Before Starting the CoC Application

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

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

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

1. The FY 2023 CoC Program Competition Notice of Funding Opportunity (NOFO) for specific application and program requirements.
2. The FY 2023 CoC Application Detailed Instructions which provide additional information and guidance for completing the application.
3. All information provided to ensure it is correct and current.
4. Responses provided by project applicants in their Project Applications.
5. The application to ensure all documentation, including attachment are provided.

Your CoC Must Approve the Consolidated Application before You Submit It

- 24 CFR 578.9 requires you to compile and submit the CoC Consolidated Application for the FY 2023 CoC Program Competition on behalf of your CoC.
- 24 CFR 578.9(b) requires you to obtain approval from your CoC before you submit the Consolidated Application into e-snaps.

Answering Multi-Part Narrative Questions

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

Attachments

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

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

1A. Continuum of Care (CoC) Identification

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2023 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

1A-1. CoC Name and Number: NY-510 - Ithaca/Tompkins County CoC

1A-2. Collaborative Applicant Name: Human Services Coalition of Tompkins County, Inc.

1A-3. CoC Designation: CA

1A-4. HMIS Lead: Sarah Schutt

1B. Coordination and Engagement–Inclusive Structure and Participation

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
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- Frequently Asked Questions

1B-1.	**Inclusive Structure and Participation–Participation in Coordinated Entry.**	
	NOFO Sections V.B.1.a.(1), V.B.1.e., V.B.1f., and V.B.1.p.	

	In the chart below for the period from May 1, 2022 to April 30, 2023:
1.	**select yes or no in the chart below if the entity listed participates in CoC meetings, voted–including selecting CoC Board members, and participated in your CoC's coordinated entry system; or**
2.	**select Nonexistent if the organization does not exist in your CoC's geographic area:**

	Organization/Person	Participated in CoC Meetings	Voted, Including Electing CoC Board Members	Participated in CoC's Coordinated Entry System
1.	Affordable Housing Developer(s)	Yes	Yes	No
2.	CDBG/HOME/ESG Entitlement Jurisdiction	Yes	Yes	Yes
3.	Disability Advocates	Yes	No	Yes
4.	Disability Service Organizations	Yes	Yes	Yes
5.	EMS/Crisis Response Team(s)	Yes	No	No
6.	Homeless or Formerly Homeless Persons	Yes	Yes	Yes
7.	Hospital(s)	Yes	Yes	No
8.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	Nonexistent	No	No
9.	Law Enforcement	Yes	No	No
10.	Lesbian, Gay, Bisexual, Transgender (LGBTQ+) Advocates	Yes	Yes	Yes
11.	LGBTQ+ Service Organizations	Nonexistent	No	No
12.	Local Government Staff/Officials	Yes	Yes	No
13.	Local Jail(s)	Yes	No	Yes
14.	Mental Health Service Organizations	Yes	Yes	Yes
15.	Mental Illness Advocates	Yes	Yes	Yes

16.	Organizations led by and serving Black, Brown, Indigenous and other People of Color	Yes	Yes	Yes
17.	Organizations led by and serving LGBTQ+ persons	Yes	Yes	Yes
18.	Organizations led by and serving people with disabilities	Yes	Yes	Yes
19.	Other homeless subpopulation advocates	Yes	Yes	Yes
20.	Public Housing Authorities	Yes	Yes	Yes
21.	School Administrators/Homeless Liaisons	Yes	No	No
22.	Street Outreach Team(s)	Yes	Yes	Yes
23.	Substance Abuse Advocates	Yes	Yes	Yes
24.	Substance Abuse Service Organizations	Yes	Yes	Yes
25.	Agencies Serving Survivors of Human Trafficking	Yes	Yes	Yes
26.	Victim Service Providers	Yes	Yes	Yes
27.	Domestic Violence Advocates	Yes	Yes	Yes
28.	Other Victim Service Organizations	Yes	Yes	Yes
29.	State Domestic Violence Coalition	No	No	No
30.	State Sexual Assault Coalition	No	No	No
31.	Youth Advocates	Yes	Yes	Yes
32.	Youth Homeless Organizations	Yes	Yes	Yes
33.	Youth Service Providers	Yes	Yes	Yes
	Other: (limit 50 characters)			
34.				
35.				

By selecting "other" you must identify what "other" is.

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

	Describe in the field below how your CoC:
1.	communicated a transparent invitation process annually (e.g., communicated to the public on the CoC's website) to solicit new members to join the CoC;
2.	ensured effective communication and access for persons with disabilities, including the availability of accessible electronic formats; and
3.	invited organizations serving culturally specific communities experiencing homelessness in the geographic area to address equity (e.g., Black, Latino, Indigenous, LGBTQ+, and persons with disabilities).

(limit 2,500 characters)

1. NY-510 eagerly welcomes all individuals or agencies invested in the goal of working collaboratively to ensure homelessness is rare, brief, and one-time to join the CoC. The CoC posts an open invitation to join the CoC bi-annually. CoC staff distribute the invitation via the Human Service Coalition's website, social media, and 3000+ member human service listserv. In addition, CoC staff attend community events and meet with diverse stakeholders, including service providers, landlords, grassroots organizations, tenant advocates, local government, and private citizens. These events offer information about the purpose of the CoC and how to join. This year, our invitation to join included details about the work of the CoC, including a recorded presentation entitled "CoC 101" to be as transparent as possible about the mission and goals of the CoC.

2. All CoC communications are written in clear language with minimal jargon and in PDF or DOCX format, accessible to screen readers. CoC materials that include images are posted and shared with a full photo description. All meetings continue to be remote meetings hosted on Zoom. The Zoom meetings are close caption enabled, recorded, and transcribed to improve access to people with disabilities.

3. The CoC conducts targeted outreach at agencies such as community centers, tenant organizations, and faith-based groups to increase awareness of the available resources, education, and opportunities available through the CoC. We conduct targeted street outreach to ensure that the work of the CoC includes people experiencing homelessness and those with prior lived experience of homelessness. This year, we successfully increased CoC membership from organizations serving culturally specific communities experiencing homelessness via an increased presence at community events and presentations. The staff of the CoC has worked hard to grow our trust within historically excluded communities and has seen an increase in representation in response to these efforts. In 2023, The CoC approved our strategic plan, Home, Together Tompkins (HTT), which centered on racial equity and disability goals and metrics. CoC staff and membership were better able to promote the work of the CoC through our community conversations about HTT. In the coming year, we plan to perform a demographic survey of our CoC members to understand current gaps in representation. This outreach is ongoing and primarily deployed by CoC staff and committee chairs.

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

	Describe in the field below how your CoC:
1.	solicited and considered opinions from a broad array of organizations and individuals that have knowledge of homelessness, or an interest in preventing and ending homelessness;
2.	communicated information during public meetings or other forums your CoC uses to solicit public information;
3.	ensured effective communication and access for persons with disabilities, including the availability of accessible electronic formats; and
4.	took into consideration information gathered in public meetings or forums to address improvements or new approaches to preventing and ending homelessness.

(limit 2,500 characters)

1. The CoC solicits feedback and opinions from various stakeholders interested in preventing and ending homelessness through targeted outreach. So far, these partners include street outreach workers, city representatives, disability advocates, health providers, housing lawyers, re-entry advocates, and affordable housing providers. In 2023, we conducted a series of individual non-CoC member stakeholder meetings with people who represented a range of identities, including members of the business community, criminal justice, elected officials, first responders, and the housed neighbors to our local encampment. We convene a Youth Advisory Board (YAB) of young people aged 24 and younger with lived experience of homelessness to advise and guide projects serving youth in our CoC.
2. The CoC communicates information and gathers public feedback through direct community interaction 5x yearly via our Homeless and Housing Task Force (HHTF) meetings. These public forums feature rotating presenters who share relevant information on topics ranging from USICH principles for addressing encampments to linkages between community health and housing. The CoC also shares and gathers information via regular communications, surveys, and specific opportunities to offer feedback designed to inform the work of the CoC with an extensive network of human service providers using a local listserv, social media, and staff and member participation in other planning networks.
3. All CoC communications are written in clear language with minimal jargon and in PDF or DOCX format, accessible to screen readers. CoC materials that include images are posted and shared with a full photo description. Most meetings continue to be remote meetings hosted on Zoom. The Zoom meetings are close caption enabled, recorded, and transcribed to improve access to people with disabilities. Written materials are available upon request, and CoC staff can provide translation as needed.
4. The CoC centers information gathered at HHTF, CoC, and general public meetings to develop and implement innovative approaches to mitigate homelessness. In FY2023, our CoC approved a strategic plan, Home, Together: Tompkins (HTT), which was sourced heavily from the findings of our committees, YAB, public and member feedback, combined with HUD leading practices and the results of our recent Homeless Needs Assessment. This strategic plan was endorsed by our local government, bringing more community partners and resources to th

1B-4.	Public Notification for Proposals from Organizations Not Previously Awarded CoC Program Funding.	
	NOFO Section V.B.1.a.(4)	

	Describe in the field below how your CoC notified the public:
1.	that your CoC will consider project applications from organizations that have not previously received CoC Program funding;
2.	about how project applicants must submit their project applications–the process;
3.	about how your CoC would determine which project applications it would submit to HUD for funding; and
4.	ensured effective communication and access for persons with disabilities, including the availability of accessible electronic formats.

(limit 2,500 characters)

1. All messaging and notifications specifically encouraged new applicants to apply. CoC staff announced the competition and presented the application process to the full CoC membership. They also offered meetings with individual providers to discuss their interest in applying and the application process. Staff also presented the funding opportunity to other providers outside of CoC membership to encourage new applicants, including the Health Planning Council, Funders Collaborative, and others. An information session on August 9th was recorded and published on the Funding Competition webpage, along with all application materials.
2. All CoC messaging and public postings clearly articulated the local application process to be submitted via email to the CoC Coordinator with a due date of 08/21/2023 at 5:00 PM. The RFP included detailed instructions about the process, and communications also contained links for accessing and navigating e-snaps. CoC staff was available to interested parties to assist with technical questions about the competition process or e-snaps.
3. CoC staff publicly posted a document explaining NY-510's review process and scoring rubrics for new and renewal applications in the competition announcement. This announcement also included a list of categories used to score projects, including system performance, HUD best practices, agency experience, a commitment to Housing First, and serving intersectional identities. The rubrics for both new and renewal projects explained how the committee would score responses to each question and the weight of each question towards the overall project score. Our rank and review process document described how these scores would be ranked and submitted to HUD in a priority listing along with the collaborative application to designate our funding priorities. This announcement provided the notification timeline and when applicants could expect to hear back about the status of their project application.
4. The CoC effectively communicates with individuals with disabilities via photo descriptions, communications accessible to screen readers, and clear, easy-to-read language. Paper versions of all application materials are available via fax, mail, or by picking them up at our centrally located physical office. CoC staff hosted presentations regarding the funding opportunity via Zoom with close captions enabled and audio/video recorded and transcribed to improve access to people with certain disabilities.

1C. Coordination and Engagement

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
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- FY 2023 CoC Application Navigational Guide;
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- PHA Crosswalk; and
- Frequently Asked Questions

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

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

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

18.		

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

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

(limit 2,500 characters)

1. The CoC consults with our local Department of Social Services (DSS) yearly to allocate Solutions to End Homelessness Program (STEHP) funds in our county via ESG funding allocated to the Office of Temporary Disability Assistance. While Tompkins County does not have an ESG entitlement, CoC leadership was a critical partner in planning Tompkins County's ESG-CV allocation from OTDA along with DSS, City and County government, and the Health Department. The CoC provided data, including racial equity data, and shared our written standards. The CoC is eager to establish a direct relationship with the NYS ESG recipient to better participate in planning for our local uses.

2. HSC is the local system administrator for HMIS and monitors ESG-CV data monthly. HSC also assists ESG-CV recipients with correcting errors and data entry support. United Way of Central New York is our HMIS lead agency and submits our Capers to SAGE. The HMIS lead has submitted all Capers on time.

3. The CoC publicly posts our annual Point in Time Count and Housing Inventory Count data on our website and sends them directly to the Ithaca Urban Renewal Agency (IURA). This agency acts as the local entity responsible for the Consolidated Plan and serves as co-chair of the CoC Governance Committee.

4. The CoC provided all information requested for the Consolidated Plan, including de-identified data sourced from HMIS and CAPER reports.

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

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

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

1C-4.	CoC Collaboration Related to Children and Youth–SEAs, LEAs, School Districts.	
	NOFO Section V.B.1.d.	

Select yes or no in the chart below to indicate the entities your CoC collaborates with:

1.	Youth Education Provider	Yes
2.	State Education Agency (SEA)	Yes
3.	Local Education Agency (LEA)	Yes
4.	School Districts	Yes

1C-4a.	Formal Partnerships with Youth Education Providers, SEAs, LEAs, School Districts.	
	NOFO Section V.B.1.d.	

Describe in the field below the formal partnerships your CoC has with at least one of the entities where you responded yes in question 1C-4.

(limit 2,500 characters)

1. The CoC works directly with the McKinney Vento school representative to identify and work with homeless families with children. The CoC also works directly with education providers through active members, including Tompkins County Youth Services, which meets regularly with all school districts in our area, and Village at Ithaca, whose mission is to work with Families in the Ithaca City School District. These education providers and the Learning Web, an agency that provides living skills and employment training to youth aging out of foster care, are all formal members of our Continuum of Care. Our McKinney Vento representative is available for consultations on assisting families experiencing homelessness. The Learning Web provides supportive transitional housing for youth through Coordinated Entry. Village at Ithaca tutors students and supports families navigating the educational system.

Most recently, all of the partners listed above have been working closely with us through our YHDP process, and both Village at Ithaca and Learning Web have successfully received funding for new TH and PSH projects. HSC has formed a close, formal partnership with these youth-serving agencies focused on centering educational opportunities and life skills for housing unstable youth as the collaborative applicant and otherwise supportive agency guiding them through the YHDP process. This process has also brought additional partners, including Ithaca City School District representatives, SEAs, and LEAs, who were involved in developing our YHDP process. The renewed charge of our Youth Homelessness Committee has allowed us to re-engage these partners in achieving some of the education and employment goals that our Youth Action Board set in their CCP.

Our site-based permanent supportive housing projects implement Early Head Start and Head Start Programs serving pregnant moms through kindergarten. Any family experiencing homelessness is categorically eligible for Head Start Programming. The program is designed to enhance children's physical, social, emotional, and intellectual development, assist pregnant women in accessing comprehensive care, support parents as their child's first teacher, and help families achieve self-sufficiency. Family involvement, developmental assessments, individualized planning, healthy meals and access to formula and diapers, and parent/teacher partnerships further enhance all children's success.

1C-4b.	**Informing Individuals and Families Experiencing Homelessness about Eligibility for Educational Services.**	
	NOFO Section V.B.1.d.	

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

(limit 2,500 characters)

1. Beginning in 2019, the CoC included a policy in its written standards that CoC-funded agencies will institute a policy and procedure to inform project participants of their rights and eligibility for education services. Our written standards have not only required this policy but also created minimum standards for case management services in our community to provide access to education.

Our strength as a CoC lies in collaborating across providers and agencies to achieve the ambitious and disruptive goals outlined in our written standards and other community planning. Using this strength, we have also emphasized the importance of access to education within our CoC-funded projects for non-school-aged adults. This push to increase access to education has resulted in collaboration with our local community college to host information sessions and help participants achieve their educational goals, whether completing GRE requirements, engaging with a technical program, or graduating from college.

Our CoC has adopted additional written materials within the past funding year to advocate for accessible educational programming for housing-insecure community members. Most recently, our YAB published our county's Coordinated Community Plan (CCP) for ending youth homelessness, with an ambitious action plan that advocates for lowering educational barriers experienced by our school-aged youth. Through our youth homelessness committee, we plan to build support services for the needs listed, such as equitable access to online schooling, flexibility in avenues for completing school work, and safe education environments for housing-insecure, LGBTQ+, and BIPOC youth. While solely informing participants of available resources may seem sufficient, we are committed to addressing the systemic barriers our YAB has identified in the CCP.

Our permanent supportive housing projects include Head Start Program enrollment during lease-up activities. The programs are optional, and if the family selects the center-based program option, supportive housing project staff help provide transportation to activities related to the program.

1C-4c.	**Written/Formal Agreements or Partnerships with Early Childhood Services Providers.**	
	NOFO Section V.B.1.d.	

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

		MOU/MOA	Other Formal Agreement
1.	**Birth to 3 years**	No	No
2.	**Child Care and Development Fund**	No	No
3.	**Early Childhood Providers**	Yes	Yes
4.	**Early Head Start**	Yes	Yes
5.	**Federal Home Visiting Program–(including Maternal, Infant and Early Childhood Home and Visiting or MIECHV)**	No	Yes
6.	**Head Start**	Yes	Yes
7.	**Healthy Start**	Yes	Yes

8.	Public Pre-K	No	No
9.	Tribal Home Visiting Program	No	No
	Other (limit 150 characters)		
10.			

1C-5.	Addressing Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors–Collaboration with Federally Funded Programs and Victim Service Providers.
	NOFO Section V.B.1.e.

In the chart below select yes or no for the organizations your CoC collaborates with:

	Organizations	
1.	state domestic violence coalitions	No
2.	state sexual assault coalitions	No
3.	other organizations that help this population	Yes

1C-5a.	Collaboration with Federally Funded Programs and Victim Service Providers to Address Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors.	
	NOFO Section V.B.1.e.	

	Describe in the field below how your CoC regularly collaborates with organizations indicated in Question 1C-5 to:
1.	update CoC-wide policies; and
2.	ensure all housing and services provided in the CoC's geographic area are trauma-informed and can meet the needs of survivors.

(limit 2,500 characters)

1. Our CoC collaborates with our local victim service provider, The Advocacy Center, to update our CoC-wide policies through individual meetings, inclusion in working groups, and intentional inclusion in CoC procedures. The Advocacy Center is a voting member of our CoC membership dedicated to supporting and advocating for Tompkins County survivors. They actively participate in our ESSHI committee to provide feedback and expertise in the real-time planning of new projects and housing units. The Advocacy Center also regularly engages with CoC staff in one-on-one meetings to discuss trends and opportunities to improve service delivery for people in their programs. Otherwise, our victim service provider sits on our street outreach committee and regularly attends full CoC meetings for long-term organization and planning for CoC-wide policies. Although we engaged The Advocacy Center in applying for DV bonus funds for this funding competition, we did not receive an application for bonus funds this round. Our goal for the future is to integrate a representative from The Advocacy Center into our CoC Governance and continue to work closely to support our local victim service provider in applying for available funding in FY2024.

2. We take pride in our CoC's ability to collaborate and facilitate connections across the continuum. This year, our CoC membership received training and consultation from our local victim services provider that has helped inform policies and procedures across our CoC, especially for the safety and planning needs of youth in our system. We also facilitated a connection between our CoC-funded PSH provider and our local victim service provider to implement a lower barrier process for survivors of domestic violence and provide training regarding trauma-informed care and mental health first aid. Some additional needs identified and served through collaboration with our PSH in FY2023 included classes that support daily living skills for residents, including a parenting class series and ongoing cooking classes, information sessions for local programs, including a college-prep program that ultimately resulted in eight residents engaging with coursework, and on-site mental health services, through 1:1 or group therapy sessions.

1C-5b.	**Coordinated Annual Training on Best Practices to Address the Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors.**	
	NOFO Section V.B.1.e.	

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

(limit 2,500 characters)

1. Our CoC coordinates to provide training and resources for best practices in serving survivors through CoC-sponsored training, collaboration with our victim services provider, and sharing resources for ad-hoc webinars available through other, larger agencies and institutions (e.g., HUD, NAEH, HomeBase). We conduct an annual DV training for full CoC membership and support staff. We refer any new projects to consult with our victim services provider for feedback and planning surrounding safety issues and other structures that will allow for a trauma-informed living space. The Advocacy Center provides training on trauma-informed response to domestic and sexual violence victims, identifying and responding to victims, safety planning, making effective referrals to victim services, impact on children, and other related topics. This relationship typically includes monthly meetings and occasional follow-ups for specific incidents or concerns. CoC staff pass along ad hoc training and webinars to staff through email- these focus on best practices for special populations and have traditionally included topics such as how to integrate trauma-informed care into case management.

2. The Advocacy Center has been integral in developing and implementing our Coordinated Entry process. Although the CoC utilizes a No Wrong Door approach, providers immediately refer persons who identify as fleeing or seeking to flee domestic violence to the Advocacy Center for assessment and access to additional resources. The Coordinated Entry lead incorporates a trauma-informed response to domestic and sexual violence and safety planning in training for all agencies participating in the Coordinated Entry process. The Advocacy Center participates in annual Coordinated Entry training that includes best practices for making effective referrals for survivors of domestic violence. At monthly Coordinated Entry list review meetings, participating agencies can discuss clients who identify as victims/survivors and coordinate with the Advocacy Center to determine the best housing and resource options, as long as clients have proper releases on file. Monthly Coordinated Entry meetings also allow the Coordinated Entry lead to improve processes based on provider feedback, including safety planning and effective referrals for DV victims.

1C-5c.	**Implemented Safety Planning, Confidentiality Protocols in Your CoC's Coordinated Entry to Address the Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors.**	
	NOFO Section V.B.1.e.	

	Describe in the field below how your CoC's coordinated entry includes:
1.	**safety planning protocols; and**
2.	**confidentiality protocols.**

(limit 2,500 characters)

1. The Coordinated Entry process offers a separate intake for survivors in our continuum that does not require personal contact or location information for a coordinated entry referral. Housing providers refer to households with a unique number ID provided to victim service provider staff to connect with the individual or family. This process helps to keep the survivor anonymous in the referral process and their location confidential while granting them access to the supportive services available in our CoC. Our planning protocols address the housing needs of survivors without forgoing confidentiality and safety in the process. This intake collects information relevant to the referral in broad categories (e.g., age range instead of actual age, unit size instead of household size) and allows us to screen for eligibility without describing specific characteristics of the household itself. Households are assigned a numeric ID and referred to using this ID throughout the referral process.

2. Our victim service provider uses a confidential, comparable database to our HMIS to collect required information without sharing it with other providers in our system. In addition, the location of our local DV shelter is confidential, and exit destinations for survivors are kept in our victim service provider's database to maintain confidentiality and safety. While our planning protocols take steps to de-identify information relevant to referrals as much as possible, our Coordinated Entry process allows survivors to refuse any responses they are uncomfortable providing. Households that decline to provide certain information can still be referred to project openings, allowing for confidentiality in their intake.

1C-5d.	**Used De-identified Aggregate Data to Address the Needs of Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors.**	
	NOFO Section V.B.1.e.	

	Describe in the field below:
1.	**the de-identified aggregate data source(s) your CoC used for data on survivors of domestic violence, dating violence, sexual assault, and stalking; and**
2.	**how your CoC uses the de-identified aggregate data described in element 1 of this question to evaluate how to best meet the specialized needs related to domestic violence and homelessness.**

(limit 2,500 characters)

1. Our CoC uses HMIS data, Coordinated Entry data, and data from our local victim service provider, the Advocacy Center, to inform best practices in our CoC. Our HMIS intake for our supportive housing projects and emergency shelter includes three questions about experiences of domestic violence: whether an experience has occurred, how recently that experience occurred, and whether or not that individual is currently fleeing violence. This real-time data helps us understand the demographics, trends, and needs of survivors in our community. Our coordinated entry pre-screening questionnaire also collects this information to understand which referrals are best utilized by survivors in our community. The Advocacy Center is a stakeholder in our CoC with a mission of providing support, advocacy, and education for survivors, friends, and families of domestic violence and sexual assault in Tompkins County. The Advocacy Center has an internal database for tracking interactions with survivors and stays in their emergency beds. It shares de-identified aggregate data from those interactions to advise our supportive housing and coordinated entry practices.

2. Our CoC uses HMIS data, Coordinated Entry data, and data from our local victim service provider, the Advocacy Center, to inform best practices in our CoC. Our HMIS intake for our supportive housing projects and emergency shelter includes three questions about experiences of domestic violence:
Whether an experience has occurred.
How recently that experience occurred.
Whether or not that individual is currently fleeing violence.

This real-time data helps us understand the demographics, trends, and needs of survivors in our community. Our coordinated entry pre-screening questionnaire also collects this information to understand which referrals are best utilized by survivors in our community. The Advocacy Center is a stakeholder in our CoC with a mission of providing support, advocacy, and education for survivors, friends, and families of domestic violence and sexual assault in Tompkins County. The Advocacy Center has an internal database for tracking interactions with survivors and stays in their emergency beds. It shares de-identified aggregate data from those interactions to advise our supportive housing and coordinated entry practices.

1C-5e.	Implemented Emergency Transfer Plan Policies and Procedures for Domestic Violence, Dating Violence, Sexual Assault, and Stalking Survivors.	
	NOFO Section V.B.1.e.	

	Describe in the field below how your CoC communicates to all individuals and families seeking or receiving CoC Program assistance:
1.	whether your CoC has policies and procedures that include an emergency transfer plan;
2.	the process for individuals and families to request an emergency transfer; and
3.	the process your CoC uses to respond to individuals' and families' emergency transfer requests.

(limit 2,500 characters)

1. The CoC's Emergency Transfer plan is included in our contracts with funded agencies. All projects in our CoC are required to provide emergency transfer information at program admission. During admission, project participants sign a certification that they have received the emergency transfer information, which the project provider keeps on file. After admission, providers include new updates regarding emergency transfer policy and VAWA protections at annual recertification. Our CoC monitors compliance with this requirement as a part of our annual site visit document review. This certification and other intake documents, such as leases and other rental agreements, are also reviewed to ensure housing providers include VAWA protections and instructions in clear and plain language for program participants. The CoC provides annual required DV response training to CoC membership agencies. Our local victim services agency tailors the training specifically to cover the intersection of homelessness and domestic violence. The training also includes detailed information about the rights afforded to people in supported and subsidized housing to access VAWA protections.

2. Households are instructed to request an emergency transfer directly from their housing program provider. The program provider collects basic details of the request and may ask for the household to certify in writing their request.

3. While the provider processes the emergency transfer request, the client can participate in a confidential referral process through Coordinated Entry. If they are interested, the CE lead prioritized the household through the confidential DV coordinated entry process for an alternative housing option. The housing provider also refers the household to our victim service provider for additional support in finding alternative housing outside of CoC-funded projects or placement in one of their emergency shelter beds.

1C-5f.	**Access to Housing for Survivors of Domestic Violence, Dating Violence, Sexual Assault, and Stalking.**	
	NOFO Section V.B.1.e.	

	Describe in the field below how your CoC:
1.	**ensures that survivors of domestic violence, dating violence, sexual assault, or stalking have safe access to all of the housing and services available within the CoC's geographic area; and**
2.	**proactively identifies systemic barriers within your homeless response system that create barriers to safely house and provide services to survivors of domestic violence, dating violence, sexual assault, or stalking.**

(limit 2,500 characters)

1. Our CoC has worked closely with our local victim services organization, the Advocacy Center, to develop a de-identified Coordinated Entry process for all survivors seeking access to supportive housing and services in our county. Our providers inform every individual who signifies that they have had an experience of domestic violence of their option to complete the de-identified Coordinated Entry process with the Advocacy Center instead of the standard intake. Even when consumers provide de-identified information, the intake for this process includes questions that pre-screen for eligibility to minimize the time and frustration consumers in crisis may face when trying to access services. In this way, our CoC ensures that survivors of domestic violence, dating violence, sexual assault, or stalking have a safe and confidential process to access all housing and services available within our county through Coordinated Entry. Case conferencing during list reviews has been an essential tool for our CoC. As we move into FY2023, we plan to include these households in our monthly coordinated entry list review without presenting any threats to the households' safety or confidentiality in the process.

2. NY-510 works closely with our victim services provider to identify gaps in the services provided and the unique needs of survivors experiencing homelessness. Currently, identified barriers to emergency shelter and support provided by our local victim services provider include sobriety requirements and mandated reporter status of the services offered.
This year, CoC staff scheduled a follow-up meeting to our annual CoC-wide domestic violence training to discuss systemic barriers within the homeless response system. This meeting prompted discussion and consultation with our emergency shelter provider to discuss designing the space and services provided to improve safety following reports of women alleging occurrences of domestic violence, dating violence, sexual assault, and stalking while in the emergency shelter.
Our local victim services provider is also a member of our ESSHI workgroup, which meets regularly to discuss services and housing provided to residents housed under ESSHI-funded Permanent Supportive Housing. Our regular meetings with this workgroup allow us to continue identifying systemic barriers to keeping survivors of domestic violence housed. The group also allows us to collaboratively develop creative ways to respond to identified barriers.

1C-5g.	Ensuring Survivors With a Range of Lived Expertise Participate in Developing CoC-Wide Policy and Programs.	
	NOFO Section V.B.1.e.	

	Describe in the field below how your CoC:
1.	ensured survivors with a range of lived expertise are involved in the development of your CoC-wide policy and programs; and
2.	accounted for the unique and complex needs of survivors.

(limit 2,500 characters)

1. While the CoC did not have sufficient planning funds available in FY2022 to support a formal paid board structure for people with lived expertise of homelessness and domestic violence, many of the people who have professional roles in our Continuum of Care also have lived expertise of domestic violence, dating violence, sexual assault, and stalking. CoC staff establish group norms in each of our committees to encourage CoC members to incorporate their own lived experiences and the experiences of the people they serve in our committees and other working spaces in the Continuum of Care.

With FY2023 planning funds, our CoC will engage individuals with lived expertise of domestic violence and homelessness by advertising the group through community listservs, social media, and the lead agency website. Staff will share posters with service providers and emergency shelter staff. We will engage our service providers to offer the opportunity to the people they serve who might be interested.

The CoC will identify a chair of the lived experience board to occupy a seat on our governance committee. The board will identify gaps and barriers for individuals with intersecting experiences of homelessness and domestic violence in our system. Staff will support board members with cash compensation, professional development, and support services (child care, technology, transportation, and linkages to community resources) as needed.

2. The CoC did not have enough planning funds in FY2022 to support a formal board structure for people with lived expertise in homelessness and domestic violence. When the funds are available in FY2023, the project manager will ensure confidentiality for participants by allowing them to pick chosen names for engagement with the project. Meetings will be held virtually over Zoom, supporting individuals to access private meeting spaces and computers for this time. Turning on cameras will be optional for meetings, and individuals will refer to each other with their chosen names. Information required for direct cash transfers would be confidential and only utilized as needed for individuals to receive payment through the program. While there will be an appointed chair of the board, individuals will be encouraged to connect with the project manager for any structural questions regarding their participation in the program as opposed to an internal governance structure to maintain their confidentiality.

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

1.	Did your CoC implement a written CoC-wide anti-discrimination policy ensuring that LGBTQ+ individuals and families receive supportive services, shelter, and housing free from discrimination?	Yes
2.	Did your CoC conduct annual CoC-wide training with providers on how to effectively implement the Equal Access to Housing in HUD Programs Regardless of Sexual Orientation or Gender Identity (Equal Access Final Rule)?	Yes
3.	Did your CoC conduct annual CoC-wide training with providers on how to effectively implement Equal Access in Accordance With an Individual's Gender Identity in Community Planning and Development Programs (Gender Identity Final Rule)?	No

1C-6a.	Anti-Discrimination Policy–Updating Policies–Assisting Providers–Evaluating Compliance–Addressing Noncompliance.	
	NOFO Section V.B.1.f.	

	Describe in the field below:
1.	how your CoC regularly collaborates with LGBTQ+ and other organizations to update its CoC-wide anti-discrimination policy, as necessary to ensure all housing and services provided in the CoC are trauma-informed and able to meet the needs of LGBTQ+ individuals and families;
2.	how your CoC assisted housing and services providers in developing project-level anti-discrimination policies that are consistent with the CoC-wide anti-discrimination policy;
3.	your CoC's process for evaluating compliance with your CoC's anti-discrimination policies; and
4.	your CoC's process for addressing noncompliance with your CoC's anti-discrimination policies.

(limit 2,500 characters)

1. Tompkins County lacks a primary organization to serve and support the needs of LGBTQ+ individuals. In place of this, we regularly engage our paid Youth Action Board (YAB), which primarily consists of peers who identify as LGBTQ+, to review and approve our anti-discrimination policy as described in our Written Standards. We also engage with YAB members through our Youth Homelessness Committee about the experiences of LGBTQ+ individuals in our Homeless Response System and how we can provide more trauma-informed services to people with intersecting identities in our service area.

In FY2023, the Continuum of Care plans to engage a consultant to review written materials and reach out to organizations that provide affirmative care to individuals who identify as LGBTQ+.

2. NY-510 monitors funded projects annually and includes a full review of agency policy and procedures, including anti-discrimination policies. Our policy reviews measure partner alignment with the CoC's anti-discrimination policy with an eye for clear language about the steps a person can take if they feel their rights have been violated. In addition, the CoC provides multiple opportunities for people experiencing homelessness to share their experiences with us, including their experiences with discrimination.

3. NY-510 monitors funded projects annually and include a full review of agency policy and procedures, including anti-discrimination policies. Our policy reviews measure partner alignment with the CoC's anti-discrimination policy with an eye for clear language about the steps a person can take if they feel their rights have been violated. In addition, the CoC provides multiple opportunities for people experiencing homelessness to share their experiences with us, including their experiences with discrimination.

4. The CoC uses a progressive engagement model for addressing non-compliance. Depending on the nature and details of the non-compliance, the CoC would attempt to correct the issue by facilitating training and resources, keeping records of the problem, and making corrections. If an agency remains out of compliance, it could be at risk of reallocation in future competitions.

1C-7.	Public Housing Agencies within Your CoC's Geographic Area–New Admissions–General/Limited Preference–Moving On Strategy.	
	NOFO Section V.B.1.g.	

You must upload the PHA Homeless Preference\PHA Moving On Preference attachment(s) to the 4B. Attachments Screen.
Enter information in the chart below for the two largest PHAs highlighted in gray on the current CoC-PHA Crosswalk Report or the two PHAs your CoC has a working relationship with–if there is only one PHA in your CoC's geographic area, provide information on the one:

Public Housing Agency Name	Enter the Percent of New Admissions into Public Housing and Housing Choice Voucher Program During FY 2022 who were experiencing homelessness at entry	Does the PHA have a General or Limited Homeless Preference?	Does the PHA have a Preference for current PSH program participants no longer needing intensive supportive services, e.g., Moving On?
Ithaca Housing Authority	24%	No	No
Tompkins Community Action (HCR)	39%	Yes-HCV	Yes

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

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

(limit 2,500 characters)

1. TCAction is the Local Administrator for the NYS Housing Trust Housing Choice Voucher Program and the primary provider of Head Start, Permanent Supportive Housing, and Tenant Based Rental Assistance in the CoC. In 2020, TCAction adopted a general homeless preference for applicants experiencing homelessness. This preference measurably changed the HCV waitlist lengths and increased exits to permanent destinations for participants. Ithaca Housing Authority is also a CoC member and valued partner. While they have not yet adopted a general homeless preference for their Public Housing units or HCVs, they maintain MOUs with the CoC for referrals from CE to the Family Unification Program and Emergency Housing Voucher programs. The CoC sends yearly emails to IHA to advocate for their adoption of a general homeless preference and sent one of these emails during FY2022. Although the IHA has not formally adopted a homeless preference, they regularly serve people experiencing homelessness and maintain a limited homeless preference for their EHV and FUP programs. The CoC will continue communicating with leadership at IHA to add a general homeless preference.

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

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

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

1C-7c.	Include Units from PHA Administered Programs in Your CoC's Coordinated Entry.	
	NOFO Section V.B.1.g.	

In the chart below, indicate if your CoC includes units from the following PHA programs in your CoC's coordinated entry process:

1.	Emergency Housing Vouchers (EHV)	Yes
2.	Family Unification Program (FUP)	Yes
3.	Housing Choice Voucher (HCV)	No
4.	HUD-Veterans Affairs Supportive Housing (HUD-VASH)	Yes
5.	Mainstream Vouchers	Yes
6.	Non-Elderly Disabled (NED) Vouchers	No
7.	Public Housing	No
8.	Other Units from PHAs:	

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

1.	Did your CoC coordinate with a PHA(s) to submit a competitive joint application(s) for funding or jointly implement a competitive project serving individuals or families experiencing homelessness (e.g., applications for mainstream vouchers, Family Unification Program (FUP), other programs)?	Yes
		Program Funding Source
2.	Enter the type of competitive project your CoC coordinated with a PHA(s) to submit a joint application for or jointly implement.	FUP

1C-7e.	Coordinating with PHA(s) to Apply for or Implement HCV Dedicated to Homelessness Including Emergency Housing Voucher (EHV).	
	NOFO Section V.B.1.g.	

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

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

	Does your CoC have an active Memorandum of Understanding (MOU) with any PHA to administer the EHV Program?	Yes
	If you select yes to question 1C-7e.1., you must use the list feature below to enter the name of every PHA your CoC has an active MOU with to administer the Emergency Housing Voucher Program.	

PHA
Ithaca Housing Au...
Homes and Communi...

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

Name of PHA: Ithaca Housing Authority

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

Name of PHA: Homes and Community Renewal

1D. Coordination and Engagement Cont'd

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2023 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

1D-1.	Discharge Planning Coordination.	
	NOFO Section V.B.1.h.	

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

1. Foster Care	Yes
2. Health Care	Yes
3. Mental Health Care	Yes
4. Correctional Facilities	No

1D-2.	Housing First–Lowering Barriers to Entry.	
	NOFO Section V.B.1.i.	

1.	Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe Haven, and Transitional Housing projects your CoC is applying for in FY 2023 CoC Program Competition.	8
2.	Enter the total number of new and renewal CoC Program-funded PSH, RRH, SSO non-coordinated entry, Safe Haven, and Transitional Housing projects your CoC is applying for in FY 2023 CoC Program Competition that have adopted the Housing First approach.	8
3.	This number is a calculation of the percentage of new and renewal PSH, RRH, SSO non-Coordinated Entry, Safe Haven, and Transitional Housing projects the CoC has ranked in its CoC Priority Listing in the FY 2023 CoC Program Competition that reported that they are lowering barriers to entry and prioritizing rapid placement and stabilization to permanent housing.	100%

1D-2a.	Project Evaluation for Housing First Compliance.	
	NOFO Section V.B.1.i.	

You must upload the Housing First Evaluation attachment to the 4B. Attachments Screen.

	Describe in the field below:
1.	how your CoC evaluates every project–where the applicant checks Housing First on their project application–to determine if they are using a Housing First approach;
2.	the list of factors and performance indicators your CoC uses during its evaluation; and
3.	how your CoC regularly evaluates projects outside of your local CoC competition to ensure the projects are using a Housing First approach.

(limit 2,500 characters)

1. The NY-510 CoC evaluates every recipient biannually using the Housing First assessment designed by HUD to determine if CoC-funded projects have integrity towards using a Housing First approach. This tool allows us to record whether a program is saying, doing, and documenting critical tenents of Housing First to assess overall fidelity to the philosophy. It also generates a score that we can use to compare subsequent assessments to determine if the project is improving, stagnating, or moving in a negative direction from its baseline score. The assessment meeting also acts as a helpful check-in to better understand participant feedback and how the project can integrate that feedback into program design.

2. The tool assesses factors such as low-barrier access, person-centered approach, expedited processes, coordinated entry participation, moving on plans, participant input, tenant rights, participant choice, participant education in their rights and housing first, responsive rent payment policies, continuity of services across any institutionalization or other transitions, culturally appropriate resources, staff training in both clinical and non-clinical strategies (e.g., harm reduction, motivational interviewing, trauma-informed approaches, strength-based approaches), harm reduction approaches to substance use in the unit, emergency transfer options, and other project specific questions depending on the structure of the program (e.g. RRH or TH-RRH) or the service of a particular subpopulation (e.g. persons in recovery).

3. The CoC uses data to track participant outcomes quarterly. If data about participant retention or exits to permanent destinations worsen, CoC staff will check in with the project. If the project provider raises concerns about Housing First principles, staff will support with resources, committee work, or consultation to ensure that participant outcomes improve. CoC staff conducts the Housing First assessment biannually, once during the funding competition and again six months later, to assess project improvement and maintenance of Housing First principles.

1D-3.	Street Outreach–Scope.	
	NOFO Section V.B.1.j.	

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

(limit 2,500 characters)

1. The CoC's Enhanced Street Outreach Committee members engage with all people experiencing homelessness through regular, sustained, and compassionate contact that prioritizes dignity. Street Outreach staff spend significant time on foot in the local encampment spaces and other places people congregate, emphasizing relationship building and vital needs, including food, water, tents, COVID testing, and vaccines. The team is comprised of staff at a range of agencies. It offers coordinated entry screening, harm reduction services, sanitation, and transportation without requiring enrollment in specific programming or other restrictions. By following these best practices, the team has earned high trust within the community, including both people experiencing homelessness and providers.

2. The CoC Street Outreach team covers 100% of the CoC's geographic area, emphasizing the encampment spaces and the downtown urban core. Beginning in 2022, Family and Children's Services (F&CS), a mental health providing agency funded through local City, County, and Private sources, added two additional rural community outreach workers to their staff. This expansion allows the rural areas surrounding the City of Ithaca to have significantly more access to high-quality street outreach services. It also helps NY-510 grow our knowledge about people experiencing homelessness in our rural areas.

3. The Enhanced Street Outreach team conducts outreach seven days a week, including evening and holiday hours. In addition, street Outreach staff are on call to respond quickly to emergent issues during non-business hours.

4. Street Outreach providers are well known to service providers and individuals experiencing homelessness in our area. The team uses word of mouth, visibility within the community, networking, and social media to reach people least likely to request assistance and those not currently connected to services. Members of the Street Outreach Committee have recent lived experiences, and those experiences have helped inform the Street Outreach's commitment to trauma-informed care tenets and harm reduction. The team "meets people where they are" and serves people without preconditions. The people they serve aren't required to fill out any paperwork, disclose identifying information, or participate in specific programs to receive services. These policies foster genuine trust across communities and increase engagement from people less likely to seek services.

1D-4.	**Strategies to Prevent Criminalization of Homelessness.**	
	NOFO Section V.B.1.k.	

Select yes or no in the chart below to indicate strategies your CoC implemented to ensure homelessness is not criminalized and to reverse existing criminalization policies in your CoC's geographic area:

	Your CoC's Strategies	Ensure Homelessness is not Criminalized	Reverse Existing Criminalization Policies
1.	**Engaged/educated local policymakers**	Yes	Yes
2.	**Engaged/educated law enforcement**	Yes	Yes

3.	Engaged/educated local business leaders	Yes	Yes
4.	Implemented community wide plans	Yes	Yes
5.	Other:(limit 500 characters)		
	Engaged media	Yes	No

1D-5.	Rapid Rehousing–RRH Beds as Reported in the Housing Inventory Count (HIC) or Longitudinal Data from HMIS.	
	NOFO Section V.B.1.l.	

		HIC Longitudinal HMIS Data	2022	2023
	Enter the total number of RRH beds available to serve all populations as reported in the HIC or the number of households served per longitudinal HMIS data, e.g., APR.	Longitudinal HMIS Data	79	89

1D-6.	Mainstream Benefits–CoC Annual Training of Project Staff.	
	NOFO Section V.B.1.m.	

Indicate in the chart below whether your CoC trains program staff annually on the following mainstream benefits available for program participants within your CoC's geographic area:

	Mainstream Benefits	CoC Provides Annual Training?
1.	Food Stamps	Yes
2.	SSI–Supplemental Security Income	Yes
3.	SSDI–Social Security Disability Insurance	Yes
4.	TANF–Temporary Assistance for Needy Families	Yes
5.	Substance Use Disorder Programs	Yes
6.	Employment Assistance Programs	Yes
7.	Other (limit 150 characters)	
	Fair Housing Rights and Programs	Yes

1D-6a.	Information and Training on Mainstream Benefits and Other Assistance.	
	NOFO Section V.B.1.m	

	Describe in the field below how your CoC:
1.	systemically provides up-to-date information on mainstream resources available for program participants (e.g., Food Stamps, SSI, SSDI, TANF, substance abuse programs) within your CoC's geographic area;
2.	works with project staff to collaborate with healthcare organizations, including substance abuse treatment and mental health treatment, to assist program participants with receiving healthcare services; and
3.	works with projects to promote SSI/SSDI Outreach, Access, and Recovery (SOAR) certification of program staff.

(limit 2,500 characters)

1. This year, our CoC is working collaboratively with our local DSS to provide eligibility training regarding access to critical mainstream benefits such as Food Stamps, TANF, and THA to coordinated entry providers. The Director of Eligibility of our local DSS hosted training on July 14th, 2023, which gave a basic understanding of OTDA requirements for DSS as a subrecipient and best practices for navigating access to resources. Attendees could ask questions and take notes to serve their clients better.
The CoC reserves time in all membership and public meetings for providers to share information and updates about available mainstream benefits. These meetings are well attended by front-line staff and leadership across the non-profit, government, and private sectors. The CoC collaborative applicant, Human Services Coalition, hosts our local 2.1.1. information and referral line. This relationship has allowed the CoC to quickly and effectively share communitywide information about available mainstream resources. The CoC extends an open invitation to providers wishing to present information about their programs in our monthly meetings. Our local DSS reports and makes announcements at all CoC and HHTF meetings.

2. NY-510 includes membership from all local SUD providers, Tompkins County Mental Health, and a local harm-reduction healthcare practice, REACH Medical. A SUD provider serves on our governance committee. As community planners, CoC staff regularly participate in cross-sector collaboration and resource allocation work with health and behavioral health providers. The CoC's role in these projects includes providing aggregate data about people experiencing homelessness' health and mental health conditions. This relationship allows the CoC to advocate for the data-supported needs of unhoused people seeking services. Recent collaborations have resulted in increased access to affirming and low-stigma healthcare. In 2023, our Health and Housing workgroup has continued planning to connect our project providers with healthcare providers, resulting in on-site SUD and behavioral health services available at least twice monthly to people in all of our CoC-funded projects.

3. The CoC consistently promotes SOAR training and certification by regularly sharing information about how to become SOAR-trained and the benefits of having a SOAR-trained staff member. The CoC has also regularly invited people to participate in SOAR Works- webinars.

1D-7.	Increasing Capacity for Non-Congregate Sheltering.	
	NOFO Section V.B.1.n.	

Describe in the field below how your CoC is increasing its capacity to provide non-congregate sheltering.

(limit 2,500 characters)

1. Since the onset of the pandemic, NY-510 has significantly reduced the number of people who stay in the 20-bed congregate shelter by utilizing motel rooms for people experiencing homelessness by an average of 40% night by night. During the ESG-CV planning process, the CoC advocated increasing funding for non-congregate shelters to ensure appropriate non-congregate spaces were available to people experiencing COVID-19 symptoms.

Among the key findings of the CoC's 2021 Homeless and Housing Needs Assessment was that our community would benefit from expanding our emergency shelter both in their capacity to serve people with non-congregate shelter beds and to expand their eligibility to include people with severe service needs. The CoC asserts that capacity consists of more than just the type or quantity of non-congregate shelter sites and the quality of services people in non-congregate sites can access from staff. Because of this, the CoC is working to support the capacity of our shelter and other service providers to serve stayers in motel sites with needed services. In 2023, the CoC approved our strategic plan, which includes a strategy to lower the threshold for people to enter our emergency shelter system and promote non-congregate sheltering.

In New York State, there is a mandate known as "Cold Weather Policy" or "Code Blue", which states that all persons have a right to emergency shelter on nights when the temperature is 32 degrees or colder (including windchill). Before 2020, individuals and families who entered shelters using "Code Blue" were sheltered in temporary, congregate settings such as local churches and community centers. Since 2020, people have been primarily provided shelter accommodation at motels. The use of motel sites has proven to be an essential public health measure. It has effectively limited the spread of infectious diseases among people experiencing homelessness.

ID-8.	Partnerships with Public Health Agencies–Collaborating to Respond to and Prevent Spread of Infectious Diseases.	
	NOFO Section V.B.1.o.	

	Describe in the field below how your CoC effectively collaborates with state and local public health agencies to:
1.	develop CoC-wide policies and procedures to respond to infectious disease outbreaks; and
2.	prevent infectious disease outbreaks among people experiencing homelessness.

(limit 2,500 characters)

1. The Continuum of Care and Tompkins County Health Department have a long history of collaboration and mutual information sharing. During 2020, CoC staff and members attended a series of planning meetings to develop a community-level response to COVID-19, including people experiencing both sheltered and unsheltered homelessness. The CoC provided demographic information to the Health Department and shared known leading practices in neighboring CoCs. NY-510 also offered feedback from stakeholders, including people currently experiencing homelessness. NY-510 is a single County CoC and defers to our public health department in its capacity to create policy and procedure that responds to infectious disease. The CoC commits to alignment with the policy and procedures established by the Public Health Department and offers the bulk of our resources to prevent the spread of infectious disease through our work facilitating the Enhanced Street Outreach Committee.

2. The Enhanced Street Outreach Committee was formed in 2020 as a response to the COVID-19 pandemic. The outreach team was able to add significant capacity and resources to preventing infectious disease through several initiatives that included a partnership with the Public Health Department. The CoC worked with partners from REACH medical and the Health Department to create and propose a CDBG-CV-funded project that offered on-site vaccines and vaccine incentives for people experiencing homelessness in unsheltered locations, in the emergency shelter, and all residents in transitional and permanent supportive housing. This project included the creation of information campaigns specifically tailored to the needs of people experiencing homelessness. These included flyers, social media, and presentations in public forums about COVID-19, Hepatitis A signs and symptoms, and local resources for accessing PPE, vaccine, and treatment.

ID-8a.	Collaboration With Public Health Agencies on Infectious Diseases.	
	NOFO Section V.B.1.o.	

	Describe in the field below how your CoC:
1.	shared information related to public health measures and homelessness, and
2.	facilitated communication between public health agencies and homeless service providers to ensure street outreach providers and shelter and housing providers are equipped to prevent or limit infectious disease outbreaks among program participants.

(limit 2,500 characters)

1. The CoC has an extensive and well-coordinated system to share information quickly between providers. This system includes two large email lists representing more than 50 local organizations, health and behavioral health organizations, government representatives, community members, and people with lived experience of homelessness. NY-510 consistently shares information across those resources and attends public events, meetings, and forums as a conduit for public health and other information about our unhoused neighbors' experiences. In 2023, the CoC added a health and housing workgroup that meets monthly and includes leadership from our local public health department and community health workers, discharge planners, and RNs. This workgroup has become an active information exchange on health, public health, and other problems and solutions. In the 2023 CoC strategic plan, Home Together; Tompkins (HTT), the CoC frames the issue of homelessness as a public health issue, and all of the interventions proposed as part of HTT are driven by local health and HMIS data. The indicators of success in the plan are aligned with public health goals. Through our participation and feedback process as part of strategic planning, we were able to present HTT directly to our public health sector, including at the Health Planning Council, Behavioral Services Advisory Board, and Tompkins County Whole Health (health department/mental health department).

2. Using several strategies, the CoC facilitates bidirectional communication between our public health agencies and our homeless response system. During the pandemic, the CoC honed its ability to create targeted spaces where members from both sectors are present. The CoC founded the Enhanced Street Outreach team, and now CoC staff sit as team members. The Enhanced Street outreach team meets monthly and includes representation from our homeless street outreach providers, Health insurance navigators, medical providers, and staff from Tompkins County Whole Health's community health outreach worker program. This network and the CoC's health and housing group are critical to our communication method around infectious diseases.

1D-9.	Centralized or Coordinated Entry System–Assessment Process.	
	NOFO Section V.B.1.p.	

	Describe in the field below how your CoC's coordinated entry system:
1.	covers 100 percent of your CoC's geographic area;
2.	uses a standardized assessment process; and
3.	is updated regularly using feedback received from participating projects and households that participated in coordinated entry.

(limit 2,500 characters)

1. Our CE system covers 100 percent of our geographic area. We have attained this metric through Coordinated Entry training and information sessions with local providers, urban and rural street outreach trained in CE, and training through 2-1-1 Tompkins/Cortland as a screening and referral tool for Coordinated Entry. Over 20 local organizations, including our local emergency shelter and DSS, have been trained to complete the Coordinated Entry assessment. In addition, our CE lead has trained 2-1-1 hotline staff to screen callers for CE eligibility and refer callers to CE-trained agencies.
2. We use the VI-SPDAT to generate a score with recommended levels of support for a client. Only agencies who receive training on administering the VISPDAT can conduct the assessment to ensure fairness in scoring outcomes across providers. Although the VI-SPDAT is a widely accepted standardized assessment, the creators of the assessment have communicated in recent years that it can contribute to disparate outcomes in prioritization and referral, especially for Black clients. In FY2022, the CoC examined the impact of using this tool on outcomes in our county disaggregated by race and found no significant difference in the population of the CE list, the population of projects receiving referrals from CE, and the population of our emergency shelter. Therefore, we have continued to utilize the VI-SPDAT in our community.
3. Coordinated Entry providers meet monthly to review names from the list and case conference with each other. In FY2022, we began integrating an additional 30 minutes during the CE list reviews for providers to ask individual questions and provide feedback regarding the process. This feedback has been critical to the continued success of Coordinated Entry in our community. It encourages engagement from providers who are completing intakes with their clients.
Recent updates to our process locally include:
Using a secure document upload for providers to submit intakes.
Dispersing flyers for providers to advertise coordinated entry.
Submitting ID documents with CE intakes to ensure these are uploaded and accessible in our HMIS.
The CoC also created a set of plain language, visually appealing flyers available to distribute to people screened for CE. These flyers include information about accessing their information and "what comes next" after a CE intake.

1D-9a.	Program Participant-Centered Approach to Centralized or Coordinated Entry.	
	NOFO Section V.B.1.p.	

	Describe in the field below how your CoC's coordinated entry system:
1.	reaches people who are least likely to apply for homeless assistance in the absence of special outreach;
2.	prioritizes people most in need of assistance;
3.	ensures people most in need of assistance receive permanent housing in a timely manner, consistent with their preferences; and
4.	takes steps to reduce burdens on people using coordinated entry.

(limit 2,500 characters)

1. Our CoC commissioned a needs assessment in 2021, indicating a need for targeted outreach for youth, people of color, and couch-surfers in our county. To better target youth, we have trained more youth-serving agencies in coordinated entry and involved them in our committee for feedback and process improvement to better understand youth resistance to utilizing services. To better reach BIPOC in our area, we have worked closely with our emergency shelter and local re-entry programs where BIPOC often access services. Last year, our PIT count committee conducted a local, informal PIT count titled the "Couchsurfer Census" to better understand the size and needs of our local couch-surfing community to develop a more specialized outreach plan.

2. The CoC uses the VI-SPDAT to prioritize people most in need of assistance. The CE lead provides PSH providers lists of clients who score an eight or higher on the assessment. PSH providers prioritize clients from highest to lowest score. The CE lead provides RRH and TH providers lists of all other clients, including those who traditionally score for PSH but do not prefer that housing or have other barriers that prevent them from entering (e.g., SO status). This year, we have integrated dynamic prioritization of individuals with severe service needs as defined by HUD to better serve people at risk of continued victimization or death in our service area.

3. The CoC hosts monthly list review meetings to discuss clients' statuses on the CE list, referrals made, the outcomes of those referrals, and the next steps for getting those clients into permanent housing as quickly as possible. In FY2022, we established a new structure for reviewing names from the CE list, with an hour set aside for youth, an hour for people experiencing chronic homelessness, and an hour for adults who don't meet the definition of chronic homelessness. This meeting structure has helped ensure that providers receive adequate time for case conferencing and navigation of identified barriers in our system for the people they serve with the most complex cases and severe service needs.

1D-9b.	**Informing Program Participant about Rights and Remedies through Centralized or Coordinated Entry–Reporting Violations.**	
	NOFO Section V.B.1.p.	

	Describe in the field below how your CoC through its centralized or coordinated entry:
1.	**affirmatively markets housing and services provided within the CoC's geographic area and ensures it reaches all persons experiencing homelessness;**
2.	**informs program participants of their rights and remedies available under federal, state, and local fair housing and civil rights laws; and**
3.	**reports any conditions or actions that impede fair housing choice for current or prospective program participants to the jurisdiction(s) responsible for certifying consistency with the Consolidated Plan.**

(limit 2,500 characters)

1. Using several strategies, NY-510 affirmatively markets the housing and services available through Coordinated Entry across the CoC. CoC staff carefully consider CoC marketing strategies to prioritize being inclusive, welcoming, and easily understood by the diverse population of people experiencing homelessness in our CoC. Among the strategies deployed is a series of plain language, visually appealing flyers that include information about the CE process, including eligibility, confidentiality, the emphasis on client choice, and other CE topics. CoC staff distributed flyers to membership agencies, street outreach teams, schools, hospitals, and the jail. Another marketing strategy the CoC uses is word of mouth via our CoC membership agencies, YAB, and other people with lived experience. The CoC equips our CoC membership with a high level of knowledge about the CE process, including how to access CE services, the general process and timeline for CE placements, and the rights of people experiencing homelessness to access information about their status in the CE process. This word-of-mouth strategy has proved incredibly successful with youth, LGBTQI+, and BIPOC communities. This strategy was driven by the 2021 Homeless Needs Assessment, which revealed a need to increase the CoC outreach to youth, BIPOC, and doubled-up populations.

2. The CoC includes basic information about Fair Housing in our CE materials. This year, the CoC added affirmatively furthering fair housing information into our written standards. In 2023, the CoC hosted a required training for membership agencies to increase knowledge of fair housing. The trainer was from CNY Fair Housing, the enforcement agency that covers our CoC. The training covered fair housing rights, protected classes, reasonable accommodations, and what to do if someone feels their rights have been violated. The CE case conferencing process regularly discusses fair housing rights, especially Source of Income protections. It keeps providers informed about and alerts them of potential violations their clients have experienced.

3. The director of community development at Ithaca Urban Renewal Agency (IURA), Nels Bohn, is the co-chair of the CoC. His involvement helps our CoC maintain regular communication with IURA and report any conditions or actions that impede fair housing choice for current or prospective program participants.

1D-10.	**Advancing Racial Equity in Homelessness–Conducting Assessment.**	
	NOFO Section V.B.1.q.	

1.	**Has your CoC conducted a racial disparities assessment in the last 3 years?**	Yes
2.	**Enter the date your CoC conducted its latest assessment for racial disparities.**	07/21/2023

1D-10a.	Process for Analyzing Racial Disparities–Identified Racial Disparities in Provision or Outcomes of Homeless Assistance.	
	NOFO Section V.B.1.q.	

	Describe in the field below:
1.	your CoC's process for analyzing whether any racial disparities are present in the provision or outcomes of homeless assistance; and
2.	what racial disparities your CoC identified in the provision or outcomes of homeless assistance.

(limit 2,500 characters)

1. Our CoC uses several processes to analyze racial disparities in our response system. The first is through disaggregated data by race. We review APR data for projects semi-annually to analyze disparate outcomes between our emergency shelter, where BIPOC are overrepresented, and our CoC and ESG projects that participate in CE. This review helps us understand whether there are any disparities in the rate that the CE process refers to or provides support services to BIPOC. The second is through a third-party analysis of our homeless response system. We commissioned a report earlier this year that looked at the representation of BIPOC in our homeless response system and their ability to attain positive outcomes. Lastly, our rank and review lead added supplemental questions to our project application this funding year to better understand how agencies strategically address racial equity within their organizations (e.g., hiring, retention, feedback). While these are our tools for formal analysis, we also consult with BIPOC members of our Youth Advisory Board (YAB) and offer opportunities for BIPOC in our PSH projects to provide feedback directly to staff.

2. Through the needs assessment and regular assessment of APR data, we observed and confirmed that BIPOC are consistently overrepresented in our emergency shelter. When comparing that data to data from our PSH, RRH, and TH projects, we found that the proportions of BIPOC entering our system through the emergency shelter are consistent with the proportion of BIPOC in our supportive projects. The needs assessment identified that PSH is a more effective intervention for BIPOC when compared to white people in our community. The needs assessment also found that entry into TH projects was more likely to result in returns to homelessness within the next year for BIPOC participants than for white participants. Our Racial Equity Committee identified a gap in outreach to communities of color. Committee members expressed that many BIPOC are unaware of the services available. Additionally, because of distrust, negative past experiences in accessing services, or both, some BIPOC in our community are less likely to access or feel like those services will meet their needs. Through the supplemental questionnaires, we discovered that most agencies are in the strategic planning stage of achieving REDI outcomes at all levels of their organization.

1D-10b.	Implemented Strategies that Address Racial Disparities.	
	NOFO Section V.B.1.q.	

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

1.	The CoC's board and decisionmaking bodies are representative of the population served in the CoC.	No
2.	The CoC has identified steps it will take to help the CoC board and decisionmaking bodies better reflect the population served in the CoC.	Yes
3.	The CoC is expanding outreach in geographic areas with higher concentrations of underrepresented groups.	Yes
4.	The CoC has communication, such as flyers, websites, or other materials, inclusive of underrepresented groups.	Yes
5.	The CoC is training staff working in the homeless services sector to better understand racism and the intersection of racism and homelessness.	Yes
6.	The CoC is establishing professional development opportunities to identify and invest in emerging leaders of different races and ethnicities in the homelessness sector.	Yes
7.	The CoC has staff, committees, or other resources charged with analyzing and addressing racial disparities related to homelessness.	Yes
8.	The CoC is educating organizations, stakeholders, boards of directors for local and national nonprofit organizations working on homelessness on the topic of creating greater racial and ethnic diversity.	Yes
9.	The CoC reviewed coordinated entry processes to understand their impact on people of different races and ethnicities experiencing homelessness.	Yes
10.	The CoC is collecting data to better understand the pattern of program use for people of different races and ethnicities in its homeless services system.	Yes
11.	The CoC is conducting additional research to understand the scope and needs of different races or ethnicities experiencing homelessness.	Yes
	Other:(limit 500 characters)	
12.		

1D-10c.	Implemented Strategies that Address Known Disparities.	
	NOFO Section V.B.1.q.	

Describe in the field below the steps your CoC is taking to address the disparities identified in the provision or outcomes of homeless assistance.

(limit 2,500 characters)

The CoC has noticed significant disparities in outcomes for people with severe service needs in our Continuum of Care. HMIS data showed that 50% of people entering the emergency shelter for the first time reported having a disability, compared to 84% of people entering the emergency shelter after four or more experiences of homelessness. There is a significant overlap between people self-reporting disabilities and those reporting sleeping in an unsheltered location when they enter the emergency shelter. These observations, paired with the findings of a housing needs assessment commissioned by the CoC in 2021, led to the creation of Home, Together: Tompkins (HTT), the CoC's strategic plan for ending unsheltered homelessness and improving service delivery for people with severe service needs.
Home, Together: Tompkins consists of the following strategies to assist and serve people with severe service needs:
A commitment to building 100 studio and 1-bedroom units of PSH.
Low-barrier shelter that uses a trauma-informed approach to safety.
A "housing surge" strategy and by-name list to better serve people living in unsheltered locations.
Mitigation funds for business owners and landlords.
Other incentives such as a shopping cart exchange and cash for trash program.
Low-barrier move-in packages and assistance for moving from homeless to housed.
Three enhanced, centralized housing navigator positions.
Paid board positions for people with lived experience to monitor and approve Home, Together: Tompkins.
Professional development opportunities for people with lived experience.
While BIPOC represent less than 9% of our local population, 40% of our emergency shelter population and 20% of our unsheltered population self-identify as BIPOC. BIPOC are traditionally underserved in our community and underrepresented in the human services sector. Home, Together: Tompkins is committed to monitoring who each project is serving and how BIPOC experiences compare to that of their white counterparts. Along with targeted outreach and incorporating the feedback of BIPOC leaders in our community, Continuum of Care staff have integrated metrics into each component of this plan to ensure equitable distribution of resources and power to BIPOC participants.

1D-10d.	**Tracked Progress on Preventing or Eliminating Disparities.**	
	NOFO Section V.B.1.q.	

	Describe in the field below:
1.	**the measures your CoC has in place to track progress on preventing or eliminating disparities in the provision or outcomes of homeless assistance; and**
2.	**the tools your CoC uses.**

(limit 2,500 characters)

1. The CoC plans to better understand the experiences of BIPOC in our CoC by convening a lived experience working group consisting of at least 50% BIPOC. This metric will allow us to track whether or not we are meeting our goal of having a working group that accurately reflects the experiences of the population we serve.

The CoC will track outreach efforts based on BIPOC leadership involvement in our CoC. There are several BIPOC leaders in the area who we have identified as interested and motivated housing advocates. We want to ensure that our meeting spaces are accessible and inclusive so that we can include and retain membership by most of the individuals we have identified. We would also like to give presentations or do other in-person outreach at major community centers for BIPOC and BIPOC-led events.

Once we receive the results of our local, informal PIT count for our couchsurfing community, we aim to identify and support the expansion of initiatives BIPOC find essential to their housing stability. In alignment with this larger goal, our enhanced street outreach team will release a survey tool to local agencies to better understand who they serve and who they employ. We aim to have at least 90% of agencies in our CoC using this tool over the next year and for our PIT count results to consist of responses from at least 30% BIPOC.

To better support agencies that applied for CoC funding in diversifying their staff and boards, we plan to include these employment and board service opportunities in all surveys, outreach, and working groups formed as a part of our progress in eliminating disparities for BIPOC over this year. We strive for 50% of CoC-funded agencies to feel they have met their goal for inclusion and active participation of BIPOC in their board leadership. We also plan on teaching agencies how to disaggregate data and better track participant outcomes through our Data committee, with at least 90% of HMIS-participating agencies indicating that they feel confident in this skill.

These metrics and others are also included in our Home, Together: Tompkins plan to end unsheltered homelessness and improve service delivery to individuals with severe service needs to ensure that new projects to serve people at risk of continued victimization or death are delivered with equity.

2. The CoC uses APR data and the CoC Analysis Tool provided by HUD to facilitate our analysis of racial disparities among people experiencing homelessness.

1D-11.	**Involving Individuals with Lived Experience of Homelessness in Service Delivery and Decisionmaking–CoC's Outreach Efforts.**	
	NOFO Section V.B.1.r.	

Describe in the field below your CoC's outreach efforts (e.g., social media announcements, targeted outreach) to engage those with lived experience of homelessness in leadership roles and decision making processes.

(limit 2,500 characters)

1. NY-510 was selected as a YHDP community in 2020. The CoC participated in a transformative and impactful process to co-create our Coordinated Community Plan (CCP) through our commitment to having the Youth Advisory Board (YAB) members take a complete leadership role in the goals, action steps, and recommendations. The YAB set the priorities of the plan and led the entire process, including self-governing their YAB meetings, setting agendas, and leading the planning process for the team of adult partners. The YAB were the primary writers of the CCP and presented the CCP at public meetings, including full CoC membership meetings and the Homeless and Housing Task Force.

The CCP has become the guiding framework of the work plan for our Youth Homelessness Committee, and has been integrated into project oversight for our YHDP projects. This year the projects were automatically renewed for funding, which substantially limited accountability of the programs to the YAB. In response to this, CoC staff worked closely with the YAB to develop a Project Improvement Plan (PIP) for each YHDP project that included action steps and metrics for the projects to achieve within FY2023 for consideration in their FY2024 project applications. In this way, projects were made aware that their funding would be competitive in the future based on their adherence to YAB values, principles, and goals for the project.

The CoC reserves two seats in our governance committee for people with lived experience, both of which are currently held by YAB members. YAB members are also represented in each of our committees and were involved in the local rank and review process for all projects.

The YHDP process has informed our current outreach strategy to reach people with lived experience of homelessness. The CoC has found that connecting to individuals through service providers, and then through peers, can be an effective way to establish and build trust for a lived experience board to thrive.

The CoC is currently seeking funding to support an adult board for people with lived experience of homelessness. Once funds are identified, the CoC would identify a chair of the lived experience board to occupy a seat on our governance committee. The board would be charged with consulting on ongoing projects in our Continuum of Care, and we would support the board with a project manager, cash compensation, professional development and support services as needed.

1D-11a.	**Active CoC Participation of Individuals with Lived Experience of Homelessness.**	
	NOFO Section V.B.1.r.	

You must upload the Letter Signed by Working Group attachment to the 4B. Attachments Screen.
Enter in the chart below the number of people with lived experience who currently participate in your CoC under the four categories listed:

	Level of Active Participation	Number of People with Lived Experience Within the Last 7 Years or Current Program Participant	Number of People with Lived Experience Coming from Unsheltered Situations
1.	Included in the decisionmaking processes related to addressing homelessness.	12	4
2.	Participate on CoC committees, subcommittees, or workgroups.	12	4
3.	Included in the development or revision of your CoC's local competition rating factors.	3	0
4.	Included in the development or revision of your CoC's coordinated entry process.	7	0

1D-11b.	Professional Development and Employment Opportunities for Individuals with Lived Experience of Homelessness.	
	NOFO Section V.B.1.r.	

Describe in the field below how your CoC or CoC membership organizations provide professional development and employment opportunities to individuals with lived experience of homelessness.

(limit 2,500 characters)

1. The CoC provides professional development and employment opportunities through referral to our area's employment services providers. We work closely with these providers to ensure that their programs offer pathways to employment for people experiencing homelessness. The CoC shares materials, including new job programs, job fairs, and employment training opportunities, with our lived experience board and CoC membership with lived experience of homelessness. We also aim to amplify the efforts of our partner providers that offer employment services by highlighting their services in our well-attended public presentations.

To enhance our current strategy of referring to our partners, the CoC is exploring partnering with a local employment readiness project called the Hospitality Employment Training Program to pilot a Housing Employment Training Program cohort. This model aims to serve people with lived experiences of homelessness with the basic skill set and knowledge to enter the housing field as an employee of a housing or human service-focused agency. This concept came from the feedback of our stakeholders, who assert that people with lived experience are valuable and hirable employees. It will prepare people new to direct service with the training they need to succeed.

CoC-funded providers include access to employment services in their programming, including offering on-site job readiness skills, resume writing workshops, and assisting with transportation for residents to get to job interviews. As some individuals with lived experience who contribute to CoC planning also participate in these programs, we ensure they know their eligibility for these services as those professional development opportunities apply to their role in CoC planning. Outside of these specific projects, the CoC has utilized planning funds to provide our Youth Action Board (YAB) with specific professional development involving training opportunities and attendance at multiple national conferences.

1D-11c.	Routinely Gathering Feedback and Addressing Challenges of Individuals with Lived Experience of Homelessness.	
	NOFO Section V.B.1.r.	

	Describe in the field below:
1.	how your CoC routinely gathers feedback from people experiencing homelessness;
2.	how your CoC routinely gathers feedback from people who have received assistance through the CoC or ESG Programs; and
3.	the steps your CoC has taken to address challenges raised by people with lived experience of homelessness.

(limit 2,500 characters)

1. Inspired by our Youth Advisory Board/ YHDP planning process, NY-510 is enthusiastically invested in the "Nothing About Us Without Us" approach to planning across all CoC activities. The CoC holds two seats in our governance committee for people with lived experience and attempts to create opportunities to hear feedback in all meetings of the CoC. The lived experience board members are compensated for their time providing feedback at live meetings, through quick surveys, and involvement in committee work. YAB members were also integrated into our rank and review process this year by providing feedback on our local application structure and questions, participating in our priority ranking, and working closely with CoC staff to generate Project Improvement Plans (PIPs) for projects receiving automatic renewals to ensure accountability to YAB principles over the next funding year.

All CoC meetings are free and open to the public, with agendas shared in advance. The Enhanced Street Outreach team is a critical partner in routinely facilitating input from people with lived experiences of homelessness. In 2023, the City of Ithaca sought public feedback on its proposal to sanction certain areas for people experiencing homelessness while making other areas illegal to camp in. The CoC worked to facilitate clear, accessible communications about the policy with people experiencing homelessness, which resulted in two people directly affected by the proposed changes appearing at City Hall to provide public comment.

2. The CoC generates flyers and other virtual materials for sharing with CoC-funded project residents to invite them to committee meetings and other CoC-sponsored events. CoC staff send these to program staff and directors for distribution on-site at the project or through text/email. Often, program staff will support the youth with transportation to the meeting or with technology to attend virtually.

3. Challenges raised by people with lived experience of homelessness are integrated into discussions and charges of the CoC committee. In FY2023, the CoC strategic plan includes several interventions that our FY2022 committees created in direct response to feedback from people experiencing homelessness. The CoC integrates the feedback into committee meetings, membership, and public meetings and places a high value on the expertise of members with lived experiences.

1D-12.	Increasing Affordable Housing Supply.	
	NOFO Section V.B.1.t.	

	Describe in the field below at least 2 steps your CoC has taken in the past 12 months to engage city, county, or state governments that represent your CoC's geographic area regarding the following:
1.	reforming zoning and land use policies to permit more housing development; and
2.	reducing regulatory barriers to housing development.

(limit 2,500 characters)

1. Our CoC has engaged multiple members of city government, including a member of the city planning and economic development council who has most recently become acting mayor. We began working with these and other partners to fortify the safety net of resources available to households at risk of displacement through the Ithaca Eviction Displacement Defense (IEDD) project. While IEDD was most successful at establishing a right-to-counsel law for evictions in the city of Ithaca, we continue to consult with the acting city mayor regarding issues related to homelessness and housing. Our consultation is focused on responding to public pushback against larger apartment complexes and ESSHI units coming online in areas traditionally zoned for single-family developments. The acting mayor has asked CoC staff to sit on a working group of people in the city government to talk through grievances about these units, which will open more positive discussions about future housing development.

2. Following the release of our homeless and housing needs assessment for Tompkins County, CoC staff gave presentations at the city and county levels, reflecting the findings and recommendations of that report. This report emphasized a need for more brick-and-mortar housing development in our county due to the bottleneck of housing supply and demand in the continuum. These presentations and discussions have led to a greater competency across local governments regarding the need for new, low-cost housing units and the state of the housing crisis. We have turned the conversation away from what people experiencing homelessness can do to more effectively compete for housing to the need for more low-cost housing for our growing population. Increasing low-cost housing to end homelessness is now being considered on a regulatory level in our county. In our conversations with legislators, we continue to center on the need to reduce barriers to development. In 2023, the CoC coordinator accepted a seat on the Tompkins County Planning Advisory Board. This role has decision-making power around planned development and examines regulatory barriers, including zoning and density. The CoC shares aggregated HMIS data with the planning department as part of a shared development tracking project to identify needs and attempt to reduce barriers for the lowest-income renters.

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

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2023 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

1E-1.	**Web Posting of Your CoC's Local Competition Deadline–Advance Public Notice.**	
	NOFO Section V.B.2.a. and 2.g.	
	You must upload the Web Posting of Local Competition Deadline attachment to the 4B. Attachments Screen.	

1.	**Enter your CoC's local competition submission deadline date for New Project applicants to submit their project applications to your CoC–meaning the date your CoC published the deadline.**	07/21/2023
2.	**Enter the date your CoC published the deadline for Renewal Project applicants to submit their project applications to your CoC's local competition–meaning the date your CoC published the deadline.**	07/21/2023

1E-2.	**Project Review and Ranking Process Your CoC Used in Its Local Competition. We use the response to this question and the response in Question 1E-2a along with the required attachments from both questions as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria below.**	
	NOFO Section V.B.2.a., 2.b., 2.c., 2.d., and 2.e.	

You must upload the Local Competition Scoring Tool attachment to the 4B. Attachments Screen.
Select yes or no in the chart below to indicate how your CoC ranked and selected project applications during your local competition:

1.	**Established total points available for each project application type.**	Yes
2.	**At least 33 percent of the total points were based on objective criteria for the project application (e.g., cost effectiveness, timely draws, utilization rate, match, leverage), performance data, type of population served (e.g., DV, youth, Veterans, chronic homelessness), or type of housing proposed (e.g., PSH, RRH).**	Yes
3.	**At least 20 percent of the total points were based on system performance criteria for the project application (e.g., exits to permanent housing destinations, retention of permanent housing, length of time homeless, returns to homelessness).**	Yes
4.	**Provided points for projects that addressed specific severe barriers to housing and services.**	Yes

5.	Used data from comparable databases to score projects submitted by victim service providers.	No
6.	Provided points for projects based on the degree the projects identified any barriers to participation (e.g., lack of outreach) faced by persons of different races and ethnicities, particularly those over-represented in the local homelessness population, and has taken or will take steps to eliminate the identified barriers.	No

1E-2a.	Scored Project Forms for One Project from Your CoC's Local Competition. We use the response to this question and Question 1E-2. along with the required attachments from both questions as a factor when determining your CoC's eligibility for bonus funds and for other NOFO criteria below.	
	NOFO Section V.B.2.a., 2.b., 2.c., and 2.d.	

You must upload the Scored Forms for One Project attachment to the 4B. Attachments Screen.
Complete the chart below to provide details of your CoC's local competition:

1.	What were the maximum number of points available for the renewal project form(s)?	100
2.	How many renewal projects did your CoC submit?	7
3.	What renewal project type did most applicants use?	PH-PSH

1E-2b.	Addressing Severe Barriers in the Local Project Review and Ranking Process.	
	NOFO Section V.B.2.d.	

	Describe in the field below:
1.	how your CoC analyzed data regarding each project that has successfully housed program participants in permanent housing;
2.	how your CoC analyzed data regarding how long it takes to house people in permanent housing;
3.	how your CoC considered the specific severity of needs and vulnerabilities experienced by program participants preventing rapid placement in permanent housing or the ability to maintain permanent housing when your CoC ranked and selected projects; and
4.	considerations your CoC gave to projects that provide housing and services to the hardest to serve populations that could result in lower performance levels but are projects your CoC needs in its geographic area.

(limit 2,500 characters)

1. The CoC used APRs generated from FY2021 to answer questions about project performance for our Rank and Review process. Based on these APRs, our rank and review committee scored each project on utilization rate, data quality, permanent housing placement and retention, employment and income growth, connections to health insurance and non-cash benefits, and time to move in. Several equity factors were informed by responses to questions about project racial equity, person-centered planning, elevating lived experience, and serving intersectional identities. The local application also included questions about data practices for monitoring disaggregated participant outcomes.

2. Time to move in was calculated using Q22c, "Average length of time to housing," from each renewal project's APR from the previous funding year.

3. Renewal projects that served populations composed 75% or higher of chronically homeless individuals, youth, or survivors of domestic violence were given 5 points for serving our most vulnerable populations. The local application also offered 15 narrative points for fidelity to a housing first and trauma-informed approach, person-centered services, and equitably serving intersectional identities where an inclusive project structure to serve those with the most severe service needs could balance less than ideal APR data findings.

Comparatively, permanent housing placement and retention were granted partial points based on our CoC-wide percentage of PSH clients retained or exited to permanent housing (94%). Assigning partial points allowed for flexibility for our projects that strive to serve individuals with severe service needs, such as our only adult-serving PSH projects that only serve persons with substance use disorder.

4. We have very few projects that receive CoC funding, especially projects that serve adults. Therefore, we emphasized the value of projects that serve single adult households with severe service needs, as those are the households experiencing longer lengths of stay and disproportionate representation in our emergency shelter.

Renewal projects that served populations composed 75% or higher of chronically homeless individuals, youth, or survivors of domestic violence were given 5 points. Renewal projects were also given up to 20 bonus points for successful past performance if they were in good standing with the Continuum of Care and were prioritized for Tier 1 funding in the FY2022 funding competition.

1E-3.	**Advancing Racial Equity through Participation of Over-Represented Populations in the Local Competition Review and Ranking Process.**	
	NOFO Section V.B.2.e.	

	Describe in the field below:
1.	**how your CoC used the input from persons of different races and ethnicities, particularly those over-represented in the local homelessness population, to determine the rating factors used to review project applications;**
2.	**how your CoC included persons of different races and ethnicities, particularly those over-represented in the local homelessness population in the review, selection, and ranking process; and**

3.	how your CoC rated and ranked projects based on the degree to which their project has identified any barriers to participation (e.g., lack of outreach) faced by persons of different races and ethnicities, particularly those over-represented in the local homelessness population, and has taken or will take steps to eliminate the identified barriers.

(limit 2,500 characters)

1. Black individuals are overrepresented in our homeless population, making up close to 30% of our emergency shelter population but only 7% of the census population. We set an intention to include more BIPOC in our rank and review process based on this understanding and paid a Black individual with lived experience of homelessness to lead and organize our rank and review to integrate their perspective and lived experiences into the process intentionally. Throughout this response, we will refer to this individual as our rank and review lead.

2. Our CoC assigned a Black rank and review lead for this funding year who has lived experience of homelessness in our continuum. This person chose our tool, led our site visits, specified equity questions for applicants, and was in the room during rank and review to give their perspective on various projects. Rather than just giving them a seat at the table, we gave this individual the support they needed to be in charge of the table. We compensated them for their time as a disruptive practice.

3. Our rank and review lead introduced a series of equity questions into our ranking tool. This individual designed the supplemental application questions and was in the room during rank and review to lend their perspective on applicant responses. These questions had a particular sway on the ultimate results of our rank and review process, as scoring in the racial equity, intersectional identities, person-centered care, and trauma-informed care sections of our application accounted for 20 out of the total 100 points available for renewal applications and 20 out of the total 95 points available for new applications.

Here is an example of a question designed to determine the extent to which applicants were disaggregating and reviewing project participant outcomes by race and ethnicity in each project.

How does your project work to eliminate racial disparities in housing outcomes? (250 words)
4-5 points: Agency has promising goals for promoting racial equity. The answer clearly demonstrates how this project will ensure equity and address racial disparities. This could include practices to assess data and outcomes disaggregately, training program staff in anti-racism and other relevant trainings, agency identifies other practices that eliminate disparities.
2-3 points: Agency is committed to equity but has no clear actionable practices.
0-1 points: Agency does not have clear commitment to racial equity.

1E-4.	Reallocation–Reviewing Performance of Existing Projects.	
	NOFO Section V.B.2.f.	

Describe in the field below:

1.	your CoC's reallocation process, including how your CoC determined which projects are candidates for reallocation because they are low performing or less needed;
2.	whether your CoC identified any low performing or less needed projects through the process described in element 1 of this question during your CoC's local competition this year;
3.	whether your CoC reallocated any low performing or less needed projects during its local competition this year; and
4.	why your CoC did not reallocate low performing or less needed projects during its local competition this year, if applicable.

(limit 2,500 characters)

1. NY-510's processes for reallocation are as follows. New and renewal projects will compete for Tier I rankings. Renewal projects that are not performing up to the CoC standards can be reduced or eliminated through reallocation, and the funds can be utilized for one or more new projects or higher-performing renewal projects. Reallocation can occur under the following circumstances:
• Current funded project declines to renew their project
• Current funded project adjusts their budget to a lower amount
• Current funded project voluntarily reallocates funding to a new project
• Ranking Committee decided to partially or fully reallocate current funded projects based on performance or HUD priorities

Underperforming projects can be defined as follows:
• Low utilization rate
• Has not participated in Coordinated Assessment
• Not serving the target population
• Has a program that does not align with HUD priorities anymore (i.e., Housing First approach)
• Misuse of federal funds
• Program design has a negative impact on systems performance and overall CoC score.

The CoC system performance/ rank and review committee uses prior year APR, HIC, and Daily Unit data to determine a project's risk of reallocation. The above reallocation standards are part of NY-510's written standards and are publicly posted year-round on our competition website.

2. No projects were identified for reallocation this year.

3. No projects were reallocated this year.

4. No projects met the threshold described in element one for reallocation this year.

1E-4a.	Reallocation Between FY 2018 and FY 2023.	
	NOFO Section V.B.2.f.	

	Did your CoC cumulatively reallocate at least 20 percent of its ARD between FY 2018 and FY 2023?	Yes

1E-5.	Projects Rejected/Reduced–Notification Outside of e-snaps.	
	NOFO Section V.B.2.g.	
	You must upload the Notification of Projects Rejected-Reduced attachment to the 4B. Attachments Screen.	

1.	Did your CoC reject any project application(s) submitted for funding during its local competition?	No
2.	Did your CoC reduce funding for any project application(s) submitted for funding during its local competition?	Yes
3.	Did your CoC inform applicants why your CoC rejected or reduced their project application(s) submitted for funding during its local competition?	Yes
4.	If you selected Yes for element 1 or element 2 of this question, enter the date your CoC notified applicants that their project applications were being rejected or reduced, in writing, outside of e-snaps. If you notified applicants on various dates, enter the latest date of any notification. For example, if you notified applicants on 06/26/2023, 06/27/2023, and 06/28/2023, then you must enter 06/28/2023.	09/12/2023

1E-5a.	Projects Accepted–Notification Outside of e-snaps.	
	NOFO Section V.B.2.g.	
	You must upload the Notification of Projects Accepted attachment to the 4B. Attachments Screen.	

	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New and Renewal Priority Listings in writing, outside of e-snaps. If you notified applicants on various dates, enter the latest date of any notification. For example, if you notified applicants on 06/26/2023, 06/27/2023, and 06/28/2023, then you must enter 06/28/2023.	09/12/2023

1E-5b.	Local Competition Selection Results for All Projects.	
	NOFO Section V.B.2.g.	
	You must upload the Local Competition Selection Results attachment to the 4B. Attachments Screen.	

	Does your attachment include: 1. Project Names; 2. Project Scores; 3. Project accepted or rejected status; 4. Project Rank–if accepted; 5. Requested Funding Amounts; and 6. Reallocated funds.	Yes

1E-5c.	Web Posting of CoC-Approved Consolidated Application 2 Days Before CoC Program Competition Application Submission Deadline.	
	NOFO Section V.B.2.g. and 24 CFR 578.95.	
	You must upload the Web Posting–CoC-Approved Consolidated Application attachment to the 4B. Attachments Screen.	

	Enter the date your CoC posted the CoC-approved Consolidated Application on the CoC's website or partner's website–which included: 1. the CoC Application; and 2. Priority Listings for Reallocation forms and all New, Renewal, and Replacement Project Listings.	

You must enter a date in question 1E-5c.

1E-5d.	Notification to Community Members and Key Stakeholders that the CoC-Approved Consolidated Application is Posted on Website.	
	NOFO Section V.B.2.g.	
	You must upload the Notification of CoC-Approved Consolidated Application attachment to the 4B. Attachments Screen.	

	Enter the date your CoC notified community members and key stakeholders that the CoC-approved Consolidated Application was posted on your CoC's website or partner's website.	

You must enter a date in question 1E-5d.

2A. Homeless Management Information System (HMIS) Implementation

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2023 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

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

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

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

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

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

	Enter the date your CoC submitted its 2023 HIC data into HDX.	04/28/2023

2A-4.	**Comparable Database for DV Providers–CoC and HMIS Lead Supporting Data Collection and Data Submission by Victim Service Providers.**	
	NOFO Section V.B.3.b.	

	In the field below:
1.	**describe actions your CoC and HMIS Lead have taken to ensure DV housing and service providers in your CoC collect data in HMIS comparable databases;**
2.	**state whether DV housing and service providers in your CoC are using a HUD-compliant comparable database–compliant with the FY 2022 HMIS Data Standards; and**

3.	state whether your CoC's HMIS is compliant with the FY 2022 HMIS Data Standards.

(limit 2,500 characters)

. The Advocacy Center is our only local victim services provider. They operate a nine-bed emergency shelter and provide case management, wrap-around services, and other support with housing. The Advocacy Center is well respected in the community for its integrity and client confidentiality. The Advocacy Center uses "Empower" as its database. Empower is considered an appropriate comparable database and adequately captures all data points required by the 2022 HMIS Data Standards. The Advocacy Center is an active member of the CoC and regularly provides deidentified data to the CoC for reports, including the Point in Time Count. CoC staff and the HMIS lead are consulting with The Advocacy Center to explore the cost and benefit of changing database providers if their current system cannot comply with 2022 HMIS data standards.

2. Empower is compliant with the 2022 HMIS data standards.

3. The CoC's HMIS through vendor WellSky complies with the FY2022 HMIS data standards.

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

Enter 2023 HIC and HMIS data in the chart below by project type:

Project Type	Total Year-Round Beds in 2023 HIC	Total Year-Round Beds in HIC Operated by Victim Service Providers	Total Year-Round Beds in HMIS	HMIS Year-Round Bed Coverage Rate
1. Emergency Shelter (ES) beds	121	6	115	100.00%
2. Safe Haven (SH) beds	0	0	0	
3. Transitional Housing (TH) beds	45	0	33	73.33%
4. Rapid Re-Housing (RRH) beds	41	0	41	100.00%
5. Permanent Supportive Housing (PSH) beds	123	0	123	100.00%
6. Other Permanent Housing (OPH) beds	71	0	0	0.00%

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

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

(limit 2,500 characters)

1. The 12 transitional beds that account for the lower percentage have been added to HMIS. At the time of the HIC the provider agency was experiencing a staffing issue and didn't feel they had capacity to enter data from their new transitional housing project "Sunflower Houses". There has been a staffing increase, and the agency reports that they will be entering into HMIS before the close of the year.
2.The CoC and HMIS lead will support the agency with a free HMIS license, training and other resources to help foster a positive relationship with data.

2A-6.	**Longitudinal System Analysis (LSA) Submission in HDX 2.0.**	
	NOFO Section V.B.3.d.	
	You must upload your CoC's FY 2023 HDX Competition Report to the 4B. Attachments Screen.	

Did your CoC submit at least two usable LSA data files to HUD in HDX 2.0 by February 28, 2023, 8 p.m. EST?	Yes

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

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2023 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

2B-1.	PIT Count Date.	
	NOFO Section V.B.4.a	

	Enter the date your CoC conducted its 2023 PIT count.	01/23/2023

2B-2.	PIT Count Data–HDX Submission Date.	
	NOFO Section V.B.4.a	

	Enter the date your CoC submitted its 2023 PIT count data in HDX.	04/28/2023

2B-3.	PIT Count–Effectively Counting Youth in Your CoC's Most Recent Unsheltered PIT Count.	
	NOFO Section V.B.4.b.	

	Describe in the field below how your CoC:
1.	engaged unaccompanied youth and youth serving organizations in your CoC's most recent PIT count planning process;
2.	worked with unaccompanied youth and youth serving organizations to select locations where homeless youth are most likely to be identified during your CoC's most recent PIT count planning process; and
3.	included youth experiencing homelessness as counters during your CoC's most recent unsheltered PIT count.

(limit 2,500 characters)

1. The CoC is fortunate to have committed and active membership from the three local agencies that serve youth experiencing homelessness. Our recent participation in the YHDP process has further strengthened those relationships and increased our opportunity to include youth-serving agencies in our annual processes, including the Point In Time (PIT) Count.
During the PIT count, youth providers provided suggestions of known locations where youth experiencing homelessness congregate, contributed to refining the youth Point in Time Count survey questions to be as trauma-informed as possible, and participated in the actual count. In addition, youth-serving providers, including Tompkins County Youth Services, The Learning Web, and The Village at Ithaca, participated in either/both the night of the count activities and by administering the service provider PITC survey throughout the week of the count. These stakeholders consistently remind our community that while recent refinements improve our success in locating youth during the Point in Time Count, there are valid concerns that the couch-surfing and hidden nature of youth homelessness in our local system will continue to result in an undercount of our youth experiencing homelessness.
To mitigate the reality of this undercount in our PIT, the CoC closely tracks our HMIS program level data and invests YHDP and CoC resources into developing a youth-centered Coordinated Entry System in partnership with the Village at Ithaca.
In FY2022, the PIT Count committee consulted with YAB members regarding creating an informal, local attempt to count couch surfers in Tompkins County titled the Couchsurfer Census. YAB members were involved in designing the questions included in the survey and conducting outreach to transition-aged youth and minors to participate in the effort. Our community learned a lot from this effort and plans to rerun the Couchsurfer Census in FY2023.
2. Our CoC is home to a large, decades-old encampment community in which most people experiencing unsheltered homelessness reside, including transition-aged youth. Beyond our efforts in the encampment space, stakeholders identified several local parks and other areas TAY are known to congregate. Youth stakeholders consistently report that they and their peers are not likely to sleep outdoors and are much more likely to be in (sometimes risky) couch-surfing situations.
3. NY-510 YAB members were critical to planning and invited to join in the count.

2B-4.	**PIT Count–Methodology Change–CoC Merger Bonus Points.**	
	NOFO Section V.B.5.a and V.B.7.c.	

	In the field below:
1.	**describe any changes your CoC made to your sheltered PIT count implementation, including methodology or data quality changes between 2022 and 2023, if applicable;**
2.	**describe any changes your CoC made to your unsheltered PIT count implementation, including methodology or data quality changes between 2022 and 2023, if applicable; and**
3.	**describe how the changes affected your CoC's PIT count results; or**
4.	**state "Not Applicable" if there were no changes or if you did not conduct an unsheltered PIT count in 2023.**

(limit 2,500 characters)

1. In 2023, we offered access to the PIT survey through hard paper copies administered by providers and a virtual online survey. This process allowed individuals to complete the survey themselves. The survey included a robust set of screening questions in plain language to ensure that individuals were in the target population for the count.

NY-510 offered PIT surveys to households in our emergency shelter and used a complete census to conduct our sheltered PIT count. This process helped us collect responses to PIT count questions from households willing to participate and better understand how the number of these households compares to our overall population experiencing sheltered homelessness.

In FY2022, we added a service-based count component to our PIT count, which yielded very few surveys. This year, our PIT count committee designed flyers and affirmative marketing to service providers before the count to inform them about the effort, which improved the response rate. Staff visited libraries and food pantries in rural areas of the county to get engagement from service providers in those areas as well.

2. In 2023, we offered access to the PIT survey through hard paper copies administered by providers and a virtual online survey. This process allowed individuals to complete the survey themselves. The survey included a robust set of screening questions in plain language to ensure that individuals were in the target population for the count. The online format also allowed the team to collect responses from people who slept in an unsheltered location that night but were not found by our team.

3. Additional unsheltered surveys, as opposed to observation forms, were collected compared to previous years. This improvement is because the CoC was able to increase accessibility for individuals experiencing homelessness and give them the agency to complete their PIT surveys through an online survey instead of requiring interaction with an outreach worker. We also engaged the rural community of service providers throughout the week that the survey was available to get more responses from people experiencing rural homelessness.

2C. System Performance

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2023 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

2C-1.	**Reduction in the Number of First Time Homeless–Risk Factors Your CoC Uses.**	
	NOFO Section V.B.5.b.	

	In the field below:
1.	**describe how your CoC determined the risk factors to identify persons experiencing homelessness for the first time;**
2.	**describe your CoC's strategies 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 your CoC's strategy to reduce the number of individuals and families experiencing homelessness for the first time**

(limit 2,500 characters)

1. Several CoC members engaged in the Anti-Displacement Learning Network funded by Enterprise Community Partners to understand risk factors for eviction and displacement in Tompkins County. This group used HMIS and other data to determine the following high-risk factors for experiencing homelessness for the first time: income below 30% AMI, rent burden, having experienced an eviction in the past, criminal justice involvement, and living in an unstable or doubled-up situation.

Feedback from service providers in our continuum revealed that severe service needs, as defined by HUD, exacerbate these risk factors. In response to this feedback, the CoC's lead agency hired a housing specialist to attend eviction court, refer tenants to local resources, and prevent avoidable evictions. The housing specialist found that at least half of the eviction court docket in the City of Ithaca regularly consisted of people who met HUD's definition of severe service needs, especially those with a history of homelessness.

2. The CoC has several strategies to reduce the number of people who become homeless. The CoC lead agency has administered multiple cash transfer pilots that attempt to answer whether a guaranteed income can improve housing stability for our city's low-income residents. The CoC lead agency is also partnered with our local DSS as the Community-based Organization (CBO) to assist with ERAP. The Lead agency's ERAP activities include application assistance, attending eviction court, and conducting outreach in local affordable housing projects. Access to ERAP resources, including legal protections, has prevented people from being evicted directly into the homeless response system.

Aside from these strategies, our CoC approved a strategic plan to better serve people with severe service needs titled Home, Together: Tompkins. Endorsed by the City of Ithaca in 2023, this plan outlines strategies to prevent first-time homelessness for people with severe service needs, including permanently funding a housing specialist position to prevent avoidable evictions through referral to community resources, a landlord liaison role, and implementing a housing surge with set aside units for people in couch-surfing situations. This strategic plan outlines our goal of a more compassionate homeless response system with a stronger safety net for people at risk of homelessness with severe service needs.

2C-1a.	**Impact of Displaced Persons on Number of First Time Homeless.**	
	NOFO Section V.B.5.b	

Was your CoC's Number of First Time Homeless [metric 5.2] affected by the number of persons seeking short-term shelter or housing assistance displaced due to:

1.	**natural disasters?**	No
2.	**having recently arrived in your CoCs' geographic area?**	No

2C-2.	Length of Time Homeless–CoC's Strategy to Reduce.	
	NOFO Section V.B.5.c.	

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

(limit 2,500 characters)

1. In 2023, The CoC approved our strategic plan to end unsheltered homelessness and improve service delivery to people with severe service needs, Home, Together Tompkins (HTT), which recommends multiple strategies to increase the rate that individuals and families exit to permanent housing.

The most creative strategy noted in HTT to reduce the length of time homeless in our community is integrating a housing surge model into our Coordinated Entry processes to coordinate rapid, streamlined exits to sustainable, permanent housing resources with the providers and landlords who hold and manage those resources. A "housing surge" is a concentrated, time-limited community effort through which key stakeholders collaborate to connect a targeted group of households to a pre-identified pool of housing subsidies and units and other resources and services to house many people in a short time frame. The housing surge expedites the housing process by streamlining procedures and creating temporary mechanisms that break through common procedural delays in rehousing.

An additional CoC strategy to reduce the length of time people experience homelessness is to continue advocating for low-cost housing development. In HTT, the CoC also recommends increasing the stock of Permanent Supportive Housing in our community to resolve the bottleneck of low-barrier supported housing for people with severe service needs. The CoC does this advocacy through engagement with local planning boards, provision of HMIS data to our community partners, letters of support for complementary projects, including ESSHI, CDBG, and HOME-ARP, and sharing our strategic plan widely across sectors. As a result of these efforts, the City of Ithaca endorsed HTT in 2023.

2. NY-510 monitors our Emergency Shelter, Coordinated Entry, and Street Outreach HMIS data to identify the individuals experiencing homelessness for the longest time. This HMIS data is used within the Coordinated Entry system to identify households who could benefit from robust case conferencing to discuss next steps to housing and avoid future experiences of chronic homelessness. Individuals experiencing homelessness for six months or longer are set aside from our Coordinated Entry list and discussed for the last hour of the CE list review. These individuals are also dynamically prioritized for referrals through CE.

3. Human Services Coalition, Coordinated Entry Lead

2C-3.	Exits to Permanent Housing Destinations/Retention of Permanent Housing–CoC's Strategy	
	NOFO Section V.B.5.d.	

	In the field below:
1.	describe your CoC's strategy to increase the rate that individuals and persons in families residing in emergency shelter, safe havens, transitional housing, and rapid rehousing exit to permanent housing destinations;
2.	describe your CoC's strategy to increase the rate that individuals and persons in families residing in permanent housing projects retain their permanent housing or exit to permanent housing destinations; and
3.	provide the name of the organization or position title that is responsible for overseeing your CoC's strategy to increase the rate that individuals and families exit to or retain permanent housing.

(limit 2,500 characters)

1. In 2023, The CoC approved our strategic plan, Home, Together Tompkins (HTT), which recommends multiple strategies to increase the rate that individuals and persons in families in literal homeless or transitional housing situations exit to permanent housing.
The first of these is increasing the stock of Permanent Supportive Housing (PSH) in our community, as PSH in our community has a 90% retention/positive exit rate that has held steady over the past five years. The second is integrating a housing surge model into our Coordinated Entry processes to coordinate rapid, streamlined exits to sustainable, permanent housing resources with the providers and landlords who hold and manage those resources. Lastly, CoC staff are working closely with our local emergency shelter provider to build a housing-first culture that promotes rapid exits to housing. Through this work, we have seen an increase in rapid exits to permanent housing from emergency shelter.
Through these efforts, the CoC hopes to decrease the average length of time to a PH exit in our community by 30 days.

2. The HTT strategic plan recommends multiple strategies to increase the rate that individuals and persons in families residing in permanent housing projects retain their permanent housing or exit to permanent housing (PH) destinations. One strategy to promote housing retention is to provide move-in boxes for people moving into housing from homelessness that include cleaning supplies, trash tags, kitchen utensils, toiletries, and linens that otherwise may not be provided in a furnished unit. Another housing retention strategy is to employ a series of housing specialists who can help connect people experiencing homelessness to resources. One of these housing specialists would focus on supporting individuals who have recently moved into housing from homelessness, fostering community connections to resources and property management. The final strategy to help people retain their permanent housing is to bolster the safety net for people at risk of losing permanent housing by providing low-barrier pathways to legal assistance and conflict dispute resolution services. Each of our PSH projects have moving on plans to support residents with obtaining sustainable PH after exiting.
Between these strategies and strategies to increase employment income for people with lived experience, our CoC hopes to see a 50% decrease in returns to homelessness in 5 years.
3. Home, Together Committee

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

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

(limit 2,500 characters)

1. NY-510 closely monitors our SPM and CE data as part of our strategy to quickly identify people who return to homelessness. To enhance our understanding of why people return to homelessness, we track additional details at the exit from our CE system, including the type and location of housing and the specific source and length of their rental assistance. Monitoring our CE data has revealed that the type of housing assistance a person has correlates to their likelihood of returning to homelessness. The CoC also maintains collaborative relationships with street outreach workers and direct service staff at our partner agencies to capture information about people who return to unsheltered homelessness in our system.

The CoC's Housing First committee has identified several known barriers to maintaining permanent housing, including disconnection from street outreach or known support services, lack of financial resources sufficient to pay for necessary items such as trash removal, and lack of knowledge and understanding of tenant rights and responsibilities. In alignment with the Home, Together: Tompkins strategic plan to end unsheltered homelessness and improve service delivery for people with severe service needs, the committee is exploring best practices to eliminate or navigate these barriers in our system.

2. The CoC's strategic plan to improve service delivery to people with severe service needs, Home, Together: Tompkins, recommends multiple strategies to reduce the rate of additional returns to homelessness.

One strategy is to provide move-in boxes for people moving into housing from homelessness that include cleaning supplies, trash tags, kitchen utensils, toiletries, and linens that otherwise may not be provided in a furnished unit. Another is to employ a series of housing specialists who can help connect people experiencing homelessness to resources. One of these housing specialists would focus on supporting individuals who have recently moved into housing from homelessness, fostering community connections to resources and property management. The final strategy is to bolster the safety net for people at risk of homelessness by providing low-barrier pathways to legal assistance and conflict dispute resolution services.

Between these strategies and strategies to increase employment income for people with lived experience, our CoC hopes to see a 50% decrease in returns to homelessness in 5 years.

3. Housing First Committee

2C-5.	**Increasing Employment Cash Income–CoC's Strategy.**	
	NOFO Section V.B.5.f.	

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

(limit 2,500 characters)

1. The CoC strategy to increase access to cash income is to quickly connect people who are able and interested in employment with one of our area's employment services providers. We also aim to amplify the efforts of our partner providers that offer employment services by highlighting their services in our well-attended public presentations.

The CoC widely shares materials with our network, including new job programs, job fairs, and employment training opportunities. CoC-funded providers include access to employment services in their programming, including offering on-site job readiness skills, resume writing workshops, and assisting with transportation for residents to get to job interviews. Increasing cash income is monitored and scored as part of our local application process.

To enhance our current strategy of referring to our partners, the CoC is exploring partnering with a local employment readiness project called the Hospitality Employment Training Program to pilot a Housing Employment Training Program cohort. This model aims to serve people with lived experiences of homelessness with the basic skill set and knowledge to enter the housing field as an employee of a housing or human service-focused agency. This concept came from the feedback of our stakeholders, who assert that people with lived experience are valuable and hirable employees.

In 2023, The CoC approved our strategic plan to end unsheltered homelessness, Home, Together Tompkins (HTT), which advocates for employing people with lived experience. In FY2023, CoC staff plan to engage employers within the CoC to build professional development tracks for people with lived expertise who may lack other higher education required by the employer. Implementing this strategy would not limit them to "peer-level" positions but rather increase access to employment cash resources that are typically out of reach for the population we serve. This year, the HTT plan received endorsement from the City of Ithaca and buy-in from other stakeholders interested in integrating the provided strategies.

2. CoC membership includes representation from our community's mainstream employment agencies, specifically Workforce, NY, Youth Employment Services, and Challenge Industries. Representatives from these employment agencies sit on committees and are integrated throughout the CoC.

3. System Evaluation/Ranking Committee

2C-5a.	Increasing Non-employment Cash Income–CoC's Strategy	
	NOFO Section V.B.5.f.	

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

(limit 2,500 characters)

1. NY-510 recognizes the importance of increasing non-cash income for people experiencing homelessness in our community. We increase access to non-cash income by quickly and efficiently sharing information about resources such as the Child Tax Credit and COVID-related stimulus payments as they become available. The CoC created materials specifically targeted to people experiencing homelessness to share information about the above opportunities and facilitated technology and support for people wishing to get help accessing available non-cash resources.

This year, our Continuum of Care solidified membership and referral pathways for both Finger Lakes Independence Center (FLIC), a local trusted agency that serves people with disabilities, and LawNY, a non-profit law firm that provides free, civil legal aid to enhance service delivery and support for individuals applying for SSDI who are also experiencing homelessness. The CoC also supports FLIC and our local emergency shelter caseworkers in becoming SOAR-trained.

Aside from efforts to expand access to SSDI, the CoC lead agency has administered multiple cash transfer pilots that attempt to answer whether a guaranteed income can improve housing stability for our city's low-income residents. The CoC is looking forward to the research findings of these pilots to consider scaling guaranteed income to include all persons experiencing homelessness.

In 2023, The CoC approved our strategic plan to end unsheltered homelessness, Home, Together Tompkins (HTT), which suggests creating a Cash for Trash program that would mimic the structure of traditional recycling redemption programs in our community. Recycling redemption is a resource that is highly utilized in our community. Various stakeholders have recommended implementing a project that provides people with trash bags to fill with street trash or trash from nearby encampments (with appropriate PPE provided) for individuals to exchange for non-employment cash income. Although this program would be open to anyone in the community, the CoC anticipates that it would have the most positive financial impact on people experiencing homelessness while keeping the streets and encampment spaces clean for their neighbors.

2. System Evaluation/Ranking Committee

3A. Coordination with Housing and Healthcare

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2023 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

3A-1.	New PH-PSH/PH-RRH Project–Leveraging Housing Resources.	
	NOFO Section V.B.6.a.	
	You must upload the Housing Leveraging Commitment attachment to the 4B. Attachments Screen.	

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

3A-2.	New PH-PSH/PH-RRH Project–Leveraging Healthcare Resources.	
	NOFO Section V.B.6.b.	
	You must upload the Healthcare Formal Agreements attachment to the 4B. Attachments Screen.	

	Is your CoC applying for a new PH-PSH or PH-RRH project that uses healthcare resources to help individuals and families experiencing homelessness?	No

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

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

Project Name	Project Type	Rank Number	Leverage Type
This list contains no items			

3B. New Projects With Rehabilitation/New Construction Costs

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2023 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

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

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

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

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

(limit 2,500 characters)

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

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2023 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

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

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

3C-2.	**Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes.**	
	NOFO Section V.F.	

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

(limit 2,500 characters)

4A. DV Bonus Project Applicants for New DV Bonus Funding

HUD publishes resources on the HUD.gov website at CoC Program Competition to assist you in completing the CoC Application. Resources include:

- Notice of Funding Opportunity (NOFO) for Fiscal Year (FY) 2023 Continuum of Care Competition and Noncompetitive Award of Youth Homeless Demonstration Program Renewal and Replacement Grants;
- 24 CFR part 578;
- FY 2023 CoC Application Navigational Guide;
- Section 3 Resources;
- PHA Crosswalk; and
- Frequently Asked Questions

4A-1.	**New DV Bonus Project Applications.**	
	NOFO Section I.B.3.I.	

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

Applicant Name
This list contains no items

4B. Attachments Screen For All Application Questions

	We have provided the following guidance to help you successfully upload attachments and get maximum points:
1.	You must include a Document Description for each attachment you upload; if you do not, the Submission Summary screen will display a red X indicating the submission is incomplete.
2.	You must upload an attachment for each document listed where 'Required?' is 'Yes'.
3.	We prefer that you use PDF files, though other file types are supported–please only use zip files if necessary. Converting electronic files to PDF, rather than printing documents and scanning them, often produces higher quality images. Many systems allow you to create PDF files as a Print option. If you are unfamiliar with this process, you should consult your IT Support or search for information on Google or YouTube.
4.	Attachments must match the questions they are associated with.
5.	Only upload documents responsive to the questions posed–including other material slows down the review process, which ultimately slows down the funding process.
6.	If you cannot read the attachment, it is likely we cannot read it either.
	. We must be able to read the date and time on attachments requiring system-generated dates and times, (e.g., a screenshot displaying the time and date of the public posting using your desktop calendar; screenshot of a webpage that indicates date and time).
	. We must be able to read everything you want us to consider in any attachment.
7.	After you upload each attachment, use the Download feature to access and check the attachment to ensure it matches the required Document Type and to ensure it contains all pages you intend to include.
8.	Only use the "Other" attachment option to meet an attachment requirement that is not otherwise listed in these detailed instructions.

Document Type	Required?	Document Description	Date Attached
1C-7. PHA Homeless Preference	No	1C-7 PHA Homeless...	09/25/2023
1C-7. PHA Moving On Preference	No		
1D-11a. Letter Signed by Working Group	Yes	1D-11a Letter Sig...	09/25/2023
1D-2a. Housing First Evaluation	Yes	1D-2a Housing Fir...	09/25/2023
1E-1. Web Posting of Local Competition Deadline	Yes	1E-1 Web Posting ...	09/25/2023
1E-2. Local Competition Scoring Tool	Yes	1E-2 Local Compet...	09/25/2023
1E-2a. Scored Forms for One Project	Yes	1E-2a Scored Form...	09/25/2023
1E-5. Notification of Projects Rejected-Reduced	Yes	1E-5 Notification...	09/25/2023
1E-5a. Notification of Projects Accepted	Yes	1E-5a. Notificati...	09/25/2023
1E-5b. Local Competition Selection Results	Yes	1E-5b Local Compe...	09/25/2023
1E-5c. Web Posting–CoC-Approved Consolidated Application	Yes		

1E-5d. Notification of CoC-Approved Consolidated Application	Yes		
2A-6. HUD's Homeless Data Exchange (HDX) Competition Report	Yes	2A-6 HUD's Homele...	09/25/2023
3A-1a. Housing Leveraging Commitments	No		
3A-2a. Healthcare Formal Agreements	No		
3C-2. Project List for Other Federal Statutes	No		
Other	No	Home, Together; T...	09/25/2023

Attachment Details

Document Description: 1C-7 PHA Homeless Preference

Attachment Details

Document Description:

Attachment Details

Document Description: 1D-11a Letter Signed By Working Group

Attachment Details

Document Description: 1D-2a Housing First Evaluation

Attachment Details

Document Description: 1E-1 Web Posting of Local Competition Deadline

Attachment Details

Document Description: 1E-2 Local Competition Scoring Tool

Attachment Details

Document Description: 1E-2a Scored Forms for One Project

Attachment Details

Document Description: 1E-5 Notification of Projects Rejected-Reduced

Attachment Details

Document Description: 1E-5a. Notification of Projects Accepted

Attachment Details

Document Description: 1E-5b Local Competition Selection Results

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: 2A-6 HUD's Homeless Data Exchange (HDX) Report

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Home, Together; Tompkins

Submission Summary

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

Page	Last Updated
1A. CoC Identification	09/18/2023
1B. Inclusive Structure	09/23/2023
1C. Coordination and Engagement	09/23/2023
1D. Coordination and Engagement Cont'd	09/23/2023
1E. Project Review/Ranking	Please Complete
2A. HMIS Implementation	09/23/2023
2B. Point-in-Time (PIT) Count	09/23/2023
2C. System Performance	09/23/2023
3A. Coordination with Housing and Healthcare	09/23/2023
3B. Rehabilitation/New Construction Costs	09/23/2023
3C. Serving Homeless Under Other Federal Statutes	09/23/2023

4A. DV Bonus Project Applicants	09/23/2023
4B. Attachments Screen	Please Complete
Submission Summary	No Input Required

1C-7: Public Housing Agencies within Your CoC's Geographic Area–New Admissions–General/Limited Preference–Moving On Strategy.

This attachment contains the following:

1. Tompkins Community Action's Administrative Plan with a General Homeless Preference
2. Executed MOU between Ithaca Housing Authority and the CoC demonstrating their Limited Homeless Preference for the EHV program
3. Executed MOU between Homes and Community Renewal and the CoC demonstrating the limited homeless preference for the EHV program

1C-7: Public Housing Agencies within Your CoC's Geographic Area–New Admissions–General/Limited Preference–Moving On Strategy.

1. Tompkins Community Action's Administrative Plan with a General Homeless Preference

Section 1.0 SELECTION AND ADMISSION POLICIES

It is the policy of HCR to ensure that all families who express an interest in housing assistance are given equal opportunity to apply and are treated in a fair and consistent manner. This section describes the policies and procedures for selecting and admitting families to the Statewide Section 8 Housing Choice Voucher (HCV) Program including completion of an application for assistance, placement and/or denial of placement on the waiting list and limitations on who may apply.

Unless otherwise approved by HCR (and HUD if regulatory waiver is required), these selection and admission processes apply to all local program areas in HCR's Statewide Program jurisdiction.

1.01 Hiring a Housing Choice Voucher Participant as an Employee of the Local Administrator's Organization

HUD rules and regulations do not prohibit a PHA from hiring as an employee a person who is also a participant in the PHA's HCV program. However, when hiring such person, the LA should apply the same Section 8 standards and policies set forth in HUD rules and regulations and HCR's Administrative Plan. The standards and policies currently used to safeguard the privacy and confidentiality of tenant information and tenant files should apply equally to the employee. Special efforts should be taken to assure that the employee/recipient is not receiving preferential treatment. This policy also applies to program participants who are relatives of employees.

Where feasible, the LA should utilize the services of another PHA/LA to conduct inspections, interim and annual reexaminations.

The LA **must submit, within 90 days of initial participation,** the names of all employees and known relatives of employees who are participants in their Housing Choice Voucher program to their HCR Statewide Section 8 Voucher Program Representative. A relative for the purpose of this requirement is defined as follows (and includes the same for relationships created by marriage): spouse, child, sibling, parent, grandparent, grandchild, aunt, uncle, niece, nephew, cousin.

1.02 Eligibility of Local Administrator's Employees for Housing Choice Voucher Program Assistance

HUD rules and regulations do not prohibit an employee (*who is otherwise qualified*) of a PHA from applying and receiving HCV program assistance from the PHA with whom he/she is employed.

Therefore, when an employee of the LA applies for Housing Choice Voucher Program assistance, the LA should apply the same Section 8 standards and policies set forth in HUD

rules and regulations and HCR's Administrative Plan. The standards and policies currently used to safeguard the privacy and confidentiality of tenant information and tenant files should apply equally to the employee. Special efforts should be taken to assure that the employee/applicant is not receiving preferential treatment. This policy also applies to relatives of employees.

The word "relative" as used in this section pertains to parent, child, grandparent, grandchild, sister, or brother of any employee.

1.03 Preferences

HCR has established local preferences for tenant-based vouchers within the Housing Choice Voucher Program to further objectives towards improved residential stability, expanding housing opportunities and alleviating homelessness within New York State.

Each LA must give preference to applicants on their general tenant-based waiting list for the Housing Choice Voucher Program, as described below:

First priority shall be given to the following:

Households defined as Homeless.
A qualified household must fall under one of the two categories listed below as defined by HUD (10% of each LA's general allocation of regular vouchers must be dedicated to this preference - additional information below):

Category 1: An individual or family who ***lacks a fixed, regular, and adequate nighttime residence***, meaning:
a. An individual or family with a primary nighttime residence that is a public or private place not designed for or ordinarily used as a regular sleeping accommodation for human beings, including a car, park, abandoned building, bus or train station, airport, or camping ground; ***or***

b. An individual or family living in a supervised publicly or privately operated shelter designated to provide **temporary** living arrangements (including congregate shelters, transitional housing, and hotels and motels paid for by charitable organizations or by federal, state, or local government programs for low- income individuals); ***or***

c. An individual who is exiting an institution where he or she resided for 90 days or less and who resided in an emergency shelter or place not meant for human habitation immediately before entering that institution.

Category 4: Any individual or family who:
a. Is ***fleeing, or is attempting to flee, domestic violence, dating violence, sexual assault, stalking***, or other dangerous or life-threatening conditions that relate to violence against the individual or a family member, including a child, that has either taken place within the individual's or family's primary nighttime residence or has made the individual or family afraid to return to their primary nighttime residence; ***and***

b. Has no other residence; ***and***
c. Lacks the resources or support networks, e.g., family, friends, and faith- based or other social networks, to obtain other permanent housing.

In addition to identifying as one of the categories listed above, **HCR requires** the applicant provide or obtain written verification from a coordinating shelter, housing provider, service agency or institution (for those being discharged) confirming the same.

Second priority will be given to the following (No limitation):
Households identified as Elderly and/or Disabled (as defined by HUD) or Families with Dependent Children.

Third priority (No limitation):

All applicants who do not meet the criteria to claim one of the preferences described above but meet all other eligibility criteria as described in HUD regulations and this Administrative Plan.

As allowed under HUD regulations, HCR has exercised its' discretion to limit the number of applicants that may qualify for a local preference, therefore, 10% of each LA's general allocation of regular vouchers, not including those programs with a separate project number (i.e., Mainstream, VASH), must be designated for the above stated homeless preference. As long as the maximum threshold of 10% for each LA has not been reached, the homeless preference remains active within their jurisdiction. Once an LA has reached the maximum allowable participants for this preference, all remaining applicants will be chosen in order of remaining priorities and by position on the waiting list. Once a participant's voucher, that was initially qualified for assistance under the homeless preference has been terminated or relinquished, the LA must re-activate the homeless preference until the maximum allowable threshold is reached. Each LA will be responsible for maintaining their tenant-based waiting list in accordance with these requirements.

For the PBV program, while the homeless preference stated above is not applicable, each project sponsor is encouraged to consider a homeless preference for their project as allowed by and through the competitive selection process, funding requirements and any additional programmatic requirements applicable at the time of award.

All LA's with closed waiting lists must first offer current applicants on the waiting list who qualify to receive the benefit of the preference to move up on the waiting list accordingly. The notice to applicants must include how to successfully apply and establish themselves with the homeless preference status which would include the same format we implement for new applicants including contacting the partnering agencies for referrals and/or determination of preference eligibility. If a closed waiting list is opened to establish homeless applicants, the LA should specify on any public notice that current waiting list applicants will also be given the benefit of the preference.

HUD regulations currently require mandatory prohibitions to the HCV program. Policies regarding sex offender status, meth production, evictions within 3 years from federal assistance and those family members currently engaged in illegal drug use or threatening activity are all still mandatory prohibitions to the program. In addition, as no policy, whether mandated by HUD or discretionary as set forth in HCR's administrative plan, can be limited to or excluded from any one population (i.e. homeless population), all policies and/or available opportunities within the program must be followed, enforced and made available to all participants, as applicable.

Any additional special purpose programs with preferences or a targeted population as required by HUD are listed in Section 3.0 of this Administrative Plan and will be provided under separate notice.

1.04 Opening the Waiting List

Each LA will utilize the following procedures for opening any waiting list, including opening a waiting list solely for the purpose of a limited scope and/or a targeted population:

When the LA determines that there are an insufficient number of applicants on its local waiting list, the LA will advertise through public notice in local media of general circulation and any available minority media in the LA jurisdiction. The public notice should provide information on income and other general eligibility requirements; and should also contain the following:

- The dates, time, location, and other relevant contact information regarding where families may apply;
- The program(s) for which applications will be taken (general list, PBV, mainstream, etc);
- The specified period (if any) for which applications will be received by the LA; and
- A brief description of the program;
- A statement that individuals with disabilities are eligible for the program and that reasonable accommodations will be made where necessary to ensure equal participation in housing assistance;
- A statement affirming compliance with equal housing opportunity requirements; and affirming compliance with equal housing opportunity requirements; and
- The federal Equal Housing Opportunity Logo.

Within 30 days of closing the waiting list, if an application is requested or submitted by a person with a disability, such request will be granted/accepted as a reasonable accommodation.

In conjunction with opening the waiting list, the LA is required to prepare an Affirmative Fair Housing Marketing Plan which addresses:

- Conducting outreach to advocacy groups (i.e., disability rights groups) on the availability of housing assistance;

- Identifying and outreaching to the population that is least likely to apply, both minority and non-minority groups, through various forms of media (i.e., radio stations, posters, newspapers) within the marketing area and through various community groups.

1.05 Closing the Waiting List

The LA may discontinue receiving applications if there are enough applicants to fill anticipated openings for the next **24** months. A local waiting list may **not** be closed if to do so would have a discriminatory effect inconsistent with applicable civil rights laws.

The LA will announce the closing of the waiting list by public notice.

1.06 Updating and Purging the Waiting List

The LA will update and purge its waiting list (***including any active PBV waiting lists***) at least annually to ensure that the pool of applicants reasonably represents families still actively interested in Section 8 HCV assistance. Updating enables the LA to update information regarding address, family composition, income category and preferences. The number of applicants on the waiting list should be at least equal to 50% of the LA's current program size or sufficient to cover the next 24 months of anticipated available vouchers, whichever is greater.

Prior to updating the waiting list:

- The LA must retain a copy of the pre-updated waiting list report.
- All applicants who are affected by the update must be notified by mail.

The updating/purging process must be performed at minimum for those applicants considered reachable within a 12 month period for each active waiting list. All correspondence must include the name and address of the applicant notified.

The LA should advise applicants to provide updated contact information in writing. Applicants will be advised that they will be removed from the waiting list if they cannot be reached at the address provided on the initial application.

The letter will indicate that the purpose of the contact is:

- to determine applicant interest in remaining on the waiting list; and
- to offer the family an opportunity to update any information previously provided to the LA.

The contact letter will require the applicant to provide return correspondence in the following circumstances:

1. The applicant wishes to be removed from the waiting list, or
2. The applicant wishes to update information currently on file provided by the LA to expedite return of requested information.

Contact letters returned by the Post Office as undeliverable will be grounds for removing an applicant from the waiting list. However, if a letter is returned by the Post Office with a forwarding address, the LA should update the information on the computer and re-mail the letter to the new address. In such cases, an applicant's name should not be removed from the active waiting list and determined ineligible unless the applicant fails to respond to this notice.

In addition, and if applicable, the LA should also notify the contact person or organization provided by the applicant on **Form HUD-92006**, "Supplement to Application for Federally Assisted Housing (see section of form entitled "Reason for Contact")", before removing the applicant's name from the active waiting list.

The LA will compare results of the update to regular annual program participant attrition rates. If the initial update results in an inadequate number of applicants to offset regular program attrition rates, the LA will conduct additional outreach until it is determined that there are sufficient numbers of active applicants.

1.07 Removal of Applicants from the Waiting List

The LA will remove an applicant's name from the waiting list under the following conditions:

- The applicant requests, in writing, that his/her name be removed;
- The applicant fails to respond to a written request for information;
- Correspondence is returned to the LA by the Post Office as undeliverable;
- The applicant misses two or more scheduled appointments/briefings; or
- The applicant does not meet either program eligibility or screening criteria.

Before removing an applicant from the waiting list due to the applicant's failure to respond to a written request, a second letter must be mailed to the applicant. If the applicant does not respond to the second notice within ten (10) business days, the name of the applicant will be removed from the waiting list.

When an extenuating circumstance prevents an applicant from responding to an LA's correspondence which resulted in the applicant being removed from the active waiting list and determined ineligible, reinstatement of the applicant shall be granted by the LA subject to acceptable documentation verifying the extenuating circumstance. If reinstatement is granted, the applicant will retain his/her original position on the waiting list.

Requests for reinstatement to the waiting list due to extenuating circumstances must be made within 60 days of the LA's notice informing the applicant that his/her name will be removed from the active waiting list. **Requests that are received after the 60 days period must be denied**.

Extenuating circumstances include, but are not limited to the following:

- When a death has occurred in the family;
- Hospitalization;
- Illness;
- Incarceration; and
- Other circumstances determined by the LA

In no event will an applicant's name be held in abeyance on the active waiting list based on his/her representation that he/she is not ready to be processed when reached on the list.

Applicants' files must be retained for at least three years after the date an application is closed, withdrawn from the waiting list, or determined ineligible.

1.08 Screening of Applicants

As part of LA processes for determining eligibility for participation, the LA will conduct criminal background checks on all adult household members, including live-in aides. These checks will be used to identify circumstances under which assistance must be denied in accordance with the requirements of Section 1.9.

All adult applicant family members will be required to sign a release of information which will authorize the LA to access criminal records.

This check may be made through state or local law enforcement or court records in those cases where the household member has lived in the local jurisdiction for the last three years. If the individual has lived outside the local area, the LA may contact law enforcement agencies where the individual had lived or request a check through the FBI's National Crime Information Center (NCIC). The LA will also check with the State sex offender registration program to determine if an individual is subject to a lifetime registration requirement as a State sex offender.

Additional screening is the responsibility of the owner. Upon the written request of a prospective owner, the LA will provide any factual information or third party written information they have relevant to a voucher holder's history of, or ability to, comply with material standard lease terms.

The LA will not screen family behavior or suitability for tenancy. The LA will not be liable or responsible to the owner or other persons for the family's behavior or the family's conduct in tenancy.

The owner is responsible for screening and selection of the family to occupy the owner's unit. At or before LA approval of the tenancy, the LA will inform the owner that screening and selection for tenancy is the responsibility of the owner. The owner is responsible for screening families based on their tenancy histories, including such factors as:

- Payment of rent and utility bills;
- Caring for a unit and premises;
- Respecting the rights of other residents to the peaceful enjoyment of their housing;
- Drug-related criminal activity or other criminal activity that is a threat to the health, safety or property of others; and
- Compliance with other essential conditions of tenancy.

All screening procedures will be administered uniformly, fairly and in such a way as not to violate rights to privacy or discriminate on the basis of race, color, nationality, religion, familial status, disability, sex or other legally protected groups under federal, New York State or local fair housing laws.

To the maximum extent possible, the LA will involve other community and governmental entities in the promotion and enforcement of this policy. This policy will be posted on the LA's bulletin board and copies made readily available to applicants and participants upon request.

1.09 Grounds for Denial of Assistance

There are two automatic bars for which the LA will permanently deny assistance:

1. The LA **will** permanently deny assistance to a family if any member of the family has ever been convicted of drug-related criminal activity for manufacture or production of methamphetamine on the premises of federally-assisted housing.

2. The LA **will** permanently deny assistance to anyone subject to a lifetime registration requirement as a State sex offender.

The LA will also deny assistance to applicants who:

1. do not meet any one or more of the eligibility criteria;

2. do not supply information or documentation required by the application process;

3. fail to complete any aspect of the application or lease-up process;

4. have a history of criminal activity by any household member involving crimes of physical violence against persons or property, or any other criminal activity, including drug-related criminal activity that **would adversely affect the health, safety or well-being of other participants or staff, or cause damage to the property**. The LA may only consider prior criminal convictions or pending arrests and may not consider arrests and/or accusations that did not result in a conviction. Even where convictions exist, those convictions cannot be an automatic bar to the applicant being granted assistance unless they are one of the two automatic bars discussed above. However, such history will not serve as the basis to

deny assistance if it has been at least five (5) years since the conviction or service of sentence whichever is later, where there has been no other such intervening criminal activity during that period that would serve as the basis to deny assistance.

5. have engaged in illegal drug use or a pattern of alcohol abuse (as specified below) within 1 year of initial lease-up of an applicant:

    - A member of the household has demonstrated a pattern of drug or alcohol abuse that threatens the health, safety or right to peaceful enjoyment of other residents and/or persons in the immediate vicinity of the premises.

The LA may waive the decision to deny assistance if:

- the person responsible for the prohibited action demonstrates successful completion of or are participating in a credible rehabilitation program approved by the LA, or

- the circumstances leading to the violation no longer exist because the person who engaged in prohibited drug-related or alcohol-related activity is no longer in the household due to death or incarceration.

- The LA may approve assistance to an eligible family, provided that the household member(s) determined to have engaged in the proscribed activities will not reside in the unit. If the violating member is a minor, the LA may consider individual circumstances with the advice of Juvenile Court officials.

If assistance is to be denied because of criminal activity, drug or alcohol abuse as outlined above, the denial will be based upon either of the following:

- Preponderance of evidence – defined as *"evidence which is of greater weight or more convincing than the evidence which is offered in opposition to it; that is, evidence which as a whole shows that the fact sought to be proved is more probable than not."*
- Credible Evidence – defined as *"evidence provided by police and court systems such as drug raids, drugs found in the dwelling unit, evidence which is tied to the activity, warrants issued, arrests made, etc."*

6. currently owe rent or other obligations to any housing authority in connection with the public housing or Section 8 programs;

7. have committed fraud, bribery, or any other corruption in connection with any Federal housing assistance program, including the intentional misrepresentation of information related to their housing application or benefits derived there from;

8. have a family member who was evicted from federally-assisted housing within the last five years;

9. have a household member who has been evicted from federally-assisted housing for drug -related criminal activity within the last three (3) years prior to anticipated date of admission. "Drug-related criminal activity" is defined as the illegal manufacture, sale, distribution or possession with the intent to manufacture, sell or distribute a controlled substance as defined in Section 102 of the Controlled Substances Act, 21 U.S.C. 802. However, an eviction within the last 3 years for drug-related criminal activity is not an automatic bar since the LA will provide assistance if:

    - The evicted household member who engaged in drug-related criminal activity has successfully completed a supervised drug rehabilitation program approved by the LA; or

    - The circumstances leading to the eviction no longer exist (for example, the household member has died or is incarcerated);

10. have a family member who is illegally using a controlled substance or abuses alcohol in a way that may interfere with the health, safety, or right to peaceful enjoyment of the premises by other residents. The LA may waive this requirement if:

    - the person demonstrates to the LA's satisfaction that the person is no longer engaging in drug-related criminal activity or abuse of alcohol;

    - the person has successfully completed a supervised drug or alcohol rehabilitation program;

    - the person has otherwise been rehabilitated successfully; or

    - the person is participating in a supervised drug or alcohol rehabilitation program.

11. have engaged in or threatened abusive or violent behavior towards any LA staff member;

12. have a family household member who has been terminated under the Pre-Merger Certificate or Voucher Programs or Housing Choice Voucher Program during the last three years. This three-year prohibition does not apply to a family member who voluntarily withdrew from the program, and was in good standing at that time;

13. have a family member who has been convicted of manufacturing or producing methamphetamine;

14. have a family member with a lifetime registration under a State sex offender registration program; or

15. is a welfare-to-work (WTW) family that willfully and persistently failed to fulfill its obligations under the welfare- to-work voucher program within the last three years.

In considering whether to deny or terminate assistance because of any actions or failure to act by the members of the family, the LA must look at relevant circumstances such as the seriousness of the case the extent of participation or culpability of the individual family members, mitigating circumstances related to the disability of a family member, and the effects of denial on the other family members who were not involved in the action or failure.

These circumstances governing denial of assistance to applicants shall also be applicable to any and all instances wherein a participant family wishes to admit an additional family member who meets any of the above conditions.

1.10 Confidentiality of Criminal Records

The LA will ensure that any criminal record received is maintained confidentially, not misused or improperly disseminated, and must be destroyed once the purpose for which it was requested is accomplished.

All criminal reports, while needed, will be housed in a locked file with access limited to LA staff individuals responsible for screening and determining eligibility for initial and continued assistance. Misuse of the above information by any employee of the LA will be grounds for termination of employment.

If the family is determined eligible for initial or continued assistance, the criminal report must be shredded as soon as the information is no longer needed for eligibility or continued assistance determination.

If the family's assistance is denied or terminated, the criminal record information must be shredded immediately upon completion of the review or hearing procedures and the final decision.

The LA will document in the family's file the circumstances of the criminal report and the date the report was destroyed.

1.11 Notification of Negative Actions

Any applicant whose name is being removed from the waiting list will be notified in writing by the LA that he/she has ten (10) business days from the date of the written correspondence to request an informal review. The letter will also indicate that the applicant's name will be removed from the waiting list if he/she fails to respond within the time limit specified.

If an applicant's criminal record was obtained from a state or local agency under section 24 CFR 5.903 or 5.905 (that is, obtained a criminal conviction or sex offender record of an adult household member from a law enforcement agency using the approved consent form) showing that a household member has been convicted of a crime relevant to applicant screening, the

family must first be provided with the subject record and an opportunity to review and dispute the accuracy and relevancy before a denial of admission is communicated if based on the same information. Written notification indicating the applicant has (10) days from the date of the written correspondence to review and/or dispute must be provided prior to a notice of denial.

The LA's system of removing applicants' names from the waiting list will not violate the rights of persons with disabilities. If an applicant's failure to respond to a request for information or updates was caused by the applicant's disability, the LA will provide a reasonable accommodation. If the applicant indicates that he/she did not respond due to a disability, the LA will verify that the applicant is disabled.

An example of a reasonable accommodation would be to reinstate the applicant on the waiting list based on the date and time of the original application.

1.12 Application Procedures

Each LA will utilize a standardized application form approved by HCR. The applicant will be responsible for completing all sections of the application. If an applicant with a disability requests assistance as a reasonable accommodation, the LA will arrange for it.

The primary purpose of the application intake function is to gather pertinent eligibility information on applicants. This process will also be utilized by LAs to provide such information to applicants as may be necessary to ensure accurate and timely decisions concerning eligibility and to expedite provision of assistance to eligible families.

Prospective applicants may either complete the application at the LA's office or request that one be sent to them for completion and return.

Each application must be accompanied by proof of the applicant's current address. The only exceptions to this requirement are:

a. Project-based applicants; however, if an applicant applies to both waiting lists (project - based and Housing Choice Voucher), proof of residency is required for the HCV waiting list.

b. Applicants who are not residing in the LA's jurisdiction at the time of application.

Should an applicant be unable to provide the required proof of residency at the time of initial application, they will be considered a "non-resident" applicant as defined in Section 1.17.

At a minimum, the application will contain the following information:

1. Head-of-household name, address, and phone number;

2. Dates of birth for all family members;

3. Social Security numbers for all family members in accordance with HUD regulations and guidance, and HCR policy notices.

4. Racial and ethnic designation of the head of household;

5. Preferences either authorized by HCR or required by HUD;
6. Annual gross income for each family member;

7. Date application was submitted; and

8. Form HUD-92006, Supplement to Application for Federally Assisted Housing. *Note: While HUD requires that this form be included as a Supplement to the PHA's Application for Federally Assisted Housing, the applicant has the option of providing additional contact information, or declining to do so. Regardless of the option chosen, the signed and dated form must be maintained in the applicant's file.*

9. Veteran status for Head of Household, Co-Head, and Spouse.

Upon receipt in the LA's office, the date and time of each application will be recorded on the application form. Persons submitting applications will not be required to attend an interview; information on the application will be accepted on a "*self-certified*" basis until the applicant is contacted for a pre-selection final eligibility determination. Incomplete applications will be returned to a family, together with a statement of what information is necessary to complete the application.

Each person submitting an application will receive written acknowledgment of receipt of the application from the LA. As further described below, the acknowledgment will indicate the applicant's tentative eligibility status.

Applicants who have submitted a complete application and have been determined to be preliminarily eligible for Section 8 HCV assistance will be placed on the waiting list until assistance is available. In the acknowledgment letter, the LA will briefly indicate the steps that will follow after the applicant's name has been placed on the waiting list.

While documents verifying date of birth may be requested at the time of submission of the application, an applicant should not be denied placement on the waiting list if this documentation is not provided. Such verification is only required at the time of the final eligibility determination.

Disclosure of Social Security numbers by applicants must conform to HUD regulations and guidance, and to HCR policy notices. Accordingly, applicant(s) have up to 180 days to meet HUD's Social Security documentation requirements before being removed from the waiting list.

If an applicant is determined ineligible based on the information provided in the application, the LA will notify the family in writing (in an accessible format upon request as a reasonable

accommodation), state the reason(s), and inform the family of its right to an informal review. Persons with disabilities may request to have an advocate attend the informal review as a reasonable accommodation.

1.13 Applicant Status While on Waiting List

All applicants who are placed on the waiting list will be informed of their responsibility to report changes in address in writing within 30 days of occurrence. Applicants will also be required to report changes in income, family composition and/or other items potentially affecting applicant eligibility.

Applicants will be notified that, if the LA is unable to contact the family due to its failure to promptly submit a change of address notification, it may result in its name being dropped from the waiting list. Applicants will also be dropped from the waiting list if they fail to respond to written requests for information or action within LA-specified time frames.

Exceptions will be granted for applicants with disabilities, as defined in 24 CFR §5.403 who were not able to respond within the time frame due to their disability. Exceptions may also be granted for applicants hospitalized for sufficient duration if the failure to respond is/was due to the hospitalization.

1.14 Time of Selection

When funding is available, families will be selected from the waiting list in sequence, regardless of family size, subject to income targeting requirements.

1.15 Income Targeting Requirement

The same income targeting rule that applies to participant-based vouchers also applies to project-based vouchers (PBV). The 75% targeting requirement is a combined factor for any LA with both participant-based and project-based vouchers.

LAs are responsible for ensuring that, in any given year, of the **combined total** of participant-based and project-based admissions, not less than 75% of admissions must be families with incomes at or below 30% of area median.

HCR's "targeting year" is the same as its program fiscal year of April 1 through March 31. LAs should look at the previous year's admission activity to determine the overall percentage of families admitted who were at or below 30% of median. No adjustments to administrative practices will be necessary if it is considerably above 75%.

HCR does not grant waivers of the income targeting policy for which an owner or landlord can apply.

In order to ensure that the targeting requirements are met on an overall basis, it is necessary that LAs meet these requirements on an individual basis. However, HCR may exercise its discretion to modify this requirement on an "as needed" or individual basis, in view of the initial impact on targeting that may result from PBV move-ins.

For PBV vacancies, LAs must continue doing everything possible to admit families with incomes at or below 30% of median. However, the LA is permitted to raise the targeting income ceiling to 50% of area median income if the LA can demonstrate that sufficient families at the 30% of area median income level are not available. In this situation, LAs should primarily, **if not solely**, admit families having incomes at or below 30% of area median income to tenant-based HCV openings, until the overall percentage of the LAs annual admissions equals or exceeds 75% of families at this income level.

1.16 Selection of Families from the Waiting List

Unless otherwise approved by HCR (and HUD if such approval is necessary), the selection of participants in all LA Program jurisdictions will be according to the following local selection order:

- For participant households with more than one family member, selection will be based on date and time of application *(or in the case of an LA using a lottery selection process, in the order generated by the lottery selection process*.)

- For single person households, persons who are elderly, disabled, handicapped or displaced will be selected before other single person households.

The qualification for the above listed preference and/or any subsequent preferences that may be added is based solely on an applicant's status **at the time of selection from the waiting list**. LAs must not ask an applicant claiming disability to specify the exact nature of (or state or explain) his/her disability, nor does the applicant have to submit proof of said disability; documentation can only state that the applicant is disabled.

Notwithstanding the above, if necessary to meet the statutory requirement that 75% of newly admitted families in any fiscal year be extremely low-income families (unless a different target is agreed to by HUD), the LA retains the right to skip higher income families on the waiting list to reach extremely low-income families. This measure will only be taken if it appears the goal will not otherwise be met. To ensure this goal is met, HCR and each LA will monitor incomes of newly admitted families and the incomes of the families on the waiting list.

If there are an insufficient number of extremely low-income families on the waiting list, the LA will conduct outreach on a non-discriminatory basis to attract sufficient numbers of extremely low-income families in order to reach the statutory requirement.

1.17 First-Year Limitation on Where Family Can Lease a Unit at Initial Participation in the Program

A "non-resident" applicant is required to utilize the voucher for the first 12 months in the initial Local Administrator's jurisdiction.

For the purposes of this provision, a "non-resident" applicant is one where neither the head of household or spouse had a "domicile" (legal residence) in the jurisdiction of the Local Administrator at the time the family submitted an application for participation in that LA's program. This section does not apply when the family or a member of the family is or has been the victim of domestic violence, dating violence, sexual assault, or stalking, as provided in 24 CFR part 5, subpart L (Protection for Victims of Domestic Violence, Dating Violence, Sexual Assault, or Stalking), and the move is needed to protect the health or safety of the family or family member, or any family member who has been the victim of a sexual assault that occurred on the premises during the 90-calendar-day period preceding the family's request to move.

The term "Legal Domicile" is defined as follows: "*The legal residence of the household head or spouse as determined in accordance with State and local law.*" New York State case law defines "domicile" as "*one's [the household head or spouse] principal and permanent place of residence where he/she always intends to return to from wherever he/she may be temporarily located and from which he/she has no present intention of moving. In other words, the 'domicile' is the location where a person intends to make his or her home indefinitely.*"

Families will be advised that, if contacted for admission to the local program wherein they were a "non-resident" at the time of application, they must utilize the assistance for 12 consecutive months in the jurisdiction of the program where they are being admitted before portability may be granted. In order to exercise their right to port, the family must provide supportive documentation establishing 12 consecutive months of residency with assistance. All documentation received must completely and sufficiently support the family's residency claim. If there is insufficient evidence to support the residency claim, the portability request must be denied. If any documentation submitted to establish residency is determined fraudulent, the family must be terminated. All "non-resident" applicants must be advised of this policy upon acceptance of their application by the LA and at the time the family is contacted to establish an eligibility certification interview.

Conversely, if the family was a resident in the LA's jurisdiction at the time of application, they will be eligible for portability at the time of initial issuance of the voucher.

The legal residence reported by the applicant at the time of application is the determining factor in the implementation of these provisions.

1.18 Eligibility of Students for Assisted Housing under Section 8

An LA should apply 24 CFR 5.609(b)(9) when determining the eligibility of a student and calculating income.

An LA shall deny Section 8 assistance if the head of household is enrolled as a full-time student at an institution of higher education unless one or more of the following circumstances applies:

- The head of households is over the age of 23;
- The head of households is a veteran of the United States military;
- The head of household is married;
- The head of household has at least one dependent child;

The above exceptions do not apply to a student residing in a Section 8 assisted unit with his or her parent(s) or who lives with his/her parent(s) who are applying to receive Section 8 assistance. Students who are living with their parents who are, individually or jointly, ineligible for assistance may not apply.

Tuition and Fees

LAs should evaluate income verification for students on a case-by-case basis. Typically, financial aid amounts exceeding tuition, fees, and other required educational expenses must be included when calculating the household's annual income. This rule applies except where the head of household falls into one of the exceptions listed above, in which case any income received from an Institution of Higher Education, including student stipends, work study, etc., is excluded. This exclusion only applies if the LA determines that the head of household is a full-time student at that Institution.

When evaluating whether a head of household qualifies as a full-time student, an LA should review the student's bill, account statement, IRS Form 1098-T, or any official documentation from the school directly. As a guide, the school's website may assist in providing an itemized list of tuition and fees typically charged students. Student loan proceeds are also excluded from income calculations.

If a program participant is seeking an income exclusion, the burden of proof is on the applicant. If the applicant provides inconsistent, conflicting, or non-credible information, it is appropriate for the LA to seek clarity and request additional supporting documentation as needed. While the LA may ask the participant, among other things, if they are a student and where they are enrolled in an educational program, 24 CFR 5.609(b)(9) does not provide a standard for determining when a participant qualifies as a student or what qualifies as an educational program.

Questions the LA may ask when evaluating student eligibility and calculating income may include:

1) Is the participant charged tuition and/or any other required fees and charges? If yes, what are itemized charges?

2) Is the financial assistance being provided intended to cover, in whole or in part, the tuition and/or other required fees and charges as are defined in PIH Notice 2015-21 and Housing Notice 2015-12?

3) Is the financial assistance provided under the Higher Education Act of 1965 from private sources or higher education institutions (as defined by the Higher Education Act of 1965)?

1.19 Initial Eligibility Certification

At the point of selection from the waiting list, all adult household applicants will be required to participate in an initial eligibility certification interview. Single persons who claim that they are elderly, disabled, handicapped or displaced must have that status verified prior to the LA's scheduling of the initial eligibility certification interview.

Information used to verify an applicant's eligibility at initial certification for the HCV program must be current, that is within 60 days of the issue date of a voucher. Upon verification of the applicants' information, the LA must update the electronic "Wait List Applicant Report" for each applicant. A copy of the "Wait List Data Sheet" must be maintained in each applicant's file.

After the above preference is verified, applicants will be required to participate in a full eligibility certification interview with an LA representative in accordance with 24 CFR 982.301. The certification and briefing interview afford the LA an opportunity to discuss the family's circumstances in greater detail, to clarify information which has been provided by the family, and to ensure that all required information is accurate and complete. The briefing phase of the interview is used as a vehicle to provide information about the certification and verification process, as well as to advise the family of other PHA services or programs which may be available.

At the certification interview, the applicant will be required to furnish complete and accurate information requested by the interviewer. The LA representative will initially complete the certification based on written and/or verbal information provided by the applicant.

At the conclusion of the certification interview, the applicant will sign and certify that all information is complete and accurate.

1.20 Requirement to Attend Briefing Interview

All adult family members are required to attend the interview and sign the eligibility certification. Exceptions may be made for students attending school out of state or for members for whom attendance would be a hardship. Interviews must be held in a manner which meets the requirements set forth by HUD and this Administrative Plan. They may be conducted in person, remotely via video-teleconferencing, or through other virtual platforms. To conduct a briefing remotely, the methodology must be consistent with the requirements in Section 14.05 (Hearing Procedures) of this Administrative Plan. It is incumbent on the LA to ensure the same equal opportunity and nondiscrimination requirements for individuals with disabilities and limited English proficient (LEP) persons under Section 504 of the Rehabilitation Act of 1973 (Section 504), the Americans with Disabilities Act of 1990 (ADA), Title VI of the Civil Rights Act of 1964, and the Fair Housing Act are followed.

The head of household or the head and spouse are required to attend the interview. If the head of household cannot attend the interview, the spouse may attend to complete the certification and certify for the family. However, the head of household will be required to attend an interview within three days to review the information and to certify by signature that all of the information is complete and accurate.

If an applicant misses a scheduled appointment, does not contact the LA to reschedule, cannot be contacted by the LA to reschedule or misses two scheduled meetings, the LA will reject the application and the applicant will be removed from the waiting list.

If an applicant is denied assistance due to failure to attend the full certification interview, the applicant will be notified in writing and offered an opportunity to request an informal review.

Reasonable accommodation will be made for persons with a disability who require an advocate or accessible offices. A designee will be allowed to participate in the interview process, but only with permission of the person with a disability.

The head of household and spouse will be required to sign the certification form and/or a supplemental form/worksheet containing the family composition, income, asset and allowance information for the family. As required by the LA, other adult members may also be asked to sign these forms.

All adult members must sign:

- HUD Form 9886 (Release of Information);
- any supplemental forms and/or documents required by the LA;
- declarations and consents related to citizenship/immigration status; and
- a consent form to release criminal conviction records and to allow the LA to receive records and use them in accordance with HUD regulations.

Applicants may also be required to sign specific verification forms for information which is not covered by HUD form 9886. Failure to do so when required will be cause for denial of the application for Section 8 assistance.

If the LA determines during or after the interview that additional information is needed directly from the applicant, the LA will specify in writing what information is required and what kind of documentation must be provided by the applicant to verify it. The family will be given ten business days to supply requested information. If the information is not supplied in this time period, the LA may deny assistance.

1.21 Portability Moves from Other PHAs

Local Administrators are required to adhere to HUD's portability requirements for initial and receiving PHAs, as set forth in HUD regulations and PIH Notices.

Policies related to absorption or billing of portability moves are established by HCR as PHA. HCR reserves the right to revise its portability billing guidelines based on budget authority granted by HUD and unit baseline allocations established by HCR for each local program.

1.22 Income Verification

All income and asset information provided by the applicant must be verified using HUD's income verification hierarchy (See below and Section 20 of this Administrative Plan). The file must be documented to leave a clear audit trail. Any documentation requested directly from the applicant must be provided within the time specified by the LA.

Annual income criteria (including definition and exclusions) can be found at 24 CFR 5.609.

HUD Verification Hierarchy and Techniques

Level	Verification Technique	Ranking
6	**Upfront Income Verification (UIV)** using HUD's Enterprise Income Verification (EIV) system (not available for income verifications of applicants)	**Highest** (Mandatory use for all participants and new admissions within 120 days)
5	**Upfront Income Verification (UIV)** using non-HUD system	**Highest** (Optional) (i.e., The Work Number, other databases)
4	**Written Third-Party Verification**	**High** (Mandatory use for all applicants where non-HUD UIV system is not available; Mandatory to supplement EIV-reported income sources and when EIV has no data; Mandatory for non-EIV reported income sources; Mandatory when tenant disputes EIV-reported employment and income information and is unable to provide acceptable documentation to support dispute.)
3	**Written Third-Party Verification Form**	**Medium-Low** (Mandatory if written third party verification documents are not available or rejected by the PHA; and when the applicant or tenant is unable to provide acceptable documentation)
2	**Oral Third-Party Verification**	**Low** (Mandatory if written third party verification is not available)
1	**Tenant Declaration**	**Low** (Use as a last resort when unable to obtain any type of third party verification)

Note: This verification hierarchy applies to income determinations for applicants and participants. EIV is not available for verifying income of applicants until after they have been admitted. Verification Hierarchy and Techniques illustrates six levels of verification starting with 6 as the highest category of Upfront Income Verification using HUD's EIV system, then 5 Upfront Income Verification (UIV) using non-HUD system, 4 Written Third Party Verification, 3 Written Third Party Verification Form, 2 Oral Third Party Verification and 1 Tenant Declaration.

1.22.01 Child Support

Periodic and determinable allowances received as child support payments must be included as annual income. However, child support payments pursuant to court order or private agreement that is nonrecurring or sporadic shall be excluded as income upon proper written verification.
The LA must also obtain third party verification of income derived from child support and/or cash contribution. Request for verification of such incomes must be made directly from the contributor or the enforcement agency (family court or Department of Social services, etc.).

1.22.02 Pay Stubs as Verification of Income

Original or authentic pay stubs generated by a third-party source dated either within the 60-day period preceding the reexamination or LA's requested date can be accepted as verification of income subject to the following:

LAs are required to obtain a minimum of two current consecutive paystubs and/or year-to-date statement to determine annual income from wages. However, at its discretion, LAs are permitted to obtain additional paystubs as warranted to determine the annual income.

The average of the paystubs and the average of the year-to-date statement must be compared; the greater of the two averages must be used. Paystubs that are not consistent with (less than) an individual's regular pay cycle (i.e.; weekly, bi-weekly, monthly, etc.) should not be used in the determination of average annual income. LAs must ascertain the reason(s) for the inconsistency and the file must be documented to leave a clear audit trail.

When the LA cannot readily anticipate income based upon current circumstances (e.g., in the case of seasonal, temporary or inconsistent employment), the LA will review and analyze historical data (tax returns, EIV) for patterns of employment, paid benefits, and receipt of other income and use the results of this analysis to establish annual income.

If the submitted paystubs or the year-to-date statement are inadequate to determine the average annual income. LAs must request/obtain third party verification of income.

1.22.03 Asset Verification

LAs are required to include in the calculation of annual income any interest or

dividends earned on assets held by the family. Original or authentic documentation (i.e.; bank statements, stocks/bonds, real estate, etc.) generated by a third-party source within the most recent three (3) months. At its discretion, the LA may obtain statements that are older than 3 months if there is/are suspicion of any irregularities.

When a family has net family assets in excess of $5000, annual income shall include the greater of the actual income derived from the net family assets or a percentage of the value of such assets based on the current passbook savings rate, as determined by HUD.

For each new admission, the LA must comply with HUD's EIV income verification requirements, including:

- review the EIV Income Report to confirm/validate family-reported income within 120 days of the PIC submission date; and
- print and maintain a copy of the Income Report in the tenant file; and
- resolve any income discrepancy with the family within 60 days of the EIV Income Report.

1.22.04 Medical Expenses

Medical expenses, as defined in 24 CFR 5.603(b) are expenses, including medical insurance premiums, that are anticipated during the period for which annual income is computed, and that are not covered by insurance.

Unreimbursed medical expense deductions exceeding 3% of the household's annual income may be permitted in families where the head, spouse, or co-head is at least 62 or is disabled. If a family meets the eligibility criteria for a medical expense deduction, the qualified medical expenses of all family members may be counted. Medical expenses must be personally incurred and not covered or reimbursed under any insurance, coverage plan or paid from any other source. In order to qualify as a medical expense deduction, it must be listed as an includable item in the most current IRS Publication 502, Medical and Dental Expenses.

*Summary of Allowable Medical Expenses from IRS Publication 502	
• Services of medical professionals • Surgery and medical procedures that are necessary, legal & non-cosmetic • Services of medical facilities • Hospitalization, long term care, and in-home nursing services • Prescription medicines and insulin, (all nonprescription & OTC medicines are not allowed unless they have been prescribed by a doctor) • Medical supplies, such as bandages • Substance abuse treatment programs • Psychiatric treatment	• Actual transportation costs for and essential to medical care (i.e., bus, taxi, ambulance) or standard medical mileage rate for a car • The cost and care of necessary equipment related to a medical condition (e.g., eyeglasses/lenses, hearing aids, crutches, and artificial teeth) • Cost and continuing care of necessary service and/or guide animals as defined in the Glossary (excludes support animals) • Medical insurance premiums or the cost of a health maintenance organization (HMO) • Amounts paid for the prevention and alleviation of dental disease
*This chart provides a summary of eligible medical expenses only. Detailed information is provided in IRS Publication 502.	

1.23 Final Determination and Notification of Eligibility

After verification is completed, the LA will make a final determination of eligibility. This decision is based upon information provided by the family, verification activities undertaken by the LA and current eligibility criteria in effect. If the family is determined to be eligible, the LA will confirm eligibility via written notification to the family. If a briefing has not already been conducted by the LA, one will be scheduled to coincide with issuance of the Housing Choice Voucher.

1.24 Document Retention for Applicants and Participants

1.24.01 Applicants

Applicant files and documents must be retained for at least three years after:

- the date an application is closed;
- the applicant has withdrawn from the waiting list; or
- the applicant is determined ineligible.

When an applicant is admitted to the program, the application and associated verification of eligibility documents must be transferred to the participant's file and must be retained in that file according to the rules for program participant files (see below).

Special rules apply to retention of U.S. Citizenship and Immigration Services

(USCIS) documents. These documents must be retained for at least five years.

1.24.02 Participants

Documents for participants must be retained during the term of the assisted tenancy and for at least three years thereafter. However, **except** for the documents listed below, ***all other documents may be destroyed after the three-year period***.

- Birth certificates or other verification of DOB
- Social security cards
- Initial application
- Initial income eligibility verification
- Initial voucher
- Initial 50058
- Initial HAP contract
- Initial lease and tenancy addendum

Note: USCIS documents must be retained for at least five years.

When a new or additional folder is created for an existing participant, the documents specified above must be transferred to the new folder.

1.24.03 Criminal Records

Special retention rules pertain to criminal records for both applicants and participants. Criminal records must be maintained confidentially until the purpose for which they were obtained has been accomplished including any informal reviews, if requested, have been completed. At that time all criminal records obtained are **required** to be destroyed. The file should be documented with a reference to the type of screening and the date the screening was performed.

1C-7: Public Housing Agencies within Your CoC's Geographic Area–New Admissions–General/Limited Preference–Moving On Strategy.

2. Executed MOU between Ithaca Housing Authority and the CoC demonstrating their Limited Homeless Preference for the EHV program

MEMORANDUM OF UNDERSTANDING - EMERGENCY HOUSING VOUCHERS

This Memorandum of Understanding (MOU) has been created and entered on July ____, 2021 by and between the following parties in relation to the Emergency Housing Vouchers (EHV).

THE ITHACA HOUSING AUTHORITY (IHA)
800 South Plain Street
Ithaca NY 14850

ITHACA/TOMPKINS HUMAN SERVICES COALITION-CONTINUUM OF CARE (ITCOC)
118 N. Tioga Street Suite 304
Ithaca NY 14850

ADVOCACY CENTER OF TOMPKINS COUNTY (ADVOCACY CENTER)
P.O. Box 164
Ithaca NY 14851

INTRODUCTION AND GOALS

The Ithaca Housing Authority (IHA), Ithaca/Tompkins Human Service Coalition-Continuum of Care (ITCoC) and the Advocacy Center of Tompkins County (Advocacy Center) commitment to administering the EHV program for the specified population listed below.

- The IHA, ITCoC and Advocacy Center recognize that access to safe and affordable housing is a significant challenge for individuals who are (1) homeless; (2) at risk of homelessness; (3) fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking; or (4) recently homeless, and

- The IHA, ITCoC, and Advocacy Center recognize the need and significant challenges facing our community to achieve safe and affordable housing, and

- The IHA, ITCoC, and Advocacy Center recognize that providing rental assistance will prevent a family or individual from homelessness or high risk of housing instability, and

- The IHA, ITCoC and Advocacy Center desire to work together to provide access to additional Housing Choice Vouchers (HCV) to further these mutual goals, and

- The IHA is committed to working with the ITCoC by integrating the prioritization and referral process for Emergency Housing Voucher eligible individuals and families into their coordinated entry process, and

- The IHA is committed to working with the ITCoC and Advocacy Center to administer the Emergency Housing Vouchers in accordance with all HUD and IHA program requirements and regulations, and

- The IHA received, from the U.S Department of Housing and Urban Development (HUD), fifteen (15) Emergency Housing Vouchers designated to individuals and families that meet the criteria of (1) homeless; (2) at risk of homelessness; (3) fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking; or (4)

recently homeless and for whom providing rental assistance will prevent the family's homelessness or having a high risk of housing instability, and

- The IHA agrees that families and individuals who are (1) homeless; (2) at risk of homelessness; (3) fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking; or (4) recently homeless and for whom providing rental assistance will prevent the family's homelessness or having a high risk of housing instability will be eligible to apply and receive the same preference, and

- The ITCoC and Advocacy Center agree to identify, verify, and assist eligible applicants in applying for the Emergency Housing Vouchers and to connect them with community supportive services to assist these individuals and families to become and remain stably housed, therefore,

- In consideration of the mutual covenants and promises contained herein, the parties hereto agree to each of the conditions and responsibilities outlined in this agreement as follows:

PHA'S GOALS AND STANDARDS OF SUCCESS IN ADMINISTERING THE PROGRAM

Our overarching goal: The EHV program will help eligible families and individuals achieve housing stability and position them to achieve self-sufficiency in all areas of life.

- Process Goal 1: That the highly integrated system outlined in this MOU is fully in place for efficacious implementation of IHA's EHV program.

  Standard of Success: That the IHA, ITCoC, and the Advocacy Center are all working in unison to maximize EHV impacts and optimize EHV progress.

- Progress Goal 2: Ensure that all EHV families and individuals re made aware of all supportive services available in the Ithaca/Tompkins community, e.g., counseling, job training, financial literacy, etc.

  Standard of Success: 100% of families and individuals who receive an EHV will offered the opportunity to meet individually with IHA Family Self-Sufficiency (FSS) Caseworkers who will share detailed information regarding the benefits of the FSS Program and the Three Pillar (financial literacy) Program that are offered by the IHA. The ITCoC and the Advocacy Center will make EHV participants aware of all supportive services known to their agency or supportive services that their agency partners with outside of this MOU.

STAFF POSITIONS AT THE IHA, ITCOC, AND THE ADVOCACY CENTER WHO WILL SERVE AS LEAD EHV LIAISONS

Lead EHV Liaisons

Ithaca Housing Authority: Megan Wiiki, Housing Choice Voucher Coordinator

Ithaca/Tompkins Continuum of Care: Liddy Barger, Director of Housing Initiatives

Advocacy Center of Tompkins County: Amy Smith, Director of Rental Services

RESPONSIBILITIES OF THE EHV LIAISONS

IHA liaison will:

- Serve as EHV point person
- Receive referrals from ITCoC
- Coordinate the intake process
- Communicate with EHV partners (ITCoC and Advocacy Center) to ensure a smooth flow of program operation in accordance with MOU
- Make referrals of potential eligible families and individuals to ITCoC
- Conduct trainings for ITCoC and Advocacy Center staff on IHA processes for EHV
- Attend ITCoC and Advocacy Center meetings related to EHV process

ITCoC liaison will:

- Serve as EHV point person
- Receive and consider referrals from the Advocacy Center, IHA and other human service agencies
- Certify EHV eligibility
- Prioritize EHV referrals utilizing the coordinated entry list
- Provide EHV referrals to IHA
- Follow up on all referrals
- Refer EHV eligible participants to all support services known to the ITCoC or to support services where a current agency partnership exists
- Communicate with EHV partners (IHA, Advocacy Center) to ensure a smooth flow of program operation in accordance with MOU
- Conduct trainings for IHA and the Advocacy Center staff of ITCoC processes for EHV
- Attend IHA and Advocacy Center meetings related to EHV process

Advocacy Center liaison will:

- Serve as EHV point person
- Make direct referrals to the ITCoC for victims of domestic violence or sexual assault who are homeless; at risk of homelessness; fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking.
- Refer EHV eligible participants to all support services known to the Advocacy Center or to support services where a current agency partnership exists
- Coordinate supportive services for families that are referred to EHV program including but not limited to case management, emotional support, safety planning, housing advocacy, flexible funding assistance to address housing barriers

- Communicate with EHV partners (ITCoC and IHA) to ensure a smooth flow of program operation in accordance with MOU
- Conduct trainings for ITCoC and IHA staff on Advocacy Center processes for EHV
- Attend ITCoC and IHA meetings related to EHV process

SERVICES TO BE PROVIDED TO ELIGIBLE EHV FAMILIES

- Partnering service providers will support individuals and families in completing applications and obtaining necessary supporting documentation to support referrals and applications for assistance, while aiding households in addressing barriers.

- Partnering service providers will support the IHA in ensuring appointment notifications to eligible individuals and families and will assist eligible households in getting to meetings with the IHA.

- IHA will establish windows of time for EHV applicants to complete intake appointments.

- Partnering service providers will provide, assist, or make referral for housing search assistance for eligible individuals or families.

- Partnering service providers will provide, assist, or make referrals for compliance counseling related to rental lease requirements.

- Partnering service providers will assess individuals and families who may require referrals for assistance on security deposits, utility hook-up fees, and utility deposits.

- Partnering service providers will assess and refer individuals and families to benefits and supportive services, where applicable.

IHA ROLES AND RESPONSIBILITIES

1. Establish an Emergency Housing Vouchers preference for individuals and families who are (1) homeless; (2) at risk of homelessness; (3) fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking; or (4) recently homeless and for whom providing rental assistance will prevent the family's homelessness or having a high risk of housing instability.

2. Add Emergency Housing Voucher referrals from the ITCoC to the HCV EHV waitlist according to the date the application is receive, in accordance with HUD regulations and IHA's Administrative Plan.

3. Provide a point of contact for Emergency Housing Voucher referrals and commit adequate staff and necessary resources to ensure that the application, certification, voucher issuance and unit inspections are completed in a timely manner.

4. Aid with the housing search; identify barriers to leasing and strategies to address barriers; application fees; security and utility deposits; and moving costs.

5. Provide owner outreach and encourage owners to rent to individuals and families using Emergency Housing Vouchers.

6. Perform duties related to the administration of the Emergency Housing Vouchers; and notify the ITCoC and Advocacy Center of any changes, as necessary.

7. Provide staff to support training and coordination of the Emergency Housing Voucher program implementation between the ITCoC, Advocacy Center and IHA if needed.

8. Schedule meetings with the ITCoC and Advocacy Center (at least quarterly).

9. Comply with the provisions of this MOU.

ITCOC ROLES AND RESPONSIBILITIES

1. Designate and maintain a lead EHV liaison responsible for coordinating and communicating the referral, application submission, and housing search assistance for individuals and families referred for an EHV voucher.

2. Outreach to providers of services to individuals or families who are fleeing, or attempting to flee domestic violence, dating violence, sexual assault, stalking, or human trafficking, regarding the availability of Emergency Housing Vouchers. The ITCoC will coordinate with these service providers to acquire client referrals to the ITCoC in a timely manner. The ITCoC agrees to coordinate and work with the Advocacy Center of Tompkins County to obtain direct referrals to the coordinated entry list to assist families and individuals who meet this criterion.

3. Identify, verify, and refer individuals and families who are (1) homeless; (2) at risk of homelessness; (3) fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking; or (4) recently homeless and for whom providing rental assistance will prevent the family's homelessness or having a high risk of housing instability, for an Emergency Housing Voucher using an agreed upon referral form.

4. Ensure the individuals and families referred are on the Coordinate Entry List and filtered by the Name or Prioritization Lists of all people in their Homeless Management Information System by demographics and review for likely Emergency Housing eligible individuals and families; verify eligibility and interest in applying for a Voucher.

5. Coordinate with service providers and provide referrals to the IHA in a timely manner. Provide any contact information that would be helpful in completing the housing assistance process such as a name, phone number or e-mail address of a support person assisting the applicant.

6. Assist directly, or through their network, individuals and families referred for an Emergency Housing voucher in completing the Housing Choice Voucher (HCV) application, providing the required verifications needed to determine HCV program eligibility and assisting in locating suitable housing.

7. Assess all households referred for EHV for mainstream benefits and support services available to support eligible individuals and families through their transition.

8. Identify and provide supportive services to EHV individuals and families, who are eligible for CoC-funded services, either directly or through their network.

9. Attend EHV participant briefings and meetings when needed.

10. Participate in regular meetings conducted by the IHA (at least quarterly).

11. Comply with the provisions of this MOU.

ADVOCACY CENTER ROLES AND RESPONSIBILITIES

1. The Advocacy Center will commit sufficient staff and resources to ensure that referrals are made, and applicants are offered sufficient support to complete applications, locate housing, and address barriers to housing. Staff who will support victims referred to the ITCoC for the EHV program include Residential Services Director, Housing Advocate, and Shelter Advocate. Additional victim support may be provided by non-residential advocates as needed.

2. Designate and maintain a lead EHV liaison to communicate with IHA and ITCoC.

3. Provide referrals to the ITCoC of individuals and families who are fleeing, or attempting to flee, domestic violence, dating violence, sexual assault, stalking, or human trafficking regarding the Emergecny Housing Vouchers.

4. Support individuals and families in completing applications and obtaining necessary supporting documentation to support referrals and applications for assistance, while aiding households in addressing barriers.

5. Support the IHA in ensuring appointment notifications to eligible individuals and families and will assist/accompany eligible households in getting to scheduled meetings with IHA.

6. Provide housing search assistance for eligible individuals and families.

7. Assess individuals and families who may require referrals for assistance with security deposits, utility hook-up fees, and utility deposits.

8. Assess and refer individuals and families to benefits and supportive services where applicable.

9. Provide comprehensive domestic violence and sexual violence services including emotional support, case management, safety planning, housing, medical, and social advocacy, legal services and advocacy, and support groups. All advocacy support services are voluntary in compliance with the Violence Against Women Act and federal Family Violence Prevention Services Act.

10. Participate in regular meetings conducted by the IHA (at least quarterly).

11. Comply with the provisions of this MOU.

PROGRAM EVALUATION

The IHA, ITCoC, and Advocacy Center agree to cooperate with HUD, provide requested data to HUD or HUD-approved contractor delegated the responsibility of program evaluation, and follow all evaluation protocols established by HUD or HUD-approved contractor, including possible random assignment procedures.

TERM

The terms of this agreement will be in effect from the effective date until the Emergency Housing Vouchers are no longer available to be used for the targeted population.

SIGNATURES

Signed and dated by the official representatives of the PHA, COC and third-party entities:

THE ITHACA HOUSING AUTHORITY

By: Brenda C. Westfall 7/30/2021
Brenda C. Westfall, Executive Director

ITHACA/TOMPKINS HUMAN SERVICE COALITION, CONTINUUM OF CARE

By: M. Kathleen Schlather 7/27/2021
Kathleen Schlather; Ithaca/Tompkins CoC Board Chair

THE ADVOCACY CENTER OF TOMPKINS COUNTY

By: Heather Campbell 7/30/21
Heather Campbell, Executive Director

1C-7: Public Housing Agencies within Your CoC's Geographic Area–New Admissions–General/Limited Preference–Moving On Strategy.

3. Executed MOU between Homes and Community Renewal and the CoC demonstrating the limited homeless preference for the EHV program

MEMORANDUM OF UNDERSTANDING
DATA SHARING FOR EMERGENCY HOUSING VOUCHERS IN NEW YORK STATE

This Memorandum of Understanding ("MOU") is made and entered into as of this 15th day of July, 2021 (the "Effective Date"). It is executed between the following parties:

New York State Homes and Community Renewal ("HCR") and its subsidiaries, including the Housing Trust Fund Corporation ("HTFC") and the Division of Housing and Community Renewal ("DHCR"), having its principal office at 38-40 State Street, Albany, NY 12207

-and-

Human Services Coalition of Tompkins County
118 North Tioga Street, Suite 304
Ithaca, NY 14850

Signing this agreement as the lead agency and authorized representative for:

NY-510 Ithaca/Tompkins Counties CoC

The following counties within the CoC service area are included within the scope of this agreement:

Tompkins County

The following counties are excluded:

None

WHEREAS, the American Rescue Plan Act (a.k.a. COVID-19 Stimulus Package or "The Act") was adopted into law on March 11, 2021, and provided for a $1.9 trillion economic stimulus package;

WHEREAS, Section 3202 of The Act authorizes $5 billion for Emergency Housing Vouchers ("EHVs") to transition people currently experiencing or at risk of homelessness, including those who are survivors of domestic violence, to stable housing; and EHVs can be used by individuals and families experiencing homelessness who have difficulty being stably housed otherwise;

WHEREAS, funding for EHVs will be allocated by the U.S. Department of Housing and Urban Development ("HUD") to state and local Public Housing Authorities ("PHAs") for distribution through waiting lists created and maintained by those PHAs;

WHEREAS, NYS HCR, through HTFC, serves as the only statewide PHA for New York State, and has received a preliminary allocation of 1,556 EHVs, with the possibility of additional allocations at a later date;

WHEREAS, HUD is requiring PHAs to coordinate with Continuums of Care, including local and regional homeless service providers, to identify households most in need, and Continuums of Care ("CoCs") are recognized by both HUD and New York State as a centralized point of access for homeless services and data;

WHEREAS, the entity listed above is the lead agency for the CoC listed above, and is authorized by the CoC Board to execute this agreement on behalf of the CoC:

NOW, THEREFORE, in consideration of mutual covenants and promises, herein, the Parties agree as follows:

I. GOALS AND OBJECTIVES

The Parties agree upon the following specific goals for this MOU:

1. Reduce the homeless population in New York State.
2. Leverage the services and local knowledge of the CoC to assist HCR in the expeditious delivery and utilization of EHVs.
3. Achieve dissemination of all federally allocated EHVs and associated budget authority to decrease the number of homeless/at-risk households potentially at risk of contracting and spreading Covid-19.

II. OBLIGATIONS OF THE PARTIES

HCR

i. HCR shall establish an amendment to its Administrative Plan (**Exhibit A**) that articulates the rules for this EHV program; HCR may make changes to this Amendment as necessary. HCR may establish additional policies and procedures as necessary to ensure the timely and appropriate utilization of federal resources.

ii. HCR shall communicate the relevant rules of the EHV program to the CoC Lead Agency.

iii. HCR shall procure a Special Purpose Local Administrator ("SPLA") to administer the EHVs, including receiving referrals, processing applications, determining eligibility, calculating subsidy, issuing vouchers, and performing inspections. The SPLA will serve as HCR's designated agent for the purpose of this MOU.

iv. HCR shall procure a technology solution for the administration of EHVs from Emphasys Technology Solutions.

v. HCR shall initiate communication between the CoC and the SPLA(s) it designates, and the SPLA will act on HCR's behalf; the SPLA will be subject to the terms of this MOU and all applicable federal and state regulations, including any relevant and applicable data privacy requirements articulated in writing by the CoC.

vi. HCR shall provide a secure, on-line referral process for the CoC to upload its referrals; HCR may modify this form as necessary.

vii. HCR, working through Emphasys, will provide a secure, on-line application portal for applicants to upload required documents with the assistance of the CoC.
viii. HCR will provide trainings for CoC staff as regarding program EHV policies and procedures.
ix. HCR shall prioritize households during the initial lease-up Phase as described in Section III of this MOU and shall establish a waiting list for each CoC following the initial lease-up.
x. HCR will administer monthly Housing Assistance Payments for EHVs.
xi. HCR will administer incentives to the landlord and issue payments as described in Section IV of this agreement.
xii. HCR shall reimburse the CoC for eligible tenant stipend expenditures.
xiii. After the initial lease-up period, HCR will establish a waiting list of referrals from each CoC to receive vouchers as they become available.
xiv. HCR will issue prompt payment for CoC services as described in this agreement.
xv. HCR will provide periodic updates regarding utilization rate for the CoC.
xvi. HCR will provide a staff member to attend CoC meetings as necessary.
xvii. HCR will provide guidance as needed on any updates from HUD that substantially change the obligations of the CoC.
xviii. HCR will provide an Implicit Bias Training option to CoC members and staff.

The CoC

A. Compliance with Standard Clauses

i. Agency's Standard Terms. The CoC shall comply in all respects with the Agency's Standard Contract Clauses (the "Standard Clauses") set forth in **Appendix I** attached hereto and incorporated by reference herein.
ii. HUD's Section 8 General Provisions. The CoC shall comply in all respects with HUD's Section 8 General Provisions for Contracts (the "Section 8 General Provisions") set forth in **Appendix III** attached hereto and incorporated by reference herein.

In the event of a conflict between the terms of this Agreement, including the Scope of Work, and terms of the Standard Clauses and HUD's Section 8 General Provisions, the order of precedence will be as follows:

a. Section 8 General Provisions
b. Standard Clauses
c. This MOU

B. Program Set-Up

i. The CoC shall select one incorporated nonprofit or government entity to serve as Lead Agency and to receive compensation on behalf of the CoC. This entity shall be responsible for ensuring all tasks listed in this MOU are completed in accordance with all applicable federal and state requirements. The Lead Agency may subcontract with other partners as necessary to deliver the required tasks and share administrative funds as necessary.
ii. The CoC shall utilize the referral process prescribed by HTFC to make referrals in a secure manner according to the instructions provided and based on the priorities listed in Section III.

iii. The CoC shall verify that the households it refers meet the requirements of PIH Notice 2021-15 and qualify under the Priority category under which they are being referred.

iv. The CoC shall be responsible for ensuring compliance with all requirements and guidance issued by HUD related to inclusiveness and diversity, and shall take proactive steps to ensure that all potentially eligible households within their service area are provided fair and equal access to housing assistance. The CoC will identify and collaborate with other local partners within their region to establish a single point of entry for all households who may be eligible for EHVs, including those who may not currently be included within their existing Coordinated Entry System. This may include but is not limited to coordinating with organizations serving victims of domestic violence or human trafficking and establishing a secure methodology to receive referrals from these organizations while maintaining the privacy of the victims.

v. The CoC shall establish an EHV steering committee with HCR that is inclusive of relevant local stakeholders, shelter providers, human service providers, landlords, and clients. The committee shall also reflect the racial and socioeconomic composition of the population served. An existing committee or board may comply with this provision. The committee must meet at least quarterly while this MOU remains in effect and must permit HCR staff to attend upon request.

vi. The CoC shall promote the availability of EHVs within its service area to a diverse range of stakeholders, and proactively seek to identify potentially eligible households of all racial and socioeconomic backgrounds, including populations who may have previously lacked access to assistance or been under-represented.

C. Referrals and Housing Searches

i. The CoC shall provide referrals of potentially eligible households to HCR's SPLA through the method prescribed by HTFC and in accordance with federal and state rules; the order and timetable for referrals shall be according to the terms listed in Section III of this agreement. The CoC agrees to give HCR the data in the manner prescribed by **Exhibit B**.

ii. The CoC shall assist the applicant in assembling the required application documents as listed in **Exhibit A**. Where necessary, the CoC will assist the applicant in uploading their application data and required documents into the applicant portal, communicating with the SPLA case manager, and receiving correspondence from HCR. The CoC shall be solely responsible for ensuring that its staff maintain confidentiality and securely handle and store any applicant data received, including Personal Identification Information, in compliance with all applicable federal and state regulations.

iii. Upon issuance of a voucher, the CoC will facilitate the housing search and assist applicants in identifying affordable housing options within the payment standard and achieving housing occupancy within 120 days where possible. This includes but is not limited to: helping applicants conduct on-line searches and navigate rental housing data sources; providing transportation to visit apartments; assisting the applicant in negotiating with landlords; maintaining a rental registry of available units; other counseling services as necessary.

iv. The CoC may request extensions for vouchers issued according to the terms in **Exhibit A**.

v. Following the initial lease-up period, the CoC shall ensure that its list of referrals is updated as necessary. This includes notifying HCR to remove households on its waiting list who are no longer eligible for EHV assistance and sending additional referrals upon request.

vi. The CoC shall validate tenant stipend expenses for reimbursement as described in Section IV of this agreement.

vii. The CoC will strive to connect participating households to services that will ensure long term success. This may include services related to health and wellness, mental health counseling, substance abuse treatment, employment training, etc. The CoC shall provide a quarterly report of service referrals for households on the CoC's. The report shall not include data on individual households that would violate confidentiality; it shall provide a high level summary of the services being offered to participating households.

viii. Where a voucher recipient referred by the CoC is identified by HTFC as falling behind in rent or otherwise becoming at risk, HTFC may refer that household to the CoC for linkages to additional services.

III. PRIORITIZATION

A. Prioritization for the Initial Lease-up Phase

The CoC shall commence sending referrals to HCR or its designated agent on or about August 16, 2021 and concluding within 6 weeks – referred to here as the **initial lease-up phase**. The referrals shall be received in the following order:

Priority 1 – HCR will only accept referrals for the following types of households within the first three weeks, or from August 16 – September 3.

1. Households meeting HUD's Definition of Chronically Homeless as determined by the CoC.
2. Any literally homeless families, as defined by HUD in the Criteria and Recordkeeping Requirements for Definition of Homeless, with minor children under 18 years of age.
3. Households who are fleeing or attempting to flee domestic violence, dating violence, sexual assault, stalking, or human trafficking.
4. Households participating in a Rapid Re-housing (RRH) program who would qualify for such assistance as defined by the terms of either the federal Emergency Solutions Grant ("ESG") program or the federal Continuum of Care program.

*Please note that households from local programs similar to RRH but serving a broader population than required within the federal definition ushould not be sent as a Priority 1 referral, unless the household being referred would have qualified under the federal definition. . To receive ESG rapid re-housing, an individual or family must demonstrate at initial evaluation that it is literally homeless (referred to as Category 1 in the Homeless Definition Final Rule).

Priority 2 – Within the second three weeks, or from September 6 to September 24, HCR will continue accepting referrals from Category 1 plus the following:

1. Any household classified as literally homeless, as defined above in Priority 1.

Failure by the CoC to adhere to these priorities may result in a loss of vouchers for that CoC. HCR may adjust this schedule, including delaying the acceptance of referrals, and to adjust the priorities as necessary to ensure full voucher utilization. HCR will notify the CoCs of any adjustments.

B. Ongoing Waiting Lists

Following the initial lease-up phase, HCR will establish a waiting list with each CoC for households to receive a voucher as one becomes available within that CoC's allocation. It is the CoC's responsibility to ensure that their waiting list is current at all times, and that households determined to be no longer eligible are removed within 30 days. As a voucher allocated to the CoC becomes available, HCR will select a new household from that CoC's waiting list based on the order in which the referral was received.

After the initial lease-up phase, CoCs may request permission to make referrals for households who do not qualify within the Priorities listed above, but who are still eligible under PIH Notice 2021-15, including at risk households. HTFC may at its discretion permit these referrals on a case by case basis.

C. Allocations

HCR does not guarantee a minimum number of vouchers for any county or CoC. HCR's EHV allocation will be divided approximately as follows within three regions:

- **New York City – 1/3**
- **Downstate Suburbs - Nassau, Suffolk, Westchester and Rockland Counties – 1/3**
- **Upstate CoCs – 1/3**

Based on the current allocation, this translates into roughly 517 EHVs for each of the three regions. This formula is subject change at HCR discretion, and is subject to available budget authority.

Within each region, vouchers will be divided among CoCs based on a variety of factors, including but not limited to the approximate, relative share of need for each county participating in HCR's EHV program, the number and timeliness of eligible referrals received from each CoC, and HCR's assessment of each CoC's ongoing rate of placement and utilization. CoCs will not receive a specific allocation of vouchers during the initial lease-up phase. CoCs are encouraged to submit referrals for all eligible households based on the prioritization listed above. The CoC acknowledges that the actual allocations may vary.

IV. INCENTIVES

To facilitate occupancy once vouchers are issued, HCR intends to offer the following:

i. Pre-inspections – HCR or its designated agent will provide inspectors to perform pre-inspection of units to ensure they qualify for the program in advance of voucher issuance if unit is vacant and staff are available.
ii. Higher Payment Standard – HCR may establish a payment standard for each EHV unit size at payment standards higher than its current HCV standard for that county; this payment standard may be adjusted at HCR's discretion depending on actual and projected HAP spending, and rent must still be determined reasonable.
iii. Incentive Payment to Landlord – HCR will pay a landlord bonus of one-month's rent at the time of lease signing.
iv. Tenant Stipend – HCR will provide up to $1,000 to reimburse tenants for moving and housing search expenses. This will include but is not limited to: purchase of necessary furniture, bedding, home appliances or hook-ups; cost of transportation to secure housing; payment of any prior utility arrears; moving costs; other costs mutually agreed upon by the CoC and HCR. The CoC will review and approve these expenses on HCR's behalf. HCR will provide reimbursements to the CoC of Stipend Payments to be provided to the household by the CoC. The CoC is permitted to advance funds to households where necessary and be re-imbursed by HCR.
v. Repair Fund – HCR will provide up to $1,000 to reimburse the landlord for repairs necessary to ensure the health and safety of the tenant; expenses will be approved by the inspector for HCR or its designated agent.
vi. Security Deposit – HCR will provide the security deposit for the household.
vii. Landlord Guarantee – Should the landlord be forced to evict the tenant for non-payment of the tenant share of rent, HCR will reimburse the landlord for losses accrued prior to the date of eviction within the first 12 months.

HCR reserves the right to adjust these incentives as necessary. All incentives are contingent upon availability of federal Section 8 funds.

V. TERM

A. This contract shall commence as of the Effective Date and shall terminate on September 30, 2023. The MOU may be extended by either party with mutual consent in writing.
B. In no event shall this MOU continue in effect beyond the expiration or termination of the Act or if federal funds are no longer available.

VI. PROCEDURES

The Parties agree that **Exhibit B**, the Data Collection Plan, sets forth the details of the Confidential Data which the CoC shall furnish to HCR or its designated agent.

VII. CONFIDENTIALITY

A. During the course of this MOU, it may be necessary for the CoC to share confidential information, including names, social security numbers, addresses to HCR or its designated agent in order to arrange for eligible families to receive EHVs. HCR or its designated agent shall not share any of this confidential information at any time.

B. In connection with its receipt, use, and disclosure of Confidential Data received from the CoC pursuant to this MOU, HCR or its designated agent shall ensure its staff, contractor or agents shall:

a. Use Confidential Data received from the CoC only for the authorized purposes specified in this MOU;

b. Limit access to Confidential Data to the authorized employees of HCR or its designated agent and its staff, agents or contractors.

c. Store and maintain Confidential Data in a place and manner that is physically secure from access by unauthorized persons (e.g., locked cabinets or storage room);

d. Store and process Confidential Data obtained from the CoC which is maintained in an electronic format, such as magnetic tapes or discs, in such a way that unauthorized persons cannot obtain the information by any means. HCR or its designated agent shall ensure that Confidential Data are never remotely accessed or maintained in a mobile or portable device, and if it is, HCR or its designated agent shall ensure that the security is maintained in the manner outlined in this section;

e. Undertake precautions to limit access to disclosed Confidential Data to authorized persons;

f. Adopt safeguards and procedures to protect the confidentiality of Confidential Data and to limit dissemination only to authorized individuals as necessary for their work on the project.;

g. Not disseminate, use, or permit the dissemination or use of Confidential Data in any manner not described in this MOU without express prior written consent from the CoC;

h. Destroy thoroughly and irretrievably all Confidential Data received under this MOU from the CoC after completion of the purpose for which the data was disclosed is served. Upon request, HCR and its designated agent shall provide proof satisfactory to the CoC that the Confidential Data have been so destroyed, including the date of destruction and the method utilized, which method must be acceptable to the CoC;

i. Not make, retain, copy, duplicate, or otherwise use any copies of Confidential Data after completion of the purpose for which the data disclosed is served without prior written permission from the CoC; and

j. Maintain a system and/or procedures for handling, storage, use, and destruction of Confidential Data governed by this MOU sufficient to allow the CoC, and/or their designee(s) to audit compliance with this MOU.

C. This section remains in full force and effect even after termination of the Agreement by its natural termination or the early termination by either party.

D. The CoC, its agents, and its employees shall not disclose any documents or data received from HCR and marked as confidential. The CoC shall not make comments to the news media or in any publicly accessible, on-line forum, regarding HCR or the administration of this program without HCR's written consent.

VIII. COMPLIANCE

It is the responsibility of the Parties to remain current on all federal rules, including new guidance issued by HUD during the contract period, to ensure that all staff employed for the program are properly trained and certified in accordance to HUD standards. In addition, the parties must remain current on all applicable State and Local laws, regulations and rules. Parties agree to cooperate with any program evaluation efforts undertaken by HUD, or a HUD-approved contractor, including compliance with HUD evaluation protocols and data sharing requests.

IX. CoC COMPENSATION FOR SERVICES

HCR will provide the following compensation to the CoC lead agency. All compensation is subject to the availability of federal funds.

A. Program Set-up

HCR agrees to provide the following total payment for the tasks listed above: $28,000

This Payment shall be paid in four (4) quarterly installments of $7,000 within the first 12 months of the agreement. The first payment shall be made approximately 30 days after MOU execution. If either party terminates the agreement prior to the end of the first year, HCR shall only be obligated for the quarterly payments due prior to the termination date. HCR may negotiate additional payments as necessary.

The Lead Agency shall provide a budget for this funding within the first 30 days. Budget items may include staffing and overhead, legal/consultant fees, an advance funding pool for tenant stipend costs, marketing and outreach, other expenses as approved by HCR. The Lead Agency will provide a summary of all budgeted and actual expenditures at the end of the first 12 months, and subsequently as required by HCR.

B. Referrals and housing searches

In addition, HCR will pay the following for each referral who is approved for a voucher and who successfully achieves occupancy within the timeframes listed below:

a. $500 for HAP in place by 11/1/21 or
b. $250 for HAP in place by 1/1/22 or
c. $100 for HAP in place after 1/1/22

X. TERMINATION

Either HCR or the CoC may terminate this agreement with 30 days' notice. The Notice of Termination must be issued pursuant to the Notices section of this MOU. In the event that the $5 billion allocated for emergency housing choice voucher as promulgated by The Act becomes exhausted, unfunded, or amended such that this funding is not available then this Agreement shall terminate. The CoC shall then contact HCR for guidance in winding down the program. Nevertheless, this MOU will terminate upon the latest funding date of the Act.

The MOU may be terminated immediately if one party is found to be in default by HUD or another federal or state regulatory agency.

XI. NEW YORK STATE EXECUTIVE LAW ARTICLE 15-A

The CoC acknowledges HCR's obligation under the law to promote opportunities for minority-and women-owned business enterprises ("MWBEs"). Where applicable, the CoC shall comply with the provisions of the Agency's Participation by Minority Group Members and Women Requirements and Procedures for Contracts, attached hereto and incorporated herein as **Appendix II**.

XII. PROGRAM ADMINISTRATION CONTACTS

A. Except as otherwise specified herein, HCR's designated contact concerning programmatic questions pertaining to this MOU, shall be:

Name:	Iryna Mogilevich
Title:	Deputy Director, Specialized Housing Choice Voucher Programs
Address:	New York State Homes and Community Renewal 25 Beaver Street New York, NY 10004
Phone:	(718) 751-6133
E-mail:	iryna.mogilevich@nyshcr.org

HCR may designate a new or alternate contact by providing the CoC a written notice to that effect.

B. The CoC designated contact concerning this MOU, including data requests and disclosures, shall be:

Name:	Liddy Bargar
Title:	Director of Housing Iniatives
Address:	Human Services Coalition of Tompkins County 118 North Tioga St. #304 Ithaca, NY 14850
Phone:	(607) 273-8686 ext.241
E-mail:	lbargar@hsctc.org

The CoC may designate a new or alternate contact by providing NYSHCR a written notice to that effect.

NOTICES

A. All notices regarding this MOU shall be sent to:

If to HCR:	Housing Trust Fund Corporation Attn: Connie Bruno, Director Section 8 Housing Choice Voucher Program 38-40 State Street Albany, New York 12240 Connie.Bruno@nyshcr.org
If to CoC:	Human Services Coalition of TC Attn: Liddy Bargar 118 N. Tioga St. #304 Ithaca, NY 14850 lbargar@hsctc.org

B. Notice given pursuant to this section shall be in writing and effective upon receipt as evidenced by either (a) electronic mail, (b) certified mail, return receipt requested, or (c) overnight courier (such Federal Express).person and/or address for notices as set forth above may be modified or amended by written notice.

XIII. OTHER PROVISIONS

A. The MOU may only be amended by the mutual consent of the Parties in writing.
B. Nothing express or implied in this Agreement is intended to confer, nor will anything herein confer upon any person other than the Parties, any rights, remedies, obligations, or liabilities whatsoever.
C. The CoC and HCR may not assign or transfer all or any portion of this MOU in any manner, either voluntarily or involuntarily, by operation of law or otherwise, or any interest, payment or rights hereunder without prior written consent of HCR and any assignment or transfer not so approved shall be considered null and void.
D. Any conflict between this Agreement and the HUD's rules, regulations, and requirements, including those set forth shall be resolved by the application of HUD's rules, regulations, and requirements. All services under this MOU are subject to federal rules and requirements.
E. The MOU constitutes the entire agreement between the Parties and supersedes all prior and contemporaneous agreement, understandings, negotiations or warranties or representations between the Parties in connection with the subject matter of the MOU.
F. This MOU shall be governed by and shall be construed in accordance with the laws of the State of the New York, without any regard to any conflict of law principles thereof. The parties hereby irrevocably and unconditionally consent to submit to the exclusive jurisdiction of the state courts located in New York, NY for any actions, suits or proceedings arising out of or relating to this MOU.

G. If any of the provisions of this MOU shall be held or made invalid by a statute, rule, regulation, decision of a tribunal or otherwise, the remainder of this MOU shall not be affected thereby and, to this extent, the provision of this MOU shall be deemed to be severable.
H. HCR, at its discretion, may exercise its option to modify any provision in this MOU including, but not limited, on as needed basis, with mutual written consent of the parties.
I. This MOU may be executed in one or more counterparts, each of which will be deemed the original and all of which taken together as a whole, shall constitute one and the same instrument.
J. Upon the expiration of this MOU, all provisions of this MOU related to confidentiality and security will survive.

CONTINUUM OF CARE LEAD ORGANIZATION

By: _____
Name: Kathleen Schlather
Title: Executive Director

HOMES AND COMMUNITY RENEWAL

By: _____
Name: Rebecca Koepnick
Title: Chief Strategy Officer for Portfolio Preservation

Approved as to Form by Legal Counsel

By: _____
Bomopregha A. Julius, HTFC Senior Attorney

Approved as to Fiscal Sufficiency:

By: _____
Stacey Mickle, HTFC Treasurer

1D-11a. Letter Signed by Working Group

1. 2023 NOFO Lived Experience Board Letter

The Ithaca Youth Action Board (YAB) is composed of over 5 young people between the ages of 16 and 24 with experience of homelessness and housing insecurity in Tompkins County. This includes Lee (he/they), Jordyn (she/her), Charlie (she/they), and multiple other YAB members who have chosen not to be named.

For the past 2.5 years, we have met once a week in order to oversee the YHDP grant projects, as well as discuss our experiences within the Tompkins County homeless response system and how we can move to address these issues. In everything we do, we are working towards a future where youth homelessness is eradicated through a youth-led network of mutual aid. We believe that everyone deserves housing, and we are committed to providing safety standards that current systems have failed to uphold. Our approach is centered on valuing homeless youth as individuals and embracing a housing-first framework that is trauma-informed, anti-racist, and abolitionist. We aim to build a community founded on youth power and equity, where all youth not only have equitable access to resources but also an equitable share of their voice in the discussion. Our mission is to create a homeless response system that prioritizes harm reduction and helps homeless youth navigate systems to ensure that homelessness is a one-time and brief experience. We are committed to addressing systemic incarceration and oppression that disenfranchise homeless youth by centering abolition, implementing trauma-informed practices, ensuring anti-racism, and promoting youth voices with lived experience into positions of power and authority. Our goal is to establish a housing-first system that guarantees a revolutionarily safe future for homeless youth.

Working towards these goals of community partnership, we have been actively involved in the Tompkins County CoC in a variety of ways. Two of our members — Lee and Jordyn — hold seats on the CoC Governance Board. Through these roles, we are able to make sure that youth voice is heard and listened to in the most influential space of the CoC. Multiple YAB members are also a part of the CoC Youth Homelessness Subcommittee, as well as the CoC Housing First Subcommittee, making sure that the focus of our work is not concentrated in the YHDP projects, but instead becomes a reality for the entire Tompkins County homeless response system. Throughout our time working with the CoC, updating the RFP application template so that the application reflects our mission and vision; to that end, members of YAB have also been involved in the annual rank and review process so that recipients of CoC funding create and maintain projects that fit our definition of safety. Outside of these CoC activities, we have been excited to be included in revisions of the Tompkins County coordinated entry process. Given our first-hand experience with the Tompkins County coordinated entry process, we have been able to provide feedback that reflects the problems we have encountered, helping to create a new process that is both accessible and equitable.

The CoC has been supportive of our voices and the continued strength of the perspectives of people with lived experience. This has been reflected in their continued references to the

Coordinated Community Plan, a plan that we wrote to help both guide YHDP projects as well as help shape community conversations surrounding youth homelessness moving forward. This support has also been reflected in the Home, Together: Tompkins Plan, which outlines a vision for the Tompkins County homeless response system that aligns with the values of YAB and the CCP. The plan's emphasis on anti-racism, harm-reduction, equity, and housing first principles made us excited to vote yes on its inclusion in official CoC guidelines, and even more than that, it made us excited to see the change that it will be able to create in the community over the coming years.

The Ithaca Youth Action Board and its members are active participants within the CoC. We are excited to continue to work with the CoC and its participating organizations in order to collaborate on community efforts that work towards our collective goals.

Sincerely,

Lee, Jordyn, Charlie, and the rest of the Ithaca Youth Action Board

1D-2a. Housing First Evaluation

1. TCAction PSH Housing First Tool Score
2. St. John's Community Services PSH Housing First Tool Score

1D-2a. Housing First Evaluation

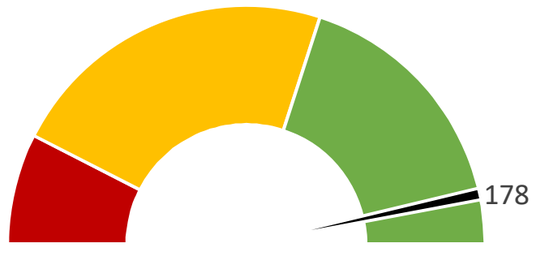
1. **TCAction PSH Housing First Tool Score**
2. St. John's Community Services PSH Housing First Tool Score

Housing First Standards: Assessment Summary

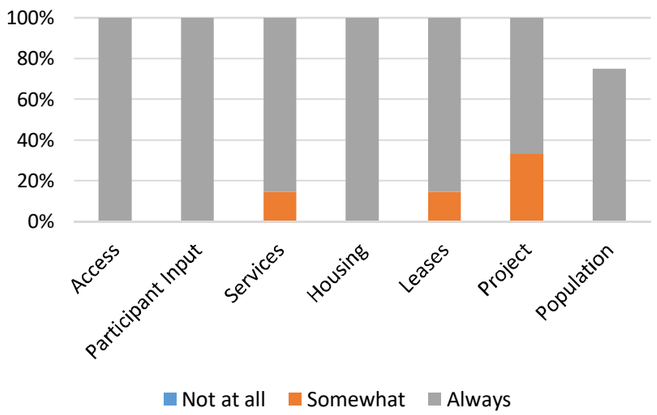
Tompkins Community Action
29-Aug-23

Your score:	**178**
Max potential score:	*204*

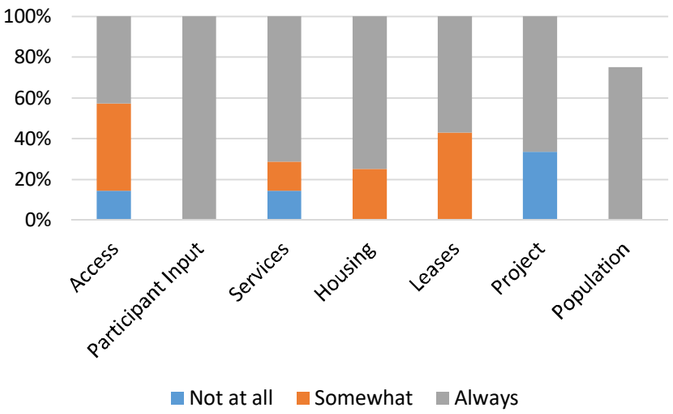
Score is calculated by awarding 1 point for standards answered 'sometimes' and 2 points for standards answered 'always'. Categories that are not applicable for your project are not included in the maximum potential score.



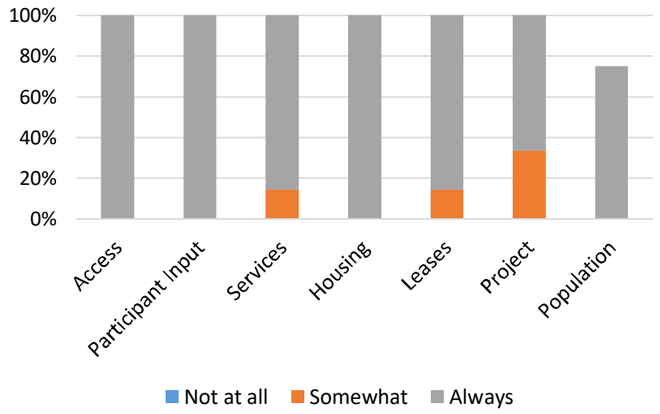
Percentage of Standards "Said"



Percentage of Standards "Documented"



Percentage of Standards "Done"



Non-Compliant Standards ("Not at all" to Whether Standard is Said)

Category	*No.*	*Name*	*Standard*

Non-Documented Standards ("Not at All" to Whether Standard is Documented)				Non-Evidenced Standard
Category	*No.*	*Name*	*Standard*	*Category*
Access	1	Projects are low-barrier	Admission to projects is not contingent on pre-requisites such as abstinence of substances, minimum income requirements, health or mental health history, medication adherence, age, criminal justice history, financial history, completion of treatment, participation in services, “housing readiness,” history or occurrence of victimization, survivor of sexual assault or an affiliated person of such a survivor or other unnecessary conditions unless required by law or funding source. *Optional notes here*	
Services	4	Services are continued despite change in housing status or placement	Wherever possible, participants continue to be offered services even if they lose their housing unit or bed (for congregate projects), or if they are placed in a short-term inpatient treatment. Ideally, the service relationship should continue, despite a service hiatus during some institutional stays. *Optional notes here*	
Project-specific	3	Property Management duties are separate and distinct from services/case management	In order to provide clear roles of staff for participants in terms of lease and rules enforcement as well as tenant advocacy, property management and service provider staff should be separate roles. However, they should work together on a regular basis through regular communications and meetings regarding Participants to address tenancy issues in order to preserve tenancy. *Optional notes here*	

s ("Not at All" to Whether Standard is Done")

No.	*Name*	*Standard*

1D-2a. Housing First Evaluation

1. TCAction PSH Housing First Tool Score
2. **St. John's Community Services PSH Housing First Tool Score**

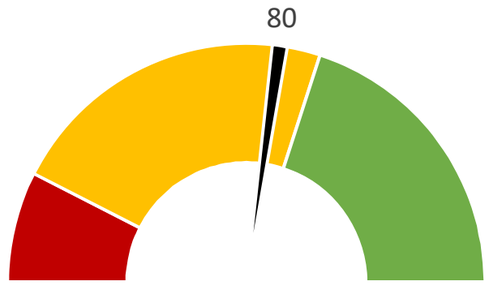
Housing First Standards: Assessment Summary

[Test Provider]
2-Nov-16

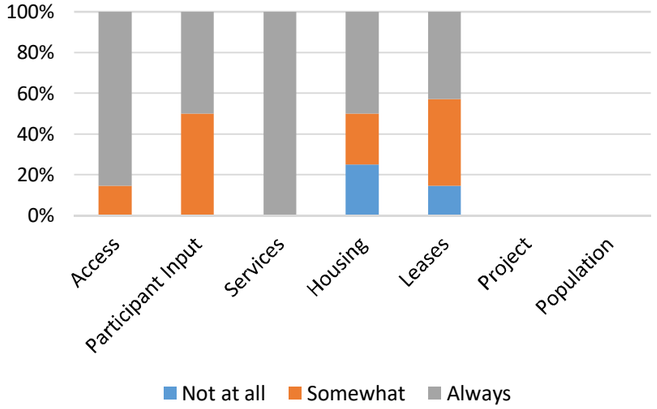
Some standards have not been evaluated. Please return and complete all standards before finalizing report.

Your score:	**80**
Max potential score:	*216*

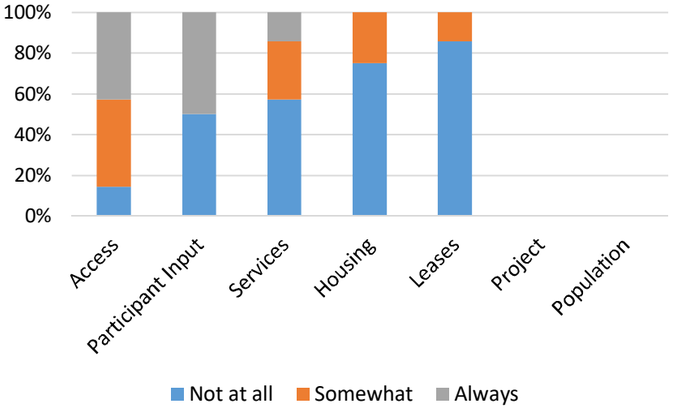
Score is calculated by awarding 1 point for standards answered 'sometimes' and 2 points for standards answered 'always'. Categories that are not applicable for your project are not included in the maximum potential score.



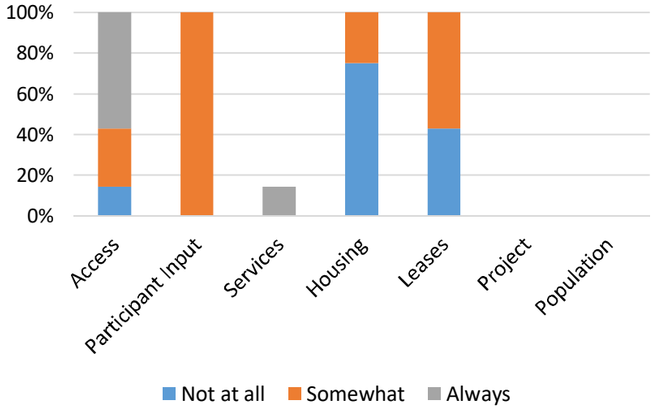
Percentage of Standards "Said"



Percentage of Standards "Documented"



Percentage of Standards "Done"



Non-Compliant Standards ("Not at all" to Whether Standard is Said)			
Category	*No.*	*Name*	*Standard*
Housing	4	Participants have the option to transfer to another project	Transfers should be accommodated for tenants who reasonably believe that they are threatened with imminent harm from further violence if the tenant remains in the same unit. Whenever possible, transfers occur before a participant experiences homelessness. *VAWA*
Leases	5		Property or building management, with services support, incorporates a culture of eviction avoidance, reinforced through practices and policies that prevent lease violations and evictions among participants, and evict participants only when they are a threat to self or others. Clear eviction appeal processes and due process is provided for all participants. Lease bifurcation is allowed so that a tenant or lawful occupant who is a victim of a criminal act of physical violence committed against them by another tenant or lawful occupant is not evicted, removed or penalized if the other is evicted. *Check with Brooklynn*

Non-Documented Standards ("Not at All" to Whether Standard is Documented)				Non-Evidenced Standard
Category	*No.*	*Name*	*Standard*	*Category*
Access	3	Access regardless of sexual orientation, gender identity, or marital status	Equal access is provided in accordance with the 2012 and 2016 Equal Access Rules, meaning that any project funded by HUD must ensure equal access for persons regardless of one's sexual orientation or marital status, and in accordance with one's gender identity. Adult only households, regardless of marital status, should have equal access to projects (if these project types are not available within a CoC, the CoC should conduct an assessment to determine if these project types are needed and work with providers to accommodate the need). Please see Equal Access Rules here: https://www.hudexchange.info/resource/1991/equal-access-to-housing-final-rule/ *Optional notes here*	Access
Participant Input	2	Projects create regular, formal opportunities for participants to offer input	Input is welcomed regarding the project's policies, processes, procedures, and practices. Opportunities include involvement in: quality assurance and evaluation processes, a participant leadership/advisory board, processes to formally communicate with landlords, the design of and participation in surveys and focus groups, planning social gatherings, integrating peer specialists and peer-facilitated support groups to compliment professional services. *Optional notes here*	Services
Services	2	Person Centered Planning is a guiding principle of the service planning process	Person-centered Planning is a guiding principle of the service planning process *Optional notes here*	Services
Services	3	Service support is as	Service connections are permanently available and accessible for participants in Permanent Supportive Housing. Rapid Re-Housing projects should, at a *Optional notes here*	Services
Services	4	Services are continued despite change in housing status or placement	Wherever possible, participants continue to be offered services even if they lose their housing unit or bed (for congregate projects), or if they are placed in a short-term inpatient treatment. Ideally, the service relationship should continue, despite a service hiatus during some institutional stays.	Services

			Optional notes here	
Services	5	Participant engagement is a core component of service delivery	Staff provide effective services by developing relationships with participants that provide immediate needs and safety, develop trust and common ground, making warm hand-offs to other mainstream service providers, and clearly explain staff roles. Engagement is regular and relationships are developed over time. *chart with explanation of roles*	Services
Housing	2	Substance use is not a reason for termination	Participants are only terminated from the project for violations in the lease or occupancy agreements, as applicable. Occupancy agreements or an addendum to the lease do not include conditions around substance use or participation in services. If the project is a recovery housing model focused on people who are in early recovery from drugs or alcohol (as outlined in HUD's Recovery Housing Brief), different standards related to use and subsequent offer of treatment may apply. See HUD's Recovery Housing brief here: https://www.hudexchange.info/resource/4852/recovery-housing-policy-brief/ *Optional notes here*	Housing
Housing	3	The rules and regulations of the project are centered on participants' rights	Project staff have realistic expectations and policies. Rules and regulations are designed to support safe and stable communities and should never interfere with a life in the community. Participants have access to the project at all hours (except for nightly in and out shelter) and accommodation is made for pets. *intake packet lays out rights*	Housing
Housing	4	Participants have the option to transfer to another project	Transfers should be accommodated for tenants who reasonably believe that they are threatened with imminent harm from further violence if the tenant remains in the same unit. Whenever possible, transfers occur before a participant experiences homelessness.	Housing

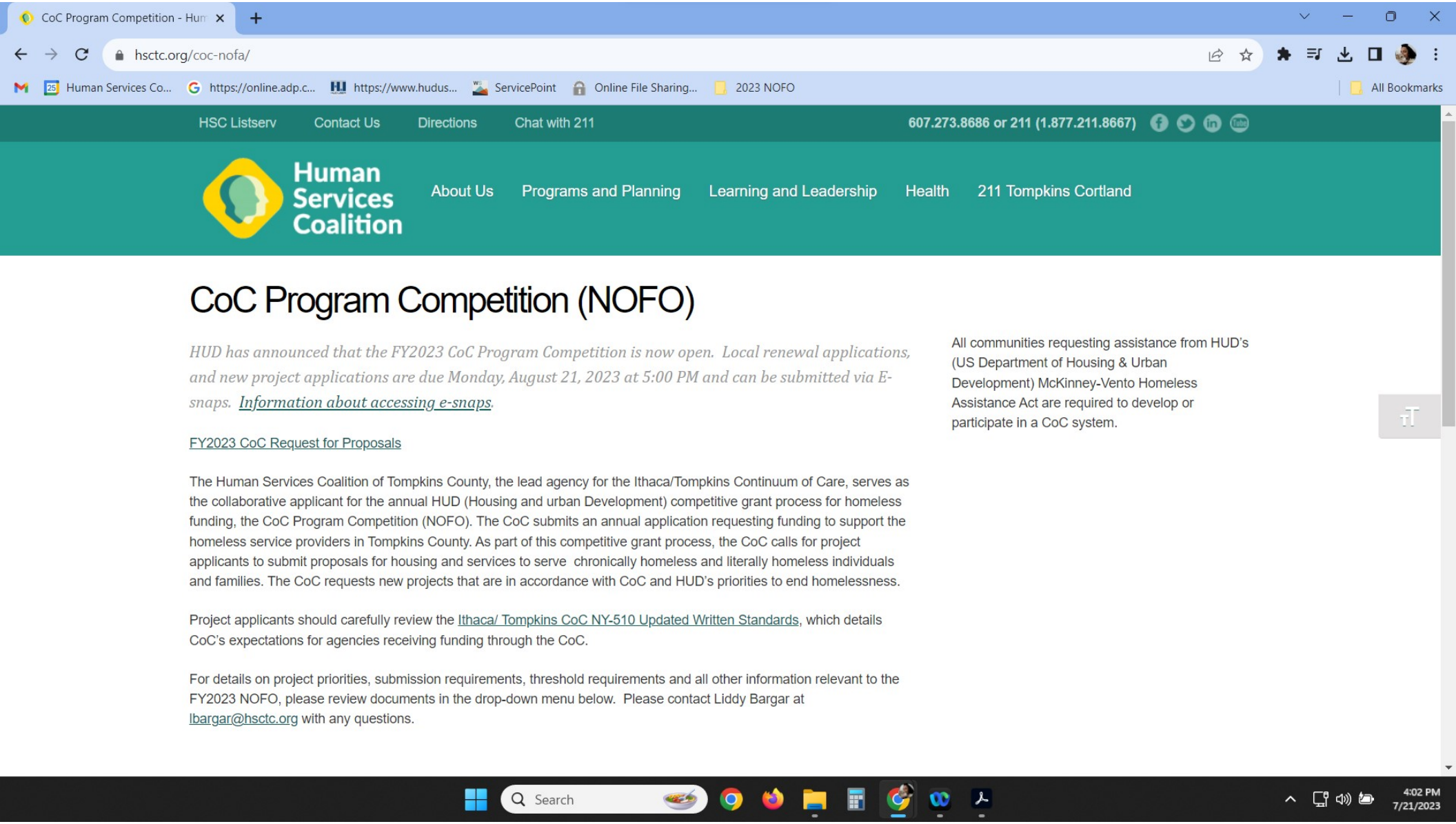
s ("Not at All" to Whether Standard is Done")

No.	*Name*	*Standard*
3	Access regardless of sexual orientation, gender identity, or marital status	Equal access is provided in accordance with the 2012 and 2016 Equal Access Rules, meaning that any project funded by HUD must ensure equal access for persons regardless of one's sexual orientation or marital status, and in accordance with one's gender identity. Adult only households, regardless of marital status, should have equal access to projects (if these project types are not available within a CoC, the CoC should conduct an assessment to determine if these project types are needed and work with providers to accommodate the need). Please see Equal Access Rules here: https://www.hudexchange.info/resource/1991/equal-access-to-housing-final-rule/ *Optional notes here*
1	Projects promote participant choice in services	Participants are able to choose from an array of services. Services offered are housing focused and include the following areas of support: employment and income, childhood and education, community connection, and stabilization to maintain housing. These should be provided by linking to community-based services. *Optional notes here*
2	Person Centered Planning is a guiding principle of the service planning process	Person-centered Planning is a guiding principle of the service planning process *Optional notes here*
3	Service support is as	Service connections are permanently available and accessible for participants in Permanent Supportive Housing. Rapid Re-Housing projects should, at a minimum, be prepared *Optional notes here*
4	Services are continued despite change in housing status or placement	Wherever possible, participants continue to be offered services even if they lose their housing unit or bed (for congregate projects), or if they are placed in a short-term inpatient treatment. Ideally, the service relationship should continue, despite a service hiatus during some institutional stays.

		Optional notes here
5	Participant engagement is a core component of service delivery	Staff provide effective services by developing relationships with participants that provide immediate needs and safety, develop trust and common ground, making warm hand-offs to other mainstream service providers, and clearly explain staff roles. Engagement is regular and relationships are developed over time. *chart with explanation of roles*
1	Housing is not dependent on participation in services	Participation in permanent and temporary housing settings, as well as crisis settings such as emergency shelter, is not contingent on participating in supportive services or demonstration of progress made on a service plan. Services must be offered by staff, but are voluntary for participants. *Optional notes here*
2	Substance use is not a reason for termination	Participants are only terminated from the project for violations in the lease or occupancy agreements, as applicable. Occupancy agreements or an addendum to the lease do not include conditions around substance use or participation in services. If the project is a recovery housing model focused on people who are in early recovery from drugs or alcohol (as outlined in HUD's Recovery Housing Brief), different standards related to use and subsequent offer of treatment may apply. See HUD's Recovery Housing brief here: https://www.hudexchange.info/resource/4852/recovery-housing-policy-brief/ *Optional notes here*
4	Participants have the option to transfer to another project	Transfers should be accommodated for tenants who reasonably believe that they are threatened with imminent harm from further violence if the tenant remains in the same unit. Whenever possible, transfers occur before a participant experiences homelessness.

1E-1: Web Posting of Local Competition Deadline

1. Web Posting with URL


CoC Program Competition - Hum
hsctc.org/coc-nofa/
Human Services Co...
https://online.adp.c...
https://www.hudus...
ServicePoint
Online File Sharing...
2023 NOFO
All Bookmarks
HSC Listserv
Contact Us
Directions
Chat with 211
607.273.8686 or 211 (1.877.211.8667)
Human Services Coalition
About Us
Programs and Planning
Learning and Leadership
Health
211 Tompkins Cortland
CoC Program Competition (NOFO)
HUD has announced that the FY2023 CoC Program Competition is now open. Local renewal applications, and new project applications are due Monday, August 21, 2023 at 5:00 PM and can be submitted via E-snaps. Information about accessing e-snaps.
FY2023 CoC Request for Proposals
The Human Services Coalition of Tompkins County, the lead agency for the Ithaca/Tompkins Continuum of Care, serves as the collaborative applicant for the annual HUD (Housing and urban Development) competitive grant process for homeless funding, the CoC Program Competition (NOFO). The CoC submits an annual application requesting funding to support the homeless service providers in Tompkins County. As part of this competitive grant process, the CoC calls for project applicants to submit proposals for housing and services to serve chronically homeless and literally homeless individuals and families. The CoC requests new projects that are in accordance with CoC and HUD's priorities to end homelessness.
Project applicants should carefully review the Ithaca/ Tompkins CoC NY-510 Updated Written Standards, which details CoC's expectations for agencies receiving funding through the CoC.
For details on project priorities, submission requirements, threshold requirements and all other information relevant to the FY2023 NOFO, please review documents in the drop-down menu below. Please contact Liddy Bargar at lbargar@hsctc.org with any questions.
All communities requesting assistance from HUD's (US Department of Housing & Urban Development) McKinney-Vento Homeless Assistance Act are required to develop or participate in a CoC system.
Search
4:02 PM
7/21/2023

1E-2a. Scored Forms for One Project

1. Amici House Scored Renewal Tool

Ithaca/Tompkins County FY2023 RENEWAL PROJECT Scoring Tool

Amici House, Tompkins Community Action

Section Number	Scored Item/Program Requirement	Scoring Criteria	Reviewer Score (Yes, Maybe, or No)	Reviewer Comments
1	**Agency Capacity and Experience**			
Threshold Criteria	1. Does the applicant have an active SAM registration with current information? 2. Does the applicant have a valid UEI (Unique Entity Identifier) Number? 3. Is the applicant a non-profit organization with active 501(c)3 status, public housing authority, or local government organization? 4. Does the applicant agree to use HMIS (or comparable database if DV)? 5. Does the applicant have a current MOU with the Human Services Coalition of Tompkins County or agree to enter an MOU? 6. Does the applicant agree to using the Coordinated Entry System to fill 100% of their project beds? 7. Does the applicant agree to adopt the Housing First model? 8. Did the applicant attach a management letter from the agency's most recent fiscal audit to demonstrate that the agency is in good standing?	**Yes** – The applicant has met all threshold criteria to be considered in this funding competition. **Maybe** – The applicant seems to have met all threshold criteria to be considered in this funding competition, but there are other concerns regarding their eligibility. **No** – The applicant has not met all threshold criteria to be considered in this funding competition.	Yes	If your answer was "Maybe" or "No," please explain why: Other review notes or comments:

Section Number	Scored Item/Program Requirement	Maximum Score	Reviewer Score	Reviewer Comments
2	**Narrative Questions**	**30**	**24**	
2.1	**Serving Intersectional Identities.** Describe how your program will provide consistent help across intersectional identities. (e.g. LGBTQIA+, youth, BIPOC, disabled people) (250 words)	**4-5 points:** Agency has a strategy to provide consistent services for people with intersectional identities. Strategies could include staff training, hiring people who represent the people served, etc. **2-3 points:** Agency commits to providing consistent service but does not identify any clear strategies. **0-1 points:** Agency does not outline strategies to provide consistent service to people across intersectional identities.	4	If you awarded less than the maximum points, please explain why: Other comments or notes:
2.2	**Elevating Lived Experience.** Describe how your program plans to elevate the voices of and employ people with lived experience of homelessness to create better support for your clients. (250 words)	**4-5 points:** Agency has actionable practices to employ and elevate people with lived experience, including employment and HR strategies, board representation, and/or intentional feedback. **2-3 points:** Agency incorporates feedback from participants in project design or conducts feedback surveys. **0-1 points:** Agency does not have a clear strategy for elevating the voices of people with lived experience. **Examples of actionable practices:** - Policies to ensure that all clients are able to access services at the level of their need - People with lived experience of homelessness, including people from BIPOC communities, are represented on the board of the organization - Client feedback on the project is requested and a process is in place to examine and improve client satisfaction - Outcome data is collected, disaggregated for race and ethnicity, and used to inform policy decisions - Training for frontline staff to provide high-	3.8	If you awarded less than the maximum points, please explain why: Other comments or notes:
2.3	**Person-Centered Planning.** Describe how your program supports and engages the individuals served throughout their participation in the project. (250 words)	**4-5 points:** Agency has actionable practices to provide ongoing supportive services throughout the duration of the project. Examples of practices include centering the participant in goal planning, creative engagement strategies, and case management training. **2-3 points:** Agency provides supportive services but has limited examples of specific practices. **0-1 points:** Agency does not have a clear strategy for providing ongoing services or services described are not person-centered.	4.3	If you awarded less than the maximum points, please explain why: Other comments or notes:

2.4	**Connection to Healthcare Services.** Describe your strategy to ensure clients are connected with and have ongoing access to appropriate healthcare services, including mental healthcare and gender-affirming healthcare. (250 words)	**4-5 points:** Agency has actionable practices to connect participants to healthcare services, including mental healthcare and gender-affirming healthcare. Examples of actionable practices can include partnerships with healthcare organizations through MOU, providing navigation services, addressing transportation barriers to healthcare services, etc. **2-3 points:** Agency provides connections to healthcare services, but connection is limited or does not specify connections to mental healthcare and gender-affirming healthcare. **0-1 points:** Agency does not have a clear strategy for connecting participants with healthcare services.	4.5	If you awarded less than the maximum points, please explain why: Other comments or notes:
2.5	**Racial Equity.** How does your project work to eliminate racial disparities in housing outcomes? (250 words)	**4-5 points:** Agency has promising goals for promoting racial equity. The answer clearly demonstrates how this project will ensure equity and address racial disparities. This could include practices to assess data and outcomes disaggregately, training program staff in anti-racism and other relevant trainings, agency identifies other practices that eliminate disparities. **2-3 points:** Agency is committed to equity but has no clear actionable practices. **0-1 points:** Agency does not have clear commitment to racial equity	2.8	If you awarded less than the maximum points, please explain why: Other comments or notes:
2.6	**Housing First and Trauma-Informed Care.** Describe your program's commitment to a Housing First model and trauma-informed care to create a safe and stable housing environment for participants exiting an experience of homelessness. Please attach policies and procedures that demonstrate/support this commitment. (250 words)	**4-5 points:** Agency incorporates Housing First into their operating policies and procedures by removing unnecessary barriers to entering housing and does not require participation in services by residents. Agency offers trainings and professional development opportunities for program staff regarding traumainformed care. **2-3 points:** Agency describes a Housing First approach, but this approach is not reflected in their written policies and procedures for residents. Trauma-informed care is a priority, but not functionally integrated into roles of program staff. **0-1 points:** Agency does not have a clear commitment to Housing First or trauma-	4.6	If you awarded less than the maximum points, please explain why: Other comments or notes:
3	**Performance Measures**	**70**	**46**	Reviewer Comments
3.1	**Utilization.** Actual Number households served during PITs (APR Q8)/ Total Number of Units in Project: October 2021 Households: January 2022 Households: April 2022 Households: July 2022 Households: Households Average Actual / Projected = Utilization %	**5 points**: 95%-100% Utilization Rate **3 points:** 90%-94% Utilization Rate **0 points:** <90% Utilization Rate	0	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.2	**Vulnerable Populations.** What percentage of clients served in FY2022 were in the following categories? Chronically Homeless (Q5a #11 / Q5a # 14): (>75%) Youth [Q27a Youth Ages 18-24 / Q5a #1]: (>75%) Domestic Violence[Q14b Yes / Q5a#1]: (>75%)	Score **5 points** if any were above 75%. Otherwise, score 0.	5	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.3	**Data Quality.** Were all of the following error rates below 5% for Q6 of your FY2022 APR? Personally-Identifying information (6a) Universal Data Elements (6b) Income and Housing Data Quality (6c) Chronic Homelessness (6d)	Score **5 points** for Yes. Otherwise, score 0.	5	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.4	**Coordinated Entry Participation.** What percentage of new entries to the project during FY2022 were matched to your project through the coordinated entry system?	Score **5 points** for 100% participation. Otherwise, score 0.	5	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.5	**Permanent Housing Placement & Retention.** For PSH, what percentage of clients served in FY2022 either stayed in the project or exited to a permanent housing destination (APR Q5a#8 Stayers, Q23c Exiting to housing destinations) (Positive housing destinations + Stayers) / (Total Participants – Persons excluded) For RRH, of the clients who exited your project, what percentage of clients served in FY2022 exited to a permanent housing destination (APR Q23c)?	The CoC-wide percentage of PSH clients retained or exited to permanent housing is 94% **10 points:** 94-100% **5 points:** 85-94% **0 points:** Less than 85% The CoC-wide percentage of RRH clients exited to a permanent housing destination is 50% **10 points:** 51-100% **5 points:** 40-50% **0 points:** Less than 40%	5	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.6	**Employment Growth:** What percentage of clients enrolled in your program within the FY2022 year increased their employment income (APR Q19a1 and Q19a2)? ({Within the "Number of Adults with Earned Income" Rows in Q19a1 & 19a2}Adults who Gained or Increased Income from Start to Annual Assessment, Average Gain+ Adults who Gained or Increased Income from Start to Exit, Average Gain)/(Total Adults in Q19a1 + Total Adults in Q19a2)	PSH: CoC-Wide Average is 12% RRH: CoC-Wide Average is 12% **5 points:** More than 12% **3 points:** Between 6 to 12% **0 points:** Less than 6%	0	If you awarded less than the maximum points, please explain why: Other comments or notes:

3.7	**Income Growth:** What percentage of clients enrolled in your program at the end of FY2022 had increased their total cash income since entering the program (Q19a1 & APR Q19a2)? ({Within the "Number of Adults with Any Income" Rows in Q19a1 & 19a2}Adults who Gained or Increased Income from Start to Annual Assessment, Average Gain+ Adults who Gained or Increased Income from Start to Exit, Average Gain)/(Total Adults in Q19a1 + Total Adults in Q19a2)	PSH: The CoC-wide percentage for PSH programs was 12% **5 points:** More than 12% **3 points:** Between 6 to 12% **0 points:** Less than 6% RRH: The CoC-wide percentage for RRH programs was 50% **5 points:** More than 50% **3 points:** 40-50% **0 points:** Less than 40%	0	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.8	**Health Insurance.** What percentage of leavers in your project had health insurance upon exit from the project (APR Q21 + APR Q5a#5)? (Number of "1 Source of Health Insurance + Number of "More than 1 Source of Health Insurance) / (Number of Leavers)	The CoC-Wide Percentage was 83% for PSH The CoC-Wide Percentage was 84% for RRH **4 points:** More than 83% **2 points:** 72-83% **0 points:** Less than 72%	0	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.9	**Non-cash Benefits.** What percentage of leavers enrolled in your project had other non-cash benefits upon exit from the project (Q20b, Q5a#7)? Number of "1 + Sources" / "Number of Adult and Head of Household Leavers"	The CoC-Wide Percentage for PSH was 22% **4 points:** More than 22% **2 points:** 11-22% **0 points:** Less than 11% The CoC-Wide Percentage for RRH was 60% **4 points:** More than 60% **2 points:** 50-60% **0 points:** Less than 50%	4	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.10	**Time to Move-in.** What was the average time for households to move into housing after enrolling in the project? (Q22c, "Average length of time to housing") The CoC-Wide Average Length of time is 25 days.	**2 points:** Less than 30 days **1 points:** Between 30-50 days **0 points:** Over 50 days	2	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.11	**Fund expenditure.** Were all funds expended in the last completed program year?	**5 points:** 100% spent **3 points:** 95-99% **0 points:** Less than 94%	5	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.12	**Cost Effectiveness.** Annual budget will be divided by number of beds. Community averages are as follows: Rapid Rehousing: $7,391/bed Permanent Supportive Housing: $13,341/bed Transitional-Rapid Rehousing: $31,734/bed SSO (Coordinated Entry): N/A	**10 points:** Project is under community averages by 10% **5 points:** Project is within 10% of community averages **0 points:** Project cost is 10% or more over averages	5	If you awarded less than the maximum points, please explain why: Other comments or notes:
3.13	**Monitoring.** Were there significant findings for your project during CoC monitoring? (Scored by CoC Staff)	**10 points:** No Findings **5 points:** Moderate Findings **0 points:** Significant Findings	10	If you awarded less than the maximum points, please explain why: Other comments or notes:
4	**Successful Past Performance Bonus**	**20**	**20**	Reviewer Comments
4.1	**Past Performance.** Renewal project is currently in good standing with the Continuum of Care and was prioritized for Tier I funding during the 2022 Rank and Review Process.	**20 points:** Project is in good standing with the Continuum of Care and was prioritized for Tier 1 funding in FY2022. **10 points:** Project is no longer in good standing with the Continuum of Care, but was prioritized for Tier 1 funding in FY2022. **5 points:** Project is in good standing with the Continuum of Care, but was not prioritized for Tier 1 funding in FY2022. **0 points:** Project is not in good standing with the Continuum of Care and was not prioritized for Tier 1 funding in FY2022.	20	If you awarded less than the maximum points, please explain why: Other comments or notes:
	Project TOTAL	100	90	

Overall Review Notes and Comments: Amici was a favorite site of the rank and review committee. One member remarked that it felt like a very trauma informed site. Clean and well-lit.

1E-2a. Scored Forms for One Project

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	Project TOTAL	100	90	

Overall Review Notes and Comments: Amici was a favorite site of the rank and review committee. One member remarked that it felt like a very trauma informed site. Clean and well-lit.

1E-5. Notification of Projects Rejected-Reduced

1. SJCS CoC Notification Screenshot

Liddy Bargar <lbargar@hsctc.org>
to Roy, Lauren, Simone

2:30 PM (1 minute ago)

Hello Roy and Lauren,

The CoC Rank and Review Committee is excited to announce the ranking results of this year's local CoC competition

These projects are recommended for renewal in the following order and amounts. The final ranking sheet is attached.

SJCS Oasis PSH was ranked in the 5th position of tier which creates a strong possibility that the project may only be partially funded. The amount prioritized in tier 1 is $11,498 with the balance of the renewal project ranked in the first position of tier 2 in the amount of $15,224.

The New/Expansion SJCS Oasis PSH project also straddles 2 tiers. The amount applied for is larger than the amount available in our competition. This created a scenario in which $64,853 in position 2 of tier with the balance of $102,135 unable to be included in the tiering due to being greater than the CoC bonus amount available, this amount will not be funded.

This year the CoC opted to use a new local application to generate our ranking. In order to better share information about how your projects performed in the local competition the CoC has generated a local competition debrief document for your review. Included in the debrief, are the scores for each question as well as comments from the system evaluation committee about site visits. Also attached are the results of the Housing First assessment, thank you for your agency's participation in our first official Housing First assessment!

Please don't hesitate to complete and submit your application in e-snaps which is due 9/21/23. Here is a handy link to all things e-snaps if you need it!.

Thank you for your high quality projects and for your continued participation in the Continuum of Care!

--
Liddy Bargar She/her
Director of Housing Initiatives
Human Services Coalition
(607)273-8686
lbargar@hsctc.org

4 Attachments • Scanned by Gmail

New Message

Search

2:32 PM
9/6/2023

1E-5a. Notification of Projects Accepted

1. Housing and Homeless Coalition of CNY HMIS Notification Screenshot
2. St. John's Community Services PSH Notification Screenshot
3. Tompkins Community Action PSH Notification Screenshot
4. Learning Web YHDP Notification Screenshot
5. Village House YHDP Notification Screenshot

1E-5a. Notification of Projects Accepted

1. **Housing and Homeless Coalition of CNY HMIS Notification Screenshot**
2. St. John's Community Services PSH Notification Screenshot
3. Tompkins Community Action PSH Notification Screenshot
4. Learning Web YHDP Notification Screenshot
5. Village House YHDP Notification Screenshot

in:sent

1 of 7,890

FY2023 CoC Local Competition Award Notification.

Liddy Bargar <lbargar@hsctc.org>
to Megan, Sarah, Simone

2:31PM (3 minutes ago)

Hello Megan and Sarah,

The CoC Rank and Review Committee is excited to announce our ranking of this year's local CoC competition.

United Way's HMIS Tompkins Project was ranked in the 4th position of tier 1 and recommended for funding in the amount of $16,733.

This year the CoC opted to use a new local application to generate our ranking. In order to better share information about how your projects performed in the local competition the CoC has generated a local competition debrief document for your review. Included in the debrief, are the scores for each question.

Please don't hesitate to complete and submit your application in e-snaps which is due 9/21/23. Here is a handy link to all things e-snaps if you need it!.

Thank you for your high quality project and for your continued participation in the Continuum of Care!

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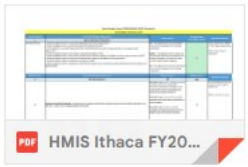
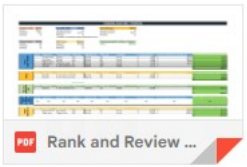
Director of Housing Initiatives
Human Services Coalition
(607)273-8686
lbargar@hsctc.org

2 Attachments • Scanned by Gmail


HMIS Ithaca FY20...


Rank and Review ...

Reply | Reply all | Forward

New Message

Search

2:35 PM
9/6/2023

1E-5a. Notification of Projects Accepted

1. Housing and Homeless Coalition of CNY HMIS Notification Screenshot
2. **St. John's Community Services PSH Notification Screenshot**
3. Tompkins Community Action PSH Notification Screenshot
4. Learning Web YHDP Notification Screenshot
5. Village House YHDP Notification Screenshot

Liddy Bargar <lbargar@hsctc.org>
to Roy, Lauren, Simone

2:30 PM (1 minute ago)

Hello Roy and Lauren,

The CoC Rank and Review Committee is excited to announce the ranking results of this year's local CoC competition

These projects are recommended for renewal in the following order and amounts. The final ranking sheet is attached.

SJCS Oasis PSH was ranked in the 5th position of tier which creates a strong possibility that the project may only be partially funded. The amount prioritized in tier 1 is $11,498 with the balance of the renewal project ranked in the first position of tier 2 in the amount of $15,224.

The New/Expansion SJCS Oasis PSH project also straddles 2 tiers. The amount applied for is larger than the amount available in our competition. This created a scenario in which $64,853 in position 2 of tier with the balance of $102,135 unable to be included in the tiering due to being greater than the CoC bonus amount available, this amount will not be funded.

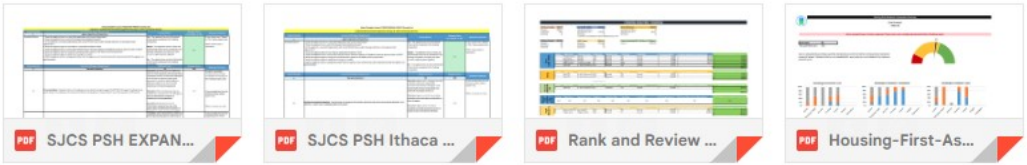
This year the CoC opted to use a new local application to generate our ranking. In order to better share information about how your projects performed in the local competition the CoC has generated a local competition debrief document for your review. Included in the debrief, are the scores for each question as well as comments from the system evaluation committee about site visits. Also attached are the results of the Housing First assessment, thank you for your agency's participation in our first official Housing First assessment!

Please don't hesitate to complete and submit your application in e-snaps which is due 9/21/23. Here is a handy link to all things e-snaps if you need it!.

Thank you for your high quality projects and for your continued participation in the Continuum of Care!

--
Liddy Bargar She/her
Director of Housing Initiatives
Human Services Coalition
(607)273-8686
lbargar@hsctc.org

4 Attachments • Scanned by Gmail



New Message

Search

2:32 PM
9/6/2023

1E-5a. Notification of Projects Accepted

1. Housing and Homeless Coalition of CNY HMIS Notification Screenshot
2. St. John's Community Services PSH Notification Screenshot
3. **Tompkins Community Action PSH Notification Screenshot**
4. Learning Web YHDP Notification Screenshot
5. Village House YHDP Notification Screenshot

FY2023 CoC Local Competition Award Notification.

Liddy Bargar <lbargar@hsctc.org>
to Danielle

1:55 PM (0 minutes ago)

Hello Danielle,

The CoC Rank and Review Committee is excited to announce our ranking of this Tompkins Community Action's FY2023 renewal projects.

These projects are recommended for renewal in the following order and amounts. The final ranking sheet is attached.

1. Chartwell House $45,498
2. Amici House $85,636
3.Magnolia House $45,088

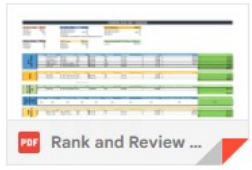
This year the CoC opted to use a new local application to generate our ranking. In order to better share information about how your projects performed in the local competition the CoC has generated a local competition debrief document for your review. Included in the debrief, are the scores for each question as well as comments from the system evaluation committee about site visits. Also attached are the results of the Housing First assessment, thank you for your agency's participation in our first official Housing First assessment!

Please don't hesitate to complete and submit your application in e-snaps which is due 9/21/23. Here is a handy link to all things e-snaps if you need it!.

Thank you for your high quality projects and for your continued participation in the Continuum of Care!

--
Liddy Bargar She/her
Director of Housing Initiatives
Human Services Coalition
(607)273-8686
lbargar@hsctc.org

5 Attachments • Scanned by Gmail



1E-5a. Notification of Projects Accepted

1. Housing and Homeless Coalition of CNY HMIS Notification Screenshot
2. St. John's Community Services PSH Notification Screenshot
3. Tompkins Community Action PSH Notification Screenshot
4. **Learning Web YHDP Notification Screenshot**
5. Village House YHDP Notification Screenshot

FY2023 YHDP Renewal Notification

External Inbox ×

Liddy Bargar <lbargar@hsctc.org>
to Olan, Michelle, Simone

Tue, Sep 12, 1:42 PM (11 days ago)

Hello Olan,

Thank you for submitting your renewal application in our local competition. As you know, YHDP renewals are non-competitive in this round and we are excited to confirm your renewal funding in the amount of $439,946

This year we provided CoC applicants with feedback about their scores in the form of a debrief and both YHDP projects with what is being called a Performance Improvement Plan (PIP). For FY2023, the CoC is asking projects who are receiving automatic funding renewals to commit to a Project Improvement Plan (PIP) in order to set goals for project implementation over the following automatically funded project year. Progress towards these goals and metrics will be assessed and integrated into the Rank and Review Committee's decision making on project ranking and funding allocations for the FY2024 funding competition. We recommend that projects receiving automatic renewals review the target goals described below and integrate these goals into program policy and procedure to be competitive in the next funding cycle.

Please make sure to submit your e-snaps application ASAP with a hard deadline of 9/21. I know you are familiar with e-snaps but if you have questions, please let me know if I can help.

Thank you for all your work in the inaugural year of YHDP! I can't wait to see what is to come for the future of your YHDP project. Please let me know if I can answer any questions.

Best,

--
Liddy Bargar She/her
Director of Housing Initiatives
Human Services Coalition
(607)273-8686

1E-5a. Notification of Projects Accepted

1. Housing and Homeless Coalition of CNY HMIS Notification Screenshot
2. St. John's Community Services PSH Notification Screenshot
3. Tompkins Community Action PSH Notification Screenshot
4. Learning Web YHDP Notification Screenshot
5. **Village House YHDP Notification Screenshot**

FY2023 YHDP Renewal Notification

External Inbox ×

Liddy Bargar <lbargar@hsctc.org>
to Meryl, West, Simone

Sep 12, 2023, 1:34 PM (11 days ago)

Hello Meryl,

Thank you for submitting your renewal application in our local competition. As you know, YHDP renewals are non-competitive in this round and we are excited to confirm your renewal funding in the amount of $484,163

This year we provided CoC applicants with feedback about their scores in the form of a debrief and both YHDP projects with what is being called a Performance Improvement Plan (PIP). For FY2023, the CoC is asking projects who are receiving automatic funding renewals to commit to a Project Improvement Plan (PIP) in order to set goals for project implementation over the following automatically funded project year. Progress towards these goals and metrics will be assessed and integrated into the Rank and Review Committee's decision making on project ranking and funding allocations for the FY2024 funding competition. We recommend that projects receiving automatic renewals review the target goals described below and integrate these goals into program policy and procedure to be competitive in the next funding cycle.

Please make sure to submit your e-snaps application ASAP with a hard deadline of 9/21. I know you are familiar with e-snaps but if you have questions please let me know if I can help.

Thank you for all your work in the inaugural year of YHDP! I can't wait to see what is to come for the future of your YHDP project. Please let me know if I can answer any questions.

Best,

--
Liddy Bargar She/her
Director of Housing Initiatives
Human Services Coalition
(607)273-8686
lbargar@hsctc.org

1E-5b. Final Project Scores for All Projects

1. Rank and Review Table

FUNDING ANALYSIS + RANKING

CoC Bonus Funding	$80,077
Allocated	$80,077
% Allocated	100%
Remaining	$0

Tier 1 (ARD - YHDP)	$204,453
Allocated to DV Bonus	$0
Allocated from Tier 1	$204,453
Remaining	$0

*If DV Bonus not selected this will be subtracted from Tier 1

Tier 2 (CoC Bonus)	$80,077
Allocated to DV Bonus	$0
Allocated from Tier 2	$80,077
Remaining	$0

DV Bonus Funding	$57,543
Allocated	$0
% Allocated	0%
Remaining	$0

YHDP Projects	$924,109
Allocated	$924,109
% Allocated	0%
Remaining	$0

Projects Exceeding ARD + CoC Bonus + DV Bonus	
Amount	$102,135

Tier 1 (ARD-YHDP)

Ranking	Project Name	Organization Name	Rating Score	Application Type	Project Type	General/DV	CoC Funding Requested	CoC Amount Expended Last Operating Year	CoC Funding Recommendation (manual entry)
1	Chartwell House	TCAction	95.2	Renewal	PSH	General	$ 45,498	$ 45,498	$ 45,498
2	Amici House	TCAction	90.2	Renewal	PSH	General	$ 85,636	$ 85,636	$ 85,636
3	Magnolia House	TCAction	90.2	Renewal	PSH	General	$ 45,088	$ 45,088	$ 45,088
4	HMIS Tompkins	United Way of CNY	90	Renewal	HMIS	General	$ 16,733	$ 16,031	$ 16,733
5	Oasis PSH	St. John's Community Services	45.3	Renewal	PSH	General	$ 26,722	$ -	$ 11,498
									$ 204,453

Tier 2

Ranking	Project Name	Organization Name	Rating Score	Application Type	Project Type	General/DV	CoC Funding Requested	CoC Amount Expended Last Operating Year	CoC Funding Recommendation (manual entry)
1	Oasis PSH	St. John's Community Services	45.3	Renewal	PSH	General	$ 26,722	$ -	$ 15,224
2	Oasis PSH	St. John's Community Services	62.7	Expansion	PSH	General	$ 166,988	$ -	$ 64,853
									$ 80,077

PROJECTS EXCEEDING ARD

Ranking	Project Name	Organization Name	Rating Score	Application Type	Project Type	General/DV	CoC Funding Requested	CoC Amount Expended Last Operating Year	CoC Funding Recommendation (manual entry)
1	Oasis PSH	St. John's Community Services	62.7	Expansion	PSH	General	$ 166,988	$ -	$ 102,135
									$ 102,135

PROJECTS NOT SELECTED FOR FUNDING

Ranking	Project Name	Organization Name	Rating Score	Application Type	Project Type	General/DV	CoC Funding Requested	CoC Amount Expended Last Operating Year	CoC Funding Recommendation (manual entry)
N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A	N/A

YHDP PROJECTS

Ranking	Project Name	Organization Name	Rating Score	Application Type	Project Type	General/DV	CoC Funding Requested	CoC Amount Expended Last Operating Year	CoC Funding Recommendation (manual entry)
1	Scattered Site PSH	Learning Web	66.2	Renewal	PSH	General	$ 439,946	$ 12,250	$ 439,946
2	Village House	Village at Ithaca	58.2	Renewal	TH	General	$ 484,163	$ 301,838	$ 484,163
									$ 924,109

2A-6. HUD's Homeless Data Exchange (HDX) Competition Report

1. 2023 HDX Competition Report

2023 HDX Competition Report

PIT Count Data for NY-510 - Ithaca/Tompkins County CoC

Total Population PIT Count Data

	2020 PIT	2021 PIT *	2022 PIT	2023 PIT
Total Sheltered and Unsheltered Count	**133**	**144**	**152**	**273**
Emergency Shelter Total	80	103	126	221
Safe Haven Total	0	0	0	0
Transitional Housing Total	19	20	14	41
Total Sheltered Count	**99**	**123**	**140**	**262**
Total Unsheltered Count	**34**	**21**	**12**	**11**

Chronically Homeless PIT Counts

	2020 PIT	2021 PIT *	2022 PIT	2023 PIT
Total Sheltered and Unsheltered Count of Chronically Homeless Persons	**60**	**33**	**49**	**67**
Sheltered Count of Chronically Homeless Persons	38	33	43	64
Unsheltered Count of Chronically Homeless Persons	22	0	6	3

2023 HDX Competition Report

PIT Count Data for NY-510 - Ithaca/Tompkins County CoC

Homeless Households with Children PIT Counts

	2020 PIT	2021 PIT *	2022 PIT	2023 PIT
Total Sheltered and Unsheltered Count of the Number of Homeless Households with Children	**5**	**9**	**6**	**14**
Sheltered Count of Homeless Households with Children	5	9	6	14
Unsheltered Count of Homeless Households with Children	0	0	0	0

Homeless Veteran PIT Counts

	2011 PIT	2020 PIT	2021 PIT *	2022 PIT	2023 PIT
Total Sheltered and Unsheltered Count of the Number of Homeless Veterans	**1**	**5**	**6**	**2**	**6**
Sheltered Count of Homeless Veterans	0	4	5	2	6
Unsheltered Count of Homeless Veterans	1	1	1	0	0

*For CoCs that did not conduct an unsheltered count in 2021, 2020 data were used.

2023 HDX Competition Report

HIC Data for NY-510 - Ithaca/Tompkins County CoC

HMIS Bed Coverage Rates

Project Type	Total Year-Round, Current Beds	Total Current, Year-Round, HMIS Beds	Total Year-Round, Current, Non-VSP Beds*	HMIS Bed Coverage Rate for Year-Round Beds	Total Year-Round, Current VSP Beds in an HMIS Comparable Database	Total Year-Round, Current, VSP Beds**	HMIS Comparable Bed Coverage Rate for VSP Beds	Total Current, Year-Round, HMIS Beds and VSP Beds in an HMIS Comparable Database	HMIS and Comparable Database Coverage Rate
ES Beds	121	115	115	100.00%	6	6	100.00%	121	100.00%
SH Beds	0	0	0	NA	0	0	NA	0	NA
TH Beds	45	33	45	73.33%	0	0	NA	33	73.33%
RRH Beds	41	41	41	100.00%	0	0	NA	41	100.00%
PSH Beds	123	123	123	100.00%	0	0	NA	123	100.00%
OPH Beds	71	0	71	0.00%	0	0	NA	0	0.00%
Total Beds	401	312	395	78.99%	6	6	100.00%	318	79.30%

2023 HDX Competition Report

HIC Data for NY-510 - Ithaca/Tompkins County CoC

2023 HDX Competition Report

HIC Data for NY-510 - Ithaca/Tompkins County CoC

Notes
***For OPH Beds, this does NOT include any beds that are Current, Non-VSP, Non-HMIS, and EHV-funded.**
****For OPH Beds, this does NOT include any beds that are Current, VSP, Non-HMIS, and EHV-funded.**
In the HIC, "Year-Round Beds" is the sum of "Beds HH w/o Children", "Beds HH w/ Children", and "Beds HH w/ only Children". This does not include Overflow ("O/V Beds") or Seasonal Beds ("Total Seasonal Beds").
In the HIC, Current beds are beds with an "Inventory Type" of "C" and not beds that are Under Development ("Inventory Type" of "U").

PSH Beds Dedicated to Persons Experiencing Chronic Homelessness

Chronically Homeless Bed Counts	2020 HIC	2021 HIC	2022 HIC	2023 HIC
Number of CoC Program and non-CoC Program funded PSH beds dedicated for use by chronically homeless persons identified on the HIC	19	11	11	5

Rapid Rehousing (RRH) Units Dedicated to Persons in Household with Children

Households with Children	2020 HIC	2021 HIC	2022 HIC	2023 HIC
RRH units available to serve families on the HIC	13	12	8	5

Rapid Rehousing Beds Dedicated to All Persons

All Household Types	2020 HIC	2021 HIC	2022 HIC	2023 HIC
RRH beds available to serve all populations on the HIC	42	68	63	41

2023 HDX Competition Report

HIC Data for NY-510 - Ithaca/Tompkins County CoC

2023 HDX Competition Report

FY2022 - Performance Measurement Module (Sys PM)

Summary Report for NY-510 - Ithaca/Tompkins County CoC

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.

	Universe (Persons)		Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Revised FY 2021	FY 2022	Submitted FY 2021	Revised FY 2021	FY 2022	Difference	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
1.1 Persons in ES and SH	491	654	64	66	78	12	36	35	53	18
1.2 Persons in ES, SH, and TH	510	675	74	80	86	6	37	40	55	15

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.

2023 HDX Competition Report

FY2022 - Performance Measurement Module (Sys PM)

	Universe (Persons)		Average LOT Homeless (bed nights)				Median LOT Homeless (bed nights)			
	Revised FY 2021	FY 2022	Submitted FY 2021	Revised FY 2021	FY 2022	Difference	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
1.1 Persons in ES, SH, and PH (prior to "housing move in")	530	715	203	269	204	-65	65	85	82	-3
1.2 Persons in ES, SH, TH, and PH (prior to "housing move in")	547	735	217	276	207	-69	80	93	84	-9

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.

	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 2021	FY 2022	Revised FY 2021	FY 2022	% of Returns	Revised FY 2021	FY 2022	% of Returns	Revised FY 2021	FY 2022	% of Returns	FY 2022	% of Returns
Exit was from SO	0	0	0	0		0	0		0	0		0	
Exit was from ES	266	200	24	19	10%	18	14	7%	17	20	10%	53	27%
Exit was from TH	17	11	2	0	0%	0	0	0%	0	0	0%	0	0%
Exit was from SH	0	0	0	0		0	0		0	0		0	
Exit was from PH	45	56	0	0	0%	6	2	4%	2	6	11%	8	14%
TOTAL Returns to Homelessness	328	267	26	19	7%	24	16	6%	19	26	10%	61	23%

Measure 3: Number of Homeless Persons

Metric 3.1 – Change in PIT Counts

2023 HDX Competition Report
FY2022 - 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 2021 PIT Count	January 2022 PIT Count	Difference
Universe: Total PIT Count of sheltered and unsheltered persons	144	152	8
Emergency Shelter Total	103	126	23
Safe Haven Total	0	0	0
Transitional Housing Total	20	14	-6
Total Sheltered Count	123	140	17
Unsheltered Count	21	12	-9

Metric 3.2 – Change in Annual Counts

This measures the change in annual counts of sheltered homeless persons in HMIS.

	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
Universe: Unduplicated Total sheltered homeless persons	514	528	699	171
Emergency Shelter Total	494	507	676	169
Safe Haven Total	0	0	0	0
Transitional Housing Total	31	34	29	-5

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 2021	Revised FY 2021	FY 2022	Difference
Universe: Number of adults (system stayers)	26	28	34	6
Number of adults with increased earned income	3	0	1	1
Percentage of adults who increased earned income	12%	0%	3%	3%

Metric 4.2 – Change in non-employment cash income for adult system stayers during the reporting period

	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
Universe: Number of adults (system stayers)	26	28	34	6
Number of adults with increased non-employment cash income	6	3	1	-2
Percentage of adults who increased non-employment cash income	23%	11%	3%	-8%

Metric 4.3 – Change in total income for adult system stayers during the reporting period

	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
Universe: Number of adults (system stayers)	26	28	34	6
Number of adults with increased total income	6	3	1	-2
Percentage of adults who increased total income	23%	11%	3%	-8%

2023 HDX Competition Report
FY2022 - Performance Measurement Module (Sys PM)

Metric 4.4 – Change in earned income for adult system leavers

	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
Universe: Number of adults who exited (system leavers)	20	20	10	-10
Number of adults who exited with increased earned income	1	1	1	0
Percentage of adults who increased earned income	5%	5%	10%	5%

Metric 4.5 – Change in non-employment cash income for adult system leavers

	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
Universe: Number of adults who exited (system leavers)	20	20	10	-10
Number of adults who exited with increased non-employment cash income	7	9	1	-8
Percentage of adults who increased non-employment cash income	35%	45%	10%	-35%

Metric 4.6 – Change in total income for adult system leavers

	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
Universe: Number of adults who exited (system leavers)	20	20	10	-10
Number of adults who exited with increased total income	8	10	2	-8
Percentage of adults who increased total income	40%	50%	20%	-30%

2023 HDX Competition Report
FY2022 - 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 2021	Revised FY 2021	FY 2022	Difference
Universe: Person with entries into ES, SH or TH during the reporting period.	469	480	646	166
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.	144	136	145	9
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)	325	344	501	157

Metric 5.2 – Change in the number of persons entering ES, SH, TH, and PH projects with no prior enrollments in HMIS

	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
Universe: Person with entries into ES, SH, TH or PH during the reporting period.	518	535	761	226
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.	163	157	173	16
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.)	355	378	588	210

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 FY2022 (Oct 1, 2021 - Sept 30, 2022) 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 2021	Revised FY 2021	FY 2022	Difference
Universe: Persons who exit Street Outreach	0	3	0	-3
Of persons above, those who exited to temporary & some institutional destinations	0	0	0	0
Of the persons above, those who exited to permanent housing destinations	0	2	0	-2
% Successful exits		67%		

Metric 7b.1 – Change in exits to permanent housing destinations

FY2022 - Performance Measurement Module (Sys PM)

	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
Universe: Persons in ES, SH, TH and PH-RRH who exited, plus persons in other PH projects who exited without moving into housing	438	424	524	100
Of the persons above, those who exited to permanent housing destinations	158	147	155	8
% Successful exits	36%	35%	30%	-5%

Metric 7b.2 – Change in exit to or retention of permanent housing

	Submitted FY 2021	Revised FY 2021	FY 2022	Difference
Universe: Persons in all PH projects except PH-RRH	100	101	152	51
Of persons above, those who remained in applicable PH projects and those who exited to permanent housing destinations	96	97	147	50
% Successful exits/retention	96%	96%	97%	1%

2023 HDX Competition Report

FY2022 - SysPM Data Quality

NY-510 - Ithaca/Tompkins County CoC

	All ES, SH			All TH			All PSH, OPH			All RRH			All Street Outreach		
	Submitted FY2020	Submitted FY2021	FY2022	Submitted FY2020	Submitted FY2021	FY2022	Submitted FY2020	Submitted FY2021	FY2022	Submitted FY2020	Submitted FY2021	FY2022	Submitted FY2020	Submitted FY2021	FY2022
1. Number of non-DV Beds on HIC	20	74	133	23	26	21	141	133	121	42	68	63			
2. Number of HMIS Beds	20	74	133	23	26	21	113	115	81	42	68	63			
3. HMIS Participation Rate from HIC (%)	100.00	100.00	100.00	100.00	100.00	100.00	80.14	86.47	66.94	100.00	100.00	100.00			
4. Unduplicated Persons Served (HMIS)	596	507	676	38	42	41	123	115	113	134	218	185	0	31	0
5. Total Leavers (HMIS)	531	441	511	19	25	21	25	42	17	70	107	122	0	3	0
6. Destination of Don't Know, Refused, or Missing (HMIS)	200	177	331	1	0	0	4	0	1	10	17	15	0	0	0
7. Destination Error Rate (%)	37.66	40.14	64.77	5.26	0.00	0.00	16.00	0.00	5.88	14.29	15.89	12.30		0.00	

2023 HDX Competition Report

FY2022 - SysPM Data Quality

2023 HDX Competition Report

Submission and Count Dates for NY-510 - Ithaca/Tompkins County CoC

Date of PIT Count

	Date	Received HUD Waiver
Date CoC Conducted 2023 PIT Count	1/23/2023	

Report Submission Date in HDX

	Submitted On	Met Deadline
2023 PIT Count Submittal Date	4/28/2023	Yes
2023 HIC Count Submittal Date	4/28/2023	Yes
2022 System PM Submittal Date	2/28/2023	Yes

Other. Home, Together: Tompkins strategic plan

1. Home, Together: Tompkins Plan (Full)
2. Home, Together: Tompkins Presentation

Other. Home, Together: Tompkins strategic plan

1. **Home, Together: Tompkins Plan (Full)**
2. Home, Together: Tompkins Presentation

Home, Together: Tompkins

The CoC's homeless response plan for ending unsheltered homelessness and enhancing service delivery for people with severe service needs.

Simone Gatson, CoC Staff and Coordinated Entry Lead

Liddy Bargar, Director of Housing Initiatives

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Letter from the CoC

We are incredibly grateful to work with and for this community in our efforts to build a homeless response system that will ultimately make homelessness rare, brief, and one-time. The CoC recognizes that our current system creates suffering for people experiencing homelessness by posing the issue of for-profit housing as a personal failing for every unhoused individual in our community. With this plan, we reject this belief and advocate for a radical culture shift to create a system that adequately serves people with severe service needs in our community.

When describing the solution to ending homelessness, people are often surprised that the answer is permanent, low-cost, supportive housing. There is usually an assumption that, as experts in this field, we must be aware of some new groundbreaking solution to homelessness that no one has considered before, but that is incorrect. The only thing radical about our solution is the insistence that every individual should have a human right to housing in our homeless response system because housing is a fundamental necessity for people to find stability and meet their long-term goals. It is also a fundamental necessity for health.

We have seen system change translate into transformative culture change in other systems. Notably, the recovery and treatment field has intentionally shifted away from punitive abstinence-only treatment models and has embraced the harm reduction model, medication-assisted treatment, and person-centered care. As recently as the mid-2000s, local treatment providers used a fully abstinence-only approach to treating addiction. It wasn't working, people were "failing" at treatment, and the heroin epidemic was in full swing. Researchers began to examine alternative treatment models and better track data to tackle the failing treatment sector. They learned that addiction is a progressive, fatal brain disease and that relapse is a natural part of the disease. Armed with that evidence and data, the harm reduction treatment model appeared. Providers began to modify their systems, practices, and, ultimately, the service delivery model. Before the shift, access to medication-assisted treatment was limited to people who could practice complete abstinence. When people relapsed, they risked losing their life-saving medication and trust was eroded between client and provider. Adopting a more person-centered system improved clients' recovery outcomes, and lives were saved. The larger community began to see the humanity in people with addiction.

The CoC intends to make a similar cultural shift in how we think about housing and homelessness. Our community currently lacks safe, habitable spaces where people can stabilize themselves and live indoors for low or no cost. *Home, Together: Tompkins* plans to address this while also acknowledging the obvious; this plan cannot be successful without all stakeholders- including legislators, service providers, outreach workers, community members, and people with lived experience of homelessness- coming together and creating the systems change necessary to alleviate our county's homeless crisis.

Simone Gatson, CoC Staff and Coordinated Entry Lead

Liddy Bargar, Director of Housing Initiatives and CoC Coordinator

Introduction

The Continuum of Care (CoC) is a program by the United States Department of Housing and Urban Development (HUD) dedicated to organizing community-wide involvement in preventing and ending homelessness. Ultimately the goal of the CoC is to rehouse homeless individuals and families while minimizing the trauma and dislocation caused to homeless individuals, families, and communities by homelessness. The Continuum of Care does this by promoting access to supportive housing and other supportive services for individuals experiencing homelessness through our Coordinated Entry (CE) process, as well as organizing community planning and education regarding building a more trauma-informed, housing-first homeless response system.

Following the findings of our most recent Homeless and Housing Needs Assessment, the Continuum of Care believes that the only way to end homelessness is by expanding access to housing opportunities in our continuum. The CoC is committed to doing precisely that to meet the demonstrated needs of people experiencing homelessness through our plan: ***Home, Together: Tompkins***.

In alignment with the federal strategic plan to end homelessness published by USICH[1], ***Home, Together: Tompkins*** integrates evidence-based best practices to end homelessness for people with severe service needs in our Continuum of Care. This plan aims to build the low-cost housing necessary to resolve the current bottleneck in our existing homeless response system and increase accessibility through targeted programming. In addition, the Continuum of Care believes that implementing coordinated, time-limited strategies to exit people from unsheltered homelessness will ultimately lead to better health outcomes for everyone.

In addition to expanding the permanent housing options available in our community, the Continuum of Care also recommends easing community tensions through the implementation of several incentive programs, including a mitigation fund for business owners and landlords, a shopping cart exchange program, a cash for trash redemption program, and move-in funds for people entering housing from homelessness. By implementing these initiatives, the CoC hopes to provide opportunities for everyone in our community to heal from the rise in unsheltered homelessness through engagement.

The last component of *Home, Together: Tompkins* is expanding the capacity of the human services sector. Many organizations within our continuum struggle to hire for positions that serve the people most in need of direct service in our community. The Continuum of Care wants to expand these organizations' hiring pools by implementing a professional development track for people with lived experience to act as peers in those positions. The CoC also recommends adding three enhanced housing navigator positions as a centralized resource for warm, rapid

[1] United States Interagency Council on Homelessness. 2018. “Home, Together: The Federal Strategic Plan to Prevent and End Homelessness.” United States Interagency Council on Homelessness (USICH). https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf.

progress toward entering and maintaining permanent housing. The final recommendation is to develop a paid board of individuals with lived experience to integrate their voices and experiences into CoC decision-making.

Our staff is committed to introducing diversion and prevention methods into our current homeless response system through trauma-informed planning. The CoC intends to use this plan to better serve individuals with severe service needs regardless of their housing status. While the Continuum of Care designed *Home, Together: Tompkins* with the goal of ending unsheltered homelessness, this plan will also introduce prevention resources through dedicated housing specialists and incentive programs for people with severe service needs who need help to stay in their housing.

Overall, the *Home, Together: Tompkins* plan covers three clear domains needing coordinated response following the COVID-19 pandemic by providing routes to permanent housing, meaningful employment, and better relations with local business owners, landlords, and neighbors for people with severe service needs. The Continuum of Care would monitor and assist the projects in this plan using our existing database and Coordinated Entry process to ensure that we meet the goals outlined in this plan.

Background

The History of the Encampment

Ithaca's West End has been home to unhoused people dating back to the 1920s when the area was home to a neighborhood of temporary structures and tents occupied by a group known as "The Rhiners".[2] The city first cleared the Rhiner community in 1927.[3] However, despite ongoing efforts to suppress the encampment throughout the decades, there has been a known encampment community in the West End Inlet area ever since.

The Continuum of Care attempts annually to determine the numbers and specific service needs of people living in the encampment space through our Point in Time Count. Before 2020 there had been small, loosely organized groups of agency staff and private citizens performing street outreach services. These services ranged from relationship building and meeting basic needs to linkages with existing services and light case management. At the onset of the COVID-19 public health crisis, the Continuum of Care assembled the Enhanced Street Outreach Team. This team included members from all existing groups performing street outreach services and added REACH medical, Loaves and Fishes, and other critical partners. The team began meeting weekly to address the health and safety needs of people residing in the encampment.

As public spaces shut down, it became nearly impossible for people living outside to reasonably meet many of their essential needs. The first initiative of the Enhanced Street Outreach Team was to secure permission from the City of Ithaca and Park Foundation funding to provide several porta-potties and handwashing stations within the encampment. Additional flexible funding came from Robert Woods Johnson Foundation, allowing the team to quickly develop responses and pilot projects. These included daily prepared meal delivery from Loaves and Fishes, facilitated telehealth appointments with REACH medical, the installation of a Mutual Aid food pantry on-site, distribution of hundreds of masks and other PPE, and a fire safety partnership with the Ithaca Fire Department that included providing more than 25 fire extinguishers. The Enhanced Street Outreach Team continues to coordinate services and connect people with coordinated entry and permanent housing.

Currently, the Continuum of Care estimates that there are approximately 40 people living in the West End Inlet area, with up to 20 people living in other unsheltered areas throughout the county. These numbers are seasonal, as many individuals move into shelter during cold weather policy at our emergency shelter, when barriers to entering the shelter are lower. As cold weather policy generally lasts from October to April, outreach workers tend to see fewer individuals sleeping in unsheltered locations during this time, and more unsheltered individuals between May and September. This gives us an estimated total of about 60 individuals experiencing unsheltered homelessness in Tompkins County during the May to September period of time.

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[2] Marteal, Erin. "Ithaca Children's Garden: Then and Now." Tompkins Weekly, 15 January 2018, https://www.tompkinsweekly.com/articles/ithaca-childrens-garden-then-and-now/. Accessed 29 November 2022.

[3] Kammen, Carol, and Jane Marsh Dieckmann. Ithaca: A Brief History. Charleston, SC, The History Press, 2008.

Housing as a Public Health Measure

Providing safe and stable housing for everyone in our county is a vital intervention to address the public health emergency faced by our unsheltered population. The National Health Care for the Homeless Council makes this case very clearly in their 2019 Article “Homelessness & Health: What’s the Connection?” where they note that “living on the street or in crowded homeless shelters is extremely stressful and made worse by being exposed to communicable disease (e.g. TB, respiratory illnesses, flu, hepatitis, etc.), violence, malnutrition, and harmful weather exposure. Chronic health conditions such as high blood pressure, diabetes, and asthma become worse because there is no safe place to store medications properly. Maintaining a healthy diet is difficult in soup kitchens and shelters as the meals are usually high in salt, sugars, and starch (making for cheap, filling meals but lacking nutritional content). Behavioral health issues such as depression, alcoholism, or other substance use disorders can develop and/or are made worse in such difficult situations, especially if there is no solution in sight. Injuries that result from violence or accidents do not heal properly because bathing, keeping bandages clean, and getting proper rest and recuperation isn’t possible on the street or in shelters. Minor issues such as cuts or common colds easily develop into larger problems such as infections or pneumonia. Numerous health conditions among people who are homeless have higher rates of illness and die on average 12 years sooner than the general U.S. population… Poor health, high stress, unhealthy and dangerous environments, and an inability to control food intake often result in frequent visits to emergency rooms and hospitalizations”.[4]

While many professionals recognize housing as a social determinant of health, the Continuum of Care asserts that access to stable housing is more than that. Housing is a prerequisite to achieving and maintaining health in our county for the reasons listed above by the NHCHC. The growth of our population experiencing unsheltered homelessness is a growing public health crisis. The solution is to create more indoor options for people to meet their basic needs with dignity and support. This relationship between housing and health is the central tenet of our plan. The Continuum of Care wants to shift the culture of managing encampment spaces towards meeting the needs of people experiencing unsheltered homelessness as a public health measure in and of itself.

Home, Together

Home, Together: Tompkins is modeled after the “Home, Together” Federal Strategic Plan to Prevent and End Homelessness from USICH, which incorporates evidence-based strategies to end homelessness. This plan follows the guiding principles of home: providing safe and stable places to live and together: strengthening our community by providing opportunities for people to collaborate on this issue. This plan integrates these best practices to meet the following goals:

- Quickly identifying and engaging people at risk of and experiencing homelessness.

[4] National Health Care for the Homeless Council. “Homelessness & Health: What's the Connection?” National Health Care for the Homeless Council, 08 2019, https://nhchc.org/wp-content/uploads/2019/08/homelessness-and-health.pdf. Accessed 29 November 2022.

- Intervening to prevent people from losing their housing and divert people from entering the homelessness services system.
- Providing people with immediate access to shelter and crisis services without barriers to entry if homelessness does occur.
- Quickly connecting people experiencing homelessness to housing assistance and services tailored to their unique needs and strengths to help them achieve and maintain stable housing.

The CoC integrates the best practices included in the plan; having a by-name list of people experiencing homelessness, coordinating outreach and housing services, expanding capacity of the human services sector, supporting policies that reduce the criminalization of homelessness, providing access to low barrier shelter, and expanding access to safe, low-cost, adequate housing with supports.[5] These are the suggested practices to end homelessness in any community and are especially relevant to our own.

Policies to End Homelessness

In addition to their Home, Together Federal Strategic Plan, USICH is consistent in their findings that any plans that criminalize homelessness, or ban sleeping outside in several locations, are **not consistent with any plan to end homelessness**. They assert that[6]

1. Criminalizing homelessness is expensive. It can cost three times more to enforce anti-homeless laws than to find housing for people who don't have it.
2. Criminalization fills jails up with people who are more likely to be victims of violent crime than perpetrators and with people who need treatment (which jails are not equipped to provide) for mental and substance use disorders. And, most importantly,
3. **Criminalization does not reduce the number of people experiencing homelessness. It breaks connections people have made with providers trying to help and exacerbates homelessness and the conditions that lead to it—such as health problems and racial disparities.**

While some policy-makers may understand criminalization as actually arresting people for sleeping in certain areas, in actuality any policy that increases interactions between people experiencing unsheltered homelessness and law enforcement will lead to increased court involvement and ultimately a longer length of time living in a homeless situation as people work to make appointments and pay fines related to that court involvement. These discriminatory laws are not effective. They put governments at risk of expensive civil-rights lawsuits and distract from implementing programs and strategies that are both effective and cost-effective.

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[5] United States Interagency Council on Homelessness. "Home, Together: The Federal Strategic Plan to Prevent and End Homelessness." United States Interagency Council on Homelessness (USICH), 18 July 2018, https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf. Accessed 29 November 2022.

[6] Olivet, Jeff. "Collaborate, Don't Criminalize: How Communities Can Effectively and Humanely Address Homelessness." United States Interagency Council on Homelessness (USICH), 26 October 2022, https://www.usich.gov/news/collaborate-dont-criminalize-how-communities-can-effectively-and-humanely-address-homelessness. Accessed 29 November 2022.

Programs like Permanent Supportive Housing and Housing First, treat homelessness as a housing and health crisis—not a problem for the criminal justice system to solve.[7]

Our plan will only be effective if the City and County shift their focus to building additional set-aside, supportive units for people experiencing homelessness. The Continuum of Care believes that increasing the stock of available rental units and shelter for this population must happen before the City of Ithaca attempts to close any existing camps. Without building adequate housing for people living outside, any policy that forces people to "move along" would put people living in these situations on a road to nowhere. Clearing camps without available housing will cause people to cycle between institutions and homelessness unless adequate housing is available to meet their needs.[8] The CoC would advocate for a continuance of the tacit acceptance approach until housing to meet this community's needs is created in alignment with this plan.

The CoC would also recommend using inclusive public space management to respond to the West End Inlet area. As discussed in the research report "Alternatives to Arrest and Police Responses to Homelessness" published by the Urban Institute in October 2020, inclusive public space management avoids punitive measures for homelessness.[9] Instead, it provides resources that act as a public benefit to anyone using the space, including people experiencing unsheltered homelessness.[10] These are an alternative to restrictive public space management, such as performing encampment sweeps, providing citations, or using restrictive furniture and other public architecture to discourage sleeping. Restrictive public space management seeks to gain control over an area without addressing the root causes of homelessness: a lack of permanent, affordable, supportive housing, and the associated public health crisis: an inability for people to meet their basic needs with dignity. Some examples of inclusive public space management that the City could implement in the west end include picking up trash regularly, providing access to drinking water, building and maintaining public restrooms, showers, and other hygiene and sanitary options, as well as ways to dispose of and exchange needles safely. These practices do not only benefit the people using these public facilities but also benefit the larger surrounding community:

- in Santa Barbara County, California—where 27 percent of the homeless population lives in cars—the Safe Parking Program provides 133 cars with a designated place for sleeping, access to hygiene resources, and connection to rapid re-housing services (Arnold Ventures 2020c). The program serves more people than any year-round shelter in the Santa Barbara area.

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[7] Ibid.

[8] National League of Cities. “An Overview of Homeless Encampments for City Leaders.” National League of Cities, January 2022, https://www.nlc.org/wp-content/uploads/2022/01/Overview-of-Homeless-Encampments-Brief.pdf. Accessed 29 November 2022.

[9] Batko, Samantha, et al. “Alternatives to Arrests and Police Responses to Homelessness: Evidence-Based Models and Promising Practices.” Urban Institute, Oct. 2020, https://www.urban.org/sites/default/files/publication/103158/alternatives-to-arrests-and-police-responses-to-homelessness.pdf.

[10] Ibid.

- Portland, Oregon, experienced a decline in reports about encampments after the start of a program that connects people in encampments to housing services (Arnold Ventures 2020b; Metraux et al. 2019)

Tompkins County Homeless and Housing Needs Assessment

Before developing a plan to assist people with severe service needs, a report titled the "Tompkins County Homeless and Housing Needs Assessment" (TCHHNA) was commissioned by the CoC, the Tompkins County Legislature, and the City of Ithaca Council in 2022. This report, written by Lisa Horn, revealed current areas in our homeless response system that need support and recommendations for providing that support. The CoC Governance reviewed this report and assembled a list of critical takeaways included in this proposal. While this plan offers a summary, Continuum of Care staff recommend that stakeholders review the entire report as it contains a more detailed analysis of additional findings.[11]

The key findings of the TCHHNA include that:

1. **Length of time homeless is increasing in our continuum**, up to 90 days on average as of 2020.
2. **Returns to homelessness in Tompkins County are the highest of comparable CoCs** at 32%, or close to a third of all individuals who exited to a permanent destination in 2020.
3. **Chronic homelessness is increasing**, with 45% or almost half of our current population experiencing homelessness.
4. The **outcomes for other populations, such as couch surfers, youth, and people of color,** indicate a need for more purposeful engagement and referral to permanent housing destinations.

The factors contributing to these worsening outcomes include a lack of low-cost, supportive beds in our continuum and difficulty accessing and maintaining housing and services without additional case management and support. The TCHHNA provided recommendations to address these factors based on real-time data from our community. These interventions are evidence-based solutions to address the recent trends of increasing homelessness and worsening conditions for people with severe service needs in our community.

Key recommendations from the TCHHNA, as identified by our Governance Committee, are as follows:

1. **Building more Permanent Supportive Housing (PSH).** Households leaving to temporary destinations were much more likely to return to homelessness (35%) than those exiting to permanent destinations. While this trend held across every group, it was most pronounced for Black and African-American Households.

[11] Horn, Lisa. "Homeless and Housing Needs Assessment for Tompkins County." Horn Research LLC, June 2022, https://hsctc.org/wp-content/uploads/2022/06/Tompkins-County-Needs-Assessment-Homelessness-and-Housing-Final-Report.pdf.

2. **Building more low-cost single-unit housing**. This recommendation supports the outcomes of single, adult-only households that comprise the bulk of our homeless population (473 single households versus 53 family households in 2020).
3. **Enhanced Housing Navigation.** Both stakeholders and interview participants mentioned agency rules and requirements and the difficulty of navigating the social services system as key reasons people live in the encampment instead of going to the emergency shelter. This intervention allows us to target the growing unsheltered population.
4. **Heightened outreach to youth, people of color, and couch-surfers in our community.** Although our current system implicitly requires couch-surfing, there are little to no funded diversion efforts to keep this population from becoming homeless. Targeted outreach addresses the accessibility of services for a large and growing number of people at-risk of homelessness.
5. **Expand the capacity of our emergency shelter.** The emergency shelter in Tompkins County is insufficiently sized to meet the needs of our unhoused population. Our community has 29 emergency shelter beds to serve 80 households typically experiencing homelessness at any time throughout the year. This bed shortage requires using overflow beds from nearby hotels since they are convenient, non-congregate settings for people experiencing homelessness. Despite their convenience, hotel rooms present several barriers to our homeless response system, including cost, transportation barriers, and lack of on-site case management. Increasing shelter capacity would allow for more consistent, site-based case management and contribute to better outcomes for individuals utilizing the shelter.

Definitions of Target Populations

The New Homeless Definition[12] (effective 1/4/2012 under the HEARTH act) has four categories:

Category 1 – Literally Homeless: An individual or family who lacks a fixed, regular, and adequate nighttime residence, meaning:

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

Category 2 – (Homeless) Within 14 days of losing home: An individual or family who will imminently lose their primary nighttime residence, provided that:

I. The primary nighttime 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, e.g., family, friends, faith-based or other social networks needed to obtain other permanent housing

Category 3 – (Homeless) Youth/Children: 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:

I. Meet the homeless definition under another federal statute; **AND**
II. Have not had a lease, ownership interest, or occupancy agreement in permanent housing at any time during the 60 days immediately preceding the date of application for homeless assistance; **AND**
III. Have experienced persistent instability as measured by two moves or more during the sixty-day period immediately preceding the date of application for homeless assistance; **AND**
IV. Can be expected to continue in such status for an extended period of time because of chronic disabilities, OR chronic physical health or mental health conditions, OR substance addiction, OR histories of domestic violence or childhood abuse (including

[12] United States Department of Housing and Urban Development. “HUD's Definition of Homelessness: Resources and Guidance.” HUD Exchange, 8 March 2019, https://www.hudexchange.info/news/huds-definition-of-homelessness-resources-and-guidance/.

neglect), OR the presence of a child or youth with a disability, OR two or more barriers to employment, which include the lack of a high school degree or General Education Development (GED), illiteracy, low English proficiency, a history of incarceration or detention for criminal activity, and a history of unstable employment

Category 4 – (Homeless) Fleeing Domestic Violence: Any individual or family who:

I. Is 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 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;
II. Has no other residence; **AND**
III. Lacks the resources or support networks, e.g., family, friends, faith-based or other social networks, to obtain other permanent housing.

Severe Service Needs are defined by the United States Department of Housing and Urban Development as any combination of one or more of the following factors:[13]

- facing significant challenges or functional impairments, including any physical, mental, developmental or behavioral health disabilities regardless of the type of disability, which require a significant level of support in order to maintain permanent housing (this factor focuses on the level of support needed and is not based on disability type)
- high utilization of crisis or emergency services to meet basic needs, including but not limited to emergency rooms, jails, and psychiatric facilities
- experiencing a vulnerability to illness or death
- having a risk of continued or repeated homelessness
- having a vulnerability to victimization, including physical assault, trafficking, or sex work
- currently living in an unsheltered situation or having a history of living in an unsheltered situation

[13] "Continuum of Care Supplemental to Address Unsheltered and Rural Homelessness." U.S. Department of Housing and Urban Development, 22 June 2022.

Other Relevant Definitions

As the NY-510 Continuum of Care presents how best to integrate these recommendations into our existing homeless response system in this plan, there are several best practices that are important to define and cite here.

Housing-First

Housing First is an approach to providing housing assistance that prioritizes placing individuals in permanent housing to end their homelessness as a basic need to work on any larger personal goals. This is guided by the belief that people need to have their basic needs such as food and housing met before being able to work on other less critical objectives such as employment or addressing substance use issues. Providing permanent housing is seen as the base or platform from which people can begin to address other issues in their lives, rather than the uphill incentive of addressing those issues first. Through this belief, there is an underlying understanding that there is no such thing as "housing ready", because everyone is ready for housing. Housing is a basic need for people to be able to take care of other issues, however many providers view housing as something that people need to earn by taking care of these other issues in advance of having that basic need met. Housing First is also founded on the idea of client choice. This understanding sees client choice in housing selection and service participation as essential to the success of these interventions to their current experience of homelessness.

Housing First is not only a philosophy, but an approach that is substantiated by data from other communities.

- A 2004 random assignment study found that homelessness programs that eliminated barriers to services, like Housing First, were more successful in reducing homelessness than programs where housing and services were contingent on sobriety and progress in treatment. When individuals were provided access to stable, low-cost housing, with services under their control, 79% remained stably housed at the end of 6 months, compared to 27% in the control group.[14]
- A 2004 long-term study found that participants in the Housing First model obtained housing earlier, remained stably housed after 24 months, and reported higher perceived choice than participants in programs where housing and services were contingent on sobriety and progress in treatment.[15]
- Canada conducted a significant evaluation, encompassing five cities – Vancouver, Winnipeg, Toronto, Montreal, and Moncton – and over 2,000 participants, making it the world's largest study on Housing First. The study found: Participants in Housing First rapidly obtained housing and retained their housing at a much higher rate than the treatment as usual group. After two years, 62% of the Housing First participants were

[14] Tsemberis, Sam & Moran, Linda & Shinn, Marybeth & Asmussen, Sara & Shern, David. (2004a). Consumer Preference Programs for Individuals Who Are Homeless and Have Psychiatric Disabilities: A Drop-In Center and a Supported Housing Program. American journal of community psychology. 32. 305-17. 10.1023/B:AJCP.0000004750.66957.bf.

[15] Sam Tsemberis, Leyla Gulcur, Maria Nakae, "Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis", American Journal of Public Health 94, no. 4 (April 1, 2004b): pp. 651-656.

housed the whole time compared to 31 percent of those who were required to participate in treatment prior to the receipt of housing.[16]

- A 2010 study of data from the Collaborative Initiative to Help End Chronic Homelessness (CICH) established by The United States Interagency Council analyzed the outcomes of 709 participants across 11 communities (Chattanooga, TN; Chicago, IL, Columbus, OH; Denver, CO, Fort Lauderdale, FL; Los Angeles, CA; Martinez, CA; New York, NY; Philadelphia, PA; Portland, OR; and San Francisco, CA). These participants were assessed every 3 months for 2 years on housing outcomes, community adjustment, work and income, mental and physical health, and health service costs. Clients who received immediate, independent housing had more days in their own place, less days incarcerated, and reported having more choice over treatment; but no differences on other clinical or community adjustment outcomes. This study found no clinical advantages for clients who had residential treatment or transitional housing prior to entry into community housing, but did find that they incurred higher substance abuse service costs.[17]
- The National Alliance to End Homelessness provides an interactive database of the available literature on Housing First here: https://endhomelessness.org/resource/data-visualization-the-evidence-on-housing-first/

Please visit the peer-reviewed studies and fact sheets below to learn more about Housing First.

- https://nlihc.org/sites/default/files/Housing-First-Research.pdf
- https://endhomelessness.org/wp-content/uploads/2022/08/Housing-First-Fact-Sheet_Aug-2022.pdf
- https://www.huduser.gov/portal/publications/hsgfirst.pdf
- https://shnny.org/uploads/Florida-Homelessness-Report-2014.pdf
- https://doi.org/10.1002/casp.723
- https://endhomelessness.org/resource/data-visualization-the-evidence-on-housing-first/
- https://www.usich.gov/resources/uploads/asset_library/Implementing_Housing_First_in_Permanent_Supportive_Housing.pdf

Trauma-Informed Care

Trauma-Informed care is an approach that recognizes the traumatic experiences of people receiving services, and provides service providers with the knowledge and skills to prevent the re-traumatization of these individuals, especially individuals with SSNs, in the provision of supportive services. Trauma-informed care supports stability and healing through understanding and support of each individual's needs. This includes focusing on that individual's experience

[16] Paula Goering, Scott Veldhuizen, Aimee Watson, Carol Adair, Brianna Kopp, Eric Latimer, Geoff Nelson, Eric MacNaughton, David Streiner & Tim Aubry (2014). National At Home/Chez Soi Final Report. Calgary, AB: Mental Health Commission of Canada. Retrieved from: http://www.mentalhealthcommission.ca

[17] Kresky-Wolff, M., Larson, M. J., O'Brien, R. W., & McGraw, S. A. (2010). Supportive housing approaches in the collaborative initiative to help end chronic homelessness (CICH). The Journal of Behavioral Health Services & Research, 37(2), 213–225. https://doi.org/10.1007/s11414-009-9206-y

through person-centered care, understanding their needs for safety, and working with them to address areas of support that they identify.

Please visit the peer-reviewed studies and fact sheets below to learn more about Trauma-Informed Care:

- https://www.air.org/sites/default/files/SHIFT_Service_and_Housing_Interventions_for_Families_in_Transition_final_report.pdf
- https://www.air.org/sites/default/files/downloads/report/Americas-Youngest-Outcasts-Child-Homelessness-Nov2014.pdf
- https://www.samhsa.gov/sites/default/files/programs_campaigns/childrens_mental_health/atc-whitepaper-040616.pdf
- https://www.air.org/sites/default/files/downloads/report/Trauma-Informed_Organizational_Toolkit_0.pdf

Harm Reduction

SAMHSA defines harm reduction as "an approach that emphasizes engaging directly with people who use drugs to prevent overdose and infectious disease transmission, improve the physical, mental, and social wellbeing of those served, and offer low-threshold options for accessing substance use disorder treatment and other health care services".[18] When serving people with SSNs in our continuum, especially those with Substance Use Disorder (SUD), harm-reduction methods can not only improve provider relationships with this population, but also help to expedite their entry into the housing they need to stabilize and exit their current homeless crisis.

Please visit the peer-reviewed studies and fact sheets below to learn more about Harm-Reduction Practices:

- https://harmreduction.org/wp-content/uploads/2020/08/Resource-HarmReductionBasics-Homelessness_HR.pdf
- https://files.hudexchange.info/resources/documents/HOPWA-Factsheet-Housing-First-and-Harm-Reduction.pdf
- https://doi.org/10.2105%2Fajph.94.4.651
- https://nhchc.org/wp-content/uploads/2020/05/Healing-Hands-Harm-Reduction_FINAL2.pdf

Racial Equity

Equity refers to proportional representation (e.g., by race, class, or gender) of opportunities in housing, healthcare, employment, and all indicators of living a healthy life. When talking about equity, it is helpful to distinguish it from equality. Equality is typically defined as treating everyone the same and giving everyone access to the same opportunities. The assumption is that everyone will benefit from the same support and services. This is not true. Some populations are situated differently because of historical and current discrimination against them. Equity addresses those differences. Equality is about sameness; it focuses on making sure everyone

[18] "Harm Reduction." SAMHSA Substance Abuse and Mental Health Administration, 16 Aug. 2022, https://www.samhsa.gov/find-help/harm-reduction.

gets the same thing. Equity is about fairness; it ensures that each person gets what the person/population needs. To achieve equity, policies and procedures may result in an unequal distribution of resources, but will lead to equitable outcomes for everyone.[19]

Please visit the articles and fact sheets below to learn more about integrating Racial Equity into discussions about housing and homelessness:

- https://housingmatters.urban.org/articles/applying-racial-equity-lens-housing-policy-analysis?trk=organization-update-content_share-embed-video_share-article_title
- https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Prevention-to-Promote-Equity.pdf
- https://www.macfound.org/media/files/hhm_research_brief_-_poor_black_women_are_evicted_at_alarming_rates.pdf
- https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Equity-Driven-Changes-to-Coordinated-Entry-Prioritization.pdf
- https://c4innovates.com/wp-content/uploads/2019/10/CES_Racial_Equity-Analysis_Oct112019.pdf
- https://www.enterprisecommunity.org/blog/improving-housing-stability-prevent-evictions-and-end-racial-disparities-0

Housing Surge

HUD defines a housing surge as a concentrated, time-limited community effort through which key stakeholders collaborate to connect a targeted group of households to a pre-identified pool of housing subsidies and units as well as other resources and services in order to house a large number of people in a short time frame.[20] Housing surges have been used to quickly rehouse people during and after natural disasters, to quickly deploy large amounts of new resources, and to target groups or people experiencing homelessness that may require special considerations, such as veterans, older adults, or youth.[21] The housing surge expedites the housing process by streamlining procedures and creating temporary mechanisms (such as a pool of vacant units, pre-inspections, and same-day application processing) that break through common procedural delays in rehousing (e.g. unit identification, inspections, check processing, etc.).[22]

Please visit the articles and fact sheets below to learn more about the concept of a "Housing Surge":

- https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Housing-Surges-Special-Considerations-for-Targeting-People-Experiencing-Unsheltered-Homelessness.pdf

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[19] "Homeless System Response: Part 1: Equity as the Foundation." US Department of Housing and Urban Development, June 2020. https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Rehousing-Activation-and-Racial-Equity-Part-1-Equity-as-the-Foundation.pdf

[20] "Homeless System Response: Planning a Housing Surge to Accelerate Rehousing Efforts in Response to COVID-19." US Department of Housing and Urban Development, June 2020.

[21] Ibid.

[22] Ibid.

- https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Planning-a-Housing-Surge-to-Accelerate-Rehousing-Efforts-in-Response-to-COVID-19.pdf
- https://endhomelessness.org/wp-content/uploads/2022/02/Progressive-Engagement-Fact-Sheet_Feb-2022.pdf
- https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Rehousing-Activation-and-Racial-Equity-Part-1-Equity-as-the-Foundation.pdf
- https://files.hudexchange.info/resources/documents/COVID-19-Homeless-System-Response-Rehousing-Activation-Planning-and-Implementation-Tips.pdf

Temporary Housing Assistance (THA)

As described in the official compilation of codes, rules and regulations of the state of New York, specifically 18 CRR-NY 352.35, "Temporary Housing Assistance is a public assistance benefit provided temporarily for an eligible homeless individual or family to meet an immediate need for shelter".[23] All individuals seeking emergency housing through the shelter are required to attain, and stay in compliance with their Temporary Housing Assistance, or THA, in order to stay in the emergency shelter and pay for their emergency housing. This regulation (18 CRR-NY 352.35) describes the various rules that people experiencing homelessness must follow in order to maintain their emergency housing. Many of these regulations as mandated by New York State law mirror and uphold the same barriers that stakeholders have identified as preventing people with severe service needs from accessing shelter. That mandate can be reviewed here:

- https://govt.westlaw.com/nycrr/Document/I50c3e46fcd1711dda432a117e6e0f345?

Cold Weather Policy/Code Blue

In 2016, New York State created the code blue policy, known locally as cold weather policy. Code blue policy directs local social service districts to work with shelter providers to extend their hours of operations and staff capacity to ensure that people experiencing homelessness can remain indoors when the temperature is 32 degrees or lower, including windchill. The state fully reimburses our Department of Social Services for these shelter stays, which means that individuals seeking shelter during nights with below freezing temperatures are not required to comply with Temporary Housing Assistance requirements (see above).
https://govt.westlaw.com/nycrr/Document/If0386b55f29f11e6848bebc42a960167?viewType=FullText&originationContext=documenttoc&transitionType=CategoryPageItem&contextData=(sc.Default)

[23] Thomson Reuters. "18 CRR-NY 352.35." New York Codes, Rules, and Regulations, Thomson Reuters, 30 April 2021, https://govt.westlaw.com/nycrr/Document/I50c3e46fcd1711dda432a117e6e0f345? Accessed 5 January 2023.

The *Home, Together: Tompkins* Plan

The *Home, Together: Tompkins* Plan (HTTP) is a series of progressive opportunities to better serve people experiencing homelessness following an analysis of the existing gaps and needs in our system and the work of several committees of the CoC. Many of these projects don't currently exist in our system due to dwindling service provider capacity and funding to pilot novel solutions to end homelessness. The Continuum of Care believes that locating funding opportunities, coordinating these projects, and expanding sector capacity under a shared goal will allow us to see this plan through to completion. The HTTP will require engagement from a wide array of partners, including an endorsement from the City and County government, to be successful. CoC staff would oversee and track the outcomes of the projects listed to ensure the plan meets the goals outlined in Appendix C.

The Continuum of Care recognizes the systemic harm our country has caused BIPOC and how that harm is reflected in the proportion of BIPOC represented in our homeless response system. While BIPOC represent less than 9% of our local population, there are 50% BIPOC utilizing emergency shelter in our homeless response system, and 20% BIPOC living in unsheltered locations. BIPOC are traditionally underserved in our community and underrepresented in the human services sector. *Home, Together: Tompkins* is committed to monitoring who this project is serving and how BIPOC experiences compare to that of their white counterparts.

Along with targeted outreach and incorporating the feedback of BIPOC leaders in our community, Continuum of Care staff have integrated metrics into each component of this plan to ensure equitable distribution of resources and power to BIPOC participants. These metrics were decided based on the current representation of BIPOC in a particular subset of people experiencing homelessness listed in this document. For example, if a particular component prioritizes people sleeping in unsheltered locations, such as the low-barrier shelter, 20% BIPOC is used as an equity indicator. If another component focuses on the overall homeless population including shelter stayers, such as permanent supportive housing, 50% BIPOC is used as an equity indicator. Please do not hesitate to contact CoC staff at sgatson@hsctc.org or lbargar@hsctc.org with any questions.

Home, Together: Tompkins consists of the following components. Each of these components are described in more detail beginning on the following page:

1. A commitment to building 100 studio and 1-bedroom units of PSH.
2. Low-barrier shelter that uses a trauma-informed approach to safety.
3. A "housing surge" strategy and by-name list to better serve people living in unsheltered locations.
4. Mitigation funds for business owners and landlords.
5. Other incentives such as a shopping cart exchange and cash for trash program.
6. Low-barrier move-in packages and assistance for moving from homeless to housed.
7. Three enhanced, centralized housing navigator positions.
8. Paid board positions for people with lived experience to monitor and approve *Home, Together: Tompkins.*
9. Professional development opportunities for people with lived experience.

1. A commitment to building 100 studio and 1-bedroom units of PSH
PSH, or Permanent Supportive Housing, has proven to be the most effective intervention for lowering returns to homelessness within 24 months in our continuum.[24] PSH is housing set aside for people experiencing literal homelessness that is affordable, permanent, and offers supportive services without requiring participation in these services. Most of the PSH in our current system also includes a mechanism for residents exiting the housing after one year to exit with a section 8 voucher for securing private market housing. This form of housing is a critical intervention in our system because it increases the number of existing beds available for people experiencing homelessness in Ithaca's competitive housing market. The Continuum of Care would also prioritize funding to ensure 20 of these units are located in rural locations, where housing is often low-cost but substandard. The CoC believes that providing access to safer permanent supportive housing with enhanced support, such as transportation and preventative medical care, would help to address health and service delivery disparities in these areas of the county. Along with the commitment to building this housing, this commitment would include finding a partner to provide these enhanced supports for PSH in rural areas.

Anticipated Date of Completion: Q4 2025
Needs for Success: Staffing, Coordination, Funding
Racial Equity Metric: At least 50 new units of PSH occupied by BIPOC households.

2. Low-barrier shelter that uses a trauma-informed approach to safety.
Many people currently living outside in the "jungle" area are not eligible for or willing to navigate the high threshold of our current emergency shelter system. In addition, our local shelter, funded through the Department of Social Services (DSS), can be difficult for people with severe service needs to access and maintain. Here are some of the prerequisites that prevent easy access to emergency shelter when people need it:

1. All people who live in our emergency shelter and receive income through employment must contribute 50%-75% of their paycheck towards their shelter stay.
2. Clients of our emergency shelter must record and submit at least five housing contacts per week to comply with THA and stay in the shelter.
3. Most beds in our shelter are offered through local hotels, which are at least a 30-minute bus ride away from most of the centralized housing resources.
4. Our current emergency shelter sanctions individuals with known or suspected substance use disorder from the shelter for diversion to recovery services before entry when cold weather policy is not active. This implicitly requires individuals with substance use disorder to engage in treatment before they can access stable housing. Failure to continue to engage in treatment can lead to THA ineligibility and no access to shelter.
5. Clients must go to DSS in person, fill out the necessary paperwork, and stay for hours to wait and find out if they were approved for shelter that night.

[24] Horn, Lisa. “Homeless and Housing Needs Assessment for Tompkins County.” Horn Research LLC, June 2022, https://hsctc.org/wp-content/uploads/2022/06/Tompkins-County-Needs-Assessment-Homelessness-and-Housing-Final-Report.pdf.

6. The THA application requires that people fill out contacts for the last three places they stayed. DSS staff call these contacts and ask if the person asking for emergency shelter cannot stay there any longer. If one of those contacts says that the person can stay there for even one night, that person is diverted from the shelter and required to apply again the next time they need a place to stay. This process also diverts people whose landlords have yet to execute a warrant of eviction because that person can technically remain in the unit for at least one more night.
7. Our county requires young adults ages 18-21 and minors to pursue child support from their caregivers before accessing shelter. Not only does this create an additional step for young adults who have identified a need for emergency housing to access it, but it requires the young adult to choose between living on the streets or affecting their parents' income and benefits. For minors, the shelter is additionally required to contact their parents who ultimately decide whether or not they can stay home another night. Understanding these complex power dynamics, and that emotional/physical abuse at the hands of parents does not qualify minors for domestic violence services or shelter, this process makes youth more vulnerable and susceptible to sleeping outside, returning to an abusive home setting, or trading housing for sexual exploitation.

There are currently two examples of low-barrier shelters in our homeless response system. However, they are both not site-based and limited in their capacity to serve individuals with severe service needs. Despite these limitations, both have been able to stably shelter individuals who would otherwise be living outside or in other unsafe conditions.

The first is the NYS cold weather policy, which allows anyone between October and April (when the weather is below freezing) to have a warm space to spend the coldest parts of the night. The CoC's Homeless Management Information System or HMIS data shows that many people experiencing unsheltered homelessness enter the shelter during this time to access warm beds, showers, bathroom facilities, and other centralized services. When the weather is consistently above freezing in April, there is migration back out of the shelter for individuals who aren't willing to pay for their stay, apply for Temporary Housing Assistance (THA), or maintain that THA. This trend is evidence that if there were a low-barrier emergency shelter where people could get their basic needs met with dignity, similar to how our emergency shelter operates under the cold weather policy, it would be utilized by many of the encampment residents and reduce the number of people experiencing unsheltered homelessness in unsafe conditions.

The second is low-barrier shelter through the LEAD (Law Enforcement Assisted Diversion) program locally. Through this, REACH Medical funds shelter stays for people who have failed to comply with shelter requirements and have a history of interactions with law enforcement. While a more recent addition to our homeless response system, this program has been a successful intervention to house people who would otherwise be sleeping outside.

The Continuum of Care recommends the formation of a site-based low-barrier shelter that prioritizes people sleeping outside. Low-barrier shelter does not mean there are no rules, but instead that these rules are expectations instead of barriers to entering or maintaining a shelter

stay. The goal is to get as many people off of the streets as possible without some of the requirements preventing people from entering our OTDA-funded emergency shelter, like identification, sobriety, payment, or strict curfews, with an emphasis on safety through harm reduction.

Many low-barrier shelters, while not requiring sobriety, prohibit possessing and using drugs, alcohol, and weapons in their facilities. They also set an expectation that people obey the law and behave respectfully towards other people using the shelter. Any behaviors that risk other residents' safety are typically not tolerated. Other typical rules and regulations may be expected but not enforced. For example: In our emergency shelter funded through DSS, someone could arrive past curfew and fall out of compliance with the shelter, ending up back on the street when their THA is denied. In a low-barrier shelter, there may be a recommended curfew with softer rules, such as not acting in a disruptive manner during quiet hours rather than having to be in a shelter bed after a certain hour. This allows people to more easily maintain their shelter stay and adjust to the culture of having neighbors in a brick-and-mortar facility. Staff in these spaces are also typically trained in de-escalation, trauma–informed care, mental health first aid, addiction sensitivity, and well-being and wellness as they interact with clients in crisis.

The Continuum of Care asserts that a refocus on safety and clear behavioral standards as opposed to compliance with funding regulations will be a key component in creating these spaces. Having a culture that focuses on trauma-informed safety for the shelter space is not only important for those residents that struggle to stay in compliance with their temporary housing assistance, but also for those with whom they share the space. Individuals with severe service needs, especially youth, have reported feeling uncomfortable and vulnerable in the emergency shelter. This has, for example, contributed to the overrepresentation of youth in the couch-surfing community as noted in the Homeless and Housing Needs Assessment as they seek out alternate options for emergency housing. A new shelter space or expansion of the existing shelter needs to address these conditions and ensure that existing and new spaces are safe for the most vulnerable and exploited members of our community. A trauma-informed culture shift for our existing emergency shelter spaces, especially as they add additional beds, will be essential to ending unsheltered homelessness for youth and others with severe service needs.

While compliance-based rules have been clearly identified as barriers to entering shelter or maintaining a shelter stay, many of the same rules cited by clients and providers as being barriers are Office of Temporary Disability Assistance (OTDA) requirements that must be met to reimburse shelters for the cost of an individual's stay. The most recent publication by the USICH, “ALL IN: The Federal Strategic Plan to Prevent and End Homelessness”, supports the “removal and reduction of programmatic, regulatory, and other barriers that systematically delay or deny access to housing for households with the highest needs".[25] It suggests building

[25] United States Interagency Council on Homelessness (USICH). “ALL IN: The Federal Strategic Plan to Prevent and End Homelessness.” United States Interagency Council on Homelessness (USICH), 1 December 2022,

programs like low-barrier shelter that work to meet the needs of the people utilizing emergency shelter, as opposed to requiring people to “fit” or be “ready” for entering a bed. Following this recommendation, CoC staff would advocate reexamination of the need for the above barriers to ensure they align with federal, state, and local policy. In order for a low-barrier shelter to be successfully implemented in our community, the organization taking on this project would need to ensure that their funding source is flexible enough to fund and operate a shelter without the barriers THA compliance presents outside of cold weather policy season. Funding options could include some of those listed in Appendix A, philanthropy, or other opportunities that become available over the course of the planning year.

The CoC recommends the following articles, fact sheets, and real examples below to learn more about the concept of low-barrier shelter, and how to implement it:

- https://media.graphassets.com/xCfY2vlQCeVXUG15y7Mn
- https://cceh.org/wp-content/uploads/2018/05/Making-the-Shift-to-a-Low-Barrier-Housing-Focused-Shelter-5.17.18-Final.pdf
- https://endhomelessness.org/wp-content/uploads/2017/04/ES-Webinar-2-Keys-to-Effective-Low-barrier-Shelter_Webpage.pdf
- https://www.crossroadsri.org/about/our-work-team/about-us

Anticipated Start: Q1 2024
Needs for Success: Staffing, Coordination, Funding
Racial Equity Metric: At least 20% of low-barrier shelter beds occupied by BIPOC.

3. A “housing surge” strategy and by-name list to better serve people living in unsheltered locations.

COVID-19 has presented new and urgent health and safety needs that necessitate expedited and efficient processes to rehouse people experiencing homelessness swiftly. In addition, the pandemic has generated a combination of political will, unprecedented collaboration within communities, and an influx of resources, all of which create an ideal environment for deploying a strategy that has proven successful in similar situations: the "housing surge."

A "housing surge" is a concentrated, time-limited community effort through which key stakeholders collaborate to connect a targeted group of households to a pre-identified pool of housing subsidies and units as well as other resources and services in order to house a large number of people in a short time frame. Housing surges have been used to rehouse people quickly during and after natural disasters, to quickly deploy large amounts of new resources, and to target groups or people experiencing homelessness that may require special considerations, such as veterans, older adults, or youth. The housing surge expedites the housing process by streamlining procedures and creating temporary mechanisms (such as a pool of vacant units, pre-inspections, and same-day application processing) that break through

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https://www.usich.gov/All_In_The_Federal_Strategic_Plan_to_Prevent_and_End_Homelessness.pdf. Accessed 5 January 2023.

common procedural delays in rehousing (e.g., unit identification, inspections, check processing, etc.).

HUD has laid out a plan (attached below) for the execution of a housing surge and other communities in which this has been an effective intervention. The Continuum of Care would incorporate this into our current system through the Coordinated Entry list, which already has a process to prioritize the most vulnerable individuals and distribute resources equitably. In alignment with HUD's operational steps and other materials, our first step would be to convene partners such as rapid re-housing providers, permanent supportive housing providers, street outreach, landlords, elected officials, service providers, and people with lived experience. Our second step would be to identify the available housing resources and work with providers to set aside those resources to ensure the housing stock meets the needs of the households interested in housing. The third step would be to set a target length of time for the surge and identify a target population which in this case would be people experiencing unsheltered homelessness in the encampments. Step four would be to conduct outreach to landlords to use rapid re-housing vouchers and create a pool of vacant units available to surge participants. These would include single units, family units, and single-room occupancies (SROs) for people interested in living in a communal space with roommates. For those individuals who indicate their interest in having a roommate, there could be roommate matching made available to ensure compatibility in those spaces.

Finally, through step five, housing surge providers would map out the expedited process and organize a pop-up destination for people to identify housing and work on the next steps with service providers on site. Throughout steps one through five, we would work closely with our enhanced street outreach team to **develop a by-name list** of everyone experiencing unsheltered homelessness and their interest in participating in the surge. This by-name list would allow us to better track households' outcomes and better understand the needs of the community experiencing unsheltered homelessness. The Continuum of Care would work on updating this list throughout and between each surge. The sixth and final step would be to track outcomes for households interested in participating in the surge, addressing any issues or barriers that prevent households from entering or maintaining the housing. This will be especially important for households receiving one-time or time-limited funding through emergency rapid re-housing support. In these cases, a housing stability plan for maintaining funding after one-time funding sunsets would be an additional seventh step for these households. The Continuum of Care would include equity checks throughout each step of this process to ensure that each housing surge serves all households in a way that supports their individual needs. The equity checks will also ensure that the demographics of housing surge participants reflect and attempt to mitigate the existing racial disparity in our system. Providers will be held accountable through their signed MOU with HSCTC to provide information for these equity checks and respond quickly to identified concerns.

An ongoing issue with HUD-funded resources, and our local coordinated entry process, is the exclusion of couch-surfers and preventative resources for people at-risk of homelessness. While the Continuum of Care is referencing the HUD framework for structuring the housing surge, this

activity would not solely depend on HUD-funded services. To follow Lisa Horn's findings that point out the need for outreach and designated resources for couch-surfers, CoC staff will set aside at least five spots per housing surge for couch-surfers with severe service needs.

Anticipated Start: Q2 2023
Needs for Success: Coordination, Policy Considerations
Racial Equity Metric: At least 20% of housing surge participants will be BIPOC.

4. Mitigation funds for business owners and landlords
At the Human Services Coalition of Tompkins County (HSCTC), the Rental Resolutions program supports Tompkins County landlords to build better tenant/landlord relationships to stave off evictions. The Human Services Coalition has a landlord liaison who helps landlords navigate conflicts with tenants, complete paperwork to comply with Section 8, and advocate for the landlord in times of uncertainty. One of the biggest draws of this position, in addition to the work of the liaison, is the mitigation fund available to landlords to cover potential damages to the unit as a consequence of renting to a tenant with severe service needs. In the *Home, Together: Tompkins* plan, the Continuum of Care proposes expanding this fund and liaison position into a mitigation fund entitled the Happy Neighborhood Program. Business owners or landlords approved by the *Home, Together: Tompkins* lived experience board would be eligible for financial support up to a certain amount in case of damages or theft incurred while serving people with severe service needs. The goal of the Happy Neighborhood Program would be to ease tensions, especially for small business owners, in our community following the years of hardship post-pandemic. The Continuum of Care has heard the West End Business Partners' concerns and wants to help rebuild lines of communication around issues related to the encampments. Not only would this program provide mitigation funds to businesses affected by the aftermath of the pandemic, but the neighborhood liaison position would act as someone to respond to the concerns of these community members and ensure their voices are heard in the encampment response without harming or harassing members of the encampment. This position would increase community engagement with issues related to the encampments and help to center the emotional recovery of the west end as all stakeholders work together to end unsheltered homelessness.

Anticipated Start: Q1 2024
Needs for Success: Community Engagement, Staffing, Funding
Racial Equity Metric: Business owners and landlords approved by the lived experience board will require unanimous approval by BIPOC members of the board.

5. Other incentives such as a shopping cart exchange and cash for trash program
There are other, smaller incentives that the Continuum of Care believes would help us engage all community members in ending unsheltered homelessness. The first is a shopping cart exchange program. The CoC would provide outreach workers with reliable, collapsible, easy-to-repair carts to exchange with their clients in return for stolen shopping carts. The enhanced street outreach team would return these and other discarded carts to the associated business, restoring thousands of dollars in value. Our primary goal is to understand the

community's need for the carts that have been stolen and provide alternatives to meet that need. These carts would also provide functionality that stolen shopping carts do not: portability for taking on the bus, easy repairs, and less stigma when navigating the community. The CoC would work closely with our enhanced street outreach team to pick the ideal carts to meet this need and disperse them among the community. Home, Together: Tompkins would also have a mechanism to track how many carts are returned and understand the effectiveness of this program.

Anticipated Start: Q1 2024
Needs for Success: Coordination, Funding
Racial Equity Metric: Outreach through BIPOC community centers to ensure access for clients

The second smaller incentive would be a cash-for-trash program. This program would follow the redemption model for recycling but for trash! An organization would provide bright-colored bags, grabbers, and PPE, such as gloves, for people to pick up trash and return full bags for cash. This initiative would be open to any community members who want to give back or engage with sanitation efforts. One of the biggest complaints about the encampment spaces is the amount of trash and its environmental impact. Cash-for-trash would help to address that and put much-needed cash in people’s pockets for spending at local businesses.

Anticipated Start: Q1 2024
Needs for Success: Community Engagement, Supplies, Staffing, Funding
Racial Equity Metric: Outreach through BIPOC community centers to ensure access for clients

6. Low-barrier move-in packages and assistance for moving from homeless to housed
The Continuum of Care has convened a housing stability committee to understand and mitigate issues related to maintaining housing. One of the gaps identified is the need for smaller goods besides furnishings, such as trash tags, cleaning supplies, shower curtains, toiletries, linens, and kitchen utensils. While these goods may seem inconsequential for people with the resources or stability to shop for them, our committee has found that they can make or break someone's housing stability when entering a new unit from homelessness, especially for individuals with severe service needs. For example, a lack of cleaning supplies can lead to bad smells or infestations, which can lead to lease violations and nuisance allegations, leading to eviction. The Continuum of Care wants to ensure that people have access to the items they need to stay stably housed and already have a model for how to do this within our community. Catholic Charities of Tompkins and Tioga Counties runs a small transitional housing program called A Place to Stay, which helps to transition participants into permanent housing. To assist with the transition from their housing into a new unit, CCTT has a flexible fund to support these smaller, additional needs on move-out. These include many of the goods that our housing stability committee identified as barriers to maintaining housing. In addition, CCTT has a small pilot program with ReUse to assist with moving help, including movers and moving trucks.

ReUse also partners with the CoC to furnish many of our PSH projects. It has been a valuable partner in keeping our site-based projects comfortable and affordable.

The CoC would suggest expanding these pilots to provide low-barrier move-in packages and assistance for individuals moving from homeless to housed. Our housing stability committee is confident that a program like this is key to helping reduce high returns to homelessness within our county.

Anticipated Start: Q1 2024
Needs for Success: Staffing, Coordination, Funding
Racial Equity Metric: 50% of move-in package and assistance recipients will be BIPOC.

7. Three enhanced, centralized housing navigator positions

Page 34 of the TCHHNA describes the nature of support services in Tompkins county. While there are many services, they are decentralized. The most frequently mentioned barrier to entering and maintaining housing and shelter in the report is navigating the paperwork and understanding the rules of the many programs and services available. One stakeholder said, "I see Tompkins County as being very service rich. There are a lot of opportunities to get services. The barrier is more a fear or reluctance to access services because of distrust with the system. There is a difficulty of accessing services without an advocate. It's so decentralized. You have to go to a different place for different things – clothing, food, health care, to apply for services, and you're constantly jumping through hoops. It causes frustration and people give up. It's easy for services to say 'they didn't follow through,' but it's literally impossible. Either have one location where service providers can be in one space, or have a case manager that can either transport and do everything from A to Z to help someone through the whole process. Doing it alone is completely overwhelming and next to impossible." This salient quote points to the need for our first project- a team of case managers who can transport and help everyone at each stage of our continuum, from homeless to housed.

Our case management team would consist of three housing specialists; one serving people experiencing literal homelessness, one serving people recently housed from homelessness, and another serving people who are housing unstable. Each housing specialist would have a small caseload of 10-12 individuals with severe service needs for situations where long-term assistance navigating barriers to housing is needed. They would each receive training in de-escalation, trauma–informed care, mental health first aid, addiction sensitivity, well-being and wellness, and cultural competence by local providers. This training would ensure that the team is prepared to serve clients with various backgrounds and needs. They would also receive training from all agencies in our continuum, be ready to fill out any program application, and understand eligibility requirements. Aside from their small caseload, they would act as a mobile resource to provide light-touch services for other situations that arise in our community. Essentially, these positions would work as a team of direct service generalists who are housing-focused and trauma-informed for those who fall through the cracks in our existing homeless response.

The housing specialist serving people experiencing literal homelessness would assist these individuals in accessing housing-related services and locating appropriate housing based on their needs. Some tasks would include helping clients fill in applications for shelter, apply for other county services, stay in compliance with the shelter, help people in unsheltered situations get into the shelter, and assist with housing search. The success of a role like this has been demonstrated in Salvation Army's program "Homeless to Housed", in which 10 out of 15 participants receiving services from a case manager like this role were able to find and maintain housing.

The housing specialist serving people who are recently housed from homelessness would be assisting these individuals in understanding the expectations of their housing and navigating any conflicts or needs that arise after move-in. Some tasks would include assisting clients in navigating local resources, staying in compliance with section 8, navigating relationships with the landlord and other tenants, providing other appropriate referrals to ensure that people do not return to homelessness, and using their relationship with landlords to act as a housing search resource. Our enhanced street outreach team has demonstrated the effectiveness of a role like this as they support their clients' moves into new housing. Although their assistance has helped people navigate the novelty of being recently housed, these outreach workers have voiced the need for a warm hand-off with the capacity to support these clients' ongoing needs.

The housing specialist serving people experiencing housing instability would help divert people from homelessness by preventing avoidable evictions and displacement through advocacy and referrals to local resources. The pipeline for referrals to this housing specialist would include high-priority calls from our local 2-1-1 line for people at risk of losing their housing, referrals for diversion from emergency housing staff at DSS, eviction court, and local legal services such as LawNY and the Tenants Legal Hotline. High-priority calls through 2-1-1 will include people in couch-surfing situations, and act as a pipeline for prevention in our continuum. In addition, this role would assist with Emergency Rental Assistance applications, complete intakes for local legal services, and connect clients with other supports. The current 2-1-1 Housing Specialist position at the Human Services Coalition has demonstrated the effectiveness of a role like this. Through these efforts, this Housing Specialist has helped to divert 53 people from their 63 person caseload from homelessness to maintain their current housing or end their couch-surfing. Unfortunately, this position expires in September of 2023. The Continuum of Care asserts that continuing a role like this with a special focus on preventing homelessness for people with severe service needs could reduce entries to homelessness from couch-surfing situations by 50%.[26]

Each of these positions and their role in the community would require approval from the lived experience board. The lived experience board would also be directly involved in the hiring of the individuals themselves, and organizations with a housing specialist position would be required to report out to the lived experience board at least once every two months with an update on the progress of this position. While CoC staff hope that three of these specialists will meet the

[26] Also noted in Appendix C

needs of our community, our community will reassess to ensure that there are an adequate number of housing navigators employed in our system by Q1 2026.

Anticipated Start: Q1 2024
Needs for Success: Staffing, Coordination, Funding
Racial Equity Metric: Housing Navigators will receive training to be culturally competent and trusted providers for BIPOC. At least 50% or 300 of their contacts per year will be for BIPOC.

8. Paid board positions for people with lived experience to monitor and approve *Home, Together: Tompkins*

The Continuum of Care wants to ensure the inclusion of people with lived experience of unsheltered homelessness in all *Home, Together: Tompkins* projects and programs through paid board membership. Our homeless response system has a Youth Advisory Board that advises and monitors projects funded through our Youth Homelessness Demonstration Project. The CoC would apply that existing model to compose and fund a similar advisory board for adults with lived experience. The board would advise and approve *Home, Together: Tompkins* projects. All participating agencies would be highly encouraged to consult with the board throughout the planning stage of their projects. Once approved, these projects would also send quarterly reports to the board to track progress toward set goals.

Board positions would be paid per hour of engagement. Board members would be tasked with consulting on Home, Together: Tompkins projects, brainstorming solutions to issues in project roll-outs, and monitoring participant outcomes. This group will offer leadership and guidance to the project. In addition, the board would be given professional development opportunities for any desired skills they would like to learn during their board membership, as well as access to additional support (transportation, childcare) to help members participate to their fullest ability. Two board members would also hold seats in the CoC's Governance committee as the Continuum of Care works to better integrate the valuable perspectives of people with lived experience into its membership.

Anticipated Start: Q1 2024
Needs for Success: Community Engagement, Coordination, Funding
Racial Equity Metric: At least 5 of 10 seats on the lived experience board will be BIPOC.

9. Professional development opportunities for people with lived experience
In response to the workforce crisis in our community, the Continuum of Care suggests offering professional development opportunities for people with lived experience of homelessness who are interested in filling these roles. This would involve a different path to employment in human services for people with lived experience who might lack other higher education requirements or experience in the field. Through professional development, a program like this could offer work experience for resume building and assist completion of a certification program or associate degree through one of our local universities. The Human Services Coalition would engage

directly with human services employers to work on building these professional development opportunities as well as capacity and funding to better support these roles.

Anticipated Start: Q1 2024
Needs for Success: Community Engagement, Coordination
Racial Equity Metric: Providers participating in professional development opportunities will also express a commitment to diversity and inclusion with personalized metrics and monitoring for success.

Planning and Implementation

The first step of implementing this plan involves seeking buy-in from critical stakeholders, including the city and county legislature, service providers, people with lived experience of homelessness, and city planners. While some components of this plan are feasible without community buy-in, the goal is to have a coordinated homeless response across Tompkins County. This step is necessary to shift our continuum of care culture to one that is person-centered and housing-first. During this stage, the CoC staff will also work to convene a lived experience board for implementing *Home, Together: Tompkins*.

The next step will be to formalize relationships with service providers or other organizations interested in taking on leadership roles in the planning. The Continuum of Care lead agency, the Human Services Coalition of Tompkins County (HSCTC), will formalize these relationships through memorandums of understanding (MOUs) with these organizations. These MOUs must receive unanimous approval from the lived experience board to be executed by HSCTC.

Once we have identified the organizations interested and committed to pursuing this work, we will enter the planning phase of *Home, Together: Tompkins*. Planning will involve seeking funding for projects through some or all of the opportunities listed in Appendix C. Organizations who apply for funding will ultimately be responsible for determining the design of the project, hiring staff, reporting, and day-to-day operations of the project. Each *Home, Together: Tompkins* partner will meet with the lived experience board at least once every two months. The topics of these discussions will include relevant trends in their project of focus and feedback for their organization's project. This process will allow for an ongoing conversation between service providers and people with lived experience and a better understanding of how to build programs that work for their target populations.

These meetings will continue once partners receive funding to begin their projects. Building the projects themselves will include adding equity checks in both the structure and monitoring of the program. Equity checks will integrate the lived experience board and real-time data in the performance evaluation of a *Home, Together: Tompkins* project.

Continuum of Care staff will advise, lead, and support identified partners in acquiring funding, structuring their projects, and monitoring participant outcomes. CoC staff will also oversee the implementation of the *Home, Together: Tompkins* plan and ensure that partners and projects are aligned in their culture and outcomes.

As mentioned in the Homeless and Housing Needs Assessment, outreach to youth, couch-surfers, and people of color will be essential to ensure this plan serves these traditionally underserved communities equitably. A preliminary plan for outreach tailored to each of these specific groups would include, but not be limited to:

1. Outreach to Minors
    a. Schools throughout the county
    b. After-school programs and peer groups

    c. Social Media
    d. Youth Employment Programs, other youth-serving organizations
    e. Youth Action Board
2. Outreach to Young Adults
    a. Youth Employment Programs, other youth-serving organizations
    b. Social Media
    c. Written Materials, Posters
    d. Local colleges
    e. Local employers
    f. Peer groups, Youth Action Board
    g. Community Events
3. Outreach to Couch-surfers
    a. Written Materials, Posters
    b. Social Media
    c. Social Services Agencies
    d. Community Events
    e. 2-1-1 Information and Referral Hotline
4. Outreach to People of Color
    a. Community Centers (e.g. Southside, Alliance for Family Justice)
    b. Churches
    c. Social Services Agencies
    d. Emergency Shelter, Hotel Stays
    e. Networking with community leaders
    f. Peer groups and community events

CoC Staff will work closely with outreach workers to bolster and staff this outreach plan over the course of our planning year for *Home, Together: Tompkins*.

Home, Together: Tompkins Outcomes

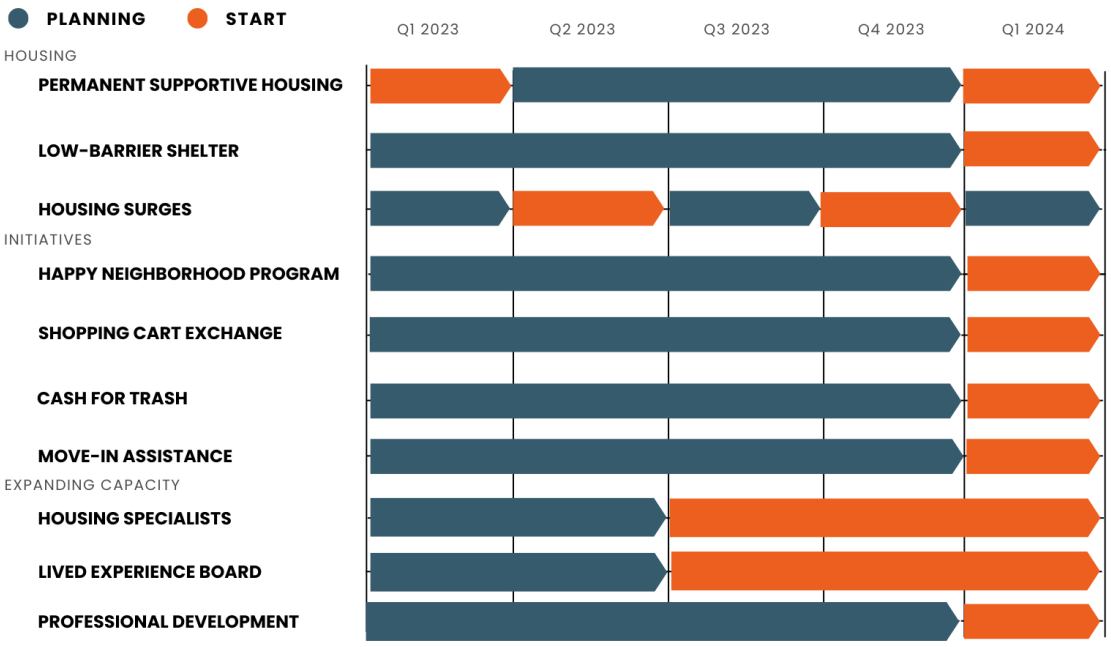
4
New Staff Positions
including three Housing Navigators and a Neighborhood Liaison Position to enhance and centralize communication across the Continuum of Care.

10
Paid Lived Experience Board Seats
for advising and approving projects

$50,000
Cash for business and landlord partners
as mitigation funds for any theft or damages incurred by serving people with severe service needs.

50
Low-Barrier Shelter Beds
with minimal pre-conditions to entering and maintaining shelter with an emphasis on safety through clear and simple expectations for residents.

100
Units of Permanent Supportive Housing
offering wrap-around services with a goal of sustaining housing through housing-first.



Opportunities for the City of Ithaca

This plan requires participation from the City of Ithaca to adopt a new outlook on its encampment spaces by working with the Continuum of Care to help address the health needs of its residents. As mentioned in the introduction of this plan, the earliest mention of clearing the same encampment spaces that our community is discussing today is from 1927. After nearly a hundred years of trying to manage this space through restrictions and clearance, CoC staff believe it is time to address the root causes of homelessness. In our community, that means addressing the lack of low-cost, permanent, safe spaces for unhoused people. Here are some opportunities for the City to engage with this issue as a part of the *Home, Together: Tompkins* Plan:

- Creating a mechanism for affordable units in new property developments to become PSH set-asides available through the CoC's Coordinated Entry process
- Considering ways the Community Housing Development Fund can be used to expand PSH units, as the CHDF is the major locally controlled funding source for expanding the supply of low-cost housing
- Performing regular inspections of city rentals and requiring property managers to address unsafe living conditions for tenants without negatively impacting current residents through forced displacement or condemnation. Many interviews with people with lived experience of homelessness revealed this is one of the main reasons people cite for leaving their homes. While the City Code does provide for payments (200% of rent) to tenants who are displaced due to failure by the landlord to comply with codes and housing standards, there may be an opportunity to ensure tenants and landlords are aware of this law and have access to legal counsel to enforce their rights.
- Continuing the tacit acceptance approach while incorporating inclusive management practices for the existing "jungle" space. These provide public utilities that benefit everyone whether or not they are currently experiencing homelessness.
- Integrating CoC staff into existing working groups to address encampment spaces.
- Working with the CoC to identify future funding priorities and screen projects for housing-first approaches and public health-centered practices.

CoC staff are available to discuss these and more opportunities for the City of Ithaca to engage in *Home, Together: Tompkins* in a way that is synergistic to the other initiatives outlined in this proposal. We invite interested legislators to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org.

Opportunities for the Tompkins County Legislature

The Tompkins County Legislature oversees the Department of Social Services, which provides many of the services our unhoused population needs, and the Community Housing Development Fund, which provides funding support for the diverse range of affordable housing needs in our community. Therefore, the engagement of the Tompkins County Legislature is essential to improving the delivery of services to our population with severe service needs. Here

are some opportunities for the County to engage with this issue as a part of our *Home, Together: Tompkins* Plan:

- Creating a mechanism for affordable units in new property developments to become PSH set-asides available through the CoC's Coordinated Entry process
- Considering ways the Community Housing Development Fund can be used to expand PSH units, as the CHDF is the major locally controlled funding source for expanding the supply of affordable housing
- Performing regular inspections of rentals outside of the city and requiring property managers to address unsafe living conditions for tenants without negatively impacting current residents through forced displacement or condemnation. Many interviews with people with lived experience of homelessness revealed this is one of the main reasons people cite for leaving their homes.
- Working with the CoC to identify future funding priorities and screen projects for housing-first approaches and public health-centered practices.
- Investigating OTDA requirements for the operation of resources through our local Department of Social Services. Many existing barriers to entering and maintaining emergency housing and other resources through DSS are mandated by law. The CoC would be interested in better understanding these statutes, especially as OTDA shifts to a low-barrier shelter model.
- Integrating CoC staff into existing committees and working groups to address housing and homelessness issues.

CoC staff are available to discuss these and more opportunities for Tompkins County's various departments to engage in *Home, Together: Tompkins* in a way that is synergistic to the other initiatives outlined in this proposal. We invite interested legislators to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org.

Other Complementary Interventions

The CoC invites anyone interested in partnering with Home, Together: Tompkins to reach out to us about projects and initiatives that may be aligned with this plan to end unsheltered homelessness and better serve people with severe service needs. Here are a few complementary interventions for which the CoC seeks partners with the capacity and interest to fill existing gaps in our system.

Community Spaces for Learning About Resources

The Continuum of Care would like to partner with community centers to discuss ways to better share resources for people experiencing homelessness in our continuum. This could include improved, more inclusive media campaigns or physical spaces to distribute some of the resources included in this plan. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model, especially partners who focus on serving BIPOC to disrupt the historical underserving of this community.

Lowering Barriers to Existing Shelter
The barriers to our current emergency shelter exist in shelters funded by the Department of Social Services across the state. While there are statutes that implicitly require some of these barriers, the CoC believes that understanding these statutes is vital to developing creative ways to lower barriers to shelter. Therefore, Continuum of Care staff invites interested advocacy groups to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this widespread issue across New York State.

Meeting Basic Needs with Dignity
In alignment with our goal of providing safe alternatives to the existing encampment as a health measure, *Home, Together: Tompkins* would support the creation of a site that allows people to **meet their basic needs with dignity without requiring engagement with services or clearance of other spaces**. The Continuum of Care believes that a site with trash services, safe needle disposal, groundskeeping, bathrooms, safe heating elements, benches, and access to clean water without security measures or policing would be the most effective health intervention for people who do continue to live outside, without increasing their interactions with law enforcement. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model.

Mental Health Crisis Respite Center
Providing crisis respite for people experiencing a mental health crisis in an unsheltered location would be an essential and valuable addition to our existing continuum of care. This would be a space with voluntary crisis beds for people to stay in while experiencing a mental health crisis, prioritizing patients currently sleeping in unsheltered locations. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model.

Opportunities for BIPOC Homeownership
Due to the enduring legacy of racism, discrimination, slavery, and genocide for Black and Indigenous people in our country, there has been a racial wealth gap for BIPOC perpetuated by a lack of rights to land and homeownership. The Continuum of Care would be interested in supporting a program that would help to provide a holistic, sustainable pathway to homeownership and landownership for BIPOC in our community. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model.

The “Paperwork Brigade”: Part-time Volunteer Positions with Stipends
A group of volunteers interested in helping people to maintain their housing stability by helping people with severe service needs fill out paperwork, understand the rules of their housing and their rights as tenants, and inform our centralized housing navigator team of any needs that come up within the first month of obtaining new housing would be a welcome addition to Home, Together: Tompkins. Continuum of Care staff invite interested partners to reach out to us at

sgatson@hsctc.org and lbargar@hsctc.org to talk more about how to integrate your group of volunteers into this framework.

Rehabilitating Rental Units in Substandard Condition
Many people entering our homeless response system are exiting naturally occurring low-cost rentals with substandard living conditions. An initiative focusing on rehabilitating these units while keeping their rents low-cost would be a welcome project to help prevent returns to homelessness in our continuum. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model.

Transportation Assistance
Our system is in need of free shuttles to expand the existing capacity of the TCAT for people experiencing homelessness in rural areas of our County. Continuum of Care staff invite interested partners to reach out to us at sgatson@hsctc.org and lbargar@hsctc.org to talk more about this model.

Trauma-Informed Training and Oversight for the Human Services Sector
Organizations interested in performing regular training for Continuum of Care partners in the human services sector should reach out to us at sgatson@hsctc.org and lbargar@hsctc.org. We are especially interested in integrating trauma-informed training with a focus on racial equity into direct training roles. The CoC would like to center an anti-racist perspective to ensure all direct service provision and management are trauma-informed for BIPOC participants.

References

"About Us." *Crossroads Rhode Island*, https://www.crossroadsri.org/about/our-work-team/about-us.

"Alliance Pressure Points Resource Series Progressive Engagement Fact Sheet." National Alliance to End Homelessness, 14 Apr. 2022.

"An Overview of Homeless Encampments for City Leaders." National League of Cities, Jan. 2022.

America's Youngest Outcasts: A Report Card on Child Homelessness. (2014). Waltham, MA: The National Center on Family Homelessness at American Institutes for Research.

Arnold Ventures. 2020a. "Philadelphia, Pennsylvania: Tale of Two Cities." Houston: Arnold Ventures.

Arnold Ventures. 2020b. "Portland/Multnomah County, Oregon: Taking Many Roads to 'A Home for Everyone.'" Houston: Arnold Ventures.

Arnold Ventures. 2020c. "Santa Barbara County, California: Affordability as the Defining Challenge." Houston:Arnold Ventures.

Batko, Samantha, et al. "Alternatives to Arrests and Police Responses to Homelessness: Evidence-Based Models and Promising Practices." Urban Institute, Oct. 2020.

"The Case for Housing First." National Low Income Housing Coalition, 3 June 2022.

"Continuum of Care Supplemental to Address Unsheltered and Rural Homelessness." U.S. Department of Housing and Urban Development, 22 June 2022.

"COVID-19 Homeless System Response: Equity-Driven Changes to Coordinated Entry Prioritization." US Department of Housing and Urban Development, May 2020.

"COVID-19 Homeless System Response: Prevention to Promote Equity." US Department of Housing and Urban Development, June 2020.

"Data Visualization: The Evidence on Housing First." *National Alliance to End Homelessness*, National Alliance to End Homelessness, 25 May 2021, https://endhomelessness.org/resource/data-visualization-the-evidence-on-housing-first/.

Desmond, Matthew. "Poor Black Women Are Evicted at Alarming Rates, Setting Off a Chain of Hardship." John D. and Catherine T. MacArthur Foundation, Mar. 2014.

"The Emergency Shelter Learning Series - End Homelessness." *Https://Endhomelessness.org/*, National Alliance to End Homelessness,

https://endhomelessness.org/wp-content/uploads/2017/04/ES-Webinar-2-Keys-to-Effective-Low-barrier-Shelter_Webpage.pdf.

Guarino, K., Soares, P., Konnath, K., Clervil, R., and Bassuk, E. (2009). Trauma-Informed Organizational Toolkit. Rockville, MD: Center for Mental Health Services, Substance Abuse and Mental Health Services Administration, and the Daniels Fund, the National Child Traumatic Stress Network, and the W.K. Kellogg Foundation. Available at www.homeless.samhsa.gov and www.familyhomelessness.org

Gulcur, Leyla, et al. "Housing, Hospitalization, and Cost Outcomes for Homeless Individuals with Psychiatric Disabilities Participating in Continuum of Care and Housing First Programmes." *Journal of Community & Applied Social Psychology*, vol. 13, no. 2, 9 Apr. 2003, pp. 171–186., https://doi.org/10.1002/casp.723.

"Harm Reduction." *SAMHSA Substance Abuse and Mental Health Administration*, 16 Aug. 2022, https://www.samhsa.gov/find-help/harm-reduction.

"Home, Together: The Federal Strategic Plan to Prevent and End Homelessness." United States Interagency Council on Homelessness, 19 July 2018.

"Homelessness & Health: What's the Connection?" National Health Care for the Homeless Council, Feb. 2019.

"Homelessness and Harm Reduction." *National Harm Reduction Coalition*, National Harm Reduction Coalition, 2 Oct. 2020, https://harmreduction.org/issues/harm-reduction-basics/homelessness-harm-reduction-facts/.

"Homeless System Response: Housing Surges—Special Considerations for Targeting People Experiencing Unsheltered Homelessness." US Department of Housing and Urban Development, Jan. 2021.

"Homeless System Response: Part 1: Equity as the Foundation." US Department of Housing and Urban Development, June 2020.

"Homeless System Response: Planning a Housing Surge to Accelerate Rehousing Efforts in Response to COVID-19." US Department of Housing and Urban Development, June 2020.

"Homeless System Response: Rehousing Activation: Planning and Implementation Tips." US Department of Housing and Urban Development, June 2020.

Horn, Lisa. "Homeless and Housing Needs Assessment for Tompkins County." Horn Research LLC, June 2022.

"Housing First and Harm Reduction." US Department of Housing and Urban Development, Apr. 2021.

"Implementing Housing First in Permanent Supportive Housing." United States Interagency Council on Homelessness, June 2014.

Kammen, Carol, and Jane Marsh Dieckmann. "Chapter 8." *Ithaca: A Brief History*, The History Press, Charleston, SC, 2008, pp. 80–81.

Kresky-Wolff, M., Larson, M. J., O'Brien, R. W., & McGraw, S. A. (2010). Supportive housing approaches in the collaborative initiative to help end chronic homelessness (CICH). The Journal of Behavioral Health Services & Research, 37(2), 213–225. https://doi.org/10.1007/s11414-009-9206-y

Marteal, Erin. "Ithaca Children's Garden: Then and Now." *Tompkins Weekly*, 15 Jan. 2018.

McDivitt, Kay Moshier. "Making the Shift to a Housing Focused, Low Barrier Shelter." *Connecticut Coalition to End Homelessness*, Connecticut Coalition to End Homelessness, 2018, https://cceh.org/.

Menschner, Christopher, and Alexandra Maul. "Key Ingredients for Successful Trauma-Informed Care Implementation." Center for Health Care Strategies, Apr. 2016.

Metraux, Stephen, Meagan Cusack, Fritz Graham, David Metzger, and Dennis Culhane. 2019. An Evaluation of the City of Philadelphia's Kensington Encampment Resolution Pilot. Philadelphia: City of Philadelphia.
National Health Care for the Homeless Council. (May 2020). Harm Reduction. Healing Hands, 24:2. (Author: Melissa Jean, Writer). Nashville, TN. Available at: www.nhchc.org.

Olivet, Jeff. "Collaborate, Don't Criminalize: How Communities Can Effectively and Humanely Address Homelessness." *United States Interagency Council on Homelessness (USICH)*, United States Interagency Council on Homelessness (USICH), 26 Oct. 2022, https://www.usich.gov/news/collaborate-dont-criminalize-how-communities-can-effectively-and-humanely-address-homelessness#:~:text=Criminalizing%20homelessness%20is%20expensive.,not%20moving%20people%20around%20them.

Paula Goering, Scott Veldhuizen, Aimee Watson, Carol Adair, Brianna Kopp, Eric Latimer, Geoff Nelson, Eric MacNaughton, David Streiner & Tim Aubry (2014). National At Home/Chez Soi Final Report. Calgary, AB: Mental Health Commission of Canada. Retrieved from: http://www.mentalhealthcommission.ca

Pearson, Carol L, et al. "The Applicability of Housing First Models to Homeless Persons with Serious Mental Illness ." U.S. Department of Housing and Urban Development Office of Policy Development and Research , July 2007.

Rogers, Jennie, and Michelle Mulcahy. "Improving Housing Stability to Prevent Evictions and End Racial Disparities." *Enterprise Community Partners*, Enterprise Community Partners, Inc, 22 Nov. 2021,

https://www.enterprisecommunity.org/blog/improving-housing-stability-prevent-evictions-and-end-racial-disparities-0.

Sam Tsemberis, Leyla Gulcur, Maria Nakae, “Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals With a Dual Diagnosis”, American Journal of Public Health 94, no. 4 (April 1, 2004b): pp. 651-656.

Shepard, Christine, and Christie Gillespie. “The Need for & Feasibility of Low-Barrier Options in Sheltering People Who Are Experiencing Homelessness.” Indianapolis Office of Public Health and Safety, 22 Oct. 2021.

Shinn, Gregory A. “The Cost of Long-Term Homelessness in Central Florida.” Impact Homelessness: An Initiative of the Central Florida Commission on Homelessness, 2014.

Thomson Reuters. “18 CRR-NY 352.35.” New York Codes, Rules, and Regulations, Thomson Reuters, 30 April 2021, https://govt.westlaw.com/nycrr/Document/I50c3e46fcd1711dda432a117e6e0f345? Accessed 5 January 2023.

Tsemberis, Sam, et al. “Housing First, Consumer Choice, and Harm Reduction for Homeless Individuals with a Dual Diagnosis.” *American Journal of Public Health*, vol. 94, no. 4, May 2004, pp. 651–656., https://doi.org/10.2105/ajph.94.4.651.

Tsemberis, Sam & Moran, Linda & Shinn, Marybeth & Asmussen, Sara & Shern, David. (2004a). Consumer Preference Programs for Individuals Who Are Homeless and Have Psychiatric Disabilities: A Drop-In Center and a Supported Housing Program. American journal of community psychology. 32. 305-17. 10.1023/B:AJCP.0000004750.66957.bf.

United States Department of Housing and Urban Development. “HUD's Definition of Homelessness: Resources and Guidance.” HUD Exchange, 8 March 2019, https://www.hudexchange.info/news/huds-definition-of-homelessness-resources-and-guidance/. Accessed 29 November 2022.

United States Interagency Council on Homelessness. “Home, Together: The Federal Strategic Plan to Prevent and End Homelessness.” United States Interagency Council on Homelessness (USICH), 18 July 2018, https://www.usich.gov/resources/uploads/asset_library/Home-Together-Federal-Strategic-Plan-to-Prevent-and-End-Homelessness.pdf. Accessed 29 November 2022.

Velasco, Gabi, and Martha Fedorowicz. “Applying a Racial Equity Lens to Housing Policy Analysis.” *Housing Matters: an Urban Institute Initiative*, Urban Institute, 4 Feb. 2022, https://housingmatters.urban.org/articles/applying-racial-equity-lens-housing-policy-analysis?trk=organization-update-content_share-embed-video_share-article_title.

Wilkey, Catriona, et al. “Coordinated Entry Systems Racial Equity Analysis of Assessment Data.” C4 Innovations (C4), Oct. 2019.

Appendices

Appendix A: Funding Options

While the Continuum of Care staff is seeking endorsement of this plan, the goal of *Home, Together: Tompkins* is ultimately to have future planning within the continuum aligned with the goals, outcomes, and overall mission outlined in this document. This plan is not a proposal seeking funding from any particular group or entity, however this appendix includes a brief summary of potential funding sources that could support the projects.

City Set-Aside Funding for Addressing Encampment Spaces: The City of Ithaca tentatively voted to approve $100,000 to set aside to support encampment responses. Eligible uses include; active management of City properties to address or prevent unauthorized encampments, including restoration of former encampments, reimbursement of out-of-pocket expenses to City Departments providing in-kind services to support development of facilities serving unsheltered homeless individuals on City-owned property, hiring an enhanced housing navigator in conjunction with Tompkins County or others. $50,000 was approved to hire a part-time homeless outreach coordinator.

Community Development Block Grant (CDBG): The Community Development Block Grant (CDBG) Entitlement Program provides annual grants on a formula basis to entitled cities and counties to develop viable urban communities by providing decent housing and a suitable living environment, and by expanding economic opportunities, principally for low- and moderate-income persons. Ithaca is typically allocated about $616,000 to spend on the following eligible project types, community facilities and improvements, public infrastructure and public services.

County Set-Aside Funding for Addressing Encampment Spaces: Tompkins County tentatively voted to approve $100,000 to set aside to support encampment responses. Additional Information has not yet been provided to the public.

Department of Corrections and Community Supervision- Community Based Residential Programs (CBRP): Community Based Residential Programs (CBRPs) are housing initiatives that assist undomiciled individuals returning home from prison in attaining stability in the community. CBRPs provide food, counseling, and other services, such as substance abuse treatment, educational/vocational training, mental health and social services either directly or through referrals. They offer structured settings and services for a period of up to 120 days with extensions available on a case-by-case basis. REO awards and manages grant funds to eligible programs to support formerly incarcerated individuals with successful reintegration through a Continuous Recruitment Request for Application.

Emergency Solutions Grant (ESG): The Homeless Emergency Assistance and Rapid Transition to Housing (HEARTH) Act of 2009 amended to the McKinney-Vento Homeless Assistance Act, revised the Emergency Shelter Grants Program and renamed it to the

Emergency Solutions Grants (ESG) program.The program provides funding to: engage homeless individuals and families living on the street, improve the number and quality of emergency shelters for homeless individuals and families, help operate these shelters, provide essential services to shelter residents, rapidly re-house homeless individuals and families, and prevent families and individuals from becoming homeless.

HOME Investment Partnerships: The City of Ithaca has an annual HOME entitlement of $304,000 in 2023. HOME funds are used for a wide range of activities including building, buying and/or rehabilitating low-cost housing for rent or homeownership or providing direct rental assistance to low-income people.

HOME American Rescue Plan Program: The American Rescue Plan (ARP) provides $5 billion to assist individuals or households who are homeless, at risk of homelessness, and other vulnerable populations, by providing housing, rental assistance, supportive services, and non-congregate shelter, to reduce homelessness and increase housing stability across the country. These grant funds will be administered through HUD's HOME Investment Partnerships Program (HOME). Ithaca has been allocated $1.2 million and will need to apply by March 31st, 2023 to be a Participating Jurisdiction or PJ.

The Homeless Housing and Assistance Program (HHAP): HHAP provides capital grants and loans to not-for-profit corporations, charitable and religious organizations, municipalities and public corporations to acquire, construct or rehabilitate housing for persons who are homeless and are unable to secure adequate housing without special assistance. HHAP has provided capital funding for a wide range of housing types for various homeless special needs populations, including but not limited to: emergency and transitional facilities for victims of domestic violence, transitional housing for adolescents aging out of foster care, programs for homeless and runaway youth, transitional programs for people in recovery, and supported housing for veterans, people living with HIV/AIDS, ex-offenders, substance abusers, the chronic homeless, and the severely and persistently mentally ill. In many instances, HHAP is the only state resource available to fund the capital development of these types of projects.

Medicaid Redesign Team (MRT) Permanent Supportive Housing Initiative:
Affordable/supportive housing for high frequency, high cost Medicaid beneficiaries who are homeless or precariously housed. MRT housing includes rental subsidies and other occupancy costs for apartments, program supervision, housing, and employment counseling.

The Neighborhood and Rural Preservation Program (NPP and RPP): For over 40 years the Neighborhood and Rural Preservation Program has provided financial and technical assistance to community-based not-for-profit corporations with a goal of providing safe, healthy, and affordable housing for families throughout New York State.

NYS Office of Addiction Services and Supports (OASAS): OASAS funds housing providers in several counties across New York State to assist individuals/families affected by addiction to locate and maintain permanent housing by providing rental subsidies and case management

services. Housing providers also assist in vocational training and employment counseling to help individuals in recovery lead self-sufficient lives.

They oversee the following brands of Permanent Supportive Housing:

> **New York/New York III (NY/NY III):** Single-site and scatter-site housing for homeless, single adults who have completed some level of substance abuse treatment, as well as chronically homeless or at-risk families, in which the head of household suffers from a substance use disorder.
>
> **Upstate Permanent Supportive Housing**: Housing which includes rental subsidies, case management, and employment services for individuals and families in recovery in rural communities, and small suburban regions of Upstate New York.
>
> **Re-entry Scatter-Site Permanent Supportive Housing:** Rental subsidies, case management and employment counseling for persons with substance abuse problems, recently released on parole in New York City.

The NYS Office of Mental Health's Empire State Supportive Housing Initiative (ESSHI): The NYS ESSHI program provides service and operating funding for congregate supportive housing across the State. The eligible target populations to be served under this program are families or individuals who are both homeless and who are identified as having an unmet housing need as determined by the CoC or local planning entity, AND have one or more disabling conditions or other life challenges.

Substance Abuse and Mental Health Services Administration (SAMHSA): SAMHSA's homelessness programs support many types of behavioral health treatments and recovery-oriented services. These services include:

- Outreach
- Case management
- Treatment for mental and/or substance use disorders
- Enrollment in mainstream benefits such as Medicaid and the Supplemental Nutrition Assistance Program (SNAP)
- Peer support services
- Employment readiness services
- Programs primarily target people experiencing homelessness who have been underserved, or who have not received any behavioral health services. Most of these programs support people who experience chronic homelessness.

Tompkins County Community Recovery Fund: One-time funding of $6.53 million that focuses on projects that will provide a "transformative" outcome in our community. Eligible types of projects that align with the Home, Together: Tompkins plan include public health/mental health, affordable housing, non-profit organizations, economic or community development

projects, and workforce initiatives. All funds must be obligated/awarded by December 31, 2024 and spent by December 31, 2026.

Appendix B: Needs Assessment Graphic

This appendix includes highlights from the Homeless and Housing Needs Assessment that the CoC Governance committee found to be most salient to understanding our homeless response system.

Needs Assessment: Data Findings

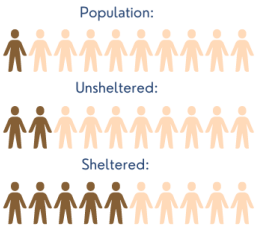
Tompkins County has the third highest rate of homelessness per 10,000 population of comparable and surrounding CoCs.

Chronic Homelessness is increasing in our county. Almost half (45.1%) of our current homeless population are experiencing chronic homelessness.

Average length of stay in shelter is increasing and was at an average of 91 days in FY2020.

91

While the local population consists of 12.4% BIPOC, we see 48% representation of BIPOC in our shelter, and 22% representation of BIPOC in unsheltered locations.



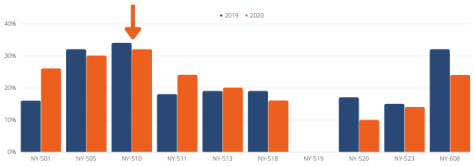
Compared with other CoCs, Tompkins County had the highest ratio of unsheltered homelessness to total homeless (34.3%).

Qualitative interviews with people with lived experience of living in the encampment spaces revealed barriers to housing

In FY2020, there was an observable bottleneck of 102 beds (including vouchers) between people experiencing homelessness and the beds available through the homeless response system.

In FY2020, Tompkins County had the highest rate of returns to homelessness of all comparable CoCs at 32% of households returning to homelessness within 24 months.

Returns to Homelessness



Adult-only households have the worst outcomes in our continuum:

FY2020 Adult- Only Households	FY2020 Adult and Child Households
473 Households	53 Households
87 days homeless on average	71 days homeless on average
8% returned to homelessness	0% returned to homelessness

Although 31% of people served by the homeless system in FY2020 come from a couch-surfing situation, there is no existing pathway to divert these households into permanent housing.

Appendix C: Home, Together Tompkins Outcome Metrics

This appendix includes outcomes that CoC staff hope to achieve over the next five years following implementation of this plan. It includes specific metrics to track as well as interventions from the *Home, Together: Tompkins* Plan that would contribute to that goal.

Home, Together: Tompkins Outcomes

Reduce unsheltered homelessness by 70%:

- Recurring Housing Surges with rapid exits to permanent housing destinations
- Prioritization of people currently sleeping in unsheltered locations or otherwise banned from the OTDA-funded shelter in the low-barrier shelter
- 80 light-touch contacts from a HTT housing specialist to serve people experiencing unsheltered homelessness.

Decrease homeless entries from couch-surfing situations by 50%

- 200 new light-touch contacts assisting people at-risk of losing their housing
  - 80 contacts per year as high-priority referrals from 2-1-1
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- 5 housing surge spots set-aside for couch-surfers with severe service needs.

Decrease the average length of time homeless by 30 days:

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- 200 light-touch contacts and successful interactions with clients to end their homelessness as soon as possible
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- Professional development for people with lived experience

Increased Community Engagement.

- Opportunities for engagement through initiatives such as cash for trash
- Paid lived experience board to enhance communication and understanding of the needs of people living outside
- Opportunities for professional development for people who lack other higher education requirements for employment in this field

Increased Accountability to Business Owners, Landlords, and Neighbors.

- $50,000 per year going directly to business owner and landlord partners
- A neighborhood liaison to foster increased communication
- Returning stolen shopping carts through the cart exchange program.

Racial Equity Lens: Serve 50% BIPOC

- Proportional to current BIPOC representation in our homeless response system
- Commitment to equity through targeted outreach

Other. Home, Together: Tompkins strategic plan

1. Home, Together: Tompkins Plan (Full)
2. **Home, Together: Tompkins Presentation**

Home, Together: Tompkins

The CoC's homeless response plan for ending unsheltered homelessness and enhancing service delivery for people with severe service needs.

SIMONE GATSON — CoC Staff, Coordinated Entry Lead

LIDDY BARGAR — CoC Coordinator, Director of Housing Initiatives

Background

Home, Together: USICH

Home, Together is the Federal Strategic Plan to Prevent and End Homelessness from the United States Interagency Council on Homelessness (USICH). This plan incorporates evidence-based strategies to end homelessness nationally with the guiding principles of home: safe and stable places to call home, and together: strengthening our community by providing opportunities for people to collaborate on this issue together.

Housing and Public Health

NY-510 asserts that access to stable housing is a requirement to achieving and maintaining the health of our county. The CoC considers the growth in the population of people experiencing unsheltered homelessness to be a public health crisis. The solution is not to relocate people from one unsheltered location to another, but to move people into suitable permanent housing where they can meet their basic needs with dignity.

Tompkins County Homeless and Housing Needs Assessment

Written by Horn Research and published in 2021, this report commissioned by our CoC, the City of Ithaca, and Tompkins County revealed current areas in our homeless response system that are in need of support, as well as recommendations for providing those supports.

Definitions

How does HUD define Severe Service Needs?

any combination of the following factors:

- facing significant challenges or functional impairments which require a significant level of support in order to maintain permanent housing (this factor focuses on the level of support needed and is not based on disability type)
- high utilization of crisis or emergency services to meet basic needs, including but not limited to emergency rooms, jails, and psychiatric facilities
- experiencing a vulnerability to illness or death
- having a risk of continued or repeated homelessness
- having a vulnerability to victimization, including physical assault, trafficking or sex work, and
- currently living in an unsheltered situation or having a history of living in an unsheltered situation.

What is housing first?

Housing First is an evidence-based approach to providing housing assistance that prioritizes placing individuals in permanent housing to end their homelessness as a basic need to working on any larger personal goals. This is guided by the belief that people need to have their basic needs such as food and housing met before being able to work on other less critical objectives such as employment or addressing substance use issues.

What is Home, Together: Tompkins?

A Community Wide Plan to Reduce Homelessness

Strategies:

-increase our stock of PSH

-expand emergency shelter capacity

-organize and implement a "housing surge"

-address staff shortages

-improve access to resources

Home, Together: Tompkins

What do we hope to achieve?

01 LESS UNSHELTERED AND CHRONIC HOMELESSNESS

Implement low-barrier shelter, increase housing stock, and create additional resources for housing stability reduce unsheltered and chronic homelessness in our community.

02 IMPROVED HEALTH OUTCOMES

Increase access to safe housing and preventative physical and mental health care, leading to less interactions with police, EMTs, and first-responders.

03 BETTER RELATIONSHIPS

Engage business owners, landlords and neighbors, leverage partnerships and strengthen relationships.

Rethinking low-barrier shelter

01

PROVIDING EASY ACCESS

Allowing people to access shelter as they are instead of requiring an application upon entry, screening for factors such as substance use or previous sanctions, and requiring ongoing payments.

02

CLEAR AND SIMPLE BEHAVIORAL EXPECTATIONS

Shifting to a focus on providing clear behavioral expectations with an emphasis on safety rather than focusing on compliance with a rigid set of rules.

03

A TRAUMA-INFORMED OPERATING CULTURE

Most people experiencing homelessness, particularly those who are unsheltered, have a history of trauma, crisis, and stress. Ensuring that any staff interacting with potential shelter residents are regularly trained in de-escalation and trauma-informed care is essential.

04

RELAXED SOBRIETY AND CURFEW MEASURES

Re-thinking these perceived safety measures and whether or not they actually contribute to positive outcomes for people with SSNs who are more likely to be the victims than the perpetrators of crimes.

Barriers to Shelter and Housing

Emergency Shelter

01 Paying 50%-75% of each paycheck

02 Submitting 5 housing contacts per week

03 Hotel placements are far from most centralized resources

04 Individuals could be sanctioned for missing appointments

05 THA application can take hours, if not an entire day to process

Voucher Services

01 Individuals are often unaware of the rules to keep their voucher

02 Discrimination against voucher holders on the private market

03 Rental cap is oftentimes too low for what is actually available

04 Habitability of available units

05 Lack of documentation to apply

Private Market Rentals

01 Individuals are often unaware of the rules of their lease

02 Individuals are often unsure of who to contact if something happens

03 Individuals are are afraid to stay in touch with landlord about issues

04 Habitability of available units

05 Lack of documentation to apply

The Home, Together: Tompkins Plan

3 broad categories of intervention: Increasing Access to Housing, Incentive Programs, and Expanding Sector Capacity

Access to housing

01 L A commitment to building **100 studio and 1-bedroom units of Permanent Supportive Housing.**

02 L **Low-barrier shelter** that removes pre-conditions and uses a trauma-informed approach to safety.

03 S Using a **"housing surge" strategy** to quickly move people into housing/shelter.

Incentive Programs

04 M **Mitigation funds** for business owners and landlords serving people with severe service needs.

05 S **Other incentives** for community members such as **shopping cart exchanges and cash for trash**

06 M **Easy access move-in packages and assistance** for people moving from homeless to housed

Expanding Sector Capacity

07 M Three enhanced, centralized **housing navigator** positions to supplement existing outreach.

08 M **Paid board positions** for people with lived experience to monitor and approve projects.

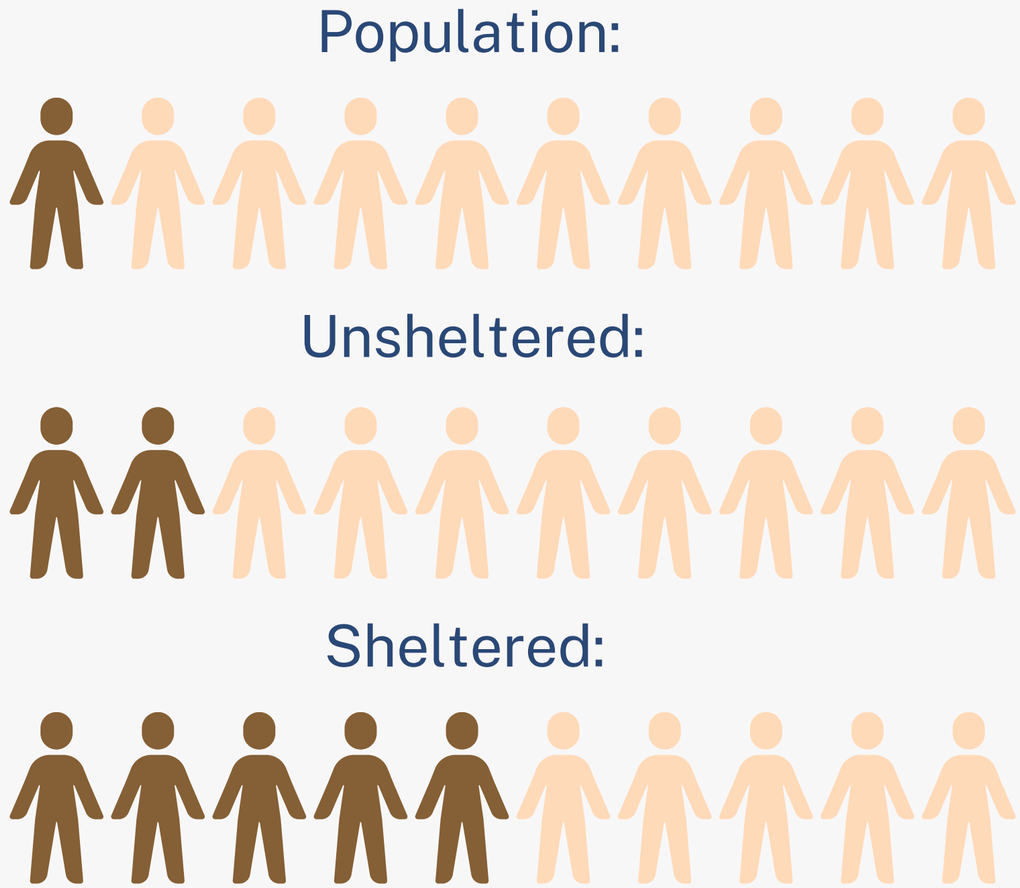
09 M **Professional development opportunities** for people with lived experience.

Short-term Intervention**= S** **Medium**-term Intervention**= M** **Long**-term Intervention**= L**

While the local population consists of 12.4% BIPOC, we see 48% representation of BIPOC in our shelter, and 22% representation of BIPOC in unsheltered locations.

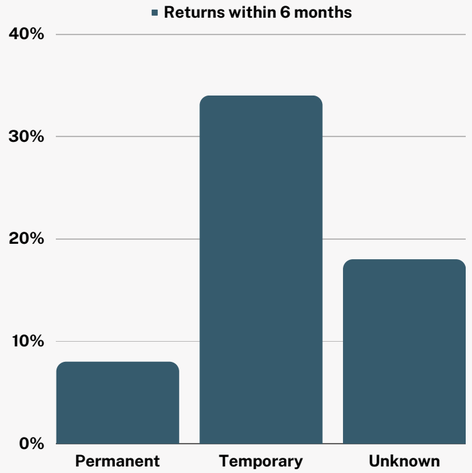
BIPOC are traditionally underserved in our community and underrepresented in the human services sector. **Home, Together: Tompkins is committed to monitoring who this project is serving and how BIPOC experiences compare to that of their white counterparts.**

Continuum of Care staff have integrated **metrics into each component of this plan** to ensure equitable distribution of resources and power to BIPOC participants.



What does the data say?

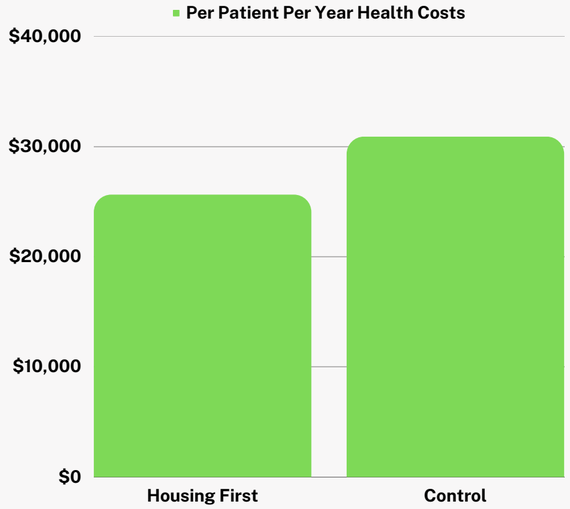
Households in our community leaving to temporary destinations were much (78%) more likely to return to homelessness than those exiting to permanent destinations.



Percent of exits who returned within 6 months

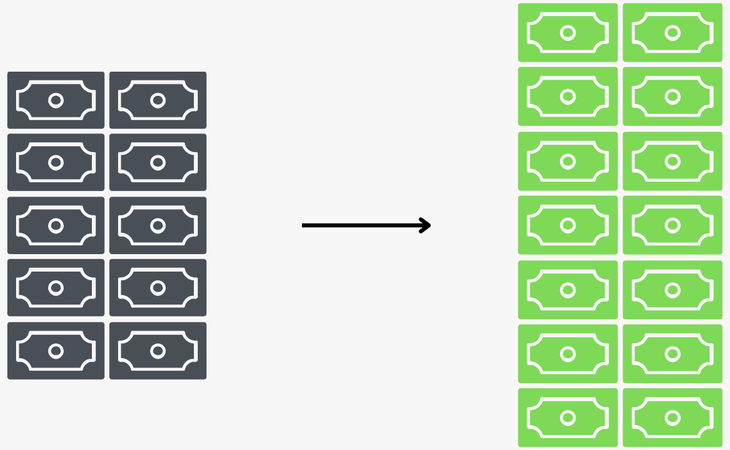
What does the data say?

Utilizing a housing first approach **reduced health care costs by an average of $5,000 per participant over the course of three years.** (health and housing first)



What does the data say?

The economic benefits exceed the intervention cost for Housing First programs in the U.S., with **societal cost savings of $1.44 for every dollar invested**. The economic benefit due to the intervention is the combined savings from healthcare, emergency housing, judicial services, welfare and disability costs, and benefits.



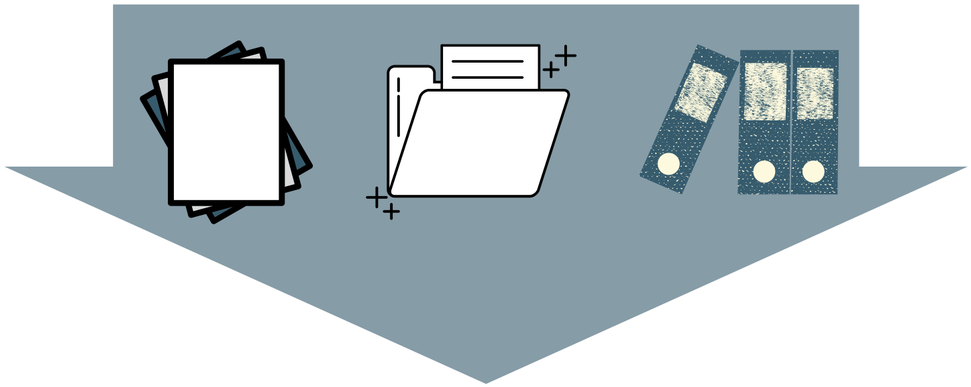
The Housing Surge Process

01 **Convening Partners**

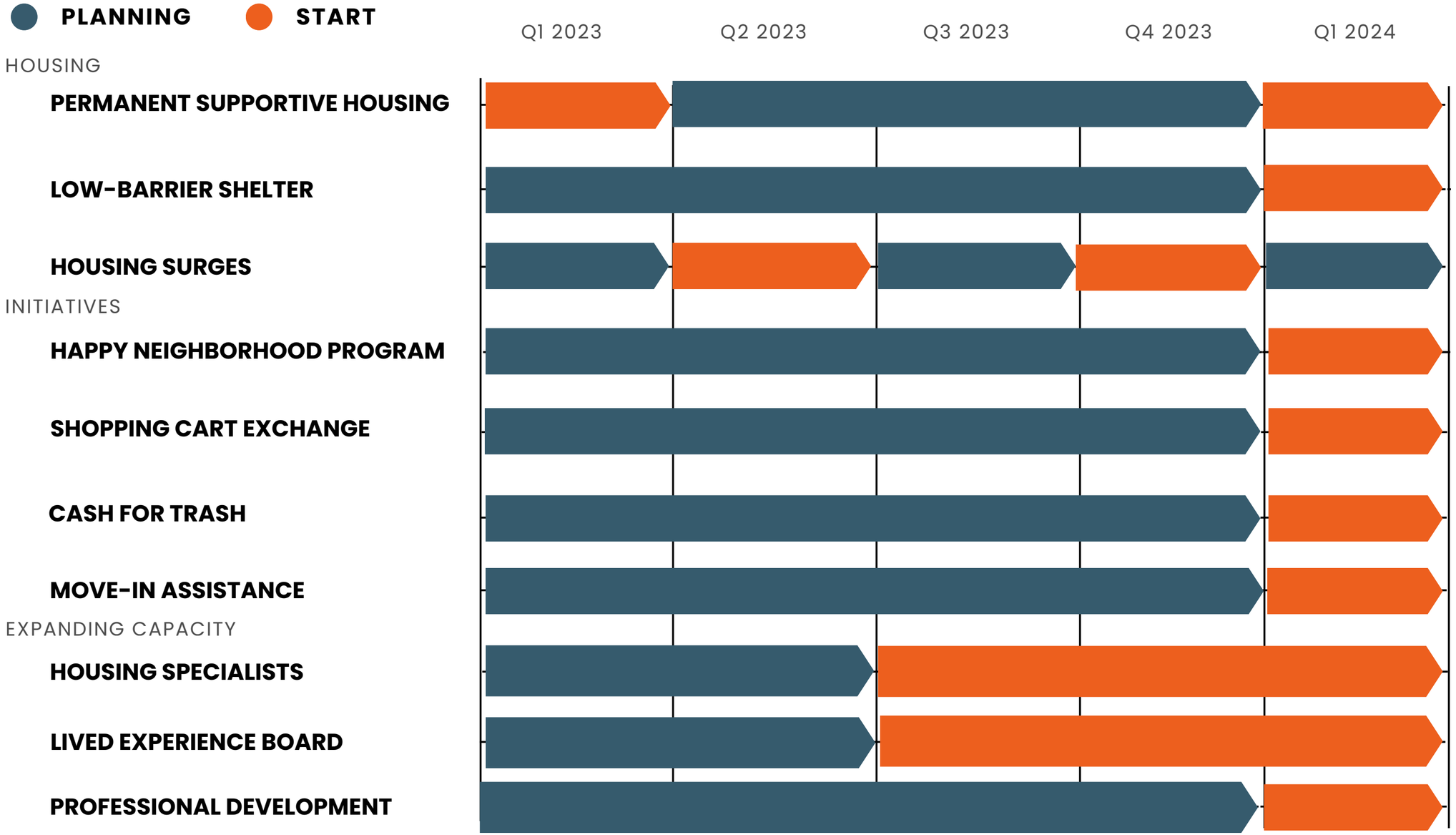
02 **Identifying Resources**

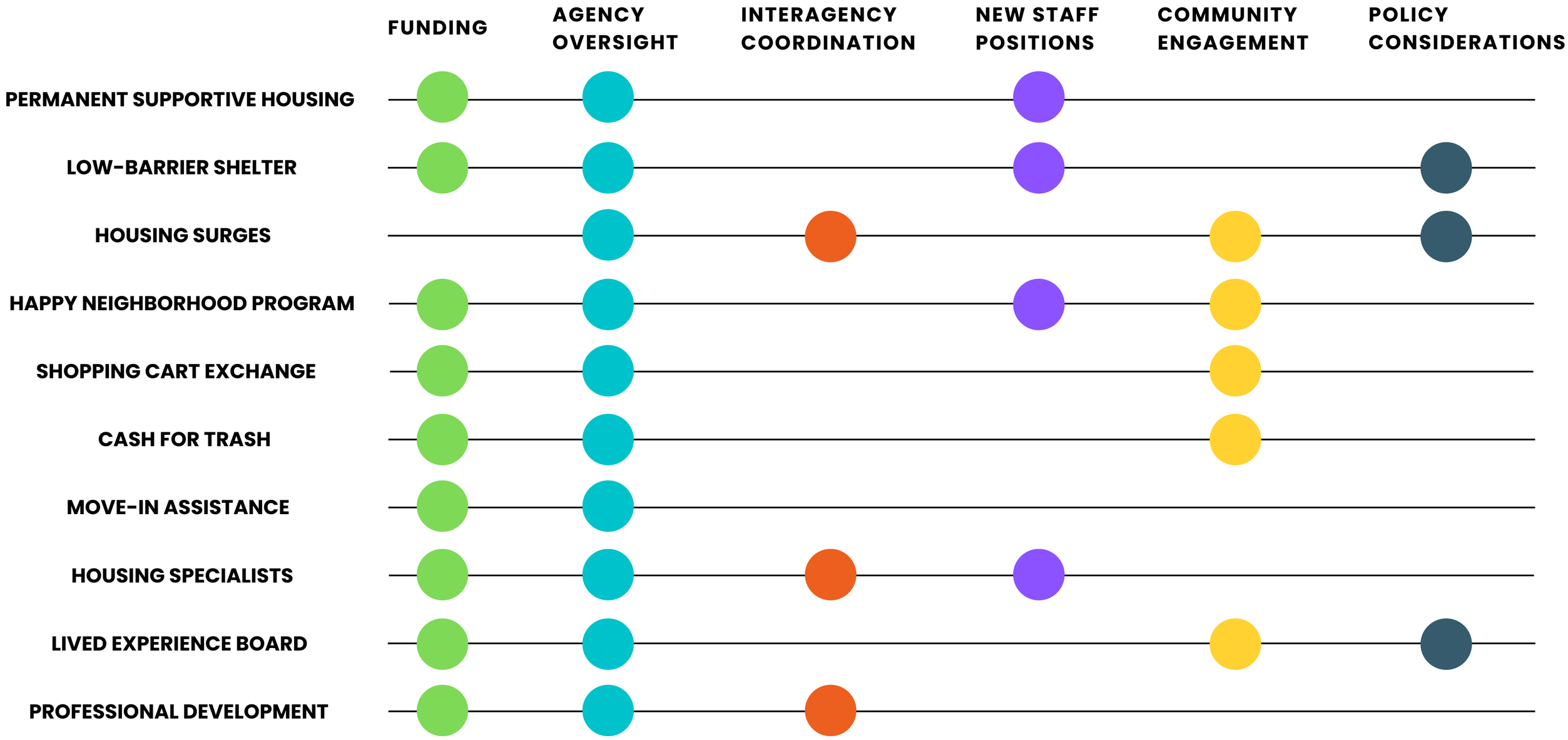
03 **Creating a pool of housing units, landlord relationships, and participants**

04 **Expediting the Rehousing Process**



05 **Implementing the surge and tracking outcomes**


PLANNING
START
Q1 2023
Q2 2023
Q3 2023
Q4 2023
Q1 2024
HOUSING
PERMANENT SUPPORTIVE HOUSING
LOW-BARRIER SHELTER
HOUSING SURGES
INITIATIVES
HAPPY NEIGHBORHOOD PROGRAM
SHOPPING CART EXCHANGE
CASH FOR TRASH
MOVE-IN ASSISTANCE
EXPANDING CAPACITY
HOUSING SPECIALISTS
LIVED EXPERIENCE BOARD
PROFESSIONAL DEVELOPMENT


FUNDING
AGENCY OVERSIGHT
INTERAGENCY COORDINATION
NEW STAFF POSITIONS
COMMUNITY ENGAGEMENT
POLICY CONSIDERATIONS
PERMANENT SUPPORTIVE HOUSING
LOW-BARRIER SHELTER
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CASH FOR TRASH
MOVE-IN ASSISTANCE
HOUSING SPECIALISTS
LIVED EXPERIENCE BOARD
PROFESSIONAL DEVELOPMENT

Other complimentary interventions

01

INCLUSIVE MANAGEMENT OF ENCAMPMENT SPACES

Create a site that allows anyone to meet their basic needs with dignity without requiring engagement with services or clearance of other spaces.

02

MENTAL HEALTH CRISIS RESPITE CENTER

Crisis respite for people who are experiencing a mental health crisis and are experiencing homelessness

03

THE “PAPERWORK BRIGADE”

Trained and compensated community members to help people complete paperwork, understand the details of their housing and their rights and responsibilites as tenants

04

TRANSPORTATION ASSISTANCE

Free shuttles to expand the existing capacity of the TCAT for people experiencing homelessness in rural areas of our county.

Should we ban camping?

United States Interagency Council on Homelessness (USICH) and The U.S Department of Housing and Urban Development (HUD) assert that:

1. **It can cost three times more to enforce anti-homeless laws than to find housing for people who don't have it.**
2. **Lead to arrests of victims of violent crime and of people who need mental health and substance use disorder treatment.**
3. **Camping bans erode trust and exacerbate homelessness and the conditions that contribute to it including health problems, stigma and racial disparities.**

The CoC recommends the use of
Inclusive Public Space Management.

This avoids punitive measures to homelessness and instead provides resources that **act as a public benefit to anyone** using the space, including people experiencing unsheltered homelessness.

This may include regular **trash disposal**, access to **drinking water**, access to **safe needle disposal**, and building and maintaining **public restrooms and showers**.

Needs Assessment: Data Findings

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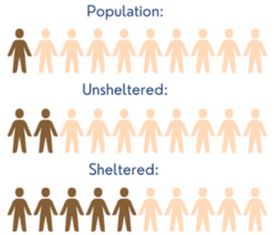

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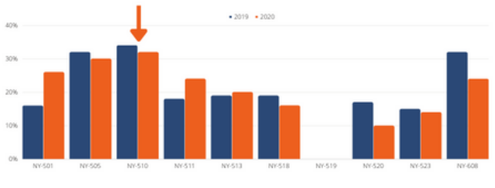

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Racial Equity Lens: Serve 50% BIPOC

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- Commitment to equity through targeted outreach

Thank you!

Questions? Email us at sgatson@hsctc.org or lbargar@hsctc.org

NY-510
ITHACA/TOMPKINS
CONTINUUM OF CARE

Home, Together: Tompkins

A commitment to building **100 units of Permanent Supportive Housing (PSH).**

PSH is housing set-aside for people experiencing literal homelessness that is affordable (residents contribute 30% of their income at most), permanent, and offers supportive services.

20 of these units will be set in rural areas of the county, and include additional supports such as free preventative healthcare and transportation.

HSC will work with TCAction on expanding staff capacity to serve additional units, starting with the 40 ESSHI units at Asteri.

01

L

Low-barrier shelter option

The Continuum of Care found that people who are currently living outside in Tompkins County are primarily people who are sanctioned from, or unwilling to navigate our current emergency shelter system.

Implementation of a site based low-barrier shelter with minimal pre-conditions to entering and maintaining shelter with an emphasis on safety through clear and simple expectations for residents.

02

L

A **"housing surge" strategy** to quickly move people indoors

A concentrated, time-limited community effort that houses a significant number of people in a short time-frame. Use the Coordinated Entry System to connect targeted households to a pre-identified pool of housing subsidies, available rental units and other resources and services. Housing Surges are a practice used for quick rehousing after natural disasters.

03

S

Mitigation funds for business owners and landlords.

Happy Neighborhood Program, provides eligible members with access to **up to $5000 support annually for damages or theft**, and support from HSC's landlord liaison.

The program will help build positive relationships, rebuild trust, and enhance communication in neighborhoods across the community.

04
M

Other **incentives**

Shopping cart return: reliable, collapsible, easy-to-repair carts to exchange for carts borrowed from businesses.

Cash for Trash: a redemption program like bottle return, but for trash (Ex. $10 per bag of collected litter)

Easy access move-in packages and assistance for moving from homeless to housed.

Expand current programs to help support housing stability by providing: trash tags, cleaning supplies, kitchen utensils, linens and more

Also, moving assistance, moving trucks, storage units and additional household basic needs.

06

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Three enhanced,centralized **housing navigator positions.**

Direct service generalists to help people access resources at all stages of the continuum: people who are currently experiencing homelessness, people who have just entered new housing, and people who are at risk of homelessness.

All three housing navigators would be trained by providers across our continuum to understand the available resources and eligibility criteria for programs. Each housing navigator would have a **small caseload of 10-12 individuals with severe service needs** for situations needing long-term assistance. They also act as a mobile, coordinated, community referral for individuals falling through the gaps of the existing safety net.

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Proposed Responsibilities

Housing Navigator 1:
Serving literally homeless

- help people fill in THA applications
- apply for other DSS services
- stay in compliance with the shelter
- help people in unsheltered situations get into shelter
- assist with housing search

Housing Navigator 2:
Serving recently housed

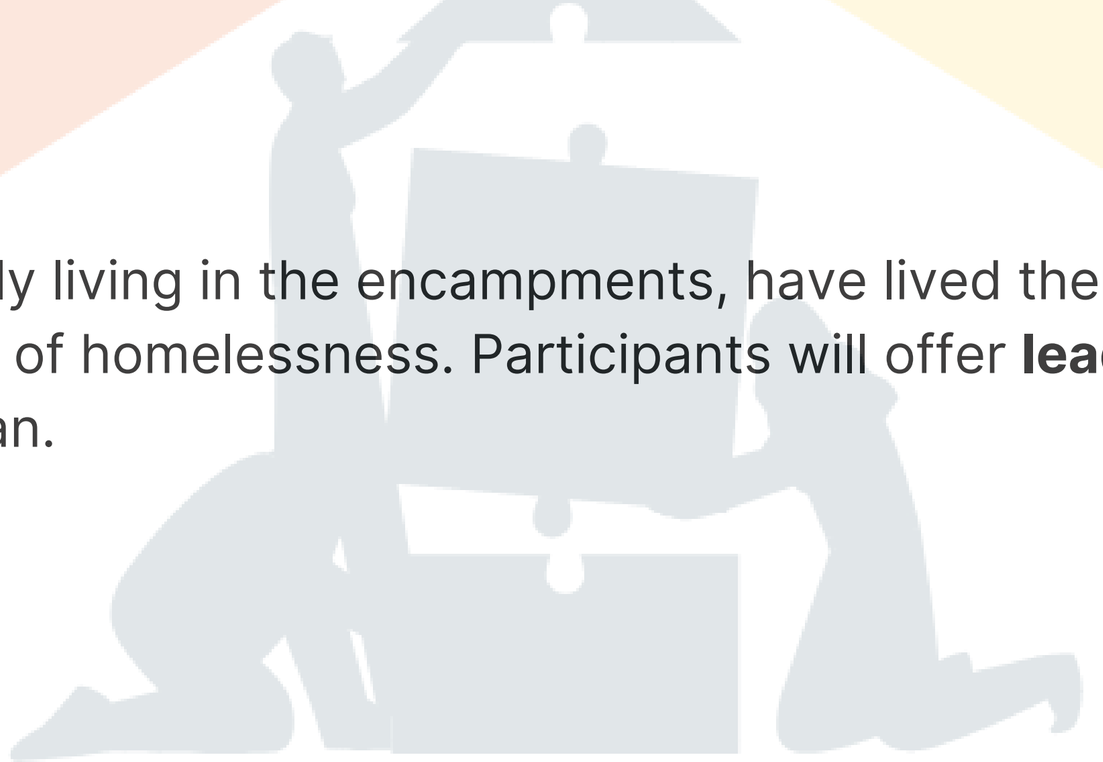
- assisting in navigating local resources
- staying in compliance with section 8
- navigating relationships with the landlord and other tenants
- providing other appropriate referrals
- acting as a housing search resource

Housing Navigator 3:
Serving housing unstable

- regularly attend eviction court at all sites in Tompkins County
- assist with finding last-resort resources to divert from homelessness
- follow up on high priority calls from our 2-1-1 line
- have a close relationship with local legal services

Paid board positions for people with lived experience

People who are currently living in the encampments, have lived there or have other expereinces of homelessness. Participants will offer **leadership** and **guidance** to the plan.



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Professional development opportunities for people with lived experience

Partner with human services employers to offer a route to employment in the sector for people with lived experience who lack education or experience requirements.

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