Before Starting the Special CoC Application

You must submit both of the following parts in order for us to consider your Special NOFO Consolidated Application complete:
1. the CoC Application, and
2. the CoC Priority Listing.

The CoC Special NOFO page provides HUD-approved resources to assist you in completing the Special NOFO CoC Application, including:

- Special Notice of Funding Opportunity to Address Unsheltered and Rural Homelessness
- 24 CFR part 578
- Special NOFO CoC Application Navigational Guide
- Section 3 Resources
- Frequently Asked Questions

As the Collaborative Applicant, you are responsible for reviewing the following:
1. The Special Notice of Funding Opportunity (Special NOFO) for specific application and program requirements.
2. The Special NOFO Continuum of Care (CoC) Application Detailed Instructions for Collaborative Applicants 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.

CoC Approval is Required before You Submit Your CoC's Special NOFO CoC Consolidated Application
- 24 CFR 578.9 requires you to compile and submit the Special NOFO CoC Consolidated Application 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 the [Specific Attachment Name] attachment to the 4A. 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

The CoC Special NOFO page provides HUD-approved resources to assist you in completing the Special NOFO CoC Application, including:

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1A-1. CoC Name and Number: RI-500 - Rhode Island Statewide CoC

1A-2. Collaborative Applicant Name: Rhode Island Housing and Mortgage Finance Corporation

1A-3. CoC Designation: CA

1A-4. HMIS Lead: RI Coalition to End Homelessness

1A-5.	New Projects	
	Complete the chart below by indicating which funding opportunity(ies) your CoC applying for projects under. A CoC may apply for funding under both set asides; however, projects funded through the rural set aside may only be used in rural areas, as defined in the Special NOFO.	
1.	Unsheltered Homelessness Set Aside	Yes
2.	Rural Homelessness Set Aside	No

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

The CoC Special NOFO page provides HUD-approved resources to assist you in completing the Special NOFO CoC Application, including:

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1B-1.	Web Posting of Your CoC Local Competition Deadline–Advance Public Notice. (All Applicants)	
	Special NOFO Section VII.B.1.b.	
	You must upload the Local Competition Deadline attachment to the 4A. Attachments Screen.	
	Enter the date your CoC published the deadline for project application submission for your CoC's local competition.	08/05/2022

1B-2.	Project Review and Ranking Process Your CoC Used in Its Local Competition. (All Applicants)	
	Special NOFO Section VII.B.1.a.	
	You must upload the Local Competition Scoring Tool attachment to the 4A. Attachments Screen.	
	Select yes or no in the chart below to indicate how your CoC ranked and selected new project applications during your CoC's 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

1B-3.	Projects Rejected/Reduced–Notification Outside of e-snaps. (All Applicants)	
	Special NOFO Section VII.B.1.b.	
	You must upload the Notification of Projects Rejected-Reduced attachment to the 4A. Attachments Screen.	
1.	Did your CoC reject or reduce any project application(s)?	Yes
2.	Did your CoC inform the applicants why their projects were rejected or reduced?	Yes
3.	If you selected yes, for element 1 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, list the latest date of any notification. For example, if you notified applicants on 6/26/22, 6/27/22, and 6/28/22, then you must enter 6/28/22.	09/23/2022

1B-3a.	Projects Accepted–Notification Outside of e-snaps. (All Applicants)	
	Special NOFO Section VII.B.1.b.	
	You must upload the Notification of Projects Accepted attachment to the 4A. Attachments Screen.	
	Enter the date your CoC notified project applicants that their project applications were accepted and ranked on the New Priority Listings in writing, outside of e-snaps. If you notified applicants on various dates, list the latest date of any notification. For example, if you notified applicants on 6/26/22, 6/27/22, and 6/28/22, then you must enter 6/28/22.	10/05/2022

1B-4.	Web Posting of the CoC-Approved Special NOFO CoC Consolidated Application. (All Applicants)	
	Special NOFO Section VII.B.1.b.	
	You must upload the Web Posting–Special NOFO CoC Consolidated Application attachment to the 4A. Attachments Screen.	
	Enter the date your CoC posted its Special NOFO CoC Consolidated Application on the CoC's website or affiliate's website–which included: 1. the CoC Application, and 2. Priority Listings.	10/17/2022

2A. System Performance

The CoC Special NOFO page provides HUD-approved resources to assist you in completing the Special NOFO CoC Application, including:

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2A-1.	**Reduction in the Number of First Time Homeless–Risk Factors.**	
	Special NOFO Section VII.B.2.b.	

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

(limit 2,500 characters)

1. To identify risk factors of persons becoming homeless for the first time, the COC uses a combination of data tracked by its CES lead agencies that is collected in the diversion scripts/applications for funding along with the universal assessments. COC Committees also analyze reports of first-time entries into HMIS to identify characteristics they have in common.
2. The Coordinated Entry System in our COC consists of a Call Center that operates 7 days a week/365 days a year. Agents in the call center are HMIS users and have the ability to assist callers in multiple languages. In addition, there are 149 additional front line staff members located throughout our COC who are trained in the Coordinated Entry workflow which enables them to enter clients into the CE project without having to call the hotline. People in our COC experiencing Homelessness for the first time can get triaged and assessed upon initial contact. The COC's strategy to address individuals and families at risk of becoming homeless is to target resources to indicated populations based on their risk factors and vulnerabilities. The CE Call center team is trained to screen callers that would be eligible to receive emergency rental assistance; referrals are made immediately at the time of screening. The Housing Problem Solving team conducts Diversion and Rapid Exit interventions with people approaching our CES. They receive daily report that contains a list of clients who are at immediate risk of homelessness (within 14 days of homelessness) to enable them to begin problem solving interventions.
3.The COC's CES Advisory Committee and its CES Lead Agencies RI Coalition for the Homeless and Crossroads RI are responsible for overseeing this strategy.

2A-2.	Length of Time Homeless–Strategy to Reduce. (All Applicants)	
	Special NOFO Section VII.B.2.c.	

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

(limit 2,500 characters)

The average LOT people remained homeless in ES, SH and TH was 189 days (we do not have any SH in RI). The CoC's HMIS Steering Committee has formed a System Performance Improvement Plan Working Group that is creating new strategies to meet this performance measure.
1 and 2: The CoC prioritizes those with longer lengths of time homeless, including those with the longest LOS in shelter for housing prioritization in CES Policy. However, this strategy alone is not effective without shelters effectively conducting housing focused services. Therefore, the SPM Committee looks at average LOT homeless data for each ES and TH provider. The committee is able to identify programs with longer average LOS's intervenes with retraining of staff on Housing focused services, supports and can introduce corrective action. COC hosted required training of CoC stakeholders on housing problem solving to expand the housing focused services delivery at all providers. HPS is an umbrella term our COC uses to describe the conversations happening before and during entry into the homeless system (includes prevention, diversion and rapid exit from CES). The HMIS is developing a dashboard that contains LOS on a project level for public posting. The Family Case Conference that occurs monthly is routinely looking at longest stayers and is working to identify the barriers to housing. In the past SPM year, the COC updated its prioritization several times to accommodate people who were temporarily sheltered in Non Congregate Shelters (NCS), while permanent housing opportunities were identified and implemented; while this achieved intended goal to not retraumatize NCS stayers, is did result in a longer aggregate length of stay for people in non-NCS ES programs. In response, the CoC has committed to augment its use of NCS with a goal to use more broadly accessed to housing problem solving and expanding year-round shelter beds.
3.The COC's HMIS Steering Committee in coordination with the HMIS and CES Agencies, Rhode Island Coalition for the Homeless and Crossroads RI and the COC planner are responsible for implementing this strategy.

2A-3.	Successful Permanent Housing Placement or Retention. (All Applicants)	
	Special NOFO Section VII.B.2.d.	

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

(limit 2,500 characters)

1. The CoC had an increase in its % exits to PH destinations from ES, SH, TH and RRH. The strategy to continue increase these placements into PH include a) improved exit destination data quality in SO and ES projects to assure the COC is capturing the true story of exits to PH and b) continuing to develop and refine its CES and train provider agencies to deploy existing PH opportunities rapidly to prioritized households c) deploying EHV and ERA housing resources including the use of a statewide housing navigation effort to respond to the challenge of a low vacancy rate and d) expanding training on housing problem solving throughout the system to find housing solutions for all households experiencing homelessness. (Housing Problem Solving is Rhode Island's chosen terminology for our Diversion from Homelessness and Rapid Exit from Homelessness strategy and programming.) The COC's HMIS Steering Committee in coordination with the HMIS and CES Agencies, Rhode Island Coalition for the Homeless and Crossroads RI and the COC planner are responsible for overseeing this strategy.

2. The very high retention rate in PH projects remained at 98% for this year. The COC's strategy to continue to maintain high performance and increase this % includes ongoing, robust Housing First and related best practices training, monitoring and surveying constituents and providers on effectiveness of services delivery within the Housing First philosophy. Additionally, the COC scores its PH renewals in part using each programs housing retention rate compared to the COC's standard. Lower scored projects are ranked lower on the annual ranking of projects to HUD. In addition to prioritizing strong services delivery within the homeless system (by implementing a Housing First philosophy consistently and to fidelity) to support housing retention, the COC collaborates with mainstream affordable housing providers (Housing Authorities/Affordable Housing Developers) and subsidized housing initiatives (Move On, Mainstream Voucher Program, FYI, etc) to assure PH opportunities are available in perpetuity. The COC's HMIS Steering Committee in coordination with the HMIS and CES Agencies, Rhode Island Coalition for the Homeless and Crossroads RI and the COC planner are responsible for overseeing this strategy.

2A-4.	Returns to Homelessness–CoC's Strategy to Reduce Rate. (All Applicants)	
	Special NOFO Section VII.B.2.e.	

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

(limit 2,500 characters)

1. The strategy to identify people who return to homelessness is to run HMIS reports on all project types in the COC (SO, ES, TH, PH, OPH). COC calls these reports recidivism reports. Reports are analyzed at the HMIS and System Performance Committees as well as at COC meetings. COC pulls recidivism reports by project types to analyze if specific projects are in need of additional training or supports to curb recidivism rates. This year, the rate of recidivism (the % of people who return to homelessness) increased slightly from 21% to 22% across all programs in the COC: SO, ES, TH, PH, OPH). These rates are identified in regular reports from the HMIS using HMIS data collected across all project types.
2.The COC assures households in TH and PH are offered robust supportive services to transition to and/or remain in PH via statewide Supportive Housing Case Management standards, which provide a baseline standard for supportive services and best practices to be provided within COC programs. COC has robust Housing First and Case Management training. Trainings are free of charge to develop staff capacity to deliver exemplary supports to stabilize households in PH (exs: trauma informed care, critical time intervention, and Housing First) philosophy and practice. If households who exited to housing experience instability again they are referred to emergency rental assistance. If they are in PH and experience housing instability, the CES Lead's Rehousing Procedure and Housing Navigation rehouses households quickly to avoid RTH whenever possible. The COC examines exits from programs quarterly and annually at COC competition when scoring projects on renewal performance metrics, which includes scoring on low % RTH at 6 and 12 months.
3.The CES Directors at Crossroads RI and RI Coalition for the Homeless are responsible for overseeing this strategy to reduce the rate individuals and persons in families return to homelessness. The HMIS System Administrator employed by RI Coalition for the Homeless as well as the RIHousing's COC Planner are responsible for obtaining, reporting and scoring the PH renewal performance metrics including the rate of returns to homelessness at 12 months after exit.

2A-5.	**Increasing Employment Cash Income–Strategy. (All Applicants)**	
	Special NOFO Section VII.B.2.f.	

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

(limit 2,500 characters)

1.COC strategy to increase employment income is twofold: it includes partnering with RI's Workforce Innovation & Opportunities Act (WIOA) agency on employment opportunities for persons with lived experience of homelessness to support their efforts to seek gainful employment; and, COC provider agencies develop employment opportunities and programs for persons with lived experience.
2.To increase access to employment opportunities, COC partnered with training organizations specializing in training and employment for COC constituents. One example is the Substance Use and Mental Health Leadership Council (SUMHLC), this partnership prepares those with lived experience of homelessness to enter the workforce. Coalition for the Homeless' community resource guide suggests employers with less stringent background check expectations and shares job opportunities. COC Providers offer job training, work readiness and career planning and link participants with mainstream training (ex: CNA and Janitorial programs) and employment services. CDBG entities align job training resources provided by other funding sources with eligible COC participants. The COC has a formal partnership with the Governor's Workforce Board (GWB) in Rhode Island, the state's primary policy making body on workforce development matters. Linking people with lived experience of homelessness and little cash income with workforce training and employment opportunities increases future potential to earn cash income. The GWB oversees and coordinates federal and state work force development policy through implementation of the Workforce Investment and Opportunity Act and allocation of the state's Job Development Fund. This partnership gives COC access to GWB's employment opportunities and training programs and ensures the GWB works to address the needs of COC constituents reentering the workforce and employment.
3.The ED of the RI Coalition for the Homeless and COC planner with RIHousing oversees this strategy

2A-5a.	Increasing Non-employment Cash Income–Strategy. (All Applicants)	
	Special NOFO Section VII.B.2.f.	

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

(limit 2,500 characters)

1. The COC has included an SSO project to increase SOAR enrollments for people experiencing unsheltered homelessness within the projects submitted in this project priority listing specifically to support the most vulnerable Rhode islanders experiencing homelessness in accessing non employment cash assistance. As stated in that project application: the project will hire 2 SOAR Specialists to provide SSI/SSDI consultation, advocacy, and application support for people experiencing homelessness with a strong focus on assisting unsheltered individuals. Applications with unsheltered people require significant time to engage referrals, outreach clients and coordinate treatment to ensure they have the necessary medical evidence to apply. It can be expected that two SOAR specialists will submit 40 SOAR applications in the 3 year grant term, and that an additional 60 individuals will be assisted through the screening process with consultation on SSI/SSDI eligibility and/or advocacy with SSA. With SOAR applications, we anticipate an approval rate of 65% on initial applications. Individuals approved will then each receive approximately $10k annually in sustainable income, based on the federal benefit rate of $841/month, resulting in increased self-sufficiency and higher chances of securing housing.

2. The COC positioned its statewide coordination of the SOAR program to the Coalition for the Homeless to align it with COC's CES and people most acute and in need of SOAR services. SOAR takes referrals based on acuity as measured by CES to assure they're serving those with highest vulnerability. The SOAR program has assisted 16 people in the last year and 291 people total people with SSI/DI applications through the SOAR model with a 80% approval rate. COC provider agencies link participants with non-employment cash sources through their supportive services programs, which are built on the COC's written standards for Supportive Housing Case Management. The COC's standards require benefits/entitlement coordination and referral to obtain access to both public and private programs, including but not limited to, General Public
Assistance, SSI/SSDI, and other state and local supportive services the household may be eligible to receive.

3. The Rhode Island Coalition for the Homeless is responsible for implementing this strategy.

2B. Coordination and Engagement–Inclusive Structure and Participation

The CoC Special NOFO page provides HUD-approved resources to assist you in completing the Special NOFO CoC Application, including:

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2B-1.	Inclusive Structure and Participation–Participation in Coordinated Entry. (All Applicants)	
	Special NOFO Sections VII.B.3.a.(1)	

	In the chart below for the period from May 1, 2021 to April 30, 2022:
1.	select yes or no in the chart below if the entity listed participates in CoC meetings, voted–including selecting CoC Board members, and participated in your CoC's coordinated entry system; or
2.	select Nonexistent if the organization does not exist in your CoC's geographic area:

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

20.	Non-CoC Funded Youth Homeless Organizations	Yes	Yes	Yes
21.	Non-CoC-Funded Victim Service Providers	Yes	Yes	Yes
22.	Organizations led by and serving Black, Brown, Indigenous and other People of Color	Yes	Yes	Yes
23.	Organizations led by and serving LGBTQ+ persons	Yes	Yes	Yes
24.	Organizations led by and serving people with disabilities	Yes	Yes	Yes
25.	Other homeless subpopulation advocates	Yes	Yes	Yes
26.	Public Housing Authorities	Yes	Yes	Yes
27.	School Administrators/Homeless Liaisons	Yes	Yes	No
28.	Street Outreach Team(s)	Yes	Yes	Yes
29.	Substance Abuse Advocates	Yes	Yes	Yes
30.	Substance Abuse Service Organizations	Yes	Yes	Yes
31.	Youth Advocates	Yes	Yes	Yes
32.	Youth Service Providers	Yes	Yes	Yes
	Other:(limit 50 characters)			
33.				
34.				

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

2B-2.	Open Invitation for New Members. (All Applicants)	
	Special NOFO Section VII.B.3.a.(2), V.B.3.g.	

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

(limit 2,500 characters)

1) COC Planner publicly posts the call to join RICOC Membership in English and Spanish. Public posting includes RICOC webpage, RIHousing website, Secretary of State website and is shared with COC stakeholder listserv for dissemination by partners. It is printed and available digitally in statewide newspapers in Spanish and English. COC Planner outreaches to cross sector system stakeholders and representation from systems critical to ending homelessness (ex: Medicaid, Behavioral Health, Corrections) regarding the opportunity.
2) All posting described above is in PDF format (English and Spanish) to maximize accessibility for people with disabilities; prior to posting any materials, they are scanned to determine accessibility for people with disabilities and revisions made as needed to increase accessibility.
3) COC surveys its membership for self identification of race, ethnicity, sexual orientation and gender identity, age, and lived expertise of homelessness and then based on the results (in comparison with the demographics of those serve in RICOC programs) engages in robust outreach strategies to fill gaps identified. A flyer designed for Membership recruitment of folks with lived expertise was circulated for posting in all RICOC programs; programs post flyer and outreach to their constituent groups about COC membership. As part of recent system planning and specifically to recruit more people with lived expertise into COC, the COC partnered with the Coalition to End Homelessness' Constituent Advisory Committee, a group of people with lived expertise who consult on the homeless system. In 2022, the RICOC has 7 persons who self identify as have lived experience serving on the Board of Directors; there are 17 total Board seats, which means 41% of the RICoC board has lived experience of homelessness. This is an increase from 4 people (23%) in 2021.
4. The COC used the survey described above in part 3 to also identify and engage organizations serving culturally specific communities experiencing homelessness in RI to advance equity and mitigate disparities within Membership and the Board. In each election for Directors, the Governance committee reminds the Membership of its equity goals, and progress towards them to inform voting decision making. In 2022, 6/17 (35%) COC Board members self-identify their race and/or ethnicity increases the race and ethnicity diversity of the COC board. 3/17 (17%) of the Board self-identifies that they believe they increase the LGBTQ+ diversity of the COC board.

2B-3.	CoC's Strategy to Solicit/Consider Opinions on Preventing and Ending Homelessness. (All Applicants)	
	Special NOFO Section VII.B.3.a.(3)	

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

(limit 2,500 characters)

1.CoC Committee structure and incorporation of people with lived experience into all levels of its governance, Board, Membership, and Committee, helps assure opinions from broad array or organizations and perspectives considered. COC and the public are encouraged and supported to participate in all CoC committees; Committees seek consensus in their recommendations to the board for actions; if consensus is not possible, multiple recommendations go to the COC to assure varied opinions are considered. CoC collaborates with Coalition to End Homelessness Constituent Advisory Committee, advocates with lived expertise of homelessness and reimburse those with lived expertise for joining policy making and written standards drafting workgroups.
2. All COC board and membership meetings are statutorily required to comply with Rhode Island's open meeting law. This is the legal standard for communicating and documenting information public forums in a standardized way to assure public can easily access agendas, minutes, and keep abreast of topics of discussion and decisions. The COC is in full compliance with the law. Additionally, CoC hosts public forums in geographically diverse and accessible locations including shelters and housing programs to assure people with lived experience provide comment to present the updates being considered and take public comment on the processes and methodologies proposed.
3.Public comment is incorporated into each COC Meeting. Public Comment always precedes voting action to assure public the opportunity to voice opinions, considerations and concerns before action might be taken. Additionally, this allows the COC board time to discuss and act upon input in public comment during their meeting or in future meetings, depending on the urgency. One example was feedback received in public comment about inconsistent Non-Congregate Shelter (NCS) communication from the state to constituents; this led to COC advocacy to the Governor's office and State resulting in increased and improved NCS communication to clients residing in NCS programs within hotels in Rhode Island. COC uses planning proceeds to attend and report back presentation from Regional and National Conferences to keep abreast of best practices and new initiatives being implemented; planning proceeds also pay people with lived expertise for their work in participating in local, regional and national public forums.

2B-4.	Public Notification for Proposals from Organizations Not Previously Funded. (All Applicants)	
	Special NOFO Section VII.B.3.a.(4)	

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

(limit 2,500 characters)

1.On 8/5/22 the COC announced the opening of the RI local Competition for Special Funding to Address Unsheltered Homelessness via a Request for Proposals (RFP) PDF posted on its public website and circulated through email blast to COC, ESG, YHDP and stakeholder and partner groups asking them to share widely on their social media platforms. The RFP for New Projects included the Announcement details, deadline, threshold and scoring criteria, and invitations to three (3) Zoom webinars to orient potential applicants to the opportunity to apply for funding.
2.The RFP issuance, emails, and webinar materials referred to in part 1 all specifically mention that the COC is soliciting and encourages proposals from nonprofits and government agencies that are not currently receiving COC program funding.
3.The RFP for New Projects included a detailed timeline inclusive of the deadline; it also included submission instructions. Webinar trainings on the opportunities and slide decks clarified the same step-by-step process and timelines. All recordings of the webinar/info sessions and each slide decks are publicly posted on the COC website so attendees and the public can access the same info about the process. New project proposal applicants were instructed to submit a complete application via electronic submission in the esnaps system; additionally applicants were instructed to email an exported copy of the esnaps application to the COC planner along with a performance report for performance scoring points. The deadline of September 9, 2022 aligned with HUD's Special NOFO expectations.
4.The RFP for New Projects issuance also included the scoring and ranking process, which determined which project applications are submitted to HUD and their order of rank.
5.All RFP for New Projects, Local Competition Announcement and Ranking, Scoring and Reallocation policy are available on the COC website in PDF format to assure accessibility.

2C. Coordination / Engagement–with Federal, State, Local, Private, and Other Organizations

The CoC Special NOFO page provides HUD-approved resources to assist you in completing the Special NOFO CoC Application, including:

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- 24 CFR part 578
- Special NOFO CoC Application Navigational Guide
- Section 3 Resources
- Frequently Asked Questions

2C-1.	Coordination with Federal, State, Local, Private, and Other Organizations. (All Applicants)	
	Special NOFO Section VII.B.3.b.	

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

	Entities or Organizations Your CoC Coordinates with for Planning or Operations of Projects	Coordinates with Planning or Operations of Projects
1.	Funding Collaboratives	Yes
2.	Head Start Program	Yes
3.	Housing and services programs funded through Local Government	Yes
4.	Housing and services programs funded through other Federal Resources (non-CoC)	Yes
5.	Housing and services programs funded through private entities, including Foundations	Yes
6.	Housing and services programs funded through State Government	Yes
7.	Housing and services programs funded through U.S. Department of Health and Human Services (HHS)	Yes
8.	Housing and services programs funded through U.S. Department of Justice (DOJ)	Yes
9.	Housing Opportunities for Persons with AIDS (HOPWA)	Yes
10.	Indian Tribes and Tribally Designated Housing Entities (TDHEs) (Tribal Organizations)	No
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.		

2C-2.	CoC Consultation with ESG Program Recipients. (All Applicants)	
	Special NOFO Section VII.B.3.b.	

	Describe in the field below how your CoC:
1.	consulted with ESG Program recipients in planning and allocating ESG 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 Consolidated Plan update.

(limit 2,500 characters)

1.RI's Consolidated Homeless Fund (CHF) combines ESG, State Conveyance Tax Revenue, and Title XX. COC and CHF share a funding committee comprised of CHF and COC stakeholders without conflicts of interest; this committee includes ESG recipients throughout Rhode Island (Cities of Providence, Woonsocket, Pawtucket, in addition to the leadership of the State) so each ESG recipient's feedback is considered as funding decision are being made. This funding committee was consulted extensively and repeatedly to inform ESG and ESG-CV funding decisions throughout the last three years and in response to the pandemic.
2.This shared funding committee inclusive of ESG recipients described in #1 also reviews COC and CHF/ESG recipients and subrecipients performance via evaluation of metrics, monitoring reports and grievances regularly and as needed if issues arise. The shared funding committed streamlines communication. Performance Reports are posted publicly on the HMIS Lead's website for transparency.
3.PIT and HIC data was presented in person at COC open, public meetings and ESG recipients and consolidated plan jurisdictions from throughout RI participate. The presentation is also circulated in case attendance or participation was not possible. PIT and HIC data is also considered at the shared ESG/CHF/COC funding committee described in #1. PIT and HIC data is also posted publicly on the HMIS Lead's website for transparency, and trainings are offered to the public and stakeholders.
4.In addition to the presentations and invitations to communicate about strategies to address homelessness done within COC meetings (to which ESG recipients and Con Plan stakeholders are invited), the COC planner and COC Board Chair circulated to the (remote) meetings of the various cities, towns and con plan jurisdictions throughout RI throughout the pandemic to have individualized conversation around ending homelessness during the pandemic as ESG-cv monies began and continued to flow into different areas of the state. These meetings have led to innovative partnerships and new opportunities within RI funded by ESG-cv and ESG funding. The COC planner participates in Consolidated Plan updates annually to assure alignment and communication of information.

2C-3.	Discharge Planning Coordination. (All Applicants)
	Special NOFO Section VII.B.3.c.

	Select yes or no in the chart below to indicate whether your CoC actively coordinates with the systems of care listed to ensure persons who have resided in them longer than 90 days are not discharged directly to the streets, emergency shelters, or other homeless assistance programs.	
1.	Foster Care	Yes
2.	Health Care	Yes
3.	Mental Health Care	Yes
4.	Correctional Facilities	Yes

2C-4.	CoC Collaboration Related to Children and Youth–SEAs, LEAs, School Districts. (All Applicants)
	Special NOFO Section VII.B.3.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

2C-4a.	CoC Collaboration Related to Children and Youth–SEAs, LEAs, School Districts–Formal Partnerships. (All Applicants)	
	Special NOFO Section VII.B.3.d.	

	Describe in the field below:
1.	how your CoC collaborates with the entities checked in Question 2C-4; and
2.	the formal partnerships your CoC has with the entities checked in Question 2C-4.

(limit 2,500 characters)

1.Youth education providers (YEP) (Examples: McKinney Vento Liaisons, RI Department of Education, school district administration, secondary education partners) serve on the COC and within its committees to inform system processes and gaps analysis. YEPs also partner directly with COC recipient and subrecipient agencies and deliver onsite services within multiple COC programs (Examples: Providence school district, Head Start, McKinney-Vento liaisons. COC recipient and subrecipient agencies in family and youth-focused projects have formal partnerships with youth education providers. Examples: formal partnership with local GED/ESL education services for young parents; this partnership brings the GED and ESL programming onsite into the provider's services central location.
The RI Dept of Education's Statewide McKinney Vento Liaison Coordinator is a long-term member of the COC; regular participation in COC meetings ensures education and district needs and goals are represented in statewide COC planning and ongoing communication about opportunities for partnership. Ex: when the State Dept of Ed was beginning to disseminate its second round of ARRA monies and the COC lead a series of workshops on the COC and fostered partnerships between districts and LEA's receiving ARRA monies and the COC agencies in their jurisdiction. COC staff attend regular SEA/LEA meetings to share resources, network and collaborate. One recent example of this collaboration in action was partnership development between the YHDP and COC grantees in Pawtucket with the Pawtucket School district for training opportunities for the district on how to identify and support homeless students in Pawtucket. This resulted from the COC leading a presentation of how McK-V liaisons could partner with the COC to meet the mutual goals of the funding which include locating youth experiencing homelessness and assuring their access to services available. The COC offers to link liaisons with specific recipient agencies in their jurisdictions to foster formal partnerships wherever necessary. Many COC recipients collaborate formally and closely with school districts (Ex: Providence School district) in services delivery. Additionally, the COC & HMIS Lead collaborate with the statewide McK-V liaison and multiple school districts throughout the state for the PIT Count &Youth PIT.
2.Formal partnerships are memorialized in the following ways: School district – MOU; SEA and LEA – Policy and Procedure; YEP – MOU

2C-4b.	CoC Collaboration Related to Children and Youth–Informing Individuals and Families Experiencing Homelessness about Eligibility for Educational Services. (All Applicants)	
	Special NOFO Section VII.B.3.d.	

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

(limit 2,500 characters)

The RICOC has a policy and procedure on Educational Services for Children and it includes a sample educational rights policy. The policy clarifies how federal and state law requires every school district and public charter school in Rhode Island to designate a homeless liaison who is responsible for ensuring the identification, school enrollment and stability, attendance and opportunities for academic success of students in homeless situations using a child-centered, best interest framework for decision making. The policy summarizes information about the responsibilities of recipients/sub-recipients of CoC and ESG funds, which includes to designate staff member(s) to ensure that participants in CoC programs are helped to understand their educational rights established under Subtitle VII-B of the McKinney-Vento Homeless Assistance Act and most recently reauthorized by the Every Student Succeeds Act: to ensure that children and young adults are immediately enrolled in school, as required by federal and State law, and to ensure that they understand their right to attend their school of origin and are connected to transportation and educational services to help them succeed in a new school. The policy includes a sample procedure that aligns with federal law and COC regulations to support recipients and subrecipients in effective implementation of the policy.

2C-5.	Mainstream Resources–CoC Training of Project Staff. (All Applicants)	
	Special NOFO Section VII.B.3.e.	

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

	Mainstream Resource	CoC Provides Annual Training?
1.	Food Stamps	Yes
2.	SSI–Supplemental Security Income	Yes
3.	TANF–Temporary Assistance for Needy Families	Yes
4.	Substance Abuse Programs	Yes
5.	Employment Assistance Programs	Yes
6.	Other	Yes

2C-5a.	Mainstream Resources–CoC Collaboration with Project Staff Regarding Healthcare Organizations. (All Applicants)	
	Special NOFO Section VII.B.3.e.	

	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, TANF, substance abuse programs) within your CoC's geographic area;
2.	works with project staff to collaborate with healthcare organizations to assist program participants with enrolling in health insurance;
3.	provides assistance to project staff with the effective use of Medicaid and other benefits; and
4.	works with projects to promote SOAR certification of program staff.

(limit 2,500 characters)

1. COC ensures program staff has current information on benefits and other resources by dissemination of materials and updates at least monthly via COC meetings, trainings, stakeholder listserv and COC website. Public, private and non-profit Stakeholders are COC members (ex: SOAR, TANF, DHS, substance use programs and behavioral health.) COC meetings include presentations on mainstream resources; examples: Medicaid Home Stabilization and Emergency Case Management during the COVID-19 pandemic programs/services; Supportive Housing Best practices; Harm reduction strategies including in COVID-19 non congregate shelter programs and resources available.
2. COC partners and funds FQCMHCs and provide supports for agencies to collaborate. COC catalyzed applicant partnership with health centers by piloting programs and then offering model to recipients to replicate. Multiple COC recipients now boast healthcare partnerships that serve the constituents enrolled in their programs: leveraging mainstream healthcare resources and centralizing care around the home. COC providers support participants in enrolling in health insurance as stipulated in COC Case Management (Written) Standards. Due to its success, the COC applied to expand these programs and for new projects leveraging healthcare resources during the FY2022 COC competition.
3. RI is a Medicaid expansion state; COC and MCO collab yielded approval of a housing stabilization services (HSS) package by CMS in. HSS provides an array of services, including home tenancy, life skill and other modeling and teaching services for individuals who require support in obtaining and maintaining a home, and/or home find services to individuals who require support in finding and transitioning to housing. COC also partners with MCO health navigators to engage homeless individuals with mainstream benefits and Medicaid provided peer-recovery specialists. COC Case managers provide benefits coordination. State Behavioral Health partners with multiple CMHCs to address the needs of high acuity individuals experiencing homelessness by placing CMs from the homeless services agencies on the assertive community treatment (ACT) teams to increase rapport and access to care
4. COC positioned SOAR leadership within its training lead agency to provide centralized access to SOAR training and resources including certification for accessibility by mainstream healthcare program staff.

3A. New Projects With Rehabilitation/New Construction Costs

The CoC Special NOFO page provides HUD-approved resources to assist you in completing the Special NOFO CoC Application, including:

- Special Notice of Funding Opportunity to Address Unsheltered and Rural Homelessness
- 24 CFR part 578
- Special NOFO CoC Application Navigational Guide
- Section 3 Resources
- Frequently Asked Questions

3A-1.	**Rehabilitation/New Construction Costs–New Projects. (Rural Set Aside Only).**	
	Special NOFO Section VII.A.	

If the answer to the question below is yes, you must upload the CoC Letter Supporting Capital Costs attachment to the 4A. Attachments Screen.	
Is your CoC requesting funding for any new project(s) under the Rural Set Aside for housing rehabilitation or new construction costs?	No

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

The CoC Special NOFO page provides HUD-approved resources to assist you in completing the Special NOFO CoC Application, including:

- Special Notice of Funding Opportunity to Address Unsheltered and Rural Homelessness
- 24 CFR part 578
- Special NOFO CoC Application Navigational Guide
- Section 3 Resources
- Frequently Asked Questions

3B-1.	Designating SSO/TH/Joint TH and PH-RRH Component Projects to Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes. (Rural Set Aside Only)	
	Special NOFO Section VII.C.	

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

3B-2.	Serving Persons Experiencing Homelessness as Defined by Other Federal Statutes. (Rural Set Aside Only)	
	Special NOFO Section VII.C.	
	You must upload the Project List for Other Federal Statutes attachment to the 4A. Attachments Screen.	
	If you answered yes to question 3B-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)

n/a, we answered no to question 3B-1

4A. Attachments Screen For All Application Questions

	Please read 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 and reduces file size. 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.	Open attachments once uploaded to ensure they are the correct attachment for the required Document Type.

Document Type	Required?	Document Description	Date Attached
1B-1. Local Competition Announcement	Yes	Local Competition...	10/11/2022
1B-2. Local Competition Scoring Tool	Yes	Local Competition...	10/11/2022
1B-3. Notification of Projects Rejected-Reduced	Yes	Notification of P...	10/11/2022
1B-3a. Notification of Projects Accepted	Yes	Notification of P...	10/11/2022
1B-4. Special NOFO CoC Consolidated Application	Yes		
3A-1. CoC Letter Supporting Capital Costs	No		
3B-2. Project List for Other Federal Statutes	No		
P-1. Leveraging Housing Commitment	No	Leveraging Housin...	10/13/2022
P-1a. PHA Commitment	No	PHA Commitment	10/13/2022
P-3. Healthcare Leveraging Commitment	No	Heathcare Leverag...	10/14/2022
P-9c. Lived Experience Support Letter	No	Lived Experience ...	10/13/2022
Plan. CoC Plan	Yes	CoC Plan	10/17/2022

Attachment Details

Document Description: Local Competition Announcement

Attachment Details

Document Description: Local Competition Scoring Tool

Attachment Details

Document Description: Notification of Projects Rejected-Reduced

Attachment Details

Document Description: Notification of Projects Accepted

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description:

Attachment Details

Document Description: Leveraging Housing Commitment

Attachment Details

Document Description: PHA Commitment

Attachment Details

Document Description: Heathcare Leveraging Commitment

Attachment Details

Document Description: Lived Experience Support Letter

Attachment Details

Document Description: CoC Plan

Submission Summary

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

Page	Last Updated
1A. CoC Identification	07/28/2022
1B. Project Review, Ranking and Selection	10/17/2022
2A. System Performance	10/12/2022
2B. Coordination and Engagement	10/12/2022
2C. Coordination and Engagement–Con't.	10/13/2022
3A. New Projects With Rehab/New Construction	No Input Required
3B. Homelessness by Other Federal Statutes	10/03/2022
4A. Attachments Screen	Please Complete
Submission Summary	No Input Required

Governance

Funding

Special Notice of Funding Competition to Address Unsheltered Homelessness

- Request for Proposals to Address Unsheltered Homelessness – issued August 5, 2022
- Scoring criteria for proposals to Address Unsheltered Homelessness

FY2022 RICoC Competition

- Local Competition for Continuum of Care Funding Announcement – issued August 5, 2022
- Permanent Housing Renewal Project Performance Metrics
- Ranking and Reallocation Policy
- Request for New Supportive Housing Project Proposals – issued June 3, 2022
- Budget form for New Supportive Housing Project Proposals (no indirect costs)
- Budget form for New Supportive Housing Project Proposals (de minimis)

Youth Homelessness Demonstration Program – Project Selection

- YHDP Projects Funding
- Request for Proposals – issued April 15, 2022
- Budget form for proposals (XLSX)
- YHDP RFP Information session #1 recording
- YHDP information session #2 recording

Archived Materials

From: Elizabeth Bioteau
To: Elizabeth Bioteau
Bcc: "holly@ywcari.org"; cristina.amedeo@uwri.org; banderson@thehouseofhopecdc.org; pasen@provhousing.org; Armin.Azar@va.gov; jennifer; kyle.bennett@uwri.org; Eileen.Botelho@ride.ri.gov; Moise.Bourdeau@oha.ri.gov; cbridgesfeliz@Lifespan.org; Brophy, Michelle (BHDDH); dbruce@opendoorsri.org; mike.burk@dcyf.ri.gov; pam.byrd@gmail.com; chaplinbenji@gmail.com; Ian Colomer; TDouglass@Providencechc.org; mduso power4good.info; sescobar@bu.edu; Amy@rihomeless.org; Karen.Flora@bhddh.ri.gov; melissalatraverseflaherty@gmail.com; sfranklin@comcap.org; Freedman, Emily; caitlin@rihomeless.org; Deborah.Garneau@health.ri.gov; alex@rihomeless.org; SGeller@rikidscount.org; Andrea.Germano7@gmail.com; alexrave5005@gmail.com; Toni@bvadvocacycenter.org; lisa.guillette@fosterforward.net; Jennifer Hawkins; paulettedhamilton@gmail.com; lharris@amoshouse.com; LHiener@dvrcsc.org; khenry@sojournerri.org; EHIRSCH@providence.edu; phudson@betterlivesri.org; Ehren Hunt; Chris.Imbriglio@doc.ri.gov; James Jahnz; Laura@thehouseofhopecdc.org; Celeste@bvadvocacycenter.org; kjeffreys@hhpartners.org; kalil.barbara@yahoo.com; jhleach@me.com; Jlogan44@ebcap.org; Stephen.Lopes@dcyf.ri.gov; ruthmadsen8@gmail.com; JMartinez@provhousing.org; Bette.McHugh@bhddh.ri.gov; Maryrose.Mensah@doa.ri.gov; imerchan@rifoundation.org; Jessica Mowry; MushipiKa@familyserviceri.org; enaser@pawthousing.org; lauren.Nocera@health.ri.gov; bunmio40@gmail.com; Darlene.Ortega@dcyf.ri.gov; nicole.pope@dot.ri.gov; rplonsky@ihpaco.org; James.C.Rajotte@ohhs.ri.gov; jray; tatiana; truel@osdri.org; tringeling@thrivebhri.org; Sarah.SaintLaurent@bhddh.ri.gov; SalemiAs@Lucyshearth.org; rhetta.scott@nechv.org; Heather.Seger@health.ri.gov; Cathy.schultz@health.ri.gov; shemtovdi@familyserviceri.org; m.sims@psnri.org; helpthehomelessri@gmail.com; Tyrone Smith; Wilma.smith217@gmail.com; Monica Spicer; mtaylor@communitycareri.org; Michael.Tondra@doa.ri.gov; jwassmer@warmshelter.org; ronjwatts02906@gmail.com; MWheelock@Lifespan.org; Michelle Wilcox; kasim.yarn@vets.ri.gov; dgladstein@newportmh.org; melissa; SimpsonTa@familyserviceri.org; DyhrbergCa@familyserviceri.org; kmmeuse@yahoo.com; Victoria.Scott@governor.ri.gov; tpimentel@amoshouse.com; Alexandreag@gtua1.org; jbarros@pawthousing.org; ayolken@weberrenew.org; cdn@weberrenew.org; kgervais@pawthousing.org; pete@rihomeless.org; LDAndrea@Lifespan.org; zarabrockman@veteransinc.org; Louisa D"Ovidio; ehayes@amoshouse.com; kraus@amoshouse.com; kgiraldo@amoshouse.com; lmontuori@amoshouse.com; tpimentel@amoshouse.com; cgonzalez@amoshouse.com; rgandhi@communitycareri.org; aallyn@communitycareri.org; DMagaw@CommunityCareRI.org; bgallogly@communitycareri.org; mtaylor@communitycareri.org; msilva@communitycareri.org; Michelle Wilcox; ksantilli@crossroadsri.org; Monica Spicer; cdove@crossroadsri.org; jnutting@crossroadsri.org; jmacdonald@crossroadsri.org; mjones@crossroadsri.org; jhoneycutt@crossroadsri.org; rjerry@EBCAP.org; jerryray79@gmail.com; droy; crossleyr@ebcap.org; adowning@ebcap.org; abaltazar@ebcap.org; jdealy@ebcap.org; ksatterley@ebcap.org; victoria.ferrara; scott.marcil@fosterforward.net; lisa.guillette@fosterforward.net; dan.quinn@fosterforward.net; caitlin.divver@fosterforward.net; Laura@thehouseofhopecdc.org; bill; Adam@thehouseofhopecdc.org; banderson@thehouseofhopecdc.org; heather@thehouseofhopecdc.org; Sara@thehouseofhopecdc.org; antoinette@thehouseofhopecdc.org; dawn@thehouseofhopecdc.org; LeeKe@LucysHearth.org; SalemiAs@Lucyshearth.org; dgladstein@newportmh.org; jlehane@newportmh.org; dboscia@newportmh.org; mgunning@newportmh.org; Jennifer Hawkins; Kearns@onenb.org; arodriguez@onenb.org; zuniga@onenb.org; pmcfarland@pawthousing.org; jbarros@pawthousing.org; enaser@pawthousing.org; kgiraldo@pawthousing.org; skawa@provctr.org; JBallou@CareNE.org; TDParker@CareNE.org; Anna Maria Moore; RPritchard@CareNE.org; caitlin@rihomeless.org; Amy@rihomeless.org; jennifer; angelina@rihomeless.org; Carol Ventura; Jessica Mowry; Elizabeth Bioteau; Eric Rollins; Cristal Lozada; Elizabeth Hernandez; Ariane Pina; vvolz@sojournerri.org; khenry@sojournerri.org; aberno@sojournerri.org; awerner@sojournerri.org; kchretien; ddumin@thrivebhri.org; TDellasandro@thrivebhri.org; kcote@thrivebhri.org; dkubasmeyer@thrivebhri.org; atouhey@thrivebhri.org; mpeterson@thrivebhri.org; tringeling@thrivebhri.org; rpartridge@warmshelter.org; jsilva@warmshelter.org; croberts@warmshelter.org; jwassmer@warmshelter.org; hnordstrom@warmshelter.org; ywcaofnri@aol.com
Subject: RICoC Issues Request for Proposals for Supplemental Continuum of Care Funding to Address Unsheltered Homelessness - deadline Sept 9
Date: Friday, August 5, 2022 11:47:53 AM
Attachments: image638122.png
image059260.png
image409092.png
image732363.png
Unsheltered NOFO request for proposals.pdf
Unshelterd homeless New Project Proposal Scoring sheet.xlsx
Importance: High

The RI Continuum of Care (RICoC) is issuing a Request for Proposals for Supplemental Continuum of Care Funding to Address Unsheltered Homelessness in Rhode Island

HUD has issued a Supplemental Notification of Funding Opportunity (NOFO) specifically to reduce unsheltered homelessness. **HUD is seeking projects, grounded in Housing First and**

public health principles, to reduce the prevalence of unsheltered homelessness, and improve services engagement, health outcomes, and housing stability among highly vulnerable unsheltered individuals and families. HUD expects communities to partner with housing and healthcare agencies to accomplish this. The Rhode Island Continuum of Care is requesting proposal(s) from qualified nonprofit organizations and/or local government agencies for new project applications for the 2022 Supplemental NOFO to Address Unsheltered Homelessness. The CoC seeks projects that can make maximum efficient, economical, and effective use of the prospective allocation of the United States Department of Housing and Urban Development (HUD) Continuum of Care (CoC) funds.

The RICoC plans to select multiple Permanent Supportive Housing (PSH), Rapid Rehousing (RRH), Transitional Housing and Rapid Rehousing (TH-RRH), Supportive Services Only (SSO), and Homeless management Information System (HMIS) projects for inclusion in its supplemental application to HUD for up to $10,553,032 in funding, which, if selected for funding, would span a three year project term. Whether the project applications are funded will be dependent on the score the RICoC receives on the supplemental CoC application. The highest scoring CoCs will have all of the projects on the project priority list funded. To obtain maximum points and increase the possibility of receiving funding, project applicants are strongly encouraged to propose projects that align with the CoC Comprehensive Plan to address those with severe service needs and that can advance the goal of leveraging significant housing and healthcare resources.

Please take careful note of the extensive information, deadlines, and training dates detailed in the attached request for proposals. The scoring sheet is also attached for reference, please take care to select the correct tab on the scoring sheet for the project type being submitted for (PSH, RRH, TH-RRH, SSO or HMIS). This information and so many more RICOC resources related to the request for proposals for the Supplemental COC funding To Address Unsheltered Homelessness are located on the RICOC website.

Deadline is September 9, 2022 at 5pm: applications must be submitted in the E-SNAPS grants management system. Additionally, project applications must be exported from the E-Snaps system into PDF form and emailed to the COC planner, Elizabeth Bioteau (ebioteau@rihousing.com). The email should also include the performance report the applicant is submitting to respond to the system performance scoring criteria on the scoring sheet.

Please contact me directly with any questions about this opportunity,
Elizabeth

Elizabeth Bioteau | *Continuum of Care Planner/Program Manager*

Rhode Island Continuum of Care

p: 401-429-1478

ebioteau@rihousing.com

RIHousing.com

RIHousing 2021 Annual Report:
Housing in the Spotlight

RHODE ISLAND CONTINUUM OF CARE

Request for Proposals for New Continuum of Care Projects to Address Unsheltered Homelessness in Rhode Island

Issued: August 5, 2022

Background

HUD has issued a Supplemental Notification of Funding Opportunity (NOFO) specifically to reduce unsheltered homelessness. HUD is seeking projects, grounded in Housing First and public health principles, to reduce the prevalence of unsheltered homelessness, and improve services engagement, health outcomes, and housing stability among highly vulnerable unsheltered individuals and families. HUD expects communities to partner with housing and healthcare agencies to accomplish this.

HUD supports and encourages CoCs to invite a variety of stakeholders to develop and implement a CoC Plan to Serve Individuals and Families Experiencing Homelessness with Severe Service Needs. The Rhode Island Continuum of Care (RICoC) has started to implement a process to develop this plan and is supporting a working group of people with lived experience of homelessness to provide direction to the planning.

Consistent with HUD NOFOs, there are strict deadlines for an internal competition for funding and for submitting the required applications to HUD. Therefore, the CoC will, in parallel, be engaging in a planning effort to address the needs of individuals and families experiencing homelessness with severe service needs and soliciting applications to address these needs.

The Rhode Island Continuum of Care is requesting proposal(s) from qualified nonprofit organizations and/or local government agencies for new project applications for the 2022 Supplemental NOFO to Address Unsheltered Homelessness. The CoC seeks projects that can make maximum efficient, economical, and effective use of the prospective allocation of the United States Department of Housing and Urban Development (HUD) Continuum of Care (CoC) funds.

The RICoC can apply for up to $10,553,032 in Supplemental NOFO funds; each **project application must span a three (3) year project term.** These funds are highly competitive, and HUD has awarded up to 30 bonus points to CoCs with large numbers of unsheltered persons. The RICoC does not qualify for any of these bonus points. Whether the project applications are funded will be dependent on the score the RICoC receives on the supplemental CoC application. The highest scoring CoCs will have all of the projects on the project priority list funded. **To obtain maximum points and increase the possibility of receiving funding, project applicants are strongly encouraged to propose projects that align with the CoC Comprehensive Plan to address those with severe service needs and that can advance the goal of leveraging significant housing and healthcare resources.**

As in the 'regular' CoC NOFO, the CoC is required to rank all project applications; in this NOFO this also includes the planning application. The CoC has adopted a special scoring tool for this competition based on the NOFO; this tool is attached to this RFP. Applicants should pay close attention to the scoring criteria and make certain that all scoring factors are addressed in their application(s).

Organizations that have never received CoC funding and those located in areas of Rhode Island that have been underserved with CoC funds are strongly encouraged to apply. Organizations with no or limited experience in Federal funding are encouraged to consider applying as subrecipients to organizations that have the requisite experience.

This will be the only request for proposals issued to solicit COC project applications for the Supplemental NOFO; interested applicant agencies should respond to this issuance on or before the deadline in order to be considered for funding under this special NOFO to address unsheltered homelessness.

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Timeline

Event	Date
Initial Planning Group Meeting	August 2, 2022
Request for Applications Issued, Supplemental NOFO	August 5, 2022
Webinar for Potential Project Applicants – project requirements, priorities, application scoring	August 11, 2022 3:00-4:30 pm
Planning Group Working Session	August 16, 2022
Webinar for Project Applicants – completing project applications in E-SNAPS	August 17, 2022 10 am - noon
"Office Hours" for project applicants	August 25, 2022
Planning Group Working Session	August 30, 2022
Submission Deadline for Projects to Address Unsheltered Homelessness Applications in E-SNAPS and emailed to COC planner	**Sept. 9, 2022**
Planning Group Working Session	Sept. 13, 2022
Special RICoC Board Meeting to accept/reject project applications	Sept. 21, 2022
Draft of Comprehensive Plan – Severe Service Needs	Sept. 23, 2022
Notification to Project Applicants whether application ranked or rejected	Sept. 23, 2022
Appeal deadline	Sept. 30, 2022
Revisions to Accepted Project Applications Due in E-SNAPS	October 5, 2022
Supplemental CoC Application Draft Complete	October 7, 2022
Public Posting of Supplemental CoC Application and Project Priority Listings	October 12, 2022
Projected Submission to HUD	October 14, 2022
FINAL HUD DEADLINE	Oct. 20, 2022

Recordings of the RFP Information Sessions and Esnaps Training webinars and Office Hours will be posted on the RICoC Webpage, in the Funding section.

Eligible Applicants

Eligible applicants must meet the following requirements:

- Be a non-profit organization or unit of local government
- Have capacity to administer federal funding.
- Have experience administering programs and services that assist people experiencing homelessness and/or housing crises

Eligible Project Types

The RICoC is requesting proposals for new projects to provide supportive housing, supportive services only, HMIS, and planning project types to address unsheltered homelessness. All projects must be for a three-year project/budget term. All housing and supportive services only projects must include trauma informed services. **Both Housing and Services are encouraged to be leveraged by mainstream resources whenever possible to maximize the RICOC's chances to receive these project awards from HUD.**

The following chart provides additional information on these eligible project types:

Permanent Supportive Housing (PSH)	
Overview : PSH is a non-time-limited, permanent housing subsidy combined with a high level of supportive services. It is a model that is most effective when combined with a Housing First approach and is typically designed for folks with the highest needs, long experiences with homelessness and a household member with a disability.	**Key Elements:** ● Households would pay a percentage of their income towards rent for an indefinite period of time ● Units can be site-based (e.g., lease up a bunch of units in an apartment complex) ● Eligible populations: Categories 1 and 4 ● Chronic homeless or dedicated PLUS definition applies
Rapid Rehousing (RRH)	
Overview : RRH is a supportive housing program where a household may receive up to 24 months of rental assistance and supportive services, with up to six months of aftercare once the rental assistance ends. Supportive services often focus on income maximization and stability planning. The participant enters into a lease directly with the landlord.	**Key Elements:** ● Rental assistance models are flexible, should align with CoC's written standards for administering RRH ● Households can choose their own units in the community/private market ● Eligible populations: Categories 1 and 4 While it is a time-limited resource, there are no indicators for who will succeed in RRH - it is a resource that can work for anyone

Joint Transitional/Rapid Rehousing Projects

Overview: The Joint TH/RRH component provides both temporary housing for households without immediate access to safe, secure housing and longer-term rapid rehousing to assist households obtain and maintain permanent housing. Total assistance for both TH and RRH cannot exceed 24 months. The TH housing will be owned or leased by the project sponsor, the RRH will provide tenant based rental assistance, allowing participants to rent units of their choice in the community. Supportive Services help participants to access permanent housing through RRH, increase and stabilize income, and support independent living.

Key Elements

- HUD expects the majority of housing resources to be devoted to RRH, suggesting that there should be double the resources for RRH as for TH
- Stays in the TH component should be as brief as possible with the goal of rapid placement into RRH
- The RRH component offers the same opportunities for tenant choice as the regular RRH program.
- Eligible populations to serve are Category 1 and 4

Supportive Services Only (SSO)

For the Supplemental NOFO, HUD is permitting SSO projects in three categories:

- **SSO Coordinated Entry**: Only entities designated by the CoC to provide coordinated entry services may apply for this assistance. The CE system must be easily accessible to all people in the State of Rhode Island seeking homeless assistance. It must employ a standardized assessment, must make efforts to reach homeless people with the highest barriers, and ensure that people are directed to the appropriate housing and services to meet their needs.
- **SSO Street Outreach**. Any eligible organization may apply for SSO Street Outreach. It must be targeted to those experiencing unsheltered homelessness and must be able to connect people to coordinated entry and housing resources. For this supplemental NOFO, Street Outreach must have a strategy to provide services to those with the highest service needs, including those with histories of unsheltered homelessness who do not traditionally engage with supportive services.
- **Stand-Alone Supportive Services.** Any eligible organization may apply for a Stand-Alone supportive services project. This must also be targeted toward those with histories of unsheltered homelessness focused on those with the most severe service needs, who have not historically been engaged in supportive services. Participants must be assisted in obtaining permanent housing in a manner that fits their needs. Applicants must demonstrate that they will individually assist participants to obtain mainstream health, social services, and employment programs for which they are eligible, and which meet their needs.

Homeless Management Information System

HUD will allow for HMIS funding through the Supplemental NOFO. The additional HMIS funding must be targeted to households with a history of unsheltered homelessness and with severe service needs. Only the designated HMIS lead may apply for HMIS funds.

CoC Planning Funds
HUD will allow the CoC lead agency to apply for planning funds to support the unsheltered homeless initiative. Planning funds can support the development and implementation of the Community Plan to Address Unsheltered Homelessness and the efforts of the Working Group of persons with lived experience of homelessness. Planning funds are limited to three percent of the total funding applied for through this initiative. The goal of this initiative is to develop a Comprehensive Plan to address people experiencing homelessness with severe service needs, to implement that plan and monitor the implementation of the plan and make modifications as appropriate. Planning funds are essential to this process. They allow for compensation to people with lived experience in the plan development and implementation and they allow funds for monitoring the implementation. It is essential therefore that the planning application be ranked so that it has a high probability of being funded, which will allow the entire initiative to proceed.

Threshold and Scoring Criteria

Applicants must demonstrate all threshold and scoring criteria in their proposal for it to be considered.

Threshold criteria: Project must demonstrate its ability to pass **all** of the threshold criteria in order for the project to be reviewed and scored by the Recipient Approval and Evaluation ("Funding") Committee. Applicants must carefully review these criteria and make certain their application is responsive to all criteria

a) Certify the project will use HMIS. For DV providers, certify use of RI's comparable database for survivors of domestic violence.
b) Certify the project will follow Coordinated Entry policy and procedure
c) Certify the project will use Housing First and low barrier approach; describe this approach in narrative
d) Certify the applicant has no outstanding delinquent federal debts; no debarments and or suspensions from doing business with the federal government
e) Certify the applicant has an accounting system that meets federal standards as described at 2 CFR 200.302
f) Certify commitment to compliance with HUD's Equal Access and Fair Housing Rules and commitment to ongoing training on both regulations that include implementation strategies
g) Describe Trauma-Informed Care approach and how TIC will be demonstrated in practice in the project
h) Target population must meet HUD homeless definition of Category 1 or 4. Identify which target and priority population(s) will be served by the project.
i) Demonstrate in the project budget that no more than 10% of the total COC program budget is for administrative costs
j) Demonstrate in the project budget that all COC funds requested are matched with an amount that is at least 25% of the COC funds requested (excluding any amount in the leasing budget line item) with cash or in-kind resources. Demonstrate clearly that all matching funds are COC eligible expenses.

Scoring Criteria: There are special scoring criteria for this Supplemental NOFO. They are attached. Applicants must carefully review these criteria and make certain their application submitted in the esnaps system is responsive to all criteria so it may be effectively scored by the funding committee.

Submission Instructions and Deadline

Deadline: Project Applications must be submitted in the E-SNAPS grants management system on or before **Sept. 9, 2022 at 5pm Eastern Daylight Time**. Additionally, project applications must be exported from the E-Snaps system and emailed to the COC planner, Elizabeth Bioteau (ebioteau@rihousing.com). The email must also include the performance report the applicant is submitting to respond to the system performance scoring criteria. Submissions submitted after the deadline may not be considered. A complete submission will require both of these steps:

1. Project application submitted in e-snaps grants management system
2. Email to ebioteau@rihousing.com of exported project application AND a system performance report (PDF format preferred for both attachments in the email.)

Please contact the COC planner at ebioteau@rihousing.com if you have questions about the submission process.

Award Notifications and Appeal Process

All applicants will be informed via email if their project was selected to be submitted as part of Rhode Island's Collaborative Application for Supplemental COC funding or rejected in accordance with the project timeline. Accepted/selected email notifications will include a total approved project budget authority. All project selections are pending final approval from HUD and may be amended per feedback from the COC's Recipient Approval and Evaluation ("Funding") Committee, the RICoC, and from HUD. Applicants with projects that are rejected for funding may appeal the decision by submitting an appeal in writing to the COC Planner at EBioteau@rihousing.com on or before the appeals deadline in the timeline. Appeals will be considered by unconflicted members of the RICoC Board of Directors. The decision of the Board is final.

Additional Resources

- The RICoC website: Continuum of Care | RIHousing
- Budget Line-Item Eligible Costs this chart show what is eligible under each of the eligible supportive service costs (case management, education services, outreach, etc.)
- Continuum of Care Interim Rule: eCFR :: 24 CFR Part 578 -- Continuum of Care Program
- HUD's definitions of homelessness: At a Glance_Criteria and Recordkeeping Requirements for Definition of Homeless (hudexchange.info)
- CoC Leasing and Rental Assistance Requirements Overview (HUD Virtual Binder): CoC Leasing and Rental Assistance Requirements - Overview - HUD Exchange
- CoC Virtual Binders: CoC and ESG Virtual Binders - HUD Exchange
  These binders provide detailed information on eligible activities, environmental review, financial management, homeless eligibility, matching funding, CoC program components, and rent calculations. **These requirements should be reviewed as part of the application process to make certain that all requested funding and activities are eligible under the CoC program.**

This should be used for TH-RRH Projects only - Supplimental NOFO Score Sheet

Provider & Project Name:

A. Support Services 32 points (23% of total score)		
Scoring Description	**Available Points**	**Assigned Points**
1. The type of supportive services that will be offered to program participants are designed to obtain and ensure successful retention in housing, and except for case management services, are offered voluntarily.	2	
2. The proposed project has a specific plan for ensuring program participants will be individually assisted to obtain the benefits of mainstream health, social, and employment programs for which they are eligible to apply, and which meet their needs (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education).	2	
3. Program participants will be assisted to obtain and remain in permanent housing in a manner that fits their needs (e.g., provides the participant with some type of transportation to access needed services, safety planning, case management, housing that meets accessibility related needs, additional assistance to ensure retention of permanent housing).	2	
4. Program participants are assisted in identifying housing. Examples of desirable responses include assessing participants to better understand their housing preferences and needs including unit type, neighborhood, and other accommodations (parking for their vehicle) they prefer; helping participants understand leases and obligations of tenancy; helping obtain required documents for housing; providing participants housing leads and transporting them to see the unit and meet with the landlord.	4	
5. Applicants engage with individuals and families experiencing unsheltered homelessness and make efforts to assist them in accessing housing and services. Applicants describe: oHow they coordinate with outreach teams and other entities that engage with unsheltered people as well as ES, TH and RRH providers; oHow they provide additional support to help people exit unsheltered homelessness; oWhat specific engagement strategies will be utilized to engage individuals and families experiencing homelessness with the highest vulnerabilities (including use of culturally appropriate strategies); and oHow they will connect individuals and families experiencing unsheltered homelessness to permanent housing	4	

6. Applicant employs people with lived homelessness experience: provider currently employs one or more people with lived experience; provider offers opportunities for people with lived experience to advance in organization; provider assists people with lived experience to advance education/professional qualifications	4	
7. Applicant utilizes Evidenced Based Practices for serving unsheltered persons and can demonstrate training and/or supervising staff to promote fidelity practices.	2	
	20	
Comments:		
B. Housing 10 points		
1. Project application demonstrates that participants coming from unsheltered locations will be rapidly assisted to secure safe, temporary housing that is appropriate for their needs.	5	
2. Proposal contains plan to move particpants quickly into permanent housing and describes how the appicant will remove barriers to move in (examples of barriers include screening for immigration status, checking credit history, looking for past evictions, lack of income, disability type, support in connecting utilities, accessing funds for moving and furnishings)	5	
	10	
Comments:		
C. System Performance 20 points (20% of total score)		
For scoring criteria C.1.-C.4 Will be based on Performance Evaluation Reports. Applicants with multple projects receiving Performance Evaluation Reports may choose the report they wish to submit. Applicants who do not have a Performance Evaluation Report from the CoC may submit a record of system performance from an equivalent database that provides a compelling explanation of the agency's performance considering HUD System Performance Measures.		
1. Housing placement- remain in PH percentage (95% or greater for full points, partial points available between 90 and 94.99%)	5	
2. Percentage of all participant leavers who exited to shelter, streets or unknown (including don't know/refused and no exit interview) during last program year	5	
3. Length of time from CE referral to program enrollment in PSH; length of time from CE referral to move-in date for RRH	5	
4.Returns to Homelessness after PH Placement - 12 months	5	
	20	
Comments:		
D. Objective Criteria 40 points (40% of total score)		
1. Proposed project budget is: a. clear, easily understandable to raters b. detailed, includes a comprehensive budget narrative and correct match with proof from sources c. reasonable, as evidenced by including only allowable activities, and	4	

d. cost effective, as compared to other projects providing the same component e. has twice as many resources for the RRH than the TH portion		
2. The respondent has experience in quickly placing households in Rapid Re-Housing	4	
3. Applicant demonstrates that people with lived experience of homelessness are involved in setting agency policies (Board members, working group…)	4	
4. Percentage of persons coming directly from places not meant for human habitation (10% or greater in a current project)	4	
5. HMIS data quality for existing project (less than 5% error rate)	4	
6. Applicant accepts participants only through coordinated entry	4	
7. Respondents included a written commitment from a health care organization, including organizations that serve people with HIV/AIDS, that the value of assistance being provided by the healthcare organization is at least: o In the case of a substance abuse treatment or recovery provider, it will provide access to treatment or recovery services for all program participants who qualify and choose those services; or o An amount that is equivalent to 50% of the funding being requested for the project(s) will be covered by the healthcare organization. Acceptable forms of commitment are formal written agreements and must include: o Value of the commitment, and o Dates the healthcare resources will be provided.	8	
8. Respondents included a written commitment that utilizes housing subsidies or subsidized housing units not funded through the CoC or ESG Programs (e.g., Housing Choice Vouchers, HOME-ARP, HOPWA). The commitment must demonstrate that these housing units, which are not funded through the CoC or ESG programs, will serve at least 50 percent of the program participants anticipated to be served by the project.	8	
	40	
Comments:		
E. Consistency with Comprehensive Plan/Severe Service Needs		
1. Recruitment/Engagement of Landlords: a) Applicant has a specific strategy to engage property owners to participate in program and house participants b) Applicant has adjusted/modified efforts to recruit landlords due to changing market circumstances	**5**	
2. Proposed project identifies specific elements in the Comprehensive Community Plan that it will address and is fully consistent with the Plan.	5	

	10	
Comments:		
TOTAL:	100	

Raters Name:	Date:

This should be used for SSO Projects only - Supplimental NOFO Score Sheet

Provider & Project Name:

A. Support Services 20 points

Scoring Description	Available Points	Assigned Points
1. The type of supportive services that will be offered to program participants are designed to obtain and ensure successful retention in housing, and except for case management services, are offered voluntarily.	2	
2. The proposed project has a specific plan for ensuring program participants will be individually assisted to obtain basic and emergency needs and assisted in identifying the benefits to which they may be entitled (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education).	2	
3. Program participants will be assisted to obtain and remain in permanent housing in a manner that fits their needs (e.g., provides the participant with some type of transportation to access needed services, safety planning, case management, housing that meets accessibility related needs, additional assistance to ensure retention of permanent housing).	2	
4. Program participants are assisted in identifying housing. Examples of desirable responses include assessing participants to better understand their housing preferences and needs including unit type, neighborhood, and other accommodations (parking for their vehicle) they prefer; helping participants understand leases and obligations of tenancy; helping obtain required documents for housing; providing participants housing leads and transporting them to see the unit and meet with the landlord.	4	
5. Applicants engage with individuals and families experiencing unsheltered homelessness and make efforts to assist them in accessing housing and services. Applicants describe: oHow they coordinate with outreach teams and other entities that engage with unsheltered people as well as ES, TH and RRH providers; oHow they provide additional support to help people exit unsheltered homelessness; oWhat specific engagement strategies will be utilized to engage individuals and families experiencing homelessness with the highest vulnerabilities (including use of culturally appropriate strategies); and oHow they will connect individuals and families experiencing unsheltered homelessness to permanent housing	4	
6. Applicant employs people with lived homelessness experience: provider currently employs one or more people with lived experience; provider offers opportunities for people with lived experience to advance in organization; provider assists people with lived experience to advance education/professional qualifications	4	
7. Applicant utilizes Evidenced Based Practices for serving unsheltered persons and can demonstrate training and/or supervising staff to promote fidelity practices.	2	

	20	
Comments:		
B. Housing 10 points		
1. Supportive services project has linkages to housing/housing providers and demonstrates that applicant can quickly refer participants to housing	5	
2. Proposal describes how the applicant will remove barriers to move in (examples of barriers include screening for immigration status, checking credit history, looking for past evictions, lack of income, disability type, support in connecting utilities, providing access to funds for moving, furniture)	5	
	10	
Comments:		
C. System Performance 20 points (20% of total score)		
There are very limited SSO projects in the CoC. Applicants with a funded supportive housing project are requested to provide system performance data for a supportive housing project that received a renewal evaluation from the RICoC. Applicants without a supportive housing project are requested to provide similar performance data from a project serving homeless or at risk people. For scoring criteria C.1.-C.5 respondents participating in HMIS must submit an Annual Performance Report (APR) for a similar project run between 10/1/20-9/30/21. Respondents who do not participate in HMIS may submit a record of system performance from an equivalent database that provides a compelling explanation of the agency's performance considering HUD System Performance Measures.		
1. Housing placement- remain in PH percentage (95% or greater for full points, partial points available between 90 and 94.99%); if PSH remain in PH or move to other PH	5	
2. Percentage of all participant leavers who exited to shelter, streets or unknown (including don't know/refused and no exit interview) during last program year	5	
3. Length of time from CE referral to program enrollment in PSH; length of time from CE referral to move-in date for RRH	5	
4.Returns to Homelessness after PH Placement - 12 months	5	
	20	
D. Objective Criteria 40 points (40% of score)		
1. Proposed project budget is: a. clear, easily understandable to raters b. detailed, includes a comprehensive budget narrative and correct match with proof from sources c. reasonable, as evidenced by including only allowable activities, and d. cost effective, as compared to other projects providing the same component	4	
2. Proposed timeline for project implementation and start of services is reasonable	4	

3. Applicant demonstrates that people with lived experience of homelessness are involved in setting agency policies (Board members, working group…)	4	
4. If a current SSO provider, 50% or more of persons served are unsheltered; if a current housing provider percentage of persons coming directly from unsheltered locations or places not meant for human habitation (10% or greater in a current project)	4	
5. HMIS data quality for existing project (less than 5% error rate)	4	
6. Applicant enters data on all participants into HMIS and refers engaged persons to coordinated entry	4	
7. Applicants included a written commitment from a health care organization,that the value of assistance being provided by the healthcare organization is at least: o In the case of a substance abuse treatment or recovery provider, it will provide access to treatment or recovery services for all program participants who qualify and choose those services; or o An amount that is equivalent to 50% of the funding being requested for the project(s) will be covered by the healthcare organization. Acceptable forms of commitment are formal written agreements and must include: o Value of the commitment, and o Dates the healthcare resources will be provided.	8	
8.Applicants included a written commitment that utilizes housing subsidies or subsidized housing units not funded through the CoC or ESG Programs (e.g., Housing Choice Vouchers, HOME-ARP, HOPWA). The commitment must demonstrate that these housing units, which are not funded through the CoC or ESG programs, will provide at least 50 percent of the units included in the project.	8	
	40	
Comments:		
E. Consistency with Comprehensive Plan/Severe Service Needs		
1. Recruitment/Engagement of Landlords: a) Applicant has a specific strategy to engage property owners to participate in program and house participants b) Applicant has adjusted/modified efforts to recruit landlords due to changing market circumstances	5	
2. Proposed project identifies specific elements in the Comprehensive Community Plan that it will address and is fully consistent with the Plan.	5	
	10	
	100	
Comments:		
TOTAL:	0	

Raters Name:	Date:

This should be used for both PSH and RRH Projects - Supplimental NOFO Score Sheet

Provider & Project Name:

A. Support Services 20 points		
Scoring Description	**Available Points**	**Assigned Points**
1. The type of supportive services that will be offered to program participants are designed to obtain and ensure successful retention in housing, and except for case management services, are offered voluntarily.	2	
2. The proposed project has a specific plan for ensuring program participants will be individually assisted to obtain the benefits of mainstream health, social, and employment programs for which they are eligible to apply, and which meet their needs (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education).	2	
3. Program participants will be assisted to obtain and remain in permanent housing in a manner that fits their needs (e.g., provides the participant with some type of transportation to access needed services, safety planning, case management, housing that meets accessibility related needs, additional assistance to ensure retention of permanent housing).	2	
4. Program participants are assisted in identifying housing. Examples of desirable responses include assessing participants to better understand their housing preferences and needs including unit type, neighborhood, and other accommodations (parking for their vehicle) they prefer; helping participants understand leases and obligations of tenancy; helping obtain required documents for housing; providing participants housing leads and transporting them to see the unit and meet with the landlord.	4	

5. Applicants engage with individuals and families experiencing unsheltered homelessness and make efforts to assist them in accessing housing and services. Applicants describe: o How they coordinate with outreach teams and other entities that engage with unsheltered people as well as ES, TH and RRH providers; o How they provide additional support to help people exit unsheltered homelessness; o What specific engagement strategies will be utilized to engage individuals and families experiencing homelessness with the highest vulnerabilities (including use of culturally appropriate strategies); and o How they will connect individuals and families experiencing unsheltered homelessness to permanent housing	4	
6. Applicant employs people with lived homelessness experience: provider currently employs one or more people with lived experience; provider offers opportunities for people with lived experience to advance in organization; provider assists people with lived experience to advance education/professional qualifications	4	
7. Applicant utilizes Evidenced Based Practices for serving unsheltered persons and can demonstrate training and/or supervising staff to promote fidelity practices.	2	
	20	
Comments:		
B. Housing 10 points		
1. The type of PH being sought through this solicitation, including the number and configuration of units, and location of units is appropriate for unsheltered persons in the CoC	5	
2. Proposal describes how the applicant will remove barriers to move in (examples of barriers include screening for immigration status, checking credit history, looking for past evictions, lack of income, disability type, support in connecting utilities, providing access to funds for moving, furniture)	5	
	10	
Comments:		
C. System Performance 20 points (20% of total score)		
For scoring criteria C.1.-C.4 Will be based on Performance Evaluation Reports. Applicants with multple projects receiving Performance Evaluation Reports may choose the report they wish to submit. Applicants who do not have a Performance Evaluation Report from the CoC may submit a record of system performance from an equivalent database that provides a compelling explanation of the agency's performance considering HUD System Performance Measures.		

1. Housing retention- remain in PH or move to other PH percentage (95% or greater for full points, partial points available between 90 and 94.99%)	5	
2. Percentage of all participant leavers who exited to shelter, streets or unknown (including don't know/refused and no exit interview) during last program year	5	
3. Length of time from CE referral to program enrollment in PSH; length of time from CE referral to move-in date for RRH	5	
4.Returns to Homelessness after PH Placement - 12 months	5	
	20	
D. Objective Criteria 40 points (40% of score)		
1. Proposed project budget is: a. clear, easily understandable to raters b. detailed, includes a comprehensive budget narrative and correct match with proof from sources c. reasonable, as evidenced by including only allowable activities, and d. cost effective, as compared to other projects providing the same component	4	
2. Proposed timeline for project implementation and occupancy is reasonable	4	
3. Applicant demonstrates that people with lived experience of homelessness are involved in setting agency policies (Board members, working group…)	4	
4. Percentage of persons coming directly from unsheltered locations or places not meant for human habitation (10% or greater in a current project)	4	
5. HMIS data quality for existing project (less than 5% error rate)	4	
6. Applicant accepts participants only through coordinated entry	4	

7. Applicants included a written commitment from a health care organization,that the value of assistance being provided by the healthcare organization is at least: o In the case of a substance abuse treatment or recovery provider, it will provide access to treatment or recovery services for all program participants who qualify and choose those services; or o An amount that is equivalent to 50% of the funding being requested for the project(s) will be covered by the healthcare organization. Acceptable forms of commitment are formal written agreements and must include: o value of the commitment, and o dates the healthcare resources will be provided.	8	
8.Applicants included a written commitment that utilizes housing subsidies or subsidized housing units not funded through the CoC or ESG Programs (e.g., Housing Choice Vouchers, HOME-ARP, HOPWA). The commitment must demonstrate that these housing units, which are not funded through the CoC or ESG programs, will provide at least 50 percent of the units included in the project.	8	
	40	
Comments:		
E. Consistency with Comprehensive Plan/Severe Service Needs		
1. Recruitment/Engagement of Landlords: a) Applicant has a specific strategy to engage property owners to participate in program and house participants b) Applicant has adjusted/modified efforts to recruit landlords due to changing market circumstances	5	
2. Proposed project identifies specific elements in the Comprehensive Community Plan that it will address and is fully consistent with the Plan.	5	
	10	
	100	
Comments:		
TOTAL:	0	

Raters Name:	Date:

Supplemental NOFO HMIS Score Sheet

Provider & Project Name:		

This should be used for HMIS Projects only - Supplimental NOFO Score Sheet

A. Experience 20 points		
Scoring Description	**Available Points**	**Assigned Points**
1.Experience in operating HMIS and ability to meet HUD deadlines	20	
B Engagement of Persons with Lived Experience of Homelessness		
1. Applicant demonstrates that people with lived experience of homelessness are involved in setting agency policies (Board members, working group…)	10	
2. Applicant employs people with lived homelessness experience: provider currently employs one or more people with lived experience; provider offers opportunities for people with lived experience to advance in organization; provider assists people with lived experience to advance education/professional qualifications	10	
	20	
Comments:		
C. Objective Criteria 40 points (40% of score)		
1. HMIS Universal Data Quality (systemwide UDEs, null/unknown error rate of less than 10% = 10 Points; less than 15% = 5 points	10	
2. Chronic Homelessness data quality in HMIS (systemwide error rate of less than 10% = 10 points; less than 15% = 5 points)	10	
3, HMIS score on HMIS related factors in 2021 CoC Application (85% - 100% of possible HMIS points = 10 points, 60% – 84% = 5 points; Less than 60% = 0 points)	10	
4. Proposed timeline for project implementation and start of services is reasonable	10	
	40	
Comments:		
D. Consistency with Comprehensive Plan/Severe Service Needs		
2. Proposed HMIS expansion is consistent with the Comprehensive Community Plan and specifically identifies how the expanded HMIS will assist in achieving goals of plan	20	
	20	
	100	
Comments:		
TOTAL:	0	

Raters Name:	Date:

This should be used for TH-RRH Projects only - Supplimental NOFO Score Sheet

Provider & Project Name:

A. Support Services 32 points (23% of total score)		
Scoring Description	**Available Points**	**Assigned Points**
1. The type of supportive services that will be offered to program participants are designed to obtain and ensure successful retention in housing, and except for case management services, are offered voluntarily.	2	
2. The proposed project has a specific plan for ensuring program participants will be individually assisted to obtain the benefits of mainstream health, social, and employment programs for which they are eligible to apply, and which meet their needs (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education).	2	
3. Program participants will be assisted to obtain and remain in permanent housing in a manner that fits their needs (e.g., provides the participant with some type of transportation to access needed services, safety planning, case management, housing that meets accessibility related needs, additional assistance to ensure retention of permanent housing).	2	
4. Program participants are assisted in identifying housing. Examples of desirable responses include assessing participants to better understand their housing preferences and needs including unit type, neighborhood, and other accommodations (parking for their vehicle) they prefer; helping participants understand leases and obligations of tenancy; helping obtain required documents for housing; providing participants housing leads and transporting them to see the unit and meet with the landlord.	4	
5. Applicants engage with individuals and families experiencing unsheltered homelessness and make efforts to assist them in accessing housing and services. Applicants describe: oHow they coordinate with outreach teams and other entities that engage with unsheltered people as well as ES, TH and RRH providers; oHow they provide additional support to help people exit unsheltered homelessness; oWhat specific engagement strategies will be utilized to engage individuals and families experiencing homelessness with the highest vulnerabilities (including use of culturally appropriate strategies); and oHow they will connect individuals and families experiencing unsheltered homelessness to permanent housing	4	

6. Applicant employs people with lived homelessness experience: provider currently employs one or more people with lived experience; provider offers opportunities for people with lived experience to advance in organization; provider assists people with lived experience to advance education/professional qualifications	4	
7. Applicant utilizes Evidenced Based Practices for serving unsheltered persons and can demonstrate training and/or supervising staff to promote fidelity practices.	2	
	20	
Comments:		
B. Housing 10 points		
1. Project application demonstrates that participants coming from unsheltered locations will be rapidly assisted to secure safe, temporary housing that is appropriate for their needs.	5	
2. Proposal contains plan to move particpants quickly into permanent housing and describes how the appicant will remove barriers to move in (examples of barriers include screening for immigration status, checking credit history, looking for past evictions, lack of income, disability type, support in connecting utilities, accessing funds for moving and furnishings)	5	
	10	
Comments:		
C. System Performance 20 points (20% of total score)		
For scoring criteria C.1.-C.4 Will be based on Performance Evaluation Reports. Applicants with multple projects receiving Performance Evaluation Reports may choose the report they wish to submit. Applicants who do not have a Performance Evaluation Report from the CoC may submit a record of system performance from an equivalent database that provides a compelling explanation of the agency's performance considering HUD System Performance Measures.		
1. Housing placement- remain in PH percentage (95% or greater for full points, partial points available between 90 and 94.99%)	5	
2. Percentage of all participant leavers who exited to shelter, streets or unknown (including don't know/refused and no exit interview) during last program year	5	
3. Length of time from CE referral to program enrollment in PSH; length of time from CE referral to move-in date for RRH	5	
4.Returns to Homelessness after PH Placement - 12 months	5	
	20	
Comments:		
D. Objective Criteria 40 points (40% of total score)		
1. Proposed project budget is: a. clear, easily understandable to raters b. detailed, includes a comprehensive budget narrative and correct match with proof from sources c. reasonable, as evidenced by including only allowable activities, and	4	

d. cost effective, as compared to other projects providing the same component e. has twice as many resources for the RRH than the TH portion		
2. The respondent has experience in quickly placing households in Rapid Re-Housing	4	
3. Applicant demonstrates that people with lived experience of homelessness are involved in setting agency policies (Board members, working group…)	4	
4. Percentage of persons coming directly from places not meant for human habitation (10% or greater in a current project)	4	
5. HMIS data quality for existing project (less than 5% error rate)	4	
6. Applicant accepts participants only through coordinated entry	4	
7. Respondents included a written commitment from a health care organization, including organizations that serve people with HIV/AIDS, that the value of assistance being provided by the healthcare organization is at least: o In the case of a substance abuse treatment or recovery provider, it will provide access to treatment or recovery services for all program participants who qualify and choose those services; or o An amount that is equivalent to 50% of the funding being requested for the project(s) will be covered by the healthcare organization. Acceptable forms of commitment are formal written agreements and must include: o Value of the commitment, and o Dates the healthcare resources will be provided.	8	
8. Respondents included a written commitment that utilizes housing subsidies or subsidized housing units not funded through the CoC or ESG Programs (e.g., Housing Choice Vouchers, HOME-ARP, HOPWA). The commitment must demonstrate that these housing units, which are not funded through the CoC or ESG programs, will serve at least 50 percent of the program participants anticipated to be served by the project.	8	
	40	
Comments:		
E. Consistency with Comprehensive Plan/Severe Service Needs		
1. Recruitment/Engagement of Landlords: a) Applicant has a specific strategy to engage property owners to participate in program and house participants b) Applicant has adjusted/modified efforts to recruit landlords due to changing market circumstances	**5**	
2. Proposed project identifies specific elements in the Comprehensive Community Plan that it will address and is fully consistent with the Plan.	5	

	10	
Comments:		
TOTAL:	100	

Raters Name:	Date:

This should be used for SSO Projects only - Supplimental NOFO Score Sheet

Provider & Project Name:

A. Support Services 20 points

Scoring Description	Available Points	Assigned Points
1. The type of supportive services that will be offered to program participants are designed to obtain and ensure successful retention in housing, and except for case management services, are offered voluntarily.	2	
2. The proposed project has a specific plan for ensuring program participants will be individually assisted to obtain basic and emergency needs and assisted in identifying the benefits to which they may be entitled (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education).	2	
3. Program participants will be assisted to obtain and remain in permanent housing in a manner that fits their needs (e.g., provides the participant with some type of transportation to access needed services, safety planning, case management, housing that meets accessibility related needs, additional assistance to ensure retention of permanent housing).	2	
4. Program participants are assisted in identifying housing. Examples of desirable responses include assessing participants to better understand their housing preferences and needs including unit type, neighborhood, and other accommodations (parking for their vehicle) they prefer; helping participants understand leases and obligations of tenancy; helping obtain required documents for housing; providing participants housing leads and transporting them to see the unit and meet with the landlord.	4	
5. Applicants engage with individuals and families experiencing unsheltered homelessness and make efforts to assist them in accessing housing and services. Applicants describe: oHow they coordinate with outreach teams and other entities that engage with unsheltered people as well as ES, TH and RRH providers; oHow they provide additional support to help people exit unsheltered homelessness; oWhat specific engagement strategies will be utilized to engage individuals and families experiencing homelessness with the highest vulnerabilities (including use of culturally appropriate strategies); and oHow they will connect individuals and families experiencing unsheltered homelessness to permanent housing	4	
6. Applicant employs people with lived homelessness experience: provider currently employs one or more people with lived experience; provider offers opportunities for people with lived experience to advance in organization; provider assists people with lived experience to advance education/professional qualifications	4	
7. Applicant utilizes Evidenced Based Practices for serving unsheltered persons and can demonstrate training and/or supervising staff to promote fidelity practices.	2	

	20	
Comments:		
B. Housing 10 points		
1. Supportive services project has linkages to housing/housing providers and demonstrates that applicant can quickly refer participants to housing	5	
2. Proposal describes how the applicant will remove barriers to move in (examples of barriers include screening for immigration status, checking credit history, looking for past evictions, lack of income, disability type, support in connecting utilities, providing access to funds for moving, furniture)	5	
	10	
Comments:		
C. System Performance 20 points (20% of total score)		
There are very limited SSO projects in the CoC. Applicants with a funded supportive housing project are requested to provide system performance data for a supportive housing project that received a renewal evaluation from the RICoC. Applicants without a supportive housing project are requested to provide similar performance data from a project serving homeless or at risk people. For scoring criteria C.1.-C.5 respondents participating in HMIS must submit an Annual Performance Report (APR) for a similar project run between 10/1/20-9/30/21. Respondents who do not participate in HMIS may submit a record of system performance from an equivalent database that provides a compelling explanation of the agency's performance considering HUD System Performance Measures.		
1. Housing placement- remain in PH percentage (95% or greater for full points, partial points available between 90 and 94.99%); if PSH remain in PH or move to other PH	5	
2. Percentage of all participant leavers who exited to shelter, streets or unknown (including don't know/refused and no exit interview) during last program year	5	
3. Length of time from CE referral to program enrollment in PSH; length of time from CE referral to move-in date for RRH	5	
4.Returns to Homelessness after PH Placement - 12 months	5	
	20	
D. Objective Criteria 40 points (40% of score)		
1. Proposed project budget is: a. clear, easily understandable to raters b. detailed, includes a comprehensive budget narrative and correct match with proof from sources c. reasonable, as evidenced by including only allowable activities, and d. cost effective, as compared to other projects providing the same component	4	
2. Proposed timeline for project implementation and start of services is reasonable	4	

3. Applicant demonstrates that people with lived experience of homelessness are involved in setting agency policies (Board members, working group…)	4	
4. If a current SSO provider, 50% or more of persons served are unsheltered; if a current housing provider percentage of persons coming directly from unsheltered locations or places not meant for human habitation (10% or greater in a current project)	4	
5. HMIS data quality for existing project (less than 5% error rate)	4	
6. Applicant enters data on all participants into HMIS and refers engaged persons to coordinated entry	4	
7. Applicants included a written commitment from a health care organization,that the value of assistance being provided by the healthcare organization is at least: o In the case of a substance abuse treatment or recovery provider, it will provide access to treatment or recovery services for all program participants who qualify and choose those services; or o An amount that is equivalent to 50% of the funding being requested for the project(s) will be covered by the healthcare organization. Acceptable forms of commitment are formal written agreements and must include: o Value of the commitment, and o Dates the healthcare resources will be provided.	8	
8.Applicants included a written commitment that utilizes housing subsidies or subsidized housing units not funded through the CoC or ESG Programs (e.g., Housing Choice Vouchers, HOME-ARP, HOPWA). The commitment must demonstrate that these housing units, which are not funded through the CoC or ESG programs, will provide at least 50 percent of the units included in the project.	8	
	40	
Comments:		
E. Consistency with Comprehensive Plan/Severe Service Needs		
1. Recruitment/Engagement of Landlords: a) Applicant has a specific strategy to engage property owners to participate in program and house participants b) Applicant has adjusted/modified efforts to recruit landlords due to changing market circumstances	5	
2. Proposed project identifies specific elements in the Comprehensive Community Plan that it will address and is fully consistent with the Plan.	5	
	10	
	100	
Comments:		
TOTAL:	0	

Raters Name:	Date:

This should be used for both PSH and RRH Projects - Supplimental NOFO Score Sheet

Provider & Project Name:

A. Support Services 20 points		
Scoring Description	**Available Points**	**Assigned Points**
1. The type of supportive services that will be offered to program participants are designed to obtain and ensure successful retention in housing, and except for case management services, are offered voluntarily.	2	
2. The proposed project has a specific plan for ensuring program participants will be individually assisted to obtain the benefits of mainstream health, social, and employment programs for which they are eligible to apply, and which meet their needs (e.g., Medicare, Medicaid, SSI, Food Stamps, local Workforce office, early childhood education).	2	
3. Program participants will be assisted to obtain and remain in permanent housing in a manner that fits their needs (e.g., provides the participant with some type of transportation to access needed services, safety planning, case management, housing that meets accessibility related needs, additional assistance to ensure retention of permanent housing).	2	
4. Program participants are assisted in identifying housing. Examples of desirable responses include assessing participants to better understand their housing preferences and needs including unit type, neighborhood, and other accommodations (parking for their vehicle) they prefer; helping participants understand leases and obligations of tenancy; helping obtain required documents for housing; providing participants housing leads and transporting them to see the unit and meet with the landlord.	4	

5. Applicants engage with individuals and families experiencing unsheltered homelessness and make efforts to assist them in accessing housing and services. Applicants describe: o How they coordinate with outreach teams and other entities that engage with unsheltered people as well as ES, TH and RRH providers; o How they provide additional support to help people exit unsheltered homelessness; o What specific engagement strategies will be utilized to engage individuals and families experiencing homelessness with the highest vulnerabilities (including use of culturally appropriate strategies); and o How they will connect individuals and families experiencing unsheltered homelessness to permanent housing	4	
6. Applicant employs people with lived homelessness experience: provider currently employs one or more people with lived experience; provider offers opportunities for people with lived experience to advance in organization; provider assists people with lived experience to advance education/professional qualifications	4	
7. Applicant utilizes Evidenced Based Practices for serving unsheltered persons and can demonstrate training and/or supervising staff to promote fidelity practices.	2	
	20	
Comments:		
B. Housing 10 points		
1. The type of PH being sought through this solicitation, including the number and configuration of units, and location of units is appropriate for unsheltered persons in the CoC	5	
2. Proposal describes how the applicant will remove barriers to move in (examples of barriers include screening for immigration status, checking credit history, looking for past evictions, lack of income, disability type, support in connecting utilities, providing access to funds for moving, furniture)	5	
	10	
Comments:		
C. System Performance 20 points (20% of total score)		
For scoring criteria C.1.-C.4 Will be based on Performance Evaluation Reports. Applicants with multple projects receiving Performance Evaluation Reports may choose the report they wish to submit. Applicants who do not have a Performance Evaluation Report from the CoC may submit a record of system performance from an equivalent database that provides a compelling explanation of the agency's performance considering HUD System Performance Measures.		

1. Housing retention- remain in PH or move to other PH percentage (95% or greater for full points, partial points available between 90 and 94.99%)	5	
2. Percentage of all participant leavers who exited to shelter, streets or unknown (including don't know/refused and no exit interview) during last program year	5	
3. Length of time from CE referral to program enrollment in PSH; length of time from CE referral to move-in date for RRH	5	
4.Returns to Homelessness after PH Placement - 12 months	5	
	20	
D. Objective Criteria 40 points (40% of score)		
1. Proposed project budget is: a. clear, easily understandable to raters b. detailed, includes a comprehensive budget narrative and correct match with proof from sources c. reasonable, as evidenced by including only allowable activities, and d. cost effective, as compared to other projects providing the same component	4	
2. Proposed timeline for project implementation and occupancy is reasonable	4	
3. Applicant demonstrates that people with lived experience of homelessness are involved in setting agency policies (Board members, working group…)	4	
4. Percentage of persons coming directly from unsheltered locations or places not meant for human habitation (10% or greater in a current project)	4	
5. HMIS data quality for existing project (less than 5% error rate)	4	
6. Applicant accepts participants only through coordinated entry	4	

7. Applicants included a written commitment from a health care organization,that the value of assistance being provided by the healthcare organization is at least: o In the case of a substance abuse treatment or recovery provider, it will provide access to treatment or recovery services for all program participants who qualify and choose those services; or o An amount that is equivalent to 50% of the funding being requested for the project(s) will be covered by the healthcare organization. Acceptable forms of commitment are formal written agreements and must include: o value of the commitment, and o dates the healthcare resources will be provided.	8	
8.Applicants included a written commitment that utilizes housing subsidies or subsidized housing units not funded through the CoC or ESG Programs (e.g., Housing Choice Vouchers, HOME-ARP, HOPWA). The commitment must demonstrate that these housing units, which are not funded through the CoC or ESG programs, will provide at least 50 percent of the units included in the project.	8	
	40	
Comments:		
E. Consistency with Comprehensive Plan/Severe Service Needs		
1. Recruitment/Engagement of Landlords: a) Applicant has a specific strategy to engage property owners to participate in program and house participants b) Applicant has adjusted/modified efforts to recruit landlords due to changing market circumstances	5	
2. Proposed project identifies specific elements in the Comprehensive Community Plan that it will address and is fully consistent with the Plan.	5	
	10	
	100	
Comments:		
TOTAL:	0	

Raters Name:	Date:

Supplemental NOFO HMIS Score Sheet

Provider & Project Name:		

This should be used for HMIS Projects only - Supplimental NOFO Score Sheet

A. Experience 20 points		
Scoring Description	**Available Points**	**Assigned Points**
1.Experience in operating HMIS and ability to meet HUD deadlines	20	
B Engagement of Persons with Lived Experience of Homelessness		
1. Applicant demonstrates that people with lived experience of homelessness are involved in setting agency policies (Board members, working group…)	10	
2. Applicant employs people with lived homelessness experience: provider currently employs one or more people with lived experience; provider offers opportunities for people with lived experience to advance in organization; provider assists people with lived experience to advance education/professional qualifications	10	
	20	
Comments:		
C. Objective Criteria 40 points (40% of score)		
1. HMIS Universal Data Quality (systemwide UDEs, null/unknown error rate of less than 10% = 10 Points; less than 15% = 5 points	10	
2. Chronic Homelessness data quality in HMIS (systemwide error rate of less than 10% = 10 points; less than 15% = 5 points)	10	
3, HMIS score on HMIS related factors in 2021 CoC Application (85% - 100% of possible HMIS points = 10 points, 60% – 84% = 5 points; Less than 60% = 0 points)	10	
4. Proposed timeline for project implementation and start of services is reasonable	10	
	40	
Comments:		
D. Consistency with Comprehensive Plan/Severe Service Needs		
2. Proposed HMIS expansion is consistent with the Comprehensive Community Plan and specifically identifies how the expanded HMIS will assist in achieving goals of plan	20	
	20	
	100	
Comments:		
TOTAL:	0	

Raters Name:	Date:

From: Elizabeth Bioteau
To: hausofcodec
Subject: RE: COC unsheltered homelessness proposal
Date: Friday, September 23, 2022 1:04:27 PM
Attachments: image001.png
image002.png
image003.png
image004.png
image905204.png
image082464.png
image694349.png
image876028.png

Gem,

I'm contacting you today on behalf of the Rhode Island Continuum of Care (RICoC) and the RICoC Funding Committee to inform you of their decision on your application recently submitted to Address Unsheltered Homelessness. As you are aware, the RICoC issued a Request for Proposals for New Projects to Address Unsheltered Homelessness on August 5, 2022. Project Proposals were due on September 9, 2022 at 5pm Eastern Daylight Time. Thank you very much for the time put into developing your proposal. The committee was very appreciative of the proposal submissions, enjoyed robust and nuanced conversations, and ultimately made some very difficult decisions on proposals to select for inclusion in the RICoC's Collaborative Application for Special Funding to Address Unsheltered Homelessness.

After deliberation, House of Codec's proposal for Joint Transitional Housing/Rapid Rehousing was not selected for inclusion in the RICoC's collaborative application to HUD for Special Funding to Address Unsheltered Homelessness.

If it is of interest to you and your team, I would be willing to meet with your team to further discuss the strengths of your application, opportunities for improvement, and provide insight into the decision-making process, all with the goal to support your continued work to end homelessness. If that is of interest, please send me some dates and times in October that could work for you for a 30 minute debriefing conversation. This is completely optional.

Applicants who's proposals were not selected to be included in the FY2022 collaborative application for Special Funding to Address Unsheltered Homelessness may choose to appeal that decision by submitting an appeal in writing to the COC Planner at EBioteau@rihousing.com on or before October 3, 2022. Appeals will be considered by two members of the original review committee and two new non-conflicted persons from the RICoC Board of Directors, and then will be presented to the Board for their decision at their October 6 meeting. The decision of the Board is final.

Thank you, again, for the time the team put into developing the proposal,

Elizabeth

Elizabeth Bioteau | *Continuum of Care Planner/Program Manager*

Rhode Island Continuum of Care

p: 401-429-1478
ebioteau@rihousing.com
RIHousing.com

RIHousing 2021 Annual Report:
Housing in the Spotlight

From: Elizabeth Bioteau
To: hausofcodec
Subject: RE: COC unsheltered homelessness proposal
Date: Tuesday, September 13, 2022 2:05:25 PM
Attachments: image001.png
image002.png
image003.png
image004.png
image028167.png
image397258.png
image362723.png
image779933.png

Gem,
The project application you submitted on Friday for $636,432 was submitted on an incorrect project application. You used the planning project application to address unsheltered homelessness instead of the project application to address unsheltered homelessness.
The planning project is not eligible to be submitted to HUD by Haus of Codec - it would need to be a project application.
Since you submitted in advance of the deadline, I'm wondering: could you please put the application into the correct format for scoring and potential for inclusion in the application to HUD?
I would still have to consult the funding committee and see what their recommendation is, but in its current format I cannot even bring it to them for consideration because its not eligbile.
If this is not possible I understand, but I need you to let me know either way as soon as possible .

E

Elizabeth Bioteau | *Continuum of Care Planner/Program Manager*

Rhode Island Continuum of Care

p: 401-429-1478
ebioteau@rihousing.com
RIHousing.com

From:	Elizabeth Bioteau
To:	Bill Stein (bill@thehouseofhopecdc.org); Laura Jaworski (Laura@thehouseofhopecdc.org); Dayna Gladstein; Kaitlin Kirwin; Alyssa Allyn; Michelle Taylor; Caitlin Frumerie; Hannah Leheny; "jennifer@rihomeless.org "; rebecca@rihomeless.org; Lindsay Cutler; Michelle Wilcox (mwilcox@crossroadsri.org); Theresa McDevitt; Jessica Mowry; Vanessa Volz (vvolz@sojournerri.org); "khenry@sojournerri.org"; Kerry Hall; Ashley Salemi; Stephen Hug
Cc:	Howard Burchman (HBurchman@housinginnovations.us)
Subject:	Special Funding to Address Unsheltered Homelessness - projects accepted and ranked notice
Date:	Wednesday, October 5, 2022 2:34:00 PM
Attachments:	Special Funding to addresss Unsheltered Homelessness approved projects ranking.pdf

Applicant Agencies for RI's Special Funding to Address Unsheltered Homelessness,

It is my pleasure to inform you that the attached list of new project applications have been accepted by the RICoC in the eSNAPS system to submit to the US Department of Housing and Urban Development (HUD) within the Rhode Island Statewide Continuum of Care's Collaborative Application to HUD for Special Funding to Address Unsheltered Homelessness. All project's listed have been and accepted and ranked for potential funding by HUD in the order listed. This list of accepted and ranked project is also available on the RICoC Website .

Thank you for your application(s) and participation in the local competition for special funding to address unsheltered homelessness. Please review the attached carefully and contact me directly with any questions.

Congratulations!
Elizabeth

Special Funding to Address Unsheltered Homelessness Proposals Accepted and Ranked by RICoC:

Rank	Applicant	Project Name	Project Type	Budget (3 year)	Score	County	Status
1	House of Hope	Enhanced Street Outreach	SSO - Street Outreach	$3,576,408	87	Bristol, Providence, Kent, Washington	Accepted
2	Newport Mental Health	Outreach / Unshletered	SSO - Street Outreach	$1,285,518	86	Newport	Accepted
3	Community Care Alliance	Unsheltered Homeless	SSO - Street Outreach	$407,066	85	Providence	Accepted
4	RI Coalition to End Homelssness	HMIS Unsheltered	HMIS	$851,400	85	Statewide	Accepted
5	Crossroads	Unsheltered SO/Housing Problem Solving	SSO - Street Outreach	$759,030	84	Providence	Accepted
6	RIHousing	Unsheltered Planning	Planning	$315,000	n/a	Statewide	Accepted
7	RI Coalition to End Homelssness	SOAR Unsheltered	SSO-Other	$538,230	74	Statewide	Accepted
8	Sojourner House	Unsheltered Homeless - Supports for DV	SSO-Other	$900,000	70	Statewide	Accepted
9	RI Coalition to End Homelssness	Coordinated Entry Unsheltered	CES	$1,169,685	68	Statewide	Accepted
10	Lucy's Hearth	Lucy's Hearth Unsheltered PSH	PSH	$316,034	67	Newport	Accepted
			Total:	**$10,118,371**			

October 11, 2022

Michelle Brophy, Chair
Rhode Island Statewide Continuum of Care (RI-500)
C/O Continuum of Care Planner
44 Washington Street
Providence, RI 02903

RE: Housing Authority Letter of Commitment to partner with CoC on Stability Voucher Program

Ms. Brophy,

Rhode Island Housing ("RIHousing") is writing to confirm our application for Stability Vouchers from the U.S. Department of Housing and Urban Development ("HUD"). Stability Vouchers are vouchers authorized through the Consolidated Appropriations Act, 2021, which makes available new incremental voucher assistance under section 8(o) of the United States Housing Act of 1937. Stability Vouchers are for use by individuals and families experiencing or at-risk of homelessness; those fleeing or attempting to flee domestic violence, dating violence, sexual assault, and stalking; veterans and families that include a veteran family member that meets one of the preceding criteria.

RIHousing is submitting its request for an allocation of Stability Vouchers to HUD by October 20, 2022. If awarded an allocation of Stability Vouchers, RIHousing is grateful for the advanced commitment of the RICoC Board of Directors, the RICoC's Coordinated Entry Advisory Committee, and the RICoC's Coordinated Entry Lead Agency to:

- Refer eligible individuals and families to RIHousing through the Coordinated Entry System for Stability Vouchers. Eligible individuals and families must meet one of four eligibility criteria:
  a. Individuals and families who are currently experiencing homelessness;
  b. Individuals and families at risk of homelessness;
  c. Individuals and families fleeing or attempting to flee domestic violence, dating violence, stalking, sexual assault; and
  d. Veterans and families that include a veteran family that meet one of the preceding criteria (a-c).
- Pair CoC-funded supportive services with Stability Vouchers to the extent those resources are available.
- Collaborate with RICoC stakeholders including but not limited to: people experiencing unsheltered homelessness, the RICoC Board, the RICoC CES Advisory Committee, and the RICoC CES Lead to develop a prioritization plan for Stability Vouchers.

RIHousing is pleased to understand that the RICoC's CES has an existing referral partnership with multiple Victims Services Providers ("VSP") and Veteran Serving Organizations ("VSO") working within the RICoC's jurisdiction: the State of Rhode Island.

If awarded an allocation of Stability Vouchers, RIHousing commits to:

1. Work with the RICoC to pair all of its awarded stability voucher allocation with CoC-funded supportive services; RIHousing anticipates its allocation from HUD to be more than two (2) vouchers, which would be the minimum number of vouchers needed to leverage 50% of the housing resources in the permanent supportive housing project being applied for in the RICOC's Special Funding to Address Unsheltered Homelessness (FR-6300-N-25S).
2. Work with the RICoC Board of Directors, the RICoC's Coordinated Entry Advisory Committee, the RICoC's Coordinated Entry Lead Agency, and other stakeholders to develop a prioritization plan for an allocation of Stability Vouchers through the CES for individuals and families experiencing homelessness, at risk of homelessness, or fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking.

RIHousing believes that the need for affordable housing subsidy among households experiencing homeless exceeds currently available housing resources to serve such households. If awarded an allotment of Stability Vouchers we are eager to enhance our collaboration with the RICoC to help the most vulnerable Rhode Islanders end their homelessness.

Finally, RIHousing is pleased to know the RICoC plans to submit an application to HUD for Special Funding to Address Unsheltered Homelessness (FR-6300-N-25S); because we know that, if Rhode Island is awarded the Special NOFO, the funding will provide extensive resources for supportive service delivery to Stability Voucher holders including, but not limited to Housing Navigation and Housing Stabilization Services.

RIHousing strongly supports the RICoC's application to HUD for Special Funding to Address Unsheltered Homelessness (FR-6300-N-25S) and looks forward to collaborating with the RICoC on a Memorandum of Understanding ("MOU") further detailing these commitments upon a successful award.

Sincerely,

DocuSigned by:
Michael DiChiaro
61114AD701D5E4FB1...

Michael DiChiaro
Director of Leased Housing Division

Providence pha Housing Authority

PROVIDENCE HOUSING AUTHORITY

100 BROAD STREET
PROVIDENCE, RI 02903-4129
TEL. 401-751-6400

EQUAL HOUSING OPPORTUNITY

October 13, 2022

Michelle Brophy, Chair
Rhode Island Statewide Continuum of Care (RI-500)
C/O Continuum of Care Planner
44 Washington Street
Providence, RI 02903

RE: Housing Authority Letter of Commitment to partner with CoC on Stability Voucher Program

Dear Ms. Brophy,

The Providence Housing Authority is writing to confirm it will apply for Stability Vouchers from the US Department of Housing and Urban Development (HUD). Stability Vouchers are vouchers authorized through the Consolidated Appropriations Act, 2021, which makes available new incremental voucher assistance under section 8(o) of the United States Housing Act of 1937. Stability Vouchers are for use by individuals and families experiencing or at-risk of homelessness; those fleeing or attempting to flee domestic violence, dating violence, sexual assault, and stalking; veterans and families that include a veteran family member that meets one of the preceding criteria.

As you know, the PHA is the largest housing authority in Rhode Island with the largest housing choice voucher program, serving the City of Providence which has large populations of households experiencing homelessness, as well as large numbers of households who are housed but severely cost burdened. These challenges have led PHA to substantially expand our programs focused on families experiencing homelessness and at risk of homelessness over the last three years, in partnership with the RICoC.

The PHA is submitting its request for an allocation of Stability Vouchers to HUD by October 20, 2022. If awarded an allocation of Stability Vouchers, the PHA is grateful for the advanced commitment of the RICoC Board of Directors, the RICoC's Coordinated Entry Advisory Committee, and the RICoC's Coordinated Entry Lead Agency commit to:

- Refer eligible individuals and families to the PHA through the Coordinated Entry System for Stability Vouchers. Eligible individuals and families must meet one of four eligibility criteria:
  a. Individuals and families who are currently experiencing homelessness;
  b. Individuals and families at risk of homelessness;
  c. Individuals and families fleeing or attempting to flee domestic violence, dating violence, stalking, sexual assault; and
  d. Veterans and families that include a veteran family that meet one of the preceding criteria (a-c).
- Pair CoC-funded supportive services with Stability Vouchers to the extent those resources are available.

- Collaborate with RICOC stakeholders including but not limited to: people experiencing unsheltered homelessness, the RICOC Board, the RICOC CES Advisory Committee, the RICOC CES Lead to develop a prioritization plan for Stability Vouchers.

The PHA is also pleased that the RICOC's CES has existing referral partnership with multiple Victims Services Providers (VSPs) and Veteran Serving Organizations (VSOs) working within the RICoC's jurisdiction: the State of Rhode Island.

If awarded an allocation of Stability Vouchers, the PHA commits to:

1. Work with the RICoC to pair vouchers with CoC-funded supportive services; and
2. Work with the RICoC Board of Directors, the RICoC's Coordinated Entry Advisory Committee, the RICoC's Coordinated Entry Lead Agency, and other stakeholders to develop a prioritization plan for an allocation of Stability Vouchers through the CES for individuals and families experiencing homelessness, at risk of homelessness, or fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking.

The PHA agrees with the RICoC that the need for affordable housing subsidy among households experiencing homeless exceeds currently available housing resources to serve such households. If PHA is selected for an allocation of vouchers, we are eager to collaborate with the CoC on Stability Voucher program to help the most vulnerable Rhode Islanders end their homelessness.

Finally, the PHA is pleased to learn the RICoC's plan to submit an application to HUD for Special Funding to Address Unsheltered Homelessness (FR-6300-N-25S); because we know that, if awarded to Rhode Island, this funding will provide extensive services resources that will support Stability Voucher Holders with the Housing Navigation and Housing Stabilization Services they so deeply need to end their homelessness in the current Rhode Island rental market.

The PHA strongly supports the RICoC's application to HUD for Special Funding to Address Unsheltered Homelessness (FR-6300-N-25S) and looks forward to collaborating with the RICoC on a Memorandum of Understanding (MOU) further detailing these commitments upon a successful award.

Sincerely,

Melissa Sanzaro
Executive Director

October 11, 2022

Michelle Brophy, Chair
Rhode Island Statewide Continuum of Care (RI-500)
C/O Continuum of Care Planner
44 Washington Street
Providence, RI 02903

RE: Housing Authority Letter of Commitment to partner with CoC on Stability Voucher Program

Ms. Brophy,

Rhode Island Housing ("RIHousing") is writing to confirm our application for Stability Vouchers from the U.S. Department of Housing and Urban Development ("HUD"). Stability Vouchers are vouchers authorized through the Consolidated Appropriations Act, 2021, which makes available new incremental voucher assistance under section 8(o) of the United States Housing Act of 1937. Stability Vouchers are for use by individuals and families experiencing or at-risk of homelessness; those fleeing or attempting to flee domestic violence, dating violence, sexual assault, and stalking; veterans and families that include a veteran family member that meets one of the preceding criteria.

RIHousing is submitting its request for an allocation of Stability Vouchers to HUD by October 20, 2022. If awarded an allocation of Stability Vouchers, RIHousing is grateful for the advanced commitment of the RICoC Board of Directors, the RICoC's Coordinated Entry Advisory Committee, and the RICoC's Coordinated Entry Lead Agency to:

- Refer eligible individuals and families to RIHousing through the Coordinated Entry System for Stability Vouchers. Eligible individuals and families must meet one of four eligibility criteria:
  a. Individuals and families who are currently experiencing homelessness;
  b. Individuals and families at risk of homelessness;
  c. Individuals and families fleeing or attempting to flee domestic violence, dating violence, stalking, sexual assault; and
  d. Veterans and families that include a veteran family that meet one of the preceding criteria (a-c).
- Pair CoC-funded supportive services with Stability Vouchers to the extent those resources are available.
- Collaborate with RICoC stakeholders including but not limited to: people experiencing unsheltered homelessness, the RICoC Board, the RICoC CES Advisory Committee, and the RICoC CES Lead to develop a prioritization plan for Stability Vouchers.

RIHousing is pleased to understand that the RICoC's CES has an existing referral partnership with multiple Victims Services Providers ("VSP") and Veteran Serving Organizations ("VSO") working within the RICoC's jurisdiction: the State of Rhode Island.

If awarded an allocation of Stability Vouchers, RIHousing commits to:

1. Work with the RICoC to pair all of its awarded stability voucher allocation with CoC-funded supportive services; RIHousing anticipates its allocation from HUD to be more than two (2) vouchers, which would be the minimum number of vouchers needed to leverage 50% of the housing resources in the permanent supportive housing project being applied for in the RICOC's Special Funding to Address Unsheltered Homelessness (FR-6300-N-25S).
2. Work with the RICoC Board of Directors, the RICoC's Coordinated Entry Advisory Committee, the RICoC's Coordinated Entry Lead Agency, and other stakeholders to develop a prioritization plan for an allocation of Stability Vouchers through the CES for individuals and families experiencing homelessness, at risk of homelessness, or fleeing or attempting to flee domestic violence, dating violence, sexual assault, or stalking.

RIHousing believes that the need for affordable housing subsidy among households experiencing homeless exceeds currently available housing resources to serve such households. If awarded an allotment of Stability Vouchers we are eager to enhance our collaboration with the RICoC to help the most vulnerable Rhode Islanders end their homelessness.

Finally, RIHousing is pleased to know the RICoC plans to submit an application to HUD for Special Funding to Address Unsheltered Homelessness (FR-6300-N-25S); because we know that, if Rhode Island is awarded the Special NOFO, the funding will provide extensive resources for supportive service delivery to Stability Voucher holders including, but not limited to Housing Navigation and Housing Stabilization Services.

RIHousing strongly supports the RICoC's application to HUD for Special Funding to Address Unsheltered Homelessness (FR-6300-N-25S) and looks forward to collaborating with the RICoC on a Memorandum of Understanding ("MOU") further detailing these commitments upon a successful award.

Sincerely,

DocuSigned by:
Michael DiChiaro
61114AD701D5E4FB1...

Michael DiChiaro
Director of Leased Housing Division

Newport Mental Health

Hope, Health, and Recovery

October 14, 2022

Ashley Salemi Tarvis
Director
Lucy's Hearth
19 Valley Road
Middletown, RI 02842

Dear Ashley,

Newport Mental Health is pleased to have treatment and recovery services (estimated valued at $25,000) available to any Lucy's Hearth clients participating in the Lucy's Hearth Permanent Supportive Housing Continuum of Care Project who are eligible for services and chooses to enroll. The program will operate from 2/1/2023 to 1/31/2026.

We look forward to building upon our long and effective partnership to improve services to people experiencing homelessness.

Sincerely,

Jamie Lehane

Jamie M. Lehane, III, MPH
President & CEO
Newport Mental Health

WEBER*RENEW

Re: Letter of Commitment for Recovery Services

September 6, 2022

To Whom It May Concern:

Project Weber/RENEW is a Rhode Island-based harm reduction and recovery service organization. Annually we serve over 6,000 people with substance use disorders and people in recovery. Project Weber/RENEW offers a range of services, including case management and peer recovery services.

Project Weber/RENEW is excited to partner with Crossroads Rhode Island on their application to the *Supplemental Continuum of Care Funding to Address Unsheltered Homelessness in Rhode Island*.

In our partnership with Crossroads, Project Weber/RENEW commits to providing access to recovery services for all program participants who qualify and choose those services.

We will also provide referrals, linkage to care, and transportation to detox and substance use treatment services to all program participants who qualify and choose those services.

Eligibility for services will comply with HUD CoC program and fair housing requirements.

Thank you for your work to support people with substance use disorder and people in recovery.

Sincerely,

Colleen Daley Ndoye

Project Weber/RENEW
Executive Director

640 Broad Street Providence, RI 02907
(401) 383-4888 • info@weberrenew.org
www.weberrenew.org

thrive
BEHAVIORAL HEALTH

2756 Post Rd, Suite 104 | Warwick, RI 02886
Tel: (401) 691-6000 | Fax: (401) 738-7718
RI Relay for the Hearing Impaired (800) 745-5555
thrivebhri.org

October 12, 2022

Laura Jaworski
Executive Director
House of Hope CDC
3188 Post Road
Warwick, RI 02888

Re: Commitment of Healthcare and Behavioral Health Services
FY22 Continuum of Care Unsheltered NOFO
Enhanced Street Outreach- House of Hope CDC

Dear Ms. Jaworski:

Thrive Behavioral Health is providing a written commitment for the permanent and unconditional availability of healthcare and behavioral healthcare services to program participants of the House of Hope Enhanced Street Outreach project in the amount of $263,082 annually to serve as both match and leveraged funding as required for the 2022 HUD Continuum of Care Program Competition. These services will be available immediately upon execution of the contract.

Specific leveraged services and associated values include:

- $258,038 for Assertive Community Treatment for 17 clients based on a bundled rate for services from a multidisciplinary team shared Thrive Behavioral Health and House of Hope CDC clients based on an average of 48 healthcare visits per year and a value of $41.65 per day.
- $5,044 for Integrated Health Home services for 4 clients based on a bundled rate for case management and nursing services shared Thrive Behavioral Health and House of Hope CDC clients based on an average of 48 healthcare visits per year and a value of $13.82 per day.

Prior to the execution of a HUD-CoC contract for the Enhanced Street Outreach project, Thrive Behavioral Health agrees to enter into an MOU with House of Hope CDC that will satisfy all conditions established by HUD for the provision and documentation of leverage and match funding.

Sincerely,

Daniel J Kubas-Meyer LCC

Daniel J. Kubas-Meyer
President/CEO

PCHC
PROVIDENCE COMMUNITY
HEALTH CENTERS

October 13, 2022

Laura Jaworski
Executive Director
House of Hope CDC
3188 Post Road
Warwick, RI 02888

Re: Commitment of Healthcare and Behavioral Health Services
FY22 Continuum of Care Unsheltered NOFO
Enhanced Street Outreach- House of Hope CDC

Dear Ms. Jaworski:

The Providence Community Health Centers Inc. (PCHC), a Federally Qualified Health Center, is providing a written commitment for the permanent availability of healthcare and behavioral healthcare services to program participants of the House of Hope Enhanced Street Outreach project in the estimated amount of $120,000 annually to serve as both match and leveraged funding as required for the 2022 HUD Continuum of Care Program Competition. These services will be available to residents immediately upon execution of the contract.

Specific leveraged services and associated values include:

- $120,000 for Primary Health Care, Case Management, and Integrated Behavioral Health Services. We estimate 20% (or 125) of our patients experiencing homelessness shared PCHC and House of Hope CDC clients based on an average of 3 healthcare visits per year and a value of $320 per visit.

Prior to the execution of a HUD-CoC contract for the Enhanced Street Outreach project, PCHC agrees to enter into an MOU with House of Hope CDC that will satisfy all conditions established by HUD for the provision and documentation of leverage and match funding.

Sincerely,

Merrill Thomas
President & CEO

Thundermist
HEALTH CENTER

Woonsocket
Medical
450 Clinton St.
Woonsocket, RI
02895

Phone: (401) 767-4100
Fax: (401) 235-6896

Dental & WIC
25 John A. Cummings Way
Woonsocket, RI 02895

Dental Phone: (401) 767-4161
Dental Fax: (401) 767-5441

WIC Phone: (401) 767-4109
WIC Fax: (401) 767-4165

West Warwick
Medical
The Cotton Shed
186 Providence St.
West Warwick, RI 02893

Phone: (401) 615-2800
Fax: (401) 615-2805

Dental
1219 Main St.
West Warwick, RI 02893

Phone: (401) 615-2804
Fax: (401) 615-2803

South County
1 River St.
Wakefield, RI
02879

Medical Phone: (401) 783-0523
Medical Fax: (401) 783-9448

Dental Phone: (401) 783-5646
Dental Fax: (401) 284-2081

WIC Phone: (401) 360-1528
WIC Fax: (401) 783-9448

September 9th, 2022

Laura Jaworski
House of Hope CDC
3188 Post Road
Warwick, RI 02888

Re: Commitment of Healthcare and Behavioral Health Services
FY22 Continuum of Care Unsheltered NOFO
Enhanced Street Outreach- House of Hope CDC

Dear Ms. Jaworski:

Thundermist Health Center, a Federally Qualified Community Health Center, is providing a written commitment for the permanent and unconditional availability of healthcare and behavioral healthcare services to program participants of the House of Hope Enhanced Street Outreach project in the amount of $151,592.00 in-kind annually to serve as both match and leveraged funding as required for the 2022 HUD Continuum of Care Program Competition. These services will be available to participants immediately upon execution of the contract.

Specific leveraged services and associated values include:

- $61,592.00 for street-based shower and hygiene for the House of Hope CDC Shower to Empower program for covering costs of operations for one day per week at both West Warwick and Woonsocket locations
- $90,000.00 for clinic-based health services for 125 shared Thundermist Health Center and House of Hope CDC clients based on an average of 3 healthcare visits per year and a value of $240.00 per visit

Prior to the execution of a HUD-CoC contract for the Enhanced Street Outreach project, Thundermist Health Center agrees to enter an MOU with House of Hope CDC that will satisfy all conditions established by HUD for the provision and documentation of leverage and match funding.

Sincerely,

Jeanne LaChance
President and CEO Thundermist

HOUSE of HOPE
COMMUNITY DEVELOPMENT CORPORATION

September 9th 2022

Commitment of Healthcare and Behavioral Health Services
FY22 Cotinuum of Care Unshelttered NOFO
Enhanced Street Outreach- House of Hope CDC

House of Hope CDC is providing a written commitment for the permanent and unconditional availability of healthcare and behavioral healthcare services to program participants of the House of Hope CDC Enhanced Street Outreach project in the amount of $140,388 annually, to serve as both match and leveraged funding as required for the 2022 HUD Continuum of Care Program Competition. These services will be available to residents immediately upon execution of the contract.

House of Hope CDC is able to provide the following healthcare commitments through existing programs:

- $48,000 for contracted street-based medical services (MD's, RN's, Psychiatry) from the House of Hope CDC Shower to Empower Grant funded through the RI Consolidated Homeless Fund.
- $92,388 for street-based shower and hygiene services from the House of Hope CDC Shower to Empower Grant funded through the RI Consolidated Homeless Fund.

Sincerely,

Laura Jaworski
Executive Director

STATE OF RHODE ISLAND

Department of Behavioral Healthcare, Developmental Disabilities & Hospitals
OFFICE OF THE DIRECTOR
14 Harrington Road
Cranston, RI 02920-3080

TEL: (401) 462-3201
FAX: (401) 462-3204
TDD: (401) 462-6087

October 13, 2022

Ms. Laura Jaworski
Executive Director
House of Hope CDC
3188 Post Road
Warwick, RI 02888

Re: Commitment of Healthcare and Behavioral Health Services
FY22 Continuum of Care Unsheltered NOFO
Enhanced Street Outreach- House of Hope CDC

Dear Ms. Jaworski:

The Rhode Island Department of Behavioral Health, Developmental Disabilities & Hospitals (BHDDH) supports the House of Hope Enhanced Street Outreach project which provides medical and behavioral health services to program participants.

The House of Hope will leverage the services with $40,000 from the SAMHSA Projects to Assist Transitions from Homelessness (PATH) grant that pass through BHDDH. These funds will be used for the provision of street-based medical services provided by subcontracted, licensed, medical providers through House of Hope CDC, including doctors and psychiatrists.

BHDDH and House of Hope CDC enter into an annual contract to provide these services which satisfies conditions established by HUD for the provision and documentation of leveraging funds.

Sincerely,

Richard Charest, MBA
Director

east bay community action program
THE BRIDGE TO SELF-RELIANCE

September 9, 2022

Mr. James Lehane, Executive Director
Newport Mental Health
127 Johnny Cake Hill Road
Middletown, RI 02842

Dear Mr. Lehane,

It is our pleasure to offer this Commitment Letter on behalf of Newport Mental Health's application to the Rhode Island Housing Continuum of Care Program as a Supportive Services Only (SSO) applicant to provide wrap around care. EBCAP is committed to working with Newport Mental Health to ensure that our over 300 shared clients in Newport County receives the mental health and medical treatment resources available.

Our long-standing positive working relationship with Newport Mental Health to support the needs of Newport County residents will continue to benefit our mutual clients. **EBCAP is happy to provide healthcare leverage for this project to over 300 shared clients.**

At EBCAP we work with adults who require medical and social services support, and we rely on our partnerships with other local non-profit service providers to prioritize the needs of clients with complex medical and mental health issues. We appreciate Newport Mental Health's use of Evidence Based Trauma Informed Behavioral Health Care and Substance Use Disorder Recovery Planning which involves a Client Centered Approach to improve client health outcomes. Our clients will directly benefit from Newport Mental Health receiving funding through this grant program. Therefore, we fully support Newport Mental Health's request to receive funding from HUD to supply services to Newport County's residents.

Sincerely,

Robert A. Crossley, MA
Vice President of Behavioral Health

Health Equity Zone
Woonsocket

The Rhode island Continuum of Care (RICoC)

RE: RFP for New Continuum of Care Projects to Address Unsheltered Homelessness in Rhode Island

Dear RICoC,

I am writing to support Community Care Alliance's (CCA) application to Address Unsheltered Homelessness in Rhode Island.

Thundermist Health Center through the Woonsocket Health Equity Zone (HEZ) intends to support CCA's efforts in securing funding to provide assistance to unsheltered individuals and families in Northern Rhode Island. Thundermist has successfully worked with CCA for several years on multiple projects that continue to yield positive results for the Woonsocket community. We resonate with CCA's mission of supporting individuals and families in their efforts to meet economic, social, and emotional challenges and enhance their well-being.

Our joint ventures include work at CCA's Safe Haven, a drop-in center for the unhoused community. This vulnerable population has improved access to Thundermist medical providers for evaluation, management and treatment of their medical needs. In addition, we collaborate on the Promoting Integration of Primary and Behavioral Health Care (PIPBHC) initiative. This initiative focuses on supporting the improvement of integrated care models for primary care and behavioral health care to improve the overall wellness and physical health status of adults with a serious mental illness and children with serious emotional disturbance. We have also integrated as needed to ensure the best outcomes for the community.

We recognize CCA's critical role in community-based services and welcome the opportunity to further collaborate. We believe this grant will provide critical funding needed to meet the challenges of the Woonsocket community.

We know CCA has the framework needed to achieve the long-term goals and look forward to supporting them.

Sincerely,

Dupe Akinrimisi

Woonsocket Health Equity Zone Project Manager

October 12, 2022

Michelle Brophy, Chair
Rhode Island Statewide Continuum of Care (RI-500)
C/O Continuum of Care Planner
44 Washington Street
Providence, RI 02903

RE: Letter of Support for RICoC's Application to HUD for Special Funding to Address Unsheltered Homelessness

Ms. Brophy,

Rhode Island's Constituent Advisory Committee (CAC) is writing to confirm our participation in the development of, our support for, and our alignment with, the application for Special Funding to Address Unsheltered Homelessness that the Rhode Island Continuum of Care developed within its Unsheltered Planning Workgroup.

The CAC is a group committed to elevating the voices of people with lived experience of homelessness in Rhode Island to inform policy and planning to strengthen the homeless system in our State. The RI Coalition to End Homelessness hosts the CAC and employs the CAC's Program Coordinator, who also has lived experience of homelessness and is a CAC member.

The CAC robustly participated in the RICOC's Workgroup to Plan to Address Unsheltered Homelessness. This workgroup designed the RICoC's plan to address unsheltered homelessness and the priorities for funding. Our work began with setting group commitments to guide our work together and included multiple workgroup meetings to reflect on the status of the existing system to address unsheltered homelessness and how that system could be improved to better serve people living outside and unsheltered. Our workgroup designed a survey of people living unhoused with Rhode Island right now their needs and wants in services, shelter, and housing expansion. These survey results directed the projects selected for submission to HUD for funding to address unsheltered homelessness. Our discussions focused on strategies to reach and serve the most vulnerable: people with severe services needs living within Rhode Island, which is the RICoC's jurisdiction. Our discussions highlighted existing gaps in the system for people with severe services needs, and highlighted person centered and trauma informed approaches and strategies to fill those gaps.

The CAC was pleased the RICoC recognized the importance of the CAC role in the Unsheltered Planning Group, and reimbursed CAC members' time and effort to participate a rate of $20/hour. We know that, if awarded to Rhode Island, this Special Funding to Address Unsheltered Homelessness (FR-6300-N-25S) will provide extensive services resources that

people living outside and unsheltered in Rhode Island so deeply need to end their homelessness.

The CAC strongly supports the RICoC's application to HUD for Special Funding to Address Unsheltered Homelessness (FR-6300-N-25S) and the priorities for addressing unsheltered homelessness identified in the plan. The CAC looks forward to its continued participation in the RICOC workgroup to address unsheltered homelessness as the guiding leaders to assure, once funded, these projects are implemented and monitored for continuous quality improvement to guarantee the projects are implemented as intended: to serve the most vulnerable Rhode Islanders, those living unsheltered with the most severe service needs.

Sincerely,

DocuSigned by:
Samantha Burnett
F8A7AC6A46904FE...
Samantha Burdett

DocuSigned by:
Wendy Thomas
9A3988D6BB64445...
Wendy Thomas

DocuSigned by:
Jillian Wassmer
3DB101D761D64EF...
Jillian Wassmer

CoC Plan for Serving Individuals and Families Experiencing Homelessness with Severe Service Needs

P-1. Leveraging Housing Resources

P-1a. Development of New Units and Creation of Housing Opportunities – Leveraging Housing.

CoC application attachment demonstrates 50% housing leveraging; there is no narrative response associated.

P-1b. Development of New Units and Creation of Housing Opportunities – PHA Commitment.

The CoC is increasing the number of permanent housing units available to individuals and families experiencing homelessness. The CoC partners closely with multiple housing authorities within the State of Rhode Island. Two (2) of those Housing Authorities, Rhode Island Housing and the Providence Housing Authority, registered interest to apply for HUD's Stability Voucher (SV) opportunity consistent with Notice PIH 2022-24(HA). If awarded, all subsidies awarded through SVs are committed to the CoC and will be made available through the Rhode Island Coordinated Entry system for people who are experiencing unsheltered homelessness. These vouchers will be distributed to eligible participants based on referral from the Rhode Island Coordinated Entry system and will be coordinated with supportive services through the CoC and mainstream resources. Coordinated entry will distribute the vouchers in support of the priorities identified in this plan, which will be memorialized in prioritization criteria set by the CoC through its Unsheltered Planning Group, which includes multiple people with lived experience of homelessness. The opportunity to project-base SVs is of particular interest. The CoC partners closely with its housing authorities and the network of housing providers associated with the State's Mortgage Finance Company, which is also the CoC's Collaborative Applicant. Project-based subsidy from the SV combined with supportive services from the CoC and its robust network of healthcare leveraging partners, provides a scalable model the CoC already uses routinely within its existing portfolio to house households rapidly as units in new and redeveloped projects come online. The CoC's experience with implementing and scaling this model makes Rhode Island the perfect landscape for an infusion of SVs coupled with special funding to address unsheltered homelessness to make homelessness rare, brief and non-recurring within Rhode Island.

P-1c. Landlord recruitment.

2. The CoC and State's Landlord recruitment strategy is a critical component of this planned response because of RI's current vacancy rate. The current vacancy rates are 2.0% statewide and 3.4% in Providence. Academic literature suggests that a 6-7% vacancy is a kind of equilibrium point where rents are stable and anything under 3% is considered extreme, leading to unstable and high market rents. In response to this low vacancy rate and due to its recognition that housing is healthcare, beginning in the early months in the COVID-19 pandemic, Rhode Island made the innovative choice to begin using federal and state funding to offer incentives to landlords to rent to participants in homeless assistance programs. As demonstrated in the program summary below, CoC and ESG collaboration was critical to this program implementation and ongoing success. In June 2020, Rhode Island's Governor announced a Landlord Challenge, an incentive program run by the State Office of Housing and Community Development to support landlords in pledging vacant units to help combat COVID-19 and end homelessness in Rhode Island. The initial program provided a $2,000 signing bonus for the first pledged unit; $500 for each additional unit; up to $2,000 per unit move-in upgrades and repairs; and guaranteed first and last month's rent.

To be eligible to receive the incentives, vacant units were pledged by the landlord or property manager contacting United Way Rhode Island's 211 call center. The initial goal was for the private market to pledge 100 units; the state surpassed that goal with a total of 127 units pledged within that initial program, which ran through December 2020. A critical piece of this initial initiative's success was that, at that stage of the pandemic, the Governor's office was hosting regular press conferences with local media providers that were broadcast regularly on multiple news outlets to update the public on COVID-19. Vacant units pledged were

assigned to households with supportive housing referrals through the CoC's coordinated entry system. Due to the success of the initial incentive programs, state and federal funding have consistently been used to fund future iterations of the landlord incentive program since that initial challenge.

1. The current issuance of the Rhode Island Landlord Challenge has increased its incentive payments. Since RI's vacancy rates have only decreased and the housing market increased in competitiveness, the increased incentives were deemed critical. The units pledged continue to be matched with clients through the CoC's CES who have supportive housing program referrals. Currently, participating landlords who offer safe, habitable and rent-reasonable units for one-year leases receive the following incentive package: $3,000 signing bonus for the first unit; $1,000 bonuses for each additional unit, and up to $3,000 per unit is available for reimbursement for necessary repairs.

a-b. Since 2021 and those initial 127 units pledged during 2020, an additional 102 units have been pledged and utilized to permanently house Rhode Islanders experiencing homelessness. Units have been pledged and utilized from every county in Rhode Island, spanning the geography of the state and the jurisdiction of the CoC.

Lessons learned from the initial program centered around strategies to more rapidly respond to landlords who pledged units. The stakeholders brainstormed ways to streamline processes to reduce the amount of time it took between a unit being pledged to it being leased. This resulted in streamlined HQS and Rent Reasonableness process, partnerships between agencies and sharing of paperwork, and fiscal procedures to quickly pay incentives while still assuring program requirements are met. Lessons Learned also included incorporating seasoned communications teams into our initiative to market the program more effectively to the private market landlords unfamiliar or uncomfortable with federal housing processes.

Since the COVID-19 press conferences that proved so critical to the success of the first landlord incentive program are no longer occurring , the OHCD and CoC pivoted its communications strategy. In addition to continuing to rely upon the Governor to message this Landlord Challenge through media events and press releases, the state allocated funding to billboard purchases in locations where people experiencing homelessness indicated they would like to live. State officials and homeless services providers have outreached the Landlord Challenge on local news television network appearances, on local radio advertisements, media events and in local publications.

3. The State and CoC continue to use data to inform this program implementation by monitoring changes in the vacancy rate statewide and in RI's core-cities, where many people experiencing homelessness choose to live, to inform incentive rates, location of billboards and other marketing materials to recruit landlords in highly desired neighborhoods. Additionally, the partners regularly review HMIS data and data from Statewide Street outreach teams tasked with supporting encampments and using that location data to inform scaling and continuous quality improvement.

P-2. Leveraging Healthcare Resources

Rhode Island is a Medicaid expansion state; the COC has long relied upon its innovative approach to leverage Medicaid reimbursable healthcare services to maximize mainstream benefits for CoC participants thereby expanding the CoC's housing resources. 7 CoC participating agencies are currently eligible to receive Medicaid Reimbursement for care provided to clients within CoC programs; multiple additional agencies are within the application process. One example of leveraged Medicaid services is the approval of a housing stabilization services (HSS) package by the Centers for Medicare and Medicaid (CMS). HSS was designed to promote positive health outcomes and housing retention with RI. HSS provides an array of services, including home tenancy, life skills and other modeling and teaching services for individuals who require support in obtaining and maintaining a home, and/or home find services to individuals who require support in finding and

transitioning to housing. Services are intended to be flexible and support recipients in becoming self-sufficient in their housing. Home Stabilization services are provided by State certified providers. The State encourages a diverse group of agencies to apply to become providers, including, but not limited to, homeless service agencies, CAP agencies, mental health treatment agencies, health clinics, and case management agencies. In addition to the HSS program described above, two additional examples of Medicaid services leveraged regularly within existing CoC programs are Assertive Community Treatment (ACT) and the Integrated Health Home (IHH). All of these services will significantly leverage special funding to address unsheltered homelessness as demonstrated by the letters of commitment attached to the CoC Application and the need data summarized below.

People currently living unsheltered in Rhode Island have extensive healthcare and behavioral healthcare needs as demonstrated by the following information: The CoC and its Unsheltered planning group, comprised significantly of people with experience of homelessness, conducted a survey of people currently living unsheltered in the state to gather their input on a variety of topics related to their shelter, housing and services wants and needs. Over 27% of the respondents reported that they needed support for mental health issues; 20% of respondents reported a need for support to address substance use issues; and over 18% reported physical health needs. Mainstream Substance Use Treatment and Recovery Services are also leveraged by multiple projects within this funding application, including the PSH project included in this proposal; the PSH applicant has a leveraging commitment from a partnering mental health agency to provide treatment and recovery services to all program clients who are eligible for services and choose to enroll. Street Outreach projects also have commitments from Substance Use and Recovery services providers to provide services to all clients who are eligible and choose those services. In addition to the mainstream and Medicaid resources described above, healthcare services leveraged for this plan also include unique and innovative partnerships with private funding and other state funded resources experienced in delivering street-based medical services (these are registered MDs, RNs, and psychiatrist teams) providing healthcare directly to people experiencing unsheltered homelessness while they are living unsheltered including within encampments. The CoC's Unsheltered Planning group, which includes many people with experience of unsheltered homelessness, discussed the close relationship between healthcare and housing and highlighted the challenge of basic hygiene while living unsheltered in one of their planning meetings. They stated the obvious connection between hygiene, health and housing and therefore recommended including in projects selected for funding services provided by "Shower to Empower", which while they are not delivered by a healthcare provider, help support the healthcare needs of people living unsheltered. The funding for Shower to Empower is also leverage supporting this plan. Shower to Empower is a street-based healthcare, shower and hygiene program that provides access to basic hygiene services coupled with housing focused street outreach services, street based medical services (MD's RN's Psychiatry) and mainstream benefits coordination. Healthcare leveraging funds through the State's SAMHSA Projects to Assist Transitions from Homelessness (PATH) are also committed by the State's Department of Behavioral Health, Developmental Disabilities & Hospitals (BHDDH), which oversees PATH locally within in RI.

P-3. CoC's Current Strategy to Identify, Shelter, and House Individuals and Families Experiencing Unsheltered Homelessness

P-3a. Current Street Outreach Strategy

1. Rhode Island's Street Outreach programs coordinate with each other to form a statewide initiative addressing unsheltered homelessness focused on seeking to engage all people living unsheltered in the state. As part of the CoC's Unsheltered planning initiative, RI sought to survey as many people experiencing unsheltered homelessness as possible within a 2-week timeframe. We succeeded in reaching 126 persons – about 38% of

those reported to be unsheltered in the most recent Point in Time count. Overwhelmingly, respondents indicated that their most pressing needs were for a safe place to stay and assistance in obtaining housing. When asked what services people needed but were not receiving, the two most common responses were housing search assistance and housing subsidies. Interestingly, the next most frequent responses were the need for case management support and the need for employment. This indicates that unsheltered people need greater support to end their homelessness and people experiencing homelessness are eager and motivated to obtain money by earning it. Existing services such as street outreach, case management, and to a limited extent, housing navigation, and housing stabilization are already made available to individuals experiencing unsheltered street homelessness with co-occurring disorders. Current outreach efforts have been successful but have been limited by available resources. Outreach is effective in urban areas; for example, Providence mobile outreach teams provide case management, linkages to housing and warm handoffs to housing case managers once placements have been made. The teams also have close linkages to community mental health providers.

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Street outreach is a proven means of connecting with individuals experiencing unsheltered homelessness who may be disconnected or alienated from mainstream resources. This regular, consistent presence allows for trust and rapport to be built slowly over time, and as a result the team is known, trusted, and available to work with people on their own terms and at their own pace. Rather than engaging constituents with contingencies to enroll in services, outreach workers start by listening, and by meeting immediate needs or addressing crisis situations. During regular street outreach rounds, outreach workers are often having conversations about life stressors, troubleshooting with constituents experiencing barriers, accessing needed services, or meeting basic needs by providing coffee, food, bus passes, or clothing.

Outreach workers are often the first point of triage for individuals in physical or behavioral health crises. And they are often the first people to treat those living unsheltered with dignity and respect. Interventions include making calls for emergency medical services or providing rides to hospitals, Safe Stations, or BHLink (crisis mental health services). Outreach workers are trained to use naloxone and to identify signs of overdose and withdrawal and receive training in Mental Health First Aid and crisis intervention. It is from these low barrier encounters that outreach case managers naturally build their caseloads.

In addition to these more intensive client relationships, outreach workers assist with short-term tasks, basic needs connections, or referrals for clients who are not yet formally connected to a case manager. These tasks include vital document replacement/acquisition, applications for disability bus passes, transportation to medical appointments, provision of clothing or other resources as available, and navigation among other service providers. One of the key roles for outreach is bridging gaps for individuals who have slipped through cracks in various service systems. As a result, outreach team members make every attempt to personally respond to requests for assistance, and to provide warm handoffs and accompaniment when making referrals to outside services.

Outreach programs are built on assertive, relational, and engagement principles that develop trust, address immediate needs, and provide linkages to services and resources. Although the goal is to move individuals from the street to services and housing, some individuals are fearful or hesitant to engage with mainstream services providers as result of past trauma or negative interactions with service providers. Outreach

staff can build trust and rapport, address immediate needs with food, hygiene products, and other basic needs, and introduce medical practitioners through street medicine teams.

Outreach is not fully consistent across the state and a focus of this funding and plan is to make it so. Outreach is well coordinated and effective in certain core-cities. When a person who is living unsheltered, contacts coordinated entry, the specialist will first seek to determine if the person is in HMIS, if not, CE will notify the relevant outreach team and, the team will seek to locate and engage the person. As rapport is developed, outreach workers will seek to complete a universal assessment so that the individual can be assessed and prioritized for the appropriate intervention.

Among the biggest challenges facing outreach once workers have developed a rapport is the shortage of available housing placements. Once the housing assessment has been completed, outreach workers need to maintain contact while people await housing placement. This process can drag on as there are limited options and a prolonged wait can make retaining rapport difficult.

One key element of current outreach is coordination with street-based medicine which allows the healthcare needs of people living unhoused to be assessed, provided treatment in place, as possible, and referred for more intensive services including physical and behavioral health as required. Of the unsheltered people surveyed, just under 40% reported a need for mental health rehabilitation services that they were NOT yet receiving. Similarly, 29% reported an unmet need for substance use disorder treatment, and 21% reported needing but not receiving healthcare services.

2. In RI cities, outreach is conducted daily. To engage people most effectively, outreach is focused on the morning and late afternoon/early evening hours. Outreach teams refer to these as the ‘golden hours’ when people are most easily located and most receptive to contact. This is the time when some people have left evening shelter, soup kitchens have yet to open, and people are leaving for or returning from morning methadone appointments. The other best time is late afternoon, early evenings. Outreach primarily occurs during the workweek when it is possible to connect those engaged with services and housing resources. In addition to street outreach, there are also harm reduction outreach teams in the major cities that seek to limit overdose deaths and connect substance users to services and these services are coordinated with homeless outreach. Outside of the cities, outreach can be more sporadic and there are people living in hard to access areas that have very infrequent outreach contact, if there is contact able to be made at all.

Street Outreach (SO) positions continue to be funded to be able to cover 100% of the COC's geography at least 5 nights/week as their capacity allows. However, Street Outreach program capacity directly relates to the number of people experiencing unsheltered homelessness within RI. While RI has long had a number of people living outside and unsheltered, since the onset of the COVID-19 pandemic CoC data and qualitative reports from street outreach teams combine to demonstrate a marked increase in unsheltered homelessness. The ongoing pandemic and regular COVID surges within RI provide additional service delivery challenges: staff unavailability, challenges in filling open positions hindering administration of programs to fidelity.

To support the Street Outreach teams to be able to respond to the marked increase in need RI has seen in recent years, the CoC’s Unsheltered Planning Group highlighted the importance of expanding RI’s existing street outreach services to respond to the gaps their discussion and this data highlighted. The groups agreement on this was reflected in the proposals selected for funding. Additionally, The CoC continues to advocate to the State’s Consolidated Homeless Fund (CHF), a braided funding stream of federal, State, and COVID recovery monies overseen by the Department of Housing to further increase funding available to support essential services to fill these gap for people experiencing homelessness, especially unsheltered homelessness, by funding projects including but not limited to: drop in centers, new shelter, expansion of shelter, Prevention/Diversion, and Housing Problem Solving (RI’s terminology for Diversion and Rapid Resolution or Rapid Exit from Shelter) with the State’s CHF.

3 & 6. The initial focus of outreach is to engage people and develop a rapport. Local outreach teams are reflective of the people experiencing homelessness; having lived experience is a primary factor for selecting staff for outreach positions. All outreach teams in RI include people with lived experience of homelessness. Outreach workers are also hired based on their ability to speak the languages of people experiencing unsheltered homelessness. Outreach teams also include traditional case management and clinical skills to engage people experiencing unsheltered homelessness most effectively. Outreach Workers develop initial rapport by addressing immediate concrete needs of people living unsheltered and once that has been established, seek to complete the universal assessment needed to be able to add their names to the coordinated entry by-name list. In Providence, the mobile outreach teams are able to continue to provide support from initial engagement to providing support after the individual has been placed in housing. If there is case management at the housing placement, the worker will do a warm handoff of services. If not, the outreach team will maintain contact and assist in maintaining housing stability. Maintaining a linkage and case management relationship after housing placement has been a significant lesson learned and outreach proposed under this special NOFO will ensure that there is either a warm handoff to housing based case management or outreach case management continues until the individual/family stabilizes in their new housing for outreach teams working in all areas of RI.

4. Once the outreach teams have engaged people, they will seek to assess their risks and vulnerabilities using the universal assessment. Those with the highest vulnerabilities will be prioritized on the by-name list and will receive housing assistance soonest. Outreach teams are local to the communities that they serve and reflect the demographics and speak the language(s) of people experiencing unsheltered homelessness in those communities. Strategies that they use to engage reflect the culture and traditions of those they are serving. For example, people identifying as Asian American Pacific Islander (AAPI) tend to be located in and around Cranston and outreach teams serving this area will include people who are AAPI and be sensitive to the cultural differences such as a deep-seated resistance to admit need for help or to accept help from strangers.

5. Outreach teams use mobile tablets and an application called Fulcrum that help outreach workers gather a large amount of data that is then entered into HMIS. Among the increased resources requested for this plan are updates to HMIS that will allow outreach workers to enter data directly into HMIS and data managers to be certain data is more timely, complete and accurate. It will also streamline outreach data processes by eliminating the time-consuming step of transferring data from one system into another.

Permanent housing is offered to unsheltered people based on the availability of resources. People assessed to need permanent supportive housing are offered that service as soon as a placement/unit is available; if there are no PSH placements/units available, coordinated entry will refer to the next available housing resource, often rapid rehousing. RI has existing policy and procedures to support Bridge Rapid Rehousing for people experiencing homelessness when there are not PSH placements available. In those instances, eligibility for PSH will be established on program entry, facilitating a future transfer to PSH if that is the continued need when a placement becomes available. This data and the coordinated entry system allow for a potential housing placement and the outreach workers work to facilitate the connection to housing. Where there is the most robust outreach, this will involve the outreach team assisting in housing location, in securing property owner approval, and providing a warm handoff to permanent housing case managers.

P-3b. Current Strategy to provide immediate access to low-barrier shelter and temporary housing.

1-2. Rhode Island does not have enough emergency shelter available to meet current demand for shelter in our State. Therefore, the CoC prioritizes access to its emergency shelter resources to assure that the most vulnerable households are referred to the shelter resources available. The CoC accomplishes this through its Coordinated Entry Lead agency that operates a combined call center and no-wrong door approach to CES and a universal assessment tool to create by name list for shelter resources, which is managed through the HMIS (and

a parallel, deidentified process for survivors of violence to access shelter and housing resources to assure their confidentiality and safety). As shelter and temporary housing resources are available, the CES lead matches the most vulnerable household eligible for the resource to the agency with the vacancy to assure rapid access.

However, while this strategy is effective at providing rapid access when resources are available, since there are not enough resources available at this time, additional funding to create more emergency shelter and temporary housing in RI is necessary. Understanding this deep need within our State, as part of this planning effort the CoC conducted a survey of people living unsheltered in Rhode Island. The survey was designed by the planning group for the unsheltered NOFO which includes many people with lived experience of homelessness. Outreach workers conducted the survey, and the CoC offered respondents a $10 gift card to one of a number of food or retail establishments to recognize and appreciate the responses. 126 people who were currently unsheltered completed the survey. One of the questions asked within the survey was, "What is the main reason you aren't staying in a shelter?" The responses clearly indicated the challenges to the RI shelter system and barriers to people experiencing unsheltered homelessness. The most common response was that the respondent tried to access shelter but was unable to do so, highlighting the limited shelter resources within RI compared with the need. The next highest response was that the respondent did not consider shelters to be 'a safe place for me', highlighting that, even when available, a number of the shelter beds are not place where people feel safe, leading to their choice to remain outside.

These results did not surprise the CoC's Unsheltered Planning group, which includes a number of people with lived experience of homelessness, during their analysis of the survey results. Their discussion and analysis aligned with the results of the survey. They highlighted there is limited access to low-barrier shelters in Rhode Island and a growing number of people experiencing unsheltered homelessness.

3. RI has demonstrated the expertise and will to rapidly grow its shelter resources within the last 3 years. In response to COVID , RI rapidly stood-up temporary non-congregate shelters, often in hotels. The goal was to provide safe, temporary housing with as few barriers as possible to entry. People experiencing homelessness significantly appreciated the privacy, safety and security of the non-congregate shelters (NCS). While the contracted providers placed few, low barriers to entry, the private owners and hotels on occasion did impose other limitations that did not align with housing first philosophy and trauma informed practices. The programs sought to intervene in these instances, however their reliance on the hotel provider to continue to provide the NCS resource sometime resulted in higher barrier shelters than were originally intended. Another significant challenge in NCS programming was the expense of hotels coupled with the funding sources limitations. RI applied to use FEMA funding, an innovative strategy allowing the State to stretch its COVID and existing resources. However, FEMA funding is temporary and only guaranteed in short time increments based on ongoing eligibility and pandemic need. This led to constant uncertainty about the ongoing availability of non-congregate shelter, which meant that the services were continuously described as time limited. The uncertainly created barriers and challenges for clients and program staff alike, who were trying to secure permanent housing resources but did not have firm timelines to rely upon. Despite these challenges, RI continues to offer NCS to respond to its growing need for shelter and client choice. Respondents to the unsheltered homeless survey overwhelmingly stated that their preference for temporary/emergency housing was a space that afforded privacy for themselves and family (if applicable); NCS provides this security. RI does continue to improve and refine its sheltering and NCS strategy to lower barriers and respond to challenges outlined above.

RI's Department of Housing oversees the Consolidated Homeless Fund (CHF), which funds the majority of the emergency shelter in the state. The CHF recognizes the data and need for additional shelter resources. In September 2022, the CHF issued an additional $3.5 million in state funding to expand the shelter system and fund 231 new, low barrier, shelter beds. The State has left their request for shelter expansion proposals open on

an ongoing rolling basis and anticipates issuing at least $1.5 million in additional funding to be disseminated this fall to fund additional shelter beds. The beds funded were identified in partnership with the CoC and State CHF using its shared funding recommendations committee who also analyzed the survey results described above and strove to select beds that aligned with the survey results. The funding committee that informed those decisions is chaired by a person with lived experience of homelessness who is also a CoC board member.

P-3c. Current Strategy to Provide Immediate Access to Low Barrier Permanent Housing for Individuals and Families Experiencing Unsheltered Homelessness

1. Rhode Island does not have enough supportive housing available to meet current demand in our State. Therefore, the CoC prioritizes access to its supportive housing resources to assure that the most vulnerable households are referred to the housing resources available. The CoC accomplishes this through its Coordinated Entry Lead agency that operates a combined call center and no-wrong door approach to CES and a universal assessment tool to create by name list for housing resources, which is managed through the HMIS (and a parallel, deidentified process for survivors of violence to access housing resources to assure their confidentiality and safety). As supportive housing resources are available, the CES lead matches the most vulnerable household eligible for the resource to the agency with the vacancy to assure rapid access. However, while this strategy is effective at providing rapid access when resources are available, since there are not enough resources available at this time, additional funding to create more housing in RI is necessary.

a. CoC policy is that all housing providers must follow the Housing First philosophy and all providers must accept all referrals for admission from the coordinated entry system. As part of its annual monitoring of providers, the CoC reviews each provider's policies and procedures regarding Housing First and also reviews clients' charts to be certain that the provider implementing the housing first policies as intended. This Housing First and CES alignment extends to State and City funded supportive housing programs as well. Coordinated entry prioritizes the most vulnerable people for housing resources consistently; for adult programs, this includes people living unsheltered.

While the CoC has continued need for supportive housing subsidies described above, even folks matched with a supportive housing referral have significant barriers to finding an available unit in RI because accessing housing in the private market has become increasingly challenging. As referenced earlier in this Plan, the current vacancy rates are 2.0% statewide and 3.4% in Providence. This aligns with qualitative reporting from CoC and State funded Housing navigators, who report that market rents have increased by about $300/month in the past year alone. Finding any housing that is affordable, meets housing quality standards, and where the owner will accept applicants who may have challenging background records and lack of, or poor credit history is the greatest barrier to housing placement in RI at this time. Respondents to the survey of people living unsheltered reported significant and widespread concern that they will experience discrimination when they seek housing either because of their homeless status, poor credit or housing history, and/or racism.

The CoC has implemented innovative strategies in recent years to increase the supply of affordable housing for people experiencing homelessness. The CoC partners closely with three housing authorities that have preferences for people with experience of homelessness and/or people fleeing domestic violence. To support these preferences the CoC provides policy language and process consultation and offers its CES for referral support. The CoC has also expanded mainstream subsidies available by partnering with housing authorities on Mainstream Voucher programs for people experiencing homelessness, Foster Youth Initiative Vouchers, Emergency Housing Voucher Programs, and application for Family Unification Program Vouchers. Most recently the CoC has established commitments with two PHAs to support their applications for Stability Vouchers. The CoC also continuously advocates to and partners with its state partners at the Department of Housing on strategies to increase the availability of units. The Department of Housing and State of RI recognize

the need for additional housing development and are in process of conducting a housing plan, which includes CoC as a key stakeholder to inform on housing for people experiencing homelessness. Additionally the CoC partners closely with the State Mortgage Finance Company which is also the CoC collaborative applicant agency. This close and consistent ability to collaborate on housing initiatives results in a number of opportunities to streamline access to units for people experiencing homelessness. One example is RIHousing's implementation of HUD's Opening Doors through multifamily housing initiative (known locally as RI's New Lease Program), which works with multifamily owners to amend their tenant selection plan to prioritize people experiencing homelessness by implementing a preference and allocating every other (or a similar cadence) vacancy to a household meeting that preference.

P-4. Updating the CoCs Strategy to Identify, Shelter and House Individuals Experiencing Unsheltered Homelessness with Data and Performance

1-3 a. As part of this planning initiative, the CoC and its Unsheltered Planning group, comprised of multiple people with lived expertise of homeless, asked statewide outreach workers to survey people currently experiencing unsheltered homelessness. Care was taken by the planning group to craft person centered, trauma informed language for the survey questions; and the CoC offered a gift card to various local establishments and stores valued at $10 per card as a thank you for the time and effort associated with participating in the survey 126 people completed the survey. Overwhelmingly respondents were seeking a safe, stable place to stay and assistance in getting housing. After those critical needs, respondents were interested in assistance in finding a way to earn money or support in obtaining the assistance they were entitled to. When respondents were asked about what they view as barriers to being housed, the most common response was concern over the ability to afford housing; the second most frequent response was concern that they would be discriminated against either because of their homelessness, credit/housing histories, and race. When asked about the kind of temporary/emergency accommodations that would meet their needs, overwhelmingly the respondents were looking for place that would provide them with privacy and security – qualities that are not present in most shelter available in Rhode Island.

Survey respondents were also asked about their preferences for permanent housing. Again, overwhelmingly participants were seeking to have their own private unit. If they weren't able to have that, a private bedroom and private access to a kitchen was preferred. Persons with lived experience participating in this planning group strongly echoed the need for private spaces and for people to have access to a kitchen to be able to meet their own needs as they reviewed these survey results. The survey also asked, "what was needed to obtain housing?" money was the most common response, followed by freedom from discrimination. Another common response was, "someone to help me pay the rent."

1-3 b. Among the key learnings from this survey are that unsheltered Rhode Islanders would like to be able to access safe, private temporary housing and are seeking to access affordable housing that is free of discrimination. They need financial assistance and support in accessing housing. While having sufficient resources to provide financial assistance to all needing housing will be challenging, many of the needs expressed such as freedom from discrimination can be addressed with stronger legal assistance. Other high priority needs identified, such as access to furniture, are more easily addressed. The survey indicates respondents have high levels of interest in obtaining earned income and willingness to share housing; this aligns with the CoC's Housing Problem Solving Strategy that there can be solutions to some household's housing crisis that may be less heavily dependent on public subsidies. (Housing Problem Solving is RI's umbrella term for its Prevention, Diversion and Rapid Resolution/Exit strategy). However, the deep service needs and co-occurring conditions reported within the survey overwhelming indicate subsidies coupled with services matched

with safe habitable units will be the most effective intervention to scale to address unsheltered homelessness. Therefore the plan and strategies focus there.

In addition to the recently completed survey, an analysis was conducted of people who sought homeless assistance in RI during State fiscal years 2017-2021 but who were NOT placed in supportive housing. This analysis was accomplished through State data matching. Rhode Island's HMIS participates in the RI State Data ecosystem, which allows for data matching across state programs and is linked to RI's State data from Medicaid, Unemployment data, and social services support data. This provided substantial information and insight into the needs of people who sought homeless assistance but were not placed in supportive housing, which is described below.

Persons not receiving supportive housing were classified into four groups based primarily on risks and vulnerability with those at highest risk of mortality or life-threatening events placed in the highest priority groups. Priority population A consisted of people with a substance use disorder, those who have experienced an overdose, people who are seriously and persistently mentally ill, and those who engaged in medication assisted treatment but subsequently experienced an overdose. Cumulatively across the four fiscal years observed, this priority group consisted of almost 45% of persons who sought homeless assistance but did not receive supportive housing. The next highest priority group consisting of just over 37% of those seeking homeless assistance but not placed in supportive housing were those with significant medical or safety concerns including those fleeing domestic violence, those with chronic serious medical conditions including HIV, cancers, diabetes, and those with injuries/conditions requiring emergency medical care. The third priority group, representing about a quarter of those seeking homeless assistance but not receiving supportive housing consisted of people who either had involvement with the criminal justice system or were unemployed. The fourth priority group includes those with special healthcare needs (traumatic brain injuries, dementia), developmental disabilities, and those determined to be disabled by Social Security. This group represented about 20% of those seeking homeless assistance but not receiving supportive housing.

For the period examined for this analysis (from State FY 2017 to FY2021) there was an increase of 82% among the group seeking homeless assistance but not receiving supportive housing placements. In the group of people seeking homeless assistance but not receiving supportive housing Blacks/African Americans were three times more over-represented than their share of the overall RI population. Furthermore, this group had disproportionately high occurrences of HIV, diabetes, and unemployment. People who identified as multi-racial were also over-represented in the population not receiving supportive housing. People identifying as multiracial had disproportionately high rates of domestic and sexual violence. Indigenous People seeking homeless assistance but not receiving supportive housing had disproportionately higher rates of unemployment, receiving SSI, and traumatic brain injury.

1-2 c. Outreach in the CoC has included street medicine workers (MDs, NPs, and nurses) as part of teams, especially in conjunction with the Shower to Empower services model. Limitations on funding have prevented this model from effectively serving all areas of the state and the increased resources proposed under this initiative will expand these partner's availability. Outreach teams have been training in addressing mental health (Mental Health First Aid) and drug use crises (overdose prevention) and this training will also be expanded state-wide. The unsheltered survey revealed a significant interest in seeking ways to obtain employment and earned income. To date, this has not been a significant focus. Moving forward, the unsheltered planning group will address opportunities to link with employers in need of staffing with this underutilized worker pool. Law enforcement has been a critical resource in identifying areas where people are living unsheltered. Expanded funding under this initiative will allow for greater collaboration with law enforcement while permitting less

threatening street outreach workers to be the public facing side of outreach with direct law enforcement involvement used only when needed to maintain safety.

P-5. Identify and Prioritize Households Experiencing or with Histories of Unsheltered Homelessness

1. The goal of this plan is to reduce the numbers of people living unsheltered across the entire State of Rhode Island. This involves comprehensive outreach coordinated among four providers – two specialized in serving targeted, underserved areas of the State, one addressing the special needs of people fleeing domestic violence, and one that will address the balance of the state. Outreach will be informed by evidence-based practices including Motivational Interviewing, Trauma Informed Care, Harm Reduction, Housing First, and Critical Time Intervention (CTI) including pre-CTI. Outreach teams will be multi-disciplinary – incorporating street medicine, peer support workers, recovery specialists, and case managers. The HMIS lead will invest in new technology so that field-based outreach workers have full and immediate access to the HMIS system and housing assessments. The expanded outreach teams will be fully reflective of the communities they serve, able to communicate in languages commonly used in the community, and sensitive to cultural mores and values unique to the different communities of our State.

Outreach teams will focus on building rapport with people living unsheltered, assisting in the resolution of crises, developing a housing assessment, assisting in addressing critical health and behavioral health needs, assist in assembling documentation and other items necessary to obtain housing, identifying income needs and assisting in accessing employment and/or benefit applications, identifying housing preferences, providing support to the process of locating housing, and either providing a warm handoff to housing based case managers when a housing placement has been made or continuing to provide in-home case management until such time as the household stabilizes in housing.

Outreach teams will have access to street medicine teams as well as street-based behavioral health workers and recovery specialists. All teams will include people with lived experience and be reflective of the population experiencing homelessness in the community. Outreach will be fortified by services such as ‘shower to empower’ which allows people living unsheltered to maintain hygiene.

Outreach services will be expanded to include housing problem solving and housing stabilization case management. Once a rapport has been established, outreach teams will identify and resolve barriers to housing, including lack of documentation, access to income, and support in the housing search process. The role of outreach will be expanded and redefined to ensure that people don’t fall between the cracks or lose engagement as they transition from being homeless to housed. The expanded outreach teams will offer comprehensive services and be reflective of people experiencing homelessness in the communities they serve.

Expanded and enhanced HMIS will enable field outreach workers to be able to have immediate access and increased staffing will allow teams to be able to both serve clients and to input real time data into the system. Increased collaboration between the CoC and PHAs in Rhode Island will facilitate access to mainstream housing resources allowing people currently in permanent supportive housing to ‘move-on’ when appropriate or providing immediate access to permanent housing for those without long-term service needs.

Housing stabilization program components will target this critical transition period to provide much needed street-based services and collaboration with Coordinated Entry, filling an enormous gap within system. A dedicated, HMIS Data Quality Specialist will address current challenges with importing data collected by Outreach Case Managers into HMIS, while also anticipating increased data demands related to the broader reach of the program. Access to street-based medicine, will be expanded through new and innovative partnerships and models, reflecting increased awareness at the state and federal level of the importance of these services in connecting individuals to mainstream health and behavioral healthcare services. As always, these projects will be expected to and monitored to assure that they are providing services in a way that is person-

centered, strengths-based, and trauma-informed, while elevating the voices of those with lived experience with a focus on evidence-based interventions such as Harm Reduction and Housing First, aligning strongly with the philosophies and interventions highlighted in this plan.

This plan highlights the following vision for outreach services, which is included here as described in the project application from the House of Hope. The ability to develop and maintain long-term relationships with clients who have been vulnerable, isolated, and wary of systems is an important measure of success in centering client choice. Outreach teams center client choice by meeting people where they are, literally and figuratively, regardless of what is convenient or comfortable. The teams meet people on their terms, their turf, at their pace, as a means of building meaningful, trusting relationships with constituents in the driver seat. Case managers assist clients with (re)connecting to primary care, psychiatry, substance use treatment, and other specialists. The outreach programs will make great efforts to develop and maintain positive relationships with a number of healthcare providers in order to build a strong and reliable referral network. Clients who are entirely disconnected from care may start by engaging with an outreach team's part-time psychiatrist or with one of the medical providers working aboard the Shower to Empower mobile unit, and from there obtain warm hand-offs to mainstream providers in the community.

Case managers walk with clients through a variety of other systems that present hurdles to accessing housing. For many, this includes navigating legal matters (e.g., maintaining conditions of probation, clearing outstanding warrants, navigating immigration, navigating registry and residential requirements associated with sex offender registration). For others, this includes working toward accessing income, either by way of employment or, more commonly, by applying for SSI/SSDI using the SOAR model. To ensure that persons with lived experience are involved initiatives that provide individuals seeking employment with relevant workforce training, internships, and in many cases, employment. This also greatly expands an outreach program's capacity to support individuals in their recovery through the powerful connections that peers with lived experience can uniquely provide.

2. While effective, current street outreach is limited and constrained by limited resources and multiple needs from being able to effectively enter data into HMIS and complete assessments required to access permanent housing. With resources through this special initiative, the HMIS team will expand capacity and provided real time assistance to outreach workers in accessing and entering data into HMIS. Coordinated entry currently prioritizes those with the highest vulnerabilities, which includes people living unsheltered. But in order to be placed on the by-name priority list, a universal assessment must be completed. This can present a barrier as completing the assessment requires a high level of engagement and up to now limited resources made this difficult due to previously described outreach capacity challenges. With expanded outreach and HMIS resources included in this plan and projects selected for funding, these assessments can be completed, and unsheltered persons more rapidly entered into the coordinated entry system to access the resources available that they need.

3. As has been described in this plan, the CoC is proposing to invest significant resources in expanding outreach and successful practices such as Housing Problem Solving (defined above) and innovative models to offer services such as Shower to Empower. Outreach teams will be inter-disciplinary including case managers, peer support workers and clinicians. They will enter data into HMIS in real time. Outreach teams will be linked to housing navigation and housing stability case management. Outreach services will not only engage people living unsheltered but will link to navigation to support the housing search process. To ensure that people supported in housing placement to maintain that housing, the outreach teams will continue working with clients post housing placement to assist in the transition to community living. All outreach workers will be and are

trained in critical evidence-based practices including Motivational Interviewing, Harm Reduction, Housing First, Trauma Informed Care and Critical Time Intervention.

4. This plan proposes to expand outreach services in a coordinated manner so that teams will be able to serve people experiencing unsheltered homelessness in all parts of the State. All outreach teams will be coached in Housing Problem Solving – a solutions-based approach to addressing housing barriers. Outreach teams will be linked to expanded navigation services that will identify new housing opportunities and help persons engaged through outreach to seek housing in the community. Outreach workers will also be linked to housing stabilization case management.

P-6. Involving Individuals with Lived Experience of Homelessness in Decision Making

2. The CoC has had a goal to continue to increase the number of people leading decision-making at the Board and Membership level. Its strategy to do so is multifaceted. The CoC surveys its board and membership regularly for self-identification of lived experience of homelessness. In its application for election to the Board of Directors, the CoC again asks interested candidates to self-identify their lived experience of homelessness. A flyer designed for Membership recruitment of folks with lived experience is circulated for posting in CoC programs during the annual calls to join Membership. The CoC's Governance Committee also conducts outreach to Membership and the Public to encourage and support people with lived experience to join its Board, Membership and Committees. At each election for the Board, the CoC's Governance committee reminds the Membership of its goal to increase lived experience among the Board and report the boards progress towards this goal to inform voting decision making. In 2022, the CoC has 7 persons who self-identify as having lived experience serving on its Board of Directors; there are 17 total Board seats, which means 41% of the CoC board has lived experience of homelessness. This is an increase from 4 people (23%) in 2021.

1. When the CoC decided to plan to specifically address unsheltered homelessness within RI, it convened a working group called the CoC's Unsheltered Planning Group tasked with informing a plan to address unsheltered homelessness and make recommendations to inform project selection. The CoC recognized that, for this planning groups work to be effective, it must be led by those closest to the problem and identified key stakeholders as people with lived experience of unsheltered homelessness and street outreach workers, many of whom are peers with lived experience. Therefore the CoC quickly partnered with the Constituent Coordinating Committee (CAC) and the Statewide Street Outreach group to combine all of their expertise and form the Unsheltered Planning Group. This workgroup ran this initiative for the CoC and designed the CoC's plan to address unsheltered homelessness and the priorities for funding. The work began with setting group commitments to guide the Unsheltered Planning Group's work together and included multiple planning meetings to reflect on the status of the existing system to address unsheltered homelessness and how that system could be improved to better serve people living outside and unsheltered. The workgroup designed a survey of people living unhoused with Rhode Island and designed the incentives the CoC would fund to encourage and appreciate constituents who engaged in the survey. These survey results directed the projects selected during the local competition; all CAC and planning group members without conflict of interest were invited to join the funding committee that scored proposals. The planning group's discussions focused on strategies to reach and serve the most vulnerable: people with severe services needs living within Rhode Island. And finally, discussions highlighted existing gaps in the system for people with severe service needs, and highlighted person centered and trauma informed approaches and strategies to fill those gaps. Every meeting and every group discussion incorporated numerous people with lived experience; and their voices guided the group and led consensus-based decision-making.

The Unsheltered Planning Group's Group Agreements included the following statements, which further demonstrate the CoC and its Planning groups dedication to incorporating lived experience through its decision-making and delivery of services. Agreements were reviewed at the beginning of each meeting to center the group in shared expectations-setting. Unsheltered Planning Group Agreements include but are not limited to:

- Keep lived experience of people experiencing homelessness at the center of the work and recognize they do not always need to be at the center of the attention. We pursue justice-seeking solutions to the growing unsheltered crisis in Rhode Island.
- Create other opportunities for input that may be more accessible for some people at this point in their lives and their housing insecurity (examples: survey, listening session, peer led opportunities)
- Notice privilege and group dynamics: we are all responsible for this space. Be aware of how people are interacting. Name power dynamics in service of building trust and respect. Notice your own privilege, defensiveness, discomfort and resistance.
- Use simple and appropriate language and ask for clarification if needed. Define acronyms for the group in speaking and in chat. Words matter; we will pay attention to our word choice.
- Avoid tokenism: making a minimal or purely symbolic effort to be inclusive to give the appearance that people are being treated fairly.
- Welcome multiple viewpoints: speak from your own experience; listen to understand not craft your next point/argument; ask questions to understand sources of disagreements. Honor the different experiences we all bring into this space.
- Be honest about the strengths and challenges of our system, organizations, etc. We are engaging in this work to identify barriers and solutions.

3. These agreements and the incorporation of lived experience in all policy making and decision making will continue as we pursue and secure funding to achieve our vision and goals. Specifically, this plan requires that, as funding is implemented, we monitor and evaluate our projects funded to assure they are being run in the trauma informed, person centered, low barrier methods described in this plan and each project and agency continues to incorporate multiple methods and processes for incorporating lived experience in their project implementation. This includes but is not limited to: training and employment opportunities within all programs; anonymous survey and feedback opportunities for constituents being served within programs; routine listening sessions with clients enrolled in programs and who recently have exited programming; and peer-led constituent groups informing program's continuous quality improvement.

P-7. Supporting Underserved Communities and Supporting Equitable Community Development

1. As indicated above in this Plan, the CoC HMIS lead has been able to link the HMIS data to that associated with Medicaid claims, unemployment and social services data. Linking HMIS data with data from other systems of care provides a more comprehensive record of the needs of people seeking homeless assistance and helps to identify those populations of people who are not being served at the same rate that they are experiencing homelessness. Specifically, it was determined that Black and Indigenous People of Color were three times more over-represented within the homeless system than the overall RI population. Furthermore, this group had disproportionately high occurrences of HIV, diabetes, and unemployment. Additionally, people who identified as multi-racial were also over-represented in the population that did not receiving a supportive housing resource but did experience homelessness. People identifying as multiracial had disproportionately high rates of experiencing domestic and sexual violence. Indigenous People seeking homeless assistance but not receiving supportive housing had disproportionately higher rates of unemployment, receiving SSI, and traumatic brain injury

To develop this Plan, the CoC also held multiple convenings of its unsheltered planning group with includes people with lived experience, advocates, homeless services providers, and public sector representatives. This group identified a number of groups of people with significant unmet needs who are being underserved by the CoC. Among the populations with significant unmet services needs are:

- Senior citizens. There are significant increases in the need for services among seniors, especially among those who are newly single after the loss of a partner, in rental housing and no longer able to afford it.
- Youth in transition from care. Young people, and especially those with intellectual or developmental disabilities, do not transition well from the youth system to the adult system and are at great risk of becoming homeless.
- People who are active and chronic substance users, including alcohol.

2. Existing services such as street outreach, case management, and to a limited extent, housing navigation, and housing stabilization are already made available to individuals experiencing unsheltered street homelessness with cooccurring disorders and in culturally sensitive ways to the many unique communities being served, as described earlier in this plan. The Street Outreach proposed for Special Funding to Address Unsheltered Homelessness will therefore focus on expanding capacity of this strong model geographically using an intentional, regionalized model. These dedicated teams will deploy regionally, honoring the unique strengths, challenges, and cultural landscapes within each region. Regional Outreach Team Leads will provide additional supports to outreach teams operating in established areas, while building capacity in regions where effective street outreach is less well-established. To ensure that outreach covers the entirety of the state, it has been divided into regions to be served by at least one program.

3. This Plan proposes to address these disparities in accessing care through a more coordinated and comprehensive approach to outreach. The creation of Regional Outreach Team Leads will provide dedicated, focused, and locally knowledgeable points around whom outreach efforts will be centered. Individuals in these positions will engage in street-based outreach with teams of outreach case managers, partners, peers, and volunteers. Equally important these individuals will coordinate efforts within the community, provide ongoing supervision, ensure effective collaboration amongst regional partners and engage in training, capacity building and technical assistance. These positions will be filled by individuals from within those communities. Acknowledging ongoing struggles with importing data collected in outreach settings into HMIS as well as awareness of an increased data burden of broader outreach efforts, there will be an Outreach HMIS Data Quality Specialist position to ensure timely, accurate, and complete HMIS data entry.

Additional program elements, intended to help individuals to obtain and maintain permanent housing will be the addition of housing stabilization case managers who will serve as a bridge between outreach and housing stabilization teams to assist unsheltered individuals in accessing housing and then transitioning from street-based to home-based supportive services.