Briefly describe why the renewal program does not follow the Housing First model.	
7. Has your agency experienced any findings, unspent balances, inability to invoice for financial expenditures in a timely manner, or failure to consistently submit all required reporting to the OHCD/HUD including in SAGE, APRs, etc. over the past two years?	☐ Yes ☐ No
If YES: Briefly discuss what issues have existed, what circumstances arose that caused them, how the agency responded/is responding and what steps are being taken to ensure agency capacity and no issues going forward during the coming renewal year.	
8. In considering the results of the most recently submitted APR and the past two quarterly reports for this program, has this project met all/exceeded all of the metrics expected of it?	☐ Yes ☐ No
If NO: Briefly discuss what issues have existed that have precluded the program from achieving these performance metrics and what steps are being taken to ensure the agency addresses and mitigates such issues going forward during the coming renewal year.	

III. FISCAL INFORMATION

9. Do you anticipate you will have unexpended funds at the expiration date of your current contract?	☐ Yes ☐ No
10.Have you had unexpended funds at the expiration of grant terms in the past two years?	☐ Yes ☐ No
If YES: Please identify how much money you anticipate leaving unexpended this year/have left in the past two years (dollar amounts by year) and briefly identify why funding was returned discussing how that will change in the coming grant cycle if the proposed renewal is funded.	

IV. MATCH

You are required to provide a SIGNED LETTER(s) on agency letterhead detailing the source and amount of the required 25% match. Match can include in-kind components that are exclusively and directly part of the project and may be cash or non-cash (in-kind) resources provided by the recipient toward the actual costs of operating the project. Cash can come from other grant funding, unrestricted general funds, fundraising activities, private donations, etc. Enter the Source, amount of your match and when the funds will be available for one year. All grant funds must be matched with an amount no less than 25% of the awarded grant amount (excluding the amount awarded to the leasing budget line item) with cash or in-kind resources. Cash and In-Kind Match entered into the budget must qualify as eligible program expenses under the CoC Program interim rule. Please note: final match letters are not due with this renewal application, however the applicant should be prepared to produce final letters upon request and dated in accordance with HUD requirements.

Amount of Match Being Provided: $_____

V. ASSURANCES

To the best of my knowledge and belief, all information in this application is true and correct. The governing body of the applicant has duly authorized this document and the applicant will comply with the following:

- Applicant agrees to complete the HUD Project Application forms with the same information as contained in this application unless the Performance Review Committee has made adjustments during the rating/ranking process. Those adjustments would supersede this document and are included in the Project Ranking Letter sent to each applicant.

- Applicant agrees to participate fully in the New Bedford Continuum of Care's Homeless Management Information System (HMIS) or comparable system for DV projects and coordinated entry system.

- Applicant understands that HUD CoC funded homeless projects are monitored by City of New Bedford as the CoC lead. This can include an annual site visit and submission annually of the applicant's most recent Annual Performance Reports (APR) submitted to HUD and most recent audited financial statement.

If awarded funding, the applicant agrees to inform the City of New Bedford when the following occurs:

- Organization has staff vacancies that are of a duration that could affect the projected number of participants served or result in HUD funds not being fully expended;

- Changes to an existing project that are significantly different than what the funds were originally approved for, including any budget amendments/modifications submitted to HUD and agrees to bring these to the city's OHCD for approval prior to the final 30 days of the grant year;
- Any increase/decrease in match funding for the project that could affect the projected number of participants served, services provided, ability to meet matching requirements, etc. and
- Significant delays in the start-up or operation of a project.

Authorized Signer's Name:	
Title:	
Phone:	
Email:	
Signature of Authorized Representative: _____ ☐ "X" indicates electronic signature submitted	
Date:	

IMPORTANT!

PLEASE ENSURE THAT YOUR APPLICATION IS COMPLETE; ANY ATTACHED MATERIALS REQUIRED AND REFERENCED WITHIN THE RFP SHOULD BE INCLUDED AND SUBMITTED WITH THIS APPLICATION AS ONE PDF DOCUMENT.

2021 COC
NEW PROJECT APPLICATION

For New Bedford New CoC Projects that will provide
Permanent Supportive Housing (PH-PSH), Permanent Housing Rapid Rehousing (PH-RRH),
Joint TH and PH-RRH projects and New DV Projects (RRH, Joint TH and PH-RRH and Coordinated Entry SSO)

The deadline for submission of this application is Friday, October 1, 2021 by 12.00 pm.

Applicants must submit a complete application including all additional materials referenced in the RFP to be considered.

I. AGENCY AND PROJECT INFORMATION

Name of Applicant Agency:			
Project Name:			
Project Location: *(Physical address of the project; if project is scattered site, write "scattered site.")*			
Check Applicable One Only:	☐ Permanent Supportive Housing (PSH) ☐ DV Bonus Project		
Check Applicable One Only if applying for a DV Bonus Project:	☐ Permanent Housing Rapid ReHousing (PH-RRH) ☐ Joint TH and Permanent Housing-Rapid Rehousing (Joint TH and PH-RRH) ☐ SSO Project for Coordinated Entry (SSO-CE)		
Proposed Total Budget Amount:			
Agency DUNS Number:		**Tax ID or EIN** *(format: 12-3456789)*	

Project Contact Person:			
Job Title of Contact Person:			
Agency Mailing Address:			
Contact Phone Number:		**Fax number:**	
Email Address:			

# of Units Proposed:		**# of Beds Proposed:**	

NOTE: Funding for new projects may come from either CoC Bonus funding, Reallocation, a combination of CoC Bonus funding and Reallocation or DV Bonus funding**.** Those new projects seeking funding through the DV Bonus must be dedicated to survivors of domestic violence, dating violence, sexual assault or stalking as defined at 24 CFR 578.3 Definition for Homeless, paragraph (4).

II. PROJECT NARRATIVES

1. Is there a need within the New Bedford CoC for the project you are proposing?	☐ Yes ☐ No
If YES: Please provide a brief description of the proposed project and data/evidence that demonstrates both the need and how the proposed project will meet that need.	

2. Will the proposed project have 100% dedicated beds for chronically homeless individuals and/or families?	☐ Yes ☐ No
If YES: Briefly demonstrate that the proposed new project will first serve the chronically homeless according to the order of priority established in the CoC Written Standards and in Section III.A. of Notice CPD-14-012. To receive full points, the applicant must clearly describe the system it will uses to determine severity of need for the chronically homeless, its process for prioritizing persons with the most severe needs, and the outreach process used to engage chronically homeless persons living on the streets and in shelter. **If NO:** Please describe what prioritization will be followed and why chronic homelessness is not prioritized.	
3. Will the proposed project actively operate following the Housing First model?	☐ Yes ☐ No
If YES: Briefly identify if there are any circumstances which would lead to your tenant's removal from the program (*e.g. failure to participate in supportive services, failure to make progress on a service plan, loss of income or failure to improve income, being a victim of domestic violence or other activity not covered in a typical lease agreement*). **If NO:** Briefly describe why the proposed program does not follow the Housing First model.	
4. Has the proposed new project planned for the use of mainstream and other community-based resources, including this program's coordination with public and private healthcare organizations consistent with the NOFO?	☐ Yes ☐ No
If YES: Briefly identify with whom such coordination has been undertaken, how long it has existed or when it is anticipated to start and provide a description of the nature of the healthcare collaboration and the extent to which it is anticipated to benefit program participants. **If NO:** Briefly describe what barriers may be faced in so doing and what future plans the program has for mitigating those barriers toward collaboration with a healthcare partner.	
5. Has the agency, specific to the proposed new project, intentionally and effectively instituted racial equity initiatives and/or equity initiatives including efforts to obtain input and include historically marginalized populations when identifying any barriers to participation faced by such persons?	☐ Yes ☐ No
If YES: Briefly describe what the agency has done or is planning to do, the breadth of its efforts and its relatedness to the proposed project. Please discuss whether this is agency-wide, program-specific, related to staff and/or related to service delivery.	

6. Has the agency, specific to the proposed new project, intentionally and effectively engaged with those with current or recent-past lived experiences of homelessness?	☐ Yes ☐ No
If YES: Briefly identify the level of involvement those with lived experience have in shaping policy and program administration. **If NO:** Briefly describe what barriers may be faced in so doing and what future plans the program has for mitigating those barriers toward empowering those with lived experience within the proposed new project in an authentic way and acting upon their suggestions.	

7. Does the agency have experience and demonstrable capacity in undertaking the kind of project being proposed?	☐ Yes ☐ No
If YES: Briefly describe the agency's relevant experience with similar programming, working with those experiencing homelessness, working with the U.S. Department of Housing & Urban Development and having the administrative and fiscal resources to undertake the proposed programming in a manner that ensures excellent performance.	
8. Has your agency experienced any findings, unspent balances, inability to invoice for financial expenditures in a timely manner, or failure to consistently submit any required reporting to state or federal funders for other grants over the past two years?	☐ Yes ☐ No
If YES: Briefly discuss what issues have existed, what circumstances arose that caused them, how the agency responded/is responding and what steps are being taken to ensure agency capacity and no issues going forward should this project be funded..	

III. PROJECT ELIGIBILITY TYPE

Eligible Types for NEW CoC Projects-Permanent Housing Bonus or DV Bonus (*Check applicable project type and answer questions specific to that selection*):

Check One	Project Type	**Questions** *(check all applicable for the project type selected)*
☐	New Permanent Supportive Housing (**PSH**)	☐ Tenant-Based Rental Assistance [RA] ☐ Sponsor-Based RA ☐ Project-Based RA ☐ Project-Based/Leasing *[leases building/units*] ☐ Project-Based/Operations [*owns building*]
		Rental Assistance Administrator: ☐ Local PHA ☐ Unit of Local Government ☐ State
		Population To Be Served: *Check all applicable* ☐ Individuals ☐ Families ☐ Unaccompanied Youth (18-24) ☐ Severe/Persistent Mental Health] ☐ Chronic Substance Use Disorder ☐ Other: _____
☐	New Permanent Housing Rapid ReHousing (**PH-RRH**) dedicated to serving survivors of domestic violence, dating violence, sexual assault or stalking that are defined as homeless	Population To Be Served: *Check all applicable* ☐ Individuals ☐ Families ☐ Unaccompanied Youth (18-24) ☐ Fleeing Domestic Violence
☐	New **Joint TH and RRH** dedicated to serving survivors of domestic violence, dating violence, sexual assault or stalking that are defined as homeless	Population To Be Served: *Check all applicable* ☐ Individuals ☐ Families ☐ Unaccompanied Youth (18-24) ☐ Fleeing Domestic Violence
		Rental Assistance Administrator: ☐ Local PHA ☐ Unit of Local Government ☐ State
☐	New SSO Project for Coordinated Entry (**SSO-CE**)	

All projects:

If your new program is selected will it....	YES	NO
Quickly move participants into Permanent Housing (PH)?	☐	☐
Require participants to live in a particular structure/unit/locality?	☐	☐
Have at least 80% of CoC PH participants remain in or exit to PH destinations?	☐	☐
Actively participate in New Bedford's Coordinated Entry and its HMIS?	☐	☐
Ensure that a 25% match requirement is met?	☐	☐

IV. FISCAL INFORMATION

Eligible Costs	ıl Assistance Requested for Grant Term (Applicant)
1a. Leased Units	$
1b. Leased Structures	$
2. Housing Relocation and Stabilization	$
3. Short-term/Medium-term Assistance	$
4. Long-term Rental Assistance	$
5. Supportive Services	$
6. Operating	$
7. HMIS	$
8. Sub-Total Costs Requested	$
9. Admin (Up to 10%)	$
10. Total Assistance plus Admin Requested	$
11. Cash Match	$
12. In-Kind Match	$
13. Total Match	$
14. Total Budget	**$**

V. MATCH

You are required to provide a SIGNED LETTER(s) on agency letterhead detailing the source and amount of the required 25% match. Match can include in-kind components that are exclusively and directly part of the project and may be cash or non-cash (in-kind) resources provided by the recipient toward the actual costs of operating the project. Cash can come from other grant funding, unrestricted general funds, fundraising activities, private donations, etc. Enter the Source, amount of your match and when the funds will be available for one year. All grant funds must be matched with an amount no less than 25% of the awarded grant amount (excluding the amount awarded to the leasing budget line item) with cash or in-kind resources. Cash and In-Kind Match entered into the budget must qualify as eligible program expenses under the CoC Program interim rule. Please note: final match letters are not due with this renewal application, however the applicant should be prepared to produce final letters upon request and dated in accordance with HUD requirements.

Amount of Match Being Provided: $_____

VI. AGENCY QUESTIONNAIRE

Please check either yes or no to the questions below:

	Yes	No
In the past ten (10) years, has your organization ever had its nonprofit status revoked or withheld by the IRS, the Secretary of State, or the State Attorney General?	☐	☐
Have you completed the annual update to your organization's registration with the federal government at www.sam.gov	☐	☐
Have all due IRS 990 filings been submitted to the IRS?	☐	☐
Does your organization currently have any unresolved fiscal reporting, or program issues with any of its funding sources?	☐	☐
Have you attached all of the materials required this application?	☐	☐

VII. ASSURANCES

To the best of my knowledge and belief, all information in this application is true and correct. The governing body of the applicant has duly authorized this document and the applicant will comply with the following:

- Applicant agrees to complete the HUD Project Application forms with the same information as contained in this application unless the Application Review Committee has made adjustments during the rating/ranking process. Those adjustments would supersede this document and are included in the Project Ranking Letter sent to each applicant.

- Applicant agrees to participate fully in the New Bedford Continuum of Care's Homeless Management Information System (HMIS) or comparable system for DV projects, and coordinated entry system.

- Applicant understands that HUD CoC funded homeless projects are monitored by City of New Bedford as the CoC lead. This can include an annual site visit and submission annually of the applicant's most recent Annual Performance Reports (APR) submitted to HUD and most recent audited financial statement.

If awarded funding, the applicant agrees to inform the City of New Bedford when the following occurs:

- Organization has staff vacancies that are of a duration that could affect the projected number of participants served or result in HUD funds not being fully expended;

- Changes to an existing project that are significantly different than what the funds were originally approved for, including any budget amendments/modifications submitted to HUD and agrees to bring these to the city's OHCD for approval prior to the final 30 days of the grant year;

- Any increase/decrease in match funding for the project that could affect the projected number of participants served, services provided, ability to meet matching requirements, etc. and

- Significant delays in the start-up or operation of a project.

Proceed to signature block on the following page.

Authorized Signer's Name:	
Title:	
Phone:	
Email:	
Signature of Authorized Representative: _____ ☐ "X" indicates electronic signature submitted	
Date:	

IMPORTANT!

PLEASE ENSURE THAT YOUR APPLICATION IS COMPLETE; ANY ATTACHED MATERIALS REQUIRED AND REFERENCED WITHIN THE RFP SHOULD BE INCLUDED AND SUBMITTED WITH THIS APPLICATION AS ONE PDF DOCUMENT.

Attachment 1E-2

New Bedford Continuum of Care
MA-505

Project Review and Selection Process

NOTE:

This Attachment includes the following material:

1. *One blank scoring form use to score renewal applications*
2. *One completed score form (renewal PSH – the Family Preservation Project)*
3. *A screenshot of the ranking results that were posted on the CoC's website and the published ranking results sheet*
4. *A screenshot of the Consolidated Application, Attachments and Priority Listing posted on the CoC website and a screenshot of the email blasts sent out to the CoC's extensive mailing list/public advising people of the availability of the material in both DRAFT and FINAL formats.*

1 **One blank scoring form use to score renewal applications**

CoC FY21 RENEWAL PROJECT – SCORING SHEET

AGENCY NAME:	
PROJECT NAME:	

BED / UNIT COMPOSITION

Program Year	Program Type	Beds	Units	Families	Individuals

BUDGET SUMMARY

Total Fund Requested	Leasing	Supportive Services	Operations	Admin	Match

CLIENTS SERVED PROFILE

Total Persons	Total Adults	Total Children	Total Households	Total Leavers	Total Stayers	Total Chronic Homeless

Project Description

❶ **One blank scoring form use to score renewal applications, *continued***

GENERAL COMMENTS

Annual Performance Report Analysis

Financial Analysis

Comments

❶ One blank scoring form use to score renewal applications, *continued*

AGENCY NAME:	
PROJECT NAME:	

PERFORMANCE STANDARDS for PERMANENT SUPPORTIVE HOUSING

GOALS	PERFORMANCE STANDARD	% ACHIEVED	COMMENTS	POINTS AWARDED
1. Housing Stability Persons residing in permanent housing exited to another form of a permanent housing destination. **Goal 85%**	Based on Q1 & Q23c *The % of persons who exited to permanent housing destinations as of the end of the operating year.*			
2. Returns to Homelessness Persons exiting permanent housing will not return to homelessness (Including Transitional Housing) **Goal <10%**	Based on Q1 &Q23c *The % of persons in the PSH program returning to homelessness shall be less than 10%.*			
3. Earned Income—Stayers Adult stayers will increase earned income (employment income). **Goal 10%**	Based on Q19a1 *The % of persons ages 18 or older staying in the program who increased their income (employment income) as of the latest annual assessment.*			
4. Non-Employment Cash Income- Stayers Adult stayers will increase non-employment cash income (mainstream resources). **Goal 40%**	Based on Q19a1 *The % of persons ages 18 or older staying in the program who increased their non-employment cash income (mainstream resources) as of the latest annual assessment.*			
5. Earned Income-Leavers- Adult leavers will increase earned income (employment income). **Goal: 20%**	Based on Q19a2 *The % of persons ages 18 or older leaving the program who increased their income (employment income) by program exit.*			

Scoring analysis continues on the following page.

❶ One blank scoring form use to score renewal applications, *continued*

GOALS	PERFORMANCE STANDARD	% ACHIEVED	COMMENTS	POINTS AWARDED
6. Non-Employment Cash Income-Leavers- Adult leavers will increase non-employment cash income (mainstream resources). **Goal: 50%**	Based on Q19a2 *The % of persons ages 18 or older leaving the program who increased their non-employment cash income (mainstream resources) by program exit.*			
7. Utilization Rate - Beds Program operates at full capacity, with low vacancy rate, and quickly fill vacancies. **Goal: 90%**	Based on Q8b *Average quarterly utilization rate during the operating year.*			
8. Data Quality - Agency's thoroughness in ensuring all data is collected and entered into HMIS. **Goal = No Omissions**	Based on Data Quality Report (Q2, 3, 4, 5)			
9. Chronic Homeless Persons - Persons who are chronically homeless by household **Goal = 100%**	Based on APR Q26b The # of chronically homeless persons divided by the total number of persons served.			
10. Fiscal Management - Complete and timely drawdown of funds. **Goal = 100% Drawdown**	Based on HUD LOCS FY19 Allocation Amount			
11. Narrative Responses - Applicant responses to narrative responses #3, #4, #5 and #6 will each be scored with a cumulative total of 10 points possible.				
TOTAL POINTS AWARDED				

❶ One blank scoring form use to score renewal applications, *continued*

ADDITIONAL EVALUATION CRITERIA QUESTIONS	COMMENTS
Agency Experience and Capacity. Administration: Applicants demonstrating extensive experience in administering HUD or other federal funds and providing the proposed service and/or serving.	
Fiscal Management. Applicants must demonstrate history of financial stability, including prompt expenditure of program funds, and no outstanding audit or HUD monitoring findings.	
Project Quality.	
Housing First: Applicants will be evaluated to the extent to which the Permanent Supportive Housing Bonus project will follow a Housing First model/low barrier approach.	
Mainstream Services: Applicants will be evaluated to the extent to which the project is fully leveraging mainstream resources for supportive services.	
Low Barrier: Projects must demonstrate low barriers to program admission and flexible participation policies designed to retain program participants.	
Consistency of Program: Applicants will be evaluated to the extent to which the project's performance is consistent against plans and goals established in the application.	

2 **One completed score form (renewal PSH – the Family Preservation Project)**

CoC FY21 RENEWAL PROJECT – SCORING SHEET

AGENCY NAME:	SEMCOA, Inc.
PROJECT NAME:	**Family Preservation Program**

BED / UNIT COMPOSITION

Program Year	Program Type	Beds	Units	Families	Individuals
September 1, 2022 – August 30, 2023	**PSH**	**46**	**16**	**X**	

BUDGET SUMMARY

Total Fund Requested	Leasing	Supportive Services	Operations	Admin	Match
$298,437	**$212,650**	**$41,719**	**$20,348**	**$23,720**	**$21,447**

CLIENTS SERVED PROFILE

Total Persons	Total Adults	Total Children	Total Households	Total Leavers	Total Stayers	Total Chronic Homeless
51	**25**	**26**	**17**	**3**	**48**	**39**

Project Description

The Family Preservation Program is a scattered site Permanent Supportive Housing (PSH) program that serves families with children experiencing chronic homelessness with a least one member of the household having a disability and a substance use disorder. The program receives referrals through coordinated entry and all clients are scored using the SPDAT. The program does not have any barriers to entry and uses a Housing First Model. Each family receives supportive services through comprehensive case management. The case manager collaborates with the participant to develop an Individual Service Plan and sets goals and needs such as employment, education, life skills. Also, each family is connected to mainstream resource benefits and health insurance. FPP partners with outside agencies such as the Department of Children and Families in order to provide a smooth transition for those families who are reunifying with their children, the Massachusetts Rehabilitation Commission to provide job training and/or education, and multiple resources in the community that provide outpatient counseling and support. FPP participants are assisted in applying for subsidized housing such as Section 8 and many obtain vouchers that allow them to move on to more permanent housing.

2 One completed score form (renewal PSH – the Family Preservation Project), *continued*

GENERAL COMMENTS

Annual Performance Report Analysis

- Program met anticipated outputs relative to numbers served.
- Submission: In FY19, the APR was submitted on time and within the 90-day HUD requirement.
- In FY20, all funds were drawn down in a timely manner and according to schedule.
- Of the 8 performance standards for PSH projects—the subrecipient achieved 7 of 8 goals. Only goal not achieved was Non-Cash Income - Leavers. No adults increased or gained earned income for leavers.

Financial Analysis

- All reimbursement requests were timely and submitted with proper backup documentation
- The subrecipient recently submitted an amendment request on 7/1/21. They moved $9,298 from leasing to supportive services. Amendment has been approved.
- For FY2020, all funds have been successfully drawdown. No balance.

Comments

- Overall, the Program continues to perform well and is meeting all required goals and objectives.
- Similar to other CoC Programs, they are experiencing challenges with the COVID Pandemic.
- Program does not have any staffing or programmatic related issues.
- Only issue identified was related to the change of ownership at Ingraham Place. The uncertainty of the new ownership created some confusion.
- The subrecipient has experienced some HMIS challenges addressing data quality and merging / unmerging families. Both issues have been addressed. The subrecipient has asked for additional HMIS training.
- Similar to other PSH programs, they continue to have difficulty finding housing for new clients that meets HQS and FMR.

2 One completed score form (renewal PSH – the Family Preservation Project), *continued*

AGENCY NAME:	**SEMCOA, Inc.**
PROJECT NAME:	**Family Preservation Program**

PERFORMANCE STANDARDS for PERMANENT SUPPORTIVE HOUSING

GOALS	PERFORMANCE STANDARD	% ACHIEVED	COMMENTS	POINTS AWARDED
5. Housing Stability Persons residing in permanent housing exited to another form of a permanent housing destination. **Goal 85%**	Based on Q1 & Q23c *The % of persons who exited to permanent housing destinations as of the end of the operating year.*	100%	Goal Achieved – 3 persons exited to permanent destinations.	**10**
6. Returns to Homelessness Persons exiting permanent housing will not return to homelessness (Including Transitional Housing) **Goal <10%**	Based on Q1 &Q23c *The % of persons in the PSH program returning to homelessness shall be less than 10%.*	0%	Goal Achieved – 0 persons exited to homelessness.	**10**
7. Earned Income—Stayers Adult stayers will increase earned income (employment income). **Goal 10%**	Based on Q19a1 *The % of persons ages 18 or older staying in the program who increased their income (employment income) as of the latest annual assessment.*	33%	Goal Achieved – 6 out of 18 persons gained or increased earned income for adult stayers.	**5**
8. Non-Employment Cash Income- Stayers Adult stayers will increase non-employment cash income (mainstream resources). **Goal 40%**	Based on Q19a1 *The % of persons ages 18 or older staying in the program who increased their non-employment cash income (mainstream resources) as of the latest annual assessment.*	50%	Goal Achieved – 9 out of 18 persons gained or increased non-employment cash income for adult stayers.	**5**
5. Earned Income-Leavers- Adult leavers will increase earned income (employment income). **Goal: 20%**	Based on Q19a2 *The % of persons ages 18 or older leaving the program who increased their income (employment income) by program exit.*	100%	Goal Achieved – 1 out of 11 persons gained or increased earned income for adult leavers.	**5**

Scoring analysis continues on the following page.

❷ One completed score form (renewal PSH – the Family Preservation Project), *continued*

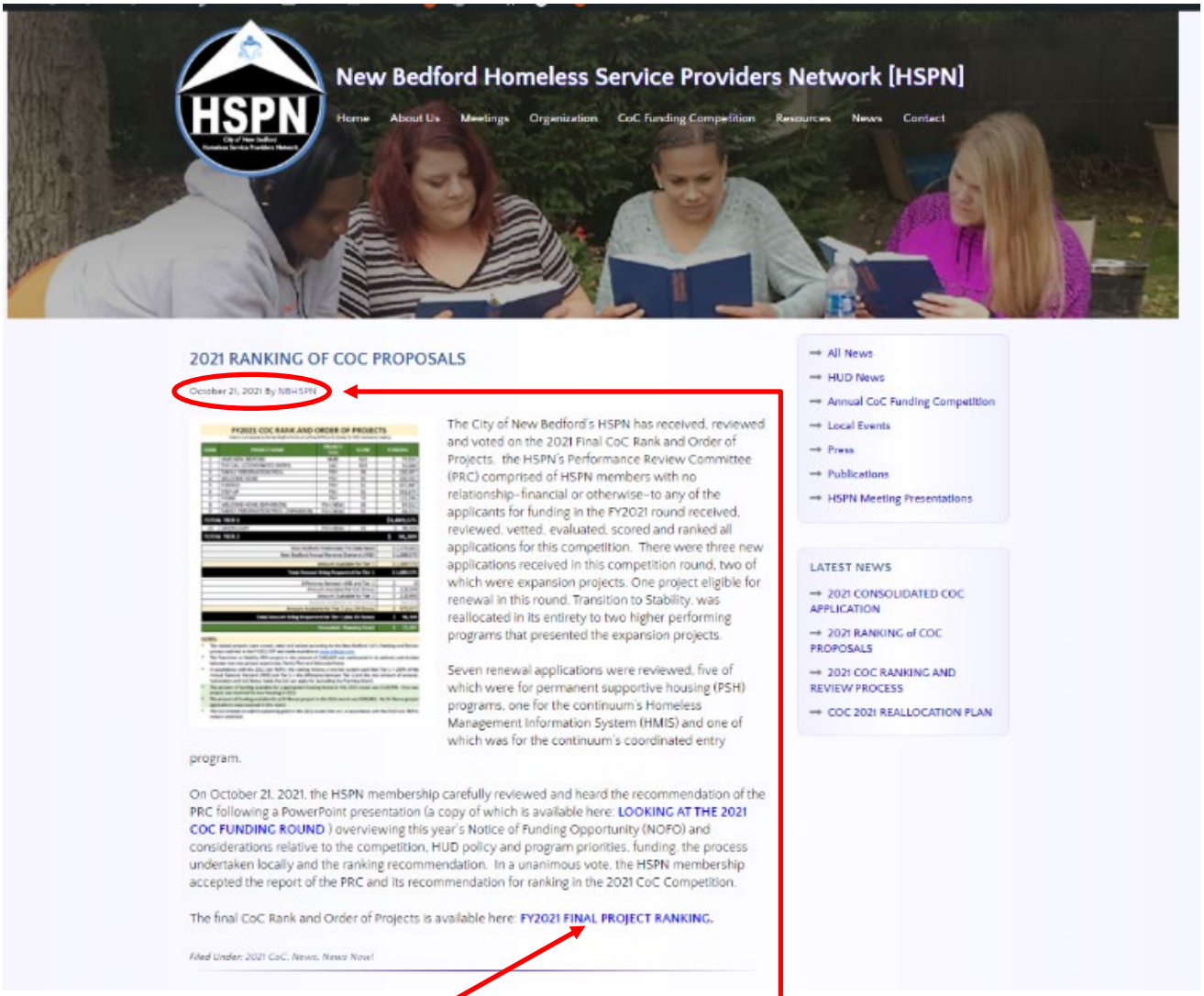
GOALS	PERFORMANCE STANDARD	% ACHIEVED	COMMENTS	POINTS AWARDED
6. Non-Employment Cash Income-Leavers- Adult leavers will increase non-employment cash income (mainstream resources). **Goal: 50%**	Based on Q19a2 *The % of persons ages 18 or older leaving the program who increased their non-employment cash income (mainstream resources) by program exit.*	0%	Goal Not Achieved – 0 persons gained or increased non-employment cash income for adult leavers.	**0**
7. Utilization Rate - Beds Program operates at full capacity, with low vacancy rate, and quickly fill vacancies. **Goal: 90%**	Based on Q8b *Average quarterly utilization rate during the operating year.*	90%	Goal Achieved – Program operates at full capacity with low vacancy rates.	**15**
8. Data Quality - Agency's thoroughness in ensuring all data is collected and entered into HMIS. **Goal = No Omissions**	Based on Data Quality Report (Q2, 3, 4, 5)	26%	Goal Not Achieved – Program had DQ errors associated with Date of Birth (5.88%) and Income & Sources at Start (20%).	**10**
9. Chronic Homeless Persons - Persons who are chronically homeless by household **Goal = 100%**	Based on APR Q26b The # of chronically homeless persons divided by the total number of persons served.	77%	Goal Not Achieved – Out of 51 persons, 39 were chronically homeless.	**12**
10. Fiscal Management - Complete and timely drawdown of funds. **Goal = 100% Drawdown**	Based on HUD LOCS FY19 Allocation Amount	99%	Goal Not Achieved – Allocation $274,604. Program returned $20 ($20 (Operations))	**8**
11. Narrative Responses - Applicant responses to narrative responses #3, #4, #5 and #6 will each be scored with a cumulative total of 10 points possible.			Applicant provided details responses to each RFP question.	**10**
TOTAL POINTS AWARDED				**88**

2 One completed score form (renewal PSH – the Family Preservation Project), *continued*

ADDITIONAL EVALUATION CRITERIA QUESTIONS	
Agency Experience and Capacity. Administration: Applicants demonstrating extensive experience in administering HUD or other federal funds and providing the proposed service and/or serving.	Agency has extensive history administering HUD based programs.
Fiscal Management. Applicants must demonstrate history of financial stability, including prompt expenditure of program funds, and no outstanding audit or HUD monitoring findings.	Applicant has history of overall financial stability. No concerns noted in either audit or HUD monitoring.
Project Quality.	
Housing First: Applicants will be evaluated to the extent to which the Permanent Supportive Housing Bonus project will follow a Housing First model/low barrier approach.	Applicant described how they would follow the Housing First model and how to address any barriers.
Mainstream Services: Applicants will be evaluated to the extent to which the project is fully leveraging mainstream resources for supportive services.	Applicant demonstrated history and extent of obtaining mainstream resources to clients.
Low Barrier: Projects must demonstrate low barriers to program admission and flexible participation policies designed to retain program participants.	All Applicants are required to follow HUD's low barrier for entry requirement.
Consistency of Program: Applicants will be evaluated to the extent to which the project's performance is consistent against plans and goals established in the application.	Applicants project performance is consistent with plans and goals established in the previous renewal applications.

3 A screenshot of the ranking results that were posted on the CoC's website and the published ranking results sheet

https://www.nbhspn.com/2021-ranking-of-coc-proposals/



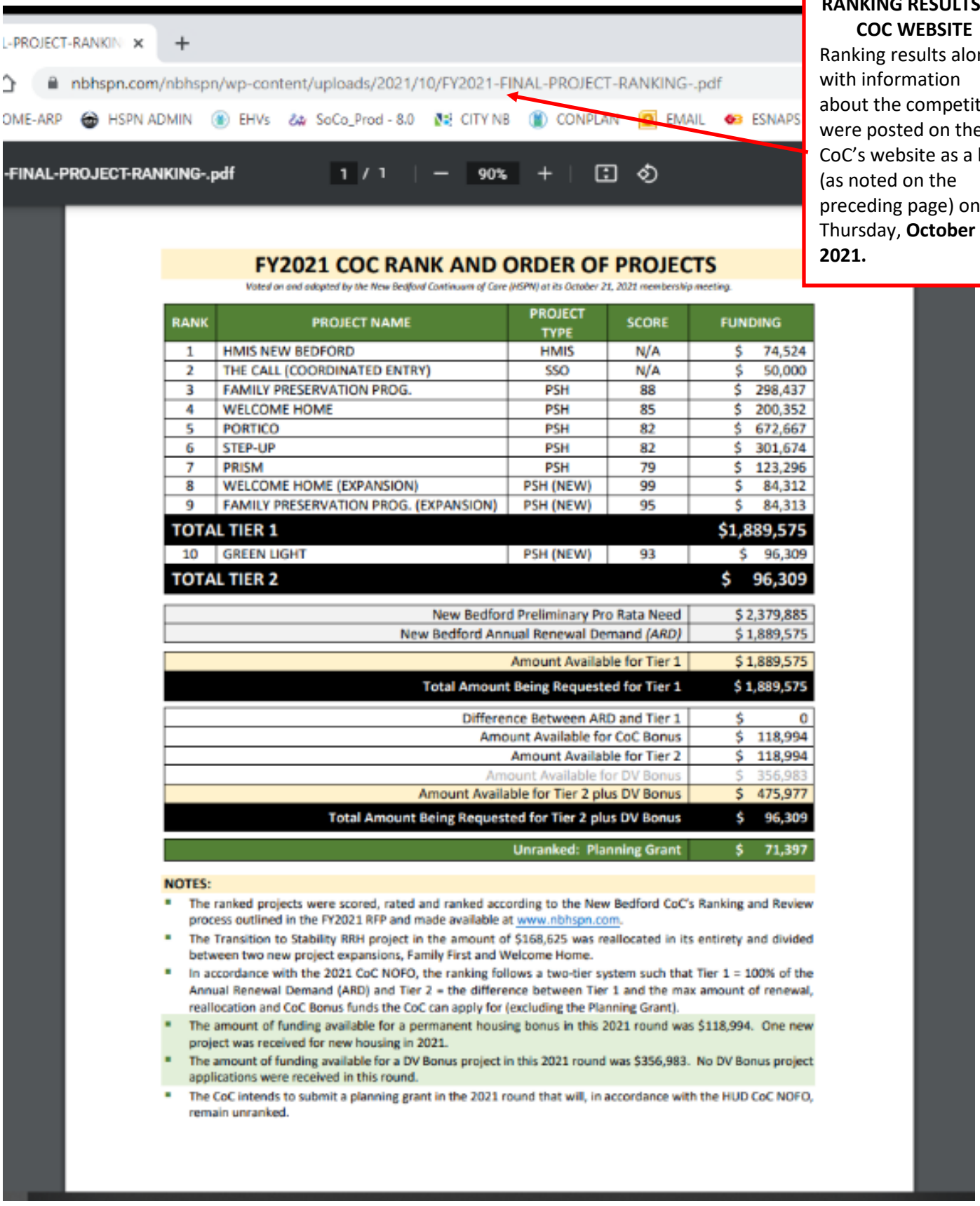
The 2021 Final Project Ranking Results were published on the CoC's website at the link noted above on **October 21, 2021**. The link result is shown on the following page of this attachment.

The 2021 Ranking of CoC Proposals was posted online at the CoC's website at the link noted above on **October 21, 2021** immediately following the vote of the CoC and notification to all parties.

3 **A screenshot of the ranking results that were posted on the CoC's website and the published ranking results sheet, *continued*.**

RANKING RESULTS on COC WEBSITE

Ranking results along with information about the competition were posted on the CoC's website as a link (as noted on the preceding page) on Thursday, **October 21, 2021.**



FY2021 COC RANK AND ORDER OF PROJECTS

Voted on and adopted by the New Bedford Continuum of Care (HSPN) at its October 21, 2021 membership meeting.

RANK	PROJECT NAME	PROJECT TYPE	SCORE	FUNDING
1	HMIS NEW BEDFORD	HMIS	N/A	$ 74,524
2	THE CALL (COORDINATED ENTRY)	SSO	N/A	$ 50,000
3	FAMILY PRESERVATION PROG.	PSH	88	$ 298,437
4	WELCOME HOME	PSH	85	$ 200,352
5	PORTICO	PSH	82	$ 672,667
6	STEP-UP	PSH	82	$ 301,674
7	PRISM	PSH	79	$ 123,296
8	WELCOME HOME (EXPANSION)	PSH (NEW)	99	$ 84,312
9	FAMILY PRESERVATION PROG. (EXPANSION)	PSH (NEW)	95	$ 84,313
TOTAL TIER 1				**$1,889,575**
10	GREEN LIGHT	PSH (NEW)	93	$ 96,309
TOTAL TIER 2				**$ 96,309**

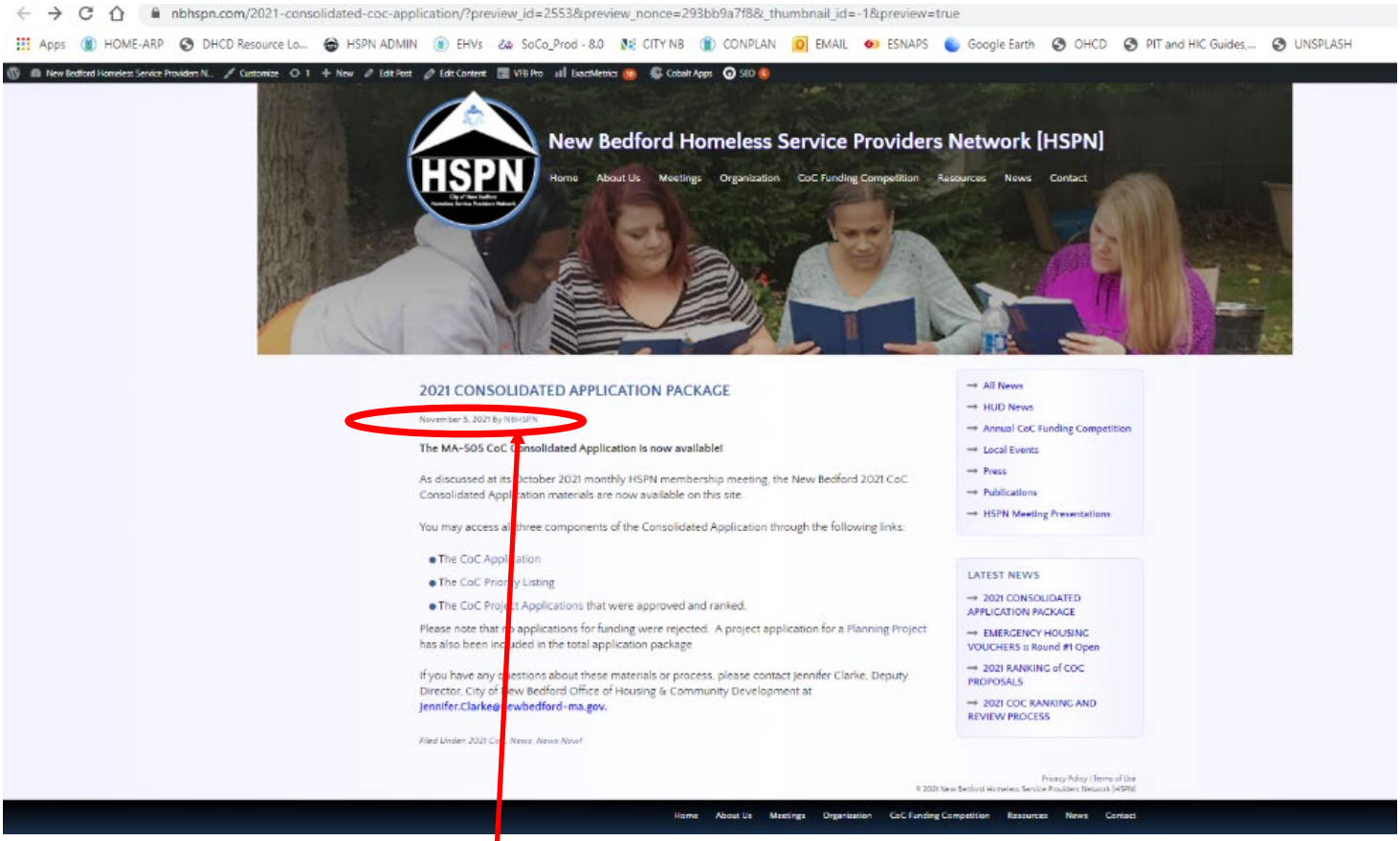
New Bedford Preliminary Pro Rata Need	$ 2,379,885
New Bedford Annual Renewal Demand *(ARD)*	$ 1,889,575
Amount Available for Tier 1	$ 1,889,575
Total Amount Being Requested for Tier 1	**$ 1,889,575**
Difference Between ARD and Tier 1	$ 0
Amount Available for CoC Bonus	$ 118,994
Amount Available for Tier 2	$ 118,994
Amount Available for DV Bonus	$ 356,983
Amount Available for Tier 2 plus DV Bonus	$ 475,977
Total Amount Being Requested for Tier 2 plus DV Bonus	**$ 96,309**
Unranked: Planning Grant	**$ 71,397**

NOTES:

- The ranked projects were scored, rated and ranked according to the New Bedford CoC's Ranking and Review process outlined in the FY2021 RFP and made available at www.nbhspn.com.
- The Transition to Stability RRH project in the amount of $168,625 was reallocated in its entirety and divided between two new project expansions, Family First and Welcome Home.
- In accordance with the 2021 CoC NOFO, the ranking follows a two-tier system such that Tier 1 = 100% of the Annual Renewal Demand (ARD) and Tier 2 = the difference between Tier 1 and the max amount of renewal, reallocation and CoC Bonus funds the CoC can apply for (excluding the Planning Grant).
- The amount of funding available for a permanent housing bonus in this 2021 round was $118,994. One new project was received for new housing in 2021.
- The amount of funding available for a DV Bonus project in this 2021 round was $356,983. No DV Bonus project applications were received in this round.
- The CoC intends to submit a planning grant in the 2021 round that will, in accordance with the HUD CoC NOFO, remain unranked.

4 A screenshot of the Consolidated Application, Attachments and Priority Listing posted on the CoC website

https://www.nbhspn.com/2021-consolidated-coc-application/

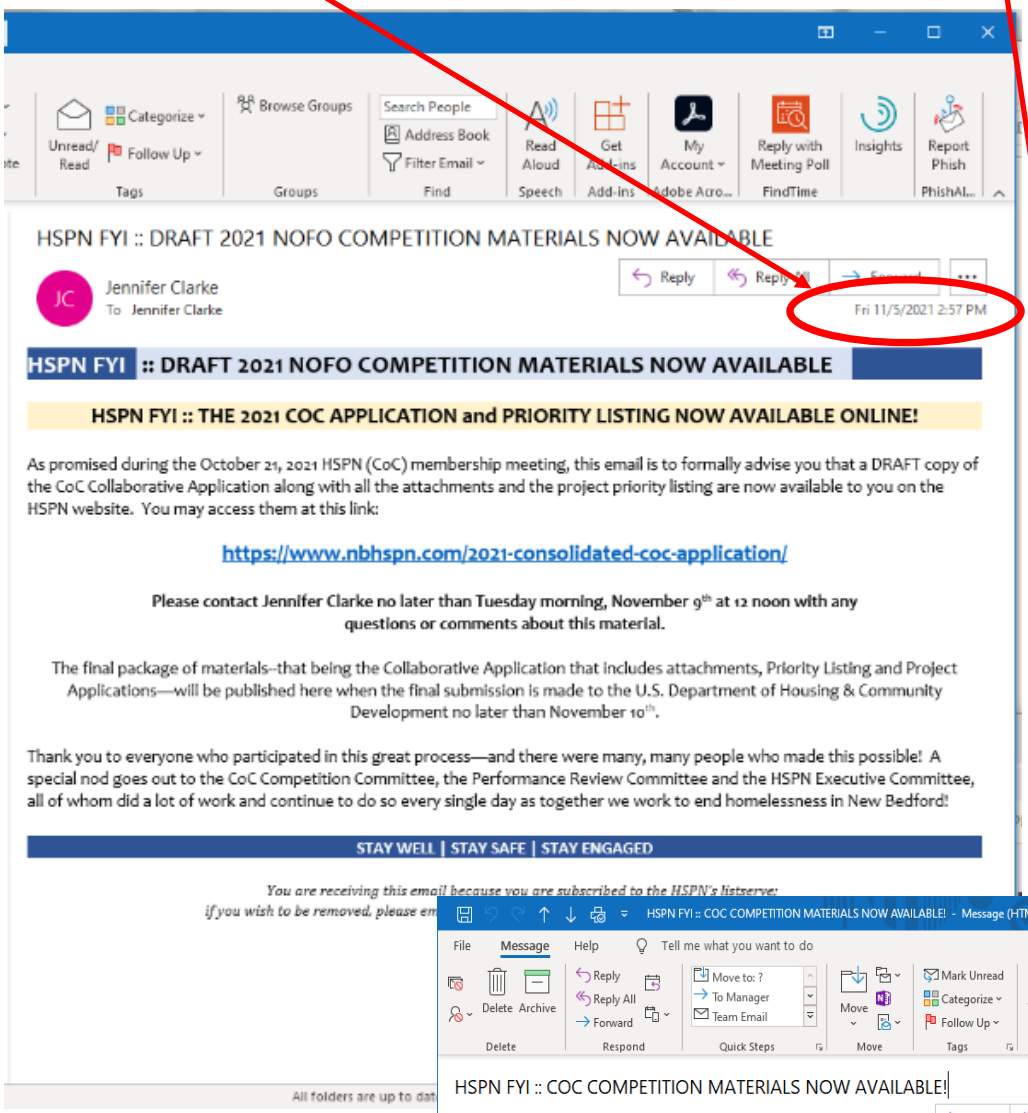


COMPETITION APPLICATION AND MATERIALS
POSTED on the COC WEBSITE

A copy of the final CoC Consolidated Application along with the application attachments and the project priority listing were all posted to the continuum's website at https://www.nbhspn.com/2021-consolidated-coc-application/ on Friday, November 5, 2021.

4 **A screenshot of the email blasts alerting the public on the email listserve as to the availability of the DRAFT and FINAL versions of the Consolidated Application, Attachments and Priority Listing posted on the CoC website.**

NOTE: The initial (DRAFT) email was sent on Friday, November 5, 2021 and the second (FINAL) email was sent on Wednesday, November 10, 2021; the mailing list in both instances was blind-copied for privacy.



HSPN FYI :: DRAFT 2021 NOFO COMPETITION MATERIALS NOW AVAILABLE

Jennifer Clarke
To Jennifer Clarke

Fri 11/5/2021 2:57 PM

HSPN FYI :: DRAFT 2021 NOFO COMPETITION MATERIALS NOW AVAILABLE

HSPN FYI :: THE 2021 COC APPLICATION and PRIORITY LISTING NOW AVAILABLE ONLINE!

As promised during the October 21, 2021 HSPN (CoC) membership meeting, this email is to formally advise you that a DRAFT copy of the CoC Collaborative Application along with all the attachments and the project priority listing are now available to you on the HSPN website. You may access them at this link:

https://www.nbhspn.com/2021-consolidated-coc-application/

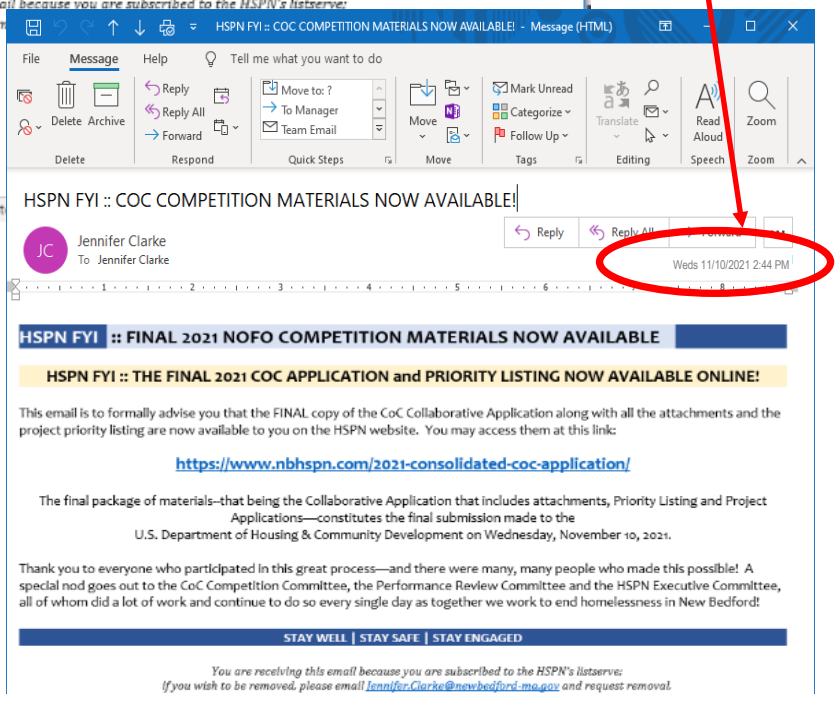
Please contact Jennifer Clarke no later than Tuesday morning, November 9th at 12 noon with any questions or comments about this material.

The final package of materials--that being the Collaborative Application that includes attachments, Priority Listing and Project Applications—will be published here when the final submission is made to the U.S. Department of Housing & Community Development no later than November 10th.

Thank you to everyone who participated in this great process—and there were many, many people who made this possible! A special nod goes out to the CoC Competition Committee, the Performance Review Committee and the HSPN Executive Committee, all of whom did a lot of work and continue to do so every single day as together we work to end homelessness in New Bedford!

STAY WELL | STAY SAFE | STAY ENGAGED

You are receiving this email because you are subscribed to the HSPN's listserve;
if you wish to be removed, please em



HSPN FYI :: COC COMPETITION MATERIALS NOW AVAILABLE! - Message (HTML)

HSPN FYI :: COC COMPETITION MATERIALS NOW AVAILABLE!

Jennifer Clarke
To Jennifer Clarke

Weds 11/10/2021 2:44 PM

HSPN FYI :: FINAL 2021 NOFO COMPETITION MATERIALS NOW AVAILABLE

HSPN FYI :: THE FINAL 2021 COC APPLICATION and PRIORITY LISTING NOW AVAILABLE ONLINE!

This email is to formally advise you that the FINAL copy of the CoC Collaborative Application along with all the attachments and the project priority listing are now available to you on the HSPN website. You may access them at this link:

https://www.nbhspn.com/2021-consolidated-coc-application/

The final package of materials--that being the Collaborative Application that includes attachments, Priority Listing and Project Applications—constitutes the final submission made to the U.S. Department of Housing & Community Development on Wednesday, November 10, 2021.

Thank you to everyone who participated in this great process—and there were many, many people who made this possible! A special nod goes out to the CoC Competition Committee, the Performance Review Committee and the HSPN Executive Committee, all of whom did a lot of work and continue to do so every single day as together we work to end homelessness in New Bedford!

STAY WELL | STAY SAFE | STAY ENGAGED

You are receiving this email because you are subscribed to the HSPN's listserve;
If you wish to be removed, please email Jennifer.Clarke@newbedford-ma.gov and request removal.

Attachment 1E-5

New Bedford Continuum of Care
MA-505

Public Posting-Projects Rejected-Reduced

NOTE:

No projects were rejected.

Attachment 1E-5a

New Bedford Continuum of Care
MA-505

Public Posting-Projects Accepted

NOTE:

This attachment includes copies of the letters sent outside of ESNAPS to the projects selected and ranked in the 2021 NOFO Competition.

City of New Bedford
Office of Housing & Community Development
608 Pleasant Street | New Bedford, Massachusetts 02740
Telephone: (508) 979.1500 Facsimile: (508) 979.1575

Patrick J. Sullivan
DIRECTOR

October 21, 2021

Susan Mazzarella, M.A., L.S.W.
Chief Executive Officer
Catholic Social Services
1600 Bay Street
P.O. Box M/So. Station
Fall River, MA 02724

RE: APPLICATION FOR COC RENEWAL
THE CALL

Dear Ms. Mazzarella:

This letter is intended to formally advise you that the above-captioned proposal submitted for funding consideration in this year's Continuum of Care (CoC) competition in New Bedford was ranked at the October Homeless Service Provider's Network (HSPN) meeting held on Thursday, October 21, 2021.

The HSPN's Performance Review Committee (PRC) met and conducted reviews and evaluations of all proposals submitted for consideration in this year's 2021 CoC Funding Competition. The PRC's recommendation for project ranking to the HSPN membership included scoring for each of the proposals submitted. The resulting scoring was such that the CALL project ranked as second overall in the CoC's ranking.

As a result, CSS' proposed renewal program will be included in this year's New Bedford CoC application as a project in Tier 1 at an amount of $50,000.

Staff from this office will be in touch with your organization within the next few days via email to advise regarding your required completion of the e-snaps application for this project. Otherwise, should you have any questions concerning this ranking, please contact Patrick Sullivan at PatrickS@newbedford-ma.gov.

Respectfully,

Jennifer Clarke, AICP
Deputy Director

City of New Bedford
Office of Housing & Community Development
608 Pleasant Street | New Bedford, Massachusetts 02740
Telephone: (508) 979.1500 Facsimile: (508) 979.1575

Patrick J. Sullivan
DIRECTOR

October 21, 2021

Wendy Bluis, Program Director
SEMCOA, Inc.
72 Kilburn Street
New Bedford, MA 02740

RE: APPLICATION FOR COC RENEWAL
FAMILY PRESERVATION PROGRAM

Dear Ms. Bluis:

This letter is intended to formally advise you that the above-captioned proposal submitted for funding consideration in this year's Continuum of Care (CoC) competition in New Bedford was ranked at the October Homeless Service Provider's Network (HSPN) meeting held on Thursday, October 21, 2021.

The HSPN's Performance Review Committee (PRC) met and conducted reviews and evaluations of all proposals submitted for consideration in this year's 2021 CoC Funding Competition. The PRC's recommendation for project ranking to the HSPN membership included scoring for each of the proposals submitted. The resulting scoring was such that the FAMILY PRESERVATION PROGRAM project ranked as third overall in the CoC's ranking.

As a result, SEMCOA's proposed renewal program will be included in this year's New Bedford CoC application as a project in Tier 1 at an amount of $298,437.

Staff from this office will be in touch with your organization shortly via email to advise regarding your required completion of the e-snaps application for this project. Otherwise, should you have any questions concerning this ranking, please contact Patrick Sullivan at PatrickS@newbedford-ma.gov.

Respectfully,

Jennifer Clarke, AICP
Deputy Director

City of New Bedford
Office of Housing & Community Development
608 Pleasant Street | New Bedford, Massachusetts 02740
Telephone: (508) 979.1500 Facsimile: (508) 979.1575

Patrick J. Sullivan
DIRECTOR

October 21, 2021

Kathleen Schedler-Clark, Executive Director
Steppingstone, Inc.
522 North Main Street
Fall River, MA 02720-3509

RE: APPLICATION FOR COC RENEWAL
WELCOME HOME

Dear Ms. Schedler-Clark:

This letter is intended to formally advise you that the above-captioned proposal submitted for funding consideration in this year's Continuum of Care (CoC) competition in New Bedford was ranked at the October Homeless Service Provider's Network (HSPN) meeting held on Thursday, October 21, 2021.

The HSPN's Performance Review Committee (PRC) met and conducted reviews and evaluations of all proposals submitted for consideration in this year's 2021 CoC Funding Competition. The PRC's recommendation for project ranking to the HSPN membership included scoring for each of the proposals submitted. The resulting scoring was such that the WELCOME HOME project ranked as fourth overall in the CoC's ranking.

As a result, Steppingstone's proposed renewal program will be included in this year's New Bedford CoC application as a project in Tier 1 at an amount of $200,352.

Staff from this office will be in touch with your organization within the next few days via email to advise regarding your required completion of the e-snaps application for this project. Otherwise, should you have any questions concerning this ranking, please contact Patrick Sullivan at PatrickS@newbedford-ma.gov.

Respectfully,

Jennifer Clarke, AICP
Deputy Director

City of New Bedford
Office of Housing & Community Development
608 Pleasant Street | New Bedford, Massachusetts 02740
Telephone: (508) 979.1500 Facsimile: (508) 979.1575

Patrick J. Sullivan
DIRECTOR

October 21, 2021

Susan Mazzarella, M.A., L.S.W.
Chief Executive Officer
Catholic Social Services
1600 Bay Street
P.O. Box M/So. Station
Fall River, MA 02724

RE: APPLICATION FOR COC RENEWAL
PORTICO

Dear Ms. Mazzarella:

This letter is intended to formally advise you that the above-captioned proposal submitted for funding consideration in this year's Continuum of Care (CoC) competition in New Bedford was ranked at the October Homeless Service Provider's Network (HSPN) meeting held on Thursday, October 21, 2021.

The HSPN's Performance Review Committee (PRC) met and conducted reviews and evaluations of all proposals submitted for consideration in this year's 2021 CoC Funding Competition. The PRC's recommendation for project ranking to the HSPN membership included scoring for each of the proposals submitted. The resulting scoring was such that the PORTICO project ranked as fifth overall in the CoC's ranking.

As a result, CSS' proposed renewal program will be included in this year's New Bedford CoC application as a project in Tier 1 in the amount of $672,667.

Staff from this office will be in touch with your organization within the next few days via email to advise regarding your required completion of the e-snaps application for this project. Otherwise, should you have any questions concerning this ranking, please contact Patrick Sullivan at PatrickS@newbedford-ma.gov.

Respectfully,

Jennifer Clarke, AICP
Deputy Director

City of New Bedford
Office of Housing & Community Development
608 Pleasant Street | New Bedford, Massachusetts 02740
Telephone: (508) 979.1500 Facsimile: (508) 979.1575

Patrick J. Sullivan
DIRECTOR

October 21, 2021

Susan Mazzarella, M.A., L.S.W.
Chief Executive Officer
Catholic Social Services
1600 Bay Street
P.O. Box M/So. Station
Fall River, MA 02724

RE: APPLICATION FOR COC RENEWAL
PRISM

Dear Ms. Mazzarella:

This letter is intended to formally advise you that the above-captioned proposal submitted for funding consideration in this year's Continuum of Care (CoC) competition in New Bedford was ranked at the October Homeless Service Provider's Network (HSPN) meeting held on Thursday, October 21, 2019.

The HSPN's Performance Review Committee (PRC) met and conducted reviews and evaluations of all proposals submitted for consideration in this year's 2021 CoC Funding Competition. The PRC's recommendation for project ranking to the HSPN membership included scoring for each of the proposals submitted. The resulting scoring was such that the PRISM project ranked as seventh overall in the CoC's ranking.

As a result, CSS' proposed renewal program will be included in this year's New Bedford CoC application as a project in Tier 1 at an amount of $123,296.

Staff from this office will be in touch with your organization within the next few days via email to advise regarding your required completion of the e-snaps application for this project. Otherwise, should you have any questions concerning this ranking, please contact Patrick Sullivan at PatrickS@newbedford-ma.gov.

Respectfully,

Jennifer Clarke, AICP
Deputy Director

City of New Bedford
Office of Housing & Community Development
608 Pleasant Street | New Bedford, Massachusetts 02740
Telephone: (508) 979.1500 Facsimile: (508) 979.1575

Patrick J. Sullivan
DIRECTOR

October 21, 2021

Kathleen Schedler-Clark, Executive Director
Steppingstone, Inc.
522 North Main Street
Fall River, MA 02720-3509

RE: APPLICATION FOR COC NEW EXPANSION PROJECT
WELCOME HOME EXPANSION

Dear Ms. Schedler-Clark:

This letter is intended to formally advise you that the above-captioned proposal submitted for funding consideration in this year's Continuum of Care (CoC) competition in New Bedford was ranked at the October Homeless Service Provider's Network (HSPN) meeting held on Thursday, October 21, 2021.

The HSPN's Performance Review Committee (PRC) met and conducted reviews and evaluations of all proposals submitted for consideration in this year's 2021 CoC Funding Competition. The PRC's recommendation for project ranking to the HSPN membership included scoring for each of the proposals submitted. The resulting scoring was such that the WELCOME HOME EXPANSION project ranked as eighth overall in the CoC's ranking.

As a result, Steppingstone's proposed new expansion program will be included in this year's New Bedford CoC application as a project in Tier 1 at an amount of $84,312.

Staff from this office will be in touch with your organization within the next few days via email to advise regarding your required completion of the e-snaps application for this project. Otherwise, should you have any questions concerning this ranking, please contact Patrick Sullivan at PatrickS@newbedford-ma.gov.

Respectfully,

Jennifer Clarke, AICP
Deputy Director

City of New Bedford
Office of Housing & Community Development
608 Pleasant Street | New Bedford, Massachusetts 02740
Telephone: (508) 979.1500 Facsimile: (508) 979.1575

Patrick J. Sullivan
DIRECTOR

October 21, 2021

Wendy Bluis, Program Director
SEMCOA, Inc.
72 Kilburn Street
New Bedford, MA 02740

RE: APPLICATION FOR COC NEW EXPANSION PROJECT
FAMILY PRESERVATION PROGRAM EXPANSION

Dear Ms. Bluis:

This letter is intended to formally advise you that the above-captioned proposal submitted for funding consideration in this year's Continuum of Care (CoC) competition in New Bedford was ranked at the October Homeless Service Provider's Network (HSPN) meeting held on Thursday, October 21, 2021.

The HSPN's Performance Review Committee (PRC) met and conducted reviews and evaluations of all proposals submitted for consideration in this year's 2021 CoC Funding Competition. The PRC's recommendation for project ranking to the HSPN membership included scoring for each of the proposals submitted. The resulting scoring was such that the FAMILY PRESERVATION PROGRAM EXPANSION project ranked as ninth overall in the CoC's ranking.

As a result, SEMCOA's proposed new expansion program will be included in this year's New Bedford CoC application as a project in Tier 1 at an amount of $84,313.

Staff from this office will be in touch with your organization shortly via email to advise regarding your required completion of the e-snaps application for this project. Otherwise, should you have any questions concerning this ranking, please contact Patrick Sullivan at PatrickS@newbedford-ma.gov.

Respectfully,

Jennifer Clarke, AICP
Deputy Director

City of New Bedford
Office of Housing & Community Development
608 Pleasant Street | New Bedford, Massachusetts 02740
Telephone: (508) 979.1500 Facsimile: (508) 979.1575

Patrick J. Sullivan
DIRECTOR

October 21, 2021

Joshua Amaral, Assistant Executive Director
PACE
166 William Street
New Bedford, MA 02740

RE: APPLICATION FOR COC NEW PROJECT
GREEN LIGHT

Dear Mr. Amaral:

This letter is intended to formally advise you that the above-captioned proposal submitted for funding consideration in this year's Continuum of Care (CoC) competition in New Bedford was ranked at the October Homeless Service Provider's Network (HSPN) meeting held on Thursday, October 21, 2021.

The HSPN's Performance Review Committee (PRC) met and conducted reviews and evaluations of all proposals submitted for consideration in this year's 2021 CoC Funding Competition. The PRC's recommendation for project ranking to the HSPN membership included scoring for each of the proposals submitted. The resulting scoring was such that the GREEN LIGHT project ranked as tenth overall in the CoC's ranking.

As a result, PACE's proposed new program will be included in this year's New Bedford CoC application as a project in Tier 2 at an amount of $96,309.

Staff from this office will be in touch with your organization within the next few days via email to advise regarding your required completion of the e-snaps application for this project. Otherwise, should you have any questions concerning this ranking, please contact Patrick Sullivan at PatrickS@newbedford-ma.gov.

Respectfully,

Jennifer Clarke, AICP
Deputy Director

Attachment 1E-6

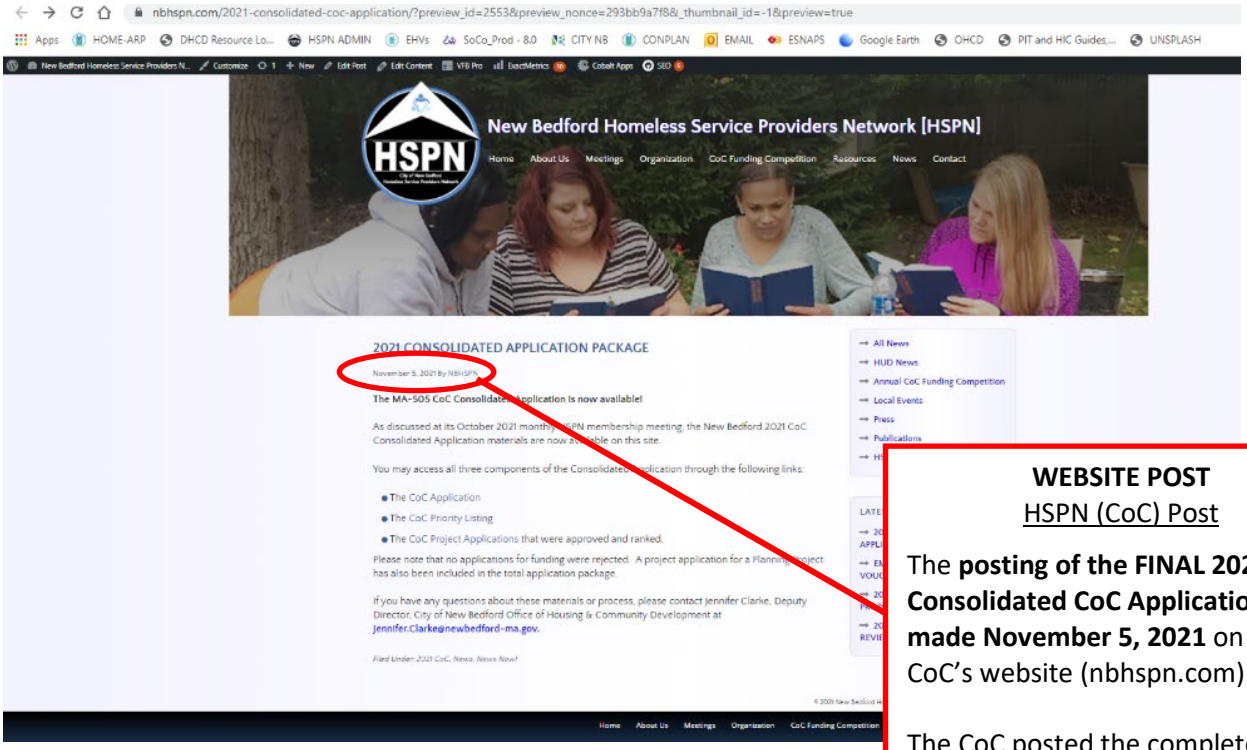
New Bedford Continuum of Care
MA-505

Web Posting-CoC Approved
Consolidated Application

Evidence of Posting

Website posting showing November 5, 2021 release of local competition material (RFP)

Posted November 5, 2021 at https://www.nbhspn.com/2021-consolidated-coc-application/



WEBSITE POST

HSPN (CoC) Post

The **posting of the FINAL 2021 Consolidated CoC Application was made November 5, 2021** on the CoC's website (nbhspn.com).

The CoC posted the complete Consolidated Application, Priority Listing and Individual Project applications as well as its Planning Application on its website in this location.

Attachment 3A-1a

New Bedford Continuum of Care
MA-505

Housing Leveraging Commitments

N/A

This year's new projects did not provide project leveraging commitments.

Attachment 3A-2a

New Bedford Continuum of Care
MA-505

Healthcare Formal Agreements

Note:

Included in this attachment are healthcare leverage commitments for the three new projects included in the submission of materials:

1. ***Welcome Home Expansion***
   - *Project FAIHR SAMHSA*
2. ***Family Preservation Expansion***
   - *Arbour Hospital*
   - *Morton Hospital*
3. ***Green Light***
   - *Commonwealth Health Insurance Connector Authority*

October 26, 2021

Kathleen Schedler-Clark Executive Director Steppingstone, Inc.
522 N. Main St.
Fall River, MA 02720 Dear Ms. Schedler-Clark,

I am providing this letter of commitment to document that Steppingstone's Project FAIHR will provide access to treatment and recovery services for all participants of the Welcome Home Expansion project who qualify and choose to participate in services. Project FAIHR provides treatment for homeless persons with co-occurring mental health and substance use disorders which is integrated with housing and wrap-around services.

FAIHR receives funding from the U.S. Substance Abuse and Mental Health Services Agency (SAMHSA). These healthcare resources will be provided from 08/01/2022 to 07/31/2023. The value of these resources is equivalent to $21,078. These healthcare resources will be available to all persons participating in the new expansion project. No person participating in the new Welcome Home Expansion project will be denied this health care.

Sincerely,

DocuSigned by:
Michael Hughes
70E22A25473A47F...

Michael Hughes
Project Director
Project FAIHR

High Point
& Affiliated Organizations

Ingatient Services

Detoxification Services (ATS)
Dual Diagnosis Unit (DDU)
Clinical Stabilization Services (CSS)

Section 35 Services

Men's Addiction Treatment Center
Women's Addiction Treatment Center

Outpatient & Community Services

Adolescent & Adult Counseling
Adolescent Community Reinforcement Approach (A-CRA)
Brockton Area Prevention Collaborative
Certified Community Behavioral Health Clinic (CCBHC)
Children's Behavioral Health Initiative (CBHI)
Community-Based Recovery Services (CBRS)
Coordinated Care Network (CCN)
Domestic Violence Services
Family Emergency Shelter Services
Healthy Families
Home-Based Counseling
Intimate Partner Abuse Education Program (IPAEP)
Massachusetts Impaired Driving (MID)
Medication Management
Office-Based Opioid Treatment (OBOT)
Opioid Treatment Program (OTP)
Prevention Services
Project AMP
REACH
Recovery Coach Services
Road to Healing
School-Based Services
South Shore Resource & Advocacy Center
Structured Outpatient Addiction Program
Substance Abuse Prevention Collaborative
Surviving Homicide's Aftermath: Resources, Education, Support (SHARES)
Telehealth Services

Residential & Shelter Services

Transitional Support Services (TSS)
Graduate House
Harmony House
Monarch House
New Chapters
Unity House
WRAP House

Fall River Family Center
Harbour House Family Center
Taunton Family Center

ily Preservation Program (FPP)
Affordable Housing

SFS SEMCOA

As of September 2020

Date of Contract: 04/2021

AGREEMENT OF LINKAGE
BETWEEN

High Point Treatment Center dba High Point and its affiliate organization SEMCOA, Inc.

AND

Arbour Hospital

The above named parties hereby sign this linkage agreement in cooperative recognition of the need to develop a continuum of care in the treatment of substance use and other health issues; to establish, strengthen, and improve the quality of services provided to patients/clients and their families/significant others.

In recognizing the need for and in appreciation of the opportunity of promoting a cooperative inter-agency network, High Point and its affiliate hereby agree to accept referrals from Arbour Hospital, which are appropriate to our stated philosophy, purpose, and programs. Said programs can include services as listed to the left side of this sheet.

Arbour Hospital hereby agrees to accept referrals from High Point and its affiliate of those persons appropriate to its stated philosophy, purpose, and programs as listed on the attached linkage summary sheet.

Both agencies agree to abide by federal, state, and program standards dealing with clients and their right to confidentiality. When appropriate, referrals will include documentation necessary to provide a continuum of care for the patient/client. Furthermore, both agencies acknowledge that in receiving, transmitting, transporting, storing, processing, or otherwise dealing with any information received from both agencies relating to clients in the program ("protected information"), they are fully bound by the provisions of the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part II and the Health Insurance Portability and Accountability Act ("HIPAA"), 45 CFR Parts 142, 160, 162, and 164. They may not use nor disclose the information except as permitted or required by this agreement or by law.

Entry into our respective programs will not be denied any individual based on race, color, creed, national origin, sex, and/or sexual preference. Responsibility for the coordination of this affiliation rests with the respective representatives of the affiliating parties. This agreement is in effect for a two (2) year period at which time renewal of this agreement will be renegotiated between both agencies.

CEO
Signature & Title

Jaeson Pinette CEO
Name & Title Printed

Address: 49 Robinwood Ave
Jamaica Plain MA 02130

Telephone: 617-390-1412

Daniel S. Mumbauer
Signature & Title/High Point

Daniel S. Mumbauer, President & CEO

72 Kilburn Street
New Bedford, MA 02740

(774) 628-1007

Agency Name **Arbour Hospital** Address: 49 Robinwood Avenue, Jamaica Plain, MA 02130-2156
Telephone: _____ TTY Telephone #: _____
Contact Name: _____ Title: _____
Agreement Expiration Date: 04-2023
Is your agency accessible to individuals with disabilities? ___ Yes ___ No

Services Offered:

Emergency Medical Treatment	
Inpatient Medical Treatment	
Inpatient Psychiatric Services	✓

Substance use	Adolescents	Adults
Inpatient Detoxification		✓
Outpatient Detoxification		
Outpatient Substance use Counseling		✓
Day/Evening Treatment		✓
Structured Outpatient Addiction Program		✓
Intensive Outpatient Treatment		✓
Group Therapy		
Home-Base Therapy		
Intervention Services		
Halfway House		
Sober House		
Women's Specialized Track/Services		

Mental Health		
Inpatient		✓
Outpatient		✓
Day/Evening Treatment		✓
Intensive Outpatient Treatment		✓
Group Therapy		
Halfway House		
Sober House		
Women's Specialized Track/Services		

Please list all available groups offered:

	Substance use	Mental Health
1.	IOP & PHP	Psychotherapy
2.		Behavioral Therapy
3.		Group Therapy
		Medication Mgmt
		Family Education

PHP

Bi-lingual services?	No ✓	Yes (please specify) ___
Medicaid:	No ___	Yes ✓
Medicare:	No ___	Yes ✓
Sliding fee offered?	No ___	Yes ✓
DPH-funded:	No ✓	Yes ___

Other services offered and/or additional comments: _____

SFS HIGH POINT SEMCOA

FAMILY PRESERVATION PROGRAM EXTENSION

High Point
& Affiliated Organizations

Inpatient Services

Detoxification Services (ATS)
Dual Diagnosis Unit (DDU)
Clinical Stabilization Services (CSS)

Section 35 Services

Men's Addiction Treatment Center
Women's Addiction Treatment Center

Outpatient & Community Services

Adolescent & Adult Counseling
Adolescent Community Reinforcement Approach (A-CRA)
Brockton Area Prevention Collaborative
Certified Community Behavioral Health Clinic (CCBHC)
Children's Behavioral Health Initiative (CBHI)
Community-Based Recovery Services (CBRS)
Coordinated Care Network (CCN)
Domestic Violence Services
Family Emergency Shelter Services
Healthy Families
Home-Based Counseling
Intimate Partner Abuse Education Program (IPAEP)
Massachusetts Impaired Driving (MID)
Medication Management
Office-Based Opioid Treatment (OBOT)
Opioid Treatment Program (OTP)
Prevention Services
Project AMP
REACH
Recovery Coach Services
Road to Healing
School-Based Services
South Shore Resource & Advocacy Center
Structured Outpatient Addiction Program
Substance Abuse Prevention Collaborative
Surviving Homicide's Aftermath: Resources, Education, Support (SHARES)
Telehealth Services

Residential & Shelter Services

Transitional Support Services (TSS)
Graduate House
Harmony House
Monarch House
New Chapters
Unity House
WRAP House

Full River Family Center
Harbour House Family Center
Taunton Family Center

Family Preservation Program (FPP)
Affordable Housing

SFS SEMCOA

As of September 2020

Date of Contract: July 1, 2021

AGREEMENT OF LINKAGE
BETWEEN

High Point Treatment Center dba High Point and its affiliate organization SEMCOA, Inc.

AND

Morton Hospital

The above named parties hereby sign this linkage agreement in cooperative recognition of the need to develop a continuum of care in the treatment of substance use and other health issues; to establish, strengthen, and improve the quality of services provided to patients/clients and their families/significant others.

In recognizing the need for and in appreciation of the opportunity of promoting a cooperative inter-agency network, High Point and its affiliate hereby agree to accept referrals from Morton Hospital, which are appropriate to our stated philosophy, purpose, and programs. Said programs can include services as listed to the left side of this sheet.

Morton Hospital hereby agrees to accept referrals from High Point and its affiliate of those persons appropriate to its stated philosophy, purpose, and programs as listed on the attached linkage summary sheet.

Both agencies agree to abide by federal, state, and program standards dealing with clients and their right to confidentiality. When appropriate, referrals will include documentation necessary to provide a continuum of care for the patient/client. Furthermore, both agencies acknowledge that in receiving, transmitting, transporting, storing, processing, or otherwise dealing with any information received from both agencies relating to clients in the program ("protected information"), they are fully bound by the provisions of the federal regulations governing the Confidentiality of Alcohol and Drug Abuse Patient Records, 42 CFR Part II and the Health Insurance Portability and Accountability Act ("HIPAA"), 45 CFR Parts 142, 160, 162, and 164. They may not use nor disclose the information except as permitted or required by this agreement or by law.

Entry into our respective programs will not be denied any individual based on race, color, creed, national origin, sex, and/or sexual preference. Responsibility for the coordination of this affiliation rests with the respective representatives of the affiliating parties. This agreement is in effect for a two (2) year period at which time renewal of this agreement will be renegotiated between both agencies.

Heidi Taylor, President
Signature & Title

Daniel S. Mumbauer
Signature & Title/High Point

Heidi Taylor, President
Name & Title Printed

Daniel S. Mumbauer, President & CEO

Address: Morton Hospital
88 Washington Street
Taunton, MA 02780

72 Kilburn Street
New Bedford, MA 02740

Telephone: 508-828-7003

(774) 628-1007

LINKAGE SUMMARY SHEET

Agency Name: **Morton Hospital**
Telephone: 508-828-7000
Contact Name: Lynn Davis
Agreement Expiration Date: 07-2023
Is your agency accessible to individuals with disabilities? ✓ Yes ___ No

Address: 88 Washington Street, Taunton, MA 02780
TTY Telephone #: 508-828-7385
Title: Director, Care Management

Services Offered:

Emergency Medical Treatment	✓
Inpatient Medical Treatment	✓
Inpatient Psychiatric Services	✓

Substance use	Adolescents	Adults
Inpatient Detoxification		
Outpatient Detoxification		
Outpatient Substance use Counseling		
Day/Evening Treatment		
Structured Outpatient Addiction Program		
Intensive Outpatient Treatment		
Group Therapy		
Home-Base Therapy		
Intervention Services		
Halfway House		
Sober House		
Women's Specialized Track/Services		

Mental Health		
Inpatient		✓ geriatric
Outpatient		✓
Day/Evening Treatment		
Intensive Outpatient Treatment		
Group Therapy		
Halfway House		
Sober House		
Women's Specialized Track/Services		

Please list all available groups offered:

Substance use	Mental Health
1.	1.
2.	2.
3.	3.

Bi-lingual services?	No ___	Yes (please specify) all languages
Medicaid:	No ___	Yes ✓
Medicare:	No ___	Yes ✓
Sliding fee offered?	No ___	Yes ___
DPH-funded:	No ✓	Yes ___

Other services offered and/or additional comments: ___

AMENDMENT 2 TO THE NAVIGATOR AGREEMENT BETWEEN THE COMMONWEALTH HEALTH INSURANCE CONNECTOR AUTHORITY AND PEOPLE ACTING IN COMMUNITY ENDEAVORS (PACE), INC.

WHEREAS, the Commonwealth Health Insurance Connector Authority ("Authority"), with a principal place of business at 100 City Hall Plaza, Boston, MA 02108, and People Acting in Community Endeavors (PACE), Inc. ("Navigator Organization"), with a principal place of business at 166 William Street, New Bedford, Massachusetts, 02740 (collectively the "Parties") entered into a Navigator Agreement effective July 1, 2020, under which Navigator Organization agreed to provide certain Navigator Grant Activities, and amended effective October 1, 2020 to append Attachment V, and this Agreement expires on June 30, 2022;

WHEREAS, the Authority gave timely notice to Navigator Organization of its desire to extend Navigator Organization's provision of additional services pursuant to Section I.E. of Attachment V to the Agreement, and Navigator Organization provided written notice of its desire to perform such services;

NOW THEREFORE, the Parties hereby agree to amend Attachment V of the Agreement effective October 1, 2021, as follows:

1. The title of Attachment V is amended by replacing the figure "2021" with "2022"

2. Section I.A. is amended by replacing the final sentence, "Navigator Organization shall offer that additional capacity throughout Open Enrollment 2020-2021 (November 1, 2020-January 23, 2021), and during any additional timeframes identified in **Section I.B.** of Attachment V." with the following sentence:

   > Navigator Organization shall offer that additional capacity throughout Open Enrollment 2020-2021 (November 1, 2020-January 23, 2021), Open Enrollment 2021-2022 (November 1, 2021-January 23, 2022), and during any additional timeframes identified in **Section I.B.** of Attachment V.

3. Section I.B. is amended by inserting at the end thereof the following:

   Pre- Open Enrollment 2021-2022 (November 1, 2021-January 23, 2022) timeframe:
   1. Total # of New Applications Submitted: 3
   2. Total # of Health Connector Enrollments Completed: 3
   3. Total # of Consumers Assisted with Maintaining Health Connector Coverage: 6

   Open Enrollment 2021-2022 (November 1, 2021-January 23, 2022) timeframe:
   1. Total # of New Applications Submitted: 20
   2. Total # of Health Connector Enrollments Completed: 15
   3. Total # of Consumers Assisted with Maintaining Health Connector Coverage: 50

   Post Open Enrollment 2022 (January 24, 2022-June 30, 2022) timeframe:
   1. Total # of New Applications Submitted: 15

2. Total # of Health Connector Enrollments Completed: 10
3. Total # of Consumers Assisted with Maintaining Health Connector Coverage: 50

4. Section I.C. is amended by deleting that section and replacing it with the following:

C. Additional Capacity Grant. The Connector hereby awards these grants to People Acting in Community Endeavors (PACE), Inc. ("Navigator Organization") in an amount of $96,243 for the performance of the scope of work described in Section I.B. of this Attachment V. The Additional Capacity Grant performance period shall be from October 1, 2020 through June 30, 2022 ("Additional Capacity Grant End Date").

5. Section I.D. is amended by replacing the first sentence "The award amount of $54,996 will be disbursed in four equal installments payable at the conclusion of each timeframe listed in Section I.B. of this Attachment V." with the following sentence:

An award amount equal to $54,996 will be disbursed in equal installments payable at the conclusion of each timeframe listed in Section I.B. of this Attachment V that occurs prior to October 1, 2021, and an award amount equal to $41,247 will be disbursed in equal installments payable at the conclusion of each timeframe listed in Section I.B. of this Attachment V that occurs after September 30, 2021.

6. Section II. Is amended by inserting at the end thereof the following:

Date Issued	October 1, 2021
Grant Period	October 1, 2021-June 30, 2022
Grant Number	014
Grantee Name	People Acting in Community Endeavors (PACE), Inc.
Grantee Address	166 William Street, New Bedford, Massachusetts, 02740
Grantee Project Director	Ginny DeSilva

Total # of Navigator Organization Grant Hours	1,428
Grant Award Amount for Additional Capacity	$ 41,247.00

7. All other provisions of the Agreement shall remain in effect as originally written.

IN WITNESS WHEREOF, the Parties have caused this Amendment to be executed as a document under seal.

On behalf of:
Commonwealth Health Insurance Connector Authority

By: _____

Name: Louis Gutierrez

Title: Executive Director

Dated: 9/27/2021

On behalf of:
People Acting in Community Endeavors (PACE), Inc.

By: _____

Name: Joshua Amaral

Title: Assistant Exec. Director

Dated: 9/17/2021

Attachment 3C-2

New Bedford Continuum of Care
MA-505

Project List for Other Federal Statutes

NOTE:

Not applicable.