Before Starting the CoC Application

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

The Collaborative Applicant is responsible for reviewing the following:

1. The FY 2018 CoC Program Competition Notice of Funding Available (NOFA) for specific application and program requirements.
2. The FY 2018 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.
6. Questions marked with an asterisk (*), which are mandatory and require a response.

1A. Continuum of Care (CoC) Identification

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

1A-1. CoC Name and Number: VA-601 - Fairfax County CoC

1A-2. Collaborative Applicant Name: Fairfax County Office to Prevent and End Homelessness

1A-3. CoC Designation: CA

1A-4. HMIS Lead: FFX County Office to Prevent and End Homelessness

1B. Continuum of Care (CoC) Engagement

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

1B-1. CoC Meeting Participants. For the period from May 1, 2017 to April 30, 2018, using the list below, applicant must: (1) select organizations and persons that participate in CoC meetings; and (2) indicate whether the organizations and persons vote, including selecting CoC Board members.

Organization/Person Categories	Participates in CoC Meetings	Votes, including selecting CoC Board Members
Local Government Staff/Officials	Yes	Yes
CDBG/HOME/ESG Entitlement Jurisdiction	Yes	No
Law Enforcement	Yes	Yes
Local Jail(s)	Yes	Yes
Hospital(s)	No	No
EMS/Crisis Response Team(s)	No	No
Mental Health Service Organizations	Yes	No
Substance Abuse Service Organizations	Yes	No
Affordable Housing Developer(s)	Yes	Yes
Disability Service Organizations	Yes	Yes
Disability Advocates	Yes	No
Public Housing Authorities	Yes	Yes
CoC Funded Youth Homeless Organizations	Yes	No
Non-CoC Funded Youth Homeless Organizations	Not Applicable	No
Youth Advocates	Yes	No
School Administrators/Homeless Liaisons	Yes	No
CoC Funded Victim Service Providers	Yes	No
Non-CoC Funded Victim Service Providers	Yes	No
Domestic Violence Advocates	Yes	No
Street Outreach Team(s)	Yes	No
Lesbian, Gay, Bisexual, Transgender (LGBT) Advocates	No	No
LGBT Service Organizations	No	No
Agencies that serve survivors of human trafficking	Yes	No
Other homeless subpopulation advocates	Yes	Yes
Homeless or Formerly Homeless Persons	Yes	Yes
Mental Illness Advocates	Yes	No
Substance Abuse Advocates	Yes	No

Other:(limit 50 characters)		
Community Foundation	Yes	Yes
Faith Based Community Representatives	Yes	Yes
Business Representatives	Yes	Yes

1B-1a. Applicants must describe the specific strategy the CoC uses to solicit and consider opinions from organizations and/or persons that have an interest in preventing or ending homelessness.
(limit 2,000 characters)

The CoC's Lead Agency has established relationships with a wide and diverse range of partners that are vital for the operation of an inclusive housing crisis response system. Frequent and consistent interaction with current partners ensures ideas and resources are freely exchanged and relevant committees have robust representation. The CoC's Consumer Advisory Council provides an avenue to solicit feedback from those with lived experience of homelessness and providers also collect input from those served in their programs. Biannual CoC Meetings held during the past year were designed to foster conversations surrounding the Point in Time count results, equity, and system performance benchmarks in addition to other key topics. Presentations, including those from the Commonwealth of Virginia's Department of Housing and Community Development and the State of Utah, brought external insight into creative approaches that could be implemented in Fairfax County's CoC to prevent and end homelessness. In order to gather perspectives from an even broader segment of the community and further expand our partnership base, the CoC Lead Agency partnered with a professor and class at a local university to distribute a survey focused on homelessness, which resulted in thousands of responses that have been analyzed and incorporated into the strategic planning process. The Governing Board has also hosted a number of meetings soliciting input for future planning as our CoC is approaching the end of our 10 Year Plan. There have also been numerous public hearings in which community members have been able to provide input on many issues related to homelessness, shelter, and permanent supportive housing as our community is embarking of the redesign of several shelters to incorporate permanent supportive housing units into the blueprint.

1B-2.Open Invitation for New Members. Applicants must describe:
(1) the invitation process;
(2) how the CoC communicates the invitation process to solicit new members;
(3) how often the CoC solicits new members; and
(4) any special outreach the CoC conducted to ensure persons experiencing homelessness or formerly homeless persons are encouraged to join the CoC.
(limit 2,000 characters)

(1) Fairfax County's CoC is comprised of a diverse representation of stakeholders – including public, private, nonprofit, and faith communities as well as representatives of homeless populations and subpopulations. The CoC Lead collaborates with members to identify sectors that should be further engaged,

organizes the outreach process, and employs a variety of communication strategies to invite new members to partner in preventing and ending homelessness.
(2) Membership forms were designed to attract interested parties by presenting the purpose and benefits of CoC membership. This information is shared via e-mail, during community meetings with human service providers, on social media, and on the CoC Lead's website. Providing a clear understanding of what CoC membership is and actively engaging stakeholders are key communication strategies in the solicitation process.
(3) The CoC Lead Agency publicizes the opportunity to formerly join the CoC on an annual basis. Membership forms are also provided throughout the year to any new agency or individual that becomes involved in homeless services or that the CoC Lead agency is made of aware of. Invitations to join the CoC have been provided to all the instructors in the CoC's Housing Location series of classes (that occurred monthly), to new agencies that applied for homeless service funding, and made available during CoC Meetings.
(4) The Consumer Advisory Council (CAC), a crucial and part of the CoC governance structure, provides vital insight into how to engage persons who currently experiencing homelessness or who have experienced homelessness to join the CoC. This input helps to ensure the process is accessible and effective. Individuals with lived experience actively participate in a variety of different ways, including serving on this Council, in the CoC.

**1B-3.Public Notification for Proposals from Organizations Not Previously Funded. Applicants must describe how the CoC notified the public that it will accept and consider proposals from organizations that have not previously received CoC Program funding, even if the CoC is not applying for new projects in FY 2018, and the response must include the date(s) the CoC publicly announced it was open to proposals.
(limit 2,000 characters)**

The CoC Lead notified the public of the opportunity to apply for bonus, reallocated, and DV bonus funding by email, website and social media on July 3rd and July 6th, 2018. An email outlining the details of the funding opportunities was sent to all CoC members and all nonprofit or governmental agencies that have been involved in or demonstrated an interest in homeless services. All forms of public notification contained detailed information on how to apply to ensure the process was accessible for both current and prospective grantees. An additional capacity section for new applicants further emphasized that applications from non-CoC Program funded organizations were welcome. This process proved to be successful since 2 of the 5 applications for funding were from 2 different non-CoC Program funded organizations. The CoC Committee thoroughly reviewed all of the submitted applications for bonus, reallocated, and DV bonus funding and representatives of the agencies also presented their proposals in person to the CoC Committee. The CoC Committee used previously agreed upon objective criteria (that was outlined within the application itself) to select the proposed projects to include in the Collaborative Application. The CoC Committee did not select either of the applications from the non-CoC Program funded organizations. The project submitted for bonus funding by the non-CoC Program funded organization proposed serving 90% fewer clients for more than double the cost per client for the same project type in comparison to the other application received. The project submitted for DV bonus funding by the non-CoC Program funded

organization was ultimately retracted by the applicant, but had proposed serving 75% fewer clients for slightly less than double the cost per client in comparison to the other application received. All projects that were not selected were offered debriefing.

1C. Continuum of Care (CoC) Coordination

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

1C-1. CoCs Coordination, Planning, and Operation of Projects. Applicants must use the chart below to identify the federal, state, local, private, and other organizations that serve individuals, families, unaccompanied youth, persons who are fleeing domestic violence who are experiencing homelessness, or those at risk of homelessness that are included in the CoCs coordination, planning, and operation of projects.

Entities or Organizations the CoC coordinates planning and operation of projects	Coordinates with Planning and Operation of Projects
Housing Opportunities for Persons with AIDS (HOPWA)	Yes
Temporary Assistance for Needy Families (TANF)	Yes
Runaway and Homeless Youth (RHY)	Yes
Head Start Program	Yes
Funding Collaboratives	Yes
Private Foundations	Yes
Housing and services programs funded through U.S. Department of Justice (DOJ) Funded Housing and Service Programs	Yes
Housing and services programs funded through U.S. Health and Human Services (HHS) Funded Housing and Service Programs	Yes
Housing and service programs funded through other Federal resources	Yes
Housing and services programs funded through State Government	Yes
Housing and services programs funded through Local Government	Yes
Housing and service programs funded through private entities, including foundations	Yes
Other:(limit 50 characters)	

1C-2. CoC Consultation with ESG Program Recipients. Applicants must describe how the CoC:
(1) consulted with ESG Program recipients in planning and allocating ESG funds; and
(2) participated in the evaluating and reporting performance of ESG Program recipients and subrecipients.
(limit 2,000 characters)

Fairfax County government is the local recipient of the Emergency Solutions Grant (ESG). ESG is administered by Fairfax County's Office to Prevent and End Homelessness (OPEH), which is also the CoC lead agency and, as such, consults with CoC members in planning and allocating ESG funds. Planning

discussions occur through regularly scheduled provider meetings; the CoC lead also contacts providers individually to solicit feedback. Fairfax County currently allocates all ESG funds towards homelessness prevention and rapid rehousing assistance, minus the payment of eligible administrative activities. OPEH monitors the use of ESG funds by its subrecipients to evaluate performance, report on the results, and adapt projects as necessary. Criteria used in the evaluation process is based on the system performance measures and metrics. Fairfax County government through the Department of Housing and Community Development (DHCD) also administers all local CDBG and HOME funds and prepares the Consolidated Plan. Data from the CoC's HMIS about ESG-funded program performance are shared with DHCD staff and communicated to the public in regular reports. The Consolidated Annual Performance and Evaluation Report (CAPER), especially, shares a large amount of HMIS data regarding the number of people served in ESG-funded programs and their outcomes

1C-2a. Providing PIT and HIC Data to Consolidated Plan Jurisdictions. Did the CoC provide Point-in-Time (PIT) and Housing Inventory Count (HIC) data to the Consolidated Plan jurisdictions within its geographic area?	Yes to both
1C-2b. Providing Other Data to Consolidated Plan Jurisdictions. Did the CoC provide local homelessness information other than PIT and HIC data to the jurisdiction(s) Consolidated Plan(s)?	Yes

1C-3. Addressing the Safety Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors. Applicants must describe:
(1) the CoC's protocols, including the existence of the CoC's emergency transfer plan, that prioritizes safety and trauma-informed, victim-centered services to prioritize safety; and
(2) how the CoC maximizes client choice for housing and services while ensuring safety and confidentiality.
(limit 2,000 characters)

(1) The CoC's Coordinated Entry policies outline clear paths to services to ensure that survivors of domestic violence (DV), dating violence, sexual assault, and stalking are connected to appropriate interventions (survivors' services, DV shelters and other housing/service options) based on their current need. Safety planning is offered to all survivors that contact the 24-hour DV hotline and the 24-hour emergency shelter for survivors of DV, which prioritizes survivors at imminent risk of lethality using the evidenced-based Lethality Assessment Program. Providers are trained to use a trauma-informed approach in all aspects of their service delivery. The County's Office for Women & Domestic and Sexual Violence Services (OFWDSVS) also provides regular trainings accessible to any service provider on all topics related to DV, including Trauma Informed Care. Providers operating various project types in the CoC collaborate with OFWDSVS as well as the non-profit provider operating the 24-hour

emergency shelter for survivors of DV to develop temporary or permanent emergency transfer plans, as needed, tailored to the individual. This includes soliciting feedback from the survivor on locations they can safely move to, when the move can occur, and how the move occurs (transportation mode, safety planning around social media, cell phone tracking, communication with schools if relevant, etc.).
(2) Providers use a victim-centered approach, meaning the victim is the expert of their situation and their choice leads the decision-making process. Shelter and housing (funded through the CoC, ESG, DOJ, and DHHS), is provided in safe, scattered sites throughout Fairfax County. Survivors are made aware of their options while protecting the status of undisclosed locations. Confidentiality is paramount as it is closely linked to safety. DV clients' information is kept in secure databases that meet the HMIS Data Standards and VAWA regulations; information is not shared electronically.

1C-3a. Applicants must describe how the CoC coordinates with victim services providers to provide annual training to CoC area projects and Coordinated Entry staff that addresses best practices in serving survivors of domestic violence, dating violence, sexual assault, and stalking. (limit 2,000 characters)

The Office to Prevent and End Homelessness (OPEH) is co-located with the Office for Women & Domestic and Sexual Violence Services (OFWDSVS) to promote collaboration and regular interaction in the provision of services to survivors of domestic violence, dating violence, sexual assault, and stalking. The OPEH Director sits on the Domestic Violence Prevention, Policy & Coordinating Council and chairs the County's Domestic Violence Housing Committee. OFWDSVS conducts several CoC wide trainings that are accessible to all CoC project staff as well as Coordinated Entry staff. This includes (1) an annual 16 hour training on the dynamics of domestic and sexual violence and stalking, the criminal & civil justice systems that respond to those crimes, and resources in the community, as well as (2) ongoing training throughout the year on best practices serving victims of DV, statistics, court and victim services, protective orders, vicarious trauma, trauma informed care, signs of and resources for those experiencing dating violence, impact of DV on children, cultural issues, etc. Regular opportunities are offered by OPEH, as the CoC and HMIS Lead, to CoC project staff and Coordinated Entry staff that provide services to survivors of domestic violence on best practices related to data entry. For designated domestic violence service programs, this includes how to enter survivors' information into the secure and confidential DV Database (that is comparable to but separate from HMIS) as well as an overview of the Coordinated Entry System processes for anonymizing clients so they are included equally in the CoC's Prioritization Pool for housing.

1C-3b. Applicants must describe the data the CoC uses to assess the scope of community needs related to domestic violence, dating violence, sexual assault, and stalking, including data from a comparable database. (limit 2,000 characters)

Fairfax County has a comprehensive coordinated community response to domestic violence, dating violence, sexual assault, and stalking. There are several coordinating bodies comprised of senior-level decision makers that

advise the Board of Supervisors, service and justice system providers, survivor representation, and religious and secular leadership that collaborate to collect and analyze data to assess the scope of community needs. There is also a multidisciplinary group specifically charged with studying domestic violence related fatalities to identify system gaps and opportunities for policy change. The Domestic Violence Prevention, Policy & Coordinating Council, with the support of all of the coordinating bodies, spearheads the release of an annual Data Compilation Report comprised of several data points used in the assessment process. This includes the number of hotline calls, numbers served in the 24 hour emergency shelter for victims of domestic violence, analysis of exit and turn away data, demographics, annual trends in numbers served, numbers served in CoC programs, domestic dispute call and arrest totals from the Fairfax County Police Department, Office of the Magistrate data, Office of the Commonwealth Attorney's data, as well as data from several non-profit legal, counseling, faith-based, and advocacy groups. State & local data is tracked and mapped by zip code to determine areas of need and to identify gaps in services. Data on those with a history of domestic violence and those who are experiencing homelessness as a result of domestic violence that are not served in designated DV programs is recorded in HMIS and captured in the Point in Time Count. A CoC-wide DV Database, comparable to but separate from HMIS, was implemented with the majority for the DV designated providers currently participating. All providers record data in secure databases that meet the HMIS Data Standards and comply with VAWA regulations.

1C-4. DV Bonus Projects. Is your CoC applying for DV Bonus Projects? Yes

1C-4a. From the list, applicants must indicate the type(s) of DV Bonus project(s) that project applicants are applying for which the CoC is including in its Priority Listing.

SSO Coordinated Entry	
RRH	X
Joint TH/RRH	

1C-4b. Applicants must describe:
(1) how many domestic violence survivors the CoC is currently serving in the CoC's geographic area;
(2) the data source the CoC used for the calculations; and
(3) how the CoC collected the data.
(limit 2,000 characters)

(1) There were 649 adults and head of household (which includes unaccompanied minors) survivors of domestic violence served within ES and TH programs in the CoC in FY18. The total number of domestic violence survivors served when including PH programs in the calculations is 848.
(2) The total of domestic violence survivors served within ES and TH programs is comprised of 460 individuals that were identified through HMIS, in accordance with the HMIS Data Standards, and 189 individuals identified

through the CoC-wide separate DV Database that is comparable to HMIS. The number is unduplicated in each system, but due to confidentiality requirements, not unduplicated between systems. The data captures and differentiates those that have experienced domestic violence within the past 3 months, 3-6 months, 6-12 months, as well as those currently fleeing. 46% (299 individuals) were listed as currently fleeing domestic violence, 19% of which were recorded in HMIS and therefore served by a non-designated domestic violence service provider at a time in which they were likely at the highest point of danger.
(3) Training is offered through Fairfax County's Office to Prevent and End Homelessness, the CoC and HMIS lead, as well as Fairfax County's Office for Women & Domestic and Sexual Violence Services to all providers operating in the CoC to ensure data collection is done in a confidential and trauma-informed manner appropriate to the sensitivity of the topics discussed. Training includes guidance on how to phrase questions, flow of conversation, identifying red flags, and awareness of the resources that exist in the CoC should connection to a different provider better protect the safety of the individuals and families seeking services. The data is documented in HMIS and in the separate DV Database.

1C-4c. Applicants must describe:
(1) how many domestic violence survivors need housing or services in the CoC's geographic area;
(2) data source the CoC used for the calculations; and
(3) how the CoC collected the data.
(limit 2,000 characters)

(1) As noted in the HMIS Data Standards, at the aggregate level, knowing the size of the population of persons experiencing homelessness who have also experienced domestic violence is critical for determining the resources needed to address the problem. All 649 survivors of domestic violence that are experiencing homelessness in a ES or TH program, as well as the children not included in the count, need permanent housing and services. Fairfax County's Office for Women & Domestic and Sexual Violence Services receives approximately 1200 calls to the domestic violence hotline per year, with 71% calling in regards to domestic violence, 18% sexual violence, 4% domestic and sexual violence, and 7% stalking. This suggests that a greater number of victims of domestic violence may need to access housing or services and there isn't capacity for them to do so.
(2) The total number of survivors currently served was calculated using reports generated from HMIS and the CoC-wide separate DV Database that is comparable to HMIS. The total number of domestic violence survivors referenced of course only includes those that successfully accessed a ES or TH program.
(3) The data was collected and documented by front line staff that provide direct services and have been trained on the HMIS Data Standards, HMIS data entry, and for domestic violence designated providers, trained on data entry in the DV Database.

1C-4d. Based on questions 1C-4b. and 1C-4c., applicant must:
(1) describe the unmet need for housing and services for DV survivors, or if the CoC is applying for an SSO-CE project, describe how the current Coordinated Entry is inadequate to address the needs of DV survivors;
(2) quantify the unmet need for housing and services for DV survivors;

(3) describe the data source the CoC used to quantify the unmet need for housing and services for DV survivors; and
(4) describe how the CoC determined the unmet need for housing and services for DV survivors.
(limit 3,000 characters)

(1&2) As noted, there were 649 adults and head of household (which includes unaccompanied minors) survivors of domestic violence served within ES and TH programs in the CoC in FY18 – all of which could benefit from housing and services. In addition to the 1200 calls to the domestic violence hotline referenced that Fairfax County's Office for Women & Domestic and Sexual Violence Services receives per year, the CoC has also taken call data into consideration from the sole 24-hour domestic violence shelter. The domestic violence shelter received 595 calls in FY18 for households seeking shelter due to domestic violence. Despite this high call volume, only 157 households were admitted to shelter, which means there is a significant number of individuals in the CoC that met the criteria for category 4 of the homeless definition that were turned away. There were also 63 households that exited the 24-hour domestic violence shelter that did not exit to permanent housing, which further accentuates that there are inadequate housing resources for domestic violence survivors in the CoC.
(3) This call data is documented by the provider in VAData, a secure database used by all domestic and sexual violence service agencies in Virginia, and shared monthly with Fairfax County's Office for Women & Domestic and Sexual Violence Services (OFWDSVS). The total number of survivors quantified as having an unmet needs was calculated using reports generated from HMIS and the CoC-wide separate DV Database that is comparable to HMIS.
(4) Fairfax County's Office to Prevent and End Homelessness has partnered closely with OFWDSVS to analyze HMIS data, DV Database data (which includes the 24-hour domestic violence shelter), Domestic Violence Hotline data as well as call data from the sole 24-hour domestic violence shelter to quantify and determine the unmet need for housing and services for domestic violence survivors.

1C-4e. Applicants must describe how the DV Bonus project(s) being applied for will address the unmet needs of domestic violence survivors.
(limit 2,000 characters)

The proposed Rapid Rehousing DV Bonus project is designated to exclusively serve survivors of domestic violence, adding housing and services for approximately 33 more households (individuals and families) per year. The addition of rapid rehousing capacity creates much needed housing and service options which will also increase domestic violence shelter vacancies. A rapid rehousing program, prioritizing survivors of domestic violence, was implemented with CoC Program funding in 2016 and a locally funded housing subsidy geared to preventing domestic violence survivors from becoming homeless was created in 2017. Despite the implementation of these new housing resources, the high volume of households experiencing domestic violence that were seeking to enter the sole 24-hour domestic violence shelter and were unable to do so remained an ongoing issue. After careful planning over the course of several years involving leadership from a variety of different stakeholders, including Fairfax County's Office for Women & Domestic and Sexual Violence Services, Fairfax County's Department of Housing and Community Development, and Fairfax County's Board of Supervisors, the

community's sole 24-hour domestic violence shelter is expanding this year from 56 to 84 beds. The scattered site emergency shelter will be based in multiple geographic locations across the 400 square mile CoC to ensure accessibility. The applicant of the proposed Rapid Rehousing DV Bonus project has facilitated the development of the CoC's Coordinated Entry policies related to survivors of domestic violence and is the operator of the current CoC Program funded RRH project prioritizing survivors as well as the 24-hour domestic violence shelter. The applicant brings expertise in addressing the unique housing and service needs of survivors of domestic violence, dating violence, sexual assault, and stalking and through the DV Bonus project, will be able to expand their impact to address the needs still unmet.

1C-4f. Applicants must address the capacity of each project applicant applying for DV bonus projects to implement a DV Bonus project by describing:
(1) rate of housing placement of DV survivors;
(2) rate of housing retention of DV survivors;
(3) improvements in safety of DV survivors; and
(4) how the project applicant addresses multiple barriers faced by DV survivors.
(limit 4,000 characters)

(1)The agency applying for the DV Bonus Project has operated the sole 24-hour domestic violence shelter serving survivors of domestic violence, dating violence, sexual assault, and stalking for the past 8 years. The agency also operates prevention, emergency shelter, rapid rehousing, transitional, permanent supportive and other affordable housing programs. The agency currently manages more than $1 million of CoC Program funding and has been a direct recipient of HUD funding for the past 5 years. In the past fiscal year, across all of its programs (including those serving domestic violence survivors), more than 70% of those exiting services (more than 200 households) moved to permanent housing.
(2)Intensive services are provided upon transition to permanent housing and reduced at a gradual rate to ensure housing stability and retention. Support offered includes assistance in applying for protective orders, court accompaniment, transportation, referrals to counseling and legal services, as well as connection to health care, mainstream benefits, child care, and employment services. CoC-wide HMIS recidivism reports show that the agency's programs contracted with the Office to Prevent and End Homelessness have recidivism rates that are below the average.
(3)Safety planning is conducted at the onset of services and is incorporated into all aspects of the ongoing services provided. Improvement in safety is assessed by directly asking the clients for their perspective through a survey administered upon exit. In FY18, more than 90% of clients responding to survey reported that because of services received, they were more aware of how to plan for their safety and thus better equipped to do so.
(4)The array of services described in #2 demonstrate the individualized approaches the project applicant uses to address the multiple barriers that domestic violence survivors face. The client's perspective and right to make their own choices is at the forefront of services.

**1C-5. PHAs within CoC. Applicants must use the chart to provide information about each Public Housing Agency (PHA) in the CoC's geographic areas:
(1) Identify the percentage of new admissions to the Public Housing or Housing Choice Voucher (HCV) Programs in the PHA who were experiencing homelessness at the time of admission;
(2) Indicate whether the PHA has a homeless admission preference in its Public Housing and/or HCV Program; and
(3) Indicate whether the CoC has a move on strategy. The information should be for Federal Fiscal Year 2017.**

Public Housing Agency Name	% New Admissions into Public Housing and Housing Choice Voucher Program during FY 2017 who were experiencing homelessness at entry	PHA has General or Limited Homeless Preference	PHA has a Preference for current PSH program participants no longer needing intensive supportive services, e.g. move on?
Fairfax County Department of Housing and Community	19.18%	Yes-Both	Yes

If you select "Yes--Public Housing," "Yes--HCV," or "Yes--Both" for "PHA has general or limited homeless preference," you must attach documentation of the preference from the PHA in order to receive credit.

**1C-5a. For each PHA where there is not a homeless admission preference in their written policy, applicants must identify the steps the CoC has taken to encourage the PHA to adopt such a policy.
(limit 2,000 characters)**

N/A, our local PHA has a homeless admission preference in written policy.

1C-5b. Move On Strategy with Affordable Housing Providers. Does the CoC have a Move On strategy with affordable housing providers in its jurisdiction (e.g., multifamily assisted housing owners, PHAs, Low Income Tax Credit (LIHTC) developments, or local low-income housing programs)? Yes

**Move On strategy description.
(limit 2,000 characters)**

The CoC does have a Move On strategy with Affordable Housing Providers. The CoC works closely with Fairfax County's Department of Housing and Community Development to utilize both public housing opportunities and turn-over Housing Choice Vouchers for households currently experiencing homelessness and for households that have previously experienced homelessness and are now served in permanent supportive housing programs. The local PHA, which receives staff support from the Department of Housing and Community Development, allocates approximately 5 vouchers each month to the CoC. The CoC's PSH providers identify households that have stabilized

in their programming and enters them into the Coordinated Entry Prioritization Pool for possible selection. Those with the longest stay in permanent supportive housing are prioritized first to move on from PSH to a HCV.

1C-6. Addressing the Needs of Lesbian, Gay, Bisexual, Transgender (LGBT). Applicants must describe the actions the CoC has taken to address the needs of Lesbian, Gay, Bisexual, and Transgender individuals and their families experiencing homelessness. (limit 2,000 characters)

The providers in the CoC's homeless service system collectively recognize the importance of creating safe and nonjudgmental access points that take into account the unique needs of all individuals served, including LGBT clients. Intake forms that include questions about sexual orientation/gender identity are designed to avoid implicit assumptions. As all programs operate with a Housing First approach, responses to these questions are not required to access services. Shelters serving individuals that have designated male and female beds have piloted asking where individuals prefer to be placed rather than asking whether or not the individual needs a male or female bed. Shelters serving families operate under a broad definition of family that only specifies that the household must have at least one adult and one minor child; this purposefully excludes any language pertaining to marital status or sexual orientation. The CoC's youth provider, which regularly serves LGBT TAY, ensures openness and acceptance is established during initial interactions in order to build trusting and productive working relationships. All providers practice with an understanding of the heightened risks that LGBT clients may face. To equip providers to do so, the Office for Women & Domestic and Sexual Violence Services held a training this past year, accessible to all grantees, on intimate partner violence within LGBT relationships which included an organizational assessment to determine the agency's readiness to serve this population. Non-Discrimination and Equal Access language is incorporated into and emphasized in Coordinated Entry policies, documentation, and trainings. Data collected in HMIS is assessed to understand the scope of services provided to LGBT individuals and identify opportunities for improvement. The CoC is currently working on building relationships with LGBT advocacy groups to ensure the CoC's outreach services effectively reach this subpopulation.

1C-6a. Anti-Discrimination Policy and Training. Applicants must indicate if the CoC implemented a CoC-wide anti-discrimination policy and conducted CoC-wide anti-discrimination training on the Equal Access Final Rule and the Gender Identity Final Rule.

1. Did the CoC implement a CoC-wide anti-discrimination policy that applies to all projects regardless of funding source?	Yes
2. Did the CoC conduct annual CoC-wide training with providers on how to effectively implement the Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity (Equal Access Final Rule)?	No
3. Did the CoC conduct annual CoC-wide training with providers on how to effectively implement Equal Access to Housing in HUD Programs in Accordance with an Individual's Gender Identity (Gender Identity Final Rule)?	No

1C-7. Criminalization of Homelessness. Applicants must select the specific strategies the CoC implemented to prevent the criminalization of homelessness in the CoC's geographic area. Select all that apply.

Engaged/educated local policymakers:	X
Engaged/educated law enforcement:	X
Engaged/educated local business leaders:	X
Implemented communitywide plans:	X
No strategies have been implemented:	
Other:(limit 50 characters)	
Collected client data to identify issues	X

1C-8. Centralized or Coordinated Assessment System. Applicants must: (1) demonstrate the coordinated entry system covers the entire CoC geographic area; (2) demonstrate the coordinated entry system reaches people who are least likely to apply homelessness assistance in the absence of special outreach; (3) demonstrate the assessment process prioritizes people most in need of assistance and ensures they receive assistance in a timely manner; and (4) attach CoC's standard assessment tool. (limit 2,000 characters)

(1) Fairfax County Human Services network is divided into four regions, with access points to Coordinated Entry available in each region for both walk-in and telephone assessment. This strategic positioning ensures Coordinated Entry has 100% geographic coverage of the CoC and is easily accessible.
(2) The CoC's outreach teams are actively engaged with individuals residing in the streets, cars, and other places not meant for human habitation, screening them for all housing programs, including rapid rehousing and permanent supportive housing, in addition to screening for shelter entry. The consistent presence of the outreach teams at drop-in centers and known "hot spots" provide the individuals least likely to engage in or apply for assistance the opportunity to interact with the homeless crisis response system on their own terms.
(3) Households calling for assistance or walking in to entry points that are not yet literally homeless are engaged in housing-focused diversion conversations to prevent their homelessness from beginning. The same screening tools for all housing and services, including emergency shelter, are used at all system entry points to ensure the assessment and triage process is consistent. The screening tools, one for individuals and one designed for families, prioritize

based on length of homelessness and vulnerability. Upon assessment, clients are entered in CoC's Coordinated Entry Prioritization Pool. All HUD funded PSH and RRH programs, as well as all County funded programs and some privately funded programs, receive clients from this centralized pool, which is published weekly. This system ensures individuals and families are efficiently prioritized by vulnerability and need and connected to housing and services in a timely manner.
(4) The CoC's standard assessment tools are attached. The VI-SPDAT is the assessment tool used for individuals and the Homeless Services Triage Tool (HSTT) is the assessment tool used for families.

1D. Continuum of Care (CoC) Discharge Planning

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

1D-1. Discharge Planning–State and Local. Applicants must indicate whether the CoC has a discharge policy to ensure persons discharged from the systems of care listed are not discharged directly to the streets, emergency shelters, or other homeless assistance programs. Check all that apply (note that when "None:" is selected no other system of care should be selected).

Foster Care:	X
Health Care:	
Mental Health Care:	
Correctional Facilities:	
None:	

1D-2. Discharge Planning Coordination. Applicants must indicate whether the CoC actively coordinates with the systems of care listed to ensure persons who have resided in them longer than 90 days are not discharged directly to the streets, emergency shelters, or other homeless assistance programs. Check all that apply (note that when "None:" is selected no other system of care should be selected).

Foster Care:	X
Health Care:	
Mental Health Care:	
Correctional Facilities:	
None:	

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

Instructions

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

1E-1. Project Ranking and Selection. Applicants must indicate whether the CoC used the following to rank and select project applications for the FY 2018 CoC Program Competition:
(1) objective criteria;
(2) at least one factor related to achieving positive housing outcomes;
(3) a specific method for evaluating projects submitted by victim services providers; and
(4) attach evidence that supports the process selected.

Used Objective Criteria for Review, Rating, Ranking and Section	Yes
Included at least one factor related to achieving positive housing outcomes	Yes
Included a specific method for evaluating projects submitted by victim service providers	Yes

1E-2. Severity of Needs and Vulnerabilities. Applicants must describe:
(1) the specific severity of needs and vulnerabilities the CoC considered when reviewing, ranking, and rating projects; and
(2) how the CoC takes severity of needs and vulnerabilities into account during the review, rating, and ranking process.
(limit 2,000 characters)

(1) A Monitoring & Evaluation (M&E) Committee comprised of representation of all HUD grantees as well as other homeless service providers in the community meet annually to revise the tool the CoC uses to review, rank, and rate the CoC projects. Ensuring that consideration is given to projects that provide housing and services to populations with higher vulnerabilities/service needs has been and remains a priority. As such the CoC's Monitoring & Evaluation Tool already included a section that awards additional points for subpopulations served. The total number of conditions/subpopulations and the total number and percent served is also taken into account. The conditions/subpopulations included were veterans, individuals with mental illness, substance abuse disorders, chronic health conditions, HIV, developmental and physical disabilities, TAY, and individuals over the age of 62. The M&E Committee elected to expand upon this list to include those served with a history of victimization (DV and/or child abuse), previous episodes of homelessness, chronic homelessness, unsheltered or no income at entry, criminal, and bad credit or rental history (including not having been a lease holder). The Ranking Committee was also made aware of the uniqueness of the project type. This included project size,

the population served, and the percent of project type of its kind within the CoC. (2) The total conditions/subpopulations were divided by the total number of clients served. This number was provided to the Ranking Committee for consideration during their deliberations. The vulnerability score of each project was discussed during project appraisal and influenced the ranking placement of projects. Projects serving populations that present with more barriers to engagement and greater service needs were awarded more points on the Monitoring & Evaluation Tool; overall M&E score is a major consideration in the ranking.

1E-3. Public Postings. Applicants must indicate how the CoC made public:
(1) objective ranking and selection process the CoC used for all projects (new and renewal);
(2) CoC Consolidated Application–including the CoC Application, Priority Listings, and all projects accepted and ranked or rejected, which HUD required CoCs to post to their websites, or partners websites, at least 2 days before the CoC Program Competition application submission deadline; and
(3) attach documentation demonstrating the objective ranking, rating, and selections process and the final version of the completed CoC Consolidated Application, including the CoC Application with attachments, Priority Listing with reallocation forms and all project applications that were accepted and ranked, or rejected (new and renewal) was made publicly available, that legibly displays the date the CoC publicly posted the documents.

Public Posting of Objective Ranking and Selection Process		Public Posting of CoC Consolidated Application including: CoC Application, Priority Listings, Project Listings	
CoC or other Website	☐	CoC or other Website	☐
Email	☐	Email	☐
Mail	☐	Mail	☐
Advertising in Local Newspaper(s)	☐	Advertising in Local Newspaper(s)	☐
Advertising on Radio or Television	☐	Advertising on Radio or Television	☐
Social Media (Twitter, Facebook, etc.)	☐	Social Media (Twitter, Facebook, etc.)	☐

1E-4. Reallocation. Applicants must indicate whether the CoC has cumulatively reallocated at least 20 percent of the CoC's ARD between the FY 2014 and FY 2018 CoC Program Competitions.

Reallocation: No

1E-4a. If the answer is "No" to question 1E-4, applicants must describe how the CoC actively reviews performance of existing CoC Program-funded projects to determine the viability of reallocating to create new high performing projects.
(limit 2,000 characters)

The Monitoring & Evaluation Tools (1 for the agency, 1 for the project), that the CoC developed serve as a comprehensive assessment of overall performance and impact. The Tools, in alignment with HUD requirements and priorities, capture information related to grant management, cost per client, participation in the CoC, adherence to the renewal applications, service level, vulnerabilities of population served, an extensive focus on outcomes reported in the APRs, and more. The Tools, which are completed by grantees annually, have been used for the past 5 years. A Monitoring & Evaluation (M&E) Committee, comprised of grantees and non-grantees, revises and enhances the Tools each year and develops general recommendations to the CoC Committee on how to address the lowest scoring projects. Factors considered include the range of the scores, areas contributing to low scores, and patterns of producing low scores. During this competition year, the CoC Committee assessed that the lowest scoring projects, which serve chronically homeless individuals in PSH and only scored 10 points below the mean and median scores, still bring significant value. The CoC Committee opted to offer technical assistance and provided a formal notice that failure to improve outcomes may result in reallocation. This was assessed to be the most efficient route to achieving higher performance. In addition to the M&E process, the CoC Lead regularly discusses reallocation strategies with the grantees – all of which operate PH projects. As a result of these ongoing conversations, one of the current grantees voluntarily re-evaluated their budget and assessed that because of the additional resources they leveraged, they were able to serve the same number of clients with $85,000 less from HUD. While this was not a performance based reallocation, it demonstrates that the CoC is still regularly using reallocation as a tool to maximize the funding to prevent and end homelessness.

1E-5. Local CoC Competition. Applicants must indicate whether the CoC: (1) established a deadline for project applications that was no later than 30 days before the FY 2018 CoC Program Competition Application deadline–attachment required; (2) rejected or reduced project application(s)–attachment required; and (3) notify applicants that their project application(s) were being rejected or reduced, in writing, outside of e-snaps, at least 15 days before FY 2018 CoC Program Competition Application deadline–attachment required. :

(1) Did the CoC establish a deadline for project applications that was no later than 30 days before the FY 2018 CoC Program Competition Application deadline? Attachment required.	Yes
(2) If the CoC rejected or reduced project application(s), did the CoC notify applicants that their project application(s) were being rejected or reduced, in writing, outside of e-snaps, at least 15 days before FY 2018 CoC Program Competition Application deadline? Attachment required.	Yes
(3) Did the CoC notify applicants that their applications were accepted and ranked on the Priority Listing in writing outside of e-snaps, at least 15 before days of the FY 2018 CoC Program Competition Application deadline?	Yes

2A. Homeless Management Information System (HMIS) Implementation

Intructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

2A-1. Roles and Responsibilities of the CoC and HMIS Lead. Does your CoC have in place a Governance Charter or other written documentation (e.g., MOU/MOA) that outlines the roles and responsibilities of the CoC and HMIS Lead? Attachment Required.	Yes
2A-1a. Applicants must: (1) provide the page number(s) where the roles and responsibilities of the CoC and HMIS Lead can be found in the attached document(s) referenced in 2A-1, and (2) indicate the document type attached for question 2A-1 that includes roles and responsibilities of the CoC and HMIS Lead (e.g., Governance Charter, MOU/MOA).	Fairfax County CoC Governance Charter, Page 8
2A-2. HMIS Policy and Procedures Manual. Does your CoC have a HMIS Policy and Procedures Manual? Attachment Required.	Yes
2A-3. HMIS Vender. What is the name of the HMIS software vendor?	Bowman Systems (A Mediware Company) ServicePoint
2A-4. HMIS Implementation Coverage Area. Using the drop-down boxes, applicants must select the HMIS implementation Coverage area.	Single CoC

2A-5. Bed Coverage Rate. Using 2018 HIC and HMIS data, applicants must report by project type:
(1) total number of beds in 2018 HIC;
(2) total beds dedicated for DV in the 2018 HIC; and

(3) total number of beds in HMIS.

Project Type	Total Beds in 2018 HIC	Total Beds in HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
Emergency Shelter (ES) beds	494	87	404	99.26%
Safe Haven (SH) beds	0	0	0	
Transitional Housing (TH) beds	274	124	150	100.00%
Rapid Re-Housing (RRH) beds	465	0	459	98.71%
Permanent Supportive Housing (PSH) beds	687	0	554	80.64%
Other Permanent Housing (OPH) beds	220	0	218	99.09%

**2A-5a. To receive partial credit, if the bed coverage rate is 84.99 percent or lower for any of the project types in question 2A-5., applicants must provide clear steps on how the CoC intends to increase this percentage for each project type over the next 12 months.
(limit 2,000 characters)**

The only project type that does not have more than 84.99% bed coverage in HMIS is Permanent Supportive Housing and the only program in the CoC with PSH beds not included in HMIS is VASH. Fairfax County's Office to Prevent and End Homelessness (OPEH), the CoC Lead, has implemented several monthly By-Name List meetings over the past year, one of which focuses on veterans and is attended by the US Department of Veteran Affairs and three Supportive Services for Veteran Family Services providers. OPEH also works closely with the local PHA and has collaborated with this office on a number of policies to better serve individuals and families experiencing homelessness. The CoC recognizes the importance of including all beds in HMIS, including those operated through VASH. Continuing to strengthen the partnerships with the relevant agencies and emphasize the importance of comprehensive bed coverage are key strategies the CoC will implement over the next year to increase the bed coverage rate for this project type, which is only a few percentage points below the target. The CoC is also engaging the Virginia Department of Veteran Services' leadership to develop possible solutions. All other PSH beds are already included in HMIS. The CoC was successful in increasing the bed coverage rate for Rapid Re-housing by 6% and for Other Permanent Housing beds by 18% from the previous year.

2A-6. AHAR Shells Submission: How many 2017 Annual Housing Assessment Report (AHAR) tables shells did HUD accept? 12

2A-7. CoC Data Submission in HDX. Applicants must enter the date the CoC submitted the 2018 Housing Inventory Count (HIC) data into the Homelessness Data Exchange (HDX). (mm/dd/yyyy) 04/27/2018

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

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

2B-1. PIT Count Date. Applicants must enter the date the CoC conducted its 2018 PIT count (mm/dd/yyyy).	01/24/2018
2B-2. HDX Submission Date. Applicants must enter the date the CoC submitted its PIT count data in HDX (mm/dd/yyyy).	04/27/2018

2C. Continuum of Care (CoC) Point-in-Time (PIT) Count: Methodologies

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

2C-1. Change in Sheltered PIT Count Implementation. Applicants must describe any change in the CoC's sheltered PIT count implementation, including methodology and data quality changes from 2017 to 2018. Specifically, how those changes impacted the CoC's sheltered PIT count results.
(limit 2,000 characters)

Not Applicable

2C-2. Did your CoC change its provider coverage in the 2018 sheltered count? Yes

2C-2a. If "Yes" was selected in 2C-2, applicants must enter the number of beds that were added or removed in the 2018 sheltered PIT count.

Beds Added:	36
Beds Removed:	19
Total:	17

2C-3. Presidentially Declared Disaster Changes to Sheltered PIT Count. Did your CoC add or remove emergency shelter, transitional housing, or Safe Haven inventory because of funding specific to a Presidentially declared disaster, resulting in a change to the CoC's 2018 sheltered PIT count? No

2C-3a. If "Yes" was selected for question 2C-3, applicants must enter the number of beds that were added or removed in 2018 because of a Presidentially declared disaster.

Beds Added:	0
Beds Removed:	0
Total:	0

2C-4. Changes in Unsheltered PIT Count Implementation. Did your CoC change its unsheltered PIT count implementation, including methodology and data quality changes from 2017 to 2018? If your CoC did not conduct and unsheltered PIT count in 2018, select Not Applicable.	Yes

2C-4a. If "Yes" was selected for question 2C-4, applicants must:
(1) describe any change in the CoC's unsheltered PIT count implementation, including methodology and data quality changes from 2017 to 2018; and
(2) specify how those changes impacted the CoC's unsheltered PIT count results.
(limit 2,000 characters)

(1) The CoC has continually made improvements each year to enhance the collection of information for unsheltered individuals. Though the methodology of the PIT count itself stayed mostly the same, improvements to the ongoing data collection process for unsheltered individuals also contributed to a more accurate PIT count. In July 2017, the CoC instituted a monthly By-Name List meeting with its street outreach programs in order to develop more comprehensive strategies and individualized plans to serve the unsheltered individuals in the CoC. The By-Name List, generated through HMIS, captures all persons in the system that are known to be experiencing unsheltered homelessness, regardless of whether or not they are engaged in services.
(2) During the 2018 PIT count, the CoC used the By-Name List to crosscheck all individuals who were physically identified during the PIT count. Because the outreach data used to generate the By-Name List is regularly updated and reviewed for accuracy, the By-Name List served as a real-time inventory of everyone who was likely unsheltered on the night of the PIT. Outreach workers followed up with individuals that were included on the By-Name List but not included on the PIT count to determine if they were actually unsheltered on the night of the count.

2C-5. Identifying Youth Experiencing Homelessness in 2018 PIT Count. Did your CoC implement specific measures to identify youth experiencing homelessness in its 2018 PIT count?	Yes

2C-5a. If "Yes" was selected for question 2C-5., applicants must describe:
(1) how stakeholders serving youth experiencing homelessness were engaged during the planning process;
(2) how the CoC worked with stakeholders to select locations where youth experiencing homelessness are most likely to be identified; and
(3) how the CoC involved youth experiencing homelessness in counting during the 2018 PIT count.
(limit 2,000 characters)

(1) The primary youth provider that operates emergency shelter, rapid

rehousing, and transitional housing programs for youth, as well as Fairfax County Public Schools Homeless Liaison's Office, were actively engaged in planning meetings in preparation for the 2018 PIT count. Representatives served on the PIT committee, which is the entity convened by the CoC lead that is responsible for orchestrating the count. Youth providers gave input on the PIT training curriculum and also facilitated trainings to providers participating in the PIT count on how best to collect information in case they encountered a youth on the night of the count.
(2&3) A survey was administered to youth providers, as well as the youth currently engaged in services, to identify the specific areas that youth experiencing homelessness were most likely to be located – beyond the known homeless service locations. Flyers explaining the what, why, and when of the PIT count were positioned in strategic locations to notify youth that the count was occurring and to promote participation. Another survey was administered to youth in the primary youth provider's programs, as well as those in emergency shelter, after the PIT count to further assess needs and solicit input on services provided.

2C-6. 2018 PIT Implementation. Applicants must describe actions the CoC implemented in its 2018 PIT count to better count:
(1) individuals and families experiencing chronic homelessness;
(2) families with children experiencing homelessness; and
(3) Veterans experiencing homelessness.
(limit 2,000 characters)

The CoC Lead convenes a PIT committee, comprised of providers serving all populations and subpopulations, to ensure the PIT count is comprehensive and reaches everyone that may be experiencing homelessness. The training curriculum, which has been used for several years, is reviewed and revised by the PIT committee two months prior to the PIT count. The training, which occurs within one month of the PIT count, is facilitated by the CoC and HMIS Lead and is attended by all service providers. The training includes an overview of the HIC and PIT count, a review of the PIT count definitions (with an extensive focus on the chronic homeless definition), and a review of how to collect and document the PIT Count data. A survey is provided to attendees after the training to ensure that it is all-inclusive and effective. In addition to the training provided, to better identify individuals and families experiencing chronic homelessness, the CoC Lead collaborates with clients as well as outreach teams and drop in centers to identify known hot spots or new areas where there may be suspected encampments, where individuals may be sleeping in cars, etc. The street outreach teams are assigned to all four human services regions of the CoC to ensure there is 100% geographic coverage for the PIT count. Flyers explaining the what, why, and when of the PIT count are positioned in emergency shelters serving individuals and families, as well as drop-in centers, to notify clients and promote participation. This supports providers in reaching all populations, including individuals and families experiencing chronic homelessness, families with children experiencing homelessness and veterans experiencing homelessness. Ongoing partnership with the five SSFV providers operating within the CoC has helped to ensure an accurate count of veterans.

3A. Continuum of Care (CoC) System Performance

Instructions

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

3A-1. First Time Homeless as Reported in HDX. In the box below, applicants must report the number of first-time homeless as reported in HDX.

Number of First Time Homeless as Reported in HDX.	2,166

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

(1) Referral data from Fairfax County's Coordinated Services Planning (primary entry point for families) is collected and analyzed alongside HMIS prevention, outreach, and shelter entry data (primary entry points for individuals) to identify emerging characteristics and risk factors of persons becoming homeless for the first time. Outcomes are discussed with providers to determine if additional screening questions should be incorporated into the system entry points to better target prevention and diversion services.
(2) Prevention services is the strategy the CoC uses to address individuals and families at risk of becoming homeless and is also the most common entry point for persons becoming homeless for the first time. As such, the Coordinated Entry (CE) eligibility criteria for prevention services was designed to be low barrier – the individual or family must meet categories 2, 3, or 4 of HUD's homeless definition and have an annual income at or below 30% of the AMI. The income threshold was determined after reviewing income data for those experiencing literal homelessness. When prevention referrals exceed capacity, family service providers prioritize by susceptibility of becoming literally homeless. Those with an episode of homelessness within the past 24 months are served first, followed by those with any experience of homelessness. Individual service providers use a scored tool that takes variety of vulnerability factors into consideration.
(3) Fairfax County's Office to Prevent and End Homelessness is responsible for overseeing these strategies. The agency employs a CE Systems Manager tasked with developing, implementing, and maintaining system-wide CE procedures, such as ensuring there are clear avenues to prevention and diversion services. The development of this role has expanded leadership capacity to improve system performance, which includes reducing the number

of individuals and families experiencing homelessness for the first time.

3A-2. Length-of-Time Homeless as Reported in HDX. Applicants must:
(1) provide the average length of time individuals and persons in families remained homeless (i.e., the number);
(2) describe the CoC's strategy to reduce the length-of-time individuals and persons in families remain homeless;
(3) describe how the CoC identifies and houses individuals and persons in families with the longest lengths of time homeless; and
(4) provide the name of the organization or position title that is responsible for overseeing the CoC's strategy to reduce the length of time individuals and families remain homeless.
(limit 2,000 characters)

(1) According to the most recent AHAR, the average length of homelessness for ES/SH increased slightly from 61 to 63 days (3%) between FY2016 and FY2017. However, the average length of homelessness for ES/SH/TH decreased significantly, from 106 to 90 days (15%).
(2) Fairfax County's Office to Prevent and End Homelessness (OPEH), also the CoC Lead, has implemented several initiatives to reduce the length of time individuals and persons in families experience homelessness. This includes the implementation of streamlined data quality processes to ensure the information being analyzed is accurate. OPEH also incorporated a performance measure, focused on length of time homeless with an expected reduction rate per year, in individual contracts held with providers operating Outreach, Prevention, ES, RRH, and PSH programs. OPEH Program Managers hold quarterly meetings with contracted providers to review all performance measures, including length of homelessness, and discuss specific strategies to elevate performance. OPEH also actively engages the few providers who do not hold contracts in discussions about the system-wide performance measures.
(3) The CoC uses HMIS to generate By-Name Lists, which are sorted by population (sheltered and unsheltered individuals, families and veterans) and prioritized by chronicity and length of homelessness. Monthly By-Name List Meetings, led by OPEH, are held with contracted and non-contracted providers to develop specific housing plans to address each individual's episode of homelessness, starting with longest length of homelessness. The CoC's Coordinated Entry Prioritization Pool, which operates in alignment with HUD's memo on prioritizing length of homelessness for permanent supportive housing programs, is used to quickly connect individuals and families to housing programs.
(4) OPEH is responsible for overseeing all of these strategies.

3A-3. Successful Permanent Housing Placement and Retention as Reported in HDX. Applicants must:
(1) provide the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid rehousing that exit to permanent housing destinations; and
(2) provide the percentage of individuals and persons in families in permanent housing projects, other than rapid rehousing, that retain their permanent housing or exit to permanent housing destinations.

	Percentage

Report the percentage of individuals and persons in families in emergency shelter, safe havens, transitional housing, and rapid re-housing that exit to permanent housing destinations as reported in HDX.	48%
Report the percentage of individuals and persons in families in permanent housing projects, other than rapid re-housing, that retain their permanent housing or exit to permanent housing destinations as reported in HDX.	92%

3A-3a. Applicants must:
(1) describe the CoC's strategy to increase the rate at which individuals and persons in families in emergency shelter, safe havens, transitional housing and rapid rehousing exit to permanent housing destinations; and
(2) describe the CoC's strategy to increase the rate at which individuals and persons in families in permanent housing projects, other than rapid rehousing, retain their permanent housing or exit to permanent housing destinations.
(limit 2,000 characters)

(1)In FY17, 48% of persons exited successfully from ES, SH, TH, and PH-RHH, which was a slight increase from 45% in FY16. The CoC has executed several strategies to increase the rate of exits from these programs to permanent housing destinations. By-Name List Meetings, with data generated by HMIS and sorted by population (sheltered and unsheltered individuals, families and veterans), are held monthly with contracted and non-contracted providers to develop individualized plans and review outflow data. Providers restructured to shift capacity to prevention and diversion services to decrease inflow and have increased capacity to support retention once rehoused. Fairfax County's Coordinated Services Planning provides eviction prevention in the CoC, which also supports a decreased inflow. In addition to programmatic shifts, the CoC carefully evaluated the range and volume of program types within the entire system and repurposed some of its transitional housing programs to increase its permanent housing stock.
(2)The percentage of successful exits from and retention of PH decreased to 92% in FY17 from 96% in FY16. Again, the CoC has executed several strategies to increase the rate of retention and exits from these programs to permanent housing destinations. The CoC strengthened its partnership with the local PHA; a preference to serve individuals and families experiencing homelessness was instituted and vouchers are now accessible for households in permanent supportive housing that no longer need intensive services. All CoC programs adopted a Housing First approach and the CoC implemented a system-wide training program for frontline staff on housing-related skills. Case managers shifted their focus to housing stability, which includes developing tangible plans to increase income and long term housing goals.

Fairfax County's Office to Prevent and End Homelessness is responsible for overseeing all of these strategies.

3A-4. Returns to Homelessness as Reported in HDX. Applicants must report the percentage of individuals and persons in families returning to homelessness over a 6- and 12-month period as reported in HDX.

	Percentage
Report the percentage of individuals and persons in families returning to homelessness over a 6- and 12-month period as reported in HDX	7%

3A-4a. Applicants must:
(1) describe how the CoC identifies common factors of individuals and persons in families who return to homelessness;
(2) describe the CoC's strategy to reduce the rate of additional returns to homelessness; and
(3) provide the name of the organization or position title that is responsible for overseeing the CoC's strategy to reduce the rate individuals and persons in families returns to homelessness.
(limit 2,000 characters)

(1) The CoC uses a report generated through HMIS to identify persons who exit homelessness to a permanent housing destination and subsequently return to homelessness within 6 to 12 months and within 24 months. Providers examine individual cases of persons returning to homelessness to determine the cause and identify if there were missed opportunities to engage. The data is also explored to see if any indicators of those most at risk for recidivism can be identified and to assess if interventions, services, or approaches should be adjusted to reduce recidivism.
(2) This recidivism data is presented to Executive Directors within the CoC as well as the Governing Board and reviewed at meetings held with non-contracted and contracted providers. The ongoing focus and commitment to regularly analyzing the recidivism data to create awareness and promote solution driven discussions is a key initial strategy to reducing the rate of additional returns to homelessness. Providers have already restructured to shift capacity to prevention and diversion services to decrease inflow and have increased capacity to support retention once rehoused. If need exceeds capacity for prevention services, the CoC has instituted a priority within its Coordinated Entry policies to first serve families with an episode of homelessness within the past 24 months. It has been hypothesized, based on recidivism data produced through HMIS, that these individuals have a higher susceptibility to becoming literally homeless. Vulnerability is still taken into consideration for individuals. Fairfax County's Office to Prevent and End Homelessness (OPEH) also incorporated performance measures, including goals to increase exits to permanent housing and decrease returns to homelessness, into contracts issued to ensure the focus on addressing recidivism is mutual.
(3) OPEH is responsible for overseeing the CoC's strategy to reduce the rate individuals and persons in families returns to homelessness.

3A-5. Job and Income Growth. Applicants must:
(1) describe the CoC's strategy to increase access to employment and non-employment cash sources;
(2) describe how the CoC works with mainstream employment organizations to help individuals and families increase their cash income; and
(3) provide the organization name or position title that is responsible for overseeing the CoC's strategy to increase job and income growth from employment.
(limit 2,000 characters)

(1) The CoC has executed several strategies to increase access to employment and non-employment cash resources. The CoC has a locally funded employment program, with a position that serves the whole system, focused on

recruiting businesses committed to hiring and training clients with employment barriers. The majority of providers, including non-CoC Program funded projects, also have employment specialist positions designed to provide employment support tailored to the individual's needs. Services include job search assistance, support in completing job applications, resume building, referrals for interview clothing, practice interviews, career planning – including exploring GED, vocational, or other education programs, etc. To support access to non-employment cash sources, all CoC Program funded projects have SOAR certified staff to assist eligible clients in obtaining SSI/SSDI. The CoC uses one form to access numerous cash and non-cash benefits, which has lowered barriers to attainment.
(2) The CoC has positioned employment services as a key focal point in the development of its next strategic plan to continue to strengthen this aspect of the system. Leadership from Fairfax County's Economic and Development Authority sits on the CoC's Governing Board, which helps to promote collaboration with mainstream employment organizations. This department houses workforce development programs such as the Virginia Employment Commission and the Northern Virginia Workforce Investment Board and SkillSource Group, both of which connect job seekers to a variety of employment, education, and training services available at the local, state and federal levels. System Performance Measure #4 in the most recently submitted AHAR has demonstrated that these strategies are effective – 4 of the 6 metrics had an increase of 20% or greater.
(3) Fairfax County's Office to Prevent and End Homelessness is responsible for overseeing the CoC's strategies to increase job and income growth.

3A-6. System Performance Measures Data Submission in HDX. Applicants must enter the date the CoC submitted the System Performance Measures data in HDX, which included the data quality section for FY 2017 (mm/dd/yyyy)	05/29/2018

3B. Continuum of Care (CoC) Performance and Strategic Planning Objectives

Instructions

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

3B-1. DedicatedPLUS and Chronically Homeless Beds. In the boxes below, applicants must enter: (1) total number of beds in the Project Application(s) that are designated as DedicatedPLUS beds; and (2) total number of beds in the Project Application(s) that are designated for the chronically homeless, which does not include those that were identified in (1) above as DedicatedPLUS Beds.

Total number of beds dedicated as DedicatedPLUS	182
Total number of beds dedicated to individuals and families experiencing chronic homelessness	295
Total	477

3B-2. Orders of Priority. Did the CoC adopt the Orders of Priority into their written standards for all CoC Program-funded PSH projects as described in Notice CPD-16-11: Prioritizing Persons Experiencing Chronic Homelessness and Other Vulnerable Homeless Persons in Permanent Supportive Housing? Attachment Required. Yes

3B-2.1. Prioritizing Households with Children. Using the following chart, applicants must check all that apply to indicate the factor(s) the CoC currently uses to prioritize households with children during FY 2018.

History of or Vulnerability to Victimization (e.g. domestic violence, sexual assault, childhood abuse)	X
Number of previous homeless episodes	X
Unsheltered homelessness	X
Criminal History	X
Bad credit or rental history	X
Head of Household with Mental/Physical Disability	X

3B-2.2. Applicants must:
(1) describe the CoC's current strategy to rapidly rehouse every household of families with children within 30 days of becoming homeless;
(2) describe how the CoC addresses both housing and service needs to ensure families successfully maintain their housing once assistance ends; and
(3) provide the organization name or position title responsible for overseeing the CoCs strategy to rapidly rehouse families with children within 30 days of becoming homeless.
(limit 2,000 characters)

(1) The majority of families in the CoC engage shortly before they become literally homeless. If homelessness cannot be prevented, staff have already oriented the family to the homeless service system and set the expectation that the episode of homelessness is to be brief. The head of household is informed prior to entering, and again upon entry, that the shelter stay is for 30 days. The intake process is low-barrier and housing focused. Housing locators provide immediate support in identifying housing options and if needed, equip the family with the skills to search for housing as well. Case managers complete a Housing & Services Triage Tool (HSTT) to support the family in developing a housing plan, which is solidified within the 1st week of residency. The HSTT, which focuses on both housing and service needs, was developed locally in partnership with the National Alliance to End Homelessness to create a uniform lens to identify the housing that may be most appropriate for the family. This includes rapid rehousing, bridging affordability (a local housing subsidy), transitional housing, and permanent supportive housing. Permanent housing with family or friends is also explored.
(2) Forethought in the placement process is the first step in helping families to maintain their housing once assistance ends. Case managers provide intensive support as families transition into housing and then services are gradually reduced once they are connected to mainstream benefits and/or increase income. Fairfax County's Office to Prevent and End Homelessness (OPEH) has incorporated performance measures focused on length of stay, exits to permanent housing, and reducing returns to homelessness into contracts held with all of the providers operating shelters serving families in the CoC to ensure a shared focus on these areas.
(3) OPEH is responsible for overseeing the CoC's strategies to rapidly rehouse families and children within 30 days of becoming homeless.

3B-2.3. Antidiscrimination Policies. Applicants must check all that apply that describe actions the CoC is taking to ensure providers (including emergency shelter, transitional housing, and permanent supportive housing (PSH and RRH) within the CoC adhere to antidiscrimination policies by not denying admission to or separating any family members from other members of their family or caregivers based on age, sex, gender, LGBT status, marital status, or disability when entering a shelter or housing.

CoC conducts mandatory training for all CoC and ESG funded service providers on these topics.	☐
CoC conducts optional training for all CoC and ESG funded service providers on these topics.	☐
CoC has worked with ESG recipient(s) to adopt uniform anti-discrimination policies for all subrecipients.	☐
CoC has worked with ESG recipient(s) to identify both CoC and ESG funded facilities within the CoC geographic area that may be out of compliance, and taken steps to work directly with those facilities to come into compliance.	☐

CoC has sought assistance from HUD through submitting AAQs or requesting TA to resolve non-compliance of service providers.	☐

3B-2.4. Strategy for Addressing Needs of Unaccompanied Youth Experiencing Homelessness. Applicants must indicate whether the CoC's strategy to address the unique needs of unaccompanied homeless youth includes the following:

Human trafficking and other forms of exploitation	Yes
LGBT youth homelessness	Yes
Exits from foster care into homelessness	Yes
Family reunification and community engagement	Yes
Positive Youth Development, Trauma Informed Care, and the use of Risk and Protective Factors in assessing youth housing and service needs	Yes

3B-2.5. Prioritizing Unaccompanied Youth Experiencing Homelessness Based on Needs. Applicants must check all that apply from the list below that describes the CoC's current strategy to prioritize unaccompanied youth based on their needs.

History or Vulnerability to Victimization (e.g., domestic violence, sexual assault, childhood abuse)	X
Number of Previous Homeless Episodes	X
Unsheltered Homelessness	X
Criminal History	
Bad Credit or Rental History	X

3B-2.6. Applicants must describe the CoC's strategy to increase:
(1) housing and services for all youth experiencing homelessness by providing new resources or more effectively using existing resources, including securing additional funding; and
(2) availability of housing and services for youth experiencing unsheltered homelessness by providing new resources or more effectively using existing resources.
(limit 3,000 characters)

(1&2) The CoC's strategy to increase housing and services for all youth experiencing homelessness, including unsheltered youth, is to improve the system's overall efficiency by quickly connecting youth to the resources currently in existence and creating movement in the system to ensure capacity remains sufficient. The CoC collaborates with the Homeless Liaison Office (HLO) of the Fairfax County Public Schools (FCPS) as well as the primary homeless services youth provider to ensure that youth at risk of or experiencing homelessness are made aware of the supports available. The primary youth provider operates a variety of housing and service interventions, including emergency shelter, transitional housing, and a CoC-Program funded rapid rehousing project serving Transition Age Youth (18-24). The rapid rehousing project, which can serve sheltered and unsheltered youth, was selected in 2015

by the CoC Committee as a new bonus project as it added a unique project type that had not previously been readily accessible to the youth population. The addition of this permanent housing project type helped to create the full scope of housing and service options that are now available to youth. The development of the Coordinated Entry system and implementation of bi-monthly Coordinated Entry Prioritization Pool meetings have also helped to streamline the access, assessment, and assignment process so youth are connected to housing programs more quickly and vacancies are filled sooner.

3B-2.6a. Applicants must:
(1) provide evidence the CoC uses to measure both strategies in question 3B-2.6. to increase the availability of housing and services for youth experiencing homelessness;
(2) describe the measure(s) the CoC uses to calculate the effectiveness of the strategies; and
(3) describe why the CoC believes the measure it uses is an appropriate way to determine the effectiveness of the CoC's strategies.
(limit 3,000 characters)

(1) The unique needs of the youth population have been a regular part of CoC discussions. To evaluate the effectiveness of the system and resources available to youth, the CoC has analyzed inflow and outflow data. Of the project types currently in existence that are designed to serve youth, including emergency shelter, transitional housing, and a CoC-Program funded rapid rehousing project serving Transition Age Youth (18-24), referrals have not exceeded system capacity. This outcome demonstrates that both of the CoC's strategies to address youth homelessness – to improve the efficiency of the system and create movement – are working.
(2) Any youth that is unsheltered is immediately connected to shelter and assessed for other available housing interventions through the Coordinated Entry Prioritization Pool. The rapid rehousing project serving Transition Age Youth (TAY) that was newly implemented at the end of 2016 has already served 11 individuals, 15 parents, and 17 children. This is a considerable expansion of permanent housing resources since this project type, solely focused on this population, did not previously exist. Outcome measures are developed for each individual project types. The outcome target for the rapid rehousing project serving youth is that 90% served will increase their income and maintain stable housing. All project types, including those serving youth, are assessed in the scope of the system wide performance measures to ensure they are effectively contributing to preventing and ending homelessness in the CoC.
(3) The needs of the youth population are being met and therefore the measures are assessed to be appropriate in determining effectiveness. However, the CoC is continuously seeking to improve its system by critically analyzing its evaluation processes to ensure measures appropriately correlate to outcomes.

3B-2.7. Collaboration–Education Services. Applicants must describe how the CoC collaborates with:
(1) youth education providers;
(2) McKinney-Vento State Education Agency (SEA) and Local Education Agency (LEA);
(3) school districts; and

**(4) the formal partnerships with (1) through (3) above.
(limit 2,000 characters)**

(1) The Homeless Liaison Office (HLO) of the Fairfax County Public Schools (FCPS), which is the local McKinney Vento Act Education Liaison, is included in all CoC meetings where issues specific to homeless youth are discussed. This includes Family Provider meetings, Coordinated Entry meetings, as well as Governing Board meetings. OPEH's point of contact for youth and family homelessness interacts regularly with the HLO to strategize solutions for complicated issues unique to homeless youth. The HLO brings specific families to the attention of the homeless service system to ensure they are connected. The HLO and the homeless service providers also regularly discuss transportation, benefits, tutoring, school access, shelter and housing options. All shelters and housing projects have staff that are knowledgeable about education issues and collaborate with the HLO.
(2) The HLO serves as the connection between the state and county, which is also the CoC.
(3) The HLO serves as the primary link between the homeless service system and the nearly 200 public schools that exist in the CoC. The HLO also coordinates with school districts in other jurisdiction when there are service needs that overlaps borders.
(4) To promote ongoing communication and collaboration, the head of the HLO meets regularly with the Director of the Fairfax County's Office to Prevent and End Homelessness (OPEH) to review policy issues. The HLO is an official member of the CoC. OPEH and FCPS jointly produced a brochure to raise awareness in the community about the needs of children experiencing homelessness.

**3B-2.7a. Applicants must describe the policies and procedures the CoC adopted to inform individuals and families who become homeless of their eligibility for education services.
(limit 2,000 characters)**

The Homeless Liaison Office (HLO) of Fairfax County Public Schools (FCPS) collaborates with all CoC providers to ensure that individuals and families experiencing homelessness are aware of their eligibility for education services and are connected. The HLO and the CoC Lead produced a brochure, available on the FCPS website and in the shelters, to inform parents of the educational resources available for school age children experiencing homelessness. This includes information such as the option to stay in the original school or enroll in any public school that students living in the same attendance area are eligible to attend, transportation resources, etc. With consent, providers serving school age children pass parent/guardian contact information, the names of the school age children, grades, and names of schools of current enrollment directly to the HLO upon entry. Providers also pass a By-Name List each month to the HLO to ensure that all parents/guardians are known and informed of the educational services available. The providers address initial transportation barriers and the HLO coordinates with the parent/guardian directly to implement ongoing transportation assistance (typically executed within 3-5 business days) provided through the HLO. The HLO also informs families that students experiencing homelessness are entitled to free and reduced breakfast and lunch. The HLO partners with the Office to Prevent and End Homelessness to provide an annual training accessible to all CoC providers to ensure they are knowledgeable of the eligibility criteria and resources available for school age children experiencing

homelessness. Educational services are also discussed with non-school age individuals. Parents of non-school age children are informed of eligibility for Head Start, eligibility for education benefits is reviewed with veterans, GED and ESL resources are discussed when applicable, and youth providers explore resources available for higher education.

3B-2.8. Does the CoC have written formal agreements, MOU/MOAs or partnerships with one or more providers of early childhood services and supports? Select "Yes" or "No". Applicants must select "Yes" or "No", from the list below, if the CoC has written formal agreements, MOU/MOA's or partnerships with providers of early childhood services and support.

	MOU/MOA	Other Formal Agreement
Early Childhood Providers	No	No
Head Start	No	Yes
Early Head Start	No	Yes
Child Care and Development Fund	No	Yes
Federal Home Visiting Program	No	No
Healthy Start	No	No
Public Pre-K	No	No
Birth to 3 years	No	No
Tribal Home Visting Program	No	No
Other: (limit 50 characters)		

3B-3.1. Veterans Experiencing Homelessness. Applicants must describe the actions the CoC has taken to identify, assess, and refer Veterans experiencing homelessness, who are eligible for U.S. Department of Veterans Affairs (VA) housing and services, to appropriate resources such as HUD-VASH, Supportive Services for Veterans Families (SSVF) program and Grant and Per Diem (GPD). (limit 2,000 characters)

The DC VA Medical Center, five SSVF providers, and the Virginia Department of Veterans Services are active members of the CoC. Veterans are identified in street outreach, shelter entry, and at drop-in centers and quickly linked to Veterans Health Administration (VHA) services, where applicable. Front line staff are trained on how to begin the conversation of service in the armed forces, as well as how to order DD-214, apply to VBA monetary benefits, and register for VHA medical services. The VA Medical Center outreach staff are readily accessible and can provide guidance on a particular veteran's eligibility for services including GPD, Community Engagement and Reintegration Services (CERS), SSVF, and HUD-VASH. After eligibility is determined, veterans are immediately referred to the appropriate services. Veterans are selected for HUD-VASH following the HUD 2016 Prioritization Notice and vulnerability scores as determined by the VI-SPDAT assessment tool. Monthly By-Name List Meetings, focusing on veterans, are attended by representatives from homeless and veterans service organizations to review the By-Name List generated through HMIS as part of the CoC's Coordinated Entry process to

ensure that all appropriate resources and solutions are provided to each veteran identified. HUD-VASH vouchers issued to Public Housing Authorities in Northern Virginia and DC are ported regionally to more effectively and efficiently target the most vulnerable veterans experiencing homelessness in the region. This allows the system to respond to a particular veteran's need at any given time, rather than waiting for an opening in a certain area.

3B-3.2. Does the CoC use an active list or by name list to identify all Veterans experiencing homelessness in the CoC?	Yes
3B-3.3. Is the CoC actively working with the VA and VA-funded programs to achieve the benchmarks and criteria for ending Veteran homelessness?	Yes
3B-3.4. Does the CoC have sufficient resources to ensure each Veteran experiencing homelessness is assisted to quickly move into permanent housing using a Housing First approach?	Yes
3B-5. Racial Disparity. Applicants must: (1) indicate whether the CoC assessed whether there are racial disparities in the provision or outcome of homeless assistance; (2) if the CoC conducted an assessment, attach a copy of the summary.	Yes

3B-5a. Applicants must select from the options below the results of the CoC's assessment.

People of different races or ethnicities are more or less likely to receive homeless assistance.	X
People of different races or ethnicities are more or less likely to receive a positive outcome from homeless assistance.	
There are no racial disparities in the provision or outcome of homeless assistance.	
The results are inconclusive for racial disparities in the provision or outcome of homeless assistance.	

3B-5b. Applicants must select from the options below the strategies the CoC is using to address any racial disparities.

The CoC's board and decisionmaking bodies are representative of the population served in the CoC.	☐

The CoC has identified steps it will take to help the CoC board and decisionmaking bodies better reflect the population served in the CoC.	☐
The CoC is expanding outreach in geographic areas with higher concentrations of underrepresented groups.	☐
The CoC has communication, such as flyers, websites, or other materials, inclusive of underrepresented groups	☐
The CoC is training staff working in the homeless services sector to better understand racism and the intersection of racism and homelessness.	☐
The CoC is establishing professional development opportunities to identify and invest in emerging leaders of different races and ethnicities in the homelessness sector.	☐
The CoC has staff, committees or other resources charged with analyzing and addressing racial disparities related to homelessness.	☐
The CoC is educating organizations, stakeholders, boards of directors for local and national non-profit organizations working on homelessness on the topic of creating greater racial and ethnic diversity.	☐
The CoC reviewed coordinated entry processes to understand their impact on people of different races and ethnicities experiencing homelessness.	☐
The CoC is collecting data to better understand the pattern of program use for people of different races and ethnicities in its homeless services system.	☐
The CoC is conducting additional research to understand the scope and needs of different races or ethnicities experiencing homelessness.	☐
Other:	☐

4A. Continuum of Care (CoC) Accessing Mainstream Benefits and Additional Policies

Instructions:

For guidance on completing this application, please reference the FY 2018 CoC Application Detailed Instructions and the FY 2018 CoC Program Competition NOFA. Please submit technical questions to the HUD Exchange Ask A Question.

4A-1. Healthcare. Applicants must indicate, for each type of healthcare listed below, whether the CoC:
(1) assists persons experiencing homelessness with enrolling in health insurance; and
(2) assists persons experiencing homelessness with effectively utilizing Medicaid and other benefits.

Type of Health Care	Assist with Enrollment	Assist with Utilization of Benefits?
Public Health Care Benefits (State or Federal benefits, Medicaid, Indian Health Services)	Yes	Yes
Private Insurers:	Yes	Yes
Non-Profit, Philanthropic:	No	No
Other: (limit 50 characters)		
Community Health Care Network	Yes	Yes

4A-1a. Mainstream Benefits. Applicants must:
(1) describe how the CoC works with mainstream programs that assist persons experiencing homelessness to apply for and receive mainstream benefits;
(2) describe how the CoC systematically keeps program staff up-to-date regarding mainstream resources available for persons experiencing homelessness (e.g., Food Stamps, SSI, TANF, substance abuse programs); and
(3) provide the name of the organization or position title that is responsible for overseeing the CoC's strategy for mainstream benefits. (limit 2,000 characters)

(1) The CoC collaborates with other agencies and mainstream programs, including the local Department of Family Services, Health Department, Community Services Board, as well as the United States Department of Veteran's Affairs, to ensure persons experiencing homelessness have access to all applicable mainstream benefits and services they may offer. The CoC has implemented one form that allows clients to apply for a range of benefits (including TANF, SNAP, General Relief, etc.) to simplify the process in accessing these resources. Frontline staff assist clients with completing forms and also help the clients navigate the systems, provide transportation to appointments, and generally advocate on clients' behalf to gain access to any benefits and services that are rightfully theirs.

(2) To consistently keep providers informed of the resources available, the CoC hosts an ongoing comprehensive educational series where presenters from public and private organizations host trainings on mainstream benefits and other community-based services. These sessions are open to everyone in the CoC and are generally offered on a rotating calendar so that those who could not attend on a particular date have the opportunity to attend at a later time. The CoC has also facilitated trainings for CoC program-funded project staff via state trainers on SSI/SSDI Outreach, Access, and Recovery (SOAR) certification. Each agency that is contracted to provide services has at least one SOAR-certified frontline staff member who can work with individuals and families on their applications.
(3) Fairfax County's Office to Prevent and End Homelessness is the primary organization responsible for overseeing the CoC's strategy for connecting clients within homeless services to mainstream benefits.

4A-2.Housing First: Applicants must report: (1) total number of new and renewal CoC Program Funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC is applying for in FY 2018 CoC Program Competition; and (2) total number of new and renewal CoC Program Funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC is applying for in FY 2018 CoC Program Competition that have adopted the Housing First approach–meaning that the project quickly houses clients without preconditions or service participation requirements.

Total number of new and renewal CoC Program Funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC is applying for in FY 2018 CoC Program Competition.	25
Total number of new and renewal CoC Program Funded PSH, RRH, SSO non-coordinated entry, Safe-Haven, and Transitional Housing projects the CoC is applying for in FY 2018 CoC Program Competition that have adopted the Housing First approach–meaning that the project quickly houses clients without preconditions or service participation requirements.	25
Percentage of new and renewal PSH, RRH, Safe-Haven, SSO non-Coordinated Entry projects in the FY 2018 CoC Program Competition that will be designated as Housing First.	100%

4A-3. Street Outreach. Applicants must: (1) describe the CoC's outreach; (2) state whether the CoC's Street Outreach covers 100 percent of the CoC's geographic area; (3) describe how often the CoC conducts street outreach; and (4) describe how the CoC tailored its street outreach to persons experiencing homelessness who are least likely to request assistance. (limit 2,000 characters)

(1) Outreach activities are performed through the CoC's Singles Outreach (SO) programs, in partnership with the Health Department's Homeless Healthcare Program (HHP) and the Community Services Board's PATH team. This multidisciplinary approach is a method used to ensure a wide variety of services are easily accessible to promote engagement.
(2) The SO programs, which are operated by 3 nonprofits, are assigned to all 4 human services regions to ensure there is 100% geographic coverage of the CoC.
(3) Routine outreach is performed weekly (at varying times of the day/week),

with SO workers going to known hot spots and/or exploring new areas where there may be encampments, cars, etc. Outreach workers also regularly respond to reports from various sources, including the Board of Supervisors, local/state public safety, Park Authority, the Virginia Department of Transportation, as well as the larger community. Between routine outreach and in response to reports made, outreach to identify and engage individuals is conducted in the CoC almost every day.
(4) By-Name List (BNL) Meetings focusing on the unsheltered population are facilitated by the CoC Lead twice per month. The BNL is generated through HMIS as part of the CoC's Coordinated Entry process and used in the meetings to ensure everyone who is unsheltered is identified, especially those who are least likely to request assistance. Outreach workers attempt to contact every person on the entire list at least once a month to confirm they are still unsheltered and to offer services. The strategy of regular, repeated contact by the same Outreach worker is designed to establish trust with those who are resistant to services with the ultimate goal being successful engagement. The BNL Meetings are also used to develop and review metrics, analyze system inflow and outflow (including an assessment of all exit destinations), staff cases, and to identify and address barriers to access.

4A-4. Affirmative Outreach. Applicants must describe:
(1) the specific strategy the CoC implemented that furthers fair housing as detailed in 24 CFR 578.93(c) used to market housing and supportive services to eligible persons regardless of race, color, national origin, religion, sex, gender identify, sexual orientation, age, familial status or disability; and
(2) how the CoC communicated effectively with persons with disabilities and limited English proficiency fair housing strategy in (1) above.
(limit 2,000 characters)

(1) The CoC partners with the local Office of Human Rights and Equity Programs and Disability Services Board to provide consistently reoccurring trainings and technical assistance to ensure that all providers are knowledgeable of and operate in compliance with fair housing requirements. These trainings include guidance on how providers can effectively serve people with disabilities and those with limited English proficiency. Coordinated Entry (CE) policies require that providers serve all people that meet eligibility criteria regardless of their race, color, religion or creed, national origin or ancestry, gender identity, sexual orientation, familial status, sex, age, physical or mental disability, or veteran status. Outreach, communication, and marketing materials are monitored to assess compliance. A definition for equity is included in the CE Manual and CE trainings reiterate the strategies providers are expected to utilize in furthering fair housing.
(2) Providers use a variety of approaches to ensure that persons with disabilities and limited English proficiency are also aware of fair housing policies. Agencies have processes in place for reasonable accommodation and/or modification requests due to a disability and staff are trained to make program participants aware of their options. Service animals are accommodated and text is provided in large print when requested or assessed to be appropriate. Providers employ staff that are fluent in American Sign Language and train all staff to utilize TTY machines. Providers also employ staff that speak a range of languages and train staff on how to access translation phone lines to ensure program participants can communicate in their preferred

language. Information on fair housing policies is incorporated into program information provided to clients and/or is posted.

4A-5. RRH Beds as Reported in the HIC. Applicants must report the total number of rapid rehousing beds available to serve all household types as reported in the Housing Inventory Count (HIC) for 2017 and 2018.

	2017	2018	Difference
RRH beds available to serve all populations in the HIC	210	465	255

4A-6. Rehabilitation or New Construction Costs. Are new proposed project applications requesting $200,000 or more in funding for housing rehabilitation or new construction? No

4A-7. Homeless under Other Federal Statutes. Is the CoC requesting to designate one or more of its SSO or TH projects to serve families with children or youth defined as homeless under other Federal statutes? No

4B. Attachments

Instructions:

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

Document Type	Required?	Document Description	Date Attached
1C-5. PHA Administration Plan–Homeless Preference	No	PHA Administrativ...	09/11/2018
1C-5. PHA Administration Plan–Move-on Multifamily Assisted Housing Owners' Preference	No	PHA Letter with M...	09/11/2018
1C-8. Centralized or Coordinated Assessment Tool	Yes	Centralized or Co...	09/10/2018
1E-1. Objective Critiera–Rate, Rank, Review, and Selection Criteria (e.g., scoring tool, matrix)	Yes	Objective Critier...	09/12/2018
1E-3. Public Posting CoC-Approved Consolidated Application	Yes		
1E-3. Public Posting–Local Competition Rate, Rank, Review, and Selection Criteria (e.g., RFP)	Yes		
1E-4. CoC's Reallocation Process	Yes	CoC's Reallocatio...	09/10/2018
1E-5. Notifications Outside e-snaps–Projects Accepted	Yes	Notifications Out...	09/12/2018
1E-5. Notifications Outside e-snaps–Projects Rejected or Reduced	Yes	Notifications Out...	09/12/2018
1E-5. Public Posting–Local Competition Deadline	Yes	Public Posting-Lo...	09/10/2018
2A-1. CoC and HMIS Lead Governance (e.g., section of Governance Charter, MOU, MOA)	Yes	CoC and HMIS Lead...	09/10/2018
2A-2. HMIS–Policies and Procedures Manual	Yes	HMIS-Policies and...	09/10/2018
3A-6. HDX–2018 Competition Report	Yes	HDX-2018 Competit...	09/10/2018
3B-2. Order of Priority–Written Standards	No	Order of Priority...	09/10/2018

3B-5. Racial Disparities Summary	No	Racial Disparitie...	09/10/2018
4A-7.a. Project List–Persons Defined as Homeless under Other Federal Statutes (if applicable)	No		
Other	No		
Other	No		
Other	No		

Attachment Details

Document Description: PHA Administrative Plan - Homeless Preference (VA-601)

Attachment Details

Document Description: PHA Letter with Move On Preference (VA-601)

Attachment Details

Document Description: Centralized or Coordinated Assessment Tools (VA-601)

Attachment Details

Document Description: Objective Critiera–Rate, Rank, Review, and Selection Criteria (VA-601)

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: CoC's Reallocation Process (VA-601)

Attachment Details

Document Description: Notifications Outside e-snaps–Projects Accepted (VA-601)

Attachment Details

Document Description: Notifications Outside e-snaps–Projects Rejected or Reduced (VA-601)

Attachment Details

Document Description: Public Posting-Local Competition Deadline (VA-601)

Attachment Details

Document Description: CoC and HMIS Lead Governance (VA-601)

Attachment Details

Document Description: HMIS-Policies and Procedures Manual (VA-601)

Attachment Details

Document Description: HDX-2018 Competition Report (VA-601)

Attachment Details

Document Description: Order of Priority-Written Standards (VA-601)

Attachment Details

Document Description: Racial Disparities Summary (VA-601)

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Submission Summary

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

Page	Last Updated
1A. Identification	09/11/2018
1B. Engagement	09/11/2018
1C. Coordination	09/12/2018
1D. Discharge Planning	09/11/2018
1E. Project Review	09/11/2018
2A. HMIS Implementation	09/11/2018
2B. PIT Count	09/11/2018
2C. Sheltered Data - Methods	09/11/2018
3A. System Performance	09/11/2018
3B. Performance and Strategic Planning	09/12/2018
4A. Mainstream Benefits and Additional Policies	09/11/2018
4B. Attachments	Please Complete

Submission Summary	No Input Required

Regular HCV Funding

Regular HCV funding may be used to assist any eligible family on the waiting list. Families are selected from the waiting list according to the policies provided in Section 4-III.C.

4-III.C. SELECTION METHOD

The FCRHA must describe the method for selecting applicant families from the waiting list, including the system of admission preferences that the FCRHA will use [24 CFR 982.202(d)].

Local Preferences [24 CFR 982.207; HCV p. 4-16]

The FCRHA is permitted to establish local preferences, and to give priority to serving families that meet those criteria. HUD specifically authorizes and places restrictions on certain types of local preferences. HUD also permits the FCRHA to establish other local preferences, at its discretion. Any local preferences established must be consistent with the FCRHA plan and the consolidated plan, and must be based on local housing needs and priorities that can be documented by generally accepted data sources.

FCRHA Policy
The FCRHA has the following local preferences:

- **Homeless** preference
  Based upon funding availability and prior year leasing, the FCRHA will allocate 50% of the projected annual new admissions for applicants that meet the Homeless preference and are referred by the Fairfax County Office to Prevent and End Homelessness (OPEH) or the Fairfax County Bridging Affordability (BA) program.

  Applicant household must meet the following criteria:

  - Referred to FCRHA by OPEH or BA;
  - Must meet the criteria of chronic homelessness

  The FCRHA defines chronic homelessness, based upon HUD's Technical Guidance issued September 2007, where a chronically homeless person is either:

  - An unaccompanied homeless individual with a disabling condition who has been continuously homeless for a year or more;
  - An unaccompanied individual with a disabling condition who has had at least four episodes of homelessness in the past three years. In its definition of a chronically homeless person, HUD defines the term "homeless" as "a person sleeping in a place not meant for human habitation (e.g. living on the streets, for example) or living in a homeless emergency shelter"

FAIRFAX COUNTY

FAIRFAX COUNTY
REDEVELOPMENT AND HOUSING AUTHORITY

3700 Pender Drive, Suite 300
Fairfax, Virginia 22030-7444

V I R G I N I A

Telephone: (703) 246-5000 ♦ Fax: (703) 653-7130
TTY: 711

September 11, 2018

HUD Headquarters

To whom it may concern:

The Continuum of Care's (CoC) commitment to the goal of ending homelessness and its mission of providing affordable housing to one of our community's most vulnerable populations is consistent with the goals of the Fairfax County Redevelopment and Housing Authority (FCHRA).

In particular, one of Fairfax County's local preferences included in both the FCRHA's Housing Choice Voucher (HCV) and Rental Assistance Demonstration Project-based Voucher (RAD) Programs is to serve individuals who are homeless and are referred to the FCRHA through the Transitional Housing, Project Homes, or Special Needs Homeless programs. This local preference includes current CoC Program participants who no longer require intensive services. This inclusion generates movement in CoC Program-funded PSH projects as referred participants transition to other housing assistance programs. As such, new vacancies are created for persons experiencing homelessness. This local preference is included in the FCRHA's Administrative Plan for the Housing Choice Voucher Program, the guiding document for implementing these programs in the county.

The criticality of prioritizing individuals and families who are homeless is also reflected in the FCRHA's waitlist policy for the HCV and RAD Programs. Current FCRHA policy is to close the waitlist for the two programs when the estimated waiting period for housing assistance for applicants on the list reaches 24 months for the most current applicants. However, since May 2008, the FCRHA approved a policy to keep the waitlist open to preferences for homelessness (Transitional Housing, Project Homes, and Special Needs Homeless) and its Family Unification allocation, even when the waitlist is closed to other applicants.

The FCRHA will continue to work with the Office to Prevent and End Homelessness, as well as the entire county human services system to identify priority populations, such as individuals and families who are homeless, and provide them with affordable, stable housing options using all the federal, state, local, and private and non-profit resources that are available to the county.

Sincerely,

Thomas Fleetwood
Assistant Secretary, Fairfax County Redevelopment and Housing Authority

The following assessment tools attached are utilized in the CoC for Coordinated Entry:

- Housing and Services Triage Tool – used for families
- Singles Eligibility and Prioritization Tool – used for individuals to prioritize entrance into emergency shelter or homelessness prevention
- VI-SPDAT – used for individuals alongside the Singles Eligible and Prioritization Tool

Housing & Services Triage Tool

This tool should be completed from the information gathered on the HOST Housing Assessment without the client present. It is to be used as a guide to determine the type of housing, amount of financial assistance, and length of services that may be needed to help a client obtain and maintain housing.

Client Name: _____ **HMIS #:** _____

Staff Name Completing Tool: _____ **Date Completed:** _____

A. Assessment – For each row, choose the description that most closely matches the Head of Household's (HoH) history. Write the column score (5, 3, 1, 0) in the "SCORE" box.
***Income –** The AMI (Area Median Income) can be found at http://www.fairfaxcounty.gov/HSRG/pages/incomeguidelines.aspx

	5	3	1	0	SCORE
Housing	2+ evictions for non-payment and/or lease violations and/or 1 foreclosure. Landlord references poor and/or security deposit may have been kept due to damage to unit	1 eviction for non-payment. Landlord references poor and/or partial damage to a unit. Some complaints by other tenants for noise	No prior rental history and/or history of some late rent payments or lease compliance issues and/or landlord references fair	0 evictions. Rental history is positive and/or has positive landlord references	
Homeless-ness	Has been homeless for at least 12 consecutive months or 4 times in the previous 3 years (excluding time in transitional housing)	History of homelessness in the last 3 years	Any history of homelessness	Never experienced homelessness	
Credit	Credit Score of 500 or below or credit history includes bad debt owed to housing	Credit score of 501 to 619 or bad debt in excess of $2000 (not related to housing) and/or identity theft issues and/or no credit history	Credit score of 620 to 699 or credit history shows bad debt (less than $2000)	Credit score 700+ or credit history is good with the exception of a few late medical and/or credit card payments	
Income	Less than 15% AMI including having a fixed income that will not increase beyond current AMI category within 90 days	15 – 30% AMI or less than 30% AMI with no ability to increase beyond 30% AMI in 1 year.	31 – 50% AMI or less than 30% AMI with ability to increase beyond 30% AMI in 1 year.	More than 50% AMI	
Criminal	Felony conviction related to a sex offense and/or methamphetamine	Any felony convictions	Prior misdemeanor convictions; no felonies	No criminal history	
Substance Abuse	Meets criteria for dependence; preoccupation with use and/or obtaining drugs/alcohol and/or withdrawal avoidance behaviors evident and/or use results in avoidance or neglect of essential life activities	Use within last 6 months and shows evidence of persistent or recurrent social, occupational, emotional or physical problems related to use	Use within the last 6 months but no evidence of persistent or recurrent social, occupational, emotional or physical problems related to use	No drug/alcohol abuse in the last 12 months or no history of substance abuse	
Health / MH	Documented long-term disability; danger to self or others and/or recurring suicidal ideations. Severe difficulty in day-to-day life due to mental health or health symptoms	Recurrent mental health symptoms that may affect behavior but not a danger to self or others. Persistent problems with functioning due to mental health or health symptoms	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health or health	Minimal symptoms that are expected responses to life stressors; only slight impairment of functioning	
Adult Ed.	Literacy, language, or lack of a U.S. diploma have a history of causing barriers to employment or housing	Enrolled in literacy and/or GED program; has difficulty communicating in English	Has high school diploma or GED but needs additional education/ training to improve employment situation	Has education beyond a high school diploma or GED	
Experience of Violence	Homeless due domestic violence or due to being the victim of violence of any type	Been the victim of an act of violence or domestic abuse (including financial, emotional, sexual, etc.) in the last 6 months	Been the victim of an act of violence or been threatened with violence in the last year	Never been threatened or the victim of violence, or the occurrence happened over 1 year ago	
Child Welfare	Currently has a child placed outside the home as a result of child welfare involvement	Current or recent child welfare involvement (CPS, PPS, Foster Care) within the past 6 months	Past child welfare involvement (CPS, PPS, Foster Care)	No history of child welfare involvement (or Not Applicable)	
Use of Crisis Systems	At least 3 interactions with the following crisis services in the past 6 months: emergency room, psychiatric hospital, jail, Child Protective Services, crisis hotlines (such as domestic violence or suicide hotlines), detox	Involvement with at least 3 of the following services in the past 12 months: Adult Protective Services, mental health treatment, substance abuse treatment, domestic violence services, care for a chronic medical condition, intellectual or developmental disability services, brain injury services	Involvement with at least 2 of the following services in the past 12 months: Adult Protective Services, mental health treatment, substance abuse treatment, domestic violence services, care for a chronic medical condition, intellectual or developmental disability services, brain injury services	Involvement with 1 or less service systems in the past 12 months	

SCORE

B. Housing Type Determiners – The following can be used to identify which housing type may be most appropriate. *If that housing type is not available*, use professional judgment to determine the next best available option and document decisions in Section D. For families, indicators apply to the Head of Household (HoH) or other adult unless otherwise noted. Circle Yes or No.

#	INDICATOR	RESULT	HOUSING TYPE *(if Result = Yes)*
1	Are there children currently in foster care that are in the process of reunifying with the head of household?	Yes / No	Client may be eligible for the Family Unification Program.
2	Is the client homeless due to domestic violence, stalking, or human trafficking?	Yes / No	Client may be eligible for programs designed specifically for those populations.
3	Is the client a veteran?	Yes / No	
4	Is the head of household between the ages of 18 – 24?	Yes / No	
5	Is the client a recent immigrant, refugee, or asylee?	Yes / No	
6	Is the client HIV positive?		
7	Is the client elderly (62 or older)?	Yes / No	
8	Does the client (or other adult in the household) have a felony?	Yes / No	Client may be ineligible for housing that has restrictions on a person with a felony.
9	Is the client (or any member of the family) a registered sex offender?	Yes / No	Very specific location and other housing requirements will need to be met for the client. Review current probation / parole requirements as well as state and local law.
10	Does the client have a documented disability (includes mental, physical, developmental or substance use disorders) which impedes activities of daily living, impacts their ability to work full-time or earn at least 30% of the AMI, or severely impairs to their day-to day functioning or ability to live independently?	Yes / No	If Yes to 10 *and* 11, client may be a good candidate for Permanent Supportive Housing (PSH) for families.
11	Is the client's income score 0 or 1?	Yes / No	Client may benefit from program options such as RRH, agency funds, transitional housing, etc. *(Overall score for transitional housing should be 14 or above)*
12	Is the client's income score 1, 3 or 5, with total score of 15 or more?	Yes / No	Client may be a good candidate for Bridging Affordability or a long-term subsidy.

C. Indicated Housing & Service Type – Determine which range the "TOTAL SCORE" from Section A fits into. *If that housing type is not available*, use professional judgment to determine the next best available option and document decisions in Section D.

SCORE **(X) WHICH APPLIES**		HOUSING / SERVICE TYPE	FINANCIAL ASSISTANCE	SOURCES	LENGTH OF SERVICES
	0 – 8	Rapid Re-Housing (short term)	Security / Utility Deposits 1 month of Rental Assistance	HOST, ESG, CSP funds, SSVF	1 - 3 Months
	9 – 16	Rapid Re-Housing (medium term)	Security / Utility Deposits Less than 12 months of Rental Assistance	BA, HOST, ESG, funds, SSVF	4 – 11 Months
	17 - 25	Rapid Re-Housing (long term) Transitional Housing	Security / Utility Deposits 12-24 months of Rental Assistance	BA, HOST, ESG, funds, SSVF, TH	12 – 24 Months
	26+	PSH (if yes to 10 & 11 in Part B) Long Term Subsidy	Permanent Supportive Housing, Project Based Voucher, Housing Choice Voucher, VASH, Other permanent housing		24+ Months

D. Worker's Notes – If you assess that a different housing / service intervention is needed (other than what is indicated on this tool), please document the information that has contributed to your assessment.

Eligibility and Prioritization Tool for Access to Emergency Shelter and Homelessness Prevention Services for Households with Only Adults

The Eligibility and Prioritization Tool for Access to Emergency Shelter and Homelessness Prevention for Households with Only Adults (known simply as the Singles E&P) should be used anytime a single individual is requesting access to emergency shelter or homelessness prevention services through the homeless services system. The purpose of this tool is to pre-screen and triage individuals to determine both eligibility and priority for both emergency shelter and prevention services. If the individual is determined to be eligible for emergency shelter, they will be added to the Shelter Triage, Access, and Referral System for Singles (STARSS). If the individual is determined to be eligible for prevention services, a referral will be made using the Coordinated Entry homelessness prevention workflow. Priority questions determine where individuals fall in the STARSS or how individuals are ranked to fill nonprofit prevention caseload spots.

For those calling to access emergency shelter – prior to administering the tool, all attempts at diverting the individual from homelessness should be made. It is important to note that diversion is NOT the refusal of services/shelter, but instead a method used to explore all other possible resources and systems available to prevent that individual from becoming homeless. Entry into the STARSS and subsequently, emergency shelter, should be a last resort.

1. The tool consists of five (5) main sections:
   - Section 1: Basic Information
   - Section 2: Eligibility Information
   - Section 3: Prioritization Information
   - Section 4: Supplemental Information for Emergency Shelter Only
   - Section 5: Total Priority Score

   In addition, there are designated areas for staff to include verification the individual granted permission for their information to be shared, as well as the best way to contact them should they be pulled for a vacant shelter bed.
2. Anyone calling to access either emergency shelter or homelessness prevention services should be asked the questions in Sections 1 and 2. Note that Question 5 in Section 2 applies ONLY to homelessness prevention referrals. If it is determined that the individual requesting services meets the eligibility criteria, then proceed with the remainder of the assessment. If the individual does not meet the eligibility criteria, do not continue administering the tool.
3. There are three (3) columns:
   - Triage Question: includes the main question, prompts that should be asked to arrive at the most accurate answer possible, and notes/instructions if it is a priority and/or eligibility question. The person administering the tool can ask other questions of the individual being screened in addition to the prompts provided if desired.
   - Triage Answer: asks the person administering the tool to check yes or no to determine the answer to the Triage Question, as well as space to record additional information. The more information that is provided, the better reference the intake worker/prevention case manager has if/when the individual officially enters either program.
   - Priority Points: includes space to record the number of points an individual receives based on their answer to the prioritization questions. Individuals can receive either 0 points if they do not meet the prioritization criteria or 1 point if they do. All points (either 0 or 1) should be recorded.
4. Once all questions have been answered, add total points awarded and record in the space available in Section 5.
5. Individuals must provide verbal permission for their screening information to be shared for the purposes of making a referral to the STARSS through the Homeless Management Information System (HMIS) or to other agencies who provide prevention services. If permission is not granted, individuals cannot be referred. This information should be recorded in the appropriate section at the very beginning of the tool.

SINGLES ELIGIBILITY AND PRIORITIZATION TOOL

DOES INDIVIDUAL GRANT PERMISSION FOR INFORMATION TO BE SHARED FOR THE PURPOSES OF REFERRAL FOR SERVICES? **Answer must be "yes" in order to proceed.**	Permission Granted? Yes ____ No ____ Staff Name (printed): _____

Triage Question	Triage Answer *Include as much information as possible*	Priority Points
SECTION 1 – BASIC INFORMATION		
1. DATE COMPLETED		
2. NAME OF INDIVIDUAL BEING SCREENED Record the name of the individual seeking shelter. If a representative is calling on behalf of an individual, record their name and affiliation here as well.		
SECTION 2 – ELIGIBILITY INFORMATION		
3. DATE OF BIRTH ***Eligibility question* - INSTRUCTIONS FOR STAFF** Individual must be at least 18 years old to be eligible for services through the singles system. ***Priority question* - INSTRUCTIONS FOR STAFF** Is the individual either between the ages of 18 and 24 OR 60 years of age or older as of today? If yes, give 1 point.	Date of Birth: _____/_____/_____ 18 years old or older? Yes ____ No ____ 18-24 years old? Yes ____ No ____ 60 years old or older? Yes ____ No ____	/1
4. IS THE INDIVIDUAL CURRENTLY HOMELESS OR AT RISK OF HOMELESSNESS? **Ask:** Are you currently homeless or at risk of becoming homeless? If the individual states they are **currently homeless**, ask – "Where did you sleep last night? Where will you sleep tonight?" If the individual states they are **currently at risk of homelessness**, ask – "Why are you at risk of becoming homeless? Do you have an eviction notice? How much longer can you stay in your current housing?" ***Eligibility question* - INSTRUCTIONS FOR STAFF** Answer must be "yes" to either being homeless or at risk of homelessness.	Homeless? Yes ____ No ____ At risk of homelessness? Yes ____ No ____ Other notes:	
5. IS THE INDIVIDUAL AT OR BELOW 30% OF THE AREA MEDIUM INCOME FOR FAIRFAX COUNTY? **DO NOT ASK THIS QUESTION FOR SHELTER REFERRALS. INCOME IS NOT AN ELIGIBILITY QUESTIONS FOR SHELTER.** ***PREVENTION ONLY Eligibility question* - INSTRUCTIONS FOR STAFF** Answer must be "yes" if individual is seeking prevention services.	At or below 30% AMI? Yes ____ No ____ Other notes:	

STOP! BASED ON INFORMATION ABOVE, IS THIS PERSON ELIGIBLE FOR (check one):

EMERGENCY SHELTER _____ PREVENTION SERVICES _____ NOT ELIGIBLE _____

If individual is not eligible for either homelessness prevention or emergency shelter, discontinue tool.

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership

Updated 4/11/2018

Triage Question	Triage Answer *Include as much information as possible*	Priority Points
SECTION 3 – PRIORITIZATION INFORMATION		
6. <u>DATE CURRENT EPISODE OF HOMELESSNESS STARTED</u> **Ask:** Being as specific as possible, what is the date of the last time when you had a place to sleep that was not an emergency homeless shelter or the streets (which includes a tent, car, bus stop, or anywhere else not meant for habitation)? In other words, what date did your current episode of homelessness begin? ***Priority question* - INSTRUCTIONS FOR STAFF** If individual has been homeless for at least 12 months <u>this</u> time, give 1 point.	Date homelessness started? _____ Based on the date, how many months has this individual been homeless <u>this time</u>? _____ Other notes:	**SHELTER REFERRALS ONLY** /1 **SHELTER REFERRALS ONLY**
7. <u>IS THE INDIVIDUAL VULNERABLE?</u> **Ask:** Do any of the following factors apply to you? Please answer "yes" or "no". Factors: 1. More than 3 hospitalizations or emergency room visits in the last year 2. More than 3 emergency room visits in the previous 3 months 3. Aged 60 or older 4. Cirrhosis of the liver 5. End-stage renal disease 6. History of frostbite, immersion foot, or hypothermia 7. HIV+/AID 8. Tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition ***Priority question* - INSTRUCTIONS FOR STAFF** Based on the answer to Question 6, determine if the individual has been homeless for at least 6 months. If the date of homelessness equals 6 months or more <u>AND</u> the individual answers "yes" to at least one of the factors, give 1 point.	Number of months homeless this time: _____ Factors: 1. Yes ____ No ____ 2. Yes ____ No ____ 3. Yes ____ No ____ 4. Yes ____ No ____ 5. Yes ____ No ___ 6. Yes ____ No ____ 7. Yes ____ No ____ 8. Yes ____ No ____ Based on number of months and factors - vulnerable? Yes ____ No ____	**SHELTER REFERRALS ONLY** /1 **SHELTER REFERRALS ONLY**
8. <u>DOES THIS INDIVIDUAL HAVE ANY HISTORY OF HOMELESSNESS IN THE LAST 2 YEARS ASIDE FROM THIS CURRENT EPISODE?</u> **For shelter referrals – Ask:** Have you slept in an emergency shelter or on the streets at any point in the last two years not including this current episode? In other words, were you homeless any other time besides this one in the last two years? When was it and where did you stay? **For prevention referrals – Ask:** Have you slept in an emergency shelter or on the streets at any point in the last two years? When was it and where did you stay? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes" to either question, give 1 point.	Homeless in the last two years other than this time? Yes ____ No ____ Other notes:	/1
9. <u>DOES THIS INDIVIDUAL HAVE A DISABILITY?</u> **Ask:** Have you been told by a doctor, therapist, or other person in the medical profession that you have a disability of any kind? If so, what is it? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes", give 1 point.	Disability? Yes ____ No ____ Other notes:	/1

10. IS THE INDIVIDUAL A UNITED STATES MILITARY VETERAN? **Ask:** Have you served in the military or armed forces in the United States before? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes", give 1 point.	US military veteran? Yes ____ No ____ Other notes:	/1
11. IS THE INDIVIDUAL PREGNANT? **Ask:** Are you currently pregnant? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes", give 1 point.	Pregnant? Yes ____ No ____ Other notes:	/1
12. DOES THE INDIVIDUAL HAVE A TERMINAL ILLNESS? **Ask:** Do you have a terminal illness? In other words, has a doctor informed you that you have an illness that will result in death? If so, what is it? What documentation do you have of the illness? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes", give 1 point.	Documented terminal illness? Yes ____ No ____ Other notes:	/1
13. IS THE INDIVIDUAL A FAIRFAX COUNTY RESIDENT? **Ask:** Do you live in Fairfax County, Cities of Falls Church or Fairfax, or Towns of Clifton, Herndon, or Vienna? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes", give 1 point.	Fairfax County resident? Yes ____ No ____ Other notes:	/1
SECTION 4 – SUPPLEMENTAL INFORMATION FOR EMERGENCY SHELTER REFERRALS ONLY		
14. WHERE IS THE INDIVIDUAL WILLING TO ACCEPT A SHELTER BED? **Ask:** If a bed becomes available, which of the following shelters are you willing to accept space? Eleanor Kennedy in South County, Bailey's Crossroads in Falls Church, and/or Embry Rucker in Reston? You can choose one, two, or all three. **INSTRUCTIONS FOR STAFF** Record all shelters that the individual is willing to go to.	Bailey's Crossroads? Yes ____ No ____ Embry Rucker? Yes ____ No ____ Eleanor Kennedy? Yes ____ No ____ Other notes:	
15. WHAT GENDER DOES THE INDIVIDUAL IDENTIFY AS FOR THE PURPOSES OF SHELTER DORM ASSIGNMENT? **Ask:** For the purposes of assigning you to a shelter bed, what gender do you identify as? **INSTRUCTIONS FOR STAFF** Record the individual's preferred dorm assignment based on their gender identity.	Dorm Assignment: Male_____ Female _____ Other notes:	
SECTION 5 – PRIORITY SCORE		
16. WHAT IS THE INDIVIDUAL'S PRIORITY SCORE? Add points and enter the total number.	Total Priority Score: _____ (ENTER SCORE)	

BEST WAY TO CONTACT INDIVIDUAL BEING SCREENED Please include either the individual's phone number or that of a representative, case manager, family member, or anyone else that would be able to easily get in touch with the individual. For anyone other than the individual themselves, also include their name and relationship	Contact Information:

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Single Adults

GENERAL INFORMATION/CONSENT

Interviewer's Name		Agency ❑ TEAM ❑ STAFF ❑ VOLUNTEER
Date	Time	Location
In what language do you feel best able to express yourself?		
First Name		Last Name
Nickname		Social Security Number
How old are you?	What's your date of birth?	Has Consented to Participate ❑ YES ❑ NO

If 60 years or older, then score 1.	**Prescreen Score**
PRE-SCREEN GENERAL INFORMATION SUBTOTAL	

A. HISTORY OF HOUSING & HOMELESSNESS

QUESTIONS			
If the person has experienced two or more cumulative years of homelessness, and/or 4+ episodes of homelessness, then score 1.	**RESPONSE**	**REFUSED**	**Prescreen Score**
1. What is the total length of time you have lived on the streets or in shelters?		❑	
2. In the past three years, how many times have you been housed and then homeless again?		❑	
PRE-SCREEN HOUSING AND HOMELESSNESS SUBTOTAL			

B. RISKS

SCRIPT: I am going to ask you some questions about your interactions with health and emergency services. If you need any help figuring out when six months ago was, just let me know.

QUESTIONS				
If the total number of interactions across questions 3, 4, 5, 6 and 7 is equal to or greater than 4, then score 1.	RESPONSE		REFUSED	Prescreen Score
3. In the past six months, how many times have you been to the emergency department/room?			❑	
4. In the past six months, how many times have you had an interaction with the police?			❑	
5. In the past six months, how many times have you been taken to the hospital in an ambulance?			❑	
6. In the past six months, how many times have you used a crisis service, including distress centers or suicide prevention hotlines?			❑	
7. In the past six months, how many times have you been hospitalized as an in-patient, including hospitalizations in a mental health hospital?			❑	
If YES to questions 8 or 9, then score 1.	YES	NO	REFUSED	Prescreen Score
8. Have you been attacked or beaten up since becoming homeless?	❑	❑	❑	
9. Threatened to or tried to harm yourself or anyone else in the last year?	❑	❑	❑	
If YES to question 10, then score 1.	YES	NO	REFUSED	Prescreen Score
10. Do you have any legal stuff going on right now that may result in you being locked up or having to pay fines?	❑	❑	❑	
If YES to questions 11 or 12; OR if respondent provides any answer *OTHER THAN* "Shelter" in question 13, then score 1.	YES	NO	REFUSED	Prescreen Score
11. Does anybody force or trick you to do things that you do not want to do?	❑	❑	❑	
12. Ever do things that may be considered to be risky like exchange sex for money, run drugs for someone, have unprotected sex with someone you don't really know, share a needle, or anything like that?	❑	❑	❑	
13. I am going to read types of places people sleep. Please tell me which one that you sleep at most often. (Check only one.)	❑ Shelter ❑ Street, Sidewalk or Doorway ❑ Car, Van or RV ❑ Bus or Subway ❑ Beach, Riverbed or Park ❑ Other (SPECIFY):			
PRE-SCREEN RISKS SUBTOTAL				

C. SOCIALIZATION & DAILY FUNCTIONS

QUESTIONS				
If YES to question 14 or NO to questions 15 or 16, score 1.	YES	NO	REFUSED	Prescreen Score
14. Is there anybody that thinks you owe them money?	❑	❑	❑	
15. Do you have any money coming in on a regular basis, like a job or government benefit or even working under the table, binning or bottle collecting, sex work, odd jobs, day labor, or anything like that?	❑	❑	❑	
16. Do you have enough money to meet all of your expenses on a monthly basis?	❑	❑	❑	
If NO to question 17, score 1.	YES	NO	REFUSED	Prescreen Score
17. Do you have planned activities each day other than just surviving that bring you happiness and fulfillment?	❑	❑	❑	
If YES to questions 18 or 19, score 1.	YES	NO	REFUSED	Prescreen Score
18. Do you have any friends, family or other people in your life out of convenience or necessity, but you do not like their company?	❑	❑	❑	
19. Do any friends, family or other people in your life ever take your money, borrow cigarettes, use your drugs, drink your alcohol, or get you to do things you really don't want to do?	❑	❑	❑	
OBSERVE ONLY. DO NOT ASK! If YES, score 1.	YES	NO		Prescreen Score
20. Surveyor, do you detect signs of poor hygiene or daily living skills?	❑	❑		
PRE-SCREEN SOCIALIZATION & DAILY FUNCTIONS SUBTOTAL				

D. WELLNESS

QUESTIONS				
If Does Not Go For Care, score 1.	**RESPONSE**			**Prescreen Score**
21. Where do you usually go for healthcare or when you're not feeling well?	❑ Hospital ❑ Clinic ❑ VA ❑ Other (specify) _____ ❑ Does not go for care			
For *EACH* YES response in questions 22 through 25 (Medical Conditions), score 1.				
Do you have now, have you ever had, or has a healthcare provider ever told you that you have any of the following medical conditions:	**YES**	**NO**	**REFUSED**	**Medical Conditions**
22. Kidney disease/End Stage Renal Disease or Dialysis	❑	❑	❑	
23. History of frostbite, Hypothermia, or Immersion Foot	❑	❑	❑	
24. Liver disease, Cirrhosis, or End-Stage Liver Disease	❑	❑	❑	
25. HIV+/AIDS	❑	❑	❑	
If YES to any of the conditions in questions 26 to 34, then mark "X" in Other Medical Condition column.	**YES**	**NO**	**REFUSED**	**Other Medical Conditions**
26. History of Heat Stroke/Heat Exhaustion	❑	❑	❑	
27. Heart disease, Arrhythmia, or Irregular Heartbeat	❑	❑	❑	
28. Emphysema	❑	❑	❑	
29. Diabetes	❑	❑	❑	
30. Asthma	❑	❑	❑	
31. Cancer	❑	❑	❑	
32. Hepatitis C	❑	❑	❑	
33. Tuberculosis	❑	❑	❑	
OBSERVATION ONLY – DO NOT ASK: 34. Surveyor, do you observe signs or symptoms of a serious health condition?	❑	❑		
If any response is YES in questions 35 through 41, score 1 in the Substance Use column.	**YES**	**NO**	**REFUSED**	**Substance Use**
35. Have you ever had problematic drug or alcohol use, abused drugs or alcohol, or told you do?	❑	❑	❑	
36. Have you consumed alcohol and/or drugs almost every day or every day for the past month?	❑	❑	❑	
37. Have you ever used injection drugs or shots in the last six months?	❑	❑	❑	
38. Have you ever been treated for drug or alcohol problems and returned to drinking or using drugs?	❑	❑	❑	
39. Have you used non-beverage alcohol like cough syrup, mouthwash, rubbing alcohol, cooking wine, or anything like that in the past six months?	❑	❑	❑	
40. Have you blacked out because of your alcohol or drug use in the past month?	❑	❑	❑	

OBSERVATION ONLY – DO NOT ASK: 41. Surveyor, do you observe signs or symptoms or problematic alcohol or drug abuse?	❑	❑		
If any response is YES in questions 42 through 48, score 1 in the Mental Health Column.	**YES**	**NO**	**REFUSED**	**Mental Health**
42. Ever been taken to a hospital against your will for a mental health reason?	❑	❑	❑	
43. Gone to the emergency room because you weren't feeling 100% well emotionally or because of your nerves?	❑	❑	❑	
44. Spoken with a psychiatrist, psychologist or other mental health professional in the last six months because of your mental health – whether that was voluntary or because someone insisted that you do so?	❑	❑	❑	
45. Had a serious brain injury or head trauma?	❑	❑	❑	
46. Ever been told you have a learning disability or developmental disability?	❑	❑	❑	
47. Do you have any problems concentrating and/or remembering things?	❑	❑	❑	
OBSERVATION ONLY – DO NOT ASK: 48. Surveyor, do you detect signs or symptoms of severe, persistent mental illness or severely compromised cognitive functioning?	❑	❑		
If the Substance Use score is 1 AND the Mental Health score is 1 AND the Medical Condition score is at least a 1 OR an X, then score 1 additional point for tri-morbidity.				**Tri-Morbidity**
If YES to question 49, score 1.	**YES**	**NO**	**REFUSED**	**Prescreen Score**
49. Have you had any medicines prescribed to you by a doctor that you do not take, sell, had stolen, misplaced, or where the prescriptions were never filled?	❑	❑	❑	
If YES to question 50, score 1.	**YES**	**NO**	**REFUSED**	**Prescreen Score**
50. Yes or No – Have you experienced any emotional, physical, psychological, sexual or other type of abuse or trauma in your life which you have not sought help for, and/or which has caused your homelessness?	❑	❑	❑	
PRE-SCREEN WELLNESS SUBTOTAL				

SCORING SUMMARY

DOMAIN	**SUBTOTAL**
GENERAL INFORMATION	
A. HISTORY OF HOUSING AND HOMELESSNESS	
B. RISKS	
C. SOCIALIZATION AND DAILY FUNCTIONS	
D. WELLNESS	
PRE-SCREEN TOTAL	

If the Pre-Screen Total is equal to or greater than 10, the individual is recommended for a Permanent Supportive Housing/Housing First Assessment.

If the Pre-Screen Total is 5, 6, 7, 8 or 9, the individual is recommended for a Rapid Re-Housing Assessment.

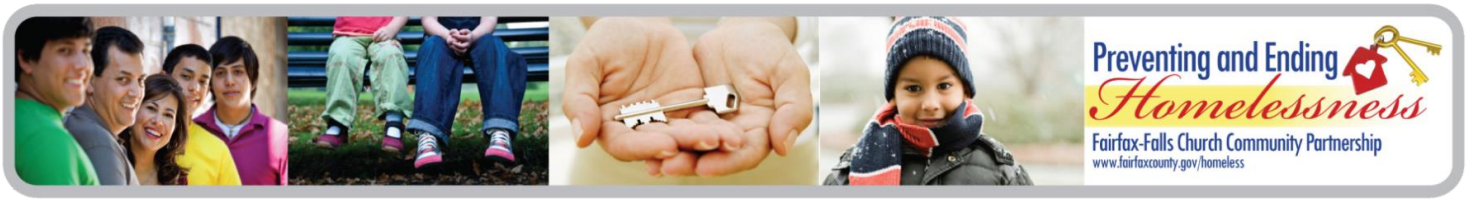
If the Pre-Screen Total is 0, 1, 2, 3 or 4, the individual is not recommended for a Housing and Support Assessment at this time.

Vulnerability Index & Service Prioritization Decision Assistance Tool (VI-SPDAT)

Prescreen for Single Adults

Finally I'd like to ask you some questions to help us better understand homelessness and improve housing and support services.

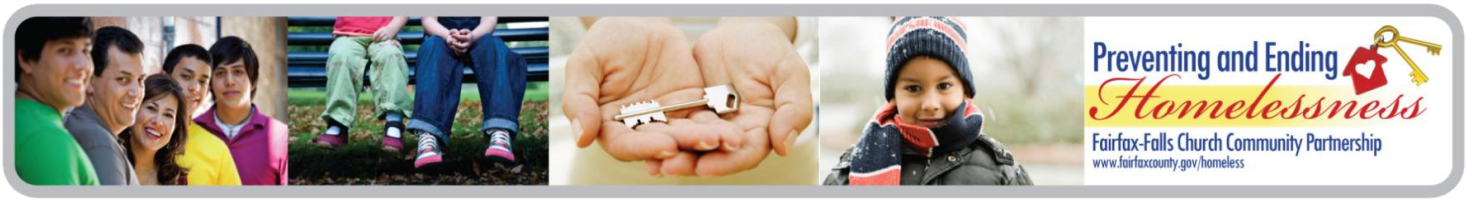
What is your gender?	❑ Male ❑ Female ❑ Transgender ❑ Other ❑ Decline to State
Have you ever served in the US Military?	❑ Yes ❑ No ❑ Refused
If yes, which war/war era did you serve in?	❑ Korean War (June 1950-January 1955) ❑ Vietnam Era (August 1964-April 1975) ❑ Post Vietnam (May 1975-July 1991) ❑ Persian Gulf Era (August 1991-Present) ❑ Afghanistan (2001-Present) ❑ Iraq (2003-Present) ❑ Other (Specify) ❑ Refused
If yes, what was the character of your discharge?	❑ Honorable ❑ Other than Honorable ❑ Bad Conduct ❑ Dishonorable ❑ Refused
What is your citizenship status?	❑ Citizen ❑ Legal Resident ❑ Undocumented ❑ Refused
Where did you live prior to becoming homeless?	❑ This city ❑ This region ❑ Other part of the State ❑ Somewhere else (specify)_____
Have you ever been in foster care?	❑ Yes ❑ No ❑ Refused
Have you ever been in jail?	❑ Yes ❑ No ❑ Refused
Have you ever been in prison?	❑ Yes ❑ No ❑ Refused
Do you have a permanent physical disability that limits your mobility? [i.e., wheelchair, amputation, unable to climb stairs]?	❑ Yes ❑ No ❑ Refused
What kind of health insurance do you have, if any? (check all that apply)	❑ Medicaid ❑ Medicare ❑ VA ❑ Private Insurance ❑ None ❑ Other (specify): _____
On a regular day, where is it easiest to find you and what time of day is easiest to do so?	
Is there a phone number and/or email where someone can get in touch with you or leave you a message?	
Ok, now I'd like to take your picture. May I do so?	❑ Yes ❑ No ❑ Refused



2018 HUD CoC Program Competition
Fairfax-Falls Church Continuum of Care
RATING & REVIEW PROCEDURES

Fairfax County VA-601 CoC Application: Rating and Review Procedure

2018 Rating and Review Procedure Packet Order:

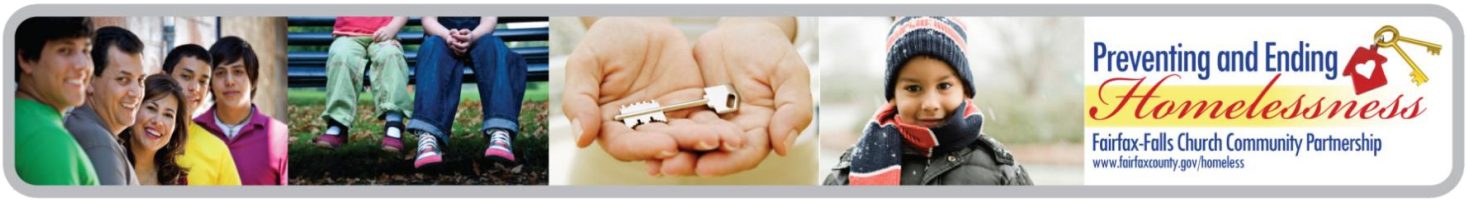


2018 HUD CoC Program Competition
Fairfax-Falls Church Continuum of Care
RATING & REVIEW PROCEDURES

CoC Monitoring, Evaluation, Reallocation and Ranking Process 2018

Monitoring and Evaluation Process:

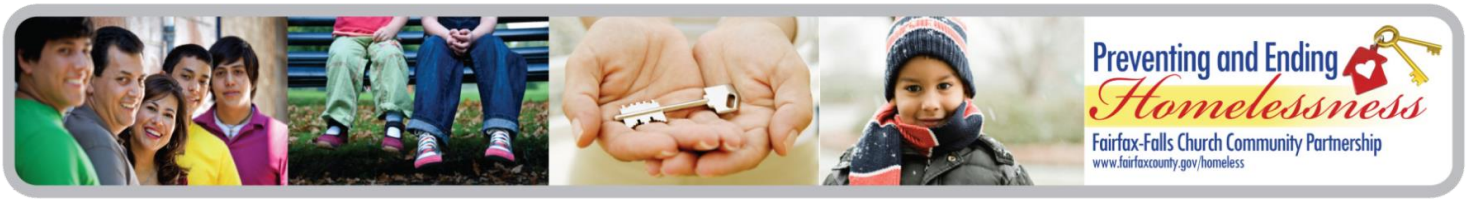
- Our CoC has implemented a comprehensive monitoring and evaluation process.
- It is overseen by the Monitoring and Evaluation (M&) Committee which is comprised of representatives from grantee agencies, non-grantee service providers, and the CoC Lead Agency – the Fairfax County Office to Prevent and End Homelessness (OPEH) staff.
- The Monitoring and Evaluation tool is updated annually to include new HUD or community standards and newly identified issues, including criteria added to the CoC Program Competition NOFA each year.
- Initial M&E Committee meeting to discuss changes was held on January 18, 2018; consensus was reached on a range of edits as well as the schedule for the 2018 process. Final version was adopted by the M&E Committee on March 1, 2018.
- There were two components; one for agencies and one for projects. Together they were able to measure a wide range of competencies including agency capacity, financial stability, adherence to HUD regulations and requirements, commitment to federal and local priorities, and project and client outcomes. APR review is part of the process.
- Community-wide performance measures are included in the tool.
- It is distributed each spring to all CoC Program grantees. Grantees that plan on applying for renewal funding as part of the next competition must complete the tool.
- Upon completion, the tools are scored by OPEH staff to ensure impartiality and confidentiality.
- The M&E Committee reviews the scores with identifying organizational project names removed. Any low scores or specific issues are discussed and follow-up is recommended as necessary. This was completed at the M&E Committee meeting held on May 17, 2018.
- The M&E Committee agreed that all renewal projects should move forward in the process and be included in the 2018 CoC Application.
- The scores, with comments concerning any issues or underperforming areas, are shared with grantees. This was done on June 6, 2018. Grantees were provided a two week period to ask questions about or contest their scores.



2018 HUD CoC Program Competition
Fairfax-Falls Church Continuum of Care
RATING & REVIEW PROCEDURES

Reallocation, Bonus, and DV Bonus Funding Process 2018

- *Reallocation Process* - Second Story volunteered to reallocate $75,000. This was later raised to $85,000 after they further reevaluated and determined that they could still serve the same number of people with even less funding from HUD.
- *Notification of Funding Opportunities* - An application for all the funding opportunities (including Reallocation, DV Bonus, and Bonus funding) was developed and distributed widely by email to all CoC members and any other individual or organization that has indicated interest in applying for HUD CoC Program funding. In addition, announcement of funding availability and application were posted on the Fairfax County Office to Prevent and End Homelessness webpage and on Facebook.
- *Application Details, soliciting non-CoC Program applicants* - The application contains a separate agency capacity section for applicants that are not currently HUD CoC program grantees, indicating that new agencies are encouraged to apply.
- *Reallocation Applications Received* - Two applicants for utilization of the reallocated funds were submitted. The CoC Committee met on August 1, 2018 to decide on the applicant for the reallocated funding. FACETS-Triumph III Expansion was of a high standard, met the needs of the homeless services system, proposed serving more clients, and had a lower cost per client between the proposals.
- *Bonus Applications Received* - Two applications for Bonus funding were received, two for bonus funding
- DV Bonus Applications Received – Two applications for DV bonus funding were received, one application was technically unspecified by assumed to be for DV Bonus based on the content. The agency ultimately forfeited their application shortly before the CoC Committee met.
- The CoC Committee met on August 1, 2018 and heard presentations from and asked questions of the applicants.
- All applicants were notified by email of the Committee's decision.



2018 HUD CoC Program Competition
Fairfax-Falls Church Continuum of Care
RATING & REVIEW PROCEDURES

Ranking Process:

- The information on all projects was compiled from the Monitoring and Evaluation tools, APRs, Project Applications, OPEH – CoC Lead Agency, and directly from Project Applicants.
- Competition and ranking and tiering information, as well as scores and project information were presented to the Ranking Committee for review.
- The Ranking Committee met on August 22, 2018. They reviewed HUD guidance as well as all the criteria, projects, scores, narratives.
- Following discussion, each member of the committee individually ranked the projects and the rankings were compiled to achieve the final ranking.
- HUD CoC Program Grantees were notified of the ranking for the 2018 competition by email on August 24, 2018.

2018 HUD CoC Program Competition
Fairfax-Falls Church Continuum of Care
COC PROGRAM COMMITTEES

CoC Committee Members

- Linda Hoffman, Policy and Strategic Initiatives Coordinator, Health and Human Services, Office of the County Executive, Fairfax County Government
- Dean Klein, Director, Office to Prevent and End Homelessness, Fairfax County Government
- Mike O'Reilly, Chairman, Fairfax-Falls Church Partnership to Prevent and End Homelessness, The O'Reilly Law Firm
- Rodney Lusk, Senior Business Development Manager, Fairfax County Economic Development Authority
- Mary Kimm, Editor and Publisher, Connection Newspaper
- Will Jasper, Commissioner, Fairfax County Redevelopment and Housing Authority
- Verdia Haywood, Former Deputy County Executive, Fairfax County Government

Ranking Committee Members

- Louise Armitage, Human Services Coordinator, City of Fairfax
- Hilary Chapman, Housing Program Manager, Metropolitan Washington Council of Governments
- Verdia Haywood, Former Deputy Executive Director for Human Services, Fairfax County Government
- Dean Klein, Director, Office to Prevent and End Homelessness, Fairfax County Government
- Peaches Pearson, member of the Consumer Advisory Council as well as Supervisory Team Lead, Office of Administration for US General, Services Administration
- Lisa Whetzel, Executive Director, Britepaths
- Gerry Williams, Former Chair, Communities of Faith United for Housing

Monitoring and Evaluation Committee Members

- Tracy Kelso, Christian Relief Services
- Jeanine Gravette, Cornerstones
- Bobbi Mason, Department of Family Services
- Maura Williams, FACETS
- Dana Murray, New Hope Housing
- Lorena McDowell, Northern Virginia Family Services
- Abby Dunner, Office to Prevent and End Homelessness
- Julie Maltzman, Office to Prevent and End Homelessness
- Michael Willson, Office to Prevent and End Homelessness
- Sharon Price Singer, Office to Prevent and End Homelessness
- Gillian Gmitter, PRS
- Eleanor Vincent, Pathway Homes
- Lauren Leventhal, Pathway Homes
- Meghan Huebner, Second Story
- Michelle Stitt, Second Story
- Dani Colon, Shelter House

CoC Monitoring and Evaluation Meeting

January 18, 2018

Fairfax County Government Center
Conference Room #7

Agenda:

- **Introductions**
- **Set 2018 M&E Schedule**
  - **Additional Meetings**
- **Homeless Representation on BOD**
- **Discuss Possible Changes to M&E Tools**
- **Review Housing First Tool**
- **Additional Issues**

CoC Monitoring and Evaluation Meeting

January 18, 2018

Fairfax County Government Center Conference Room 7

- Schedule
    - Everyone is fine with March 19 being the date for organizations to receive M&E tools, instructions, and schedule
        - Training will be primarily Q&A
        - Changes will be highlighted
        - People can call in with questions at any time
    - Turning in documents
        - Same process as last year
        - Julie will not notify people on April 18 if she does not receive it
        - Next meeting
            - Thursday, March 1st 2-4pm
- Julie will be sending out a letter informing organizations that they need a homeless or formerly homeless person on their board of directors if they do not have already one
    - Agencies have the option to apply for a waiver to HUD
    - The current policy is:
        - Organizations with a homeless or formerly homeless individual on their board of directors gain two points.
        - Organizations with a homeless or formerly homeless individual on another policy making entity gain one point
        - Organizations that lacks a homeless or formerly homeless individual don't receive any points
    - For this year:
        - Organizations that have a homeless or formerly homeless individual on their board gain a point
        - Organizations that have a homeless or formerly homeless individual on another policy making entity do as well
        - Organizations that do not have a homeless/formerly homeless individual and applied for a waiver and were accepted gain a point
        - Organizations that do not have a homeless/formerly homeless individual on their board or another policy making entity loose four points
            - This includes organizations that applied for a waiver and were rejected
        - You have three months to either place a homeless/formerly homeless individual on your BOD/policy making entity or apply for a waiver and receive a positive response from HUD
- Changes to the tools:
    - Remove vacancies section for this year due to implementation of new Coordinated Entry system
        - Next year, there will be a discussion on revising it

        - Organizations still need to fill vacancies and might be penalized by HUD if they do not do so in a timely manner
    - APRs are due 90 days after organizations receive their grants
        - After submission in SAGE, email PDF copy to Walter and Julie
        - Ensure that it is readable and contains all the information necessary
        - The new APR has sections on Veterans, TAY, Chronically Homeless; they will not be used as outcomes for this year's monitoring and evaluation process
    - Data quality
        - Cindy will report on timeliness of submission for this past year
    - Grantees must attend meetings; not just subrecipients
    - Environmental Reviews
        - For PSH, all units must have an environmental review when new (leased or purchased) and every five years thereafter
        - For RRH, one environmental review needed for entire program
    - Certain questions will be removed this year based on full compliance and not needed for inclusion in the Collaborative Application
        - There will be a list of them at the next meeting
        - We will keep a record of them for any new organization or future usage
    - We will combine questions 42-43, using a similar method to what we currently have to determine the difficulties facing the population served by each project
        - Each project will list how many clients fit each category
        - Will be added up and divided by total number of participants
        - We will add 62+ as a special population
        - Everything should be based off of the APR
        - We will look more into clients who are employed and unemployed.
            - Subtract clients 62+ from employment percentage
        - Drugs and alcohol counts as one category in terms of special populations
        - Will examine if we need a different point system for RRH
- Homework
    - Housing First Assessment Tool
        - Everyone must look through it and decide if they want to use any of the questions from the documents in the M&E applications
    - Do we want to start having site visits?
    - Get back to Julie in two weeks (Thursday, February 1)
        - She will send you an email as it gets closer to remind you

2018 M&E Tool Potential Changes

Agency Tool:

- #3 – Add point for policies aligning with CFR 200
    - Final Decision
        - Everyone agrees
- #5 – Review wording of question and number of points.
    - Point difference between BOD and other policy making entity
    - Number of points to subtract if a number of questions/points eliminated in rest of tool.
        - It can be interpreted that HUD's goal of having a consumer/former consumer on an agency's BOD gives them the opportunity to contribute in policy making. For some agencies, the BOD are not the policy makers. Therefore HUD allows consumer representative on another policy making entity. We have distinguished between these two in the past.
            - Decision made to treat them the same as HUD includes both in regulations.
            - Agencies will have to explain their other "policy making entity and consumer representation" if selecting this option.
        - Consumers must be able to provide feedback on the programs that are serving them. While this can influence policy, this does not have the same effect as representation on a board that sets policy.
        - If an agency receives a waiver from HUD, same points will be awarded.
        - Discussion as to how many points and if they should be positive or negative. Loosing points could leave a stronger message than not receiving points. How much emphasis should be on this one question?
        - Final Decision: Plus points (3 points) for either BOD, other policy entity adequately explained, or HUD waiver
- #8 – Remove
    - Final Decision
        - Everyone agrees
- #10 – Remove
    - We will keep a copy of everything that was removed for use in the future as necessary – either because of lax adherence or new agencies becoming grantees
    - Final Decision
        - Everyone agrees
- #11 – Remove
    - Final Decision
        - Everyone agrees

- #12 – Keep grievance policy – delete others
    - Final Decision
        - Everyone agrees
        - Will be worth one point
- #13 – Remove
    - This can be seen as a value statement. It lets HUD know how our consumers/former consumers are staying involved.
        - Final Decision
            - We will be keeping it

Project Tool:

- #3 – Attach documentation of summary page that documents total amount expended
    - It could be helpful to provide examples to avoid confusion
    - Final Decision
        - Everyone agrees
- #5 – Cost per client changed slightly to include RRH projects
    - Slightly lower amount - $8,000
    - For PSH – one point in time
    - For RRH – cost per client over grant year
    - RRH – some points more accessible, some less
        - Final Decision
            - Everyone agrees
- #8 – Remove? One agency didn't fully comply and important regulation
    - Final Decision
        - We will be leaving it
- #9 – Remove? Important regulations
    - Final Decision
        - We will be leaving it
- #10 – Remove
    - Final Decision
        - Everyone agrees
- #11 – Remove
    - Final Decision
        - Everyone agrees
- #14 – Deliverables will be specified in tool, to include Project Application, Project Description, Client Vulnerabilities, etc.
    - Final Decision
        - Everyone agrees

- #15 – Remove
    - Final Decision
        - Everyone agrees
- #16 – Remove
    - Final Decision
        - Everyone agrees
- #17 – Remove
    - Final Decision
        - Everyone agrees
- Add – does this project have an active member of the HMIS Super User Group?
    - Final Decision
        - Everyone agrees
- #27 – Add from HF tool?
    - No provisions that are not included in mainstream leases
    - Education of clients about their leases
        - It should just be a lease.
            - Take out "…and/or program agreement?"
            - With a lease being a legal document, it is important that consumers understand what they are signing.
                - Final Decision
                    - No points
- #29 – Remove
    - Final Decision
        - Everyone agrees
- #30 – Remove
    - Final Decision
        - Everyone agrees
- #31 – Add from HF tool? Medication adherence, history of victimization, DV, or sexual assault. Either with this question or separate question? Access regardless of gender identity, sexual orientation or marital status.
    - Do we want to create a separate question for gender identity, sexual orientation or marital status?
    - If a project serves only a specific gender, it will not count as discrimination to deny housing to someone who was not that gender. It would count as discrimination if the person was transgender, for example.
    - Julie will send the document defining chronic homeless households to everyone
    - Final Decision
        - All or nothing for one point
        - We will be adding additional items to the question
- #33 – Remove

    - Final Decision
        - Everyone agrees
- #36 – Remove
    - Final Decision
        - Everyone agrees
- #38 – Remove
    - Final Decision
        - Everyone agrees
- #39 – Edit to reflect new APR submission process
    - Missing data?
    - Timeliness of data entry?
        - We do not want points yet
        - Data will not get better because it records when you entered data for current clients. If they don't leave the program, data will be the same next year.
        - This is something that HUD will be looking at, so it could be helpful to leave this in here, even if points are not awarded for it.
        - Final Decision
            - We will put this on the agenda to discuss later. Will look into exactly what the new APR tracks regarding timeliness and missing data.
            - Data should not be missing, it should be "don't know" or "refused". If an agency gets that data later on, they must add it immediately. There should be very few if none data points in general.
- #42 and #43 will be combined and will contain following conditions and subpopulations:
    - Mental Health Problem
    - Substance Abuse
    - Chronic Health Condition
    - HIV/AIDS
    - Developmental Disability
    - Physical Disability
    - Veteran
    - DV
    - CH at entry
    - Single adult or Head of Household between the ages of 18-24
    - Single adult of Head of Household 62 or older
    - Number of people in each category, added together and divided by number of adults served

- Suggested points:
  - From 1- 1.9 – one point (does it need to be 0?)
  - From 2 – 2.9 – two points
  - From 3 – 3.9 – three points
  - From 4 up – four points
    - For DV, we will specify that it is for this episode of homelessness
    - We will add up the number of adults in each category and divide it by the total number of adults served.
    - We will be using the current definitions and not the definitions of when the consumer was entered into HMIS.
    - Julie will change the wording for TAY households
    - A consumer will be counted for each condition they have
      - Final Decision
        - We will combine the two questions and points will be awarded as listed above.

- APR questions will be renumbered to align with new APR
- #46 - Subtract people over 62+ from percentage of employed?
  - We need more information before we can adjust it
  - We take data from APR, which might already account for age
  - Will get more detailed information
  - Final Decision
    - We will discuss it later
- #50 – Movement to PH – last year informational, this year points?
  - RRH vs PSH?
    - Some agencies cannot move people to PH without vouchers
    - More consumers are passing away before they are able to move on from PSH
    - Final Decision
      - Question will be removed at this time.

FAIRFAX COUNTY CONTINUUM OF CARE

Monitoring & Evaluation

2018 Instructions

Introduction

To ensure effective and efficient use of their region's HUD Continuum of Care (CoC) Program Funding, all CoC's are responsible for maintaining local monitoring and evaluation procedures. The Fairfax County CoC Monitoring and Evaluation Committee has updated last year's tools based on your feedback and current standards.

The Monitoring & Evaluation Tools are structured to provide the most objective measurement of agency and program performance. The questions contained in the tools not only determine current practices, outcomes and compliance with HUD regulations for each project and grantee, but also highlight the priorities and strategic directions of both HUD and the Fairfax County CoC. The scores received on these tools will be used as major criteria during the project rankings which once again will be a part of the 2018 HUD CoC Program application process.

A sub-committee of the CoC Monitoring and Evaluation Committee comprised of the Office to Prevent and End Homelessness (OPEH) staff will review and score all of the completed tools. Scoring methodology is outlined in the tools for transparency.

The tools will be emailed to grantees on Monday, March 19, 2018. **There will be a training and review of the updated tools on March 22, 2018 from 2:00 – 4:00 p.m. at the Government Center in room #359.** Attendance of at least one person from each organization is recommended. Please review the tools prior to the training and bring any questions you may have with you to the meeting. In addition, please bring a copy of the tools with you.

Instructions

- **Both Agency and Project Component Tools (hard copies) are due to the Office to Prevent and End Homelessness (OPEH) by 4:00 p.m. on Monday April 16, 2018.**
    - **4 points will be subtracted per day from each tool submitted late**. **No tools will be accepted after 4:00 p.m. on Friday, April 20, 2018.**
- Submit two hard copies of each completed tool.
- Only one hard copy of each attachment is required.
    - Each component should contain all the required attachments as listed at the end of each tool.
    - Compile the attachments in the same order as requested in the tools.
    - Separate each attachment by including a piece of paper prior to each attachment labeled with the name/description of the attachment.
- Each component with attachments should be bound separately with butterfly clip or rubber band (no binders).
    - Compile one Agency Tool, one set of Agency Tool attachments, and then another copy of the Agency Tool.
    - Compile one Project Tool, one set of Project Tool attachments, and then another copy of the Project Tool.
- Insert name but not a score on cover sheet of each tool.
- Submission methods:
    - Mail/Courier: OPEH, attention CoC Lead, 12000 Government Center Parkway, Suite 333, Fairfax, VA 22035. Julie Maltzman will confirm receipt by email.
    - In Person: OPEH, 12000 Government Center Parkway, Suite 333, Fairfax, VA 22035. Place the tools in the red box in cubicle 335.4 marked Monitoring and Evaluation Tools. Julie Maltzman will confirm receipt by email.

- If you prefer to submit your tools to a person contact Michael Willson at 703-324-3470 or Julie Maltzman at 703-324-3965 to arrange a time to deliver the tools.

- **Electronic submission of tools or attachments will not be accepted.**
- Agency Component must be submitted by all agencies applying for renewal or same agency reallocation funding during the 2018 HUD CoC Program Competition.
- Each grantee agency must complete only one Agency Component Tool, regardless of how many grants it currently receives. See notes below for Agencies with subrecipients.
- An entire project component must be completed for each project/grant applying for renewal or same agency reallocation funding during the 2018 Competition.
- It is the responsibility of each grantee to complete all forms and all questions. Subrecipients should be consulted as appropriate. For Agency Tool, both grantee and all subrecipients must answer each question and include all attachments/documentation. For Project Tool, all subrecipients must answer each question and include all attachments/documentation.
- Tools are formatted so that areas that require answers and attachments are highlighted in red.
- Points available are included in italics.
- Points will be subtracted for incomplete, inaccurate or missing information, including informational only questions.
- Executive Director (preferred), Agency Director (preferred), or other Authorized Representative must certify that all information is true, complete and accurate to the best of their knowledge.
- Please note the reporting time periods in various questions as they may differ.
    - For Agency Component there are the following, which are specified in the questions :
        - Each Agency's fiscal year
        - Calendar year 2017
    - For Project Component there are the following, which are specified in the questions:
        - Year of last complete grant for which an APR has been submitted
        - Calendar year 2017
        - Information from 2017 Competition/Application
- Scores will be distributed to all grantees by the end of May.

Additional Information

If there are any questions concerning completion of this tool please contact Julie Maltzman at Julie.Maltzman@fairfaxcounty.gov or 703-324-3965 prior to 4:00 p.m. on Tuesday April 10, 2018. No technical assistance will be available following that date.

FAIRFAX COUNTY CONTINUUM OF CARE

Monitoring & Evaluation 2018 Agency Tool

17 Points

Agency: Click here to enter text.

Score: / 17

AGENCY INFORMATION

Agency Name:	Click here to enter text.
Name of all current U.S. Dept. of Housing and Urban Development (HUD) Projects:	• Click here to enter text. • Click here to enter text. • Click here to enter text. • Click here to enter text. • Click here to enter text.
Agency Contact Information:	Name: Click here to enter text. Title: Click here to enter text. Address: Click here to enter text. Phone: Click here to enter text. Email: Click here to enter text.
Additional Contact Information:	Name: Click here to enter text. Title: Click here to enter text. Address: Click here to enter text. Phone: Click here to enter text. Email: Click here to enter text.

SUBRECIPIENT INFORMATION (if applicable)

- For agency tool, both grantee and all subrecipients must answer all questions and include all attachments/documentation.
- If your agency has subrecipients for any grants complete the following information:

Name of Project #1:	Click here to enter text.
Subrecipient/s Project #1:	Agency Name: Click here to enter text. Agency Name: Click here to enter text.
Name of Project #2:	Click here to enter text.
Subrecipient/s Project #2:	Agency Name: Click here to enter text. Agency Name: Click here to enter text.
Name of Project #3:	Click here to enter text.
Subrecipient/s Project #3:	Agency Name: Click here to enter text. Agency Name: Click here to enter text.

FINANCIAL: **8 POINTS**

QUESTION	SCORE	POSSIBLE
1. Does the agency have an independent financial audit completed within 12 months of the end of the agency's fiscal year? Yes ☐ No ☐ • Attach 1st page of most recent audit management letter *(1 point for attachment and 1 point if attachment shows audit was completed within 12 months)* • If no, when was the date of you last audit? Click here to enter text.		**2**
2. Does the agency have the fiscal capacity to operate all of its HUD CoC grants? Yes☐ No ☐ • Attach first page of 2016 IRS Form 990 (*1 point with attachment)* • Attach most recent IRS Form 941 that was submitted in 2017 (*1 point with attachment)*		**2**
3. Does agency have financial/accounting policies, procedures and controls? Yes☐ No ☐ (*1 point if yes)* • Attach financial/accounting policies, procedures, and controls documents *(1 point with attachment)* • Do these policies align with HUD financial guidelines including the new regulations contained in 2 CFR Part 200, (guidance on audits, procurement, timesheet verification, documentation, etc.) Yes☐ No ☐ *(1 point if yes)*		**3**
4. Does agency have a system to track matching funds, both cash and in-kind? Yes☐ No ☐ (*1 point if yes)*		**1**

GOVERNANCE: 7 POINTS

QUESTION:	SCORE	POSSIBLE
5. Does your agency have a homeless or formerly homeless representative on your Board of Directors? Yes☐ No ☐ (*3 points if yes – skip to question #6)* • Does your agency have an equivalent policymaking entity with consumer representation: Yes☐ No ☐		**3**

If yes, describe equivalent policymaking entity and consumer representation: Click here to enter text. *(3 points if adequately described – skip to question #6)* • Has your agency received a waiver from HUD regarding this requirement? If yes, attach copy of waiver. Yes☐ No ☐ (*3 points if yes and waiver attached)*		
6. Attach a list of your Board of Directors as well as equivalent policymaking entity as applicable. (*1 point with attachment)*		**1**
7. Do representatives from your agency participate in homeless system committees and meetings? Yes☐ No ☐ • List the committees and representatives. Click here to enter text. *(1 point with list)*		**1**
8. Have all agency-wide deliverables been submitted to HUD and OPEH in a timely manner this past year? (e.g. GIW, Applicant Profile) ***To be determined by OPEH in consultation with HUD*** *(1 point if most, 2 points if all)*		**2**

POLICIES AND PROCEDURES: 2 POINTS

QUESTION	SCORE	POSSIBLE
9. For clients does your agency have: • Client Grievance policy Yes☐ No ☐ ○ Attach agency's grievance policy *(1 point if attached)*		**1**
10. From January 1, 2017 – December 31, 2017 did any former or current consumers participate in your agency via… *(1 point if any)* • Employment opportunities Yes☐ No ☐ • Volunteer opportunities Yes☐ No ☐ • Group feedback sessions Yes☐ No ☐		**1**

REQUIRED ATTACHMENTS FOR AGENCY COMPONENT:

☐ Latest agency audit management letter (Not necessary for Fairfax County Governmental Agencies)

☐ First page of 2016 IRS Form 990 – Return of Organization Exempt from Income Tax (Not necessary for Fairfax County Governmental Agencies)

☐ Agency's latest IRS Form 941 submitted in 2017 – Employer's Quarterly Federal Tax Return (Not necessary for Fairfax County Governmental Agencies)

☐ Agency's financial/accounting policies, procedures and controls documents

☐ Consumer Representation Waiver from HUD (if applicable)

☐ List of Board of Directors (or Advisory Board for Governmental Agencies)

☐ List of members of equivalent policymaking entity (if applicable)

☐ Client Grievance Policy

FAIRFAX COUNTY CONTINUUM OF CARE

Monitoring & Evaluation
2018 Project Tool
89 Points

Project: Click here to enter text.

Score: / 89

SUBRECIPIENTS:

- For agency tool, both grantee and all subrecipients must answer all questions and include all attachments/documentation.
- For project tool, all subrecipients must answer all questions and include all attachments/documentation.
- All unearned points in this section will be deducted from the program's total score so that programs with subrecipients are not given the advantage of additional points.

8 POINTS

QUESTION	SCORE	POSSIBLE
Does this grant have any subrecipients? ☐ Yes ☐ No • If no, skip to financial section • If yes, list them here: Click here to enter text.		___
Does the grantee have contracts with all subrecipients? ☐ Yes ☐ No Attach copy of contracts with all subrecipients. *(3 points if contract with all subrecipients attached)*		**3**
Does the grantee perform programmatic, administrative and financial monitoring of the subrecipients on a regular basis? ☐ Yes ☐ No If yes, when was the most recent onsite monitoring completed by the grantee for each subrecipient? Click here to enter text. *(3 points if each subrecipient was monitored within the last year)*		**3**
Does the grantee update all subrecipients of HUD regulations and changes as necessary? ☐ Yes ☐ No If yes, what is the grantee's process for updating subrecipients? *(1 point if described)* Click here to enter text.		**1**
Does the grantee share administrative funds with the subrecipient agencies? ☐ Yes ☐ No *(1 point if yes)*		**1**

FINANCIAL: **13 POINTS**

QUESTION	SCORE	POSSIBLE
1. What is the grant year for this project (e.g.: 2/1 – 1/31)? • Click here to enter text. *(1 point if correct grant year entered)*		**1**

2. What is the total grant amount applied for from HUD during the 2017 Competition? Click here to enter text. *(1 point if correct)*
• What <u>percentage</u> of this grant is: *(1 point if correct)*
  • Rental Assistance Click here to enter text.
  • Leasing Click here to enter text.
  • Operations Click here to enter text.
  • Supportive Services Click here to enter text.
  • Administration Click here to enter text.
		2

3. Attach documentation of all HUD's Line of Credit Control System (LOCCS) drawdowns indicating dates and amounts for the last completed grant year. Documentation should include summary of total amount expended as well as dates of withdrawals (no need to attach each voucher). *(1 point if attached)*
• Does this project draw down funds from HUD's Line of Credit Control System (LOCCS) at least quarterly?
  Yes ☐ No ☐ *(1 point if yes & confirmed by attachment)*
• Have all HUD funds been drawn down for the last complete grant year?
  • Yes ☐ No ☐ *(3 points if yes & confirmed by attachment – same as above)*
  • If no, how much was unspent? Click here to enter text.
  • If no, why were funds unspent? Click here to enter text. *(1 point if unspent amount & adequate explanation provided)*
		5

4. How many years has funding <u>not</u> been completely utilized in the past three years? *(1 point subtracted for each year funds were not completely utilized)* Click here to enter text.		**-3**

5. Cost per client/household:
• What is the total HUD grant amount divided by the number of PSH households (each family or single) in the program at one point in time and/or the number of RRH households (each family or single) in a program over the course of the grant year? Click here to enter text.
  • Between $8,000 - $15,000 – *(3 points)*
  • Between $15,001- $23,000 – *(2 points)*
  • Over $23,000 – *(1 point)*
		4

• Are the units owned ☐ or leased ☐ ? *(1 point if leased)* If the project utilizes both owned and leased units provide details: Click here to enter text.		
6. Does the agency receive program/rental income from this project? Yes ☐ No ☐ • If yes, how much during the last complete grant year? Click here to enter text. • If yes, were these funds used exclusively for eligible expenses (items that can be charged to a grant) as defined in the Interim Rule? Yes☐ No ☐ *(1 point if yes to all)*		**1**

ADMINISTRATIVE: **9 POINTS**

QUESTION	SCORE	POSSIBLE
7. When was the last time this project was monitored by HUD? Click here to enter text. • Attach monitoring report. If not attached, provide explanation: Click here to enter text. *(Minus 1 point if monitored and report not attached unless adequate explanation is provided.)* • Attach agency's response to monitoring report. If not attached, provide explanation: Click here to enter text. *(Minus 1 point if monitored and response not attached unless adequate explanation is provided.)*		**-2**
8. Does this project conduct Housing Quality Standards reviews at least annually for all units? (Note: this is different than housing cleanliness standards, and Housing Quality Standards are defined by HUD) • Yes ☐ No ☐ *(1 point if yes)* • Attach form used to conduct Housing Quality Standards reviews. *(1 point if attached)*		**2**
9. Does this project have guidelines in place to adhere to Fair Market Rent and Rent-Reasonableness? (Note: Both are necessary) Yes ☐ No ☐ • Attach agency guidelines for FMR and Rent-Reasonableness. *(1 point for each)*		**2**

10. How many units are utilized in this project at one point in time? Click here to enter text. • For PSH: Attach list of the addresses for all of this project's units and the date the environmental review was completed for each. For PSH - Environmental review date required for all project's units even if completed in July 2014. Only list this project's units on this form. Therefore, number of units on environmental review list must be equal to number of units in project. *(2 points if all unit addresses and environmental review dates attached.)* • For RRH: Attach a copy of overall ER for project. *(2 points for project ER.)*		**2**
11. Has this program been represented by the grant applicant at all HUD Grantee Meetings? Meetings: • CoC Program Meeting: April 5, 2017 • CoC Program Meeting: May 2, 2017 • CoC Program Meeting: July 26, 2017 Yes ☐ No ☐ *(1 point if yes and verified by OPEH)*		**1**
12. Have all project deliverables been submitted to OPEH in a timely manner this past year? (e.g. Project Application, Project Description, Client Vulnerabilities) *To be determined by OPEH (1 point if most, 2 points if all)*		**2**

HMIS: **6 POINTS**

QUESTION	SCORE	POSSIBLE
13. Attach a PDF of just the one page **'Tab B1 – Overall Report Card"** of the ART report 0252 - Data Completeness Report Card for last year – January 1, 2017 through January 1, 2018 for this project. *(1 point if correct report attached)* • Does this project have 100% for both "HUD UDE ONLY" and "Additional ONLY" Yes ☐ No ☐ *(1 point if yes and documented on report)* • Does this project have 95% for both "HUD Verification ONLY" and "OVERALL" Yes ☐ No ☐ *(1 point if yes and documented on report)*		**3**
14. Was DQ submitted in a timely fashion from January 2017 through December 2017 Yes ☐ No ☐ PSH – 4 submissions; RRH – 11 submissions *To be confirmed by OPEH (1 point if most, 2 points if all)*		**2**
15. Does this project have an active member of the HMIS super user Group? Yes ☐ No ☐ *(1 point if yes and verified by OPEH)*		**1**

SERVICES & POLICES: **17 POINTS**

QUESTION	SCORE	POSSIBLE
16. What program staff member is responsible for ensuring that minors and Transitioning Age Youth (18-24) are in school and/or receiving appropriate educational services per HUD Requirements? Note: all programs must have staff with educational services knowledge as all programs may serve people between the ages of 18-24. Click here to enter text. *(1 point if name provided)*		**1**
17. Is there a systematic process for ensuring that clients apply for and obtain all mainstream resources to which they are entitled? (TANF, SSI/SSDI, SNAPS, Medicaid, SCHIP, local mental and somatic health care, etc.) Yes ☐ No ☐ • Describe process and people responsible for implementation: Click here to enter text. *(1 point for clear processes and 1 point for people responsible for implementation)*		**2**
18. Does this project utilize a form that allows clients to apply for 4 or more benefits at once? Yes ☐ No ☐ • Attach form used to allow clients to apply for 4+ benefits *(1 point if attached)*		**1**
19. Does this project provide transportation assistance to clients wishing to receive help getting to benefit appointments, employment training and/or jobs? Yes ☐ No ☐ *(1 point)*		**1**
20. Does this project provide follow-up to ensure benefits are received and maintained? Yes ☐ No ☐ *(1 point)*		**1**
21. Provide the name and title of your agency's SOAR certified staff member who is available to participants of this program in need of this service. Click here to enter text. *(2 points if name and job title provided)*		**2**
22. Does this project utilize a housing first model as defined by HUD as stated below? *"Any project that indicates that it follows a Housing First model cannot place preconditions or eligibility requirements—beyond HUD's eligibility requirements—on persons entering housing, nor can it require program participants to participate in supportive service activities or make other rules, such as sobriety, a condition of housing. Recipients may offer and encourage program participants to participate in services, but there may be*		**2**

no time limit as to when he/she must do so." *(A program can require regular meetings with a case manager)* Yes ☐ No ☐ *(2 points if yes)*		
23. Does each client in the program have a standard lease? Yes ☐ No ☐ • Attach copy of lease *(1 point if attached)* • Does the lease contain provisions of a standard lease? Yes ☐ No ☐ *(informational only)* • Does this lease contain additional requirements not contained in a standard lease? Yes ☐ No ☐ *(informational only)* • Is each client educated about the details of the lease? Yes ☐ No ☐ *(informational only)*		**1**
24. Does this program have a policy for discharging clients for non-compliance? Yes ☐ No ☐ • Attach form document outlining your discharge policy. *(1 point if attached)* • Does this program have policies and/or procedures for eviction for non-payment of rent and/or other reasons? Yes ☐ No ☐ If yes attach all *(informational only)*		**1**
25. Does this project accept participants regardless of issues with the following: *(1 point for yes to all responses)* • Actively using ☐ Yes ☐ No • Criminal history ☐ Yes ☐ No • Bad credit ☐ Yes ☐ No • Bad rental history ☐ Yes ☐ No • Untreated mental illness ☐ Yes ☐ No • No income ☐ Yes ☐ No • Medication adherence ☐ Yes ☐ No • History of victimization, DV, or sexual assault ☐ Yes ☐ No		**1**
26. Does this project accept and serve people irrespective of gender identity, sexual orientation or marital status? ☐ Yes ☐ No *(1 point for yes)*		**1**
27. What is the service level of this project? • Service Level 1: Scattered Sites ☐ Yes *(1 point)* • Service Level 2: Part Time Onsite Staff ☐ Yes *(2 points)* • Service Level 3: 24/7 or almost 24/7 Onsite Staff ☐ Yes *(3 points)* • If there are multiple service levels within one project, provide explanation: Click here to enter text.		**3**

GENERAL OUTCOMES: **24 POINTS**

QUESTION	SCORE	POSSIBLE
28. Have all program participants been given the opportunity to complete client satisfaction surveys during calendar year 2017? Yes ☐ No ☐ • Attach client satisfaction survey with date administered *(1 point if attached with date surveyed)* • Attach summation of all clients' responses *(1 point if attached)*		**2**
29. Attach list of all heads of household's HMIS numbers for only those who entered your program from January 1, 2017 through December 31, 2017 • Referring agency *(1 point if referring agency provided for all clients)* • Living situation (streets, shelter, transitional housing, institution, etc.) prior to entering your program *(1 point if prior living situation provided))* • If PSH, whether or not the head of household was chronically homeless at entry – must come from shelter or place not meant for human habitation *(1 point if all clients entering PSH were chronically homeless at entry)* **Minus 1 point for each client/family that was not literally homeless at entry.*		**3**
30. What is the capacity of this program when full, both units and beds? Click here to enter text. *(1 point if correct)*		**1**
31. Attach a PDF copy of the last APR submitted in Sage. Note: Please print out each page of the APR on one page. *(1 point for attachment and 2 points if general information is correct)* • Attach a copy of the Sage submission page that states the date it was submitted (not the date in the APR itself). • If late for a specific reason explain here: Click here to enter text. *(1 point if the APR was submitted within 90 days of the end of the grant year or if not adequate explanation provided.)* **Minus 1 point for every 30 days past the 90 day deadline that the APR was not submitted.*		**4**
32. How many total adults were served during the last grant year? Click here to enter text. • How many total families with children, if applicable, were served during the last grant year? Click here to enter text. *(1 point if both adult and family numbers are correct)*		**1**

• For those programs serving both singles and families, how many singles and how many families were served during the last grant year? Click here to enter text. *(informational only)* **On APR - question 7a (adults), question 8a (total number of families and households)**		
33. What was the average utilization rate on the past APR? • Click here to enter text. • 95 - 100% *(3 points)* • 90 - 94% *(2 points)* • 85 – 89% *(1 point)* • 75 – 84% *(0 points)* • 50 – 74% *(-1 point)* • Below 50% *(-2 points)* **On APR - Question #8b – add up the four Point-in-Time Count of Households Served (January, April, July, and October), divide by four, then divide by number of units(families)/beds(singles) available at capacity.**		**3**
34. **From APR and case files**, add up all known physical and mental health conditions and other subpopulations of **only adults** (during last complete grant year) at entry and divide by total number of adults served. • Total number of conditions/subpopulations in all categories: Click here to enter text. • Total number of adults served: Click here to enter text. • Divide total conditions/subpopulation by number of adults served: Click here to enter text. • **From 1 - 1.9 - *(1 point)*** • **From 2 – 2.9 - *(2 points)*** • **From 3-3.9 - *(3 points)*** • **From 4 up – *(4 points)*** • Mental Health Problems (**On APR – question #13a)**: Number - Click here to enter text. • Substance Abuse (**On APR – question #13a)**: Number - Click here to enter text. • Chronic Health Conditions (**On APR – question #13a)**: Number - Click here to enter text. • HIV/AIDS (**On APR – question #13a)**: Number - Click here to enter text.		**4**

• Developmental Disability (**On APR – question #13a)**: Number - Click here to enter text. • Physical Disability (**On APR – question #13a)**: Number - Click here to enter text. • Veterans: (**On APR – question #5a)** Number - Click here to enter text. • Homeless this episode due to DV: (**On APR – question #14b)** Number - Click here to enter text. • CH at entry to program: (**On APR – question #5a)** Number - Click here to enter text. • Single Adults or Heads of Household 18-24 (only households where everyone in the household is 24 or younger): **(APR question #5a)** Number - Click here to enter text. • Single Adults or Heads of Household 62 or older: (**On APR – question #11)** Number - Click here to enter text. Explain any numbers that might not align with the APR: Click here to enter text.		
35. From APR – what is the average Length of Stay for Leavers and for Stayers – in terms of day? • Leavers - Click here to enter text. • Stayers - Click here to enter text. (For programs with multiple entries – enter both numbers and average for each category.) For each: • Over 2,000 - *(1 point)* • Between 1,000 – 2,000 - *(2 point)* • Under 1,000 - *(3 point)* **On APR – question #22b**		**6**

HOUSING SPECIFIC OUTCOMES: **20 POINTS**

QUESTION	SCORE	POSSIBLE

36. From the APR - how many adults had income?
• Number of adults that have been in the program more than a year plus all leavers: (available in APR – question #16) Click here to enter text.
• Number of adults that met this measurement: Click here to enter text.
• Percentage of adults that met this measurement: Click here to enter text.
  • 90 - 100% (4 points)
  • 80 - 89% (3 points)
  • 70 - 79% (2 points)
  • 60 - 69% (1 point)
  • Below 60% (0 points)
On APR - question #16 – add those with cash income at latest annual assessment for stayers who have been in the program more than a year and at exit for all leavers.
		4

37. From the APR - how many adults were employed?
• Number of adults that met this measurement: Click here to enter text.
• Percentage of adults that met this measurement: Click here to enter text.
  • 50 - 100% (4 points)
  • 35 - 49% (3 points)
  • 20 - 34% (2 points)
  • 10 - 19% (1 point)
  • Below 10% (0 points)
On APR - question #17 – add those with earned income at latest annual assessment for stayers who have been in the program more than a year and at exit for all leavers.
		4

38. From the APR - how many adults increased income while in the program?
• Number of adults that met this measurement: Click here to enter text.
• Percentage of adults that met this measurement: Click here to enter text.
  • 80 - 100% (4 points)
  • 60 - 79% (3 points)
  • 40 - 59% (2 points)
		4

• 20 - 39% (1 point) • Below 20% (0 points) **On APR - question #19a3, the second to last number in the last column.**		
39. From the APR - how many adults received non-cash benefits? • Number of adults that met this measurement: Click here to enter text. • Percentage of adults that met this measurement**:** Click here to enter text. • 90 - 100% (4 points) • 80 - 89% (3 points) • 70 - 79% (2 points) • 60 - 69% (1 point) • Below 60% (0 points) **On APR - question #20 and #21– add those with non-cash benefits or government provided health insurance at latest annual assessment for stayers who have been in the program more than a year and at exit for all leavers; need to use case files to determine so that there is no overlap.**		**4**
40. From the APR - how many adults maintained their housing stability, either in your program or by moving to other permanent housing? (Do not count program participants that passed away in this measure.) • Number of adults that met this measurement: Click here to enter text. • Percentage of adults that met this measurement: Click here to enter text. • 95 - 100% *(4 points)* • 90 - 94% *(3 points)* • 85 - 89% *(2 points)* • 80 - 84% *(1 point)* • Below 79% *(0 points)* **On APR - question #23a and #23b for leavers and #5a for number of stayers**		**4**

REQUIRED ATTACHMENTS FOR PROJECT COMPONENT:

☐ Copy of Subrecipient contracts, if applicable.

☐ Documentation of LOCCS drawdowns; should include summary of total amount expended as well as dates of withdrawals. The two documents can be found in the under Grant Information – General Tab and Vouchers Tab.

☐ If monitored by HUD, attach monitoring report and response.

☐ Housing Quality Standards form.

☐ FMR and Rent Reasonableness policies/forms.

☐ For PSH - List of Units' Addresses and the dates of their environmental reviews for this project. For RRH – Copy of overall environmental review.

☐ PDF of Tab B – Project Chart from ART report 252 for latest grant year

☐ Application form utilized to apply for 4 or more mainstream benefits.

☐ Sample client lease.

☐ Discharge for non-compliance policy.

☐ Eviction policy and/or procedures.

☐ Copy of client satisfaction survey, date survey was conducted, and a summation of the responses.

☐ A list of clients with HMIS numbers who entered your program from January 1, 2017 through December 31, 2017 with original referral source, living situation prior to your program entry and if they were chronically homeless at entry.

☐ PDF copy of the last APR submitted in Sage, printed on one side of paper only.

☐ Copy of the Sage submission page with APR submission date (not the date on the APR itself).

CoC Monitoring and Evaluation Meeting

May 17th, 2018

Fairfax County Government Center

Agenda:

- **Overview of Monitoring & Evaluation**
- **Review of Scores**
- **Further Actions 2018**
- **Planning for 2019**

CoC Monitoring and Evaluation Meeting

May 17, 2018

- Comments
    - New APR was confusing
        - Need to change some of the questions
            - Ex: “Do they have mainstream benefits when that is divided into two sections now?”
            - Should we give points for having insurance or just government provided insurance?
- Scoring
    - Lowest agency score: 13
    - Highest agency score: 17
    - Highest possible agency score: 17
    - Lowest project score: 55
    - Highest project score: 79
    - Highest possible project score: 89
- Comments from Cindy
    - Appreciates people organizing the packets
        - Having the cover sheets a different color
        - Using paper clips
    - Make sure that you are using current documents
    - Make sure that you are using the right date
        - Calendar year
        - Grant year
    - Some projects did not include the dates that the surveys were completed
- Comments from Michael
    - Make sure that you are using the calendar year when running the 252 Report Card
    - Make sure that you run the 252 Report Card as a PDF as opposed to an Excel document.
        - The Excel document does not include the date
        - Will suggest adding that to the tool for next year
- Comments from Julie

- The numbers you use for questions 31-40 of the project tool should reflect what is in the APR
- If there is a situation where the APR has incorrect data, it needs to be corrected
- Keep the data in HMIS up-to-date and correct. Make sure that it reflects your outcomes accurately
- When you submit your APR in SAGE, print out the confirmation page that day
- Financial policies varies greatly
  - Some agencies have several pages worth
  - Others have a page or two
- Misunderstanding on audit letter
  - Needs to be the letter from the auditor, not the letter you send to the auditor
- We will be comparing the scores of this year's to last year's
  - When we did this last year, we paired a low performing agency with a high performing agency to help improve their scoring for this year
- We will be reporting the M&E scores to the CoC Committee
- Leases
  - Needs to look like a standard lease
  - There were some projects that claimed not to have additional requirements when they did
  - Shorter is better
    - Most of our clients will not be reading a twenty page lease
    - Needs to be something that clients can get through quickly and still understand their rights
- Discharge Policies
  - Most policies were not very clear
- Does this measure how well a program has done or how well they have filled out a form?
  - Little bit of both

- Further action

- Subcommittee to be formed to review leases, eviction and discharge policies and have standards that grantees would be encouraged to utilize but maybe not mandatory.
- We will be sending out the scored tools by the end of May
    - Agencies will have two weeks to ask questions about their scores
- Meet in the late fall/early winter to review changes and decide how to go about it for next year
- Look at the items that were marked “informational” for this year and decide on whether they should be required for next year
- Make sure that the questions for next year are consistent with the APR
- HUD might be moving the competition up to two months earlier
    - Would we want to change when we do M&E?
    - It might be too much to do both applications and M&E at the same time
- Should we look into having site visits?
    - M&E use to be done through peer evaluations
        - Not a good evaluation, but people enjoyed it
    - Should we have peers visit or everyone visit?

2018 Monitoring and Evaluation

Agency Identifier	Agency Score
A	17
B	13
C	16
D	16
E	15
F	16
G	17
H	17

Project Identifier	Project Score
1	72
2	62
3	74
4	74
5	60
6	74
7	67
8	72
9	59
10	76.5
11	72
12	72.5
13	66.5
14	61
15	64
16	75
17	75
18	68
19	63
20	66
21	70
22	66
23	64

Tools Scores

Agency Tool:

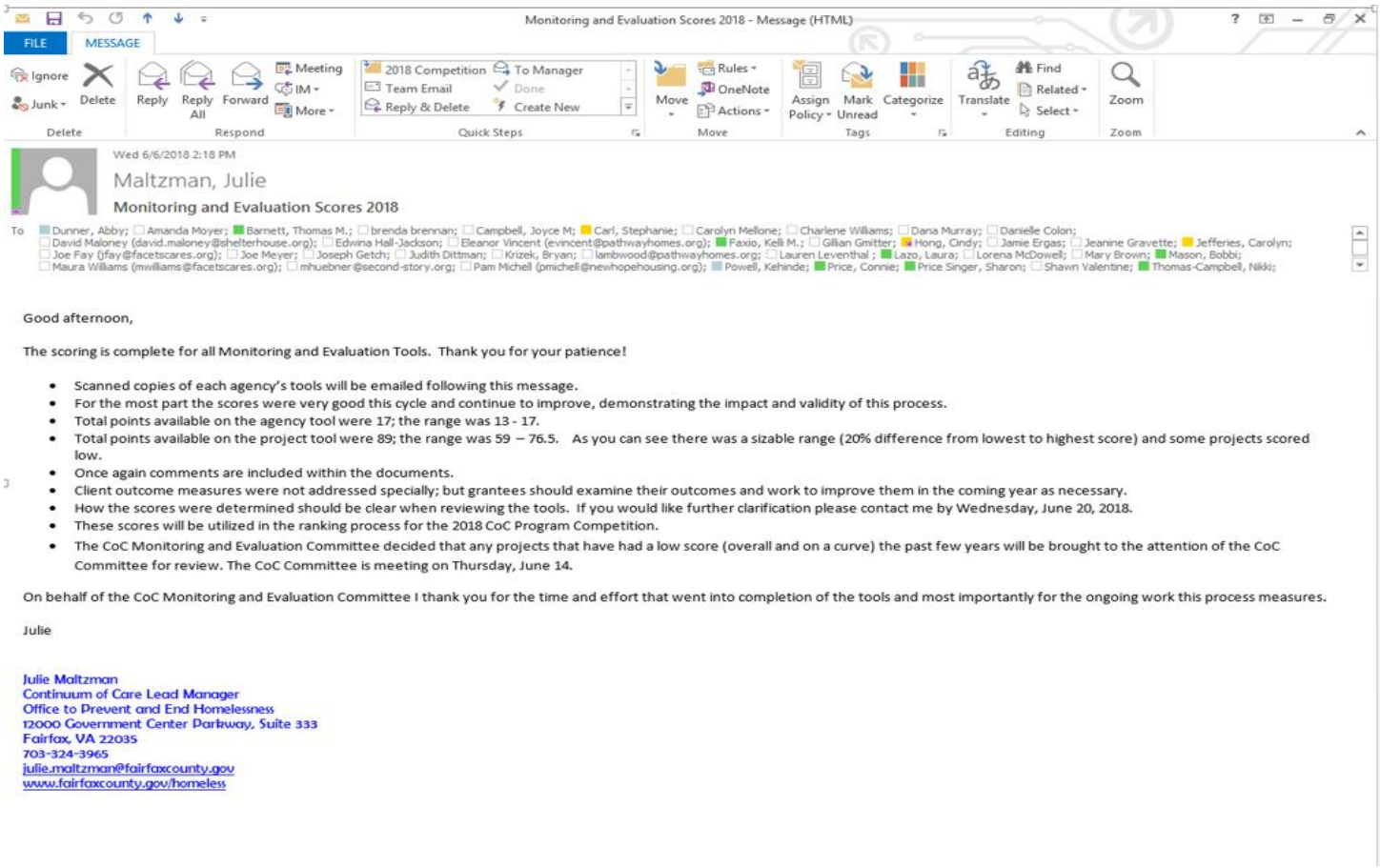
Agency Possible Score: **17**

Range: **13-17**

Project Tool:

Agency Possible Score: **89**

Range: **59 – 76.5**



Monitoring and Evaluation Scores 2018 - Message (HTML)

FILE MESSAGE

Ignore Junk Delete | Reply Reply All Forward | Meeting IM More | 2018 Competition Team Email Reply & Delete To Manager Done Create New | Move Rules OneNote Actions | Assign Policy Mark Unread Categorize | Translate Find Related Select | Zoom

Delete Respond Quick Steps Move Tags Editing Zoom

Wed 6/6/2018 2:18 PM

Maltzman, Julie

Monitoring and Evaluation Scores 2018

To Dunner, Abby; Amanda Moyer; Barnett, Thomas M.; brenda brennan; Campbell, Joyce M; Carl, Stephanie; Carolyn Mellone; Charlene Williams; Dana Murray; Danielle Colon; David Maloney (david.maloney@shelterhouse.org); Edwina Hall-Jackson; Eleanor Vincent (evincent@pathwayhomes.org); Faxio, Kelli M.; Gillian Gmitter; Hong, Cindy; Jamie Ergas; Jeanine Gravette; Jefferies, Carolyn; Joe Fay (jfay@facetscares.org); Joe Meyer; Joseph Getch; Judith Dittman; Krizek, Bryan; lambwood@pathwayhomes.org; Lauren Leventhal ; Lazo, Laura; Lorena McDowell; Mary Brown; Mason, Bobbi; Maura Williams (mwilliams@facetscares.org); mhuebner@second-story.org; Pam Michell (pmichell@newhopehousing.org); Powell, Kehinde; Price, Connie; Price Singer, Sharon; Shawn Valentine; Thomas-Campbell, Nikki;

Good afternoon,

The scoring is complete for all Monitoring and Evaluation Tools. Thank you for your patience!

- Scanned copies of each agency's tools will be emailed following this message.
- For the most part the scores were very good this cycle and continue to improve, demonstrating the impact and validity of this process.
- Total points available on the agency tool were 17; the range was 13 - 17.
- Total points available on the project tool were 89; the range was 59 – 76.5. As you can see there was a sizable range (20% difference from lowest to highest score) and some projects scored low.
- Once again comments are included within the documents.
- Client outcome measures were not addressed specially; but grantees should examine their outcomes and work to improve them in the coming year as necessary.
- How the scores were determined should be clear when reviewing the tools. If you would like further clarification please contact me by Wednesday, June 20, 2018.
- These scores will be utilized in the ranking process for the 2018 CoC Program Competition.
- The CoC Monitoring and Evaluation Committee decided that any projects that have had a low score (overall and on a curve) the past few years will be brought to the attention of the CoC Committee for review. The CoC Committee is meeting on Thursday, June 14.

On behalf of the CoC Monitoring and Evaluation Committee I thank you for the time and effort that went into completion of the tools and most importantly for the ongoing work this process measures.

Julie

Julie Maltzman
Continuum of Care Lead Manager
Office to Prevent and End Homelessness
12000 Government Center Parkway, Suite 333
Fairfax, VA 22035
703-324-3965
julie.maltzman@fairfaxcounty.gov
www.fairfaxcounty.gov/homeless

HUD FY18 CoC Program Competition - New Funding Opportunities - Message (HTML)

FILE | MESSAGE

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Tue 7/3/2018 11:17 AM

Ergas, Jamie

HUD FY18 CoC Program Competition - New Funding Opportunities

To

Message | New Funding Opportunities Application - 2018 CoC Competition.doc (947 KB) | Agency Capacity Form - 2018 CoC Competition.docx (887 KB) | Application Deliverables and Due Dates - 2018 CoC Competition.docx (212 KB)

Good morning,

HUD's Continuum of Care Program is a significant component of the community-wide goal to prevent and end homelessness. As part of HUD's FY18 Continuum of Care Program Competition, which opened on June 20th and ends on September 18th, there is a total of **$996,212 in new funding opportunities** available. This application process is a great avenue to pursue more resources for those experiencing homelessness in our community. The New Funding Opportunities Application that is attached provides more details and includes information such as:

- types of funding opportunities (Bonus, Reallocation, and Domestic Violence Bonus funding)
- eligible projects for each funding type and,
- total $ amount in each funding type.

The Agency Capacity Form attached is only required as part of the New Funding Opportunities Application process for agencies that are not *currently* HUD CoC Program Grantees.

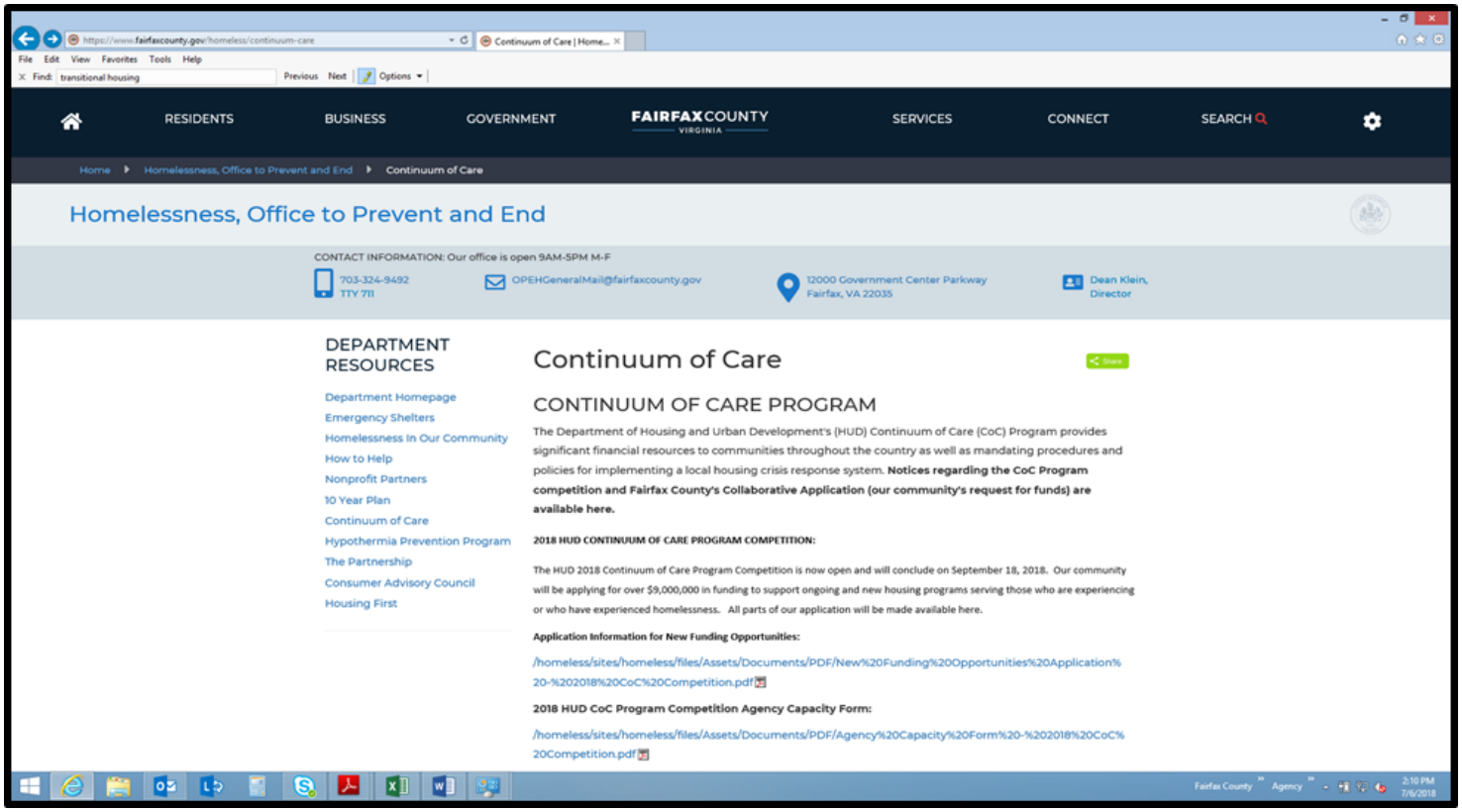
An outline of all of the deliverables and due dates for the CoC Competition is also attached. A few upcoming dates and next steps specifically related to the New Funding Opportunities are listed below.

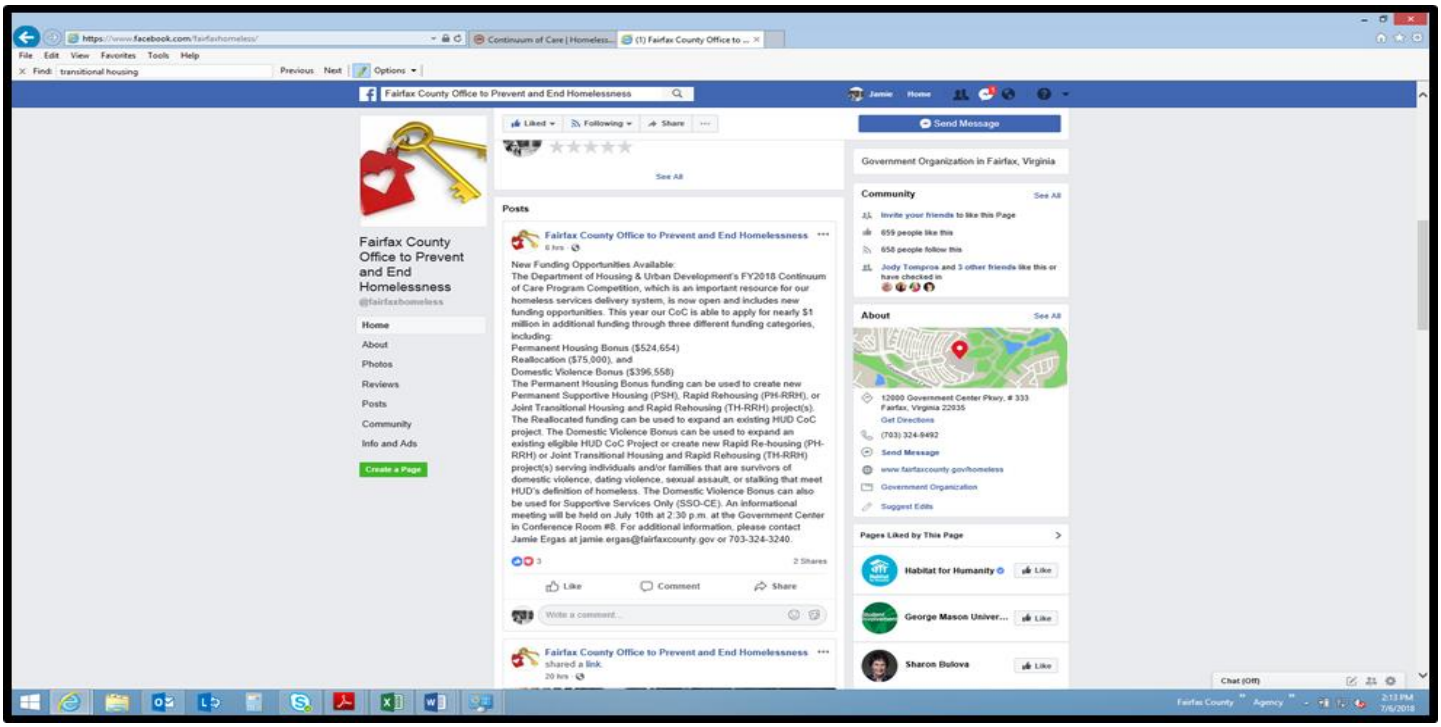
- **New Funding Opportunities (*Informational Meeting, optional*):** **July 10th, 2:30 pm, Gov't Center Room 8**
- Notify CoC Lead of interest in applying for the New Funding: July 17th, 4:00 pm
- New Funding Opportunities (*Application Due to CoC Lead*): July 26th, 4:00 pm

Please do not hesitate to contact me with any questions. Thank you!

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager
Fairfax County Office to Prevent and End Homelessness
12000 Government Center Parkway, #333, Fairfax, VA. 22035
Direct: 703-324-3240 | Main: 703-324-9492 | Fax: 703-653-1365
E-mail: jamie.ergas@fairfaxcounty.gov
Website: http://www.fairfaxcounty.gov/homeless


RESIDENTS
BUSINESS
GOVERNMENT
FAIRFAX COUNTY
VIRGINIA
SERVICES
CONNECT
SEARCH
Home
Homelessness, Office to Prevent and End
Continuum of Care
Homelessness, Office to Prevent and End
CONTACT INFORMATION: Our office is open 9AM-5PM M-F
703-324-9492
TTY 711
OPEHGeneralMail@fairfaxcounty.gov
12000 Government Center Parkway
Fairfax, VA 22035
Dean Klein,
Director
DEPARTMENT RESOURCES
Department Homepage
Emergency Shelters
Homelessness In Our Community
How to Help
Nonprofit Partners
10 Year Plan
Continuum of Care
Hypothermia Prevention Program
The Partnership
Consumer Advisory Council
Housing First
Continuum of Care
CONTINUUM OF CARE PROGRAM
The Department of Housing and Urban Development's (HUD) Continuum of Care (CoC) Program provides significant financial resources to communities throughout the country as well as mandating procedures and policies for implementing a local housing crisis response system. Notices regarding the CoC Program competition and Fairfax County's Collaborative Application (our community's request for funds) are available here.
2018 HUD CONTINUUM OF CARE PROGRAM COMPETITION:
The HUD 2018 Continuum of Care Program Competition is now open and will conclude on September 18, 2018. Our community will be applying for over $9,000,000 in funding to support ongoing and new housing programs serving those who are experiencing or who have experienced homelessness. All parts of our application will be made available here.
Application Information for New Funding Opportunities:
/homeless/sites/homeless/files/Assets/Documents/PDF/New%20Funding%20Opportunities%20Application%20-%202018%20CoC%20Competition.pdf
2018 HUD CoC Program Competition Agency Capacity Form:
/homeless/sites/homeless/files/Assets/Documents/PDF/Agency%20Capacity%20Form%20-%202018%20CoC%20Competition.pdf


Fairfax County Office to Prevent and End Homelessness
Fairfax County Office to Prevent and End Homelessness
@fairfaxhomeless
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New Funding Opportunities Available:
The Department of Housing & Urban Development's FY2018 Continuum of Care Program Competition, which is an important resource for our homeless services delivery system, is now open and includes new funding opportunities. This year our CoC is able to apply for nearly $1 million in additional funding through three different funding categories, including:
Permanent Housing Bonus ($524,654)
Reallocation ($75,000), and
Domestic Violence Bonus ($396,558)
The Permanent Housing Bonus funding can be used to create new Permanent Supportive Housing (PSH), Rapid Rehousing (PH-RRH), or Joint Transitional Housing and Rapid Rehousing (TH-RRH) project(s). The Reallocated funding can be used to expand an existing HUD CoC project. The Domestic Violence Bonus can be used to expand an existing eligible HUD CoC Project or create new Rapid Re-housing (PH-RRH) or Joint Transitional Housing and Rapid Rehousing (TH-RRH) project(s) serving individuals and/or families that are survivors of domestic violence, dating violence, sexual assault, or stalking that meet HUD's definition of homeless. The Domestic Violence Bonus can also be used for Supportive Services Only (SSO-CE). An informational meeting will be held on July 10th at 2:30 p.m. at the Government Center in Conference Room #8. For additional information, please contact Jamie Ergas at jamie.ergas@fairfaxcounty.gov or 703-324-3240.
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2018 HUD CoC Program Competition
CoC Committee Meeting - AGENDA
August 1, 2018 | 1:30 pm | Government Center, Room #8

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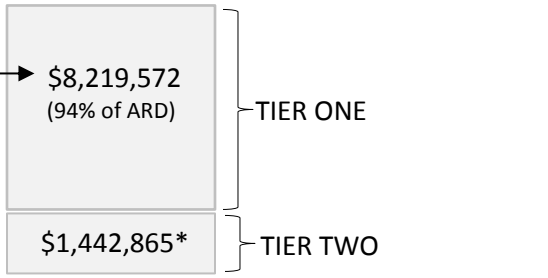
1) Overview of the FY18 Competition:

Annual Renewal Demand (ARD)		$8,744,225
New Funding Opportunities	**BONUS FUNDING**	**$524,654**
	REALLOCATION	**$75,000**
	DOMESTIC VIOLENCE BONUS	**$396,558**
TOTAL Fairfax County's CoC can apply for		$9,665,437*

*$75,000 already included in the ARD



*Assuming we apply for 100% of the New Funding Opportunities

ARD (including reallocation)
+ BONUS/DV Bonus
– Tier One
Tier Two

2) New Funding Opportunities Applications (see attached):

- HUD / local requirements
- Meeting the community need
- Using this resource to assist in making homelessness rare and brief

3) Presentations of New Funding Opportunities Applications:

Time	Agency	Funding Type	Project Type	Amount Requested	Proposed to serve
1:50	Operation Renewed Hope	Bonus	*Unspecified*	$137,360 / (26%)	4 households
2:10	FACETS	Bonus	RRH for singles	$524,654 / (100%	36 individuals
2:30	FACETS	Reallocation	PSH for singles	$75,000 / (100%)	3 individuals
2:50	Shelter House	Reallocation	PSH for families	$75,000 / (100%)	2 households (7)
3:10	Shelter House	DV Bonus	RRH for DV	$396,558 / (100%)	33 households (83)
3:30	Beth El House	*Unspecified*	TH-RRH for DV	$142,200 / (36%)	8? households

4) Decisions on New Funding Opportunities Applications

5) Ranking and Tiering Process

- Ranking and Tiering Decisions and Discussion
- Confirm members of Ranking Committee

Project	Organization	Grant Amount	Grant Type	Agency Score	Project Score	Combined Score	Combined Score (%)	PSH or RRH	Target Pop.	Singles and/or Families	Number of Clients	Cost per Client/household	Rent or Own	Service Level *
				17	89	106								

2018 Competition Measures

Vulnerability of Clients Served - PSH

Instructions: Numbers below should account for one point in the past fiscal year in which the program was at full capacity. Programs serving families should answer for adults only.

Agency: _____

Program: _____

Number of adults served at full capacity: _____

Measure	Number of Clients with Measure
History of victimization – DV and/or child abuse	
Number of previous homeless episodes prior to program entry	
Chronic Homeless at entry	
Unsheltered at entry	
No income at entry	
Criminal history	
Bad credit or rental history (including not having been a leaseholder)	
Has mental disability, including substance abuse disorder	
Has physical disability	
Had more than one disability at entry	

Vulnerability of Clients Served - RRH

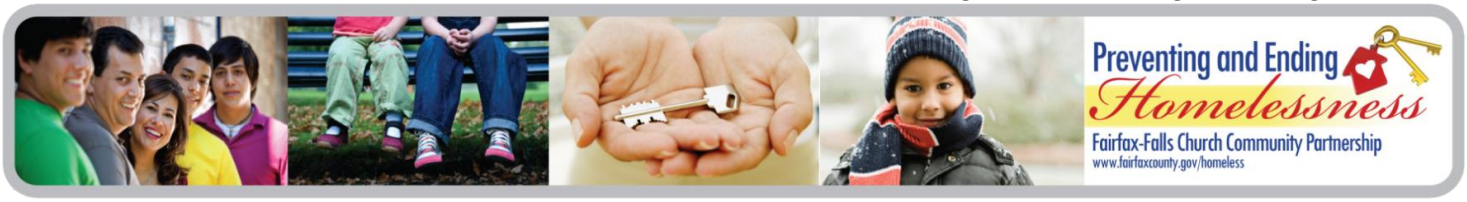
Instructions: Numbers below should account for all adults served since the beginning of your program last year.

Agency: _____

Program: _____

Number of adults served since beginning of program: _____

Measure	Number of Clients with Measure
History of victimization – DV and/or child abuse	
Number of previous homeless episodes prior to program entry	
Chronic Homeless at entry	
Unsheltered at entry	
No income at entry	
Criminal history	
Bad credit or rental history (including not having been a leaseholder)	
Has mental disability, including substance abuse disorder	
Has physical disability	
Had more than one disability at entry	



2018 HUD CoC Program Competition
Ranking Committee Meeting – AGENDA & BACKGROUND
August 22, 2018 | 1:00 pm | Government Center, Room #8

1) Competition Funding

Annual Renewal Demand (ARD)		$8,744,225
New Funding Opportunities	BONUS FUNDING	$524,654
	REALLOCATION	*$85,000
	DOMESTIC VIOLENCE BONUS	$396,558
		$9,665,437

*Reallocation ($85K) is a part of the ARD ($8,744,225)

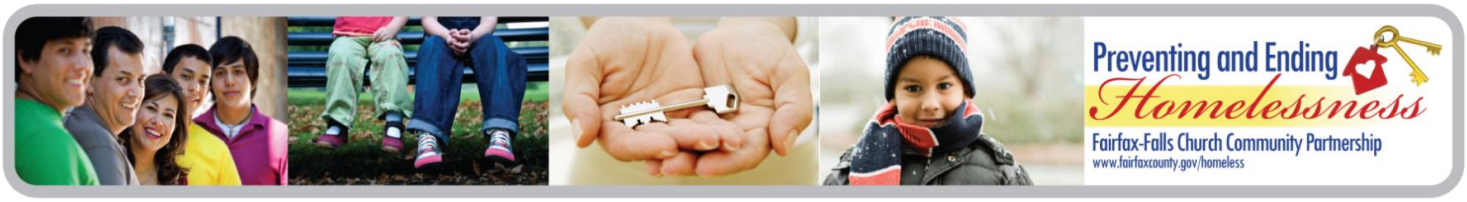
$8,219,572 (94% of ARD) — TIER ONE

$1,445,865 — TIER TWO

ARD (including reallocation)
+ BONUS/DV Bonus
– Tier One
Tier Two

2) Tiering

- Historical award patterns: Tier 1 has historically been awarded; Tier 2 is *at risk of not* being awarded
- If HUD reduces funding available: In the event HUD is required to drastically reduce the total amount of funds available under this NOFA, the Tier 1 amount per CoC will be reduced proportionately among all CoCs which could result in some Tier 1 projects falling into Tier 2. The priority and ranking for all project applications in Tier 1 AND Tier 2 should be carefully considered.
- Tier 2 Scoring – All projects in Tier 2 will be awarded a point value using a 100-point scale
  - CoC Score: Up to 50 points will be awarded based on the CoC Collaborative Application (i.e. if CoC received 100 out of 200 points, the project applications in Tier 2 would receive 25 out of 50 points)
  - Commitment to Housing First: Up to 10 for applying a Housing First model
  - CoC Ranking Position: Up to 40 points will be assigned based on the position of the ranking; *this is the only area that will differentiate Tier 2 projects. Projects ranked higher in Tier 2 have higher chance of being funded.*
- Projects straddling Tier 1 & Tier 2: If a project application straddles the Tier 1 and Tier 2 funding line, HUD will conditionally select the project up to the amount of funding that falls within Tier 1 and then, using the CoC score, HUD may fund the Tier 2 portion of the project. If HUD does not fund the Tier 2 portion of the project, HUD may award project funds at the reduced amount, provided the project is still feasible with the reduced funding (e.g., is able to continue serving homeless program participants effectively).



2018 HUD CoC Program Competition
Ranking Committee Meeting – AGENDA & BACKGROUND
August 22, 2018 | 1:00 pm | Government Center, Room #8

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3) Ranking Criteria

The criteria remains the same as last year; criteria was compiled with input from all HUD grantees and approved by the CoC Committee. Items selected were based on HUD's guidance regarding system-wide performance measures and project outcomes as well as items scored in the project and Collaborative Applications.

- Monitoring and Evaluation Tool Scores – contains all major criteria required by HUD/local standards
- Project Description – Paragraph about each project highlighting challenges and successes
- Need – Need for project in the homeless service system
- Considerations – Balanced homeless delivery system that takes into account: service continuity for families and singles, and sub-population, HUD and 10-Year Plan priorities, uniqueness of project type.

4) Renewal & New Project Applications

The Monitoring and Evaluation Committee decided that all projects have made the threshold to be included in the Collaborative Application**.** There are a few that have performed low historically**.** The grantees were notified that they were at risk of reallocation in the future if performance was not improved**.** They were offered mentoring opportunities.

Renewal Applications	22 Renewals	20 Permanent Supportive Housing
		2 Rapid Rehousing
Reallocation	3 New	1 Permanent Supportive Housing (expansion)
DV BONUS *(new this year)*		1 Rapid Rehousing (DV)
BONUS		1 Rapid Rehousing

5) Decisions

- Which criteria presented should we consider as most important in the decision process
- Rank all 25 projects from 1 through 25
- New projects – no recommendation from CoC Committee on placement
- The reallocated new project is an expansion of a renewal grant
  - Expansion will not be funded if renewal is not funded
  - Decision as to whether it should be ranked alongside renewal grant
- Communication regarding ranking and tiering

County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

SENT ON BEHALF OF THE CoC RANKING COMMITEE

August 24, 2018

Dear CoC Applicants,

As you know, HUD has once again required the ranking and tiering process as part of the 2018 HUD CoC Program Competition, limiting the percentage of the CoC's funding request that can be placed in Tier 1. This was a requirement in prior competitions and as such, our CoC utilized the previously established process to rank and tier projects this year as well.

The CoC Committee met and reappointed the Ranking Committee. The Ranking Committee consists of: Louise Armitage, Human Services Coordinator, City of Fairfax; Hilary Chapman, Housing Program Manager, Metropolitan Washington Council of Governments; Verdia Haywood, Former Fairfax County Deputy Executive Director for Human Services; Dean Klein, Director, Fairfax County Office to Prevent and End Homelessness; Peaches Pearson, Member of the Consumer Advisory Council as well as Supervisory Team Lead, Office of Administration for US General Services Administration; Lisa Whetzel – Executive Director, Britepaths (formerly Our Daily Bread); and Gerry Williams – Former Chair, Communities of Faith United for Housing. Louise Armitage and Verdia Haywood were unable to join for the Ranking Committee deliberations this year.

The Ranking Committee reviewed the guidance provided in the NOFA on the ranking process instituted as part of HUD's 2018 CoC Program Competition. In addition, they examined and evaluated material on all the renewal and new project applications submitted as part of the Competition, including the project narratives as well as monitoring and evaluation process scores and findings.

The Ranking Committee members were intensely aware of the impact and importance of their choices and thus deliberated carefully. This process has grown ever challenging as all of the CoC's renewal and new projects are for permanent housing. The Ranking Committee members expressed appreciation for all of your ongoing efforts to end homelessness in our community. Following discussion, each committee member ranked the projects individually and then the rankings were tallied to produce the order.

The final ranking order is attached. The projects are listed in this order in the CoC's Collaborative Application. As previously expressed, we are unable to project what HUD will choose to fund in this competitive process.

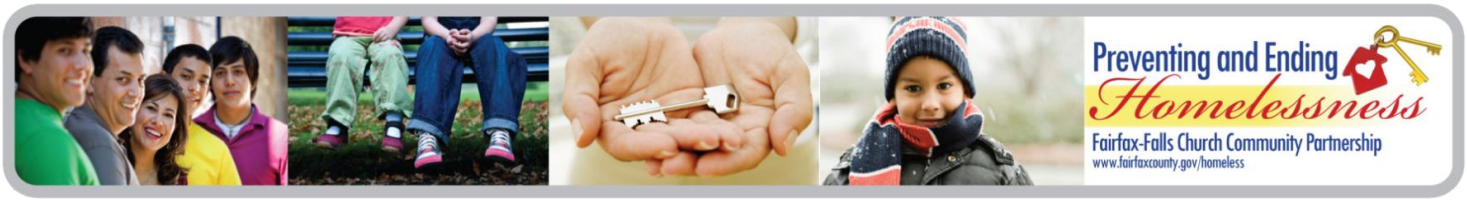
Once again, I thank you for our ongoing partnership.

Dean H. Klein

Dean H. Klein, MSW
Director

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership
www.fairfaxcounty.gov/homeless

Office to Prevent and End Homelessness
12000 Government Center Parkway, Suite 333
Fairfax, VA 22035
Phone: 703-324-9492 **Fax**: 703-324-9491 **TTY:** 711
www.fairfaxcounty.gov/homeless



2018 HUD CoC Program Competition
Fairfax-Falls Church Continuum of Care
PROJECT RANKINGS

	#	Project Name	Agency Name
TIER 1	1	1991 CRSC/Pathway Homes SHP	Pathway Homes
	2	2009 Pathway Homes SHP	Pathway Homes
	3	2007 Pathway Homes SHP	Pathway Homes
	4	2011 Pathway Homes SHP	Pathway Homes
	5	TRIUMPH III Permanent Supportive Housing	FACETS
	6	1991 Pathway Homes SHP Expansion	Pathway Homes
	7	2014 Pathways Homes SHP	Pathway Homes
	8	DHCD/Pathway Homes SPC 9C	Fairfax County DHCD
	9	Rapid Re-Housing Project	Shelter House
	10	DHCD/Pathway Homes SPC 10C	Fairfax County DHCD
	11	TRIUMPH Permanent Supportive Housing	FACETS
	12	TRIUMPH III Permanent Supportive Housing *(expansion)*	FACETS
	13	DHCD/Pathway Homes SPC 1C	Fairfax County DHCD
	14	RISE	Shelter House
	15	2015 Pathway Homes SHP	Pathway Homes
	16	Rapid Rehousing for Transition Age Youth	Second Story (Alternative House)
	17	Domestic Violence Rapid Re-Housing Project	Shelter House
	18	PSH Group Homes	New Hope Housing
1&2	19	Linda's Gateway Permanent Supportive Housing *(92% in Tier 1, 8% in Tier 2)*	FACETS
TIER 2	20	1994 CRSVA/PH/PRS SHP	Pathway Homes
	21	1995 CRSVA/PH/PRS SHP	Pathway Homes
	22	PRS Intensive Supportive Housing	PRS, Inc.
	23	Rapid Rehousing Project	FACETS
	24	Milestones	New Hope Housing
	25	Just Homes-Fairfax	New Hope Housing

2018 HUD CoC Program Competition - Ranking Information - Message (HTML)

FILE | MESSAGE

Ignore | Junk | Delete | Reply | Reply All | Forward | Meeting | IM | More | 2018 Competition | Team Email | Reply & Delete | To Manager | Done | Create New | Move | Rules | OneNote | Actions | Assign Policy | Mark Unread | Categorize | Follow Up | Translate | Find | Related | Select | Zoom

Fri 8/24/2018 11:21 AM

Ergas, Jamie

2018 HUD CoC Program Competition - Ranking Information

To: Dunner, Abby; Amanda Moyer; Anthony Arnolie; Barnett, Thomas M.; Brenda Brennan; Campbell, Joyce M; Carl, Stephanie; Carolyn Mellone; Charlene Williams; Dana Murray; Danielle Colon; David Maloney (david.maloney@shelterhouse.org); Edwina Hall-Jackson; Eleanor Vincent (evincent@pathwayhomes.org); Faxio, Kelli M.; Gillian Gmitter; Hong, Cindy; Jeanine Gravette ; Jefferies, Carolyn; Joe Fay (jfay@facetscares.org); Joe Meyer; Joseph Getch; Judith Dittman; Krizek, Bryan; lambwood@pathwayhomes.org; Lauren Leventhal ; Lazo, Laura; Mary Brown; Mason, Bobbi; Maura Williams (mwilliams@facetscares.org); Meghan Huebner; Pam Michell (pmichell@newhopehousing.org); Powell, Kehinde; Price, Connie; Price Singer, Sharon; Shawn Valentine; Thomas-Campbell, Nikki;

Cc: Klein, Dean H.; Mike O'Reilly

Message | 2018 Rankings Letter.pdf (124 KB) | 2018 Rankings.pdf (402 KB)

Good morning HUD CoC Grantees,

First, thank you for your diligent work in completing the new and renewal project applications. Your efforts and collaboration to accomplish this aspect of the competition is greatly appreciated. The CoC Ranking Committee met on Wednesday and after careful and thoughtful deliberations, ranked all applications. A letter from Dean Klein containing important information regarding our CoC's ranking process and the final ranking order are attached. All applications have been uploaded and ranked in e-snaps at this time. I would like to publically thank Committee members for their efforts; the charge of ranking the projects has become increasingly difficult each competition cycle.

To comply with this year's NOFA instructions, all grantees will be receiving individual emails to serve as the official acknowledgment that the CoC has accepted your project application for inclusion in the CoC's Collaborative Application. The entire CoC Application, including the ranking process and order, will be available on the OPEH website prior to the end of the competition.

Please let me know if you have any questions. Again, thank you.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager
Fairfax County Office to Prevent and End Homelessness
12000 Government Center Parkway, #333, Fairfax, VA. 22035
Direct: 703-324-3240 | Cell: 703-223-2003 | Main: 703-324-9492 | Fax: 703-653-1365
E-mail: jamie.ergas@fairfaxcounty.gov
Website: http://www.fairfaxcounty.gov/homeless

Fairfax County VA-601 CoC Application: CoC Process for Reallocation

Reallocation 2018

- Second Story volunteered to reallocate $75,000. This was later raised to $85,000 after they further reevaluated and determined that they could still serve the same number of people with even less funding from HUD.
- An application for use of this funding was developed and distributed widely by email to all CoC members and any other individual or organization that has indicated interest in applying for HUD CoC Program funding. In addition, announcement of funding availability and application were posted on the Fairfax County Office to Prevent and End Homelessness webpage and on Facebook.
- The application contains a separate agency capacity section for applicants that are not currently HUD CoC program grantees, indicating that new agencies are encouraged to apply.
- Two applicants for utilization of the reallocated funds were submitted. The CoC Committee met on August 1, 2018 to decide on the applicant for the reallocated funding. FACETS-Triumph III Expansion was of a high standard, met the needs of the homeless services system, proposed serving more clients, and had a lower cost per client between the proposals.
- All applicants were notified by email of the Committee's decision.

2018 HUD CoC Program Competition

Bonus | Reallocation | DV Bonus

APPLICATION for NEW FUNDING OPPORTUNITIES

BACKGROUND:

Fairfax County's Continuum of Care (CoC) is seeking applications for eligible project types to include as part of the CoC's 2018 Collaborative Application for HUD CoC funds. The types of new funding opportunities are:

- *Bonus Funding* – The Notice of Funding Availability (NOFA) states that CoCs are eligible to apply for up to 6% of their Final Pro Rata Need for Bonus funding (funding beyond the renewal amount).
- *Reallocation* – Second Story voluntarily contributed a portion of their Rapid Rehousing project, which created available Reallocation funding for the 2018 Competition.
- *Domestic Violence (DV) Bonus Funding* – The Domestic Violence (DV) Bonus is new in the 2018 Competition. The Notice of Funding Availability (NOFA) states that CoCs are eligible to apply for up to 10% of their Preliminary Pro Rata Need (PPRN), or a minimum of $50,000, whichever is greater. This funding is designed to serve survivors of domestic violence, dating violence, sexual assault, or stalking that meet the definition of homeless in paragraph (4) of 24 CFR 578.3 to dedicate additional units, beds, persons served, or services provided to existing program participants to this population.

The amounts available for each funding type are under the Detailed Application Information on Page 2 of this document. These numbers are established by HUD and can be found on the FY 2018 CoC Program Competition Estimated ARD Report (https://www.hudexchange.info/resources/documents/FY-2018-CoC-Program-Estimated-ARD.pdf), which provides the PPRN, Estimated ARD, Estimated ARD at 94 percent (Tier 1), CoC Planning, and Permanent Housing Bonus amounts for each CoC listed.

GENERAL APPLICATION INFORMATION:

- The proposed Projects must meet all requirements and regulations of the Interim CoC Program Rule and the NOFA for the FY18 CoC Competition:
  - https://www.onecpd.info/resources/documents/CoCProgramInterimRule_FormattedVersion.pdf
  - https://www.hudexchange.info/resources/documents/FY-2018-CoC-Program-Competition-NOFA.pdf
- Agencies may apply for all *or* part of the Bonus funding or DV Bonus funding.
- Agencies should apply for *all* of the Reallocation funding within one project.
- The CoC Committee will determine how many applications will be submitted to HUD.
- The Project must commit to accept all clients through the Fairfax County CoC's Coordinated System, utilize HMIS or the comparable DV database, and comply with all federal and local expectations of HUD CoC Program grantees.
- The Project may request up to 1 year of funding.
- The Project must utilize a housing first model: "A model of housing assistance that prioritizes rapid placement and stabilization in permanent housing that does not have service participation requirements or preconditions (such as sobriety or a minimum income threshold). Transitional housing and supportive service only projects are considered using a Housing First model for the purposes of this NOFA if they operate with low-barriers, work to quickly move people into permanent housing, do not require participation in supportive services, and, for transitional housing projects, do not require any preconditions for moving into the transitional housing (e.g., sobriety or minimum income threshold)" *NOFA Page 18*

2018 HUD CoC Program Competition

Bonus | Reallocation | DV Bonus

APPLICATION for NEW FUNDING OPPORTUNITIES

DETAILED APPLICATION INFORMATION:

	Bonus	Reallocation	Domestic Violence (DV) Bonus
Amount	$524,654	$75,000	$396,558
Funding Combination Options	The Bonus funding *cannot* be combined with Renewal funding or Reallocation funding at this time. This must be a NEW project.	The Reallocated funding *should* be combined with eligible Renewal projects to EXPAND an existing project.	The DV Bonus *can* be combined with eligible Renewal projects but does not need to be; it can be a NEW project. The DV Bonus *cannot* be combined with Reallocation or Bonus funding.
Eligible Project Types (more detailed outline below)	○ Permanent Supportive Housing (PSH) serving 100% either chronically homeless or DedicatedPLUS individuals and/or families ○ Rapid Rehousing (PH-RRH) serving individuals and/or families ○ Joint Transitional Housing and Rapid Re-Housing (TH-RRH) serving individuals and/or families		PH-RRH and TH-RRH project types should serve individuals and/or families that are survivors of domestic violence, dating violence, sexual assault, or stalking that meet the definition of homeless in paragraph (4) of 24 CFR 578.3 ○ Rapid Re-housing (PH-RRH) ○ Joint TH and PH-RRH (TH-RRH) ○ Supportive Services Only (SSO-CE)

DESCRIPTION OF ELIGIBLE PROJECT TYPES:

- **Permanent Supportive Housing (PSH)**
  - Provides non-time limited housing and appropriate supportive services.
  - Budget line items can be rental assistance or leasing and operations, supportive services, and administrative costs. Agencies must provide a 25% cash or in-kind match for all funding including rental assistance, excluding leasing. The match must be used for items that are eligible expenses according to HUD regulations.
  - According to the NOFA, CoCs may create new PSH projects that meet the requirements of the DedicatedPLUS or where 100% of the beds are dedicated to chronic homelessness.
    NOFA page 16 – DedicatedPLUS project. A permanent supportive housing project where 100 percent of the beds are dedicated to serve individuals, households with children, and unaccompanied youth that at intake are: (1) experiencing chronic homelessness (CH) as defined in 24 CFR 578.3; (2) residing in a TH project that will be eliminated and meets the definition of CH in effect at the time in which the individual or family entered the TH project; (3) residing in a place not meant for human habitation, emergency shelter, or safe haven and had been admitted and enrolled in a permanent housing project within the last year but were unable to maintain a housing placement and met the definition of CH as defined by 24 CFR 578.3 prior to entering the project; (4) residing in TH funded by a TH-RHH project and who were experiencing CH as defined at 24 CFR 578.3 prior to entering the project; (5) residing and has resided in a place not meant for human habitation, safe haven, or emergency shelter for at least 12 months in the

last three years, but has not done so on four separate occasions and the individual or head of household meet the definition of 'homeless individual with a disability'; or (6) receiving assistance through a Department of Veterans Affairs (VA)-funded homeless assistance program and met one of the above criteria at initial intake to the VA's homeless assistance system.)

- **Rapid Rehousing (RRH)**
  - RRH provides time limited term rental assistance, case management and optional supportive services.
  - Budget line items can be short- or medium-term tenant-based rental assistance, supportive services and administrative costs. Leases must be exclusively in the client's name and their portion of the rent must be paid directly to the landlord. Grantee agencies do not receive any rental/program income to fund additional services in the program. In addition, the entire RRH budget must be matched by a 25% cash or in-kind agency contribution. The match must be used for items that are eligible expenses according to HUD regulations.
  - New RRH projects may serve homeless individuals and families, including unaccompanied youth, who meet the following criteria: residing in a place not meant for human habitation or an emergency shelter; persons meeting the criteria of the definition of homeless in paragraph (4) of the CFR 578.3, including persons fleeing or attempting to flee domestic violence situations; residing in transitional housing funded by a Joint TH and PH-RRH component project; or receiving services from a VA-funded homeless assistance program and met one of the above criteria at initial intake to the VA's homeless assistance system.
- **Joint Transitional Housing - Rapid Rehousing (TH-RRH)**
  - The Joint TH and PH-RRH component project includes two existing program components – transitional housing and permanent housing-rapid rehousing – in a single project to serve individuals experiencing homelessness, including individuals or families fleeing or attempting to flee domestic violence. A Joint TH and PH-RRH component project must be able to provide both components, including the units supported by the transitional housing component and the tenant-based rental assistance and services provided through the PH-RRH component, to all participants. A program participant may choose to receive only the transitional housing unit or the assistance provided through the PH-RRH component, but the recipient or subrecipient must make both types of assistance available. Participants can utilize services for up to a total of 24 months.
  - Budget line items can be leasing of a structure or units and operating costs to provide transitional housing, short- or medium-term tenant-based rental assistance on behalf of program participants to pay for the rapid rehousing portion of the project, supportive services and administrative costs. Agencies must provide a 25% cash or in-kind match for all funding including rental assistance, excluding leasing. The match must be used for items that are eligible expenses according to HUD regulations.
- **Supportive Services Only (SSO-CE)**
  - SSO Projects for Coordinated Entry (SSO-CE) to implement policies, procedures, and practices that equip the CoC's coordinated entry to better meet the needs of survivors of domestic violence, dating violence, sexual assault, or stalking (e.g., to implement policies and procedures that are trauma-informed, client-centered or to better coordinate referrals between the CoC's coordinated entry and the victim service providers coordinated entry system where they are different).

2018 HUD CoC Program Competition

Bonus | Reallocation | DV Bonus

APPLICATION for NEW FUNDING OPPORTUNITIES

APPLICATION INSTUCTIONS

Due via e-mail to jamie.ergas@fairfaxcounty.gov by Thursday, July 26th by 4:00 pm

Application should include the items in the table below. The Application is limited to a maximum of four pages:

1) Name of agency; point of contact and contact information
2) Project Name
3) Amount and type of funding requested (bonus, relocation, DV bonus)
4) Overall description of proposed project, including project model, number to be served, housing type and quantity, services that will be provided
5) Community need for proposed program citing data if possible
6) Experience with operating similar programs
7) Experience operating Housing First programs
8) If applicable, experience with administering rental assistance
9) Experience with managing federal funding
10) Projected staffing plan for new project
11) Simple budget including how the HUD CoC Program funds will be divided between rental assistance, leasing, supportive services, operating and administrative funds and basic description of line items, as well as the sources and amount of cash and in-kind match

The attached Agency Capacity Tool is required for agencies that are not currently HUD CoC Program Grantees

CRITERIA FOR EVALUATION OF APPLICATIONS:

The CoC Committee of the Governing Board of the Community Partnership to Prevent and End Homelessness will consider the following factors in selecting an project to be included in the CoC application to HUD:

- Need in the community addressed by the project
- Overall quality of the application
- Demonstrated experience of the organization in successfully implementing similar projects
- Number of homeless persons the project will serve and range and depth of the services that will be provided
- Experience operating Housing First programs
- Commitment to the CoC's Coordinated System and serving those prioritized by the CoC's policies and procedures
- Capacity of organization to implement and operate new program

PROCEDURE FOLLOWING SUBMISSION OF APPLICATIONS:

- Applicants will be notified if the CoC Committee requests a presentation about the project.
- Applicants will be notified if they are/are not chosen to submit an application to HUD as part of the 2018 Comp.
- The applicant/s selected will be required to fill out a new project application in e-snaps as part of the competition. A draft is due to OPEH on **Monday, August 13th** prior to 4:00 p.m. and the final application must be submitted in e-snaps on **Thursday, August 16th** prior to 4:00 p.m.
- The project will be ranked as part of the CoC-wide ranking process. *Inclusion of the project application in the Collaborative Application does not guarantee funding.* Decision on funding of all projects will be announced by HUD at a later date.

2018 HUD CoC Program Competition

AGENCY CAPACITY FORM

INSTUCTIONS

The Agency Capacity Form is only required for agencies applying for new funding opportunities *that are not currently HUD CoC Program Grantees*. This Form should be included with the Application for New Funding Opportunities, which is **due via e-mail to jamie.ergas@fairfaxcounty.gov by Thursday, July 26th by 4:00 pm.** Please submit all attachments as one PDF.

1. Name of Agency: Click here to enter text.
2. Governmental or non-profit agency? Click here to enter text.
   If non-profit attach verification of 501 (c)(3) status
3. What are the dates of your agency's fiscal year? (Sample 7/1 – 6/30) Click here to enter text.
4. Attach management letter of most recent financial audit*
5. What is your agency's DUNS # Click here to enter text.
6. Are you currently registered in System for Award Management (SAM)?
   ☐ Yes ☐ No
7. Attach the first page of most recent IRS Form 990
8. Attach a list of Board of Directors
9. Does your agency have financial/accounting policies, procedures and controls?
   ☐ Yes ☐ No
10. Are there agency procedures for evaluating internal programs and then utilizing the results to improve programs?
    ☐ Yes ☐ No
11. Does your agency have a staff policies and procedure manual that covers the following items: non-discrimination, sexual harassment, standards of professional conduct, position descriptions and responsibilities, and conflict of interest?
    ☐ Yes ☐ No
12. Does your agency provide ongoing, services directed, training and staff development?
    ☐ Yes ☐ No
13. For consumers, does your agency have the following policies: grievance, non-discrimination, confidentiality?
    ☐ Yes ☐ No

The following questions are for informational purposes only but are expectations of HUD CoC Program grantees:

14. Does your agency have a homeless or formerly homeless person on your Board of Directors?
    ☐ Yes ☐ No
15. Do representatives from your agency participate in Fairfax County homeless system committees and meetings?
    ☐ Yes ☐ No
16. Does your agency provide opportunities for former or current consumers to participate via employment or volunteer opportunities?
    ☐ Yes ☐ No

HUD FY18 CoC Program Competition - New Funding Opportunities - Message (HTML)

FILE | MESSAGE

Ignore | Junk | Delete | Reply | Reply All | Forward | Meeting | IM | More | 2018 Competition | Team Email | Reply & Delete | To Manager | Done | Create New | Move | Rules | OneNote | Actions | Assign Policy | Mark Unread | Categorize | Translate | Find | Related | Select | Zoom

Delete | Respond | Quick Steps | Move | Tags | Editing | Zoom

Tue 7/3/2018 11:17 AM

Ergas, Jamie

HUD FY18 CoC Program Competition - New Funding Opportunities

To

Message | New Funding Opportunities Application - 2018 CoC Competition.doc (947 KB) | Agency Capacity Form - 2018 CoC Competition.docx (887 KB) | Application Deliverables and Due Dates - 2018 CoC Competition.docx (212 KB)

Good morning,

HUD's Continuum of Care Program is a significant component of the community-wide goal to prevent and end homelessness. As part of HUD's FY18 Continuum of Care Program Competition, which opened on June 20th and ends on September 18th, there is a total of **$996,212 in new funding opportunities** available. This application process is a great avenue to pursue more resources for those experiencing homelessness in our community. The New Funding Opportunities Application that is attached provides more details and includes information such as:

- types of funding opportunities (Bonus, Reallocation, and Domestic Violence Bonus funding)
- eligible projects for each funding type and,
- total $ amount in each funding type.

The Agency Capacity Form attached is only required as part of the New Funding Opportunities Application process for agencies that are not *currently* HUD CoC Program Grantees.

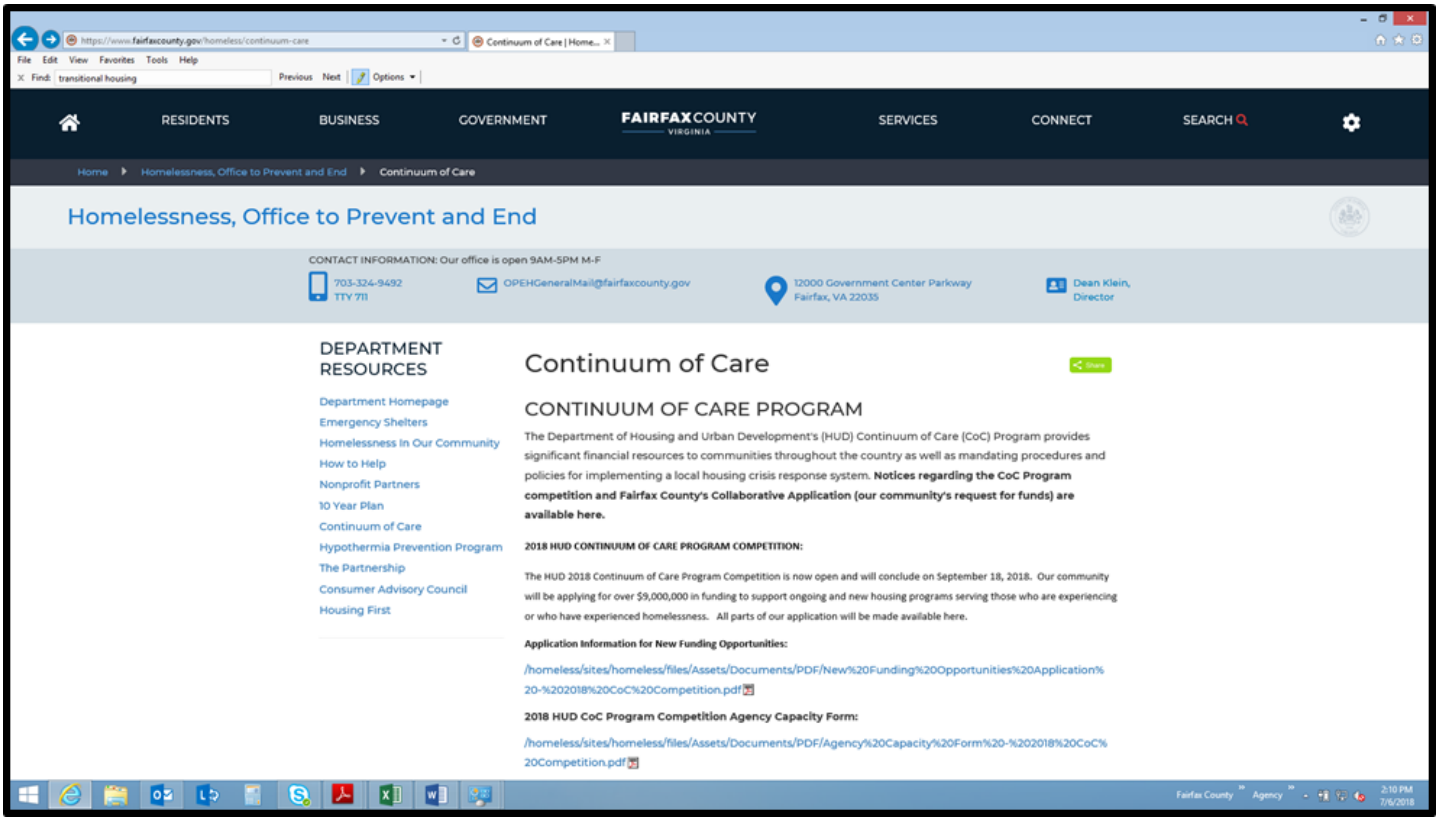
An outline of all of the deliverables and due dates for the CoC Competition is also attached. A few upcoming dates and next steps specifically related to the New Funding Opportunities are listed below.

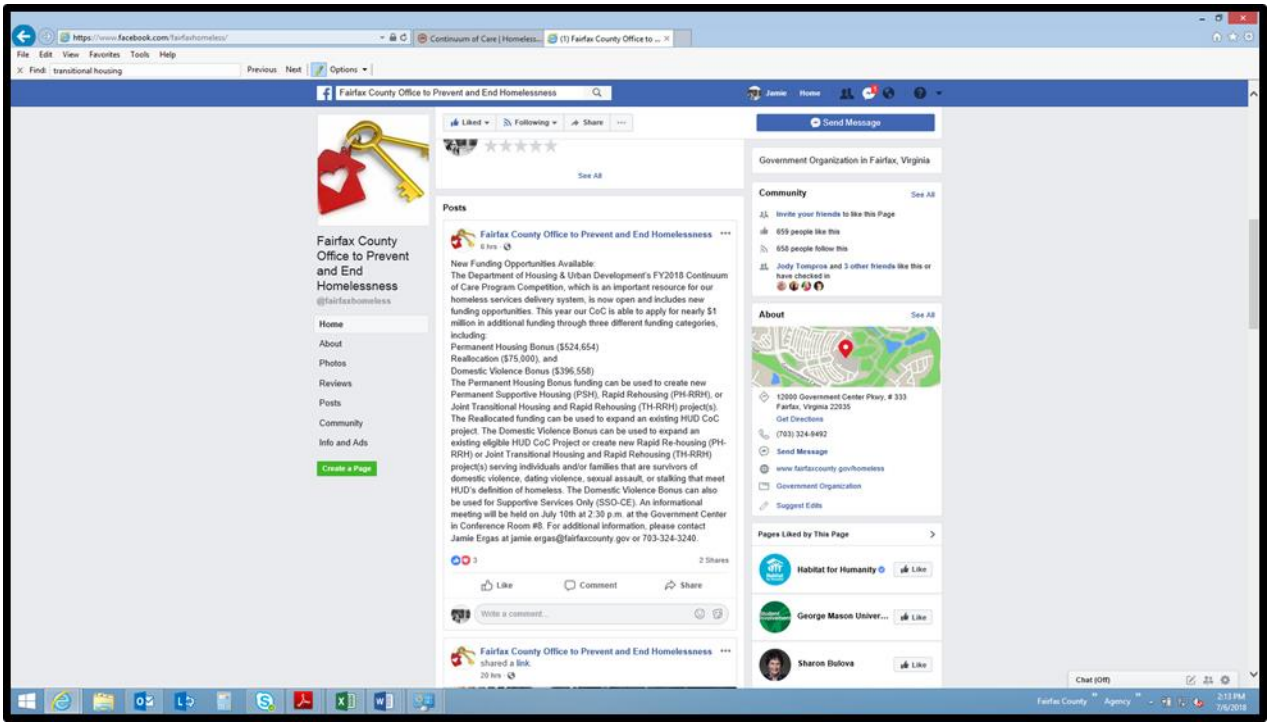
- **New Funding Opportunities (*Informational Meeting, optional*):** **July 10th, 2:30 pm, Gov't Center Room 8**
- Notify CoC Lead of interest in applying for the New Funding: July 17th, 4:00 pm
- New Funding Opportunities (*Application Due to CoC Lead*): July 26th, 4:00 pm

Please do not hesitate to contact me with any questions. Thank you!

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager
Fairfax County Office to Prevent and End Homelessness
12000 Government Center Parkway, #333, Fairfax, VA. 22035
Direct: 703-324-3240 | Main: 703-324-9492 | Fax: 703-653-1365
E-mail: jamie.ergas@fairfaxcounty.gov
Website: http://www.fairfaxcounty.gov/homeless


https://www.fairfaxcounty.gov/homeless/continuum-care
Continuum of Care | Home...
File Edit View Favorites Tools Help
Find: transitional housing
Previous Next Options
RESIDENTS
BUSINESS
GOVERNMENT
FAIRFAX COUNTY
VIRGINIA
SERVICES
CONNECT
SEARCH
Home
Homelessness, Office to Prevent and End
Continuum of Care
Homelessness, Office to Prevent and End
CONTACT INFORMATION: Our office is open 9AM-5PM M-F
703-324-9492
TTY 711
OPEHGeneralMail@fairfaxcounty.gov
12000 Government Center Parkway
Fairfax, VA 22035
Dean Klein,
Director
DEPARTMENT RESOURCES
Department Homepage
Emergency Shelters
Homelessness In Our Community
How to Help
Nonprofit Partners
10 Year Plan
Continuum of Care
Hypothermia Prevention Program
The Partnership
Consumer Advisory Council
Housing First
Continuum of Care
Share
CONTINUUM OF CARE PROGRAM
The Department of Housing and Urban Development's (HUD) Continuum of Care (CoC) Program provides significant financial resources to communities throughout the country as well as mandating procedures and policies for implementing a local housing crisis response system. Notices regarding the CoC Program competition and Fairfax County's Collaborative Application (our community's request for funds) are available here.
2018 HUD CONTINUUM OF CARE PROGRAM COMPETITION:
The HUD 2018 Continuum of Care Program Competition is now open and will conclude on September 18, 2018. Our community will be applying for over $9,000,000 in funding to support ongoing and new housing programs serving those who are experiencing or who have experienced homelessness. All parts of our application will be made available here.
Application Information for New Funding Opportunities:
/homeless/sites/homeless/files/Assets/Documents/PDF/New%20Funding%20Opportunities%20Application%20-%202018%20CoC%20Competition.pdf
2018 HUD CoC Program Competition Agency Capacity Form:
/homeless/sites/homeless/files/Assets/Documents/PDF/Agency%20Capacity%20Form%20-%202018%20CoC%20Competition.pdf
Fairfax County
Agency
2:10 PM
7/6/2018


Fairfax County Office to Prevent and End Homelessness
Fairfax County Office to Prevent and End Homelessness
@fairfaxhomeless
Home
About
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Reviews
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Community
Info and Ads
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Posts
New Funding Opportunities Available:
The Department of Housing & Urban Development's FY2018 Continuum of Care Program Competition, which is an important resource for our homeless services delivery system, is now open and includes new funding opportunities. This year our CoC is able to apply for nearly $1 million in additional funding through three different funding categories, including:
Permanent Housing Bonus ($524,654)
Reallocation ($75,000), and
Domestic Violence Bonus ($396,558)
The Permanent Housing Bonus funding can be used to create new Permanent Supportive Housing (PSH), Rapid Rehousing (PH-RRH), or Joint Transitional Housing and Rapid Rehousing (TH-RRH) project(s).
The Reallocated funding can be used to expand an existing HUD CoC project. The Domestic Violence Bonus can be used to expand an existing eligible HUD CoC Project or create new Rapid Re-housing (PH-RRH) or Joint Transitional Housing and Rapid Rehousing (TH-RRH) project(s) serving individuals and/or families that are survivors of domestic violence, dating violence, sexual assault, or stalking that meet HUD's definition of homeless. The Domestic Violence Bonus can also be used for Supportive Services Only (SSO-CE). An informational meeting will be held on July 10th at 2:30 p.m. at the Government Center in Conference Room #8. For additional information, please contact Jamie Ergas at jamie.ergas@fairfaxcounty.gov or 703-324-3240.
Government Organization in Fairfax, Virginia
Community
About
12000 Government Center Pkwy, # 333
Fairfax, Virginia 22035
(703) 324-8492
www.fairfaxcounty.gov/homeless
Pages Liked by This Page
Habitat for Humanity
George Mason Univer...
Sharon Bulova

Fairfax County VA-601 CoC Application: Notification of Accepted Projects Outside of E-Snaps

1. **Email Notification of All Accepted Projects**
2. **Email Notification of Accepted New Projects**
3. **Letters from CoC Committee to Accepted New Projects**

Ergas, Jamie

From: Ergas, Jamie
Sent: Thursday, August 30, 2018 10:59 AM
To: 'Pamela Michell'; 'Dana Murray'
Cc: Willson, Michael
Subject: 2018 HUD Program Competition - Notification of Projects Accepted

Good afternoon Pam and Dana,

As noted in the Ranking Information email sent on Friday, this is the official acknowledgement that the New Hope Housing, Inc. project applications listed below have been accepted and ranked on the Priority Listing as part of the Fairfax County CoC's Application for the 2018 HUD CoC Program Competition:

Projects	Beginning of Grant Number
PSH Group Homes	VA0109
Milestones	VA0110
Just Homes-Fairfax	VA0218

The Priority Listings will be posted on the OPEH website before the end of the competition on September 18, 2018. Please feel free to contact me if you have any questions. Thank you for your ongoing partnership and collaboration during the application process.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager

Ergas, Jamie

From: Ergas, Jamie
Sent: Thursday, August 30, 2018 11:06 AM
To: 'Joe Fay (jfay@facetscares.org)'; 'Maura Williams'
Cc: Willson, Michael
Subject: 2018 HUD Program Competition – Notification of Projects Accepted

Good morning Joe and Maura,

As noted in the Ranking Information email sent on Friday, this is the official acknowledgement that the FACETS project applications listed below have been accepted and ranked on the Priority Listing as part of the Fairfax County CoC's Application for the 2018 HUD CoC Program Competition:

Projects	Beginning of Grant Number
TRIUMPH Permanent Supportive Housing	VA0094
Linda's Gateway Permanent Supportive Housing	VA0278
TRIUMPH III Permanent Supportive Housing	VA0287
TRIUMPH III Permanent Supportive Housing	New – Reallocation
Rapid Rehousing Project	New – PH Bonus

The Priority Listings will be posted on the OPEH website before the end of the competition on September 18, 2018. Please feel free to contact me if you have any questions. Thank you for your ongoing partnership and collaboration during the application process.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager

Ergas, Jamie

From: Ergas, Jamie
Sent: Thursday, August 30, 2018 11:11 AM
To: 'wgradison@prsinc.org'; 'Gillian Gmitter'; 'Charlene Williams'
Subject: 2018 HUD Program Competition - Notification of Project Accepted

Good morning Wendy, Gillian and Charlene,

As noted in the Ranking Information email sent on Friday, this is the official acknowledgement that the PRS, Inc. project application listed below has been accepted and ranked on the Priority Listing as part of the Fairfax County CoC's Application for the 2018 HUD CoC Program Competition:

Projects	Beginning of Grant Number
PRS Intensive Supportive Housing	VA0112

The Priority Listings will be posted on the OPEH website before the end of the competition on September 18, 2018. Please feel free to contact me if you have any questions. Thank you for your ongoing partnership and collaboration during the application process.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager

Ergas, Jamie

From: Ergas, Jamie
Sent: Thursday, August 30, 2018 11:14 AM
To: 'Judith Dittman'; Meghan Huebner
Cc: Willson, Michael
Subject: 2018 HUD Program Competition - Notification of Project Accepted

Good morning Judith and Meghan,

As noted in the Ranking Information email sent on Friday, this is the official acknowledgement that the Abused and Homeless Children's Refuge – Second Story project application listed below has been accepted and ranked on the Priority Listing as part of the Fairfax County CoC's Application for the 2018 HUD CoC Program Competition:

Project	Beginning of Grant Number
Rapid Rehousing for Transition Age Youth	VA0277

The Priority Listings will be posted on the OPEH website before the end of the competition on September 18, 2018. Please feel free to contact me if you have any questions. Thank you for your ongoing partnership and collaboration during the application process.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager

Ergas, Jamie

From: Ergas, Jamie
Sent: Thursday, August 30, 2018 11:20 AM
To: 'Joe Meyer'; 'Danielle Colon'
Cc: Willson, Michael
Subject: 2018 HUD Program Competition - Notification of Projects Accepted

Good morning Joe and Dani,

As noted in the Ranking Information email sent on Friday, this is the official acknowledgement that the Shelter House, Inc. project applications listed below have been accepted and ranked on the Priority Listing as part of the Fairfax County CoC's Application for the 2018 HUD CoC Program Competition:

Projects	Beginning of Grant Number
RISE	VA0114
Rapid Re-Housing Project	VA0286
Domestic Violence Rapid Re-Housing Project	New – DV Bonus

The Priority Listings will be posted on the OPEH website before the end of the competition on September 18, 2018. Please feel free to contact me if you have any questions. Thank you for your ongoing partnership and collaboration during the application process.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager

Ergas, Jamie

From: Ergas, Jamie
Sent: Thursday, August 30, 2018 11:30 AM
To: 'lambwood@pathwayhomes.org'; 'Eleanor Vincent (evincent@pathwayhomes.org)'
Cc: Willson, Michael
Subject: 2018 HUD Program Competition – Notification of Projects Accepted

Good morning Sylisa and Eleanor,

As noted in the Ranking Information email sent on Friday, this is the official acknowledgement that the Pathway Homes project applications listed below have been accepted and ranked on the Priority Listing as part of the Fairfax County CoC's Application for the 2018 HUD CoC Program Competition:

Projects	Beginning of Grant Number
1991 Pathway Homes SHP Expansion	VA0096
2007 Pathway Homes SHP	VA0144
2009 Pathway Homes SHP	VA0156
2011 Pathway Homes SHP	VA0197
2014 Pathway Homes SHP	VA0257
2015 Pathway Homes SHP	VA0288
1991 CRSC/Pathway Homes SHP	VA0095
1994 CRSVA/PH/PRS FY2017	VA0097
1995 CRSVA/PH/PRS SHP FY2017	VA0098

The Priority Listings will be posted on the OPEH website before the end of the competition on September 18, 2018. Please feel free to contact me if you have any questions. Thank you for your ongoing partnership and collaboration during the application process.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager

Ergas, Jamie

From: Ergas, Jamie
Sent: Thursday, August 30, 2018 11:37 AM
To: Lazo, Laura; Walker, Kehinde
Cc: Willson, Michael
Subject: 2018 HUD Program Competition – Notification of Projects Accepted

Good morning Laura and Kehinde,

As noted in the Ranking Information email sent on Friday, this is the official acknowledgement that the Department of Housing and Community Development project applications listed below have been accepted and ranked on the Priority Listing as part of the Fairfax County CoC's Application for the 2018 HUD CoC Program Competition:

Projects	Beginning of Grant Number
DHCD/Pathway Homes SPC 1C	VA0100
DHCD/Pathway Homes SPC 9C	VA0101
DHCD/Pathway Homes SPC 10C	VA0145

The Priority Listings will be posted on the OPEH website before the end of the competition on September 18, 2018. Please feel free to contact me if you have any questions. Thank you for your ongoing partnership and collaboration during the application process.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager

Reply Reply All Forward IM

Fri 8/3/2018 10:40 AM

Ergas, Jamie

FY18 HUD CoC Program Competition - CoC Committee Decision on Application

To 'Danielle Colon'

Cc 'Joe Meyer'; Laura Woody

Message Shelter House - FY2018 HUD CoC Program Competition, CoC Committee Decision on New Funding Application (DV).pd...

SENT ON BEHALF OF THE COC COMMITTEE

Good morning,

I am pleased to share the CoC Committee's decision, which is attached, regarding your application (*Rapid Rehousing Project proposal serving households with and without children with the DV Bonus Funding*) to the New Funding Opportunities available to Fairfax County's CoC during HUD's FY18 CoC Program Competition.

Please do not hesitate to contact me if you have any questions.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager
Fairfax County Office to Prevent and End Homelessness
12000 Government Center Parkway, #333, Fairfax, VA. 22035
Direct: 703-324-3240 | Cell: 703-223-2003 | Main: 703-324-9492 | Fax: 703-653-1365
E-mail: jamie.ergas@fairfaxcounty.gov
Website: http://www.fairfaxcounty.gov/homeless

Reply Reply All Forward IM

Fri 8/3/2018 10:35 AM

Ergas, Jamie

FY18 HUD CoC Program Competition - CoC Committee Decision on Application

To 'Maura Williams'; 'mavila@facetscares.org'

Message FACETS - FY2018 HUD CoC Program Competition, CoC Committee Decision on New Funding Application.pdf (114 KB)

SENT ON BEHALF OF THE COC COMMITTEE

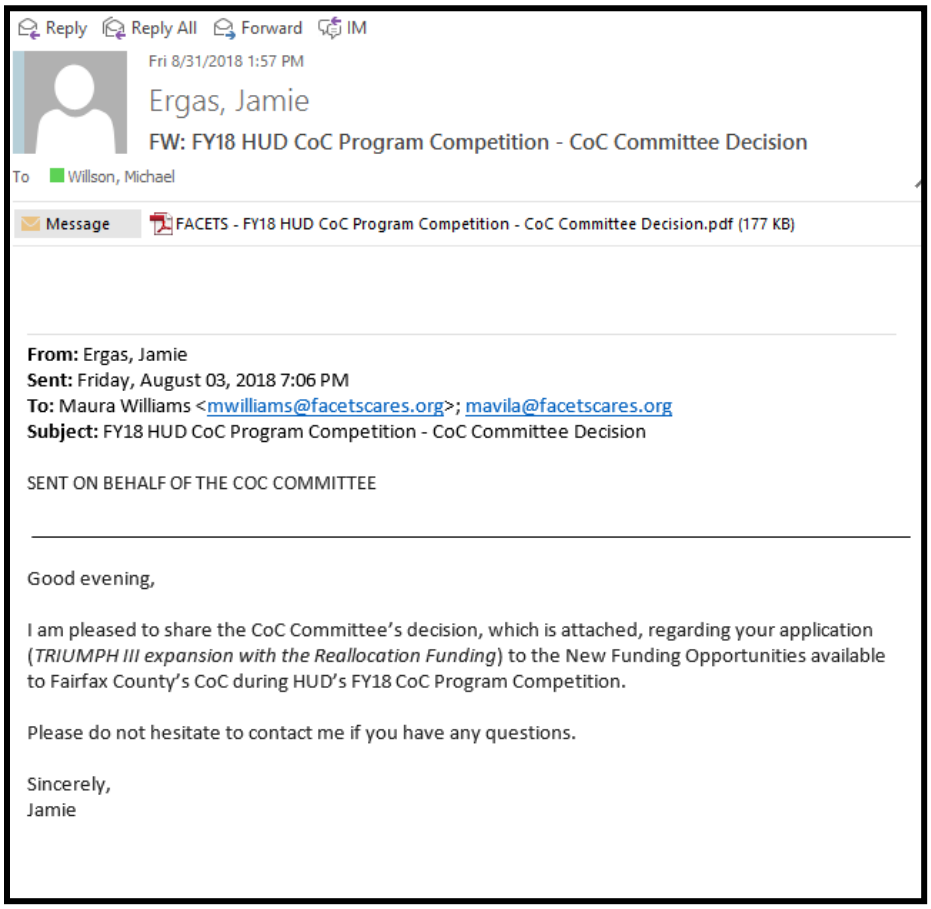
Good morning,

I am pleased to share the CoC Committee's decision regarding your application (*Rapid Rehousing Project proposal serving singles with the Bonus Funding*) to the New Funding Opportunities available to Fairfax County's CoC during HUD's FY18 CoC Program Competition.

Please do not hesitate to contact me if you have any questions.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager
Fairfax County Office to Prevent and End Homelessness
12000 Government Center Parkway, #333, Fairfax, VA. 22035
Direct: 703-324-3240 | Cell: 703-223-2003 | Main: 703-324-9492 | Fax: 703-653-1365
E-mail: jamie.ergas@fairfaxcounty.gov
Website: http://www.fairfaxcounty.gov/homeless



Reply Reply All Forward IM

Fri 8/31/2018 1:57 PM

Ergas, Jamie

FW: FY18 HUD CoC Program Competition - CoC Committee Decision

To Willson, Michael

Message FACETS - FY18 HUD CoC Program Competition - CoC Committee Decision.pdf (177 KB)

From: Ergas, Jamie
Sent: Friday, August 03, 2018 7:06 PM
To: Maura Williams <mwilliams@facetscares.org>; mavila@facetscares.org
Subject: FY18 HUD CoC Program Competition - CoC Committee Decision

SENT ON BEHALF OF THE COC COMMITTEE

Good evening,

I am pleased to share the CoC Committee's decision, which is attached, regarding your application (*TRIUMPH III expansion with the Reallocation Funding*) to the New Funding Opportunities available to Fairfax County's CoC during HUD's FY18 CoC Program Competition.

Please do not hesitate to contact me if you have any questions.

Sincerely,
Jamie

SENT ON BEHALF OF THE COC COMMITTEE

August 3, 2018

Dear Maura Williams, Deputy Executive Director, FACETS,

Thank you for your application to the New Funding Opportunities available to Fairfax County's CoC during HUD's FY18 CoC Program Competition. The competition was extremely robust this year and included six applications, proposing three different housing types, with numerous target populations. We are pleased to officially notify you that your proposed Rapid Rehousing Project serving 36 individuals with $524,654 of the Bonus funding has been selected by the CoC Committee to be ranked and included in Fairfax County's Collaborative Application during HUD's FY18 CoC Program Competition.

The Continuum of Care Manager, Jamie Ergas (jamie.ergas@fairfaxcounty.gov or 703-324-3240) will provide support on next steps.

Congratulations and thank you for applying for this funding opportunity and furthering the CoC's effort to ensure that homelessness is rare, brief, and one-time.

Mike O'Reilly
Chairman
Fairfax-Falls Church Partnership to Prevent and End Homelessness

CC: Dean Klein – Director, Fairfax County Office to Prevent and End Homelessness
Jamie Ergas – Continuum of Care Manager, Fairfax County Office to Prevent and End Homelessness

Office to Prevent and End Homelessness
12000 Government Center Parkway, Suite 333
Fairfax, VA 22035
Phone: 703-324-9492 **Fax**: 703-324-9491 **TTY:** 711
www.fairfaxcounty.gov/homeless

SENT OF BEHALF OF THE COC COMMITTEE

August 3, 2018

Dear Maura Williams, Deputy Executive Director, FACETS

Thank you for your application to the New Funding Opportunities available to Fairfax County's CoC during HUD's FY18 CoC Program Competition. The competition was extremely robust this year and included six applications, proposing three different housing types, with numerous target populations. We are pleased to officially notify you that your proposed expansion of TRIUMPH III serving 4 individuals with $85,000 of the Reallocation funding has been selected by the CoC Committee to be ranked and included in Fairfax County's Collaborative Application during HUD's FY18 CoC Program Competition.

The Continuum of Care Manager, Jamie Ergas (jamie.ergas@fairfaxcounty.gov or 703-324-3240) will provide support on next steps.

Congratulations and thank you for applying for this funding opportunity and furthering the CoC's effort to ensure that homelessness is rare, brief, and one-time.

Mike O'Reilly
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CC: Dean Klein – Director, Fairfax County Office to Prevent and End Homelessness
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County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

SENT ON BEHALF OF THE COC COMMITTEE

August 3, 2018

Dear Dani Colón, Deputy Executive Director, Shelter House,

Thank you for your application to the New Funding Opportunities available to Fairfax County's CoC during HUD's FY18 CoC Program Competition. The competition was extremely robust this year and included six applications, proposing three different housing types, with numerous target populations. We are pleased to officially notify you that your proposed Rapid Rehousing Project serving 33 households with $396,558 of the Domestic Violence Bonus funding has been selected by the CoC Committee to be ranked and included in Fairfax County's Collaborative Application during HUD's FY18 CoC Program Competition.

The Continuum of Care Manager, Jamie Ergas (jamie.ergas@fairfaxcounty.gov or 703-324-3240) will provide support on next steps.

Congratulations and thank you for applying for this funding opportunity and furthering the CoC's effort to ensure that homelessness is rare, brief, and one-time.

Mike O'Reilly
Chairman
Fairfax-Falls Church Partnership to Prevent and End Homelessness

CC: Dean Klein – Director, Fairfax County Office to Prevent and End Homelessness
Jamie Ergas – Continuum of Care Manager, Fairfax County Office to Prevent and End Homelessness

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Fairfax County VA-601 CoC Application: Notifications of Rejected and Reduced Projects Outside of E-Snaps

1. **Email Notification of Rejected (2) and Reduced (1) Projects**
2. **Letters from CoC Committee to Rejected New Projects**

Reply Reply All Forward IM

Fri 8/3/2018 10:21 AM

Ergas, Jamie

FY18 HUD CoC Program Competition - CoC Committee Decision on Application

To Oona Schmid

Cc 'Sherry O'Rourke'; 'Donald@orhfoundation.org'

Message ORHF - FY2018 HUD CoC Program Competition, CoC Committee Decision on New Funding Application.pdf (114 KB)

SENT ON BEHALF OF THE COC COMMITTEE

Good morning,

Attached is the CoC Committee's decision regarding your application to the New Funding Opportunities available to Fairfax County's CoC during HUD's FY18 CoC Program Competition.

Please do not hesitate to contact me if you have any questions.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager
Fairfax County Office to Prevent and End Homelessness
12000 Government Center Parkway, #333, Fairfax, VA. 22035
Direct: 703-324-3240 | Cell: 703-223-2003 | Main: 703-324-9492 | Fax: 703-653-1365
E-mail: jamie.ergas@fairfaxcounty.gov
Website: http://www.fairfaxcounty.gov/homeless

Reply Reply All Forward IM

Fri 8/31/2018 1:56 PM

Ergas, Jamie

FW: FY18 HUD CoC Program Competition - CoC Committee Decision

To Willson, Michael

Message Shelter House - FY18 HUD CoC Program Competition - CoC Committee Decision.pdf (177 KB)

From: Ergas, Jamie
Sent: Friday, August 03, 2018 6:59 PM
To: Danielle Colon <danielle.colon@shelterhouse.org>
Cc: laura.woody@shelterhouse.org; Joe Meyer <joe.meyer@shelterhouse.org>
Subject: FY18 HUD CoC Program Competition - CoC Committee Decision

SENT ON BEHALF OF THE COC COMMITTEE

Good evening,

Attached is the CoC Committee's decision regarding your application (*expansion of RISE with reallocation funding*) to the New Funding Opportunities available to Fairfax County's CoC during HUD's FY18 CoC Program Competition.

Please do not hesitate to contact me if you have any questions.

Sincerely,
Jamie

Jamie Ergas, MSW, LSW
Continuum of Care Manager
Fairfax County Office to Prevent and End Homelessness
12000 Government Center Parkway, #333, Fairfax, VA. 22035
Direct: 703-324-3240 | Cell: 703-223-2003 | Main: 703-324-9492 | Fax: 703-653-1365
E-mail: jamie.ergas@fairfaxcounty.gov
Website: http://www.fairfaxcounty.gov/homeless

Reply Reply All Forward IM

Fri 8/31/2018 2:01 PM

Ergas, Jamie

2018 HUD Program Competition - Notification of Project Reduced ($85K)

To Judith Dittman; Meghan Huebner

Cc Willson, Michael

Good afternoon Judith and Meghan,

As noted in the Ranking Information email sent on Friday, this is the official acknowledgement that the Abused and Homeless Children's Refuge – Second Story project application listed below has been reduced by $85,000. This funding has been reallocated as part of the Fairfax County CoC's Application for the 2018 HUD CoC Program Competition:

Project	Beginning of Grant Number	Portion reduced for reallocation
Rapid Rehousing for Transition Age Youth	VA0277	$85,000

Please feel free to contact me if you have any questions. Thank you for your ongoing partnership and collaboration during the application process.

Sincerely,
Jamie

County of Fairfax, Virginia

To protect and enrich the quality of life for the people, neighborhoods and diverse communities of Fairfax County

SENT ON BEHALF OF THE COC COMMITTEE

August 3, 2018

Dear Oona Schmid, Chief of Staff, Operation Renewed Hope Foundation,

Thank you for your application to the New Funding Opportunities available to Fairfax County's CoC during HUD's FY18 CoC Program Competition. The competition was extremely robust this year and included six applications, proposing three different housing types, with numerous target populations. The CoC Committee was very interested in your proposal and would very much like your Foundation to actively participate in our programs. However, the CoC Committee did not believe that your application met the threshold requirements at this time. This serves as your official notification that your project was not selected to be included in the Fairfax County, VA-601 Collaborative Application submitted to HUD.

If you could like to debrief, you may do so with the Continuum of Care Manager, Jamie Ergas (jamie.ergas@fairfaxcounty.gov or 703-324-3240).

Once again I thank you for your interest in applying for this funding opportunity and the time and effort you dedicated to do so.

Mike O'Reilly
Chairman
Fairfax-Falls Church Partnership to Prevent and End Homelessness

CC: Dean Klein – Director, Fairfax County Office to Prevent and End Homelessness
Jamie Ergas – Continuum of Care Manager, Fairfax County Office to Prevent and End Homelessness

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SENT OF BEHALF OF THE COC COMMITTEE

August 3, 2018

Dear Dani Colon, Deputy Executive Director, Shelter House, Inc.

Thank you for your application to the New Funding Opportunities available to Fairfax County's CoC during HUD's FY18 CoC Program Competition. The competition was extremely robust this year and included six applications, proposing three different housing types, with numerous target populations. As all of the project applications for reallocated funding met the threshold requirements, the decision was made on the basis of which prospective project would best serve the needs of the community. We greatly appreciate the comments of your Executive Director indicating that Shelter House would agree and support whatever decision the Committee made. This serves as your official notification that your project submitted for reallocation funding to expand RISE was not selected to be included in the Fairfax County, VA-601 Collaborative Application submitted to HUD.

If you could like to debrief, you may do so with the Continuum of Care Manager, Jamie Ergas (jamie.ergas@fairfaxcounty.gov or 703-324-3240).

Once again I thank you for your interest in applying for this funding opportunity and the time and effort you dedicated to do so.

Mike O'Reilly
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Homeless Management Information System (HMIS) Policies and Procedures Manual

Updated 01/17/2018

Table of Contents

Appendices

1. Introduction

The Fairfax/Falls Church Partnership to Prevent and End Homelessness **Homeless Management Information System** (HMIS) is a client information system that meets the Housing and Urban Development (HUD) requirements and satisfies the U.S. Congress directive for the implementation of an HMIS. The HMIS provides a standardized tool for our partners to collect information regarding our clients experiencing homelessness and at-risk population. It allows individual projects and system wide reporting of data.

The goals of the HMIS are to:

- Improve the availability of data to aid participating projects and their funding partners in making planning and funding decisions about services to people experiencing homelessness in the Continuum of Care (CoC).
- Provide an unduplicated count of people experiencing homelessness in the CoC.
- Measure project and system outcomes.
- Meet federal, state and local reporting requirements.

This document provides the policies, procedures, and guidelines for the Fairfax/Falls Church Partnership to Prevent and End Homelessness HMIS and are in accordance with the HMIS Governance Charter.

The "Super" User committee will be responsible for maintaining and updating the Policy and Procedures Manual and will make recommendations for needed changes to the CoC HMIS Committee. The "Super" User committee will review the Policy and Procedure manual annually.

The CoC HMIS Committee is responsible for approval and implementation of the HMIS policies and procedures.

The current vendor for our Homeless Management Information System (HMIS) is Mediware / Bowman Systems and the application is known as ServicePoint.

A. Identified Stakeholders

The Fairfax County CoC consists of the following stakeholders. Descriptions below identify how each party interacts with the HMIS in the Fairfax County CoC.

i. **CoC** – The CoC is the planning body of representative stakeholders in the community's work toward ending homelessness. Its work includes gathering and analyzing information in order to determine the needs of local people experiencing homelessness, to measure results which are reported to HUD, Congress, and community stakeholders, and implements strategic responses.

ii. **CoC HMIS Committee -** The CoC HMIS Committee will act on behalf of the Fairfax County CoC to fulfill the regulatory duties of a CoC set forth in 24 CFR § 578. CoC HMIS Committee shall be responsible for approval and implementation of all CoC HMIS Policies and Procedures. It will suggest changes to HMIS governance to be considered by the CoC and its Governing Board. The committee will consist of representatives from the HMIS Lead, CoC Lead, Executive Directors, Program Managers, Super Users and End Users.

iii. **HMIS Lead** – The Office to Prevent and End Homelessness (OPEH) has been designated the HMIS Lead Agency. This agency works closely with the CoC to implement all aspects of the HMIS system. OPEH houses the HMIS System Administration team.

iv. **Super User Committee** – The Super User Committee is an advisory committee made up of a least one user representative from each of the HMIS Participating Agencies in the CoC. This committee works closely with the HMIS System Administrator and Single and Family Program Managers in developing and recommending changes and upgrades to the system as well as the HMIS Policies and Procedures and defining reporting needs. The Super User Committee makes recommendations to the CoC HMIS Committee.

v. **HMIS Participating Agencies** – All agencies and/or programs that participate in the data collection through the Fairfax County CoC HMIS. These organizations provide data to the CoC for system-wide decision making and reporting purposes, as well as to run their own reports for data analysis, funding requirements, and general reporting.

For listing of Super User Roles and Responsibilities refer to APPENDIX E.

B. Which Agencies Can Participate?

Any project that serves those experiencing homelessness and at-risk populations should participate in the HMIS, and participation is mandatory for HUD projects serving those experiencing homelessness and at-risk populations. However, projects whose primary mission is to provide services to victims fleeing domestic violence, dating violence, sexual assault, stalking or human trafficking are not permitted to enter client-level data directly in HMIS as outlined in the HMIS standard procedure "**HMIS Guidance for Programs Serving Victims of Domestic Violence, Dating Violence, Sexual Assault, Stalking or Human Trafficking" adopted: 09/12/2009 (APPENDIX I).**

C. How to Participate?

Participation in the HMIS is open to all members of the Fairfax Falls Church Partnership to Prevent and End Homelessness who serve those experiencing homelessness and at-risk populations.

Agencies wanting to join and participate in HMIS need to contact the Information Systems Manager at the Office to Prevent and End Homelessness. Agencies will be required to sign an

Agency Participation Agreement (APPENDIX A) that outlines confidentiality, system use, data requirements and data quality.

D. How to Obtain End User Access to the Homeless Management Information System?

Before a user is granted access to HMIS the following must happen:

i. A user must complete a User Policy, Responsibility statement and Code of Ethics Agreement (further referred to as – End User Responsibility Form) (APPENDIX B)
ii. Attend an End User Training session (refer to APPENDIX J for registration instructions).

2. HMIS Training

A. HMIS End User Training

End User training is offered twice a month, one of which is a hard date, and the other is a soft date in which that training may be cancelled and registrants will be rescheduled if there are less than two registrations. The HMIS End User training is required of all HMIS users and provides general knowledge of the application and the workflow for case management (refer to APPENDIX J for registration instructions).

Trainees must successfully complete the practical exercise at the end of the training, as demonstration of adequate knowledge of the application, before they are granted access to the HMIS.

B. HMIS Shelter Workflow Training

Shelter Workflow training is offered once a month. Users may attend Shelter Workflow training following adequate completion of the HMIS End User Training. Staff accessing the ShelterPoint module must complete both the End User and the complete Shelter Workflow training.

C. Advanced Reporting Tool (ART) Training

ART training is offered every other month and provides basic knowledge of running ART reports and understanding them for the purpose of data quality and accurately completing the Fairfax County CoC Data Quality Verification forms.

D. Training Registration

Trainees can register for all above HMIS trainings by submitting the HMIS training form (APPENDIX J) and the HMIS End User Responsibility Form (for new users only) (APPENDIX B) to the Office to Prevent and End Homelessness at OPEHTraining@fairfaxcounty.gov.

E. Ad Hoc Training

Individual programs and ad hoc training may occur or be required depending on the specific project.

3. Privacy and Security Standards

A. Application Security

ServicePoint is a web application that uses a 128-bit encryption, user authentication, and user access levels to protect from intrusion.

The "Mediware Privacy Policy and Procedures" and "Mediware Information Security Policy and Practices" document is available from the HMIS Lead upon request.

B. Agency Endpoint Security

i. Agencies and users are required to provide a secure location for the computers which will access the Homeless Management Information System.

ii. ServicePoint has an automatic logout function for users who have been idle for a pre-determined period of time. This function decreases potential viewing and/or manipulation of client data by unauthorized individuals. Fairfax Falls Church CoC HMIS is set to 30 minutes

iii. Agencies participating in the HMIS must have an information technology security policy that addresses the following:

- Privacy including password security
- Screen saver usage
- Security awareness and training
- Firewall
- Virus detection
- Restriction on access to HMIS in public settings and or public forums

C. End User Security

The Homeless Management Information system (HMIS) contains client data; therefore, users are responsible to maintain confidentiality and ensure security of the data. As a user, they must maintain and safeguard their password.

i. User Name

User names are issued by the HMIS system administrator only. The system administrator must ensure that user names are unique.

Each user is assigned a role that determines what the user can and cannot do or see.

Users must sign a user responsibility agreement (APPENDIX B) before a user name and password is assigned

ii. Passwords

Security of a user's password is essential. If a user misplaces a password or shares it with someone else, there is a risk of breaching confidential client information. Temporary passwords are issued for each user at the time HMIS access is granted.

Password characteristics:

1. Passwords must be 8 to 16 characters in length and must contain at least two numbers somewhere in the password.
2. The System allows only one login per user id at a time. Users cannot log into the system on two terminals at the same time using a single user id.
3. Passwords will expire every 45 days and user is prompted to create a new password. Best practices is to never repeat the same password.
4. Password allows only 3 instances for a user to key in the correct password, after 3 unsuccessful attempts that user account is locked.

iii. Password Resets

Users should contact their Agency Administrator for password reset. If Agency Administrator is not available, contact the Information Systems Manager or send an email to OPEHPrograms@fairfaxcounty.gov

D. User Terminations/Separations

Agencies and Projects are responsible to ensure that only active users have access to the Homeless Management Information System (HMIS).

i. An End User Terminations Request must be sent to OPEHPrograms@fairfaxcounty.gov immediately upon termination or separation of any employee who has access to the HMIS. To ensure data protection, the Information Systems Manager will immediately remove HMIS access to the user in question and notify agency when action has been completed.

ii. As part of the Data Quality process, the Information Systems Manager will require agencies to review a list of active users and confirm that they still require access to HMIS.

5. HMIS Data Standards and CoC Fields

The HMIS policy and procedure manual only documents the general data fields that are required for all projects. Core HMIS Data fields and collection standards are outlined in APPENDIX F. Additional assessments or data fields that are project specific are not documented in this policy and procedure manual.

A. Data Fields

The data fields collected in the HMIS are in compliance with the Department of Housing and Urban Development (HUD) published HMIS data standards (APPENDIX F).

B. Annual Review

HMIS data fields and pick lists are reviewed at least annually by the "Super" User Committee to ensure compliance with the HMIS data standards, the Fairfax/Falls Church Partnership to Prevent and End Homelessness needs and the data required for the Regional Enumeration produced by the Metropolitan Washington Council of Governments.

C. Assessment Structure

HMIS organizes data fields (APPENDIX F) into forms called assessments. When additional project specific data fields are required, they are organized in special assessments dedicated to the particular project. The additional projects will supply the documentation of the project specific requirements and HMIS workflow.

6. Client Rights

A. HMIS Notice

All HMIS participating agencies/projects must display and explain the HMIS notice to their clients (APPENDIX C).

B. Releases of Information

HMIS participating agencies/projects should encourage clients to sign a release of information to facilitate data sharing among providers (APPENDIX D). Release of information when granted must be entered in HMIS to allow sharing of data within the application.

7. ServicePoint Modules

Information in ServicePoint is organized in modules. The Fairfax Falls Church Partnership to Prevent and End Homelessness requires use of two modules: ClientPoint and ShelterPoint. Details for Data Entry/Exit are found in the HMIS Training Manual.

A. ClientPoint Module

Contains individual client information. Following is a description of each section within ClientPoint and its required use.

i. Client Profile Tab

Client Profile tab contains client basic demographic information and household information. All projects are required to use the client profile.

ii. Households Tab

Creating a household makes it faster and easier to record data in ServicePoint. By grouping client records together, the user may update or provide services, enter a Release of Information (ROI), or create an entry for all household members in one action, thereby eliminating the need to individually create entries for each member receiving services.

iii. ROI Tab

A Release of Information indicates that a ServicePoint client has given their permission for a provider/organization to share their information with other providers outside of the provider's group, or Continuum. A client **must** have an ROI in the system in order for their information to be viewed by providers outside of their group.

iv. Entry/Exit Tab

An entry and exit to a specific project is required for all clients. An entry/exit associates a client with a project and is key to reporting. Project Entry and Exit Information should be recorded within 48 hours to allow timely reporting.

v. Case Managers Tab

The Case Manager tab allows users to add, edit, and delete case managers. When a ServicePoint user is set as a case manager, the case manager record is actually tied back to the user, so updates made to the user will apply to the case manager as well.

vi. Case Plans Tab

The Case Plans Tab allows providers to create and manage client goals and record progress notes. Projects are not required to use this tab and HMIS User training on the Case Plans tab is not included.

vii. Measurements Tab

The Measurements Tab which holds the self-sufficiency matrix is not required in the CoC data entry workflow. Training on the Measurements Tab is included in End User Training and may be used by Partners to fulfill organizational requirements.

viii. Assessments Tab

The Assessments Tab should not be used in data entry workflow. All assessment data is collected through the EntryExit Tab in the ClientPoint Module or through the ShelterPoint Module.

ix. Service Transactions Tab

The service transaction tab is not required in the CoC data entry workflow, but is available for any project that requires financial reporting. All projects that make use of this tab to enter services are required to conduct internal monthly data quality review of services entered to ensure accuracy and completeness of HMIS services data.

B. ShelterPoint Module

The ShelterPoint module allows shelters to manage bed lists. All shelters are required to manage daily bed lists through ShelterPoint.

i. The ShelterPoint workflow for Emergency Shelter includes household group entry, assessment data completion, automatic creation of the Entry/Exit and ability to add ROIs so that the data collection workflow can all be completed through the ShelterPoint module. This reduces the data entry workflow and the possibility of data entry errors.

ii. Night-By-Night Emergency Shelter (a bed is not reserved for a specific client) bedlist management does not include the additional workflow elements configured for Emergency Shelter Projects. Shelter stays in Night-By-Night Projects should never be longer than one night. Each night is recorded as an individual shelter stay through ShelterPoint.

C. SkanPoint

The SkanPoint module facilitates service data entry. Projects are not required to use this tab and HMIS User training on the Case Plans tab is not included.

D. Reports

The Reports module of ServicePoint allows users to build various reports about users, clients, and services in ServicePoint. Choose from preformatted reports or generate custom, on demand reports providing thorough analysis of clients served, unmet needs, cost of service, source of funds, source of referrals, outcomes measurement and more.

i. Reports can be generated either for an individual agency/program or the entire system.

ii. Reports are divided into three main categories: Audit Reports, Provider Reports, and Custom Reports. Access to each report depends on your user level.

iii. Advanced Reporting Tool Reports (ART), are custom reports that give users access to a wide variety of reports to handle everything from System Administration to Data Quality, Program Management, Case Management, and Outcome and Performance Measures. Because they are written using Business Objects each customer is then able to modify the reports as needed to meet any specific reporting requirements that they may have.

E. Admin

The Admin module is available to Agency Administrators for the purposes of resetting user passwords. Agency Administrators are not to use any other functionality in the Admin Module.

8. HMIS Data Quality

Agencies and projects must review their project and client information on a regular basis to ensure information is correct, up to date and reliable. Data deficiencies should be addressed as soon as they are identified.

Agencies have an array of reports that allows data review for quality, verification and consistency. See APPENDIX G for a list of data quality reports and descriptions.

Through the Data Quality Process, Agency Directors or their designee must certify that the HMIS data has been reviewed, verified, and is accurate. Data Quality Verification must be submitted for all active projects, to the Office to Prevent and End Homelessness either on a monthly or quarterly basis (APPENDIX H).

System Wide and Individual Outcome Reports will be reviewed on a quarterly basis by the "Super" User Committee.

9. Uses of Data

HMIS data is the source for federal, state and local reporting. HMIS ability to de-duplicate clients and provide overall project and system information is critical to understanding those experiencing homelessness and at-risk populations.

Agencies can use HMIS reports to review the demographic profile of clients served during a period of time, evaluate discharge placements and project length of stay among other data.

HMIS is used to generate all appropriate federal program and System Wide Reports.

In addition, there are many project reports in HMIS that allow providers to evaluate outcomes (goals, project exit information).

Reporting needs can be discussed and addressed with the Information Systems Manager.

For a glossary of HMIS definitions and acronyms refer to APPENDIX K.

APPENDIX A

Agency Participation Agreement

AGENCY PARTICIPATION AGREEMENT

For Fairfax-Falls Church Community Partnership to Prevent and End Homelessness
Fairfax County Continuum of Care (CoC) Homeless Management Information System

I. Introduction

The Fairfax-Falls Church Partnership to Prevent and End Homelessness – Fairfax County Continuum of Care (hereafter called FFX CoC) Homeless Management Information System (HMIS) is a client information system that provides a standardized assessment of consumer needs, creates individualized service plans and records the use of housing and services which communities can use to determine the utilization of services of participating Agencies, identify gaps in the local service continuum and develop outcome measurements.

The purpose/goals of a web-based computerized HMIS are to:

- Improve the quality and integration of services.
- Improve the availability of data to aid participating programs and their funding partners in making planning and funding decisions about services to homeless people.
- Provide an unduplicated count of homeless people.
- Improve quality of client services by providing faster linkage to housing, benefits, and services.
- Identify gaps in the service system.
- Deliver a cost-effective system that streamlines the information management processes and improves data processing for homeless service providers.
- Measure the effectiveness of homeless programs.

The signature of the Executive Director of the Agency indicates agreement with the terms set forth and must be executed before a HMIS account can be established for the Agency.

The FFX CoC is the primary coordinating entity. The Office to Prevent and End Homelessness (OPEH) shall be the HMIS Lead Agency (HLA) and is responsible for administering the HMIS on behalf of the CoC. In this Agreement, “Participating Agency” is an Agency participating in Homeless Management Information System, "Client" is a consumer of services, “Agency” is the Agency named in this agreement, “Super User” is an Agency designated staff member(s) and “CoC HMIS Committee” is the CoC authorized representation to provide oversight to the HMIS.

The FFX CoC is a collaboration of representatives of both private and public organizations who represent all components in the homeless delivery system and whose focus is community planning for the delivery of homeless services in the Fairfax County area.

II. HMIS Lead Agency Responsibilities

A. HLA will make a best effort to provide the Agency 24-hour access to the HMIS database system, except during routine system maintenance, scheduled system upgrades and unexpected system failures.

B. The HLA will provide both initial training and periodic updates to that training to select Agency staff regarding the use of the HMIS, with the expectation that the Agency, through their Super User (team), will take responsibility for conveying this information and subsequent changes to all Agency staff using the system.

C. The HLA will provide basic user support and technical assistance, within reason (i.e. troubleshooting and assistance with standard report generation).

III. Privacy and Confidentiality

A. Protection of Client Privacy

1. The Agency shall uphold relevant federal and state confidentiality regulations and laws that protect Client records and the Agency shall only release Client records with written consent by the Client, unless otherwise provided for in the regulations.

2. The Agency shall abide specifically by federal confidentiality regulations as contained in the Code of Federal Regulations, 42 CFR Part 2 regarding disclosure of alcohol and/or drug abuse records. In general terms, the federal rules prohibit the disclosure of alcohol and/or drug abuse records unless disclosure is expressly permitted by written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Agency understands the federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patients.

3. The Agency will comply specifically with the Health Insurance Portability and Accountability Act (HIPAA) of 1996, 45 C.F.R. Parts 160 & 164, and corresponding regulations established by the U.S. Department of Health and Human Services.

4. The Agency will comply with all policies and procedures established by HMIS pertaining to protection of Client privacy. If the Agency is an HIPAA-covered entity, the Agency is required to operate in accordance with HIPAA regulations and is exempt from the privacy and security standards found in HUD's Data and Technical Standards.

B. Client Confidentiality

1. The Agency agrees to provide a copy of the HMIS Privacy Notice to each consumer. The Agency shall provide a verbal explanation of HMIS Privacy Notice and the terms of consent and shall arrange for a qualified interpreter or translator in the event that an individual is not literate in English or has difficulty understanding the consent form.

2. The Agency shall prominently display the HMIS Privacy Notice at each intake desk (or comparable location).

3. The Agency shall not solicit or input information from Clients into the HMIS unless it is essential to provide services, or to conduct evaluation or research.

4. The Agency agrees not to release any confidential information received from the HMIS to any organization or individual without proper Client consent.

5. The Agency shall ensure that all staff, volunteers and other persons issued a User ID and password for the HMIS receive a formal confidentiality training and abide by this Participation Agreement.

6. The Agency acknowledges that ensuring the confidentiality, security and privacy of any information downloaded from the system by the Agency is strictly the responsibility of the Agency.

7. The Agency understands the file server, which will contain all Client information, including encrypted identifying Client information, will be located at Bowman Internet System, Inc. offices and that all Client data will be encrypted at the server level using encryption technology provided by Bowman Internet Services.

C. Inter-Agency Sharing of Information

1. The Agency will utilize the Fairfax County Uniform Authorization to Use and Exchange Information (ROI), as developed in conjunction and coordination with Participating Agencies, for all clients providing information for the HMIS. The ROI, once signed by the Client authorizes information sharing with HMIS Participating Agencies for the time period stipulated on the Consent form.

2. The Agency will comply with the "Best Practices' on utilization of ROI as set forth in the HMIS Policy and Procedure Manual and APPENDIX D.

3. The Agency shall maintain appropriate documentation of Client consent to participate in the HMIS.

4. The Agency shall keep signed copies of the ROI for HMIS for a period of up to seven years or as required by state law, after which time the forms will be discarded in a manner that ensures client confidentiality is not compromised.

5. The Agency will develop an internal procedure to be used in the event of a violation of any of the HMIS security protocols. In the event of a violation, the Director of the Agency and/or designated security officer shall notify the HLA immediately within twenty-four (24) hours.

D. Custody of Data

1. If this Agreement is terminated, HLA and remaining Participating Agencies shall maintain their right to the use of all Client data previously entered by the terminating Participating Agency; this use is subject to any restrictions requested by the Client.

2. The CoC does not require or imply that services must be contingent upon a Client's participation in the HMIS. Services should be provided to Clients regardless of HMIS participation provided the Clients would otherwise be eligible for the services.

3. The Agency shall not be denied access to Client data entered by the Agency. Participating Agencies are bound by all restrictions placed upon the data by the Client of any Participating Agency. The Agency shall diligently record in the HMIS all restrictions requested. The Agency shall not knowingly enter false or misleading data under any circumstances.

IV. Homeless Management Information System (HMIS) Use, Training, Data Entry and Data Integrity

A. An agency is considered to be an HMIS Participating Agency ("Agency") when it collects client-level data on homeless Clients within the CoC.

B. The Agency will not permit User ID's and Passwords to be shared among users.

C. The Agency shall follow, comply with and enforce the User Policy, Responsibility Statement & Code of Ethics (APPENDIX B).

D. The Agency will enter all minimum required data elements as defined in the Policy and Procedures Manual.

E. The Agency will take all steps reasonably necessary to verify the information provided by Clients for entry into the HMIS, and to see that it is correctly entered into the HMIS by the Agency User.

F. The Agency shall ensure that all staff, volunteers and other persons issued a User ID and password for HMIS receive confidentiality training, HMIS training, and comply with the HMIS User Policy, Responsibility Statement & Code of Ethics (APPENDIX B), and the HMIS Participation Agreement (APPENDIX A).

G. The Agency will share Client information in compliance with the "Best Practices" on utilization of the ROI as set forth in the HMIS Policy and Procedure Manual and APPENDIX D

H. The Agency shall only enter individuals in the HMIS that exist as Clients under the Agency's jurisdiction. The Agency shall not misrepresent its Client base in the HMIS by entering known, inaccurate information.

I. The Agency shall use Client information in the HMIS, as provided to the Agency or Participating Agencies, to assist the Agency in providing adequate and appropriate services to the Client.

J. The Agency shall consistently enter information into the HMIS and will strive for real-time, or close to real-time data entry or will enter data in the HMIS in compliance with the Policy and Procedure Manual.

K. The Agency will routinely review records it has entered in the HMIS for completeness and data accuracy. The review and data correction process will be made according to HMIS published Policies and Procedures.

L. The Agency will not alter information in the HMIS that is entered by another Agency with known, inaccurate information. (i.e. Agency will not purposefully enter inaccurate information to over-ride information entered by another Agency).

M. The Agency shall not include profanity or offensive language in the Homeless Management Information System except as clinically necessary.

N. The Agency will keep updated virus protection software on Agency computers that access the HMIS.

O. The transmission of material in violation of any federal or state regulations is prohibited. This includes, but is not limited to, copyright material, material legally judged to be threatening or obscene, and material considered protected by trade secret.

P. The Agency shall not knowingly enter false or misleading data under any circumstance, nor use HMIS with intent to defraud federal, state or local governments, individuals or entities, or to conduct any illegal activity.

Q. The Agency agrees that a "Super" User Committee will meet on a regular basis to discuss and/or recommend updates for policy and procedure guidelines, data analysis, and software/hardware upgrades and will be the liaison between the HMIS Lead Agency and the Participating Agency. The Agency will designate at least one Staff member or a Staff team as their Super User and to regularly attend Super User meetings.

R. All recommendations agreed upon by the "Super" User Committee will be reviewed by the HMIS Committee for approval and finalization.

V. Reports

A. The Agency shall retain access to identifying and statistical data on the Clients it serves only.

B. The Agency may make aggregate data available to other entities for funding or planning purposes pertaining to providing services to homeless persons. However, such aggregate data shall not directly identify individual Clients.

C. The CoC's HMIS committee will provide guidance to the HLA on the use of the data collected in the system and the reports to be produced. Only unidentified, aggregate data will be used for homeless policy and planning decisions. Aggregate data may also be used in preparing federal, state or local applications for homelessness funding, to demonstrate the need for and effectiveness of programs and to obtain a system-wide view of program utilization, as directed by the CoC HMIS Committee.

VI. Data Quality

A. Agency to familiarize itself and fully comply with the latest HMIS Data Quality Plan.

B. Collect all HUD mandatory data elements and +4 elements, according to the data completeness and accuracy requirements.

VII. Super User

A. Each agency will designate at least one specific Staff member or a Staff team as their Super User (Super User roles and responsibilities may be shared as a designated team), dependent on organization projects/programs/grants or those projects/programs/grants your organization accesses.

B. Agency will ensure that there is a succession plan in place so that there is no interruption to their Super User representation.

C. The Agency shall comply with responsibilities outlined in the Super User Roles and Responsibilities document (APPENDIX E).

D. Agency will agree to and support time commitment needed for fulfillment of Super User responsibilities (APPENDIX E).

E. Agency Supervisor to designate staff member or staff team to be Super User based on the knowledge, skills and abilities needed to fulfill the Super User Roles and Responsibilities outlined in APPENDIX E.

VIII. "Super" User Committee

A. The CoC will establish a "Super" User Committee as its authorized representative to provide recommendations and oversight to the HMIS. The "Super" User Committee will be made up of a designated "Super" User or Team "Super" User from each Participating Agency.

B. The CoC through its "Super" User Committee will make recommendations to the HMIS Committee to include, but not limited to, HMIS policies and procedures, HMIS end user training, Data Quality Process and "Best" practices.

C. Agency designated Super User or Team Super User will communicate recommendations, questions and concerns on behalf of their Agency to the "Super" User Committee.

IX. CoC HMIS Committee

A. The CoC will establish a CoC HMIS Committee whose members embody the CoC and include representatives from the HMIS Lead, the CoC Lead, the Executive Directors Committee, Program Managers, Super Users and End Users.

B. The CoC HMIS Committee makes HMIS Governance Charter recommendations and submits to the CoC for final approval.

C. The CoC HMIS Committee reviews HMIS Policy and Procedure recommendations made by the "Super" User Committee for final approval. The Agency agrees to comply with these policies and procedures and shall require its employees and agents to do the same.

X. Proprietary Rights of Bowman Internet System

A. The Agency shall not give or share assigned passwords and access codes of the HMIS with any other Agency, business, or individual.

B. The Agency shall not cause in any manner, or way, corruption of the HMIS.

VIII. Terms and Conditions

A. Neither the CoC nor the Agency shall transfer or assign any rights or obligations without the written consent of the other party.

B. This Agreement shall be in-force until revoked in writing by either party provided funding is available.

C. This Agreement may be terminated with 30 days written notice.

D. This agreement may be modified or amended by written agreement executed by both parties with 30 days advance written notice.

_____ _____

Signature of Executive Director Date

_____

AGENCY

_____

STREET ADDRESS

_____ _____

CITY ZIP CODE

Homeless Management Information System

ASSURANCE

_____ (Name of Agency) assures that the following fully executed documents will be on file and available for review.

- ❑ The Agency's Confidentiality Policy.
- ❑ The Agency's Grievance Policy, including a procedure for external review.
- ❑ The Agency's official *Privacy Notice* for HMIS clients.
- ❑ Executed HMIS *Client Release of Information* forms.
- ❑ Executed Agency *Authorizations for Release of Information* as needed.
- ❑ A fully executed *User Agreement* for all HMIS System Users.
- ❑ A copy of the *Agency Participations Agreement between* FFX CoC and the Agency.

By: _____

Title: _____

Signature: _____

Date: _____

APPENDIX B

User Policy, Responsibility Statement & Code of Ethics

User Policy, Responsibility Statement, and Code of Ethics

For the Fairfax-Falls Church Continuum of Care Homeless Management Information System (HMIS: ServicePoint) and Advance Reporting Tool [ART])

Agency _____

User

Name _____ **Hire Date** _____

Title _____ **Phone** _____

Email _____

Supervisor

Name _____ **Phone** _____

Title _____ **Email** _____

User Policy

At the discretion of Partner Agencies information shall be shared for provision of services to homeless persons through the Homeless Management Information System (HMIS), which establishes electronic communication among the Partner Agencies.

Consistent with client permission and restrictions, Partner Agencies shall at all times have rights to the data pertaining to clients created or entered by their staff in HMIS.

It is a Client's decision about which information, if any, entered into HMIS shall be shared and with which Partnering Agencies. The Client Consent to Exchange Information form shall be signed if the Client agrees to share Information with Partner Agencies.

Minimum data entry on each client is defined in the Policy and Procedure Manual.

The Homeless Information System is a tool to assist agencies in focusing services and locating alternative resources to help homeless persons. Therefore, agency staff should use the client information in the system to target services to the client's needs.

Minimum Data Entry

All Clients	Follow guidelines as described in the ServicePoint HMIS Procedure Manual.
Clients Receiving Services through HUD Grants	Data required for the HUD APR.

The Homeless Information System is a tool to assist agencies in focusing services and locating alternative resources to help homeless persons. Therefore, agency staff should use the client information in the system to target services to the client's needs.

Recommended Data Entry

- Data necessary for the development of aggregate reports of homeless services, including services needed, services provided, referrals.
- Client goals and outcomes should be entered to the greatest extent possible.

User Responsibilities

Your User ID and Password give you access to the Fairfax County Homeless Information Management Information System (HMIS). Initial each item below to indicate that you understand the policy and agree to comply. Failure to uphold any of these policies may result in immediate termination from the HMIS.

_____ My User ID and Password are for my use only. I will not share them with anyone.

_____ I will take all reasonable means to keep my Password physically secure, and not utilize the browser capacity to remember passwords. I will enter the password each time I open the HMIS.

_____ I understand that only authorized HMIS users (and the Clients to whom the information pertains) are permitted to view information in the HMIS.

_____ I will only view, obtain, disclose, or use client information when necessary to perform my job.

_____ I will log out of the HMIS any time I leave my computer. I understand that a computer logged into the HMIS must never be left unattended.

_____ I understand that failure to log out of the HMIS may result in a breach in client confidentiality and system security.

_____ I will not transmit confidential client information in email form.

_____ I will not discuss HMIS confidential client information with staff, clients, or on the telephone in any area where the public might overhear my conversation.

_____ I understand that all "hard copies" of HMIS data must be kept in a secure file and not leave hard copies in public view of my desk, on a photocopier, printer or fax machine.

_____ I understand that hard copies of HMIS data must be properly destroyed when are no longer needed, in a way that will maintain confidentiality. (That is, shredded or otherwise rendered unreadable.)

_____ If I notice or suspect a security breach, I will immediately notify my HMIS Agency Administrator, as well as a System Administration at the Fairfax County Office to Prevent and End Homelessness (OPEH).

_____ I will notify my HMIS Agency Administrator, as well as an OPEH System Administration of any change in employment status or need to access HMIS.

_____ Upon termination of employment I am still bound to uphold client confidentiality and not share information gained through HMIS.

User Code of Ethics

- Treat Partner Agencies with respect, fairness and good faith.
- Each Maintain high standards of professional conduct in the capacity as an HMIS User.
- Relate to the clients of other Partner Agencies with full professional consideration.
- Not use the HMIS with the intent to conduct illegal activity, or solicit clients for personal gain.

I understand and agree to comply with all the statements listed above.

HMIS User Signature _____ Date _____

Access Level

(Supervisor to select an access level from the table below.)

Level	Description
☐ **Case Manager II**	**Case Managers** have access to all ***ServicePoint*** features except those needed to run audit reports and features found under the ***Admin*** tab. They have access to all screens within ***ClientPoint***, including assessments and service records. **Case Manager II** users can also create/edit client infractions if given access by an **Agency Administrator** or above.
☐ **Agency Admin**	**Agency Administrators** have access to ServicePoint features that allow them to edit their organization's data, shadow other users and run high level reports. **Agency Administrators** can delete clients that were created by organizations within their organizational tree. They cannot, however delete clients who are shared across organizations trees. **Agency Administrators** can delete needs and services created within their own organization tree, unless the needs and services are for a shared client. **Agency Administrators** also have access to the *ServicePoint* Admin module- User Admin to ***reset passwords only***. ***Agency Administrators do not have the training or permission to access any other features within the Admin module*****.**
☐ **Executive Director**	**Executive Directors** have the same access rights as **Agency Administrators**; however, they are ranked above **Agency Administrators**.
☐ **Other Role**	**Other Roles** to be discussed. Call HMIS Administrator to discuss your special needs.

HMIS Username: (select one) ☐ *OPEH* ☐ *Agency/Organization (ex. FACETS)*

Supervisor Signature _____ Date _____

Please scan and return the complete, signed form via email at OPEHtraining@fairfaxcounty.gov or at the Fairfax County Government Center, 12000 Government Center Parkway, # 333, Fairfax, VA. 22035. Thank you

APPENDIX C

HOMELESS MANAGEMENT INFORMATION SYSTEM NOTICE

THIS NOTICE DESCRIBES WHAT INFORMATION IS COLLECTED, HOW IT MAY BE USED AND DISCLOSED AND YOUR PRIVACY RIGHTS.
PLEASE REVIEW IT CAREFULLY.
Effective Date: October 15, 2009

HMIS System Notice

When you request or receive services and give information about yourself and your family, it is entered into a computer system called the Homeless Management Information System (HMIS). Fairfax-Falls Church Community Partnership partner agencies that provide services to homeless persons and others in need use the same computer system because it helps agencies do a better job of providing services to people in the community.

WHAT INFORMATION IS COLLECTED AND HOW IS IT USED OR SHARED?

The information is used to: (1) Plan and deliver services to you and your family; (2) For statistical purposes and to meet federal reporting guidelines, such as determining the number of persons who are homeless; (3) To track individual program-level outcomes; (4) To identify unfilled service needs and plan for the provision of new services; (5) and other uses allowed by law.

There are two types of information collected and different rules about how and when the information is shared.

1. **Basic Identifying Information** (Client profile) **-** Name, Gender, Social Security Number, and Date of Birth.

   By reviewing this notice, you are giving your permission to have your **Basic Identifying Information** *entered in HMIS.*

2. **Case Information** (Assessment information - HUD Universal Data Elements, Program Entry/Exit, and Homelessness Prevention and Rapid Re-housing Program Data Elements and services) **-** such as family composition, race, ethnicity, income, financial resources, military duty status, prior living situation, length of stay, zip code of last permanent address, disability information, housing status, homeless status, employment history, domestic violence status, financial assistance/benefits, debts, expenses and contact information.

   By signing the attached "Uniform Authorization to Use and Exchange Information" form **Case Information** *may be shared with the Fairfax - Falls Church Community Partnership* ***only*** *if you give specific permission to share it so you may be better served by partner agencies.*

HOW WILL MY INFORMATION BE KEPT SECURE?

Several measures have been taken to ensure that your information is kept safe and secure:

- The HMIS system has the highest degree of security protection available;
- Any information that could identify you, like your name or date of birth, will be viewed only by people working to provide services to you, and will be removed before reports are issued to local, state, or federal agencies;
- Employees using the HMIS system receive training in confidentiality and privacy protection and agree to follow rules before using the system.

KNOW YOUR INFORMATION RIGHTS:

As a client receiving services, you have the following rights:

1. ***Access to your record -*** You have the right to view your HMIS record. At your request, we will prepare a report of your records or assist you in viewing them.
2. ***Correction of your record -*** You have the right to have your record corrected so that information is up-to-date, accurate, and to ensure fairness in its use.
3. ***Refusal -*** You have the right to refuse consent. You cannot be denied services that you would otherwise qualify for if you refuse to sign the "*Uniform Authorization to Use and Exchange Information"*. Please note that if you refuse, information will still be entered into the system for statistical purposes, but all of your information will be closed so that no other user agency will have access to it.
4. ***Withdrawal of the Consent -*** Your consent to share information can be withdrawn at any time upon demand.
5. ***Appeal -*** You have the right to complain if you believe your privacy rights have been violated. You will not be penalized or denied service for filing a complaint.

Fairfax -Falls Church Community Partnership

Annandale Christian Community for Action
Bethany House of Northern Virginia
Britepaths
Christian Relief Services Charities
Committee for Helping Others
Cornerstones
Ecumenical Community for Helping Others
FACETS
Fairfax County Department of Administration for Human Services
Fairfax County Department of Family Services
Fairfax County Department of Housing and Community Development
Fairfax County Department of Neighborhood and Community Services
Fairfax County Health Department
Fairfax County Office for Women and Domestic and Sexual Violence Services
Fairfax County Office to Prevent and End Homelessness
Fairfax-Falls Church Community Services Board
Fairfax For Immediate Sympathetic Help (FISH)
Foundation for Appropriate and Immediate Temporary Help
Friendship Place
Good Shepherd Housing and Family Services
Helping Children Worldwide
Homestretch
Housing Counseling Services
Inova Health System
Kurdish Human Rights Watch
Lorton Community Action Center
Lutheran Social Services
New Hope Housing
Northern Virginia Family Service
OAR of Fairfax County
Operation Renewed Hope Foundation
Pathway Homes
PRS
Residential Youth Services
Second Story
SHARE
Shelter House
The Lamb Center
United Community Ministries
US VETS
Volunteers of America-Chesapeake
Western Fairfax Christian Ministries
Future Partner Agencies of the Fairfax-Falls Church Community Partner

APPENDIX D

Fairfax County Uniform Authorization to Use and Exchange Information

FAIRFAX COUNTY VERSION OF COMMONWEALTH OF VIRGINIA
UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON)

_____
(FULL PRINTED NAME OF INDIVIDUAL)

_____
(INDIVIDUAL'S ADDRESS) *(INDIVIDUAL'S BIRTH DATE)*

My relationship to the individual is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other Legally Authorized Representative

I want the following confidential information about the individual to be exchanged; each item must be checked:

Yes	*No*		*Yes*	*No*		*Yes*	*No*	
☐	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed, Planned, and/or Received	☐	☐	Health Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records
☐	☐	Substance Abuse Records (one time use only, see page 2)						

Other Information (write in): _____

I want _____
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)
and the following entities to be able to use and exchange this information among themselves:

Fairfax County

Yes	*No*	
☐	☐	Alcohol Safety Action Program
☐	☐	Family Services
☐	☐	Fairfax County Courts
☐	☐	Health Department
☐	☐	Housing & Community Development
☐	☐	Juvenile & Domestic Relations Court Services
☐	☐	Neighborhood & Community Services
☐	☐	Office for Women
☐	☐	Probation & Parole
☐	☐	Fairfax County Public Schools
☐	☐	Fairfax-Falls Church Community Services Board
☐	☐	Fairfax-Falls Church Community Partnership

Other Identify By Name

☐ ☐ _____
☐ ☐ _____

State/Local/Private/Non-Profit ***Identify By Name***

Yes	*No*	
☐	☐	Dept. of Behavioral Health & Developmental Services Developmental Services
☐	☐	Dept. of Medical Assistance Services
☐	☐	Dept. of Social Services
☐	☐	Dept. of Rehabilitation Services
☐	☐	Area Agencies on Aging _____
☐	☐	Community Services Boards _____
☐	☐	Home Health Agencies _____
☐	☐	Hospices _____
☐	☐	Local Health Departments _____
☐	☐	Nursing Facilities _____
☐	☐	Physicians _____
☐	☐	Community Based Organizations _____

Other Identify By Name

☐ ☐ _____
☐ ☐ _____

I want this information to be exchanged ONLY for the following purpose(s):
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination ☐ Other: _____

I want this information to be shared by the following means: *(check all that apply)*
☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data ☐ Fax

I want to share additional information received after this authorization is signed: ☐ Yes ☐ No
This authorization is effective: _____
(DATE)
This authorization is good until: ☐ My service case is closed. ☐ Other: _____

I can withdraw this authorization at any time by notifying any involved agency listed on the form. The listed agencies must stop sharing information after they know my authorization has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all agencies to accept a copy of this form as valid consent to share information. **If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed.** However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s): _____ Date: _____
(AUTHORIZING PERSON)

Person Explaining Form: _____
(Name) *(Address)* *(Phone Number)*

Other *(If Required)*: _____
☐ Parent ☐ Witness *(Signature)* *(Address)* *(Phone Number)*

FAIRFAX COUNTY VERSION OF COMMONWEALTH OF VIRGINIA
UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION

Full Printed Name of Individual: _____

FOR AGENCY USE ONLY

AUTHORIZATION HAS BEEN:

☐ Revoked in entirety
☐ Partially revoked as follows:

NOTIFICATION THAT AUTHORIZATION WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐ Telephone ☐ In Person

DATE REQUEST RECEIVED: _____

AGENCY REPRESENTATIVE RECEIVING REQUEST:

_____
(AGENCY REPRESENTATIVES FULL NAME AND TITLE)

_____
(AGENCY ADDRESS) *(PHONE NUMBER)*

SUBSTANCE ABUSE RECORDS:

These records *(select only one):*

☐ **ARE** protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are protected by 42 CFR, Part 2, I understand a recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization, except as otherwise permitted by the Regulations. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

☐ **ARE NOT** protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are not protected by 42 CFR Part 2, I understand that the HIPAA Privacy Regulations require I be advised that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by federal HIPAA regulations.

AUTHORIZATION TO USE AND EXCHANGE INFORMATION

Introduction

Specified information can be shared among ALL of the agencies listed below without having to obtain any additional signed consent from the individual. The *Authorization to Use and Exchange Information* form was developed for use by the following agencies:

- Local departments of social services
- Area agencies on aging
- Health department clinics and programs
- Community services boards
- Department of Correctional Education
- Department of Youth and Family Services
- Service delivery areas for the Job Training Partnership Act
- Local departments of Rehabilitative Services
- Local school systems
- Regional offices, Department of Corrections
- Regional outreach offices, Department for the Deaf and Hard of Hearing
- Regional Offices, Department for the Blind and Vision Impaired
- Virginia Employment Commission Offices
- Fairfax / Falls Church Community Partnership

The "referring agency" is defined as the agency that initiates the completion of the *Authorization to Use and Exchange Information* form with the individual. The referring agency may use the form to request or to transmit information to other agencies. Agencies may be considered either a "referring" or an "other" agency, depending upon which agency is contacted first by the individual. If all parties agree, additional public and private agencies, facilities, and organizations may be included.

Agencies are assured that, when properly executed, this is a legally valid form that meets not only their own agency's state and federal requirements, but also those of the other participating agencies. The *Authorization to Use and Exchange Information* form has been reviewed by the Office of the Attorney General to assure compliance with federal and state confidentiality requirements. Agencies may choose to use a different uniform release form that addresses their individual needs if it meets the state and federal confidentiality and release of information statutory and regulatory requirements of ALL involved agencies.

Alcohol and Drug Abuse Confidentiality Requirements

To ensure compliance with federal alcohol and drug abuse confidentiality requirements, this form excludes the general sharing of information about individuals in drug and alcohol programs. A separate release of information form specifically for alcohol and drug abuse records should be used each time information is shared between agencies.

Purpose of the Authorization to Use and Exchange Information Form

The *Authorization to Use and Exchange Information* form is designed for use by agencies that work together to jointly provide or coordinate services for individuals with complex needs and should be used along with the referring agency's specific procedures for obtaining a valid release to exchange information. It also can be used to assist agencies obtain information needed from other agencies to determine an individual's eligibility for services or benefits. The completed form should reflect that the individual (or his or her representative) controlled the choices and understood the process. When using this form, always keep in mind the importance of individual wishes, individual choices, and individual comprehension of the process.

Agency staff and the consenting person will first determine whether the individual might be eligible for services or benefits provided by other agencies. This determination should be based upon the needs, interests, and circumstances of the individual as well as staff's knowledge of other agencies' services or benefits and eligibility requirements.

Referring agency staff must explain the following to the individual:

- Potential services and benefits that might be available from other agencies.
- What information these agencies might need and for what purpose(s).
- The purpose of the form.
- The consequences of signing or not signing this release.
- Key provisions and protections (e.g., revocation, access to agencies' written record).

Staff should make every attempt to ensure that the consenting person understands the provisions of the form and should make appropriate efforts to accommodate the special needs of the consenting person. If the consenting person is unable to read or is blind or visually impaired, staff should read the form to him or her. Interpreters should be made available for people who do not speak English and for those who are deaf or hearing impaired. If the consenting person does not appear to comprehend the meaning of the form, it should be explained. If staff have ANY doubts that the consenting person is not comprehending the purpose and provisions of the form, they should ask the consenting person questions about the form (what the form allows the agency to do, etc.).

Based upon these answers, if staff determine that the consenting person is NOT comprehending the purpose and provisions of the form, staff should follow their agency's procedures for assuring that the form is signed by a legally authorized consenting person who fully comprehends the purpose and provisions of the form. The signature of a consenting person who does NOT comprehend what he or she is signing is not valid.

If the consenting person agrees, the form should be completed. This should be done by the consenting person, wherever possible. The consenting person must sign the form and insert the date in the indicated place. Staff explaining the form to the consenting person must sign the form in the indicated place. For those agencies with procedures requiring a witness (e.g., for a person who cannot write), space is provided for a witness to sign the form. The witness must observe the consenting person signing or placing a mark on the form and then must sign as indicated. The referring agency must give a copy of the completed form to the consenting person.

Sharing Information with Other Agencies

It is important for the referring agency to notify the other listed agencies that they are parties to this agreement to exchange information. This notification can be by telephone or through written correspondence. This notification must be entered into the individual's record. If the referring agency wants to receive information from other agencies, it must provide a copy of the signed consent form with its initial request for information form each listed agency.

Virginia Privacy Protection Act Requirements

To ensure compliance with the Virginia Privacy Protection Act, each time information is disclosed by any of the listed agencies, staff of the disclosing agency must enter the following information into the individual's record:

- Name of the agency and the name, title, telephone number of the individual receiving the information.
- Type and source of the information disclosed.
- Reason or purpose for the disclosure.
- Date the information was disclosed.

This requirement can be met by using a disclosure log (sample attached) or through the agency's own record keeping policies and procedures.

NOTE: The consenting person has the right to review the records of disclosure of the referring and other agencies upon request during the agencies' normal business hours.

Agency Record Keeping Policies and Procedures

Referring Agency: The original signed copy of the *Authorization to Use and Exchange Information* form, disclosure record, and any related materials shall be maintained in accordance with the agency's record keeping policies and procedures.

Other Agencies: A copy of the *Authorization to Use and Exchange Information* form, disclosure record, and any related materials shall be maintained in accordance with the agency's record keeping policies and procedures.

Renewing or Amending the Authorization Form

The referring agency can renew or amend (e.g., by adding additional agencies) the original signed copy of the *Authorization to Use and Exchange Information* form by having the consenting person sign and insert the date beside the amendment on the original form. The referring agency must give a copy of the amended form to the consenting person and forward a copy of the amended form to each of the listed agencies.

Revocation of Authorization

Consent to exchange information will expire on the date or condition agreed to by the consenting person. However, anytime prior to the expiration, the consenting person may choose to revoke or cancel this consent either with all or with selected agencies.

The consenting person may revoke his or her consent by informing any of the involved agencies in writing, by telephone, or in person. This notification must be noted on the back of the *Authorization to Use and Exchange Information* form and signed and dated by the agency staff person receiving the request to revoke the consent.

If the consenting person exercises the option of revoking his or her consent (in entirety or with selected agencies) to share information under the agreement, the agency receiving this notice shall inform all other listed agencies that are authorized to exchange information under the agreement of the revocation of the consent.

Individuals Who Refuse to Sign the Authorization Form

It is absolutely essential that the individual understand and appreciate what will happen as a result of signing this form. The individual also needs to understand that there is no requirement to sign this form, but that not signing the form will result in specific consequences. If the form is not signed, the individual must deal with each agency individually to obtain needed information, and/or the agency may not be able to provide services. If the form is signed, the process for applying for and receiving services may be easier for both the individual and the involved agencies.

When Not to Use This Form

The *Authorization to Use and Exchange Information* form should not be used with:

- Individuals who do not comprehend the purpose and substance of the consent form; or
- Individuals for whom drug or alcohol abuse diagnostic or treatment information is being shared. In these cases, a separate consent form should be used.

Can Other Interagency Consent Forms Be Used?

Agencies should accept the *Authorization to Use and Exchange Information* form as a legally valid form. However, they may choose to use a different release form that addresses their individual needs IF it meets the state and federal confidentiality statutory and regulatory requirements of ALL the involved agencies.

APPENDIX E

Super User Roles and Responsibilities & Agency Super User Designation Form

"Super" User Roles & Responsibilities

1. Serves as a representative on the "Super" User Committee

2. Proficient Understanding and Demonstration of:
    a. The HMIS as it relates to your organization's projects/programs or those that your organization accesses
    b. The homeless services system
    c. CoC data standards and performance measures
    d. Funding stream Data eligibility requirements specific to your agency/program/grant
    e. Data Quality Process
    f. Data Analysis to support organization
    g. HMIS Reporting Processes
        i. Running reports
        ii. Interpret/Analyzing reports
        iii. Take action

3. Advisory Functions:
    a. Communicates recommendations and suggestions from the parent organizations to the "Super" User Committee
        i. Best Practices
        ii. Policy and Procedures
        iii. Training Curriculum
        iv. Concerns
    b. As a committee, develops recommendations and suggestions from the parent organizations and presents to the CoC HMIS Committee for approval
        i. Best Practices
        ii. Policy and Procedures
        iii. Training Curriculum
        iv. Concerns
    c. Serves as a liaison between HMIS Lead Agency staff and the agency/program/grant in which they are employed
    d. Supports HMIS Lead Agency staff in rolling out new and changing HMIS initiatives
    e. Communicates and reinforces HMIS changes and updates to agency staff
    f. Agency's main point of contact for HMIS Lead Agency

4. In-house Agency Trainer and Liaison
    a. Supplemental end user training
        i. HMIS
            1. Data Standards
            2. Data Process
            3. Data Quality
        ii. Agency/Program/Grant Specific
        iii. Funding Streams
        iv. Policy and Procedures
    b. HMIS Reporting Processes
        i. How to run and read reports
        ii. Tools to analyze reports
        iii. Data Quality Reports
    c. Front line Q&A for agency
        i. Agency/Program's first point of contact
        ii. Provide end user support to agency/program's HMIS users
        iii. First line of troubleshooting data issues within agency/program before contacting System Admin
    d. Shares knowledge and experiences
    e. Makes recommendations to agency regarding staff HMIS training needs
    f. Develops succession plan for training replacement "Super" User Committee members
    g. Develops training plan for new staff
    h. Adapts training for organizational needs

5. Attend "Super" User committee, subcommittee and supplemental meetings and training on a regular basis.

Agency Super User Designation Form

For the Fairfax County Continuum of Care Homeless Management Information System

Agency_____

Instructions:

- Each agency will designate at least one specific Staff member or a Staff team as their Super User (Super User roles and responsibilities may be shared as a designated team), dependent on organization projects/programs/grants or those projects/programs/grants your organization accesses.
- Executive Director or Designee to designate staff member or staff team to be Super User based on the knowledge, skills and abilities needed to fulfill the Super User Roles and Responsibilities outlined in APPENDIX E of the HMIS Policies and Procedures Manual.
- Agency will ensure that there is a succession plan in place so that there is no interruption to their Super User representation and will complete a new Agency Super User Designation Form indicating replacement designee. (For a Team Type, please resubmit including the entire team).

Super User Designee Type: ☐ **Individual** ☐ **Team**

Designated Super User(s)

Name	Title	Phone	E-mail

Executive Director or Designee Signature

Signature _____ **Date** _____

Printed Name _____ **Title** _____

Please scan and return the completed, signed form via email at OPEHPrograms@fairfaxcounty.gov or at the Fairfax County Government Center, 12000 Government Center Parkway, #333, Fairfax, VA 22035. Thank you.

APPENDIX F

HMIS Data Collection Fields

Appendix F

HMIS Data Collection Fields

This section includes information about the data collection fields in HMIS, including who the information needs to be collected from, when the information needs to be collected, and what project types must collect the information. The appendix has five tables. The first four tables are divided into two sections – "Collected From" and "When Collected", while the last table only lists by project type. See below for explanations of the tables and the columns.

- Universal Data Elements (UDEs)

  Universal Data Elements (UDEs) are required to be collected by all projects, regardless of project type.

- "Plus 4" Data Elements

  "Plus 4" (or +4) Data Elements are required to be collected by all projects, regardless of type. It is important to note that only a Yes/No response is required for all projects (Table 2.1), while some projects require additional information for these data elements, known as "HUD Verifications" (Table 2.2).

- Extended Data Elements

  The data elements in this table need to be collected for the following projects: Homeless Prevention, Transitional Housing, and Permanent Housing (to include Rapid Rehousing, Housing Only, Permanent Supportive Housing, and non-homeless Permanent Housing projects). These Extended Data Elements also include the "HUD Verifications".

- All Remaining Data Elements

  This table lists out the remaining data elements and indicates which projects the information must be collected for.

If the table marker falls in the below categories, the data element must be collected:

- ALL – from all household members
- HOH – from the identified head of household only
- HOH & Adults – from the head of household and all adult (18 and older) household members

6. Record Creation – at the time the individual's HMIS profile is created
7. Project Start – at the time the individual enters into the project
8. At Occurrence – at the time the individual meets the requirements of the listed element
9. At Update – at the time the individual's information needs to be updated
10. Annual Assessment – at the time the individual's information requires an annual assessment

Project Exit – at the time the individual exits a project

Universal Data Elements (UDEs)
Collected from all clients on all Projects

Number	Universal Data Element	Collected From			When Collected					
		ALL	HOH	HOH & Adults	Record Creation	Project Start	At Occurrence	At Update	Annual Assesment	Project Exit
3.1	Name	◊			◊					
3.2	Social Security Number	◊			◊					
3.3	Date of Birth	◊			◊					
3.4	Race	◊			◊					
3.5	Ethnicity	◊			◊					
3.6	Gender	◊			◊					
3.7	Veteran Status				◊					
3.8	Disabling Condition	◊				◊		◊	◊	◊
3.10	Project Start Date	◊				◊				
3.11	Project Exit Date	◊								◊
3.12	Destination	◊								◊
3.15	Relationship to Head of Household	◊				◊		◊		
3.16	Client Location		◊			◊	◊*			
3.20	Housing Move-In Date		◊				◊**			
3.917	Living Situation			◊		◊				
4.2	Income and Sources (Yes/No Only)			◊		◊		◊	◊	◊
4.3	Non-Cash Benefits (Yes/No Only)			◊		◊		◊	◊	◊
4.4	Health Insurance (Yes/No Only)	◊				◊		◊	◊	◊
4.11	Domestic Violence	◊				◊		◊	◊	◊

*At time the client's location changes from one COC to another, if applicable.

**At time of move-in to Permanent Housing, if applicable.

*** Note: For OUTREACH and Night-By-Night (NbN)Shelter projects: collect and enter as many UDEs as possible. As more data is collected, update UDEs through ENTRY assessment or Client Demographics

Collection for OUTREACH, NIGHT-BY-NIGHT, AND SHELTER PROJECT

Number	Universal Data Element	Collected From			When Collected					
		ALL	HOH	HOH & Adults	Record Creation	Project Start	At Occurrence	At Update	Annual Assesment	Project Exit
4.2	Income and Sources (Yes/No Only)	◊				◊		◊	◊	◊
4.3	Non-Cash Benefits (Yes/No Only)	◊				◊		◊	◊	◊
4.4	Health Insurance (Yes/No Only)	◊				◊		◊	◊	◊
4.11	Domestic Violence	◊				◊		◊	◊	◊

*** Note: For OUTREACH and Night-By-Night (NbN)Shelter projects: collect and enter as many UDEs as possible. As more data is collected, update UDEs through ENTRY assessment or Client Demographics

Collection for Projects except Outreach, Night-By-Night, and Emergency Shelter (PREVENTION, RAPID REHOUSING, PERMANENT HOUSING, PH-OTHER PROJECTS)

Number	Universal Data Element	Collected From			When Collected					
		ALL	HOH	HOH & Adults	Record Creation	Project Start	At Occurrence	At Update	Annual Assesment	Project Exit
4.2	Income and Sources (Yes/No Only)			◊		◊		◊	◊	◊
4.3	Non-Cash Benefits (Yes/No Only)			◊		◊		◊	◊	◊
4.4	Health Insurance (Yes/No Only)			◊		◊		◊	◊	◊
4.11	Domestic Violence			◊		◊		◊	◊	◊

*** Note: For OUTREACH and Night-By-Night (NbN)Shelter projects: collect and enter as many UDEs as possible. As more data is collected, update UDEs through ENTRY assessment or Client Demographics

Extended Data Elements - HUD Verifications
All Project Types except Outreach, Night-By-Night, and Emergency Shelter

Number	Extended Data Elements	Collected From			When Collected					
	Elements Apply to: Homeless Prevention, Transitional Housing, PH: RRH, PH: Housing Only, PH: PSH and non-homeless PH projects	ALL	HOH	HOH & Adults	Record Creation	Project Start	At Occurrence	At Update	Annual Asst	Project Exit
4.2	Income and Sources			◊		◊		◊	◊	◊
4.3	Non-Cash Benefits			◊		◊		◊	◊	◊
4.4	Health Insurance	◊				◊		◊	◊	◊
4.5	Physical Disability	◊				◊		◊		◊
4.6	Developmental Disability	◊				◊		◊		◊
4.7	Chronic Health Condition	◊				◊		◊		◊
4.8	HIV/AIDS	◊				◊		◊		◊
4.9	Mental Health Problem	◊				◊		◊		◊
4.10	Substance Abuse	◊				◊		◊		◊

		Project Type							
Number	Additional Data Elements	Outreach	PATH	Emerg Shelter	Hless Prev	SSVF	Coord Entry	Perm Housing/ Rapid RH	Runaway Hless Youth
4.12	Contact	◊	◊						◊
4.13	Date of Engagement	◊	◊						◊
4.14	Bed Night Date			◊					
4.18	Housing Assessment Disposition						◊		
W5	Housing Assessment at Exit				◊				
P1	Services Provided - PATH Funded		◊						
P2	Referrals Provided - PATH		◊						
P3	PATH Status		◊						
P4	Connection with SOAR		◊			◊			
R1	Referral Sources								◊
R2	RHY - BCP Status								◊
R3	Sexual Orientation								◊
R4	Last Grade Completed					◊			◊
R5	School Status								◊
R6	Employment Status								◊
R7	General Health Status								◊
R8	Dental Health Status								◊
R9	Mental Health Status								◊
R10	Pregnancy Status								◊
R11	Formerly a Ward of Child Welfare/Foster Care Agency								◊
R12	Formerly a Ward of Juvenile Justice System								◊
R13	Family Critical Issues								◊
R14	RHY Services Connections								◊

		Project Type							
Number	Additional Data Elements	Outreach	PATH	Emerg Shelter	Hless Prev	SSVF	Coord Entry	Perm Housing/ Rapid RH	Runaway Hless Youth
R15	Commercial Sexual Exploitation/Sex Trafficking								◊
R16	Labor Exploitation/Trafficking								◊
R17	Project Completion Status								◊
R18	Counseling								◊
R19	Safe and Appropriate Exit								◊
R20	Aftercare Plans								◊
V1	Veteran's Information					◊			
V2	Services Provided - SSVF					◊			
V3	Financial Assistance - SSVF					◊			
V4	Percent of AMI (SSVF Eligibility)					◊			
V5	Last Permanent Address					◊			
V6	VMAC Station Number					◊			
V7	SSVF HP Targeting Criteria					◊			

APPENDIX G

Data Quality Reports List

APPENDIX G:

DATA QUALITY REPORTS

Data quality reporting provides agencies across the Fairfax County Continuum of Care (COC), with a centralized data review system to ensure the completeness, accuracy, and consistency of their data in HMIS. It also ensures providers and the CoC access to data for monitoring purposes, or to meet reporting requirements. Included in this appendix are lists of required and supplemental data quality reports, where to find them in ART, brief descriptions, the purpose of each report, and which reports apply to a specific program.

The Data Quality Reports are divided into two categories: required and supplemental. The required reports are due to the Office to Prevent and End Homelessness for either monthly or quarterly submission. The supplemental reports are not required by the CoC, but the information in the reports can be useful for monitoring client progress, informing stakeholders about programs, and general data clean up.

Below is the list of Data Quality Reports used by the Fairfax County CoC.

Required Data Quality Reports:

- 252-Data Completeness Report Card
- 252-EntryExit Companion Report
- 222-Workflow Elements by Client
- Coordinated Entry Data Quality Report
- Hypothermia Program Report
- 260-HUD CoC APR Data Quality Completeness
- 347A-Services (Billing) Summary
- 263-RHY Data Completeness
- 254-Shelter – History, Overlap, and Return

Supplemental Data Quality Reports:

- 123-ServicePoint User Last Login Report
- 216-Unexited Clients Exceeding Maximum Length of Stay
- 220-Data Incongruity Locator
- 315-Daily Program Census
- 347B-Services - Bedlist
- Clients with Self Sufficiency Matrix
- 405-SSOM Client Achievement Report
- 631-HUD Coc APR Detail

CoC Active/Required Data Quality ART Reports (for applicable projects according to DQ Verification forms)

Rpt #	Name	ART folder location	Description	Purpose	Required for
252	Data Completeness Report Card	ART | Public Folder | Data Quality	Data quality monitoring tool that generates a letter grade based upon program's data completion rate for required data elements at the time of client entry into the program. The report can be run for multiple programs and is sectioned by provider so that each provider's report card will be displayed on a separate page, allowing batch printing.	1) To ensure required elements are completed at time of program entry. 2) When run for Parent Providers - ensures that EntryExit records are not attached to parent providers.	All EntryExit Projects
252	EntryExit Companion Report	ART | Public Folder | Data Quality	Flagship report for Fairfax Falls Church CoC. This report can be run for one project or for Entire CoC all at once. Summary tabs provide analysis at the HUD project type level and at the project level. Client Entry and Update/Exit tabs provide data details for HMIS Data Standard Data Elements excluding: 1) HMIS DE recorded in sub-assessments (data can be found in 260 report) 2) HMIS DE exclusive to only one program type (PATH, RHY, VA). The Entry and Update/Exit tabs are designed to be downloaded into Excel for evaluation and analysis. It is not possible to view the data in these tabs without download. Several calculated fields are also provided in the Entry and Update/Exit tabs which assist in evaluation and project analysis.	To provide a report to organizations which will facilitate easy review of client level data to improve the quality of the data. Provide summary counts in the same report; enabling transparent analysis. Provide a tool through which partners can download their data for analysis purposes.	All EntryExit Projects
347A	Services (Billing) Summary	ART | Public Folder | Case Mgmt	The 0347A Services Summary report supports reviewing all of the services delivered by your programs, service type, client, and case worker.	To provide accurate service counts for clients.	Almost all EntryExit Programs (excluding HHP, Seasonsal, Outreach, and Shelter projects)

222	Workflow Elements by Client	ART | Public Folder | Data Quality	This report is an enhanced version of the Bowman report. Reprogrammed for our Continuum's workflow. It can only be run on one program at a time.	For program managers to ensure that staff are entering all of the required data workflow elements for clients (ROIs, EntryExit, Services, Case Manager)	All EntryExit Projects
254	Shelter - History, Overlap and Return	ART | Public Folder | Data Quality	This report will display all of a client's services and EntryExit history with alerts to notify the user when the client has multiple stays in the same period at different providers. This report can also be used to determine the number of clients that return to the Shelter within a certain time period, allow users to calcuate the percentage of repeat clients within that time.	To identify EntryExits or Shetler Stay records that are overlapping within the CoC.	Primarily for Shelter Projects, but can be used by other projects to identify overlaps in E/E
260	HUD APR	ART | Public Folder | HUD | APR	This report is the HUD CoC APR Data Quality and Completeness report that provides information about both missing data (Data completeness) and accuracy (Data Quality). Prompts allow the user to specify a data range and to select the provider(s) on which to base the report. The report includes a detailed section to assist users in finding and fixing data entry omissions.	To ensure adherence to the HUD EntryExit workflow invovling the proper collection and recording of the HUD required universal and program specific data elements.	Almost all EntryExit Programs (excluding HHP, Seasonsal, Outreach, and Shelter projects)
	Coordinated EntryData Quality	ART | Public Folder | Data Quality	This report supports review of all the data for the Coorinated Entry Pool (CE) process. Summary and detailed tabs help to keep track of complete and incomplete CE Pool applications, as well was to identify any CE EntryExit records created in the incorrect workflow.	To ensure accurate and complete data entry of the Coordinated Entry Pool applications, as well, as track complete EntryExits in the approval process for the CE Pool.	Coordinated Entry Projects only
	Hypother Program Report	ART | Public Folder | Program Specific Reports | Hypothermia Reports	This report is a data quality reporting tool to capture counts of unduplicated clients, basic client demographic information, counts of EntryExit records, and length of Shelter Stays.	To identify client data that are incorrectly created through the wrong workflow (e.g., Shelter Stays greater than one day) and for calcuation of EntryExit end dates for seasonal projects.	For Seasonal Projects only (Hypo & Winter Seasonal)
263	RHY Data Completeness Quality Report	ART | Public Folder | Data Quality	This report is a data completeness monitoring tool for Entry and Exit assessment data that provides both missing data and Client Doesn't Know/Client Refused data. Summary and detailed Tabs assist users in finding and fixing data entry omissions.	To ensure adherence to the RHY Program EntryExit workflow involving the proper collection and recording of RHY-required universal and project specific data elements.	Runaway Homeless Youth (RHY) Projects only

CoC Supplemental Data Quality ART Reports

Rpt #	Name	ART folder location	Description	Purpose	Applies To
123	ServicePoint User Last Login Report	ART | Public Folder | System Administration	To be run at the Parent Provider Level. Provides a list of all users in an organization and the numbers of days since login.	For review so that users who have left employment in the Partner Agencies are reported for deletion. NOTE: Users should be immediately reported when terminated from employment. They should never be allowed access to confidential data after leaving employment.	All Parent Providers (providers which should not have EntryExits attached)
216	Unexited Clients Exceeding Maximum Length of Stay	ART | Public Folder | Data Quality	Monitors data quality by insuring that clients in selected program have a timely program exit. The report allows the User the ability to examine the length of stay (los) for all unexited clients in up to five selected programs. The User is also prompted to specify the maximum length of stay for each program enabling the report to flag clients whose los has exceeded the limit. The report also identifies unexited clients with multiple entries.	To ensure clients' program exits are recorded in time and to alert program managers of clients exceeding length of stay. Also assists in identifying clients with multiple entries into the same program simultaneously.	None - no longer used
220	Data Incongruity Locator	ART | Public Folder | Data Quality	Assists users in locating data entry errors resulting in incongruous information related to the client's recorded age, gender and/or household relationship(s).	To ensure client data is consistent	HMIS staff run on a monthly basis formal contact to agencies with Incongruit data. If it happens to often - will have to be added back to monthly DQ process

315	Daily Program Census	ART | Public Folder | Data Quality	Provides daily program census for a selected program for a 31 day period of time specified by the user. The reported daily census is based on client entries and exits, and includes individual counts, household counts, percent of capacity and breakdowns by gender, age, race, ethnicity and prior living situation. In addition to this summary data, the report includes the client detail related to each breakdown, and combined counts for the entire reporting period	To provide a daily census for verification of who is in the program during the reporting period.	None - no longer used
347B	Services - Bedlist	ART | Public Folder | Data Quality	A modified version of 0347. Services Summary report supports reviewing all of the services delivered by your programs, service type, client, and case worker but has additional tabs at the end with shelter bedlist.	A modified version of 0347. This report supports any program which uses ShelterPoint. The same tabs are included which support Services Analysis but the final tabs of the report have been added to support reviewing the bedlist data.	Hypothermia Programs
	Clients with Self Sufficiency Matrix	ART | Public Folder | SSOM Reports	Lists clients who have a self-sufficiency matrix recorded in HMIS. Overly simplistic report which needs enhancements in the near future	To provide a list as requested by the partners of the clients who have SSOMs in ServicePoint.	Any projects continuing to administer the SSOM
405	SSOM client Achievement Report	ART | Public Folder | SSOM Reports	This report compares the initial and the final Self Sufficiency Outcome rating for each of the clients in a selected program. Initial/Final comparisons with calculated gains/losses are reported for each domain where at least one value has been recorded, as well as an average score for all domains. A second report tab compares the program averages by domain and by overall average. Both the client report and the program report display the results both graphically and in table format. To be included in this report the client must have an initial SSOM assessment and a final SSOM assessment by the specified provider and on or after the reports specified start date.	To ensure that all clients who have exited the program have an SSOM	Any projects continuing to administer the SSOM

631	HUD CoC APR Detail	ART | Public Folder | HUD | APR | ntc	This ART Gallery report is a companion to report 0625 and displays the record level detail behind the CoC APR summary tables. This CoC APR Detail report consist of several sub-reports each of which focus on a portion of the CoC APR data, including client demographics, household membership, types and levels of service, entry-exit related data, length of stay, income, non-cash benefits, etc. The report also included additional feature to assist in data quality monitoring including null data flags, identification of non-HUD assessment question values, and a sub-report that identifies duplicate clients included in the dataset.	Overall program evaluation and reporting consistent with HUD requirements. As all programs follow the same workflow whether HUD program or local, the report is extremely useful. The report includes features to assist in data quality monitoring including null data flags, identification of non-HUD assessment question values, and a sub-report that identifies duplicate clients included in the dataset.	Almost all Entry Exit Programs (Excluding HHP, Hypothermia, Outreach)

APPENDIX H

Data Quality Verification Forms

APPENDIX H

Data Quality Verification Forms

Appendix H includes submission information and the required submission forms used in submitting project data quality to OPEH. It is broken out into 3 sections: explanation of the data quality process, the project submission chart, and submission forms.

The data quality process section is an overview of the data quality submission process. It identifies to whom and when the data quality report should be submitted, as well, as the method to compare agency internal data reports with reports developed by OPEH.

The project submission chart is a list of the projects required to submit data quality reports, the frequency in which they should be submitted, and the appropriate forms needed for each project.

The data quality verification forms are used to determine accuracy of data entered into HMIS. Each of the project types has an associated data quality form. Each form is completed, signed by the appropriate authority at your agency and then submitted to OPEH.

The forms are:

- Data Quality Verification Form – Parent Provider/Organization
- Data Quality Verification Form – Rapid Rehousing/Bridging Affordability/Prevention
- Data Quality Verification Form – Outreach
- Data Quality Verification Form – Emergency Shelter
- Data Quality Verification Form – Winter Shelter/Hypothermia
- Data Quality Verification Form – Permanent Supportive Housing/Transitional Housing/Permanent Housing Other
- Data Quality Verification Form – Second Story
- Data Quality Verification Form – Coordinated Entry

2017-2018 DATA QUALITY INFORMATION SHEET

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership
www.fairfaxcounty.gov/homeless

NEW DATA QUALITY PROCESS

- The Parent Organization/Agency DQ Verification form, along with forms for each individual HMIS Project must be submitted according to the 2017-2018 DQ Submission Chart.
    - The 2017-2018 DQ Submission Chart lists all the projects in HMIS that need to submit either monthly or quarterly reports; the information is sorted by Parent Organizations and also lists the frequency of reporting and project types.
- Run ART reports from your organization according to what's required on the monthly and quarterly DQ Verification forms.
- Reports should be run for **the past 12 months** for all HMIS projects and parent organizations.
- Correct errors and contact OPEH for assistance with data quality **before the due date**.
- Compare the Organization run 0252 EECR to the 02520System Admin EECR (delivered to the Parent Organization ART inbox) sent by OPEH
    - The System Admin 0252 EECR will be delivered daily from the 1st of each month up to the due date. Reports will be delivered after the noon/afternoon refresh.
    - DQ verification forms must indicate the creation date of the System Admin 0252 EECR used for reporting on the DQ Verification form. **DO NOT DELETE** the current month's report used for the DQ Verification form from the Parent Organization ART inbox. Past month's 0252 EECR can be deleted.
    - Instructions for picking up the 0252 SysAdm EECR are in the HMIS training manual.
- Correct errors/differences between the Organization- run 0252 EECR and the System Admin 0252 EECR.
- Complete one DQ Verification form for each HMIS project.
- Submit all forms to the Office to Prevent and End Homelessness at OPEHPrograms@fairfaxcounty.gov.
- Attach a single DQ form per email and indicate the project name as the subject of the email.
- DQ Verification forms (along with any applicable attachments) are DUE by the 10th of the month. If the 10th is a weekend or holiday, submissions are due the next business day.

When reviewing the 2017-2018 DQ Submission Chart or the new DQ Verification Forms, please contact OPEH (OPEHPrograms@fairfaxcounty.gov) with any questions or concerns. If you feel that a project is listed in error or missing, please contact us immediately. You will be notified via HMIS NEWS – DQ Blog of any updates to the DQ Info Sheet, DQ Submission Chart, or DQ forms. Consequently, we encourage you to frequently read HMIS NEWS because it is the main source of communication for HMIS-related events/topics.

Please report any errors or corrections, or changes needed on this chart to OPEHPrograms@fairfaxcounty.gov.

ALL DATA QUALITY VERIFICATION FORMS NEED TO BE SUBMITTED TO THE OFFICE TO PREVENT AND END HOMELESSNESS
Send emails to OPEHPrograms@fairfaxcounty.gov

HMIS Provider Type	Data Quality Form Name
Parent Organization	Data Quality Verification Form - Parent Organization
Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA
Street Outreach (HUD)	Data Quality Verification Form - Outreach
Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter
Emergency Shelter (HUD) *Winter / Hypo*	Data Quality Verification Form - Hypo/Winter Seasonal
Transitional housing (HUD)	Data Quality Verification Form - PH PSH Other TH*
PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA
PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*
PH - Housing only (HUD)	Data Quality Verification Form - PH PSH Other TH*
PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*
Services Only (HUD)	Data Quality Verification Form - RRH Prevent BA
Other (HUD)	Various see chart
Second Story Exceptions	Data Quality Verification Form - Second Story
Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry

*Note: Quarterly project DQ Verification Forms are due October, January, April, and June.

Cornerstones				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Cornerstones (11)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	CS - Bridging Affordability II Wait List (323)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
3	CS - Bridging Affordability II Homeless (356)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
4	CS - CAHP - Homeless Families (438)	PH - Housing only (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
5	CS - CAHP - Homeless Singles (441)	PH - Housing only (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
6	CS - CAHP - Non-Homeless Families (440)	PH - Housing only (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
7	CS - CAHP - Non-Homeless Singles (442)	PH - Housing only (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
8	OPEH - R3 Motel Projects - CS (520)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
9	OPEH - R3 Family Prevention - CS(417)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
10	OPEH - R3 Family Rapid Rehousing - CS(425)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
11	OPEH - R3 FS - Embry Rucker Family Shelter - CS(409)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
12	OPEH - R3 Single Prevention - CS(413)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
13	OPEH - R3 Single Rapid Rehousing - CS(421)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
14	OPEH - R3 Singles Outreach - CS(401)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
15	OPEH - R3 SS - Embry Rucker Medical Respite Shelter - CS (427)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
16	OPEH - R3 SS - Embry Rucker Single Shelter - CS (408)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly

17	OPEH - R3 Singles Rapid Rehousing VHSP - CS (485)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
18	OPEH - R3 SS Hypothermia -CS (475)	Emergency Shelter (HUD) Winter / Hypo	Data Quality Verification Form - Hypo/Winter Seasonal	Monthly
19	OPEH - R3 SS Winter Seasonal -CS (479)	Emergency Shelter (HUD) Winter / Hypo	Data Quality Verification Form - Hypo/Winter Seasonal	Monthly
20	Coordinated Entry Singles Cornerstones (489)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
21	Coordinated Entry Families Cornerstones (490)			

Department of Family Services (DFS)				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Department of Family Services	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	OPEH - Medical Respite Case Management (472)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
3	Coordinated Entry Singles DFS	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
4	Coordinated Entry Families DFS			

FACETS				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	FACETS (20)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	FACETS - Bridging Affordability II Wait List (324)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
3	FACETS - Bridging Affordability II Homeless (351)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
4	FACETS Linda's Gateway PSH (481)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly

5	FACETS TRIUMPH III (480)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
6	FACETS TRIUMPH II (321)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
7	FACETS TRIUMPH I (192)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
8	OPEH - FS - Last Resort Motel Project - FACETS(431)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
9	OPEH - R1 Motel Project - FACETS (518)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
10	OPEH - PSH Single - Home Connections - FACETS(429)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
11	OPEH - R1 Family Prevention - FACETS(415)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
12	OPEH - R1 Family Rapid Rehousing - FACETS(423)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
13	OPEH - R1 FS - Next Steps Family Shelter - FACETS(405)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
14	OPEH - R4 Single Prevention - FACETS(414)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
15	OPEH - R4 Single Rapid Rehousing - FACETS(422)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
16	OPEH - R4 Singles Outreach - FACETS(402)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
17	OPEH - R4 SS Hypothermia -FACETS (476)	Emergency Shelter (HUD) Winter / Hypo	Data Quality Verification Form - Hypo/Winter Seasonal	Monthly
18	Coordinated Entry Singles FACETS (493)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
19	Coordinated Entry Families FACETS (494)			

Fairfax/Falls Church Community Services Board (CSB)				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency

1	Fairfax/Falls Church Community Services Board (12)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	CSB - PATH Outreach(437)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
3	CSB - PATH Services (457)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
4	Coordinated Entry Singles CSB (495)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
5	Coordinated Entry Families CSB			

Family Preservation and Strengthening Services (FamilyPASS)				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Family Preservation and Stengthening Services (225)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	Family PASS - Bridging Affordability II Homeless (331)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
3	Family PASS - Housing Project(249)	Other (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
4	Coordinated Entry Singles Family PASS (506)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
5	Coordinated Entry Families Family PASS (514)			

Fairfax County Department of Health				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Fairfax County Health Department (147)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly

2	HD - HHP Nurse Practitioners(149)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
3	HD - HHP Outreach(148)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
4	HD - Non-HHP Nurse Practitioners(379)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
5	HD - Medical Respite NP (513)	Other (HUD)	Data Quality Verification Form - Outreach	Monthly
6	Coordinated Entry Singles Health Department (506)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
7	Coordinated Entry Singles Health Department (514)			

Homestretch, Inc.				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Homestretch, Inc. (9)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	Homestretch - Bridging Affordability II Homeless(329)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
3	Homestretch - HOME Transitional Housing Program(182)	Transitional housing (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
4	Homestretch - Permanent Supportive Housing Program(388)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
5	Homestretch - Transitional Housing Program(213)	Transitional housing (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
6	Coordinated Entry Singles Homestretch (507)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
7	Coordinated Entry Families Homestretch (508)			

New Hope Housing				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	New Hope Housing (6)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly

2	NHH - Bridging Affordability II Wait List (325)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
3	NHH - Bridging Affordability II Homeless (354)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
4	NHH - Just Home Fairfax PSH(382)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
5	NHH - Milestones II(253)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
6	NHH - Milestones(102)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
7	NHH - PSH Group Homes Gartlan(159)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
8	NHH - PSH Group Homes Max's(381)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
9	NHH - RISE PSH(242)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
10	OPEH - PSH Single - Housing First Apartments - NHH(430)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
11	OPEH - PSH Single - Mondloch Place - NHH(433)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
12	OPEH - R1 Single Prevention - NHH(411)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
13	OPEH - R1 Single Rapid Rehousing - NHH(419)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
14	OPEH - R1 Single Rapid Rehousing VHSP - NHH(463)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
15	OPEH - R1 Singles Outreach - NHH(399)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
16	OPEH - R1 SS - APS Shelter - NHH(454)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
17	OPEH - R1 SS - Eleanor Kennedy Single Shelter - NHH(404)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
18	OPEH - R1 SS - Mondloch House I - NHH(435)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
19	OPEH - R1 WS - Friends of Falls Church Winter Shelter(439)	Emergency Shelter (HUD) Winter / Hypo	Data Quality Verification Form - Hypo/Winter Seasonal	Monthly

20	OPEH - R1 SS Hypothermia -NHH (473)	Emergency Shelter (HUD) Winter / Hypo	Data Quality Verification Form - Hypo/Winter Seasonal	Monthly
21	OPEH - R1 SS Winter Seasonal -NHH (477)	Emergency Shelter (HUD) Winter / Hypo	Data Quality Verification Form - Hypo/Winter Seasonal	Monthly
22	OPEH - R2 Singles Prevention - NHH(412)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
23	OPEH - R2 Single Rapid Rehousing - NHH(420)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
24	OPEH - R2 Singles Outreach - NHH(400)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
25	OPEH - R2 SS - Bailey's Crossroads Single Shelter - NHH(406)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
26	OPEH - R2 SS Hypothermia -NHH (474)	Emergency Shelter (HUD) Winter / Hypo	Data Quality Verification Form - Hypo/Winter Seasonal	Monthly
27	OPEH - R2 SS Winter Seasonal -NHH (478)	Emergency Shelter (HUD) Winter / Hypo	Data Quality Verification Form - Hypo/Winter Seasonal	Monthly
28	Coordinated Entry Singles New Hope Housing (501)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
29	Coordinated Entry Families New Hope Housing (502)			

Northern Virginia Family Services (NVFS)				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Northern Virginia Family Services (18)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	NVFS Bridging Affordability II Wait List(332)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
3	NVFS Bridging Affordability II Homeless(355)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
4	NVFS - VHSP Prevention Program(367)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
5	OPEH - Prevention City Wide - NVFS(459)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
6	Coordinated Entry Singles NVFS (491)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
7	Coordinated Entry Families NVFS (492)			

Pathway Homes, Inc.				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Pathway Homes, Inc. (5)	Parent Organization	Data Quality Verification Form - Parent Organization*	Quarterly
2	Pathways 1991 McKinney-CRS(317)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
3	Pathways 1991 McKinney-PHI(316)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
4	Pathways Semi-Independent Cedar Cove/Links Program (1995 McKinney-CRS)(78)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
5	Pathways Semi-Independent Joust/Mockingbird Program (1994 McKinney-CRS)(84)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
6	Pathways SHOP Shelter Plus Care 01C Program(234)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
7	Pathways SHOP Shelter Plus Care 09C Program(246)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
8	Pathways SHOP Shelter Plus Care 10C Program(282)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
9	Pathways SHP 2007(167)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
10	Pathways SHP 2009(245)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
11	Pathways SHP 2011(305)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
12	Pathways SHP 2014(398)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
13	Pathways SHP 2015(482)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
PRS, Inc.				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency

1	PRS, Inc. (15)	Parent Organization	Data Quality Verification Form - Parent Organization*	Quarterly
2	PRS - Intensive Supporting Housing(214)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
3	PRS Supported Housing (1994 McKinney-CRS)(216)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
4	PRS Supported Housing (1995 McKinney-CRS)(281)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly

Second Story				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Second Story (19)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	Second Story - CoC Rapid Rehousing Project (483)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
3	Second Story - RHY Transitional Living Program(394)	Transitional housing (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
4	Second Story - Bridging Affordability II Homeless (330)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
5	Second Story - HYI Transitional Housing (396)	Transitional housing (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
6	Second Story AYM I - RHY MGH Transitional Housing (392)	Transitional housing (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
7	Second Story Teen Shelter - RHY Basic Center Program (395)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
8	Second Story Teen Shelter - Shelter Program (446)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
9	Coordinated Entry Singles Second Story (504)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
10	Coordinated Entry Families Second Story (503)			

Shelter House, Inc.				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency

1	Shelter House, Inc. (17)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	SH - Bridging Affordability II Wait List(326)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
3	SH - Bridging Affordability II Homeless(359)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
4	Shelter House, Inc. / CoC Rapid Rehousing (484)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
5	Shelter House, Inc. / Offsite Program(41)	Transitional housing (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
6	Shelter House, Inc. / RISE PSH(241)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
7	OPEH - PSH Family - Kate's Place - SH(432)	PH - Permanent Supportive Housing (disability required for entry) (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly
8	OPEH - R2 Motel Project - SH (519)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
9	OPEH - R2 Family Prevention - SH(416)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
10	OPEH - R2 Family Rapid Rehousing - SH(424)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
11	OPEH - R2 FS - Patrick Henry Family Shelter - SH(407)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
12	OPEH - R2 Family Rapid Rehousing VHSP - SH(461)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
13	OPEH - R4 Motel Project - SH (521)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
14	OPEH - R4 Family Prevention - SH(418)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
15	OPEH - R4 Family Rapid Rehousing - SH(426)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
16	OPEH - R4 Family Rapid Rehousing VHSP -SHH(462)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
17	OPEH - R4 FS - Kate Hanley Family Shelter - SH(410)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
18	Coordinated Entry Singles Shelter House (499)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly

19	Coordinated Entry Families Shelter House (500)			

The Lamb Center				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	The Lamb Center (464)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	TLC - Homeless Outreach (467)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
3	TLC - Homeless Case Management (465)	Service Only (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
4	TLC - Non Homeless Outreach (468)	Street Outreach (HUD)	Data Quality Verification Form - Outreach	Monthly
5	TLC - Non Homeless Case Management (466)	Service Only (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
6	Coordinated Entry Singles The Lamb Center (498)	Coordinated Assessment (HUD)		Monthly
7	Coordinated Entry Families The Lamb Center			

Volunteers of America (VOA)				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Volunteers of America (25)	Parent Organization	Data Quality Verification Form - Parent Organization	Monthly
2	VOA - Bridging Affordability II Homeless(360)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
3	VOA - SSVF Prevention FxFCH CoC only(309)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
4	VOA - SSVF Prevention Non-FxFCH CoC only(487)	Homelessness Prevention (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
5	VOA - SSVF Rapid Rehousing FxFCh Coc Only(350)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
6	VOA - SSVF Rapid Rehousing Non-FxFCh Coc Only(488)	PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly

7	Coordinated Entry Singles VOA (496)	Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry	Monthly
8	Coordinated Entry Families VOA (497)			

Please report any errors or corrections needed on this chart to OPEHPrograms@fairfaxcounty.gov.

ALL VERIFICATION FORMS NEED TO BE SUBMITTED TO THE OFFICE TO PREVENT AND END HOMELESSNESS
Send emails to OPEHPrograms@fairfaxcounty.gov

Provider Type	Data Quality Form Name
Parent Organization	Data Quality Verification Form - Parent Organization
Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter
Transitional housing (HUD)	Data Quality Verification Form - PH PSH Other TH*
PH - Rapid Re-Housing (HUD)	Data Quality Verification Form - RRH Prevent BA
Other (HUD)	Various see chart
Coordinated Assessment (HUD)	Data Quality Verification Form - Coordinated Entry

*Note: Quarterly project DQ Verification Forms are due October, January, April, and June.

Beth El House Virginia				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Beth El House DQ Transitional Housing (384)	Transitional housing (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly

Family Preservation and Strengthening Services				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	Family Pass DV Rapid Rehousing and Stabilization (388)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly

Shelter House, Inc.				
	EE Provider	HUD Provider Type	DQ Verification Form	DQ Frequency
1	OFW Artemis House DV Emergency Shelter (383)	Emergency Shelter (HUD)	Data Quality Verification Form - Emergency Shelter	Monthly
2	OFW DV Bridging Affordability (389)	PH - Housing with services (no disability required for entry) (HUD)	Data Quality Verification Form - RRH Prevent BA	Monthly
3	OFW Artemis House Transitional Housing (390)	Transitional housing (HUD)	Data Quality Verification Form - PH PSH Other TH*	Quarterly

*Note: Quarterly project DQ Verification Forms are due October, January, April, and June.

DATA QUALITY (monthly) VERIFICATION FORM

Agency Name: _____
(List your Agency/Parent Provider project in HMIS, not a specific HMIS project)

Reporting Period (MM/DD/YY – MM/DD/YY): _____ Submission Date: _____

Instructions

1. Pick up the 0252 EECR in the Parent Organization ART inbox that was scheduled by a HMIS System Admin for all of the projects within a Parent Organization or Agency. The EECR will be run for the **past 12 months**.
2. Begin running and correcting reports the 1st of the month so that there is sufficient time to request assistance from OPEH for Data Quality issues.
3. Investigate errors/differences between Organization run EECR and the SysAdm EECR. Correct errors when applicable. One Parent Provider Data Quality Verification Form is needed for **a Parent Organization/Agency** within HMIS.
4. The Parent Organization DQ form should be submitted once all the specific projects have completed data clean-up.
5. Submit a single DQ form per email to OPEHPrograms@faifaxcounty.gov, and **state the Agency name as the subject of the email**. Please do not include multiple DQ forms on an email.
6. Final submission is due by COB on the 10th of the month. If the 10th is a weekend or holiday, final submissions are due the next business day. Submissions for the entire CoC are tracked and may be published.

0252 – Entry Exit Companion Report (EECR) - Organization run report

(ART | In Box (Parent Organization)
Note: Complete the values based on Organization run EECR (not the SysAdm EECR)

Tab A – Overall Chart Note: Counts are in the bottom row of the chart.	_____	Households (Family + singles)
	_____	Clients
	_____	Veterans
	_____	Households Exit Between Report Dates
	_____	Average LOS Household Leavers
	_____	Household Exit Destination Permanent Housing
	_____	Chronically Homeless Households

0252 – SysAdm Entry Exit Companion Report (SysAdm EECR)

The SysAdm EECR is delivered to the ART inbox of the organization's ART Report username.

Tabs A, B1, C, & D. Do not delete current month's SysAdm EECR reports from the Parent Organization ART Inbox. Old reports can be deleted.	_____	Counts on the 252 SysAdm EECR that was delivered to the Parent Organization ART Inbox have been reviewed. Creation date of the SysAdm EECR: _____/_____/_____ .
	_____	I verify that there are no EntryExits that are attached to the Parent Organization; it does not show up on the SysAdm EECR (initials). *In HMIS, projects (such as the Parent Organization) that have no data attached to it will not appear on the report.*
	Initial only one of the following options:	
	_____	Our Agency/Organization approves the data reported on the SysAdm EECR.
	_____	Differences between SysAdm EECR and Organization EECR have been investigated and current differences on the SysAdm EECR are not actual errors. Data in HMIS is correct; the SysAdm EECR is reporting inaccurately. The Organization run EECR data accurately reflects good data in HMIS.

Comments

The signature below ***certifies*** that the HMIS data in ServicePoint has been reviewed for **quality**, **completeness** and **consistency**.

Responsible Party Signature: _____

Responsible Party Name: _____

Executive Director (or Designee) Signature: _____

Executive Director Name (or Designee): _____

PH – Rapid Rehousing, Prevention & Briding Affordability
MONTHLY DATA QUALITY VERIFICATION FORM

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership
www.fairfaxcounty.gov/homeless

Agency/Parent Provider Name: _____

HMIS Project Name & #: _____
(a separate form is required for each HMIS Program)

Reporting Period (MM/DD/YY – MM/DD/YY): _____ Submission Date: _____

Instructions

1. A **separate** Data Quality Verification Form is needed for **each RRH, Prev, or BA project** within HMIS on a MONTHLY basis August through June.
2. Each project must report data quality for the **past 12 months**. For example, when reporting in August, the year's data in ART should be collected from 8/1/2016 - 8/1/2017 (End Date plus 1 day).
3. Begin running and correcting reports the 1st of the month so that there is sufficient time to request assistance from OPEH for Data Quality issues.
4. Submit a single DQ form per email to OPEHPrograms@fairfaxcounty.gov, and **state the project name as the subject of the email**. Please do not include multiple DQ forms on an email.
5. Final submission is due by COB on the 10th of the month. If the 10th is a weekend or holiday, final submissions are due the next business day. Submissions for the entire CoC are tracked and may be published.

0252 – Data Completeness Report Card ART | Public Folder | Data Quality folder		
Please review and make corrections necessary to achieve the highest possible Data Completeness grade.	_____	Overall Grade

0252 – EntryExit Companion Report (EECR) – Organization run report ART | Public Folder | Data Quality folder Note: Please complete this section using the Organization EECR, not the SysAdm EECR.		
Values entered MUST match values on ART Report. Do not submit DQ form until ART is run and data corrections are verified. HINT: Use SCHEDULER; 0252 – *EntryExit Companion Report TWO* might be of some assistance in clean-up effort. Download report to EXCEL and review TAB C and TAB D data elements for accuracy. Make corrections where necessary to ensure client data in ServicePoint is accurate.	_____	Data on Tab C is accurate (initial)
	_____	Data on Tab D is accurate (initial)
	_____	Clients Served Tab B1 (number)
	_____	Households Exits Between Report Dates Tab B1 (number)
	_____	Households Exit Dest Perm Tab B1 (number)

0252 – SysAdm Entry Exit Companion Report The SysAdm EECR is delivered to the ART inbox of the organization's ART Report username.		
Tabs A, B1, C, & D. Do not delete current month's SysAdm EECR reports from the Parent Organization ART Inbox. Old reports can be deleted.	_____	Data reported on the 252 SysAdm EECR (delivered to the Parent Organization ART Inbox) have been reviewed (initial).
	_____	I approve of the data reported on the SysAdm EECR for this project (initial).
	Initial only one of the following options:	
	_____	Counts on the 0252 SysAdm EECR match the counts on Organization run EECR. There are no differences upon data clean-up. Creation date of the delivered SysAdm EECR: _____/_____/_____ .
	_____	Differences between SysAdm EECR and Organization EECR have been investigated and current differences on the SysAdm EECR are not actual errors. Data in HMIS is correct; the SysAdm EECR is reporting inaccurately. The Organization run EECR data accurately reflects good data in HMIS. Creation date of the delivered SysAdm EECR: _____/_____/_____ .

APR reports are complex and take a LONG time to run; USE THE ART SCHEDULER to improve the workflow of your reporting process. A Scheduler webinar link is listed in System News in the HMIS WEBINAR BLOG.

Cleanup of Duplicate sub-assessment records identified in 260 - Tab D and Tab E under Potential Data Quality errors will take a while to cleanup. As new clients come in, the sub-assessment data should be cleaned up, no overlapping or duplicate sub-assessment. The HUD data standards webinar should assist. The link is available in System News in the HMIS WEBINAR BLOG.

0260 - HUD CoC APR Data Quality Completeness (HUD APR) ART | Public Folder | HUD | APR		
Tab C	_____	Tab C: Errors have been resolved (initial). If there are any remaining potential errors that appear on the report, they are not actual errors.
TAB D	**TAB D - Initial only one of the following options:**	
	_____	Tab D: Potential Data Quality Errors for Entry Details have been resolved (initial). Any remaining potential errors that appear on the report are not actual errors.
	_____	Tab D: We are continuing to work on clean-up of potential entry data errors (initial).
Tab E	**TAB E - Initial only one of the following options:**	
	_____	Tab E: Potential Data Quality Errors for Exit Details have been resolved (initial). Any remaining potential errors that appear on the report are not actual errors.
	_____	Tab E: We are continuing to work on clean-up of potential exit data errors (initial).
Tab F	**TAB F - Initial only one of the following options:**	
	_____	Tab F: Annual Reviews are all valid (initial).
	_____	Tab F: Annual Reviews are all valid. Any potential errors on the report are not actual errors (initial).

222 – Workflow Elements by Client
ART | Public Folder | Data Quality

Please review 'Tab A – Detail' for completeness This DQ Report is only asking for clarification on a few items but the ART report is an extremely helpful high level view of the clients in a project and the workflow elements.	All clients with an EntryExit also have an accurate and up to date:	
	____	ROI Provider/Project (initial)
	____	ROI Organization (initial)
	____	Case Manager (initial)

347A – Services Summary
ART | Public Folder | Case Mgmt

Run for previous 12 months to ensure the project is compliant with services Data Standards required for the project type. See HUD Program Manuals for details. Please review and correct any discrepancies.	_____	Tab A: Summary counts are accurate for past 12 months for project requirements(initial)
	_____	Projects receiving funds for services Tab A1: – all services with funds attached are complete and accurate for the past 12 months

The signatures below ***certifies*** that the HMIS data in ServicePoint has been reviewed for quality, completeness and consistency.

Explanation of errors:

Print Name: _____ Signature: _____

Title: _____

April Reporting Only:
The signature below certifies that the HMIS data on 252 DCRC and 347A SS are complete and accurate.

Print Name: _____ Signature: _____
Title: _____

June Reporting Only:
The signature below certifies that the HMIS data on 252 DCRC, 252 EECR, 260 HUD APR, 222 WEBC, and 347A SS are complete and accurate.

Print Name: _____ Signature: _____

Title: _____

Outreach
MONTHLY DATA QUALITY VERIFICATION FORM

Agency/Parent Provider Name: _____

HMIS Project Name & #: _____
(a separate form is required for each HMIS Program)

Reporting Period (MM/DD/YY – MM/DD/YY): _____ Submission Date: _____

Instructions

1. A **separate** Outreach Data Quality Verification Form is needed for **each outreach project** within HMIS on a MONTHLY basis August through June.
2. Each project must report data quality for the **most recent 12 months** (an entire year). For example, when reporting in August, the year's data in ART should be collected from 8/1/2016 - 8/1/2017 (end date plus 1 day).
3. Begin running and correcting reports the 1st of the month so that there is sufficient time to request assistance from OPEH for Data Quality issues.
4. Submit a single DQ form per email to OPEHPrograms@fairfaxcounty.gov, and **state the project name as the subject of the email**. Please do not include multiple DQ forms on an email.
5. Final submission is due by COB on the 10th of the month. If the 10th is a weekend or holiday, final submissions are due the next business day. Submissions for the entire CoC are tracked and may be published.

0252 – Data Completeness Report Card ART | Public Folder | Data Quality folder		
Please review and make corrections necessary to achieve the highest possible Data Completeness grade.	_____	UDE Only Grade
	_____	Additional Only Grade

0252 – EntryExit Companion Report (EECR) – Organization run report ART | Public Folder | Data Quality folder Note: Please complete this section using the Organization EECR, not the SysAdm EECR.		
Values entered MUST match values on ART Report. Do not submit DQ form until ART is run and data corrections are verified. HINT: Use SCHEDULER; 0252 – *EntryExit Companion Report TWO* might be of some assistance in clean-up effort. Download report to EXCEL and review TAB C and TAB D data elements for accuracy. Make corrections where necessary to ensure client data in ServicePoint is accurate.	_____	Data on Tab C is accurate (initial)
	_____	Data on Tab D is accurate (initial)
	_____	Clients Served Tab B1 (number)
	_____	Exits before 'between report dates' Tab B1 (number)
	_____	Clients ExitDest PermHsng Tab B1 (number)
	_____	Report 10 Tab: After July 2017, clients without a contact (Date of Contact column) for 3 consecutive months have been closed (initial)
	_____	Report 10 & D Tabs: Clients who are no longer unsheltered in FFX County are closed (initial)

0252 – SysAdm Entry Exit Companion Report

The SysAdm EECR is delivered to the ART inbox of the organization's ART Report username.

Tabs A, B1, C, & D. Do not delete current month's SysAdm EECR reports from the Parent Organization ART Inbox. Old reports can be deleted.	_____	Data reported on the 252 SysAdm EECR (delivered to the Parent Organization ART Inbox) have been reviewed.
	_____	I approve of the data reported on the SysAdm EECR for this project.
	Initial only one of the following options:	
	_____	Counts on the 0252 SysAdm EECR match the counts on Organization run EECR. There are no differences upon data clean-up. Creation date of the delivered SysAdm EECR: _____/_____/_____ .
	_____	Differences between SysAdm EECR and Organization EECR have been investigated and current differences on the SysAdm EECR are not actual errors. Data in HMIS is correct; the SysAdm EECR is reporting inaccurately. The Organization run EECR data accurately reflects good data in HMIS. Creation date of the delivered SysAdm EECR: _____/_____/_____

222 – Workflow Elements By Client

ART | Public Folder | Data Quality

	Clients with EntryExit also have an accurate and up to date:	
Please review 'Tab A – Detail' for completeness This DQ Report is only asking for clarification on a few items but the ART report is an extremely helpful high level view of the clients in a project and the workflow elements.	_____	ROI Provider/Project (initial)
	_____	ROI Organization (initial)

The signature below ***certifies*** that the HMIS data in ServicePoint has been reviewed for quality, completeness and consistency.

Explanation of errors:

Print Name: _____ Signature: _____

Title: _____

April Reporting Only:
The signature below certifies that the HMIS data on 0252 DCRC and 347A SS are complete and accurate.

Print Name: _____ Signature: _____

Title: _____

June Reporting Only:
The signature below certifies that the HMIS data on 252 DCRC, 252 EECR, 222 WEBC, and 347A SS are complete and accurate.

Print Name: _____ Signature: _____

Title: _____

Emergency Shelter
MONTHLY DATA QUALITY VERIFICATION FORM

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership
www.fairfaxcounty.gov/homeless

Agency/Parent Provider Name: _____

HMIS Project Name & #: _____
(a separate form is required for each HMIS Program)

Reporting Period (MM/DD/YY – MM/DD/YY): _____ Submission Date: _____

Instructions

1. A **separate** Emergency Shelter Data Quality Verification Form is needed for **each shelter project** within HMIS on a MONTHLY basis August through June.
2. Each project must report data quality for the **past 12 months**. For example, when reporting in August, the year's data in ART should be collected from 8/1/2016 - 8/1/2017 (End Date plus 1 day).
3. Begin running and correcting reports the 1st of the month so that there is sufficient time to request assistance from OPEH for Data Quality issues.
4. Submit a single DQ form per email to OPEHPrograms@fairfaxcounty.gov, and **state the project name as the subject of the email**. Please do not include multiple DQ forms on an email.
5. Final submission is due by COB on the 10th of the month. If the 10th is a weekend or holiday, final submissions are due the next business day. Submissions for the entire CoC are tracked and may be published.

0252 – Data Completeness Report Card ART | Public Folder | Data Quality folder		
Please review and make corrections necessary to achieve the highest possible Data Completeness grade.	_____	UDE Only Grade
	_____	Additional Only Grade

0252 – EntryExit Companion Report (EECR) – Organization run report ART | Public Folder | Data Quality folder		
Values entered MUST match values on ART Report. Do not submit DQ form until ART is run and data corrections are verified. HINT: Use SCHEDULER; 0252 – *EntryExit Companion Report TWO* might be of some assistance in clean-up effort. Download report to EXCEL and review TAB C and TAB D data elements for accuracy. Make corrections where necessary to ensure client data in ServicePoint is accurate.	_____	Data on Tab C is accurate (initial)
	_____	Data on Tab D is accurate (initial)
	_____	Clients Served Tab B1 (number)
	_____	Household Exits Between Report Dates Tab B1 (number)
	_____	Household Exit Dest Perm Tab B1 (number)

0252 – SysAdm Entry Exit Companion Report The SysAdm EECR is delivered to the ART inbox of the organization's ART Report username.

Tabs A, B1, C, & D. Do not delete current month's SysAdm EECR reports from the Parent Organization ART Inbox. Old reports can be deleted.	_____	Data reported on the 252 SysAdm EECR (delivered to the Parent Organization ART Inbox) have been reviewed (initial).
	_____	I approve of the data reported on the SysAdm EECR for this project (initial).
	Initial only one of the following options:	
	_____	Counts on the 0252 SysAdm EECR match the counts on Organization run EECR. There are no differences upon data clean-up. Creation date of the delivered SysAdm EECR: _____/_____/_____ .
	_____	Differences between SysAdm EECR and Organization EECR have been investigated and current differences on the SysAdm EECR are not actual errors. Data in HMIS is correct; the SysAdm EECR is reporting inaccurately. The Organization run EECR data accurately reflects good data in HMIS. Creation date of the delivered SysAdm EECR: _____/_____/_____

0254 – EE and Shelter – History, Overlap, and Return

ART | Public Folder | Data Quality folder

Accept provider default prompt which **includes ALL of the shelter projects in our Continuum**. We must ensure that there are no **SHELTER STAYS** overlapping in our ENTIRE Continuum. A client cannot be in two different shelters on the same night. Review the overlapping stays (indicated by blue background and O in right column) correct shelter stays for your Organizations which are overlapping with other projects.	_____	There are no Shelter Stays overlapping with this project; overlapping Shelter Stays have been resolved. (initial – provide NOTES about any exceptions)
Don't forget to fix the EntryExit record as well.	_____	There are no EntryExits overlapping with this project; overlapping EntryExits have been resolved. (initial – provide NOTES about any exceptions)

222 – Workflow Elements by Client

ART | Public Folder | Data Quality

Please review 'Tab A – Detail' for completeness This DQ Report is only asking for clarification on a few items but the ART report is an extremely helpful high level view of the clients in a project and the workflow elements.	All clients with an ShelterStay also have an accurate and up to date:	
	_____	EntryExit (initial)
	_____	ROI Provider/Project (initial)
	_____	ROI Organization (initial)

The signatures below ***certifies*** that the HMIS data in ServicePoint has been reviewed for quality, completeness and consistency.

Explanation of errors:

Print Name: _____ Signature: _____

Title: _____

April Reporting Only:
The signature below certifies that the HMIS data on 252 DCRC and 0254 HOR are complete and accurate.

Print Name: _____ Signature: _____

Title: _____

June Reporting Only:
The signature below certifies that the HMIS data on 252 DCRC, 252 EECR, 254 HOR, and 222 WEBC are complete and accurate.

Print Name: _____ Signature: _____

Title: _____

HYPOTHERMIA/WINTER SEASONAL DATA QUALITY VERIFICATION

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership
www.fairfaxcounty.gov/homeless

NOTES:

START with the 'HYPOTHERMIA PROGRAM REPORT'

All Night By Night Shelter Stays should be equal to 1. (Friends of Falls Church is a Winter Shelter and follows the EntryExit workflow, not the Night By Night workflow)

Do not attempt to tackle the 'Shelter History, Overlap and Return' report until all of the Shelter STAYS NOT EQUAL to 1 are corrected and the database has refreshed. Otherwise, you will be wasting valuable time.

If you happen to complete the Hypothermia Program Report, Night by Night Shelter Stays cleanup BEFORE the database refresh starts *(no idea – sometime around 11:30 same as it ever was)* – THEN congratulate yourselves! After patting each other on the back, get started on the 'Workflow Elements by Client' report. If you have clients who stayed in your shelter and are missing the required data elements, complete the data entry.

After the database refresh, work on the Shelter History, Overlap and Return report. If the Night By Night Shelter Stays were not cleaned up before the database refresh – this is a waste of time, wait for a database refresh. If you did finish – run the report for **ALL of the Single Shelters** in the Continuum under the OPEH tree.

Instructions

1. This is the Data Quality Verification form for the Winter Seasonal / Hypothermia Program. The above reports can be used by program staff and managers to help analyze and identify program data which has been entered incorrectly or has not followed the program workflow.

To submit the Data Quality Verification

Submit only this completed form to both

Email: Abigail.Dunner@fairfaxcounty.gov
OPEHPrograms@fairfaxcounty.gov

Be sure to type the Project Name on the subject of the email.

HYPOTHERMIA/WINTER SEASONAL DATA QUALITY VERIFICATION

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership
www.fairfaxcounty.gov/homeless

Agency Name _____

HMIS Project/Region _____

(A separate form is required for each HMIS Project)

Reporting StartDate _____ **End Date** _____ **Date Submitted** _____

Hypothermia Program Report **ART | Public Folder | Program Specific Reports | Hypothermia Reports**		
Run report to cover the ENTIRE SEASON (October 1 - current)		
Bed list Data Set Tab **Filter By Region**	_____	All **Night By Night** Shelter Stays are = 1 (initial)
Demo Summary Tab	_____	Client Count for Region
	_____	Bed Nights for Region
	_____	Shelter Stays for Region
Comments:		

0252 – Data Completeness Report Card **ART | Public Folder | Data Quality**	**Run report to cover the ENTIRE SEASON (October 1 - current)**	
Please review and make corrections necessary to achieve the highest possible Data Completeness grade. Run report for the past 12 months	_____	UDE Only Grade
	_____	Additional Only Grade
Comments:		

0252 – EntryExit Companion Report (EECR) **ART | Public Folder | Data Quality**	**Run report to cover the ENTIRE SEASON (October 1 - current)**	
Values entered MUST match values on ART Report. Do not submit DQ form until ART report is run and data corrections are	_____	**Clients Served Tab B1 (number)**
	_____	Data on TAB C is accurate (initial)

verified. **HINT: Use SCHEDULER; *0252 – EntryExit Companion Report TWO'* might be of some assistance in clean-up efforts.**	_____	Data on TAB D is accurate (initial) – **FINAL DQ ONLY**
	_____	Households Exit Dest Perm Tab B1 (number) – **FINAL DQ ONLY**

0252 – SysAdm Entry Exit Companion Report

The SysAdm EECR is delivered to the ART inbox of the organization's ART Report username.

Tabs A, B1, C, & D. Do not delete current month's SysAdm EECR reports from the Parent Organization ART Inbox. Old reports can be deleted.	_____	Data reported on the 252 SysAdm EECR (delivered to the Parent Organization ART Inbox) have been reviewed (initial).
	_____	I approve of the data reported on the SysAdm EECR for this project (initial).
	Initial only one of the following options:	
	_____	Counts on the 0252 SysAdm EECR match the counts on Organization run EECR. There are no differences upon data clean-up. Creation date of the delivered SysAdm EECR: _____/_____/_____ .
	_____	Differences between SysAdm EECR and Organization EECR have been investigated and current differences on the SysAdm EECR are not actual errors. Data in HMIS is correct; the SysAdm EECR is reporting inaccurately. The Organization run EECR data accurately reflects good data in HMIS. Creation date of the delivered SysAdm EECR: _____/_____/_____

0222 – Workflow Elements by Client

ART | Public Folder | Program Specific Reports | Hypothermia Reports

Run report to cover the ENTIRE SEASON (10/1/2016 – today)

This report assists in finding clients who are missing EntryExits or ROIs.	_____	All Clients with a ShelterStay in this Region also have an EntryExit, Project ROI and an OPEH ROI (Initial)
Comments:		

0254 – Shelter – History, Overlap, and Return **ART | Public Folder | Program Specific Reports | Hypothermia Reports**		
Run report to cover the ENTIRE SEASON (October 1 - current) **Include ALL SHELTERS in the Continuum** **Number of Days for Return: 0** **Service Code Description: Emergency Shelter**		
NOTE: Cleanup NbN Shelter Stays from Hypothermia Report and wait for database refresh before running this report. Cleanup Overlapping Stays and in appropriate Overlapping EntryExits. Include all OPEH Single Shelters when running this report.	_____ _____	Number of clients with OVERLAPPING Emergency Shelter Stays (should be zero); Please explain any overlaps in comments section. There are no OVERLAPPING EntryExits for this single project (initial). (Note: To verify this, run this report for ONLY one project and there should not be any OVERLAPPING EntryExits) – **FINAL DQ ONLY**
Comments:		

In the space provided below, please explain any discrepancies.

By our signatures, we ***certify*** that the HMIS data in ServicePoint has been reviewed for quality, completeness and consistency.

Name of Responsible Party	*Signature of Responsible Party*
Name of Executive Director or Designee	*Signature of Executive Director or Designee*

Comments/Explanation of Errors

PH - Permanent Supportive Housing
Transitional Housing & PH Other
QUARTERLY DATA QUALITY VERIFICATION FORM

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership
www.fairfaxcounty.gov/homeless

Agency/Parent Provider Name: _____

HMIS Project Name & #: _____
(a separate form is required for each HMIS Program)

Reporting Period (MM/DD/YY – MM/DD/YY): _____ Submission Date: _____

Instructions

1. A **separate** Data Quality Verification Form is needed for **each PSH or TH project** within HMIS on a QUARTERLY basis. Submissions are required **October, January, April, and June**.
2. Each project must report data quality for **the past 12 months**. For example, when reporting in August, the year's data in ART should be collected from 8/1/2016 - 8/1/2017 (End Date plus 1 day).
3. Begin running and correcting reports the 1st of the month so that there is sufficient time to request assistance from OPEH for Data Quality issues.
4. Submit a single DQ form per email to OPEHPrograms@fairfaxcounty.gov , and **state the project name as the subject of the email**. Please do not include multiple DQ forms on an email.
5. Final submission is due by COB on the 10th of the month. If the 10th is a weekend or holiday, final submissions are due the next business day. Submissions for the entire CoC are tracked and may be published.

0252 – Data Completeness Report Card ART | Public Folder | Data Quality folder		
Please review and make corrections necessary to achieve the highest possible Data Completeness grade.	_____	Overall Grade

0252 – EntryExit Companion Report (EECR) – Organization run report ART | Public Folder | Data Quality folder Note: Please complete this section using the Organization EECR, not the SysAdm EECR.		
Values entered MUST match values on ART Report. Do not submit DQ form until ART is run and data corrections are verified. HINT: Use SCHEDULER; 0252 – *EntryExit Companion Report TWO* might be of some assistance in clean-up effort. Download report to EXCEL and review TAB C and TAB D data elements for accuracy. Make corrections where necessary to ensure client data in ServicePoint is accurate.	_____	Data on Tab C is accurate (initial)
	_____	Data on Tab D is accurate (initial)
	_____	Clients Served Tab B1 (number)
	_____	Households Exit Between Report Dates Tab B1 (number)
	_____	Households Exit Dest Perm Tab B1 (number)

0252 – SysAdm Entry Exit Companion Report The SysAdm EECR is delivered to the ART inbox of the organization's ART Report username.		
Tabs A, B1, C, & D. Do not delete current month's SysAdm EECR reports from the Parent Organization ART Inbox. Old reports can be deleted.	_____	Data reported on the 252 SysAdm EECR (delivered to the Parent Organization ART Inbox) have been reviewed (initial).
	_____	I approve of the data reported on the SysAdm EECR for this project (initial).
	Initial only one of the following options:	
	_____	Counts on the 0252 SysAdm EECR match the counts on Organization run EECR. There are no differences upon data clean-up. Creation date of the delivered SysAdm EECR: _____/_____/_____ .
	_____	Differences between SysAdm EECR and Organization EECR have been investigated and current differences on the SysAdm EECR are not actual errors. Data in HMIS is correct; the SysAdm EECR is reporting inaccurately. The Organization run EECR data accurately reflects good data in HMIS. Creation date of the delivered SysAdm EECR: _____/_____/_____

APR reports are complex and take a LONG time to run; USE THE ART SCHEDULER to improve the workflow of your reporting process. A Scheduler webinar link is listed in System News in the HMIS WEBINAR BLOG.

Cleanup of Duplicate sub-assessment records identified in 260 - Tab D and Tab E under Potential Data Quality errors will take a while to cleanup. As new clients come in, the sub-assessment data should be cleaned up, no overlapping or duplicate sub-assessment records. The HUD data standards webinar should assist. The link is available in System News in the HMIS WEBINAR BLOG.

0260 - HUD CoC APR Data Quality Completeness (HUD APR) ART | Public Folder | HUD | APR		
Tab C	_____	Tab C: Errors have been resolved (initial). If there are any remaining potential errors that appear on the report, they are not actual errors.
TAB D	**TAB D - Initial only one of the following options:**	
	_____	Tab D: Potential Data Quality Errors for Entry Details have been resolved (initial). Any remaining potential errors that appear on the report are not actual errors.
	_____	Tab D: We are continuing to work on clean-up of potential entry data errors (initial).
Tab E	**TAB E - Initial only one of the following options:**	
	_____	Tab E: Potential Data Quality Errors for Exit Details have been resolved (initial). Any remaining potential errors that appear on the report are not actual errors.
	_____	Tab E: We are continuing to work on clean-up of potential exit data errors (initial).
Tab F	**TAB F - Initial only one of the following options:**	
	_____	Tab F: Annual Reviews are all valid (initial).
	_____	Tab F: Annual Reviews are all valid. Any potential errors on the report are not actual errors (initial).

222 – Workflow Elements By Client ART | Public Folder | Data Quality		
Please review 'Tab A – Detail' for completeness This DQ Report is only asking for clarification on a few items but the ART report is an extremely helpful high level view of the clients in a project and the workflow elements.	All clients with an EntryExit also have an accurate and up to date:	
	____	ROI Provider/Project (initial)
	____	ROI Organization (initial)
	____	Case Manager (initial)

347A – Services Summary ART | Public Folder | Case Mgmt		
Run this report to ensure the project is compliant with services Data Standards required for the project type. See HUD Program Manuals for details. Please review and correct any discrepancies.	____	Tab A: Summary counts are accurate for reporting period (initial)
	____	Tab A: Summary counts are accurate for project requirements (initial)

The signatures below ***certifies*** that the HMIS data in ServicePoint has been reviewed for quality, completeness and consistency.

Explanation of errors:

Print Name: _____ Signature: _____

Title: _____

April Reporting Only:
The signature below certifies that the HMIS data on 252 DCRC and 347A SS are complete and accurate.

Print Name: _____ Signature: _____

Title: _____

June Reporting Only:
The signature below certifies that the HMIS data on 252 DCRC, 252 EECR, 260 HUD APR, 222 WEBC, and 347A SS are complete and accurate.

Print Name: _____ Signature: _____

Title: _____

Second Story Projects
DATA QUALITY VERIFICATION FORM
Emergency Shelter & Service only(monthly)
transitional housing (quarterly)

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership
www.fairfaxcounty.gov/homeless

Agency/Parent Provider Name: _____

HMIS Project Name & #: _____
(a separate form is required for each HMIS Program)

Reporting Period (MM/DD/YY – MM/DD/YY): _____ Submission Date: _____

Instructions

1. This form is intended for use August through June and applicable for Second Story's Emergency Shelter, Service Only, and Transitional Housing projects.
2. A **separate** Data Quality Verification Form is needed for **each project** within HMIS.
3. Each project must report data quality for the **past 12 months**. For example, when reporting in August, the year's data in ART should be collected from 8/1/2016 - 8/1/2017 (End Date plus 1 day).
4. Quarterly Reporting Projects:
    a. Reports are due **October, January, April, and June**.
    b. **If data completeness grade (261 & 262) falls below an A, monthly reports are required until the next reporting date.**
5. Begin running and correcting reports the 1st of the month so that there is sufficient time to request assistance from OPEH for Data Quality issues.
6. Submit a single DQ form per email to OPEHPrograms@fairfaxcounty.gov, and **state the project name as the subject of the email**. Please do not include multiple DQ forms on an email.
7. Final submission is due by COB on the 10th of the month. If the 10th is a weekend or holiday, final submissions are due the next business day. Submissions for the entire CoC are tracked and may be published.

This DQ Verification form is for use with Second Story's Emergency Shelter, Service Only, and Transitional Housing projects. It is not to be used for Second Story's Bridging Affordability, Prevention, or Rapid Rehousing Projects.

0263 – RHY Data Completeness – Quality Report

ART | Public Folder | Data Quality folder

Please review and make corrections necessary to achieve the highest possible Data Completeness grade.	_____	Overall Grade

0252 – EntryExit Companion Report (EECR) – Organization run report

ART | Public Folder | Data Quality folder

Note: Please complete this section using the Organization EECR, not the SysAdm EECR.

Values entered MUST match values on ART Report. Do not submit DQ form until ART is run and data corrections are verified. HINT: Use SCHEDULER; 0252 – *EntryExit Companion Report TWO* might be of some assistance in clean-up effort. Download report to EXCEL and review TAB C and TAB D data elements for accuracy. Make corrections where necessary to ensure client data in ServicePoint is accurate.	_____	Data on Tab C is accurate (initial)
	_____	Data on Tab D is accurate (initial)
	_____	Clients Served Tab B1 (number)
	_____	Households Exit Between Report Dates Tab B1 (number)
	_____	Households Exit Dest Perm Tab B1 (number)

0252 – SysAdm Entry Exit Companion Report

The SysAdm EECR is delivered to the ART inbox of the organization's ART Report username.

Tabs A, B1, C, & D. Do not delete current month's SysAdm EECR reports from the Parent Organization ART Inbox. Old reports can be deleted.	_____	Data reported on the 252 SysAdm EECR (delivered to the Parent Organization ART Inbox) have been reviewed (initial).
	_____	I approve of the data reported on the SysAdm EECR for this project (initial).
	Initial only one of the following options:	
	_____	Counts on the 0252 SysAdm EECR match the counts on Organization run EECR. There are no differences upon data clean-up. Creation date of the delivered SysAdm EECR: _____/_____/_____ .
	_____	Differences between SysAdm EECR and Organization EECR have been investigated and current differences on the SysAdm EECR are not actual errors. Data in HMIS is correct; the SysAdm EECR is reporting inaccurately. The Organization run EECR data accurately reflects good data in HMIS. Creation date of the delivered SysAdm EECR: _____/_____/_____

222 – Workflow Elements By Client ART | Public Folder | Data Quality		
Run the report for the past month Run the report for the past 12 months Please review 'Tab A – Detail' for completeness This DQ Report is only asking for clarification on a few items but the ART report is an extremely helpful high level view of the clients in a project and the workflow elements.	All clients with an EntryExit also have an accurate and up to date:	
	_____	ROI Provider/Project (initial)
	_____	ROI Organization (initial)
	_____	Case Manager (initial)

347A – Services Summary ART | Public Folder | Case Mgmt		
This report is to assist projects in checking services to ensure funding requirements have been met. The report can be run for one month at a time and for a full year.	_____	Tab A: Summary counts are accurate for project funding requirements (initial)

APR reports are complex and take a LONG time to run; USE THE ART SCHEDULER to improve the workflow of your reporting process. A Scheduler webinar link is listed in System News in the HMIS.

Cleanup of Duplicate sub-assessment records identified in 260 - Tab D and Tab E under Potential Data Quality errors will take a while to cleanup. As new clients come in, the sub-assessment data should be cleaned up, no overlapping or duplicate sub-assessment. The HUD data standards webinar should assist. The link is available in System News in the HMIS WEBINAR BLOG.

0260 - HUD CoC APR Data Quality Completeness (HUD APR) Note: Not required of ES or Service Only projects ART | Public Folder | HUD | APR		
Tab C	_____	Tab C: Errors have been resolved (initial). If there are any remaining potential errors that appear on the report, they are not actual errors.
TAB D	**TAB D - Initial only one of the following options:**	
	_____	Tab D: Potential Data Quality Errors for Entry Details have been resolved (initial). Any remaining potential errors that appear on the report are not actual errors.
	_____	Tab D: We are continuing to work on clean-up of potential entry data errors (initial).
Tab E	**TAB E - Initial only one of the following options:**	
	_____	Tab E: Potential Data Quality Errors for Exit Details have been resolved (initial). Any remaining potential errors that appear on the report are not actual errors.
	_____	Tab E: We are continuing to work on clean-up of potential exit data errors (initial).
Tab F	**TAB F - Initial only one of the following options:**	
	_____	Tab F: Annual Reviews are all valid (initial).
	_____	Tab F: Annual Reviews are all valid. Any potential errors on the report are not actual errors (initial).

The signatures below ***certifies*** that the HMIS data in ServicePoint has been reviewed for quality, completeness and consistency.

Explanation of errors:

Print Name: _____ Signature: _____

Title: _____

April Reporting Only:
The signature below certifies that the HMIS data on 0263 RHYDC and 347A are complete and accurate.

Print Name: _____ Signature: _____

Title: _____

June Reporting Only:
The signature below certifies that the HMIS data on 263 RHYDC, 252 EECR, 222 WEBC, 347A SS, and 260 HUD APR are complete and accurate.

Print Name: _____ Signature: _____

Title: _____

Coordinated Entry
MONTHLY DATA QUALITY VERIFICATION FORM

Agency Name: _____ Submission Date: _____
(Not a specific HMIS project name)

Instructions

1. Run the Coordinated Entry Data Quality report for both Singles and Family projects for your Organization at the same time. This report includes both open and closed EntryExit data.
2. Begin running and correcting reports the 1st of the month so that there is sufficient time to request assistance from OPEH for Data Quality issues.
3. Submit a single DQ form per email to OPEHPrograms@fairfaxcounty.gov, and **state Coordinated Entry and the Organization name as the subject of the email**. Please do not include multiple DQ forms on an email.
4. Final submission is due by COB on the 10th of the month. If the 10th is a weekend or holiday, final submissions are due the next business day. Submissions for the entire CoC are tracked and may be published.

Coordinated Entry Data Quality report ART | Data Quality		
Run report for both Family and Single programs		
Summary TAB	_____	Count of HoH records - Singles
	_____	Count of HoH records - Families
Simple Report TAB	_____ Or _____	**Initial only one of the following**: There are no blanks on the Simple Report TAB. All Blanks on the Simple Report TAB have been reviewed and actively working to obtain Supervisor review and approval.
EntryExit TAB	_____	(Column P) EntryExit Provider Creating: All Entry Records are created in the correct EDA mode, Provider #374 (initial).
	_____	(Column R) EntryExit Provider Update: All Entry Records are created in the correct EDA mode, Provider #374 (initial).
Additional Client Data Tabs	_____	Client Data Tabs (EE Asst, CM, VI-SPDAT, Triage, CPP Referral, Home Cert, Housing History, Contacts, Attachments, ROIs, Disabilities, & Income) have all been reviewed for accuracy (initial).
	_____	All Clients without Contacts in the past 3 months have been Exited (initial).

The signature below ***certifies*** that the HMIS data in ServicePoint has been reviewed for **quality**, **completeness** and **consistency**.

Responsible Party Signature: _____

Responsible Party Name: _____

Executive Director (or Designee) Signature: _____

Executive Director Name (or Designee): _____

APPENDIX I

HMIS Guidance for Programs Service Victims of Domestic Violence, Dating Violence, Sexual Assault Stalking or Human Trafficking

APPENDIX I

HMIS Guidance for Programs Serving Victims/Survivors of Domestic Violence, Dating Violence, Sexual Assault, Stalking, or Human Trafficking

APPENDIX I is a letter from Dean Klein, Director of The Office to Prevent and End Homelessness, to the CoC partners that work with clients that have a history of domestic violence, dating violence, sexual assault, or stalking regarding data entry guidelines in the HMIS database.

Homeless Management Information System Standard Operating Procedure

Procedure Number:
Procedure Title: HMIS Guidance for Programs Serving Victims of Domestic Violence, Dating Violence, Sexual Assault, Stalking or Human Trafficking
Date Adopted: 09/12/2009
Date Revised: 12/xx/2017

PURPOSE:

To provide guidance regarding the use of the Homeless Management Information System (HMIS) operated through the Fairfax County Office to Prevent and End Homelessness when serving victims of domestic violence, dating violence, sexual assault, stalking or human trafficking.

RESPONSIBILITY:

It is the responsibility of all Continuum of Care providers to be familiar with and adhere to this procedure. Each nonprofit organization has the final responsibility to ensure this procedure is followed.

PROCEDURE:

1. Pursuant to Federal and State law, programs *whose primary mission* is to provide services to victims of domestic violence, dating violence, sexual assault, stalking or human trafficking are not permitted to enter client-level data directly in HMIS. (See Violence Against Women and Department of Justice Reauthorization Act of 2005, Pub. L. 109-162; and Virginia Code § 63.2-104.1).

2. Domestic and sexual violence programs (DV/SV) that receive sub grants through the American Recovery and Reinvestment Act of 2009 (ARRA) Homelessness Prevention and Rapid Re-Housing Program (HPRP) are not permitted to enter data directly in HMIS, but are required to use a comparable database to generate and submit unduplicated aggregate quarterly reports about individuals and families served with HPRP funds.

3. All other programs that are not primarily dedicated to serving victims of domestic violence, dating violence, sexual assault, stalking or human trafficking but provide services to such victims, are required to enter client-level data in HMIS.

   a) In order to protect the victim/survivor's confidentiality and safety, the **non-**DV/SV provider must have a full discussion with the victim/survivor about HMIS. (See Fairfax Falls Church HMIS Notice).
   b) If a victim/survivor fully consents to sharing their client-level data (i.e., Assessment information - HUD Universal Data Elements, Program Entry/Exit, and Homelessness Prevention and Rapid Re-Housing Program Data Elements) by

Office to Prevent and End Homelessness
12000 Government Center Parkway, Suite 333
Fairfax, VA 22035
Phone: 703-324-9492 **Fax**: 703-324-9491 **TTY:** 711
www.fairfaxcounty.gov/homeless

signing the "Uniform Authorization to Use and Exchange Information" form, then a release of information form will be entered in HMIS and client-level data will be shared with the Fairfax Falls Church Continuum of Care only

c) If the victim/survivor indicates that they do not want their personal identifying information (e.g., name, date of birth, gender and last four digits of their social security number) and other case-related information accessible to other providers that use HMIS, then the **non**-DV/SV provider is not permitted to enter victim/survivor's data.
d) If victim/survivor was previously created and the victim/survivor changes their mind indicating they no longer want their information accessible to other providers, then victim/survivor's Entry/Exit record in HMIS must be immediately closed.

Additional Information:

Violence Against Women and Department of Justice Reauthorization Act of 2005 applicability to HUD programs; March 16, 2007 Notice

https://www.hudexchange.info/resource/1580/violence-against-women-and-doj-reauthorization-act-of-2005/

Confidentiality of records of persons receiving domestic and sexual violence services, Commonwealth of Virginia:

https://law.lis.virginia.gov/vacode/title63.2/chapter1/section63.2-104.1/

Approved _____

Dean Klein, Director
Office to Prevent and End Homelessness

Revised December XX, 2017

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership
www.fairfaxcounty.gov/homeless

Office to Prevent and End Homelessness
12000 Government Center Parkway, Suite 333
Fairfax, VA 22035
Phone: 703-324-9492 **Fax**: 703-324-9491 **TTY:** 711
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APPENDIX J

HMIS Training Registration

APPENDIX J
HMIS Training Registration

The HMIS Training registration form is used to register for the HMIS End User training, the HMIS Shelter Workflow training, and the Advanced Reporting Tool (ART) training. This form, along with the HMIS User Responsibility form must be submitted to OPEHTraining@fairfaxcounty.gov in order to successfully register for a training.

Training forms can be obtained from an HMIS Agency Administrator within an organization and needs to be approved by a supervisor. Training request forms can also be found in the ART environment under Public Folder | OPEH Documents | HMIS Forms.

In order for the training to be most effective, all new users must be employed for at least two weeks before attending HMIS New User Training and trained as case managers for the programs they will support.

Training Registration or Cancellation

Date of Request _____

Name _____

Organization _____

Telephone _____ E-mail _____

I would like to register or cancel my registration for the following trainings:

____ Register ____ Cancel	**End User - Case Management Workflow** (Must be accompanied by a signed HMIS User Responsibility Form for all New Users)	_____ Training Date:
____ Register ____ Cancel	**Shelter Workflow** (Must be accompanied by a signed HMIS User Responsibility Form for all New Users)	Training Date: _____
____ Register ____ Cancel	**Advanced Reporting Tool (ART)**	Training Date: _____

Submit completed form to: OPEHTraining@fairfaxcounty.gov

APPENDIX K

Glossaries of HMIS Definitions and Acronyms

APPENDIX K
Glossaries of HMIS Definitions and Local Nonprofit Homeless Service Organizations

APPENDIX K provides a comprehensive list of CoC HMIS definitions. The latter portion of the appendix lists local nonprofit homeless service organizations and a summary of their services.

Activities of Daily Living (ADLs) – term used in healthcare to refer to people's daily self-care activities (bathing, eating etc.)

Alliance of Information & Referral Systems (AIRS) – professional association for 1,000+ community information and referral (I&R) providers serving primarily the US and Canada; AIRS maintains taxonomy of human services

American Recovery and Reinvestment Act (ARRA)- Recovery Act, was a stimulus package enacted by the 111th U.S. Congress and signed into law by President Barack Obama in February 2009. Federal funding that was in response to the recession and had the key purpose of reviving the economy.

Annual Homeless Assessment Report (AHAR) – Annual report to Congress on the extent and nature of homelessness in each CoC

Annual Progress Report (APR) – Report that tracks/assesses performance outcomes in HUD CoC Program granted projects

Audit Trail - A record showing who has accessed a computer system and what operations he or she has performed during a given period of time; Most database management systems include an audit trail component

Biometrics - Refers to the identification of a person by computerized images of a physical feature (ex: fingerprinting)

Child Protective Services (CPS) – state or local agency intended to identify, assess and serve children and families in effort to protect the children, prevent further maltreatment and preserve families when possible; often deal with neglected or abused children

Chronic homelessness (CH) – long-term or repeated homelessness, coupled with a disability; by HUD standards the individual (or adult in a family) must have a disability and have experienced homelessness for a year or more, or experienced 4 episodes in the past 3 years which total at least 12 months and are currently living in an emergency shelter or a place not meant for human habitation

Client Intake – The process of collecting a client's information upon entry into a program

Collaborative Applicant (CA) - entity that applies for CoC grants from HUD on behalf of the continuum it represents (OPEH in Fairfax)

Community Based Organization (CBO) – non-profits and faith based groups, with experience solving issues that affect their immediate locality in a way that promotes regional change, and ultimately influences larger systems

Community Case Management (CCM) – process of assessing, planning, coordinating care, and connecting individual to services

Community Development Block Grant (CDBG) – HUD program providing annual grants on a formula basis to local governments and states to address community development needs

Community Healthcare Network (CHCN) – partnership of health professionals, physicians, hospitals and local government formed to provide primary healthcare for low income and uninsured residents of Fairfax County, Fairfax City and Falls-Church

Community Services Board (CSB) –local agency serving as the point of entry into publicly-funded service system for mental health, intellectual disability and substance abuse

Comprehensive Services Act (CSA) – allows for the pooling of 8 specific funding streams to support services for high-risk youth in Virginia

Consumer –individuals or families currently accessing prevention or homeless assistance services

Continuing Education Unit (CEU) – measure used in programs to provide evidence of completion of mandated continuing education requirements

Continuum of Care (CoC) – A HUD term referring to each local homeless services system

Coordinated Services Planning (CSP) – central intake hub for accessing human services in Fairfax County; also serve as the central intake for homeless families and some individuals into the local homeless services system

Coverage - number of beds in HMIS over total number of beds available; used by CoC's/service providers to refer to the number of beds represented in their HMIS

Covered Homeless Organization (CHO) – Any organization that records, uses, or processes data on homeless clients for an HMIS; requirements of the HMIS Final Notice apply to all CHO's

Data Quality (DQ) - The accuracy and completeness of all information collected and reported to the HMIS.

Data Standards – The basic data that is required to be entered into HMIS

De-identification - The process of removing or altering identification data in a client record; allows non-clinical applications to use real data without violating client privacy

Department of Corrections (DOC) – state departments under the DOJ responsible for the custody of inmates in state institutions and prisons and the supervision of offenders sentenced to probation or parole

Department of Family Services (DFS) – local government agency tasked with bettering the well-being of children and families living in challenging situations

Department of Housing and Community Development (DHCD) – local government agency responsible for regional policy and programs that address housing needs that improve/develop communities, and enforce fair housing laws

Digital Certificates - attachments to an electronic message used for security purposes; commonly used to verify the sender's ID and provide the receiver with the means to encode a reply

Disabling Condition - Condition limiting an individual`s ability to work or perform ADL's; in reference to HUD's definition of chronic homelessness, disabling conditions include: diagnosable substance use disorder, serious mental illness, developmental disability or chronic physical illness/disability

Domestic Violence (DV) – Abuse of one household member by another; there are many dimensions to DV including mode, frequency and severity, so instances can be obvious and overtly criminal (physical/sexual violence, etc.) or not (financial/emotional abuse, etc.)

Domestic Violence/Sexual Violence (DV/SV)- Computerized data collection tool designed to capture client-level information over time for victim/survivors experiencing domestic violence, dating violence, sexual assault, stalking and human trafficking.

Earned Income Tax Credit (EITC) – refundable tax credit for low/moderate income working people, particularly families; the amount of EITC benefit depend on household income and the number of children

Electronic Special Needs Assistance Program (E-SNAPs) – electronic grants management system operated by HUD's Office of SNAPS; supports the annual CoC Program Application

Emergency Shelter (ES) – Any facility whose primary purpose is to provide immediate, temporary shelter and services to people experiencing homelessness

Emergency Solutions Grants (ESG) –federal grant that awards funds to cities and counties to provide services to people at risk of or experiencing homelessness so they may obtain stable housing

Encryption – scrambles plain text into unreadable data using code to mask the data's meaning unauthorized viewers

Ethnicity - identity with a particular racial, national, linguistic, or cultural group; in HUD's reporting ethnicity is a question of Latino/Hispanic or non-Latino/Hispanic

Extensible Markup Language (XML) – markup language that defines a set of rules for encoding document in a format that is readable by people and computers; it is used to share data across different information systems via the Internet, and can encode documents and serialize data

Fair Market Rent (FMR) – A HUD term that applies to the amount of rent that may be paid with a subsidy in each jurisdiction based on average rents throughout the community

Family and Youth Services Bureau (FYSB) – provides national leadership, funding and support to organizations that work to end youth homelessness, adolescent pregnancy and domestic violence

Federally Qualified Community Health Center (**FQCHC) –** reimbursement designation for CBO's that provide healthcare services to people regardless of financial/health insurance status; mission is to enhance primary care services in underserved communities

Final Notice – Final regulations statement from HUD on specific areas

Geographic Information Systems (GIS) – captures, stores, analyzes, manages, shares and displays geographically referenced information

Hashing – hash values are numbers/series of numbers generated from input data by a formula so that it is unlikely to be converted back or that another record will produce the same hash values; used to securely check whether two records are identical (ex:
comparing client records in HMIS without identifying the clients)

Health Insurance Portability and Accountability Act of 1996 (HIPAA) – U.S. law designed to provide privacy standards to protect patients' medical records and other health information provided to health plans, doctors, hospitals, and other health care providers. Developed by the Department of Health and Human Services, these standards provide patients access to their medical records and give them more control over how their personal health information is used and disclosed.

Health Resources and Services Administration (HRSA) – department of HHS tasked with improving healthcare services for the uninsured, isolated or medically vulnerable

Homeless Emergency Assistance and Rapid Transition to Housing Act (HEARTH Act) - The HEARTH Act amends and reauthorizes the McKinney-Vento Homeless Assistance Act with substantial changes, including a consolidation of HUD's competitive grant programs, now called the HUD CoC Program. Congress passed this act in 2009 and it was implemented in 2012.

HMIS Data and Technical Standards Final Notice - regulations issued by HUD via the Federal Register describing HMIS implementation requirements; notes who needs to participate in HMIS, what data to collect, and how to protect client info

HMIS Lead Organization – organization designated to operate the CoC's HMIS; provides training and technical assistance and support to participating agencies; OPEH is the lead organization for the Fairfax CoC

Housing First (HF) – strategy that attempts to move people experiencing homelessness into permanent housing as soon

as possible, then provides supportive services to ensure housing stability

Home Investment Partnerships Program (HOME) – formula grant to states and localities to fund affordable housing activities including building, buying, renting and rehabbing properties as well as rental assistance for low-income people

Homeless Management Information System (HMIS) –computerized data collection tool designed to capture client-level information over time on the characteristics and service needs of people experiencing homelessness

Housing Inventory Count (HIC) – community's stock of beds/units available for homeless individuals/families in the local emergency shelters and housing programs; counted and then reported to HUD in conjunction with the PIT count

Housing Opportunities for Persons with AIDS (HOPWA) – provides grants to local communities, States and nonprofits for projects that benefit low-income persons medically diagnosed with HIV/AIDS

Intake Coordinator (IC) – person(s) tasked with assisting clients gain access to services; often ask basic questions about the client before referring them to a service provider based on need

Inferred Consent – assumed consent for data entry into HMIS after providing client an oral explanation of HMIS; must be a person of legal age and in possession of all his/her faculties

Information and Referral (I&R) – process for obtaining information about the program and service options available to homeless persons and linking them to these resources; HMIS includes features to facilitate information and referral

Informed Consent - A client is informed of options of participating in an HMIS system and then specifically asked to consent. The individual needs to be of age and in possession of all of his faculties (for example, not mentally ill), and his/her judgment not impaired at the time of consenting (by sleep, illness, intoxication, alcohol, drugs or other health problems, etc.)

Length of Stay (LOS) – the duration of time a client remains in a particular program; this measurement is often used in emergency shelter programs to quantify how quickly they can solve clients' housing crises

McKinney-Vento Act – Congressional Act that authorized HUD's homeless assistance programs

Metropolitan Washington Council of Governments (COG aka MWCOG) – nonprofit that brings DC Metro leaders together to address regional issues in DC, MD and VA; OPEH represents Fairfax County on the COG Homeless Services Committee; PIT numbers from CoCs in the DC Metro area are reported to COG to create a regional snapshot of homelessness

Local Education Agency (LEA) – synonymous with a school district, it is an entity which operates local public primary and secondary schools within a specific region

Local Education Agency (LEA) Homeless Liaison – LEA employee responsible for implementation of McKinney-Vento Act regarding children experiencing homelessness in public schools

National Alliance to End Homelessness (NAEH) – national organization addressing homelessness; produce data for advocacy and policy reform as we well provide technical assistance and best practice research to CoCs

Not in My Back Yard (NIMBY) – characterization of residents' opposition to new development because it is close to them; sentiment is often directed towards homeless service organizations because of the population they serve

Notice of Funding Availability (NOFA) – HUD's annual announcement of funding available for programs or activities; the NOFA outlines funding limits and regulations for the CoC Program Competition

Neighborhood Stabilization Program – federal grants that provides emergency assistance to state and local governments in

acquiring and redeveloping vacant/foreclosed properties that would otherwise be sources of abandonment and blight

Office to Prevent and End Homelessness (OPEH) – department within Fairfax County Human Services that serves as the lead agency for the Fairfax County CoC in Fairfax, VA and leads efforts to prevent and end homelessness locally

Projects for Assistance in Transition from Homelessness (PATH) – administered by SAMHSA, provides formula grants to providers that serve homeless or at risk persons with a mental illness or substance abuse issues – operated by the local CSB providing street outreach

Penetration Testing – process of probing a computer system to identify security vulnerabilities and the extent to which they may be exploited

Performance Measures – values used to evaluate programs' impact on the clients they serve

Permanent Housing (PH) – long-term housing options for homeless persons, often including time-limited support services; seen as the solution to homelessness

Permanent Supportive Housing (PSH) – long-term community-based housing with supportive services for homeless persons with disabilities so they may live independently as possible in a permanent setting

Personal Protected Information (PPI) – information that can be used to identify, contact or locate someone, or enable disclosure of their personal information

Public Housing Authority (PHA) – Term for local agency that implement HUD affordable housing projects and priorities at the local level such as housing choice vouchers and public housing

Point in Time County (PIT) – A snapshot of the local homeless population recorded by each CoC in the last week of January and reported to HUD annually; includes all individuals/families that are literally homeless on the night of the PIT

Privacy Notice - public statement of an agency's privacy practices informing clients of how personal information is used and disclosed; all CHO's must have a privacy notice

Public Keys - contain information that a sender can use to encrypt information such that only a particular key can read; recipient also can verify the identity of the sender through the sender`s public key

Public Key Infrastructure (PKI) – An arrangement that binds public keys with respective user identities by means of a certificate authority (CA). The user identity must be unique for each CA. The binding is established through the registration and issuance process, which, depending on the level of assurance the binding has, may be carried out by software at a CA or under human supervision. The PKI role that assures this binding is called the Registration Authority (RA). For each user, the user identity, the public key, their binding, validity conditions, and other attributes are made unforgeable in public key certificates issued by the CA.

Race – American Indian or Alaska Native; Asian, Black or African American; Native Hawaiian or Pacific Islander; White, or multi-racial

Redevelopment and Housing Authority (RHA) –in Fairfax this is a subdivision of DHCD – the Public Housing Authority - which administers low-income housing programs

Request for Proposal (RFP) – solicitation by an agency or company, often through a bidding process, interested in procurement of a commodity, service or valuable asset to potential suppliers to submit proposals; homeless services in Fairfax County are secured by local government through an RFP process

Results-Accountability (RBA) – management tool that facilitates collaboration amongst human series agencies as a

method of decentralizing services and an innovative regulator process; implies clearly articulated goals and regular data analysis to understand if these goals are being met

Rapid Re-housing (RRH) – homeless service delivery approach that helps people access housing as quickly as possible; one housing is secured, supportive services are wrapped around clients so housing stability can be maintained

Runaway and Homeless Youth Management Information System (RHYMIS) – An automated information tool designed to capture data on the runaway and homeless youth seeking services from FYSB's Basic Center Program and Transitional Living Program for Older Homeless Youth (TLP) and contacts made by the Street Outreach Program grantees and the brief service contacts made with youth or families calling the FYSB programs.

SAGE – online system for submitting HUD CoC Program Annual Progress Reports

Social Security Disability Income (SSDI) – federal insurance program for individuals who are unable to work due to a disability (physical or mental); the disability should be over a year in duration and applicants must be under 65 years old and working prior to their disability

Social Security Number (SSN) – A 9-digit number issued by the Social Security Administration to individuals who are citizens, permanent residents, and temporary (working) residents

SSI/SSDI Outreach, Access and Recovery (**SOAR)** – program that certifies professionals to expedite client applications for SSI/SSDI

Substance Abuse (SA) – patterned use of a drug in which the amounts or methods of consumption are harmful to the user or those around them

Substance Abuse and Mental Health Services Administration (SAMHSA) – branch of HHS that attempts to improve quality and availability of prevention, treatment and rehab services in order to reduce death, illness, disability and economic costs resulting from substance abuse and mental illness

Supplemental Nutrition Assistance Program (SNAP) – the largest program in the domestic hunger safety net, it provides nutrition assistance to low-income individuals and families; formerly known as food stamps

Supplemental Nutrition Assistance Program Employment and Training (SNAP E&T) – provides SNAP participants with access to affordable employment and training programs through formula grants and reimbursement of state, local and non-profit providers

Supplemental Security Income (SSI) – federal insurance program for individuals who are unable to work due to a disability (physical or mental); the disability should be over a year in duration and have little or no work history.

Supportive Services - services that may assist homeless persons transition into, and maintain permanent housing

System Performance Measures – values used to evaluate the outcomes of an entire homeless service system as well as the programs that make up the system; HUD has developed specific measures which are used to evaluate each CoC

Technical Assistance (TA) – provision of advice, assistance, and training pertaining to installation, operation and maintenance of business functions; HUD provides TA to CoC's for a variety of tasks including coordinated access and HMIS

Technical Submission – The form completed in the second phase of the SHP fund application process where an applicant that is successful in the competition (called a "conditionally selected grantee" or "selectee") then provides more detailed technical information about the project that is not contained in the original application. This is completed through e-snaps.

Temporary Assistance for Needy Families (TANF) – provides cash assistance to families with dependent children through HHS without any or sufficient income

Transitional Age Youth – youth between the ages of 18-24, either by themselves or with their children

Transition in Place (TIP) – housing model that allows participants to remain in their housing unit after completion of transitional housing program

Transitional Housing (TH) – project intended to facilitate the movement of homeless individuals and families to permanent housing, usually providing up to 2 years of rental subsidies and mandatory service participation

Unaccompanied Youth – Minors not in the physical custody of a parent or guardian, including those living in inadequate housing such as shelters, cars, or on the streets. Also includes those who have been denied housing by their families and under-age mothers who have no housing of their own.

Unduplicated Count – count of homeless persons that has been reviewed to ensure individuals are counted once regardless of the number of entries/exits from the homeless system or the number of programs in which they are served

Universal Data Element (UDE) – data required to be collected from all clients serviced by homeless assistance programs using an HMIS including DOB, gender, race, ethnicity, veteran status, and SSN etc.

U.S. Department of Education (ED) – Department of the federal government responsible for establishing policy for, administering and coordinating federal assistance to education as well as collecting data on U.S. schools and enforcing federal educational laws regarding privacy and civil rights

U.S. Department of Health and Human Services (HHS) - Department of the federal government responsible for protecting the health of all Americans and providing essential human services

U.S. Department of Housing and Urban Development (HUD) - Department of the federal government responsible for national policy and programs that address housing needs that improve/develop communities, and enforce fair housing laws; mission is to create a suitable living environment for all Americans

U.S. Department of Justice (DOJ) – Department of the federal government responsible for law enforcement and administration of justice

U.S. Department of Labor (DOL) – Department of the federal government responsible for occupational safety, wage & hourly, unemployment benefits, reemployment services and some economic statistics

Utilization Rate - measurement of the amount of beds/units in a program that are occupied within a specific time frame

Veteran's Affairs Medical Center (**VAMC)** – hospitals and clinics located nationwide that provide healthcare services to individuals and families that are eligible for VA benefits; our local VAMC is in Washington DC

Veterans Affairs Supportive Housing (VASH) – Permanent supportive housing for VA eligible veterans

Veterans Affairs (VA) – the US military veteran benefit system is responsible for administering programs of veterans' benefits for veterans, their families, and survivors including disability compensation, pension, education, home loans, life insurance, vocational rehabilitation, survivors' benefits, medical benefits, and burial benefits

Violence Against Women Act (VAWA) – Act of Congress which regulates a wide range of programs and policies surrounding domestic violence; pertains to homeless system programs with DV as target population

Virginia Employment Commission (VEC) – state agency dedicated to promoting economic growth and stability in Virginia by delivering and coordinated workforce services like job placement, income support, training services, etc.

Virginia Homeless Solutions Program (VHSP) - a state- and federally-funded program funded by the State General Fund and the federal Emergency Solutions Grant (ESG) to support Continuum of Care (CoC) strategies and homeless service and prevention programs throughout Virginia

Virginia Housing Development Agency (VHDA) - state agency responsible for commonwealth policy and programs that address housing needs that improve/develop communities, and enforce fair housing laws in Virginia

Virginia Housing Trust Fund (HTF) – pool of funds intended to create and preserve affordable housing and reduce homelessness in the commonwealth of Virginia

Workforce Innovation & Opportunity Act (WIOA) – provides federally funded employment services, workforce development and basic education to improve workforce quality, reduce welfare dependency, and enhance competiveness and productivity across the US

Written Consent – document completed and signed by a client that assumes understanding of the options and risks of sharing data in an HMIS system; signed document kept on file by agency

Local Nonprofit Homeless Service Organizations

Beth El House – The mission of Beth El House (BEH) is to help homeless families, with emphasis on victims of domestic violence. The focus of Beth El House services is on transition to independent living through its program of subsidized housing and individualized services. Our organization is operated by a 100% volunteer board and we continue to find value in strengthen our volunteer base.

Bethany House – Bethany House of Northern Virginia, Inc. (BHNV) is a nonprofit organization whose mission is to help women and their children who have suffered from domestic violence regain health and dignity and become reestablished in their community. BHNV provides temporary housing and support for survivors to regain control of their lives. Domestic violence survivors receive safe housing, comprehensive services and specialized counseling to recover from the physical and emotional trauma of abuse.

Britepaths – formerly Our Daily Bread - A volunteer-based organization focused on identifying and addressing the unmet fundamental needs of residents and empowering the community to help neighbors maintain self-sufficiency

Christian Relief Services (CRS) – Christian Relief Services, along with its affiliate Christian Relief Services of Virginia, own and operate scattered site housing units throughout Fairfax County working in partnership with public agencies and other non-profits to provide transitional, permanent supportive and affordable housing for families and adults who may be homeless, disabled and/or low-income depending on program eligibility criteria. In addition, owns and operates Safe Places Transitional Housing offering safe, trauma-informed support services to victims of domestic violence and their children for up to 24 months. Volunteer opportunities are available.

Community Residences - Serves people with mental health diagnoses or intellectual disabilities providing supportive housing

Cornerstones – Founded in 1970, Cornerstones exists so that individuals and families who are homeless or living in poverty can access vital resources that solve their needs for emergency shelter, affordable housing, childcare, employment, food and other

human services. Cornerstones promotes self-sufficiency by providing support and advocacy for those in need in northwestern Fairfax County and the Dulles corridor, and works in partnership with all sectors to build strong and connected communities where individuals have opportunities to contribute and thrive.

FACETS - FACETS began as a meal distribution outreach effort in 1988. FACETS opens doors by helping parents, their children, and individuals who suffer the effects of poverty in Fairfax County. We meet their emergency shelter, food, and medical needs, help them gain safe sustainable and permanent housing, and work with them to end the cycle of homelessness and poverty through educational, life skills, and career counseling programs.

Family Preservation and Strengthening Services (Family PASS) – Family PASS focuses on case management and homelessness prevention for families in Fairfax County. Our goal is to strengthen families experiencing and at risk of homelessness by providing emergency assistance and wrap-around case management and by connecting them to resources and services needed to become self-sufficient, such as education, employment services, child care, food, transportation, and health care.

Good Shepherd Housing & Family Services (GSHFS) - Good Shepherd Housing provides affordable housing in southeast Fairfax County. Clients who are in our housing receive budget counseling and referrals to other resources to promote self-sufficiency.

Homestretch - Homestretch provides housing and services for homeless families with children. Individualized case plans focus on addressing all the barriers in the family's path to stability and self-sufficiency, and providing a depth of services to equip the families to increase their income, reduce their debt, acquire certifications and degrees, build savings, restore health, resolve legal problems and secure permanent housing. Services include case management, credit counseling, employment services, scholarships for training and school, therapy, on-site medical clinic, life skills and parenting classes, ESOL classes, after-school programs for teens, an onsite nursery and licensed pre-K program for children ages 3-5.

Lamb Center – The Lamb Center was started in 1992 as a homeless drop-in shelter serving the poor and poor in spirit. Over the years we have added meals, showers, laundry service, a clothing closet, medical & mental health care, case management, and a dental clinic.

New Hope Housing (NHH) - Founded in 1977, the mission of New Hope Housing is to end homelessness in Northern Virginia by providing shelter, housing, and the tools to build a better life for homeless men, women, and families. Today, New Hope Housing operates 6 shelters, 3 short-term and 9 permanent supportive housing programs, as well as outreach, prevention, and employment programs in Fairfax County, Arlington County, Alexandria, and Falls Church. Volunteers are welcome to prepare and serve meals, tutor or mentor residents, and help prepare shelter guests for employment.

Northern Virginia Family Service (NVFS) – Northern Virginia Family Service (NVFS), established in 1924, actively assists residents in Fairfax County and beyond in accessing safe, affordable housing. We leverage community partners and volunteers to provide wraparound services that empower families and individuals to improve their quality of life.

Opportunities Alternatives and Resources (OAR) - Aims to rebuild lives and break the cycle of crime with opportunities, alternatives, and resources for offenders and their families to create a safer community

Pathway Homes - Since 1980, Pathway Homes has provided a variety of non-time-limited housing and supportive services to adults with serious mental illnesses and co-occurring substance use disorders. We do so by partnering with individuals on their personal journey toward self-fulfillment and realization of their dreams while maintaining permanent stable housing in the community. Pathways complements the work of its dedicated staff with support from individual volunteers, and volunteer groups.

Psychiatric Rehabilitation Services (PRS) – Founded in 1963, PRS has transformed the lives of thousands of people in Northern Virginia and Washington, D.C. through its mental health, crisis intervention and suicide prevention services. PRS provides a variety of mental health services to ensure our clients achieve safety, personal wellness, recovery, community integration and remain independent in our community. PRS volunteers serve in our programs through direct client support, board leadership, administrative support and committee participation.

Second Story, formerly Alternative House – Founded in 1972 as a shelter for runaway youth, Second Story helps children, youth and families by stepping in at critical moments and providing safe havens and opportunities to grow and thrive. Second Story

offers crisis intervention, short term shelter and long-term housing assistance to young people ages 13 to 24 as well as safe housing and services to pregnant and parenting young women and their children.

Shelter House (SH)- Shelter House prevents and ends homelessness and domestic violence by engaging the community, building effective relationships and providing crisis intervention, safe housing and supportive services. Shelter House operates two family shelters and Fairfax County's only 24/7 Domestic Violence Shelter.

United Community Ministries (UCM) - United Community Ministries mobilizes the power of community to equip, educate, and empower people to measurably improve their lives. UCM prevents homelessness and provides critical supportive services to vulnerable families. UCM clients have access to case management, emergency food, assistance to prevent eviction and utility cut-off, access to medical, dental, and prescription drug assistance.

Volunteers of America-Chesapeake - The Supportive Services for Veterans Families Program (SSVFP) is a housing first, supportive services outreach program operated by VOA Chesapeake, Inc. and the VA SSVF Program Office. The SSVFP is a community-based program which provides a range of supportive services to very low income Veteran families, defined as a Veteran and family members or single Veterans, in or transitioning to permanent housing to promote housing stability. The primary goals are to assist families transitioning from homelessness to permanent housing and prevent at-risk families from becoming homeless—consistent with the HUD HPRP's (Homeless Prevention and Rapid Re-housing Programs).

APPENDIX L

Fairfax/Falls Church Partnership to Prevent and End Homelessness Acronym Guide

APPENDIX L

Fairfax/Falls Church Partnership to Prevent and End Homelessness Acronym Guide

APPENDIX L provides a comprehensive list of commonly used acronyms.

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Fairfax/Fall Church Partnership to Prevent and End Homelessness Acronym Guide

ACF – Administration for Children and Families

ADL's – Activities of Daily Living

AHAR-Annual Homeless Assessment Report

AIRS – Alliance of Information & Referral Systems

AMI – Area Median Income

APA-Annual Program Report

ARA – Annual Renewal Amount

ARRA – American Recovery and Re-Investment Act

AYM – Assisting Young Mothers

BYC – Base Year Calculator

CA – Collaborative Applicant

CAAA – Coordinated Access, Assessment & Assignment

CBO – Community Based Organization

CCM – Community Case Management

CDBG – Community Development Block Grant

CDC – Community Development Corporation

CEU-Continuing Education Unit

CH – Chronic Homelessness

CHCN – Community Healthcare Network

CHO – Covered Homeless Organization

CHRP – Community Housing Resource Program

COC – Continuum of Care

COG (MWCOG) – (Metropolitan Washington) Council of Governments

CPS – Child Protective Services

CRS – Christian Relief Services

CS – Cornerstones

CSA – Comprehensive Services Act

CSB – Community Services Board

CSCG – Child Services Coordinator Grant

CSP – Coordinated Services Planning

DFS – Department of Family Services

DHCD – Department of Housing and Community Development

DHS – Department of Human Services

DOB – Date of Birth

DOC – US Department of Corrections

DOL – US Department of Labor

DOJ – US Department of Justice

DQ – Data Quality

DV – Domestic Violence

DV/SV-Domestic Violence/Sexual Violence

DVS – Virginia Department of Veteran Services

ED – US Department of Education

EITC – Earned Income Tax Credit

ERCS – Embry Rucker Community Shelter

E*SNAPS – Electronic Special Needs Assistance Program

ES – Emergency Shelter

Fairfax/Fall Church Partnership to Prevent and End Homelessness Acronym Guide

ESG – Emergency Solutions Grant

EWS – Emergency Winter Shelter

XML- Extensible Markup Language

Family PASS-Family Preservation and Strengthening Services

FCRP – Fairfax County Rental Properties

FFCPPEH – Fairfax/Falls Church Programs to Prevent and End Homelessness

FIPS – Federal Information Processing Standards

FMR – Fair Market Rent

FQCHC – Federally Qualified Community Health Center

FYSB – Family and Youth Services Board

GIS – Geographic Information Systems

GIW – Grant Inventory Worksheet

GPRA – Government Performance and Results Act

GSH – Good Shepherd Housing

HCH – Healthcare for the Homeless

HEARTH (Act) – Homeless Emergency Assistance and Rapid Transition to Housing

HF – Housing First

HHS – US Department of Health and Human Services

HIC – Housing Inventory Chart

HIPAA – Health Insurance Portability and Accountability Act

HMIS – Homeless Management Information System

HOME-Homeless Investment Partnership Program

HOPWA – Housing Opportunities for Persons with AIDS

HOST – Housing Opportunities Services Team

HPP – Homeless Prevention Program

HRSA – Health Resources and Services Administration

HSG – Homeless Solutions Grant

HTF – Virginia Housing Trust Fund

HUD – US Department of Housing and Urban Development

HYI – Homeless Youth Initiative

IC-Intake Coordinator

I&R – Information and Referral

KHFS – Katherine Hanley Family Shelter

KHRW – Kurdish Human Rights Watch

LEA – Local Education Agency

LOB – Lines of Business

LOS – Length of Stay

MOU – Memorandum of Understanding

MRP – Medical Respite Program

NAEH – National Alliance to End Homelessness

NHH – New Hope Housing

NIMBY – Not in My Backyard

NLCHP – National Law Center on Homelessness and Poverty

NOFA – Notice of Funding Availability

NOVACO – Northern Virginia Coalition

NSP – Neighborhood Stabilization Program

NVFS – Northern Virginia Family Services

OAR – Opportunities Alternatives and Resources

OPEH – Office to Prevent and end Homelessness

OPH – Other Permanent Housing

PATH – Projects for Assistance in Transition from Homelessness

PDE – Program Data Element

PH – Permanent Housing

PHA – Public Housing Authority

PHFS – Patrick Henry Family Shelter

PIT – Point in Time (Count)

PKI – Public Key Infrastructure

PPI – Personal Protected Information

PRS – Psychiatric Rehabilitation Services

PSH – Permanent Supportive Housing

RBA – Results Based Accountability

RFP – Request for Proposal

RHA – Redevelopment Housing Authority

RHY – Runaway/Homeless Youth

RHYMIS – Runaway and Homeless Youth Management Information System

RISE – Reaching Independence through Support and Education

RRH – Rapid Rehousing

SA – Substance Abuse

SAMHSA – Substance Abuse and Mental Health Services Administration

SH – Shelter House

SHP – Supportive Housing Program

SNAP – Special Needs Assistance Program

SNAP E&T – Special Needs Assistance Program Employment and Training

SOAR – SSI/SSDI Outreach Access and Recovery

SPC (S+C) – Shelter Plus Care

SRO – Single Room Occupancy

SSDI – Social Security Disability Income

SSI – Supplemental Security Income

SSN – Social Security Number

SSO – Supportive Services Only

SSOM – Self-Sufficiency Outcome Matrix

SSP – System Performance Predictor

TA – Technical Assistance

TAC – Technical Assistance Collaborative

TANF – Temporary Assistance for Needy Families

TIP – Transitions in Place

TH – Transitional Housing

THRIVE – Total Housing Reinvention for Individual Success Vital Services and Economic Empowerment

TTAP – Transitional Therapeutic Apartment Program

UCM – United Community Ministries

UDE – Universal Data Element

USICH – US Interagency Council on Homelessness

VA –Veterans' Affairs

VAMC – Veterans' Affairs Medical Center

VASH – Veterans' Affairs Supportive Housing

VAWA – Violence Against Women Act

VCEH – Virginia Coalition to End Homelessness

VEC – Virginia Employment Coalition

VHDA – Virginia Housing Development Agency

VOA-C – Volunteers of America-Chesapeake

WIA – Workforce Initiative Act
WIOA – Workforce Innovation and Opportunity

2018 HDX Competition Report

PIT Count Data for VA-601 - Fairfax County CoC

Total Population PIT Count Data

	2016 PIT	2017 PIT	2018 PIT
Total Sheltered and Unsheltered Count	**1059**	**964**	**987**
Emergency Shelter Total	590	637	686
Safe Haven Total	0	0	0
Transitional Housing Total	395	219	215
Total Sheltered Count	**985**	**856**	**901**
Total Unsheltered Count	**74**	**108**	**86**

Chronically Homeless PIT Counts

	2016 PIT	2017 PIT	2018 PIT
Total Sheltered and Unsheltered Count of Chronically Homeless Persons	**149**	**150**	**173**
Sheltered Count of Chronically Homeless Persons	106	87	119
Unsheltered Count of Chronically Homeless Persons	43	63	54

2018 HDX Competition Report

PIT Count Data for VA-601 - Fairfax County CoC

Homeless Households with Children PIT Counts

	2016 PIT	2017 PIT	2018 PIT
Total Sheltered and Unsheltered Count of the Number of Homeless Households with Children	**178**	**142**	**151**
Sheltered Count of Homeless Households with Children	178	141	151
Unsheltered Count of Homeless Households with Children	0	1	0

Homeless Veteran PIT Counts

	2011	2016	2017	2018
Total Sheltered and Unsheltered Count of the Number of Homeless Veterans	**55**	**37**	**34**	**33**
Sheltered Count of Homeless Veterans	46	25	21	22
Unsheltered Count of Homeless Veterans	9	12	13	11

2018 HDX Competition Report

HIC Data for VA-601 - Fairfax County CoC

HMIS Bed Coverage Rate

Project Type	Total Beds in 2018 HIC	Total Beds in 2018 HIC Dedicated for DV	Total Beds in HMIS	HMIS Bed Coverage Rate
Emergency Shelter (ES) Beds	**494**	**87**	**407**	**100.00%**
Safe Haven (SH) Beds	**0**	**0**	**0**	**NA**
Transitional Housing (TH) Beds	**274**	**124**	**150**	**100.00%**
Rapid Re-Housing (RRH) Beds	**465**	**0**	**459**	**98.71%**
Permanent Supportive Housing (PSH) Beds	**683**	**0**	**554**	**81.11%**
Other Permanent Housing (OPH) Beds	**220**	**0**	**218**	**99.09%**
Total Beds	2,136	211	1788	92.88%

2018 HDX Competition Report

HIC Data for VA-601 - Fairfax County CoC

PSH Beds Dedicated to Persons Experiencing Chronic Homelessness

Chronically Homeless Bed Counts	2016 HIC	2017 HIC	2018 HIC
Number of CoC Program and non-CoC Program funded PSH beds dedicated for use by chronically homeless persons identified on the HIC	242	295	311

Rapid Rehousing (RRH) Units Dedicated to Persons in Household with Children

Households with Children	2016 HIC	2017 HIC	2018 HIC
RRH units available to serve families on the HIC	40	39	100

Rapid Rehousing Beds Dedicated to All Persons

All Household Types	2016 HIC	2017 HIC	2018 HIC
RRH beds available to serve all populations on the HIC	195	210	465

2018 HDX Competition Report

FY2017 - Performance Measurement Module (Sys PM)

Summary Report for VA-601 - Fairfax County CoC

For each measure enter results in each table from the System Performance Measures report generated out of your CoCs HMIS System. There are seven performance measures. Each measure may have one or more "metrics" used to measure the system performance. Click through each tab above to enter FY2017 data for each measure and associated metrics.

RESUBMITTING FY2017 DATA: If you provided revised FY2017 data, the original FY2017 submissions will be displayed for reference on each of the following screens, but will not be retained for analysis or review by HUD.

ERRORS AND WARNINGS: If data are uploaded that creates selected fatal errors, the HDX will prevent the CoC from submitting the System Performance Measures report. The CoC will need to review and correct the original HMIS data and generate a new HMIS report for submission.

Some validation checks will result in warnings that require explanation, but will not prevent submission. Users should enter a note of explanation for each validation warning received. To enter a note of explanation, move the cursor over the data entry field and click on the note box. Enter a note of explanation and "save" before closing.

Measure 1: Length of Time Persons Remain Homeless

This measures the number of clients active in the report date range across ES, SH (Metric 1.1) and then ES, SH and TH (Metric 1.2) along with their average and median length of time homeless. This includes time homeless during the report date range as well as prior to the report start date, going back no further than October, 1, 2012.

Metric 1.1: Change in the average and median length of time persons are homeless in ES and SH projects.
Metric 1.2: Change in the average and median length of time persons are homeless in ES, SH, and TH projects.

a. This measure is of the client's entry, exit, and bed night dates strictly as entered in the HMIS system.

FY2017 - Performance Measurement Module (Sys PM)

	Universe (Persons)			Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Submitted FY 2016	Revised FY 2016	FY 2017	Submitted FY 2016	Revised FY 2016	FY 2017	Difference	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
1.1 Persons in ES and SH	2831		2828	61		63	2	44		46	2
1.2 Persons in ES, SH, and TH	3077		3013	106		90	-16	50		50	0

b. This measure is based on data element 3.17.

This measure includes data from each client's Living Situation (Data Standards element 3.917) response as well as time spent in permanent housing projects between Project Start and Housing Move-In. This information is added to the client's entry date, effectively extending the client's entry date backward in time. This "adjusted entry date" is then used in the calculations just as if it were the client's actual entry date.

The construction of this measure changed, per HUD's specifications, between FY 2016 and FY 2017. HUD is aware that this may impact the change between these two years.

	Universe (Persons)			Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Submitted FY 2016	Revised FY 2016	FY 2017	Submitted FY 2016	Revised FY 2016	FY 2017	Difference	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
1.1 Persons in ES, SH, and PH (prior to "housing move in")	2775		2761	116		223	107	50		73	23
1.2 Persons in ES, SH, TH, and PH (prior to "housing move in")	3039		2954	162		245	83	58		83	25

2018 HDX Competition Report

FY2017 - Performance Measurement Module (Sys PM)

Measure 2: The Extent to which Persons who Exit Homelessness to Permanent Housing Destinations Return to Homelessness

This measures clients who exited SO, ES, TH, SH or PH to a permanent housing destination in the date range two years prior to the report date range.Of those clients, the measure reports on how many of them returned to homelessness as indicated in the HMIS for up to two years after their initial exit.

After entering data, please review and confirm your entries and totals. Some HMIS reports may not list the project types in exactly the same order as they are displayed below.

	Total # of Persons who Exited to a Permanent Housing Destination (2 Years Prior)		Returns to Homelessness in Less than 6 Months			Returns to Homelessness from 6 to 12 Months			Returns to Homelessness from 13 to 24 Months			Number of Returns in 2 Years	
	Revised FY 2016	FY 2017	Revised FY 2016	FY 2017	% of Returns	Revised FY 2016	FY 2017	% of Returns	Revised FY 2016	FY 2017	% of Returns	FY 2017	% of Returns
Exit was from SO		130		22	17%		13	10%		15	12%	50	38%
Exit was from ES		989		116	12%		78	8%		72	7%	266	27%
Exit was from TH		143		1	1%		3	2%		7	5%	11	8%
Exit was from SH		0		0			0			0		0	
Exit was from PH		451		52	12%		20	4%		41	9%	113	25%
TOTAL Returns to Homelessness		1713		191	11%		114	7%		135	8%	440	26%

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

2018 HDX Competition Report
FY2017 - Performance Measurement Module (Sys PM)

This measures the change in PIT counts of sheltered and unsheltered homeless person as reported on the PIT (not from HMIS).

	January 2016 PIT Count	January 2017 PIT Count	Difference
Universe: Total PIT Count of sheltered and unsheltered persons	1059	964	-95
Emergency Shelter Total	590	637	47
Safe Haven Total	0	0	0
Transitional Housing Total	395	219	-176
Total Sheltered Count	985	856	-129
Unsheltered Count	74	108	34

Metric 3.2 – Change in Annual Counts

This measures the change in annual counts of sheltered homeless persons in HMIS.

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Unduplicated Total sheltered homeless persons	3118		3043	-75
Emergency Shelter Total	2851		2851	0
Safe Haven Total	0		0	0
Transitional Housing Total	327		234	-93

Measure 4: Employment and Income Growth for Homeless Persons in CoC Program-funded Projects

Metric 4.1 – Change in earned income for adult system stayers during the reporting period

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults (system stayers)	272		294	22
Number of adults with increased earned income	15		34	19
Percentage of adults who increased earned income	6%		12%	6%

Metric 4.2 – Change in non-employment cash income for adult system stayers during the reporting period

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults (system stayers)	272		294	22
Number of adults with increased non-employment cash income	87		153	66
Percentage of adults who increased non-employment cash income	32%		52%	20%

Metric 4.3 – Change in total income for adult system stayers during the reporting period

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults (system stayers)	272		294	22
Number of adults with increased total income	89		170	81
Percentage of adults who increased total income	33%		58%	25%

2018 HDX Competition Report
FY2017 - Performance Measurement Module (Sys PM)

Metric 4.4 – Change in earned income for adult system leavers

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults who exited (system leavers)	97		60	-37
Number of adults who exited with increased earned income	17		8	-9
Percentage of adults who increased earned income	18%		13%	-5%

Metric 4.5 – Change in non-employment cash income for adult system leavers

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults who exited (system leavers)	97		60	-37
Number of adults who exited with increased non-employment cash income	23		36	13
Percentage of adults who increased non-employment cash income	24%		60%	36%

Metric 4.6 – Change in total income for adult system leavers

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Number of adults who exited (system leavers)	97		60	-37
Number of adults who exited with increased total income	37		39	2
Percentage of adults who increased total income	38%		65%	27%

2018 HDX Competition Report

FY2017 - Performance Measurement Module (Sys PM)

Measure 5: Number of persons who become homeless for the 1st time

Metric 5.1 – Change in the number of persons entering ES, SH, and TH projects with no prior enrollments in HMIS

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Person with entries into ES, SH or TH during the reporting period.	2652		2673	21
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	814		772	-42
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time)	1838		1901	63

Metric 5.2 – Change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollments in HMIS

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	3056		3130	74
Of persons above, count those who were in ES, SH, TH or any PH within 24 months prior to their entry during the reporting year.	1031		964	-67
Of persons above, count those who did not have entries in ES, SH, TH or PH in the previous 24 months. (i.e. Number of persons experiencing homelessness for the first time.)	2025		2166	141

Measure 6: Homeless Prevention and Housing Placement of Persons defined by category 3 of HUD's Homeless Definition in CoC Program-funded Projects

This Measure is not applicable to CoCs in FY2017 (Oct 1, 2016 - Sept 30, 2017) reporting period.

Measure 7: Successful Placement from Street Outreach and Successful Placement in or Retention of Permanent Housing

Metric 7a.1 – Change in exits to permanent housing destinations

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Persons who exit Street Outreach	439		591	152
Of persons above, those who exited to temporary & some institutional destinations	79		71	-8
Of the persons above, those who exited to permanent housing destinations	93		123	30
% Successful exits	39%		33%	-6%

Metric 7b.1 – Change in exits to permanent housing destinations

FY2017 - Performance Measurement Module (Sys PM)

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	2734		2708	-26
Of the persons above, those who exited to permanent housing destinations	1242		1304	62
% Successful exits	45%		48%	3%

Metric 7b.2 – Change in exit to or retention of permanent housing

	Submitted FY 2016	Revised FY 2016	FY 2017	Difference
Universe: Persons in all PH projects except PH-RRH	942		683	-259
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	906		625	-281
% Successful exits/retention	96%		92%	-4%

2018 HDX Competition Report

FY2017 - SysPM Data Quality

VA-601 - Fairfax County CoC

This is a new tab for FY 2016 submissions only. Submission must be performed manually (data cannot be uploaded). Data coverage and quality will allow HUD to better interpret your Sys PM submissions.

Your bed coverage data has been imported from the HIC module. The remainder of the data quality points should be pulled from data quality reports made available by your vendor according to the specifications provided in the HMIS Standard Reporting Terminology Glossary. You may need to run multiple reports into order to get data for each combination of year and project type.

You may enter a note about any field if you wish to provide an explanation about your data quality results. This is not required.

2018 HDX Competition Report

FY2017 - SysPM Data Quality

	All ES, SH				All TH				All PSH, OPH				All RRH				All Street Outreach			
	2013-2014	2014-2015	2015-2016	2016-2017	2013-2014	2014-2015	2015-2016	2016-2017	2013-2014	2014-2015	2015-2016	2016-2017	2013-2014	2014-2015	2015-2016	2016-2017	2013-2014	2014-2015	2015-2016	2016-2017
1. Number of non-DV Beds on HIC	354	419	407	424	371	311	287	173	484	622	924	1001	204	401	195	182				
2. Number of HMIS Beds	354	407	407	424	297	265	283	173	404	450	744	824	180	396	185	169				
3. HMIS Participation Rate from HIC (%)	100.00	97.14	100.00	100.00	80.05	85.21	98.61	100.00	83.47	72.35	80.52	82.32	88.24	98.75	94.87	92.86				
4. Unduplicated Persons Served (HMIS)	2788	2844	2734	2757	532	424	277	188	477	558	1178	1169	826	1394	2064	2045	0	0	18	113
5. Total Leavers (HMIS)	2392	2425	2410	2431	263	192	155	93	48	82	216	297	615	888	1548	1441	0	0	7	54
6. Destination of Don't Know, Refused, or Missing (HMIS)	758	603	777	933	7	11	10	3	2	3	7	14	15	35	157	176	0	0	1	15
7. Destination Error Rate (%)	31.69	24.87	32.24	38.38	2.66	5.73	6.45	3.23	4.17	3.66	3.24	4.71	2.44	3.94	10.14	12.21			14.29	27.78

2018 HDX Competition Report

Submission and Count Dates for VA-601 - Fairfax County CoC

Date of PIT Count

	Date	Received HUD Waiver
Date CoC Conducted 2018 PIT Count	1/24/2018	

Report Submission Date in HDX

	Submitted On	Met Deadline
2018 PIT Count Submittal Date	4/27/2018	Yes
2018 HIC Count Submittal Date	4/27/2018	Yes
2017 System PM Submittal Date	5/29/2018	Yes

Preventing and Ending Homelessness

Fairfax-Falls Church Community Partnership

www.fairfaxcounty.gov/homeless

Coordinated Entry System Policies and Procedures Manual for the Fairfax Continuum of Care

1st Edition (February 2018)

Fairfax-Falls Church Partnership to Prevent and End Homelessness Continuum of Care

Coordinated Entry System Policies and Procedures Manual

1st Edition (February 2018)

Table of Contents

Introduction

Coordinated Entry is defined by the Department of Housing and Urban Development (HUD) as a consistent, streamlined process for accessing the resources available in the homeless crisis response system. Through coordinated entry, a Continuum of Care (CoC) ensures that the highest need, most vulnerable households in the community are prioritized for services and that the housing and supportive services in the system are used as efficiently and effectively as possible. Coordinated entry transforms a CoC from a network of projects making individual decisions about whom to serve, into a fully integrated housing crisis response system.

The Fairfax/Falls Church Community Partnership to Prevent and end Homelessness' Continuum of Care (hereafter referred to Fairfax CoC) began planning for its Coordinated Entry System (CES) in December 2014 through a collaborative process. Agency staff, providers, and stakeholders were equal partners in developing its policies, procedures and written standards following the guidance provided by HUD regarding requirements and qualities of an effective CES.
Our Coordinated Entry system has been developed to make rapid, effective, and consistent client-to-housing and service matches—regardless of a client's location within a CoC's geographic area—by standardizing the access and assessment process and by coordinating referrals across the CoC. Coordinated Entry paves the way for more efficient homeless assistance systems by:

- Helping people move through the system faster (by reducing the amount of time people spend moving from program to program before finding the right match);

- Reducing new entries into homelessness (by consistently offering prevention and diversion resources upfront, reducing the number of people entering the system unnecessarily); and

- Improving data collection and quality and providing accurate information on what kind of assistance consumers need.

In its "Policy Brief on Coordinated Entry," HUD identified 17 qualities of an effective CES. Fairfax CoC incorporated all of them in its planning and development process and they are reflected operationally in our system and throughout this manual.
Some of the qualities HUD identified serve as fundamental principles in the day to day operations of all of the services and housing we provide and are worth noting. These include programs and services that:

1. **Use a Housing First orientation** – People experiencing homelessness are housed as quickly as possible without preconditions or requirements to participate in services.

2. **Are person-centered** – During interviews and assessments, participants may choose to refuse to answer questions based on their level of comfort or knowledge without impact on their access to housing and services. Participants identify their choices for geographical locations, type of housing, level of services etc. and their choices are honored. The decision to accept housing and participate in services is theirs.

3. **Are low barrier** – People are not screened out of programs because of qualities that are perceived as barriers and/or making them harder to serve.

4. **Prioritize those with the greatest needs** – People that are experiencing homelessness that are particularly vulnerable and/or have experienced a lot of homelessness are at great risk and need to be served ahead of those less vulnerable.

5. **Are non-discriminatory** – Programs and services are in compliance with comply with the nondiscrimination and equal opportunity provisions of Federal civil rights laws as specified at 24 C.F.R. 5.105(a),. In addition, HUD's Equal Access Rule at 24 CFR 5.105(a)(2) prohibits discriminatory eligibility determinations in HUD-assisted or HUD-insured housing programs based on actual or perceived sexual orientation, gender identity, or marital status, including any projects funded by the CoC Program, ESG Program, and HOPWA Program.

Regarding the development of a CES, HUD specified that CoCs plan and implement the following Core Elements of Coordinated Entry:

1. Access – The manual specifies how/where people experiencing homelessness can become engaged and be assessed for housing and services in our continuum.

2. Assessment – Fairfax CoC providers do assessments to learn the participants housing needs, preferences and vulnerability. Assessment tools for programs are standardized and the same tools are used throughout the system. Assessment results help identify the most appropriate housing options and level of support services in which the participant might realize the most benefits. (Note: They still have the choice to choose different options)

3. Prioritization – Assessments help Fairfax CoC identify the most vulnerable people experiencing homelessness in its community. Prioritizing the most vulnerable in the community for housing and services ensures that those with the greatest need receive the supports necessary to resolve their housing crisis.

4. Referral – Participants are referred to housing opportunities and services in accordance with our CoC's prioritization guidelines.

This manual details the policies and procedures regarding these core elements in the Fairfax CoC Coordinated Entry System. It includes the standards for eligibility and the prioritization process for programs; policies for access and assessment; procedures for referrals and applications; and tools and requirements for filling vacancies.

Staff using these policies, procedures and written standards should also reference the Homeless Management Information System (HMIS) Policies and Procedures Manual, as well as related HMIS training materials, for more guidance.

Note: The manual is organized by populations so that staff working with a particular population can focus on that section of the manual and easily find the information they need. Therefore, for ease of use of the document by case managers, housing locators, or others, there is some repetition between the sections for Adult Only Households and Households with Children.

Homeless Assistance Programs for Adult Only Households

For the purposes of this document, “adult-only households” will hereafter be referred to as “singles” or “individuals”. The Fairfax CoC’s programs for this population include homelessness prevention, rapid rehousing, emergency shelter, street outreach, permanent supportive housing, other permanent housing, and hypothermia prevention for those who are at least 18 years old.

2.1 Homelessness Prevention - Singles

The following table summarizes coordinated entry processes for entrance into homelessness prevention projects for singles. Each element is explained in detail in the manual.

Coordinated Entry – Homelessness Prevention Singles				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
1. Homeless as defined by HUD Categories 2, 3 or 4 2. At Risk of Homelessness as defined by HUD	Highest Score on Singles E&P Tool (When capacity requires prioritization)	CSP	Singles E&P Tool	From CSP to Regional Non-Profit Note: Additional steps may be necessary if regional non-profit is at capacity.

Homelessness prevention is the approach used to stabilize households in their current housing or help them to move into new housing without entering the shelter system or experiencing homelessness. Services may include financial assistance (security or utility deposits, utility payments, and moving cost assistance), short- or medium-term rental assistance, housing location, legal assistance, mediation, credit counseling, and case management. The support is provided to help households resolve their immediate housing crisis and access ongoing sources of support in the community in order to remain housed.

Diversion is a type of homelessness prevention, which seeks to prevent homelessness for those who are seeking emergency shelter by helping them identify immediate alternate housing arrangement. Diversion is not the refusal of services but instead, the provision of different services in an attempt to prevent someone’s homelessness and their entry into shelter. Diversion targets people as they are applying for entry into shelter.

It is important to note that homelessness prevention, including diversion, cannot be attempted with someone who is already experiencing literal homelessness, as it occurs before someone reaches that point. Costs of homelessness prevention are only eligible to the extent that the assistance is necessary to help the program participant regain stability in the program participant’s current housing or move into other permanent housing and achieve stability in that housing.

The overall goals of homelessness prevention services are to:

1. reduce the number of individuals who become homeless for the first time; and

2. reduce the number of individuals experiencing multiple episodes of homelessness.

With the establishment of this CES, each regional nonprofit agency who is contracted by the Fairfax County Office to Prevent and End Homelessness (OPEH) to provide homelessness prevention services will be required to adhere to a pre-determined prevention caseload capacity, equal to no less

than two (2) prevention cases per contracted case manager. Only when the contracted agency has reached the minimum number of prevention cases can the agency close for additional prevention referrals. Agencies can choose to serve more than two prevention cases per case manager if they have the capacity to do so and those two prevention spots need only be filled when there is an active referral. The two prevention cases per case manager can be divided however the agency sees fit – for example, if the agency has three case managers, all three can carry two prevention cases each, one can carry all six, etc.

Eligibility

Singles households must meet the criteria listed in either section (1) or (2) below in order to be eligible for homelessness prevention assistance.

1. The household must meet all three of the criteria below, (a) through (c):

    a. The household must be homeless in Categories 2, 3 or 4 per the HUD definition (detailed below).

    b. The household has an annual income at or below 30 percent of the area median income (AMI) for the area, as determined by HUD.

    c. Any additional eligibility requirements specific to the project's funding (ex. programs for survivors of domestic violence, programs for people with serious mental illness or chronic substance abuse or programs for veterans, etc.).

    Details of HUD Categories 2, 3 and 4:

    - <u>Category 2 - Imminent Risk of Homelessness</u>
      Individual or family who will imminently lose their primary nighttime residence, provided that:
        - Residence will be lost within 14 days of the date of application for homeless assistance;
        - No subsequent residence has been identified; and
        - The individual or family lacks the resources or support networks needed to obtain other permanent housing

    - <u>Category 3 - Homeless under other Federal statutes</u>
      Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
        - Are defined as homeless under the other listed federal statutes;
        - Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;
        - Have experienced persistent instability as measured by two moves or more during the preceding 60 days; and
        - Can be expected to continue in such status for an extended period of time due to special needs or barriers

- Category 4 - Fleeing/Attempting to Flee Domestic Violence

  Any individual or family who:
  - Is fleeing, or is attempting to flee, domestic violence;
  - Has no other residence; and
  - Lacks the resources or support networks to obtain other permanent housing

OR

2. The individual or family must be "At Risk of Homelessness" as defined by HUD:

   a. An individual or family who:

      i. Has an annual income below 30% of median family income for the area; and

      ii. Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the "homeless" definition;

      iii. Meets one of the following conditions:

         A. Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR

         B. Is living in the home of another because of economic hardship; OR

         C. Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR

         D. Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR

         E. Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR

         F. Is exiting a publicly funded institution or system of care; OR

         G. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness. OR

   b. A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute. or

c. An unaccompanied youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under section 725(2) of the McKinney-Vento Homeless Assistance Act, and the parent(s) or guardian(s) or that child or youth if living with him or her.

Prioritization

Providers offering homelessness prevention assistance should consider the identified target populations served by the project. If there is a need to prioritize prevention cases due to caseload capacity, individuals will be prioritized using the following order:

1. The highest score on the Eligibility and Prioritization Tool for Access to Emergency Shelter and Homelessness Prevention for Adult-Only Households (known simply as the Singles E&P Tool) which obtains information regarding the following:

    a. Homeless history
    b. Vulnerability
    c. Disability status
    d. Veteran status
    e. Age
        i. Youth (ages 18-24)
        ii. Elderly (ages 60+)
    f. Women who are pregnant
    g. Terminal illness
    h. Fairfax County residency status

2. Experiencing homelessness in HUD Categories 2 or 4

3. Experiencing homelessness in HUD Categories 3

4. At Risk of homelessness as defined by HUD

Access, Assessment & Referral

Below are the steps to be taken if an individual is seeking homelessness prevention assistance:

1. Individuals should call Coordinated Services Planning (CSP) at 703-222-0880 to be assessed for prevention services. Depending on the level of need, CSP may be able to help the individual resolve their housing crisis without making a referral to the homeless services system. Individuals who call nonprofit providers directly should be instructed to call CSP.

2. If a resolution through CSP is not available, CSP will make a referral to the homeless services system by directing it to the appropriate regional nonprofit who is contracted to provide homelessness prevention services in the area where the individual is residing.

3. Regional nonprofit staff will contact the individual within two (2) business days to administer the Singles Eligibility and Prioritization (E&P) Tool. Once eligibility and prioritization have been determined, the individual's case will be assigned to a case manager. The case manager then has 2 business days to contact the individual to set up an in-person meeting. If the regional nonprofit receives more than one referral on the same day, individuals with the highest Singles E&P Tool scores will be prioritized for prevention services until all prevention caseload spots are full.

4. If the regional nonprofit that provides homeless services in the area where the individual currently resides is at capacity for homelessness prevention referrals, the nonprofit will send the referral to the Coordinated Entry System Manager (CESM) with OPEH. Prevention services may only be declined if the regional nonprofit has exceed the approved number of prevention cases as set forth by OPEH.

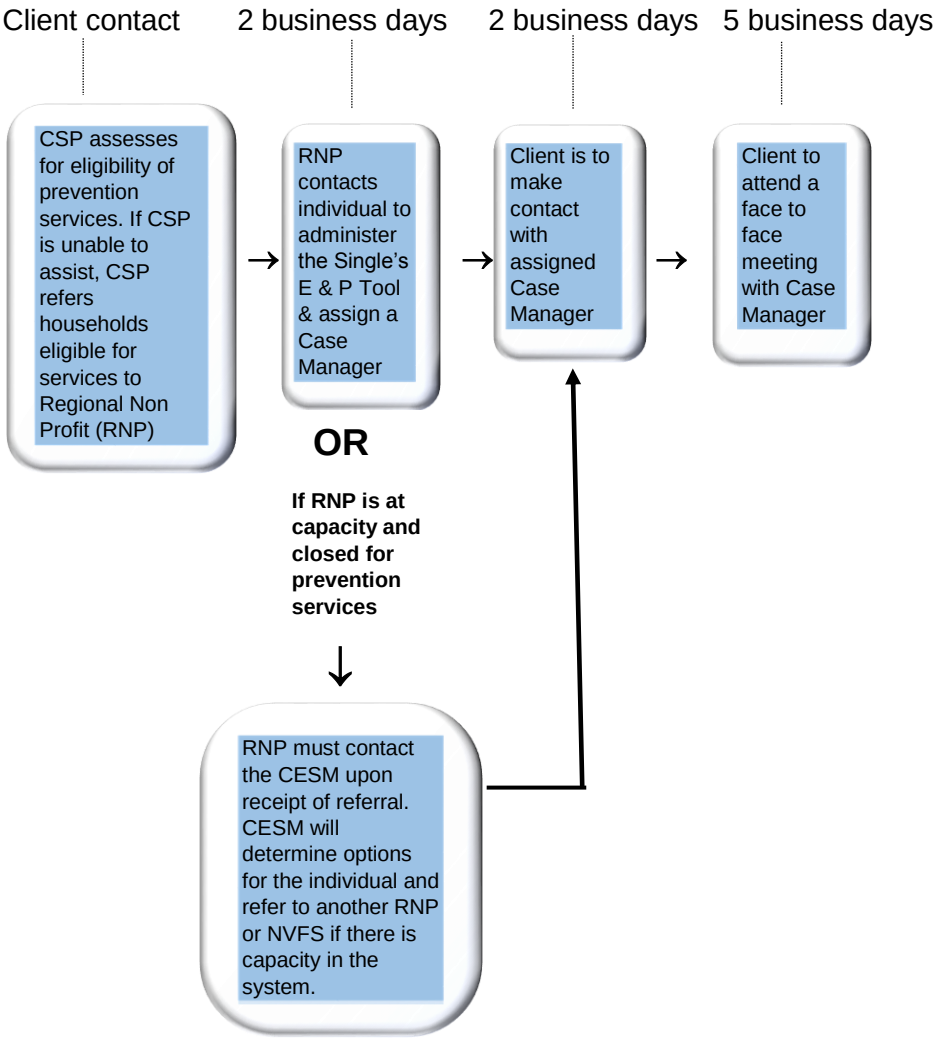
5. The CESM will confirm caseload capacity and if determined appropriate, refer the individual's case to Northern Virginia Family Service's (NVFS) County-Wide Homeless Prevention Program

6. If NVFS is at capacity and unable to accept the referral, the CESM will then look for additional resources, to include prevention caseload capacity at other regional nonprofits who provide homelessness prevention. If no other resources can be identified, the CESM will inform the individual that the homeless services system is at capacity and unable to provide them with prevention services.

7. Once a prevention case has been accepted by either NVFS' county-wide program or by one of the regional nonprofits, staff will complete the Standardized Intake Form, Release of Information, and any other necessary paperwork. During this initial intake, the individual will be made aware that the primary purpose of accessing prevention services is to provide short-term housing stabilization services with the intent to prevent possible homelessness.

8. If the individual is determined not to be eligible for prevention services, a connection to mainstream resources should be provided.

The process for individual's accessing prevention services is shown below.



2.2 Outreach - Singles

Coordinated Entry Summary – Outreach Singles				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
Anyone residing in places not meant for human habitation	As many as capacity allows but if capacity is an issue: 1) Chronically homeless (CH) with most homeless history & highest severity of service needs 2) CH w/most homeless history 3) CH w/ highest severity of service needs 4) All others living in place not meant for human habitation.	Unsheltered individuals can either request services by calling or dropping into any of the shelters or nonprofit offices or be offered services through community outreach efforts regularly performed by all outreach workers	Client-specific based on willingness to engage	Self-Referral Community Referral

"Street outreach" (or "outreach") is defined by HUD as the act of reaching out to unsheltered homeless individuals and families, connecting them with emergency shelter, housing, or critical services, and providing them with urgent, non-facility-based care. To engage this very vulnerable population, Fairfax has operated outreach programs for many years and it is included in the tasks to be performed by agencies contracted by OPEH for "case management" services within their respective regions. This program is known as Singles Outreach.

Coordinated Entry for programs serving unsheltered individuals is important because it not only defines the means for which individuals experiencing unsheltered homelessness can access the services that will help move them to permanent housing, but will also allow the Community Partnership to collect the necessary data to know who is experiencing unsheltered homelessness throughout the entire year. To accomplish these goals, the following Coordinated Entry standards for Singles Outreach were established to provide:

1. a streamlined framework for outreach services throughout all four human services regions; and

2. clear expectations of ongoing engagement attempts for the "hardest to serve".

Collaboration is essential between the regional Singles Outreach programs, the Fairfax County Health Department's Homeless Healthcare Program (HHP), and the Fairfax-Falls Church Community Services Board's (CSB) Projects for Assistance in Transition from Homelessness (PATH) program in order to provide comprehensive outreach services to those experiencing unsheltered homelessness in our community. These Policies and Procedures are a means to provide standards of engagement ONLY for Singles Outreach. Any policies and procedures related to HHP and PATH should be obtained by either the Health Department or the CSB.

Eligibility

Anyone experiencing unsheltered homelessness in the Fairfax community is eligible for outreach services through Singles Outreach. For clarification, individuals experiencing unsheltered

homelessness reside in “places not meant for human habitation”, including cars, parks, wooded areas, sidewalks, abandoned buildings, etc.

Prioritization

Providers offering Singles Outreach programs should work to engage as many individuals experiencing unsheltered homelessness in their respective regions as possible. However, if there is a demonstrated need to restrict caseload size, providers should use the following order of priority for Singles Outreach programs:

1. Unsheltered chronically homeless individuals with the longest history of homelessness and with the highest severity of service needs.

2. Unsheltered chronically homeless individuals with the longest history of homelessness.

3. Unsheltered chronically homeless individuals with the highest severity of service needs.

4. Unsheltered individuals, regardless of length of homelessness or severity of service needs.

Regardless of caseload size and capacity to actively engage / provide case management and housing services, providers should attempt to make contact with all persons experiencing unsheltered homelessness at least once a month to determine:

1. If they are still experiencing unsheltered homelessness; and

2. if they are interested in receiving services. (More information about “contact” can be found in the sections “Access and Assessment” and “’By-Name List”.)

Access and Assessment

Access to Singles Outreach programming for those experiencing unsheltered homelessness is two-fold and can be accomplished through either direct outreach or referral / ”inreach”.

According to HUD, the act of outreach to those experiencing unsheltered homelessness should include:

1. Engagement: The location, identification, and relationship building with individuals experiencing unsheltered homelessness with the purpose of providing immediate and long-term support, interventions, and connection with other homeless assistance programs and/or mainstream social services/housing programs.

2. Case management: The assessment of housing and other service needs in order to develop an individualized service plan geared towards moving individuals experiencing unsheltered homelessness into permanent housing.

3. Emergency health services: Such as those provided by the Homeless Healthcare Program (HHP) under contract with the Fairfax County Health Department (HD).

4. Emergency mental health services: Such as those provided by the Projects for Assistance in Transition from Homelessness (PATH) teams under the Fairfax-Falls Church Community Services Board (CSB).

Singles Outreach programs are expected to have a system in place to provide ongoing and consistent outreach to commonly-frequented "hot spots" where individuals experiencing unsheltered homelessness are known to reside or congregate. Outreach should also take place at locations such as drop-in centers, libraries, laundromats, airports, etc..

Referral / "Inreach"

For the purposes of outreach services, a referral is a means by which an individual experiencing unsheltered homelessness engages in a Singles Outreach program either through self-referrals or requests from the larger community. These methods are also known as "inreach". There are two main ways that Singles Outreach programs could receive referrals for outreach services, including (but not limited to):

1. Self-referral: individuals experiencing unsheltered homelessness may contact or visit a nonprofit partner directly with a request for services; (this includes walk-ins and cold calls), and

2. Referral from community: Singles Outreach workers are made aware of one or more individuals thought to be experiencing unsheltered homelessness from those in the larger community, usually through direct calls to OPEH, Board of Supervisors' offices, police department, etc.

Once an individual has been identified as experiencing unsheltered homelessness, regardless of the method, it is the responsibility of the Singles Outreach worker to try and engage with the individual on an ongoing basis while the individual continues to be unsheltered. With those individuals who are unsheltered, the Singles Outreach worker should attempt to:

1. Establish a rapport/relationship to develop trust.

    a. During this time, the Singles Outreach worker should attempt to gather as much information about the individual as possible in order to open them into the appropriate regional Singles Outreach program in the HMIS.

        i. Singles Outreach workers are encouraged to maintain some form of an internal tracking system in addition to HMIS to assist with the location and identification of individuals experiencing unsheltered homelessness.

    b. Provide, either directly or through a referral to another agency / provider, assistance with basic needs (food, clothing, bus tokens, etc.).

2. Determine if individual is willing to engage past basic needs assistance and discuss other services, most notably housing. If so, the Singles Outreach worker should complete the necessary assessment forms to determine program eligibility.

    a. Determine whether or not individual could benefit from and is willing to engage in either physical or mental health services; if so, the Singles Outreach worker should make the appropriate referral to either HHP or PATH.

    b. If individual is determined to be appropriate for a rapid rehousing program, the Singles Outreach worker should open the individual into the appropriate program in HMIS, following the correct workflow, and engage the individual in rapid rehousing services; Singles Outreach worker should continue to serve and engage the individual until they

are housed (and possibly longer depending on continuing case management needs/agency structure).

c. If the individual is determined to be appropriate for permanent supportive housing (PSH) or other permanent housing (OPH) options, the Singles Outreach worker should make a referral, following the correct workflow, and should continue to serve and engage the individual until they are housed.

3. If the individual is not willing to continue past the initial engagement or basic needs assistance, they should continue to remain in the Singles Outreach project and be put on the outreach worker's list of people who receives ongoing engagement.

Ongoing Engagement / Contacts

Outreach workers are expected to re-engage all individuals experiencing unsheltered homelessness at least once a month in order to determine whether those individuals are:

1. still unsheltered; and

2. interested in services / housing.

This re-engagement is considered a "contact" and is recorded as such in HMIS (see HMIS workflow for more details). It is important to note that for the purposes of documenting chronic homelessness, "a single encounter with a homeless service provider on a single day within one month that is documented through third-party documentation is sufficient to consider an individual or family as homeless for the entire month unless there is any evidence that the household has had a break in homeless status during that month" (HUD). Therefore, diligent engagement and documentation efforts will aid significantly in establishing length of homelessness for some of our community's most difficult to serve and thus, move them forward towards the potential for permanent housing options.

Official "engagement" in the Fairfax-Falls Church Singles Outreach system is defined as participation in any type of service past the point of basic needs assistance (please refer to the section entitled "Access" for more information). Once someone has officially "engaged", they should have also completed some sort of intake/release of information/other paperwork in order to move them forward with services. This should also be used as the "Date of Engagement" in HMIS. Please note that the ongoing engagement and re-engagement attempts/efforts referenced above build up to full on "engagement", so as not to confuse the two.

By-Name List (BNL) and Unsheltered BNL Staffing Meetings

As previously stated, in order to understand what unsheltered homelessness looks like throughout the entire year, it is critically important that there is a mechanism to capture this information. As such, the use of a BNL will be implemented as an essential tool in this process. A BNL is defined as a real-time, up-to-date list of all people experiencing homelessness which can be filtered across categories, and shared across agencies (HUD). The use of BNLs have been proven to be critical in efforts to end homelessness across the country, especially for those who are considered to be the hardest to serve.

To create the Unsheltered BNL, individuals should remain open and active in Singles Outreach projects regardless of the level of participation in services (only basic needs assistance, participates in housing case management services, qualifies for and/or receives services from either HHP or PATH services, or is not interested in obtaining any services at all). Participation in Singles Outreach ends only when an individual is:

1. Housed:

    a. No longer experiencing unsheltered homelessness in Fairfax County, examples include staying in a year-round emergency shelter, transitional housing program, etc.

    b. The Hypothermia Prevention Program does not count as an emergency shelter for the purposes of Singles Outreach and individuals should remain open in outreach even if they are participating in Hypothermia.

2. Deceased.

3. Unable to be located within three months of last contact.

By retaining individuals in Singles Outreach, regardless of their level of participation in services, the Unsheltered BNL will be created through the use of program entries and exits.

Due to the challenging nature of serving those who are experiencing unsheltered homelessness, regular case conferencing / staffing meetings have been identified as effective ways to ensure that the BNL is accurate, up-to-date, and unduplicated. As such, the Fairfax-Falls Church Partnership maintains biweekly (once every two weeks) Unsheltered BNL staffing meetings, which are required meetings where outreach partners will go through the Unsheltered BNL; share information and updates about those listed; and determine if there are any duplicates on the list. All Singles Outreach workers will be required to attend these meetings. Workers from HHP, PATH, and anyone else who interacts or works with those experiencing unsheltered homelessness are encouraged to attend as well. Should biweekly meetings become unnecessary, the frequency of the meetings may change.

2.3 Emergency Shelter Singles

Coordinated Entry requires shelters that serving individuals operate within the same, coordinated system, with the same eligibility and prioritization standards, as well as assessment and access processes. This ensures that shelters no longer operate as a "first-come, first-served" model or in siloed regions with their own entry and access processes and standards.

The three main, year-round emergency shelters for singles in the Fairfax CoC include:

1. Baileys Crossroads Community Shelter- Falls Church

2. Eleanor U. Kennedy Community Shelter-Alexandria

3. Embry Rucker Community Shelter-Reston

The following table summarizes coordinated entry processes for entrance into emergency shelter for singles. Each element is explained in detail in the manual. Separate Coordinated Entry processes are maintained for seasonal emergency shelters and shelters dedicated to special populations, such as the Medical Respite Program and Mondloch House.

Coordinated Entry Summary – Emergency Shelter Singles				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
1. HUD Definition of Homelessness, Category 1, 2 & 4 2. All other viable housing options have been considered and are not appropriate or available	Highest Score on Singles E&P Tool	Any emergency shelter for singles	Singles E&P Tool	STARSS

Eligibility

Single individuals seeking emergency shelter services are required to meet all of the following basic eligibility guidelines:

1. Be considered homeless under the HUD definitions of Categories 1, 2, or 4:

    a) <u>Category 1 - Literally Homeless</u>

    Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

    i. Has a primary nighttime residence that is a public or private place not meant for human habitation;

    ii. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

iii. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution. (**NOTE: The applicant can be no more than three days from discharge to be referred to emergency shelter**.)

b) Category 2- Imminent Risk of Homelessness

Individual or family who will imminently lose their primary nighttime residence, provided that:

i. residence will be lost within 14 days of the date of application for homeless assistance; (**NOTE: The applicant can be no more than three days from losing their residence to be referred to emergency shelter**.)

ii. no subsequent residence has been identified; and

iii. the individual or family lacks the resources or support networks needed to obtain other permanent housing

c) Category 4 - Fleeing/ Attempting to Flee Domestic Violence

Any individual or family who:

i. is fleeing, or is attempting to flee, domestic violence;

ii. has no other residence; and

iii. lacks the resources or support networks to obtain other permanent housing.

2. All other viable housing options have been considered and are not appropriate or available:

a. Diversion options should be explored and pursued before entering emergency shelter.

b. For those shelters that serve both singles and families, a Sex Offender Registry search must be conducted before admitting any adult in the household into the emergency shelter.

Prioritization

Emergency shelters that serve single individuals in the Fairfax-Falls Church community are filled utilizing a tool known as the Shelter Triage, Access and Referral System for Singles (STARSS). Individuals can choose to be placed in the STARSS for one, two, or all three of the emergency shelters for single individuals: the Bailey's Crossroads Community Shelter; the Eleanor U. Kennedy Community Shelter; and the Embry Rucker Community Shelter. Individuals will be prioritized based on the highest score on the Singles E&P Tool, which obtains information regarding the presence of the following prioritization components:

1. Homeless history

2. Vulnerability
3. Disability status
4. Veteran status
5. Age
    a. Youth (ages 18-24)
    b. Elderly (ages 60+)
6. Currently pregnant
7. Terminal illness
8. Fairfax County residency status

Access, Assessment and Referral

Access to emergency shelter for single individuals experiencing homelessness is accomplished through the following steps:

1. Individuals seeking shelter must call one of the three emergency shelters that serve single adults. They can call at any time, 24 hours a day, 7 days a week, 365 days a year. If the individual calls Coordinated Services Planning (CSP), they should be instructed to call one of the emergency shelters directly. For individuals who are unable to call for themselves, such as those without access to a phone, those with an intellectual disability, brain injury, or serious mental illness, calls will be accepted by a representative/professional. Individuals without access to a phone personally or through a professional may go to the nearest shelter to be assessed on-site.

2. Each emergency shelter must have at least one person available on-site for a minimum of 8 hours between 8:00am and 6:00pm who is trained to administer the Singles E&P Tool and has access to the STARSS. This person, known as the "STARSS Specialist", must be a staff member of the agency/emergency shelter – volunteers, interns, etc. may not be designated as the STARSS Specialist. The agency/shelter can designate as many staff members as desired to be a STARSS Specialist as long as they are trained in the Singles E&P Tool and the STARSS. At least one STARSS Specialist must be on-site during the designated 8 hour shift and they must be immediately available to speak with individuals seeking shelter.

3. When an individual seeking shelter (or representative) calls one of the three emergency shelters that serve single adults between the hours of 8:00am and 6:00pm, they will be transferred directly to the STARSS Specialist on duty that day. If an individual seeking shelter (or representative) calls outside of the hours that the STARSS Specialist is on-site, the person answering the phone will take a message, informing the individual that they will receive a call back the following business day. This message should be delivered to the designated STARSS Specialist and the individual should be called back within the first 4 hours of their 8 hour shift the following business day.

4. Either at the time of the call or upon returning a message, the STARSS Specialist will administer the Singles E&P Tool to determine the individual's eligibility and priority score based on the previously mentioned criteria. If the STARSS Specialist determines that the individual is eligible, diversion to safe and stable housing is unsuccessful, no other housing options are available, and the individual provides verbal permission to allow their information be stored in the STARSS in HMIS, the STARSS Specialist will add the individual to the STARSS within 6 working hours of eligibility determination. Regardless of which shelter the individual has called, they can elect to be placed into the STARSS for any or all of the three emergency shelters that serve single adults. It is important to note that:

a. The STARSS is not a traditional waiting list and cannot be used as a discharge plan for people exiting institutions (jail, hospitals, etc.), facing eviction, or otherwise not meeting the previously mentioned eligibility requirements, unless literal homelessness is verifiably imminent within the next three (3) days.

b. Individuals will be ranked in the STARSS based on their prioritization score, which is calculated using the Singles E&P Tool. These rankings are not stagnant and are subject to change as new individuals are added to the STARSS.

c. If an individual states that they are currently experiencing unsheltered homelessness, a referral to the Singles Outreach program must be made so that street outreach services can be offered/provided while the individual is in the STARSS. Shelters are required to develop a system to ensure that this transfer of knowledge takes place.

d. When an individual is added to the STARSS, they will be informed that if they do not receive a call for shelter in six (6) months from their entry date, they will be exited from the STARSS and will need to call back should they still be in need of shelter. They will also be made aware that if they turn down three (3) appropriate shelter opportunities (based on their stated preferences on the Singles E&P Tool), they will be exited from the STARSS and will need to call back should they still be in need of shelter.

5. Individuals will be called into shelter beds Monday through Friday (except holidays), as beds become available. To determine the next eligible person, the STARSS Specialist should follow the instructions below:

    a. Identify the person with highest Singles E&P Tool score on the STARSS.

        i. If there is more than one person with the same Singles E&P Tool score, determine who has the earliest entry date into the STARSS

    b. Apply the following filters to those who have been identified to determine if they are appropriate for the bed space available:

        i. Preferred dorm assignment (based on gender identification).

        ii. Preferred region/shelter location.

    c. Ensure there are no applicable bans in place that would prevent the individual from being eligible to access the shelter bed by looking in the individual's HMIS profile.

    The individual with the highest Singles E&P Tool score and meets the filter criteria for the available bed should be selected to fill the vacancy. If two or more individuals have the same Singles E&P Tool score then the individual with the earliest entry date into the STARSS should be selected. It is important to note that individuals with an active shelter-specific ban in place for the shelter that has the bed vacancy and/or a system-wide ban in place for all Fairfax County shelters will not be eligible for the vacant bed until their ban has expired or has been lifted. In order to find this information, shelter staff will need to go into the individual's HMIS client profile and look under "Incidents" before admitting the individual into shelter.

6. To ensure that shelter beds are filled quickly and do not stay vacant for an extended period of time shelter staff should start the process of contacting and selecting the next prioritized individual when a bed is known to be coming available prior to it actually becoming vacant.

   To further ensure that beds are filled quickly, staff should contact the first three individuals in the STARSS when attempting to fill a bed. If the first person/representative cannot be contacted immediately (i.e. doesn't answer phone), staff should try and contact the second person. If the second person cannot be contacted immediately, staff should contact the third person. The first person who returns the call to enter shelter and is eligible will be selected for the bed, while the others will remain in the STARSS for the next available vacancy.

7. Prior to shelter entry, staff should attempt to divert individuals from entering shelter (family, friends, other acceptable housing placement, etc.). If an individual is experiencing literal homelessness, diversion is not appropriate and should not be attempted. Staff must confirm that the individual is still eligible for the bed.

8. Once an individual has been admitted into the shelter, staff will complete the Standardized Intake Form, Release of Information, and any other necessary paperwork.

   During this initial intake, the individual will be made aware that the primary purpose of accessing shelter is to provide a safe but temporary place for the person to reside, but the main focus of all services provided will be on transitioning to safe, affordable, and permanent housing. While other case management services will also be made available, individuals should be fully aware that the main purpose of these services will be entry into permanent housing as quickly as possible.

   For individuals with an existing case manager in HMIS through outreach or another program, intake staff should notify that case manager that the individual is currently residing in the shelter. Once the individual has started their shelter stay, the shelter staff should exit them from the STARSS as soon as possible.

9. If an individual determined to be the next eligible person for a shelter bed and is unable to fill the bed that same day, the following consideration should be taken:

   a. If the individual states they are currently experiencing homelessness and indicates they can get to the shelter the following day, the bed should be held. If the individual does not make it to the shelter by the agreed upon time set forth by the shelter, the next eligible person in the STARSS will be contacted for the available bed. The individual who was initially selected should remain in the STARSS for the next available bed.

   b. If the individual states they are no longer experiencing homelessness because they are currently in the hospital, staying at a friend's house temporarily, or otherwise housed, they should be exited from the STARSS and the next eligible person in the STARSS should be selected. If the individual states they will be at that location for no more than three (3) days and will be literally homeless at that time, the bed should be held pending verification.

c. If the individual states they are no longer experiencing homelessness because they are permanently housed, no longer in Fairfax County, etc., they should be exited from the STARSS.

d. If the individual who is next in the STARSS is unable to be reached, they should remain in the STARSS and shelter staff should contact the next eligible individual. If the individual cannot be successfully contacted after five (5) different bed opportunities, they should be exited from the STARSS.

10. Providers must exercise due diligence when filling vacancies to ensure that individuals are served based on the prioritization indicated in this document. Some individuals, particularly those experiencing unsheltered homelessness and living on the streets or other places not meant for human habitation, might require significant engagement and contacts prior to entering services and all attempts should be made before moving onto the next eligible individual.

STARSS Management

There will be a monthly data quality process to ensure that the STARRS is kept as up-to-date and accurate as possible. To further this goal, individuals will be exited from the STARSS for the following reasons:

1. Entry into shelter – once an individual has entered into one of the three full-time emergency shelters, they should be immediately exited from the STARSS by the shelter that accepted them into a bed. Individuals who have entered into a Hypothermia or Winter Seasonal program should remain in the STARSS.

2. Entry into permanent housing – if an individual states that they have entered permanent housing and / or is no longer experiencing homelessness, they should be exited from the STARSS by the shelter that contacted them for a bed.

3. No longer eligible – if an individual no longer meets the eligibly criteria at the time the bed becomes available, they should be exited from the STARSS by the shelter that contacted them for the bed.

4. Refusal of three (3) different shelter opportunities – if an individual refuses 3 opportunities for shelter that meet their stated preferences, they will be exited from the STARSS under the assumption that they are no longer in need of shelter.

5. Have been inactive for more than six (6) months – individuals who have been in the STARSS for 6 months but have not been contacted for a vacant bed opportunity will be exited from the STARSS through the monthly HMIS data quality process.

Suspensions, Bans and System-Wide Bans

The safety and security of shelter staff, volunteers, and guests is the highest priority when it comes to operating an effective emergency shelter program. As a result, the use of suspensions and bans are sometimes necessary to ensure that these risks are minimized as much as possible. While there are a variety of behaviors and actions that may be considered inappropriate and warrant some sort of disciplinary action, a low-barrier shelter philosophy implies that there should be thresholds for which an individual is suspended and / or banned, centered primarily around safety.

A low-barrier approach also encourages emergency shelters to limit the number of individuals who are exited from shelter into homelessness as a result of behaviors not related to physical violence, other threats to personal safety, and illegal behavior. As a result, the following guidance should be followed by all emergency shelters that serve individuals experiencing homelessness in the Fairfax-Falls Church Partnership. This guidance applies to full-time emergency shelter programs; the Hypothermia Prevention and Winter Seasonal programming should operate similarly, with an added emphasis on being low-barrier due to the life-saving nature of the program. More can be found about the Hypothermia / Winter Seasonal program throughout the guidance below, as well as in Section 2.4 – Hypothermia Prevention and Winter Seasonal Program. It is important to note that while this guidance should be used as the template for shelter providers to make disciplinary decisions, agency discretion on the part of those operating the shelter is always advised.

Additionally, for the sake of consistent and clear messaging to those who utilize shelter services throughout Fairfax County, all shelters and Hypothermia programs should use the following disciplinary terms when talking about or implementing *temporary suspensions, shelter-specific bans, and system-wide bans.* Other language previously used by individual agencies (stay away, no trespass, suspension of services, etc.) should not be used in order to maintain consistency throughout shelter programs.

Lastly, agencies must adhere to the Fairfax County contract language regarding incident reporting, which states that shelters must "provide a written report, within 24 hours, following any incident that has resulted in an injury requiring medical attention or death to any person(s) or substantial damage to property such that it requires replacement or professional repair by the County." If there is a death, in addition to the written report, Contractor is required to notify the Director or Program Manager of OPEH within one hour.

The written report must include the following information:

1. Person(s) name.
2. Date of birth.
3. Place of birth.
4. Previous residence.
5. When possible, the contractor should have on record of the person(s) brief health history, the name of the most recent health provider and location (clinic, hospital) where the person was attended, description of incidence, date/time, person(s) involved, who was informed after the fact, what follow up action(s) have been taken or planned and who to contact for follow up.
6. Details of the incident and all parties involved.

Ineligible Behaviors for Automatic Suspension and Bans

In order to follow the philosophy of being a low-barrier shelter, there are many behaviors that should not be permitted, but should also not result in the individual being exited from the shelter back into homelessness as the immediate response. Instead, other interventions should be attempted in order to correct the behavior while still allowing the individual to remain sheltered and continue working

towards securing permanent housing. Examples of behaviors that should not automatically result in a suspension or ban from shelter include, but are not limited to:

1. Violation of shelter/agency rules not related to safety.
2. Refusal to participate in services.
3. "Disrespectful" language towards staff *.
4. Having food in prohibited areas.
5. Missing curfew.
6. Possession or consumption of alcohol **.
7. Possession of illegal drugs **.

* There is a distinction between language that is considered "disrespectful" and language that threatens harm to those around them. With this in mind, discretion should be applied when interpreting these disciplinary procedures.

** Drugs and alcohol should be disposed of appropriately when they are identified; an individual's refusal to relinquish these items and allow for their disposal as directed by staff could result in a temporary suspension or shelter-specific ban. Possession of alcohol or illegal drugs or the consumption of alcohol while on shelter property should not be permitted, but should not result in a suspension from shelter unless the action/offense results in a serious threat to the safety of others or if the action continues to be repeated after multiple attempts at curbing the behavior have been taken. The use of illegal drugs while on shelter property could result in an immediate temporary suspension at the discretion of the shelter director.

Temporary Suspensions

A temporary suspension is a short period of time where an individual is unable to access a particular shelter program. Suspensions may be enforced when an individual staying at the shelter behaves in a way that is inappropriate/unacceptable but does not pose a threat to the overall safety of themselves or others. Examples of behaviors that could result in a temporary suspension from emergency shelter include, but are not limited to:

1. Purposeful destruction of shelter property.
2. Use of illegal drugs while on shelter property.
3. Repeated consumption of alcohol while on shelter property.
4. Possession of an object/instrument/substance which could be used as a weapon, including a knife, metal pipe, shears, bleach, etc..
5. Stealing from staff, volunteers, or another guest.
6. Speech or behavior that threatens harm to other shelter guests, staff, or volunteers.

If the offense takes place during participation in the Hypothermia / Winter Seasonal program, all other options should be explored before a suspension is implemented, including relocating the individual to a different site. Furthermore, any offenses that take place during the Hypothermia/Winter Seasonal season should be treated with additional consideration and discernment due to the life-saving nature of the program.

Once an individual has been temporarily suspended, the shelter should note the suspension in the individual's HMIS profile through the use of *Client Notes*. In order to be found easily, please start the note with the word "Suspension" and the date. An incident report and / or notification of OPEH is not necessary for temporary suspensions.

Temporary suspensions should not exceed one (1) month, with seven (7) days being the maximum amount of time permitted during the Hypothermia season, at which time the individual can be referred back to shelter where the offense took place through the STARSS. It is important to note that a temporary suspension at one shelter does not bar an individual from being referred to one of the other singles shelters and the individual should be informed of that opportunity prior to leaving the property.

Shelter-Specific Bans

A shelter-specific ban is an extended period of time where someone is barred from entering the shelter where the offense that led to the ban took place. An individual may be banned from one of the shelters that serve single individuals if he/she commits a serious offense that is a direct threat to the safety of themselves, staff, volunteers, and/or other residents. Serious offenses include, but are not limited to:

1. Physically threatening behavior that cannot be deescalated or requires intervention from the police.

2. Refusal to comply with staff direction related to the possession/disposal of drugs, alcohol, or potential weapons.

3. Repeated suspensions for behaviors that disrupt the overall operations or services of the shelter and associated programs

Bans should not exceed a period of one calendar year (or one season if the offense takes place while participating in the Hypothermia / Winter Seasonal program), with consideration given to the severity of the action and the resulting outcome of that action when determining the length of time an individual is barred from the shelter. Additional consideration is required if the offense takes place during the winter months.

It is recommended that a one-year ban be reserved for the most serious of offenses and not be considered the default time period for all bans. Once a timeframe has been set and a ban has been placed on the individual, the shelter must note the ban in the individual's HMIS profile under *"Incidents*" in the Client Profile and email the individual's HMIS number to the Singles Programs Manager at OPEH. The email should include the reason for the ban and the length of time it will be instituted. OPEH reserves the right to overturn the ban or alter the timeframe of the ban should it be determined an inappropriate response or overly punitive based on the standards set forth in this document. An incident report must be sent to the Singles Programs Manager at OPEH anytime an individual is banned. Once OPEH has approved the ban, the shelter must email the directors of the other singles shelters and hypothermia programs, as well as the Single Programs Manager, with the reason for the ban and the length of time it will be instituted.

System Wide/Fairfax County Bans

Depending on the seriousness of the offense and the resulting outcome, a system-wide ban resulting in an individual's inability to access any emergency shelter within Fairfax County may be implemented. Examples of behaviors which could result in a system-wide ban include, but are not limited to:

1. Possession of a firearm on shelter property.

2. Physical violence that results in the harm/injury of another resident, staff, volunteer, or anyone else on shelter property.

3. Refusal to comply with policies regarding illegal drug use on shelter property.

In order to implement a system-wide ban, the directors of each of the singles shelters must unanimously agree that such an action is necessary and appropriate; and request approval from OPEH to implement the ban. A preliminary incident report detailing the events that led to the request for a system-wide ban should accompany the request. Depending on the offense, a system-wide ban could be implemented for an undetermined time-period, with the individual possibly being barred from the Fairfax County shelter system permanently. Once OPEH approves the system-wide ban, either the Singles Programs Manager or another representative from OPEH will inform the rest of the Fairfax CoC, as well as neighboring jurisdictions and other stakeholders as appropriate.

The initiating shelter should note the ban in the individual's HMIS profile under "*Incidents*" in the Client Profile. In addition to the circumstances provided above in the contract language regarding incident reporting, a full incident report must be sent to the Singles Programs Manager at OPEH within 24 hours of the incident that resulted in the ban. Any additional supporting documentation, such as written statements from witnesses, police reports, etc. should accompany the incident report or provided at a later date once they are made available.

System-wide bans are reserved for the most serious offenses and severe threats of safety and their implementation will serve as a last resort only when no other options are available/appropriate. OPEH reserves the right to reject a system-wide ban if it is determined to be inappropriate response or overly punitive based on the standards set forth in this document.

Length of Stay

Emergency shelter is meant to provide a safe, but temporary environment for individuals to get connected with services, most notably permanent housing. Individuals should be made aware of this fact as soon as they enter shelter. While the ideal length of stay in shelter should not exceed 30 days, it is also important to ensure individuals experiencing homelessness transition into permanent housing and do not exit back into homelessness as much as possible. Therefore, shelter staff should do everything possible to keep shelter stays short and exits back into homelessness low.

A summary graphic of the work-flow for Single's prevention, outreach and emergency shelter is provided in the Tools and Forms – Adult Only Households section at the end of this manual.

2.4 Hypothermia Prevention and Winter Seasonal (WS) Programs - Singles

Through the operation of the Hypothermia Prevention / Winter Seasonal programming, the capacity of the emergency shelters that serve single individuals is expanded to ensure that no one is at risk of dying from hypothermia due to lack of shelter space. Nonprofit agencies partner with faith communities and other county agencies to provide ancillary space for individuals to access shelter when the year-round emergency shelters are full. At its core, the Hypothermia Prevention / WS programs are life-saving and aim to be as low barrier as possible, allowing for anyone who is over the age of 18 and seeking shelter to participate. Because the Hypothermia Prevention / WS programs expand the emergency shelter capacity to accommodate everyone who needs it, prioritization, access, and assessment criteria are not necessary to determine who is able to participate.

Case management services will be offered to every individual who participates in the program, but will not be required to continue accessing the program for shelter. There is no length of stay maximum and individuals can access the program for as long as they need to throughout its duration.

No Turn Away / Overflow

During the non-Hypothermia program months (April through November), emergency shelters return to their normal capacity correlated to the number of physical beds they have in the building. The operation of additional "overflow" where people are accommodated on the floor, couches, etc. in the event that all of the actual shelter beds are full should only be utilized in the case of emergencies or other special situations on an extremely limited/temporary basis. Emergencies and special situations could include (but may not be limited to) providing shelter to someone who:

1. is considered extremely vulnerable;

2. presents at the shelter in the middle of the night with no other options; or

3. is considered a flight risk and shelter staff needs to know their whereabouts the following day for a specific case management / housing-related purpose.

Anyone who is placed in "overflow" for the night should be advised of their options the following day about other accommodations and/or referred to the STARSS if appropriate. Individuals who spend the night at the shelter, regardless of the reason, must complete a basic assessment and release of information (ROI) to be entered into HMIS.

If that individual is unsheltered, a referral should be made to the agency's Singles Outreach staff so that the individual can be added to the Unsheltered By-Name List and be connected with case management services if they are interested. "Overflow" stays should not exceed a few days.

A "no turn away" policy is enacted when there is the need to increase the normal capacity of the emergency shelter system to ensure the safety of those experiencing homelessness. When "no turn away" is in place, any individual experiencing homelessness can request and access shelter. There is a standing "no turn away" policy in place from December 1 through March 31 in association with the Hypothermia Prevention and Winter Overflow Programs. From April 1 through November 30, "no turn away" is enacted if and when the weather forecast for Fairfax (based on Accuweather – www.accuweather.com) is predicting the following temperatures or conditions at any point throughout the day/night:

1. temperatures at or below 36 degrees Fahrenheit (actual or "feels like");
2. temperatures at or above 100 degree Fahrenheit (actual or "feels like"); or

3. other severe weather conditions, including flash flooding, hail, etc..

There may also be the need to expand shelter capacity through overflow accommodations due to other extraordinary circumstances, which will be dealt with on a case by case basis and communicated to all stakeholders as appropriate.

2.5 Rapid Rehousing – Singles

The following table summarizes coordinated entry processes for rapid rehousing (RRH) for singles. Each element is explained in detail in the manual.

Coordinated Entry Summary – Rapid Rehousing Singles				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
HUD Definition of Homelessness Categories 1 & 4	When RRH resources are limited and single's seeking RRH, the following is used for Prioritization: 1. Fairfax County Residency 2. VI-SPDAT scores 5-9	Emergency Shelter, including Hypo Prevention Program Single's Outreach	VI-SPDAT	No formal requirements for referral to RRH See special populations for additional information regarding RRH programs for 1) youth and 2) those fleeing domestic violence

Rapid rehousing programs provide the support services and financial assistance necessary to help people experiencing homelessness move as quickly as possible into permanent housing and achieve stability in that housing.

The following policies, procedures and written standards provide a minimum set of guidelines for RRH projects in the Fairfax CoC. Local RRH projects must also refer to the rules and regulations established by their respective funders to ensure compliance with specific funding requirements. Local RRH projects are funded by a variety of public and private sources, such as government grants and contracts:

- Federal – Continuum of Care (CoC); Emergency Solutions Grant (ESG); and Supportive Services for Veteran Families (SSVF).
- State – Virginia Homeless Solutions Program (VHSP).
- Local – Fairfax County's Programs to Prevent and End Homelessness.

As well as grants and donations from:

- Foundations.
- Businesses.
- Faith communities.
- Individuals.

The three core components of a rapid rehousing program, as defined by the National Alliance to End Homelessness (NAEH) are:

1. Housing Identification:

    a. Recruit landlords to provide housing opportunities for individuals experiencing homelessness.

    b. Address potential barriers to landlord participation such as concern about short term nature of rental assistance and tenant qualifications.

c. Assist households to find and secure appropriate rental housing.

2. Rent and Move-In Assistance (Financial):

    a. Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance (typically six months or less) necessary to allow individuals to move immediately out of homelessness and to stabilize in permanent housing."

3. Rapid Re-housing Case Management and Services:

    a. Help individuals experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources.

    b. Help individuals and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues).

    c. Help individuals and families negotiate manageable and appropriate lease agreements with landlords.

    d. Make appropriate and time-limited services and supports available to families and individuals to allow them to stabilize quickly in permanent housing.

    e. Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing assistance is provided.

    f. Provide or assist the household with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the household has access to resources related to benefits, employment and community-based services (if needed or appropriate) so that they can sustain rent payments independently when rental assistance ends.

    g. Ensure that services provided are client-directed, respectful of individuals' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance.

Eligibility

Rapid rehousing assistance may be provided to program participants who meet the following two criteria:

1. Meet the HUD definition of "Homeless", Categories 1 or 4:

    a. <u>Category 1 - Literally Homeless</u>

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

i. Has a primary nighttime residence that is a public or private place not meant for human habitation;

ii. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

iii. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

b. Category 4 -Fleeing/Attempting to Flee Domestic Violence

Any individual or family who:

i. Is fleeing, or is attempting to flee, domestic violence;

ii. Has no other residence; and

iii. Lacks the resources or support networks to obtain other permanent housing

2. Additional eligibility standards may be required for some RRH projects based on the specific project's funding (e.g. veterans, survivors of domestic violence, or transition age youth).

Prioritization

RRH projects may provide all or some of the core elements to program participants based on the available resources. Like most communities, there is a scarcity of housing and services resources; therefore it is important that RRH projects prioritize people for assistance. In some cases, the "housing identification" and "rapid rehousing case management and services" may be readily available but "rent and move-in assistance (financial)" will not.

When necessary, RRH projects should prioritize households using the criteria below:

1. Fairfax County residents (See "Key Terms" section for the definition of "Fairfax County Residency Status") should have a priority over those who are not; and

2. individuals with VI-SPDAT scores between five (5) and nine (9).

The Fairfax CoC uses the "*Progressive Engagement"* model (US Department of Veteran Affairs, 2016) in rehousing individuals experiencing homelessness. This model is based on the strategy of assisting the greatest number of people possible by using the minimal amount of resources necessary to end an individual's or family's homelessness. The model also promotes greater flexibility and individualization in determining how much assistance is provided.

All individuals experiencing homelessness for the first time should be offered a basic level of rapid rehousing assistance from all three core components: housing identification, rent and move-in financial assistance, and case management. The level of financial assistance for rent and move-in costs should begin at a minimal amount, such as the security deposit and one month of rent. The specific amount of initial financial assistance will vary depending on a program participant's financial capacity and needs, as well as programs' funding restrictions and availability. Once the program participant is in permanent housing, additional evaluations are used to determine whether more months of assistance are required for the household to maintain housing stability.

Access, Assessment & Referral

Individuals can access rapid rehousing assistance via emergency shelter or street outreach. Please refer to those sections of the manual for information regarding how individuals access shelter or participate in singles outreach. Seasonal emergency shelters, such as the Hypothermia Prevention Program, also serve as points of access to RRH assistance.

Rapid rehousing staff will assess a prospective program participant using the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)

All Fairfax County emergency shelters and outreach providers offer case management, housing location, and direct assistance (financial or rental) when available. Shelter and outreach providers should start providing individuals with rapid rehousing assistance when:

1. Information provided by the client indicates they meet the eligibility criteria for admission;
2. Client has indicated they want to be housed with rapid rehousing assistance; and
3. Client is able to access services and housing.

The expectation is the project has a housing opening or expects to have one in a reasonably short amount of time. (Note that the admission criteria mirrors the HUD HMIS Data Standards for "Project Start Date" in a RRH project.)

Special Populations & External Referrals

Fairfax CoC maintains unique rapid rehousing projects with distinct referral processes for special populations who are experiencing homelessness that would require referral(s) to another organization, or "external referrals". Please see the "Special Populations" chapter for more information on how to refer to dedicated RRH projects for the following special populations:

1. Transition Age Youth.
2. Survivors of Domestic Violence.
3. Veterans.

Individual RRH projects have ultimate responsibility for determining the eligibility of prospective participants in their programs and for collecting and maintaining eligibility documentation. However, referring workers should do a preliminarily eligibility screening before making a referral to determine the likelihood of a prospective participant's eligibility. The collection of documents to determine eligibility might be ongoing, starting at initial triage and building over time as more in-depth assessments are completed as needed. Therefore, eligibility will be determined as part of the assessment process, as well as by the agency receiving the referral. Documentation and eligibility might be initially determined, but would need to be re-established at the point of RRH project entry, especially if a long period of time has passed between assessment and project entry.

When two or more RRH projects are providing assistance for a household, they must work collaboratively to avoid service redundancies and successfully rehouse the program participants as quickly as possible. Frequent, regular communication between the RRH project staff and between staff and program participants is essential to effectively achieve this goal.

Referral Rejection Protocols

A referral may be rejected by the potential participant, or the housing or supportive services provider. Many factors or issues can precipitate a rejection.

1. Potential participants may perceive the referral as representing a housing or services option that does not address their immediate housing goals and preferences. In those instances, the referring entity should make every effort to identify other referral options and work with the potential participant to find alternative accommodations.

2. The project receiving the referral through the coordinated entry process may be the source of the referral rejection. For example, a project might be experiencing situational staffing constraints. Programmatic changes or funding issues might necessitate a temporary hold on accepting referrals. Or, after considering the unique housing barriers and attributes of a particular referral, the project receiving the referral might decide the project does not have sufficient programmatic capacity or expertise to provide the housing and services necessary to resolve the person's housing crisis. Other reasons for programmatic rejection includes the following situations:
    a. The client lacks required eligibility documentation; or
    b. Does not follow through with the admission process in a timely manner; or
    c. Homeless services were previously terminated as a result of violence or threats of violence.

Regardless of the specific circumstances of the project's rejection, in all situations the project should communicate the decision clearly and quickly (no more than two business days) to the entity making the referral. This communication should include:

1. the reason for the rejection;
2. any factors or a change in circumstances that could allow the project to reconsider and actually accept the referral; and
3. other pertinent information that came to light during the referral review that might affect the potential participant's referral standing at other housing and services projects.

In cases where rejection to a RRH project is uncertain, partner organizations are encouraged to conduct a case conference in which the entity making the referral, the project rejecting the referral, and potentially the participant meet to share information and collectively consider alternative referral options. The goal of the referral process is to quickly and successfully connect persons experiencing a housing crisis to available housing and services. A case conferencing meeting among all parties concerned is often the most effective way to achieve this goal when the standard referral process is not working as planned.

2.6 Permanent Supportive Housing (PSH) – Singles

The following table summarizes coordinated entry processes for PSH for singles. Each element is explained in detail in the manual.

Coordinated Entry Summary – PSH Singles				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
1. HUD Definition of Homelessness, Category 1 2. Documented disability 3. VI-SPDAT Score of 10+	1. CH w/ most homeless history **and** highest VI - SPDAT score 2. CH with most homeless history 3. CH with highest VI-SPDAT score If there are no eligible CH 4. Homeless w/ disability and the most homeless history. 5. Homeless w/disability and highest VI-SPDAT Score	1. Emergency Shelter 2. Outreach	VI-SPDAT	Prioritization Pool in HMIS

Permanent supportive housing is permanent housing in which supportive services are provided to assist homeless persons with a disability to live independently. It should serve people with the longest length of homelessness, highest needs and greatest barriers towards obtaining and maintaining housing on their own, especially those who are experiencing chronic homelessness.

Eligibility

Singles must meet the following four criteria to be eligible for PSH:

1. Individuals defined as homeless under the HUD definition, Category 1:

   An Individual who lacks a fixed, regular, and adequate nighttime residence, meaning:

   a. Has a primary nighttime residence that is a public or private place not meant for human habitation;

   b. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

   c. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

2. The individual must have a documented, long-term disability *(See "Key Terms" section for definition and requirements for Documented, Long-Term Disability);* and

3. Have a score of 10 or greater on the VI-SPDAT.

4. Any additional eligibility requirements specific to the project's funding (e.g. programs for survivors of domestic violence, programs for people with serious mental illness or chronic substance abuse or programs for veterans).

Prioritization

PSH providers should consider the identified target populations served by the project and use the following order of priority to select participants for the PSH project:

1. Individuals experiencing chronic homelessness with the longest history of homelessness and with the highest severity of service needs *(See the "Key Terms" section for definitions).*

2. Individuals experiencing chronic homelessness with the longest history of homelessness.

3. Individuals experiencing chronic homelessness with the highest severity of service needs.

If a PSH provider is not able to identify any eligible individuals experiencing chronic homelessness then the PSH provider can proceed to fill vacancies using the following order of priority).

1. Individuals experiencing homelessness with a disability and the longest period of cumulative homelessness.

2. Individuals experiencing homelessness with a disability with the most severe service needs.

Providers must exercise due diligence when filling program vacancies to ensure that persons are served in the order of priority above. However, some persons – particularly those living on the streets or in places not meant for human habitation – might require significant engagement and contacts prior to entering housing. Providers are not expected to keep units vacant while case managers and outreach workers continue to work with these individuals to accept housing. If someone refuses an offer of housing, they remain eligible, but the provider should move onto the next person. Case managers and outreach staff should continue to make attempts to engage these individuals.

Access, Assessment & Referral

1. Individuals will be assessed within 10 business days of seeking assistance with the Vulnerability Index – Service Prioritization Decision Assistance Tool (VI-SPDAT)

2. Homeless assistance staff should complete a referral in HMIS for all individuals who have a disability and a score of 10 or more on the VI-SPDAT.

See the Prioritization Pool and HMIS Workflow section of the manual for directions on entering referrals and to learn how providers use the Pool to fill vacancies.

Program Selection Policies

The PSH provider is responsible for notifying the referring case manager and the individual if the individual was not accepted into the program.

1. Common reasons individuals are not accepted into the program include:

    a. Lack of required eligibility documentation.

b. Not meeting minimum eligibility criteria.

c. Program unable to meet client needs (ex: clients in need of assisted living level of care may not be appropriate for an independent living program with 1 – 2 weekly visits).

d. Denied based on appropriateness of client as per tenant screening procedures which must be outlined in the program's publicly-posted tenant selection plan that is maintained by the property owner, property manager or program staff (See '*Common Tenant Selection Process*' listed below).

e. Client applicant does not provide additional documentation as requested or repeatedly misses program appointments.

f. Client applicant is not willing to participate in housing program.

The following is a list that is often used by property managers to determine eligibility for their specific housing resources. None of the following are automatically disqualifiers. Clients who are denied due to tenant selection policies have not been rejected from the program and may be able to be successfully housed in a different opportunity.

2. Common Tenant Selection Policies:
    a. Credit history.
    b. Income / employment / education requirements.
    c. Size of unit as compared to size of household.
    d. Criminal history, such as a felony conviction or being on the sex offender registry.

Clients retain the ultimate right to accept or refuse housing. Clients who refuse housing are not considered to have been rejected by the program provider.

3. Client Choice Factors:
    a. Geographic location of housing.
    b. Accessibility of unit.
    c. Client willingness or ability to share housing (if applicable).
    d. Preferred service provider.

This information should be captured in HMIS as described in the Pool and HMIS workflow section. Per HUD requirements, there is no limit as to how many times a client can reject housing opportunities. They remain in the Prioritization Pool as long as they are eligible and interested in offers of housing.

Documentation of Denials and Appeals

Providers must use the following procedures for denials and appeals.

1. *Denial of Tenancy:*

    a. Denials must be in compliance with the coordinated entry policies and procedures as outlined in this manual.

b. Provider must document the reason for denial of tenancy in HMIS and send it to the referring case manager and client.

c. Repeated denials of Individuals and Families by a PSH Provider for tenancy may require additional monitoring and evaluation of the provider's decisions by the Fairfax County Office to Prevent and End Homelessness.

2. *Client Rejection and Appeals:*

a. PSH program must have an appeal process in place and available to anyone who requests a copy.

b. Appeals must be submitted in writing within three (3) days of rejection. PSH providers should respond to the appeal letter within 3 days of receipt. The client must make every reasonable effort to provide the necessary information and documentation required for tenancy.

c. The PSH provider must inform the CES Manager of any appeals in process.

2.7 Other Permanent Housing - Singles

2.7 a. Bridging Affordability

The following table summarizes Coordinated Entry for Bridging Affordability for singles.

Coordinated Entry Summary – Bridging Affordability, Singles				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
1. Participants must meet the HUD definition for Homelessness, Category 1. 2. Households must have a source of income. 3. Gross income must be below 30% of AMI for Homeless households. 4. Must be resident of Fairfax County. 5. Household must have legal presence in the United States. 6. VI-SPDAT score between 7 and 11.	Highest Score on the VI-SPDAT in the 7 to 11 range.	Emergency Shelter	VI-SPDAT	Prioritization Pool in HMIS

Fairfax County funds a rental assistance program called Bridging Affordability. The program is administered by the Department of Housing and Community Development and contracted to a local non-profit, Northern Virginia Family Services (NVFS). Through a collaborative agreement this program has dedicated some of its slots to individuals experiencing homelessness. Participants secure a lease in their name and receive supportive services and rental subsidies for up to a year.

Eligibility

Prospective program participants must meet all five of the following eligibility criteria:

1. Participants must meet the HUD definition for Homelessness – Category 1:

   A family that lacks a fixed, regular, and adequate nighttime residence, meaning:

   a. Has a primary nighttime residence that is a public or private place not meant for human habitation;

   b. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

   c. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

2. Households must have a source of income.

3. Gross income must be under 30% of AMI for homeless households.

4. Must be resident of Fairfax County.

5. Household must have legal presence in the United States.

Prioritization

The following lists the prioritization order for Bridging Affordability:

1. Participants with earned income that is within the eligibility requirements listed above. *

2. VI-SPDAT scores between 7 and 11.

3. Longest history of homelessness.

   * While earned income is prioritized, Bridging Affordability will accept individuals who have non-earned income (ex. disability benefits) on a case-by-case basis.

Access, Assessment and Referral

Access to Bridging Affordability is through the emergency shelter or outreach systems. Individuals are assessed using the VI- SPDAT. Referrals are made to the Prioritization Pool. See the Prioritization Pool and HMIS workflow section for the details of submitting the referral.

2.7 b. Supported Upward Stability Through Advocacy In New Housing (SUSTAIN)

The Fairfax-Falls Church Community Services Board (CSB) manages a state-funded program for vulnerable, severely mentally ill individuals called Supported Upward Stability Through Advocacy In New Housing (SUSTAIN). The program provides housing and intensive support services. They have designated five (5) slots for homeless individuals in the Fairfax CoC. Individuals for these slots will be pulled from the Prioritization Pool as units become available using the established prioritization order of the Pool.

Homeless Services Programs for Households with Children

For the purposes of this document *Households with Children* will hereafter be referred to as "families" The Fairfax CoC's programs for this population include homelessness prevention, rapid rehousing, emergency shelter, transitional housing, permanent supportive housing, and other permanent housing.

3.1 Homelessness Prevention – Families

The following table summarizes coordinated entry processes for prevention services for families. Each element is explained in detail in the manual.

Coordinated Entry Summary – Prevention Families				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
1. At Risk For Homelessness as defined by HUD 2. Homeless as defined by HUD, Categories 2, 3, or 4	Highest Score on HSTT (When capacity requires prioritization)	CSP	CSP Assessment Family Prevention Screening Tool	From CSP to regional non-profit Note: Additional steps may be necessary if regional non-profit is at service capacity.

Homelessness prevention is the approach used to stabilize households in their current housing or help them to move into new housing without entering the shelter system or experiencing homelessness. Services may include financial assistance (security or utility deposits, utility payments, and moving cost assistance), short- or medium-term rental assistance, housing location, legal assistance, mediation, credit counseling, and case management. The support is provided to help households resolve their immediate housing crisis and access ongoing sources of support in the community in order to remain housed.

Diversion is a type of homelessness prevention, which seeks to prevent homelessness for those who are seeking emergency shelter by helping them identify immediate alternate housing arrangement. Diversion is not the refusal of services but instead, the provision of different services in an attempt to prevent someone's homelessness and their entry into shelter. Diversion targets people as they are applying for entry into shelter.

It is important to note that homelessness prevention, including diversion, cannot be attempted with someone who is already experiencing literal homelessness, as it occurs before someone reaches that point. Costs of homelessness prevention are only eligible to the extent that the assistance is necessary to help the program participant regain stability in the program participant's current housing or move into other permanent housing and achieve stability in that housing.

The support is provided to help households resolve their immediate housing crisis and access ongoing sources of support in the community in order to remain housed. The overall goal of prevention services is to:

1. reduce the number of families who become homeless for the first time; and

2. reduce the number of families experiencing multiple episodes of homelessness.

Due to its size, Fairfax County services are broken out into four Human Service Regions and referrals are made first to the region in which the family seeking assistance currently resides. If the regional program is unable to accommodate new homelessness prevention referrals (or they can only take case management referrals), they will contact the Coordinated Entry Systems Manager (CESM) who will verify whether closure for additional prevention cases is necessary. The CESM will then check availability with Northern Virginia Family Services (NVFS) that provides County-wide prevention assistance. If NVFS is unable to assist, then the CESM will identify other resources, if possible, for the prevention case. Collaboration and consistency across regions is important to the success of this structure.

**Dependent upon the availability of funding. The household must also meet the eligibility criteria of the funding source.*

Eligibility

Families must meet the criteria listed in either section (1) or (2) below in order to be eligible for homelessness prevention assistance.

1. The household must meet all three of the criteria below, (a) through (c):

    a. The household must be homeless in Categories 2, 3 or 4 per the HUD definition (detailed below).

    b. The household has an annual income at or below 30 percent of the area median income (AMI) for the area, as determined by HUD.

    c. Any additional eligibility requirements specific to the project's funding (ex. programs for survivors of domestic violence, programs for people with serious mental illness or chronic substance abuse or programs for veterans, etc.).

Details of HUD Categories 2, 3 and 4

- <u>Category 2 - Imminent Risk of Homelessness</u>
  Individual or family who will imminently lose their primary nighttime residence, provided that:
    - Residence will be lost within 14 days of the date of application for homeless assistance;
    - No subsequent residence has been identified; and
    - The individual or family lacks the resources or support networks needed to obtain other permanent housing

- <u>Category 3 - Homeless under other Federal statutes</u>
  Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:
    - Are defined as homeless under the other listed federal statutes;
    - Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;

- Have experienced persistent instability as measured by two moves or more during the preceding 60 days; and
- Can be expected to continue in such status for an extended period of time due to special needs or barriers

- Category 4 - Fleeing/Attempting to Flee Domestic Violence

  Any individual or family who:
  - Is fleeing, or is attempting to flee, domestic violence;
  - Has no other residence; and
  - Lacks the resources or support networks to obtain other permanent housing

OR

2. The family must be "At Risk of Homelessness" as defined by HUD:

   a. A family who:

      i. Has an annual income below 30% of median family income for the area; and

      ii. Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the "homeless" definition;

      iii. Meets one of the following conditions:

         A. Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR

         B. Is living in the home of another because of economic hardship; OR

         C. Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR

         D. Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR

         E. Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR

         F. Is exiting a publicly funded institution or system of care; OR

         G. Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness. OR

b. An unaccompanied youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under section 725(2) of the McKinney-Vento Homeless Assistance Act, and the parent(s) or guardian(s) or that child or youth if living with him or her.

Prioritization

Providers offering homelessness prevention services should use the following order of priority:

1. Families defined as "homeless" under the HUD definition Categories 2 or 4. Within these categories, families should be prioritized by those that meet the *most number* of the following three criteria:

   a. Fairfax County residents (*See "Key Terms" section for Fairfax County Residency Status definition*).

   b. Previous stay in emergency shelter as documented in HMIS (and / or verified by an emergency shelter serving victims of domestic violence) within 24 months after their date of exit to permanent housing.

   c. Any experience of homelessness.

2. Families defined as Homeless under the HUD definition Category 3.

3. At Risk of Homelessness.

Access, Assessment and Referral

1. Families seeking homelessness prevention assistance should call Coordinated Services Planning at (703) 222-0880 to be assessed to determine current housing status and level of need. CSP will send a referral to the Regional Homeless Referral Coordinator (RHRC) for families that meet the eligibility criteria as previously outlined. (*See "Key Terms" section for Regional Homeless Referral Coordinator definition*). Households who have received homeless services within the last year and are seeking services again are referred by CSP to the regional partner agency last providing services.

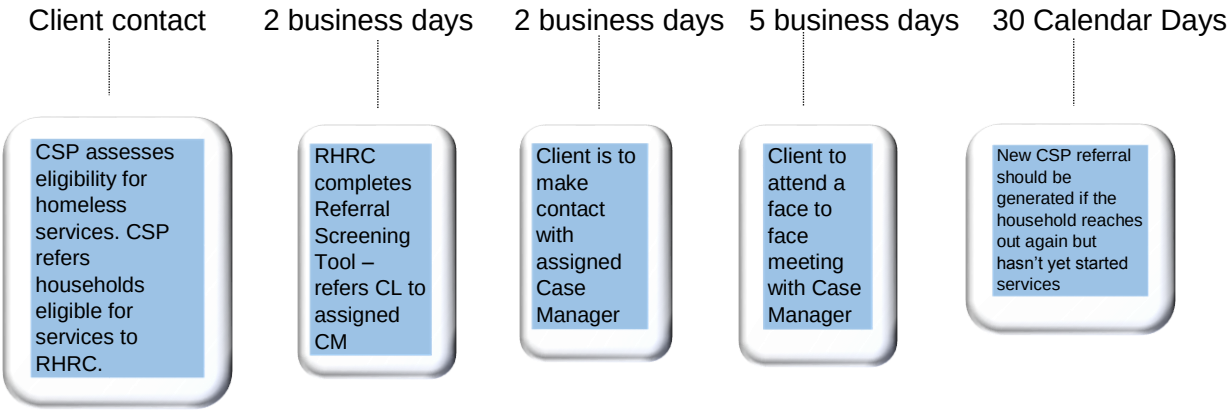
2. Upon receipt of the referral, the RHRC completes the Prevention Screening Tool in person or over the phone with the head of household to confirm eligibility.

3. The RHRC will provide the name and contact information of the assigned case manager to the head of household if the RHRC assesses the family to be eligible. The RHRC will also inform the client of their responsibility to make contact with the case manager within two (2) business days. A face to face meeting should occur within five (5) business days. The receiving agency will enter the household into HMIS once the case manager is assigned and the prevention intake is completed. During the first meeting with the client, the case manager will collect documentation

that confirms eligibility. If the household is receiving financial assistance, recertification must occur every 90 days.

4. On a monthly basis, the RHRC will provide outcomes of referrals from CSP on the Referral Outcome Tracker. In addition, RHRC should provide feedback directly to CSP Leadership on cases/situations/referrals that are challenging and/or likely to result in additional contact with CSP. CSP Leadership includes the CSP Program Manager and Regional Supervisors/Team Leaders who should be contacted here: ncs-cspteamleaders@fairfaxcounty.gov.

A referral from CSP will be considered valid for 30 calendar days. RHRCs should notify CSP on a monthly basis using the Referral Outcome Tracker of the outcome of all referrals received.



The homeless services provider is responsible for notifying the client and CSP if the client was not approved for services. The following is a summary of why this may occur:

Common reasons client is not accepted into program, include:

a. Lack of required eligibility documentation.
b. Not meeting minimum eligibility criteria.
c. Not following up within the timeframe established.
d. Homeless services were previously terminated as a result of threats of violence or violence.

Client Choice

Clients retain the ultimate right to accept or refuse services and / or entrance into services. Clients who refuse services are not considered to have been rejected by the program provider.

Denial of Services and Appeals Process for Prevention

1. *Denial of Services*

   The provider must document the reason for denial of services. Family service providers should notify Coordinated Services Planning of the outcome of the referral in writing. Family service providers should notify the client of the outcome verbally and in writing when possible.

2. *Client Participation and Appeals*

a. Every emergency shelter provider must have an appeal process in place and available to anyone who requests a copy.

b. The client must make every reasonable effort to provide the necessary information and documentation required for the appeal within the time frame of the appeal.

Family Services Planning Team (FSPT) Meetings

1. *Definition & Purpose* – FSPTs are the gathering of health and human service professionals that have experience working with the family or are from different agencies that may be able to provide support in developing a housing plan. At least one Fairfax-Falls Church Community Partnership staff person in addition to the primary housing or service provider must be present in order to qualify the meeting as a FSPT.

2. Types of FSPTs:

a. Entry FSPTs – An Entry FSPT may be held for households that have previously engaged in homeless services *or* are not experiencing literal homelessness but are requesting shelter instead of engaging in prevention services. The purpose of the Entry FSPT may be to (1) assist the family in addressing barriers to prevent or divert them from homelessness, (2) to review the details of a previous Exit FSPT (if applicable) including any requirements, contingencies, or time limits that were given, and/or (3) to determine if additional services or interventions can be offered moving forward. If they are literally homeless, they should be entered into shelter.

b. Exit FSPTs – Some participants receiving homeless services will fail to comply with the terms and conditions of their participant agreements or exceed their assigned length of stay in emergency shelter without identifying a housing plan. Program violations can run the gamut from minor to major issues, and the program operator must comply with the appeals process established for the program type. In some instances, program violations will be severe and/or repeated to the point that immediate program termination is necessary. If a household is reporting they will be literally homeless if exited and there are no safety risks posed to the provider, a FSPT should be scheduled to help the household identify options and OPEH notified.

c. Optional FSPTs – FSPTs can also be held any time that staff or clients feel it could be beneficial such as when (1) clients are experiencing difficulties in following their service plan (2) attempting to re-enter a program after a past successful exit or (3) voluntarily exiting a program.

3. *Documenting and Communicating FSPT Outcomes* – Following the determination of the FSPT, the homeless services worker that scheduled the FSPT should ensure that Coordinated Services Planning is aware of the decision of the meeting. If the family is exiting shelter into literal homelessness with minor children, and is determined to be ineligible for re-entry, the homeless services worker that scheduled the FSPT should make a report to Child Protective Services (CPS) via the CPS Hotline at (703) 324-7400. The family must be made aware that CPS will be called. This call should be made at actual program exit, when it is determined that the family will be unsheltered with minor children. Information shared with CPS staff should include the interventions that were provided, the reasons that they are being terminated, the reasons behind their ineligibility for re-entry, and any other information as it pertains to the safety or well-being of the children.

3.2 Emergency Shelter – Families

The following table summarizes coordinated entry processes for emergency shelter for families. Each element is explained in detail in the manual.

Coordinated Entry Summary – Emergency Shelter Families				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
HUD Definition of Homelessness- Categories 1,2 or 4	1. Category 1 with Fairfax residency status & Category 4 2. Category 1 without residency confirmation 3. Category 2	CSP	CSP assessment Family Prevention Screening Tool	From CSP to regional non-profit

Fairfax County emergency shelters serve families according to the following eligibility and prioritization criteria with the goal of transitioning those served back into permanent housing in 30 days or less.

Eligibility

Those seeking emergency shelter services are required to meet ***all*** of the following basic eligibility guidelines:

1. Be considered homeless under the HUD definitions of Categories 1, 2, or 4:

   Category 1 - Literally Homeless

   Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

   i. Has a primary nighttime residence that is a public or private place not meant for human habitation;

   ii. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

   iii. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

   Category 2- Imminent Risk of Homelessness

   Individual or family who will imminently lose their primary nighttime residence, provided that:

   i. residence will be lost within 14 days of the date of application for homeless assistance;

ii. no subsequent residence has been identified; and

iii. the individual or family lacks the resources or support networks needed to obtain other permanent housing

Category 4 - Fleeing/ Attempting to Flee Domestic Violence

Any individual or family who:

i. is fleeing, or is attempting to flee, domestic violence;

ii. has no other residence; and

iii. lacks the resources or support networks to obtain other permanent housing.

2. All other viable housing options have been considered and are not appropriate or available:

    a. Diversion options should be explored and pursued before entering emergency shelter.

    b. For those shelters that serve both singles and families, a Sex Offender Registry search must be conducted before admitting any adult in the household into the emergency shelter.

Prioritization

Emergency shelter providers should use the following order of priority when placing families in emergency shelter:

1. Families defined as "homeless" by HUD under Category 1 - Literally Homeless - that meet the Fairfax County residency status and verification of loss of permanent housing in Fairfax County; and Category 4 – fleeing or attempting to flee violence.

2. All other families defined as Homeless under the HUD Definition Category 1: Literally Homeless.

3. Families defined as "homeless" by HUD under Category 2 - At Imminent Risk of Literal Homelessness - that meet the Fairfax County residency status and verification of loss of permanent housing in Fairfax County.

Providers must exercise due diligence when filling vacancies to ensure that persons are served in the order of priority above. Some persons – particularly those living on the streets or in places not meant for human habitation – might require significant engagement and contacts prior to entering services.

Documentation verifying Fairfax County residency status *and* verification of loss of permanent housing in Fairfax County needs to be collected for families that meet the HUD "homeless" definition under Categories 1 and 2 (this does not include Category 4) in order to apply the prioritization criteria:

1. Fairfax County Residency Status: At least one of the following forms of documentation should be collected upon entry to emergency shelter to verify Fairfax County Residency Status, including:

a. Driver's license or any form of identification with an address in Fairfax County.

b. Utility bill with a name and address within the past 180 days for a residential unit located in Fairfax County.

c. Documentation of receipt of entitlement benefits, such as SNAP, TANF, or Medicaid from the Fairfax County Department of Family Services.

d. Children currently in physical and legal custody enrolled in Fairfax County Public Schools.

e. Otherwise verifiable documentation through a third party connecting the household to Fairfax County.

2. Verification of Loss of Permanent Housing in Fairfax County: Documentation should be collected upon entry to emergency shelter to verify Loss of Permanent Housing in Fairfax County, including:

   a. A written legal rental lease or property mortgage for at least 180 consecutive days prior to their date of homelessness for property located in Fairfax Count.

   b. An eviction or foreclosure notice indicating the date that the housing was list in Fairfax County.

   c. If the family never had a legal lease or property mortgage in Fairfax County, then the family must provide documentation to verify they have resided permanently in Fairfax County for at least 180 days.

Access, Assessment and Referral

1. Families seeking homeless services assistance are assessed by Coordinated Services Planning (CSP) to determine current housing status and level of need. CSP will send a referral to the Regional Homeless Referral Coordinator (RHRC) for families that meet the eligibility criteria as previously outlined. Households who stayed in emergency shelter within the last year and are seeking services again are referred by CSP to the regional partner agency last providing services.

2. Upon receipt of the referral, the RHRC completes the Prevention Screening Tool in person or over the phone with the head of household to confirm eligibility.

3. If the household is assessed to be experiencing literal homelessness without any other safe, viable housing options, the RHRC will coordinate placement in emergency shelter.

4. On a monthly basis, the RHRC will provide outcomes of referrals from CSP on the Referral Outcome Tracker. In addition, RHRC should provide feedback directly to CSP Leadership on cases/situations/referrals that are challenging and/or likely to result in additional contact with CSP. CSP Leadership includes the CSP Program Manager and Regional Supervisors/Team Leaders who should be contacted here: ncs-cspteamleaders@fairfaxcounty.gov.

Documentation verifying eligibility will be collected upon entry into emergency shelter, which may include self-declaration of income, bank statements, pay stubs, etc..

If the household is not literally homeless but is eligible for prevention services, the "Access & Assessment" process for prevention services should be followed.

Overflow for Emergency Shelter

If there are no vacancies in the emergency shelter that received the referral, the RHRC should utilize the following steps to identify an option for the family:

1. The RHRC should contact the other family shelters within Fairfax County to locate a vacancy.

2. If all other options have been pursued and no beds are vacant in any emergency shelters, the RHRC should coordinate the use of floor space (with air mattresses, cots, couches, etc.) in common spaces within the family shelters in Fairfax County. Multiple families can also be placed in the same room (e.g. two families with two members each in one four-person room) if this is a feasible option for the households.

3. If there is no space in any family shelters within Fairfax County, and if the family has ties in another jurisdiction, the RHRC should assist the household in accessing emergency shelter placement the current episode of homelessness originated.

4. If the designated common spaces are occupied, the RHRC should place the family in a motel. This option should not be provided to the family until all other options have been exhausted. Case management services should be provided by the referring agency with the goal being to transition those served back into permanent housing in 30 days or less. The family may be transitioned into an emergency shelter bed if it becomes available before permanent housing is located and there are no other families in need of emergency shelter placement. (*See "Motel Policy" for more details in appendix*).

Denial of Services and Appeals Process

1. *Denial of Services:*

    a. The emergency shelter provider must document the reason for denial of services. Family service providers should notify Coordinated Services Planning of the outcome of the referral in writing. Family service providers should notify the client of the outcome verbally and in writing when possible.

    b. Repeated denials of families by an emergency shelter provider may require additional monitoring and evaluation of the provider's decisions by the Fairfax County Office to Prevent and End Homelessness and other Community Partnership staff.

2. *Client Participation and Appeals*

    a. Every emergency shelter provider must have an appeal process in place and available to anyone who requests a copy.

    b. The client must make every reasonable effort to provide the necessary information and documentation required for the appeal within the time frame of the appeal.

Family Services Planning Team (FSPT) Meeting

1. *Definition & Purpose* – FSPTs are the gathering of social service professionals that have experience in working with the household or are from different agencies that may be able to provide support in developing a housing plan. At least one other Fairfax-Falls Church Community Partnership social service professional must be present to qualify the meeting as a FSPT.

2. Types of FSPTs:

a. Entry FSPTs – An Entry FSPT may be held for households that have previously engaged in homeless services *or* are not experiencing literal homelessness but are requesting shelter instead of engaging in prevention services. The purpose of the Entry FSPT may be to (1) assist the family in addressing barriers to prevent or divert them from homelessness, (2) to review the details of a previous Exit FSPT (if applicable) including any requirements, contingencies, or time limits that were given, and/or (3) to determine if additional services or interventions can be offered moving forward. If they are literally homeless, they should be entered into shelter.

b. Exit FSPTs – Some participants receiving homeless services will fail to comply with the terms and conditions of their participant agreements or exceed their assigned length of stay in emergency shelter without identifying a housing plan. Program violations can run the gamut from minor to major issues, and the program operator must comply with the appeals process established for the program type. In some instances, program violations will be severe and/or repeated to the point that immediate program termination is necessary. If a household is reporting they will be literally homeless if exited and there are no safety risks posed to the provider, a FSPT should be scheduled to help the household identify options and OPEH notified.

c. Optional FSPTs – FSPTs can also be held any time that staff or clients feel it could be beneficial such as when (1) clients are experiencing difficulties in following their service plan (2) attempting to re-enter a program after a past successful exit or (3) voluntarily exiting a program.

3. *Documenting and Communicating FSPT Outcomes*– Following the determination of the FSPT, the homeless services worker that scheduled the FSPT should ensure that Coordinated Services Planning is aware of the decision of the meeting. If the family is exiting shelter into literal homelessness with minor children, and is determined to be ineligible for reentry, the homeless services worker that scheduled the FSPT should make a report to Child Protective Services (CPS) via the CPS Hotline (703) 324-7400. The family is made aware that CPS will be called. This call should be made at actual program exit, when it is determined that the family will truly be unsheltered with minor children. Information shared should include the interventions that were provided, the reasons that they are being terminated, the reasons behind their ineligibility for re-entry, and any other information as it pertains to the safety or well-being of the children.

3.3 Rapid Rehousing (RRH) – Families

The following table summarizes coordinated entry processes for RRH for families. Each element is explained in detail in the manual.

Coordinated Entry Summary – Rapid Rehousing				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
HUD Definition of Homelessness Categories 1 or 4	1. Category 1 with Fairfax residency status & Category 4 2. Category 1 without residency confirmation 3. Category 2	Emergency Shelter	When RRH resources are limited and a family is seeking RRH, the following is used for prioritization: 1. Fairfax County residency 2. HSTT scores between 0 and16	No formal requirements for referral to RRH See special populations for additional information regarding two RRH programs for 1) youth and 2) those fleeing violence

Rapid rehousing (RRH) programs provide the support services and financial assistance necessary to help a homeless families move as quickly as possible into permanent housing and achieve stability in that housing.

The following policies, procedures and written standards provide a minimum set of guidelines for RRH projects in the Fairfax CoC. Local RRH projects must also refer to the rules and regulations established by their respective funders to ensure compliance with specific funding requirements. Local RRH projects are funded by a variety of public and private sources, such as government grants and contracts:

- Federal – Continuum of Care (CoC); Emergency Solutions Grant (ESG); and Supportive Services for Veteran Families (SSVF).
- State – Virginia Homeless Solutions Program (VHSP).
- Local – Fairfax County's Programs to Prevent and End Homelessness.

As well as grants and donations from:

- Foundations.
- Businesses.
- Faith communities.
- Individuals.

The three core components of a rapid rehousing program, as defined by the National Alliance to End Homelessness (NAEH) are:

1. Housing Identification:

    a. Recruit landlords to provide housing opportunities for individuals experiencing homelessness.

    b. Address potential barriers to landlord participation such as concern about short term nature of rental assistance and tenant qualifications.

    c. Assist households to find and secure appropriate rental housing.

2. Rent and Move-In Assistance (Financial):

a. Provide assistance to cover move-in costs, deposits, and the rental and/or utility assistance (typically six months or less) necessary to allow individuals to move immediately out of homelessness and to stabilize in permanent housing."

3. Rapid Re-housing Case Management and Services:

a. Help individuals experiencing homelessness identify and select among various permanent housing options based on their unique needs, preferences, and financial resources.

b. Help individuals and families experiencing homelessness address issues that may impede access to housing (such as credit history, arrears, and legal issues).

c. Help individuals and families negotiate manageable and appropriate lease agreements with landlords.

d. Make appropriate and time-limited services and supports available to families and individuals to allow them to stabilize quickly in permanent housing.

e. Monitor participants' housing stability and be available to resolve crises, at a minimum during the time rapid re-housing assistance is provided.

f. Provide or assist the household with connections to resources that help them improve their safety and well-being and achieve their long-term goals. This includes providing or ensuring that the household has access to resources related to benefits, employment and community-based services (if needed or appropriate) so that they can sustain rent payments independently when rental assistance ends.

g. Ensure that services provided are client-directed, respectful of individuals' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance.
h. Ensure that services provided are client-directed, respectful of individuals' right to self-determination, and voluntary. Unless basic, program-related case management is required by statute or regulation, participation in services should not be required to receive rapid re-housing assistance.

Eligibility

Rapid rehousing assistance may be provided to program participants who meet the following two criteria:

1. Meet the HUD definition of "Homeless", Categories 1 or 4:

a. <u>Category 1 - Literally Homeless</u>

Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

i. Has a primary nighttime residence that is a public or private place not meant for human habitation;

ii. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

iii. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

b. Category 4 -Fleeing/Attempting to Flee Domestic Violence

Any individual or family who:

i. Is fleeing, or is attempting to flee, domestic violence;

ii. Has no other residence; and

iii. Lacks the resources or support networks to obtain other permanent housing

2. Additional eligibility standards may be required for some RRH projects based on the specific project's funding (e.g. veterans, survivors of domestic violence, or transition age youth).

Prioritization

RRH projects may provide all or some of the core elements to program participants based on the available resources. Like most communities, there is a scarcity of housing and services resources; therefore it is important that RRH projects prioritize people for assistance. In some cases, the "housing identification" and "rapid rehousing case management and services" may be readily available but "rent and move-in assistance (financial)" will not.

When necessary, RRH projects should prioritize households using the criteria below:

1. Fairfax County residents (See "Key Terms" section for the definition of "Fairfax County Residency Status") should have a priority over those who are not; and

2. families with HSTT scores between zero (0) and sixteen (16).

Families who have previously been assisted with rapid rehousing and return to homelessness multiple times, despite progressively greater levels of assistance, should be prioritized for other types of programs, such as permanent supportive housing.

The Fairfax CoC uses the "*Progressive Engagement"* model (US Department of Veteran Affairs, 2016) in rehousing individuals experiencing homelessness. This model is based on the strategy of assisting the greatest number of people possible by using the minimal amount of resources necessary to end an individual's or family's homelessness. The model also promotes greater flexibility and individualization in determining how much assistance is provided.

All families experiencing homelessness for the first time should be offered a basic level of rapid rehousing assistance from all three core components: housing identification, rent and move-in

financial assistance, and case management. The level of financial assistance for rent and move-in costs should begin at a minimal amount, such as the security deposit and one month of rent. The specific amount of initial financial assistance will vary depending on a program participant's financial capacity and needs, as well as programs' funding restrictions and availability. Once the program participant is in permanent housing, additional evaluations are used to determine whether more months of assistance are required for the household to maintain housing stability.

Access, Assessment and Referral

Rapid rehousing assistance for families is accessed via local emergency shelters for families. Please refer to those sections of the manual for information regarding access to those programs.

Rapid rehousing staff will assess a prospective program participant using the assessment tool that is designated for the specific household type. The Fairfax CoC uses the Housing and Services Triage Tool (HSTT) for the assessment (see appendix)

All Fairfax County emergency shelters providers offer case management, housing location, and direct assistance (financial or rental) when available. Shelter providers should start providing individuals with rapid rehousing assistance when:

1. Information provided by the client indicates they meet the eligibility criteria for admission;
2. Client has indicated they want to be housed with rapid rehousing assistance; and
3. Client is able to access services and housing.

The expectation is the project has a housing opening or expects to have one in a reasonably short amount of time. (Note that the admission criteria mirrors the HUD HMIS Data Standards for "Project Start Date" in a RRH project.)

Special Populations & External Referrals

The Partnership maintains unique rapid rehousing projects with distinct referral processes for special populations who are experiencing homelessness that would require referral(s) to another organization, or "external referrals." Please see the "Special Populations" chapter for more information on how to refer to dedicated RRH projects for the following special populations:

1. Transition Age Youth
2. Survivors of Domestic Violence
3. Veterans

Individual RRH projects have ultimate responsibility for determining the eligibility of prospective participants in their programs and for collecting and maintaining eligibility documentation. However, referring workers should do a preliminarily eligibility screening before making a referral to determine the likelihood of a prospective participant's eligibility.

The collection of documents to determine eligibility might be ongoing, starting at initial triage and building over time as more in-depth assessments are completed as needed. Therefore, eligibility will be determined as part of the assessment process, as well as by the agency receiving the referral. Documentation and eligibility might be initially determined, but would need to be re-established at the point of RRH project entry, especially if a long period of time has passed between assessment and project entry.

When two or more RRH projects are providing assistance for a household, they must work collaboratively to avoid service redundancies and successfully rehouse the program participants as

quickly as possible. Frequent, regular communication between the RRH project staff and between staff and program participants is essential to effectively achieve this goal.

Referral Rejection Protocols

A referral may be rejected by the potential participant, or the housing or supportive services provider. Many factors or issues can precipitate a rejection.

1. Sometimes potential participants perceive the referral as representing a housing or services option that does not address their immediate housing goals and preferences. In those instances, the referring entity should make every effort to identify other referral options and work with the potential participant to find alternative accommodations.

2. Sometimes the project receiving the referral through the coordinated entry process is the source of the referral rejection. For example, a project might be experiencing situational staffing constraints. Programmatic changes or funding issues might necessitate a temporary hold on accepting referrals. Or after considering the unique housing barriers and attributes of a particular referral, the project receiving the referral might decide the project does not have sufficient programmatic capacity or expertise to provide the housing and services necessary to resolve the person's housing crisis. Other reasons for programmatic rejection includes the following situations:

    a. The client lacks required eligibility documentation.

    b. Does not follow through with the admission process in a timely manner.

    c. Homeless services were previously terminated as a result of violence or threats of violence.

Regardless of the specific circumstances of the project's rejection, in all situations the project should communicate the decision clearly and quickly (no more than two business days) to the entity making the referral. This communication should include the following:

1. the reason for the rejection;

2. any factors or a change in circumstances that could allow the project to reconsider and actually accept the referral; and

3. other pertinent information that came to light during the referral review that might affect the potential participant's referral standing at other housing and services projects.

In cases where rejection to a RRH project is uncertain, partner organizations are encouraged to conduct a case conference in which the entity making the referral, the project rejecting the referral, and potentially the participant meet to share information and collectively consider alternative referral options. The goal of the referral process is to quickly and successfully connect persons experiencing a housing crisis to available housing and services. A case conferencing meeting among all parties concerned is often the most effective way to achieve this goal when the standard referral process is not working as planned.

3.4 Transitional Housing

The following table summarizes coordinated entry processes for transitional housing for families. Each element is explained in detail in the manual.

Coordinated Entry Summary – Transitional Housing				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
1. HUD definition of homelessness, Category 1 2. HSTT score between 17 and 25	1. Annual income at or below 50 percent of the Fairfax County area median income 2. Highest HSTT score in 17-25 range	Emergency Shelter	HSTT	Prioritization Pool in HMIS

Introduction

Transitional housing (TH) is temporary housing with intensive supports and services meant to build skills and bridge the gap between homelessness and permanent housing. Our community does not have TH providers that are mandated to participate in Coordinated Entry (due to their funding sources), however we are fortunate that many have volunteered to participate in this system so that their housing resources can be accessed by those seeking housing opportunities in our CoC.

To ensure that all Transitional Housing vacancies are used as strategically and effectively as possible, the Transitional Housing resource should to be targeted to serve persons with the highest severity of service needs that is within the numeric range of the Housing Services Triage Tool (HSTT) indicating that these families can move toward self-sufficiency usually within a two year period.

Eligibility

Transitional Housing providers should strive to ensure that all program participants and tenants meet the following basic eligibility guidelines:

1. Families defined as “homeless” by HUD under Category 1.

    a. <u>Category 1 - Literally Homeless</u>
    Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

        i. has a primary nighttime residence that is a public or private place not meant for human habitation;

        ii. is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

        iii. is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

2. HSTT score between 17 and 25.

3. Any additional eligibility requirements specific to the project's funding (e.g. programs for survivors of domestic violence, programs for youth, or programs for veterans, etc.)

Prioritization

Transitional Housing providers should consider the identified target populations served by the project and prioritize prospective program participants with the following characteristics:

1. Families with an annual income at or below 50 percent of the Fairfax County area median income.

2. Families with the highest HSTT score (between 17 and 25).

Access, Assessment and Referral

1. Families seeking assistance will be assessed immediately by regional homeless assistance staff person to determine current housing status.

2. All families who are "homeless" as defined by HUD under Category 1 – Literally Homeless – will be assessed within 10 business days of seeking assistance using the Housing Services Triage Tool (HSTT)

3. Homeless assistance staff should complete a referral in HMIS for all where the family meets eligibility criteria and has an HSTT score between 17 and 25. Referrals must be uploaded into HMIS to complete the referral. (See the Prioritization Pool and HMIS Workflow section at the end of the manual for specific instructions).

3.5 Permanent Supportive Housing (PSH) – Families

The following table summarizes coordinated entry processes for PSH for families. Each element is explained in detail in the manual.

Coordinated Entry Summary – PSH Families				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
HUD Definition of Homelessness, Category 1 Documented Disability HSTT with a score of 26 or greater	1. CH with most homeless history **and** highest HSTT score 2. CH with most homeless history 3. CH with highest HSTT score If no eligible CH 4. Homeless w/ disability and the most homeless history. 5. Homeless w/disability and highest HSTT Score	Emergency Shelter Outreach	HSTT	Prioritization Pool in HMIS

Permanent Supportive Housing is designed to serve persons with the longest length of homelessness, highest needs and greatest barriers towards obtaining and maintain housing on their own, especially those who are experiencing chronic homelessness.

Eligibility

Families must meet the following five criteria to be eligible for PSH:

1. Families who are "homeless" as defined by HUD under Category 1:

   A family that lacks a fixed, regular, and adequate nighttime residence, meaning:

   a. has a primary nighttime residence that is a public or private place not meant for human habitation;

   b. is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

   c. is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

2. The head of household must have a documented, long-term disability *(See "Key Terms" section for definition of Documented, Long-Term Disability);**

3. A score of 26 or greater on the HSTT.

4. the household must include at least one adult and one minor child; and

5. any additional eligibility requirements specific to the project's funding (e.g. programs for survivors of domestic violence, programs for people with serious mental illness or chronic substance abuse or programs for veterans).

The Fairfax CoC includes a PSH program for families that receives ONLY local funding giving the Community Partnership flexibility regarding the disability status. At Kate's Place, the disability could be a child's **IF** a professional that is legally allowed to license and treat the disability documents that the disability is of long term duration, not expected to resolve, significantly impacts activities of daily living and is so significant that it requires ongoing caregiving by the parent or head of household.

Prioritization

Permanent supportive housing providers should consider the identified target populations served by the project and use the following order of priority to select participants for the PSH project:

1. Individuals and families experiencing chronic homelessness with the longest history of homelessness and with the highest severity of service needs *(See the "Key Terms" section for definitions)*

2. Individuals and families experiencing chronic homelessness with the longest history of homelessness

3. Individuals and families experiencing chronic homelessness with the highest severity of service needs

If a PSH provider is not able to identify any eligible individuals and families experiencing chronic homelessness as defined above then the PSH provider can proceed to the fourth and fifth order of priority to fill vacancies.

1. Families experiencing homelessness with a disability and the longest period of cumulative homelessness.

2. Families experiencing homelessness with a disability with the most severe service needs.

Providers must exercise due diligence when filling program vacancies to ensure that persons are served in the order of priority above.

Providers are not expected to keep units vacant where a family has refused housing and they are at the top of prioritization list. The vacancy should be offered to the next family. Families that refuse housing remain eligible for future opportunities.

Access, Assessment and Referral

1. Current housing status will be determined when individuals and families seek assistance to confirm that they are "homeless" under the HUD definition, Category 1 as defined above.

2. Individuals and families will be assessed within 10 business days of seeking assistance with either the Housing Services Triage Tool (HSTT).

3. Homeless assistance staff should complete a referral in HMIS for all Families whose scores on the HSTT is 26 or greater. (See the Prioritization Pool and HMIS Workflow section at the end of this manual for specific instructions on submitting referrals).

Program Selection Policies

The PSH provider is responsible for notifying the referring case manager and the individual if the individual was not accepted into the program.

1. Common reasons individuals are not accepted into the program include:

    a. Lack of required eligibility documentation.

    b. Not meeting minimum eligibility criteria.

    c. Program unable to meet client needs (ex: clients in need of assisted living level of care may not be appropriate for an independent living program with 1 – 2 weekly visits).

    d. Denied based on appropriateness of client as per tenant screening procedures which must be outlined in the program's publicly-posted tenant selection plan that is maintained by the property owner, property manager or program staff (See '*Common Tenant Selection Process*' listed below).

    e. Client applicant does not provide additional documentation as requested or repeatedly misses program appointments.

    f. Client applicant is not willing to participate in housing program.

The following is a list that is often used by property managers to determine eligibility for their specific housing resources. None of the following are automatically disqualifiers. Clients who are denied due to tenant selection policies have not been rejected from the program and may be able to be successfully housed in a different opportunity.

2. Common Tenant Selection Policies:
    a. Credit history.
    b. Income / employment / education requirements.
    c. Size of unit as compared to size of household.
    d. Criminal history, such as a felony conviction or being on the sex offender registry.

Clients retain the ultimate right to accept or refuse housing. Clients who refuse housing are not considered to have been rejected by the program provider.

3. Client Choice Factors:
    a. Geographic location of housing.
    b. Accessibility of unit.
    c. Client willingness or ability to share housing (if applicable).
    d. Preferred service provider.

This information should be captured in HMIS as described in the Pool and HMIS workflow section.

Per HUD requirements, there is no limit as to how many times a client can reject housing opportunities. They remain in the Prioritization Pool as long as they are eligible and interested in offers of housing.

Documentation of Denials and Appeals

Providers must use the following procedures for denials and appeals.

1. *Denial of Tenancy:*

    a. Denials must be in compliance with the coordinated entry policies and procedures as outlined in this manual.

    b. Provider must document the reason for denial of tenancy in HMIS and send it to the referring case manager and client.

    c. Repeated denials of Individuals and Families by a PSH Provider for tenancy may require additional monitoring and evaluation of the provider's decisions by the Fairfax County Office to Prevent and End Homelessness.

2. *Client Rejection and Appeals:*

    a. PSH program must have an appeal process in place and available to anyone who requests a copy.

    b. Appeals must be submitted in writing within three (3) days of rejection. PSH providers should respond to the appeal letter within 3 days of receipt. The client must make every reasonable effort to provide the necessary information and documentation required for tenancy.

    c. The PSH provider must inform the CES Manager of any appeals in process.

3.6 Other Permanent Housing– Families

3.6 a. Bridging Affordability

The following table summarizes Coordinated Entry for Bridging Affordability for singles.

Coordinated Entry Summary – Bridging Affordability, Singles				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
7. Participants must meet the HUD definition for Homelessness, Category 1. 8. Households must have a source of income. 9. Gross income must be below 30% of AMI for Homeless households. 10. Must be resident of Fairfax County. 11. Household must have legal presence in the United States. 12. VI-SPDAT score between 7 and 11.	Highest Score on the VI-SPDAT in the 7 to 11 range.	Emergency Shelter	VI-SPDAT	Prioritization Pool in HMIS

Fairfax County funds a rental assistance program called Bridging Affordability. The program is administered by the Department of Housing and Community Development and contracted to a local non-profit, Northern Virginia Family Services (NVFS). Through a collaborative agreement this program has dedicated some of its slots to individuals experiencing homelessness. Participants secure a lease in their name and receive supportive services and rental subsidies for up to a year.

Eligibility

Prospective program participants must meet all five of the following eligibility criteria:

1. Participants must meet the HUD definition for Homelessness – Category 1:

   A family that lacks a fixed, regular, and adequate nighttime residence, meaning:

   d. Has a primary nighttime residence that is a public or private place not meant for human habitation;

   e. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

   f. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

2. Households must have a source of income.

3. Gross income must be under 30% of AMI for homeless households.

4. Must be resident of Fairfax County.

5. Household must have legal presence in the United States.

Prioritization

The following lists the prioritization order for Bridging Affordability:

1. Participants with earned income that is within the eligibility requirements listed above. *

2. VI-SPDAT scores between 7 and 11.

3. Longest history of homelessness.

   * While earned income is prioritized, Bridging Affordability will accept individuals who have non-earned income (ex. disability benefits) on a case-by-case basis.

Access, Assessment and Referral

Access to Bridging Affordability is through the emergency shelter or outreach systems. Individuals are assessed using the VI- SPDAT. Referrals are made to the Prioritization Pool. See the Prioritization Pool and HMIS workflow section for the details of submitting the referral.

Special Populations

Recognizing that there are some populations that have particular vulnerabilities or circumstances, HUD allows for some flexibility for them to access the housing service and opportunities they need. These populations include unaccompanied and transition age youth, those fleeing domestic violence, and veterans.

4.1 Youth

Second Story, a local nonprofit, operates an emergency shelter for unaccompanied youth (ages 13-17). Recognizing that this population must have a safe place to sleep at night without barriers to access it, unaccompanied youth can access this shelter directly 24 hours a day, 7 days a week, 365 days a year by any of the following means:

- Calling Second Story's youth hotline at 1-800-SAY-TEEN.
- Texting TEENHELP to 855-11.
- Going directly to the shelter at 2100 Gallows Road, Vienna VA 22182.

The shelter provides:

- Food and clothing.
- Intensive individual counseling.
- Group counseling.
- Family counseling.
- Academic support.

Second Story also has a HUD-funded RRH program that serves Transition Age Youth who are between the ages of 18 and 24, regardless of whether they are singles or a families. Referrals to this program are made in HMIS. Second Story utilizes the Prioritization Pool fill these vacancies.

The following table summarizes Coordinated Entry into the RRH for Transitioning Aged Youth.

Coordinated Entry Summary – RRH Program for Transitioning Aged Youth				
Eligibility	**Prioritization**	**Access**	**Assessment**	**Referral**
HUD Definition of Homelessness Categories 1 & 4	1. Most Homeless History 2. VI SPDAT Scores 5-9	1. Emergency Shelter (Families and Singles including Hypo Prevention Program 2. Single's Outreach	VI-SPDAT	Prioritization Pool in HMIS

This dedicated program serves singles and families. It can serve up to 20 youth per year. The number of transition age youth and children served by the program varies depending on how many families are served and how many children they have. The program provides rental assistance and case management that is predicted to continue for one year per household although that is an estimate and different circumstances will require different timelines. This population has equal access to all other programs described in this manual. This is an additional resource dedicated to this particularly vulnerable population.

4.2 Individuals and Families Fleeing Domestic Violence (DV)

In addition to the OPEH-contracted emergency shelters listed previously, the Community Partnership also has specific shelters dedicated to serve those actively fleeing or survivors of domestic violence. Domestic violence, or DV, is typically a pattern of coercive behaviors used by an individual to gain or maintain power and control over another individual in the context of an intimate, dating, or familial relationship.

Fairfax County recognizes the following relationships under domestic violence:

1. current or former spouse, even if they do not live together;
2. parent or stepparent, children or stepchildren;
3. brother, sister, half-brother, or half-sister;
4. grandparent or grandchildren, even if they do not live together;
5. any in-laws (father, mother, son, daughter, sister or brother) who reside in the same house;
6. any individuals who have a child in common, even if they have never been married or lived together; and
7. any individuals who have lived together within the last 12 months (even if not currently living together) and any of their children who have lived in the same house with either individual.

Individuals and families fleeing domestic violence, dating violence, sexual assault, stalking, or human trafficking that are presenting to the homeless and victim or survivor * services systems have access to the full range of housing and service intervention options available in the Continuum of Care. This section outlines the protocols designed to ensure this population has safe and confidential access to the coordinated entry process. Likewise, individuals and families who access the Community Partnership's DV-specific shelters also have equal access to services and resources through the coordinated entry process. If they are being referred to one of these resources, special steps are taken to remove identifying information in order to protect their anonymity. Those steps are provided in Appendix A4-4, Coordinated Entry HMIS Workflows.

**These terms are both commonly used when referring to someone who has been directly impacted by domestic violence or sexual assault. Both can be appropriate but should be used according to the preference of the individual receiving services.*

4.2 a Domestic Violence Prevention Services

Eligibility

Victims/survivors seeking or directed to homelessness prevention services are required to meet all of the following basic eligibility guidelines:

1. Individuals and families defined as homeless by the HUD definition Category 4:
    a. Individuals and Families [fleeing, or] attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken

place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;

Prioritization

The households that meet the most number of criteria listed below will be considered the highest priority for prevention services.

1. Fairfax County Residents (*See "Key Terms" section for Fairfax County Residency Status definition*).

2. Households with annual income at or below 30 percent of Fairfax County area median income.

3. Previous stay in emergency shelter as documented in HMIS (and /or verified by an emergency shelter serving victims/survivors of domestic violence) within 24 months after their date of exit to permanent housing.

4. Any experience of homelessness.

4.2b Domestic Violence Emergency Shelter

Eligibility

Those seeking placement within a domestic violence emergency shelter are required to meet all of the following basic eligibility guidelines:

1. Individuals and families defined as "homeless" under the HUD definition, Category 4:

    a. individuals and families fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence;

    b. has no other safe* residence; and

    c. lacks the resources or support networks, e.g., family, friends, and faith-based or other social networks, to obtain other safe* permanent housing.

**Safe may include a location that the abuser does not know about, a location that would be challenging for the abuser to locate, or the caller has no concerns (based on either history or intuition) that the abuser will attempt to access the location.*

Prioritization

Domestic violence shelter providers should use the following order of priority when placing individuals and families in emergency shelter:

1. Individuals or families assessed to be in imminent danger according to the Lethality Assessment Screening Tool.

2. All other individuals or families fleeing domestic violence, dating violence, sexual assault, stalking, or human trafficking.**

*** Because Artemis House is the only domestic violence shelter in Fairfax County that is accessible 24 hours per day, Artemis House will not move to the second prioritization unless demand for the first prioritization has decreased and remained consistently lower over the course of several months.*

Access, Assessment and Safety Planning

Individuals and families fleeing domestic violence, dating violence, sexual assault, stalking, or human trafficking are not required to enter homeless and victim/survivor services systems through a single point of entry. The system is designed to be flexible because of the specific circumstances relevant to this vulnerable population. The following is an overview of the resources that can provide support in determining how to direct a victim/survivor seeking services:

Access Point	Contact Information	Services Provided
Fairfax County's Coordinated Services Planning 8am – 4:30pm	703-222-0880 https://www.fairfaxcounty.gov/ncs/csp/	Information, referral, linkage, and advocacy to public and private human services available to Fairfax County residents
Artemis House – 24 hour emergency domestic violence shelter	703-435-4940 http://shelterhouse.org/wp-content/uploads/2014/09/AH-Flyer-WEBSITE.pdf	Emergency shelter for victims/survivors at imminent risk of lethality, victims/survivors of sexual assault, stalking or human trafficking
Bethany House – domestic violence shelter 9am – 5pm	703-658-9500 https://www.bhnv.org/	Emergency shelter for victims/survivors of domestic violence
Fairfax County Sexual and Domestic Violence 24 Hour Hotline	703-360-7273 https://www.fairfaxcounty.gov/dfs/women/dsvs.htm	Safety planning, options counseling, hospital accompaniment, and connection to resources
Fairfax County Domestic Violence Action Center 8am – 4:30pm	703-246-4573 4000 Chain Bridge Road, Suite 2702, Fairfax, VA 22035 https://www.fairfaxcounty.gov/domesticviolence/dvac/	Crisis intervention, safety planning, advocacy, and court attire, court accompaniment
Fairfax County Office for Women & Domestic and Sexual Violence Services 8am – 4:30pm	703-324-5730 12000 Government Center Pkwy, Suite 339, Fairfax, VA 22035 https://www.fairfaxcounty.gov/ofw/	Short-term individual and group counseling (free), support services focusing on legal and economic issues, and batterer intervention programs

CONFIDENTIALITY

The Violence Against Women Act (VAWA) amended the McKinney-Vento Homeless Assistance Program to protect victims'/survivors' personally identifying information by preventing local Victim Service Providers from putting personally identifying information about victims/survivors into Homeless Management Information Systems (HMIS). Victim Service Providers receiving HUD funds must use a comparable database that adheres to the same technology data standards as mainstream HMIS systems.

1. It is critical that providers in both the homeless and victim services systems educate victims/survivors about their right to decline having any information about them entered into an HMIS system and also educate other HUD-funded agencies to provide full notice and obtain explicit, informed consent. Services will not be withheld if the client decides not to be entered into the system.

2. The confidentiality protections set forth in these federal laws and grant conditions apply to any survivor who (1) requests services (regardless if they are provided services or not), (2) is receiving services, or (3) has received services in the past.

The Fairfax CoC has a HUD funded RRH program that specifically prioritizes this population. The program is administered by Shelter House, a local nonprofit, and referrals from shelter to this program can be made directly to Shelter House, using confidential processes established. This program uses the same eligibility prioritization processes described earlier in this section.

People working with this population should **also** submit referrals in HMIS (**using the procedures for anonymity established by the CoC, see Appendix 4, A4-4) for** the programs that use the Prioritization Pool to fill vacancies. These programs include: Bridging Affordability, Transitional Housing, Second Story Rapid Rehousing (ages18-24 only) and Permanent Supportive Housing. Staff should refer to those sections of the manual for details on eligibility, prioritization, access, assessment and referral.

4.3 Veterans

Veterans have equal access to any of the programs listed above. However, in 2015, the Fairfax CoC joined the "Mayor's Challenge to End Veteran's Homelessness" and developed additional strategies to streamline and expedite processes for veterans to access services and housing opportunities specific to them. A Master List for veterans was created and is staffed at a monthly Veteran's Workgroup meeting. Access to services for veterans experiencing homelessness is accomplished through the following steps:

1. Veterans are identified at entry into local emergency shelter, including Hypothermia Prevention Program sites; transitional housing; or street outreach ("ES/TH/SO") projects.

2. The intake and assessment forms (e.g. VI-SPDAT) are completed by ES/TH/SO staff. Supportive Services for Veteran Family (SSVF) providers may routinely visit emergency shelter sites and conduct street outreach in order to assist with the identification of veterans experiencing homelessness and complete assessments.

3. Referrals from ES/TH/SO staff are sent via email to a distribution list that includes points of contact from each of the five SSVF providers that serve the Fairfax-Falls Church community, as well as the US Department of Veteran Affairs (VA). The distribution list of SSVF and VA points of contact is maintained by staff from the Fairfax County Office to Prevent and End Homelessness. The referral email should include:

    a. Location of the household (shelter name or, if unsheltered, zip code, city, town, or census designated place, etc.)
    b. The number of people in the veteran household;
    c. The assessment score and level of assistance recommended (e.g. rapid rehousing versus permanent supportive housing);
    d. Whether documentation is available (yes/no for DD-214 and photo identification);
    e. Veteran status;
    f. Discharge status;
    g. Time served in active duty;
    h. Gross annual income;
    i. Income sources; and
    j. Preferred contact information for the ES/TH/SO worker so services can be coordinated for the veteran.

4. SSVF and VA staff decide which provider will take the veteran's case based on the assessment score, type of assistance provided, and providers' available case load capacity.

5. At the time of the monthly Veterans Workgroup meeting, any veteran that is not referred or accepted by a specific SSVF provider is matched during the meeting.

6. A Master List of all veterans experiencing homelessness in the Fairfax-Falls Church community will note the designated homeless assistance provider taking the lead in resolving the veterans housing crisis. Providers include the following organizations:

    a. Locally-funded ES/TH/SO and rapid rehousing providers, including:
        i. Cornerstones
        ii. FACETS
        iii. New Hope Housing

iv. Shelter House

b. SSVF providers
   v. Friendship Place
   vi. Housing Counseling Services
   vii. Operation Renewed Hope Foundation
   viii. US Vets
   ix. Volunteers of America Chesapeake

c. VA for Veteran Affairs Supportive Housing (VASH) referrals

Recordkeeping Requirements

Record Keeping Requirements to Document Homeless & Chronically Homeless Status
The following recordkeeping requirements have been established for all local partnership organizations in order to document the homeless and chronically homeless status of program participants.

Order for Priority of Evidence

Partner organizations must maintain the following records to ensure compliance with the definition of "homeless" and "chronically homeless" per 24 CFR 578.3. The following list is the order of priority for obtaining evidence:

1) Third-party documentation (Records contained in an HMIS or comparable database used by victim service or legal service providers are acceptable evidence of third-party documentation and intake worker observations if the HMIS retains an auditable history of all entries, including the person who entered the data, the date of entry, and the change made; and if the HMIS prevents overrides or changes of the dates entries are made.);

2) Intake worker observations; and

3) Certification from the person seeking assistance.

Evidence of Homeless Status

Partner organizations that provide housing or services that are dedicated or prioritized to people experiencing homelessness must maintain records evidencing that the individuals or families receiving the assistance in those beds meets the definition for homeless at 24 CFR 578.3.

Evidence of an individual or head of household's current living situation may be documented by a written observation by an outreach worker, a written referral by housing or service provider, or a certification by the household seeking assistance that demonstrates that the individual or head of household is currently homeless and living in a place not meant for human habitation, in an emergency shelter, or a safe haven.

Evidence of Chronically Homeless Status

Partner organizations that provide beds that are dedicated or prioritized to the chronically homeless must maintain records evidencing that the individuals or families receiving the assistance in those beds meets the definition for chronically homeless at 24 CFR 578.3. Such records must include evidence of the homeless status of the individual or family (paragraphs (1)(i) and (1)(ii) of the definition), the duration of homelessness (paragraph (1)(ii) of the definition), and the disabling condition (paragraph (1)(iii) of the definition). When applicable, recipients must also keep records demonstrating compliance with paragraphs (2) and (3) of the definition.

1. **Evidence of homeless status.** Evidence of an individual or head of household's current living situation may be documented by a written observation by an outreach worker, a written referral by housing or service provider, or a certification by the household seeking assistance that demonstrates that the individual or head of household is currently homeless and living in a place not meant for human habitation, in an emergency shelter, or a safe haven. For paragraph (2) of

the definition for chronically homeless at 24 CFR 578.3, for individuals currently residing in an institution, acceptable evidence includes:

a. Discharge paperwork or a written or oral referral from a social worker, case manager, or other appropriate official of the institution, stating the beginning and end dates of the time residing in the institution that demonstrate the person resided there for less than 90 days. All oral statements must be recorded by the intake worker; or

b. Where the evidence above is not obtainable, a written record of the intake worker's due diligence in attempting to obtain the evidence described in the paragraph i. above and a certification by the individual seeking assistance that states that they are exiting or have just exited an institution where they resided for less than 90 days; and

c. Evidence that the individual was homeless and living in a place not meant for human habitation, a safe haven, or in an emergency shelter, and met the criteria in paragraph (1) of the definition for chronically homeless in 24 CFR 578.3, immediately prior to entry into the institutional care facility.

2. **Evidence of the duration of the homelessness.** Partner organizations documenting chronically homeless status must also maintain the evidence described in paragraph (a) or in paragraph (b) below, and the evidence described in paragraph (c) below:

   a. **Evidence that the homeless occasion was continuous, for at least one year.**
      i) Using any combination of allowable documentation described in the Order of Priority for Evidence section of the Recordkeeping requirements, partner organizations must provide evidence that the homeless occasion was continuous, for a year period, without a break in living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter. For the purposes of this policy, a break is considered at least seven or more consecutive nights not residing in a place not meant for human habitation, in shelter, or in a safe haven.

      ii) At least 9 months of the 1-year period must be documented by one of the following: (1) HMIS data, (2), a written referral, or (3) a written observation by an outreach worker. In only rare and the most extreme cases, HUD would allow a certification from the individual or head of household seeking assistance in place of third-party documentation for up to the entire period of homelessness. Where third-party evidence could not be obtained, the intake worker must obtain a certification from the individual or head of household seeking assistance, and evidence of the efforts made to obtain third-party evidence as well as documentation of the severity of the situation in which the individual or head of household has been living. An example of where this might occur is where an individual has been homeless and living in a place not meant for human habitation in a secluded area for more than 1 year and has not had any contact with anyone during that entire period.
      iii) A single encounter with a homeless service provider on a single day within 1 month that is documented through third-party documentation is sufficient to consider an individual or family as homeless for the entire month unless there is any evidence that the household has had a break in homeless status during that month (e.g., evidence in HMIS of a stay in transitional housing).

   b. **Evidence that the household experienced at least four separate homeless occasions over 3 years.**

i) Using any combination of allowable documentation described in the Order of Priority for Evidence section of the Recordkeeping requirements, the recipient must provide evidence that the head of household experienced at least four, separate, occasions of homelessness in the past 3 years.

ii) Generally, at least three occasions must be documented by either: (1) HMIS data, (2) a written referral, or (3) a written observation. Any other occasion may be documented by a self-certification with no other supporting documentation.

iii) In only rare cases should self-certification from the individual or head of household seeking assistance be permitted in place of third-party documentation for the three occasions that must be documented by either: (1) HMIS data, (2) a written referral, or (3) a written observation where third-party evidence could not be obtained, the intake worker must obtain a certification from the individual or head of household seeking assistance, and must document efforts made to obtain third-party evidence, and document of the severity of the situation in which the individual has been living. An example of where this might occur is where an individual has been homeless and living in a place not meant for human habitation in a secluded area for more than one occasion of homelessness and has not had any contact with anyone during that period.

c. **Evidence of diagnosis with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in Section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability.** Evidence of this criterion must include one of the following:

i) Written verification of the condition from a professional licensed by the state to diagnose and treat the condition;

ii) Written verification from the Social Security Administration;

iii) Copies of a disability check (e.g., Social Security Disability Insurance check or Veterans Disability Compensation);

Key Terms

1. **At-Risk of Homelessness. HUD provides the following definition.**

   Category 1 – applies to individuals and families

   An individual or family who: (i) Has an annual income below 30% of median family income for the area; AND (ii) Does not have sufficient resources or support networks immediately available to prevent them from moving to an emergency shelter or another place defined in Category 1 of the "homeless" definition; AND (iii) Meets one of the following conditions: (A) Has moved because of economic reasons 2 or more times during the 60 days immediately preceding the application for assistance; OR (B) Is living in the home of another because of economic hardship; OR (C) Has been notified that their right to occupy their current housing or living situation will be terminated within 21 days after the date of application for assistance; OR (D) Lives in a hotel or motel and the cost is not paid for by charitable organizations or by Federal, State, or local government programs for low-income individuals; OR (E) Lives in an SRO or efficiency apartment unit in which there reside more than 2 persons or lives in a larger housing unit in which there reside more than one and a half persons per room; OR (F) Is exiting a publicly funded institution or system of care; OR (G) Otherwise lives in housing that has characteristics associated with instability and an increased risk of homelessness, as identified in the recipient's approved Con Plan

   Category 2 – applies to unaccompanied youth
   A child or youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under another Federal statute

   Category 3 –applies to families with children and youth
   An unaccompanied youth who does not qualify as homeless under the homeless definition, but qualifies as homeless under section 725(2) of the McKinney-Vento Homeless Assistance Act, and the parent(s) or guardian(s) or that child or youth if living with him or her.

2. **Chronically Homeless.** The definition of "chronically homeless" currently in effect for the CoC Program is that which is defined in the CoC Program interim rule at 24 CFR 578.3, which states that a chronically homeless person is:

   a. An Individual who:
      i. Is homeless and lives in a place not meant for human habitation, a safe haven, or in an emergency shelter; and

      ii. Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last 3 years; and

      iii. Can be diagnosed with one or more of the following conditions: substance use disorder, serious mental illness, developmental disability (as defined in section 102 of the Developmental Disabilities Assistance Bill of Rights Act of 2000 (42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from brain injury, or chronic physical illness or disability;

   b. An Individual who has been residing in an institutional care facility, including a jail, substance abuse or mental health treatment facility, hospital, or other similar facility, for fewer than 90

days and met all of the criteria in paragraph (1) of this definition [as described in Section I.D.2.(a) of this Notice], before entering that facility; or

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

3. **Continuum of Care**. A regional or local planning body that coordinates housing programs and services, and funding for individuals and families experiencing homelessness. In the Fairfax CoC, the Lead Manager of the CoC program is a staff person in the Office to Prevent and End Homelessness.

4. **Coordinated Entry.** According to the US Department of Housing and Urban Development (HUD), "Coordinated Entry" is defined as "a centralized or coordinated process designed to coordinate program participant intake, assessment, and provision of referrals. A centralized or coordinated assessment system covers the geographic area, is easily accessed by Individuals and Families seeking housing or services, is well advertised, and includes a comprehensive and standardized assessment tool." (CoC Interim Rule, Section 578.3)

2. **Coordinated Services Planning (CSP)–** Located within the Fairfax County's Department of Neighborhood and Community services, they are a centralized call-center service for individual and families in need. CSP assesses situations, develops an integrated service plan, and coordinates the connection to available programs and services to assist residents in addressing their immediate and long-term needs. Those in need of assistance should call 703-222-0880.

5. **Diversion.** Programs that help people seeking shelter identify immediate alternative housing arrangements (e.g., a shared housing arrangement, reestablished lease arrangements with a previous landlord, moving in with friends/relatives) and if necessary connect them with services (such as short term case management, conflict mediation and moving in expenses) to help them return to permanent housing. The main difference between diversion and other permanent housing-focused interventions centers on the point at which intervention occurs. Prevention targets people at imminent risk of homelessness, diversion targets people as they are applying for entry into shelter, and rapid re-housing targets people who are already homeless. Financial assistance is dependent upon the availability of funding; the household must also meet the eligibility criteria of the funding source.

6. **Documented, Long-term Disability.** A disability documented by a licensed professional (approved to treat the disability) which impedes activities of daily living, impacts the Individual's ability to work full-time or earn at least 50 percent of the Area Median Income, or creates significant difficulty with functioning and requires some type of professional intervention. This disability must be expected to be of long, continued and indefinite duration. For households with children, where the child is disabled, the disability must be such that it requires the head of household to provide on-going, intensive care related to the disability. This care must impact the head of household's ability to work full-time or earn at least 50 percent of the Area Median Income.

7. **Domestic Violence Database.** A database comparable to HMIS that is compliant with Continuum of Care and Violence Against Women Act regulations that collects victim service provider client-level data over time and generates unduplicated aggregate reports based on the data, which is

administered by the Fairfax County Department of Administration for Human Services and the Office to Prevent and End Homelessness as the HMIS lead agency.

8. **Emergency Shelter.** Emergency shelter is defined by the Department of Housing & Urban Development as any facility with overnight sleeping accommodations, the primary purpose of which is to provide temporary shelter for the homeless in general or for specific populations of the homeless. Fairfax County emergency shelters serve Individuals and Families according to the following eligibility and prioritization criteria with the goal of transitioning those served back into permanent housing in 30 days or less.

9. **Equity.** Ensuring full inclusion of the entire region's residents in the economic, social, and political life of the region, regardless of race/ethnicity, nativity, age, gender, neighborhood of residence, or other characteristics. This can be found in the Equitable Growth Profile document, Fairfax County, 2015.

10. **Fairfax County Residency Status.** At least one of the following forms of documentation should be collected upon entry to emergency shelter to verify Fairfax County Residency Status, including:

    a. Driver's license or any form of ID with an address with Fairfax County, *or*
    b. Utility bill with a name and address within the past 180 days for a unit located in Fairfax County, *or*
    c. Verification documentation of receipt of entitlement benefits, such as SNAP, TANF, Medicaid from the Fairfax County Department of Family Services, *or*
    d. Children currently in physical and legal custody enrolled in Fairfax County Public Schools*, or*
    e. Otherwise verifiable documentation through a third party connecting the household to Fairfax County

11. **History of Homelessness.** For the purposes of Coordinated Assessment, "History of Homelessness" is defined as the total number of days that an Individual or family is homeless in the Fairfax-Falls Church Community in the three years prior to seeking assistance as documented in the Fairfax County HMIS, and by independent third-party certification of homelessness from the Fairfax County domestic violence homeless assistance database or other service providers.

12. **Homeless.** The definition of homelessness can be found under paragraph (1) of the "homeless" definition in §576.2 of Title 24 in the Code of Federal Regulations (US Government Publishing Office, 2017) and is summarized by HUD as follows:

    Category 1 -Literally Homeless
    Individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

    a. Has a primary nighttime residence that is a public or private place not meant for human habitation;

    b. Is living in a publicly or privately operated shelter designated to provide temporary living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state and local government programs); or

    c. Is exiting an institution where (s)he has resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution

Category 2- Imminent Risk of Homelessness
Individual or family who will imminently lose their primary nighttime residence, provided that:

a. Residence will be lost within 14 days of the date of application for homeless assistance;

b. No subsequent residence has been identified; and

c. The individual or family lacks the resources or support networks needed to obtain other permanent housing

Category 3 -Homeless under other Federal statutes
Unaccompanied youth under 25 years of age, or families with children and youth, who do not otherwise qualify as homeless under this definition, but who:

a. Are defined as homeless under the other listed federal statutes;

b. Have not had a lease, ownership interest, or occupancy agreement in permanent housing during the 60 days prior to the homeless assistance application;

c. Have experienced persistent instability as measured by two moves or more during in the preceding 60 days; and

d. Can be expected to continue in such status for an extended period of time due to special needs or barriers

Category 4 -Fleeing/ Attempting to Flee Domestic Violence
Any individual or family who:

a. Is fleeing, or is attempting to flee, domestic violence;

b. Has no other residence; and

c. Lacks the resources or support networks to obtain other permanent housing

13. **Household Type.** For specificity and clarity, individuals and families can be identified as being a member of one of three different household type possibilities, where " children" is a person who is less than 18 years of age and "adult" is someone who is greater than 18 years of age:
    a. Adult only household
    b. Households with children, and
    c. Households with only children.

14. **Housing First.** Housing First is an approach in which housing is offered to people experiencing homelessness without preconditions (such as sobriety, mental health treatment, or a minimum income threshold) or service participation requirements and in which rapid placement and stabilization in permanent housing are primary goals. PSH projects that use a Housing First approach promote the acceptance of applicants regardless of their sobriety or use of substances, completion of treatment, or participation in services. HUD encourages all recipients of CoC Program-funded PSH to follow a Housing First approach to the maximum extent practicable. Any recipient that indicated that they would follow a Housing First approach in the FY 2013 CoC Project Application must do so for both the FY 2013 and FY 2014 operating year(s), as the CoC score for the FY 2013–FY 2014 CoC Program Competition was affected by the extent in which

project applications indicated that they would follow this approach and this requirement will be incorporated into the recipient's FY 2013 and FY 2014 grant agreement.

15. **Permanent Supportive Housing (PSH).** Non time-limited, affordable housing with optional wrap around intensive support services for people experiencing homelessness where the head of household has a long term disability that is not expected to resolve and significantly interferes with their activities of daily living.

16. **Homelessness Prevention.** Programs that provide financial assistance and supportive services that stabilize households in their current housing or help them to move into new housing without first entering the shelter system or experiencing homelessness. Services may include financial assistance (security or utility deposits, utilities payments, moving cost assistance), short or medium-term rental assistance, housing placement services, legal assistance, mediation, credit counseling and case management. The goal is to help households resolve their crisis, secure short-term financial or rental assistance as needed, and access ongoing sources of support in the community in order to remain housed. If the individual or family is unable to stay in their existing housing, the prevention program helps the household to find an alternative housing arrangement that is safe, reasonably affordable and adequate. Financial assistance is dependent upon the availability of funding; the household must also meet the eligibility criteria of the funding source.

17. **Rapid Rehousing.** Rapid Rehousing is an approach to help Individuals and Families experiencing homelessness move quickly into permanent housing, ideally within 30 days of becoming homeless. Rapid re-housing assistance is generally offered without preconditions (such as employment, income, absence of criminal record, or sobriety) and the resources and services provided are typically tailored to the unique needs of each household. Services include housing search and selection support, assistance in negotiating the terms of a lease, short term rent subsidies and move-in assistance,* individualized case management, ongoing crisis prevention and crisis management services, facilitated access to community resources (i.e. benefits, employment), and other supportive services.*Dependent upon the availability of funding. The household must also meet the eligibility criteria of the funding source.

18. **Regional Homeless Referral Coordinator (RHRC).** The Regional Homeless Referral Coordinator is the general term for the individuals in each of Fairfax County's 4 service regions that are responsible for receiving homeless service referrals from Coordinated Services Planning (CSP), conducting triage of clients seeking homeless services, communicating with other RHRCs regarding capacity (including vacancies within emergency shelter and the need for emergency shelter placement), and communicating the outcome of referrals to CSP. The exact title at each agency may vary (example: Intake Coordinator, Sr. Case Manager, Case Management Supervisor, etc.).

19. **Severity of Service Needs.** Persons who have been identified as having the most severe service needs based on the assessment tool used for each household type:

    a. Households with at least one adult and one child – Highest score as measured by the Housing and Services Triage Tool (HSTT).

    b. Households without children – Highest score as measured by the Vulnerability Index-Service Prioritization Decision Assistance Tool (VI-SPDAT) score excluding the Socialization and Daily Functioning section. The full VI-SPDAT score will be maintained on file for program assignment.

20. **Transitional Housing.** Temporary housing with intensive support and services meant to bridge the gap from homelessness to permanent housing.

21. **Trauma Informed Care**. Trauma Informed Care is an organizational structure and treatment framework that involves understanding, recognizing, and responding to the effects of all types of trauma. Trauma Informed Care also emphasizes physical, psychological and emotional safety for both consumers and providers, and helps survivors rebuild a sense of control and empowerment.

22. **Verification of Loss of Permanent Housing in Fairfax County.** Documentation should be collected upon entry to emergency shelter to verify Loss of Permanent Housing in Fairfax County, including:

    a. A written legal rental lease or property mortgage for at least 180 consecutive days prior to their date of homelessness for property located in Fairfax County, *or*

    b. An eviction or foreclosure notice indicating the date that the housing was list in Fairfax County, *or*

    c. If the family never had a legal lease or property mortgage in Fairfax County, then the family must provide documentation (Third Party Housing Status Verification Form) to verify they have resided permanently in Fairfax County for at least 180 days.

Appendix 1 - Forms and Tools Used by Adult Only Households & Households with Children

A1-1 Fairfax County Version of Commonwealth of Virginia Uniform Authorization to use and Exchange Information (ROI)

A1-2 Prioritization Pool Referral Form

A1-3 Homeless History Form

A1-4 Homeless Certification Form

A1-1 Fairfax County Version of Commonwealth of Virginia Uniform Authorization to use and Exchange Information

FAIRFAX COUNTY VERSION OF COMMONWEALTH OF VIRGINIA UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION

I understand that different agencies provide different services and benefits. Each agency must have specific information to provide services and benefits. By signing this form, I allow agencies to use and exchange certain information about me, including information in an electronic database, so it will be easier for them to work together efficiently to provide or coordinate these services or benefits.

I, _____, am signing this form for
(FULL PRINTED NAME OF CONSENTING PERSON)

_____
(FULL PRINTED NAME OF INDIVIDUAL)

_____
(INDIVIDUAL'S ADDRESS) *(INDIVIDUAL'S BIRTH DATE)*

My relationship to the individual is: ☐ Self ☐ Parent ☐ Power of Attorney ☐ Guardian ☐ Other Legally Authorized Representative

I want the following confidential information about the individual to be exchanged; each item must be checked:

Yes	No		Yes	No		Yes	No	
☒	☐	Assessment Information	☐	☐	Medical Diagnosis	☐	☐	Educational Records
☐	☐	Financial Information	☐	☐	Mental Health Diagnosis	☐	☐	Psychiatric Records
☐	☐	Benefits/Services Needed, Planned, and/or Received	☐	☐	Health Records	☐	☐	Criminal Justice Records
			☐	☐	Psychological Records	☐	☐	Employment Records
☐	☐	Substance Abuse Records (one time use only, see page 2)				Other Information (write in): _____		

I want _____
(NAME AND ADDRESS OF REFERRING AGENCY AND STAFF CONTACT PERSON)

and the following entities to be able to use and exchange this information among themselves:

Fairfax County

Yes	No		Identify By Name
☐	☐	Alcohol Saf… Action …rogram	
☐	☐	Family Servi…	
☐	☐	Fairfax County Co…	
☐	☐	Health Depa…ment	
☐	☐	Housing & C… …Dev…ment	
☐	☐	Juvenile & Domestic Relations Court Services	
☐	☐	Neighborhood & Community Services	
☐	☐	Office for Women	
☐	☐	Probation & Parole	
☐	☐	Fairfax County Public Schools	
☐	☐	Fairfax-Falls Church Community Services Board	
☒	☐	Fairfax-Falls Church Community Partnership	

Other Identify By Name

☐ ☐ _____
☐ ☐ _____

State/Local/Private/Non-Profit

Yes	No		Identify By Name
☐	☐	…t. of B… …Health & D… …lopmental Services	
		…elopm… …l S…ices	
☐	☐	…t. of …sical …sistance Ser…	
☐	☐	…t. of Social S…ices	
☐	☐	…eh… …vices	
☐	☐	Area Agencies on Aging	_____
☐	☐	Community Services Boards	_____
☐	☐	Home Health Agencies	_____
☐	☐	Hospices	_____
☐	☐	Local Health Departments	_____
☐	☐	Nursing Facilities	_____
☐	☐	Physicians	_____
☐	☐	Community Based Organizations	_____

Other Identify By Name

☐ ☐ _____
☐ ☐ _____

I want this information to be exchanged ONLY for the following purpose(s):
☐ Service Coordination and Treatment Planning ☐ Eligibility Determination ☐ Other: _____

I want this information to be shared by the following means: *(check all that apply)*
☐ Written Information ☐ In Meetings or By Phone ☐ Computerized Data ☐ Fax

I want to share additional information received after this authorization is signed: ☐ Yes ☐ No
This authorization is effective: _____
(DATE)
This authorization is good until: ☐ My service case is closed. ☐ Other: _____

I can withdraw this authorization at any time by notifying any involved agency listed on the form. The listed agencies must stop sharing information after they know my authorization has been withdrawn. I have the right to know what information about me has been shared, and why, when, and with whom it was shared. If I ask, each agency will show me this information. I want all agencies to accept a copy of this form as valid consent to share information. **If I do not sign this form, information will not be shared and I will have to contact each agency individually to give information about me that is needed.** However, I understand that treatment and services cannot be conditioned upon whether I sign this authorization. There is a potential for information disclosed pursuant to this authorization to be re-disclosed by the recipient and not be subject to the HIPAA Privacy Rule.

Signature(s): _____ Date: _____
(AUTHORIZING PERSON)

Person Explaining Form: _____
(Name) *(Address)* *(Phone Number)*

Other *(If Required)*: _____
☐ Parent ☐ Witness *(Signature)* *(Address)* *(Phone Number)*

Fairfax County version 10/07/09

FAIRFAX COUNTY VERSION OF COMMONWEALTH OF VIRGINIA UNIFORM AUTHORIZATION TO USE AND EXCHANGE INFORMATION

Full Printed Name of Individual: _____

FOR AGENCY USE ONLY

AUTHORIZATION HAS BEEN:

☐ Revoked in entirety
☐ Partially revoked as follows:

NOTIFICATION THAT AUTHORIZATION WAS REVOKED WAS BY:

☐ Letter (Attach Copy) ☐ Telephone ☐ In Person

DATE REQUEST RECEIVED: _____

AGENCY REPRESENTATIVE RECEIVING REQUEST:

_____
(AGENCY REPRESENTATIVE FULL NAME AND TITLE)

_____
(AGENCY ADDRESS) *(PHONE NUMBER)*

SUBSTANCE ABUSE RECORDS:

These records *(select only one)*:

☐ **ARE** protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are protected by 42 CFR Part 2, I understand a recipient is prohibited from making any further disclosure of this information unless expressly permitted by my written authorization, except as otherwise permitted by the Regulations. 42 CFR Part 2 also restricts any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

☐ **ARE NOT** protected by Federal Drug & Alcohol Confidentiality Regulations (42 CFR Part 2). If these records are not protected by 42 CFR Part 2, I understand that the HIPAA Privacy Regulations require I be advised that information used or disclosed based on this authorization may be subject to re-disclosure and no longer protected by federal HIPAA regulations.

Fairfax County version 10/07/09

AUTHORIZATION TO USE AND EXCHANGE INFORMATION

Introduction

Specified information can be shared among ALL of the agencies listed below without having to obtain any additional signed consent from the individual. The *Authorization to Use and Exchange Information* form was developed for use by the following agencies:

- Local departments of social services
- Area agencies on aging
- Health department clinics and programs
- Community services boards
- Department of Correctional Education
- Department of Youth and Family Services
- Service delivery areas for the Job Training Partnership Act
- Local departments of Rehabilitative Services
- Local school systems
- Regional offices, Department of Corrections
- Regional outreach offices, Department for the Deaf and Hard of Hearing
- Regional Offices, Department for the Blind and Vision Impaired
- Virginia Employment Commission Offices
- Fairfax / Falls Church Community Partnership

The "referring agency" is defined as the agency that initiates the completion of the *Authorization to Use and Exchange Information* form with the individual. The referring agency may use the form to request or to transmit information to other agencies. Agencies may be considered either a "referring" or an "other" agency, depending upon which agency is contacted first by the individual. If all parties agree, additional public and private agencies, facilities, and organizations may be included.

Agencies are assured that, when properly executed, this is a legally valid form that meets not only their own agency's state and federal requirements, but also those of the other participating agencies. The *Authorization to Use and Exchange Information* form has been reviewed by the Office of the Attorney General to assure compliance with federal and state confidentiality requirements. Agencies may choose to use a different uniform release form that addresses their individual needs if it meets the state and federal confidentiality and release of information statutory and regulatory requirements of ALL involved agencies.

Alcohol and Drug Abuse Confidentiality Requirements

To ensure compliance with federal alcohol and drug abuse confidentiality requirements, this form excludes the general sharing of information about individuals in drug and alcohol programs. A separate release of information form specifically for alcohol and drug abuse records should be used each time information is shared between agencies.

Purpose of the Authorization to Use and Exchange Information Form

The *Authorization to Use and Exchange Information* form is designed for use by agencies that work together to jointly provide or coordinate services for individuals with complex needs and should be used along with the referring agency's specific procedures for obtaining a valid release to exchange information. It also can be used to assist agencies obtain information needed from other agencies to determine an individual's eligibility for services or benefits. The completed form should reflect that the individual (or his or her representative) controlled the choices and understood the process. When using this form, always keep in mind the importance of individual wishes, individual choices, and individual comprehension of the process.

Agency staff and the consenting person will first determine whether the individual might be eligible for services or benefits provided by other agencies. This determination should be based upon the needs, interests, and circumstances of the individual as well as staff's knowledge of other agencies' services or benefits and eligibility requirements.

Referring agency staff must explain the following to the individual:

- Potential services and benefits that might be available from other agencies.
- What information these agencies might need and for what purpose(s).

Fairfax County version 10/07/09

- The purpose of the form.
- The consequences of signing or not signing this release.
- Key provisions and protections (e.g., revocation, access to agencies' written record).

Staff should make every attempt to ensure that the consenting person understands the provisions of the form and should make appropriate efforts to accommodate the special needs of the consenting person. If the consenting person is unable to read or is blind or visually impaired, staff should read the form to him or her. Interpreters should be made available for people who do not speak English and for those who are deaf or hearing impaired. If the consenting person does not appear to comprehend the meaning of the form, it should be explained. If staff have ANY doubts that the consenting person is not comprehending the purpose and provisions of the form, they should ask the consenting person questions about the form (what the form allows the agency to do, etc.).

Based upon these answers, if staff determine that the consenting person is NOT comprehending the purpose and provisions of the form, staff should follow their agency's procedures for assuring that the form is signed by a legally authorized consenting person who fully comprehends the purpose and provisions of the form. The signature of a consenting person who does NOT comprehend what he or she is signing is not valid.

If the consenting person agrees, the form should be completed. This should be done by the consenting person, wherever possible. The consenting person must sign the form and insert the date in the indicated place. Staff explaining the form to the consenting person must sign the form in the indicated place. For those agencies with procedures requiring a witness (e.g., for a person who cannot write), space is provided for a witness to sign the form. The witness must observe the consenting person signing or placing a mark on the form and then must sign as indicated. The referring agency must give a copy of the completed form to the consenting person.

Sharing Information with Other Agencies
It is important for the referring agency to notify the other listed agencies that they are parties to this agreement to exchange information. This notification can be by telephone or through written correspondence. This notification must be entered into the individual's record. If the referring agency wants to receive information from other agencies, it must provide a copy of the signed consent form with its initial request for information form each listed agency.

Virginia Privacy Protection Act Requirements
To ensure compliance with the Virginia Privacy Protection Act, each time information is disclosed by any of the listed agencies, staff of the disclosing agency must enter the following information into the individual's record:

- Name of the agency and the name, title, telephone number of the individual receiving the information.
- Type and source of the information disclosed.
- Reason or purpose for the disclosure.
- Date the information was disclosed.

This requirement can be met by using a disclosure log (sample attached) or through the agency's own record keeping policies and procedures.

NOTE: The consenting person has the right to review the records of disclosure of the referring and other agencies upon request during the agencies' normal business hours.

Agency Record Keeping Policies and Procedures
Referring Agency: The original signed copy of the *Authorization to Use and Exchange Information* form, disclosure record, and any related materials shall be maintained in accordance with the agency's record keeping policies and procedures.

Other Agencies: A copy of the *Authorization to Use and Exchange Information* form, disclosure record, and any related materials shall be maintained in accordance with the agency's record keeping policies and procedures.

Renewing or Amending the Authorization Form
The referring agency can renew or amend (e.g., by adding additional agencies) the original signed copy of the *Authorization to Use and Exchange Information* form by having the consenting person sign and insert the date beside the amendment on the original form. The referring agency must give a copy of the amended form to the consenting person and forward a copy of the amended form to each of the listed agencies.

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Revocation of Authorization
Consent to exchange information will expire on the date or condition agreed to by the consenting person. However, anytime prior to the expiration, the consenting person may choose to revoke or cancel this consent either with all or with selected agencies.

The consenting person may revoke his or her consent by informing any of the involved agencies in writing, by telephone, or in person. This notification must be noted on the back of the *Authorization to Use and Exchange Information* form and signed and dated by the agency staff person receiving the request to revoke the consent.

If the consenting person exercises the option of revoking his or her consent (in entirety or with selected agencies) to share information under the agreement, the agency receiving this notice shall inform all other listed agencies that are authorized to exchange information under the agreement of the revocation of the consent.

Individuals Who Refuse to Sign the Authorization Form
It is absolutely essential that the individual understand and appreciate what will happen as a result of signing this form. The individual also needs to understand that there is no requirement to sign this form, but that not signing the form will result in specific consequences. If the form is not signed, the individual must deal with each agency individually to obtain needed information, and/or the agency may not be able to provide services. If the form is signed, the process for applying for and receiving services may be easier for both the individual and the involved agencies.

When Not to Use This Form
The *Authorization to Use and Exchange Information* form should not be used with:

- Individuals who do not comprehend the purpose and substance of the consent form; or
- Individuals for whom drug or alcohol abuse diagnostic or treatment information is being shared. In these cases, a separate consent form should be used.

Can Other Interagency Consent Forms Be Used?
Agencies should accept the *Authorization to Use and Exchange Information* form as a legally valid form. However, they may choose to use a different release form that addresses their individual needs IF it meets the state and federal confidentiality statutory and regulatory requirements of ALL the involved agencies.

A1-2 Prioritization Pool Referral Form

FAIRFAX-FALLS CHURCH COMMUNITY PARTNERSHIP TO PREVENT AND END HOMELESSNESS
PRIORITIZATION POOL REFERRAL FORM

1. Household Information *(Please list the name(s) of all referred household members that will be living together. If additional household members may join the household (i.e. pregnancy, family reunification, etc.), please include them in Section 6 -Additional Information)*

#	Name	Name of School *(school age children only)*	Relationship to HoH	HMIS#	Gender	DOB
1			Head of Household			
2						
3						
4						
5						
6						
7						
8						

2. Contact Information

Head of Household (HoH) Name	HoH Phone	HoH Email
Primary Worker Name	Worker Phone	Worker Email

3. Housing Placement Assessment

VI-SPDAT Score *(Households with only adults)*	HSTT Score *(Households with adults & children)*	Current Living Situation *(Attach a print out of HMIS entry exits from HMIS along with Housing History and Length of Homelessness)*

#	Is the client willing to accept the following geographic areas, if available? Check all that apply.	Yes	No
3.1	Region 1 (Route 1, Alexandria area)?		
3.2	Region 2 (Falls Church / Annandale)?		
3.3	Region 3 (Reston / Herndon)?		
3.4	Region 4 (Fairfax / Centreville)?		
#	Has any member of the household ever been convicted of the following: *(Check all that apply)*	Yes	No
3.5	Felony Drug Charge?		
3.6	Felony Assault Charge?		
3.7	Misdemeanor Drug Charge?		
3.8	Misdemeanor Assault Charge?		
3.9	Arson?		
3.10	Sex Offense?		
3.11	Any other convictions? (If yes, what?)		
3.12 a.	Does the client have a **documented** disability?		
3.12 b.	If undiagnosed or not yet documented, based on your professional opinion and interactions with the Client/HoH do you believe she/he has a mental health and/or substance abuse disorder?		

Page 1 of 2

Updated 01/18/18

FAIRFAX-FALLS CHURCH COMMUNITY PARTNERSHIP TO PREVENT AND END HOMELESSNESS
PRIORITIZATION POOL REFERRAL FORM

#	Question	Answer
3.13	If the household is fleeing **domestic violence**, what protective orders, legal action, or safety issues needs to be considered?	
3.14	In what types of housing **do you think** the client could be successful in sustaining housing? (Check all that apply)	
	☐ Scattered Site housing with case management available and no roommates(households with or without children)	
	☐ Individual housing on a property where staff are available if needed (for households with or without children)	
	☐ Scattered site housing with case management available and one roommate (for households *without* children only)	
	☐ Shared housing with roommates and staff on site for some time every day (for households without children only). **NOTE: This "group home" type of housing should only be checked for those clients that need the most intensive supports and services. For those that won't require that level of support, limit your checks to the options above.**	
3.15	Will the client need special accommodations, e.g., housing without stairs; public transportation etc.? If so, please list accommodation needed.	

4. Income Information		
Total monthly household income.		
Is any of the income, earned income?	Yes	No
Please list all sources of income.		

5. ADL Assessment - assess the household member(s) in the following areas *(include the initials of the household member in each ranking)*			
Skill	A Lot of Assistance	Some Assistance	No Assistance
Personal Hygiene			
Cooking and Nutrition			
Housekeeping			
Getting up in the AM/Maintaining [illegible]			
Medication Management			
Budget/Money Management			
Using Public transportation/operating own vehicle			
Interpersonal and social skills			
Complying with lease/Negotiating with landlord			
Paying 30% of household Income towards rent			
Providing basic needs care to minor children *(if applicable)*			

6. Additional Information - *(Please note: Additional information for Section 1 including pregnancy due date or expected family reunification date; Explanation of answers in Section 3; Primary language if not English; Current legal issues; Special housing related considerations - ie must have parking, close to bus, pets, etc.; Any case management concerns regarding client answers to questions.) Attach additional Pages as necessary.*

7. Date Completed	**Supervisor/Reviewer Name**	**Supervisor/Reviewer Signature**

A complete referral includes the following documents:
For all programs:

- ROI- (Release of Information)
- Homelessness Certification Form
- Homeless History Form
- VI-SPDAT (Adult Only Households) or HSTT (Families) - completed within the last 6 months

Additional Requirement for PSH: Written verification of disabling condition per the requirements listed in the Coordinated Entry Policy Manual

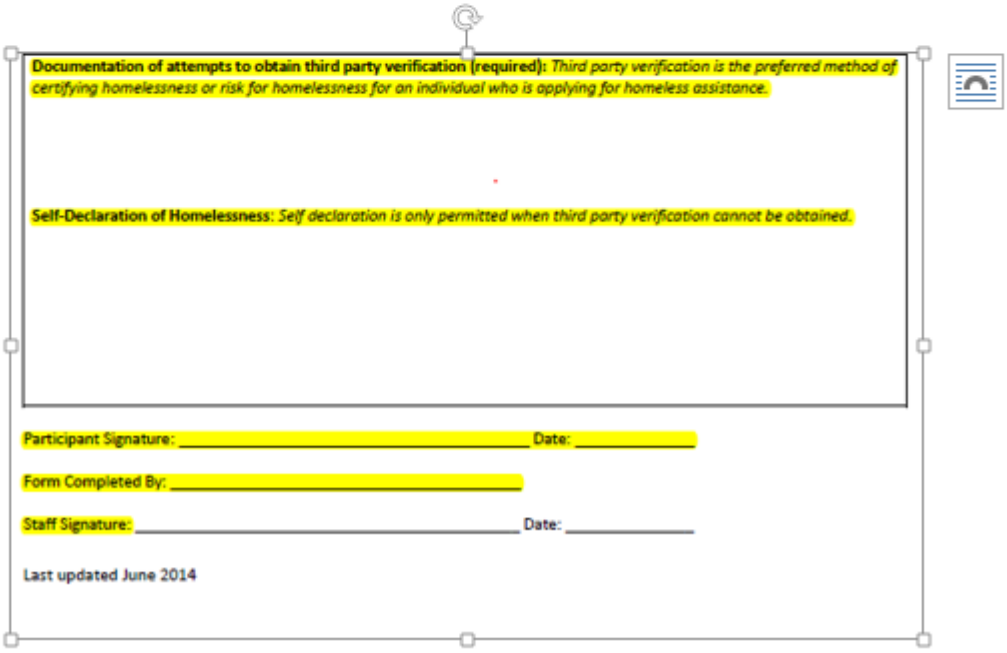
A1-3 Homeless History Form

Fairfax-Falls Church Partnership to Prevent and End Homelessness

Homeless History Form Instructions

The information in the form is important to verify prioritization and/or eligibility for homeless services programs. This form is used to document a client's history of homelessness beginning with their current episode of homelessness and working backward to get as much history as possible.

- Provide **only homeless episodes**. Each box should contain only one episode. Any gaps in timeline will be assumed as housed.
- **Institutions:**
  - Client must have been homeless upon entering an institution for the time in the institution to be counted as homeless (as long as that time also complies with below).
  - Time spent in institutions of 90 or more days ends the episode of homelessness and cannot be counted.
- An episode of homelessness ends anytime a client is housed (per the HUD definition[1]) for 7 days or more
- When HMIS is used to document homelessness, a copy of the record should be included and uploaded as proof of refer
- Any homele s that cannot be ed in MIS require additional do on
  - Third Par Do ion th th pre rred type documen ion and should be ob as m ch as p si e.
  - Self-Certification & Documentation of Attempts to Obtain Third Party Documentation should **ONLY** be used when Third Party Documentation can't be obtained. Both of the sections highlighted below **MUST** be completed on pg 2. of the Homeless Certification Form when utilizing self-certification.



Documentation of attempts to obtain third party verification (required): *Third party verification is the preferred method of certifying homelessness or risk for homelessness for an individual who is applying for homeless assistance.*

Self-Declaration of Homelessness: *Self declaration is only permitted when third party verification cannot be obtained.*

Participant Signature: _____ Date: _____

Form Completed By: _____

Staff Signature: _____ Date: _____

Last updated June 2014

Fairfax-Falls Church Partnership to Prevent and End Homelessness
Homeless History Form

Participant Name: _____ Date: _____

Where client stayed	Dates client stayed at this location.	Documentation Type Documents are listed in preferred order. Docs are to be included with referral	NOTES
☐ Place not meant for human habitation ☐ Shelter/ Hypo Prevention Program ☐ Safe Haven ☐ Inst. < 90 days		☐ HMIS ☐ Third Party Documentation ☐ Other Data Base (please id in notes) ☐ Self-Cert. & CASE MANAGER verification of attempts to get 3rd party documentation *	
☐ Place not meant for human habitation ☐ Shelter/Hypo Prevention Program ☐ Safe Haven ☐ Inst. < 90 days		☐ HMIS ☐ Third Party Documentation ☐ Other Data Base(please id in notes) ☐ Self-Cert. & CASE MANAGER verification of attempts to get 3rd party documentation *	
☐ Place not mea or human habitation ☐ Shelter/Hypo Prevention Progra ☐ Safe Haven ☐ Inst. < 90 days		☐ HM ☐ Th rty ncum at ☐ er ata se (please in notes) ☐ lf-C t. & ASE MANA verificat of attempts to get 3rd party documentation *	
☐ Place not meant for human habitation ☐ Shelter/Hypo Prevention Program ☐ Safe Haven ☐ Inst. < 90 days		☐ HMIS ☐ Third Party Documentation ☐ Other Data Base (please id in notes) ☐ Self-Cert. & CASE MANAGER verification of attempts to get 3rd party documentation *	
☐ Place not meant for human habitation ☐ Shelter/Hypo Prevention Program ☐ Safe Haven ☐ Inst. < 90 days		☐ HMIS ☐ Third Party Documentation ☐ Other Data Base(please id in notes) ☐ Self-Cert. & CASE MANAGER verification of attempts to get 3rd party documentation*	

Attach additional pages if needed

Additional Pages Attached? Y_____ N_____ If yes, how many?_____

*Does the history of homelessness include more than 3 months of Self Certification? Yes ☐ No☐

If yes, please be advised of the following: Only 25% (or less) of households served by a provider can have self-certification of 3 months or more.

Fairfax-Falls Church Partnership to Prevent and End Homelessness
Homeless History Form

Based on the homeless history, please provide the following information:
Number of times homeless in the last 3 years** _____
Total # months homeless in the last 3 years_____
Total # months of homelessness: _____

The number of times homeless refers to the **episodes of homelessness **NOT locations**. If in a consecutive period of time, the client experienced homelessness in more than one location, do NOT count locations as episodes. For example, if an individual lived in her car for one month and then went to an emergency shelter the next month. This is one episode of homelessness (that included two locations).

Part II: Disability Verification
Does the client have a diagnosed disability? Yes ☐ or No ☐

Documentation of disabling condition must be included. The following are acceptable forms of documentation:

- SSDI or SSI documents from Social Security Administration (e.g. letters of disability benefits, copy of benefit check)
- Written verification of the disability from a professional licensed by a state to treat and diagnose the disability. This documentation must include ALL of the following:
  - Verification of the disabling condition
  - Verification that the disability is expected to be ongoing/of indefinite duration
  - Verification that the disability substantially impedes the individual's ability to live independently
  - Verification that the disability could improve with more suitable housing

Disabling Condition. Check all appropriate boxes

☐ A developmental disability
☐ A diagnosable substance use disorder
☐ A serious mental illness
☐ A chronic physical illness or disability, including the co-occurrence of two or more of these conditions.

Part III: Chronic Homelessness
For a household to be determined as experiencing chronic homelessness, all of the following must apply:
☐ An individual/household is currently residing in an emergency Shelter, safe haven, or a place not meant for human habitation
☐ The head of household has a documented disability; **and**
☐ The household has either been continuously homeless for at least 12 months or has had 4 episodes of homelessness totaling 12 months of homelessness (or more) in the last 3 years.

Is the client Chronically Homeless? (**All 3 boxes** must be checked to meet requirements)? Yes ☐ or No☐

Staff Name: _____ Staff Title: _____

Organization: _____ Signature: _____Date:_____

A1-4 Homeless Certification Form

HOMELESS CERTIFICATION FORM

Applicant Name and Unique Identifier: _____

Staff Member Name: _____

☐ Household without dependent children (complete one form for each adult in the household)
☐ Household with dependent children (complete one form for household)
Number of persons in the household: _____

This is to certify that the above named individual or household is currently either literally or imminently homeless based on the check mark, other indicated information, and signature indicating their current living situation. Check the appropriate type of documentation used to verify homelessness and attach it to this worksheet

CHRONICALLY HOMELESS CERTIFICATION

Please continue to the General Homeless Certification after selecting "Yes" or "No"

CHRONICALLY HOMELESS: ☐Yes* ☐No

***Documentation of continuous or episodic homelessness and diagnosis REQUIRED**

☐ Individual or family:

(i) Has been homeless and living or residing in a place not meant for human habitation, a safe haven, or in an emergency shelter continuously for at least one year or on at least four separate occasions in the last three years; and

(ii) Has an adult head of household (or minor head of household if no adult is present in the household) with a diagnosable substance use disorder, serious mental illness, developmental disability (as defined in Section 102 of the Developmental Disabilities Assistance and Bill of Rights Act of 2000, 42 U.S.C. 15002)), post-traumatic stress disorder, cognitive impairments resulting from a brain injury, chronic physical illness or disability, including the co-occurrence of 2 or more of those conditions.

GENERAL HOMELESS CERTIFICATION

Complete with information on the primary cause of homelessness

	Homeless Status	Type of Eligible Documentation	Documentation/Eligibility
	LITERAL HOMELESSNESS (RAPID RE-HOUSING ELIGIBLE)		
☐	**Persons living on the street or sleeping in a place not designed for or ordinarily used as a regular sleeping accommodation**	• Signed and dated written certification by person seeking services • Signed and dated written certification by an outreach worker	☐Yes ☐No ☐ N/A
☐	**Persons living in a shelter designed to provide temporary living arrangements** - congregate/scattered site emergency shelters - transitional housing - hotels/motels paid for by a charitable organization or government program	• HMIS shelter record • Written referral from previous shelter staff • Written referral from charitable organization or government program	☐Yes ☐No ☐ N/A
☐	Persons exiting an institution where they resided for 90 days or less and resided in a place not meant for human habitation immediately before entering institution	• HMIS shelter record • Written referral from previous shelter staff • Written referral from institution	☐Yes ☐No ☐ N/A

HOMELESS CERTIFICATION FORM

☐	Persons fleeing domestic violence.*Must meet one of the homeless status categories listed above*	• Written, signed and dated verification from the participant • Written, signed and dated verification from the domestic violence service provider.	☐Yes ☐No ☐ N/A
	IMMINENT RISK OF HOMELESSNESS (PREVENTION/DIVERSION ELIGIBLE)		
☐	Person will imminently lose primary nighttime residence within 14 days and meets both of the following circumstances - No appropriate subsequent housing options have been identified - Household lacks the financial resources [illegible] needed t[illegible] housing or [illegible] housing	• Documentation of efforts to divert from homelessness (contact with prevention provider)—Notate in case file • Eviction letter from tenant/homeowner (If living with another, i.e. doubled up) • Letter from hotel/motel [illegible] checks [illegible] by the [illegible] Court [illegible]er/eviction [illegible]otice	☐Yes ☐No ☐ N/A
☐	Persons fleeing domestic violence *Must also be imminently homeless*	• Written, signed and dated verification from the participant • Written, signed and dated verification from the domestic violence service provider.	☐Yes ☐No ☐ N/A

Documentation of attempts to obtain third party verification (required): *Third party verification is the preferred method of certifying homelessness or risk for homelessness for an individual who is applying for homeless assistance.*

Self-Declaration of Homelessness: *Self declaration is only permitted when third party verification cannot be obtained.*

Participant Signature: _____ Date: _____

Form Completed By: _____

Staff Signature: _____ Date: _____

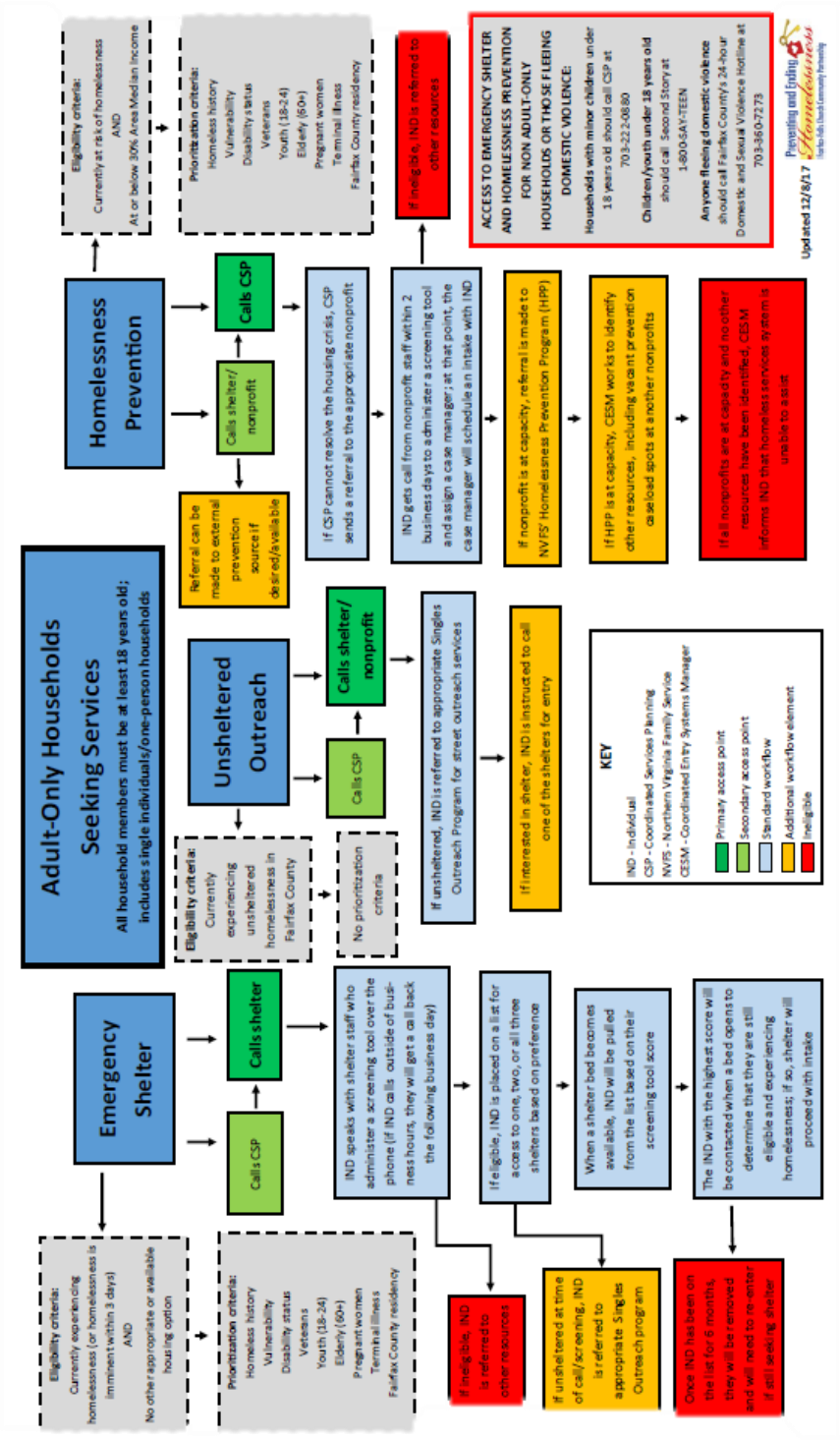
Appendix 2 -Forms and Tools Unique to Adult Only Households

A2-1 Workflow graphic for Single's Prevention, Outreach and Emergency Shelter

A2-2 Eligibility and Prioritization Tool for Access to Emergency Shelter and Homelessness Prevention Services for Households with Only Adults

A2-3 Placeholder for Single's Intake Tool

A2-1 Workflow graphic for Single's Prevention, Outreach and Emergency Shelter


Adult-Only Households Seeking Services
All household members must be at least 18 years old; includes single individuals/one-person households
Homelessness Prevention
Eligibility criteria:
Currently at risk of homelessness
AND
At or below 30% Area Median Income
Prioritization criteria:
Homeless history
Vulnerability
Disability status
Veterans
Youth (18-24)
Elderly (60+)
Pregnant women
Terminal illness
Fairfax County residency
Calls CSP
Calls shelter/ nonprofit
Referral can be made to external prevention source if desired/available
If CSP cannot resolve the housing crisis, CSP sends a referral to the appropriate nonprofit
IND gets call from nonprofit staff within 2 business days to administer a screening tool and assign a case manager; at that point, the case manager will schedule an intake with IND
If ineligible, IND is referred to other resources
If nonprofit is at capacity, referral is made to NVFS' Homelessness Prevention Program (HPP)
If HPP is at capacity, CESM works to identify other resources, including vacant prevention caseload spots at another nonprofits
If all nonprofits are at capacity and another resources have been identified, CESM informs IND that homeless services system is unable to assist
ACCESS TO EMERGENCY SHELTER AND HOMELESSNESS PREVENTION FOR NON ADULT-ONLY HOUSEHOLDS OR THOSE FLEEING DOMESTIC VIOLENCE:
Households with minor children under 18 years old should call CSP at 703-222-0880
Children/youth under 18 years old should call Second Story at 1-800-SAY-TEEN
Anyone fleeing domestic violence should call Fairfax County's 24-hour Domestic and Sexual Violence Hotline at 703-360-7273
Updated 12/8/17
Preventing and ending Homelessness
Unsheltered Outreach
Eligibility criteria:
Currently experiencing unsheltered homelessness in Fairfax County
No prioritization criteria
Calls CSP
Calls shelter/ nonprofit
If unsheltered, IND is referred to appropriate Singles Outreach Program for street outreach services
If interested in shelter, IND is instructed to call one of the shelters for entry
KEY
IND - Individual
CSP - Coordinated Services Planning
NVFS - Northern Virginia Family Service
CESM - Coordinated Entry Systems Manager
Primary access point
Secondary access point
Standard workflow
Additional workflow element
Ineligible
Emergency Shelter
Eligibility criteria:
Currently experiencing homelessness (or homelessness is imminent within 3 days)
AND
No other appropriate or available housing option
Prioritization criteria:
Homeless history
Vulnerability
Disability status
Veterans
Youth (18-24)
Elderly (60+)
Pregnant women
Terminal illness
Fairfax County residency
Calls CSP
Calls shelter
IND speaks with shelter staff who administer a screening tool over the phone (if IND calls outside of business hours, they will get a call back the following business day)
If ineligible, IND is referred to other resources
If eligible, IND is placed on a list for access to one, two, or all three shelters based on preference
When a shelter bed becomes available, IND will be pulled from the list based on their screening tool score
The IND with the highest score will be contacted when a bed opens to determine that they are still eligible and experiencing homelessness; if so, shelter will proceed with intake
If unsheltered at time of call/screening, IND is referred to appropriate Singles Outreach program
Once IND has been on the list for 6 months, they will be removed and will need to re-enter if still seeking shelter

A2-2 Eligibility and Prioritization Tool for Access to Emergency Shelter and Homelessness Prevention Services for Households with Only Adults

The Eligibility and Prioritization Tool for Access to Emergency Shelter and Homelessness Prevention for Households with Only Adults (known simply as the "Singles E&P Tool") should be used anytime a single individual is requesting access to emergency shelter or homelessness prevention services through the homeless services system. The purpose of this tool is to pre-screen and triage individuals to determine both eligibility and priority for both emergency shelter and prevention services. If the individual is determined to be eligible for emergency shelter, they will be added to the Shelter Triage, Access, and Referral System for Singles (STARSS). If the individual is determined to be eligible for prevention services, a referral will be made using the Coordinated Entry homelessness prevention workflow. Priority questions determine where individuals fall in the STARSS or how individuals are ranked to fill nonprofit prevention caseload spots.

For those calling to access emergency shelter – prior to administering the tool, all attempts at diverting the individual from homelessness should be made. It is important to note that diversion is NOT the refusal of services/shelter, but instead a method used to explore all other possible resources and systems available to prevent that individual from becoming homeless. Entry into the STARSS and subsequently, emergency shelter, should be a last resort.

1. The tool consists of five (5) main sections:
   - Section 1: Basic Information
   - Section 2: Eligibility Information
   - Section 3: Prioritization Information
   - Section 4: Supplemental Information for Emergency Shelter Only
   - Section 5: Total Priority Score

   In addition, there are designated areas for staff to include verification the individual granted permission for their information to be shared, as well as the best way to contact them should they be pulled for a vacant shelter bed.
2. Anyone calling to access either emergency shelter or homelessness prevention services should be asked the questions in Sections 1 and 2. Note that Question 5 in Section 2 applies ONLY to homelessness prevention referrals. If it is determined that the individual requesting services meets the eligibility criteria, then proceed with the remainder of the assessment. If the individual does not meet the eligibility criteria, do not continue administering the tool.
3. There are three (3) columns:
   - Triage Question: includes the main question, prompts that should be asked to arrive at the most accurate answer possible, and notes/instructions if it is a priority and/or eligibility question. The person administering the tool can ask other questions of the individual being screened in addition to the prompts provided if desired.
   - Triage Answer: asks the person administering the tool to check yes or no to determine the answer to the Triage Question, as well as space to record additional information. The more information that is provided, the better reference the intake worker/prevention case manager has if/when the individual officially enters either program.
   - Priority Points: includes space to record the number of points an individual receives based on their answer to the prioritization questions. Individuals can receive either 0 points if they do not meet the prioritization criteria or 1 point if they do. All points (either 0 or 1) should be recorded.
4. Once all questions have been answered, add total points awarded and record in the space available in Section 5.

5. Individuals must provide verbal permission for their screening information to be shared for the purposes of making a referral to the STARSS through the Homeless Management Information System (HMIS) or to other agencies who provide prevention services. If permission is not granted, individuals cannot be referred. This information should be recorded in the appropriate section at the very beginning of the tool.

SINGLES ELIGIBILITY AND PRIORITIZATION TOOL

DOES INDIVIDUAL GRANT PERMISSION FOR INFORMATION TO BE SHARED FOR THE PURPOSES OF REFERRAL FOR SERVICES? **Answer must be "yes" in order to proceed.**	Permission Granted? Yes ____ No ____ Staff Name (printed): _____

Triage Question	Triage Answer *Include as much information as possible*	Priority Points
SECTION 1 – BASIC INFORMATION		
1. DATE COMPLETED		
2. NAME OF INDIVIDUAL BEING SCREENED		
SECTION 2 – ELIGIBILITY INFORMATION		
3. DATE ***Eligibility question* - INSTRUCTIONS FOR STAFF** Individual must be at least 18 years old to be eligible for services through the singles system. ***Priority question* - INSTRUCTIONS FOR STAFF** Is the individual either between the ages of 18 and 24 OR 60 years of age or older as of today? If yes, give 1 point.	e of Birth: ____/____/____ 18 years old or older? Yes ____ No ____ 18-24 years old? Yes ____ No ____ 60 years old or older? Yes ____ No ____	/1
4. IS THE INDIVIDUAL CURRENTLY HOMELESS OR AT RISK OF HOMELESSNESS? **Ask:** Are you currently homeless or at risk of becoming homeless? If the individual states they are **currently homeless**, ask – "Where did you sleep last night? Where will you sleep tonight?" If the individual states they are **currently at risk of homelessness**, ask – "Why are you at risk of becoming homeless? Do you have an eviction notice? How much longer can you stay in your current housing?" ***Eligibility question* - INSTRUCTIONS FOR STAFF** Answer must be "yes" to either being homeless or at risk of homelessness.	Homeless? Yes ____ No ____ At risk of homelessness? Yes ____ No ____ Other notes:	
5. IS THE INDIVIDUAL AT OR BELOW 30% OF THE AREA MEDIUM INCOME FOR FAIRFAX COUNTY? **DO NOT ASK THIS QUESTION FOR SHELTER REFERRALS. INCOME IS NOT AN ELIGIBILITY QUESTIONS FOR SHELTER.** ***PREVENTION ONLY Eligibility question* - INSTRUCTIONS FOR STAFF** Answer must be "yes" if individual is seeking prevention services.	At or below 30% AMI? Yes ____ No ____ Other notes:	

STOP! BASED ON INFORMATION ABOVE, IS THIS PERSON ELIGIBLE FOR (check one):

EMERGENCY SHELTER _____ PREVENTION SERVICES _____ NOT ELIGIBLE _____

If individual is not eligible for either homelessness prevention or emergency shelter, discontinue tool.

Preventing and Ending Homelessness
Fairfax-Falls Church Community Partnership

Updated 1/16/18

Triage Question	Triage Answer *Include as much information as possible*	Priority Points
SECTION 3 – PRIORITIZATION INFORMATION		
6. DATE CURRENT EPISODE OF HOMELESSNESS STARTED **Ask:** Being as specific as possible, what is the date of the last time when you had a place to sleep that was not an emergency homeless shelter or the streets (which includes a tent, car, bus stop, or anywhere else not meant for habitation)? In other words, what date did your current episode of homelessness begin? ***Priority question* - INSTRUCTIONS FOR STAFF** If individual has been homeless for at least 12 months this time, give 1 point.	Date homelessness started? _____ Based on the date, how many months has this individual been homeless this time? _____ Other notes:	**SHELTER REFERRALS ONLY** /1 **SHELTER REFERRALS ONLY**
7. IS THE INDIVIDUAL VULNERABLE? **Ask:** Do any of the following factors apply to you? Please answer "yes" or "no". Factors: 1. More than 3 hospitalizations or emergency room visits in the last year 2. More than 3 emergency room visits in the previous 3 months 3. Aged 60 or ol 4. Cirrhosis of t iver 5. End-stage ren 6. History of frostbite, im sion oth ia 7. HIV+/AID 8. Tri-morbidity: co-occurring psychiatric, substance abuse, and chronic medical condition ***Priority question* - INSTRUCTIONS FOR STAFF** Based on the answer to Question 6, determine if the individual has been homeless for at least 6 months. If the date of homelessness equals 6 months or more AND the individual answers "yes" to at least one of the factors, give 1 point.	Number of months homeless this time: _____ Factors: 1. Yes ____ No ____ 2. Yes ____ No ____ 3. Yes ____ No ____ 4. Yes ____ No ____ 5. Yes ____ No ____ 6. Yes ____ No ____ 7. Yes ____ No ____ 8. Yes ____ No ____ Based on number of months and factors - vulnerable? Yes ____ No ____	**SHELTER REFERRALS ONLY** /1 **SHELTER REFERRALS ONLY**
8. DOES THIS INDIVIDUAL HAVE ANY HISTORY OF HOMELESSNESS IN THE LAST 2 YEARS ASIDE FROM THIS CURRENT EPISODE? **For shelter referrals – Ask:** Have you slept in an emergency shelter or on the streets at any point in the last two years not including this current episode? In other words, were you homeless any other time besides this one in the last two years? When was it and where did you stay? **For prevention referrals – Ask:** Have you slept in an emergency shelter or on the streets at any point in the last two years? When was it and where did you stay? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes" to either question, give 1 point.	Homeless in the last two years other than this time? Yes ____ No ____ Other notes:	/1
10. DOES THIS INDIVIDUAL HAVE A DISABILITY? **Ask:** Have you been told by a doctor, therapist, or other person in the medical profession that you have a disability of any kind? If so, what is it? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes", give 1 point.	Disability? Yes ____ No ____ Other notes:	/1

11. IS THE INDIVIDUAL A UNITED STATES MILITARY VETERAN? **Ask:** Have you served in the military or armed forces in the United States before? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes", give 1 point.	US military veteran? Yes ____ No ____ Other notes:	/1
12. IS THE INDIVIDUAL PREGNANT? **Ask:** Are you currently pregnant? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes", give 1 point.	Pregnant? Yes ____ No ____ Other notes:	/1
13. DOES THE INDIVIDUAL HAVE A TERMINAL ILLNESS? **Ask:** Do you have a terminal illness? In other words, has a doctor informed you that you have an illness that will result in death? If so, what is it? What documentation do you have of the illness? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes", give 1 point.	Documented terminal illness? Yes ____ No ____ Other notes:	/1
14. IS THE INDIVIDUAL A FAIRFAX COUNTY RESIDENT? **Ask:** Are you a Fairfax County resident? ***Priority question* - INSTRUCTIONS FOR STAFF** If answer is "yes", give 1 point.	Fairfax County resident? Yes ____ No ____ Other notes:	/1
SECTION 4 – SUPPLEMENTAL INFORMATION FOR EMERGENCY SHELTER REFERRALS ONLY		
15. WHERE IS THE INDIVIDUAL WILLING TO ACCEPT A SHELTER BED? **Ask:** If a bed becomes available, which of the following shelters are you willing to accept space? Eleanor Kennedy in South County, Bailey's Crossroads in Falls Church, and/or Embry Rucker in Reston? You can choose one, two, or all three. **INSTRUCTIONS FOR STAFF** Record all shelters that the individual is willing to go to.	Bailey's Crossroads? Yes ____ No ____ Embry Rucker? Yes ____ No ____ Eleanor Kennedy? Yes ____ No ____ Other notes:	
16. WHAT GENDER DOES THE INDIVIDUAL IDENTIFY AS FOR THE PURPOSES OF SHELTER DORM ASSIGNMENT? **Ask:** For the purposes of assigning you to a shelter bed, what gender do you identify as? **INSTRUCTIONS FOR STAFF** Record the individual's preferred dorm assignment based on their gender identity.	Dorm Assignment: Male_____ Female _____ Other notes:	
SECTION 5 – PRIORITY SCORE		
17. WHAT IS THE INDIVIDUAL'S PRIORITY SCORE? Add points and enter the total number.	Total Priority Score: _____ (ENTER SCORE)	

BEST WAY TO CONTACT INDIVIDUAL BEING SCREENED Please include either the individual's phone number or that of a representative, case manager, family member, or anyone else that would be able to easily get in touch with the individual. For anyone other than the individual themselves, also include their name and relationship	Contact Information:

A2-3 Placeholder for Single's Intake Form

Appendix 3 - Forms & Tools Unique to Households with Children

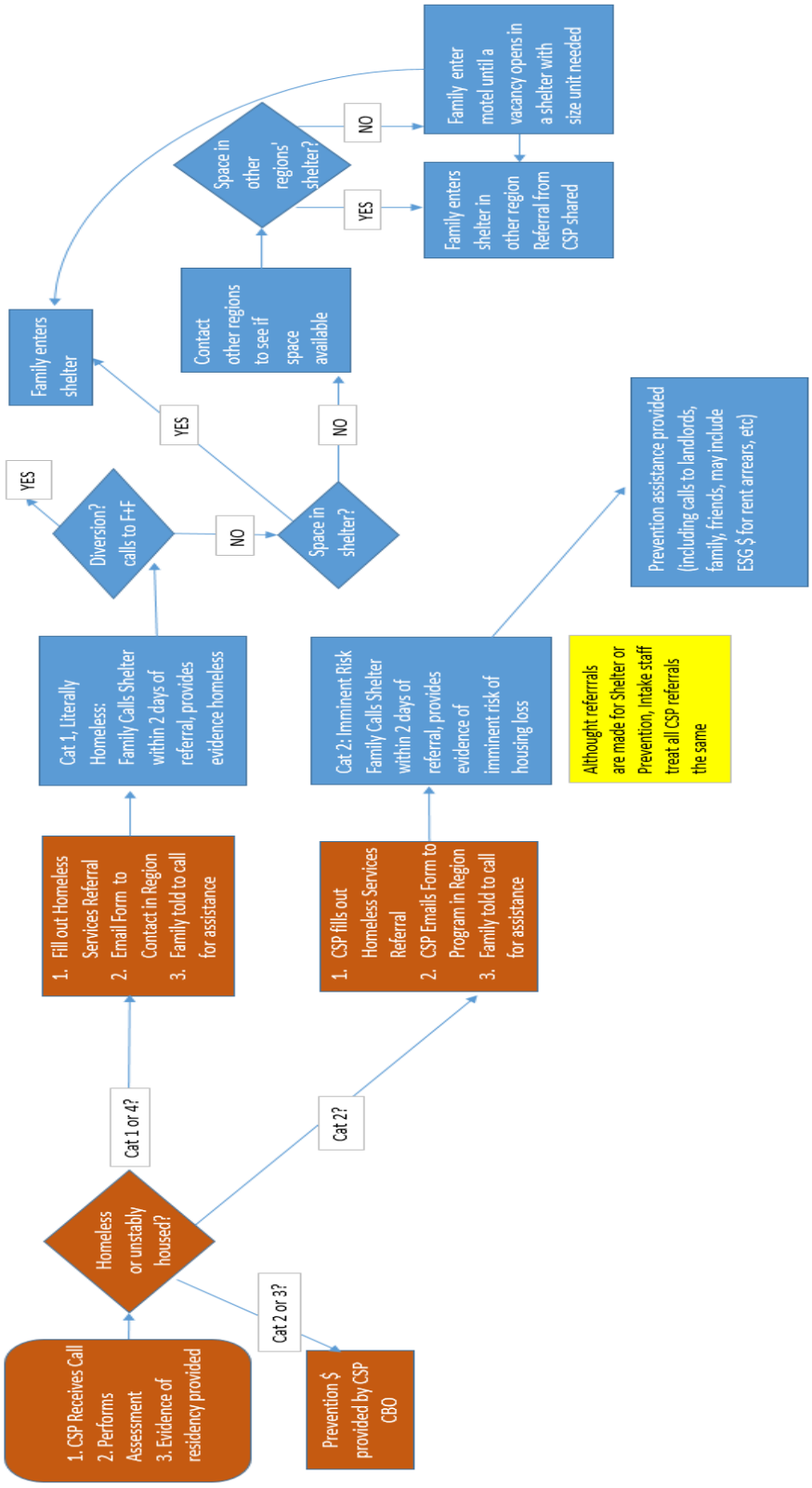
A3-1 Flow Chart for Family Prevention and Shelter

A3-2 Family Prevention Screening Tool

A3-3 HOST Family Housing Assessment Tool

A3-4 HSTT

A3-1 Flow Chart for Family Prevention and Shelter



A3-2 Family Prevention Screening Tool

RESULT:

FAMILY PREVENTION SCREENING TOOL

CLIENT NAME:		# ADULT/#KID:		PHONE:	
SCREEN DATE:		CATEGORY:		STAFF COMPLETING:	

IS FAMILY ALREADY IN HMIS? ☐YES ☐NO

HMIS NOTICE: Do you understand by engaging in Homeless Services your info will be recorded in a secure FFX Co. database, & you consent to the use/exchange of this information between agencies to coordinate services? ☐YES ☐NO

FULL NAME	SSN	DOB		FULL NAME	SSN	DOB

HOUSING

1. Where did your family stay last night? | Fairfax Co.? ☐YES ☐NO
2. Why can't you stay? | When do you have to leave?
3. Do you have proof you must leave? ☐YES ☐NO | Explain:
4. What was your most recent permanent address? | Fairfax Co.? ☐YES ☐NO
5. How long did you live there? | How much was rent? | Do you owe arrears? ☐YES ☐NO
6. Why can't you stay/why did you have to leave?
7. When do you have to leave/when did you leave? | Do you receive a Sheriff's Notice? ☐YES ☐NO
8. How many times have you been homeless in the last 3 years? | How many months in the last 3 years?
9. In what city or county did previous homelessness/shelter stays occur?
10. Have you ever [illegible] a Hous[illegible] Vouche[illegible]ogram ☐YE[illegible] [illegible]ere/when?

Staff: Based on info[illegible]tion collect[illegible] a[illegible]ve an[illegible]refe[illegible]s f[illegible]ly ch[illegible]ica[illegible] homeless ☐YES ☐NO

INCOME/BENFITS - Ple[illegible] v[illegible] fol[illegible]wi[illegible]nf[illegible]ma[illegible]on gather[illegible] during [illegible]P referral:

1. Monthly Income[illegible] | [illegible]ys[illegible]os A[illegible]aila[illegible]? ☐[illegible]ES ☐NO
2. Current Savings: | Statements Available? ☐YES ☐NO
3. Benefits: ☐TANF ☐SNAP ☐Medicaid ☐Health Ins. ☐Child Support ☐Tax Return:
4. Do you have proof of FxCo Residency? ☐Lease ☐School ☐Benefits ☐License ☐Other:
5. Do you have a car? ☐YES ☐NO

TRIAGE

1. Who have you asked to stay with/assist you?
2. Who is worried about your situation? | Who is your emergency contact?
3. Is your family (including those out-of state) aware of your situation?
4. Are you working with other service providers? ☐School ☐CYF ☐Faith Group ☐OFC ☐Other:
5. Where do you receive mail/have you received in the past?
6. Can you/someone pay for a motel tonight? ☐YES ☐NO | Please explain:
7. If there was no Shelter space tonight, where would you go?
8. If experiencing domestic violence, did you complete the DV shelter Phone Screen? ☐YES ☐NO | Result:
9. Do you understand Shelter can't guarantee special access to Subsidized/HCV/Transitional Housing? ☐YES ☐NO
10. Do you understand FxCo Shelter is limited to 30 days & we assist clients to find market rate housing? ☐YES ☐NO
11. Do you understand you don't have to be in Shelter for case mgmt/housing location/1x rental help? ☐YES ☐NO
12. Are you willing to relocate? ☐YES ☐NO
13. What are you expectations of Shelter help?

PRIOR TO PROGRAM INTAKE CASE MANAGER MUST VERIFY THE FOLLOWING:

***RELEASE OF INFORMATION:** Do you understand that to receive Homeless Services you must provide contact info for your former landlord & the person you are currently staying with, as well as least THREE friends, family, church & other social supports; AND consent to Staff contacting them to verify homelessness and lack of social /financial support?* **YES / NO**

PREVIOUS LANDLORD __ CHECK IF N/A	NAME	CONTACT INFO	RESULT

Was a Sheriff's Eviction Notice served? **YES / NO** Amount, if any of arrears owed? _____
Would you allow family back if Shelter paid off the arrears? **YES/ NO**
Can the family stay/return temporarily to prevent homeless shelter entry while we work on a plan? **YES/ NO**
What can Shelter do (ie: gift cards, rent, Case Management) to prolong the family's stay? _____

PERSON CLIENT STAYED WITH LAST __ CHECK IF N/A	NAME	CONTACT INFO	RESULT

Can the family stay longer/temporarily to prevent entry into a homeless Shelter while we work on a plan? **YES / NO**
Why can't the family stay? _____
Are you willing to provide a Letter or documentation stating the family can no longer stay? **YES / NO**
What can the family do (ie: contribute rent/food, chores, etc.) to stay longer? _____
What can Shelter do (ie: gift cards, rent, Case Management) to prolong the family's stay? _____

SUPPORT SYSTEM CONTACTS:	SUGGESTED QUESTIONS:
• Friends, Co Workers (neighb… • Family (Fairfax & Out …tate) • Church Contacts • Children's School Friends	• …family …with y… mp…ily to p…en…meless she… entry while we work on a plan? • …uld …me o… the …'s ch…ren tem…ran…stay with yo… • …hat … the f…ily …o…; c…trib…d, ch…s, etc.) to s… longer? • …hat c… She… do… gift…rds…nt, Case Man…ement) to p…ng the family's stay? • Can you …lp t… fam… find …usi… (ie: transport, … ca… …s, referrals etc.)?

RELATIONSHIP	NAME	CONTACT INFO	RESULT

Was/Is Client currently being served by another HMIS provider?	**VERIFIED WITH:** __ HMIS Record
Was client a FFX Co. Resident for at least 2 weeks? **YES/ NO**	**VERIFIED WITH:** __ Lease __ School Reg. __ FFX Benefits __ FFX License **IF OTHER, EXPLAIN:** _____
Can client self-pay for Motel? **YES/ NO**	**VERIFIED WITH:** __ Bank Statements __ Pay Stubs __ Benefits Statements **IF OTHER, EXPLAIN:** _____
Can client temporarily return to unit/previous place? **YES/ NO**	**VERIFIED WITH:** __ Sheriff's Notice __ Letter from Family/Friend **CALLS MADE TO:** __ Previous Landlord __ Person Stayed with Last Night **IF OTHER, EXPLAIN:** _____
Does client/children have a temporary place to stay? **YES/ NO**	**CALLS MADE TO:** __ THREE Family/Friends/Supports **IF OTHER, EXPLAIN:** _____

THE FOLLOWING DOCUMENTATION IS INCLUDED (ATTACHED TO) SCREENING:

PROOF OF RESIDENCY	PROOF OF FINANCIAL MEANS	PROOF OF HOMELESSNESS
__ Fairfax Co. Driver's License __ Fairfax County Benefits Letter __ Fairfax County School Registration	__ Most recent Pay Stubs __ Most recent Bank Statements	__ Sheriff's Eviction Notice __ Third Party Verification Letter __ Client Self Declaration

NOTES:

A3-3 HOST Family Housing Assessment

Updated October 2013

HOST Family Housing Assessment

Please fill out this form so we can understand your family better and assist you with your housing plan.

1. Contact Information

Name _____ Telephone Number _____

Address: _____

E-mail Address _____ Emergency Contact (EC) Name _____

EC Telephone Number _____ Relationship to Emergency Contact _____

2a. Household Information

Primary & Secondary Race (please write in for each adult & child below)

American Indian or Alaskan Native
Asian
Black or African American
White
Native Hawaiian or Other Pacific Islander
Don't Know
Other

Ethnicity Options

Hispanic / Latino
Non-Hispanic / Non-Latino
Don't Know

# Names of ADULTS living with you	SSN	Date of Birth	Gender	Race(s)	Ethnicity	Relationship
1						SELF
2						
3						
4						
5						

# Names of CHILDREN living with you	SSN	Date of Birth	Gender	Race(s)	Ethnicity	Relationship
1						
2						
3						
4						
5						
6						
7						
8						

Page 1 of 10

2b. Household Information

A. Are all school age children currently enrolled in school? (YES / NO)

If Yes, please list the schools and grades: _____

If No, please talk with your worker for information on how to enroll.

B. Have you or anyone else currently living with you been on active military duty? (YES / NO)

If Yes, please list who, when, and what branch: _____

C. Please list the country or countries where you and your child(ren) were born: _____

What language(s) do you speak? _____

Do you need a translator (YES / NO)

D. Do you have a valid ID? (YES / NO)

Please check all the forms of ID that you have:

___Birth Certificates ___Birth Registration ___Custody Papers ___Driver's License
___Employment Identification ___Green Card ___ID Card ___Learner's Permit
___ Military ID Card ___ Military Discharge Papers ___ Passport
___Social Security Card ___Student Visa ___Work Visa

E. Do you have any current domestic violence or safety concerns? (YES / NO)

If Yes, please describe concerns: _____

Do you have an active protective order? (YES / NO)

F. Have you experienced any domestic violence in the past? (YES / NO)

Worker's Notes: _____

Page 2 of 10

3a. Housing History

A. What brought you to needing services today? _____

B. Why did you have to leave your last housing? _____

C. Where did you stay last night? _____

D. Where you did last live for more than 90 days? (*please include zipcode*) _____

E. When did you live at this address? (*include start and end dates*) _____

F. Have you had a lease in your name before? (YES / NO) *If Yes*, when _____

G. Have you had an eviction in your name? (YES / NO)

If Yes, list when, how many evictions, and if you owe money: _____

H. Have you been homeless before? (Yes / No) *If Yes,* when and how many times? _____

I. Have you stayed in any of the following Fairfax County programs? (YES / NO) *If Yes*, check which programs:

Program Name	Date(s) MM/YY	Program Name	Date(s) MM/YY
___Artemis House		___Katherine Hanley Family Shelter	
___Bailey's Crossroads Com. Shelter		___Linda's Gateway	
___Bethany House		___Next Steps / Mondloch II	
___Eleanor U. Kennedy Shelter		___Mondloch House I	
___Embry Rucker Community Shelter		___Patrick Henry Family Shelter	
___FACETS Motel Program		___RISE	
___Fairfax Hypothermia Program		___Transitional Housing	
		___Other:	

J. Have you [illegible] (YES / NO)

If Yes, pl[illegible]ist when and w[illegible]e: _____

3b. Housing History

A. Have you ever lived in subsidized housing (Public Housing, Housing Choice Voucher, etc.) (YES / NO)

If Yes, where and when? _____

B. Are you on any housing wait lists for Fairfax County or anywhere else? (YES / NO)

If Yes, where and when did you sign up? _____

Do you owe any funds to a housing authority anywhere? (YES / NO) *If Yes*, how much do you owe? _____

C. Have you received emergency financial assistance for rent, security deposit or utilities? (YES / NO)

If Yes, when and how much? _____

D. Have you ever owned a home that went into foreclosure? (YES / NO) *If Yes*, when? _____

E. Where have you stayed over the last 3 years? Please check all that apply:

___Apartment - Lease Holder	___Own Home	___Unsheltered
___Apartment - Non-lease Holder	___Substance Abuse Treatment Program	___Other: _____
___Motel - Paid by someone else	___Temporary with a friend	
___Motel - Self Paid	___Temporary with a family member	

Please list the dates and locations: _____

Worker's Notes: _____

4. Planning for Housing

A. What size housing are you looking for (how many bedrooms)? _____

B. How many people will be moving into housing with you? _____

C. How much rent do you think you can afford? _____

D. Where are you looking for housing? _____

E. How have you found housing in the past? _____

F. Are you working with any of the following agencies?

(YES / NO) Alcohol Safety Action Program
Department of Aging & Rehabilitative Services
(YES / NO) Family Services (check which apply)
___Child Protective Services (list dates) _____
___Daycare through Office for Children
___Protection & Preservation Services _____
___VIEW
(YES / NO) Fairfax County Courts
(YES / NO) Fairfax County Public Schools
(YES / NO) Fairfax-Falls Church Community Services Board (Mental Health Treatment, Substance Abuse Treatment)
___Mental Health Treatment
___Substance Abuse Treatment
(YES / NO) Health Dep
(YES / NO) Housing &
(YES / NO) Juvenile &
(YES / NO) Office for Women
(YES / NO) Probation
(YES / NO) Neighborhood &
___Community & Recreation Services
___Coordinated Services Planning

If there any are services that you would like to help you obtain and maintain housing, please list below: _____

_____

_____

_____

5. Employment

A. Are you currently employed? (YES / NO)

If Yes, where are you working? _____

How many hours per week are you working? _____ How much do you earn per hour? _____

If No, where did you last work? _____

Where are you looking for employment? _____

What kind of work would you like to do? _____

What level of education did you / and adults in your household complete? _____

B. Do you have a resume? (YES / NO)

If Yes, please attach it.

If No, how many jobs have you started and stopped in the last year? _____

C. Why did your last job end? _____

D. Has your ability to obtain or maintain employment or housing been affected by alcohol or drug use? (YES / NO)

Are you actively using drugs or alcohol? (YES / NO)

When did you last use? ___N/A ___In the past 30 days ___In the past 6 months ___More than 12 months ago

Worker's Notes: _____

_____

_____

6a. Finances

A. Please check the types of income that you receive each month and list the amounts:

___Alimony _____	___General Relief _____	___ TANF_____
___Child Support _____	___Pension / 401K _____	___ Tax Refund _____
___Court Awards _____	___Social Security _____	___ Unemployment _____
___Employment _____	___SSDI _____	___ Workman's Comp. _____
___Food Stamps _____	___SSI _____	___ Other:_____

Total Monthly Income: _____

6b. Finances

A. Please check the types of expenses that you have each month and list the amounts:

___Bus Fare / Trans. _____	___Fines / Fees _____	___Telephone _____
___Car Insurance _____	___Garnishment _____	___Utilities _____
___Car Payment _____	___Gas _____	___Work / School Exp. _____
___Cable / Internet _____	___Groceries _____	___Other _____
___Child Support _____	___Rent / Mort. _____	___Other _____

Total Monthly Expenses: ☐

B. Have you ever filed for bankruptcy? (YES / NO) *If Yes*, has it been discharged and when? _____

C. Have you had any identify theft issues? (YES / NO) _____

D. Do you owe anyone money? (YES / NO) *If Yes*, please check the types and list the amounts:

___Car _____	___Credit Card _____	___ Medical _____
___Child Care _____	___Debt Consolidation _____	___ Student Loans _____
___Child Support _____	___DMV _____	___ Rent / Mort. _____
___Court _____	___Garnishments _____	___ Utilities _____
		___Other _____

Total Debt: ☐

E. Have you seen a copy of your credit report within the last 12 months? (YES / NO)

Do you know what your credit score is? (YES / NO) *If Yes*, what is it? _____

You can receive [illegible] of your [illegible] report [illegible] a year [illegible]ww.[illegible]report[illegible]om from ea[illegible]ansunion, equifax, experian)

F. Do you have a[illegible] money saved? [illegible] / NO [illegible]*Yes*, [illegible]muc[illegible]

G. Do you have a bank[illegible]unt? [illegible]ES [illegible]O)

If Yes, which [illegible]k do y[illegible]us[illegible]nd how [illegible]uch [illegible]in [illegible]ac[illegible]unt _____

If No, where do you save your money? _____

Worker's Notes: _____

7. Health Information

A. Do you or anyone else in your household have health or mental health concerns? (YES / NO)

If Yes, please list who and what the concerns are: _____

B. Are you or anyone in your household receiving treatment? (YES / NO)

If Yes, please list who and where: _____

If No, would you like to receive services? (YES / NO)

B. Do you have documentation from a licensed medical professional regarding the health or mental health issues? (YES / NO)

If Yes, please provide copies of contact information for your medical professional _____

C. Do you have health insurance? (YES / NO)

If Yes, what type of health insurance and who is covered? _____

If No, have you applied for Medicaid? (YES / NO)

D. Do any of the diagnosed health or mental health concerns require special accomodations when searching for housing or employment? (YES / NO)

8. Criminal History

A. Has any household member ever been arrested? (YES / NO) *If Yes*, when and for what? _____

B. Does any household member have any pending charges or warrants? (YES / NO)

C. Has any household member been convicted of a misdemeanor? (YES / NO) *If Yes*, when and for what? _____

D. Has any household member been convicted of a felony? (YES / NO) *If Yes*, when and for what? _____

E. Is any household member on the sex offender registry? (YES / NO)

Worker's Notes: _____

9. Transportation

A. Do you know how to use public transportation if needed? (YES / NO)

B. Do you have a car? (YES / NO) *If Yes,* please answer the following:

Make:_____ Model:_____ Color:_____

Year: _____ License Plate #:_____

Is the car in your name? (YES / NO)

Is the car registered? (YES / NO) Is the car insured? (YES / NO)

Do you have any restrictions / suspensions on your driver's license? (YES / NO)

9. Support System

A. Do you have any friends or family members that could co-sign for an apartment? (YES / NO)

B. Are you connected to any faith communities? (YES / NO)

C. Describe the level of support you receive from your family or friends:

D. Please list references that could be used for housing or employment:

Name Telephone Number Relationship

10a. Summary

Please list anything else that you think would be helpful for us to know to help you with your housing plan (the back page can be used as well if needed):

10b. Summary

I do herby swear and attest that all the information above about me and my family income is true and correct. Any intentional or willful misrepresentation of the facts included on this declaration may result in termination from the program. Further, I am aware that the information I have provided is subject to review and verification. I allow the release of this information for verification purposes and understand that it will be used to determine eligibility.

Client Name (Printed) Client Signature Date

Staff Name (Printed) Staff Signature Date

A3-4 Housing and Services Triage Tool

Housing & Services Triage Tool

This tool should be completed from the information gathered on the HOST Housing Assessment without the client present. It is to be used as a guide to determine the type of housing, amount of financial assistance, and length of services that may be needed to help a client obtain and maintain housing.

Client Name: _____ **HMIS #:** _____

Staff Name Completing Tool: _____ **Date Completed:** _____

A. Assessment – For each row, choose the description that most closely matches the Head of Household's (HoH) history. Write the column score (5, 3, 1, 0) in the "SCORE" box.
*Income – The AMI (Area Median Income) can be found at http://www.fairfaxcounty.gov/HSRG/pages/incomeguidelines.aspx

	5	3	1	0	SCORE
Housing	2+ evictions for non-payment and/or lease violations and/or 1 foreclosure. Landlord references poor and/or security deposit may have been kept due to damage to unit	1 eviction for non-payment. Landlord references poor and/or partial damage to a unit. Some complaints by other tenants for noise	No prior rental history and/or history of some late rent payments or lease compliance issues and/or landlord references fair	0 evictions. Rental history is positive and/or has positive landlord references	
Homeless-ness	Has been homeless for at least 12 consecutive months or 4 times in the previous 3 years (excluding time in transitional housing)	History of homelessness in the last 3 years	Any history of homelessness	Never experienced homelessness	
Credit	Credit Score of 500 or below or credit history includes bad debt owed to housing	Credit score of 501 to 619 or bad debt in excess of $2000 (not related to housing) and/or identity theft issues and/or no credit history	Credit score of 620 to 699 or credit history shows bad debt (less than $2000)	Credit score 700+ or credit history is good with the exception of a few late medical and/or credit card payments	
Income	Less than 15% AMI including having a fixed income that will not increase beyond current AMI within 90 days	15 – 30% AMI or less than 30% AMI with no ability to increase by 30% AMI year.	31 – 50% AMI or less than 30% AMI with ability to increase beyond in 1 year	More than 50% AMI	
Criminal	Felony conviction and/or a sex offense and/or meth	Felony conviction	Misdemeanor convictions; no	No criminal history	
Substance Abuse	Meets criteria for dependence preoccupation and obtaining drugs/alcohol withdrawal avoidance behaviors evident and/or use results in avoidance or neglect of essential life activities	last 6 months shows evidence of persistent or recurrent social, occupational, emotional or physical problems related to use	Use within the last 6 months but no evidence of persistent or recurrent social, occupational, emotional or physical problems related to use	No drug or alcohol abuse in the last 6 months or no history of substance abuse	
Health / MH	Documented long-term disability; danger to self or others and/or recurring suicidal ideations. Severe difficulty in day-to-day life due to mental health or health symptoms	Recurrent mental health symptoms that may affect behavior but not a danger to self or others. Persistent problems with functioning due to mental health or health symptoms	Mild symptoms may be present but are transient; only moderate difficulty in functioning due to mental health or health	Minimal symptoms that are expected responses to life stressors; only slight impairment of functioning	
Adult Ed.	Literacy, language, or lack of a U.S. diploma have a history of causing barriers to employment or housing	Enrolled in literacy and/or GED program; has difficulty communicating in English	Has high school diploma or GED but needs additional education/ training to improve employment situation	Has education beyond a high school diploma or GED	
Experience of Violence	Homeless due domestic violence or due to being the victim of violence of any type	Been the victim of an act of violence or domestic abuse (including financial, emotional, sexual, etc.) in the last 6 months	Been the victim of an act of violence or been threatened with violence in the last year	Never been threatened or the victim of violence, or the occurrence happened over 1 year ago	
Child Welfare	Currently has a child placed outside the home as a result of child welfare involvement	Current or recent child welfare involvement (CPS, PPS, Foster Care) within the past 6 months	Past child welfare involvement (CPS, PPS, Foster Care)	No history of child welfare involvement (or Not Applicable)	
Use of Crisis Systems	At least 3 interactions with the following crisis services in the past 6 months: emergency room, psychiatric hospital, jail, Child Protective Services, crisis hotlines (such as domestic violence or suicide hotlines), detox	Involvement with at least 3 of the following services in the past 12 months: Adult Protective Services, mental health treatment, substance abuse treatment, domestic violence services, care for a chronic medical condition, intellectual or developmental disability services, brain injury services	Involvement with at least 2 of the following services in the past 12 months: Adult Protective Services, mental health treatment, substance abuse treatment, domestic violence services, care for a chronic medical condition, intellectual or developmental disability services, brain injury services	Involvement with 1 or less service systems in the past 12 months	

SCORE

B. **Housing Type Determiners** – The following can be used to identify which housing type may be most appropriate. *If that housing type is not available*, use professional judgment to determine the next best available option and document decisions in Section D. For families, indicators apply to the Head of Household (HoH) or other adult unless otherwise noted. Circle Yes or No.

#	INDICATOR	RESULT	HOUSING TYPE *(if Result = Yes)*
1	Are there children currently in foster care that are in the process of reunifying with the head of household?	Yes / No	Client may be eligible for the Family Unification Program.
2	Is the client homeless due to domestic violence, stalking, or human trafficking?	Yes / No	Client may be eligible for programs designed specifically for those populations.
3	Is the client a veteran?	Yes / No	
4	Is the head of household between the ages of 18 – 24?	Yes / No	
5	Is the client a recent immigrant, refugee, or asylee?	Yes / No	
6	Is the client HIV positive?		
7	Is the client elderly (62 or older)?	Yes / No	
8	Does the client (or other adult in the household) have a felony?	Yes / No	Client may be ineligible for housing that has restrictions on a person with a felony.
9	Is the client (or any member of the family) a registered sex offender?	Yes / No	Very specific location and other housing requirements will need to be met for the client. Review current probation / parole requirements as w[illegible]nd local law.
10	Does the client [illegible] documen[illegible] disability (in[illegible]m[illegible]a[illegible]hys[illegible] developmental or subst[illegible]e us[illegible] whi[illegible]m[illegible]ad[illegible]ties[illegible] living, impact[illegible]eir abil[illegible]o w[illegible] full-tim[illegible]r ea[illegible]at l[illegible]30%[illegible]f th[illegible]MI, or severely imp[illegible]er day[illegible]o day fun[illegible]ning[illegible]or at[illegible]y to [illegible] independently?	Yes / No	If Ye[illegible]11, client may be a good canc[illegible]te for Permanent Supportive Housing (PSH[illegible]r families.
11	Is the client's income score 0 or 1?	Yes / No	Client may benefit from program options such as RRH, agency funds, transitional housing, etc. *(Overall score for transitional housing should be 14 or above)*
12	Is the client's income score 1, 3 or 5, with total score of 15 or more?	Yes / No	Client may be a good candidate for Bridging Affordability or a long-term subsidy.

C. **Indicated Housing & Service Type** – Determine which range the "TOTAL SCORE" from Section A fits into. *If that housing type is not available*, use professional judgment to determine the next best available option and document decisions in Section D.

SCORE (X) WHICH APPLIES		HOUSING / SERVICE TYPE	FINANCIAL ASSISTANCE	SOURCES	LENGTH OF SERVICES
	0 – 8	Rapid Re-Housing (short term)	Security / Utility Deposits 1 month of Rental Assistance	HOST, ESG, CSP funds, SSVF	1 - 3 Months
	9 – 16	Rapid Re-Housing (medium term)	Security / Utility Deposits Less than 12 months of Rental Assistance	BA, HOST, ESG, funds, SSVF	4 – 11 Months
	17 - 25	Rapid Re-Housing (long term) Transitional Housing	Security / Utility Deposits 12-24 months of Rental Assistance	BA, HOST, ESG, funds, SSVF, TH	12 – 24 Months
	26+	PSH (if yes to 10 & 11 in Part B) Long Term Subsidy	Permanent Supportive Housing, Project Based Voucher, Housing Choice Voucher, VASH, Other permanent housing		24+ Months

D. **Worker's Notes** – If you assess that a different housing / service intervention is needed (other than what is indicated on this tool), please document the information that has contributed to your assessment.

Appendix 4 – HMIS Workflows Specific to Coordinated Entry

This section of the manual assumes the reader has participated HMIS End User Training and has a fundamental understanding of entering clients and data into the system. The workflows in this section are provided for workflows unique to coordinated entry.

A4-1 STARSS Details

A4-2 Entering Referrals for Inclusion in the Prioritization Pool

A4-3 Instructions and Screen Shots of HMIS Workflow for Pool

A4-4 Anonymization Process for Entering Clients Fleeing Domestic Violence in HMIS

A4-1 Placeholder for STARSS Details

A4-2 Entering Referrals for Inclusion in the Prioritization Pool

Fairfax CoC developed a Prioritization Pool (the Pool) which includes all of the eligibility and prioritization components of the programs it is used for. Housing Providers use the pool to fill vacancies in Permanent Supportive Housing, Other Permanent Housing, Transitional Housing, and a HUD funded Rapid Rehousing program dedicated to serving youth (18 years – 24 years).

The Prioritization Pool is generated from referrals entered into HMIS.

Referring staff should use the following steps when making a referral into the Prioritization Pool.

1. Prior to entering a client into the Prioritization Pool in HMIS, the Case Manager should check HMIS to see if the client has already been referred to the Pool.

2. Required paperwork for Referral:
   a. Prioritization Pool Referral Form

   b. Homeless Certification Form (with self-certification verification and verification of efforts to obtain third party documentation, if needed)

   c. Homeless History Form (with third party documentation if needed)

   d. VISPDAT (singles) or HSTT (families), and

   e. Release of Information (ROI) should be completed by the applicant and case manager if there is not already a current ROI in HMIS

   f. Documentation of disability (for PSH Programs)

3. Referring staff must enter the information from completed forms into HMIS Prioritization Pool

4. The required paperwork (listed in #2 above) must be scanned and uploaded into HMIS.

5. Supervisor/ other designee review must be completed and documented in HMIS before a referral will be reviewed by OPEH for inclusion in the Prioritization Pool.

Updating Referrals
When any portion of a referral becomes outdated, e.g. the VISPDAT is older than 6 months; the income information has changed, the disability information has changed THAT part of the referral needs to be updated in HMIS. Referring staff DO NOT need to complete an entirely new referral but they must update the assessments and information so that the referral is always up to date. This is critical in making the Prioritization Pool as accurate as possible. Staff should follow the procedures noted in the HMIS manual for updating referrals.

OPEH REVIEW

1. Referrals must be entered/updated correctly by Tuesday to be included in that week's Prioritization Pool (assuming all information is correct/accurate).

2. Referrals without documentation of supervisory/designee approval are not reviewed by OPEH staff for inclusion in the Prioritization Pool.

3. OPEH staff will first review referrals for completeness. A review to ensure that the referral was entered into HMIS correctly is also done (L2 Review).

4. After a referral passes the L2 review, it proceeds for a content review to ensure information was documented correctly and it meets eligibility for program(s) utilizing The Prioritization Pool to fill vacancies. This is the L3 Review.

5. If at either stage (L2 or L3) corrections need to be made, the referral is rejected, information is documented in HMIS and the referral is "returned to the Supervisor" in HMIS.

6. After necessary corrections are made, the referral should be re-submitted in HMIS and the CE Review Status should be changed to reflect re-submission so the review team will be alerted of its resubmission.

7. Once a referral passes L3 review, it is included in the next Prioritization Pool which is published in HMIS.

8. The Prioritization Pool is updated and published weekly. There are separate *Pools* for singles and for families.

FILLING VACANCIES

1. PSH Provider goes to the Prioritization Pool in HMIS when filling a vacancy.

2. By default, the Pools are sorted by

    a. Chronic Homelessness,

    b. Longest cumulative homelessness (most homeless history), and

    c. Highest vulnerability, as measured by the VI-SPDAT.

    Providers then have the ability to utilize additional filters (e.g. gender, location where client will live, client's ability to live with others, diagnosis etc.) to identify clients that match the available vacancy to create the customized pool for their specific vacancy.

3. Provider should identify the top three individuals or families from the Prioritization Pool based on the eligibility & prioritization standards outlined above. If a provider chooses to contact all 3 for interviews (rather than doing them in sequence), they **MUST** notify the client that others are being considered for the vacancy and being interviewed is not a guarantee of housing. If someone higher in the pool is offered and accepts housing, the potential client will remain in the pool and continue to be considered for vacancies as they arise.

Provider contacts case manager to notify them that the client is being considered for a vacancy. If any paperwork is outdated, provider notifies the Case Manager that the paperwork must be updated (see #5).

NOTE: Any additional programmatic paperwork that the provider requires beyond the referral into Coordinated Entry is the provider's responsibility to obtain. Coordinated Entry is simply a way for clients to access potential housing opportunities. Clients should be given a reasonable deadline to secure such documents and the provider can explain to the client that if they do not get such documents by the deadline, they need to move onto the next eligible client and client will be returned to the Pool.

4. The referring case manager must upload updated referral documentation to HMIS within two business days of the provider's request in order for the client to be considered for tenancy. The referring case manager should notify the provider as soon as the documentation has been uploaded.

5. Provider contacts the client and referring worker to schedule an interview within 3-5 business days of receiving the documentation, unless housing unit repairs require additional time for work to be completed.

6. Case Managers should assist providers in cases when clients are difficult to reach/contact. If the client cannot be contacted within 3 business days, then the Provider may move on to the next eligible client on the list.

7. Provider must notify the case manager and client of the decision on the referral within two business days of the interview.

PRIORITIZATION POOL MANAGEMENT

Pool management is an ongoing responsibility and information in referral should always be up to date. As a back-up to day to day pool management, referring staff should review the pool for active clients during their normal data quality process by the 10th of each month. Referring staff verify that open referrals are still legitimate and close referrals when appropriate. Referrals are closed – by exiting it out of Coordinated Entry in HMIS-by the referring agency when:

1. Client chooses to close referral;

2. Client is no longer eligible for housing programs utilizing the Prioritization Pool;

3. Client has not been seen in six months; or

4. Client has already been housed.

Referring agency establishes all of the relevant client data at referral. Information must be updated at least once every six months, but should be updated whenever the referring agency is aware of changing client circumstances. When clients move to another location or program, then a new referring agency must staff the case with the original referring agency before changing prioritization information, such as length of homelessness or severity of service needs.

Receiving agency should close referrals when clients are housed through their program by exiting client from Coordinated Entry and entering client into their program.

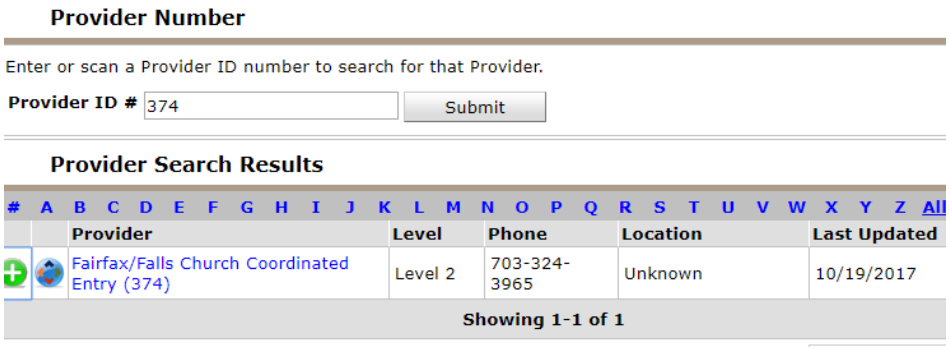
A4-3 Placeholder for Instructions and Screen Shots of HMIS Workflow for Pool

(These are being updated to correspond to updates in forms).

A4-4 Anonymization Process for Entering Clients Fleeing Domestic Violence into HMIS (that are NOT already in HMIS)

Entering a New Referral: New Entry Record

1. Log-in to regular HMIS
2. Set your data entry mode in HMIS to **EDA (Enter Data As)** for Fairfax/Falls Church Coordinated Referral
   (374).



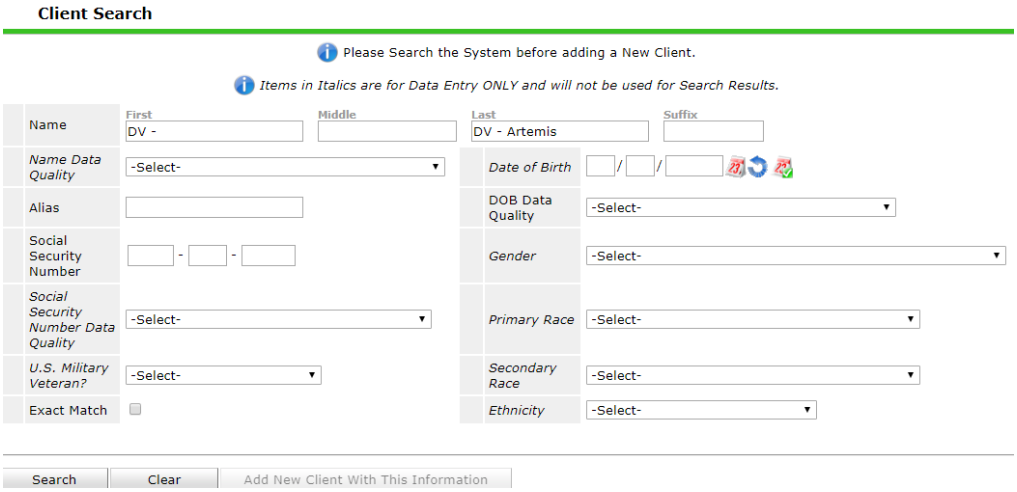
3. Enter Client Point. You will be required to search for the client's anonymized referral, even though you have not yet created it. In order to comply with the Violence Against Women Act and protect client confidentiality, DV referrals must be entered into HMIS using the following format:
   Last Name: DV - [Program Name]

   First Name: DV - [leave blank for the time being]

   Please note that there is one space before the hyphen and one space after the hyphen in both the first name and last name.

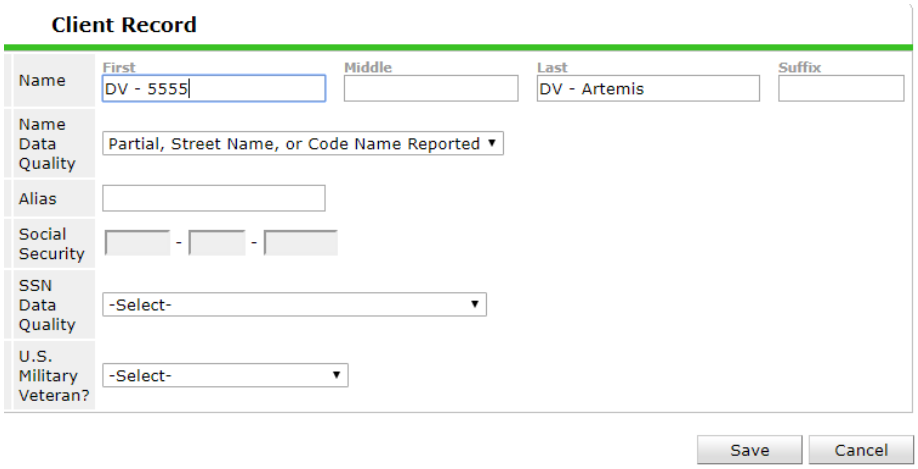
   For example, a referral from Artemis House would be entered as:

   Last Name: DV - Artemis First Name: DV-

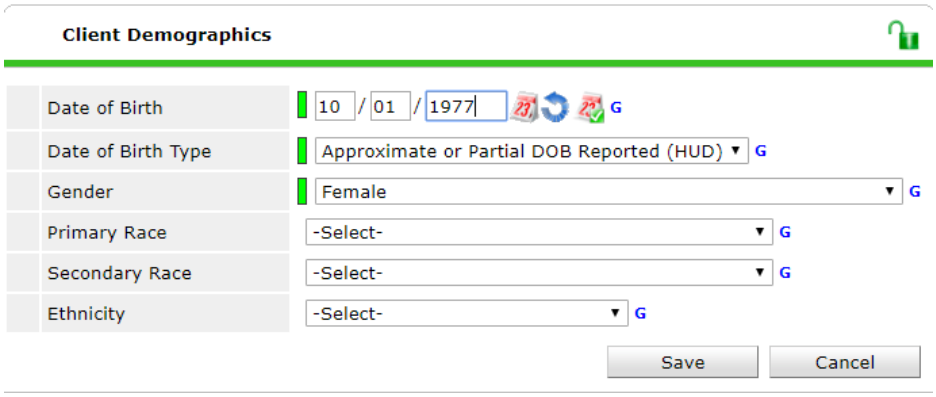


4. After clicking **Search**, Select **Add New Client With This Information.**
   a. A reminder may be displayed about the current System Date. If so, click on **Use Current System Date.**
   b. **NOTE:** For DV Referrals, only the Head of Household is entered.

5. Once you have created the referral, an HMIS number will be assigned to the referral. The HMIS number can be found at the top of the HMIS record in parenthesis. Copy this number and click on the **Client Profile** tab.
   a. Click the pencil located next to “Client Record”
   b. Under first name, edit the field to state, “DV - [Referral Number]. For example. If the referral number is 5555, the First Name should be edited to read “DV - 5555”.
   c. From the dropdown menu next to “Name Data Quality,”select **Partial, Street Name, or Code Name Reported.**
   d. Click **Save.**

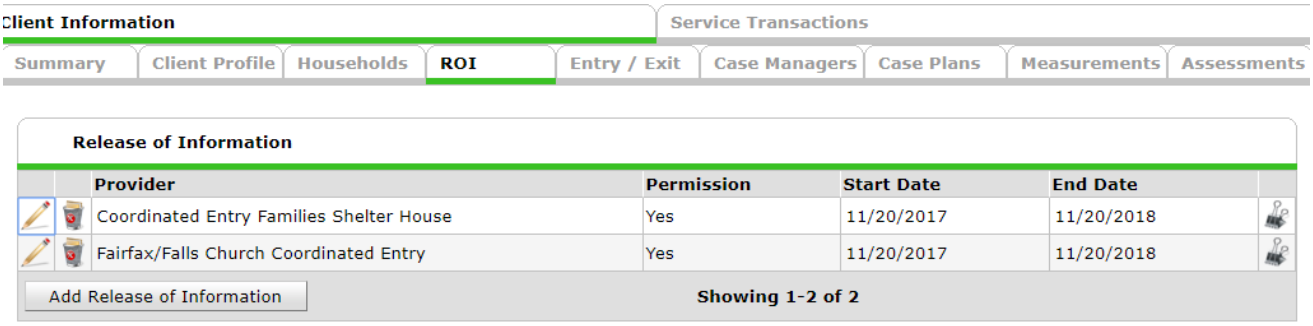


6. Next, you will update the client demographics. Click the pencil located next to "Client Demographics."
   a. In order to protect client confidentiality, the Date of Birth should be entered as follows:
      i. Month: Use the client's actual birth month
      ii. Day: Always enter "01"
      iii. Year: Use the client's actual birth year
      iv. For example, a client whose birthday is October 15th, 1977 would be entered as: 10/01/1977
   b. From the drop-down menu next to "Date of Birth Type," select **Approximate or Partial DOB Reported (HUD).**
   c. Select the client's gender.
   d. Click **Save.**



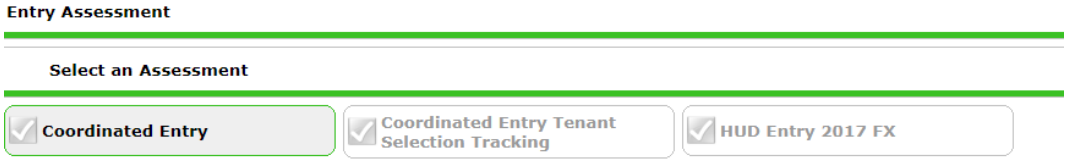
7. Next you will add a Release of Information (ROI). Click on the **ROI** tab.
   a. Create 2 ROIs (Parent Organization & Specific HMIS Project).
   b. For the Parent Organization ROI, the Provider number is #374: Fairfax/Falls Church Coordinated Referral
   c. For the Specific HMIS Project ROI, each agency is assigned a project for Coordinated Referral Singles of Coordinated Referral Families. Be sure to select the HMIS project for your agency.

Refer to Chapter 7 of the HMIS SPV5 Training Manual for details about how to create/add a Release of Information



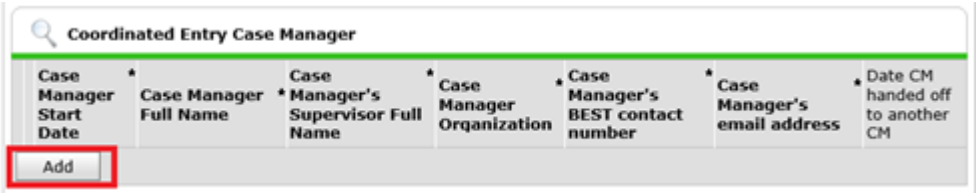
8. Next you will create an Entry/Exit Record. Client on the **Entry/Exit** tab.
   a. Click **Add Entry/Exit** to create a new record.
   b. Search for the Provider: Select your agency's specific HMIS Coordinated Referral Project.
   c. Assessment Type: HUD
   d. Entry Date if the date the Referral is being made to Coordinated Entry (see Policies and Procedures)

9. Complete the "**Coordinated Entry Referral Form" assessment**. The page will default to this assessment. You must complete all of the information required by the Policies and Procedures or the referral is incomplete. See pp. in this manual for more information
   Select your agency under "Fairfax Falls Church CoC Partner".



Coordinated Entry Case Manager: Adding a Case Manager is required by the Coordinated Entry Policies and Procedures.

a. Under "Coordinated Entry Case Manager," click **Add.**



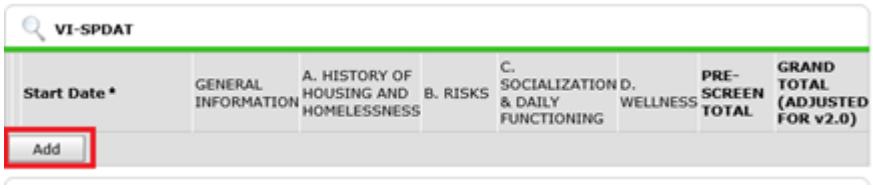
b. Enter the Case Manager information and click **Save.**

NOTE: Case Manager data must be reviewed for accuracy on a monthly basis through the Data Quality process. In order to update the Case Manager information, an Interim Assessment must be added.

- Input responses for Relationship to Head of Household, Chronic Homeless Status, Gender, and the client's Date of Birth. Date of Birth must be anonymized following the instructions provided when updating the client profile. Leave the "Name of School" field blank.

VI-SPDAT: Complete this section if required by the Coordinated Entry Policies and Procedures.

a. If the VI-SPDAT was already added to HMIS and is not visible here, *refer to Chapter 7 of the HMIS SPV5 Training Manual for details about how to create/add a Release of Information.*

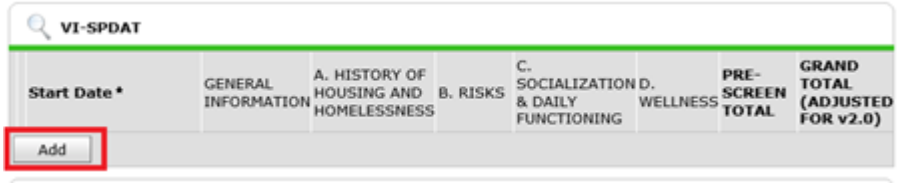


b. If the VI-SPDAT has not yet been added, click **Add** to enter a new VI-SPDAT sub-assessment.

NOTE: VI-SPDAT data must be reviewed for accuracy on a monthly basis through the Data Quality process. In order to update the VI-SPDAT, an Interim Assessment must be added.

Housing and Services Triage Tool for Families: Complete this section if required by the Coordinated Entry Policies and Procedures.

a. If the Housing and Services Triage Tool was already added to HMIS and is not visible here, *refer to Chapter 7 of the HMIS SPV5 Training Manual for details about how to create/add a Release of Information.*
b. If the Housing and Services Triage Tool has not yet been added, click **Add** to enter a new

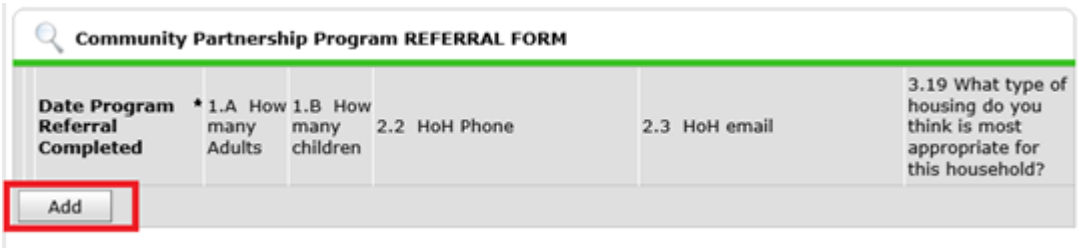


Housing and Services Triage Tool sub-assessment.

NOTE: The Housing & Services Triage Tool data must be reviewed for accuracy on a monthly basis through the Data Quality process. In order to update the Housing & Services Triage Tool, an Interim Assessment must be added.

Community Partnership Program REFERRAL FORM: This sub-assessment is required and can only be accessed through Coordinated Entry.

a. Click **Add** to enter new data.



b. After entering data, click **Save.**

NOTE: The Referral Form must be reviewed for accuracy on a monthly basis through the Data Quality process. In order to update the Referral Form, an Interim Assessment must be added.

Homeless Certification and Housing History Form: Complete this section if required by the Coordinated Entry Policies and Procedures.

a. Click **Add** to enter new data. This sub-assessment is two forms in one sub-assessment
b. After entering data, click **Save.**

Homeless History Details: **For DV referrals, do not complete this section.**

Monthly Income: Enter the client's income information. For DV referrals, this information will never auto-populate.

Disabilities: Enter the client's disability information. For DV referrals, this information will never auto-populate.

Once all areas of the Coordinated Entry Referral Assessment have been completed, click **Save & Exit.**

9. In order to complete the referral you must attach documentation.

For DV referrals, all identifying information (Client name, children's names, date of birth, contact information, etc.) **MUST be redacted so that the information cannot be seen when scanned and uploaded. In order to ensure proper redaction, you may need to "white-out" the information and then cover the white-out with black marker.

a. Six documents must be attached separately, named and labeled appropriately, in the same location. Once each of the Coordinated Entry Referral forms has been redacted, scan each form individually and save as a PDF file, follow the naming convention outlined below. This naming convention is how you will name each saved file.

Naming Convention: [Form Name][Client Anonymized First and Anonymized Last Name][Date]

Form Names can be found below:

Form	Document Name
Coordinated Entry Referral Form	CE Referral

Homeless Certification Form	Homeless Certification
Housing History Form	Housing History
Housing & Services Triage Tool	HSTT
Authorization to Use and Exchange Information (ROI)	ROI
VI-SPDAT	VI-SPDAT
Document of Disability Letter	Disability

For example, for a client named “Robert Ludlum” whose referral was submitted on 12/28/2016, files would be named as follows:

i. ROI Robert Ludlum 20161228

ii. VI-SPDAT Robert Ludlum 20161228

iii. Family Triage Robert Ludlum 20161228

iv. CE Referral Robert Ludlum 20161228

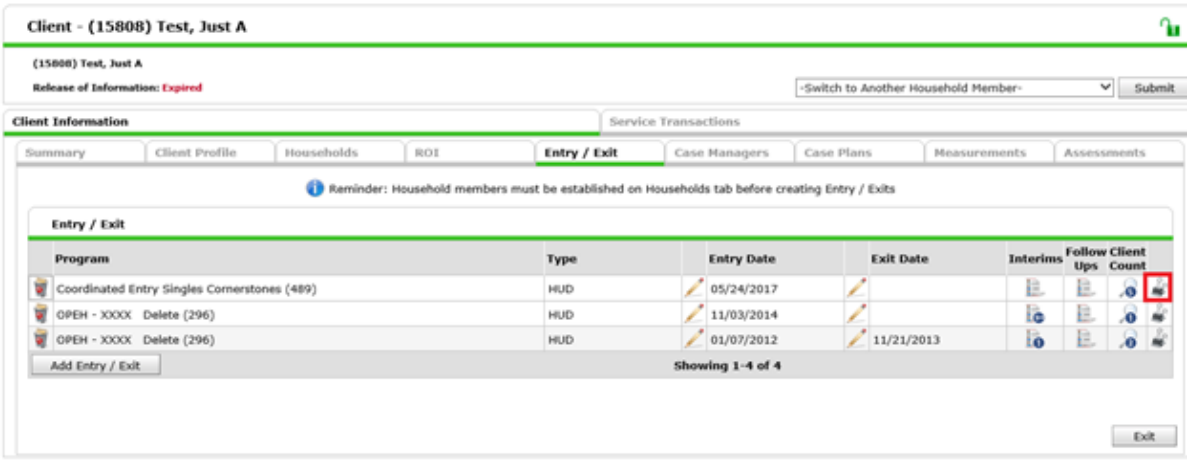
v. Homeless Certification Robert Ludlum 20161228

vi. Housing History Robert Ludlum 20161228

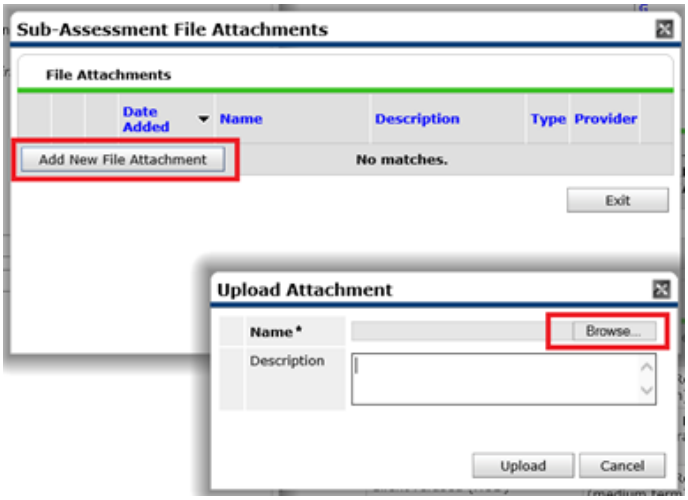
For DV clients, this naming convention will result in file names such as the one below. In this example, the client is referral number 5555 from Artemis House, and the file was uploaded on 12/26/2017.

CE Referral DV - 5555 DV - Artemis 20171226

b. Once files have been redacted an appropriately named they are ready to be attached to the referral. To attach, on the Entry/Exit tab, click on the binder clip on the far right.



To upload each saved file, click **Add New File Attachment.** In the window that opens, click **Browse** and select the appropriate file. Copy and paste the file name into the description field. Click **Upload.** Repeat for each file.



Once you upload a document and click 'Exit,' a number will appear next to the binder clip. The number displayed should reflect the number of file attachment(s). You should have a total of at least six file attachments.

10. Supervisor Review

a. After you have completed entry of the Coordinated Entry paperwork, notify the Reviewing Authority or Supervisor that this client's referral data is ready to be reviewed.

b. Once the Reviewing Authority or Supervisor has reviewed and passed the referral data entry in HMIS, the Reviewing Authority or Supervisor's name that reviewed the referral data should be entered in the Reviewed by Supervisor field.

c. Click on Save & Exit

Note: This field should only be completed after the client's referral data has been reviewed. Also, if this field is not completed, the referral will not show up on the Level 2 review report and therefore the referral will not make it to the Coordinated Entry Pool.

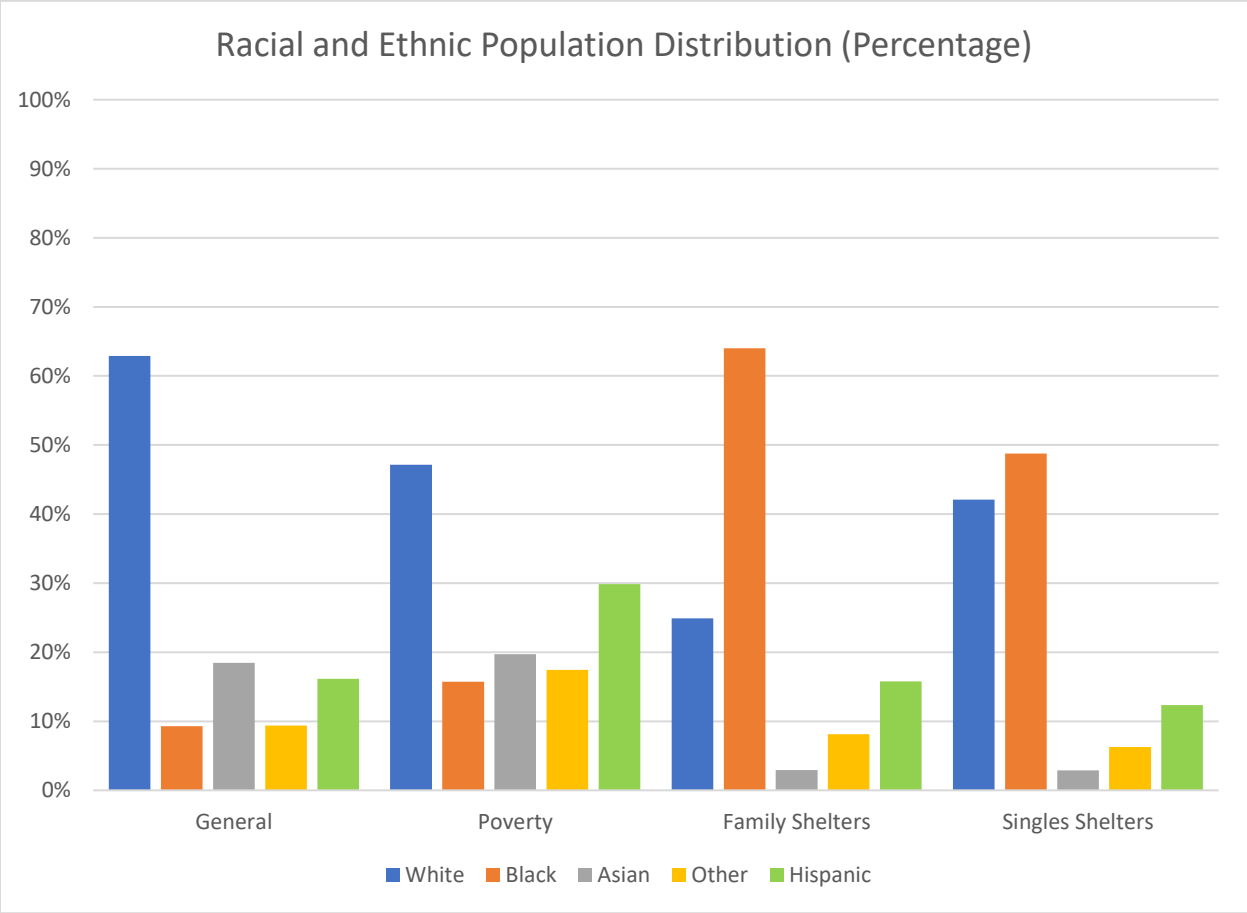
FAIRFAX-FALLS CHURCH PARTNERSHIP TO PREVENT AND END HOMELESNESS

EQUITY POPULATION DATA

The following table and chart depict the racial and ethnic distribution in Fairfax County populations. Comparisons are made between the population served in local emergency shelters with the general population and those people with household incomes below the federal poverty level.

	General		Poverty		Family Shelters		Singles Shelters	
Race	**Persons**	**Percent**	**Persons**	**Percent**	**Persons**	**Percent**	**Persons**	**Percent**
White	704,130	63%	31,475	47%	254	25%	774	42%
Black	103,933	9%	10,484	16%	653	64%	897	49%
Asian	206,534	18%	13,169	20%	30	3%	53	3%
Other *	104,860	9%	11,634	17%	83	8%	115	6%
TOTAL	1,119,457	100%	66,762	100%	1,020	100%	1,839	100%
Hispanic	180,605	16%	19,929	30%	161	16%	227	12%

* "Other" includes American Indian, Alaska Native, Native Hawaiian, Other Pacific Islander, Other Races, Multiple Races, Missing Information.
(Data Sources: 2016 Annual Homeless Assessment Report (AHAR) - OPEH; US Census, 2011-2015 American Community Survey 5-Year Estimates, Poverty Status in the Past 12 Months.)



FAIRFAX-FALLS CHURCH PARTNERSHIP TO PREVENT AND END HOMELESSNESS

EQUITY OUTCOME DATA

The following tables are from emergency shelters data in the local Homeless Management Information System (HMIS) for calendar years 2012 through 2016 (January 1, 2012 – December 31, 2016).

Number of People Served

Race	People	Percentage
Black or African American	5554	**56%**
White	3759	**38%**
Asian	380	**4%**
Other	113	**1%**
American Indian or Alaska Native	67	**1%**
Native Hawaiian or Other Pacific Islander	57	**1%**
Unknown	54	**1%**

Length of Time in Shelter

Race	Exits	Total (days)	Average (days)	Median (days)
Black or African American	11,112	595,880	54	**73**
Other	162	9,491	59	**73**
White	7,934	389,383	49	**63**
Asian	730	38,202	52	**58**
American Indian or Alaska Native	131	6,793	52	**53**
Native Hawaiian or Other Pacific Islander	92	4,547	49	**51**
Unknown	93	3,835	41	**37**

Exits from Shelter to Permanent Destinations

Race	Exits, Permanent Housing	Exits, All	Pct. to Perm. Housing
Asian	986	1,789	**55%**
Native Hawaiian, Other Pacific Islander	73	153	**48%**
Black or African American	10,300	22,761	**45%**
Other	157	368	**43%**
White	6,280	16,722	**38%**
Unknown	76	217	**35%**
American Indian or Alaska Native	68	240	**28%**

RESOLUTION

"One Fairfax"

Whereas, Fairfax County takes pride as a great place to live, learn, work, and play; and,

Whereas, Fairfax County is the largest and strongest economy in the Washington Metropolitan area and one of the strongest in the nation; and,

Whereas, county and school leaders and staff are committed to providing excellent services for every resident of Fairfax; and,

Whereas, Fairfax County government has established a vision of Safe and Caring Communities, Livable Spaces, Connected People and Places, Healthy Economies, Environmental Stewardship, Culture of Engagement and Corporate Stewardship; and Fairfax County Public Schools has established goals of Student Success, a Caring Culture, a Premier Workforce, and Resource Stewardship; and,

Whereas, Fairfax County embraces its growing diverse population and recognizes it as a tremendous economic asset but recognizes that racial and social inequities still exist; and,

Whereas, achieving racial and social equity are integral to Fairfax County's future economic success, as illustrated in the Equitable Growth Profile and highlighted as a goal in the Strategic Plan to Facilitate the Economic Success of Fairfax County; and,

Whereas, we define **Racial Equity** as the development of policies, practices and strategic investments to reverse racial disparity trends, eliminate institutional racism, and ensure that outcomes and opportunities for all people are no longer predictable by race; and

Whereas, we utilize the term **Social Equity** to consider the intersection and compounding effects of key societal issues such as poverty, English as a second language, disability, etc. with race and ethnicity; and,

Whereas, as servants of the public we are committed to the definition of social equity adopted by the National Academy of Public Administration – "the fair, just and equitable management of all institutions servicing the public directly or by contract; the fair, just and equitable

distribution of public services and implementation of public policy; and the commitment to promote fairness, justice, and equity in the formation of public policy."

Whereas, it is essential to identify and address institutional and systemic barriers that exist and understand that these barriers may impede access to opportunities for achieving the visions and goals set forth by county leaders; and,

Whereas, an extensive body of research has established that a community's access to an interconnected web of opportunities shapes the quality of life for all; and,

Whereas, to truly create opportunity, we need to understand and improve our work through a racial and social equity lens from the very core of the organization outward, focusing intentionally and deliberately towards sustainable structural changes; and,

Whereas, a growing number of local jurisdictions across the United States are adopting intentional equity strategies and see equity as an economic growth model;

NOW, THEREFORE, BE IT RESOLVED BY THE FAIRFAX COUNTY BOARD OF SUPERVISORS AND THE FAIRFAX COUNTY SCHOOL BOARD that:

The time is now to move beyond embracing diversity as an asset and implement a new growth model driven by equity — just and fair inclusion into "One Fairfax," a community in which everyone can participate and prosper.

"One Fairfax" can only be realized with an intentional racial and social equity policy at its core for all publicly delivered services. A racial and social equity policy provides both the direction and means to eliminate disparities, and work together to build a vibrant and opportunity-rich society for all.

In July 2016, the Fairfax Board of Supervisors and School Board join in this resolution and direct the development of a racial and social equity policy for adoption and strategic actions to advance opportunities and achieve equity that include intentional collective leadership, community engagement, equity tools and infrastructure to support and sustain systemic changes, and shared accountability so collectively, we will realize "One Fairfax," a community where everyone can participate and prosper.

ONE FAIRFAX POLICY – November 21, 2017

I. PURPOSE

Fairfax County embraces its growing diverse population and recognizes it as a tremendous asset but also knows that racial and social inequities still exist. This policy defines expectations for consideration of racial and social equity, and in particular, meaningful community involvement when planning, developing, and implementing policies, practices, and initiatives. It provides a framework to advance equity in alignment with our stated visions and priorities. This policy informs all other policies and applies to all publicly delivered services in Fairfax County Government and Fairfax County Public Schools.

II. SUMMARY OF CHANGES SINCE LAST PUBLICATION

This is a new policy.

III. DEFINITIONS

Equity: The commitment to promote fairness and justice in the formation of public policy that results in all residents – regardless of age, race, color, sex, sexual orientation, gender identity, religion, national origin, marital status, disability, socio-economic status or neighborhood of residence or other characteristics – having opportunity to fully participate in the region's economic vitality, contribute to its readiness for the future, and connect to its assets and resources.

Equity Tools: Information and processes used to identify who is affected by a decision, policy, or practice; how they are affected; and to guide recommendations to encourage positive impacts and/or mitigate negative impacts.

Publicly delivered: The services provided by government or public schools either directly (through the public sector) or through financing the provision of services.

Race: A socially constructed category of identification based on physical characteristics, ancestry, historical affiliation, or shared culture.

Racial Equity: The absence of institutional and structural barriers experienced by people, based on race or color that impede opportunities and results.

Social Equity: The absence of institutional and structural barriers experienced by people, based on other societal factors such as age, sex, sexual orientation, gender identity, religion, national origin, marital status, disability, socio-economic status, neighborhood of residence, that impede opportunities and results.

IV. AREAS OF FOCUS TO PROMOTE EQUITY

Helping people reach their highest level of personal achievement is vital to our county's successful ability to compete in the global economy. Linking our residents and families to opportunities including education, workforce development, employment, and affordable housing helps ensure lifelong learning, better health, resilience, and economic success. The systems, structures, and settings in which our residents and families live, work, play, and learn, create an equitable community and are, in part, a product of policy and resourcing decisions.

Fairfax County Government and Fairfax County Public Schools, working in conjunction with higher education, business, nonprofit, faith, philanthropy, civic and other sectors, will give particular consideration to these initial areas recognizing that additional areas of focus may emerge based on changing factors and that assessment and prioritization are necessary to guide and inform collective actions to support a thriving community and promote equity with a goal of achieving the following:

1. Community and economic development policies and programs that promote wealth creation and ensure fair access for all people.
2. Housing policies that encourage all who want to live in Fairfax to be able to do so, and the provision of a full spectrum of housing opportunities across the county, most notably those in mixed-use areas that are accessible to multiple modes of transport.
3. Workforce development pathways that provide all residents with opportunity to develop knowledge and skills to participate in a diverse economy and earn sufficient income to support themselves and their families.
4. An early childhood education system that ensures all children enter kindergarten at their optimal developmental level with equitable opportunity for success.
5. Education that promotes a responsive, caring, and inclusive culture where all feel valued, supported, and hopeful, and that every child is reached, challenged, and prepared for success in school and life.
6. Community and public safety that includes services such as fire, emergency medical services, police, health, emergency management and code enforcement that are responsive to all residents so that everyone feels safe to live, work, learn, and play in any neighborhood of Fairfax County.
7. A criminal justice system that provides equitable access and fair treatment for all people.
8. Neighborhoods that support all communities and individuals through strong social networks, trust among neighbors, and the ability to work together to achieve common goals that improve the quality of life for everyone in the neighborhood.
9. A vibrant food system where healthy, accessible, and affordable food is valued as a basic human necessity.
10. A health and human services system where opportunities exist for all individuals and families to be safe, be healthy and realize their potential through the provision of accessible, high quality, affordable and culturally appropriate services.
11. A quality built and natural environment that accommodates anticipated growth and change in an economically, socially, and environmentally sustainable and equitable manner that includes mixes of land use that protects existing stable neighborhoods and green spaces, supports sustainability, supports a high quality of life, and promotes employment opportunities, housing, amenities and services for all people.

12. A healthy and quality environment to live and work in that acknowledges the need to breathe clean air, to drink clean water now and for future generations.
13. A parks and recreation system that is equitable and inclusive by providing quality facilities, programs, and services to all communities; balancing the distribution of parks, programs and facilities; and providing accessible and affordable facilities and programs.
14. A multi-modal transportation system that supports the economic growth, health, congestion mitigation, and prosperity goals of Fairfax County and provides accessible mobility solutions that are based on the principles associated with sustainability, diversity, and community health.
15. Digital access and literacy for all residents.
16. Intentional, focused recruitment efforts that bolster a diverse applicant pool; hiring and evaluation practices, and processes for employee feedback, to achieve and preserve a culture of equity and fairness for all employees.
17. Policies that prohibit all forms of discrimination under Federal and State law in county and school system activities, and ensure that all practices provide fair treatment for all employees, contractors, clients, community partners, residents, and other sectors who interact with Fairfax County including higher education, business, nonprofit, faith, philanthropy, and civic.

V. PROCESS

To achieve equity and advance opportunity for all, Fairfax County Government and Fairfax County Public Schools will work in partnership with others and utilize the influence of each respective institution to leverage and expand opportunity. Organizational capacity in the following areas will enable the development, implementation, and evaluation of policies, programs, and practices that advance equity:

a. Community Engagement

To foster civil discourse and dialogue, community engagement shall ensure that the breadth of interests, ideas, and values of all people are heard and considered. Outreach and public participation processes will be inclusive of diverse races, cultures, ages, and other social statuses. Effective listening, transparency, flexibility, and adaptability will be utilized to overcome barriers (geography, language, time, design, etc.) that prevent or limit participation in public processes. Fairfax County Government and Fairfax County Public Schools will engage with sectors such as higher education, business, nonprofit, faith, philanthropy, civic and others to collectively address barriers to opportunity.

b. Training and Capacity Building

Training will be designed for individual and collective learning with an emphasis on building competencies and skills to implement strategies that promote racial and social equity in employees' daily work. Foundational training will include, but will not be limited to: an understanding of implicit bias; institutional and structural racism; and the use of equity tools. Additional training for role and business area specific training will also be provided.

c. Applying Equity Tools

Consideration will be given to whole community benefits and burdens, identifying strategies to mitigate negative impacts, and promoting success for all people in planning and decision making.

Equity tools such as structured questions, equity impact analyses, disparity studies, etc. will be used to ensure that equity is considered intentionally in decision-making and the One Fairfax policy is operationalized.

d. Racial and Social Equity Action Planning

All organizations and departments within Fairfax County Government and Fairfax County Public Schools will conduct analysis, devise plans, set goals, and take actions through specific practices, policies, and initiatives within their purview.

e. Accountability Framework

Fairfax County Government and Fairfax County Public Schools will incorporate data and publish performance measures that can be analyzed, quantified, and disaggregated to evaluate the extent to which our systems are achieving goals identified through the racial and social equity action planning.

VI. ROLES

Fairfax County Government and Fairfax County Public Schools will designate and support staff members to lead the implementation of the One Fairfax policy. These staff members will work in conjunction with:

- The Board of Supervisors, School Board, and One Fairfax Executive Leadership Team to provide strategic, collective leadership in support of the equity-informed planning and decision-making processes prescribed by this policy and the development and pursuit of identified equity goals; and

- A multi-department, cross-systems equity staff team to facilitate coordination of racial and social equity action planning, collective action, and shared accountability across and within county and schools organizations.

- Boards, Commissions, Authorities and Advisory Committees to promote stakeholder engagement and input in support of equity informed planning and decision making.

Related policies and regulations:

Fairfax County Public Schools Policy 1450 – Nondiscrimination
Fairfax County Government Procedural Memorandum 39-06 – Harassment
Fairfax County Government Procedural Memorandum 39-04 – Reasonable Accommodation in Employment
Fairfax County Government Procedural Memorandum 39-05 – Reasonable Accommodation of Services and Devices
Fairfax County Government Procedural Memorandum 02-08 – Language Access Policy
The Code of Fairfax County, Virginia – Chapter 11 – Human Rights Ordinance

Equitable Growth Profile of Fairfax County
Summary

Communities of color are driving Fairfax County's population growth, and their ability to participate and thrive is central to the county's success. While the county demonstrates overall strength and resilience, wide gaps in income, employment, education, and opportunity by race and geography place its economic future at risk.

Equitable growth is the path to sustained economic prosperity in Fairfax County. By creating pathways to good jobs, connecting younger generations with older ones, integrating immigrants into the economy, building communities of opportunity throughout the county, and ensuring educational and career pathways for all youth, Fairfax County can put all residents on the path toward reaching their full potential, and secure a bright future for the whole county.

Foreword

Fairfax County, Virginia, is a diverse and thriving urban county and is the most populous jurisdiction in both the state of Virginia and the Washington, DC, metropolitan area with over one million residents. Fairfax County ranks second nationally in terms of household income with a median of $110,292. While Fairfax County's socioeconomic data tends to be extremely positive overall, not all residents are prospering.

Earlier this year, representatives from public, private, nonprofit, faith, and community sectors came together to expand our understanding of equity as a key economic driver in Fairfax County. We also had the opportunity to bring forward a local perspective in the development of this study prepared by PolicyLink and by the University of Southern California's Program for Environmental and Regional Equity (PERE). These learnings are compelling. We recognize that our community's future will be much brighter if we ensure the full inclusion of all residents in our county's economic, social, and political life.

We believe that, by using this profile, we can engage our community in conversations to better understand the growth realities we face and spark actions that ensure our continued economic growth and competitiveness. We are committed to working together as public, private, and community leaders to guide our path toward a vision of "One Fairfax" – a community in which everyone can participate and prosper.

Karen Cleveland
Interim President/CEO
Leadership Fairfax, Inc.

Patricia Harrison
Deputy County Executive
Fairfax County Government

Patricia Mathews
President & CEO
Northern Virginia Health Foundation

Overview

Across the country, communities are striving to put plans, policies, and programs in place that build healthier, more prosperous regions that provide opportunities for all of their residents to participate and thrive.

Equity – full inclusion of all residents in the economic, social, and political life of the region, regardless of race/ethnicity, and nativity, age, gender, neighborhood of residence, or other characteristics – is essential for regional prosperity. As the nation undergoes a profound demographic transformation in which people of color are quickly becoming the majority, ensuring that people of all races and ethnicities can participate and reach their full potential is more than just the right thing to do – it is an absolute economic imperative.

In the past, equity and growth have often been pursued on separate paths, but it is now becoming increasingly clear that they must be pursued together. The latest research on national and regional economic growth, from economists working at institutions including the International Monetary Fund and Standard and Poor's, finds that inequality hinders economic growth and prosperity, while greater economic and racial inclusion fosters greater economic mobility and more robust and sustained growth.[1]

Embedding equity into local and regional development strategies is particularly important given the history of metropolitan development in the United States. America's regions are highly segregated by race and income, and these patterns of exclusion were created and maintained by public policies at the federal, state, regional, and local levels. In the decades after World War II, housing and transportation policies incentivized the growth of suburbs while redlining practices and racially restrictive covenants systematically prevented African Americans and other people of color (as well as some White immigrant populations, such as Jewish Americans) from buying homes in new developments while starving older urban neighborhoods of needed reinvestment. Many other factors – continued racial discrimination in housing and employment, exclusionary land use practices that prevent construction of affordable multifamily homes in more affluent neighborhoods, and political fragmentation – have reinforced geographic, race, and class inequities.

Today, America's regions are patchworks of concentrated advantage and disadvantage, with some neighborhoods home to good schools, bustling commercial districts, services, parks, and other crucial ingredients for economic success, and other neighborhoods providing few of those elements. The goal of regional equity is to ensure that all neighborhoods throughout the region are communities of opportunity that provide their residents with the tools they need to thrive.

The Equitable Growth Profile of Fairfax County examines demographic trends and indicators of equitable growth, highlighting strengths and areas of vulnerability in relation to the goal of building a strong, resilient economy. It was developed by PolicyLink and the Program for Environmental and Regional Equity (PERE) to help the Fairfax County government, advocacy groups, elected officials, planners, business leaders, funders, and others working to build a stronger region.

This summary document highlights key findings from the profile along with policy and planning implications.

Equitable Growth Indicators

This profile draws from a unique Equitable Growth Indicators Database developed by PolicyLink and PERE. This database incorporates hundreds of data points from public and private data sources such as the U.S. Census Bureau, the U.S. Bureau of Labor Statistics, and Woods & Poole Economics, Inc. The database includes data for the 150 largest metropolitan regions and all 50 states, and includes historical data going back to 1980 for many economic indicators as well as demographic projections through 2040. It enables comparative regional and state analyses as well as tracking change over time.

Geography

This profile describes demographic and economic conditions in Fairfax County and Fairfax City, which are situated within the Washington, DC, metropolitan statistical area. In some cases, we present data separately for the county and city, as well as census tract level data. Unless otherwise noted, all data follow this regional geography, which is simply referred to as "Fairfax County."

Profile Highlights

The region is undergoing a major demographic shift

Fairfax County is growing and its demographics are quickly diversifying. Since 1980, its population has nearly doubled, from 600,000 to over 1 million. During the same time period, the share of residents who are people of color has more than tripled, from 14 to 45 percent. By 2044, when the nation is projected to become majority people of color, over 70 percent of the county's population will be people of color.

Communities of color – especially Latinos, Asians, and people of other and mixed racial backgrounds – accounted for all of the net population growth over the last decade, contributing 130 percent of the growth and offsetting a decline in the White population. Latinos were the fastest growing group, increasing 57 percent and gaining more than 62,000 residents, followed by Asians, with a 50 percent growth rate and a slightly higher net gain of over 64,000 residents. For both Latinos and Asians, the U.S.-born has a faster growth rate over the decade than immigrants. The county's Black population has stabilized and will remain about a tenth of the population for the foreseeable future. The majority of the county's Middle Eastern population are immigrants (60%), but the U.S.-born Middle Eastern population is growing more quickly than the immigrant population.

The county's demographic shift is taking place throughout the county and the city of Fairfax. By 2040, two-thirds of Fairfax City's residents will be people of color, compared with 72 percent in Fairfax County. Between 2010 and 2040, people of color will continue to drive growth in the county.

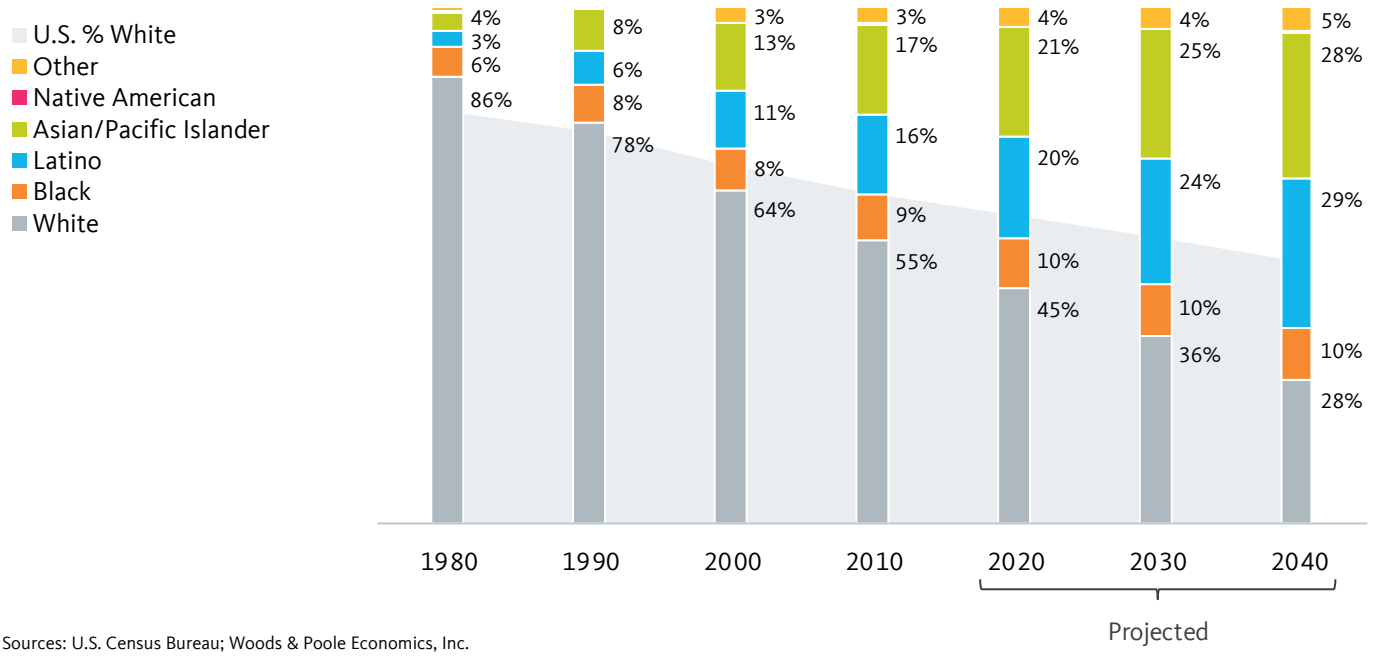
Youth are at the forefront of the county's changing demographics, and Fairfax's young residents are much more diverse than its seniors. Today, 52 percent of youth are people of color, compared with 27 percent of seniors. This 25 percentage point racial generation gap between young and old has risen very quickly, more than tripling since 1980. This gap presents a potential economic risk for the county because a large racial generation gap often corresponds with lower investments in the educational systems and community infrastructure needed to support the economic participation of youth.[2]

Stronger and more equitable growth is the key to the county's future prosperity

While Fairfax County's economy has been strong in the past and remains so to this day, it has struggled somewhat to recover from the Great Recession: while its GDP and job growth remain higher than national averages, its GDP is growing at less than half its pre-recession rate. Additionally, while growth in jobs and earnings has outpaced averages for the nation and the Washington, DC, metro as a whole since 1990, much of it has been concentrated in high-wage jobs: jobs and earnings for high-wage workers have increased by more than the combined rates for medium and low-wage workers. While this should be celebrated as a sign of strength, it has also contributed to heightened economic inequality and a shrinking middle class, which can pose a threat to maintaining a prosperous and sustainable economy moving forward.

The share of people of color is projected to increase through 2040

Racial/Ethnic Composition, 1980-2040



Sources: U.S. Census Bureau; Woods & Poole Economics, Inc.

In addition to these trends of uneven growth, racial gaps – especially for Blacks and Latinos – in education, employment, and income have persisted and in some cases widened over time. As the county grows more diverse, these inequities become an even more serious threat to economic strength and competitiveness. Below are several key challenges the county will need to address to ensure a strong economy and a better shot at returning to the high growth seen prior to the recession.

Educational barriers for marginalized communities remain

A strong education is central to labor market competitiveness in today's knowledge and technology-driven economy, but a growing segment of Fairfax's workforce lacks access to the education needed for the jobs of the future. According to the Georgetown Center for Education and the Workforce, 45 percent of all jobs in Virginia will require an associate's degree or higher by 2020. Today only 25 percent of Latino immigrants in Fairfax County have that level of education. Even without achievement gaps, Latino immigrants have limited access to good jobs: while every other group with a bachelor's degree or higher has over half of its workforce in high-opportunity jobs, only 37 percent of Latino immigrants with the same level of education work in these positions. Similarly, college-educated Latino immigrants work in low-opportunity jobs at a rate nearly four times higher than the county average.

The middle and lower classes are being squeezed

A strong middle class is the foundation for a strong economy, but Fairfax County's middle class is being squeezed while inequality is on the rise. Since 1979, the share of middle-class households in the county has shrunk significantly, from 40 percent to 33 percent. This decrease has been absorbed by lower-class households, whose share of all households grew from 30 percent to 40 percent during the same period. Encouragingly, the racial composition of middle-class households has shifted to become more reflective of the racial composition of the county's households. People of color make up 34 percent of middle-class households compared to 37 percent of all households. This provides evidence of some economic inclusion of Black and emerging Latino and Asian/Pacific Islander populations.

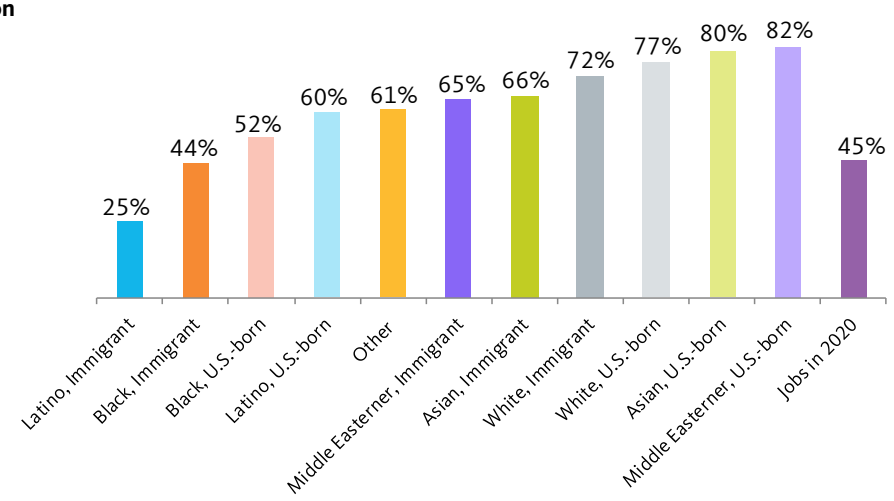
While earnings for low-wage jobs have increased 18 percent over the past two decades, that is slightly more than half the rate of the increase for middle-class jobs and – alarmingly - less than one-third the increase for high-wage jobs during the same time period. At the far end of the spectrum, wages for the bottom 10th and 20th percentiles have actually decreased since 1979. This has a disproportionate impact on people of color who are more likely to work in low-wage jobs.

Racial economic gaps

Across a host of indicators, including employment, wages, poverty, working poor rates, and access to "high-opportunity" occupations, people of color fare worse in the Fairfax labor market than their White counterparts. These racial economic gaps remain even after controlling for education, which reveals the persistence of racial barriers to economic opportunity – including overt discrimination as well as more subtle forms of exclusion that are embedded into institutions and systems.

Raising educational attainment among the county's communities of color is critical to building a prepared workforce

Share of Working-Age Population with an Associate's Degree or Higher by Race/Ethnicity and Nativity, 2012, and Projected Share of Jobs that Require an Associate's Degree or Higher, 2020



Sources: Georgetown Center for Education and the Workforce; IPUMS. Universe for education levels of workers includes all persons ages 25 through 64.
Note: Data for 2012 by race/ethnicity and nativity represent a 2008 through 2012 average at the county level; data on jobs in 2020 represents a state-level projection for Virginia.

While overall unemployment in Fairfax County is lower than the national average, Latinos, Blacks, and especially people with other and mixed racial backgrounds have much higher rates of unemployment than Whites. Black workers face higher unemployment rates than their White and Latino counterparts at almost every education level, and both Black and – especially – Latino residents earn lower wages than Whites at every education level. Wage disparities persist even among highly educated workers, with college-educated (BA degree only) Blacks and Latinos earning $9/hour and $16/hour less than their White counterparts, respectively. Middle Eastern groups, too, lag behind Whites earning $9/hour less.

Poverty and a growing number of people who are working poor (defined here as working full-time for an income below 150 percent of the poverty level) are both on the rise in the county and are most severe for communities of color. Over one in ten Latinos and Blacks now live below the poverty level, compared to less than one in 30 Whites. Working poverty is particularly a problem for Latinos and Middle Easterners. In addition, U.S.-born Latino and Black children are five and six times more likely, respectively, to live in poverty compared to White children. Finally, a disproportionate share of Black and Latino households (49 and 56 percent) are rent burdened compared to Asian and White households (42 and 39 percent), which further limits geographic and economic mobility.

Disconnected youth

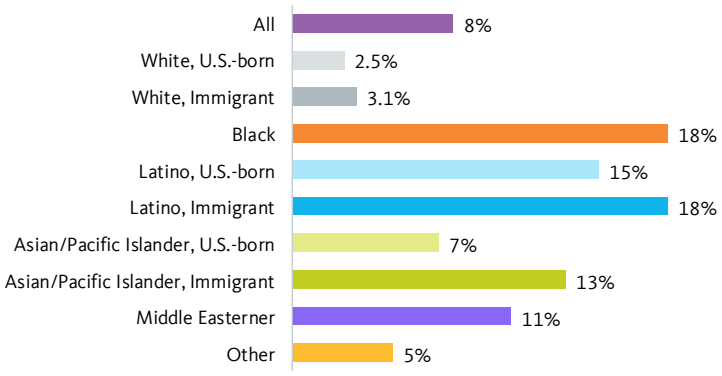
The county's future quite literally depends on the ability of its youth to power its economy in the years to come. Although the fact that more of the county's youth are getting high school degrees than in the past is a positive sign, the number of "disconnected youth" who are neither in school nor working is also on the rise. In the county, nearly 9,200 youth are currently disconnected, nearly half of whom are Black and Latino. On the positive side, dropout rates have improved significantly over the past decade for Blacks and U.S.-born Latinos, although more than a quarter of Latino immigrant youth still drop out of high school or lack a diploma, compared to only 1 percent of Whites.

An uneven geography of opportunity and prosperity

While Fairfax County as a whole is quite prosperous, the wealth of opportunities that the county has to offer are not distributed evenly across the county. In particular, the southeastern portion of the county has the lowest child opportunity and health opportunity when compared to other areas in the county. Similarly, communities in the southeastern portion of the county have higher poverty rates and higher shares of rent-burdened households (households spending 30 percent or more of income on rent). Not coincidentally, communities of color are concentrated in the same areas that are faring worse.

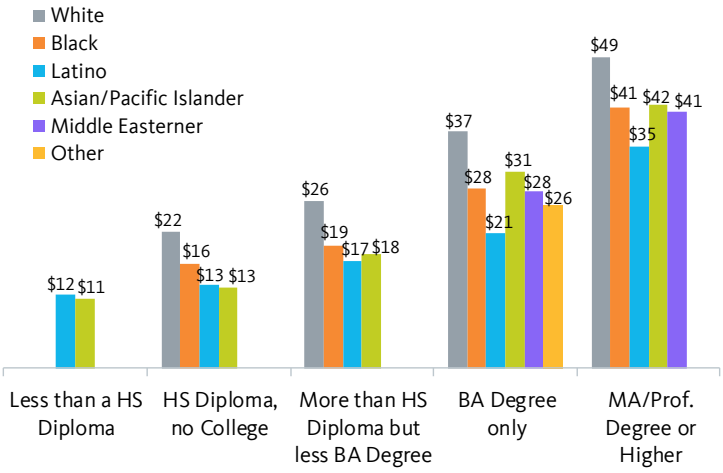
The county's Blacks and Latinos earn disproportionately low wages and are more likely to have children living in poverty

Child Poverty Rate by Race/Ethnicity and Nativity, 2012



Source: IPUMS. Universe includes the population under age 18 not in group quarters.
Note: Data represent a 2008 through 2012 average.

Median Hourly Wage by Educational Attainment and Race/Ethnicity, 2012



Source: IPUMS. Universe includes civilian non-institutional full-time wage and salary workers ages 25 through 64. Note: Data represent a 2008 through 2012 average.

Racial economic inclusion would strengthen the economy

Fairfax County's rising inequality and racial gaps are not only bad for communities of color – they hinder the whole county's economic growth and prosperity. According to our analysis, if there were no racial disparities in income, GDP would have been $26.2 billion higher in 2012. Unless racial gaps are closed, the costs of inequity will grow as Fairfax County becomes more diverse.

Implications

Fairfax's growing, diverse population is a major economic asset that will help the county compete in the global economy, if the county's leaders invest in ensuring all of its residents can connect to good jobs and contribute their talent and creativity to building a strong next economy. Our data analysis suggests focusing on the following goals to spur more equitable growth in the county. Below we describe each goal and share strategies that the county's leaders might pursue to advance these goals.

County leaders have already thought through many of these same issues, documented in the County Board of Supervisors Strategic Plan to Facilitate Economic Success, for example. Yet the goals we suggest are much more intentional in defining that successful growth means equitable growth and that the county's people of color – often marginalized from the economic processes – are key drivers to the economic future.

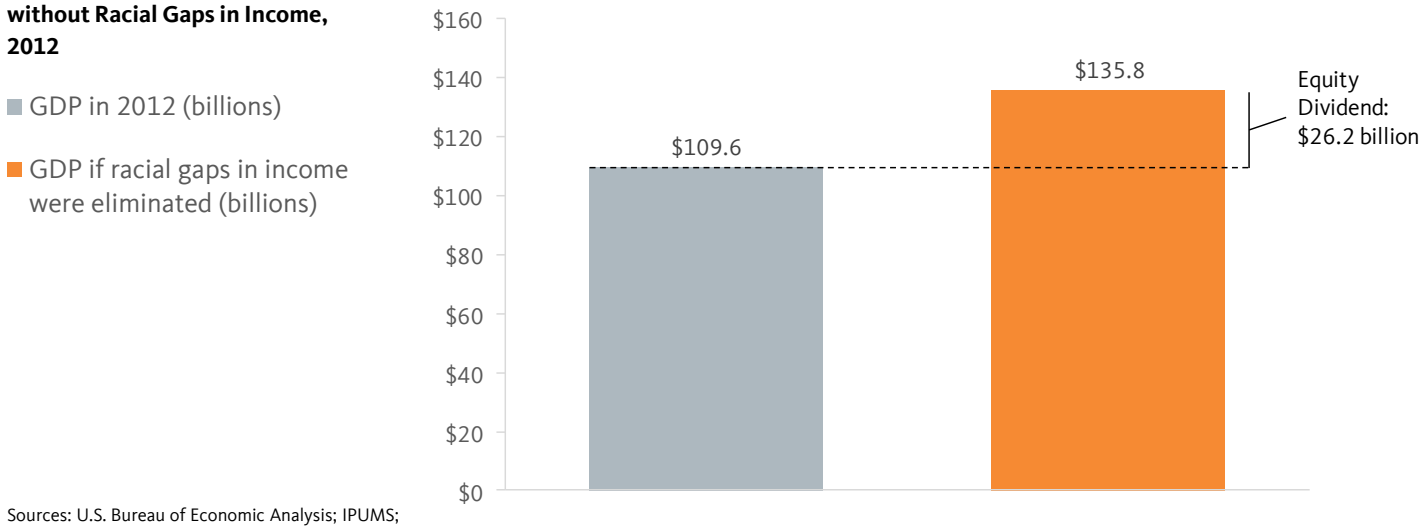
Create pathways to good jobs for workers facing barriers to employment

The county's higher levels of unemployment and lower levels of educational attainment for many members of its communities of color call for a strong focus on creating on-ramps to good, family-supporting careers for these populations. There are several promising approaches to building these pathways:

- Implement sectoral workforce strategies that connect workers with low education levels to high-quality training programs that lead to gainful employment in growing sectors of the economy. Such approaches are a win-win for employers who need access to skilled workers as well as workers seeking employment.
- Ensure public investments in roads, transit, sewers, and other community infrastructure are made in ways that create job opportunities for the underemployed and unemployed. This can be done by targeting investments in neighborhoods where unemployment and poverty are high and by implementing local and targeted hiring and training strategies.
- Remove barriers and implement strategies to help minority-owned businesses expand. This can create employment pathways for people who are jobless because these firms tend to hire more employees of color and people living in the community.

Fairfax County's GDP would have been $26.2 billion higher in 2012 if there were no racial disparities in income

Actual GDP and Estimated GDP without Racial Gaps in Income, 2012



Sources: U.S. Bureau of Economic Analysis; IPUMS; U.S. Bureau of Labor Statistics.

- Leverage the economic power of large anchor institutions, like hospitals and universities, for community economic development. These anchors can develop intentional strategies to hire jobseekers facing barriers to employment, create on-the-job training opportunities, and purchase more goods and services from local- and minority-owned businesses who provide local jobs.

Fairfax County's effort to create career pathways for long-term growth. The Northern Virginia Workforce Investment Board (NVWIB) is a team of private and public sector partners who share a common goal to promote Northern Virginia economic prosperity and long-term growth. The board receives and administers annual federal Workforce Investment Act (WIA) dollars that help fund comprehensive employment and training services to area employers, job seekers, and youth. The NVWIB oversees six SkillSource One Stop Employment Centers and they offer a broad array of employment assessment, workforce counseling, job training, and support services for jobseekers. Total adult job seekers' visits to the SkillSource Centers are projected to exceed 65,000 in FY 2015. Learn more at www.myskillsource.org.

Bridge the racial generation gap

Bridging the racial generation gap between youth of color and a predominantly White senior population is critical to ensure a strong workforce in the county. This is reflected by the Fairfax County Board of Supervisors when it initiated its Fairfax 50+ Community Plan that addresses the dramatic aging of the baby boomer population and the long-term socioeconomic planning needed to facilitate a well-cared-for and opportunity-rich region for all.

One arena where seniors and young workers of color and their families have shared interests is elder care. Ensuring living wages, benefits, and adequate training and standards for care workers is a win-win path to strengthen the quality of elder care. When care jobs are good jobs that can support a family, turnover is lower and care is not disrupted. Worker organizing, innovative business models, and policy changes are all strategies to improve the quality of elder care and care work. Another way to build bridges is to plan for multigenerational communities, which allow the elderly to age in place while providing safe and healthy environments for families to raise children. Investments in multigenerational community facilities and public spaces (for example, schools that include facilities for seniors) can encourage social interaction between residents of all ages.

Caring Across Generations Campaign advocates for the rights of seniors and their care workers. The Caring Across Generations campaign is a national movement to bring together families, workers, and others to transform the care industry and ensure seniors and care workers can live with dignity. In Illinois, Missouri, Ohio, and elsewhere, the campaign builds broad coalitions to make care work visible, highlighting its value to the overall economy and the support it provides families. Caring Across Generations' policy reforms include increasing access to in-home care for Medicaid recipients and ensuring care jobs pay a living wage and provide benefits, training opportunities, and a pathway to citizenship. Learn more at www.caringacross.org.

Integrate immigrants into the county's economy

Immigrants are contributing to growth in the county, yet they face barriers to fully participating in economic and civic life. Many regions are implementing successful strategies to ensure immigrants have access to the services, education and training, entrepreneurship, and job opportunities they need to thrive. The high growth rate among immigrant populations reinforces the necessity of strong local programs focused on integration and training into the local and national economy.

Tennessee welcomes immigrants to build a stronger economy. Responding to a rapidly growing immigrant population (the third-fastest growing in the nation), the Welcoming Tennessee Initiative was launched in 2005 to counter anti-immigrant backlash and strengthen the local economy. Using dinner conversations between long-time residents and immigrants, billboards, and other community strategies, the initiative successfully defeated English-only referendums and legislation. Since then, the project has inspired a national Welcoming America initiative, with affiliates in 21 states. Learn more at www.welcomingamerica.org.

Build communities of opportunity throughout the county

All neighborhoods located throughout the county should provide their residents with the ingredients they need to thrive and also open up opportunities for low-income people and people of color to live in neighborhoods that are already rich with opportunity (and from which they've historically been excluded).

Coordinating transportation, housing, and economic development investments over the long term will foster more

equitable development patterns and healthier neighborhoods across the county. Addressing lingering racially discriminatory housing and lending practices and enforcing fair housing laws are also critical to expand opportunity for all.

Reinforcing the link between equity and health in California. In 2010, The California Endowment launched a 10-year $1 billion Healthy Neighborhoods Initiative to advance statewide policy, change the narrative, and transform 14 of California's communities most devastated by health inequities into places where all people have an opportunity to thrive. Research on the social determinants of health has found that 70 percent of health outcomes are determined by the social, political, and economic environments that shape the choices we make. The Building Healthy Communities place-based investment prioritizes working with residents and the public sector on policy changes. Learn more at www.calendow.org/building-healthy-communities/.

Ensure education and career pathways for all youth

Ensuring that all youth in the county, including Blacks, Native Americans, Latinos, and immigrants, can access a good education that leads to a career is critical to develop the human capital to power the county's economy in the future. The high share of immigrant youth without high school degrees signals the need for intentional strategies to ensure young people have the supports they need to successfully complete high school and enter college or another training program that leads to a job. Replacing overly harsh "zero tolerance" school discipline policies with strategies focused on positive behavior support and restorative justice can work to lower suspension and expulsion rates and reduce the number of disconnected youth. Increasing the availability of apprenticeships, career academies, and other education and training supports that provide work experience and connections can also keep more youth on the track to graduation, college, and careers.

Strengthening the K-12 public school system by ensuring sufficient and equitable funding for schools attended by lower-income students is also essential to build a vital workforce. Bilingual education and other language access strategies can help youth who are English-language learners excel in school. And it is not enough to only address in-school time; high-quality afterschool and youth development activities that provide learning opportunities outside of the school day are also critical ingredients for academic success. And Fairfax County is already on the right path by looking forward to ensure coordination and delivery of workforce training programs for students by partnering with the Northern Virginia Community College and Fairfax County Public Schools. This strategy entails talking with key employers along with assessing workforce development programs to determine if they are properly aligned to meet the projected employment needs in the county. This can feed into ensuring these investments in educational success follow children throughout their lifespan, from cradle to college to career. The research shows that balanced investments spread throughout the lives of vulnerable children reap the greatest rewards.

Foster diverse civic participation and leadership

Given the county's rapid demographic shifts that are being driven by the increasing diversity of the youth population, it is important for county leaders in every sector to proactively take steps to ensure opportunities for communities of color to participate in decision making and leadership. Strategies to build diverse leadership include the following:

- Create a durable countywide equity network or collaborative of leaders across race, age, issue areas, and geography to advance equitable growth strategies and policies.
- Facilitate active engagement by all racial and ethnic communities in local planning processes by implementing best practices for multicultural engagement (e.g., translation services, provision of child care during meetings, etc.).
- Support leadership development programs (such as the Boards and Commissions Leadership Institute), including youth-focused programs, to help neighborhood, organizational, and civic leaders build their leadership and capacity to serve in government and on decision-making bodies.

Boards and Commissions Leadership Institute trains next generation of leaders. Since 2010, Urban Habitat's Boards and Commissions Leadership Institute has been training leaders from underrepresented San Francisco Bay Area communities to serve on decision-making bodies. The Institute empowers residents to become leaders on the issues that have the most direct impact on their neighborhoods: transportation, housing, jobs, and more. Graduates have won 35 seats on priority boards and commissions, including planning commissions, housing authorities, and rent boards. The program is being replicated in the Twin Cities, Sacramento, and elsewhere. Learn more at www.urbanhabitat.org/leadership/bcli.

Conclusion

Community leaders in the public, private, and nonprofit sectors are already taking steps to connect its more vulnerable communities to educational and economic opportunities, and these efforts must continue. To secure a prosperous future, Fairfax needs to implement a growth model that is driven by equity – just and fair inclusion into a society in which everyone can participate and prosper. Concerted investments and policies for, and developed from within, communities of color will also be essential to ensure the county's fastest-growing populations are ready to lead it into the next economy.

[1] Andrew G. Berg and Jonathan D. Ostry, *Inequality and Unsustainable Growth: Two Sides of the Same Coin?*, Staff Discussion Note (Washington, DC: International Monetary Fund, 2011) http://www.imf.org/external/pubs/ft/sdn/2011/sdn1108.pdf; Jonathan D. Ostry, Andrew Berg, and Charalambos G. Tsangarides, *Redistribution, Inequality, and Growth*, Staff Discussion Note (Washington, DC: International Monetary Fund, 2014) http://www.imf.org/external/pubs/ft/sdn/2014/sdn1402.pdf; Joe Maguire, *How Increasing Inequality is Dampening U.S. Economic Growth, and Possible Ways to Change the Tide* (New York, NY: Standard & Poor's Financial Services LLC, 2014) https://www.globalcreditportal.com/ratingsdirect/renderArticle.do?articleId=1351366&SctArtId=255732&from=CM&nsl_code=LIME&sourceObjectId=8741033&sourceRevId=1&fee_ind=N&exp_date=20240804-19:41:13; Manuel Pastor, *Cohesion and Competitiveness: Business Leadership for Regional Growth and Social Equity*, OECD Territorial Reviews, Competitive Cities in the Global Economy, Organisation For Economic Co-Operation And Development (OECD), 2006; Manuel Pastor and Chris Benner, "Been Down So Long: Weak-Market Cities and Regional Equity," in *Retooling for Growth: Building a 21st Century Economy in America's Older Industrial Areas* (New York, NY: American Assembly and Columbia University, 2008); Randall Eberts, George Erickcek, and Jack Kleinhenz, *Dashboard Indicators for the Northeast Ohio Economy,* prepared for the Fund for Our Economic Future (Cleveland, OH: Federal Reserve Bank of Cleveland, 2006), https://www.clevelandfed.org/~/media/Files/Working%20Papers/wp2006/wp0605-dashboard-indicators-for-the-northeast-ohio-economy-prepared-for-the-fund-for-our-economic-future.pdf?la=en.

[2] David N. Figlio and Deborah Fletcher, Suburbanization, Demographic Change and the Consequences for School Finance, working paper (Cambridge, MA: National Bureau of Economic Research, 2010), http://www.nber.org/papers/w16137.pdf.

Cover photos courtesy of Fairfax County, Virginia.

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Racial Inequities in Fairfax County

2011–15

Leah Hendey and Lily Posey

December 2017

Fairfax County, Virginia, is an affluent jurisdiction, with average household incomes for every racial and ethnic group near or exceeding $100,000. But the county has underlying inequities in education, income, employment, and homeownership, particularly for Hispanic residents and immigrants. There are also clear inequities in outcomes between and within supervisor districts, with large inequities in the Lee and Mason districts, among others.

This brief measures inequities by race and ethnicity in Fairfax County and its supervisor districts and provides a profile on what equity would look like for people of color. Quantifying this information will help Fairfax County agencies, school board, policymakers, and advocates working to implement the One Fairfax social and racial equity policy recognize the community's needs and to build new solutions and create a more equitable county.[1]

This brief was originally developed as an internal memorandum for the Consumer Health Foundation and the Meyer Foundation to inform their strategic thinking and investments and to share with grantees. It describes the major highlights on demographics, education, income, employment, housing, and mobility from the tables posted here: https://www.urban.org/research/publication/racial-inequities-fairfax-county-2011-15.

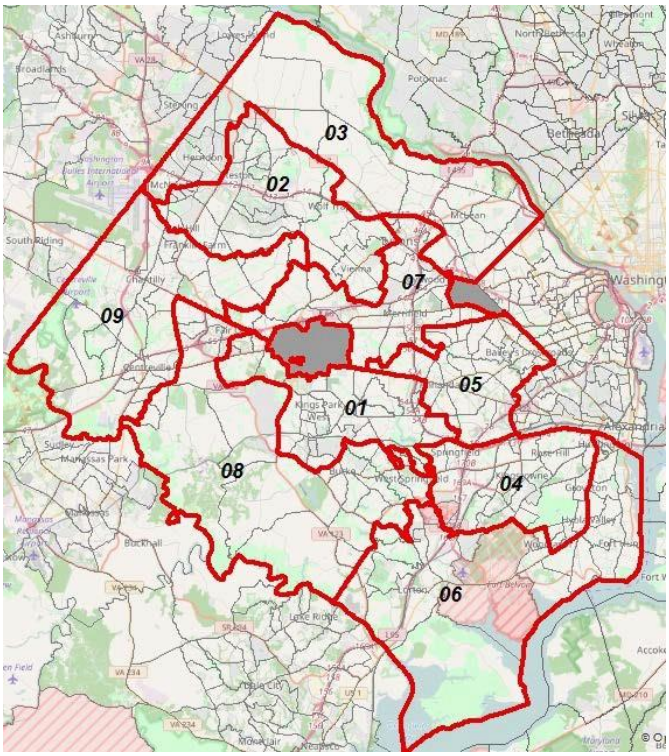
Methodology

We present the methodology first to make it easier to understand what follows. There are important caveats to be aware of when interpreting the data. This brief includes data presented for Fairfax County and the nine districts represented by the Fairfax County board of supervisors (figure 1):[2]

- 01: Braddock
- 02: Hunter Mill
- 03: Dranesville
- 04: Lee
- 05: Mason
- 06: Mount Vernon
- 07: Providence
- 08: Springfield
- 09: Sully

FIGURE 1

Supervisor Districts in Fairfax County, Virginia



Sources: OpenStreetMap and contributors CC-BY-SA and Fairfax County geographic information systems and mapping.
Notes: The light gray boundaries outline census tracts, and the red boundaries outline supervisor districts. The grayed-out areas represent the cities Fairfax and Falls Church, which are independent jurisdictions and are excluded from this analysis.

Categorizing the Fairfax County Population by Race and Ethnicity

Racial and ethnic groups used in this brief are not mutually exclusive because of tabulations available in the American Community Survey. Further breakouts by nationality are also not available, and the categories we use may mask some of these differences. We use the following categorization:

- White (non-Hispanic)
- Black (and no other race, regardless of ethnicity)[3]
- Hispanic (of any race, including those who identify as Latino)
- Asian or Pacific Islander (those who identified either as Asian or Native Hawaiian and other Pacific Islander and no other race, regardless of ethnicity)[4]
- American Indian, Alaska Native, other or multiple races (all regardless of ethnicity)[5]

Because the groups are not mutually exclusive, percentages may not total 100 percent. In the above categories, Hispanics can appear in the black, Asian, Pacific Islander, American Indian, Alaska Native, other, or multiple race groups. Though there are inequities that American Indian, Alaskan Native, and other or those who identify as multiracial face, the American Community Survey does not have sufficient sample sizes to break out the data for these groups.

Though the information is limited because of the tabulations the American Community Survey provided, we have included information on Fairfax County's foreign-born population. Foreign-born includes all people born outside the US who would not be considered "native" (people born in Puerto Rico or other US island areas or born abroad to American parents are native).

Calculation of Equity Gaps

One method to explore what an equitable Fairfax County would look like is to close the *equity gaps* between whites and other racial and ethnic groups. These gaps are calculated based on the countywide white rate for the indicator. At the supervisor district level, the comparison is still to the countywide white rate. For example, to calculate the gap in the poverty rate for blacks in the Mason district (13 percent), we compare it with the countywide white poverty rate (3 percent) and determine the additional number of blacks in Mason who would leave poverty if the black rate were 3 percent. The gaps are rounded to the nearest 100 people or to the nearest 10 people if less than 100. Equity gaps for each race *should not be added together*, as there may be overlap between the Hispanic population and the black or the Asian or Pacific Islander populations.

Margins of Error

The numbers and percentages in this brief and the accompanying tables are estimates based on the five-year 2011–15 American Community Survey. Because they are survey estimates and have margins of error, readers should use caution when comparing numbers. The margins of error have been provided for each indicator in the accompanying tables.

We emphasize only estimates where the margins of error were small and the estimates are reliable. But when one looks at small subpopulations, the margins of error are likely to be relatively large and the estimates less reliable. We suppressed the data where we did not consider the estimates reliable.[6] The equity gaps were also not calculated if an estimate for a group in a district was not statistically significantly different than the countywide white estimate.

Demographics

Race and Ethnicity

At the county level, the population was majority white (53 percent), and Asians or Pacific Islanders (18 percent) and Hispanics (16 percent) were the next-largest demographic groups. The black population stood at 9 percent, and other racial or ethnic groups made up less than 5 percent each.

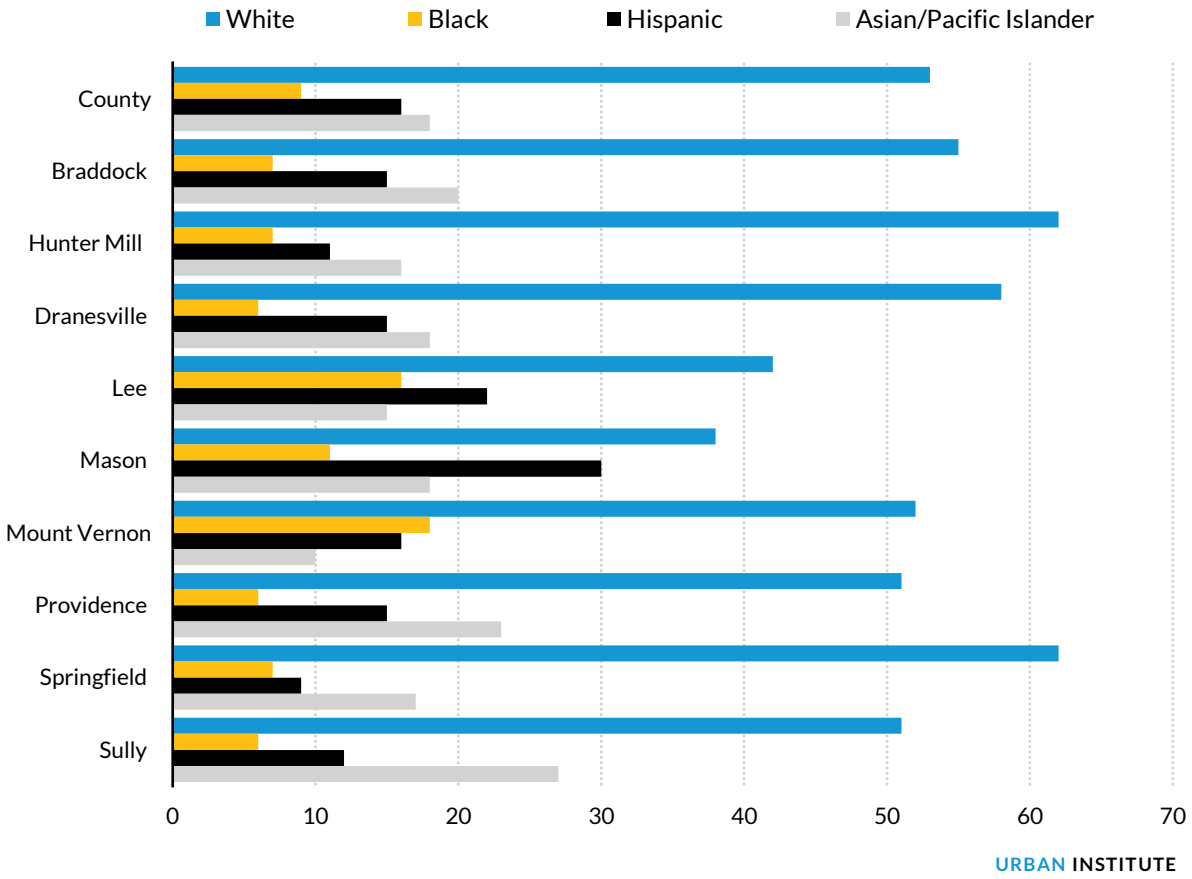
Though Fairfax County's supervisor districts roughly mirrored the county's demographic breakdown, some districts contained greater concentrations of specific racial and ethnic groups (figure 2). Districts such as Dranesville, Hunter Mill, and Springfield that are on the county edge and farthest west had the largest proportion of whites (each about 60 percent). Mount Vernon and Lee, in southern Fairfax, contained the largest proportion of blacks (18 and 16 percent, respectively). Mason was the most diverse, with a population that was 30 percent Hispanic, 18 percent Asian or Pacific Islander, 11 percent black, and 38 percent white. Sully had the highest proportion of Asians or Pacific Islanders (27 percent).

Figure 3 shows the spatial distribution of racial and ethnic groups in Fairfax County by supervisor district. There were higher shares of blacks in the southern portion, and Hispanics were more concentrated in the southern and eastern districts.

FIGURE 2

Racial and Ethnic Composition of the Population by Supervisor District in Fairfax County

2011–15

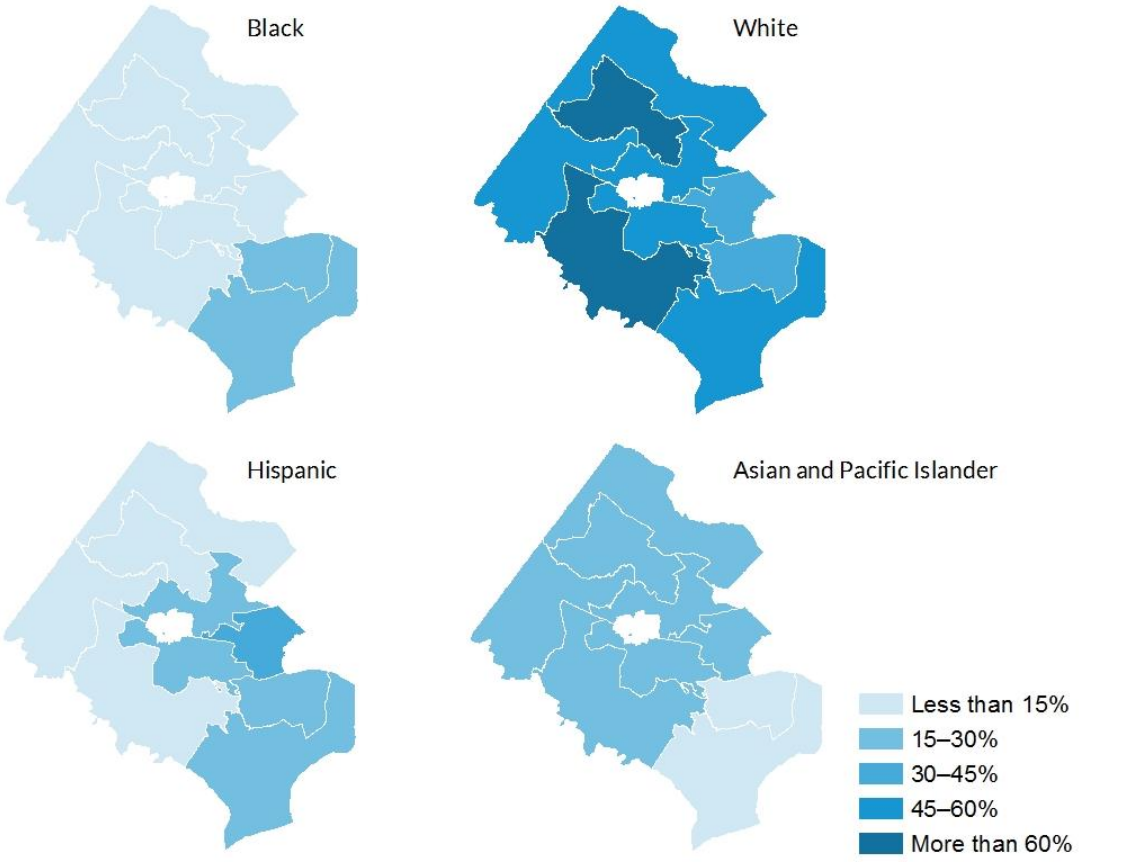


Source: American Community Survey, 2011–15.

FIGURE 3

Spatial Distribution of Racial and Ethnic Groups by Supervisor District in Fairfax County

2011–15



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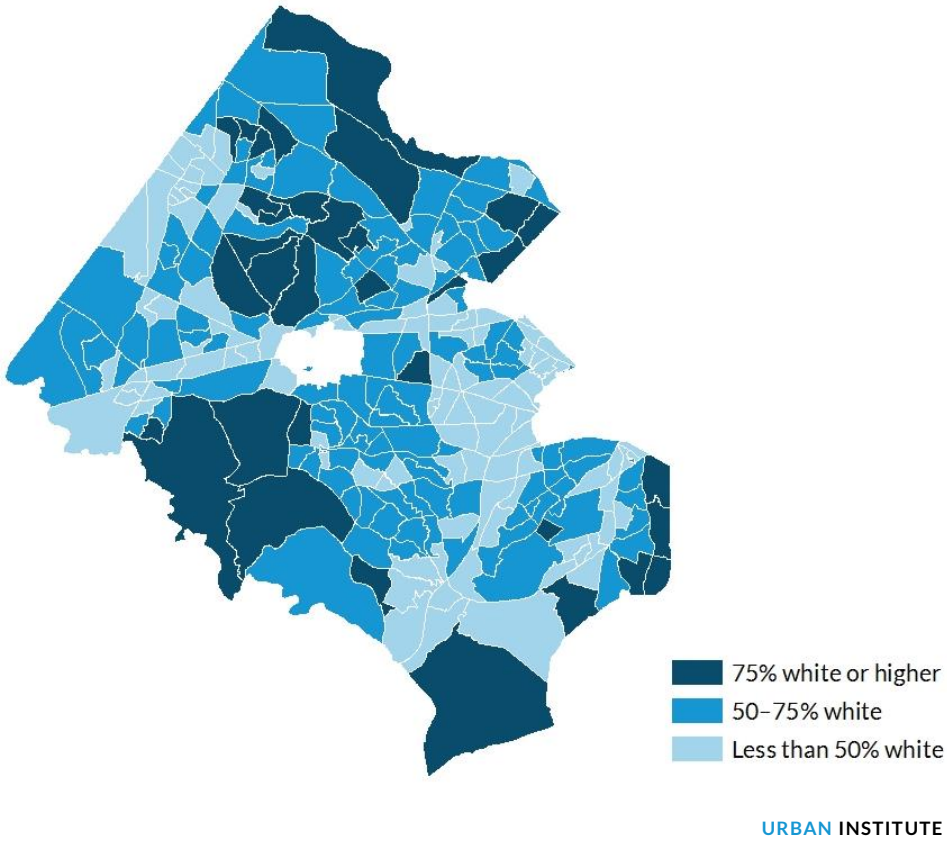
Source: American Community Survey, 2011–15.
Note: In this figure, all groups are mutually exclusive.

Figure 4 shows that many Fairfax County neighborhoods were not racially diverse. Of the 259 census tracts in Fairfax County, whites made up more than 75 percent of the tract population in 34 tracts and between 50 and 75 percent in 117 tracts. People of color were the majority of residents in only one-third of census tracts.

FIGURE 4

Racial Composition by Census Tract in Fairfax County

2011–15



Source: American Community Survey, 2011–15.

Age Distribution

In Fairfax County, children made up 24 percent of the population, 18- to 34-year-olds 22 percent, 35- to 64-year-olds 43 percent, and people age 65 and older 11 percent. Hispanics in Fairfax County tended to be younger than other groups. Nearly three in five Hispanics were age 34 and younger. Between racial and ethnic groups and between districts, the proportion of children younger than 18 was consistent, but Hispanics had the largest proportion of children (30 percent) and whites the least (21 percent). Sully had the largest proportion of children of any district (27 percent), a reflection of having the largest proportion of children for both Hispanics (35 percent) and Asians or Pacific Islanders (26 percent). The millennial generation (ages 18 to 34) was highest for Hispanics (28 percent). All other racial and ethnic groups were 20 to 25 percent millennials. At the other end of the age spectrum, 15 percent of whites were age 65 and older compared with 4 to 9 percent for other groups.

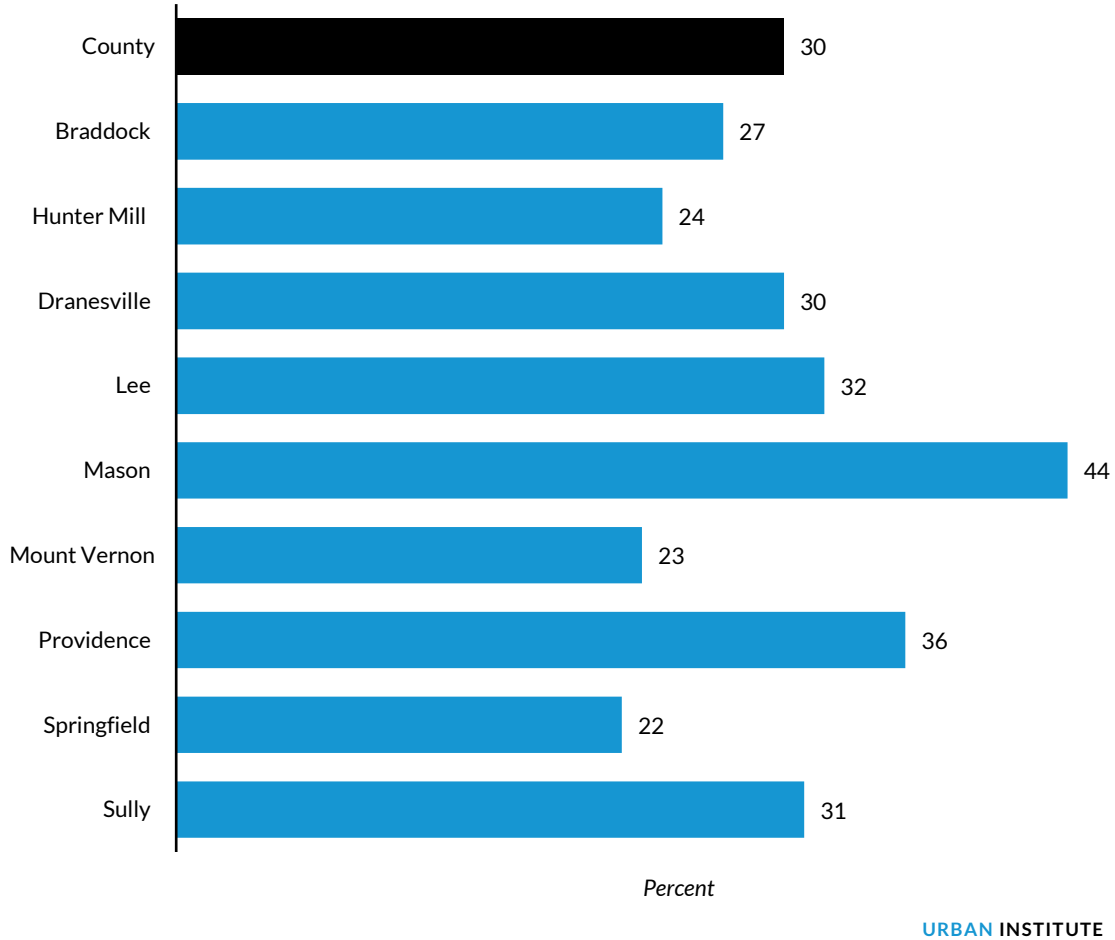
Foreign-Born Population

Immigrants made up 30 percent of Fairfax County's population, and the largest share (44 percent) were in Mason (figure 5). Springfield had the smallest immigrant population (22 percent). The racial and ethnic group with the largest share of immigrants was Asian or Pacific Islanders (77 percent), followed by Hispanics (54 percent), blacks (28 percent), and whites (9 percent). The largest shares across all racial and ethnic groups lived in Mason.

FIGURE 5

Share of the Population That Is Foreign Born by District

2011–15



Source: American Community Survey, 2011–15.

Educational Attainment

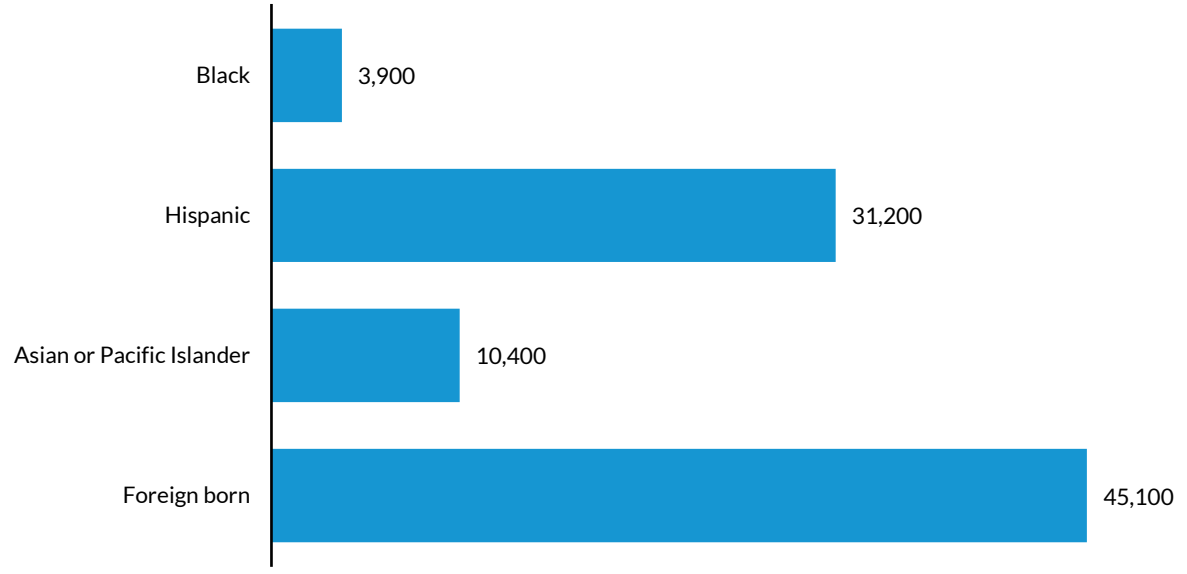
There were substantial differences in educational attainment for Hispanics and immigrants, and there were lower rates of educational attainment across the board in Lee and in Mason. Ninety-eight percent of white adults age 25 and older held high school diplomas or GED, and 88 percent had some college education. The rates for educational attainment were the same for the native-born population. More than 90 percent of black and Asian or Pacific Islander adults age 25 and older had high school degrees, but only 71 percent of black and 78 percent of Asian or Pacific Islander adults had some college. Eighty-three percent of immigrants had their high school degrees, as did 69 percent of Hispanic adults. Sixty-five percent of immigrants and 48 percent of Hispanic adults had some college experience.

In an equitable Fairfax County, 45,000 more foreign-born adults, 31,000 more Latinos, 10,000 more Asians or Pacific Islanders, and 3,900 more blacks would have high school degrees (figure 6). Similarly, 68,000 more immigrants, 43,000 more Hispanics, 15,000 more Asians or Pacific Islanders, and 11,000 more blacks would have some postsecondary education. For blacks and Asians or Pacific Islanders in many districts, the rate of high school degree attainment was not statistically different from the rates for white adults.

FIGURE 6

Increase in the Number of People with High School Degrees with Equity

2011–15



Source: American Community Survey, 2011–15.

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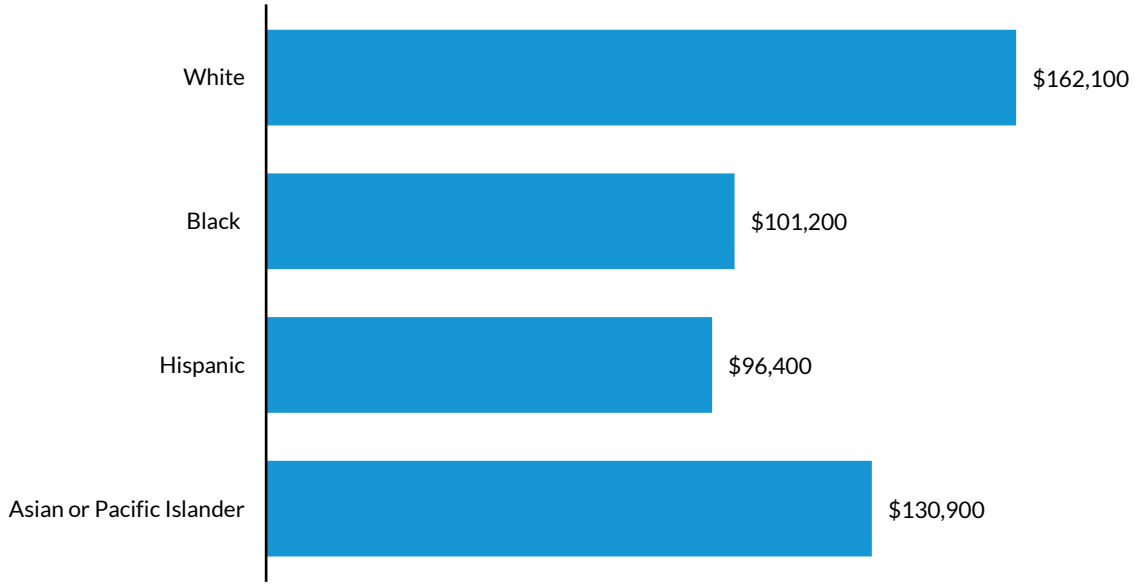
Income

Among households, which include both families and households where single adults or nonrelated people live together, the average household income in Fairfax County was $143,000. Households headed by whites were the only ones that were above average, at $162,000 (figure 7). Asian- or Pacific Islander–headed households had an average household income of $131,000, followed by households headed by blacks ($101,000) and Hispanics ($96,000). Across districts, average household income ranged from $108,500 in Mason to $210,500 in Dranesville.

FIGURE 7

Average Household Income in 2015 Dollars

2011–15



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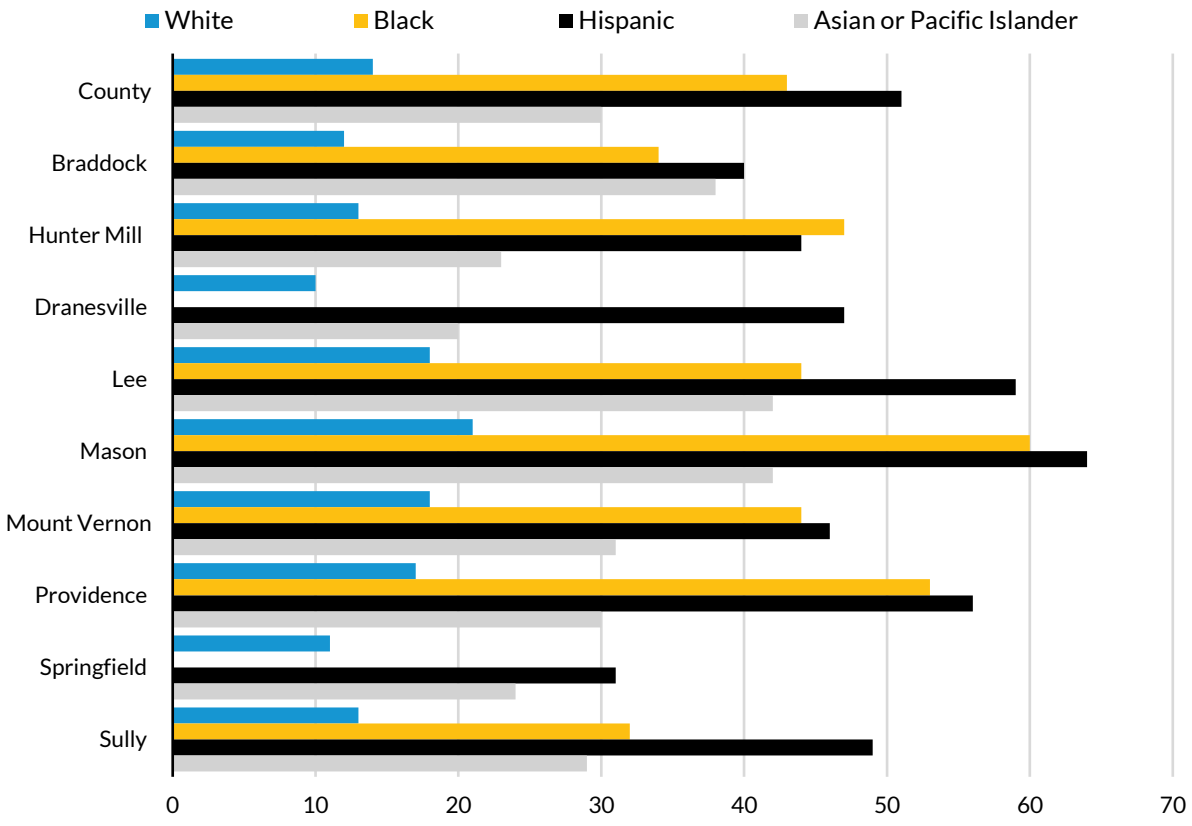
Source: American Community Survey, 2011–15.

According to the Massachusetts Institute of Technology Living Wage Calculator, the living wage in Fairfax County, which would enable a full-time worker to provide for a family with two children, was approximately $33.30 an hour or about $69,000 a year.[7] But many families in Fairfax County struggled to earn a living wage, especially in Mason, where 41 percent of families had annual incomes below $75,000.[8] There were clear racial and ethnic inequities for the families who had incomes below the living wage level. Fifty-one percent of Hispanic families, 43 percent of black families, and 30 percent of Asian or Pacific Islander families had incomes below $75,000, compared with only 14 percent of white families. Within districts, the income inequities by race and ethnicity were also stark, even in well-off districts, such as Dranesville and Hunter Mill (figure 8). In an equitable Fairfax County, an additional 13,000 Hispanic families, 8,000 Asian or Pacific Islander families, and 7,000 black families would have annual incomes above $75,000.

FIGURE 8

Share of Families with Annual Income below $75,000 in 2015 Dollars

2011–15



Source: American Community Survey, 2011–15.

Note: Data have been suppressed for estimates that are not reliable.

White families were more likely to have higher incomes. One in three white families had annual incomes above $200,000. Twenty-two percent of Asian or Pacific Islander families, 14 percent of black families, and 9 percent of Hispanic families had incomes above $200,000.

The poverty rates for whites (3 percent) and Asians or Pacific Islanders (6 percent) were at or below the rate for the county (6 percent), but the rates for blacks (10 percent), Hispanics (11 percent), and immigrants (9 percent) were above the county rate. Poverty was most prevalent in Mason (12 percent), where the poverty rates were above the county averages for all racial and ethnic groups. In an equitable Fairfax County, 20,000 more immigrants and 14,000 more Hispanic, 7,000 more black, and 6,000 more Asian or Pacific Islander residents would live above the federal poverty level, with more than half the gains for Hispanics and 30 percent for blacks in Lee and in Mason.

The child poverty rate was higher for blacks (4 times) and for Hispanics (3.5 times) than that for whites (4 percent). The child poverty rate for Asians or Pacific Islanders (6 percent) was just above that for whites. As with poverty overall, child poverty was highest in Lee and in Mason.

In an equitable Fairfax County, an additional 13,000 Hispanic families, 8,000 Asian or Pacific Islander families, and 7,000 black families would have annual incomes above $75,000. And 20,000 more immigrants and 14,000 more Hispanic, 7,000 more black, and 6,000 more Asian or Pacific Islander residents would live above the federal poverty level.

Employment

Although annual incomes for black and Hispanic families were the lowest among racial and ethnic groups, the employment rates for 16- to 64-year-olds were similar between groups, with whites, blacks, and Hispanics all between 77 and 78 percent. The Asian or Pacific Islander employment rate (73 percent) was below the county average (77 percent).

When looking at the population age 16 and older in the labor force, which includes only people who are employed or actively looking for work (unemployed), inequities in employment are revealed. Blacks (8 percent) and Hispanics (6 percent) had the highest unemployment rates, compared with 4 percent for whites, and 5 percent for Asians or Pacific Islanders. In an equitable Fairfax County, 2,400 more black residents, 2,200 more Hispanic residents, and 1,700 more Asian or Pacific Islander residents would beemployed (figure 9).

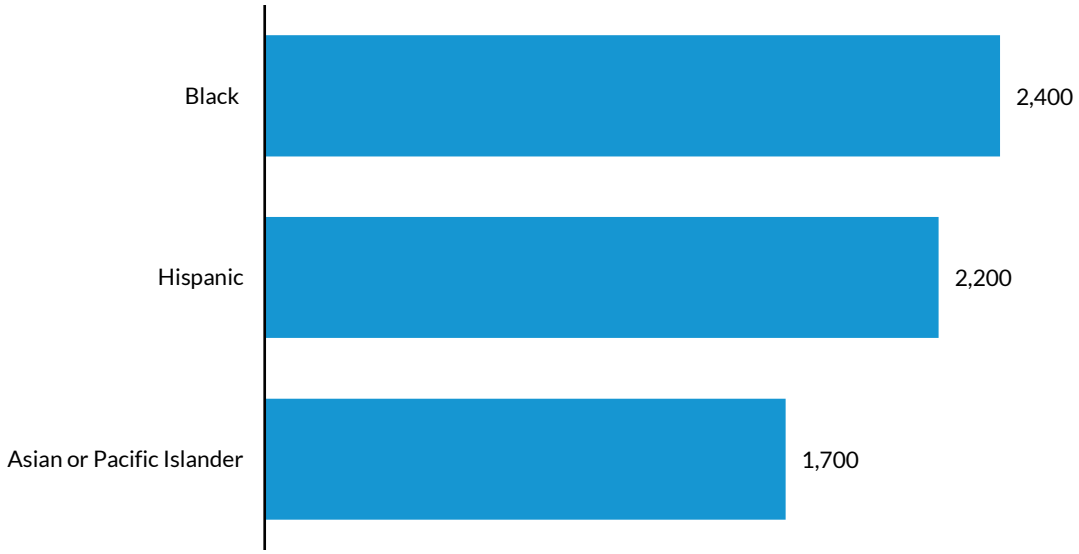
Between racial and ethnic groups, the share of the population age 16 and older working full time was comparable. Most were around the county average (51 percent), with slightly higher rates for black (56 percent) and Hispanic (54 percent) residents. Black and Hispanic full-time workers were

more likely to earn less than $35,000, roughly half the annual income needed to earn a living wage (figure 10). About 1 in 10 white residents age 16 and older in Fairfax County working full time earned less than $35,000, compared with 1 in 5 Asian or Pacific Islander residents, 1 in 4 black residents, and almost 1 in 2 Hispanic residents. In an equitable Fairfax County, 26,000 fewer Hispanics, 10,000 fewer Asians or Pacific Islanders, and 7,000 fewer blacks working full time would have earnings below $35,000.

FIGURE 9

Increase in the Number of Employed People with Equity in Fairfax County

2011–15



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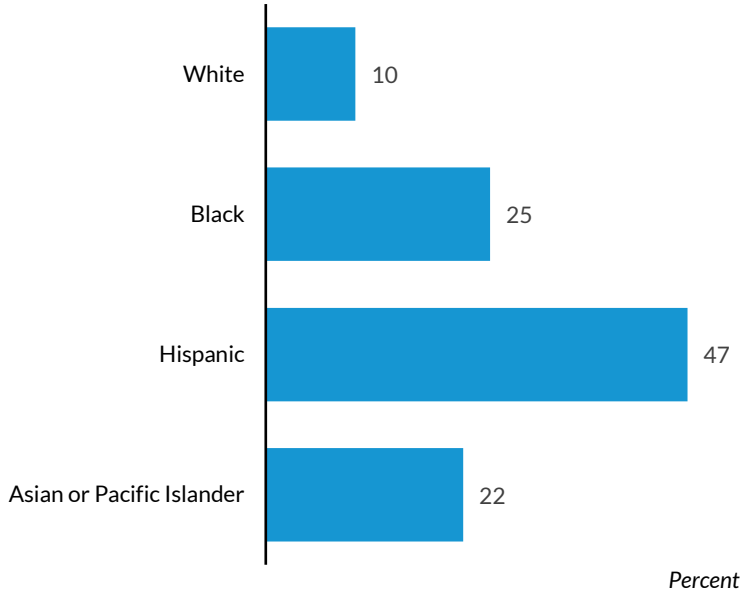
Source: American Community Survey, 2011–15.

FIGURE 10

Share of Population Working Full Time with Earnings below $35,000

2011–15



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Source: American Community Survey, 2011–15.

There were similar inequities for people working full time and earning less than $75,000 annually. More than 8 in 10 Hispanic residents, 6 in 10 black residents, and 5 in 10 Asian or Pacific Islander residents working full time did not earn this living wage, compared with fewer than 4 in 10 white residents. In an equitable Fairfax County, an additional 30,000 Hispanic residents, 12,000 Asian or Pacific Islander residents, and 12,000 black residents would earn a living wage.

Some of the income inequities may be attributable to occupational differences. About two-thirds of whites worked in management, business, science, or art occupations. About one-third of Hispanics worked in service occupations; 19 percent worked in natural resources, construction, and maintenance occupations; and 16 percent worked in sales and office occupations. For blacks, about 48 percent worked in management, business, science, or art occupations; 22 percent worked in sales and office occupations; and 19 percent worked in service occupations. More than half of Asians or Pacific Islanders worked in management, business, science, or art; 21 percent worked in sales and office occupations; and 15 percent worked in service occupations.

In an equitable Fairfax County, 26,000 fewer Hispanics, 10,000 fewer Asians or Pacific Islanders, and 7,000 fewer blacks working full time would have earnings below $35,000.

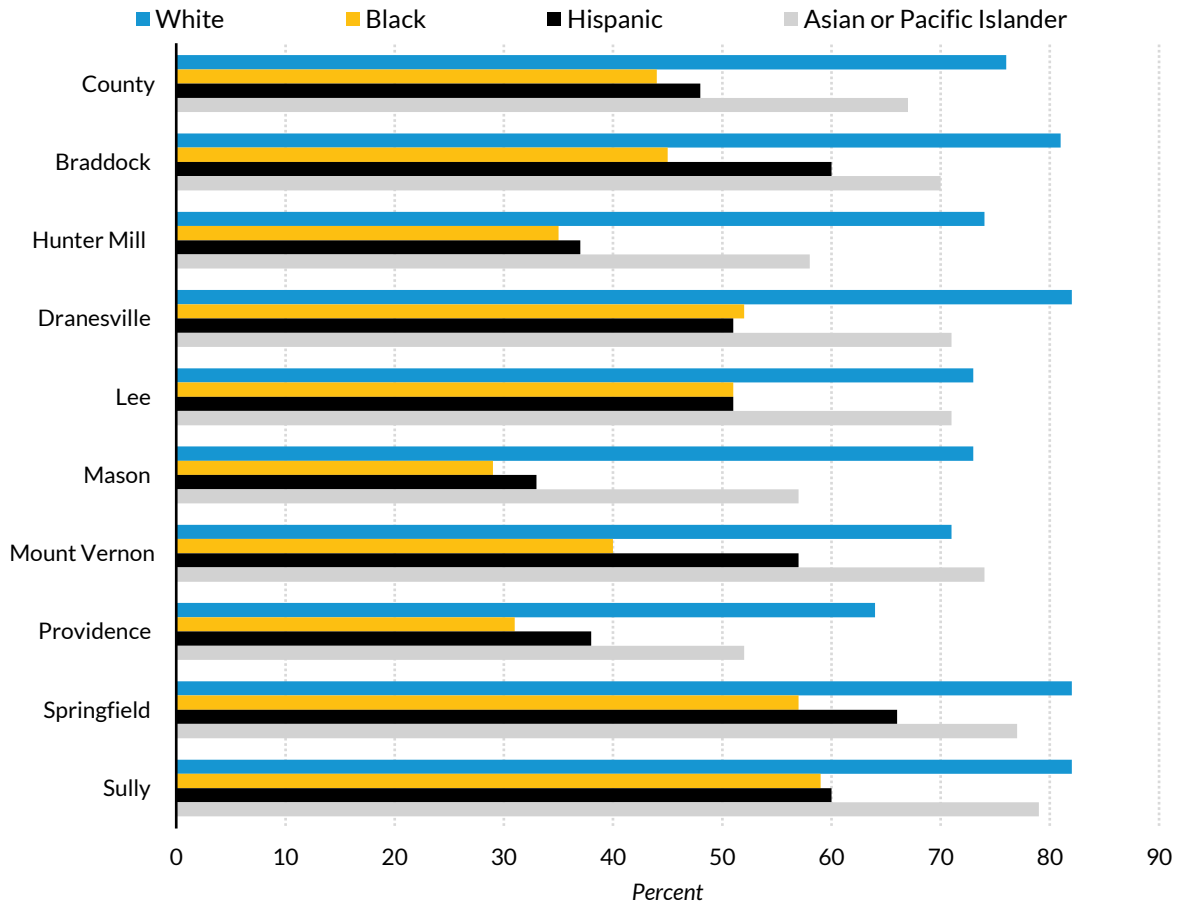
Homeownership and Mobility

The homeownership rate for Fairfax County was 68 percent. Blacks had the lowest homeownership rate (44 percent), followed by Hispanics (48 percent), Asians or Pacific Islanders (67 percent), and whites (76 percent). Mason had the lowest homeownership rates (56 percent) and had some of the lowest rates for most racial and ethnic groups, though the homeownership rate for whites was only slightly below average, at 73 percent (figure 11). Providence also had lower homeownership rates (56 percent) and was reflected in lower homeownership across all racial and ethnic groups. In an equitable Fairfax County, 12,500 more Hispanics would be homeowners, as would 12,000 more blacks and 5,500 more Asians or Pacific Islanders. Similarly, Mason would see the largest increase of any district for Hispanic homeowners, Mount Vernon would have the largest increase in homeownership for blacks, and Providence would have the largest increase for Asians and Pacific Islanders.

FIGURE 11

Homeownership Rate by Supervisor District in Fairfax County

2011–15



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Source: American Community Survey, 2011–15.

In an equitable Fairfax County, 12,500 more Hispanics would be homeowners, as would 12,000 more blacks and 5,500 more Asians or Pacific Islanders.

About 14 percent of Fairfax County residents moved in the previous year, comparable with the national rate of 15 percent. Mobility was slightly higher in Providence (18 percent). Blacks had the highest mobility rates (18 percent), followed by Asians or Pacific Islanders (16 percent), Hispanics (14 percent), and whites (11 percent).

About 8 percent of Fairfax County residents had moved into the county from somewhere outside the county in the previous year. This was a little above the national rate of 6 percent. Blacks were the most likely to have moved into Fairfax from outside the county (9 percent), followed by Asians or Pacific Islanders (8 percent), whites (7 percent), and Hispanics (6 percent). As with overall mobility, Providence had the highest share of residents who moved in from outside the county (11 percent). Sully had the lowest rate at 5 percent.

Notes

1. "One Fairfax: School Board and Board of Supervisors Joint Policy," Fairfax County Public Schools, accessed December 26, 2017, https://www.fcps.edu/onefairfax.
2. For more information on the board of supervisors, including the representatives, see "Board of Supervisors," Fairfax County Government, accessed December 1, 2017, https://www.fairfaxcounty.gov/government/board/; see also Fairfax County Government (n.d.).
3. Only 3 percent of blacks in Fairfax County in 2011–15 who identified as their race as black alone also identified as Hispanic.
4. Less than 1 percent of Asians and Pacific Islanders also identify as Hispanic.
5. There is more overlap between this category and the Hispanic category in Fairfax County than we find for blacks and for Asians and Pacific Islanders. About 93 percent of people identified as some other race, 43 percent of those who identified as American Indians, and 25 percent of those who identified as two or more races also identified as Hispanic.
6. Estimates have been suppressed if the coefficient of variation for the estimate is greater than 30 percent (US Census Bureau 2009).
7. Represents the living wage in 2015. See "Living Wage Calculation for Fairfax County, Virginia," Living Wage Calculator, accessed December 1, 2017, http://livingwage.mit.edu/counties/51059.
8. Earnings are discussed in the employment section. This section focuses on all income for a family. The American Community Survey tabulations do not break out income at $69,000, so we used $75,000 as the closest proxy.

References

US Census Bureau. 2009. *A Compass for Understanding and Using American Community Survey Data: What Researchers Need to Know*. Washington, DC: US Government Printing Office.

Fairfax County Government. n.d. "Fairfax County Board of Supervisors." Fairfax, VA: Fairfax County Government.

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