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

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

- CoC Consolidated Application - CoC Project Listings

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

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

For Detailed Instructions click here.

1A. Continuum of Care (CoC) Identification

Instructions:

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

CoC Name and Number (From CoC Registration): (dropdown values will be changed)	CO-504 - Colorado Springs/El Paso County CoC
Collaborative Applicant Name:	City of Colorado Springs, Colorado
CoC Designation:	CA

1B. Continuum of Care (CoC) Operations

Instructions:

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

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

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

Name of CoC Structure: Homeward Pikes Peak

How often does the CoC conduct open meetings? Monthly

Are the CoC meetings open to the public? Yes

Is there an open invitation process for new members? Yes

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

We maintain a distribution list of over 350 people (and constantly growing) covering all types of organizations and individuals in the community. All open meetings are announced using this distribution list and we actively encourage all members to share broadly. Word of mouth regularly brings new organizations and individuals to the meetings. In addition, our local newspaper regularly carries articles about issues and activities, and an invitation to get involved along with contact information is regularly provided.

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

Does the CoC provide

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

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

We are currently developing the coordinated intake & assessment process. We have a new statewide (3 CoC's) HMIS; our vendor has shown us two clients' already implemented processes which include a common set of assessment & basic program eligibility questions as well as a single CoC-wide client wait list & available beds list. Our CoC's coordinated process will be implemented before the end of calendar 2013 & will include 1 (or limited) points of entry, common intake/assessment/assignment forms & processes as well as shared client data (at least universal data elements). This year we initiated a statewide HMIS committee to address process & data needs at a state level & are working together to develop processes that are as much alike as possible while meeting our individual CoC needs. Metro-Denver is taking the lead on sharing & coordinated intake/assessment; Colorado Springs is taking the lead on using HMIS for all of our PIT data (including the unsheltered surveys).

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

CoC meetings have written agendas which are communicated ahead of time using the CoC general distribution list. Agendas are kept on file with the attendance record (which includes attendee name, organization, & contact information).
ESG projects are monitored monthly or quarterly via desk audit to ensure that all documentation for expenditure requests are adequate & meet the guidelines & intent of the program & fulfill the contract requirements between the agency & the City of Colorado Springs. If no problems or concerns exist with the agency an annual site visit is conducted. If risk factors are determined via desk audit, multiple site visits can occur during the contract period to ensure that all guidelines & any changes required as a result of monitoring have been implemented. All projects (CoC & ESG) are included in the monthly data quality & performance reviews.
Note: all of our CoC policies, procedures, agreements, &forms are under review to ensure full compliance with HEARTH.

Does the CoC have the following written and approved documents:

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

1C. Continuum of Care (CoC) Committees

Instructions:

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

Committees and Frequency:

Name of Group	Role of Group (limit 750 characters)	Meeting Frequency
Strategic Planning Committee	Primary oversight/decision-making body for the CoC. Comprised of reps from all provider & service-type sectors (see Structure & Membership attachments). Responsible for development & approval of CoC structure, policies & procedures, project ranking, 10-year plan & performance goals, priorities, etc. Responsible for reviewing/approving the work of and recommendations made by the sub-committees, and reviewing/monitoring project & CoC performance. Will complete the review/revision of the CoC governance & policies/procedures documents this year. HEARTH Implementation Review sub-committee is responsible for reviewing all federal documents & determining areas needing development/improvement in order to meet requirements.	Monthly or more
Monitoring & Review Committee	Reviewed project performance (APR's & data quality, completeness, & utilization) and created project ranking (using a pilot rubric). Ongoing: participate in setting of CoC and project performance goals; determine needs for regular HMIS reporting; review project and CoC performance monthly; review APR's and project performance vs. goals; identify areas needing attention and communicate to Strategic Planning Committee; modify project ranking process based on feedback/results from this year.	Monthly or more
CMS (HMIS) Advisory Committee	Establishes and maintains policies and procedures, and minimum data requirements; monitors data quality & completeness; reviews/approves baseline forms and documents; reviews system updates; sets upgrade/development priorities; provides general oversight of HMIS function and usage in the CoC; ensures implementation and meeting of standards and requirements. This committee is now providing inputs on needs and priorities to the Colorado CIS which is a new statewide effort to address data and process needs at a state level, and will participate in the development of the coordinated intake and assessment processes. All HMIS policies, procedures, forms, and plans are under review/development.	Monthly or more

Housing Committee & Sub-committees	This committee has a primary focus this year. We have more than enough TH and not enough PH and affordable housing, but limited resources for converting and created new housing. Sub-committees for each housing type (ES, TH, PH, Affordable) are gathering information, assessing needs, identifying groups needed at the table (including public organizations, businesses, and funders), and developing strategies for moving our inventory to what is needed in a methodical manner while protecting existing clients and helping organizations prepare for and execute the necessary changes.	Bi-monthly
CHAP (Community Homeless Assistance Providers)	The CHAP meets monthly with an open agenda designed to facilitate discussion of the most pressing needs of the community as well as addressing the formal requirements of the CoC. Training, such as accessing mainstream resources, is regularly provided in this meeting. Introductions to new programs and/or organizations are covered here. People are recruited for the other CoC committees though participation in CHAP is not a requirement for involvement in the other committees. Everyone in the community is welcome; all are encouraged to participate and invite new people/organizations.	Monthly or more

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

Not applicable

1D. Continuum of Care (CoC) Member Organizations

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

Membership Type
Public Sector
Private Sector
Individual

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

Instructions:

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

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

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

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

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

Number of Public Sector Organizations Represented in Planning Process

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

Number of Public Sector Organizations Serving Each Subpopulation

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

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

Number of Public Sector Organizations Participating in Each Role

	Law Enforcement/ Corrections	Local Government Agencies	Local Workforce Investment Act Boards	Public Housing Agencies	School Systems/ Universities	State Government Agencies	Other
Roles							
Committee/Sub-committee/Work Group	3	14	1	1	1	4	1
Authoring agency for consolidated plan	0	3	0	0	0	0	0
Attend consolidated plan planning meetings during past 12 months	0	7	0	1	0	1	0
Attend consolidated plan focus groups/ public forums during past 12 months	0	2	0	0	0	0	0
Lead agency for 10-year plan	0	2	0	0	0	0	0
Attend 10-year planning meetings during past 12 months	3	5	1	1	1	4	1
Primary decision making group	3	5	1	1	1	3	1

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

Instructions:

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

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

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

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

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

Number of Private Sector Organizations Represented in Planning Process

	Businesses	Faith-Based Organizations	Funder Advocacy Group	Hospitals/ Med Representatives	Non-Profit Organizations	Other
Total Number	6	21	4	4	37	1

Number of Private Sector Organizations Serving Each Subpopulation

	Businesses	Faith-Based Organizations	Funder Advocacy Group	Hospitals/ Med Representatives	Non-Profit Organizations	Other
Subpopulations						
Seriously mentally ill	0	1	0	1	7	1
Substance abuse	1	5	0	1	8	1
Veterans	0	0	0	0	7	1
HIV/AIDS	0	0	0	0	2	0
Domestic violence	0	2	0	0	5	0
Children (under age 18)	0	1	0	1	6	0
Unaccompanied youth (ages 18 to 24)	0	1	0	1	4	0

Number of Private Sector Organizations Participating in Each Role

	Businesses	Faith-Based Organizations	Funder Advocacy Group	Hospitals/ Med Representatives	Non-Profit Organizations	Other
Roles						
Committee/Sub-committee/Work Group	6	21	4	4	37	1
Authoring agency for consolidated plan	0	0	0	0	0	0
Attend consolidated plan planning meetings during past 12 months	0	3	0	0	9	0
Attend Consolidated Plan focus groups/ public forums during past 12 months	0	0	0	0	3	0
Lead agency for 10-year plan	0	0	0	0	2	0

Attend 10-year planning meetings during past 12 months	4	6	1	3	14	0
Primary decision making group	2	6	0	3	14	0

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

Instructions:

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

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

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

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

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

Number of Individuals Represented in Planning Process

	Homeless	Formerly Homeless	Other
Total Number	0	5	10

Number of Individuals Serving Each Subpopulation

	Homeless	Formerly Homeless	Other
Subpopulations			
Seriously mentally ill	0	0	1
Substance abuse	0	3	1
Veterans	0	0	2

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

Number of Individuals Participating in Each Role

	Homeless	Formerly Homeless	Other
Roles			
Committee/Sub-committee/Work Group	0	5	10
Authoring agency for consolidated plan	0	0	0
Attend consolidated plan planning meetings during past 12 months	0	0	0
Attend consolidated plan focus groups/ public forums during past 12 months	0	0	0
Lead agency for 10-year plan	0	0	0
Attend 10-year planning meetings during past 12 months	0	3	3
Primary decision making group	0	3	1

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

Instructions:

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

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

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

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

Because of the significant changes this year, we used an “open book” method. All current recipients & new applicants together evaluated all projects: APR’s, HMIS participation & data quality/completeness, bed utilization, program goals vs. performance. We had no CoC or HUD findings or unexecuted grants to review. Current & proposed projects were reviewed for readiness, experience, organizational capacity & CoC participation. Consensus ranking was developed to meet current needs & position for future changes. Alternate plans decided if new projects (bonus housing & CoC planning) not awarded. Ranking presented to & approved by Strategic Planning Committee. Match requirements &leverage documents were reviewed & confirmed in esnaps submittal.

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

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

The Strategic Planning Committee determines the priorities for the application year and issues an open invitation to submit letters of interest. This is communicated at the monthly general meeting and sent to the entire general distribution by email. Interested parties are invited to contact the CoC leads. If needed, specific organizations are contacted. Application and review processes are explained, and all applicants are assisted throughout the process. Resources (HUD HRE, etc.) are communicated to the general membership as well as the specific applicant list. This year, the entire process included all applicants so feedback was immediate. CoC leadership is always available for private conversation as needed.

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

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

Not applicable

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

Instructions:

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

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

Emergency Shelter: Yes

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

Total ES beds decreased by 12 based on changes in two programs. 1) A VA program moved 2 beds to TH. 2) We have a motel-based program which changed focus to accommodate an increase in homeless families with children which we experienced due to persistent unemployment. With children, there is less flexibility in unit configuration. This is a non-HUD funded program and they also experienced a decrease in funding, so had to use fewer units at the motel. The combined effect resulted in a loss of 10 beds.

HPRP Beds: Yes

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

Total HPRP beds decreased by 42 beds due to the expenditure of all of our HPRP funds. In 2011, we have had 3 organizations active in HPRP which were done by January 2012. Note that this is a temporary decrease as our SSVF program came on-line and will be reflected in the 2013 HIC. They had a wait-list of clients in January 2012 but had not housed anyone with the funds. When they started entering data into HMIS, they backed up to the beginning of the program in order to capture data for all clients served. In addition, we will see more beds as the ESG-funded programs become active.

Safe Haven: No

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

Not applicable - we don't have any Safe Haven beds

Transitional Housing: Yes

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

Total TH beds increased by 33 beds. 2 beds under development were added with a new HUD grant. 6 beds were added during the VA-HIC reconciliation when new treatment beds were reported. The remainder was due to increases in family size or adding beds in order to accommodate increased demand, mostly in our private faith-funded programs. Our biggest HUD-funded program increased in 2012 due to family size, but will decrease in 2013 as 5 units were converted to create more affordable permanent housing. In this program, one unit was transition-in-place in 2012 and at least one more will be transition-in-place in 2013.

Did any projects within the CoC utilize transition in place; i.e., participants in transitional housing units transitioned in place to permanent housing?	Yes
If yes, how many transitional housing units in the CoC are considered "transition in place":	1

Permanent Housing: Yes

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

Total PH beds increased by 1, but there were changes within the number. 4 units under development came available. One PSH program converted some individual units to family units as the VASH program targeted more CH individuals. Total CH bed count decreased significantly because the VASH beds were incorrectly reported as all CH beds in the 2011 HIC when only about half of them were actually CH. We also expected more VASH vouchers to become active but did not list them in the HIC last year because the case management portion was not confirmed at that time. More details on the VASH-related items are provided in the objectives and achievements sections.

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

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

Instructions:

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

Did the CoC submit the HIC data in HDX by April 30, 2012?	Yes
If 'No', briefly explain why the HIC data was not submitted by April 30, 2012 (limit 750 characters)	Not applicable
Indicate the type of data sources or methods used to complete the housing inventory count (select all that apply):	HMIS plus housing inventory survey
Indicate the steps taken to ensure the accuracy of the data collected and included in the housing inventory count (select all that apply):	Follow-up, Updated prior housing inventory information, Training, Instructions, HMIS, Confirmation

Must specify other:

Not applicable

Indicate the type of data or method(s) used to determine unmet need (select all that apply):	Provider opinion through discussion or survey forms, Unsheltered count, HMIS data, Stakeholder discussion, Housing inventory

Specify "other" data types:

Not applicable

If more than one method was selected, describe how these methods were used together (limit 750 characters)

Through provider/stakeholder discussions (CHAP, HMIS Advisory Committee, Homeward Pikes Peak, and city and county housing & community development organizations), we reviewed our PIT (sheltered & unsheltered), HIC, and HMIS data, including the utilization reports. We took into account agency wait lists and capacity to take new clients, SSVF funds and VASH vouchers becoming available, and our local economic situation including our unemployment rate (higher than the national and state average) and our apartment and affordable housing stock (consistently over 95% occupancy). We are continuing to evaluate and execute a reduction of transitional housing in favor of more prevention and permanent housing.

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

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

Select the HMIS implementation coverage area:	Single CoC
Select the CoC(s) covered by the HMIS (select all that apply):	CO-504 - Colorado Springs/El Paso County CoC
Is there a governance agreement in place with the CoC?	Yes
If yes, does the governance agreement include the most current HMIS requirements?	No

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

We do have an agreement in place but it was signed in 2009 and is now under review/revision to meet the new requirements. Note that we have a statewide HMIS system, but with CoC control over implementation which is why we selected “Single CoC” for the HMIS implementation coverage area. Our goal though is to be as consistent as possible statewide in order to facilitate statewide sharing and reporting. We are in the early stage of discussion on sharing client demographic information at the state level. We have agreement in principle and are working on the detailed policy and procedure changes. As a result we will update our document to cover the new requirements as well as the future plans for statewide efforts. The old version is attached at the end of the application.

Does the HMIS Lead Agency have the following plans in place?	Data Quality Plan, Privacy Plan, Security Plan

Has the CoC selected an HMIS software product?	Yes
If 'No', select reason:	
If 'Yes', list the name of the product:	Adaptive Enterprise Solutions
What is the name of the HMIS software company?	Adsystech, Inc.
Does the CoC plan to change HMIS software within the next 18 months?	No
Indicate the date on which HMIS data entry started (or will start): (format mm/dd/yyyy)	12/01/2005
Indicate the challenges and barriers impacting the HMIS implementation (select all the apply):	Other, Inadequate staffing

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

Not applicable

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

Our HMIS (Adsystech; conversion completed at the end of 2011) has much more functionality than our old system; it is more administrator-intensive in set-up complexity & level of effort for on-going support; & Adsystech is lagging in understanding & implementing HMIS requirements & reporting needed for the application process & CoC management. Most required reports such as APR and AHAR do exist, though HIC & PIT are incomplete, & we have identified areas where reports do not meet the 2010 data standard or other new requirements. Also, we are expanding use of HMIS for housing & service programs, & working to bring on VASH. We are addressing staffing through ESG funds that have been awarded & user fees for non-CoC programs; general user fees could be added in the next year or two as needed. Negotiations are underway to bring VASH onto HMIS. We are addressing the vendor & system issues through regular account meetings & intensive work with their technical support & development staff.

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

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

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

Operating Start Month/Year	July	2012
Operating End Month/Year	June	2013

Funding Type: Federal - HUD

Funding Source	Funding Amount
SHP	$200,353
ESG	$8,000
CDGB	$0
HOPWA	$0
HPRP	$0
Federal - HUD - Total Amount	$208,353

Funding Type: Other Federal

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

Funding Type: State and Local

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

Funding Type: Private

Funding Source	Funding Amount
Individual	$0
Organization	$80,200
Private - Total Amount	$80,200

Funding Type: Other

Funding Source	Funding Amount
Participation Fees	$7,000

Total Budget for Operating Year	$295,553

Is the funding listed above adequate to fully fund HMIS? No

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

The ESG funds only cover a partial year because of timing, so the annual amount will be higher. We are also awaiting a second ESG award from the State. User fees are under discussion to determine if, when, and how much. We are developing guidelines for agency and community requests (new data elements, new assessment forms/question, new reports, data analysis, etc.) that should be paid for rather than part of the current budget.

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

If Other, explain (limit 750 characters)

Not applicable

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

Instructions:

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

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

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

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

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

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

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

In the PH category, if the HUD VASH beds were included in the calculation, the coverage would drop to 62% as VASH is not yet participating. There are current discussions underway between the VA and AspenPointe (a local PH provider) to provide the data entry into HMIS for the VASH vouchers. In addition, the Housing Authority has begun data entry retro-active to October 2011, so when VASH comes on board, we will be at 100% coverage in PH beds.

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

Instructions:

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

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

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

Types of Services	Volume coverage percentage
Outreach	0%
Rapid Re-Housing	100%
Supportive Services	18%

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

Type of Housing	Average Length of Time in Housing (Months)
Emergency Shelter	35
Transitional Housing	135
Safe Haven	0

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

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

Universal Data Element	Records with no values (%)	Records where value is refused or unknown (%)
Race	0%	1%
Gender	0%	0%
Veteran status	0%	0%
Disabling condition	0%	2%
Residence prior to program entry	0%	4%
Zip Code of last permanent address	0%	3%
Housing status	0%	0%
Destination	0%	30%
Head of household	0%	0%

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

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

We worked with our vendor to develop counts of people (utilization) and data quality reports covering the universal and program-specific data elements. The reports are reviewed monthly at our HMIS advisory committee and Strategic Planning Committee (our CoC board) meetings. The summary reports are supported by program and client detail reports so that our agencies – and we – can dive into the details to make corrections. In addition to the monthly reviews, we add reviews focused on the required reports (AHAR, APR's, PIT, and HIC). Because of the complexity of HMIS, we still have to provide considerable 1-1 assistance either by providing lists of clients and/or providing tutorials on data correction and/or special-case documentation.

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

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

Not applicable

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

Indicate which reports the CoC submitted usable data (Select all that apply):	2012 AHAR Supplemental Report on Homeless Veterans, 2012 AHAR
Indicate which reports the CoC plans to submit usable data (Select all that apply):	2013 AHAR Supplemental Report on Homeless Veterans, 2013 AHAR

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

Instructions:

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

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

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

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

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

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

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

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

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

Instructions:

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

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

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

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

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

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

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

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

HMIS Lead Agency	X
Contributory HMIS Organizations (CHOs)	X

If 'Yes', indicate date of last review or update by CoC:	05/30/2012
If 'Yes', does the manual include a glossary of terms?	No
If 'No', indicate when development of manual will be completed (mm/dd/yyyy):	06/30/2013

2G. Homeless Management Information System (HMIS) Training

Instructions:

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

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

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

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

Instructions:

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

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

How frequently does the CoC conduct the its sheltered point-in-time count:	annually (every year)
Indicate the date of the most recent sheltered point-in-time count (mm/dd/yyyy):	01/24/2012
If the CoC conducted the sheltered point-in-time count outside the last 10 days in January, was a waiver from HUD obtained prior to January 19, 2012?	Not Applicable
Did the CoC submit the sheltered point-in-time count data in HDX by April 30, 2012?	Yes

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

Not applicable

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

Housing Type	Observation	Provider Shelter	Client Interview	HMIS
Emergency Shelters	0%	25%	0%	75%
Transitional Housing	0%	25%	0%	75%
Safe Havens	0%	0%	0%	0%

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

While 2 of 8 ES programs (1 DV and 1 non-HUD funded) and 4 of 16 TH programs (all non-HUD funded and 3 faith-based) do not use HMIS, all report Point In Time data so we have a reliable count. We had very little change in the sheltered count (851 in 2012 vs. 854 in 2011) because our total number of beds was also stable and utilization remained near capacity (92% in 2012 vs. 93% in 2011).

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

Need/Gap	Identified Need/Gap (limit 750 characters)
*** Housing**	Based on the unsheltered count and ES/TH/PH utilization, we showed a need for ES, TH, and PH beds in our unmet need chart. However, our entire housing model is under review. Our goals are to create more PH and affordable housing, reduce TH housing and shorten stays in ES and TH where it makes sense, and increase movement from ES and TH into PH/affordable. In order to do this, we need to gradually reduce TH as clients move out and reallocate these units to PH/affordable. We are working on a plan to accomplish these goals.
*** Services**	We need to build capacity in the following areas: tools/processes for consistent assessment of needs, including housing and services (thus the work on the coordinated intake/assessment/assignment; case managers to work with more clients in scattered PH/affordable housing; job-readiness skills training; and basic life skills training.
*** Mainstream Resources**	The need/demand for mainstream benefits is on the rise, but the Department of Human Services staff is on the decline. El Paso County is the highest and fastest growing population, and our unemployment rate is 1.4% higher than the state. Our current performance is very good (23% cash benefits and 74% non-cash benefits, but this will be a challenge to maintain while the economy lags. DHS staffing and community focus on economic recovery will be key.

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

Instructions:

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

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

Survey providers:	X
HMIS:	X
Extrapolation:	
Other:	

If Other, specify:

Not applicable

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

We begin the process by verifying/updating our housing inventory. This is used as the basis for determining providers to be included during the PIT. The information is reviewed/updated again as part of the PIT/HIC survey in January. Providers who are not yet using HMIS use a survey instrument matched to the data we collect in our HMIS and covering all data elements needed for CoC reports. Training is provided on the use of the survey. The training includes a copy of the charts/reports the CoC must generate so that survey takers understand the significance of each data element. A phone survey gathers the number of active clients for comparison to the number of surveys received. After the PIT, the survey data is put into an EXCEL spreadsheet. Providers who use HMIS are reminded to ensure that all data is current and accurate for active clients on the date of the PIT. Data quality is reviewed and worked as needed, including review of required data elements and program entry and exit dates. The same phone survey asking for the number of active clients on the date of the PIT includes HMIS participants. This information is compared to our HMIS data and discrepancies resolved. Data from our HMIS is exported and added to the EXCEL spreadsheet to provide a single set of client data.

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

Instructions:

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

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

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

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

If Other, specify:

Not applicable

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

The data was collected as described in 2I. The survey instrument included all of the data elements and response categories (including refused/don't know) needed to determine the subpopulations numbers. Our HMIS participants agree to collect all of the program-specific data elements, including most of the optional ones plus a couple of community-specific items. Thus, the HMIS data collection requirements also cover all of the data elements needed to determine the subpopulations numbers. As described in 2I, the HMIS data and non-HMIS data from survey forms were combined to create a single set of data for reporting.

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

Instructions:

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

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

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

If Other, specify:

Not applicable

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

All participating providers enter name, date of birth, SSN, and gender into HMIS & our data quality is nearly perfect on these elements. Our HMIS does prevent duplication within a provider, but not between providers as data sharing is not in use at this time. For 2012, our vendor created a PIT report which generated an unduplicated count for the participating programs. However, our non-participating programs used paper surveys. Therefore, we exported the data into an EXCEL file and merged it with the data from the paper surveys. Our paper survey form asked the same client identifying questions. We used the EXCEL data de-duplication tools and manual review/assessment based on the identifying data elements to de-duplicate across HMIS participant data & paper survey data. Because it was the HMIS-generate PIT report was new, we also used the EXCEL spreadsheet to verify that the report was producing an accurate count.

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

For HMIS providers, we provided instructions/training and reminders on what data needed to be completed, reviewed, and verified and in what timeframe. This was done at our regular users meetings and via email. We also fielded phone calls and placed phone calls if we did not receive email responses. We pulled data quality/completeness and people-count reports and provided these to the providers (these are reviewed monthly, but with added review leading up to and following the PIT date). This covered all of the data elements required for the populations and sub-populations counts, as well as program entry and exit dates, and review of client counts. Data was also reviewed when pulled for analysis and problems addressed. For non-HMIS providers, we held training sessions prior to the PIT. The survey form included all data elements collected in HMIS and needed to determine PIT populations and subpopulations. The training included detailed instructions on the survey form and the importance and relevance of the data elements, as well as the date of the PIT. Reminders were also provided by email and phone if needed. Survey forms were reviewed prior to and during data entry, and problems were addressed.

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

Instructions:

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

How frequently does the CoC conduct an unsheltered point-in-time count?	annually (every year)
Indicate the date of the most recent unsheltered point-in-time count (mm/dd/yyyy):	01/24/2012
If the CoC conducted the unsheltered point-in-time count outside the last 10 days in January, was a waiver from HUD obtained prior to January 19, 2011 or January 19, 2012?	Not Applicable
Did the CoC submit the unsheltered point-in-time count data in HDX by April 30, 2012?	Yes

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

Not applicable

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

There was an increase over 2011: 276 compared to 170. There were 3 major factors. 1st, our VA office was much more actively involved in the process which resulted in counting 50 more veterans overall with 44 of those being unsheltered. This brought our veteran count much closer to the VA estimate based on service contact. 2nd, we redoubled our training efforts for the survey takers, showing them good vs. bad forms and explaining the result of incomplete data on our ability to give an accurate picture of needs I our community. This resulted in a significant drop in unusable forms. 3rd, we saw a real increase in homeless as our economy lagged behind the country and the rest of the state but our housing resources remained static.

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

Instructions:

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

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

If Other, specify:

Not applicable

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

Our outreach team and service providers have worked hard in the last 3 years to establish relationships of trust with many/most of our unsheltered homeless. The VA has been reaching out to vets. The geographic size and configuration of our area makes it difficult to de-duplicate using simple counts (without identifying information). Therefore we adopted a policy of including only those for whom we had adequate information to de-duplicate. Surveys were taken at our soup kitchen (only 1 on weekdays and most eat here regularly), service providers, homeless health clinic, detox, and in known gathering places. The VA surveyed the people who accessed their services and actively encouraged participation. In addition, our outreach team and volunteers walked the creek beds and known camping areas. We continue to have people we cannot find and who do not access services on that day, but we continue to find ways to reduce this number with greater awareness and provider coverage. The data gathered was entered into the same EXCEL spreadsheet used for the sheltered population (HMIS and non-HMIS). This ensured that we did not count as unsheltered someone who was already counted in a program somewhere.

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

Instructions:

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

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

If Other, specify:

Combination was explained in 2M.

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

Instructions:

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

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

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

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

If Other, specify:

For the street outreach part of the survey, the survey takers were the outreach team. Their knowledge of the people they were interviewing and the level of trust already established helped to ensure accurate information was gathered from people who might otherwise have been reluctant.

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

As described in section 2K, our paper survey form contained all of the same identifying elements (name, DOB, SSN, gender) collected in HMIS. Anyone who was to be taking surveys was trained prior to the PIT, and the training included detailed instructions on the form and the significance of the data elements, with emphasis on un-duplicated counts. Copies of the required CoC charts were provided to show context for the data. All forms were examined prior to data entry for a first pass data completeness review. The data was entered into the same EXCEL spreadsheet we used for our HMIS and non-HMIS housing providers. In the data analysis, we eliminated people for whom we did not have enough information to de-duplicate. We then used the EXCEL de-duplication tools and data analysis/review to remove duplicates. Therefore, we were able to ensure that people were counted only once and in the appropriate category (sheltered or unsheltered).

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

We continue to see new HH w/ children because we are now the largest, fastest growing county in the state & our unemployment is lagging the country & the state, yet we have reduced unsheltered homeless households with children from 24 (with 59 people) in 2010 to 2 (with 5 people) in 2012. This is due to the HPRP program, the opening of a motel-style ES, efforts of the outreach team to locate & place HHs w/ children immediately, & focus/prioritization of HH w/ children by our service providers. Housing organizations which serve homeless HHs w/ children notify our local 2-1-1 when they have openings. This information is used for referrals, disseminated to our CHAP distribution list & at our meetings. Eligible households are identified & connected with the available resources & we continue to prioritize these household into available housing. Providers analyze clients who are being refused so that the CoC can determine if/when programs with different requirements are needed. With our ESG funds, we will prioritize rapidly rehousing these household based on the effectiveness of the HPRP program in this area. The coordinated intake/assessment/assignment process under development includes assessment of client needs & program availability. Our major soup kitchen (faith-based, non-HUD recipient) has expanded associated services, is actively engaging HHs w/ children (& those without), & is connecting them with available resources while also monitoring progress toward self-sufficiency.

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

The soup kitchen effort is mentioned above. Our Resource Advocacy Program (RAP) engages clients over an extended period of time to build trust, provide counseling, introduce resources, & eventually stabilize & house clients. Our Homeless Outreach Team (HOT) of police officers regularly engage the homeless population. They have gained the trust of the population & the providers, & have worked successfully with our RAP & Housing First programs to move chronic homeless into housing & to direct those not yet ready for housing to other resources. We have 2 mental health workers working with the HOT team. Together, they continue to reach out to the not-ready group to keep & enhance the dialogue & trust-building. This program won an international award for creativity & effectiveness & is being modeled in other cities. Our homeless health clinic has a mobile van which goes to known locations/encampments & engages & serves clients. A dinner truck provides an evening meal at a central downtown location. Other providers come to that location to engage clients. Our community mental health organization has an outreach program which goes to the soup kitchen, health clinic, & other locations to engage clients & provide mental health counseling. We received a SAMHSA grant which expanded this effort & moved more chronic homeless into supportive housing. Our SSVF program is another resource for veterans, & our VA office is using a Vulnerability Index tool to identify & prioritize CH vets.

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

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

Instructions:

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

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

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

How many permanent housing beds are currently in place for chronically homeless persons?	134
In 12 months, how many permanent housing beds designated for chronically homeless persons are planned and will be available for occupancy?	149
In 5 years, how many permanent housing beds designated for chronically homeless persons are planned and will be available for occupancy?	169
In 10 years, how many permanent housing beds designated for chronically homeless persons are planned and will be available for occupancy?	194

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

We made an error in the 2011 HIC and CoC submission. Our VASH vouchers were incorrectly classified as 100% CH beds. This is described in more detail in section 4A. The number has been corrected here. The planned addition of 15 beds will come from the 2011 bonus grant which was awarded and units are currently being leased up. There could be additional CH beds as the VA is targeting CH for their VASH vouchers as openings occur, but we do not have a definite number so have not included them in the 12 month plan.

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

In succeeding years, we plan to add at least 5 designated CH beds per year until we reach 200. This will come from assisting the VA with targeting the VASH vouchers toward CH veterans, and using a combination of reallocation of TH projects, new PH housing bonus grants, and conversion of current beds to CH status as chronic clients are accommodated. We are also looking at the possibility of a PRA project in coordination with the housing authority and state division of housing. As we build inventory, we continue to work to get Section 8 vouchers where appropriate, thus freeing up units for new clients. Work with HMIS vendor to create report showing current CH bed status (currently only covers participating agencies rather than entire CoC).

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

Our goal is to have housing available for every citizen of Colorado Springs/El Paso County who seeks assistance, and to actively reach out to those who are not yet ready in order to engage them in services and eventually housing. We will not have enough designated CH beds in 2015, but we continue to prioritize chronic homeless clients into housing units that become available. Our intake/assessment/assignment process under development will incorporate the Vulnerability Index to identify the most vulnerable. The tool is being piloted by the VA in our January 2013 PIT, and our HMIS vendor is building it into the system so that it will be a standard part of the process. The combination of more units and better identification and prioritization of clients will move us toward the national goal.

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

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

Instructions:

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

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

What is the current percentage of participants remaining in CoC-funded permanent housing projects for at least six months?	79%
In 12 months, what percentage of participants will have remained in CoC-funded permanent housing projects for at least six months?	80%
In 5 years, what percentage of participants will have remained in CoC-funded permanent housing projects for at least six months?	80%
In 10 years, what percentage of participants will have remained in CoC-funded permanent housing projects for at least six months?	80%

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

We are already at 79.3% so 80% is achievable and sustainable given our programs & partnerships. Current strategies include: working with HMIS vendor to develop/enhance/implement assessment tools to better assess and deliver services clients need to remain in housing, including general & specific life skills programs; continue agency collaboration to maintain & grow housing-first program; get all PH beds covered by HMIS so that all programs can be monitored/measured consistently (VASH is only outstanding program). Housing First & Resource Advocacy Programs continue collaborating to ensure clients are better prepared to enter PH (thru relationship building, counseling, life skills assessment & education, & readiness assessment). Continue building the focus on the first 6 months across all programs to better engage and support clients. Share best practices between agencies, including successful outcomes measurement.

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

Long-term plans include: continue development of the life skills and assessment programs addressed above; continue development of the PH capacity as described under Objective 1; promote access to mainstream benefits to create stability; work with HMIS vendor to develop APR-type reports at CoC level to measure performance on a monthly/quarterly basis; and, develop a threshold mechanism (using HMIS) to alert the CoC should progress fall below the minimum standard. Our outreach team works on building trust which helps ensure clients are ready for & more likely to remain stable in PH. Our SAMHSA grant is aimed specifically at clients with mental illness & one of the goals of this program is long-term housing/treatment and retention. And our VASH and SSVF programs will collaborate to house & retain veterans in PH.

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

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

Instructions:

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

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

What is the current percentage of participants in CoC-funded transitional housing projects will have moved to permanent housing?	53%
In 12 months, what percentage of participants in CoC-funded transitional housing projects will have moved to permanent housing?	65%
In 5 years, what percentage of participants in CoC-funded transitional housing projects will have moved to permanent housing?	65%
In 10 years, what percentage of participants in CoC-funded transitional housing projects will have moved to permanent housing?	65%

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

2 changes impacted our performance this year (see section 4A). In order to move people into a program more quickly (TH for chronic homeless w/ substance abuse), a requirement for 28 days clean/sober & active engagement in case management during that period was relaxed. The negative impact was seen within 6 months by monitoring outcomes & the tighter requirements were restored. This program is now back over 70% move to PH. In order to move HH w/ children quickly into housing we entered several into a “temporary” TH situation at a site better suited to singles/couples, then into a better TH housing situation when available. It benefited the families by getting them into housing but impacted this metric because they exited one TH program to go to another TH program. Removing these families, performance was 70.4%. We are addressing strategies to accomplish the household benefit without affecting the overall goal. Continue focus on gathering all exit information.

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

Continue and expand focus on outcomes measurement in areas of income, employment, education, housing stability, & overall self-sufficiency. Continue focus on intensive case management & supportive services in the 1st 6 months of program enrollment (which demonstrated higher outcomes for those remaining in programs more than 90 days). Demonstrate ability to sustain higher outcomes, then evaluate and adjust the LT goals. Work with HMIS vendor to develop APR-type reports at CoC level to measure performance on a monthly/quarterly basis; and, develop a threshold mechanism (using HMIS) to alert the CoC should progress fall below the minimum standard. Increase % of TH persons employed at program exit (to increase likelihood of moving to PH). Evaluate existing program effectiveness in ensuring clients reach self-sufficiency levels needed for success and develop programs to fill gaps.

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

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

Instructions:

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

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

What is the current percentage of participants in all CoC-funded projects that are employed at program exit?	25%
In 12 months, what percentage of participants in all CoC-funded projects will be employed at program exit?	21%
In 5 years, what percentage of participants in all CoC-funded projects will be employed at program exit?	22%
In 10 years, what percentage of participants in all CoC-funded projects will be employed at program exit?	23%

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

We continue to exceed our 12 mos goal because several of our programs focus heavily on employment assistance. Results were lower this year because our city/county unemployment remains high (1.4% higher than the State). While the city & county focus on job creation, our goals include: increase number of providers tracking employment data at program entry & exit; identify resources needed to support providers & clients in increasing employment, both number employed & employment level (part-time vs. full-time). Engage businesses more actively in our planning process. Due to the link between education & income, we added a goal to increase number of providers tracking education data at program entry & exit. We continue to increase the capacity of existing or develop new employment assistance programs such as resume-writing & interview skills.

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

Our existing focus on education and employment in our current programs is working well. Our goal is to develop more formal evaluation and monitoring capability. Thus, the long-term plan includes: develop resources needed to better support providers and clients in increasing employment (as identified by short-term goal mentioned above); more fully engage our workforce planning center and employers in strategic planning; evaluate successful programs and implement lessons learned; implement employment readiness/capability evaluation process using outcome domains and employment/education data; and, work with HMIS vendor to develop APR-type reports at CoC level to measure performance on a monthly/quarterly basis; and, develop a threshold mechanism (using HMIS) to alert the CoC should progress fall below the minimum standard.

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

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

Instructions:

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

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

What is the current percentage of participants in all CoC-funded projects that receive mainstream benefits at program exit?	23%
in 12 months, what percentage of participants in all CoC-funded projects will have mainstream benefits at program exit?	20%
in 5 years, what percentage of participants in all CoC-funded projects will have mainstream benefits at program exit?	21%
in 10 years, what percentage of participants in all CoC-funded projects will have mainstream benefits at program exit?	21%

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

All of our programs focus on employment and accessing mainstream benefits with good results: 25% have earned income; 23% have cash benefits; and 74% have non-cash benefits. Our concern for the coming year is that the demand is growing (largest & fastest growing county in the state) but the DHS resources to process requests have shrunk due to budgets, attrition, etc. For the next 12 months our goals include continuing the excellent focus at the provider level, continue the engagement with DHS to address volume and staff levels, and identify/implement strategies to overcome the challenges.

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

In addition to the short-term measures aimed at maintaining/improving our performance, our long-term goals include: work with HMIS vendor to develop APR-type reports at CoC level to measure performance on a monthly/quarterly basis; and, develop a threshold mechanism (using HMIS) to alert the CoC should progress fall below the minimum standard; use the DHS example to more fully engage SSA, VA, and workforce center personnel in our strategic planning process; support the local VA efforts to target the most vulnerable clients; and work with the vendor to incorporate the vulnerability index and needs assessments tools into HMIS so that we can better assess needs and target resources.

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

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

Instructions:

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

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

What is the current total number of homeless households with children as reported on the most recent point-in-time count?	105%
In 12 months, what will be the total number of homeless households with children?	125%
In 5 years, what will be the total number of homeless households with children?	120%
In 10 years, what will be the total number of homeless households with children?	115%

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

Our county is the fastest growing in the state, has an influx of military families due to relocation of a unit to Fort Carson, & unemployment is 1.4% higher than the state. Our HHs w/ children increased but we further reduced the number of unsheltered. 2013 total will go up because we have prioritized housing for these HH but we have a shortage of PH/affordable housing. A motel-style program averages about 2 months for return to stable housing. Our ESG funds will ramp up in 2013. SSFV program is in 2nd year & addressing the military needs. Other short-term plans include: continue focus on income, employment, education, overall self-sufficiency, & time-in-program outcome measures; focus outreach programs on finding & engaging households with children (example: our soup kitchen & outreach programs); & implement the HMIS outcome domains to assess clients likely to move quickly through ES and/or TH into permanent situations.

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

The long-term goals include: target ESG funds to this group; monitor and evaluate effectiveness of homeless prevention and rapid re-housing programs, and modify/expand as necessary; develop sustainable funding to replace/augment local foundation funding; develop and implement life skills, employment, and education programs (or increase capacity of existing programs); work with military resources to do the same for military families; and work with HMIS vendor to develop APR-type reports at CoC level to measure performance on a monthly/quarterly basis; and, develop a threshold mechanism (using HMIS) to alert the CoC should progress fall below the minimum standard. We are developing more PH and affordable housing options, and are evaluating moving some TH capacity to PH as prevention and RRH efforts lessen the demand on TH. We continue to work with the McKinney-Vento reps in our schools districts to quickly identify and assist homeless and at risk households w/ children.

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

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

Instructions:

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

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

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

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

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

We only have 1 SSO project in the community. The provider has developed alternate plans if that project is not renewed this year, but another year of support will be helpful for the overall strategy so we chose not to re-allocate it this year but rather rank it in Tier 2. The provider is working with the CoC to methodically convert TH units to PH/affordable (more below). We are finding more local and foundation support for supportive services when the housing is solidly funded, so our HUD focus is to continue that movement, and continue to build alternate capacity for the supportive services.

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

In 2012 we converted 5 units from TH to affordable housing, and converted the grant to an SSO grant (noted above) to assist another TH program that needed more supportive services. The conversion happened as clients left the program, 1 family transitioned in place & another will do so in 2013. Our strategy is to continue this methodical conversion as clients are ready, as other PH/affordable housing is developed, and as ESG ramps up to move people quickly into housing thus by-passing TH altogether. This provider has also intensified programming in the first 6 months & instituted more defined requirements & consequences thus shortening the stay in TH & increasing capacity using a smaller number of units. This model will now be carried to other programs as appropriate.

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

Instructions:

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

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

If "Other," explain:

Pathways Home Colorado, the Colorado 10-Year Plan, identifies discharge planning for foster care, health care, mental health, and corrections institutions as a priority. Efforts are underway or being supported at the state level, but where there are gaps, local efforts are identified and implemented. The CoC works with the State to provide inputs and make modifications as needed.

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

Office of Homeless Youth Services (OHYS) is responsible for improving discharge planning practices for child welfare & juvenile justice systems & works with Depts of Corrections, Justice, Education, Health Care Policy & Financing, Human Services, Public Safety, Public Health & Environment, nonprofits, federal depts & other stakeholders. OHYS did a statewide survey in 2008 & continues to develop policies/processes for youth exiting systems of care. The action plan & resources are at http://www.colorado.gov/cs/Satellite/DOLA-Main/CBON/1251595346101. Div. of Child Welfare developed/distributed a checklist for emancipation. El Paso County DHS implemented the Vital Documents guidelines, Emancipation Services checklist, & other best practices not yet formalized by the state. Local youth services providers work with OHYS & DHS. They provide transitional housing & services to youth exiting foster care. Colorado extended Medicaid coverage to Foster Care Youth from 18 to 21 years of age.

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

We are creating a formal document of the plan and practices in place and functioning for inclusion in an annual CoC document review process. We still have gaps in funding and therefore quantity of service available.

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

Colorado Office of Homeless Youth Services; Colorado Department of Human Services; El Paso County Department of Human Services and sub-contractors; AspenPointe Youth Directions; Griffith Centers for Children; Urban Peak Colorado Springs; Young Williams Child Support Services; Pikes Peak United Way 211 (for referrals). Mile High United Way is piloting a project, Bridging the Gap, in collaboration with local human service agencies, the CO. Dept. of Housing, nonprofits, school districts and foundations with the intention of replication.

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

AspenPointe Youth Directions; Griffith Centers for Children; Young Williams Child Support Services

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

Instructions:

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

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

If "Other," explain:

Pathways Home Colorado, the Colorado 10-Year Plan, identifies discharge planning for foster care, health care, mental health, and corrections institutions as a priority. Efforts are underway or being supported at the state level, but where there are gaps, local efforts are identified and implemented. The CoC works with the State to provide inputs and make modifications as needed.

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

Discharge policies for homeless & at-risk patients include: guidelines for identifying patients; finding housing; providing medications/access to medications; referrals to health care options & support services; transportation from hospital to housing. Emergency shelter provides respite beds for homeless clients discharged from hospital or referred by clinic. Peak Vista Homeless Health Clinic is co-located with the shelter. Expanded respite services to increase discharge options & decrease hospital costs. Clients with intoxication, behavioral, &/or mental health issues are addressed by a new detox/sobering beds facility. For long-term medical needs of clients, we received a local technical assistance & training grant to implement SOAR to improve access to SSI/SSDI/Medicaid for homeless persons w/ disabilities. Collaborative effort w/ the regional SSA & CO Div. of Disability Determination Services for flagging/expediting homeless applications & measuring outcomes (speed of approval).

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

We are creating a formal document of the plan and practices in place and functioning for inclusion in an annual CoC document review process. We need to develop additional funding for transportation (taxi vouchers), medications, and additional respite capacity.

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

Penrose-St. Francis Health System; Memorial Health System; Peak Vista Homeless Health Clinic; Peak Vista Community Health Centers; S.E.T. Family Medical Clinics; Ascending To Health; Open Bible Medical Clinic; Mission Medical Clinic; Pikes Peak United Way 211 (for referrals)

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

Ascending To Health; Peak Vista Homeless Health Clinic; S.E.T. Family Medical Clinics; Open Bible Medical Clinic; Mission Medical Clinic

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

Instructions:

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

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

If "Other," explain:

Pathways Home Colorado, the Colorado 10-Year Plan, identifies discharge planning for foster care, health care, mental health, and corrections institutions as a priority. Efforts are underway or being supported at the state level, but where there are gaps, local efforts are identified and implemented. The CoC works with the State to provide inputs and make modifications as needed.

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

Discharge policy for state mental health institutions prevents/limits discharging persons to ES or homelessness. CoC abides by protocol, participates in qtrly mtgs of system & policy review/revision. Qtrly mtgs attended by reps of state mental health services office, mental health institutes, community mental health ctrs, state drug & alcohol division, & ad hoc service providers. CoC's providers have guidelines based on state policies covering admission, care, & discharge of all clients. AspenPointe works w/ El Paso County jail to reach inmates suffering from mental illness & provide discharge planning w/ goal of reducing recidivism by ensuring services (clinical care, access to & receipt of mainstream benefits, housing, & vocational training) are available on release. AspenPointe & clients call 211 for referrals to appropriate services. If people w/ mental health issues become homeless, Resource Advocacy Program & Homeless Outreach Team connect them quickly to available resources.

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

We are creating a formal document of the plan and practices in place and functioning for inclusion in an annual CoC document review process. Colorado ranks very low in state aid for mental health, so funding limits our capacity. And, funding for critical medications is lacking.

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

AspenPointe Health Services; El Paso County Community Justice Center; Colorado Mental Health Services; Colorado Drug & Alcohol Division; Beth Haven; Pikes Peak United Way 211 (for referrals)

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

AspenPointe Health Services; Ecumenical Social Ministries; Beth Haven

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

Instructions:

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

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

If "Other," explain:

Pathways Home Colorado, the Colorado 10-Year Plan, identifies discharge planning for foster care, health care, mental health, and corrections institutions as a priority. Efforts are underway or being supported at the state level, but where there are gaps, local efforts are identified and implemented. The CoC works with the State to provide inputs and make modifications as needed.

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

CO law mandates access to benefits for exiting offenders. Council on Homelessness created treatment & diversion program. Dept. of Corrections began SOAR program to improve applications & expedite enrollment for persons w/ disabilities, & Re-Entry Specialists work w/ parole officers, faith/community based orgs, case managers, education staff, to support creation of transition plans including: resources for successful transition to community, functioning on their own, & enhance public safety. Local Reintegration/Recovery program reduced recidivism 67% & includes: needs assessment/diagnosis, life skills education (anger management, therapy, substance abuse treatment, family/parenting skills), employment program (during & after incarceration), legal assistance, housing, transportation. S.E.T. Clinic offers comprehensive health care re-entry program to exiting offenders. Outreach team identifies/assists offenders who become homeless and connects to services.

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

We are creating a formal document of the plan and practices in place and functioning for inclusion in an annual CoC document review process. As in many communities, we have inadequate capacity/resources for sex offenders.

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

Department of Corrections; El Paso County Community Justice Center; El Paso County Sheriff

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

Mesa House, Alano House, Grace Be Unto You (all faith-based or private organizations)

3C. Continuum of Care (CoC) Coordination

Instructions:

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

Does the Consolidated Plan for the jurisdiction(s) that make up the CoC include the CoC strategic plan goals for addressing homelessness?	Yes
If 'Yes', list the goals in the CoC strategic plan that are included in the Consolidated Plan:	The City of Colorado Springs 2010-2014 plan references and supports the CoC's 10-Year Blueprint to Serve Every Homeless Citizen in the Pikes Peak Region, specifically addressing development & implementation of CoC strategic goals, provision of housing to meet CoC goals, homeless prevention & rapid re-housing, & provision of support in achieving other CoC goals. The 2012/13 annual action plans reference the current CoC plan of record. El Paso County developed its 2012-2016 Consolidated Plan and 2012/13 annual action plans in coordination with the CoC. The plan cites the homeless prevention, rapid re-housing, affordable housing, and emergency assistance goals of the 10 Year Plan. Both Consolidated Plans cite & use the PIT & HIC data provided by the CoC, as well as the output from our planning sessions. Both plans include emphasis on permanent housing.

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

The CoC is plays an integral role in working with service providers in the community to address the population types served by the HPRP program(s). The CoC serves on the RFP evaluation committee for ESG allocations which is the primary source of funding used to continue to serve this segment of the population. In addition, the CoC will play a major role in bringing together service providers to develop a coordinated intake and assessment tool that will serve as the entry point for most if not all homeless individuals and families seeking assistance in the community. The HPRP program provided many lessons learned and served as a catalyst for implementing a coordinated intake and assessment component for serving those homeless individuals and families specifically in the area of rapid re-housing and homeless prevention.

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

The CoC & the City of Colorado Springs work together in the development & implementation of the CoC programs. The Neighborhood Stabilization Program is managed by the City of Colorado which is also the CoC Lead Organization. The City coupled its NSP funding with the State of Colorado and two multi-family projects have been purchased. The first multi-family project funded under NSP in the State was in Colorado Springs. A total of 45 units (through two projects) of affordable permanent housing were made available through this program with 22 units rented to persons between 30 and 55% of AMI. And 10 units set aside for chronically homeless persons. NSP-3 funds were also awarded to the City and negotiations to purchase a 36 unit multi-family housing complex were completed and projects brought on line in 2012. These units will be rented to individuals and families between 30 and 60% AMI. In addition CDBG-R funds were used to provide energy efficiency retro-fits. Due to the City's involvement in the CoC every effort is made to utilize HUD funding in a complementary manner with CoC funding. The CoC is working closely with the Veteran's Administration on the delivery of HUD VASH in our community, identifying & referring veterans who are eligible for vouchers. The CoC has worked with regional HUD &VA offices to make 2 more allotments of VASH vouchers available to our CoC. We continue these efforts because we still have ~100 veterans on a waiting list. A representative from the VA is a regular member of the CHAP committee in our community and works with us on this coordination. Colorado was also awarded an SSVF grant, the majority of which will be expended in El Paso County. The grantee will work in partnership with the CoC and the VA to provide services to our veterans, and was awarded the PH bonus grant in 2011 to provide housing were services are not enough.

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

If 'Yes', describe the established policies that are in currently in place:	Homeless service providers are required to ensure that families are advised of their rights & available McKinney-Vento services. Each school district has a McKinney-Vento contact and these are the people with whom the service providers work. Children must be or get enrolled in order for the family to remain in the program (agencies work with them to ensure this happens). If families leave a program with children not enrolled, the Department of Human Services is notified. The service providers must work with the school districts to ensure transportation is provided to the school of record. We have an early learning initiative aimed at improving 3rd grade reading levels which providers support and participate in as appropriate for their programs. Providers work with child care providers to ensure that need is met.

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

All school districts in the CoC have McKinney-Vento coordinators, & the CoC meets with them regularly to ensure the needs of our homeless children are being met. The two lowest income districts in our region are particularly responsive, generally having all services requested, including school lunches and private transportation to the home school of record, in place within 24 hours. The school districts provide information to all students & parents alerting them to services available. The school districts also include a survey at the beginning of the year. One of the questions provides information to indicate homeless or at risk families. Teachers are trained to identify potentially homeless children & work with their coordinators to ensure services are made available. All school districts are required to provide transportation to the child's school of record. Our food bank and a faith-based organization provide weekend food back-packs. We have several organizations which provide school supplies and immunization/health clinics. Schools provide information on these services to families, and they refer people to our 211 Information & Referral line which maintains current lists of these and other programs/services in the community.

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

Our programs do not deny admission because of children, though some programs obviously serve the individual population. The only program in the CoC that separates men from women and children is our large ES facility, and it is because it is a dormitory-style facility. The separation is a security measure for the protection of the women and children (potential DV or unknown sex offender). In order to compensate, the facility has a duplex on site where some family combinations can be accommodated. In all cases (program eligibility or capacity), families are prioritized for referral to our family emergency shelters and/or to TH or permanent housing programs as appropriate.

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

We have a large military population & large # of homeless veterans. CoC has lead role in finding & assisting homeless veterans. Outreach team visits campgrounds & homeless gathering places. When veterans are identified, we assure their basic needs are met. If veteran-specific shelter is not available, we refer to our locally-funded motel-style program which provides food, clothing & basic medical care while individuals wait to be seen by the VA & to acquire their VA & other benefits. We contact the local homeless veterans coordinator (a member of CHAP) to gain access to VASH & other programs. HPP continues to work w/ regional HUD & VA directors to get more VASH vouchers for our CoC to meet housing needs identified. Our housing 1st & other programs are open to veterans, & transfer to VASH is facilitated as possible. The VA is using a vulnerability index to target chronic homeless vets for VASH. All of our service providers work w/ veterans to access benefits. Many of our providers are run & staffed by veterans, so needs of veterans are high priority in our community. El Pomar Foundation has a military affairs director who assists w/ funding for Colorado veterans' programs. We received an SSVF grant; the manager & 6 of 8 case workers are in Colo Sprgs to focus on our veterans & provide supportive services. Two new grants (2011), will provide additional TH & PH housing for veterans. These cover our goals of outreach, collaboration, continuum of services, & improved lives.

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

Youth homelessness is important & of concern in our CoC. Our primary provider, Urban Peak, is a licensed shelter serving this vulnerable group. Urban Peak provides a dormitory-style ES for male & female youth, including showers, lockers/storage, kitchen/dining facilities serving meals, group spaces, admin/outreach/staff offices, computer lab, health clinic, & recreational space. It operates a PH program for youth w/ disabilities & a scattered site TH for youth w/ income, supported w/ HUD funding. Urban Peak offers a full range of supportive services: intensive case management including counseling, substance abuse treatment, mental health services, & life skills; employment; education including on-site GED. Urban Peak reaches over 300 youth annually thru model outreach. Using a Positive Youth Development Model, Urban Peak staff builds trust & guides youth to identify unique abilities & strengths to reach their full potential. Participation is voluntary; outcomes are positive; support systems are real; expectations are high & realistic. Youth earn a donated bicycle by enrolling in school, getting a job, or securing housing; they learn to build, repair & maintain their bikes for use as transportation/exercise/recreation. Our CoC has a Teen Court program & youth detention center that focuses on life skills & support systems to assist youth exiting from corrections. These efforts cover the CoC strategic goals of outreach, collaboration, continuum of services & improved lives.

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

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

Our coordinated intake/assessment/assignment process is under development, collaboratively with the other two CoC's in the state. Our intent is to be as common as possible while meeting local needs. Our HMIS vendor (migration to new system completed 12/2011 in our CoC and 5/2012 in the other two CoC's) had demonstrated the working coordinated intake/assessment process in two other communities and we are using those as an example. Expected elements include: limited points of entry (Colorado Springs may use 211), a common set of assessment questions, shared basic client information, a common client wait list and program availability list, and a common housing assignment process. Sharing is available but not yet used in our HMIS so the processes and documents are also under development.

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

The City of Colorado Springs is the ESG jurisdiction for the CoC and the grant administrator for the City is an active member of the CoC. The City is also the Collaborative Applicant and one of the CoC Lead Agencies. The CoC lead agencies are members of the ESG RFP evaluation committee and the CoC Strategic Planning Committee provides valuable input on the CoC needs that ESG funds could support. This input was used in developing the RFP for the use of ESG funds in the community.

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

Fair Housing requirement training was provided in May 2012 at our general CoC meeting (CHAP). All services providers in the community are aware of the fair housing requirements as it relates to federal funding and are required if HUD funding is received by the agency to affirmatively market any services or available housing in a manner that does not discriminate on the basis of the categories listed above. Each agency is required to utilize or develop a plan to affirmatively market services and housing. In the coming year the CoC will monitor this activity more closely and look at developing a marketing template that can be utilized by all agencies in the community.

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

Instructions:

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

Has the CoC developed a strategic plan? Yes

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

Yes. From our 10-Year Blueprint to Serve Every Homeless Citizen in the Pikes Peak Region: the vision is "to house every citizen of Colorado Springs" and the goal is "an optimized set of solutions for homelessness in the Pikes Peak Region." The 15 sectors described in the document are: health care; housing; food; emergency services; veterans' services; prison re-entry; access to services; clothing and furniture; disability services; discharge policies and processes; day care; youth services; police/corrections; transportation; and education. This document is under review to address the requirements of the HEARTH Act.

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

Since the Administrators of the HUD funds for both the City and the County are members of the CoC Strategic Planning Committee and are actively involved with most of the agencies represented by the CoC, information is readily available as a result of planning sessions and meetings to assist in the completion of the Consolidated Plans. In addition, the Administrators of the HUD funding regularly provide information and request information during the Consolidated Plan process. The CoC consolidated application is developed with and reviewed by the City and County, and all CoC reports (e.g. AHAR, PIT, HIC) are published to the CoC general membership which includes City and County administrators.

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

The original plan was created/approved in 2004 as a 5-Year Plan. The 10-Year Plan was created/approved in 2009. The document is under review as noted above, and one of the items identified for inclusion is an annual or biannual review/action plan.

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

As our 10-Year plan was approved in 2009, it does not yet incorporate the “Opening Doors” goals. That is one of the purposes for the review and update. However our stated goal of “an optimized set of solutions for homelessness” and the 15 sectors identified directly address the target areas of the “Opening Doors” goals: youth, families with children, veterans, and chronic. Each year we set our goals and priorities based the vision of having a program and/or services available for every person who presents or we identify through outreach.

Select the activities in which the CoC coordinates with the local Emergency Solutions Grant(ESG):	Determines how to allocate ESG grant for eligible activities, Develop standards for evaluating the outcomes of activities assisted by ESG funds, Develop performance standards for activities assisted by ESG funds, Develop funding policies and procedures for the operation and administration of HMIS for ESG funded projects

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

The ESG administrator is on the CoC Strategic Planning Committee and the other CoC Leads are part of the ESG RFP evaluation committee, so the needs of the community are at the heart of both the CoC and ESG planning and funding decisions. All ESG programs are required to use the HMIS so are held to the same data, performance, and evaluation standards. The CoC Monitoring and Review Committee in conjunction with the CMS (HMIS) Advisory Committee is developing those standards for all programs, both CoC and ESG. The funding and operation of HMIS is also jointly reviewed/determined, and HMIS is funded by both CoC and ESG funds.

Does the CoC intend to use HUD funds to serve families with children and youth defined as homeless under other Federal statutes?	No
If 'Yes', has the CoC discussed this with the local HUD CPD field office and received approval?	No

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

Not applicable at this time, but may be in the future.

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

Not applicable at this time, but may be in the future.

3E. Reallocation

Instructions:

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

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

4A. Continuum of Care (CoC) FY2011 Achievements

Instructions:

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

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

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

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

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

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

Objective	FY2011 Proposed Numeric Achievement		FY2011 Actual Numeric Achievement	
Create new permanent housing beds for the chronically homeless	205	**Beds**	134	**Beds**
Increase the percentage of homeless persons staying in permanent housing over 6 months to at least 77%	80	**%**	79	**%**
Increase the percentage of homeless persons moving from transitional housing to permanent housing to at least 65%	66	**%**	53	**%**
Increase the percentage of homeless persons employed at exit to at least 20%	23	**%**	25	**%**
Decrease the number of homeless households with children	92	**Households**	105	**Households**

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

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

Objective 1: Our VASH beds were incorrectly reported as 100% CH beds, and 4 CH beds under development were included in the 2011 application as current. The 2011 count should have 117 with the 12 month goal at 132 (we achieved 134). The 2012 HIC was corrected and we have corrected the application goals.
Objective 2: 2011 achievement was 78.7% and improved to 79.3% in 2012 – just shy of the goal.
Objective 3: One program changed entry requirements for 6 mos, then reverted when this metric decreased so much; the program is back over 70%. In an effort to quickly house families, we enrolled a few families in a temporary TH program and then moved them to another better suited to families; it was good for the families but negatively impacted the metric; this program is also at 70%.
Objective 5: The number of unsheltered families did decrease from 3 (9 people) to 2 (5 people), but we have seen an increase in homeless families due to prolonged unemployment; we are housing them quickly but have a shortage of affordable housing so are using ES and TH.

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

At this time, through APR's and comparison to CoC goals and project goals submitted during the application phase. One of our goals for this year is to have our HMIS vendor create an APR-type report that can be run at the CoC level so we can monitor project and CoC performance without manual calculation. To complement this, we'll either seek to build in the stated goals, and create a separate grid of goals for comparison to performance. As stated elsewhere, we already monitor data quality and completeness as well as bed utilization on a monthly basis.

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

Performance is reviewed and goals set by the Strategic Planning Committee and all recipients are currently members of that committee so all are aware both of their own performance and what goals we set. We work with recipients to ensure that they have the data, reports, and knowledge to use them to monitor their programs. One provider has led the way in outcomes measurement and using the data to make program changes. Sharing those best practices then helps others.

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

We help providers determine what causes are at work; suggest best practices they can model; make specific suggestions as appropriate; and have even arranged transfer of programs that either really didn't fit a provider's core competencies or where capacity building was not an option. The group process has really helped to raise awareness.

Does the CoC have any unexecuted grants awarded prior to FY2011? No

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

Project Awarded	Competition Year the Grant was Awarded	Awarded Amount
Not applicable; not unexecuted grants	N/A	$0
	Total	$0

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

We are able to determine average length of stay in programs from our HMIS data, but it does not yet exist as a management-type report, it requires manual manipulation, and it does not de-duplicate across multiple program entries. We are currently working with the vendor to understand all of the various metrics and pieces of data we need to help us report easily. We will also implement sharing of client data which will help with the unduplicated view of length of time. As the process has not yet started, we don't know the magnitude of merging client records.

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

As noted above, we will be implementing sharing of client data this year. Even at just the client demographic level, this is expected to allow us to make this determination. However, it will again require development on the part of the vendor and we do not yet know when they will be able to accommodate this.

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

We have a Homeless Outreach Team (HOT) which engages homeless persons at provider locations such as the soup kitchen as well as known locations downtown, in parks, along creek beds, etc. On each contact, they offer referrals to programs and services. They make contact with providers when clients are ready to engage. The soup kitchen provides outreach and engagement, and welcomes other outreach personnel (such as mental health providers, SOAR volunteer) to engage with clients as well. All of our providers use and provide information to 211 to assist with referrals to programs. All of our emergency services providers engage clients and refer to programs.

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

We used the HPRP funds quickly and are using the lessons learned to improve the use of the ESG funds, some of which will be used for homeless prevention. Our emergency services providers who provide rent and utility assistance and other prevention services using zip code to determine areas of coverage. Our 211 Information & Referral center assists people with accessing services to prevent homelessness, as well as being a resource to providers who are looking for referrals beyond their services. Our 2009 10-Year Plan did not specifically address prevention, but rather the services. As noted elsewhere, the plan is under review/revision to incorporate the HEARTH Act requirements and “Opening Doors” goals.

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

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

Not applicable at this time, but may be in the future.

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

Not applicable at this time, but may be in the future.

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

Instructions:

HUD tracks each CoCs progress toward ending chronic homelessness.

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

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

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

Year	Number of CH Persons	Number of PH beds for the CH
2010	334	116
2011	178	190
2012	257	134

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

The HUD definition of homelessness as published as part of the HEARTH Act forms the basis for determining eligibility along with the specific program requirements. Documents, declarations, diagnoses, and where available HMIS data, or provider contact or observation information are collected and reviewed by the providers to determine eligibility. Data is recorded in HMIS upon program entry. The VA has started using a vulnerability index (VI) assessment to assist with the process, and we are working with our HMIS vendor to build the VI assessment tool into the system. When available, that will be available to all providers and an outreach version could be used as well (these are not yet available).

Indicate the number of new permanent housing beds in place and made available for occupancy for the chronically homeless between February 1, 2011 and January 31, 2012: 17

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

Reference sections 3A and 4A objective 1: our VASH CH beds were reported incorrectly in the 2011 HIC and application: the count should have been 117, so the number of beds did increase: 4 from SHP 3-year grant; 12 from VASH; 1 just increased capacity due to rent contribution. The number of chronic homeless reported also increased because the VA was more actively engaged in our PIT and improved reporting of both sheltered and unsheltered counts.

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

Cost Type	HUD McKinney-Vento	Other Federal	State	Local	Private
Development	$0	$0	$0	$0	$0
Operations	$148,024	$0	$0	$0	$16,119
Total	$148,024	$0	$0	$0	$16,119

4C. Continuum of Care (CoC) Housing Performance

Instructions:

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

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

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

Participants in Permanent Housing (PH)	
a. Number of participants who exited permanent housing project(s)	40
b. Number of participants who did not leave the project(s)	139
c. Number of participants who exited after staying 6 months or longer	38
d. Number of participants who did not exit after staying 6 months or longer	104
e. Number of participants who did not exit and were enrolled for less than 6 months	18
TOTAL PH (%)	79

Instructions:

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

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

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

Participants in Transitional Housing (TH)	
a. Number of participants who exited TH project(s), including unknown destination	306
b. Number of SHP transitional housing participants that moved to permanent housing upon exit	162
TOTAL TH (%)	53

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

Instructions:

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

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

Total Number of Exiting Adults: 256

Total Number of Exiting Adults

Cash Income Sources (Q25a1.)	Number of Exiting Adults	Exit Percentage (Auto-Calculated)
Earned income	63	25%
Unemployment insurance	3	1%
SSI	7	3%
SSDI	6	2%
Veteran's disability	0	0%
Private disability insurance	1	0%
Worker's compensation	0	0%
TANF or equivalent	15	6%
General assistance	4	2%
Retirement (Social Security)	0	0%
Veteran's pension	0	0%
Pension from former job	0	0%
Child support	7	3%
Alimony (Spousal support)	1	0%
Other source	25	10%
No sources (from Q25a2.)	134	52%

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

Does the CoC have any non-HMIS projects for which an APR was required to be submitted? No

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

Instructions:

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

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

Total Number of Exiting Adults: 256

Total Number of Exiting Adults:

Non-Cash Benefit Sources (Q26a1.)	Number of Exiting Adults	Exit Percentage (Auto-Calculated)
Supplemental nutritional assistance program	140	55%
MEDICAID health insurance	90	35%
MEDICARE health insurance	3	1%
State children's health insurance	11	4%
WIC	27	11%
VA medical services	1	0%
TANF child care services	28	11%
TANF transportation services	3	1%
Other TANF-funded services	11	4%
Temporary rental assistance	0	0%
Section 8, public housing, rental assistance	18	7%
Other source	11	4%
No sources (from Q26a2.)	67	26%

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

Does the CoC have any non-HMIS projects for which an APR was required to be submitted? No

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

Instructions:

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

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

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

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

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

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

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

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

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

APRs are submitted to the CoC as well as to HUD, and we can pull them directly from HMIS for all of our programs (all HUD CoC funded programs are using HMIS). APRs are reviewed and problem areas are identified. Our programs all assist clients with accessing mainstream programs and consistently exceed goals. We completed the migration to a new HMIS and continue to expand our monitoring and reporting capabilities. This year we pulled APR's from HMIS and compared to esnaps as part of the ranking and evaluation process. Next year programs will be measured on accuracy and use of the HMIS APR. This year, our review was annual. Our goal is to review 2-4 times per year as we improve the process.

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

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

Our new Strategic Planning Committee (CoC board) met 7/16/2012 and 9/10/2012 with CoC requirements as agenda items, and will set the schedule for training and evaluation of performance. Our monthly general membership meeting (CHAP) is used as the forum to provide training on mainstream benefits, with the following specific items in the 2011-2012 year: 11/10/11 – accessing affordable housing; 12/8/11 – Dept. of HS on Affordable Care Act and accessing HHS resources; 1/12/12 – employment services through workforce center; 4/12/12 – veterans outreach and access; 5/10/12 – fair housing, and pro bono legal services.

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

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

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

Our HMIS is not used formally to screen for eligibility because there is a statewide system called CBMS (Colorado Benefits Management System) which is used for that purpose. However, our providers do know based on the data collected in HMIS who is likely to be eligible, and do record in HMIS the status, and amounts where applicable, for all of the following: unemployment, SSI, SSDI, veterans' disability, private disability insurance, workers' compensation, TANF, general assistance, SS retirement, veterans' pension, job pension, child support, alimony/spousal support, Needy and Disabled, old age pension, food stamps, Medicaid, Medicare, state childrens' health insurance, WIC, VA medical, TANF child care, TANF transportation, other TANF, and rental assistance/section 8/housing vouchers. Our new HMIS has eligibility functionality, so this may be evaluated at some point in the future.

Has the CoC participated in SOAR training?	Yes

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

03/10/11 at the CHAP meeting. We also received a technical assistance and training grant (through Rocky Mountain Hope Connection), and this organization is now providing training to other providers as needed.

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

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

Activity	Percentage
1. Case managers systematically assist clients in completing applications for mainstream benefits. **1a. Describe how service is generally provided:**	100%
All of our providers' case managers do an intake assessment (we have a generic form used for HMIS to which providers can add other information as needed). Based on that intake assessment, they determine for which programs clients are likely to qualify, and then assist clients with completing the necessary forms as needed. SSA and VA have their own sets of forms, and DHS has a single form which is used for all of the services covered by them (see item 3 below). We have a new SOAR technical assistance and Training grant which is expanding assistance with SSI/SSDI.	

2. Homeless assistance providers supply transportation assistance to clients to attend mainstream benefit appointments, employment training, or jobs:	100%

3. Homeless assistance providers use a single application form for four or more mainstream programs: **3.a Indicate for which mainstream programs the form applies:**	100%
DHS has a single form which is used for input into their CBMS (Colorado Benefits Management System). The CBMS process includes: TANF, AND, CCAP (child care assistance), WIC, CCHP (children's health), Medicare, Medicaid, and Food Stamps.	

4. Homeless assistance providers have staff systematically follow-up to ensure mainstream benefits are received:	100%
4a. Describe the follow-up process:	
Agencies have a defined service plan that is created at intake. The service plan is reviewed, evaluated and updated as the client's situation evolves. Many agencies also conduct in-home visits with program participants to assess progress. This process includes keeping track of mainstream benefit status, and providing further assistance as needed. Updates are recorded in HMIS as appropriate (updated income and benefits information). Our new HMIS has a follow-up reminder function which we will deploy upon completion of the conversion.	

4I. Unified Funding Agency

Instructions

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

Is the collaborative applicant able to apply to HUD for funding for all of the projects within the geographic area and enter into a grant agreement with HUD for the entire geographic area? No

Is the collaborative applicant able to enter into legal binding agreements with subrecipients and receive and distribute funds to subrecipients for all projects with the geographic area? No

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

Not applicable at this time.

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

Not applicable at this time.

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

Not applicable at this time.

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

Not applicable at this time.

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

Not applicable at this time.

Attachments

Document Type	Required?	Document Description	Date Attached
Certification of Consistency with the Consolidated Plan	Yes	2012 CO-504 Certi...	01/17/2013
CoC-HMIS Governance Agreement	No	CO-504 CoC-HMIS G...	01/13/2013
Other	No	CoC-504 CoC-Agenc...	01/13/2013
Other	No	2012 CO-504 CoC 1...	01/17/2013
Other	No	2012 CO-504 CoC B...	01/17/2013
Other	No	2012 CO-504 CoC S...	01/17/2013
Other	No	2012 CO-504 HMIS ...	01/17/2013
Other	No		

Attachment Details

Document Description: 2012 CO-504 Certification of Consistency

Attachment Details

Document Description: CO-504 CoC-HMIS Governance Agreement

Attachment Details

Document Description: CoC-504 CoC-Agency Partnership Agreement

Attachment Details

Document Description: 2012 CO-504 CoC 10-Year Plan and Action Plan Documents

Attachment Details

Document Description: 2012 CO-504 CoC Board Governance Documents

Attachment Details

Document Description: 2012 CO-504 CoC Structure and Membership Documents

Attachment Details

Document Description: 2012 CO-504 HMIS Forms Agreements Policies Procedures

Attachment Details

Document Description:

Submission Summary

Page	Last Updated
1A. Identification	No Input Required
1B. CoC Operations	01/15/2013
1C. Committees	01/15/2013
1D. Member Organizations	01/15/2013
1E. Project Review and Selection	01/15/2013
1F. e-HIC Change in Beds	01/16/2013
1G. e-HIC Sources and Methods	01/16/2013
2A. HMIS Implementation	01/16/2013
2B. HMIS Funding Sources	01/16/2013
2C. HMIS Bed Coverage	01/12/2013
2D. HMIS Data Quality	01/16/2013
2E. HMIS Data Usage	01/13/2013
2F. HMIS Data and Technical Standards	01/16/2013
2G. HMIS Training	01/13/2013
2H. Sheltered PIT	01/16/2013
2I. Sheltered Data - Methods	01/16/2013
2J. Sheltered Data - Collections	01/16/2013
2K. Sheltered Data - Quality	01/16/2013
2L. Unsheltered PIT	01/16/2013
2M. Unsheltered Data - Methods	01/16/2013
2N. Unsheltered Data - Coverage	01/13/2013
2O. Unsheltered Data - Quality	01/16/2013
Objective 1	01/17/2013
Objective 2	01/17/2013
Objective 3	01/17/2013
Objective 4	01/17/2013

Objective 5	01/17/2013
Objective 6	01/17/2013
Objective 7	01/17/2013
3B. Discharge Planning: Foster Care	01/17/2013
3B. CoC Discharge Planning: Health Care	01/17/2013
3B. CoC Discharge Planning: Mental Health	01/17/2013
3B. CoC Discharge Planning: Corrections	01/17/2013
3C. CoC Coordination	01/17/2013
3D. CoC Strategic Planning Coordination	01/17/2013
3E. Reallocation	01/12/2013
4A. FY2011 CoC Achievements	01/17/2013
4B. Chronic Homeless Progress	01/17/2013
4C. Housing Performance	01/11/2013
4D. CoC Cash Income Information	01/11/2013
4E. CoC Non-Cash Benefits	01/11/2013
4F. Section 3 Employment Policy Detail	01/08/2013
4G. CoC Enrollment and Participation in Mainstream Programs	01/16/2013
4H. Homeless Assistance Providers Enrollment and Participation in Mainstream Programs	01/13/2013
4I. Unified Funding Agency	No Input Required
Attachments	01/17/2013
Submission Summary	No Input Required